Derbyshire Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY, 14 JANUARY 2025 TO COMMENCE AT 9.30AM
CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY, DE22 3LZ

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and declarations of interest 1.1 Trust Vision and Values 1.2 Register of Interests 2024/25	Selina Ullah
PATIENT STORY			
2.	9.35	Staff Story – International Educated Nurses	Tumi Banda
STANDING ITEMS			
3.	10.00	Minutes of the Board of Directors meeting held on 5 November 2024	Selina Ullah
4.		Matters arising – Action Matrix	
5.		Questions from members of the public	
6.	10.05	Chair's update	Selina Ullah
7.	10.15	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE			
8.	10.25	Integrated Performance report, to include Finance, People and Quality	Vikki Ashton Taylor/ Tumi Banda/Rebecca Oakley/James Sabin
11.00am BREAK			
STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
9.	11.10	Trust Strategy Progress Update	Vikki Ashton Taylor
QUALITY GOVERNANCE			
10.	11.20	Fundamental Standards of Care	Tumi Banda
BOARD COMMITTEE ASSURANCE			
11.	11.30	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES			
12.	12.00	<u>Quality and Safeguarding Committee</u> 12.1 Learning from Deaths/Mortality Report 12.2 Guardian of Safe Working Hours Report <u>Mental Health Act Committee</u> 12.3 Patient and Carers Race Equality Framework	Lynn Andrews Deborah Good
CLOSING BUSINESS			
13.	12.10	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
14.		Meeting effectiveness	
FOR INFORMATION			
Forward Plan 2024/25 Glossary of NHS Acronyms Summary of Council of Governors meeting held 5 November 2024			

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

The next meeting will be held on 4 March 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway. Arrangements will be notified on the Trust website seven days in advance of the meeting.

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

Strategy on a page

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision

We make a positive difference in everything we do

Our strategic priorities

Patient focused

Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.

Partnerships

We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.

People

We will attract, involve and retain staff creating a positive culture and sense of belonging.

Productive

We will improve our productivity and design and deliver services that are financially sustainable.

Our values

Caring

We provide safe care and support people to achieve their goals.

Inclusive

We respect everyone in all we do.

Ambitious

We offer high quality services, and we commit to ongoing improvement.

Belonging

We come together to create a culture that is welcoming, open and trusting.

Collaborative

We work together to achieve the best outcomes for our people and communities.

WE MAKE A POSITIVE DIFFERENCE • IN EVERYTHING WE DO •

Find out more

derbyshirehealthcareft.nhs.uk/about-us/strategy

Our vision, values and strategic priorities are central to everything we do. They are the 'thread' that ties together all our work, explaining how we can best serve the people of Derby and Derbyshire and support each other. How does your role form part of that thread?

DECLARATION OF INTERESTS REGISTER 2024/25		
NAME	**INTEREST DISCLOSED**	**TYPE**
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Magistrate, covering mainly Derbyshire and Nottinghamshire Courts	(e)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore, Derby	(e)
Ashiedu Joel *(until 31-Jul-2024)* Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council • Fellow, Society for Leadership Fellows Windsor Castle • Elected Member, Leicester City Council • School of Business and Law Advisory Board Member, De Montfort University • Independent Chair, Derby and Derbyshire Drug and Alcohol Strategic Partnership • Justice of the Peace, Leicester, Leicestershire and Rutland Magistracy	(a) (a) (a) (a) (a) (a) (a) (a) (e) (e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environments	(e)
Selina Ullah Trust Chair	• Non-Executive Director, Solicitors Regulation Authority • Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(a) (e) (e) (e) (e) (e) (e)
All other members of the Board of Directors have submitted a nil return, meaning they have no 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).

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday, 5 November 2024

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 11.59pm

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust Chair
	Ralph Knibbs	Senior Independent Director
	Lynn Andrews	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professionals, Quality and Patient Experience
	Dr Arun Chidambaram	Medical Director
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Associate Director of Communications and Engagement
DHCFT2024/089	Jill Nelson	Guest for Patient Story
DHCFT2024/089	Joe Thompson	Assistant Director of Clinical and Professional Practice
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Deborah Good	Non-Executive Director
	Rebecca Oakley	Director of People, Organisational Development and Inclusion
OBSERVERS	Jim Austin	Chief Executive, Derbyshire Community Health Services (DCHS) NHS Foundation Trust
	Fiona Birkbeck	Public Governor, High Peak and Derbyshire Dales
	Rachel Yates	Living Well Practice Lead

DHCFT/ 2024/088	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah, welcomed Board colleagues and observers to today's meeting. Apologies were as stated. There were no declarations of interest with any agenda items. However, Lynn Andrews, Non-Executive Director, asked for it to be noted that with effect from 31 October 2024, she is no longer a Trustee of Ashgate Hospice.
DHCFT/ 2024/089	**PATIENT STORY "MY PERSONAL JOURNEY FROM DERBYSHIRE RECOVERY PARTNERSHIP TO RECOVERY THROUGH NATURE (RTN)"** Joe Thompson, Assistant Director of Clinical and Professional Practice introduced Jill Nelson, who was to share her positive experience of recovery.

The Board of Directors noted that following some life obstacles, Jill had been a drinker for 17 years. Jill explained that she started to have concerns around her mental health, however, a request for a bipolar/psychology referral was rejected due to the mention of alcohol. Thereafter, Jill's GP recommended she self-refer to Derbyshire Recovery Partnership.

Jill recalled the initial telephone contact with Ann, Key Worker, which had put her at ease and was followed up by a face-to-face appointment in April 2023. Despite being full of trepidation and scepticism about the appointment, Ann had made Jill feel safe through listening and reassurance.

Ann introduced Jill to eye movement desensitisation and reprocessing (EMDR) to help deal with past trauma. which proved to be very effective and supported her abstinence from drinking completely. The Board applauded Jill's announcement that she has been 19 months without a drink.

To sustain recovery, Ann recommended 'Recovery through Nature (RTN)', which is a highly effective therapeutic programme that engages teams of people in a range of practical conservation and horticultural projects to aid their recovery.

Jill highlighted her uncertainty and readiness, at that time, to meet new people who are in recovery and initially, was reluctant to participate. It had taken a good deal of encouragement from Mark, RTN Lead, Phoenix Futures, who continued to reach out to encourage her. When Jill eventually attended, she declared it was one of the best decisions she has ever made; she now attends four times a week and is hoping to become an official volunteer very soon.

The Board noted that there are challenges with room availability as the current venue is inadequate to meet the demand of service users and Jill stressed the importance of face-to-face interaction.

In conclusion, Jill extended her gratitude to Ann and Mark for their continued efforts to help her become a changed person.

Selina thanked Jill for her inspiring story and Arun Chidambaram, Medical Director recognised the optimism, insights and how social prescribing had made a significant difference to Jill's life.

Lynn asked for more detail on the venue challenges and was interested to learn what had changed Jill's mind, following her early reluctance. Jill explained that due to the high number of simultaneous appointments with key workers, the available rooms are commandeered on a first come-first served basis. She added that the St Mary's Gate venue is quite old and that some appointments take place at the Derbyshire Addictions Advice Service (DAAS) at New Square, Chesterfield, which is modern, air conditioned and more appropriate.

In relation to Lynn's second question. Jill advised it was due to Mark's continued tenacity to engage with her, via 'phone calls and messages, which encouraged Jill to attend.

It was noted that all those involved with RTN have some kind of addiction and there is no judgement. Jill highlighted that some people have never taken a moment to enjoy nature, listen to the birds and smell the rain, all of which had been embraced the previous day, whilst working in the garden. She reflected on the positive feeling when the produce is thriving. She added that this is an inspirational venture, everyone encourages each other and is made to feel worthwhile.

Mark Powell, Chief Executive, praised Jill for the brave and motivating account. He added that the Board is aware of the building issues and he appreciated the feedback, which describes the good partnership between the Trust and Phoenix Futures.

	Selina appreciated the stigma around addictions and advocated that Jill's voice would be of great encouragement for others. She added that the GP had made a great suggestion, as the bipolar pathway may not have led to the success realised through social prescribing. **RESOLVED: The Board of Directors was greatly inspired by Jill's story and keen to address the challenges around a suitable venue.**
DHCFT/ 2024/090	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 1 October 2024 were accepted as a correct record of the meeting.
DHCFT/ 2024/091	**ACTION MATRIX AND MATTERS ARISING** The Board reviewed and closed the completed action. Due to the absence of Rebecca Oakley, Director of People, Organisational Development and Inclusion, it was agreed the update in relation to DHcFT/2024/078 would be carried forward to January 2025.
DHCFT/ 2024/092	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2024/093	**CHAIR'S UPDATE - VERBAL** The Board was provided with Selina's reflections on activity since the previous Board meeting on 1 October 2024. Selina reported that within NHS Providers, of which she is a Trustee, the emphasis has been on the new Labour Government, the dynamics between the different departments and how information from Provider surveys feeds into policy discussions with Ministers and their offices. She was pleased to recognise that NHS Providers champion Mental Health and Children's services and members work hard to raise the profile. In relation to the Integrated Care Board's role, Selina indicated that the Government is keen for them to focus more on transformation. However, she questioned if the changes are achievable through the Integrated Care Systems as many are overspent. The tremendous pressure on leaders was noted, along with the need to take necessary risks and that making efficiencies can provide part but not all of the solution. At a local level, Selina advised that Julie Houlder, Chair, Derbyshire Community Health Services (DCHS) Foundation Trust, has convened a Chairs and Chief Executive Officers Group and that she and Mark attend. The Board noted that further to a change of members over the last 12-18 months, there has been a leap from conversation to practical action, which is welcomed. It was noted that one of the Trust's Governors, Alison Martin, who is also Councillor and Council Cabinet member for Adult Social Care and Health, Derby City Council and Robyn Dewis, Director of Public Health, Derby City Council, had met with Selina and Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, to discuss the challenges faced and the best outcomes for relevant, vulnerable groups. Selina was encouraged to share that Councillor Martin took away a number of issues to raise with the commissioners, thus supporting external focus. Following attendance at certain stakeholder meetings, Tony Edwards, Deputy Chair, observed that some ICBs are leading the way, however, recent discussions at the Finance and Performance Committee highlighted that there is a lack of clarity and often activity direction, framework and principles are unclear. He applauded the voice Selina gives to improve the situation in Derbyshire and stressed the urgency.

	Mark pointed out the ICB is not in attendance at this meeting, it is purely providers. He added that the consensus for clarity and direction is wider than Derbyshire and the East Midlands and that a framework is essential. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT/ 2024/094	**CHIEF EXECUTIVE'S UPDATE** Mark's report provided an update on current local issues and national policy developments. The report also reflected a wider view of the Trust's operating environment. Following on from Selina's update around the wider political arena, Mark drew attention to the 10-year Health Plan, the context of which is the Lord Darzi's independent review of the NHS. He informed that the Department of Health and Social Care and NHS England want the public and staff to share their experiences and ideas to help reimage the NHS. It was noted that a regional engagement event will take place on 28 November, followed by system-wide and internal engagement. Mark stressed these events present an ideal opportunity to raise the profile of Mental Health, Learning Disabilities, Children's and non-acute services. The first meeting under the National Oversight Framework (NOF) Segment 3 was held in September and Mark was satisfied this had been productive in agreeing the exit criteria for the Trust to revert to Sector 2. Having reviewed the tender documentation for the provision of Talking Therapy services (IAPT), Mark was saddened to announce a bid will not be submitted. He explained that due to the financial envelope, it is no longer possible for the Trust to provide these services. It was noted that the Trust is working with the ICB to ensure a good and safe transition throughout 2024/25 to the new provider(s) and that IAPT staff will transfer over with protected employment rights. Mark expressed his delight that the Trust's new Strategy is being presented for approval today, recognising that this is an important milestone and he extended his thanks and appreciation to all colleagues involved. Finally, Mark gave a high-level summary on the Making Room for Dignity (MRfD) programme and informed that Audrey House is almost completed and the Bluebell Ward is expected to open shortly. It was noted that a small number of specification changes have resulted in in a short delay for both Adult Acute Units, which are expected to open spring 2025. Mark explained that unforeseen construction issues have led to exceptionally noisy work for extensive periods of time and this has impacted on patient care. He announced the decision to pause work until patients have moved over to the new unit. It was noted that this sensible decision will slightly delay the overall programme and the Trust is reviewing the financial impact. In relation to the 10-year plan, Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, emphasised the inclusion of the patient experience perspective is critical for the national engagement. Lynn queried the communications strategy around the MRfD delays and Mark responded that initial messages were issued at the end of August these have now been formalised. He added that face to face feedback from staff has been positive and there is agreement that this is the right decision for patient care. It was noted that the Communications team is working to ensure awareness. Vikki highlighted that staff on the Radbourne Unit led the work on managing the noise issues and have driven some of the decision making.

	Consideration was given to the required transformational change as part of the 10-year plan and the challenge for people to undertake extra work along with their existing duties. It was noted that the Trust has allocated a small team of individuals, with very clear roles, to focus on delivery, therefore, there should be no impact on main roles. **RESOLVED: The Board of Directors is requested scrutinised the report and sought further assurance around any key issues raised.**
DHCFT/ 2024/095	**<u>FOCUSED PERFORMANCE REPORT</u>** Selina stated that this item is slightly different from the regular Integrated Performance Report as this was presented at the previous Board meeting on 1 October. Vikki explained the purpose of this report is to provide a focused review of performance around improving flow in Adult Acute services and to summarise the current financial position and safety improvements. It was noted that the report covers deep dive work to improve patient flow during the period April to September. Subsequentially, there has been a significant increase in demand and Vikki stressed consideration of the work prior to this is important. The Board noted that the multi-agency discharge event (MADE) undertaken in May had led to a number of improvements, such as increased in-home treatments, a different support package, the introduction of a Children's 3.5 service and decreased requirement for non-local beds. However, Vikki reported an increase in admission to inpatient beds and in the number of those placed out of area. She added that the system has struggled with the ability to discharge those patients who are clinically ready for discharge (CRFD) which would free up beds. This is an ongoing challenge for 10 patients, found to be CRFD in May, as there is no suitable care available. Tony welcomed the approach taken as it demonstrates engagement and a willingness to improve. He congratulated Vikki and the team for retaining focus and taking steps to address when not sustained. Arun highlighted the Trust is working with system partners and progress has been made with re-admission rates. Referring to 'inappropriate' to 'appropriate' out of area care, Geoff Lewins, Non-Executive Director, observed the continued additional cost. Vikki concurred and added that the Trust had made a conscious decision to utilise out of area beds to support transition to the new builds. In response to a further query from Geoff, it was noted that the 12-hour Emergency Department Breach measurement had been adjusted prior to August 2024 and this is reflected in the report. The immense pressures were discussed further, in relation to demand, indicating a significant change over the last two to three weeks, especially in relation to those patients Clinically Ready for Discharge. Mark made a plea for Board support with formal escalation. Tony stated that Board support needs to be more formal. Vikki detailed some of the factors in and outside of the Trust's control, such as natural peaks in demand, ability to flex delivery of services, environmental and system pressures. She stressed the need to recognise the significant financial pressure that other organisations are under, which impacts on decision making and she stated that no-one would want their loved one in an inpatient bed when they are well enough to be discharged. It was noted that there is an under-utilisation of crisis beds and the Trust is working with clinical colleagues to review suitability, as the beds commissioned do not meet the needs of mental health patients.

	Tumi summarised improvements in safety, in particular a restrictive practice project which is progressing well. He shared that an area of concern has been around seclusion, and following input from the CQC and Experts by Experience, improvements are evidenced with reduced episodes of seclusion, physical restraint and self-harm/ligature incidents. Tumi added the preference is for a more therapeutic approach, rather than rather than enhanced observations. It was further explained that the majority of patients use personal items, such as clothing, leggings, belts, socks, laces and under garments. The risk assessment and care plans are put in place to manage the danger whilst also maintaining the patient's dignity. It was noted that the opportunity to talk to people and staff interventions have helped to manage restrictive practices. James Sabin, Director of Finance, gave a brief overview of the financial position which is on plan at Month 6. In order to achieve the forecast, a key assumption is delivery of the Cost Improvement Programme in full, with all gaps mitigated. It was noted that there is overspend due to the out of area and CRFD issues. Mark alerted that there is pressure from the system to deliver an even better position than that already agreed. **RESOLVED: The Board of Directors accepted limited assurance on current performance across the areas presented.**
DHCFT/ 2024/096	**<u>APPROVAL OF NEW TRUST STRATEGY – 2024-2028</u>** The final draft of the new Trust Strategy 2024-2028 was presented for approval. Vikki thanked Anna Shaw, Associate Director of Communications and Engagement and her team for their help. The series of engagement events which have supported the work were highlighted by Lynn and she was keen to understand how the Strategy is to be launched. It was noted that on approval, the next steps will be a significant launch process across the organisation and ongoing engagement to develop delivery plans against the key components of the Strategy. Tony recognised the quality of the Strategy and the amount of engagement, ensuring it has been developed in an open and transparent way. However, he emphasised the importance to swiftly complement with the measures and action plans. Mark referred to the Board Development Session scheduled for 18 December and the plan to follow up from the October session with all leaders to work on the timelines and detail. It was agreed that the impetus needs to be maintained and ownership encouraged across the organisation. **RESOLVED: The Board of Directors approved the new Trust Strategy.**
DHCFT/ 2024/097	**<u>TRUST SEALINGS (SIX-MONTHLY, FOR INFORMATION)</u>** This report provided the Board with a six-month update of the authorised use of the Trust Seal since the last report on 7 May 2024. As the size of the organisation's contract values have grown, Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, reported that a review of the Trust's Standing Financial Instructions has allowed a more practical method for the signing of contracts, which will result in fewer entries. **RESOLVED: The Board of Directors noted the Trust seal report.**

DHCFT/ 2024/098	**BOARD ASSURANCE FRAMEWORK (BAF) UPDATE, ISSUE 3, 2024/25, VERSION 3.3** The Board was presented with the third issue of the BAF for 2024/25. It was noted that approval of the new Trust Strategy provides the opportunity to revisit and align the risks and mitigations. Justine highlighted that the updates in this issue related to: • The expected Lord Darzi report • Review of Community Mental Health – Nottinghamshire Healthcare recommendations • National Oversight Framework – Level 3 • Making Room for Dignity (MRfD). In his capacity as Chair of the Audit and Risk Committee, Geoff observed that a lot of actions have rolled over to the following quarter and he suggested there should be increased focus on completion dates. Mark agreed this is a valid challenge and that the column heading, 'expected completion or (review)' is ambiguous; as such this will be reviewed. **Action, Mark.** Tony commented that the new Trust Strategy presents a great source of energy and fresh thinking and suggested this is deliberated collectively. **RESOLVED: The Board of Directors:** **1. Reviewed and approved this third issue of the BAF for 2024/25 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives** **2. Agreed to continue to receive updates in line with the forward plan for the Trust Board.**
DHCFT/ 2024/099	**BOARD COMMITTEE ASSURANCE SUMMARIES** Summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: **Finance and Performance:** Tony Edwards, Committee Chair, gave a verbal update on yesterday's meeting, at which a thorough discussion had taken place around the Estates Strategy and MRfD programme. It was noted that engagement with the Gateway Review had elicited positives from the challenges and learning opportunities. Tony echoed agreement with James' earlier statement that the financial plan is becoming progressively harder to achieve. Reference was made to Maria Riley, the newly appointed Assistant Director of Transformation and Tony welcomed the structure and process implementations. It was noted that the Health and Safety Annual report supports good progress. In conclusion, Tony declared the Trust's exit from managing IAPT services, reflects a major change. **People and Culture Committee:** Ralph Knibbs, Committee Chair, outlined September's discussions, including Deep Dives for Employee Relations, Sickness Absence and Triangulation of Leaver data for AHPs. He acknowledged the benefit of Lynn and Tony being present at meetings, to provide Quality and Safeguarding and Finance and Performance perspectives, especially in relation to MRfD consideration and triangulated oversight. It was noted that the WRES and WDES Action Plans have made slow progress and this is to be accelerated over the next 12 months. **Quality and Safeguarding Committee:** Lynn Andrews, Committee Chair, reflected on the very strong progress made following the CQC inspections and the ambition to ensure this is disseminated across the organisation. In addition, Lynn highlighted a change in terminology

	from Junior to Resident Doctor and confirmed the Trust is compliant with the Health and Social Care Act Infection Prevention and Control (IPC) requirements. Justine applauded the full assurance agreed for Quality and Equality Impact Assessment (QEIA) and remarked positively at the inclusion of the Director of Nursing update, which provides a fresh outlook. **Audit and Risk Committee:** Geoff Lewins, Committee Chair, stated all items covered in the meeting were generally positive, he emphasised that objectives set in the Risk Management Strategy are being met and that the implementation of the Freedom to Speak up framework is well managed. Attention was drawn to Operational Risk Management and concerns at the number of overdue risk reviews. However, it was noted that Kel Sims, Risk and Assurance Manager, is driving improvement. The importance of data security and quality was pointed out, along with the necessity to follow defined Standard Operating Procedures. Where there are concerns around overdue risks and/or irregular review, Lynn recommended Deep Dives may aid resolution. **Mental Health Act Committee:** In the absence of Deborah Good, Committee Chair, Geoff outlined the key points from September's meeting, which included limited assurance on the reading of rights due to data quality issues and missed deadlines. It was noted that the Training Report had provided inadequate data and the Committee expected a complete set for the next presentation. Selina asked if this was an ongoing problem and Arun responded that it was a pre-existing issue and that a joined-up approach for assurance is being worked on. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT/ 2024/100	**<u>REPORTS FOR NOTING ON ASSURANCE FROM THE QUALITY AND SAFEGUARDING COMMITTEE</u>** These reports were received for information and noting, having previously provided assurance to the Quality and Safeguarding Committee. **<u>Guardian of Safe Working Report</u>:** This quarterly report from the Trust's Guardian of Safe Working (GOSW) provided data about the number of resident doctors in the Trust, full transition to the 2016 Resident Doctor contract (Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016) and any issues arising therefrom. The paper detailed arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation. **RESOLVED: The Board of Directors:** **1. Supported the transition to using the term 'Resident Doctor' in place of 'Junior Doctor'** **2. Noted that the Quality and Safeguarding Committee accepted significant assurance that that the duties and requirements as set out in the 2016 Resident Doctor contract are being met.** **<u>Learning from Deaths/Mortality Report</u>:** The Quality and Safeguarding Committee regularly receives and scrutinises the Mortality Report. This report covered the period 1 April 2024 to 31 July 2024. **RESOLVED: The Board of Directors:** **1. Noted that the Quality and Safeguarding Committee accepted significant assurance of the Trust's approach** **2. Agreed for the report to be published on the Trust's website as per national guidance.**

	Annual Report – Children in Care/Looked After Children: This report provided an overview of the progress, challenges, opportunities, and future priorities to support and improve the health and wellbeing of Children in Care in Derby City. It was noted that this is an assurance report to provide the Trust with scrutiny of how this service is discharging its legal duties and clinical standard requirements. **RESOLVED: The Board of Directors:** **1. Noted that the Quality and Safeguarding Committee received significant assurance of the work within the Trust around Children in Care 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. Noted that the Quality and Safeguarding Committee accepted the annual report and agreed on the key priorities set for 2024/25.** **Annual Report – Safeguarding Children and Adults at Risk:** The Annual Report is a governance requirement of both the Trust and the Safeguarding Children Partnership and Adult Safeguarding Boards. It provides assurance that the Trust is meeting its legal and statutory performance and governance requirements. Lynn drew the Board's attention to the significant amount of work taking place within the Safeguarding team, particularly in relation to children and that the team is at capacity. **RESOLVED: The Board of Directors received the Safeguarding Children and Adults Annual report which was offered by the Quality and Safeguarding Committee with significant assurance regarding the fulfilment of legal and statutory duties.** **Annual Report - Special Educational Needs and Disabilities (SEND):** This report meets the quality requirement in the schedule from the Derby and Derbyshire Integrated Care Board (ICB) to provide an annual report. **RESOLVED: The Board of Directors received the Annual SEND report which was offered by the Quality and Safeguarding Committee with significant assurance on progress and the actions to address the gaps.** **Annual Report - Infection Prevention and Control (IPC) Report 2023/24:** This report outlined Trust compliance with the Infection Prevention Control Board Assurance framework as part of the Trust's regulatory compliance in accordance with the Health and Social Care Act. **RESOLVED: The Board of Directors:** **1. Noted the reporting of key areas, such as surveillance of healthcare associated infections – alert organisms, outbreaks of infection, staff training** **2. Noted that the Quality and Safeguarding Committee received significant assurance that approaches and learning are evolving in accordance with emerging evidence and international/national and regional learning** **3. Noted that the Quality and Safeguarding Committee received significant assurance on standards of cleanliness of clinical areas and food preparation areas.**
DHCFT/ 2024/101	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** There were no changes identified.
DHCFT/ 2024/102	**MEETING EFFECTIVENESS** Jim Austin, Chief Executive, Derbyshire Community Health Services (DCHS) NHS Foundation Trust, expressed thanks for the opportunity to observe today and he recognised similarities with DCHS around the issues, concerns and shared learning opportunities.

	Fiona Birkbeck, Public Governor, High Peak and Derbyshire Dales, had been particularly interested in Jill's story and experience with social prescribing. The Board agreed that the Focused Performance Report had been a highlight and it was suggested that to replicate this, the Integrated Performance Report could be developed and aligned with the new Trust Strategy, with emphasis on progress. Rachel Yates, Living Well Practice Lead, reflected on the Trust Strategy and was interested to understand plans for the launch. Anna confirmed there are a few different ideas to embed the Strategy in the coming days and longer term. Mark extended a plea to colleagues to limit the use of acronyms within the public arena.
The next meeting to be held in public session will be held in person on 14 January 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS - JANUARY 2025							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
05-Nov-2024	DHCFT/2024/098	Board Assurance Framework (BAF) Update, Issue 3, 2024/25, Version 3.3	Justine Fitzjohn	Revisit and clarify the column heading wording in the BAF (expected completion or review) to avoid ambiguity and increase focus on completion dates.	14-Jan-2025	Please be advised that where a deadline has been set, this is noted in the column. If it is not possible to identify a completion date, the next review date is shown in brackets in the column. This reflects the column heading '**Expected completion or (review)**'. This is explained in the key on the BAF. Action Owners consider all deadlines and review dates every quarter as part of their Director updates. The Director Leads can help with any queries in relation to specific actions.	Green

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

Trust Chair's update

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with, and for, the Trust since the previous Board meeting on 5 November 2024. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. On 20 November we had our 2024 HEARTS Staff Awards at Kingsway. It was a wonderful opportunity to acknowledge and celebrate the fantastic work of our colleagues and teams who go over and beyond the call of duty. I was particularly humbled by our lifetime achievement award to the Occupational Therapists, Jan Nicholson, Elaine Rickett and Janet Taylor, who collectively had 120 years' service between them, having developed and implemented many innovations in practice as well as advising regionally and nationally during the course of their careers. The Long Service Award went to Balbir Kaur who has worked for the Trust for 50 years. After the celebration, in a very matter of fact approach, she said, '*right, I need to go for my shift now*'. Our Communications and Engagement team and Shirley Houston in particular worked tirelessly behind the scenes and on the day to make this a very special occasion for everyone. A big thank you to her and the Communications team.

2. I undertook some service visits with Justine Fitzjohn, Director of Corporate Affairs, Trust Secretary and Senior Information Risk Owner (SIRO) on 26 November to the Addictions services in Chesterfield, Adults of Working Age Neighbourhood team in Bolsover, Dementia Rapid Response team (DRRT) and In-Reach Home Treatment team (IRHTT) in Chesterfield and North East Scarsdale House. On 27 November, Tony Edwards, Deputy Chair, and I also visited the Community Perinatal Mental Health team and Killamarsh Community Mental team. On both days we spoke to a mix of staff from the service managers, clinicians and consultants to the admin teams and were impressed by their pride and passion for their services and patients. They highlighted the quality improvement and service transformation they had instigated and the strong team ethos in each of the team and they felt connected to the Trust. On behalf of Tony, Justine and myself, I would like to convey heartfelt thanks to all who spoke to us.

3. On 3 December, I visited the Research and Development team and learned about the wide-ranging ways the team supported clinicians in research as well as putting the Trust at the forefront of cutting edge research and engagement activities. I was interested to hear about the clinical trials the Trust is involved in and how they can facilitate access to new drugs/medicines which are often very costly. These service visits give me, the Non-Executive Directors (NEDs) and the Executive Directors further insight and opportunity to triangulate board reports and hear directly from our colleagues about their challenges and achievements.
4. On 11 December, Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, and I went to assess the entries at the Radbourne Unit for the Christmas Decorations Competition. Our NEDs and Executive colleagues have been busy doing this too. It is a fiercely battled competition with teams and patients showing great creativity, engagement and truly brings the festive cheer to our services and environment. We visited Medical Education, the Hope and Resilience Hub, Jackie's Pantry, the Beeches, Perinatal Community South team, and Wards 33, 34 and 36. Vikki and I were particularly impressed by the engagement of patients in the making and displaying of the Christmas decorations and the strong sense of inclusion expressed by a very diverse group of patients on one ward in particular, who showed us their work and spoke of their sense of safety and inclusion on the ward.
5. Finally, I would like to thank all our colleagues for their ongoing commitment and dedication shown to the Trust and our patients and service users. A special thank you to our colleagues who worked through the Christmas and New Year break keeping our patients and services users safe, helping them to stay well and connected to our services as per their individual need.

Council of Governors

6. I have continued to meet Governors both formally and informally. We met face to face for a coffee and catchup at Kingsway on 21 November and 26 November in Chesterfield at Bayheath House and an online meeting on 9 December. The Governors and I find these sessions useful and it helps to foster our understanding of each other's perspectives.
7. On 25 November, I met with our Staff Governors, Jo Foster, Sifo Dlamini, Claire Durkin and Marie Hickman, as part of our bi-monthly catch ups. This gives me and them the opportunity to pick up on any issues that may require attention as well as hear from them how colleagues are feeling with new developments, any changes and the general sense of wellbeing and challenge within the organisation.
8. On 3 December, I met with Susan Ryan, Lead Governor, Hazel Parkyn, Deputy Lead Governor and Denise Baxendale, Membership and Involvement Manager. These meetings are an important way of building the relationship and understanding of the working of the Board and the Council of Governors. At our meeting, I received an update on the preparations for the Governor elections taking place soon. Hazel also raised some concerns she had picked up regarding the Integrated Care Board (ICB) Public and Patient Mental Health Engagement Group, which has been disbanded as it reviews its governance arrangements, as well as some issues around access and support for people in crisis in Swadlincote. I am grateful to our Governors for all their work and for ensuring the needs of their constituents and all Derbyshire communities are at the forefront of our service planning and delivery.
9. The Governance Committee, chaired by David Charnock, met on 4 December. This was David's final meeting as he has taken retirement from the University of Nottingham, and he was the Appointed Governor representing the University.

David has been an active member of the Council of Governors and was involved in the Nominations and Remunerations Committee. He helped with recruitment of nearly all of the NEDs and the Trust Chair. I would like to extend my thanks to him on behalf of the Board for his service to the Trust and wish him success in the next chapter of his life.

10. The Nominations and Remunerations Committee met on 10 December to agree the recommendation of the preferred candidate for the position of NED to the Council of Governors for approval.

11. An extraordinary Council of Governors meeting was held on 11 December to approve the recommendation for the appointment of Andrew Harkness as a NED to the Board of Directors.

12. The next meeting of the Council of Governors will be on 4 March, following the Public Board meeting on that day. The next Governance Committee takes place on 5 February.

Board of Directors

13. Much of November and early December was taken up with the recruitment to the NED vacancy on the Board of Directors. Justine, in her capacity as Trust Secretary, and I spoke to several interested candidates resulting with 34 applications. We shortlisted five candidates for interview. With the help of Susan, Fiona Rushbrook, Staff Governor and Lead Occupational Therapist, Brian Edwards, Governor for Buxton and Kalwran Sangha, Recruitment Inclusion Guardian and Operational and Clinical Lead, and two stakeholder groups with representation from EQUAL, Executive colleagues, Governors, Staff Networks and NED colleagues, we successfully recruited Andrew Harkness to the role, as outlined above. My thanks to everyone involved in the recruitment process, in particular to Justine and Alex Dougall, Strategic Recruitment Lead, who supported and advised me throughout the process.

14. On 20 November and 18 December, the Board held development days. These sessions enable the unitary board to come together and discuss key operational developments and risks, as well as explore the medium and long term priorities in a less formal context allowing for the development of ideas and approaches to matters that are either pressing or linked to strategic priorities and risks.

15. On 9 December, the Confidential Board meeting was held. The Board was appraised of a number of matters linked to the delivery of priorities.

16. I continue to meet with my NED colleagues on a quarterly basis to review their objectives, development needs and to discuss their perspectives on how the Board and Trust is delivering Trust priorities. This quarter, I met with Deborah Good, Ralph Knibbs, Geoff Lewins and Lynn Andrews.

17. On 13 December the Board Remuneration and Appointments Committee received reports on plans for recruiting to the existing Executive vacancies. We also discussed the requirements of a Board Development Programme following the Well Led Review recommendations and Board member training compliance, which I am pleased to report is fully green.

18. We held our Board Development session on 18 December. The day focussed on developing priority actions for implementing the strategic priorities in the Trust Strategy. The session was attended by the senior management team including our clinicians.

System Collaboration and Working

19. The four Derbyshire Provider Chairs continue to meet. On 12 December, the Chairs shared their challenges which are mainly in relation to the financial deficit position of the Integrated Care System.

20. The Chairs and CEOs of providers met for the Joined Up Care Provider Collaboration Board meeting on 25 November. Both Mark Powell, CEO, and I were unable to attend, however, Tony attended on our behalf. The meeting held on 16 December covered an update on Enabling Services, looking at wider collaboration in particular service areas using the learning and experience from other service collaborations, eg Neurodevelopment Learning Disabilities (NDLD), an update on Patient-Led Assessments of the Care Environment (PLACE) development and transformation, and the governance arrangements to support this.

21. I have continued to meet regularly with the Chairs of the East Midlands Alliance of Mental Health Trusts, which has been a very useful source of sharing best practise and peer advice.

22. On 13 January, Mark and I met with Chris Clayton, CEO, ICB and Kathy McLean, Chair, ICB, which is part of a series of scheduled meetings going forward as a means of keeping each other appraised of what is going on within our respective organisations and as a means of staying connected to wider system developments and pressures.

Regulators, NHS Providers and NHS Confederation and others

23. On 6 November, I joined an extraordinary board meeting of NHS Providers to approve the appointment of Professor Sir Terence Stephenson, as the new Chair of NHS Providers. He is currently the Chair of the Health Research Authority and takes up his new role with NHS Providers in February.

24. On 12 and 13 November, I attended the NHS Providers Annual Conference in Liverpool, along with Mark, James Sabin, Director of Finance and Justine. This event was well attended by NHS Chief Executives, Executive Directors, Chairs and Non-Executive Directors. We heard from both Wes Streeting, Secretary of State for Health and Amanda Pritchard, CEO of NHS England. They shared their expectations and priorities for the NHS, the three shifts and the forthcoming 10-Year Plan, together with the continued emphasis on productivity and financial balance.

25. I attended the NHS Providers Board meeting on 4 December, where we discussed the operational plan and the new strategy and alignment with government priorities.

26. I continue to join the NHS Confederation Chairs weekly online meetings, where the key items for discussion centre on policy and operational issues with external speakers. These meetings are both informative and a means of support for Chairs of Mental Health and Learning Disabilities trusts.

27. I have attended regular briefings from NHS England for the Midlands region. The emphasis in the most recent meetings has been on winter planning, ambulance waits, winter vaccinations and financial sustainability. The drive for elective recovery continues and the need to work as a whole system in managing the ongoing pressures. The planning guidance and the financial allocations for 2025/26 was expected prior to the Christmas break with an expectation that the process will be more streamlined than previous years and submissions are due in late January 2025.

28. I have also joined the weekly calls established for Chairs of Mental Health trusts hosted by the Mental Health Network in collaboration with the Good Governance Institute.

29. On 8 January I chaired the NHS Providers, Race Equality Advisory Committee.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

Covered as part of the individual items.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work. I have supported the work of the Trust in promoting an inclusive culture and an inclusive Board. I have instigated a Board Development Programme on inclusion which will assist in developing the Board's understanding and response to the inclusion challenges faced by many of our staff.

With respect to our work with Governors, we work actively to encourage a wide range of nominees to our governor elections and strive that our Council of Governors is representative of the communities they serve.

We also provide support to any current or prospective Governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings.

Demonstrating inclusive leadership at Board level

As a Board member, I have ensured that I am visible in my support and leadership on all matters relating to diversity and inclusion. I attend meetings to join in the debates and conversation and to challenge where appropriate, and also to learn more about the challenges of staff from groups who are likely to be, or seem to be, disadvantaged. I ensure that the NEDs are also engaged and involved in supporting inclusive leadership within the Trust.

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

Recommendations

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

Report prepared and presented by: **Selina Ullah**
Trust Chair

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 14 January 2025

Chief Executive's Update

Purpose of report

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

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

Executive summary

National context

At the NHS Providers Conference in November, it was good to delve deeper into many of the issues that our Board already has on its radar, such as digital innovation, reducing inequalities: and sustainability and productivity. The conference theme was *Next Generation* and how we can focus our collective efforts to maximise the social and economic value of the NHS, ensuring it remains responsive, effective, and centred on patient and community needs.

In November I was a guest speaker at the national Healthcare Strategy Forum, leading discussions about the use of digital technologies and AI (artificial intelligence) in mental healthcare. There were a number of really interesting conversations about virtual support (including the use of AI), digital literacy and potential opportunities associated with mental health services. It was interesting to see how closely aligned these conversations were with the topics we explored during our recent Staff Conference.

National engagement continues on Change NHS, ahead of the development of the new national 10-year health plan. Last month the Trust submitted our views and feedback which highlights priorities for children's, mental health and neurodevelopmental services. We have outlined the growing demand for the services we provide, the need for true parity of esteem and the importance of supporting vulnerable people in our communities, and the positive societal impact that would have.

New laws to reform the Mental Health Act were introduced into Parliament in November. The reforms have been updated to improve treatment of patients and address disparities. They include introducing statutory care and treatment plans, end the use of police and prison cells to place people experiencing a mental health crisis, and end the inappropriate detention of autistic people and people with learning disabilities. The new Act also promotes a greater involvement of patients, families and carers alongside new laws that give patients sectioned under the Mental Health Act more dignity and say over their care.

At the end of November national guidance on Right Care, Right Person (RCRP) was issued, aimed at supporting the implementation of this national project which is about avoiding unwarranted police involvement in mental healthcare by improving access to personalised mental health support. The Trust is involved in a working group to ensure multi-agency working throughout the four phases of RCRP implementation. It is also a key topic at the Mental Health, Learning Disabilities and Autism Delivery Board.

In December, the Centre for Mental Health published a report called *'Care Beyond Beds – Exploring Alternatives to Hospital Based Mental health Care'.* CentreforMH_CareBeyondBeds.pdf

Care beyond beds was commissioned by NHS England to support a bold vision for the future model of mental health services, including alternatives to inpatient care. Drawing on qualitative research and a review of relevant literature, it finds that experiences of inpatient settings are often marked by unsafe levels of bed occupancy, chronic staffing shortages and dilapidated facilities. Black people, neurodivergent people, children, and people from the LGBTQ+ community are among the most poorly served.

Limited community support means that people struggling with their mental health are funnelled towards the more acute end of the system, causing further distress and higher costs. This is especially the case for out-of-area placements, with patients being sent miles from their homes and support networks to get a hospital bed.

Care Beyond Beds shows that small-scale, incremental improvement to inpatient care will not be enough to create the systemic change needed. A radical overhaul of the system is required, with a reorientation to meeting people's needs far earlier, closer to home, in settings that are therapeutic and accessible.

The Centre for Mental Health states that the next five years is an opportunity to engender that systemic change. With proper investment as part of the NHS 10-year plan, integrated care boards have the power to build better systems of support that will reduce reliance on hospital beds, taking the pressure off local inpatient services and making out-of-area placements unnecessary.

Regional and local context

Towards the end of 2024 the Trust received a report summarising the Care Quality Commission (CQC) inspection of our acute inpatient units in Spring 2024. Following publication, the CQC revisited the Trust in December to inspect the improvements made over the last eight months. We are currently awaiting the report from this most recent visit.

At the time of writing, final arrangements were being made for Bluebell Ward (our new ward for our older adult patients, based at Walton Hospital in Chesterfield) to open to patients on Tuesday, 7 January 2025. This is exciting news and I look forward to seeing our older adult patients benefit from these bespoke facilities in the new year.

Thanks to all colleagues who completed this year's Staff Survey. Our final response rate was 63%. This is a small increase on the previous year, which is very positive. I look forward to hearing colleagues' comments once the survey results are published next spring. More importantly, I am committed to continue to respond to colleagues' feedback and to supporting our leaders in making meaningful improvements at both team and Trust level.

On 18 December, the Integrated Care Board's development session was focused on Mental Health Care. Professor Tim Kendall, National Clinical Director for Mental Health, NHS England, provided the Board with an excellent presentation that focused on the ambition to provide 24/7 community mental health care. I also presented on the progress that has been made in Derbyshire over the last five years as a result of having mental health ring-fenced funding, alongside key challenges that we continue to respond to, such as the lengthy waiting times in many of our services.

The latest common board paper for the East Midlands Alliance (EMA) is appended to my report. It provides a summary of the work and plans of the East Midlands Alliance. This paper is shared with the six Boards of the providers that make up the East Midlands Alliance for mental health, learning disabilities and autism.

Staff engagement

- Recent months have seen a high level of staff engagement, with several important events taking place. A special event took place in our conference rooms at Kingsway Hospital on 20 November as we celebrated the Trust's annual HEARTS awards. The awards ceremony, hosted by members of the Trust's Board of Directors and sponsored by Integrated Health Projects (IHP), Kier Construction and Tilia Homes, recognised individual Trust employees and teams who have gone above and beyond the call of duty and performed at a consistently high level over the last year to support patients, carers and fellow colleagues.

  Congratulations to our winners and everyone who was nominated and shortlisted for an award. Last year's awards received the highest number of nominations to date, and the panel had a very difficult task in shortlisting entries across the award categories. I would like to give a special mention to Balbir Kaur, whose long service was recognised at the HEARTS awards, as Balbir completed 50 years' service within Derbyshire Healthcare.

- In October the Trust launched a new Partners in Progress reciprocal mentoring scheme, which aims at building a genuine awareness of the barriers and challenges that colleagues face, with the ability to build new connections, improve staff experiences and reduce inequalities. Participants on the programme have been matched on the responses shared about what people would like to gain from the programme. I met with my partner on both 18 November and 13 December and so far have found the programme to be a useful way of sharing experiences and making wider connections.

- The new Trust Strategy was approved at the November Board of Directors meeting, following engagement that had taken place throughout the year with colleagues, governors, partners and wider stakeholders to develop a new vision, values, strategic priorities and personal accountability framework. Printed materials have recently been shared with colleagues to disseminate across teams and to ensure the new Trust Strategy is embedded into our ways of working.

- I have continued to get out and about to see our colleagues and service users at the following sites:

  - Visit to the Substance Misuse Service in Ripley with Ellie Houlston, Director of Public Health for Derbyshire County Council on 7 November
  - Visit to Kedleston Unit on 11 November
  - Visit to Rivermead, Belper and The Ritz at Matlock on 14 November
  - Visit to Unity Mill, Belper on 26 November
  - Visit to Ilkeston Resource Centre on 2 December
  - Visit to Temple House, Derby on 13 December

  I also visited clinical and corporate teams over the festive period, including those who entered the Trust's Christmas decorations competition.

MP visits

I have been pleased to continue to host visits to our new Making Room for Dignity facilities by our local MPs, with Adam Thompson, MP, visiting the new Carsington Unit on 6 December. Further visits are planned into the New Year.

Wider News

The Executive Leadership Team (ELT) has agreed and committed to the Trust becoming totally smoke free. We plan to launch this at the same time as our new acute inpatient facilities opening in 2025. This is in line with the national expectation that all NHS sites and services are smoke free.

The latest issue of Connect, our revamped magazine for Trust members has recently been published and includes many articles that will be of interest to colleagues. These include a personal recovery story from Derby Drug and Alcohol Recovery Service, recent staff successes and details of upcoming staff and governor vacancies.

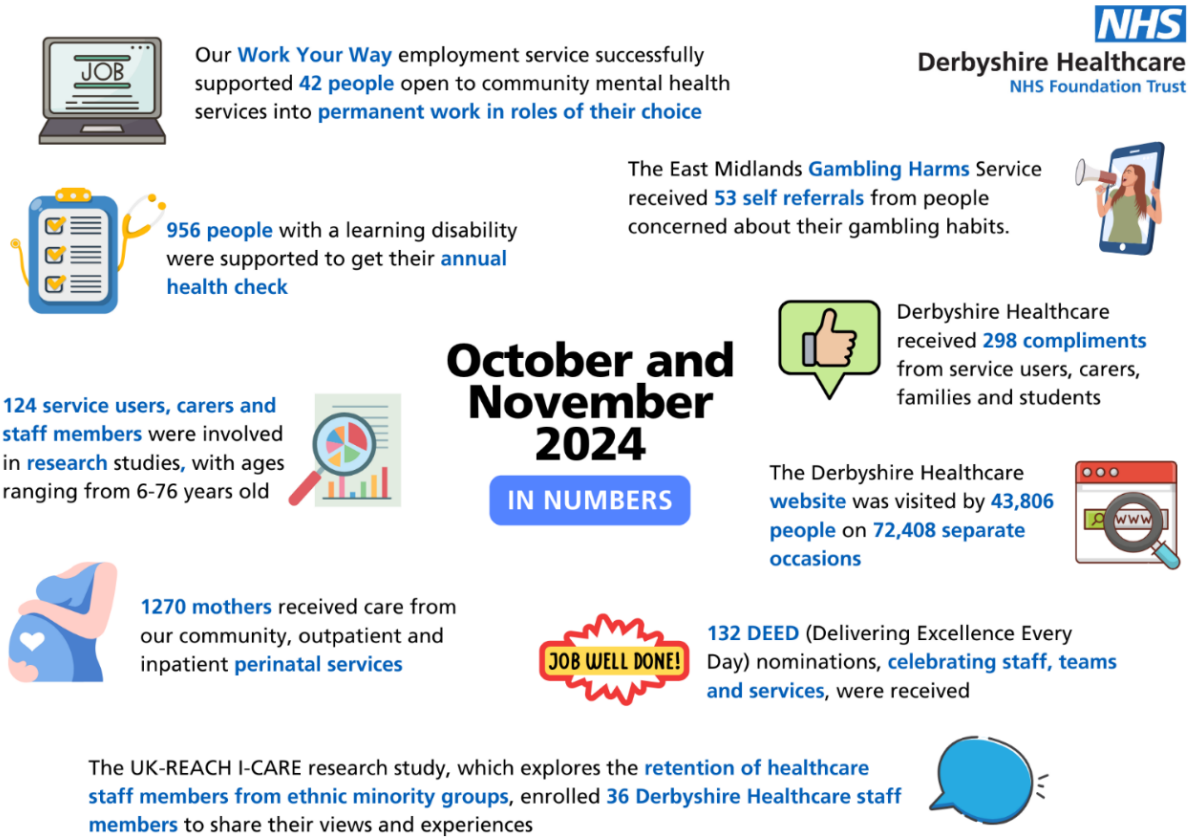
Recent achievements:

- In October, Jan Nicholson, Advanced Paediatric Occupational Therapist, who works with local children with life limiting conditions was presented with a Merit Award by the Royal College of Occupational Therapists. Jan was particularly celebrated for her dedication to children's Occupational Therapy and to the promotion of Occupational Therapy as a profession during a career exceeding 40 years.
- Hayley Lawrence, Clinical Nurse Educator and ex-army medic, was honoured with the role of carrying the Book of Remembrance at this year's Festival of Remembrance at the Royal Albert Hall in November, to honour the sacrifices made by the British and Commonwealth Armed Forces community. Hayley received the honour after devoting 20 years of service to the military as a combat medical technician and a mental health nurse.
- Congratulations to our recent DEED winners. Melanie Chan, Ward Administrator, at Tissington House, who was our DEED winner for November. Melanie's nomination described how she regularly goes above and beyond her role by displaying the utmost kindness to all patients on the ward. Recently, Melanie met a distressed member of the public on site who had become lost coming from Royal Derby Accident and Emergency (A&E). Melanie was able to comfort her, gain her trust and ensure she was able to get home safely. October's DEED winners were the Catering team based at Kingsway Hospital, who were nominated for providing work experience placements to a local school, giving pupils the opportunity to gain transferable skills to take into employment.
- The Trust celebrated its annual Christmas decoration competition in December. There were some fantastic displays, which certainly spread some Christmas joy amongst service users, carers, and colleagues. The Executive Team and wider members of the Board of Directors thoroughly enjoyed visiting all the teams who were in the running for the competition and were very impressed by the effort showcased in this year's competition.

Raising awareness

Over recent months, the Trust has supported awareness raising for Occupational Therapy Week, Nursing Support Workers' Day, Disability History Month and Safeguarding Adults Week. International Stress Awareness Week was an opportunity to raise awareness around stress management and combating the stigma of stress and mental health issues. We also worked with the local media to provide useful advice to people ahead of the festive period, knowing this can be a difficult time for many people.

Trust activity



Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to scrutinise the report and seek further assurance around any key issues raised.

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

Common Board paper

November 2024

1. Introduction

This paper provides a summary of the work and plans of the East Midlands Alliance including the discussions and agreements from the most recent East Midlands Alliance Board meeting and the Alliance Learning event held in September.

The same Board paper, agreed by the CEO group, is shared with the six Boards of the providers that make up the East Midlands Alliance for mental health, learning disabilities and autism.

2. The East Midlands Alliance

The East Midlands Alliance is made up of the six largest providers of mental health services in the East Midlands region:

- Derbyshire Healthcare
- Leicestershire Partnership
- Lincolnshire Partnership
- Northamptonshire Healthcare
- Nottinghamshire Healthcare
- St Andrew's Healthcare

The Alliance has agreed a **vision** for the Alliance:

Working together in partnership to enable the best mental health, learning disability and autism care and support for the people of the East Midlands.

The Alliance has also agreed a set of **values**:

- Working together
- Respectful
- Integrity
- Supportive

The Alliance agreed a set of **principles**:

- Patient first
- Care closer to home and maximising independence
- Subsidiarity – take decisions as locally as possible
- Collaboration by consent
- Not acting to the detriment of others
- Sharing and applying learning at pace

The Alliance agreed five **strategic objectives**:

1. Quality improvement and productivity
2. Enabling safe care
3. Developing our workforce
4. Improving population health
5. Reducing inequalities

3. Alliance learning and networking event

The Alliance held a learning event for the six member Boards on 9 September at the St Andrew's site in Northampton. The takeaway messages from the 9 September Alliance learning and networking event were:

a) There was very positive feedback on the value of meeting face-to-face and on the opportunity for cross-organisation and cross-professional group networking.

b) It was helpful to think together about the future and to be encouraged to be more outward looking, while grounding that thinking in reality.

c) The opening presentation from Andy Bell, CEO of the Centre for Mental Health, provided very valuable underpinning for the day and helped to put the more immediate operational challenges and longer term opportunities into a wider context. It was helpful to hear such a clear long term narrative of the journey to improve mental health services.

d) The Patient and Carer Race Equality Framework session led by Jacqui Dyer and Husnara Malik enthused and inspired attendees to be bolder and act at pace on race equity in our services.

e) Participants found it valuable to find out more about the work of the Patient Safety programme and the coverage and progress of the Communities of Practice. There was strong praise for the films focused on lived experience.

f) Attendees welcomed the opportunity to shape the future direction of the Patient Safety programme and were very supportive of going further with the work on Sexual Safety and Reducing Suicide and Self Harm. There was enthusiasm for some new joint work on patient safety indicators and to expand the work of the Patient Safety programme beyond inpatient wards to community provision.

g) There was a lot of learning about the significant progress made by the mental health collaboratives and their future plans.

h) Participants were keen to have a focus on learning disabilities at a future event.

i) Most participants had not visited the St Andrew's site before and thought it was an excellent venue.

j) Attendees welcomed the active participation of the Chief Executives and welcomed the positive, collaborative and open tone that they set.

k) The value of the Alliance, the importance of sharing learning and acting together when it adds value, were much clearer following the day.

l) There was enthusiasm for further annual events and a commitment to attend the regional Patient Safety learning event on 18 March which will be held in Nottingham.

4. Quality improvement and productivity

4.1 Physician Associates in mental health settings

The Alliance agreed to receive £150,000 of funding from NHS England to support the development of Physician Associates in mental health settings. The Alliance Medical and Nurse Directors agreed to use the funding to:

- promote the potential use of Physician Associates and success elsewhere to the wider clinical body through an Alliance conference
- support the recruitment of new Physician Associates
- funding for the costs of supervision backfill for new recruits
- offering places on the Sheffield Physician Associate development programme to new Physician Associate recruits
- and support with recertification and CPD with a focus on the physical health modules for staff who choose to work in mental health.

Funding has been allocated to support six new Physician Associate roles in Derbyshire, Lincolnshire and St Andrew's. Further funding is available to support additional new Physician Associates in 2024/25.

4.2 Therapy Supervision Hub

The Alliance secured external funding to develop a Therapy Supervision hub to match those in need of supervision and potential supervisors. Access to therapy supervisors is a common challenge across the Alliance and this new system enables supervision at a distance between Alliance providers and for others to sign up to provide supervision into the Alliance.

St Andrew's has taken a lead on behalf of the Alliance in developing the booking software, recruiting supervisors and undertaking needs audits in each provider.

Additional supervisors and staff looking for supervision have registered on the system and the number of matches is increasing each month.

The Programme Board agreed to use some of the funding to train new ACAT and CBT supervisors. Each Alliance provider has been asked to nominate three members of staff for each funded training programme. This will significantly boost the pool of potential supervisors.

4.3 Innovation and learning

The Alliance Medical and Nurse Directors met with leads from Thalamos who have digitised the Mental Health Act process and paperwork with a group of six mental health providers in London.

The Alliance Strategy Directors received a presentation on the use of AI in clinical notetaking and Virtual Reality in the work of Healthy Minds. The latter innovation is being used in Northamptonshire and Leicestershire.

The Alliance agreed to receive external funding from Health Innovation East Midlands (AHSN) to appoint a dedicated regional Innovation lead for mental health embedded in the Alliance. The Medical and Nurse Directors have fed into the work programme for the role.

The post is currently vacant. Interviews took place in October for the Alliance Mental Health Innovation lead role. The preferred candidate accepted an alternative role. The Strategy Director forum in November will agree next steps to fill the role.

4.4 National Inpatient Improvement programme

The Alliance continues to work closely with the national Inpatient Improvement programme. The regional programme lead attended the Alliance Medical and Nurse Director forum in October. The most recent meeting of the East Midlands Inpatient Improvement programme

was held on 5 November. The programme ran a Housing and Mental Health event in Nottingham in October. The new Midlands lead for the Quality elements of the Inpatient Improvement programme has been invited to meet with the CEO group in December.

4.5 Learning review

The Alliance CEOs agreed to the terms of reference for a case review and learning exercise for a protracted and difficult Derbyshire case. The review will consider the referral criteria and escalation process for service users who do not neatly fit the criteria of a particular service. The review will be undertaken by a Medical Director, Nurse Director and Finance Director from Lincolnshire, Nottinghamshire and St Andrew's.

5. Enabling safe care

5.1 East Midlands Mental Health Patient Safety programme

The Alliance works in partnership with Health Innovation East Midlands to run a region-wide Patient Safety programme involving leads from all six Alliance provider organisations.

The national programme support ended in other regions, but the Alliance secured external funding to extend the programme by two years in the East Midlands. The programme takes a community of practice approach involving lived experience voices to develop and share best practice.

The Alliance Medical and Nurse Director forum agreed five priority areas for the programme:

- Reducing restrictive practice
- Reducing suicide and self-harm
- Sexual safety
- Mechanical restraint in high secure settings
- Patient Safety Incident Response Framework

The patient safety programme includes a series of share and learn deep dive sessions. The next share and learn session will focus on sharing the learning from Northamptonshire Healthcare on escalating a physically deteriorating patient using the communication tool SBARD. The session will be led by Dr David Ibrahim and Daniel Boultbee-Jefferys.

The mental health patient safety programme will hold a further large learning event on the 18 March 2025 in Nottingham with a focus on Service User Experience and Patient Safety. Each Community of Practice will present their work from the year, learning and share best practice.

The Alliance CEOs, Medical and Nurse Directors will meet in the same venue on the same date to have their own focus on patient safety. This will also allow the CEOs and Directors to attend the learning event and hear from provider leads and those with lived experience on the work of the Communities of Practice. Other Board members from Alliance providers are

encouraged to attend the event and hear more about the work of the Communities of Practice.

The programme will undertake a restrictive practice audit in each of the Alliance providers between November and January with confidential reports produced for each provider and a themed Alliance report shared in February 2025. This builds on two previous audits undertaken in 2020 and 2022. For the 2024 audit, there will be a focus on race equity and the collection of some PCREF data alongside the standard audit.

The Preventing Suicide and Self Harm Community of Practice has produced a new video and guide to help build awareness of appropriate language relating to suicide.

The Mechanical Restraint Community of Practice will publish a report in November 2024 on the use of mechanical restraint in High Secure settings. The report will include learning for Medium and Low Secure settings.

5.2 Urgent and Emergency Mental Health Capital

The Alliance was asked to prioritise the allocation of £800,000 of national Urgent and Emergency mental health capital to be used in 2024/25. The Alliance Board put three proposals forward which have now all been funded:

- Perinatal estate improvements proposals from Derbyshire
- Crisis Service telephony proposal from Nottinghamshire
- Work to increase inpatient bed capacity from Leicestershire

5.3 Mental Health Act best practice

The Alliance secured external funding to share and promote best practice in the application of the Mental Health Act. Northamptonshire Healthcare will take forward the procurement of a legal partner to run a series of best practice workshops and clinics across the Alliance. The Alliance Medical Directors have agreed a series of specific topics for focus for the best practice workshops.

5.4 Clinical escalation process for the regional collaboratives

The Alliance Medical and Nurse Directors developed a protocol to manage exceptional cases that require escalation. The protocol sets out the expected steps in a swifter escalation process and the use of independent nurse and medical input from within the Alliance in an escalated dispute. The protocol was agreed at the Alliance Board.

5.5 Focus on safety indicators and a common safety framework

The Alliance CEO group have agreed to focus collectively on safety indicators and the potential development of a common safety framework. This will build on the work undertaken in Alliance providers on safety indicators. It will also be informed by some new national work on early warning signs.

The Medical and Nurse Directors will work together and with Health Innovation East Midlands to develop a framework and a common set of core indicators that can be used across the Alliance. This will enable benchmarking and the sharing of learning. This work will be an area of focus at the December Alliance Board and the 18 March meeting between CEOs, Nurse and Medical Directors.

6. Developing our workforce

6.1 Retaining and developing Clinical Support Workers

The Alliance has run a very successful programme to support the development, retention and career aspirations of Clinical Support Workers. Across the Alliance there have been issues with the recruitment and retention of Clinical Support Workers (those working in salary bands 2-4). The Alliance secured significant external funding to run a shared package of development programmes.

The core programme is called Developing Healthcare Talent. It is complemented by a programme that works with the line managers of Clinical Support Workers, known as the Developing Healthcare Leaders programme. Over 300 staff have been through the programmes to date. Both courses have very high completion rates, and the feedback has been very positive. Further cohorts of both programmes will run to March 2025. Case studies for both programmes have been developed and shared nationally.

The Alliance HR Director forum supported two pilots using the same methodology with nurses. Lincolnshire Partnership has been piloting the approach with newly recruited international nurses, many of whom begin working in CSW roles. St Andrew's piloted the approach with newly qualified nurses.

NHS England offered further funding to the Alliance to develop the programme. This funding has been distributed to the Alliance providers for local activities to complement the Alliance wide programmes. Each provider received £100,000 for a range of activities including CSW careers events; a CSW conference; CSW recruitment campaign; a CSW marketing role; a CSW Education Facilitator; Advanced Physical Healthcare skills programme; trialling a new recruitment approach; and developing a new Senior CSW/Healthcare Assistant programme. An event to share the learning from the initiatives run in individual providers will take place in March 2025.

The Alliance is discussing potential additional funding for CSW and other support roles with NHS England.

6.2 Workforce benchmarking dashboard

Nottinghamshire Healthcare has taken a lead on behalf of the HR Director network to develop a dashboard for a common set of Key Performance Indicators linked to workforce. The HR Director group agreed some further measures to include in the future. The dashboard has been shared with CEOs at the Alliance Board.

6.3 Recruitment and Retention Payments and Golden Hello audit

The HR Director network sponsored an update to the audit of special recruitment and retention payments in the East Midlands. This audit was shared with the HR Director network and then the CEO group in September.

7. Improving population health

7.1 East Midlands Gambling Addiction service

The Alliance Board in September received an update from Derbyshire Healthcare as the lead provider for a new East Midlands Gambling addictions service funded by NHS England through the Alliance.

There has been significant work to review and change the promotional information relating to the service as there has been a reduction in referrals in 2024.

There have also been changes made to the treatment pathway including the delivery vehicles and timing of support. These amendments are made in response to some issues in retaining people in treatment. The treatment programme options have been amended to offer increased flexibility with the goal of improving retention.

The Alliance Board welcomed the changes to the model to respond to patient need and the flexibility of delivery to promote engagement.

7.2 Bed planning across the East Midlands Collaboratives

The Alliance CEOs agreed to undertake some joint work on bed planning across the regional collaboratives. This work was developed by the Strategy Directors with input from the Collaborative leads.

The CEOs received a report covering each Collaborative, setting out their current bed stock; the pressures on those beds (measured by bed closures, bed occupancy, waiting lists and out of area placements); recent or planned bed reviews; and future bed plans.

The CEOs noted the Perinatal and CAMHS bed reviews that are underway and discussed the impact of the Tier 3.5 service roll out across the East Midlands in reducing referrals and admissions into CAMHS Inpatient beds.

8. Reducing inequalities

8.1 Patient and Carer Race Equality Framework

One key area of focus for the Alliance on reducing inequalities has been the joint work to progress implementation of the Patient and Carer Race Equality Framework (PCREF).

Over the last year an Alliance network has met four times and shared issues and progress, as well as hearing from two of the five national PCREF pilot Trusts with a focus on the voice of lived experience and establishing leadership and governance for the PCREF.

The Alliance provider PCREF leads will meet in mid-November with national PCREF leads to help to design a dashboard to look at PCREF data across the regional collaboratives. This work would support the Collaborative Boards and the Alliance Board to scope priority work to address issues of race equity illuminated by the data which would be considered alongside feedback mechanisms that hear directly from service users.

9. Regional mental health collaboratives

9.1 Op COURAGE in the East Midlands

Op COURAGE is an NHS service developed with people who have served in the Armed Forces and experienced mental ill-health. In the Midlands (East and West), Op COURAGE is delivered in partnership by Lincolnshire Partnership NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust, Coventry and Warwickshire Partnership NHS Trust, St Andrew's Healthcare, Walking with The Wounded, The Ripple Pond, Tom Harrison House, and Mental Health Matters.

The Op Courage update to the September Alliance Board highlighted issues of staff sickness, vacancies and higher demand feeding into longer waits for support. A recovery plan is in place and has been approved by NHS England. A business case has been submitted to NHS England for an increase in staffing in urgent and non-urgent teams.

9.2 Perinatal Collaborative

The specialist Perinatal collaborative for the East Midlands, led by Derbyshire Healthcare NHS Foundation Trust, launched on 1 October 2023. The East Midlands Perinatal Mental Health Provider Collaborative is a partnership to deliver high-quality care for pregnant women and new mothers with serious mental illnesses who require admission to a Mother and Baby Unit, and to ensure seamless support between Mother and Baby Units and community perinatal mental health teams.

The collaborative partners include community perinatal service providers, creating an opportunity to bring together decision-making on inpatient services from providers across the whole pathway and work closely with community teams to connect services and improve quality.

The Alliance Board in September received an update on progress with the Perinatal collaborative. Key points highlighted included the baseline assessment of bed usage and occupancy levels across the two Mother and Baby units. There is a significant difference in average length of stay between the two units

9.3 Impact Forensic Collaborative

The Alliance Board in September considered the NHS England commissioned review of the efficiency and effectiveness of the Impact Hub. The Impact update report also considered progress with the Care Treatment & Education Review (CTR) function which transferred from NHS England to Impact on 1 July 2024. The Impact Forensic Risk and Incentive Agreement was implemented in April 2024.

The Alliance Board noted the further improvements in patient flow, reduction in length of stay and bed occupancy. The report highlighted the increasing waiting list due to pressures from outside of the East Midlands.

9.4 CAMHS Collaborative

The Alliance Boards in June and September discussed the longer term funding of the CAMHS community models. The CAMHS 3.5 Services continue to have a positive impact supporting young people in the community and reducing demand for beds. National funding for the CAMHS 3.5 support has ended but continues to be funded through the Collaborative with discussions to make this recurrent.

The Alliance Board discussed the success in driving a left shift in the model and the impact on some providers of reduced income as bed occupancy has been successfully reduced. The Board agreed to develop a case study on the CAMHS success story in shifting the model. Some of the expenditure savings on CAMHS have been distributed to help to offset the reduced income for providers that have fixed and sunk costs.

The CAMHS report to the September Alliance Board highlighted the significant progress made to reach a position in which the waiting list for a bed has not been above one young person over the previous quarter. Overall admissions reduced again, as did the number of admissions of young people with a diagnosis of learning disabilities and/or autism.

The CAMHS collaborative is progressing a bed review involving input from a Public Health consultant. The review should report by the end of the year.

9.5 Adult Eating Disorders Collaborative

The Alliance Board in September reviewed the progress made by the Adult Eating Disorders Collaborative. This included detail on the Waterlily approach which continues to deliver positive outcomes and has now been rolled out across the region.

The Waterlily Inpatient Prevention Pilot is an intensive 12-16 weekday programme, that is mainly delivered virtually to patients with anorexia nervosa. The programme delivers practical and psychoeducational groups along with therapeutic 1:1 interventions, for referred patients with the primary aim of restoring weight alongside delivering treatment and preventing inpatient admission.

9.6 Aggregating the Collaborative updates

Each Collaborative provides a detailed assurance update to the Alliance Board. Following the September Board meeting, the updates were aggregated into two documents to be shared in confidence with the Alliance provider Boards. This is intended to increase understanding of the work, risks, issues and successes of the regional Collaboratives.

9.7 ICB delegation of Specialised Services commissioning from NHS England

The Alliance was invited to nominate a senior lead to join an NHS England Delegation Working Group for the Midlands region. The group is considering options for the delegation of the commissioning function currently run by NHS England. The CEOs agreed to nominate Paul Sheldon, the Director lead for the CAMHS and Adult Eating Disorder Collaboratives and Chief Finance Officer at Northamptonshire Healthcare.

9.8 Phase two for the regional collaboratives

The Alliance CEOs held a face to face meeting in Leicester in mid-September which focused on the opportunities for joint bed planning and a phase two for the regional Specialised Services collaboratives.

The phase two collaborative discussions included a review of the Impact Collaborative Hub review commissioned by NHS England. The CEOs also discussed opportunities for the future provision of Collaborative hub support across the East Midlands, and the governance of the Collaboratives and Alliance.

The Alliance Board agreed that key strategic issues and decisions should be presented for CEO review and agreement prior to final decisions being taken at the relevant Collaborative Board.

The list of issues includes:

- Investment of discretionary funding and the commitment of underspends

- Changes to bed provision
- Changes to pricing/payment mechanisms
- Changes to Hub support arrangements
- Changes to Collaborative governance or leadership arrangements
- Any other decisions that might bind or contradict the position of other regional Collaboratives or individual providers

Strategy Directors and Chief Finance Officers will meet face to face in Leicester on 8 November to take forward the CEO requests in relation to an Alliance bed plan, hub support for the regional Collaboratives and ICB delegation.

10. Alliance Communications

A further Alliance newsletter was published in October 2024. The Communications team as also developed a case study of the CAMHS Tier 3.5 service and the positive impact on admissions and out of area placements in the East Midlands and a film from the Alliance learning event. The website (www.eastmidlandsalliance.org.uk) provides a hub for information about the Alliance and the provider collaboratives.

11. Alliance plan for 2024/25

The leaning event in September included discussions on the progress made in implementing the Alliance annual plan for 2024/25. The CEO group reviewed the comments and agreed updates to the plan. A further review of progress will take place at the Alliance Board in December with an initial discussion of priorities for 2025/26.

12. Actions and recommendations

The Boards of the Alliance providers are asked to note the progress made under each strategic objective and receive the updates from each regional mental health collaborative.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 14 January 2025

Integrated Performance Report

Purpose of Report

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

Executive Summary

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

Operational Performance

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

Most challenging areas:

- Waiting times for adult autistic spectrum disorder (ASD) assessment – **demand continues to outstrip capacity**. However, the high volume of assessments being completed by the team each month is making a positive difference and is gradually reducing the number of people waiting over two years to be seen
- Community paediatric waiting times and numbers waiting remain significantly high owing to **ongoing pathway issues and high levels of demand.** Work is ongoing within the Children's Division to address matters
- Inappropriate out of area placements and inpatient bed occupancy levels – enduring high-level of need for inpatient treatment. The inappropriate out of area position for adult acute has increased significantly recently. Actions are in progress to address acute flow issues and free up bed capacity within the Trust.

Most improved areas:

- The number of completed adult ASD assessments per month has remained significantly high and after eight months **over double the number of assessments** have been completed than are contracted for the full year
- The Psychological services waiting list continues to reduce significantly
- The Child and Adolescent Mental Health service (CAMHS) triage and assessment team continues to manage the waiting lists effectively, with number waiting and waiting times both now sustained at a reasonable and manageable level.

Areas of success:

- National standards for early intervention in psychosis two-week referral to treatment, NHS Talking therapies 18-week referral to treatment, and three-day follow-up of discharged inpatients are all consistently achieved
- The individual placement and support service, ***Work Your Way***, continues to support ever-increasing numbers of people with finding permanent employment

- The rate of **dementia diagnosis** remains high – third highest in the region and twelfth highest in the country
- Community Perinatal services continue to **exceed the access target**, flexing to meet the ongoing high level of demand
- Community Mental Health services, both adult and children and young people, continue to exceed their respective target activity levels for patient contacts
- **Mental health response vehicle impact (MHRV):** a joint service commenced in October 2024 between the Trust and East Midlands Ambulance service (EMAS). Prior to the MHRV launch, EMAS was conveying around 55% of all contacts with a mental health need to Emergency Departments. The target was to reduce this via the MHRV, to around 20%. The conveyance rate since October 2024 has dropped to around 7-9%.

Regional comparison

NHS Derby and Derbyshire Integrated Care Board (ICB) continues to perform favourably against a number of long-term plan targets to which the Trust contributes, when compared with other ICBs in the region: dementia diagnosis, children and young people contacts, adult community mental health contacts, and perinatal access. Inappropriate out of area placements remain challenging, with Derby and Derbyshire reportedly having the joint highest level in the region.

Finance

At the end of November, the year to date (YTD) position is a deficit of £3.2m which is better than plan by £2.1m.

The forecast position remains in line with the plan submission of £6.4m deficit.

Current financial risks to deliver the planned deficit:

- Delivery of the £12.5m efficiency programme in full, with a significant proportion delivered recurrently
- Management of adult acute out of area expenditure in line with the reducing trajectory Management of in-patient expenditure to a reduced run rate
- Management of agency expenditure within budget
- Management of any new emerging cost pressures
- Additional costs related to supporting a patient with complex needs ended at the beginning of September.

The Board Assurance Framework (BAF) risk that the *Trust fails to deliver its revenue and capital financial plans*, remains rated as **Extreme** for 2024/25 due to the inherent risks that are built into the financial plan.

Efficiencies

The plan includes an efficiency requirement of £12.5m with a higher proportion phased from quarter 2. The plan assumes that 71% of savings are delivered recurrently.

At the end of November savings to the value of £8m have been realised against a plan of £7.8m, therefore ahead of plan by £0.2m. These schemes have a full year effect of £11.3m against the plan of £12.5m. This has been an improvement on last month's position by £2.3m.

Agency

Agency expenditure YTD totals £4.1m which is below plan by £0.4m. This includes £1.2m of additional costs to support a patient with complex needs (which ceased at the beginning of September). Excluding this additional support, agency expenditure would be below plan by £1.6m.

Business as usual agency expenditure (excluding the support to the patient with complex needs and zonal observations) has been reducing from August 2024 and November has seen the lowest level for several months.

The two highest areas of agency usage continue to relate to consultants and nursing staff.

The agency expenditure, as a proportion of total pay for November, has significantly reduced to 1.9%. NHSE use of resources includes an action to improve workforce productivity and reduce agency spend to a maximum of 3.2% of the total pay bill across 2024/25.

The full year plan for agency expenditure totals £6.3m and expenditure levels for 2024/25 are forecast to be below plan by £0.9m.

Work continues to take place to reduce agency expenditure further with recent focus on CAMHS medical agency and in-patient nursing.

Out of Area Placements

The plan for out of area expenditure is based on a reducing trajectory from 22 to zero beds by the end of the financial year. In addition to this, the plan also included a further six block beds for part of the financial year.

At the end of November total expenditure is £6.2m which is £2.1m above plan. The forecast assumes a reducing trajectory for inappropriate out of area placements along with two block contracts, with expenditure totalling £8.9m which is above plan by £4.0m.

Capital Expenditure

At the end of November, the Trust is £1.7m above plan against the system capital allocation and forecasting to be significantly above plan by the end of the financial year. This is due to the residual Making Room for Dignity (MRfD) cost pressure after the original business as usual capital schemes have been scaled back to help provide some mitigation.

NHS England is asking all ICBs and providers, as part of the month 8 financial monitoring returns, to provide specific Board approval that the provider operational capital expenditure forecasts are accurate and robust. This declaration has been provided by the Chief Finance Officer and the Chief Executive on behalf of the Trust Board.

Cash

Cash at the end of November is at £34m (£26.4 last month) which is £11.1m above plan. This increase in cash in November relates to timing of receipts and payments in relation to the MRfD programme.

The cash levels are forecast to reduce to £14.2m by the end of the financial year which is £5.0m below plan. This forecast adverse variance to plan is related to the additional capital expenditure for MRfD programme which is now included in the forecast.

People

Annual Appraisals

Appraisal compliance continues to remain high at 87% against a target of 90%. However, there has been a slight decrease in compliance during the month of August. Low compliance continues to remain a particular challenge within Corporate services and efforts continue to address both appraisals that are out of date and those coming up for renewal.

Annual Turnover

Overall turnover continues to remain in line with national and regional comparators and has remained below the Trust's 12% upper tolerance for the last two months.

Compulsory Training

Overall, the 85% target has been achieved for the last 24 months. Operational services are currently 92% compliant and Corporate services are at 87%, both maintaining the same compliance since the last reporting period.

Staff Absence

The annual sickness absence rate is running at 6.01% and compared to the same period last year it is 0.03% lower. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by surgery and other musculoskeletal problems.

Proportion of Posts Filled

At the end of August, 85% of funded posts overall were filled with contracted staff. At the start of the financial year, new investment is released which creates brand new vacancies, initially reducing the percentage of funded posts filled. This year will see a staged release of funding throughout the year.

Bank and Agency Staff

Agency usage has reduced significantly over recent months and continues to fall following a temporary increase in agency usage due to a requirement for increased clinical observations. The Authorisation Panel to oversee agency requests across the Trust continues to remain in place and the eradication of all non-clinical agency use continues to be enforced.

Supervision

Compliance continues to see improvements in both clinical and management supervision at 85%. Following the audit of supervision processes, the Trust is now following up on the recommendations which will help towards achieving its target for both clinical and non-clinical supervision.

Quality

This report will give a bi-monthly update on the Trust's progress against key clinical performance indicators as identified in the main body of the report.

Compliments

The number of compliments recorded between August and November 2024 range from 125 to 138 This is in line with common cause variation and the number of compliments received are expected to continue to exceed the set margin of 119.

Complaints

The number of complaints Identified as “quick resolution” increased from 12 to 16 between August and November 2024. The complaints categorised as “closer look”, which involve a Trust commissioned investigation, reduced from 25 to 11 between August and November 2024. This is in line with common cause variation and will continue to be monitored by the Patient Experience team.

Clinically Ready for Discharge (CRD)

The proportion of service users meeting the criteria of Clinically Ready for Discharge (CRD) has increased from 8% to 12% between August and November 2024.

The most common reason for patients meeting the criteria for CRD continues to be a lack of available, appropriate housing, establishing funding, and availability of social care placements.

The Trust Strategic Integrated Flow Lead continues to attend the weekly system-wide Pathways Operations Group, system-wide, weekly Discharge Planning Implementation Group and monthly Strategic Discharge Group and this is expected to support the co-ordination of care, reduce avoidable length of stay and improve flow and access to local beds over the next three months. A weekly mini multi-agency discharge event (MADE) meeting led by the Trust has now been established to facilitate partner actions to enable discharge.

Employment and Settled Accommodation

Patients open to the Trust in settled accommodation have remained static at 49% between August and November 2024 and the number of patients open to employment have continued to remain between 11 and 13 percent since August 2022.

This measure continues to be monitored by individual services and a report which informs teams if there are gaps in the current Data Quality Maturity Index information recorded on referral is available to Ward and Service Managers who have been asked to review this report weekly and action any gaps identified.

Incidents

The number of medication incidents between August and November 2024 has fallen from 87 to 46 and the number of incidents is expected to continue under the mean of 90. It should be noted that the medication incidents reported are largely of low-level harm.

The number of falls recorded has continued above the Trust target of 25 falls between August and November. The higher numbers are attributed to repeated incidents of a small group of patients with challenging conditions. Following these patients being discharged to more appropriate environments, the number of falls is expected to reduce over the next two months.

The Number of DATIX incidents occurring recorded as moderate to catastrophic harm increased between August and November 2024 from 46 to 85 incidents. Analysis suggests that this is due to an increase in the number of incidents reported by staff recorded as “self-harm” and physical assault from patients to staff and patient to patient and an increase in the number of deaths reported. This will be reviewed further and discussed with the Patient Safety team in relation to any themes or patterns.

New episodes of seclusion between August and November 2024 have decreased from 15 to 10. This is in line with common cause variation and below the Trust margin of 14 incidents.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

1. Confirm the level of assurance obtained on current performance across the areas presented. The recommended level is significant assurance: there is a generally sound system of control designed to meet the system's objectives, however, some weakness in the design or inconsistent application of controls puts the achievement of particular objectives at risk (see appendix 2)
2. Formally agree that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting
3. Determine whether further assurance is required.

Report presented by:	**Vikki Ashton Taylor** **Deputy Chief Executive and Chief Delivery Officer**
	James Sabin **Director of Finance**
	Rebecca Oakley **Director of People, Organisational Development and Inclusion**
	Tumi Banda **Director of Nursing, Allied Health Professionals, Quality and Patient Experience**
Report prepared by:	**Peter Henson** **Head of Performance**
	Rachel Leyland **Deputy Director of Finance**
	Rebecca Oakley **Director of People, Organisational Development and Inclusion**
	Joseph Thompson **Assistant Director of Clinical Professional Practice**

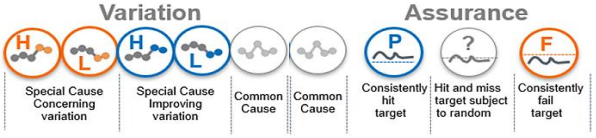
Performance Summary	
Areas of Improvement	**Areas of Challenge**
Operations	
• High level of adult ASD assessments completed • Psychological services waiting times continue to reduce and the number of people waiting has dropped significantly • CAMHS waiting times managed effectively • Positive impact of the mental health response vehicle going live.	• Adult ASD assessment waiting times remain high • Community paediatric waiting times continue to prove challenging • NHS Talking Therapies waiting times from first to second treatment • Inappropriate out of area placements • Inpatient bed occupancy levels remain high.
Finance	
• Agency expenditure usage continues to reduce and is at the lowest level for the year • Efficiency delivery is slightly ahead of plan year to date, and the gap continues to reduce.	• Financial deficit and achievement of the financial plan • Adult acute out of area expenditure is significantly higher than planned • Effective management/mitigation of cost pressures including those CQC driven aspects • Capital expenditure now forecast to significantly overspend against plan due to Making Room for Dignity cost pressures • Long-term plans to progress back to financial sustainability and balance.
People	
• Compulsory and role specific training • Annual turnover.	• Staff absence • Bank staff use • Agency staff use • Annual appraisals • Supervision.
Quality	
• Care plan reviews, gradual improvement continues • Sustained number of compliments recorded exceeding Trust target • Reduction in restrictive interventions • Sustained reduction in medication incidents.	• Incidents of moderate to catastrophic harm remains high • Care hours per patient day • Number of falls continues above Trust target • The proportion of service users meeting the criteria of Clinically Ready for Discharge (CRD) has increased.

Assurance Summary

A. Operations

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1a	Waiting list - adult CMHT - average wait to be seen	L	F	5	4	7	9	8
1b	Waiting list - older adult CMHT - average wait to be seen		P	1	4	1	2	1
2a	Waiting list - adult CMHT SPOA - number waiting	L		734		686	930	808
2b	Waiting list - older people CMHT SPOA - number waiting			53		20	118	69
2c	Older people mental health 4 week referral to treatment			93%		11%	95%	53%
2d	Adult mental health 4 week referral to treatment			94%		0%	95%	47%
2e	Waiting list - ASD assessment - average wait to be seen	L		61		62	71	67
2f	Waiting list - ASD assessment - number waiting at month end	L		1,585		2001	2313	2157
2g	ASD assessments	H	P	85	26	27	83	55
3a	Waiting list - psychology - average wait to be seen			21		10	47	29
3b	Waiting list - psychology - number waiting at month end	H		525		622	777	699
4a	Waiting list - CAMHS - average wait to be seen	L		10		12	19	16
4b	Waiting list - CAMHS - number waiting at month end	L		265		293	437	365
5a	Waiting list - community paediatrics - average wait to be seen	H		52		34	40	37
5b	Waiting list - community paediatrics - no. waiting at month end			2,655		2520	2863	2692
B1	3 day follow-up		?	89%	80%	79%	96%	88%
D1	Community Mental Health Access (2 plus contacts)	H	F	12,395	11,899	10756	11576	11166
E1	Children & Young People Mental Health Access (1 plus contact)	H		3,415		3120	3302	3211
E4	Children & Young People Eating Disorder Waiting Time - Routine		P	100%	95%			
E5	Children & Young People Eating Disorder Waiting Time - Urgent		P	100%	95%			
G3	Early intervention 14 day referral to treatment - complete		P	92%	60%	61%	106%	83%
G3	Early intervention 14 day referral to treatment - incomplete		?	71%	60%	48%	122%	85%
H0	IAPT 6 week referral to treatment	H	F	91%	75%	57%	75%	66%
H1	IAPT 18 week referral to treatment		P	99%	95%	98%	101%	99%
H2	IAPT 1st to 2nd Treatment over 90 Days	H	F	60%	10%	16%	40%	28%
H7	IAPT patients completing treatment who move to recovery		?	45%	50%	43%	59%	51%
I1	Individual Placement and Support Access		?	485	343	147	490	319
K2	Average patients out of area per day - adult acute	H	F	26	0	1	23	12
K2	Patients placed out of area - adult acute	H	F	37	0	4	35	19
K2	Average patients out of area per day - PICU		F	15	0	13	23	18
K2	Patients placed out of area - PICU		F	23	0	21	36	28
L1	Perinatal Rolling 12 Months Access	H	F	11.4%	10%	7%	8%	7%
L2	Perinatal Access Year to Date		F	805	1,070	274	831	553
N4	Data quality maturity index	L	P	98%	95%	98%	98%	98%

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			87%	90%	81%	87%	84%
2	Annual turnover			11%	8-12%	11%	13%	12%
3	Compulsory training			92%	85%	89%	91%	90%
4	Staff absence			6%	5%	5%	7%	6%
5	Clinical supervision			85%	95%	78%	83%	80%
6	Management supervision			85%	95%	75%	81%	78%
7	Filled posts			85%	100%	89%	95%	92%
8	Bank staff use			5%	5%	4%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	No. of compliments received			138.0	119.0	72.8	192.7	132.8
2	No. of formal complaints received ("quick resolution")			16.0		4.6	41.9	23.3
3	No. of formal complaints received ("closer look")			11.0		0.0	32.5	15.4
4	Proportion of patients clinically ready for discharge			0.1	0.0	0.1	0.1	0.1
5	Proportion of patients on CPA >12 months who have had their care plan reviewed			0.7	1.0	0.6	0.7	0.6
6	Patients who have their employment status recorded as "in employment"			0.1		0.1	0.1	0.1
7	Patients who have their accommodation status recorded as "settled"			0.5		0.4	0.5	0.4
8	Number of medication incidents			46		51	115	83
9	No. of incidents of moderate to catastrophic actual harm			85	48	32	80	56
10	No. of incidents requiring Duty of Candour			1	1	0	3	1
11	No. of incidents involving prone restraint			8	12	0	27	12
12	No. of incidents involving physical restraint			93	46	30	131	81
13	No. of new episodes of patients held in seclusion			10	14	4	33	18
14	No. of falls on inpatient wards			38	30	9	59	34

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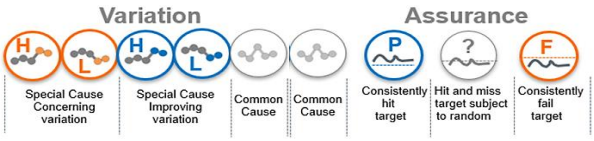

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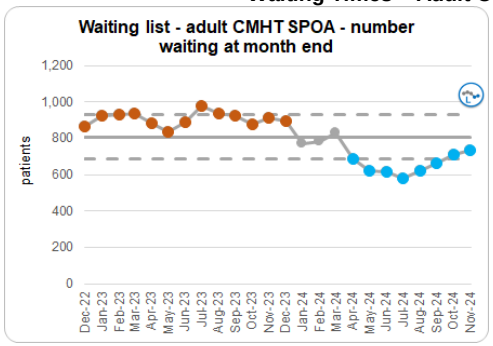
[1]The rating symbols were designed by NHS Improvement

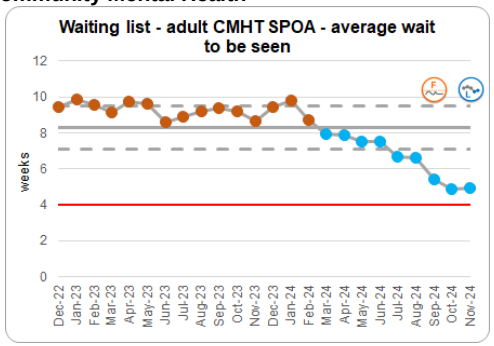
Derbyshire Healthcare
NHS Foundation Trust

Operations

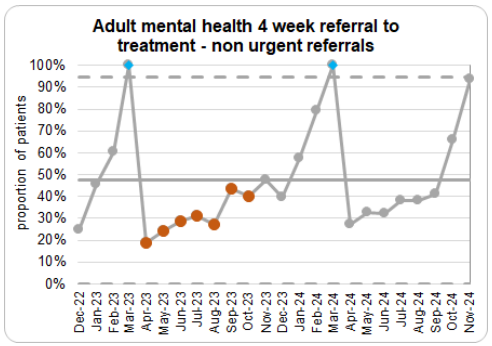
Operational Performance

Waiting Times – Adult Community Mental Health





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



Currently this is an internal measure:

- 4-week referral to treatment performance is based on referral to second contact. The data does not show patients who are currently waiting for their second contact.
- Currently showing phase 1 compliance and does not take into account SNOMED codes or specific interventions.
- All data is for episodes referred within the selected years.

Summary

Although services are seeing an increase in referrals, the average wait to be seen continues to reduce and is currently just over 6 weeks.

Referrals versus discharges

In September 2024, there was a 22% increase in the number of referrals received into the SPOA teams from April 2024, in October 2024, there was a 35% increase, and in November 2024, a 27% increase. This is attributed to the mobilisation of the Living Well model. From April 2024 to Aug 2024 the overall number of discharges was higher than the number of referrals, ensuring there was flow through the pathway and an ability to be responsive to people accessing the service. However, following a significant increase in referrals in September, October, and November, there were 283 more referrals over these 3 months than there were discharges, which is reflected in the upward trajectory of number waiting at month end. If this increase in referrals continues and remains higher than the number of monthly discharges, there is a high risk that waiting lists will increase and people will not get timely access services when they require it.

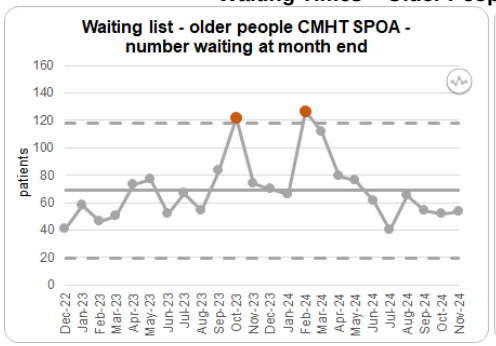
Recovery action plan

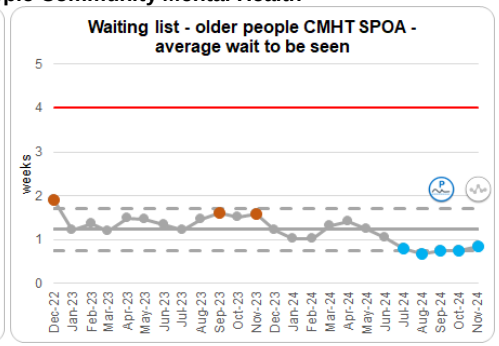
To reduce numbers waiting and length of time waiting, there is an ongoing focus on productivity within all parts of the service pathway to ensure we increase flow, reduce unwarranted variation, and get best value for money. This includes targeted messaging; setting expectations – number of contacts, caseload numbers vs productivity; consistent use of the Employee Improvement Policy and Procedure; quality improvement approach to outpatient caseload management; optimised caseloads within the long-term offer; positive impact of the Living Well transformation once complete – see the following 2 pages.

By when we will have recovered the position

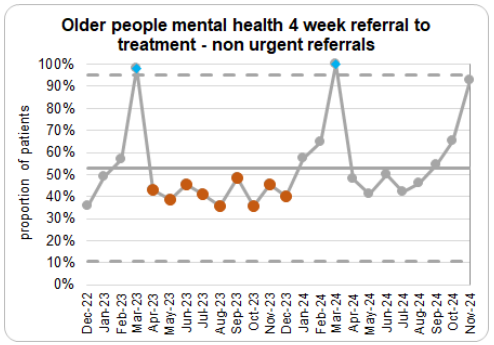
The plan is positively impacting on waiting times and this can be seen in the reduction in wait times over the last 9 months, which is a statistically significant reduction.

Waiting Times – Older People Community Mental Health





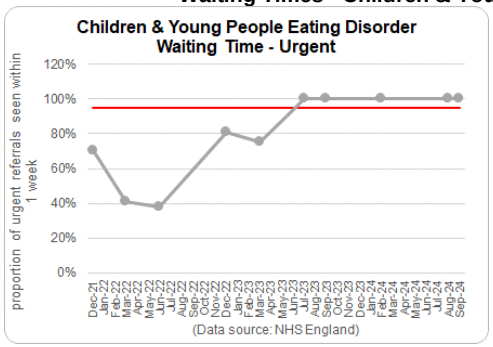
SPOA = single point of access – the route for external referrals into the services

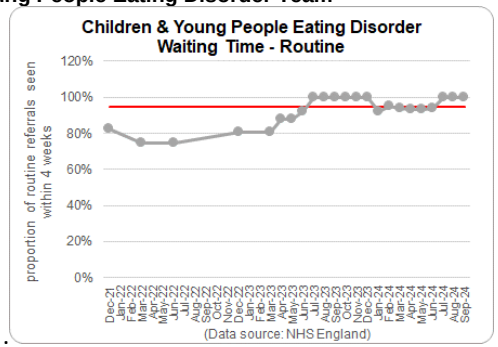


Summary

The Older Adults Division continues to manage flow. Wait times in south Derbyshire will reduce to 13 weeks in the next week with an anticipated further reduction. The division is working through recruitment and mitigating other workforce factors to remain well under 18 weeks. Focus on returning people to caseload from crisis to ensure capacity in crisis services to support admission avoidance. Work continues on the dementia pathway and engagement with stakeholders.

Waiting Times - Children & Young People Eating Disorder Team





Summary

Data indicates that the Trust's Child & Adolescent (C&YP) Eating Disorder Service is generally achieving around 100% for both standards. The Division internally monitors the C&YP Eating Disorder Service waits from 1st to 2nd contact (days):

Days	Qtr1	Qtr2	Qtr3	Qtr4	
2023/24	11	4	4	8	
2024/25	2	3	4		

Operational Performance

https://livingwellderbyshire.org.uk/

Mental Health services that are available in the community to support people with mental ill health are changing and improving. In alignment with the Community Mental Health Framework, mental health services are transforming to reach a wider cohort of people, including those who have traditionally fallen between the gaps of primary and secondary care, as well as those people with a severe mental illness. Health services, social care and the voluntary, community and social enterprise (VCSE) sector are working in partnership to deliver new integrated ways of working that are modernising community mental health services for adults and older adults, taking into account the particular needs of each local area. In Derbyshire, this is called the Living Well Derbyshire programme. In Derby, it is called the Derby Wellbeing programme.

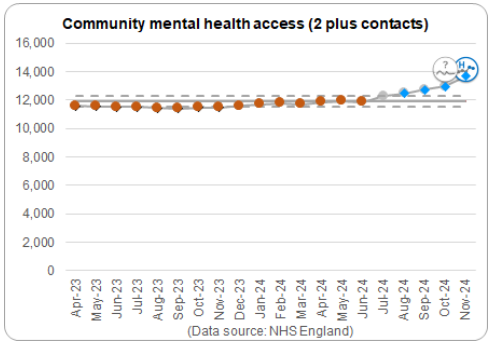
The new services went live during 2023/24:

- August 2023: High Peak
- September 2023: Derby City
- October 2023: Chesterfield
- January 2024: North East Derbyshire/ Bolsover
- February 2024: Amber Valley, and Erewash
- March 2024: Derbyshire Dales, and South Derbyshire

Community Mental Health Framework/Living Well Programme

DHCFT is a partner in the programme alongside the voluntary, community or social enterprise sector and the local authorities. Go live of the Living Well sites commenced in 2023/24 (August to March) so it is early days to yet understand true impact, however we can already see positive impact in terms of case load sizes (long term caseloads reducing whilst short term caseloads have increased). In addition, there are early indications of reducing referrals to MH Liaison Teams which frees up capacity to provide greater support to complex cases in the community and therefore to reduce presentations at A&E.

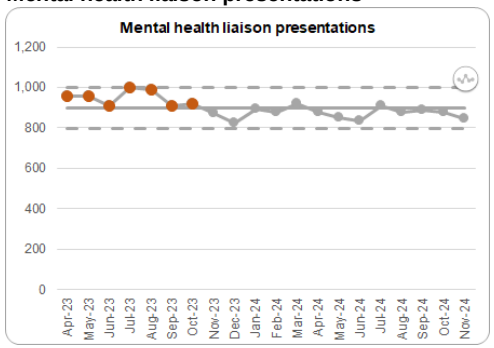
Community mental health access 2 plus contacts (NHS long term plan target)



Summary

The system was set a target to increase the number of adults and older adults receiving 2 or more contacts in a year from community mental health services to 10,044 by the end of March 2023, which was an increase of 14% on current performance. The target was achieved. For financial year 2023/24 the year-end target was increased to 11,899 and for the last 4 months the target was exceeded. For financial year 2024/25 NHSE have published data up to September, which demonstrates that year to date the target level of activity has been sustained each month. Data for October & November 2024 is unofficial, using internal measurement, and awaiting final validation.

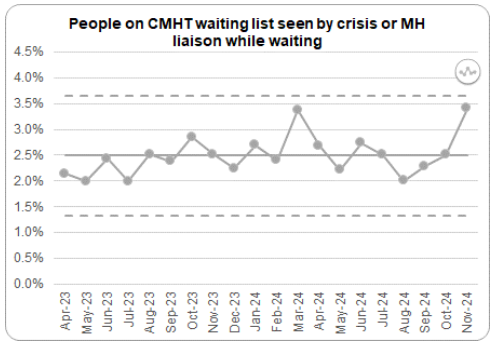
Mental health liaison presentations



Summary

One aim of living well is to free up capacity within secondary care mental health community teams to be able to provide support to more acutely unwell patients in the community. This approach should result in fewer presentations at acute trust emergency departments and support admission avoidance. The data indicates that the number of presentations has been below average in 9 of the last 12 months.

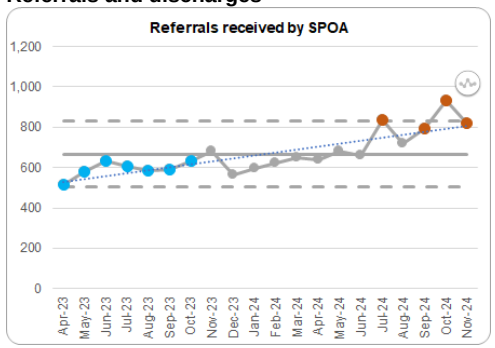
People on the community mental health team waiting list who have been seen by crisis services or mental health liaison while waiting

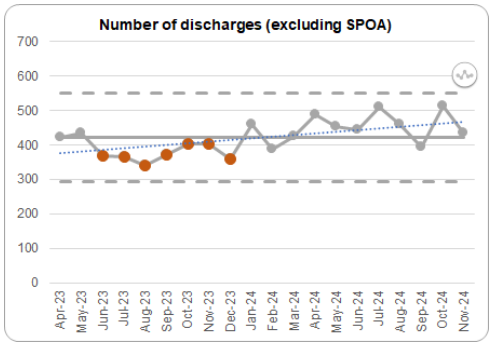


Summary

People who are waiting to be seen by community mental health teams should be seen sooner, therefore we would be expect the number of people needing to access crisis services whilst waiting for community mental health services to decrease, reducing demand on secondary services. However, to date there is no evidence of any reduction. There is a specific piece of work through the enabler MaST (Management and Supervision Tool) to review those patients in high escalation on CMHT caseloads to increase activity to prevent them from further health escalation/deterioration.

Referrals and discharges





Summary

The volume of referrals received has been steadily increasing since December 2023, with a significant increase experienced in recent months, this is attributed to the Living Well mobilisation. The volume of discharges has also been increasing over time since December 23.

Operational Performance

https://livingwellderbyshire.org.uk/

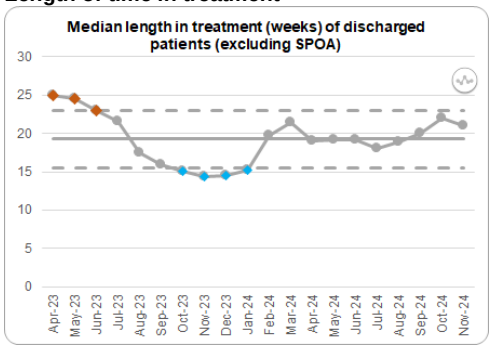
Caseload sizes

Over time you would expect to see long term offer caseloads reducing, and short-term offer caseloads increasing. The data demonstrate that this is the case, although interestingly the long-term offer proportion of caseloads in both Derby City Teams increased slightly in November. The columns below give the proportion of caseload that was long term offer in each team each month:

STO & LTO caseloads	Proportion of caseload that is long term offer									
Team	Oct-23	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Movement
CHESTERFIELD	95.9%	75.0%	72.1%	79.0%	72.8%	75.0%	74.7%	73.2%	71.8%	
HIGH PEAK	70.7%	53.7%	54.5%	53.4%	53.4%	53.7%	48.9%	45.8%	46.9%	
AMBER VALLEY	100.0%	100.0%	100.0%	100.0%	99.8%	99.8%	79.9%	73.5%	72.5%	
EREWASH	99.7%	91.1%	89.1%	90.2%	88.4%	88.7%	78.6%	75.3%	75.4%	
SOUTH DERBYSHIRE	100.0%	92.6%	89.4%	85.4%	80.1%	80.5%	73.0%	69.3%	68.6%	
DERBY CITY B	72.1%	56.7%	57.8%	66.2%	60.4%	65.1%	63.0%	67.0%	69.3%	
DERBY CITY C	73.8%	61.2%	59.5%	67.0%	58.4%	59.7%	58.8%	63.0%	68.0%	
Grand Total	**88.8%**	**76.7%**	**75.6%**	**79.5%**	**75.4%**	**77.0%**	**70.4%**	**68.9%**	**69.3%**	

NB Bolsover, Killamarsh, North & South Dales are excluded from this table, as those teams only hold long term offer caseloads and so will always be 100%. Their short-term offer caseloads are held elsewhere.

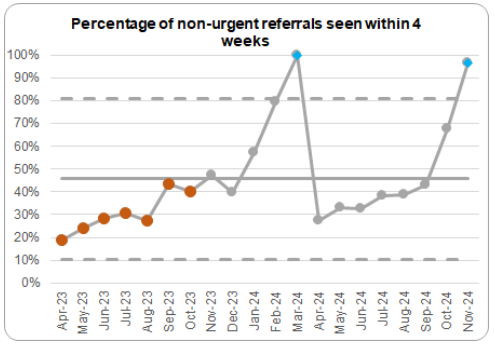
Length of time in treatment



Summary

Discharges would be expected to increase and length in treatment to reduce, owing to the short-term offer throughput offering a 12-week service. The flow of people through the service would ensure there is capacity to support people in a timely manner.

Community mental health team 4-week referral to treatment

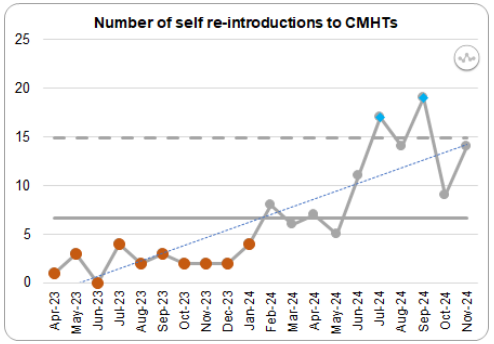


Summary

NB 4-week referral to treatment performance is based on referral to second contact of patients who had their 2nd contact in the month. The data does not show patients who are currently waiting for their second contact.

A significant piece of work is underway to correct multiple patient contacts that have been recorded incorrectly on SystmOne. Once complete this will positively impact on reported waiting times and the true picture will be more accurately reflected.

Self re-introductions to community mental health services



Summary

The Living Well Service enables people to readily access services up to 2 years following discharge from a previous spell of treatment. The number of self re-introductions would be expected to increase over time, through the provision of easier access to services, and is also expected to reduce demand on primary care. The ability to self-reintroduce will be established during phase 2 of the Living Well transformation. The data indicates an increase in self-referrals on an upward trajectory.

Operational Performance

Adult Neurodevelopmental Division (ND)

Key priorities for Quarter 3 and Quarter 4

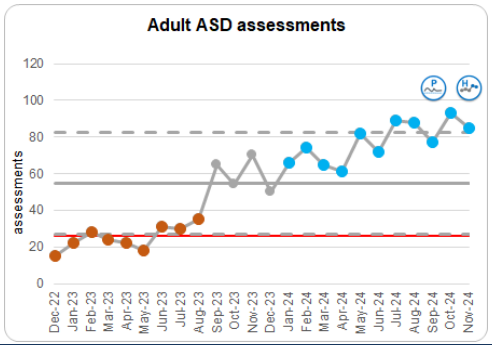
- Supporting Major Service Change for Short Breaks/Assessment Treatment Unit (ATU) through the executive oversight group led by the ICB.
- Working with the system to determine new ASD/ADHD contract/commissioning. Ongoing gap in adult ADHD services across Derbyshire. We continue building an agreed service specification and the resource needed to fulfil the potential commissioned service. Led by the Managing Director for Planned Care and the Chief Psychologist.
- Efficiency planning for 25/26.

Inpatient/Flow/Avoiding Inappropriate Admissions

- The Short-Term Intervention Team (STIT) SDF funded has yet to be further agreed by the ICB for 2025-26. Contract currently to cease end of March 2025. A service evaluation/business case is being developed to support discussions.
- New psychiatrist in post, providing further support to the improvement plan.
- ND Patient Assurance Team are reviewing and developing new processes to ensure efficient and effective service delivery with timely completion of Care & Treatment Reviews (CTRs) in line with national guidance. A recovery action plan is in place.

Transforming care programme	Target	Completed
Number of adults in ICB commissioned inpatient care	**16**	**12**
Number of adults in secure inpatient care	**16**	**20**
CTR - Post admission Adult	**75%**	**100%**
CTR - 6mth follow up - ICB Commissioned	**75%**	**100%**
CTR - 12 mth follow up - Secure Inpatient	**75%**	**100%**

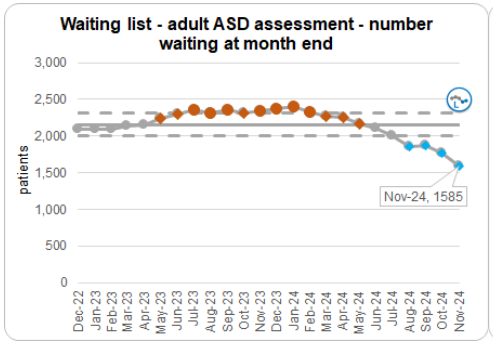
Recovery Action Plans (RAP)
ND Patient Assurance Team: review this month showed significant progress, support by workforce factors. A review of operational processes have been begun to be implemented.
Appraisals: A recovery action plan is in place across the alliance to improve the statistics on appraisal performance. To be reviewed in Operational & Clinical Operational Assurance Team (COAT meetings monthly.

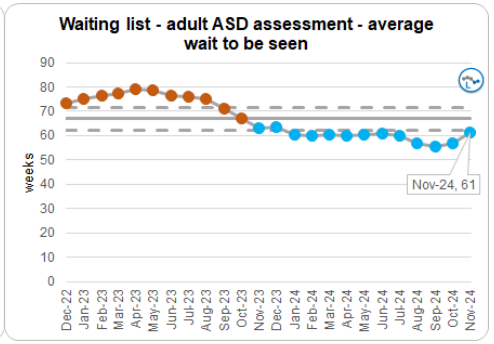


Autism Services

Adult Diagnostic Service
The number of completed assessments per month has remained high and after 8 months over double the number of assessments have been completed than are contracted for the full year. The number of people waiting continues to reduce significantly. Continued discussions with the ICB are taking place regarding extending the Autism diagnostic service (16 year +) following on from the closure of Sheffield diagnostic service.

Adult Neurodevelopmental Division (ND)





Attention deficit hyperactive disorder (ADHD)
Ongoing gap in adult ADHD services. The Trust are continuing to build an agreed service specification and the resource needed to fulfil the potential commissioned service. Led by the Trust Managing Director for Planned Care and Chief Psychologist, ongoing discussions are progressing with the ICB and ND division.

Challenges
Capturing patient experience: barrier to using the electronic patient survey as requires additional investment.

Experts by experience coproduction and engagement as a non-Trust carers group is due to disband owing to lack of Derbyshire County Council funding.

Successes

- Annual health check completion has improved compared to last year's position YTD. Targeted work with North short breaks service saw an increase of 13% in uptake.
- The Quality Improvement and Quality Assurance Committee won the HEART Award for Quality Improvement/Research Excellence. A recent targeted piece of work has resulted in some key insights into underserved communities who access ND services. The findings of this to be shared with Trust Leadership Team.
- Phase one of Clinical Care Pathways has been rolled out, embedding evidence based clinical pathways across the ND division. Phase two commences in January 2025 with a focus on embedding the pathways and working through coproduced toolkits and resources.
- Core capability training - successful rollout to the staff across the division as part of workforce development.

Quality/ Research
Embedded research project completed to Identify underserved communities and address the barriers to their engagement with services and recruitment into research. Key findings from this are supporting Divisional workplan 25/26 to support health inequality.

Dynamic Hospital-Led Inreach
New tiered system in place supporting and enabling mental health services to work more effectively with autistic adults.

Operational Performance

Psychology & Psychological Therapies

The Division has maintained its excellent reputation in the region for being a fantastic place for psychologists to work and remains the employer of choice in the region. The Division currently have around 9% vacancy, with a head count of 261 staff (226 WTE). The new divisional vision was reviewed by staff in September, and it has been updated in line with this and the Trust's updated strategy.

Engagement: The next engagement hour is mid-January 2025. In relation to the anonymous shared space, the Division has had nothing raised in the recent period.

Workforce update highlights: *Sickness & morale:* Sickness within the division remained low, and below the Trust average, at 2.9% in November 2024. The Division continues to work hard to maintain this through supporting staff where possible. Morale appears to be team dependent and remains variable. The Division has one investigation following a patient complaint.

Trainees and research: New intake of trainee clinical psychologists started in September. Within the employing trusts DHCFT is now a popular choice with 16 trainees across 3 year groups. Staff are contributing to both teaching and research supervision at the university of Nottingham. One of our staff in Adult Working Age Community Division has been successful in gaining National Institute for Health & Care Research (NIHR) funding for a day a week for 12 months to complete some research around dissociation, which will benefit the people we serve.

Talking Mental Health Derbyshire (TMHD)*:* See separate report; 6-week treatment target achieved and being maintained. No update from the ICB regarding the future of services.

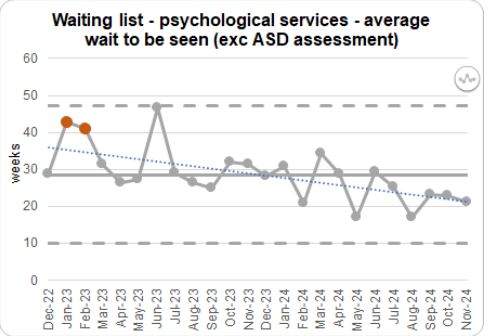
Safety and quality: The Division have no outstanding risk assessments of DATIX actions**.** The Division had three incidents reported in November. Teams continue to complete a monthly managers update with all performance metrics. Psychological care planning contribution and use of formulation remains a focus. The Division have received 24 compliments and two complaints in September and October.
Friends and Family Test, where reported, continues to show excellent feedback. In the last 12 months:

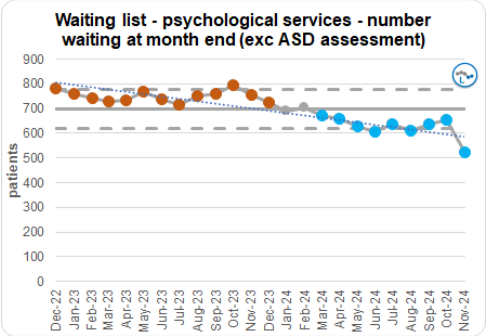
- Adults of working age psychology received 30 returns showing 86% positive feedback. The less positive feedback due to waiting times.
- Cognitive Behavioural Therapy & psychodynamic therapy received 29 responses and 100% were positive
- NHS Talking Therapies received 1,759 responses and 98% were positive.
- South & Dales Older Adult Psychology received 3 responses and 100% were positive.

Trust wide staff wellbeing: Wellbeing remains a priority for all teams. Divisional staff receive continued requests to support individuals and teams which remains challenging.

Policies and risks: All policies are up to date. There is one remaining risk of note, which relates to the gap in psychological services provision between primary care and secondary or specialist mental health services. This risk may be heightened with the reduction in treatments delivered through system wide talking mental health.

Data: There does remain a challenge regarding data quality in workforce metrics, including training data. The Division are working with the Training & Development team and ESR colleagues to rectify this. It remains an ongoing issue. The Division are also taking action to support accurate productivity data.





Waiting lists and referrals: Overall, there continues to be a sustained reduction in the number of people waiting for psychological input to around 19 weeks. This has taken much work and sustaining this remains a focus in all areas. The pressure point remains ASD assessment where the average wait is 58 weeks (as recorded in October).

ASD and ADHD services: the Trust are currently in discussion with the ICB to fund an ADHD service and to extend the ASD assessment service to meet the needs of the population. The service are now working to an effective and efficient assessment protocol.

Key performance indicators: Clinical and managerial supervision remain high at 90% and 92% respectively, although there is still work to be done to improve this. Annual appraisal completion has risen since the last report to 89%, but still needs to improve further. Return to work interviews remain low (but an increase on last report) at 53.3% for November (however, noting data accuracy, this appears to be based on only 131 people).

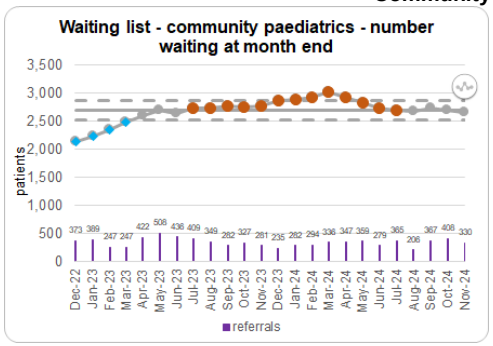
Mandatory training: All areas of mandatory training for the division are above requirement at 90% or higher with the exception of basic life support/ resuscitation which is at 70.6% (a rise from last month). This is being addressed through supervision and monthly governance meetings but one of the challenges is booking this training. The overall divisional performance on mandatory training is 92%. There remain issues with data accuracy in relation to job specific training.

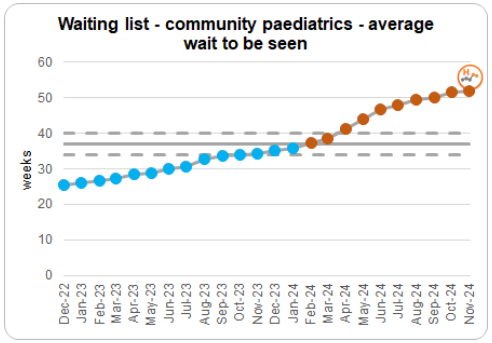
Increasing psychological awareness: Bite size psychological teaching sessions continues to have good attendance with a range of topics being delivered. This week's is focused on trauma informed practice.

Productivity: Productivity remains a focus for all teams. The leadership team have shared expectations around job planning and delivery with managers and this will start to filter into teams with some impact. Accurate data is still a challenge. From April to date, we have received 1,249 referrals and have discharged 1,252 people from treatment. We are also looking at the number of treatment sessions delivered and thinking about standards to be applied. Digitisation of assessment tools is one of the next steps needed to improve the efficiency of the division.

Operational Performance

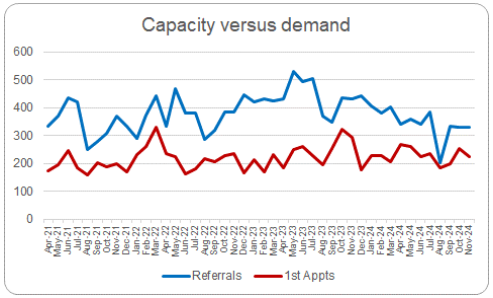
Community Paediatrics





Summary

At the end of November 2024 there were 2,655 children waiting to be seen and the average wait time was 52 weeks. Whilst referrals continue to rise, the positive impact of the internal review of processes, job plans etc. which enabled us to increase the number of assessments in 2023/24 by 34% compared to 2022/23, has continued into the current financial year to date. However, demand continues to outstrip capacity, and results in lengthening waits. Over the next 3 months there are likely to be over 300 patients in the Community Health Services Data Set who have been waiting over 104 weeks to be seen.



Internal factors:

- There is ongoing difficulty in discharging children under NICE guidance and shared care agreements in relation to medication for ADHD – specialist nursing team caseloads continue to expand causing problems with flow from the community paediatrics service.
- Recruitment and retention of medical staff: recruitment to mitigate expected turnover in the next quarter period.

External factors contributing to increased demand on Community Paediatricians:

- Significant increase and enduring demand for ASD/ADHD specialist assessment. Demand for ASD and ADHD assessments is linked to an increase in SEND in schools, school pressures, cost of living crisis and reduced community support.
- Ongoing increased volume of referrals to community paediatricians owing to developmental delay, which has persisted since the pandemic.
- Increased complexity of children & young people's presenting needs post the pandemic, resulting in longer appointments, which reduces capacity to see more patients.
- Ongoing ADHD supply issues continue to impact on demand and management of cases needing to be expedited.

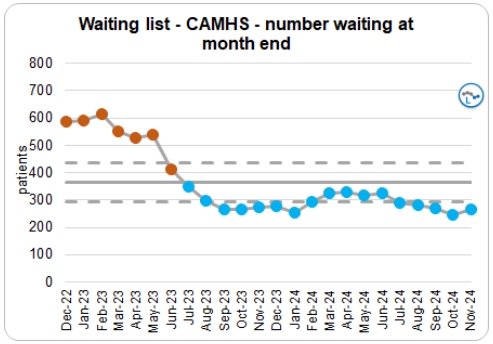
Actions:

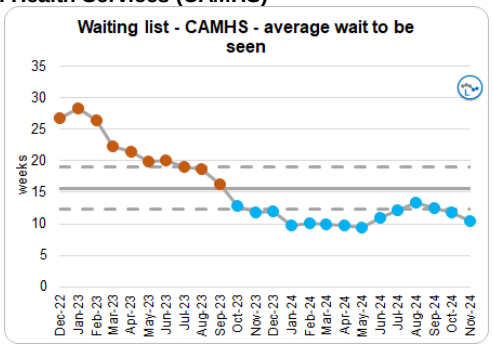
- Deputy Area Service Manager is continuing to lead on transformation work for the CYP neurodevelopmental pathway. A service transformation programme will aim to review roles/skill mix/service specification to mitigate the loss of the medical posts.
- Ongoing senior leadership attendance at system neurodevelopmental meetings to highlight risks and increase Local Authority, Education and Primary Care accountability for the increasing demand.
- Ongoing triage review of long waiters, with a system decision made to focus on education/schools in order to reduce referrals by offering advice, support and signposting as needed.

Trajectory for community paediatric wait times:

Waiting times for community paediatrics are likely to continue to rise. The ongoing challenge is to reduce the growth and speed at which this takes place.

Child & Adolescent Mental Health Services (CAMHS)





Summary

At the end of November 2024, 265 children were waiting to be seen and the average wait time was 10 weeks. The average wait is now more accurately reflected. Priority assessments remain to be seen within 4-6 weeks and routine assessments up to 20 weeks, however this is still a significant improvement from where we were in 2022.

Actions

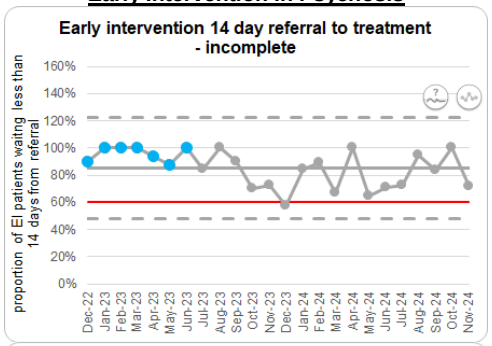
- The triage and assessment team are continuing to positively impact on external waiting times and are adhering to the Trust waiting well policy. Owing to the efficiency of the Triage and Assessment Team, it is necessary to limit the rate of assessments so that the teams further down the pathway do not become overwhelmed. This is still the case. Having reduced the number of assessments a wte band 6 clinician is conducting from 8 to 4. This is increasing up to 6 in January.
- A business case was worked up with the ICB to access long term plan children & young people (CYP) services transformation money for 2024/25. The proposal with amendments has been submitted and is now in final stages of scrutiny within the ICB.
- Waits and CAMHS performance oversight in COAT and reported to Trust Leadership Team. Also oversight at the CYP Mental Health Board.
- Escalation via the ICB Fragile Services Committee – monthly updates provided.
- CAMHS Assessment Team clinicians are also supporting with the QB clinic assessments to help reduce wait times. At the rate of 1 clinic per week. With the clinicians rotating. The assessment team is also supporting with CAMHS ASD assessments, at the rate of 1-2 assessments per clinician per week. This is resulting in young people, who were solely waiting for an ASD assessment potentially being discharged from service at a much faster rate than had they been waiting for the CAMHS specialist assessment team.
- Assessment Service Leads are closely monitoring the impact of the closure of national gender services, as referrals start to be sent through. As yet, there has not been a significant impact, with roughly 30 gender referrals having been sent through since model change (late Spring/early Summer 2024). A significant number of those referred in were already known to services/open to services, so the time spent triaging was minimal.

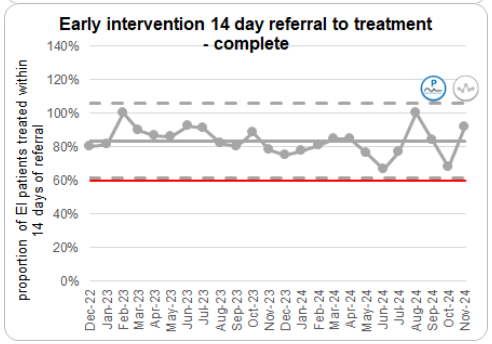
Recovery timescales:

Average wait is below 18 weeks however a national target of 4 weeks is being requested by the system. This would require a case of change in terms of new investment as outlined in the business case above and would take 2-3 years to fully implement if supported.

Operational Performance

Early Intervention in Psychosis



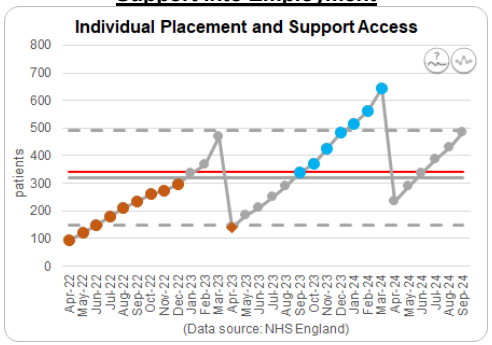


Summary

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

The service continues to be extremely responsive and has consistently achieved or exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than 2 weeks to be seen.

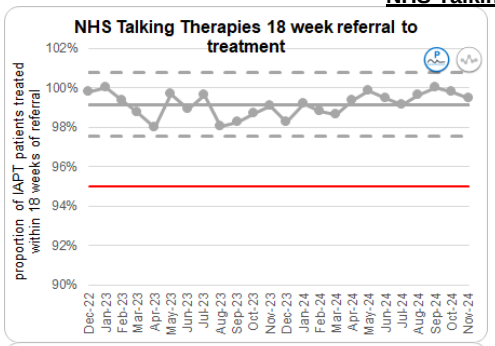
Support into Employment

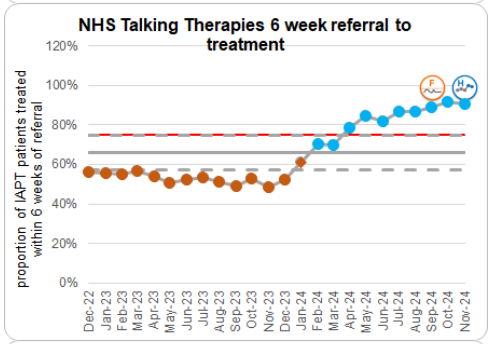


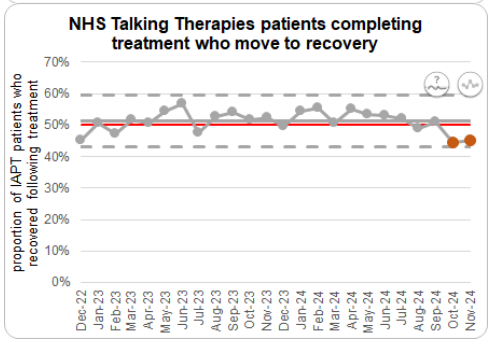
Summary

Work Your Way is a team of employment specialists and peer support workers helping people using community mental health services in Derbyshire to find work and stay in work. The team is continuing to be extremely productive and in 2023/24 supported 645 people to access the service, and supported people to find permanent work in 176 jobs in roles of their choice. In the first 6 months of this financial year a significant number of people have been supported to access the service.

NHS Talking Therapies

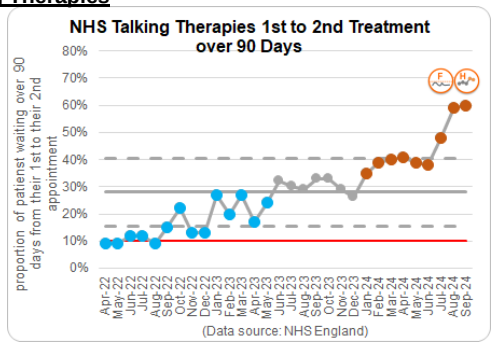






Summary

- 18-week referral to treatment performance and 6 6-week wait for referral to assessment/ 1st treatment entered continue to exceed target.
- Recovery rates achievement has been volatile due to imbalances in the service with the reduction in capacity for counselling from our sub-contractors.
- Reliable improvement achieved and recovery rates are still green year to date, however the reliable recovery figure has dipped slightly below.



Summary

1st to 2nd treatment over 90 days continued to be high up to September. Indications for October and November 2024 are that this figure is falling and shows an improving picture.

Actions

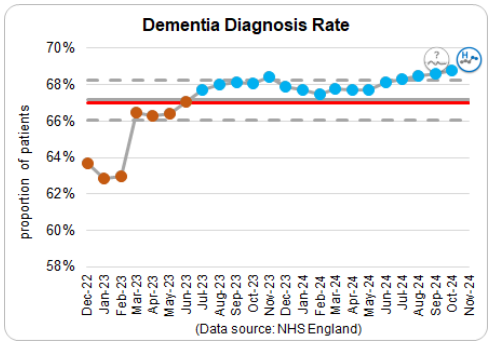
- Reductions in activity negotiated with sub-contractors to achieve cost reductions in line with ICB request.
- Productivity of staff maintained despite the uncertainty of future service provision.
- Bolstered the triage provision in order to achieve the new thresholds.
- Now working on exit strategy and plans up to the 30 June 2025 in preparation for a single or lead provider to manage the contract going forwards. Tender process is stalled with no revised timelines to work towards.
- Mutual aid has ended and DRCS and IESO are taking their last referrals from the wait lists. This will mean large increases in wait times for counselling and CBT across the coming months.

By when we will have recovered the position

- Awaiting the identification of providers as part of the ICB led procurement process continues to cause pressures on staff, managers and patients.

Operational Performance

Dementia Diagnosis Rate



Summary

There has been a national drive to increase the proportion of people estimated to have dementia, who have a coded diagnosis of dementia. The target for Derby & Derbyshire ICB has been achieved since June 2023 and steadily increasing for the last 5 months. NB this is national data and the November position is yet to be published by NHSE.

Regional Comparison October 24

Dementia diagnosis rate

Organisation Name	Measure Value STR
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	73.9%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	70.8%
NHS DERBY AND DERBYSHIRE ICB	68.8%
NHS LINCOLNSHIRE ICB	68.3%
NHS BLACK COUNTRY ICB	65.6%
NHS NORTHAMPTONSHIRE ICB	65.5%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	65.1%
NHS BIRMINGHAM AND SOLIHULL ICB	62.4%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	61.4%
NHS COVENTRY AND WARWICKSHIRE ICB	57.6%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	55.0%

NHS Derby & Derbyshire ICB has the 3rd highest diagnosis rate in the region, with performance exceeding the long-term plan trajectory target.

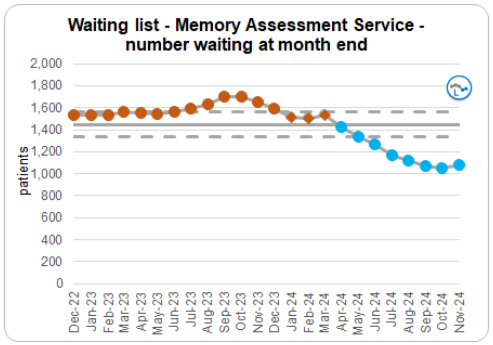
Dementia Diagnosis Benchmarking Data

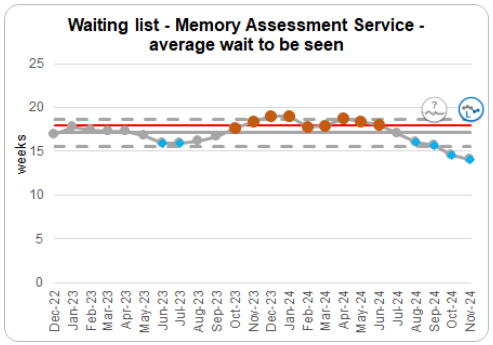
Org Type	Code	Diagnosis rate
ICB	QF7	76.3
ICB	QOP	74.9
ICB	QNC	73.9
ICB	QWE	73.2
ICB	QT1	70.8
ICB	QUY	70.3
ICB	QKK	70.1
ICB	QWO	70.1
ICB	QHG	69.6
ICB	QE1	69.4
ICB	QHM	69.1
ICB	QJ2	68.8
ICB	QJM	68.3
ICB	QNQ	68.3
ICB	QXU	68
ICB	QH8	67.8
ICB	QYG	67.6
ICB	QMJ	67.3
ICB	QUA	65.6
ICB	QPM	65.5
ICB	QRV	65.4
ICB	QR1	65.4
ICB	QK1	65.1
ICB	QM7	65.1
ICB	QNX	63
ICB	QU9	62.6
ICB	QHL	62.4
ICB	QRL	62.2
ICB	QMM	62.1
ICB	QMF	61.8
ICB	QT6	61.7
ICB	QOX	61.5
ICB	QOC	61.4
ICB	QUE	61.1
ICB	QJG	60.6
ICB	QKS	60.3
ICB	QOQ	60.1
ICB	QJK	58.9
ICB	QVV	58.3
ICB	QWU	57.6
ICB	QSL	56
ICB	QGH	55

Primary Care Dementia Data - NHS England Digital

The diagnosis rate in Derby & Derbyshire continues to compare very favourably with other areas nationally.

Dementia Diagnosis Waiting Times





Summary

At the end of November 2024 there were 1,077 people on the waiting list, with an average wait of 14 weeks, which includes people currently waiting as well as those who were assessed in month. Waiting times for initial assessment have remained at approximately 24 weeks. Some progress has been made on assessment to diagnosis which is currently 8 weeks across the county, which is a reduction from 20 weeks in the north.

Reasons for underperformance

- There continues to be an extremely high demand for the service which exceeds capacity.
- The situation in unlikely to improve as the prevalence of dementia is predicted to increase significantly by the end of the decade.

Action plan

- Quality improvement project to maximise and make best use of current resource, to ensure maximum capacity and quality of current provision, with a focus on the medical workforce and diagnostic capacity. All elements have been completed apart from the medical workforce. Planning is underway for this, with a new Specialty Doctor starting on 7 January 2025.
- MAS 24 has been fully absorbed into the CMHT Care Homes Project.
- Reducing the DNA rate. There are still a number of cancellations, but the service are working hard to rebook people into suitable slots. A cancellation list is held and pull people are seen in the clinics where there are DNA's.
- Dementia assessment pathway work remains ongoing, with further engagement with Primary Care underway. Weekly emails to staff with individual performance data to ensure individual accountability for service provision.
- Regular monitoring of wait times and data cleansing.
- Continued focus on staff wellbeing and support.
- Complex case/under 55 pathway review completed.
- Medical workforce review. Partially complete: new Specialty Doctor starting on 7 January 2025, with a plan around clinics and multidisciplinary meetings which will be reviewed 3 months post start date.

By when we will have recovered the position

Quality improvement actions to optimise performance within the current service offer and financial envelope have been fully implemented, apart from medical workforce. Any further developments will be minor and classified as business as usual.

Operational Performance

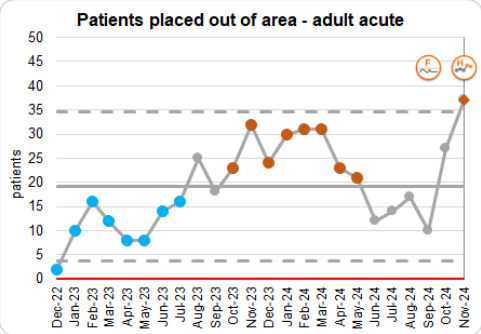
Summary
The national measure up to the end of 23/24 gave a combination of inappropriate out of area adult acute placements and psychiatric intensive care unit placements, calculated on a rolling 3 months' basis, at both ICB and sending provider level. From April 24 NHS England changed to measuring the number of placements at month end, at ICB level only. From internal data, at the end of November 24 there were 25 inappropriate out of area adult acute patients and 14 inappropriate out of area PICU patients. NB these figures exclude placements where continuity of care principles have been put in place, which are classed as appropriate placements.

Reasons for underperformance
There is an ongoing high level of demand for acute and PICU beds. Adult acute wards continue to operate at around 100% capacity, however leave beds are utilised where safe to do so.

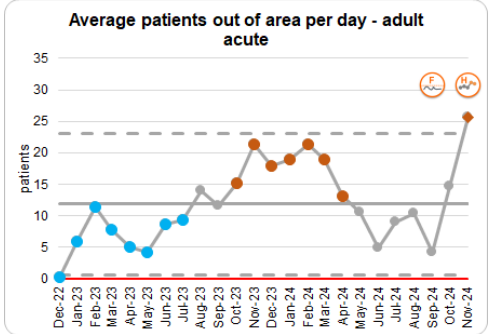
The level of acuity remains persistently high, resulting in the need for PICU beds and represented by the increase in adult acute admissions under the Mental Health Act, which account for 69% of all admissions. The level of acuity may also result in people taking longer to recover.

There are no PICU beds in Derbyshire at this time and therefore all patients placed in PICU are placed in out of area beds.

There is an increasing number of inpatients, both internally and out of area, who are clinically ready for discharge but who cannot be discharged for various reasons, predominantly linked to social care including housing factors.

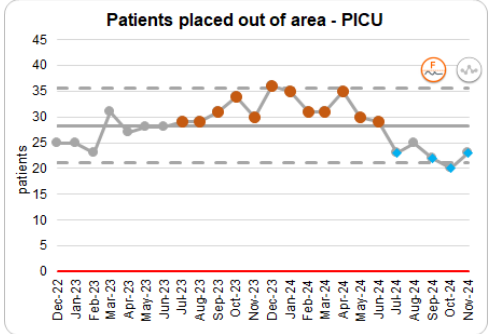


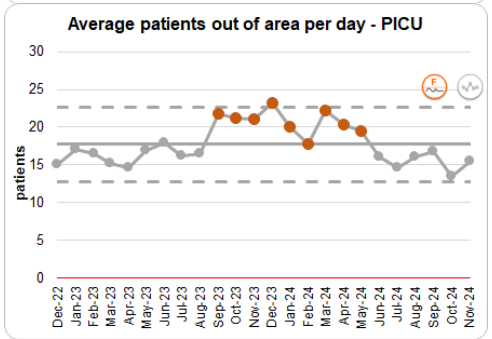
Recovery action plan
- A comprehensive recovery action plan has been developed and is being implemented.
- Step down beds to help with discharge flow and crisis house beds are being utilised to help avoid admissions where safe to do so.
- The crisis teams continue to work with higher than usual caseloads to avoid admissions to hospital wherever possible and appropriate.
- The Trust Strategic Integrated Flow Lead and Medical Lead for Clinical Transformation continue to support the improved flow of patients into and out of hospital.
- Changes to the learning disability & autism patients pathway to improve assessment and decision making have been implemented which have helped to manage this to ensure community alternatives are explored prior to admission.
- A weekly mini-MADE event as an escalation process for CRFD patients has been established.
- Liaison with the ICB regarding commissioning of inpatient services for people living in High Peak
- Gatekeeping has been implemented to provide a multi-agency response to the admission challenges.
- Implementation of community based Clozaril initiation, avoiding the need for admission to hospital.
- Enhance the impact of the emotional regulation pathway to support prevention of admission to hospital and/or facilitate early discharge.
- Derbyshire Mental Health Response Vehicle implemented in October 2024. This consists of one vehicle staffed by a paramedic and a mental health nurse.



Recovery action plan (cont.)
- The establishment of MAST in CMHTs ensuring focused input to those of greatest need and at greatest risk of admission.
- Cascade a communication to staff seeking a focus/support to improve flow and reduce inappropriate out of area placements.
- Review, refine and cascade OPEL differentiated actions.
- Develop and implement criteria led discharge guidance.
- Challenge and confirm process incorporated into review of out of area patients.
- Automatic multi-disciplinary review of patients identified as "extended length of stay".
- Estimated discharge date established during admission process and discharge planning to start at point of admission.
- ICB to facilitate a multi-agency out of area event in January 2025 to consider blockages to flow.
- Derbyshire ICB have agreed strategy to achieve maximum delayed discharge will be 24 hours. At the moment the average delayed discharge is 65 days with between 20 and 30 patients identified as "delayed discharge" at any one time.
- To engage with housing and clinical colleagues to ensure that homelessness pathway is robust as a discharge option.

By when we will have recovered the position
- End of March 2025.



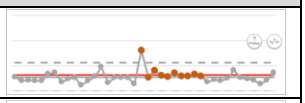
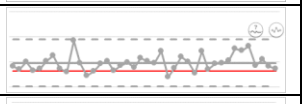
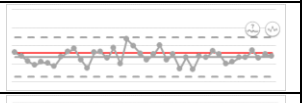
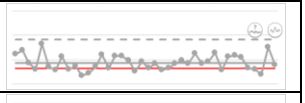
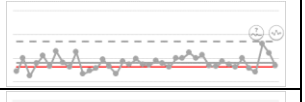
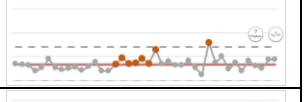
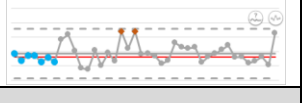
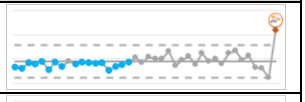
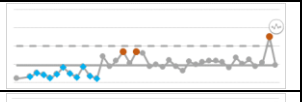
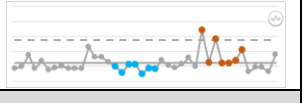
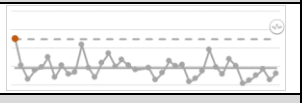
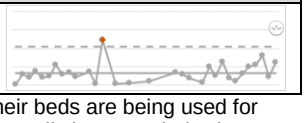


Summary
There is no local PICU provision, therefore anyone requiring psychiatric intensive care must be placed out of area. Work continues on the provision of a new build male PICU for Derbyshire, and an enhanced care ward for females at the Kingsway site.

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

Operational Performance

Occupancy & length of stay (days)

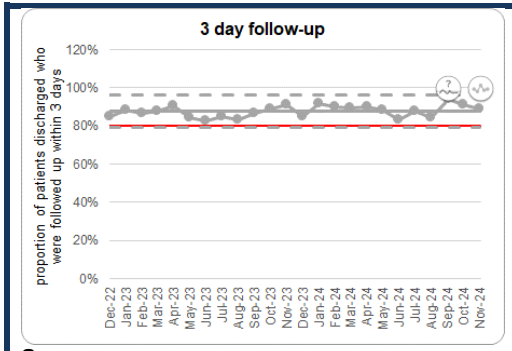
Clinical area	Beds	Bed occupancy Nov-24	Average duration of stay to date of current patients		Average length of stay Nov-24 discharged		Change versus previous month discharged		Change over time – median length of stay of discharged inpatients
Adult Acute			Mean	Median	Mean	Median	Mean	Median	
Morton	20	101%	49	39	49	37	↗	↗	
Pleasley	21	98%	108	52	69	36	↗	↘	
Tansley	21	105%	53	29	32	28	↘	↘	
Ward 33	20	93%	55	49	97	39	↘	↘	
Ward 34	20	97%	39	22	47	34	↘	↘	
Ward 35	20	103%	109	65	67	44	↗	↘	
Ward 36	21	100%	55	31	58	65	↗	↗	
Older People									
Cubley Female	18	62%	76	50	221	221	↗	↗	
Cubley Male	18	79%	77	66	81	92	↘	↘	
Tissington	18	96%	85	74	158	89	↗	↗	
Perinatal									
The Beeches	6	89%	47	47	24	31	↗	↗	
Rehabilitation									
Cherry Tree Close	23	97%	304	263	625	625	↗	↗	

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

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

Operational Performance

3 day follow-up



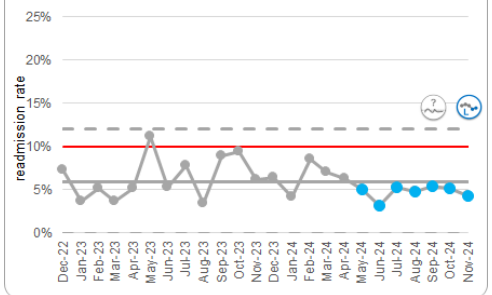
Summary

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

Actions

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

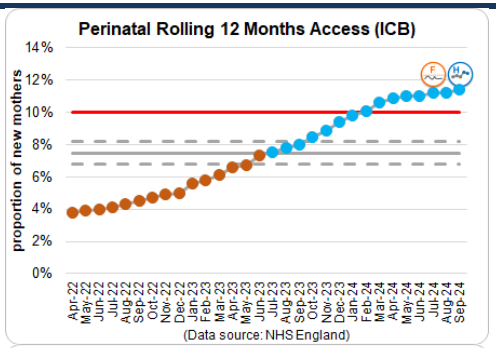
28 day readmissions



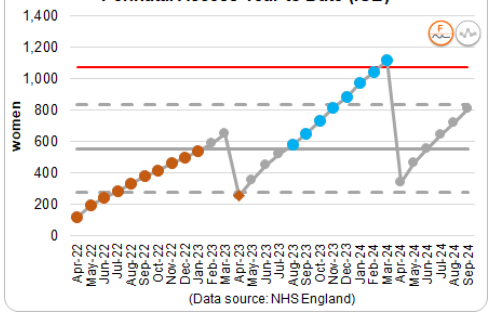
Summary

The rate of patients readmitted within 28 days of discharge from inpatient wards has remained within common cause variation throughout the reporting period and below the 10% contractual target for the vast majority of the time.

Perinatal Rolling 12 Months Access (ICB)



Perinatal Access Year to Date (ICB)



Summary

The service continues to exceed the 10% access target, rolling access rate is currently 11.7%. The service is now fully recruited to and has specialist assessor roles in place. Accepting self-referrals into the service and a developing an outreach workstream is improving inclusive, parity of access to the service. There is a consistently high demonstrable demand for the service. The service continues to flex at pace to ensure capacity and ensure that patients are seen within a timely manner. Completion of assessments within the maternal mental health service (MMHS) and psychology are lower than initially projected owing to length of stay on caseload and workforce challenges.

Actions needed to maintain target

- Continued action plan to address DNA's.
- Service to continue strategic direction to address health inequalities and potential barriers to access.
- Waiting list to continue to be monitored by RAP and monthly exception report.
- MMHS and psychology team to increase capacity to assess and manage wait times for the service.

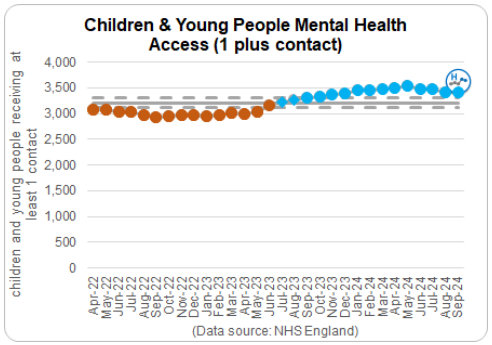
Regional comparison September 24

Perinatal access – rolling 12 months

Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag.
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	680	501	136%
NHS NORTHAMPTONSHIRE ICB	1,030	905	114%
NHS DERBY AND DERBYSHIRE ICB	1,240	1111	112%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1,285	1298	99%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	1,190	1259	95%
NHS BLACK COUNTRY ICB	1,505	1585	95%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	730	781	94%
NHS BIRMINGHAM AND SOLIHULL ICB	1,840	1953	94%
NHS LINCOLNSHIRE ICB	695	742	93%
NHS COVENTRY AND WARWICKSHIRE ICB	945	1045	90%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	980	1215	81%

NHS Derby & Derbyshire ICB was the 3rd highest performing in the region, with activity exceeding long-term plan trajectory.

Children & Young People Mental Health Access (1 plus contact)



Summary

Performance has remained significantly high since August 2023.

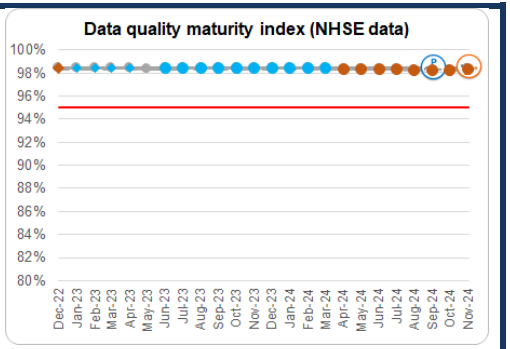
Regional comparison September 24

C&YP access 1 plus contact

Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag.
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	20,375	16124	126%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	17,690	14553	122%
NHS NORTHAMPTONSHIRE ICB	9,900	9600	103%
NHS DERBY AND DERBYSHIRE ICB	14,465	14463	100%
NHS COVENTRY AND WARWICKSHIRE ICB	12,420	12972	96%
NHS BLACK COUNTRY ICB	17,435	20240	86%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	9,835	11865	83%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	14,185	17273	82%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	6,250	8341	75%
NHS LINCOLNSHIRE ICB	8,525	11829	72%
NHS BIRMINGHAM AND SOLIHULL ICB	16,860	24834	68%

NHS Derby & Derbyshire ICB was the 4th highest performing in the region, with activity slightly aligned to the long-term plan trajectory.

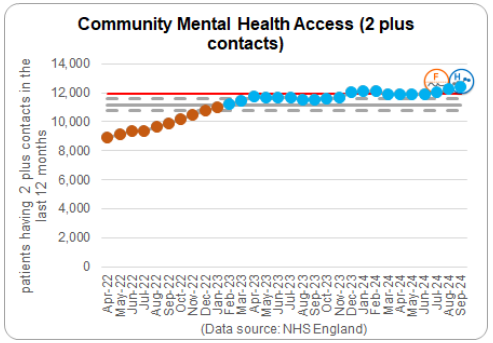
Data quality maturity index (NHSE data)



Summary

The level of data quality is consistently higher than the required standard. Work is in progress to correct many incorrectly recorded patient contacts which are impacting on reported waiting times.

Community Mental Health Access (2 plus contacts)



Summary

NHSE have published data for the current financial year 2024/25 up to September, which demonstrates that the target level activity has been achieved and sustained.

Regional comparison September 24

Community mental health 2 plus contacts

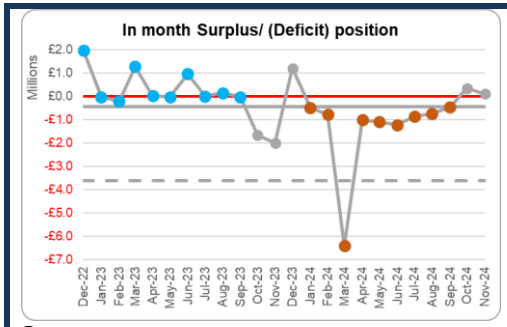
Organisation Name	Measure Value STR	LTP Trajectory STR	l Trajectory Percentag.
NHS BIRMINGHAM AND SOLIHULL ICB	25,200	10153	248%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	14,350	6714	214%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	15,805	7882	201%
NHS NORTHAMPTONSHIRE ICB	8,540	4870	175%
NHS DERBY AND DERBYSHIRE ICB	12,505	7229	173%
NHS BLACK COUNTRY ICB	14,260	8450	169%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	11,930	7720	155%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	7,885	5193	152%
NHS LINCOLNSHIRE ICB	7,545	5338	141%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	4,190	3350	125%
NHS COVENTRY AND WARWICKSHIRE ICB	7,800	6294	124%

NHS Derby & Derbyshire ICB was the 5th highest performing in the region, with activity exceeding the long-term plan trajectory by 73%.

Derbyshire Healthcare
NHS Foundation Trust

Finance

Financial Performance



Summary

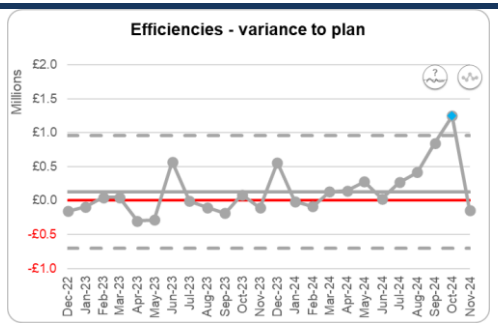
At the end of November, the financial position is a deficit of £3.2m which is better than plan by £2.1m.

The forecast position remains in line with the plan submission of £6.4m deficit.

Current risks to deliver the planned deficit:

- Delivery of efficiencies in full
- Management of Adult Acute out of area expenditure to reducing trajectory
- Management of in-patient expenditure to budget
- Additional costs of complex patient (now ceased)
- Management of agency expenditure within budget
- Management of any new cost pressures

The Board Assurance Framework (BAF) risk *that the Trust fails to deliver its revenue and capital financial plans for 2024/25,* remains rated as EXTREME due to the financial risks above.



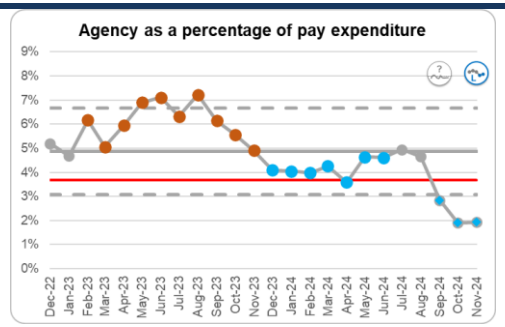
Summary

The plan includes an efficiency requirement of £12.5m with a proportion phased from quarter 2. The plan assumes 71% of the savings are delivered recurrently.

There has been a significant improvement in the position at the end of November. The plan YTD is set at £7.76m and actuals transacted are £8.0m, so we are now ahead of plan by £0.2m.

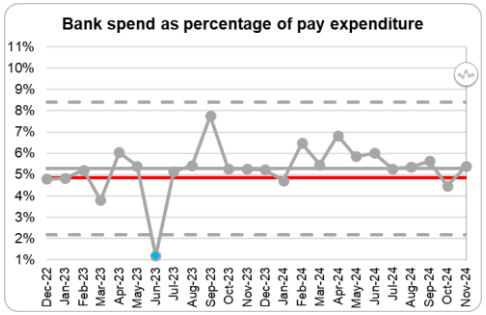
At the end of month 8 £11.3m (£9.0m last month) of the £12.5m planned efficiency delivery has been transacted in the ledger following the EQIA sign off process.

The Efficiency Programme Delivery Group, held fortnightly, continuous to oversee progress of the required savings.



Summary

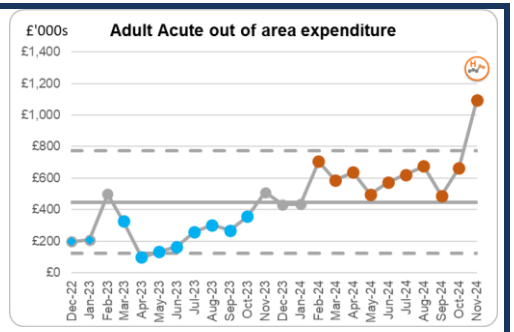
Agency expenditure YTD totals £4.1m which is below plan by £0.4m. This includes £1.2m of additional costs to support a patient with complex needs (ceased at the beginning of September). Excluding that cost the agency expenditure would be below plan by £1.6m.
The agency expenditure as a proportion of total pay for November is 1.9%.
The forecast agency expenditure of £5.3m is below plan by £0.9m (£2.1m below plan excluding the additional costs).
There has been a significant reduction in agency expenditure since July (37%), with November being the lowest for the financial year.
The two highest areas of agency usage continue to relate to consultants and nursing staff.



Summary

Bank expenditure YTD totals £6.3m, which is above plan by £0.6m.

Some of the additional staff on the wards in relation to CQC actions are through bank use, where the plan was set against agency.



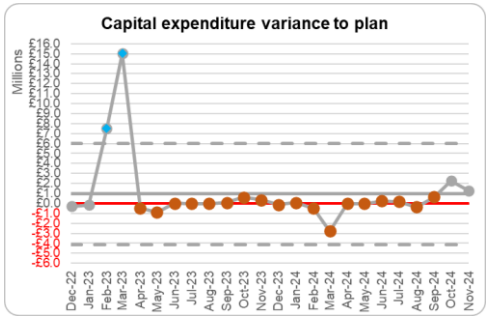
Summary

The plan for out of area expenditure is based on a reducing trajectory from twenty-two to zero beds by the end of the financial year. In addition to this the plan also included a further 6 block beds for part of the financial year.

At the end of November, the number out Adult Acute out of area placements are above the reducing trajectory which is generating an overspend of £2.1m.

The forecast does assume that the current number of inappropriate placements reduces over the remainder of the financial year along with the continuation of the current sue of block beds. This generates an overspend of £4.0m at the end of the financial year.

Financial Performance

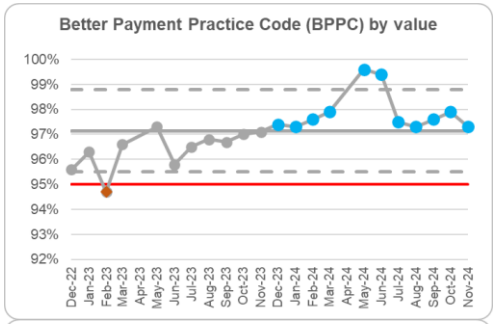


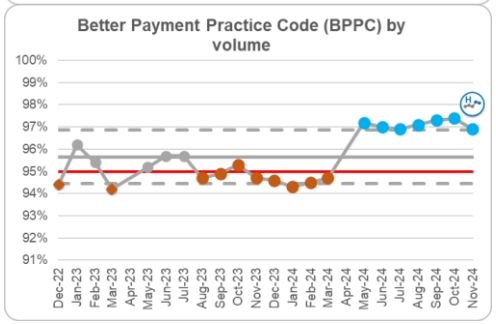
Summary
Capital expenditure against the system capital allocation at the end of November is above plan by £1.7m. This reflects the additional costs in relation to the Making Room for Dignity (MR4D) programme, of which some costs have been mitigated from pausing existing planned schemes.

Additional national funding for the MRFD programme has been confirmed (subject to certain conditions) and the costs are included in the forecast.

Any additional risks related to any new leases, which due to the changes in accounting treatment, will now need to be funded from the system capital allocation.

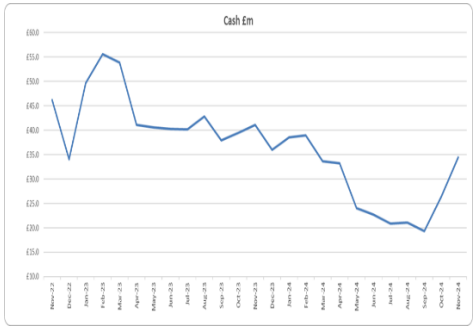
NHS England have requested that Providers provide specific Board approval that the capital expenditure forecasts are accurate and robust. This declaration can be provided by Chief Finance Officers or Chief Executives on behalf of the Trust Board.





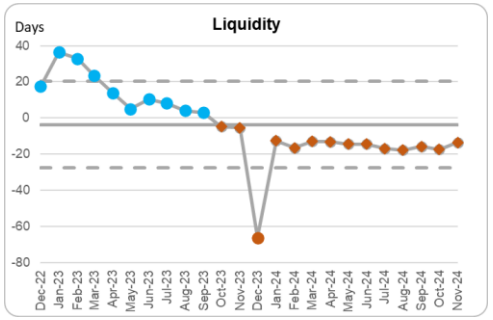
Summary
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of November, both the value and volume of invoices exceeded the target at 97.3% and 96.9% respectively.



Summary
Cash at the end of November is at £34m (£26.4m last month) which is above plan by £11.1m. This relates to timing of receipts and payments in relation to the MR4D programme.

With the forecast over commitment of capital expenditure, cash is now forecast to be at £14.2m by the end of the financial year, which is below plan by £5.0m.



Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22, however in 2022/23 the liquidity reduced due to the timing of cash receipts related to the centrally funded capital scheme for the MR4D programme. The Public Dividend Capital (PDC) drawdown requests caught up in January 2024 which increased the level back up. Drawdown requests are transacted monthly which has stabilised liquidity levels during 2024/25.
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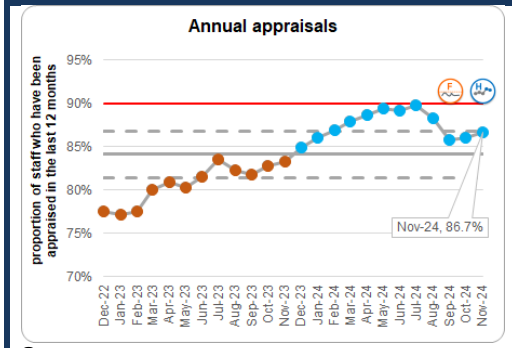
Derbyshire Healthcare
NHS Foundation Trust

People

People Performance

Annual appraisals



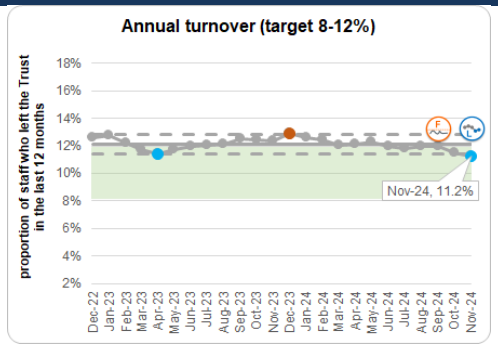
Summary

Overall, performance remains slightly below target. Operational Services are currently at 87% and Corporate Services at 84%, against the target of 90%.

Actions

- Work has been undertaken to understand why there are challenges within corporate services to achieve full compliance. As a result, a shortened version of the appraisal is being developed for estates and facilities and team appraisals are being considered to support the division.
- A new IT function has been set up to automatically notify and send calendar reminders to both appraiser and appraisee – this has been trailed in the people directorate and will now be rolled out across the Trust.
- Targeted emails from the DOP and CEO are being sent to managers where compliance remains consistently below target.
- Appraisal data is being used with other key people performance metrics to identify hotspot areas and bespoke targeted OD work is being commissioned.

Annual turnover (target 8-12%)



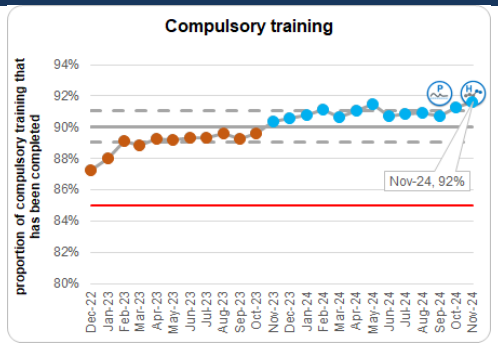
Summary

Overall turnover has been on target for the last 6 months and remains in line with national and regional comparators.

Actions

- The review of staff benefits to support engagement and retention has been completed. One of the key components of the review was the Trusts salary sacrifice schemes. The scheme was re-launched in August 2024 and is proving extremely popular with our colleagues.
- The Trust continues to run a vacancy control panel to monitor all recruitment activity.
- Stay surveys are now becoming embedded in a retention programme at 3,6 and 9 months to ensure managers and colleagues are supported to address any early concerns and to support retention.

Compulsory training



Summary

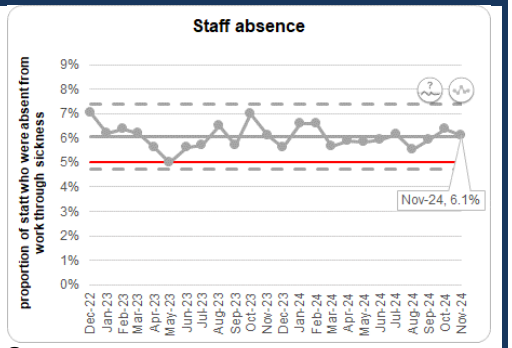
Overall, the 85% compliance target has been achieved for the last 24 months. Operational Services are currently 92.6% compliant and Corporate Services are 87%.

Actions

The following actions remain in place to support achievement of compliance:

- A review and monitoring of all 'did not attend' (DNA's) occurrences is regularly fed back to ensure all employees re-book in a timely manner.
- A targeted campaign of prioritising compulsory training elements that have been out of date the longest has been undertaken.
- The Training and Education Group continue to oversee and review training compliance, changes and challenges.

Staff absence



Summary

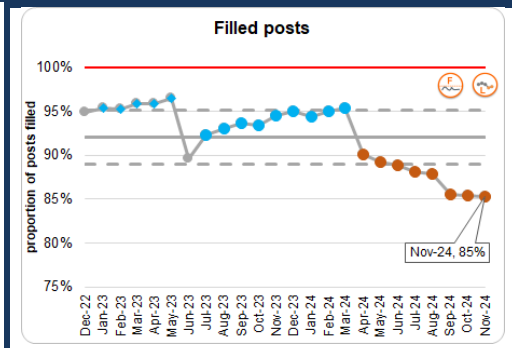
The monthly sickness absence rate is 6.1%, which is a small reduction from last month (0.16) and from this time last year (0.04).

November saw a small reduction in short term and long term absence with stress or depression related illness remaining the highest reason for sickness absence, followed by surgery and other musculoskeletal problems.

Actions:

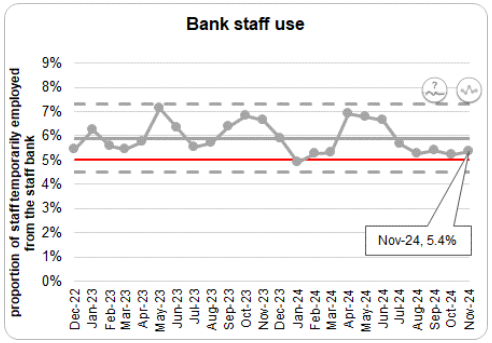
- A review continues to take place with a view to ensure early intervention takes place at an earlier stage.
- All long-term absences are reviewed each month with the Director of People, Organisational Development & Inclusion and the Employee Relations to ensure a supportive and robust approach continues to be taken to managing all absences.

People Performance

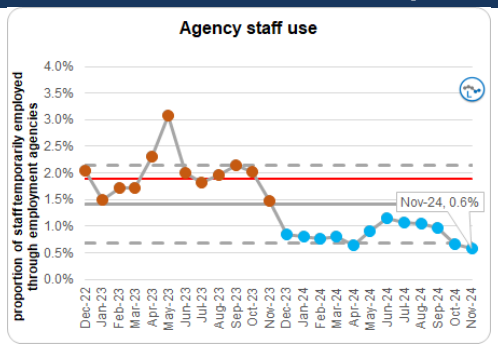


Summary
At the end of November 2024, 85% of posts overall were filled. New investment released from April 2024 onwards has created brand new vacancies.

Actions
- Work continues towards planning and recruiting into the Trust's key transformation project 'Making Room for Dignity' programme.

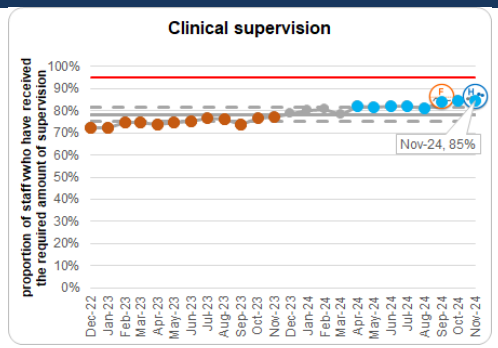


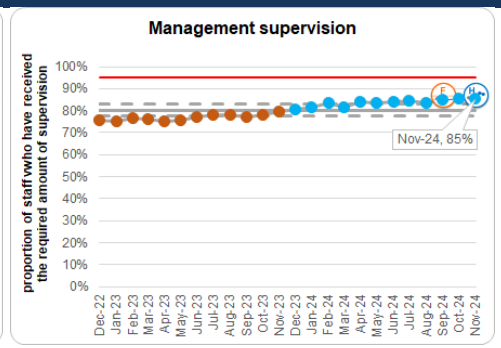
Summary
The proportion of staff employed from the bank ranges from 4-7% per month. Bank staff are predominantly employed on inpatient wards. Reasons for temporary staffing include cover for vacancies, sickness and maternity leave, and for increased levels of observations.



Summary
Agency usage has reduced significantly over recent months and continues to fall following a temporary increase in agency usage due to a requirement for increased clinical observations.

Actions
The actions previously identified below, continue to remain in place and operational as business as usual.
- Weekly Authorisation Panel continues to oversee agency requests across the Trust.
- All admin and clerical agency usage remains eliminated.
- Clear protocols are in place to cover the circumstances where the various levels of agency workforce (including Thornbury) relate to enhanced, safer and emergency staffing levels.
- Ongoing actions are taking place to support the reduction in medical agency, these include creative recruitment campaigns, alternative workforce roles where appropriate and continued increase of availability of temporary staffing through the Trust's medical bank function.





Summary
Overall compliance is 85% for both clinical and management supervision.

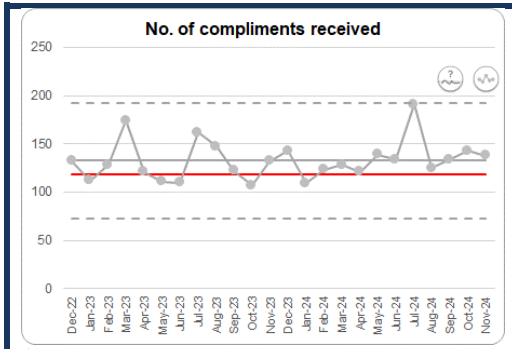
Actions
Following the audit of supervision processes, the Trust is now following up on the recommendations which will help towards achieving its target for both clinical and non-clinical supervision.

The recommendations include:
- the Supervision Policy and consider whether a full review/refresh is required based on the findings in this report and the responses to the survey of Trust staff
- arrangements for documenting and recording supervision to ensure these are clearly outlined within the policy and ensure these responsibilities and communicated and compliance is monitored
- training arrangements for supervisors
- governance arrangements in place to monitor supervision compliance to ensure forums are in receipt of sufficiently detailed reports to oversee and scrutinise performance of all types of supervision
- the actions in place to improve supervision and the performance reporting in place to ensure these are consistent across Operational and Corporate Services
- reporting across the Trust covers all areas of supervision required as outlined within the Trust's policy. minimal supervision expectations and how these are allocated throughout the year and update reporting to reflect this requirement to assess compliance

Derbyshire Healthcare
NHS Foundation Trust

Quality

Quality Performance

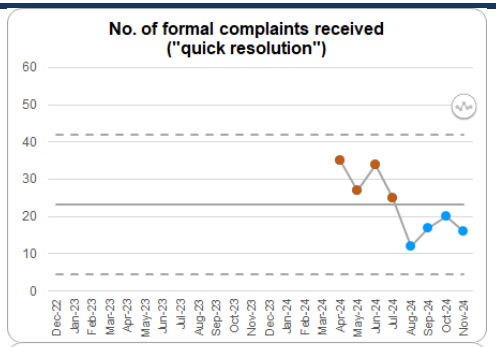


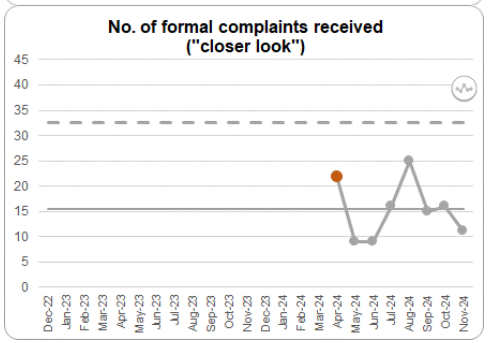
Summary
The number of compliments recorded between August and November 2024 range from 125 to 138 This is in line with common cause variation and the number of compliments received are expected to continue to exceed the set margin of 119.

Actions
The Head of Nursing/Practice team continue to monitor this data via the quarterly patient and carer experience report and have identified actions to improve the gathering of compliments.

However, it is noted that all services would benefit from improving the recording of compliments as it is clear from looking at trust provision such as the delivering everyday excellence (DEED) awards that compliments received are not accurately recorded.

The Heads of Nursing/Practice will attend their Divisional Clinical Reference Group (CRG) to explore the barriers of getting feedback from services and the progress will continue to be monitored.



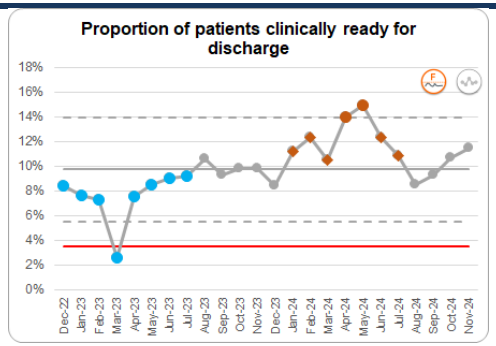


Summary
The number of complaints Identified as “quick resolution” increased from 12 to 16 between August and November 2024.

The complaints categorised as “closer look”, which involve a Trust commissioned investigation, reduced from 25 to 11 between August and November 2024.

This is in line with common cause variation and will continue to be monitored by the Patient Experience Team.

Actions
The Patient Experience Team monitor complaints and where specific themes are identified, these are passed on to the HoN/P Team and explored in a quarterly thematic analysis Patient and Carer Experience Committee report which is sent to both the Patient and Carer operational group and the Trust Quality and Safeguarding Committee for assurance.

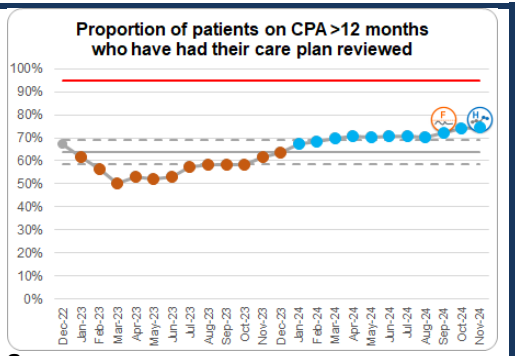


Summary
The proportion of service users meeting the criteria of Clinically Ready for Discharge (CRD) has increased from 8% to 12% between August and November 2024.

The most common reason for patients meeting the criteria for CRD continues to be a lack of available, appropriate housing, establishing funding, and availability of social care placements.

Escalation processes and partnership support

- An Adult CRD meeting continues to be held 3 times a week, which includes social care services.
- The Trust Strategic Integrated Flow Lead continues to attend the weekly system wide Pathways Operations Group, system wide, weekly Discharge Planning Implementation Group and monthly Strategic Discharge Group.
- A Discharge Tracking Tool as requested by NHS England has been in progress since July 2024, reviewing all adult admissions and onward referrals, allocations and barriers to discharge. This tool is used to monitor timescales, escalations and identify themes such as a lack of available, appropriate housing, establishing funding, and a lack of availability of social care placements.
- The System priorities identified from the Discharge Planning Implementation Group are expected to achieve continuity and coordination of care, reduce avoidable length of stay and improve flow and access to local beds over the next 3 months.



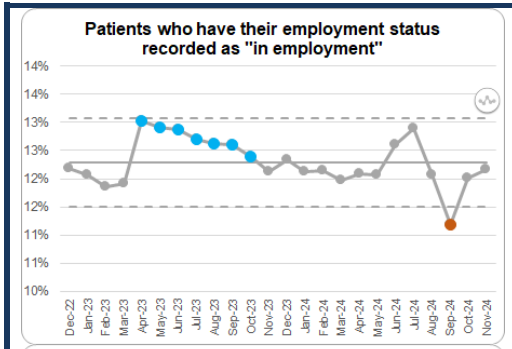
Summary
The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 74%. The trust target is 95% compliance however compliance continues to improve month on month with 1% improvement between August and November 2024. A number of actions as identified below have been identified to support more efficient improvement. It should however be noted that 89.5% of patients have a care plan present.

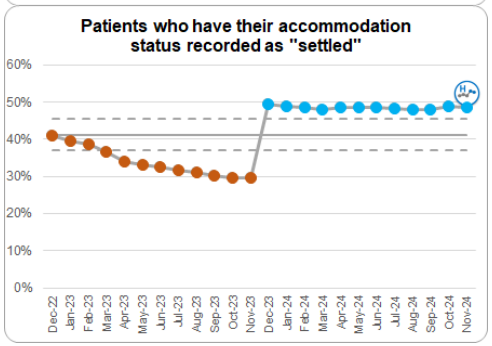
Actions

The Trust services with compliance lower than 85% have identified action plans to improve care plan, risk screen and CPA compliance as below:

- A process for monitoring compliance and quality has been implemented in each division and is monitored via the monthly Fundamentals of Care meeting, (in Inpatients, the Clinical Reference group) and the Divisional Clinical Operational Assurance Team (COAT) meetings.
- The Trust Digital practice team sent out “quick user guides” to services and offer drop-in sessions to support staff in inputting information correctly but have stated there is no way to prevent staff creating the care plans in an incorrect way which is not picked up by the algorithm.
- With improved care plan compliance, it is expected that more timely reviews of CPA will follow. There is also a working group in place which meets monthly to review the Trust approach to CPA led by NHS England and attended by the trust head of nursing for Community Services and the Practice lead for the Trust Living Well service.

Quality Performance



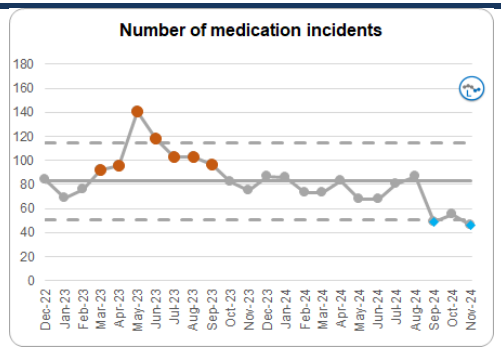


Summary

Patients open to the Trust in settled accommodation has remained static at 49% between August and November 2024 and the number of patients open to employment has continued to remain between 11 and 13 percent since August 2022. This measure continues to be monitored by individual services.

Actions

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

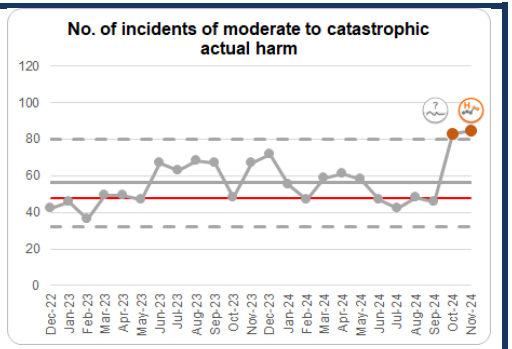


Summary

The number of medication incidents between August and November 2024 have fallen from 87 to 46 and the number of incidents is expected to continue under the Mean of 90. It should be noted that the medication incidents reported are largely of low-level harm.

Actions

- The “Quick medicine reference guide” relating to Controlled Drugs and measuring liquids is now available on FOCUS as part of Medicine Code and hard copies are available in all inpatient clinic rooms.
- To improve medicine temperature monitoring a task and finish group including Heads of Nursing, pharmacy and clinical leads started in January 2024 and is expected to reduce the number of incidents recorded following its conclusion. This could be influencing incidents not going over 90 since January 2024.
- DHCFT Pharmacy are feeding back to ward managers on a quarterly basis about shared learning from Monthly meetings with Chesterfield Royal Hospital pharmacy.
- The number of medication incidents is reviewed via the monthly medication management subgroup and is reported on within the quarterly thematic “Feedback Intelligence Group” (FIG) report by the Heads of Nursing/Practice and is included in the Serious Incidents Bi-monthly report. Any actions identified are reviewed via the medicines management subgroup and the Serious Incidents Bi-monthly report is taken quarterly to the Quality & Safety Committee (QSC) for assurance.



Summary

This data demonstrates the number of DATIX incidents recorded as moderate or catastrophic harm. The number of incidents increased between August and November 2024 from 46 to 85 incidents.

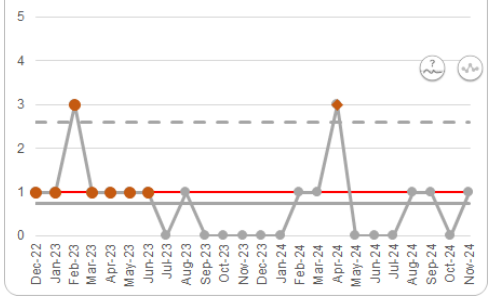
Analysis suggests that this is due to an increase in the number of incidents reported by staff recorded as “self-harm” and physical assault from patients to staff and patient to patient and an increase in the number of deaths reported. This will be reviewed further and discussed with the patient safety team in relation to any themes or patterns.

A pattern of a high number of repeated incidents involving to a small group of patients continues to be seen in relation to self-harm and physical assault and is consistent with anecdotal reports from staff that acuity on the inpatient wards is high and this is most prevalent on the female acute wards.

This will be monitored by the Patient Safety team and the Heads of Nursing/Practice.

Quality Performance

No. of incidents requiring Duty of Candour



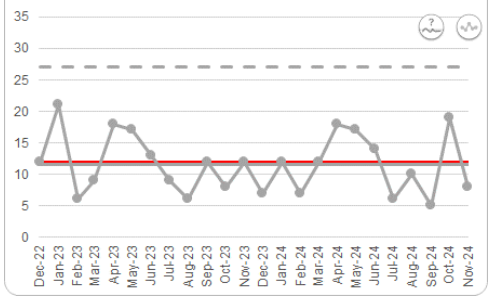
Summary
Duty of Candour remains within expected thresholds between August and November which required duty of candour disclosure.

The Trust Family Liaison Office has created information leaflets and standing operating procedures to support staff in completing Duty of Candour communications. Furthermore, these are reviewed twice weekly within serious incident groups.

The Trust Family Liaison Office has created information leaflets and standard operating procedures to support staff in completing duty of candour communications. Furthermore, these are reviewed twice weekly within serious incident groups.

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

No. of incidents involving prone restraint

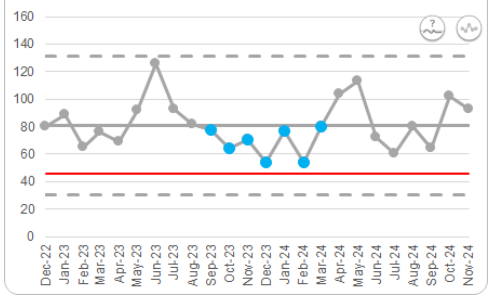


Summary
Incidents of prone restraint have continued within common cause variation between August and November 2024 and are currently below the Trust margin of 12 incidents.

The increase in October 2024 was attributed to a small number of unwell individuals who required multiple interventions and numbers have reduced in line with the recovery of these individuals

Action
This data is monitored via the monthly Reducing Restrictive Practise group and is presented for assurance to the Trust Mental Health Act committee and Quality and Safeguarding committee.

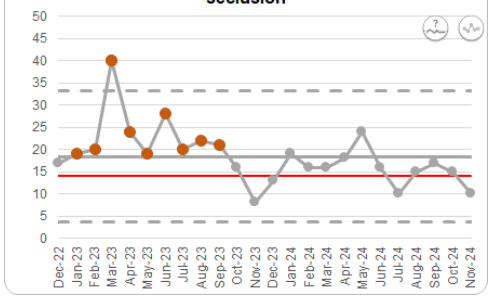
No. of incidents involving physical restraint



Summary
Physical restraints have increased from 80 to 93 incidents between August and November 2024 and continue above the Trust margin of 45 incidents. The increase in episodes of physical restraint is attributed to an increase in self-harm incidents and a correlating increase in staff intervention required to prevent individuals harming themselves.

Action
The Trust Positive and Safe Support team continues to offer supplementary training sessions to improve training availability for staff and compliance with positive and safe training is currently at 77% for teamwork and 68% for breakaway training. The slower than anticipated increase in compliance is due to staff who were previously identified as medically exempt, now requiring training and an increase in staffing who require the training related to the making room for dignity programme Compliance with training is monitored in monthly divisional assurance review meetings and the monthly Reducing Restrictive Practise group. Compliance is expected to increase monthly and the PSST team aim to get both breakaway and teamwork training to 85% by December 2024 due to the increase in staff who require training.

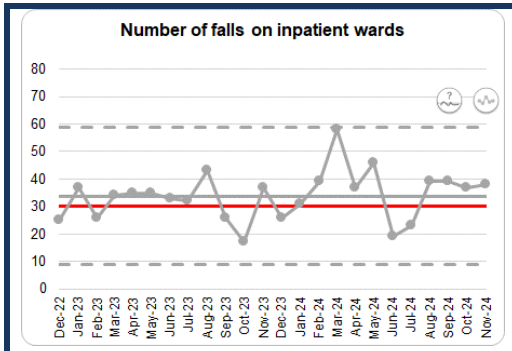
No. of new episodes of patients held in seclusion



Summary
Seclusions August and November 2024 have decreased from 15 to 10 episodes of seclusion. This is in line with common cause variation and below the Trust target of 14 incidents.

Action
- Episodes of seclusion continue to be monitored via the monthly Reducing Restrictive Practice group.
- A review focused on peer support including debrief is expected to have an impact on reducing the number of seclusion incidents was expected to be complete by October 2024 however due to unexpected delays related to the working group capacity, this is now expected in January 2025
- This review will be presented, and progress monitored through the monthly Trust Reducing Restrictive Practice Group when completed.

Quality Performance



Summary

The number of falls recorded have continued above the Trust margin of 25 falls between August and November. The higher numbers are attributed to repeated incidents attributed to a small group of patients with challenging conditions. Following these patients being discharged to more appropriate environments, the number of falls is expected to reduce over the next 2 months. The Older persons service have also reported that from September 2024 there has been an increase in frail patients who have high levels of physical care needs.

It should also be noted that 90% of the falls recorded over this period were categorised as minor or insignificant meaning that no harm came to the individuals involved.

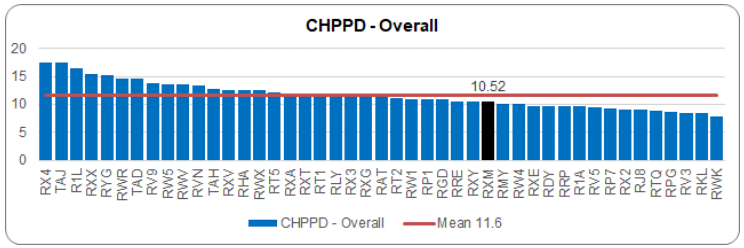
Actions

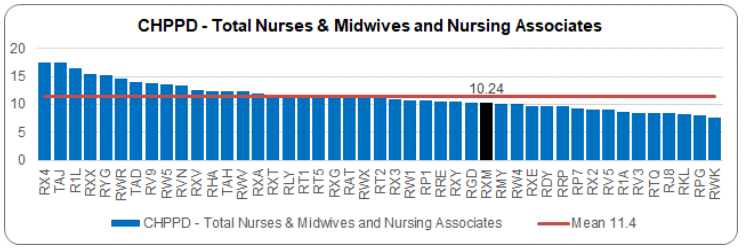
- The patients identified as high risk of falling are discussed in the biweekly falls prevention meeting and have fall prevention care plans in place
- Support from a dedicated falls prevention Physiotherapist has not been embedded as expected and this is due to be escalated to a newly recruited Physiotherapy lead in January 2025.
- The number of falls reported is monitored via the Falls Lead Occupational Therapist, Head of Nursing and Clinical Matron and learning from the bi-weekly falls prevention meeting is reviewed in the monthly Divisional COAT meeting.

Care Hours per Patient Day (CHPPD)

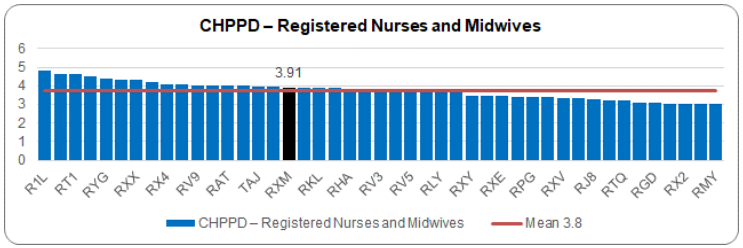
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying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

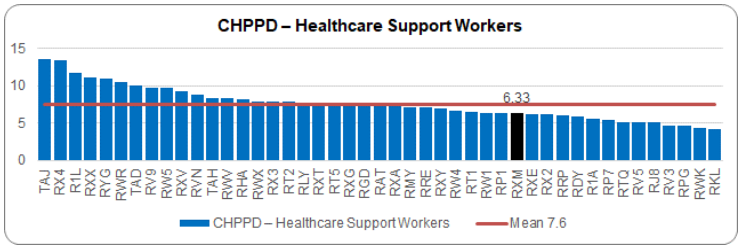
The charts below indicate that the Trust's CHPPD overall achieved 10.52 hours, which was below average when benchmarked against other mental health trusts in the country (11.6). For total nurses and nursing associates the Trust achieved 10.24 hours against the national average of 11.4 hours:





For registered nurses the Trust achieved 3.91 hours against the national average of 3.8 hours. For healthcare support workers the Trust achieved 6.33 hours against the national average of 7.6 hours:



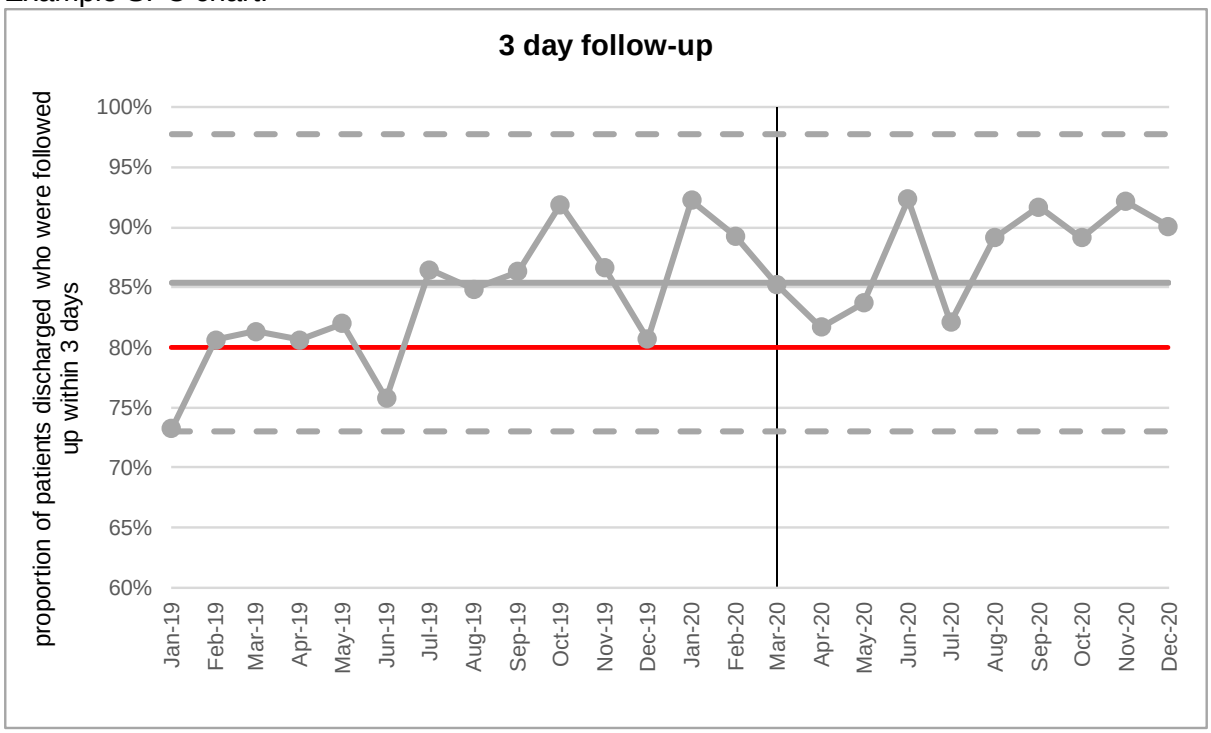


https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-data/

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



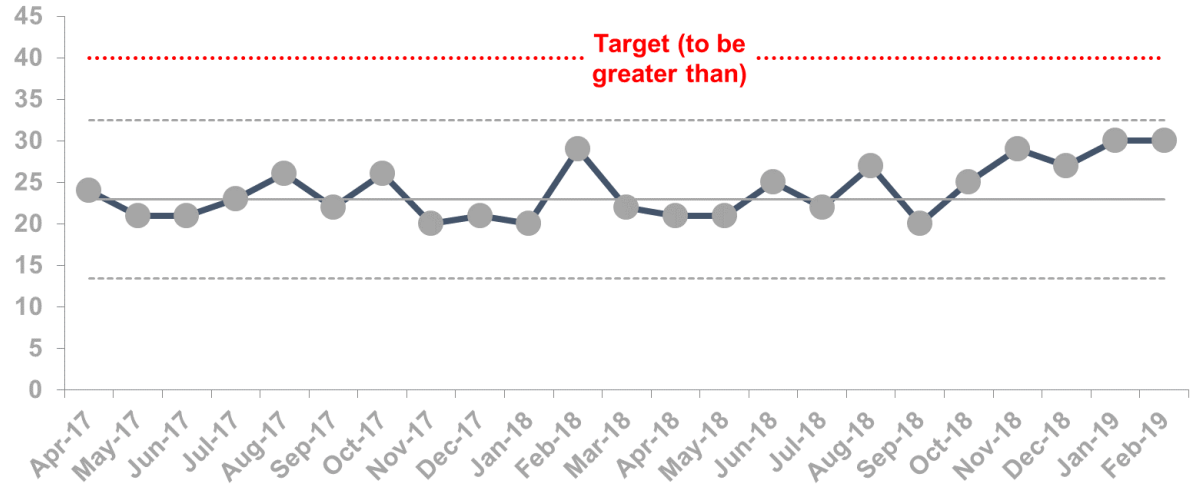
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

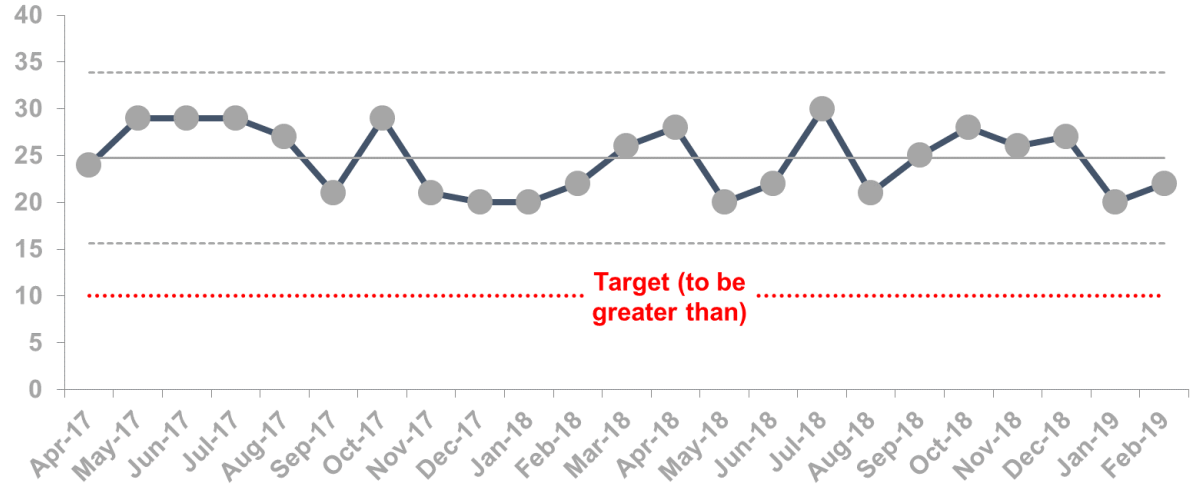
Things to look out for:

1. A process that is not working:



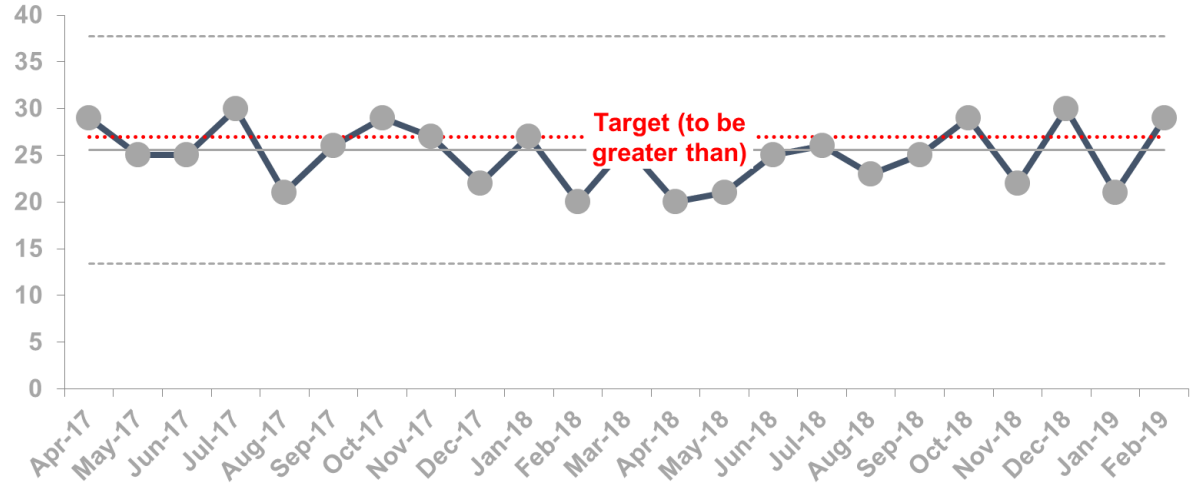
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



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

3. An unreliable system:

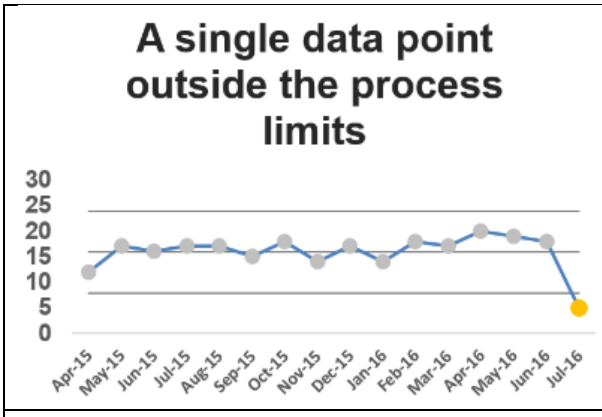


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

<table>
<tr>
<td> 
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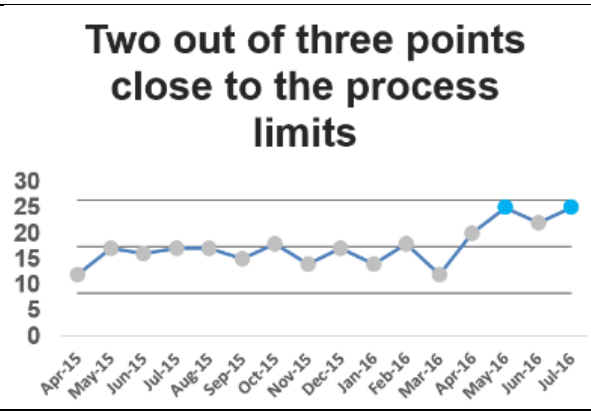
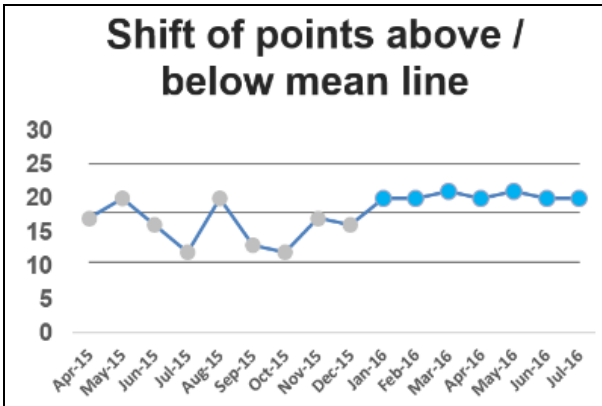
<td> 
</td>
</tr>
<tr>
<td>In this example the July 2016 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.</td>
<td>Two out of three points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.</td>
</tr>
<tr>
<td> 
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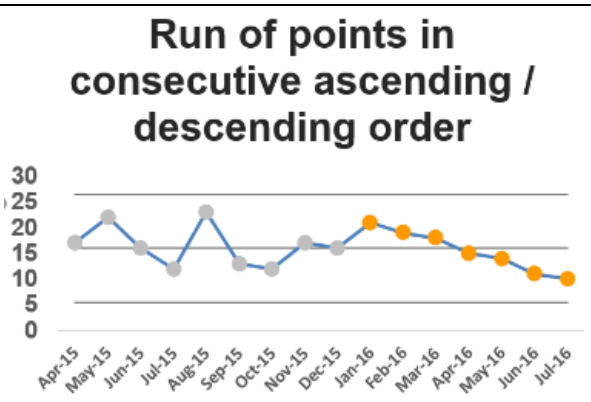
<td> 
</td>
</tr>
<tr>
<td>A run of seven points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 2016 that has proven to be effective.</td>
<td>A run of seven points in consecutive ascending or descending order is significant. In this example things are getting worse over time.</td>
</tr>
</table>

Frequently seen in the NHS:

"**Spuddling**" - to make a lot of fuss about trivial things, as if they were important.
Spuddling leads to tampering and tampering nearly always increases variation.

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

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

Appendix 2

Assurance Ratings

- **Full Assurance** can be provided that the system of internal control has been effectively designed to meet the system's objectives, and controls are consistently applied in all areas reviewed
- **Significant Assurance** can be provided that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk
- **Limited Assurance** can be provided as weaknesses in the design or inconsistent application of controls put the achievement of the system's objectives at risk in the areas reviewed
- **No Assurance** can be provided as weaknesses in control, or consistent non-compliance with key controls, could result [have resulted] in failure to achieve the system's objectives in the areas reviewed.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 14 January 2025

Trust Strategy Progress Report

Purpose of Report

To provide the Board with an update on progress since the launch of the new 2024–2028 Trust Strategy in October 2024, and to provide a final update on the remaining actions set out in the previous 2022–2025 Trust Strategy.

Executive Summary

The new Trust Strategy was launched in October 2024 and action has since been progressed to develop the associated strategic delivery plan and embed the personal accountability framework. A draft strategic plan for 2025-2028 has been developed, based on the outputs of the Board Development Session in October, and the dialogue on transformational opportunities hosted at the staff conference.

The initial draft strategic plan was reviewed and tested through a further workshop-style Board Development Session on 18 October. The outputs of this are being applied to further develop plan content, and a final draft will be produced in January for validation by the Executive team and then approvals through all relevant governance forums. The Leadership Forum in January will be harnessed as a first opportunity to socialise the strategic delivery plan content with leaders across the organisation, with further activities planned to cascade this within the organisation once the final version is approved and published.

In relation to the previous Trust Strategy, there are three remaining priority actions to be fully completed, updates on progress are included in the Roadmap for 2024/25 (Appendix A). These are as follows:

- Making Room for Dignity: improve the safety, privacy and dignity of patients.
- Deliver less than 32 days average length of stay on Trust Acute Mental Health wards.
- Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree the 3-5 year financial plan.

All the other priority actions set out in the strategy have been delivered. It is intended that the remaining three priority actions are transferred to the new strategy and progress reported as part of the new strategy updates to Board.

The Board is asked to note the progress following Trust Board approval of the new 2024–2028 Trust Strategy, and the intention to add the as yet incomplete actions from the previous strategy to the delivery plan for the new strategy to enable oversight and assurance on future implementation/delivery.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

New Trust Strategy approved by the Trust Board in October 2024.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

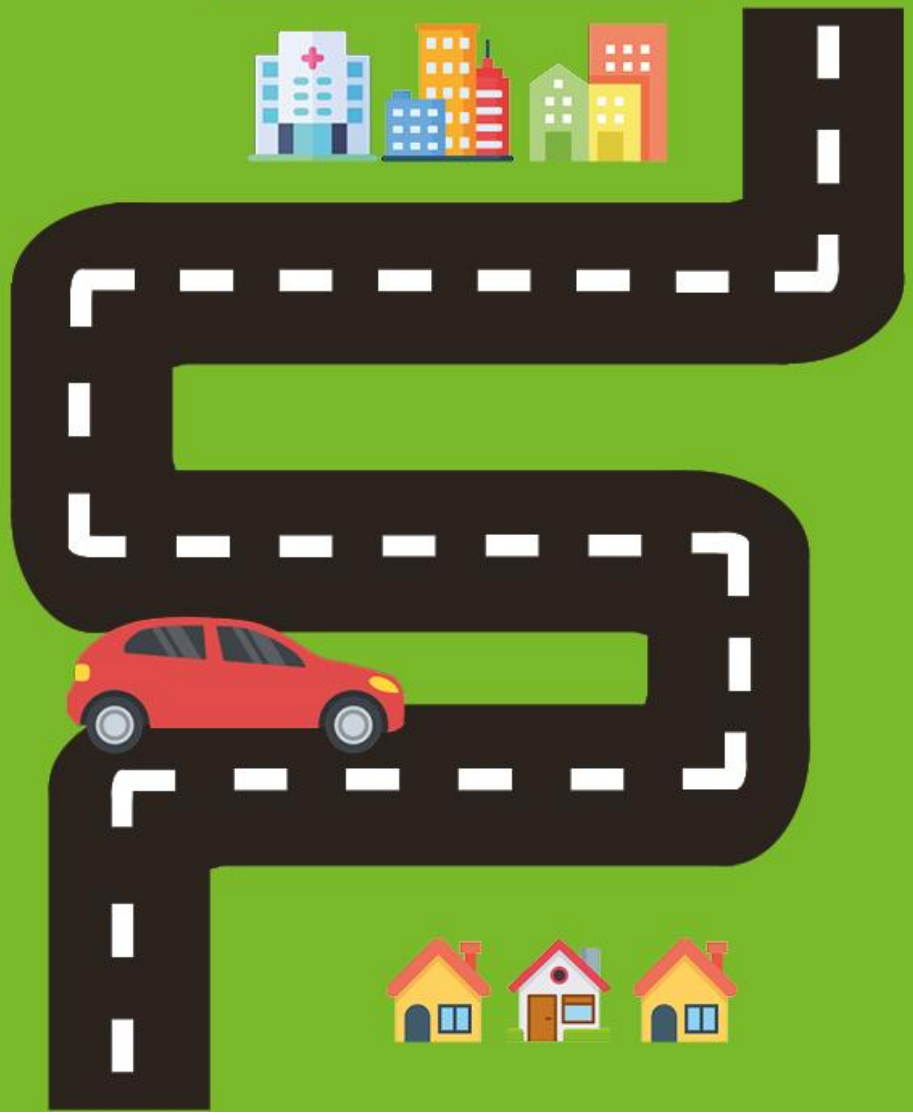
Recommendations

The Board is requested to note the progress following Trust Board approval of the new 2024–2028 Trust Strategy, and the intention to add the as yet incomplete actions from the previous strategy to the delivery plan for the new strategy to enable oversight and assurance on future implementation.

Report presented by: **Vikki Ashton Taylor**
Deputy Chief Executive and Chief Delivery Officer

Report prepared by: **Maria Riley**
Assistant Director of Transformation

Priorities we will deliver in 2024/25



- Improve processes for those experiencing stress in and out of work
- Successfully implement and lead the provider collaborative for Perinatal inpatient services
- Deliver perinatal community mental health access standard of 10% of prevalence
- Work in partnership to progress the harmonisation of Learning Disabilities and Autism services
- Develop a consistent approach to people-centred leadership
- Develop a workforce plan
- Each division will have its own specific quality requirement standards
- Making Room for Dignity: Improve the safety, privacy and dignity of patients through our Making Room for Dignity programme
- Deliver a less than 32 days average length of stay on our acute mental health wards
- Deliver electronic prescribing and transfer prescriptions element of the OnEPR programme
- Recover dementia diagnosis rates to national target of 67%
- Improve recruitment and retention to support new services and ensure safer staffing levels
- Deliver our Long Term Plan Commitments including Transforming Care Partnership (TCP) and Living Well
- Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued
- Optimise the use of SystmOne across the Trust
- Focusing on the safety domain of practice and preparing for changes in mental health legislation
- Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree our 3-5 year financial plan

Completed
Partially completed
In progress

Progress in Delivering 2024/25 Priorities

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Making Room for Dignity: Improve the safety, privacy and dignity of patients	Partially completed. Construction / refurbishment completed for Bluebell Ward and Audrey House with some additional works required at Audrey House. Construction nearing completion for new builds. Refurbishment at the Radbourne Unit has been delayed and results in a change to the timeline as set out below. Recruitment progressing for additional posts required. Bluebell Ward, Walton Hospital Derwent Unit, Chesterfield Royal Hospital Audrey House Enhanced Care Unit Carsington Unit, Kingsway Hospital Kingfisher House PICU, Kingsway Hospital Jasmine Ward, Radbourne Unit Orchid Ward, Radbourne Unit – pending additional capital	Ongoing Go-live 7 Jan 2025 Feb / March 2025 Feb / March 2025 Feb / March 2025 April / May 2025 Spring 2026 Spring 2027Ongoing	Finance & Performance Committee People & Culture Committee Quality and Safeguarding Committee
Deliver Perinatal community MH access standard of 10% of prevalence	Delivered. The target is measured on a rolling 12 month period. The full year 10% target has been achieved in February 2024 (10.1%)	Delivered	Finance and Performance Committee
Develop a consistent approach to people centred leadership	Delivered. Leadership development strategy and approach finalised and discussed at May People and Culture Committee. Senior leadership programme has now been commissioned. Ongoing leadership programmes on offer to colleagues and bespoke team development in place. Assurance will continue to be fed into PCC on progress and delivery.	Delivered - September 2024	Quality and Safeguarding Committee People and Culture Committee
Deliver less that 32 days average length of stay on our acute MH wards	In progress. NHS England monitors the mean length of stay (LoS) for patients discharged from adult acute inpatients beds, which for the Trust is currently reported as 52.9 days. This is a worsening position and a result of a small number of extremely long LoS patients. For example, 12 patients were discharged in October who had been inpatients for more than 100 days, 1 of whom exceeded 500 days. This position is affected by patients who are ready for discharge but who are unable to be discharged. The establishment of the ICB Executive Discharge Group now provides a forum for DHcFT to escalate delays to discharge for clinically ready to discharge (CRFD) patients. There has also been an increased focus from partners such as Derby City Council, to reduce delays to social worker allocation, panel decisions and representation at the weekly CRFD meeting held. Year to date, the median length of stay for adult acute inpatients was 33 days. As this number excludes very short and very long LoS patients, the focus therefore continues to be on reducing the longest length of stay patients, where clinically appropriate.	March 2025	Finance and Performance Committee

Progress in Delivering 2024/25 Priorities

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Each division will have its own specific quality requirement standards	The Divisions and services will be assessed through the Single Assessment Framework (CQC). The Fundamental Standards of Care have been revised and reflect the standards of from the CQC and other evidence based standards such as AIMs, NICE Guidance related to each service.	Delivered	Quality and Safeguarding Committee
Work in partnership to progress the harmonisation of learning Disabilities and Autism services	Delivered. A MoU has been developed between executive leaders across the organisations to provide a joined-up approach for citizens, a common vision, objectives and purpose and improved quality, pathways or access to care for patients and carers. An integrated leadership structure has been implemented via a single Head of Service Derbyshire Healthcare NHS Foundation Trust (DHcFT) employee)	Delivered	Trust Board
Improve processes for those experiencing stress in and out of work	Delivered. In house staff Clinical Psychologist in place and offering support to colleagues both in and out of work. This is to complement the existing offer via Employee Assistance Programme (EAP) and Resolve. Alignment with long term absences in place.	Delivered	Quality and Safeguarding Committee
Successfully implement and lead the provider collaborative for perinatal inpatient services	Delivered. Approval granted by NHS England for Derbyshire Healthcare NHS Foundation Trust (DHcFT) to become Lead Provider in October 2023. Formal governance arrangements are now established in relation to contracting and quality oversight.	Delivered	Quality and Safeguarding Committee People and Culture Committee
Deliver electronic prescribing and transfer prescriptions element of the OnEPR programme	Delivered. Successful implementation and roll out. Optimisation work underway to improve standard operating procedures in services where improvement opportunities have been identified.	Delivered	Finance and Performance Committee

Progress in Delivering 2024/25 Priorities

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Recover dementia diagnosis rates to national target of 67%	Delivered. The diagnostic rate is above target (67.4%) and has remained over target month on month following extensive continuous quality improvement work undertaken by the team.	Delivered	Finance and Performance Committee
Focusing on the safety domain of practice and preparing for changes in mental health	Delivered : PSIRF is now embedded with improved timeliness in allocation of reviews. We have established Learning forums in divisions. Trust wide learning forum is now part of Executive Safety Incident Group. We have completed the preparation for changes to Mental Health Act during this year.	March 2025	Quality and Safeguarding Committee
Improve recruitment and retention to support new services and ensure safer staffing levels	Delivered. New approaches developed and embedded that consider a more creative and innovative way to attract and recruit and allow a more diverse pool of candidates both at application through to appointment. Ongoing work to improve retention in place, targeting key professions and teams where turnover is above Trust average.	Delivered	Quality and Safeguarding Committee People and Culture Committee
Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued	Delivered. Strengthened organisational communication and engagement channels to colleagues, including introducing a face to face leadership forum. The staff survey 2023 measures indicate improvements across our key engagement and belonging measures. Bespoke team development programmes arranged where there have been areas of concern or development needed for the team to move to a more compassionate and inclusive approach. Independent review of Michelle Cox lessons learnt has been completed and recommendations feed into the EDI steering group to strengthen our approach on bullying and discrimination. This is a continued priority into the 2024 strategy.	September 2024	Quality and Safeguarding Committee People and Culture Committee

Progress in Delivering 2024/25 Priorities

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree our 3-5 year financial plan	In progress. The full Trust Long Term Financial Model updated 5-year financial plan is still outstanding. Cost Improvement Programmes (CIPs) of at least 5% per annum for 3 years are the minimum expectation. Our 24/25 plan demonstrate a longer-term plan is required to return to financial balance and sustainability. The medium-term options are being scoped further to consider potential financial impact, and priority of any potential wider transformation and service change. JUCD agreed an approach to refresh the 5 year plan across the derbyshire system. All partners have been requested for the work to be developed in system wide standard format. The ask was to complete templates for submission by early September and again in November 24. Initial process builds on 24/25 plans and adjusts for NR and FYE factors to arrive at the updated underlying deficit . This then models simplistic baselines. (Assume no growth money and pre future efficiency requirement). Recognised, will take longer to develop into a full LTFM. Planning principles agreed for 2025/26. This continues to feed into 2025/26 system planning. 1st draft due for completion in January 25	September – March 2025	Finance and Performance Committee
Optimise the use of SystmOne across the Trust	Completed. All standard operating procedures(SOPs) and training completed. To further embed the use of the system and new functionalities system training and SOP will be monitor though the agreed digital governance processes. Communication Annex functionality launched in December 2024. Communication Annex along with improvement in digital competence and clinical practice issues will help resolve data quality issue challenges. Full implementation will be complete in April 2025	September 2024	Finance and Performance Committee

Progress in Delivering 2024/25 Priorities

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Deliver our Long term Plan commitments including TCP and Living Well	Delivered. The Living Well final wave (wave 3) fully mobilised in quarter 4. Focus now on optimising benefits of new model of care. Full System Development Funding (SDF) mapped out and awaiting approval for 2024/25 to deliver on TCP. System partners engaged with and working with health to ensure objectives and deliverables are realistic, achievable and in line with National Health Service England (NHSE) Learning Disability and Autism (LDA) priorities.	Delivered	Finance and Performance Committee
Develop a workforce plan	Delivered. The workforce plan is complete and is on the board agenda for October	Delivered	People and Culture Committee

Derbyshire Healthcare NHS Foundation Trust
Report Board of Directors – 14 January 2025

Fundamental Standards of Care Report

Purpose of Report

To update the Committee on the below actions:

- Care Quality Commission (CQC) visit to Acute care in April 2024 action plan. The report has been published and the Acute wards remain rated as requires improvement whilst the Trust retained the rating of Good
- Mock CQC visits
- Fundamental Standards of Care and community teams
- Update from previous report on:
  - Safeguarding concerns
  - Serious incidents
  - Regulation 28
- Missing/AWOL patients from Radbourne unit.

Executive Summary

The report was discussed in The Quality and Safeguarding Committee on 10 December 2024. Updates regarding the April Inspection Report and the subsequent reinspection of the Acute wards, feedback and lifting of restrictions have not been discussed in the Committee due to the timing of events and the sequence the meeting. The published report and action plan will be monitored, and the Committee will receive assurance on the completion of the action plan.

Safe

- Works to address the Radbourne Unit blind spots have now been completed and further works to ensure that the learning of this is considered across all inpatient wards. As such, Estates have been consulted with and mirrors for all wards ordered and planned
- Monthly update on safeguarding, serious incidents and Regulation 28 are reported
- The report evidences the impact on ‘locking’ the front door of the Radbourne Unit and the subsequent reduction in those absent without leave (AWOL). This appears to have had a positive impact on the Right Care Right Person (RCRP) agenda.

Effective

- Continued improvement on the action plan developed, based on the verbal feedback from the CQC is noted. Acknowledgement that the Trust has now received the CQC report and is working to develop an action plan.

Caring

- Noted the number of compliments received increased by 22%.

Well-Led

- Mock CQC visits have been carried out on the Radbourne Unit and consideration taken to also look at community teams’ current performance to delivery of high standard of care. This includes a commissioned piece of work that supports by triangulating information being given by team leads and front-line staff
- Commissioned piece of work to engage will all Trust community teams will triangulate the message from leads and senior staff around identification of risks and plans to address risks alongside exploring the feedback from frontline staff.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

- Significant assurance that the Trust responded to the legal restrictions imposed by the CQC
- Whilst work is underway to change the shift patterns, shift patterns remain unchanged and do not comply with the Working Time Directive and remain an area of risk.

Consultation

- Operational CQC Group
- Executive CQC Group
- Executive Leadership Team.

Governance or Legal Issues

CQC regulated activity.

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:

Improving compliance with the fundamental standards will ensure a high standard of care for all patients including those who may have protected characteristics. Therefore, the areas covered by this report do not disproportionately affect any of the nine protected characteristics.

Recommendations

The Board of Directors is requested to:

1. Note the improved position on the Fundamental Standards of Care in the Adult Acute Wards
2. Accept limited assurance on the Fundamental Standards of Care Compliance, Quality and Safeguarding Committee is yet to review the report and the action plan following publication of the April report.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Libby Runcie**
Deputy Director of Nursing

Fundamental Standards of Care and CQC

Updates CQC report and regulatory compliance: Section 31

An application to remove all remaining conditions was submitted to the CQC on 15 November 2024.

On 23 November 2024 the Trust received the draft report from the April Inspection. The report was reviewed for accuracy, and it was published on 11 December 2024.

The report is in the new format based on the single assessment framework and there are no “must do’s” or “should do’s”; there are areas of improvement highlighted under the quality statements.

The overall rating for the Trust remains Good.

Rating for Acute wards of Working Age Adults:

Overall	Required Improvement
Safe:	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well Led	Requires Improvement

The report reflects information given in the verbal feedback and an action plan is being developed. The action plan will take into account the work already completed from the verbal feedback. The report has not been to Quality and Safeguarding Committee due to the sequence of the meetings and when the report was published. The Quality and Safeguarding Committee will monitor and receive assurance on completion of the action plan.

On 16-17 December 2024, the Acute Wards at both sites, Radbourne Unit and Hartington Unit, were re-inspected; the inspection was unannounced. On 18 December, verbal feedback was given to the Trust which acknowledged that the issues raised in the April inspection had been resolved and there were no safety concerns raised on the wards.

The Trust received confirmation on 24 December 2024 that the four conditions placed on Trust’s CQC registration (Section 31) for the Radbourne Unit site were removed.

The Trust has now received the draft report from the December 2024 inspection, which is going through factual accuracy checking. The report is expected to be published in January 2025.

Safety: *Safety is a priority for everyone, and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse, and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.*

Environment

Following the CQC visit in April 2024, an external, independent review was completed of the physical environment within the Radbourne Unit and recommendations made. The action plan regarding these recommendations from the feedback is now complete.

Restrictions Radbourne Unit

Wards 35 and 33 have updated ligature management procedures. Walkaround for Wards 33 and 35 evidence that the toilet doors on the wards are locked. This is also recorded on the inpatient Acute Working Age Adult (WAA) Senior Nurse walkaround for Wards 33 and 35 on the assurance dashboard on Focus, which is a weekly walk around completed by the Senior Nurse on the wards.

The blind spots identified by CQC have been resolved and this has been taken further to include all stairwells.

Learning for this has been considered across all inpatient wards and there is now a plan to introduce mirrors across all wards. There is a national shortage, however orders have been placed. Working with Estates colleagues, all wards have now been appraised, mirrors have been ordered and placements identified.

The Ligature Policy has been updated and was ratified by the Quality and Safeguarding Committee.

Safeguarding Concerns:

We have had a total of 157 Adult safeguarding concerns from 1 August 2024 to 31 November 2024 that resulted in an Adult safeguarding referral.

The highest referral reason was abuse/aggression (actual or alleged) other party to patient.

There were six cases that were referred to both Children's and Adult Safeguarding and 36 referrals to Social Services (Children).

Serious Incidents:

From August 2024 to November 2024, the Trust has recorded 64 incidents categorised as catastrophic.

29 incidents have been recorded as major over this period; the highest type of incident was self-harm at six incidents.

Regulation 28:

There are currently no Regulation 28 actions in place across the Trust. There are three coroner's court hearings; two were in December and one in January 2025. These three patients died whilst under the inpatient care of our services.

Missing and Absent Patients/AWOL:

Total number of incidents reported as missing and absent patients from 1 August 2024 to 30 November 2024.

	2024				
Incident	**Aug**	**Sep**	**Oct**	**Nov**	**Total**
Informal patient - attempted AWOL (from inpatient unit)	3	2			5
Informal patient - AWOL (from inpatient unit)	6	8	2	6	22
Total	**9**	**10**	**2**	**6**	**27**

Ward 35 saw the most incidents recorded for attempted escape from inpatient unit in October.

The front door of the Radbourne Unit was 'locked' (controlled access only by reception) on 21 October. In the immediate two weeks following the door being 'locked' there has been a significant reduction in the number of AWOLs. Between 24 October and 15 November, there were five recorded incidents.

Breakdown of the five reported incidents:

- one x wrongly marked AWOL (was a failed to return from leave). No police contact
- two x incidents of reception letting the patients out by mistake in early days of locking. Followed up with actions to support reception in new system and don't open the doors. One of these was reported to police due to imminent risk
- one x tailgated a visitor. No police contact
- one x patient physically kicked through the doors at reception. Police were called due to violence and aggression risk.

Effective: *People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflect these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.*

Ward cross-checks occur weekly with Matrons, clinical leads and senior leaders/Executives that ensure the wards are reviewing their performance/data and that there is evidence of demonstrable improvement. Where there are challenges to this, these are then clinically and operationally addressed.

Areas covered within this meeting include:

- training compliance
- supervision compliance
- number of serious incidents and or seclusions
- safer staffing.

Restrictions to Wards 33 and 35 at the Radbourne Unit remained in place till 24 December 2024. Following a 59 hours breach female patient over the weekend of 29 November 2024, when the team could have admitted to Ward 33, but given CQC do not have an out of hours approval process for admissions, this left a patient in Emergency Department until Monday, 2 December 2024. This incident was reviewed, and a new process was agreed with the CQC on how to approve admissions during the weekend.

The restrictions to admissions to Wards 33 and 35 were lifted from 24 December 2024, admissions to the wards are being managed through the Trust's bed management procedures.

Caring: *People are always treated with kindness, empathy, and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity are respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.*

There were a total of 442 compliments documented in Q4, which is an increase of 22% compared with Q3. It is not possible to identify a specific reason for the fluctuation in compliments recorded, as compliments are mostly received verbally and staff do not always accurately record them. Compliments are currently recorded on Datix and this is a complex system to log compliments and it is likely that some are missed. The Heads of Nursing and the Patient Experience team are working together to explore other effective means of capturing compliments.

The Older People's service, Adult Community and Adult Acute services recorded the most compliments respectively, which is the same as in in the previous 12 months. In Q2 The Substance Misuse service recorded a higher than average number of compliments.

Well-Led: *There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.*

From the CQC inspection in April 2024, the action plan that was developed and is now complete except for one action. Action 9d Staff on the Acute wards to have breaks during their shifts. The plan to address this has been agreed and signed off at JNCC and will be completed following staff engagement in January 2025.

Mock CQC Inspections Acute

In November 2024, Nursing and Quality carried out further mock CQC inspections for the Radbourne Unit. Each ward at the Radbourne was visited with Heads of Nursing, operational colleagues and alongside EQUAL members. These were written up and shared with each ward, including highlighting the positives and a plan established with every Ward Manager and the clinical leads. This plan is being held by Heads of Nursing, Matrons, Ward Managers and clinical leads.

Community Teams

General Managers and Managing Directors have been tasked at Trust Leadership Team Committee to ask every Community Team Lead/Area Service Manager to outline their top three risks and what the plan is to address them. This was supported by the Executives. The Deputy Director of Nursing has commissioned a piece of work to meet with every community team within the Trust. This will be meeting with the front-line staff to ask them what they see as the top three risks and their plans to address them and also what they are most proud of as a team. The purpose of this piece of work is to:

- support staff within the community teams to articulate what their risks are and be able to describe what the plans are to address those risks in relation to quality and safety
- support the staff to articulate what they are proud of to external new people and in doing so build confidence about talking about positives
- triangulate the risks that managers and leads are describing that these are being fed into the teams and that these reflect the risks of the staff within frontline posts
- Embed the Fundamental Standards of Care in the community settings
- Improve awareness of the Single Assessment Framework.

Board Committee Assurance Summary Reports to Trust Board – 14 January 2025

The following summaries cover the meetings that have been held since the last public Board meeting held on 5 November 2024 and are received for information.

- Mental Health Act Committee 13 December
- People and Culture Committee 26 November
- Finance and Performance Committee 4 November (13 January, verbal update)
- Quality and Safeguarding Committee 12 November and 10 December

Key:

	Full Assurance received during the meeting with the accompanying report
	Significant assurance received during the meeting with the accompanying report
	Limited assurance received during the meeting with the accompanying report
	No Assurance received during the meeting with the accompanying report
	items shared **for information** to advise the committee on progress and next steps

Mental Health Act (MHA) Committee - key assurance levels for items – 13 December 2024	
	MHA Operational Group The Committee receives the notes and action matrix of the above Group, for information. Amendments to the terms of reference to reflect the membership changes needed to ensure that the Group can, as its primary function, consider, scrutinise and resolve operational issues and provide assurance on these to the MHA Committee were approved.
	MHA Managers Report The MHA Quarterly Report covering MHA Office activity from 1 July to 30 September was considered. Points of note included: • performance for the explanation of Section 132 inpatient rights was being monitored, training was available for ward staff and work was on-going to move to an electronic format (via SystmOne) which would allow closer monitoring by the wards • the analysis of rapid tranquilisation data by the Deputy Chief Pharmacist • an overview of the use of Section 5(4) Nurses' holding power and Section 5 (2) Doctors' holding office was presented, all were appropriate, but staff are being encouraged to complete the paperwork correctly and in a timely manner • the results of the audit into the use of Section 62 Urgent Treatment Requests were presented, there will be a push to ensure requests are not being submitted late • there had been no lapses in Community Treatment Orders (CTOs) activity. It was felt that this is, in part, due to the new proactive monitoring and reminder system embedded within the department. The data showed improved compliance with follow up rights being read than rights being read within the first one month of the CTO creation • details on the Associate Hospital Managers (AHM) training session. **Significant assurance** was agreed on the improvements identified in the report and **limited assurance** on the reading of rights, but it was hoped that this would be improved when the e-system was embedded

	Training Report The Committee received a revised report format for training compliance for Safeguarding Adults Level 1, Level 2, and Level 3 MHA, Mental Capacity (MCA) and Deprivation of Liberty Safeguards (DoLS). The report included: • which areas are not currently meeting the targets • which staff are expected to be compliant in which training and at what frequency • ongoing actions to maintain compliance • current training capacity to deliver sessions. The Committee discussed whether or not to increase the Safeguarding Adult's competence target to the same as MCA, MHA and DoLS, which is 96%. Overall it was felt that this should be worked towards over the next 12 months, but initially have a 95% target as this was stipulated in the contract. **Limited assurance** on the basis that there are a number of areas not meeting the training targets.
	Section 12 Doctor Assurance Report – Verbal Update The Committee agreed to remove this standard update on the basis that there is now a centralised monitoring system overseen at the MHA Operational Group and there has been good progress against the actions. The Committee agreed **significant assurance** on the current position on the basis that the system is now in place and noted that 360 Assurance (internal auditor) is scheduled to undertake an audit of the new system and the report findings will come back to the Committee in due course.
	Report on the use of Section 135/136 Suites The report showed an upward trend in the use of S136 suites which had been high for the last 18 months. There were mixed outcomes following MHA assessment and data showed the delays were often due to the availability of second approved doctors. The S136 Steering Group will continue to escalate matters and it was hoped that the opening of the new suites would improve the delays. The Joint Nurse/Police risk assessment was live and the 'Right Care Right Person' (RCRP) Group is auditing turnaround times. Physical health checks in Section 136 suites continue to be positive. There is a joint new policy in place for the Section 136 MHA and the RCRP National Agreement. The 136 team had been nominated for clinical team of the year in the Trust's HEARTS awards by an ICB care partner and were very proud of this nomination. The Committee noted the current position and supported the continued ongoing work and improvements for the Section 135/136 Group, agreeing **significant assurance**.
	Verbal Update from Associate Hospital Managers (AHMs) The AHMs gave a verbal update on their activities, including completion of the annual peer reviews, participation in the training and induction event, and the proposal to buddy up with the new AHMs, who had been attending hearings. The AHMs present at the meeting had been supportive of AHMs attending the MHA operational group instead of the MHA Committee as they could bring in their operational perspective, however not all of the AHM cohort had been asked for their views.
	Restrictive Practice Quality Report This report was deferred to a future meeting as the lead had not been available, however the Committee agreed with the assessment of **limited assurance.**
	Patients and Carers Race Equality Framework (PCREF) PCREF is mandated for all Mental Health Trusts following the recommendations of Independent Review of the MHA. The Committee received a briefing on the implementation of PCREF, noting the three domains of deliverables and key components and their relationship with Committee functions as well as the plan for mobilising dedicated resource in the context of current capacity constraints.

Report on Complaints from Patients Detained under the MHA

The Committee received a report on themes and trends that arise from complaints and concerns raised by patients under detention of the MHA 1983, providing data broken down into various categories (for example ethnicity, age, gender and by ward and comparison 2021 Census data). The main issues raised regarding patients on a section in the last six months was the same as the previous six months and are relating to:

- care planning
- patient safety
- staff attitude.

The Committee agreed **limited assurance** on the high numbers and delays in response times.

Mental Health Bill

The Committee was reminded about the content of the Bill, recently introduced in Parliament, and largely the same as the one introduced in 2022, with some additional content connected to recent national incidents. It is anticipated that the Bill will receive Royal Assent in the summer of 2025 and be implemented in phases after that.

Policy Review

The Committee supported the Joint Policy for Derbyshire on the Operation of Section 136 of the Mental Health Act 1983 and Right Care Right Person National Agreement and approved the Seclusion and Long-Term Segregation – Psychiatric Emergency Policy and Procedure and the Mental Health Act 1983 Receipt, and Scrutiny and Management of Section Papers Policy and Procedure.

Escalations to Board or other Committees: None

Items added to the Board Assurance Framework: None

Next scheduled meeting: 21 March 2025

Committee Chair: Deborah Good	**Executive Lead: Arun Chidambaram, Medical Director**

People and Culture Committee – key assurance levels agreed – 26 November 2024

People and Inclusion Assurance Dashboard

The Committee reviewed the current performance, highlighting the following:

Training

October's overall compliance level remains above target.

Staff Turnover, Vacancies and Recruitment the vacancy control process has impacted on this metric, resulting in an increased vacancy rate. Following a deep dive into turnover within three divisions, data would be triangulated with exit interviews. The Committee was pleased to note the commencement in post of 45 newly qualified Mental Health Nurses (RMNs), with a further 40 due to start over the next two months. The Trust is also exploring international recruitment for medics, part of the plan to develop a long-term consultancy workforce, thus reducing agency spend.

Bank Usage plans are underway to increase the bank staff cohort therefore reducing agency use.

Freedom to Speak Up (FTSU) the Committee receives narrative on the FTSU themes.

Significant assurance was accepted on progress shown for mandatory training, staff turnover, vacancies and recruitment, bank usage and Freedom to Speak Up (FTSU).

	Attendance and Absence the October monthly sickness absence levels are above target, benchmarking across the Midlands alliance and system is underway and a focus at the Trust will be on long-term absence management. Employee Relations a reduction in the number of formal cases was noted by the Committee, along with an increase in early resolution outside of the formal process, supported by the Civility, Respect and Resolution policy. Annual Appraisals and Supervision appraisal documentation is being adapted for some worker groups to encourage participation. Supervision rates are on a trajectory for improvement but remain below target. **Limited assurance** was accepted on the progress shown for attendance and absence, Employee Relations, clinical supervision and annual appraisals.
	Making Room for Dignity – Programme Update The vast majority of staff are now in post with a relatively small number of staff to still be recruited, including the Consultant post. Staffing for each new ward is being mapped out, with a balance of experience and newly-qualified staff. All training is due to be completed by the end of December 2024. The philosophical model of care training is available to all staff, in addition to familiarisation sessions. The Committee requested sight of the detailed training programme to understand how Organisational Development and the Model of Care overlap. The Committee received **limited assurance** on the actions and progress being taken to mitigate the risk of significant numbers of 'hard-to-recruit' and 'national workforce shortage' posts required and **limited assurance** on the development of, and progress with, the service and cultural transformation work, and implementation.
	System Developments – Verbal Update The Committee was presented with a slide show to summarise local and national updates, which included: The Worker Protection (Amendment of Equality Act 2010) Act 2023 it was noted that a legal duty has been introduced for employers to take proactive steps to prevent sexual harassment and the national framework and charter is now included at induction. The Employment Rights Bill examples of the areas covered include day one right to unfair dismissal, enhanced family rights, flexible working and zero hours contracts. National, system and local updates all trusts are to align to the core skills training (national statutory and mandatory), which the Trust already does. Management and Leadership Code of Practice the Trust has until 6 December to comment on the Code and it is a priority to align with the new Strategy. A further update will be shared in January. System People Priorities the plan details specific improvement areas for the system Human Resource Development (HRD) group to work on collectively, such as the shared challenges around agency reduction and job evaluation. Trust-level key updates a Service Level Agreement (SLA) is now in place for Recruitment and Temporary Staffing services. The new Deputy Director of People starts with the Trust on 20 January, the Head of EDI post is being re-advertised.

	Deep Dive – Health and Wellbeing An internal audit report had provided the Trust with moderate assurance on the staff health and wellbeing processes and a number of actions would be implemented to improve them, this included a review of current governance arrangements to provide the appropriate assurances that objectives are being achieved. It was agreed that moving to an SLA can build in more of the expectations that have resulted from the audit.
	Annual Workforce Plan – Update on Turnover of New Recruits, Benchmarking and Future Plans to Attract Students and Apprentices This report provided the Committee with the position on staff leaving the organisation within the first 12 months of employment. A review improved retention for the last two years. Some benchmarking comparison with other mental health trusts was recommended. The Committee discussed the value of exit interviews, honest conversations between the leaver and their manager, quality of induction and the onboarding process. The Staff Survey had revealed that a great induction experience is committed to attendees' long-term memory. The possibility of incorporating annual 'stay interviews' with the appraisal was suggested, along with pilot surveys focused on new starters and onboarding should continue for at least two years. **Significant assurance** was received that effective systems and processes are in place.
	Temporary Staffing Workforce Update – Agency Focus System benchmarking data showed a positive comparison of overspend and off-framework usage with other trusts. Additional activity includes the transfer of existing agency medics onto a direct engagement model, which will reduce cost. The Committee received **significant assurance** on the work completed so far to reduce agency usage and actions plans in place to help reduce this further.
	Talent Management and Succession Planning (Update on Identification of Talent and Benchmarking Exercise) Lessons learned from the 2023 career conversations process have been taken into account and a new, phased approach has commenced. There would be more simplified paperwork and accessibility.
	Board Assurance Framework (BAF) – key risks identified: The Committee's BAF is to be aligned with the new strategic priorities, along with the themes discussed today, including explicit narrative around leadership authority and accountability.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: The Committee reflected on some of the recurrent themes discussed at meetings and the need for staff to take greater responsibility for appraisal, development and training and the need to see improvements in performance in these areas. It was agreed this should be scrutinised further at Board level and the theme of accountability might be considered within a forthcoming Board Development session. **Next scheduled meeting:** 28 January 2025.
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

Finance and Performance Committee – key assurance levels for items – 4 November 2024	
	Assurance on Estate Strategy – specifically Making Room for Dignity Programme (MRfD) The Committee received **limited assurance** from the pace at which the programme is progressing and due to the associated risks and critical next steps.
	Updated Draft Estate Strategy This report provided an update on progress of a revised Estates plan for the Trust (consciously no longer a strategy). The opportunity for further rationalisation and better use of corporate space was recognised, to align with flexible and agile working. **Significant assurance** was received on progress towards completion.
	Sustainability Strategy, incorporating Green Plan – Progress Report A plan for the remainder of 2024/25, which is reflective of the limited resources available, was outlined to the Committee. The key performance indicators and measures are in development and it was noted that capital restrictions are a limiting factor in the speed of some of the planned improvements to the Trust's estate.
	Financial Governance and Performance – Month 6 Finance Report At month 6, a £4.1m deficit was reported, £100k ahead of plan and still forecasted to deliver the plan of £6.4m deficit for the year. It was noted that the risks are driven by the: • current out of area position • continued overspend on the outpatient wards and the • lack of progress in terms of closing the underlying cost improvement programme (CIP) gap. The Committee received **limited assurance** on the financial performance for 2024/25 and noted the particular focus on the risks being managed.
	Operational and Financial Planning The Committee accepted **significant assurance** on the approach to financial planning agreed across Joined-Up Care Derbyshire (JUCD) and the collaborative and consistent approach.
	Continuous Improvement The Committee noted the key activities within transformation and improvement.
	Operational Performance **Limited assurance** was accepted around improving flow in Adult Acute services; the current financial position and improvements in safety.
	Health and Safety Annual Report and Terms of Reference (ToR) The report provided the Committee with **significant assurance** of the high compliance on activities and achievements in Fire, Health and Safety, and Security Management from 1 April 2024 to 30 September 2024.
	Contracts Update The portfolio of contracts which are overseen by the contracting function was noted. It was highlighted that a recovery action plan is in place to address challenges around the transition and exit of the Talking Therapies and Improving Access to Psychological Therapies (IAPT) services.

	System Updates: ICB Finance Committee/System Directors of Finance (DoFs) The discussion focused on collaborative working with the system and the enabling of working groups to deliver on opportunities. It was noted that the Director of Finance is now leading the estates workstream and JUCD are developing a financial framework to support decommissioning principles.
	Emergency Preparedness, Resilience and Response (EPRR) Policy for Sign-Off The Committee accepted **significant assurance** that the Trust is substantially compliant and the policy was approved. It was noted that the Trust's many areas of best practise are to be shared with other partners.
	Board Assurance Framework (BAF) 2024/25 Risks Overview It was agreed that a more thorough review of the Making Room for Dignity risks is required, along with a refresh of the Director Leads.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 13 January 2025.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Director of Finance**

Quality and Safeguarding Committee – key assurance levels for items – 12 November 2024	
	Director of Nursing Update The updates covered attendance at the Chief Nursing Officer Summit in London and the national strategy to align with the 10-year health plan. It was noted that work is underway across England to agree metrics to raise productivity, specifically for mental health services. Following initiation of the locked doors protocols on Acute Wards, feedback is positive; staff feel safer and the number of patients absent without leave has reduced. It was noted that the Trust is engaging with local authorities, Integrated Care Boards (ICBs) and leads for 'smoke free' in the Derbyshire and Derby city localities and that the Executive Leadership Team (ELT) is considering a definitive position to go 'smoke free'.
	Fundamental Standards Report The following points were highlighted: CQC Action Plan: it was noted that work on the alteration of shift patterns and breaks is underway and the draft policy on Seclusion awaits ratification. ICB Quality Visits: a changed dynamic was announced, whereby the ICB representative is allowed free reign to engage with operational services, rather than be steered. MHA Visits: following recent visits, the Information Management, Technology and Records (IMT&R) team is working on improvements to the dashboard, which will signal non-conformances. Healthwatch Visits: the Committee noted that some patients are appreciative of the designated smoking and vaping areas. Board Action – CQC Domains Report: a new format was proposed to replace the CQC Domains Report to Board with a revised Fundamental Standards of Care report, based on the five domains, which would provide a single assessment framework to assure on the status of each. The Committee discussed corporate and ward governance, accountability and conformity, along with reduced numbers in attendance at oversight meetings to enhance focus. **Limited assurance** was accepted from the report.

	Ligature Risk Reduction – Six Month Summary Report The high number of incidents, particularly on the female wards, was highlighted. The Committee noted that shared learning from Cygnet ACER has provided valuable insights for the Trust. It was reported that a Ligature Monitoring Group has been convened and this will drive a safety culture with the least restrictive approach. The Committee noted that reduced ligature risk, increases the risk of other methods of self-harm, and this can be managed by replacing a custodial-type environment with increased engagement. The Ligature Policy was ratified, and the policy includes the changes to the ligatures assessments and the use of heat maps and learning from recent CQC inspections. The services are in transitioning to the new policy. The differences around safety planning between the Health Services Safety Investigations Body (HSSIB) and the Care Quality Commission (CQC) were discussed. Due to the transition between processes, **limited assurance** was accepted.
	Medicines and Pharmacy Update Attention was drawn to the Trust's Medicine Management Committee Action Plan. It was noted that the Trust is linking with the ICB, to promote awareness and improve non-compliance, in relation to the risks associated with valproate safe prescribing to women of child-bearing potential. The Committee accepted **limited assurance** and agreed to support the action plan for valproate prescribing and monitoring to ensure Trust adherence to the MHRA regulations.
	Quality Dashboard The Committee received **limited assurance** on progress towards clinical performance targets. The dashboard evidenced an improving position for restrictive practice and a reduction in prone restraints. Also noted were positive reductions for absconsions, falls, medication incidents and 'closer look' complaints. An area of risk around venous thromboembolism (VTE) assessment was highlighted due to a lack of progress and this has been referred to the Physical Health Group to support an improvement plan. It was noted that there are significant bed pressures with many patients waiting on other services due to the available social care packages. This has been escalated to the Derbyshire Chief Executives for a collective resolution.
	Care Planning/Person-Centred Care It was reported a greater multi-disciplinary focus is now being applied. A suitable alternative solution to monitor compliance, where the data is not currently picked up by the report algorithm, is to be discussed in November. It was agreed that regular assurance is required until performance has improved. However, a suggestion to maintain a bi-annual report, along with a monthly update on progress was accepted. **Limited assurance** was accepted from the report.
	Divisional Performance Reviews (DPRs) The Committee accepted **limited assurance** on overall clinical performance. Attention was drawn to the Balanced Score Cards which set a high level summary of the position and it was noted that there is a stronger Executive presence and more focused conversation within these meetings. Increasing demand and the ability to manage and respond was a related theme, along with difficulty in achieving the Cost Improvement Programme (CIP) and transformation of services to enable increased capacity with a reduced financial envelope. It was noted that cross-Division and multi-disciplinary team working requires greater involvement.

	Deep Dive – Drug and Alcohol Services The Committee was presented with an overview of the current service delivery position, with the Trust as the lead provider for treatment in Derby city, Derby Alcohol Recovery services (DDARS) and Derbyshire, Derbyshire Recovery Partnership (DRP). It was noted that the strategic actions for both services include: • increasing numbers in treatment across the three treatment modalities, alcohol, opiates and non-opiates • reducing drug-related deaths • improving access to treatment through increased community provision, proactive out-reach in the community, in-reach into inpatient secondary care and improved pathways with health/social care providers • improved data quality. **Significant assurance** was accepted and the risks associated with the of the onward provision of drug and alcohol services with increases in demand (without increased resources) was noted.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 10 December 2024.
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Quality and Safeguarding Committee – key assurance levels for items – 10 December 2024	
	Director of Nursing Update The Care Quality Commission (CQC) report had been received and it was reported that inaccuracies have been submitted for review. Once agreed, the final draft will be published. Following the SEND inspection, the Integrated Care Board (ICB) has convened an Improvement Board, on which, the Director of Nursing, AHPs, Quality and Patient Experience will sit. The action plan to improve the direction and strategy will be overseen by the ICB. It was noted that the smoke-free stance had been unanimously supported at Executive Leadership Team (ELT) and would be effective across the whole Trust from February 2025.
	Fundamental Standards of Care Report The Committee received updates on the: • CQC visit to Acute Care in April 2024 action plan • mock CQC visit • Fundamental Standards of Care and Community teams • missing/absent without leave (AWOL) patients from the Radbourne Unit. The Committee was encouraged to learn that the locked door policy has resulted in a decrease in those patients AWOL, that staff have been able to intervene where people try to force the doors and have advised they feel safer. Although no Fundamental Standards of Care visits had been scheduled, informal 'walk arounds' had highlighted that staff are unfamiliar with some of the processes around IPC, environmental ligature management. As a result, awareness is being heightened, with a focus on Inpatient and Community services. **Limited assurance** was accepted, recognising that the restrictions on the Radbourne Unit female wards have been reviewed and a plan to allow admissions out of hours indicates CQC assurance on the improvements made.

	Guardian of Safe Working (GoSW) Hours Report The Committee received **significant assurance** that the duties and requirements as set out in the 2016 Resident Doctor contract are being met. It was reported that the British Medical Association (BMA) and NHSE are discussing a change to the exception reporting system, which will provide auto-approval of two hours or less. Attention was drawn to recommendations from the Task and Finish Group and reversing payments for course fees during study leave. Upgrades to ESR will help the streamlining of statutory and mandatory training, providing a solution to ensure this follows rotating doctors.
	Making Room for Dignity (MRfD) Programme (to include Model of Care Update) The Committee noted that a full trial shift, with no patients, is planned for 3 January 2025 ahead of the go live date on 7 January. In addition, mobilisation strategies for all remaining units will be finalised in line with the respective go live dates. The mobilisation for Audrey House and Kingfisher House will focus on out of area placements as the transfer of existing patients is not involved. The key points of the clinical model of care and quality were highlighted and the Committee was advised that the training itself has now gone through every member of staff and there will be over 90% compliance by the end of January. It was noted that the Standard Operating Procedures and policies will be ready for ratification/sign-off in January. It was stressed that the departing areas will be completely emptied and ward staff were applauded for the significant housekeeping and decluttering already undertaken. **Significant assurance** was received on the mobilisation/operationalisation plans for Bluebell and **limited assurance** was received on the mobilisation/operationalisation planning for the remaining units and on the plans to deliver clinical model of care training, flow plan, Standard Operating Procedures/clinical policies and quality assurance framework.
	Review of Intensive and Assertive Community Treatment for People with Severe Mental Health Problems – Verbal Update It was noted that the paper had not been revised and a contemporaneous report would be presented in February.
	Patient Safety Incident Report – Verbal Update The current position of the Patient Safety team and associated staffing challenges was shared. It was noted that two of the seven members are actively working. Business continuity plans have been implemented. **Limited assurance** was received from the verbal update. In order to manage the situation, the team is providing significant input to action plans, which are then handed back to the investigation team and where appropriate, reporting will be commissioned externally to reduce the burden. The Committee noted that the Team Lead continues to monitor Datix information with Executive oversight of serious incidents and patient safety data. It was acknowledged that this is not a sustainable solution and is affecting the production and timeliness of reports.
	Risk Report The Committee noted that work is underway to improve the reporting format and there will be better-quality ligature risk assessments. It was stipulated that those risks that have not been reviewed for some time are being followed up and steps are in place to ensure timely updates. The Director of Nursing, AHPs, Quality and Patient Experience agreed an action to investigate some long-standing risks and update the Committee Chair. **Significant assurance** was accepted regarding the risk management and reporting strategy.

	Safeguarding Children Assurance Report Attention was drawn to the increased number of advice calls and it was noted that calls in relation to adults had not been recorded. The information is now captured differently using a new template which includes children and adults. A concern at the increased number of child deaths was emphasised, with two in the Trust's area. It was noted that this is under national review and the Committee will be kept updated. Following a recent CQC visit to the Beeches and Margaret Oates Mother and Baby Units, the Committee was delighted to learn that no concerns had been raised. It was highlighted that the Named Doctor role continues to be covered by a Trust Psychiatrist, rather than a designated Paediatrician. It was noted that there had been no interest from within the System and that most Paediatricians do not have mental health experience. The Trust ensures the appropriate Paediatric support is provided and options around an honorary contract for the provision of remote support is being explored. The Committee accepted **significant assurance** around Safeguarding Children activity, systems, and controls within the Trust.
	Safeguarding Adults Assurance Report The main areas of concern are in relation to domestic violence cases, which have increased from 316 to 325 and sexual safety within the Trust, mainly 'other party to patient' and 'patient to staff'. Campaigns are ongoing to raise awareness of sexual safety and the subject is now covered at induction. It was reported that action is being taken to raise awareness of the Deprivation of Liberty Safeguards (DoLS) as a recent Mental Health Act visit had identified that staff on Ward 33 did not understand the process. The Committee accepted **full assurance** that the statutory duties are being met and around Safeguarding Adult activity, for Safeguarding Adult Reviews and Domestic Homicide within the Trust.
	Safer Staffing Establishment Review It was established that oversight has moved from the operational leads to nursing, in line with the rostering 'check and challenge', which streamlines the governance and assurance. The Committee noted that care hours per patient day remains unchanged, and although slightly under the national average for mental health trusts, this is working well. It was confirmed that patients receive good care and contact with staff. Due to the combination of high acuity and observations, it was acknowledged that wards are reliant on bank and agency for core safer staffing, which needs to be addressed. It was noted that registered Nursing vacancies currently stand at 15%, which is unlikely to change until the September cohorts are available. In addition, an increase will be seen as all Making Room for Dignity posts are not fully recruited to. However, the Trust is currently over-subscribed in some areas, and the additional staff are working in open wards before migration to the new areas. With effect from January 2025, a change to rostering rules has been approved, which will ensure compliance with Working Time Directives, staff welfare, safety and efficient rostering. As the level of resourcing will always present a challenge, the Committee received **limited assurance** on safer staffing within the Trust and noted the progress made.

	Patient Experience Report (Quarterly) **Limited assurance** was received on the complaints process, noting the improvements made, along with significant delays in responses in some cases. The Committee was advised of an increase in people advising they have received a good or very good experience and the team is working to increase the response rate. The number of complaints was raised as an area of concern and it was appreciated that there are challenges around waiting lists and allocation of a care co-ordinator. It was noted that three investigators are being upskilled to help reduce the backlog. Recognising that staff attitude and behaviour is a recurrent theme, the Committee was hopeful that the Personal Accountability Charter will help to address.
	Learning from Deaths/Mortality Report The Committee noted that a Suicide Prevention Lead has been appointed, which links into current training development for Safety Planning, Risk Assessment and Suicide Prevention, the timescale for which is January 2025. The Committee accepted **limited assurance** of the Trust's approach and agreed for the report to be considered by the Trust Board of Directors and then published on the Trust's website as per national guidance. **Learning Disabilities (LD) Mortality Review (LeDeR)** The three part review (annual and quarterly performance and a summary) was presented to the Committee. It was noted that a Steering Committee meets regularly for focused review, compliance, timelines and breakdown of LD and autism. Priorities for 2024/25 were based on themes from the earlier period and included aspiration pneumonia, care co-ordination, epilepsy, managing deterioration and understanding the influences of physical health. It was highlighted that due to a lack of LeDeR reviewers, the Derbyshire programme is currently achieving 57% performance of targets. It was emphasised that mitigations should focus on prevention and how patients are supported, in terms of accessing the right care for physical and/or mental health. Based on resources from the LeDeR team, **limited assurance** on performance was accepted and the Committee approved the report for Board submission.
	Care Planning/Person-Centred Care (Monthly Update) **Limited assurance** was accepted on the progress made to improve compliance. It was specified that training and drop in sessions have been facilitated to help staff to navigate SystmOne recording and accountability is being encouraged through supervision and Heads of Nursing. The Clinical Digital team is to support development of a care plan compliance monitoring process where this is administered outside of SystmOne. The information and additional steps being taken were welcomed by the Committee.
	East Midlands Perinatal Mental Health Provider Collaborative (Quarterly) A recent CQC visit to the Derby service had elicited positive feedback in a number of areas. The Committee was delighted to note there were no areas of concern or risk to be escalated. It was conveyed that the national picture of under-utilised beds, is now changing due to winter pressures. **Significant assurance** was received on the quality and safety of services provided.

	Board Assurance Framework (BAF) – key risks identified: It was communicated that changes are being made to the BAF to represent the four Ps of the new Trust Strategy, Patient Focus; People; Productive and Partnerships. The Committee noted that although the risks are unchanged, the objective is to align them with the Strategy and Executive Leads will synchronise on completion of the review.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 11 February 2025.

Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 14 January 2025

Learning from Deaths/Mortality Report - 1 August 2024 to 30 September 2024

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 August 2024 to 30 September 2024.

Executive Summary

- All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they also meet a Datix red flag, in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. During 1 August 2024 to 30 September 2024 there were no deaths reported where the patient tested positive for COVID-19
- The Trust received 326 death notifications of patients who had been in contact with our services in the last six months. There is very little variation between male and female deaths; 158 male deaths were reported compared to 168 females
- The Trust has reported no Learning Disability deaths in the reporting timeframe and no deaths of patients with a diagnosis of autism
- Medical Examiner Officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community trusts. The implementation of this process came into force on 9 September 2024. Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning
- A process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	

Consultation

- This report has been reviewed by the Medical Director
- Quality and Safeguarding Committee, 10 December 2024.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- During 1 August to 30 September 2024, there was very little variation between male and female deaths; 158 male deaths were reported compared to 168 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of the Trust's approach and agree for the report to be considered by the Trust Board of Directors and then published on the Trust's website as per national guidance.

Report presented by: **Arun Chidambaram**
Medical Director

Report prepared by: **Louise Hamilton**
Safer Care Co-ordinator

Learning from Deaths - Mortality Report

1. Background

In line with the Care Quality Commission's (CQC) 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'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all of the required guidelines.

The report presents the data for 1 August to 30 September 2024.

2. Current Position and Progress (including COVID-19 related reviews)

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. This will improve once Medical Examiners commence the process of reviewing the Trust's non-coronial deaths in September 2024. The Trust continues to meet with the Medical Examiners on a regular basis.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 14 August 2024.

- A process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

- The Mortality Case Record review panel process has been evaluated and plans are in place to re-design this to act as an assurance and audit panel over incidents closed through the Operational Incident Review group.

- The Trust Mortality Committee has been evaluated and developed into a Learning the Lessons Oversight Committee which will improve governance around learning and drive quality improvement.

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information from 1 August 2024 to 30 September 2024.

	August	September
Total Deaths Per Month	151	175
LD Referral Deaths	0	0

Correct as at 21 October 2024

From 1 August to 30 September 2024, the Trust received 326 death notifications of patients who have been in contact with our services. Of these deaths 158 patients were male, 168 female, 243 were white British and 6 Asian British. The youngest age was 0 years, the oldest age recorded was 99. The Trust has reported no Learning Disability deaths in the reporting timeframe and no deaths of patients with a diagnosis of autism.

4. Review of Deaths

Total number of deaths from 1 August 2024 to 30 September 2024 reported on Datix.	32 “Unexpected deaths”. Zero COVID deaths. Six “Suspected deaths”. One “Expected - end of life pathway”. NB some expected deaths have been rejected so these incidents are not included in the above figure.
Incidents assigned for a review.	38 incidents assigned to the operational incident group.

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
- Death of a patient with Autism
- Death of a patients who had a diagnosis of psychosis within the last episode of care.

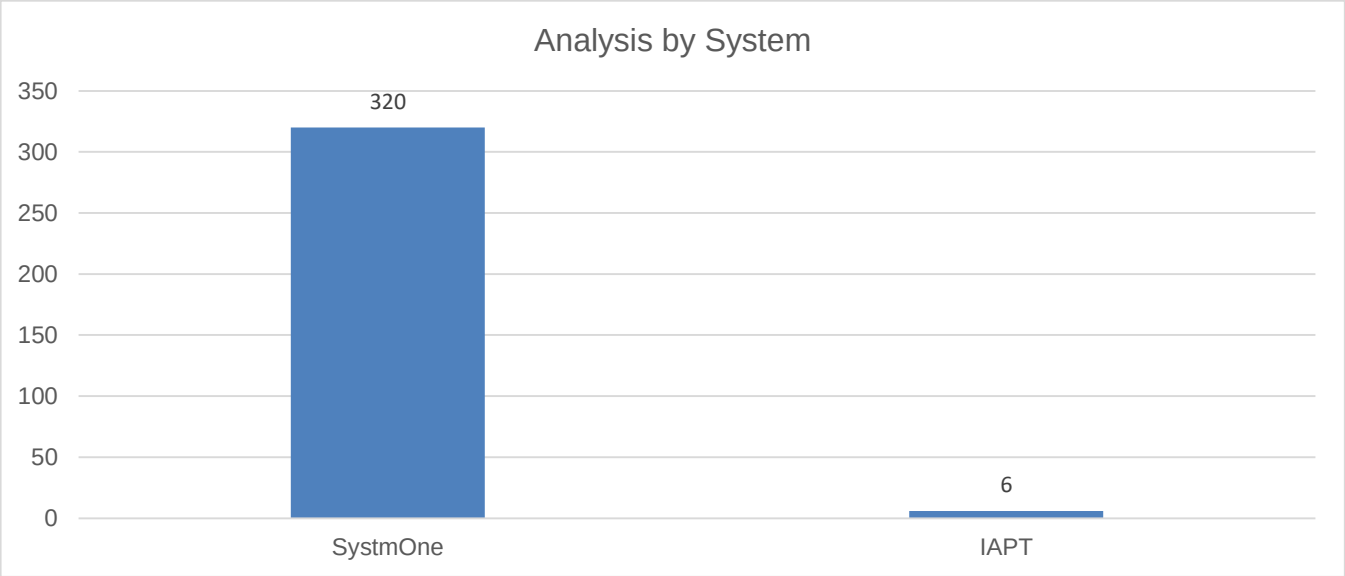
5. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process, a process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services.

There is a process for weekly random audits of deaths against the Red Flags to provide assurance that the new process is working as intended however this has been impacted by long term sickness over recent weeks however a plan is in place to address this.

6. Analysis of Data

6.1 Analysis per notification system since 1 August 2024 to 30 September 2024



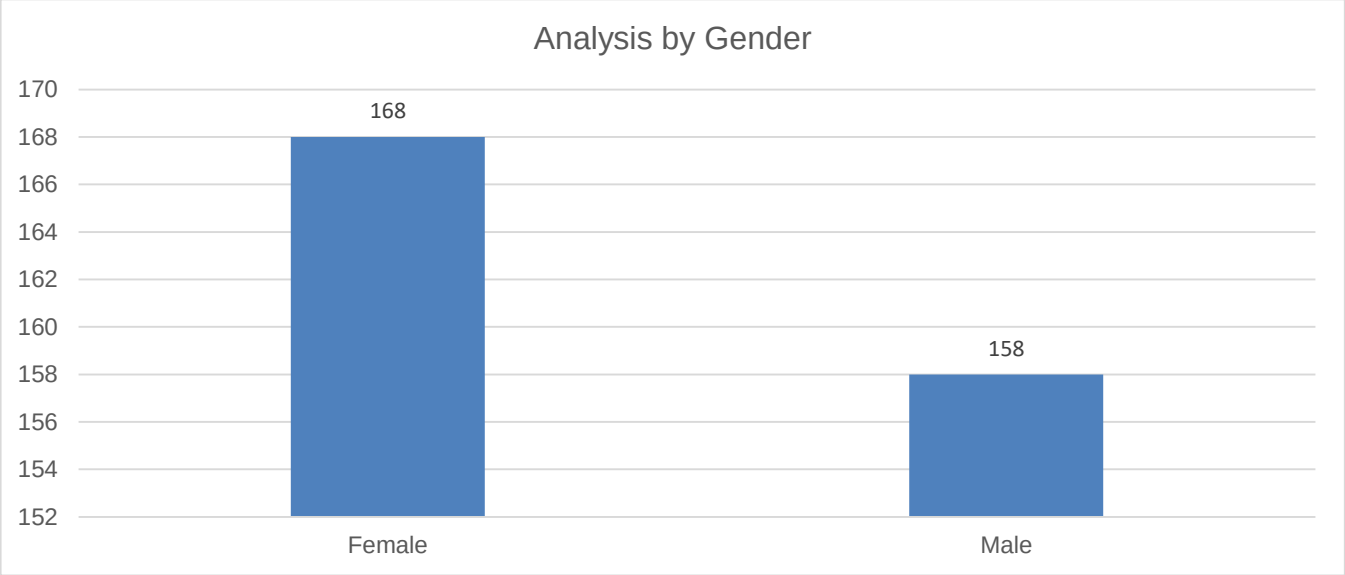
System	Number of Deaths
SystmOne	320
IAPT	6
Grand Total	**326**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. 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.

From the 1 August 2024 to 30 September 2024, there have been no deaths reported where the patient tested positive for COVID-19.

6.2 Analysis by Gender

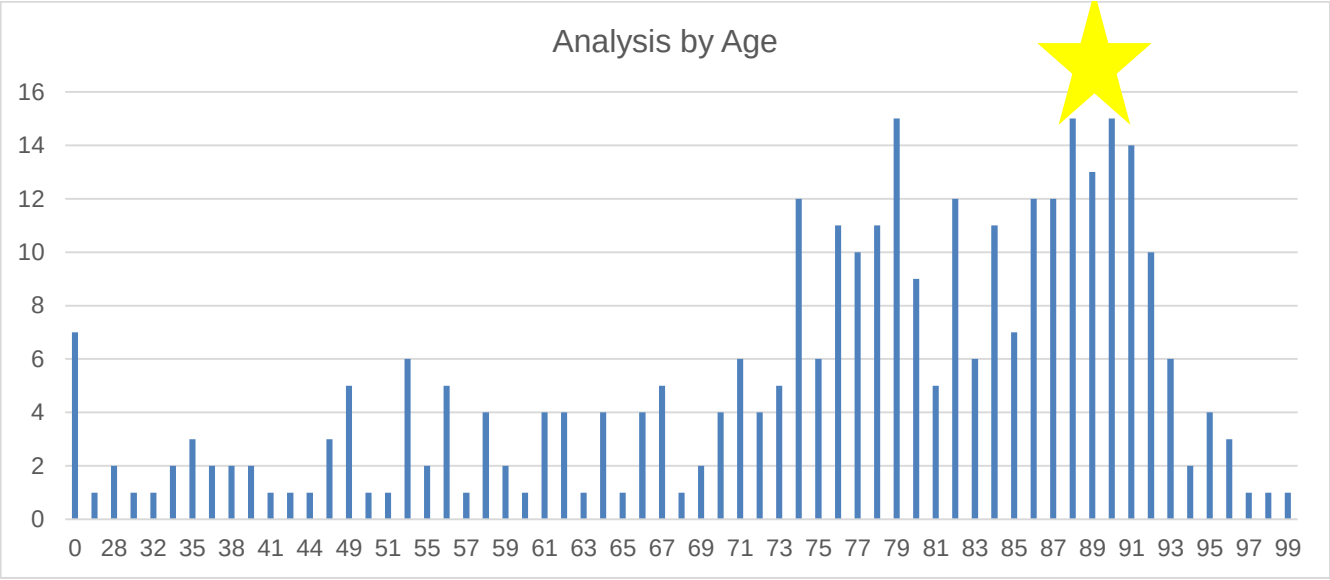
The data below shows the total number of deaths by gender 1 August 2024 to 30 September 2024. There is very little variation between male and female deaths; 168 female deaths were reported compared to 158 males:



Gender	Number of Deaths
Female	168
Male	158
Grand Total	**326**

6.3 Analysis by Age Group

The youngest age was classed as 0, and the oldest age was 99 years. Most deaths occurred within the 86 to 92 age groups (indicated by the star):



6.4 Learning Disability Deaths (LD)

	August	September
LD Deaths	0	0
Autism	0	0

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 LeDeR programme. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

From 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, twelve patients have been referred.

During 1 August 2024 to 30 September 2024, the Trust has recorded no Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

6.5 Analysis by Ethnicity

White British is the highest recorded ethnicity group with 243 recorded deaths, 28 deaths had no recorded ethnicity assigned, and 1 person did not state their ethnicity. The chart below outlines all ethnicity groups:

Ethnicity	Number of Deaths
White – British	243
Other ethnic groups - any other ethnic group	38
Not known	28
White - any other white background	8
Asian or Asian British - Pakistani	2
Asian or Asian British - Any other Asian background	2
Asian or Asian British - Indian	2
Not stated	1
White – Irish	1
Black or Black British - Caribbean	1
Grand Total	**326**

6.6 Analysis by Religion

Christianity is the highest recorded religion group with 126 recorded deaths, 175 deaths had no recorded religion assigned. The chart below outlines all religion groups.

Religion	Number of Deaths
Christian	126
(blank)	89
Not religious	84
Church of England, follower of	7
Church of England	5
Christian, follower of religion	3
Patient religion unknown	2
Christian religion	2
Roman Catholic	2
Muslim	2
Sikh	1
Protestant	1
Catholic religion	1
Methodist	1
Grand Total	**326**

6.7 Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 212 recorded deaths. 113 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	212
(blank)	94
Sexual orientation not given - patient refused	11
Sexual orientation unknown	6
Female homosexual	1
Person declined to disclose	1
Unknown	1
Grand Total	**326**

6.8 Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 70 recorded deaths.

Disability	Number of Deaths
Gross motor disability	70
Disability	25
Intellectual functioning disability	18
Emotional behaviour disability	13
Hearing disability	8
Disability questionnaire - behavioural and emotional	5
Physical disability	3
Disability questionnaire - mobility and gross motor	2

There were a total of 152 deaths with a disability assigned and the remainder 174 were blank (had no assigned disability).

7. Recommendations and Learning

The table below outlines the current themes arising from incidents.

Improvement issue	Improvement plan
Transfer, Leave and Discharge.	**Transfer of the deteriorating patient.** Internal investigations highlighted themes around the transfer and return of patients between inpatient services for the Trust and Acute providers. This includes handover of information, and the way patients are conveyed. A quality improvement project has been undertaken between Derby Hospital and DHcFT to develop a transfer and handover proforma which is now in place. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements** Several investigations have highlighted issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan was developed. The works will include review of the pathway of communication and documentation (including risk assessments and care plan) between Crisis Resolution and Home Treatment/Community teams and Inpatient services when a patient is due to be on s17 leave/discharged. This will be reviewed within the Adult Acute Learning the Lessons Subgroup.
Suicide Prevention.	**Suicide Prevention training** The Trust has identified the need to re-establish Suicide Prevention training across services, this is being led by the Trust Medical Director. A Trust Suicide Prevention Lead has now been appointed and this links into current training development in relation to Safety Planning, Risk Assessment and Suicide Prevention expected for Nov 2024.
Training and awareness of Emotionally Unstable Personality Disorder.	The Trust will develop a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Multi-agency engagement following incidents.	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Physical Health management within inpatient environments.	Quality improvement work in relation to improving physical healthcare management, observation, and care planning within Older People's services. Enhancement of wound care management and infection prevention and control investigation and follow up within inpatient services. Introduction of RESTORE2 into ILS training framework including review of current ILS provision. Establish a physical health reporting working group to establish the new system one reporting frameworks to improve reports for assurance.

Improvement issue	Improvement plan
	Introduction of RESTORE2 into ILS training framework including review of current ILS provision. Notification of increased NEWS score via system one to senior colleagues to be reviewed. Improving knowledge, skills, and technological support such as NEWS2 within SystmOne.
MDT process improvements within CMHTs.	Investigations have highlighted themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Self-harm within inpatient environments including management of contraband.	Improvement works in relation to Ligature risk assessment and care planning within inpatient services. Quality Improvement programme in relation to self-harm via sharps of females within inpatient services (local priority). Improvement to environment. Improvement to therapeutic engagements. Improvement to risk assessment and management including observation levels. To continue commissioned working group to review handheld clinical devices and compliance with observations including physical health observations.
Dissemination of learning and service improvements following incidents including assurance and governance.	Work is underway to improve the way in which the Trust learning improves from incidents, this will include a revision to the processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process. Develop pathway to offer clear governance processes. Develop service line learning briefings specific to service learning. Trust-wide learning the lessons to share high level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative Learning Responses.
Application of red flags and flow of incidents resulting in death.	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the ‘Mortality’ process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance.
Interface between Mental Health and Substance Misuse service.	Suspected Suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been rejected by Community Mental Health services is an area which has been noted through Case Record Review. This

Improvement issue	Improvement plan
	has been selected as a new local priority for the trust. Themes will be feed into Learning the Lessons subgroups for both services to jointly develop and improvement plan.
Substance Misuse services and Adult Acute Inpatient environments.	Learning Responses for unexpected deaths post discharge/ whilst on leave have highlighted gaps around knowledge, support and process for the management and support of risk in relation to addiction and substance misuse. Currently, several actions in place. Improvement plan to be developed and managed through the services Learning the Lessons subgroup.
Risk assessment, management, and care planning.	This is an area which repeatedly shows need for improvement and the trust is currently finalising a Safety Planning training package which will consist of four modules and incorporate suicide prevention.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 14 January 2025

Learning Difficulty and Autistic People (LeDeR) Update and Annual and Quarterly Reports

Purpose of Report

To update the Board on the Learning Disabilities Mortality Review (LeDeR) performance from October 2024, and the quarterly LeDeR report (Q2).

To update the Board on the LeDeR annual report and accept the priorities for 2024/25.

The Board is also invited to be aware that the LeDeR processes are provided from the ICB and the capacity within that team is limited providing limited assurance to the Trust.

Executive Summary

Summary of performance - completed reviews in Quarter 2: There were 15 reviews completed for people with learning disabilities in Quarter 2. 11 were completed as "Initial Reviews" and four completed as the more detailed "Focused" review (ie 27% were completed as focused reviews).

There were no Autism only (no Learning Disability) reviews completed in this quarter.

During the quarter the top reasons for death were aspiration pneumonia (with three deaths) and respiratory infections (with three deaths) listed as the main reasons for death on the death certificate (1a on the death certificate).

It is difficult to capture any trends over such small numbers, but the report aims to show areas we have identified through actions and learning and the review of health conditions. The report also identifies priority areas for the next quarter in relation to addressing inequalities.

Identified Priority areas for 2024/25

Aspiration Pneumonia – a review of the six-month project using learning from LeDeR reviews in relation to aspiration pneumonia deaths will be completed during August/September 2024. The information will be reviewed and themes/learning identified along with next steps to be considered based on this learning.

Care Coordination - we will continue to use LeDeR to evidence the need for care coordination of individuals, particularly those with a mild learning disability who do not have the support they need to manage and understand their health appointments.

Epilepsy – we will continue to identify issues found in relation to those individuals with epilepsy and highlight the importance of an Epilepsy Lead across the system.

Managing Deterioration – based on learning through LeDeR in 2023/24 we will be considering where the information and learning can be shared across the System to encourage better understanding of managing deterioration.

Mental Capacity Act - an emerging theme is that of mental capacity for people with a learning disability and autistic people. LeDeR has found some evidence to suggest that capacity is assumed, and the individual is making an unwise decision but without the necessary professional curiosity. We will continue to monitor this through LeDeR.

Minority Ethnic Communities – we will continue to work with the Minority Ethnic leads for LeDeR to increase awareness across all agencies and communities of the role of LeDeR and why notifying LeDeR of deaths is a first important step. To further raise awareness of the even poorer health outcomes for some members of minority ethnic communities who have learning disabilities, sharing the learning from LeDeR.

ReSPECT/DNACPR – the information included in this report in relation to ReSPECT and DNACPR will be shared as detailed and used as appropriate to promote learning.

LeDeR Capacity Challenges

The limited capacity within the ICB LeDeR team was raised at the February MH/LDA delivery board. Based on this the Derbyshire LeDeR programme is currently rag rated as Amber with concerns due to resource issues that is resulting in being unable to continue to meet performance targets and progress action from learning.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

Risks are on the Trust risk register and ICB risk register.

Consultation

- Resource risks are considered as system-wide JUCD and consultation on system-wide resources and discussed through LD/MH system delivery board.
- Quality and Safeguarding Committee, 10 December 2024

Governance or Legal Issues

LeDeR programme is national and is currently managed through ICB governance.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

None.

Recommendations

The Board of Directors is requested to note the scrutiny and limited assurance received at the Quality and Safeguarding Committee on performance based on resources from the LeDeR team.

Report presented by: **Arun Chidambaram**
Medical Director

Report prepared by: **Libby Runcie**
Deputy Director of Nursing

Joined Up Care Derbyshire

NHS
Derby and Derbyshire
Integrated Care Board

Derbyshire Learning from Deaths of those with a Learning Disability and Autistic People

The LeDeR Programme

Annual Report

1st April 2023 to 31st March 2024

Derbyshire LeDeR Learning from Lives & Deaths Annual Report 2023-2024

Responsible Committee	Derby & Derbyshire LeDeR Steering Group
Target Audience:	Report for agencies involved in the programme across the Derbyshire system and for sharing across the public domain:- LeDeR Steering Group Mental Health, Learning Disabilities, Autism & Children's System Delivery Board Neurodevelopmental Programme Delivery Group Joined Up Care Derbyshire National LeDeR Programme NHS England
Date of Approval:	23rd September 2024
Document Type	Annual Report (Quality)

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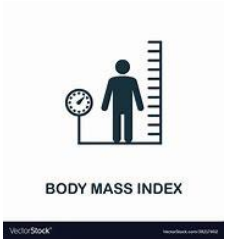
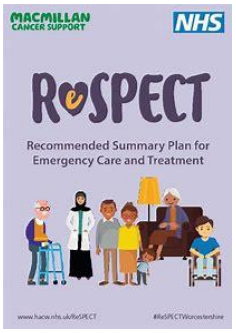
List of Abbreviations

Abbreviation	Explanation	Symbol
AHC	Annual Health Check	
BMI	Body Mass Index	
CDOP	Child Death Overview Panel	
CLDT	Community Learning Disability Team	
CQC	Care Quality Commission	Care Quality commission
DCHS	Derbyshire Community Health Services	NHS Derbyshire Community Health Services NHS Foundation Trust

DHcFT	Derbyshire Healthcare NHS Foundation Trust	
DNACPR	Do not attempt resuscitation	
GP	General Practitioner	
IAPT	NHS Talking Therapies	
JUCD	Joined Up Care Derbyshire	
LAC	Local Area Contact	

ICS	Integrated Care System	
LD	Learning Disability	
LeDeR	Learning from lives and deaths of people with learning disabilities and autistic people	
MCA	Mental Capacity Act	
NCMD	National Child Mortality Database	

NHSE	NHS England	
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment	
T2	**Transition 2** in Derby is a college for young adults aged 18 to 25 with learning disabilities and/or autism	

Executive Summary

The people whose deaths are reported in this report are people who were known and loved by many and whose loss will have had and continue to have a profound impact on those around them. The LeDeR Programme in Derbyshire wishes to thank all those who provided information when requested, especially considering the additional pressures faced during the last year. These include families and carers, GP Practices, NHS Trusts, Local Authorities, Managers, and staff working in Residential and Social Care Homes, Supported Living, Domiciliary, Day Care and other health and social care settings. Further thanks go to the reviewers for their compassion when completing the reviews, keeping the person at the centre of the process, to identify learning and share good practice.

This report is the fifth annual report for Derbyshire on the learning from deaths of those with learning disabilities and autistic people. The report uses data collated from 1st April 2023 up until 31st March 2024. Thanks to those with lived experience who have been involved in producing this report and the Derby & Derbyshire Integrated Care Board LeDeR Team.

The purpose of the report is to share the findings and the learning with those involved in the LeDeR programme and those working with individuals with learning disabilities and autistic people, to demonstrate how Joined Up Care Derbyshire (JUCD) is delivering on local actions as identified in LeDeR reviews. It is signed off through the LeDeR Steering Group and shared with the JUCD System Quality Group, the Neurodevelopmental Delivery Group and the Mental Health/Learning Disability & Autism Board for information. The report, including an accessible version, is published each year and available on the JUCD website. The report is shared with NHSE regional teams by 30th September 2024.

Summary of local data and findings

Since the programme began there have been 425 (adult i.e. age 18+) deaths reported to LeDeR in Derbyshire covering the period April 2017 to end March 2024, of which 374 of these deaths have had a review undertaken and completed.

From 1st April 2023 to 31st March 2024 there were 83 notifications and 65 completed reviews in that year period. Some of those 65 completed will have been notifications received in the previous year and some will be part of the 83 notifications received in 23/24.

Of the 65 completed reviews 2 were for autistic people but with no learning disabilities. These 2 reviews have been separated out within the report and a separate section relates to their learning. The remainder of the information throughout this annual report is based on the 63 reviews that were **completed** during 2023/24.

Of the 63 completed reviews for people with learning disabilities,30 of the reviews were male, 33 of the reviews were female.

Average age at death for females was 61 years and 60 years for males. In the national LeDeR report for 2022 the average age at death was 62.9 for both female and male.

58 of the completed reviews were for the population identifying as White British. Five reviews were completed reviews for those identifying from a minority ethnic community (2 Pakistani, 2 "Any Other White Background" and 1 "Any Other Mixed or Multiple Ethnic Background"). This is the same number as the previous year. Note that the minority ethnic backgrounds/descriptions used are as requested through the LeDeR programme.

Hospital was the most common place of death, with 36 of the 63 completed reviews showing hospital as the place of death.

During 2023/24 there have been three reviews completed as confirmed Covid-19 deaths. There have been three additional completed reviews where the individual had Covid-19 at death although Covid-19 was not listed as their main reason for death. There have been no notifications made in the year where Covid-19 is mentioned on the notification.

The top reason for death was Pneumonia for 19% of our Derbyshire population. Aspiration Pneumonia (not included in the more generic Pneumonia as reason for death) was separated out and was the third top reason for death with 11% (alongside heart conditions which also had 11%). Cancer was the second reason for death at 13%. Three out of the 8 cancer deaths in 2023/24 (37.5%) were caused by bowel cancer/colorectal carcinoma (1a on the person's death certificate).

Of the 83 notifications received in the year, 5 were notifications for individuals with autism (no learning disability). Only one of these was completed in the year and details are included in the section relating to the 2 completed reviews for autistic people but no learning disabilities. In total there have only been 7 notifications since January 2022 of autistic people but had no learning disabilities. Five of these reviews are on hold as they are awaiting coroner investigation.

Local learning and making changes

Our priority is to use the learning from LeDeR to make service improvements for people with learning disability and autistic people in our local community and lots of work is happening in this area and detailed later in this report. Focus has particularly been on deaths from aspiration pneumonia and looking at learning in relation to ReSPECT/DNACPR.

Constipation has been a priority area in Derbyshire for a number of years now and it is good to see that the percentage is remaining low compared to earlier years, this year showing at 37% in health conditions. However, we will be continuing to monitor this closely as this is a slight increase on last year which was 34%.

In last year's report epilepsy was seen in 38% of the completed reviews in health conditions, this year it has

increased to 48% and we will continue to raise the importance of prioritising this area of work.

Priority areas for 2024/25

The report highlights a number of local priority areas for work across the system as identified through the LeDeR learning seen throughout 2023/24:-

Aspiration Pneumonia – A review of the 6 month project using learning from LeDeR reviews in relation to aspiration pneumonia deaths will be completed during August/September 2024. The information will be reviewed and themes/learning identified along with next steps to be considered based on this learning.

Care Coordination - We will continue to use LeDeR to evidence the need for care coordination of individuals, particularly those with a mild learning disability who do not have the support they need to manage and understand their health appointments.

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Mental Capacity Act - An emerging theme is that of mental capacity for people with a learning disability and autistic people. LeDeR has found some evidence to suggest that capacity is assumed, and the individual is making an unwise decision but without the necessary professional curiosity. We will continue to monitor this through LeDeR.

Minority Ethnic Communities – We will continue to work with the Minority Ethnic leads for LeDeR to increase awareness across all agencies and communities of the role of LeDeR and why notifying LeDeR of deaths is a first important step. To further raise awareness of the even poorer health outcomes for some members of minority ethnic communities who have learning disabilities, sharing the learning from LeDeR.

ReSPECT/DNACPR – the information included in this report in relation to ReSPECT and DNACPR will be shared as detailed and used as appropriate to promote learning.

Introduction to the LeDeR Programme

LeDeR is a service improvement programme for people with a learning disability and autistic people.

The programme was established in 2017 by NHS England. LeDeR aims to:

- improve care for people with a learning disability and autistic people
- reduce health inequalities for people with a learning disability and autistic people
- help stop people with a learning disability and autistic people dying early.

Nationally, annual reports have been produced for the past 7 years and previous reports are available to view here.

It is important to note when looking at any findings in relation to LeDeR that notification to the LeDeR programme is not mandatory, so does not have complete coverage of all deaths of people with learning disabilities and that numbers in some sub-categories are small so must be interpreted with caution.

The "Learning from lives and deaths – people with a learning disability and autistic people (LeDeR) policy" was introduced in March 2021 to serve as a guide to professionals working in all parts of the health and social care system on their roles in delivering LeDeR. The policy includes NHS England's (NHSE) delivery expectations of local areas, which includes a local LeDeR annual report demonstrating how the ICS is delivering on local actions addressing those areas identified in LeDeR reviews and asking that it demonstrates effective delivery of actions from learning from LeDeR reviews.

The *LeDeR Policy* [1] informed of the inclusion of LeDeR reviews for autistic people with no learning disability. This took affect from 1st January 2022.

As per requirements of the LeDeR Policy a *Derbyshire LeDeR 3-year strategy* [2] was produced using the learning that has been found and reported in Derbyshire and submitted to NHSE in March 2022.

A new LeDeR platform was introduced in 2021/22 which altered the review process from previously including new formats to the reviews. In February 2023 a LeDeR23 form was introduced which made changes to some of the information that is gathered to complete the review process.

All notifications of death for individuals age 18+ follow the LeDeR process. Anyone under the age of 18 is referred through the separate Child Death Review process. In Derbyshire, referrals to the LeDeR programme are accepted for those registered with a Derbyshire GP practice. For autistic people with no learning disability a clinical diagnosis of autism must be visible.

Depending on the complexity of the person's life and death a decision is made to complete as an Initial Review or Focused Review. However, all LeDeR reviews are automatically Focused if:-

[1] See References section
[2] See References section

- the person is from a Black, Asian or minority ethnic background
- an autistic person with no learning disability
- the person had been under mental health or criminal justice restrictions at the time of death or 5 years previously
- where there is likely to be learning from the life of the person to inform service improvements
- local priorities for focused reviews
- where the family have requested a focused review
- where there are any concerns about the care the person received

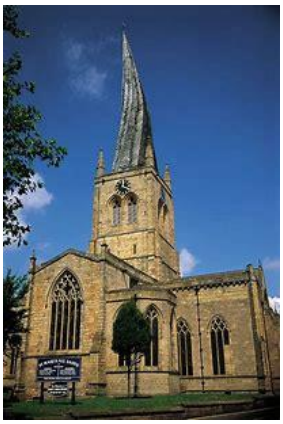
As a service improvement programme locally in Derbyshire, we are working as Joined Up Care Derbyshire ICS to use the learning found through LeDeR to improve our local services for people with a learning disability. As LeDeR also develops into a service improvement programme for people with autism the strategy will adapt and evolve to show how we aim to collect information and hope to also improve services for people with autism.

The LeDeR Programme in Derbyshire

Estimates of people with a learning disability for Derby and Derbyshire are slightly more than 2% of the population, which is approximately four times the proportion of the population who are known to services. It is estimated that there are 15,250 people in Derbyshire and 4,950 people in Derby with a learning disability (people with mild to severe learning disability). (*Reference: JUCD website*[3])

It is estimated that 1% of the population have autism. Research has identified between 44% and 52% of people with autism may have a learning disability and between 48% and 56% do not have a learning disability. Data from GPs in Derby and Derbyshire show there are 3,358 people with autism (who have no learning disability). (*Reference: JUCD website*[4])[5]

Work started on the LeDeR programme in Derbyshire early 2017. The first LeDeR Steering Group ran in February 2017 and the first reviews started in April 2017. Since that date we have received 425 notifications for those age 18+, of which 374 have had a review undertaken and completed (local collated data as of 31st March 2024). The information in this report is taken from LeDeR reviews completed between 1st April 2023 to 31st March 2024.



Learning from individual reviews is collated through an action tracker. Good practice is acknowledged and shared with organisations and individual actions are agreed and discussed at the Derbyshire LeDeR Governance Panel and fed back up to organisations through their members that attend the meetings.

Themes are also collated from each review and the theme form is evaluated alongside the review as part of the quality review process. Our reviewers have been collecting themes since 2020/21 that also identify the responsible care provider. Themes are collated and reviewed to identify areas where commissioning concerns may need to be identified. These themes are shared with organisations via the Derbyshire LeDeR Steering Group to enable them to see themed areas of work that are relevant to them for potential review and for discussion as a wider Derbyshire system.

[3] See References section for link to JUCD website
[4] See References section for link to JUCD website
[5] Note that there may be different figures available in relation to local populations within learning disability and autistic people, which reflects some of the uncertainty about prevalence & how many people are known to services.

The Derbyshire Vision for LeDeR

As Joined Up Care Derbyshire we continue to aim and work towards our Derbyshire LeDeR Vision in everything we do as part of the LeDeR programme.

Derbyshire LeDeR Vision

By 2024, we will have significantly improved the lives of people with learning disabilities and autism to work towards preventing them from dying sooner than the general population. We will do this by improving the quality of person-centred care they receive in their daily lives and making all services accessible to them; making sure they have knowledge and understanding of the services that are available for them to use and helping them to understand how to improve their own physical health.

Co-production and Engagement

Dan attends our LeDeR Steering Group Meetings as our person with lived experience. Dan has also been involved with producing the Annual Report and worked with us to make it more user friendly. This is what Dan produced to tell you a bit about what his role is and how he supports the LeDeR programme.

	Hello My name is Dan Walmsley, I am an assistant Health Facilitator in the Neurodevelopment Team .
	I have been attending the LeDeR Steering Group Meetings.
	I like to attend the meetings to share my views.
	The meetings are important, to help stop people with Learning Disabilities passing away too soon from illness.
	In the meetings we talk about people's lives and the care they had received.
	We talk about things like epilepsy, illness and other things, and about how we can improve.
	I like to give my advice on easy read.
	I like to talk about Annual Health Checks because it is important for people to go to them to try to keep healthy.

Denise co-produced the LeDeR annual report last year. This year she's been involved by reviewing the annual report and providing her feedback on the format and way the report is written and she's helped with the easy read version of this report. Here's a bit about Denise:-

Hello, my name is Denise. I am a Director on the Board of Inclusion North who are a group of people who raise awareness of the barriers to inclusion for people with a learning disability, autistic people and their families, and work to remove them. In April of 2024 I won an award at the 2024 Learning Disability and Autism Leaders List awards through Dimensions, in the award category of advocacy policy and media.

My Experience

I have a mild learning disability, but only got diagnosed at the age of 21.

I have lots of experience as part of a Care and Treatment Review panel where we work to try to help to sort out any problems which can keep people in hospital longer than necessary and try to help them stay living safely in the community.

I am an Enter and View authorised representative for Healthwatch Derbyshire where I visit health and social care settings to see how they are working and make suggestions for improvement.

My Skills and Knowledge

I am able to ask the right questions at the right time.
A good communicator.
Approachable.
A good team player.

What is important to me

Listening to people.
Being understanding.
Being kind and caring.
My family and friends.
That people are given a chance.

What people say about me

I like a bit of banter.
I am confident in myself.
A friendly person.
Kind and caring.

I Enjoy

Singing and song writing.
Going to gigs and concerts.
Socialising.
Holidays abroad.
Being a voice for people with disabilities.
Reading the news for Inclusion North.

Partnership working across the Integrated Care System

Work has continued throughout the year to ensure good partnership working across the LeDeR programme and sharing of information. This has included:-

- Quarterly LeDeR Steering Group meetings attended by people with lived experience and partners across Joined Up Care Derbyshire.
- Regular LeDeR Governance Panel meetings (approximately once a month depending on number of focused reviews for quality checking and sign off) attended by partners across Joined Up Care Derbyshire.
- Working with DCHS Mortality Review Group to ensure learning from LeDeR is incorporated into their reports and fed back to their Mortality Review Group meetings, to enable a robust look at LeDeR themes within Derbyshire to improve sharing and quality improvements.
- The LeDeR team working together with the Strategic Learning Disability Health Facilitation Team to deliver workshops across health and social care providers, promoting learning from LeDeR and the work of the Health Facilitators with particular emphasis on promotion of learning disabilities annual health checks, health action planning and making reasonable adjustments.
- Meetings between LeDeR and Safeguarding to ensure we are working together on any appropriate reviews and attending Safeguarding Adult Board meetings to share LeDeR learning. LeDeR reviewers work closely with Safeguarding Adult Board for any reviews that have been progressed as a Safeguarding Adult Review (SAR), including meeting families together with the SAR reviewer and attending the SAR meetings.
- Working with adult social care both to improve LeDeR processes and to ensure themes and learning are appropriately shared.
- Working with Royal Derby Hospital to deliver learning from LeDeR as part of the end of life study days
- Delivering learning from LeDeR at Derbyshire County Care Home Forum
- Regular meetings with managers of learning disability community care providers to share learning from LeDeR and discuss and agree next steps and how the learning can be used across Derbyshire to improve services.
- Sharing quarterly reports and updates with System Quality groups.
- Sharing LeDeR learning with the Good Health Group and Learning Disability Partnership Boards – meetings attended by people with lived experience and their carers.
- Sharing LeDeR learning at Mental Health, Learning Disability and Autism Delivery Board meetings

Child Deaths

A national report has been produced by the National Child Mortality Database (NCMD) which is available here in full and easy read and aims to identify trends in child mortality among children and young people with a learning disability and autistic children.

Locally, LeDeR no longer captures information in relation to child deaths. All child deaths are reviewed through the CDOP (Child Death Overview Panel) process and information and themes captured separately through this process.

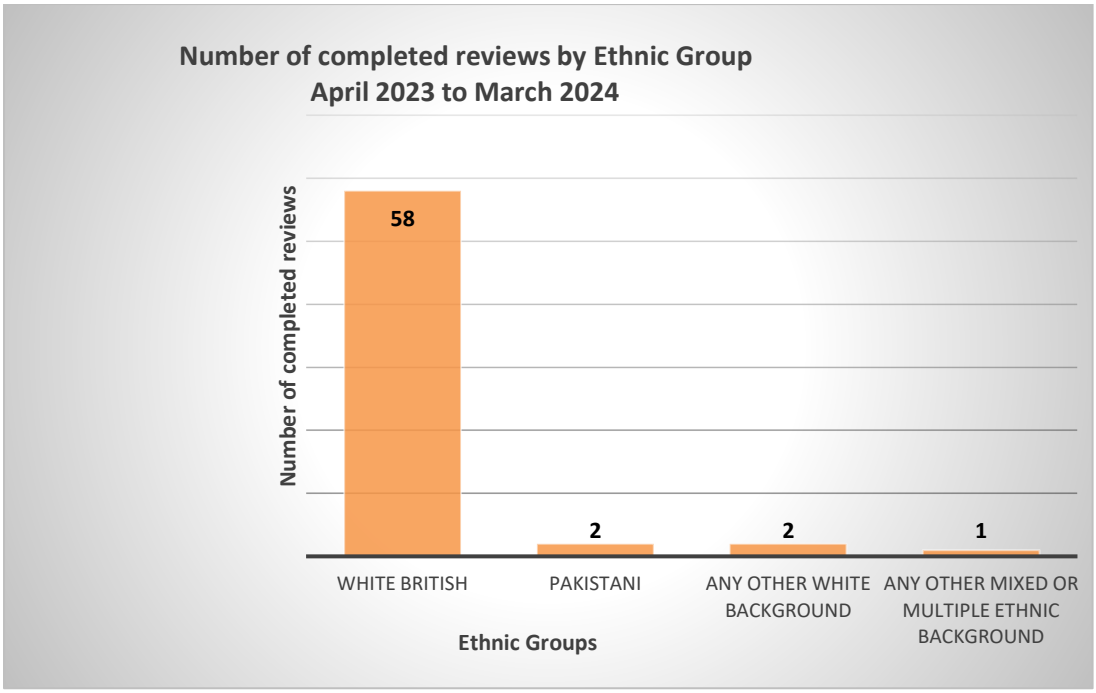
Staffing and Governance Arrangements

The LeDeR programme is part of the Nursing and Quality team within the Derby and Derbyshire Integrated Care Board (ICB). The LeDeR team are made up of the LeDeR Administrator, Local Area Contact (LAC), Senior Reviewer and 1.0 wte Reviewers. Any issues and risks are supported within the wider Nursing and Quality directorate and reported via the LeDeR Governance Panel and LeDeR Steering Group and fed into the system wide Neurodevelopmental Programme Delivery Group, and ultimately to the JUCD Mental Health/Learning Disability & Autism Delivery Board.

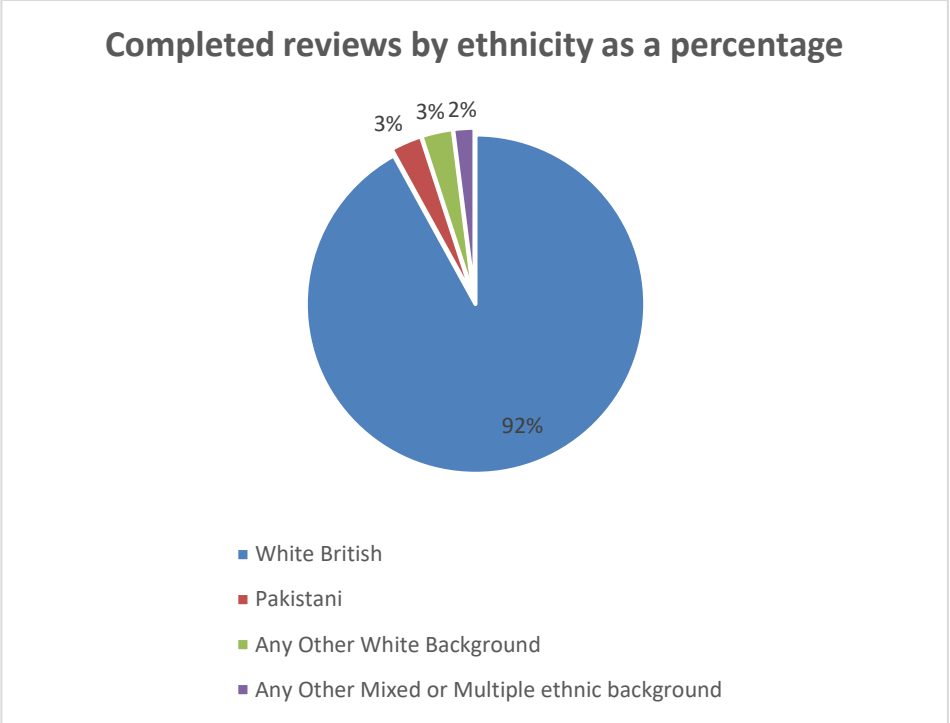
Equality Impact

Addressing Inequalities across Black Asian & Minority Ethnicity communities

During 2023/2024 five reviews (8%) were completed for those identifying from a minority ethnic community. This is the same number of reviews completed for people identifying from a minority ethnic community as last year.



**Note that the minority ethnic backgrounds/descriptions used are as requested through the LeDeR programme.*



In Derbyshire County our minority ethnic population is estimated to be about 3.9% (although this varies across the County and is separated out as Derbyshire Dales, North East Derbyshire and South Derbyshire by the Office of National Statistics) and in Derby City the minority ethnic population is estimated to be about 26.2% (taken from the Office of National Statistics, Census 2021 data[6]).

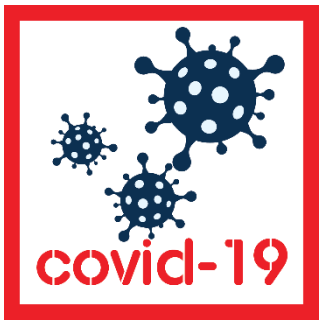
Therefore, if we break this down further to compare completed reviews separately across the City and County:-

- 16 of the overall completed reviews were individuals from the City. 4 of these individuals were from minority ethnic communities i.e., 25%.
- 47 of the overall completed reviews were individuals from the County. 1 of these individuals was from a minority ethnic community i.e., 2%.

These are encouraging as the number of notifications are closer aligned to those expected from minority ethnic communities than in previous years, however we aim to continue to promote LeDeR and the programme aims in these communities and to further raise awareness of the even poorer health outcomes for some members of minority ethnic communities who have learning disabilities.

[6] See References

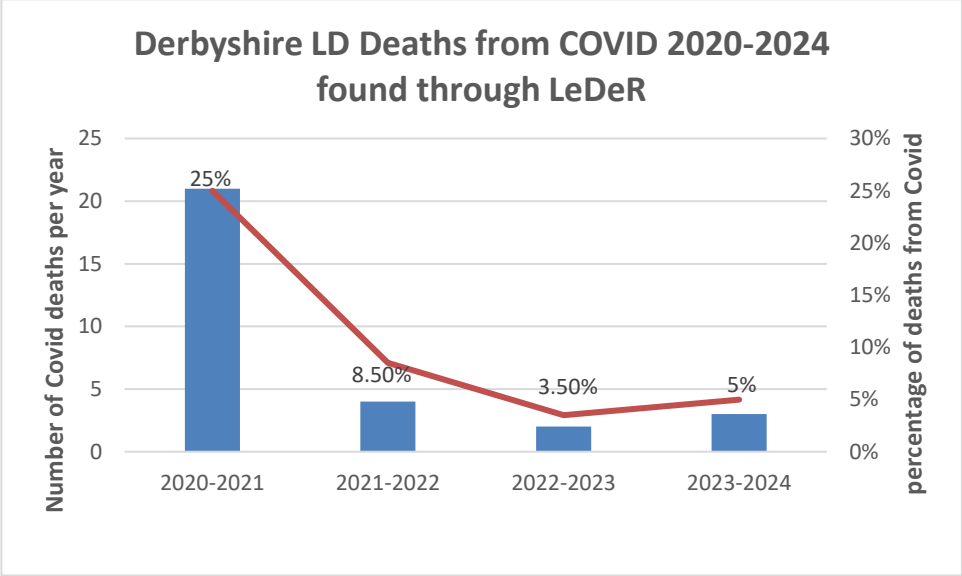
Covid-19



During 2023/24 there have been 3 reviews completed as confirmed Covid-19 deaths. Two of these individuals died in hospital and one in the Care Home.

There have been an additional 3 completed reviews where the individual had Covid-19 at death although Covid-19 was not listed as their main reason for death.

The table below shows the percentage of deaths from COVID (Covid cause of death as per 1a of the Death Certificate) seen in completed LeDeR reviews from 2020 to 2024.



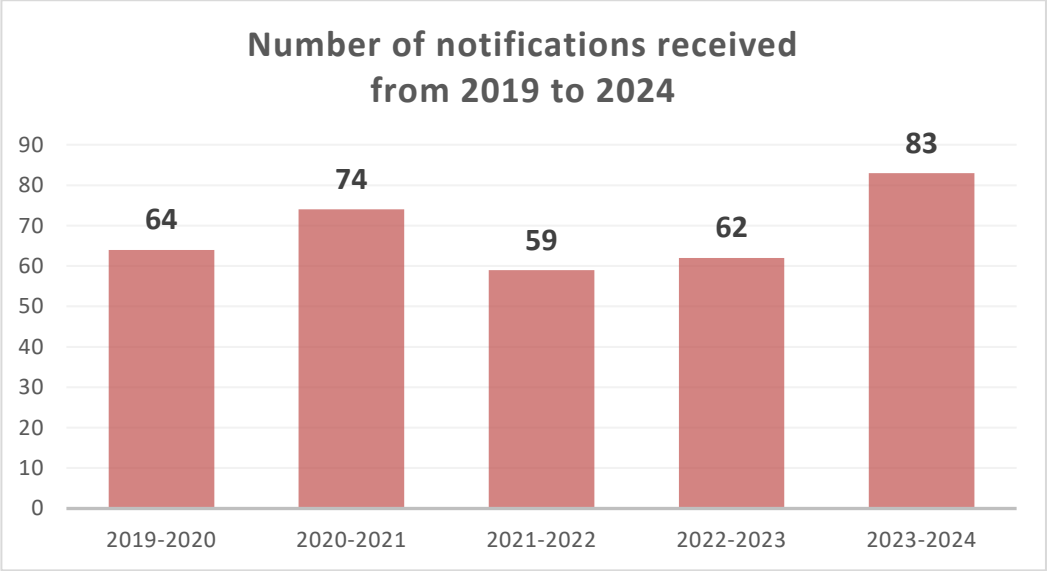
In 2020-2021 the number of LD deaths totalled 21 (25% of notified deaths) which has decreased significantly to 3 deaths (5%) in 2023-2024.

Local Demographic Data & Findings

Since the programme began there have been 425 deaths reported to LeDeR in Derbyshire covering the period April 2017 to end March 2024 of which 374 of these deaths have had a review undertaken and completed. [NB. As mentioned previously all notifications referred to are for 18+ only]

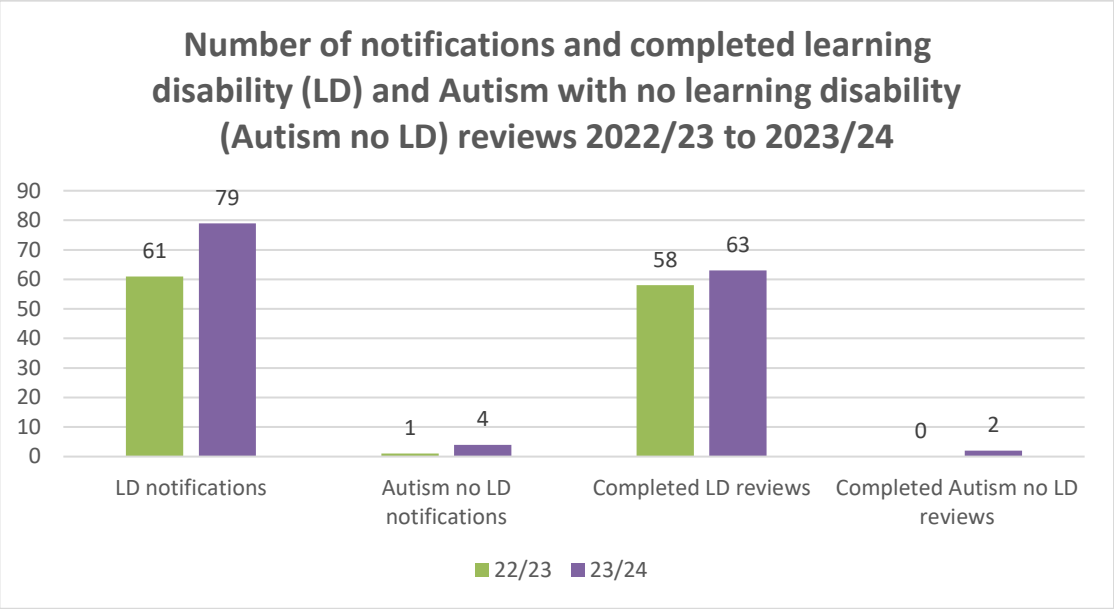
For the year 1st April 2023 to 31st March 2024 there were 83 notifications and 65 completed reviews in the year. Some of those 65 completed are from notifications received in the previous year and some will be part of the 83 notifications received in 2023/24. Information throughout the annual report is based on the reviews that were completed during 2023/24.

The table below illustrates the number of notifications to the LeDeR programme in Derbyshire from 2019 to 2024. There has recently been a significant increase in the notification rate which has increased by 34% between 2022/2023 and 2023/2024.



Autism (no learning disability) deaths

There were 2 reviews completed in 2023/24 for deaths of autistic people but did not have a learning disability. There were 4 notifications of deaths for individuals who had Autism but no Learning Disability in 2023/2024.



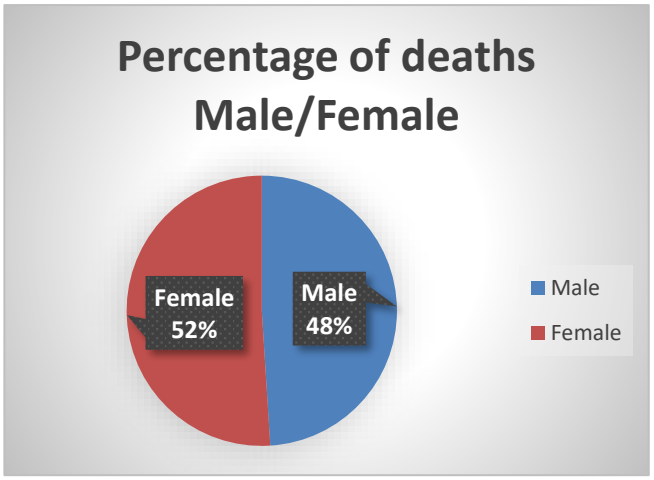
As there have only been 2 completed LeDeR reviews for individuals with autism but no learning disability we are not yet in a position to start to capture any themes. However, we can report that both these completed reviews were males in their mid 30s, both died at home, and had mental health issues. Both deaths were investigated by the Coroner, one was found to be suicide and the other was given a reason for death as "Unascertainable" by the Coroner.

For the additional autism (no learning disability) reviews that have been notified between 2022 and 2024 all were also male, age ranging from 18 to 45.

In total, there have been 7 notifications to Derbyshire for individuals with autism but no learning disability. The seventh review not yet mentioned was notified to us in 2021/22. This is the only female notification we have received, and this review is still not completed as is still being investigated by the Coroner.

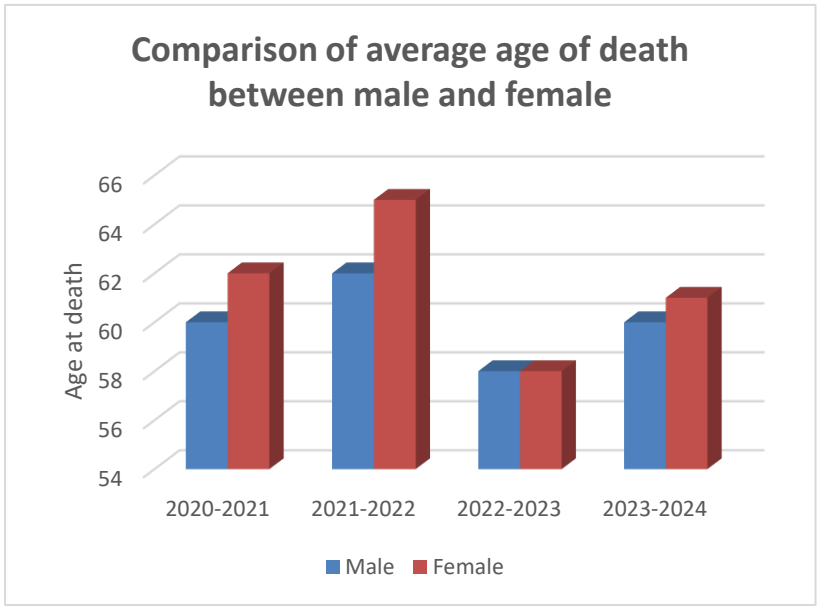
The remainder of this report will refer to the 63 reviews that were completed during 2023/24 for individuals who had a learning disability (NB some of those people will have been an autistic person as well as having a learning disability).

The following graphs represent data taken from the 63 completed reviews for 2023/24:-

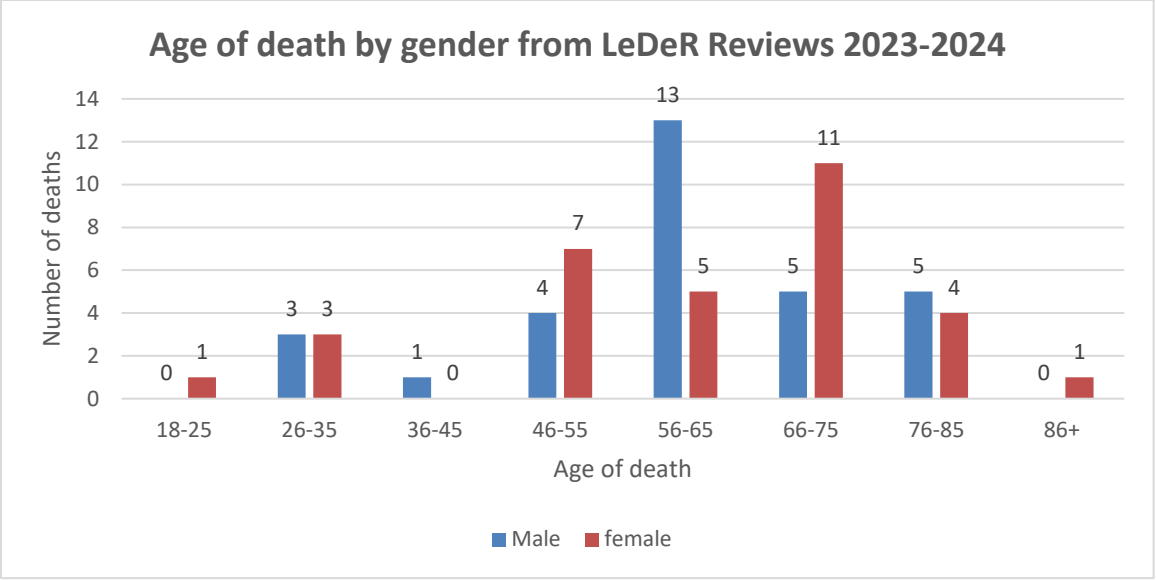


30 of the deaths reviewed were male (48%)
33 of the deaths reviewed were female (52%)

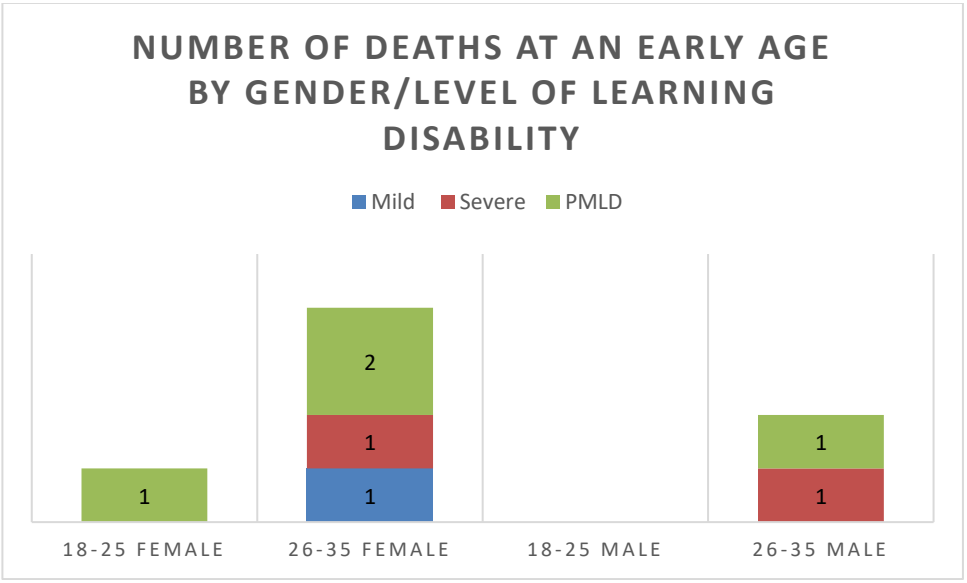
Learning from LeDeR showed that the average age of death in Derbyshire was 60 for males and 61 for females from reviews completed in 2023 to 2024.



This represents an improvement from last year as the average age was 58 for both male and females.

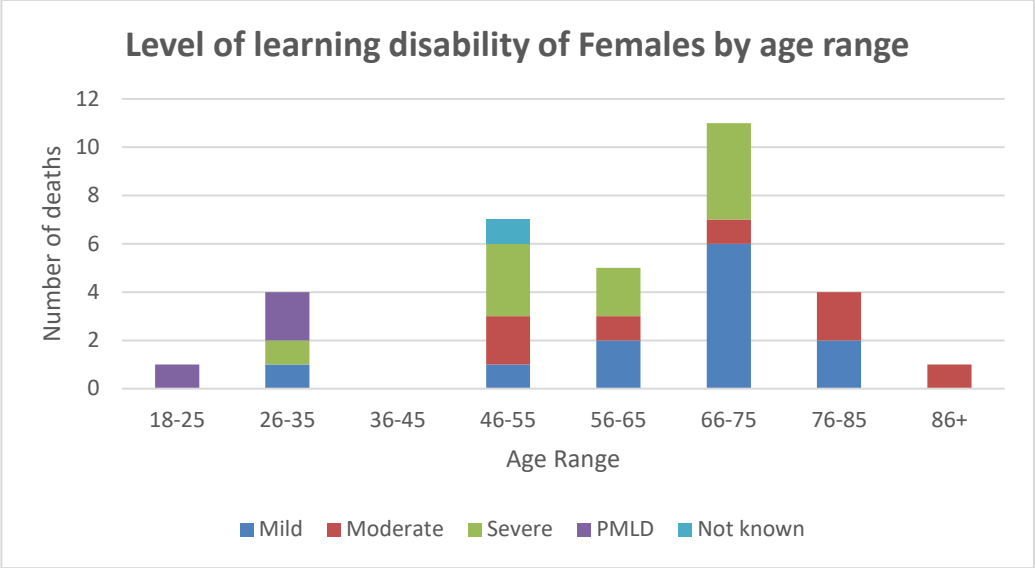


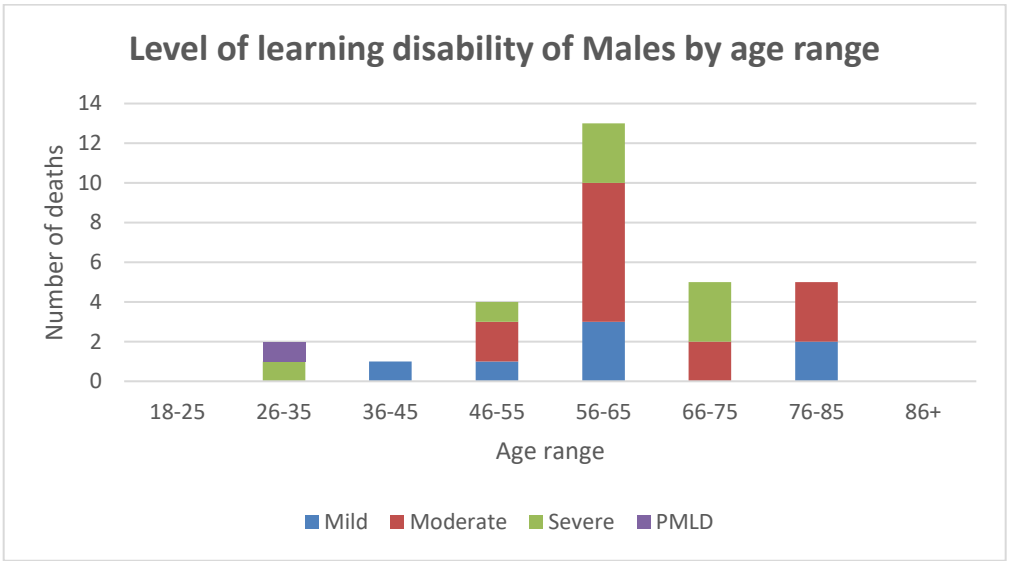
For 2023/2024, more males died in the age category 56 to 65, while more females died in the higher age category of 66 to 75.

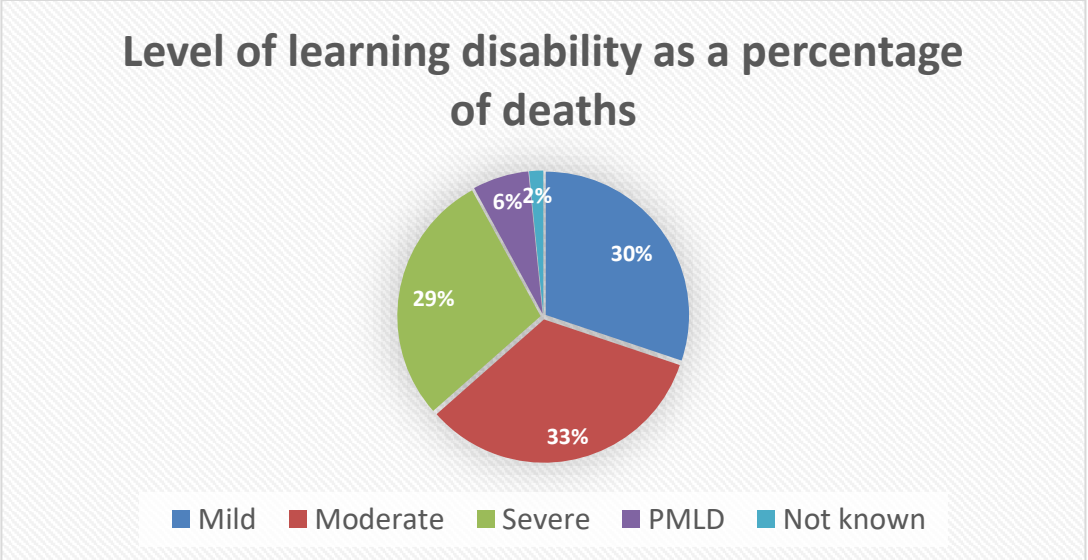


The youngest female to have died at an early age (under 35) was 18 years old and she had a profound and multiple learning disability. The cause of death was Respiratory Failure. This review was completed as a focused review.

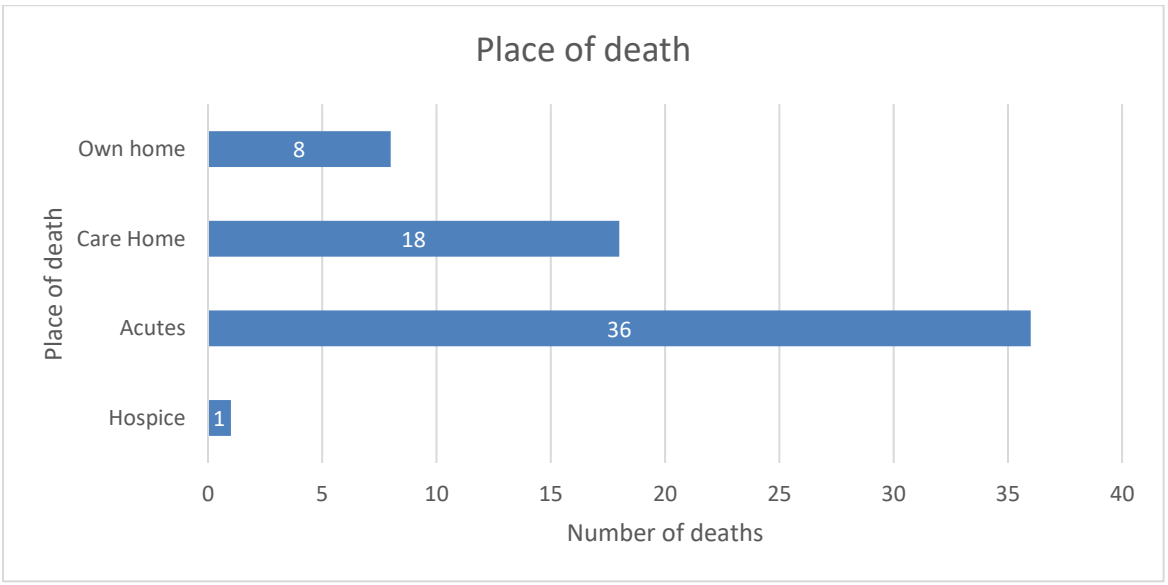
The youngest male to have died at an early age (under 35) was 30 years old and had a severe learning disability. The cause of death was Aspiration Pneumonia. This review was also completed as a focused review.


Level of learning disability of Females by age range
Number of deaths
12
10
8
6
4
2
0
18-25
26-35
36-45
46-55
56-65
66-75
76-85
86+
Age Range
Mild
Moderate
Severe
PMLD
Not known

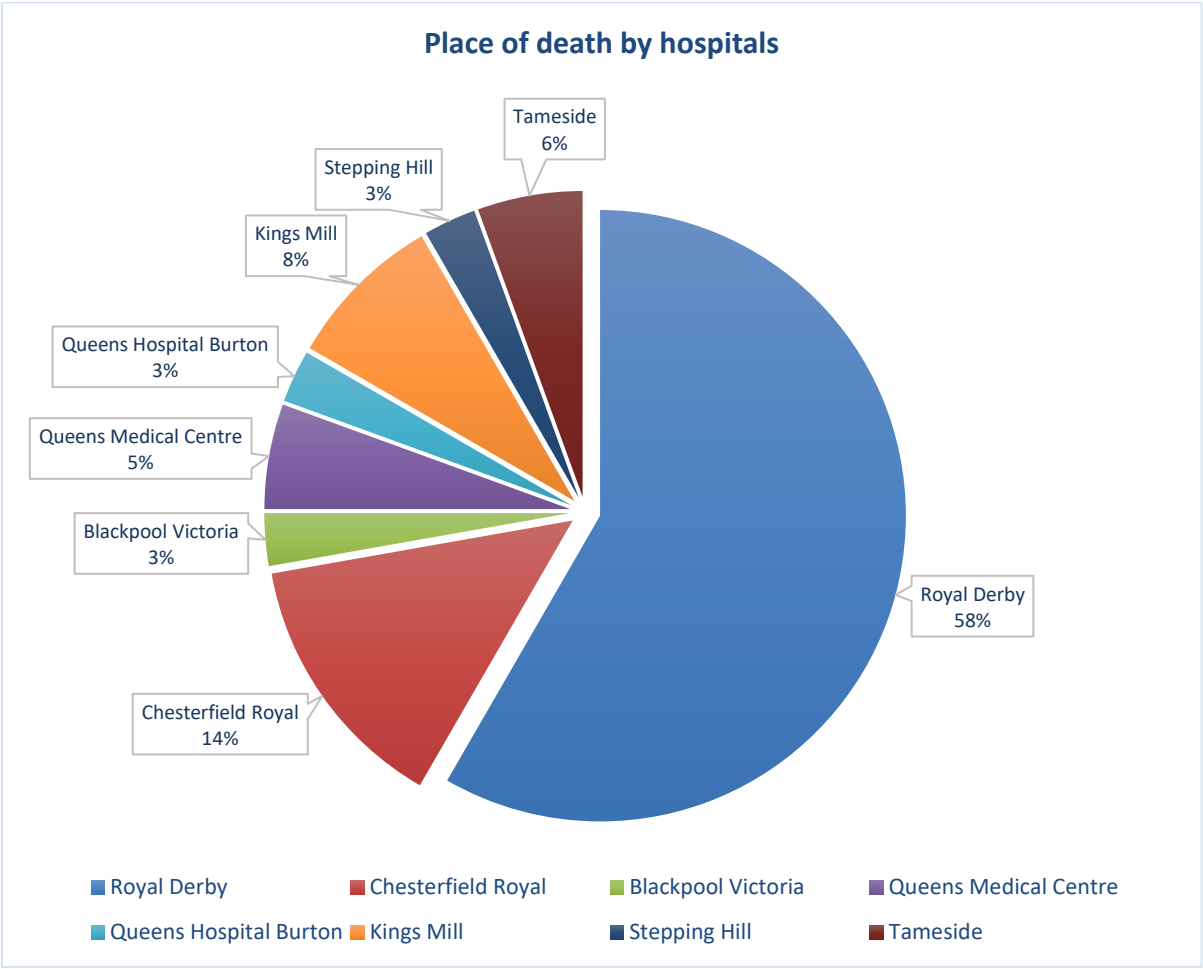

Level of learning disability of Males by age range
Number of deaths
14
12
10
8
6
4
2
0
18-25
26-35
36-45
46-55
56-65
66-75
76-85
86+
Age range
Mild
Moderate
Severe
PMLD


Level of learning disability as a percentage of deaths
30%
33%
29%
6%
2%
Mild
Moderate
Severe
PMLD
Not known

Hospital was the most common place of death, with 57% or 36 of the 63 completed reviews showing hospital as the place of death.



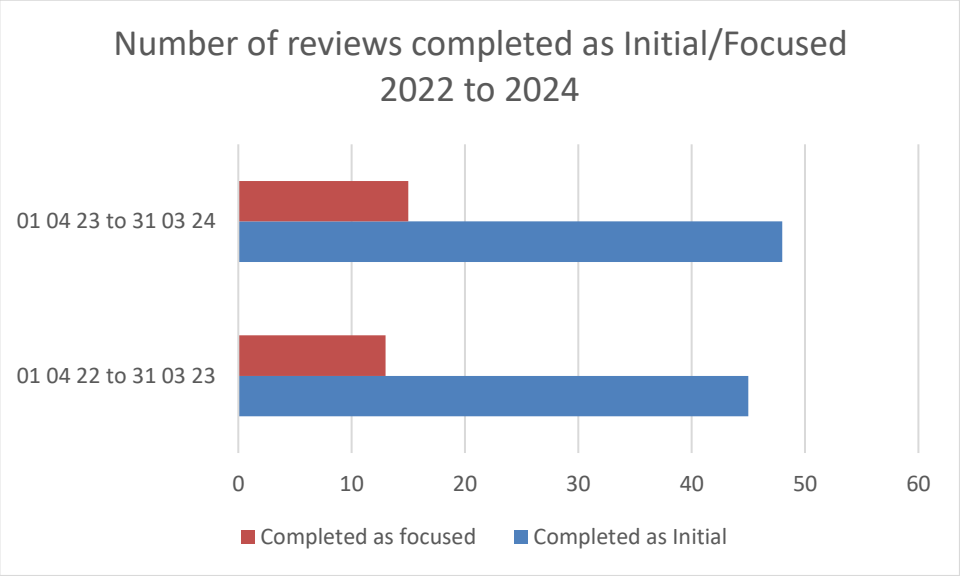
Of the 36 deaths which occurred in hospital, 28% of these took place in hospitals out of Derbyshire.

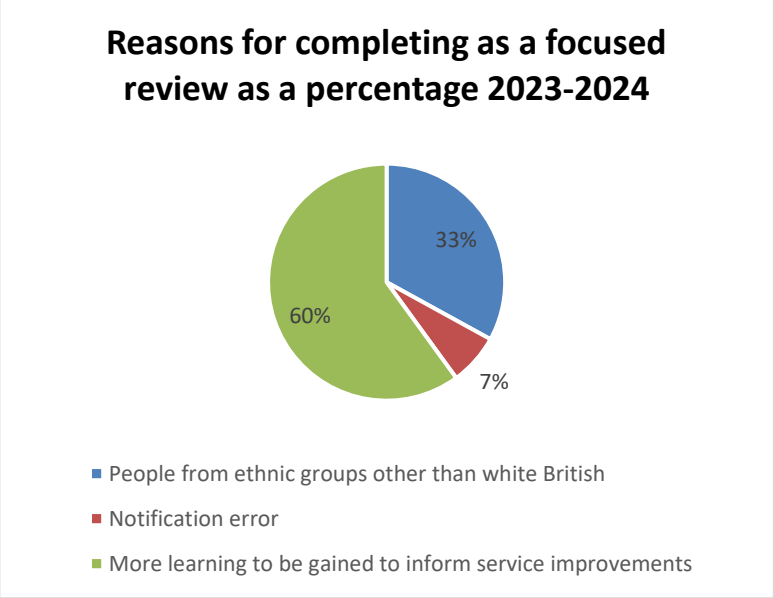


Focused and Initial Reviews

All reviews are completed either as Initial or Focused as per the national LeDeR policy. During 2023/24 there were 48 reviews (76%) completed as initial reviews and 15 (24%) completed as the more detailed focused review.

There is a slight increase in the number of both initial and focused reviews completed this year compared to the previous year. The graph below shows the number of focused and initial reviews over the last 2 years.





Of the 15 reviews completed as focused 60% of them (9) were moved to a focused review from an initial review in order to gather more learnings for service improvement.

33% were automatically completed as focused due to being individuals from a minority ethnic background.

Individual actions are identified from each review, this may show good practice and/or areas where it is felt improvements could be made. Some areas of learning are evidenced through case studies to identify local priorities and agree actions. Case studies from LeDeR reviews completed in Derbyshire during 2023/24 are shared throughout this report to evidence this.

A national target set by NHSE is that 35% of reviews are completed as focused reviews.

Grading of Care

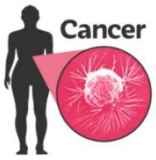
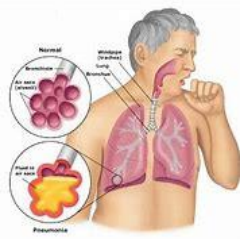
In the current version of the LeDeR platform there is only an option to grade care in reviews that are completed as Focused, and therefore the information below only relates to 15 completed Focused reviews. It is appropriate to note that Focused reviews in the majority are completed where issues have been identified and a fair assumption is that it is unlikely that grading of care would be scored at a high level. It is likely that an Initial review would have potentially been scored at a higher level.

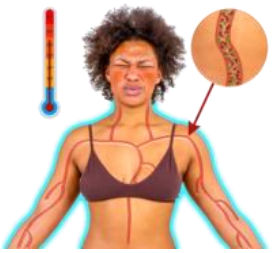
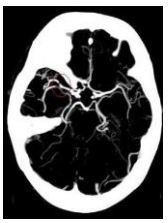
NB. If a comparison is to be looked at this can only be compared to annual reports since 2021/22 as in earlier years (when using the earlier LeDeR platform) grading of care was captured for all reviews.

Grade		Percentage against the 15 focused reviews 2023/2024	Percentage for the focused reviews 2022/23	Percentages for focused reviews in 2021/22
6	This was excellent care (it exceeded expected good practice	**13%**	**0%**	**0%**
5	This was good care (it met expected good practice)	**27%**	**23%**	**30%**
4	This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's wellbeing)	**20%**	**38%**	**20%**
3	Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death	**33%**	**31%**	**20%**
2	Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death	**7%**	**8%**	**30%**
1	Care fell far short of expected good practice and this contributed to the cause of death	**0%**	**0%**	**0%**

Reasons for Death in Derbyshire

Of the completed reviews during the period 1st April 2023 to 31st March 2024 the reasons for death are categorised and separated out below.

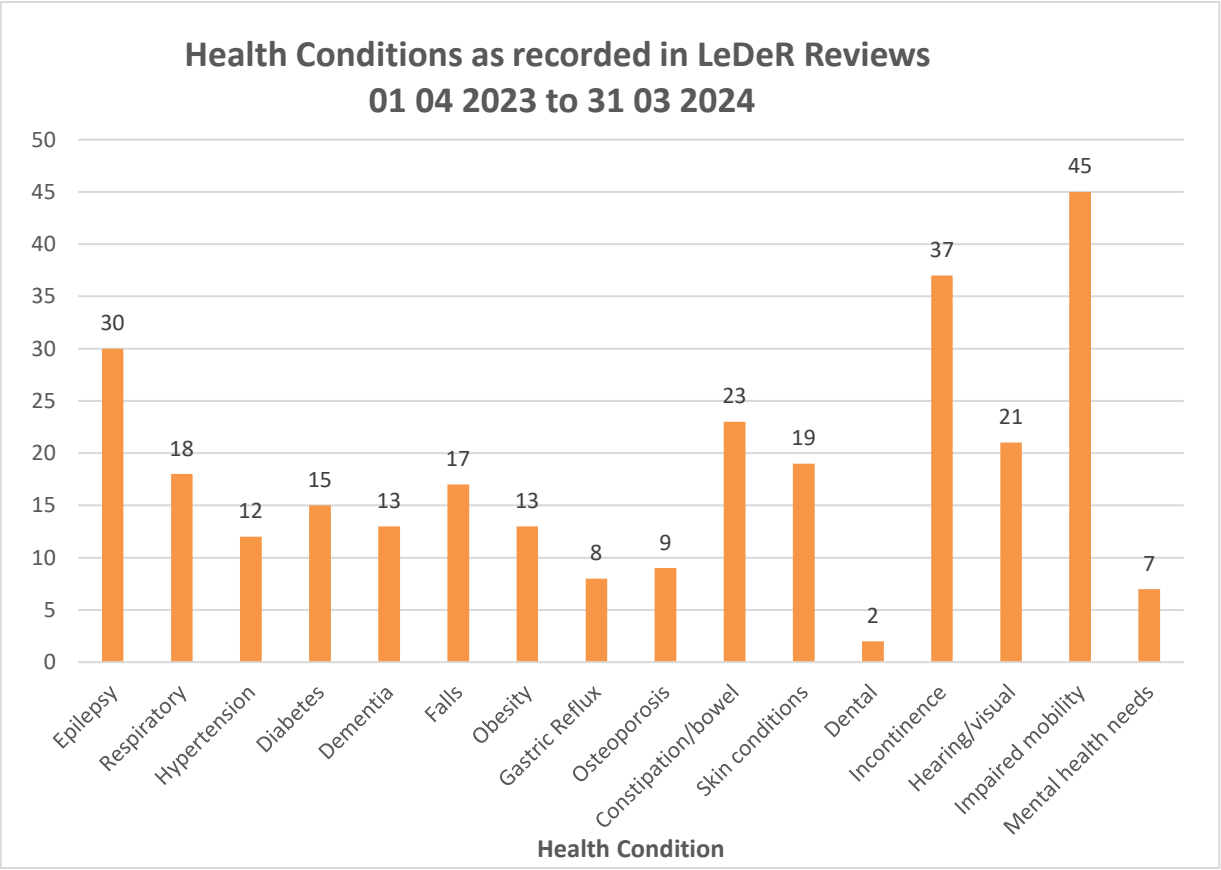
For Reviews completed 2023/2024		
Death category		**Percentage with this death category at 1a of death certificate**
Respiratory Infections	Respiratory infections such as **pneumonia, bronchopneumonia, Community Acquired Pneumonias and Hospital Acquired pneumonias, along with chest infections.** A respiratory tract infection can affect the airways, such as with bronchitis, or the air sacs at the end of the airways, as in the case of pneumonia 	**24%**
Cancers	Disease in which some of the body's cells grow uncontrollably and spread to other parts of the body 	**13%**
Aspiration Pneumonia	**Aspiration pneumonia is pneumonia that is caused by something other than air being inhaled (aspirated) into your respiratory tract.** These non-air substances can be **food, liquid, saliva, stomach contents, toxins** or even a small foreign **object.** 	**11%**
Heart Conditions	When blood flow becomes limited or stopped, the body shuts down and - without intervention - can lead to death. 	**11%**

Sepsis/Septic shock	Happens when your body overreacts to an infection you already have and starts to damage your body's own tissues and organs 	**5%**
Covid-19	An infectious disease caused by a virus characterised mainly by fever and cough and can progress to more severe symptoms 	**5%**
Frailty	Increased vulnerability to poor health outcomes due to underlying conditions 	**3%**
Multi Organ Failure	When the inflammation from a severe infection or injury causes dysfunction in two or more organ systems 	**3%**
Stroke	A stroke can occur when blood flow to the brain is blocked or there is sudden bleeding in the brain. 	**3%**
Others		**22%**

Health Conditions

Data is collected locally of the health conditions of everyone who receives a LeDeR review. This information is used to enable us to identify possible areas of work.

A graph for 2023/24 is shown below identifying the health conditions and the number of times each condition was identified. This information is taken from the 63 completed LeDeR reviews during that period.



Constipation has been a priority area for us for a number of years now and it is good to see that the percentage is remaining low compared to earlier years, here showing at 37% (23 of the 63 completed reviews). We will be continuing to monitor this closely as this is a slight increase on last year which was 34%.

In last year's report epilepsy was seen in 38% of the completed reviews, this year it has increased to 48% and we will continue to raise the importance of prioritising this area of work.

Impaired mobility is associated with osteoporosis and yet impaired mobility is recorded 45 times in the health conditions graph above compared to 9 for osteoporosis. It is known that FRAX, a diagnostic tool used to evaluate the 10-year probability of bone fracture risk developed by the University of Sheffield, is not sufficiently sensitive enough to identify osteoporosis in people with learning disabilities, and therefore likely to be undiagnosed in many cases. For this reason, the title *Diagnosed Osteoporosis* will be used moving forward rather than just osteoporosis. It is likely that if more people with learning disability were diagnosed with osteoporosis then impaired mobility and osteoporosis would possibly show more similar numbers.

Themes from reviews

Themes are collated for every completed review. This information is collated and used to highlight local priorities. Themes collated for the 2023/24 year are included in Appendix 3 of this report.

The two joint highest themes mentioned in **35%** of the 63 reviews completed in 2023/2024 are:

"No/poor evidence of reasonable adjustments being made"

"No GP Health Action Plan"

Followed by:

"No evidence that Mental Capacity Act has been followed in relation to best interest decisions" - **32%**

"Poor sharing of information from one organisation to another" - **29%**

"No evidence that Mental Capacity Act has been followed in relation to consent" - **26%**

Mental capacity

An emerging theme is that of mental capacity for people with a learning disability and autistic people. LeDeR has found some evidence to suggest that capacity is assumed, and the individual is making an unwise decision but without the necessary professional curiosity.

The correct application of the presumption of capacity in Section 1(2) of the Mental Capacity Act (MCA) is a difficult question and often misunderstood by those involved in care. It is sometimes used to support non-intervention, lack of engagement or non-concordance with treatment but this can leave people with care and support needs exposed to risk of harm.

One example seen in our Derbyshire reviews showed a lady in her 40's with a mild learning disability and autistic traits (awaiting an autism assessment) who went for her annual health check and had a significantly high BMI, the GP explained that she needed to lose weight to improve her respiratory condition however, it was documented that "this fell on deaf ears". This is an example of presumed capacity and the assumption of her making a poor decision. Mental Capacity is important in this example when there is a risk of harm.

What work has been happening in Derbyshire in 2023/24

This section of the report details areas of work that have been happening across Derbyshire during 2023/24. Some of this work is as a direct result of learning seen through the LeDeR programme and others are areas of work that are happening to reduce health inequalities and have been shared with and promoted through the LeDeR Steering Group throughout the year.

LeDeR Steering Group

Learning from LeDeR is shared across the System and is discussed at the quarterly LeDeR Steering Group. Specific learning is also shared across certain members of the System where it is appropriate for work they are involved in. This includes working with the Mortality Review Facilitator at DCHS to produce regular reports which includes LeDeR learning that is then fed back to the Mortality Group, and working with Safeguarding Leads at Derbyshire County Council to look at specific themes that are raised as part of actions and recommendations from the LeDeR reviews. As a result of this where there were concerns that mental capacity assessments and best interest decisions were not always considered or actioned, Derbyshire County Council have completed mental capacity briefings to further educate colleagues. Case studies in this report show real experience of the importance of correct mental capacity assessments.

Addressing Inequalities across minority ethnic communities

As part of the LeDeR programme we now have two Minority Ethnic Leads who will share the role in Derbyshire. Both individuals attended their first LeDeR Steering group in July 2023.

A system-wide meeting has been held to complete a mapping exercise, the focus of this was to determine what each service is currently doing to address health inequalities across minority ethnic communities and what are the key priority areas as a System we need to think about. There has been a particular focus on ethnic minority groups as a result of the 'We Deserve Better' Report which was fed into this meeting.

The Health Facilitation Team have given presentations about the "We Deserve Better Report" at the Good Health Group and Learning Disability Partnership Boards and the Interim Lead Health Facilitator has met with the DCC BME forum lead and hoping to present to them soon and/or further develop links.

Ageing Well Team

The team, which cover the Chesterfield and Dronfield area of the County, provide primary care for a number of care home for residents with learning disability and autism. They also visit patients who are permanently or temporarily housebound on behalf of their GPs. This includes people for whom a home visit would be a reasonable adjustment due to their diagnoses. They have employed a Care Coordinator

to specifically manage work with this cohort of patients.

They continue to have regular MDTs regarding complex patients, working with the specialist learning disability team from Ash Green in Chesterfield.

As they prepare for a CQC (Care Quality Commission) visit they have been doing some work around audits, one of which includes assessment and documentation of mental capacity.

The team are also trying to build on early work that has been done with teams in secondary care to avoid admission for those for whom this is appropriate, but also to improve access to treatment and investigations for patients who need this.

The team also work on Respect forms, which they do on behalf of the GP.

Autism Services

A number of autism services have been commissioned:-

- **Derbyshire Autism 1-1 Empowerment and Support service** – offers free short term 1-1 support to autistic people (including those who self ID and those awaiting a diagnosis)
- **Living Well with Autism service** – offers 3 free different autism education/knowledge/training courses (1x for professionals / 1x for IAPT practitioners / 1x for autistic people (including those who self ID and those awaiting a diagnosis) and their support networks)
- **Derbyshire Autism Information and Advice service** – offers free autism digital and telephone signposting for professionals and general public. Includes an autism awareness course which is free to statutory services.

Bowel Screening

Three out of the 8 cancer deaths in 2023/24 (37.5%) were caused by bowel cancer/colorectal carcinoma (1a on the person's death certificate). It is important that individuals are supported to participate in bowel cancer screening which can detect these types of cancer.

At Chesterfield Royal Hospital a quality improvement programme has been set up that aims to increase

screening participation for people with a learning disability by identifying obstacles caused by health inequalities. They are part of a task and finish group, Cancer Prevention Workstream Group, and their first study is looking at people with a learning disability.

The model for the programme has been agreed, providing additional support to people with learning disabilities when they are invited for bowel screening. Six weeks after the invite has been sent out the team will offer the individual extra support to help them make the right decision regarding whether to be part of the bowel screening. Should a colonoscopy be required following the initial bowel screening the team will also check to make sure the individual is fully supported and has all the information they need to attend, ensuring the information that is provided to the individual is appropriate to their needs. The team aim to pilot this work with patients/data from a number of GP practices in Derbyshire.
It is planned that any learning the Trust gather as part of this programme will then be shared across other screening services to allow them to adopt some of the ways to better support people with learning disabilities.

Cervical screening

Reasons for non-attendance of cervical screening (as identified by Derbyshire LeDeR programme) include assumptions that screening is unnecessary when a woman is (thought to be) sexually inactive and / or acceptance that women with learning disabilities are likely to be non-compliant with screening. In fact, support is available and should be sought to enable all women of eligible age to access cervical screening.

Following the learning from LeDeR in relation to poor uptake of cervical screening for women with learning disabilities of eligible age a summary of information was gathered from integrated sexual health services, North South community learning disability teams and Strategic Health Facilitation Team, as follows:

- Integrated sexual health services are divided into clinical, health promotion and system wide development and engagement (sexual health alliance). Easy read information is available but may require further adjustment according to need. Health promotion can offer bespoke education sessions, but the team are not able to lead on mental capacity assessments.
- The Strategic Health Facilitation Team have accessible screening resources; they include cancer screening as part of GP training and advise that it would not usually be in a woman's best interest to pursue screening where she lacks capacity to consent. Those who have capacity but do not consent to screening should be kept on recall.
- Primary care should be the first port of call for support with mental capacity assessment for cervical screening and reasonable adjustments to enable access. A specialist learning disability referral is needed for support from the community learning disability team (CLDT) who can offer education, desensitisation, reasonable adjustment, and will lead on mental capacity assessment. Although CLDTs

have good links with sexual health services, they receive few referrals for cervical screening support for women with learning disabilities.

On the back of this information gathering, representatives from the Strategic Health Facilitation Team and Community Learning Disability Teams attended the Sexual Health Alliance meeting as part of System wide development and engagement.

Another upcoming agenda is women's health hub development, led in the ICB and in liaison with the Public Health Lead in Sexual Health via the Sexual Health Alliance. The Public Health Lead planned to engage with the Health Facilitation Team and learning disability services to support ongoing development specific to needs of women with learning disabilities and in particular cervical screening.

Clinical Care Pathways

ND adult aligned health services are implementing new clinical care pathways across Derbyshire including complex physical health, functional independent and social inclusion, eating and drinking, dementia, distress and dysregulation, relationships and trauma.

Epilepsy

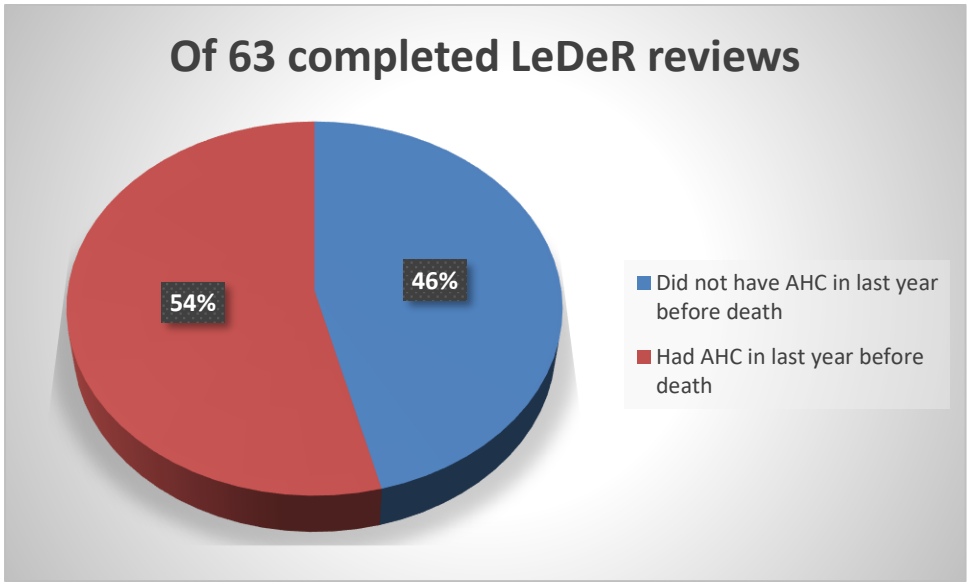
It has been escalated across the System that there is a need for an Epilepsy Lead/Commissioner as there is currently a gap here for adults. Throughout the year we have chased the possibility of this or any alternative solutions. Unfortunately, this has not progressed during the year but continues to be something we will continue to prioritise as epilepsy is still one of the highest health conditions we see in our learning from LeDeR. Work to be done was also evidenced through the NHS England Midlands Epilepsy Benchmarking exercise.

Learning Disability Annual Health Checks and the Strategic Health Facilitation Team

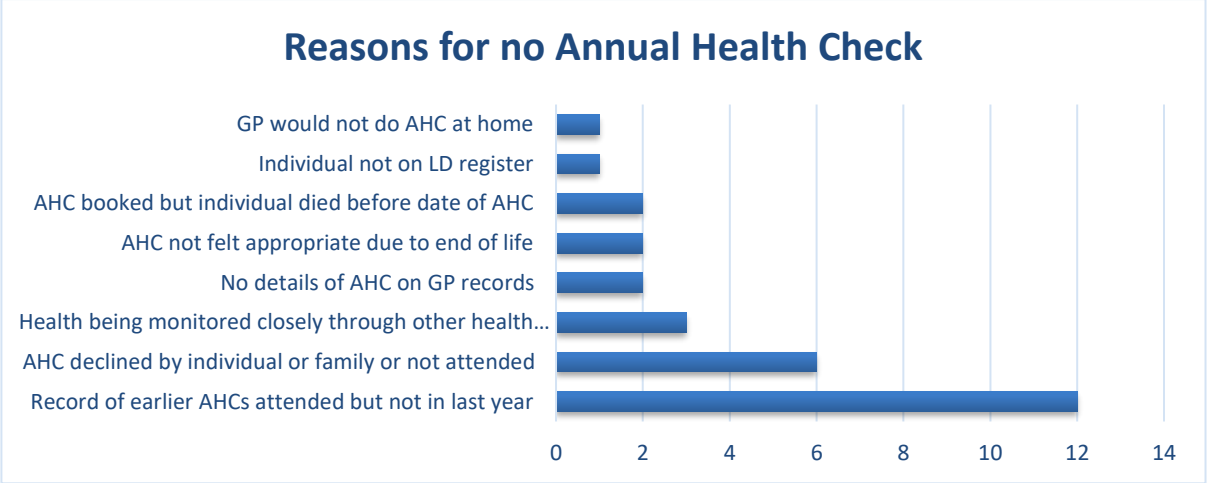
People with a learning disability often have poorer physical and mental health than other people. It is important that everyone over the age of 14 who is on their doctor's learning disability register has an annual health check (AHC).

An annual health check can help the individual stay well by talking to a doctor or nurse about their health and finding any problems early, so they can be sorted out.

We have been capturing data through LeDeR to monitor information in relation to annual health checks. Out of the 63 completed reviews, there were 29 individuals who did not have a health check in the last year before they died, and 34 individuals that did.



Reasons for no annual health check are shown in the graph below:-



Examples of good practice seen are shown below:-

- Annual health check carried out as telephone review as individual was housebound. As soon as the individual was able to travel to GP practice another appointment was made to see them in person.
- Use of accessible letters.
- Invite shared with individual to visit the breast clinic routinely to familiarise herself with the equipment and staff after the breast screening appointment had to be stopped due to distress of patient.
- Individual seen by specific GP who they had a good relationship with - the only doctor they allowed to take bloods.
- The annual health check was a holistic and person-centred review.

- Easy read health action plan with pictures was provided to aid the individual's understanding.
- Although declined by mum the referral was shared with learning disability team to see if they could support and make reasonable adjustments to support the individual to attend cervical screening.
- The annual health check template was filled out thoroughly along with a thorough physical examination.
- Reasonable adjustments were recorded that appointment reminders were sent to family members and appointment times should be based on carer availability, easy read letter should be sent and more time made available for telephone calls.
- Evidence of annual health checks carried out at individuals' homes.
- Link for easy read information on cervical screening was sent by text to parents following discussion at annual health check.

There were some areas where it was thought improvements could have been made to the health check. In a number of cases where it was stated the individual had an annual health check there was no health action plan visible to the reviewer in the GP notes. Some notes were very detailed about the annual health check, but others were not.

What work have the Strategic Health Facilitation been doing?

The team have produced a survey to find out more from individuals and their carers as to why people have not been attending their annual health checks. The survey was codesigned with experts by experience and was sent out to a range of major stakeholders in Derbyshire including partnership boards, advocacy organisations and carer representatives. The survey report was also sent to all Neurodevelopmental Teams to complete with service users and was also take to T2 in Derby (Transition 2 in Derby is a college for young adults aged 18 to 25 with learning disabilities and/or autism).

The results from the survey found:-

- 50% of people with a learning disability didn't know what the Annual Health Check was.
- 25% of carers didn't know what the check was.
- 64% of people with a learning disability and 71% of carers identified that help was needed to get them to the appointment.
- 93% of people with a learning disability said they needed help to understand during an appointment.
- 57% of people with a learning disability needed help to contact their doctors if they were poorly.
- The majority of people with a learning disability and their carers think that the Annual Health Check is important.
- Those who felt the check was not important said they were already seeing consultants and some said they thought it was a "tick box exercise".

The survey also found the following in relation to problems that stop people going to the health check:-

- Person with a learning disability doesn't like the physical examination.
- The surgery is bright and noisy and busy.
- "Transition" from child to adult services can be difficult.

The survey results were taken to the Learning Disability Derby City Partnership Board to ask for ideas of solutions. Some of the options discussed were:-

- Look at rolling out a learning disability champion system.
- Help with roll out of reasonable adjustment flag.
- Look at how the annual health check can be offered in community settings.
- Transition role to improve transition process within Derbyshire.
- Offer reasonable adjustment training to doctors' surgeries.
- Look at how health passports, health action plans can be improved.

These options are being considered.

In addition to the survey work the Health Facilitation team continue to promote annual health checks and support GP practices to ensure their Learning Disability registers are up to date. This year the team have also offered quality checks to GP practices which have been further adapted to include lifestyle factors and health promotion with a focus of including these in health action plans. Following the launch of Pharmacy First in January 2024 they are also looking at how to work with pharmacies around raising awareness of the annual health check.

Additional work the team are involved in includes:-

- They have started to offer bitesize training sessions to social care and voluntary sector staff - one has been delivered on lifestyle issues, one is due on constipation.
- Attending learning disability partnership boards and have presented on lifestyle, increasing awareness of annual health checks amongst people from an ethnic minority and other issues.
- They have started to look at improving links with Live Life better Derbyshire and Public Health and hope to continue further work in this area.

Public Health

The Mental Health and Suicide Prevention Team (Derbyshire County Council Public Health) are working on a number of pieces of work to raise awareness and decrease stigma and change culture. Work includes posts and articles on social media, podcasts, networks and producing hard copy information. This is being delivered at population level and targeted groups. They are also working in partnership with Derbyshire Autism Service to develop a training session on neurodiversity and suicide, planned for Spring/Summer 2024. The Team is also developing an easy read poster and making amendments to wellbeing booklets co-produced with Derbyshire Reps on Board Learning Disability Partnership Forum.

The Community Support and Resilience team (Derbyshire County Council Public Health) have relaunched the Derbyshire Safe Place Scheme post-pandemic to increase the number of Safe Place venues across the County and to raise public awareness of the Keep Safe Card. The scheme is now part of the Safe Places National Network, meaning venues can be located on a smart phone app as well as being identifiable by a nationally recognised window sticker. Whilst the scheme is open to anyone it is particularly pertinent for people with learning disabilities and/or autistic people as a tool to increase confidence when accessing the community independently. A video is currently being co-produced with representatives from these communities to improve understanding of how the scheme works.

Reasonable Adjustments

Under the Equality Act 2010, health and social care organisations must make changes in their approach or provision to ensure that services are accessible to disabled people as well as everybody else. Here's some work that has been done during 2023/24 in Derbyshire related to reasonable adjustments:-

- A **Reasonable Adjustment Group** has been set up that aims to bring together people across Derbyshire who experience, are involved in projects, or lead on reasonable adjustments for people who are neurodiverse (this includes people with Learning Disabilities, autistic people and those with ADHD).
- At DHcFT easy read training has been rolled out to improve consistency and high-quality production of accessible written information across ND adult health services.
- The Head of Practice at DHcFT has been working with the Adult In Reach Team to work through a reasonable adjustment template for admissions.
- Following involvement with LeDeR the Learning Disability Social Care Team at Derby City Council have been focussing on reasonable adjustments and ensuring all learning disability health checks, hospital passports, health action plans are in place when they undertake care reviews. The team have been analysing how many individuals they support have these in place and have highlighted the areas in their electronic social care records to highlight any reasonable adjustments required. This also means that they will then be automatically populated in individuals social care assessments. It was found through this scoping exercise that individuals living with family carers at home were the least likely to have a hospital passport and this was to be an area of focus at future reviews.
- The Learning Disability Liaison Nurse at Chesterfield Royal Hospital, who already works with the Imaging department to support patients with learning disabilities, has been doing additional working with the department to look at pathways and where reasonable adjustments can be made for patients with learning disabilities.

ReSPECT/DNACPR

The aim of the ReSPECT process is to create personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

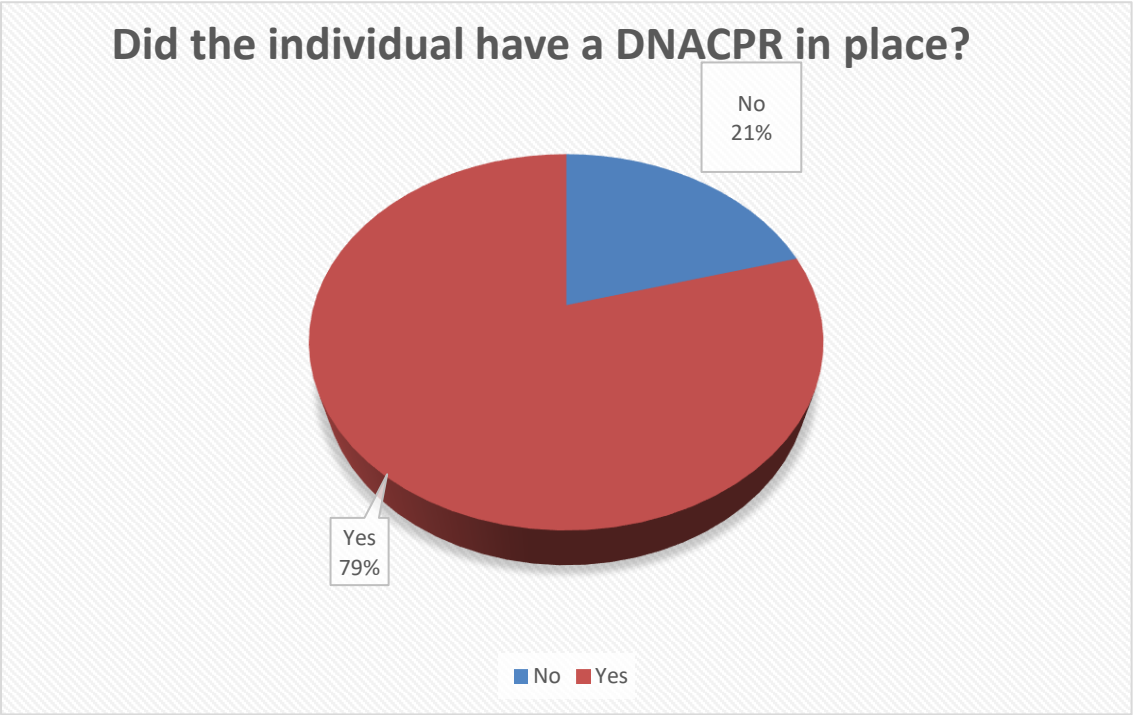
These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment. The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

As part of the LeDeR review, information is gathered with regards to the conversations that are held around DNACPR and how this information was recorded on the individual's ReSPECT form and in their health records. DNACPR stands for do not attempt cardiopulmonary resuscitation. It is sometimes called DNAR (do not attempt resuscitation) or DNR (do not resuscitate) but they all refer to the same thing. DNACPR means if your heart or breathing stops your healthcare team will not try to restart it.

Learning found through LeDeR

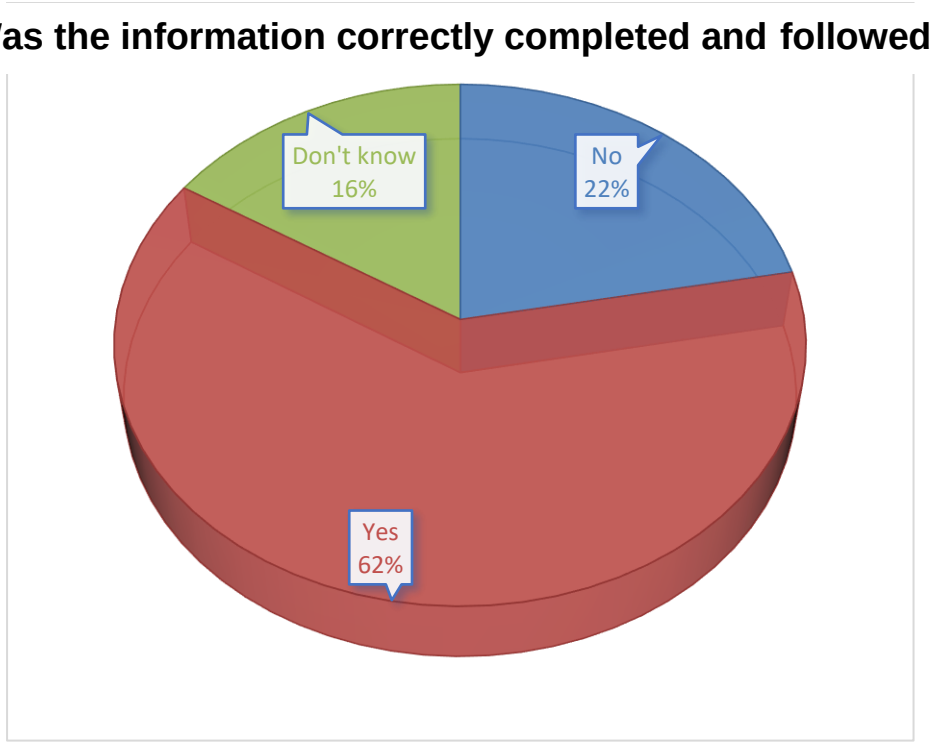
For the 2023/24 period, of the 63 completed LeDeR reviews for people with learning disabilities, the information captured shows:-

50 individuals had a DNACPR in place, 13 did not have a DNACPR in place.



Of the 50 individual who had a DNACPR in place:-

For 31 of the individuals it was reported in the LeDeR review that the information had been completed and followed correctly, for 11 of the individuals it had not, and in 8 cases it was not known.



Where the answers were recorded as not known this is due to the ReSPECT/DNACPR form not being available for the reviewer to see.

Evidence provided as to why the answers were recorded as no against "*Was the information correctly completed and followed*":-

Documentation was only partially complete and indicated a required capacity assessment, which had not taken place

Section 2 relating to having a legal welfare proxy in place is not completed despite mother having health and welfare lasting power of attorney.

DNACPR form states discussed with patient but no narrative and no indication given on the form that a capacity assessment was considered.

Does not contain any evidence pertaining to individual's wishes (either at the time or previously). Individual had a regular care team involved and the DNACPR should have involved them.

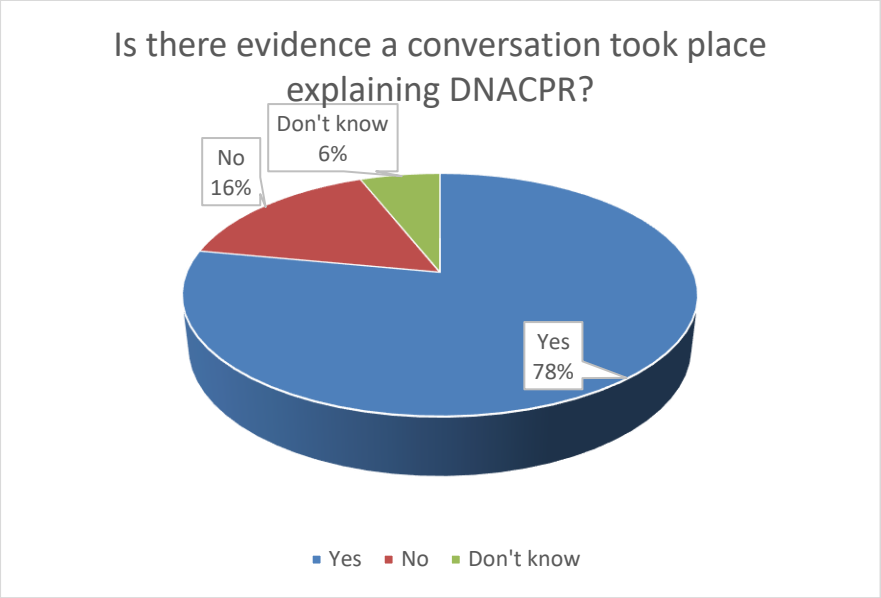
Sections were left blank or incomplete on the ReSPECT form. Shared understanding of health and current condition section states that individual was "bed bound ...since August 2022" which was inaccurate as she was mobile in her wheelchair. The mental capacity assessment of the ReSPECT form had been left blank.

The section relating to the lawful decision maker was not completed and it was recorded that Best Interest discussions had taken place with the family, but detail of that discussion was not documented on the form

It was documented in hospital record that a conversation was had with family but this was not on the ReSPECT form

Although there was a best interest decision agreed with family and carer involvement this section was incomplete on the ReSPECT form

The reviewer could see in the electronic records that the DNACPR was updated on 18th August 2020, but the date was not added to the ReSPECT form

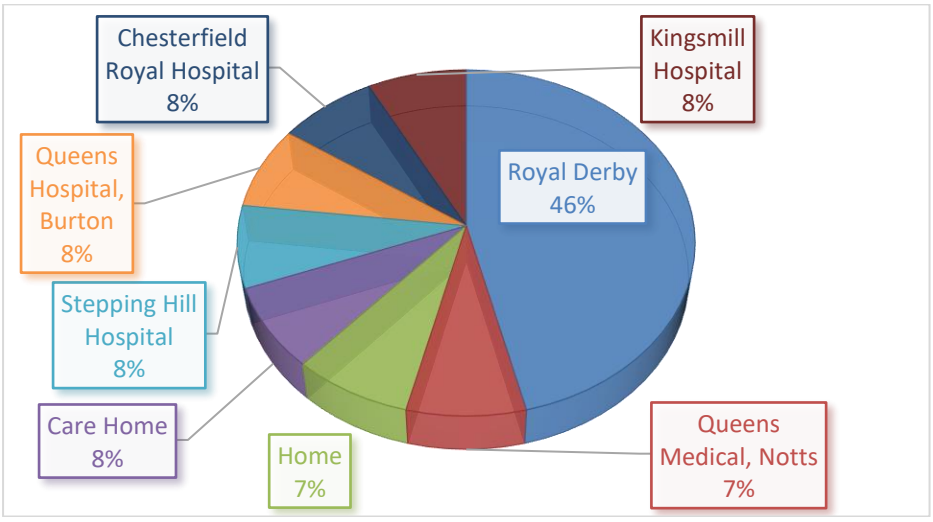


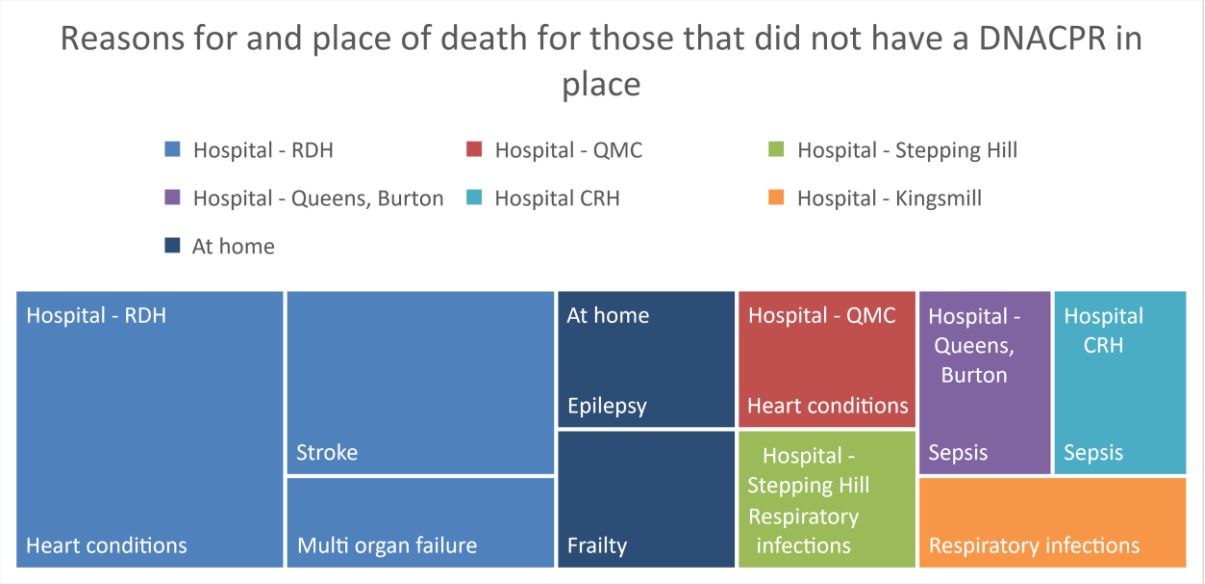
Out of the 50 who had a DNACPR in place there was evidence to show a conversation took place to explain DNACPR in 39 of the reviews, there was no evidence in 8 of the reviews, and for 3 of the reviews this could not be answered as the ReSPECT form was not reviewed and no information provided during any conversations the reviewer had.

29 (or 58%) of the reviews showed evidence that this conversation was recorded in records and on the ReSPECT form. The figure is lower than the 39 as in some cases the conversation was not actually recorded on the ReSPECT form, but the LeDeR reviewer saw evidence that the conversation was recorded in medical records or the reviewer was told by family/carers that they had been involved in a conversation. There were only 6 reviews that showed evidence of the individual having capacity and being engaged in this discussion and decision making. Often the person was too unwell to be involved in these conversations particularly for those in a hospital setting.

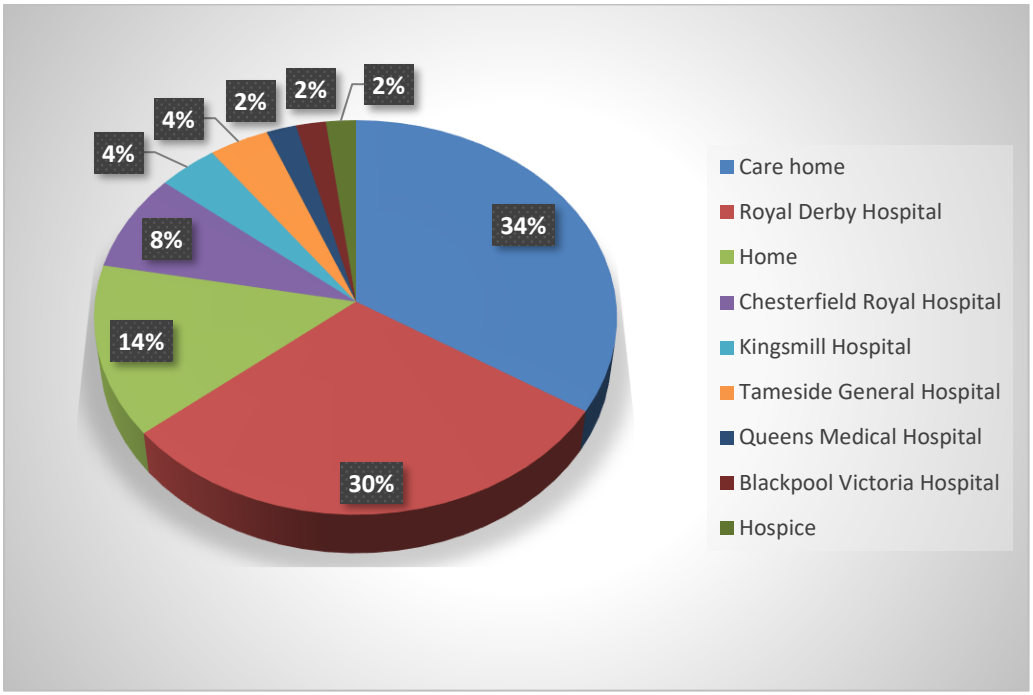
Hospital deaths

Of the 13 that did not have a DNACPR in place at the time of their death, 11 died in hospital, with the majority being at Royal Derby Hospital at the time of their death.





For those that had a DNACPR in place at the time of their death the most common place of death was the care home with 17 deaths, followed by Royal Derby Hospital with 15 deaths. Seven individuals died at home and 4 individuals died at Chesterfield Royal Hospital.



Good practice seen

It's important to share that evidence of some good practice has been seen in the learning from LeDeR in relation to DNACPR. Evidence of this is shown below taken directly from the LeDeR reviews:-

Cousin informed that the original DNACPR was completed in hospital when xx had his PEG inserted and that this was regularly reviewed during subsequent hospital admissions. She was always contacted as next of kin and involved in the decision making process. She reports that xx did not have capacity to understand this and that's why best interest decisions were made.

It was not appropriate to provide accessible communication to aid understanding due to the individual's level of learning disability. Mum was involved in all of the discussions and part of decisions made in individual's best interests.

An MCA was completed as part of this and xx did not have capacity due to delirium and learning disability. The decisions were made in her best interests and fully considered her health status each time as well as what would be considered her wishes for treatment and dislike of hospitals. The most recent form stated that a community ReSPECT form was in place and that this had been discussed with her brother.

DNACPR was discussed at length and agreed in a meeting with palliative care nurse, sister, and a member of the care home nursing team. The discussion was documented in the notes and on the ReSPECT form, which was correctly dated and signed.

Documented on ReSPECT form that individual does not have the mental capacity, even with support, to participate in making these recommendations. Best Interests professionals meeting held 21/4/2023 attended by Learning Disability team, Gastroenterology Consultant, GP, Social Worker and Care Workers from supported living.

What work has been done in 2023/24?

Earlier learning from LeDeR evidenced that 69% of DNACPRs (where in place) were correctly completed and followed, (note that the later learning collated in this report across the whole of the year now shows this percentage to be lower at 62%) and based on this earlier evidence a ReSPECT/DNACPR meeting was held at the end of Quarter 2. The aim of the group was to bring colleagues together across the System to hear about what is happening across care providers in relation to understanding what learning is already available with regards to ReSPECT/DNACPR, are the issues already known and what training is available to support the ReSPECT process.

The meeting was well attended with colleagues from both Derbyshire acute hospitals, general practice, a local hospice, community care providers and ICB.

Some key points taken from the meeting were:-

- This meeting wasn't about changing the ReSPECT forms in any way but was to open a discussion about whether they are completed and followed correctly
- Audits are completed within the acute hospitals
- CQC will audit some ReSPECT forms as part of their inspections of GP practices
- There are already lots of pieces of work happening individually across the system
- Although the meeting had been set up to talk about ReSPECT across the whole population (not just people with learning disabilities and autistic people) it was widely acknowledged in the meeting that it was such things as the mental capacity section and the making of reasonable adjustments for individuals where appropriate that were key areas where work was still needed to make improvements
- Education and training were acknowledged to be key and the need to build the confidence of people to have the conversations around ReSPECT and for it to be clear whose responsibility it is.

Some areas of work that are already happening:-

- The Derbyshire Alliance End of Life Care toolkit that exists in Derbyshire. This is a very valuable resource that shares information and knowledge, it has been around for a number of years and supports the whole delivery of education and knowledge and information around every aspect of end of life care, including ReSPECT information. There's also lots of information that supports the encouragement of ReSPECT being used correctly and education and training. Derbyshire is currently part of a programme of work that is a collaboration between three ICBs (Derbyshire, Notts and Birmingham/Solihull), funded by NHSE, to improve the toolkit. Project delivery is planned for this year and will include an education and training portal as part of the toolkit. Part of the ambition across the three ICBs is that this could be shared across the Midlands.
- GP working with NHSE looking at ReSPECT/Advance Care Planning and how to roll out ReSPECT on a Midlands footprint. Aim for how each system can put training packages together but there are loads of resources on the site already so there is no need to reinvent the wheel. Hoping if one area has an educational programme then this could be shared across the whole of the Midlands.

- Standardised resus training is held locally and has been shared by resus leads across the system at UHDB and Chesterfield. There have been lots of audits completed around Respect forms and how they are completed. When delivering training they are aware there has been the need to build on the confidence of people to have the conversations around ReSPECT and be clear whose responsibility it is. A working group has been set up about how to reframe and support some of those conversations and communication skills.
- Specific Tier 2 ReSPECT communication skills training has been developed and being delivered by both Advanced Communication Skills Facilitators at Treetops Hospice and by the acute End of Life Facilitators education offer at UHDB as a pilot . There has been a small amount of money to pilot this training across Derbyshire community clinical services (100 places, 2023/24 Treetops Hospice). Both have been using RealTalk direct evidence base and CRH hope to deliver some Tier 2 also. The confidence building and increasing number of clinicians able to have these conversations are in line with the recommendations of the PHSO report (2024) but there are gaps as no further funding at present.
- Work with Shared Care Record – The Derbyshire Electronic Palliative Care Coordination System (EPaCCS) records people's care preferences and important details about their care at the end of life. The aim is that this will be rolled out in Autumn 2024 alongside a new education package for the new form. This will ensure there will be one place where we can document conversations and preferences about end of life care that everybody can access and read and write to, so everyone will have access to the latest information.

Conclusion and Next steps

Learning from LeDeR has shown us:-

Better recording needs to be included in the ReSPECT form. We have seen evidence that the conversation did take place in some cases to explain DNACPR and/or to involve families or carers in decision making, but this was not always recorded on the ReSPECT form.

In some reviews we have seen that conversations about ReSPECT could have been held earlier when the individual was in the community, rather than waiting until they are in hospital where the individual is more ill and often does not have the capacity to be involved in the conversations.

The figure of 22% for the number of ReSPECT/DNACPR forms that are in place and not completed and/or followed correctly is obviously concerning and we want to improve on this figure.

We will be sharing the information captured in this section across a number of sources as shown below:-

- With training leads in order that learning can be used to identify where training is needed and work with staff who are involved in the ReSPECT conversations.
- With LeDeR contacts in Derbyshire acute settings and community to encourage the learning to be shared and used as feedback with staff involved in the ReSPECT conversations.
- With care home leads to encourage the ReSPECT/DNACPR conversations to be held in the community with care staff and the individuals involvement in the discussions.

- With GP practices – in some cases the report has shown that a record of the DNACPR decision and/or the ReSPECT process form cannot be located. GP Practices to ensure that they have a copy of the form in all cases appropriately filed on electronic systems. CQC state that "*The presence of a ReSPECT or DNACPR form should be clearly highlighted in the patient's clinical record for all who access it*" (CQC GP Mythbuster 105)

In addition, from a LeDeR perspective we need to continue to work to improve on the number of "Don't knows" to ensure we have a clearer picture of what is being recorded on the ReSPECT/DNACPR forms.

This learning will also be shared with the JUCD End of Life Operational Group.

Healthy Lifestyle

People with a learning disability are more likely to have problems with their weight. Some people may be underweight because their disability means they have difficulties with eating or swallowing, for example. Others may be overweight because they have a condition that increases their risk of obesity, such as Down's syndrome and Prader-Willi syndrome.
It has been recognised for many years that people with learning disabilities are at increased risk of being overweight or obese compared to the general population, with poorly balanced diets and very low levels of physical activity.
Being obese puts people at much greater risk of many important health problems including - heart disease, high blood pressure, strokes, diabetes, several types of cancer, mobility difficulties.

As noted in the PHE 2020 to 2025 strategy, poor diets and excess body weight deprive people in England of more than 2.4 million life years through premature mortality, illness and disability each year. There are close links to broader social disadvantage, such as poverty, poor housing and social isolation, which is experienced disproportionately by people with learning disabilities.
The most recent data on the prevalence of excess weight in people aged 18 and older with learning disabilities is based on analysis of data from GPs across the whole of England. This showed that, in comparison to the general population, a smaller proportion of people with learning disabilities are in the milder category termed 'overweight' (27% of people with learning disabilities compared to 31.8% of people without a learning disability). However, there are higher proportions in the more severe category of obese (37% of people with learning disabilities compared to 30.1% of people without learning disabilities).

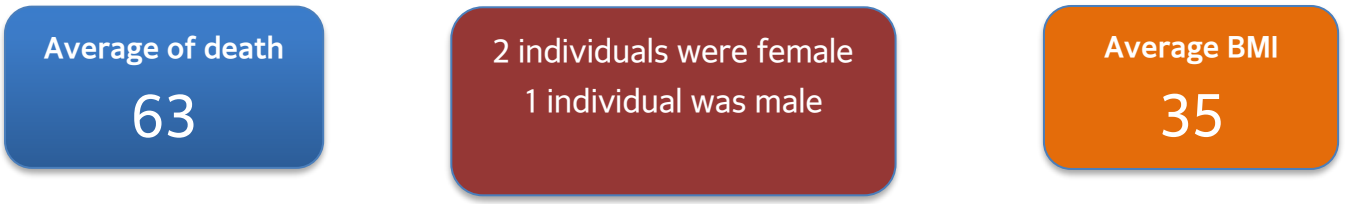
Autistic women are much more likely to develop anorexia than non-autistic women. According to Autistica, more than 2 in 10 women with anorexia are autistic. Research suggests between 4% to 23% of people with an eating disorder are also autistic.

*NHS Digital **Autistica

The above information is taken from the Learning Disability, Autism and SEND Interactive Data Source Repository

In Derbyshire we have started to collate information through LeDeR in relation to healthy lifestyles. There is only a limited amount of information currently available as the collection of this did not start until February 2024. The information shown below relates to only 3 reviews that were completed between February 2024 and 31st March 2024 where a high BMI was documented and therefore further information captured in relation to lifestyle. We have since started to capture information for those with a low BMI, as quoted there are issues with individuals who are underweight, not just overweight.

Learning showed us (taken from the 3 completed reviews):-



Data being captured includes whether there is a record that the individual was referred to the Derbyshire Live Life Better Derbyshire (county) or Live Well (city) services. In one of the 3 cases a referral had been made to the weight management service, although this was declined by the individual. In the other 2 cases there was no evidence that discussions had been held with the individual about diet or exercise.

What more can we do?

This information is shared with our Learning Disability Health Facilitation teams who are working with GP practices to promote the use of the Live Life Better and Live Well services in Derbyshire.

Through LeDeR we will continue to capture this information to share where we are identifying positive practice or gaps in services.

The following case study, details taken from a LeDeR review that we have received in Derbyshire, highlights the importance of a healthy lifestyle and also links to the next section: weight management.

Case Study

Background

J was a 54-year-old man with mild learning disabilities and multimorbidities (including insulin dependent type 2 diabetes and morbid obesity) and lived independently with minimum support. J communicated verbally and needed reasonable adjustments to optimise his understanding and engagement.

J enjoyed going into town on his mobility scooter and often treated himself to fish and chips, sugary drinks, and cakes. J relied on district nursing team to administer insulin every morning but was admitted to hospital on numerous occasions due to hypoglycaemia (blood glucose levels too low) or hyperglycaemia (blood glucose levels too high).

Issues

1.Person-centred goals

When J's placement broke down he wanted to move to Hertfordshire to be close to his brother. He was moved to a care home in Derbyshire for a period of six weeks respite until appropriate accommodation in Hertfordshire was found. Despite efforts to find alternative accommodation J remained in the Derbyshire care home for eighteen months which affected his mental and physical health.

2.Diabetes Management

A community diabetes nurse showed the care home nursing team how to safely administer J's insulin injections prior to each meal.

J was given a blood glucose monitor and could read and record his blood glucose levels and knew when the levels were too high, but his capacity to manage his diabetes was not assessed specifically. It was the responsibility of the nursing team to manage his diabetes with support from specialist community diabetes team.

3.Mental capacity assessments/best interest decisions:

J was "assumed" to have capacity in relation to his eating habits and was "assessed" to have capacity to go to town on his mobility scooter whenever he pleased BUT would indulge in eating whatever he liked without insulin. As a result J continued to present with hyperglycaemia, with increased risks to his health. DoLS (Deprivation of Liberty Safeguarding) mental capacity assessment found J lacked capacity to make decisions concerning his "health needs" including type of accommodation to meet his needs, but that he had capacity to decide where he wanted to live in terms of location.

4.Weight Gain

The care home nursing team were concerned that J had gained nearly two stones in one month and asked the GP if dietetic referral could be considered. The GP agreed to the referral but due to J's "assumed" capacity doubted it would be effective.

Dietician found that J was "unmotivated" and was discharged after two appointments as he continued to indulge in unhealthy eating habits. Staff were issued with healthy eating guidance to try and encourage J towards a healthy diet. Specialist community diabetes team worked with care home nursing team as did the community dietician, but services worked in silo and didn't implement reasonable adjustments for communication needs (information given in small chunks, familiar language, and time to process).

J gained eight stone in weight during his eighteen months at the care home and before he died weighed twenty-four stones and one pound, and his body mass index was 51.89kg/m2 indicating morbid obesity.

Death

The death certificate shows that J died of acute left ventricular (heart) failure, caused by obesity-associated cardiomyopathy (weight related heart disease).

The case was referred to the coroner and safeguarding but there was no postmortem or inquest and there was no evidence to suggest that J's death was due to neglect or acts of omission.

Learning was identified through LeDeR

Communication is key to all decision making and reasonable adjustments must be made when considering capacity.

Person centred care; J's care was heavily biased towards his health needs compared to his person-centred needs and although placements in Hertfordshire were being addressed J's mental health and physical health suffered the longer he remained in the care home away from his family.

A Personalised Integrated Package of Care could potentially have been explored to support a personalised approach to care.

Mental Capacity & Diabetes Management

J had capacity to go out independently, but critically his capacity in relation to eating his favourite foods without insulin in the community was not questioned. Had the capacity question been more specific to include the matter of eating out whilst accessing the community independently, it is likely that a best interest decision would have been agreed and consideration of least restrictive safe community access.

Mental Capacity & Weight Management

J was assumed to have capacity to eat and drink what he liked but gained eight stones in weight and died from heart failure due to obesity associated heart disease. Where capacity is "assumed", but doubt exists or high risk is identified as in J's case, mental capacity assessment is justified and should be completed.

Weight management

Obesity and Weight Management guidelines for People with learning disabilities (2020) recommends a multidisciplinary approach to weight management. This was lacking in J's case despite a specialist (multidisciplinary team) weight management service being available within DCHS. There was a lack of awareness about the service and although currently under review, the service will need to be promoted well across the System.

Weight Management

Based on LeDeR learning such as seen in the case study above and there seems to be a lack of awareness of what services are available, this prompted an exploration of what is available in Derbyshire in relation to weight management services.

Background

There is an increased risk of severe obesity in people with a learning disability and a higher incidence of associated serious health conditions compared to people without a learning disability. Whilst lifestyle factors such as low activity levels and poor diet contribute to the risk of obesity for people with and without learning disability, additional factors such as family and carer knowledge and attitude, inconsistent nutrition and difficulty in understanding change behaviour strategies for people with learning disabilities add to the complexity of *managing* obesity in this population.

Services in Derbyshire

Derbyshire Adult Social Care commission a Health Tier 2 weight management programme which forms part of the Live Life Better Derbyshire www.livelifebetterderbyshire.org.uk. scheme. This programme provides a personalised approach to weight loss programmes and considers emotional and psychological elements of weight management as well as food and activity.

There is a self-assessment which can be completed online and if the outcome meets the Tier 2 referral criteria below individuals can self-refer.

- Aged 18 years or over
- Live in Derbyshire
- Body Mass Index* of 25+ and 23+ for people of Asian and black ethnicity

It is possible people with learning disabilities would need reasonable adjustments and support with a self-referral and face to face attendance or remote access to the sessions. Support workers, carers and family are all are encouraged to attend to improve knowledge and consistency across the system and improve individual outcomes.

Bespoke group sessions can be discussed and accessed by contacting the service development officers directly. The team have recently worked in partnership with Fairplay Day Services for young adults. The team are passionate about their programmes and are happy to talk to different organisations about what they do and are very keen to work with other learning disability day services, supported living environments and care homes.

All individuals with a BMI in between 25 and 49 with or without comorbidity must have attended the Tier 2 weight Management programme before they can be considered by the GP for referral to DCHS Tier 3 weight management service.

The current DCHS Tier 3 weight management service provides specialist multiagency support to individuals presenting with a BMI of 35-49 with comorbidity, or a BMI of more than 50 (with or without comorbidity). The team consists of psychology, psychotherapy, nutrition and dietetics, doctors, and Tier3 weight management advisors.

The service is accessed through GP referrals only and the focus is on managing weight through long-term behavioural/ lifestyle changes, exploring the relationship with food and how it features in the patients' lives. This reflects NICE weight management guidelines (2022).

The Tier 3 service was granted funding in 2021 to do some research around health inequality and weight management and learning disabilities was one of the areas they explored. The project has been submitted and is awaiting approval but there is a potential opportunity to become involved in the Tier 3 project following an update in October 2023 and with Tier 2 who are also keen to include people with learning disabilities. During 2023/24 the DCHS Tier 3 weight management service completed an inequalities audit and have been doing improvement work in response to this which has included training all of the staff around working effectively with people with learning disabilities.

However, there have been issues with regards to the high numbers of people on the waiting list although work to improve the current service model, waiting list management and clarify the prescribing pathway, is in progress.

There is an equivalent weight management service available to Derby City residents through Livewell | Derby City Council's wellbeing service (livewellderby.co.uk).

References:

https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-

disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance

Obesity: identification, assessment and management

Clinical guideline Published: 27 November 2014 Last updated: 26 July 2023

Footnote * BMI of 25 to 29.9 is classed as overweight, 30 to 39.9 as obese, and a BMI of 40 or more as severely obese.

Managing Deterioration

Managing Deterioration refers to spotting that a person's physical condition is worsening and responding appropriately, to get them the best support and keep them safe.

The following case study, taken from one of Derbyshire's LeDeR reviews in 2023/24 shows the importance of managing deterioration.

Case Study

Background

D was a 64-year-old man with learning disability moderate frailty and chronic constipation. He lived in 24- hour supported living accommodation with ten 1:1 hours for support with communication and going out. He was independent with personal activities of daily living and some domestic activities of daily living. With support he enjoyed doing his own shopping and liked to go to the pub for a beer.

He had a history of chronic constipation and acid reflux and was prescribed laxatives to prevent constipation and medication to prevent reflux. D could communicate verbally but he could be difficult to understand for people who were not familiar with him. For optimal communication with D, reasonable adjustments were essential, which included speaking slowly and clearly and allowing time for D to process information.

On 7th August 2023, D presented with subtle changes in his behaviour which staff thought was due to constipation and attempted to treat it in the usual way with laxatives and diet, but the following day D was struggling to breathe, and his stomach was distended.

Emergency services were called, and whilst in the ambulance D vomited and aspirated faecal matter. On arrival in the emergency department a CT scan showed a twisted bowel, which was conservatively treated, a chest x-ray was taken and this was clear. He was treated with intravenous (IV) antibiotics and IV fluid. Support staff were unable to provide details of when D last opened his bowels as they did not monitor or document his bowel movements.

That evening D vomited and aspirated again which caused a chest infection and aspiration pneumonia. D

sadly died four days after admission.

Family were shocked by the death of D as they were under the impression he was improving after successful treatment for twisted bowel. Their experience of D's patient journey was poor, and it was their perception that there was lack of learning disability awareness amongst staff on the hospital ward.

Family learnt that a Do Not Attempt Resuscitate (DNAR) order had been instigated without discussion with them.

Cause of Death

Aspiration pneumonia, caused by bowel obstruction, caused by twisted bowel.

LeDeR Issues and Learning Identified

1. Managing Deterioration

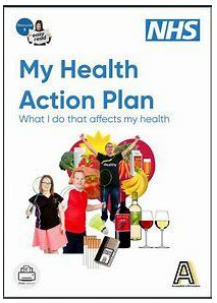
No health action plan was provided with guidance around bowel management, including guidance for staff to monitor bowel movements, or when to escalate concerns

Staff weren't monitoring bowel movements so weren't aware that preventative management of constipation wasn't effective

Staff identified D was constipated but said they were treating his constipation in "the usual way"

Staff did not recognise subtle changes in behaviour as Soft Signs (proxy measures for physiological deterioration including observed changes in person's normal behaviour, such as sleep, eating, drinking and mood, which present up to five days before physiological signs).

Learning



- Health action plans should be provided to identify health needs, what will happen about those needs (including what the patient needs to do), who will help and when this will be reviewed.
- Monitoring bowel movements is essential to identify when to escalate concerns to review and adjust management plan.

National Patient Safety Improvement Programmes
Managing Deterioration

- Training in Management of deterioration in people with learning disability which includes recognition and escalation of soft signs using deterioration / escalation tools such as Restore2 Mini and SBARD (Situation, Background, Assessment, Recommendation, Decision).

Action

Feedback sent to GP about accessible health action plans. Response received to say the GP will take this on board for future and ensure they document accurately the advice given.

To consider managing deterioration as a priority area of work for LeDeR.

LeDeR Issues and Learning Identified

2. Good Care for people with learning disabilities in hospital settings

Sister and family experienced a lack of dignity and respect, care and compassion and communication and a lack of awareness and skill amongst some of the staff caring for people with learning disability in the hospital setting, creating a barrier to good care.

No discussion about DNAR was held with family prior to D's death.

Learning

Shared; "Who I am Matters" **Report: Who I am matters – Experiences of being in hospital for people with a learning disability and autistic people** for the attention of Acute Learning Disability Liaison Team at the hospital, for the team to meet with ward staff and share document and family feedback. The document describes 6 NHS values that constitute good care, including Dignity and Respect, Compassion and Everyone counts and more.

CPR doesn't work for everyone, and the consultant informed the family that D was too frail for CPR. Useful sources of information for patients and families are the Do Not Attempt Cardiopulmonary Resuscitation (DNAR) patient leaflets which explain how decisions are made and can be helpful for families to see in advance.

Action

DNAR is a local theme/priority, and this is captured as part of local LeDeR themes and the priority work in progress. This was an action also taken back to hospital ward staff by the hospital LeDeR Governance Panel members.

Reducing Health Inequalities Working Group

A Neurodevelopmental Reducing Health Inequalities working group, chaired by the LAC for LeDeR in Derbyshire, and closely supported by the Area Service Manager for the Community Support Team, meets on a monthly basis and aims to ensure local and national priorities are being met in relation to learning disabilities and autism. This has included promoting the STOMP STAMP framework, looking at services that promote Health Lifestyle and how to take forward the "We Deserve Better" report in relation to the minority ethnic population as well as continuing to pull information together to ensure assurance of our System processes that relate to learning from the Clive Treacey report. The group is attended by individuals across Joined Up Care Derbyshire including an expert by experience. Daniel H, our expert by experience has written a few words about his involvement with the group:-

"It's been interesting getting to know what different organisations and job roles do and good for people to get together. We talk about policies and important work like; LeDeR, Epilepsy, Autism, STOMP and STAMP. We talk about Inequalities that affect people with learning disabilities and autism and about Physical health and mental health.
I follow up and put pressure on the group about not having an Epilepsy lead in Derbyshire, reminding the group.

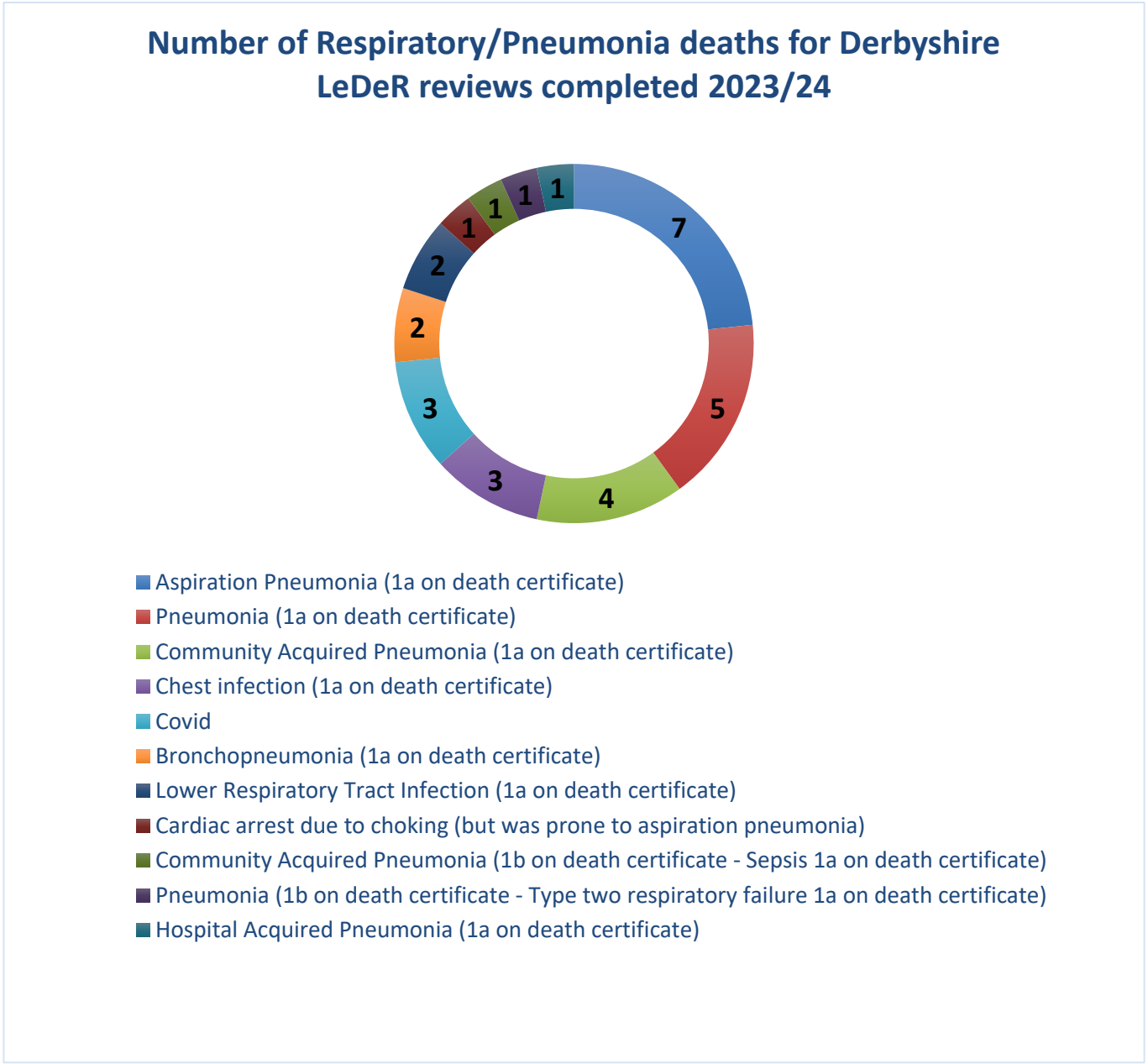
I ask the group to use simpler language and explain things clearer to make it easier to understand, which they do. I asked for a 5 minute break to be added to the meeting, which has worked well.
As a person with Down's Syndrome, I have personal experiences that help me influence the group."

Respiratory/Pneumonia Deaths

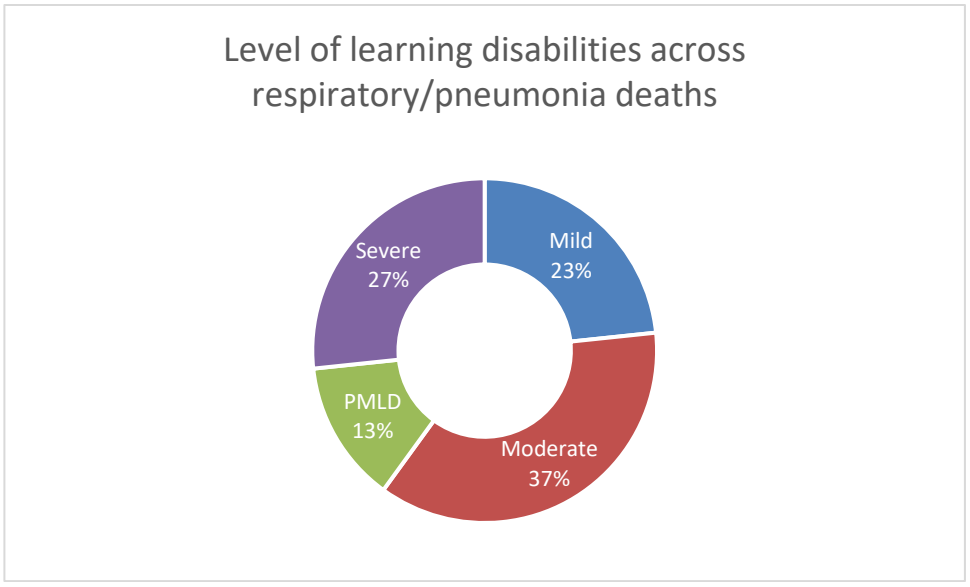
The top reason for death in Derbyshire was Pneumonia for 24% of our Derbyshire population. Aspiration Pneumonia (not included in the more generic Pneumonia as reason for death) was separated out and was the third top reason for death with 11%.

A large proportion of the deaths in Derbyshire are due to the various forms of pneumonia and this has been reviewed and broken down further.

Of the 63 completed reviews for 2023/24 in Derbyshire, 30 (or 48%) of those reviews were due to deaths directly linked to pneumonias or where there is a potential link to some form of pneumonia. A further breakdown of this is shown in the graph below:-



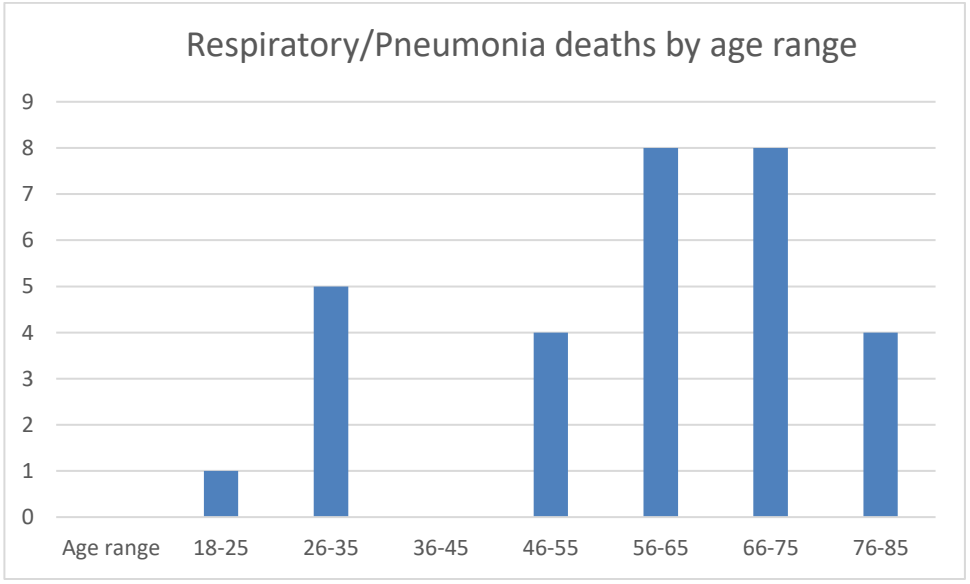
The level of learning disability ranged from mild to profound & multiple learning disabilities across the reviews.



Age of death ranged from 18 years of age to 84 years of age.

The 18 year old was female with profound multiple learning disabilities (PMLD). Type 2 respiratory failure was listed as the main reason for death (1a) with pneumonia listed as Other disease/condition leading to death (1b) on the death certificate.

The 84 year old was male with a moderate learning disability with Covid listed as the main reason for death (1a) on the death certificate.



Next Steps?

Pneumonia, and particularly aspiration pneumonia, is a prominent cause of death in people with a learning disability (NHSE). The national LeDeR annual report for 2022 (latest published) identified respiratory deaths as the third most common cause of death. In Derbyshire we are seeing respiratory deaths as the most common cause of death.

Pneumonias was also our top reason for death in our Derbyshire 2022/23 LeDeR annual report.

Aspiration Pneumonia, as the most common cause of respiratory death, has been highlighted as a priority area for Derbyshire across 2023/24 and this will continue into 2024/25.

As a result of this we have set up a 6 month project (started January 2024) where we are focusing on any deaths where aspiration pneumonia is the main cause of death or the individual has had issues with aspiration pneumonia. Members of the LeDeR team are meeting on a regular basis with the Speech and language therapy Professional Lead at DHcFT to discuss the LeDeR reviews in greater detail in relation to aspiration pneumonia findings. Through these discussions we are identifying themes. At the end of the 6 month project it is intended to review the findings to see what themes have been identified and to pull together a larger project group of people across the JUCD System where discussions will be held as to how these findings can be used to improve care.

Wheelchair services

There has been an increase in concerns seen through LeDeR in 2023/24 in relation to the provision of specialist and custom-made wheelchairs for people with learning disability and complex physical disability. In Derbyshire our wheelchairs are provided by AJM Healthcare. Issues found in Derbyshire particularly are related to delays in reviews and provision of equipment. Some short case studies are shown below which highlight the issues:-

Case 1

The initial wheelchair referral in 2019 considered anticipated seating needs based on the inevitable decline in posture and mobility associated with dementia. The individual's posture did decline to the point she could not sit safely in her transit wheelchair. A re-referral to wheelchair services was made in May 2021 and the wheelchair received in September 2022 but this no longer met her needs due to weight loss.

By the time additional parts were ordered and delivered in January 2023 the individual was being cared for in bed.

LeDeR learning identified that AJM and therapists can work more effectively towards client need if AJM accepted referral information (provided by experienced therapists) as a valuable contribution to effective wheelchair prescription.

Case 2

The LeDeR review found that interventions from wheelchair services between January and April 2023 had not been effective in addressing the individual's risk of harm.

Concerns raised with wheelchair services included increased risk of aspiration whilst seated in wheelchair due to inadequate head support. There was, however, no specialist dysphagia referral informing wheelchair services of optimal head and neck position to facilitate safe swallow.

There was lack of awareness and coordinated, multi-agency approach to postural care.

Case 3

Despite a wheelchair referral in August 2022 to request a review of current wheelchair seating to improve the individual's seating posture, there was no record of any seating interventions prior to her death in September 2023 (thirteen months).

How are we trying to make improvements to services?

- AJM Wheelchair Services asked to be part of LeDeR reviews and be given the opportunity to feed into the LeDeR reviews where any concerns have been raised in relation to wheelchair provision. This means that future LeDeR reviews will be able to address the concern within the actual review rather

than just raising the concern as an issue following completion of the review. They have subsequently also asked to be part of future LeDeR Governance Panels so they can be involved in the discussions when addressing actions and learning to help to improve future care and make further improvements.

- In February 2024 Healthwatch Derbyshire reached out to wheelchair users and their carers, to find out what they thought about the wheelchair service in Derbyshire. Following on from this they produced a report that shows the experiences of wheelchair users in Derbyshire. The report includes a series of recommendations aimed at improving wheelchair services in Derbyshire which mirrored some of the concerns found through LeDeR. These include:

    - Calls for better assessment processes
    - Better communication with people whilst they're waiting for assessments, parts, and repairs
    - More engagement with wheelchair users in their care.

    Following the survey, AJM wheelchair service have taken on board the feedback from wheelchair users and put a plan in place. The plan shows what they aim to do, or have started doing, with clear dates to be achieved by. This shows a positive reaction by the AJM wheelchair services which will provide improved future care.

Oliver McGowan training

The training is named after Oliver McGowan whose death showed the requirement for health and social care staff to have better skills, knowledge and understanding of the needs for autistic people and people with a learning disability. The training is delivered in 2 Tiers. Health and social care staff need to complete either Tier 1 or Tier 2.

Both tiers consist of 2 parts. The first part of both Tier 1 and Tier 2 is e-learning.

Everyone will need the e-learning regardless of where they work and the Tier of training they require. It is free and can be accessed here.

The second part of the training is either a live 1 hour online interactive session for those needing Tier 1, or, a 1-day face to face training for people who require Tier 2.

In Derbyshire:-

Tier 2: fortnightly sessions are being held based on trainer capacity and additional trainers are being recruited. The training is being delivered to a mixed audience across the four NHS organisations, adult social care and primary care. Performance data is monitored by NHSE.

Tier 1: Trainers who work in "trios" are currently going through the assessment and accreditation process and will commence delivery as soon as that has been completed. The aim is to run 2 training sessions a month, increasing to a session each week as trainer capacity increases. The training for Tier 1 trios is extremely complex however they have commenced a second recruitment drive.

What we said our Local Priorities would be for 2023/24 and what we have done

Priority 1: We said….

We would increase the number of focused reviews to reach the national target of 35%

We did…

- In 23/24 24% of reviews completed were focused. This is an increase since 22/23 when 22% of the completed reviews were focused.
- Processes are continually checked and updated and reviews go through a quality check to ensure reviews are progressed to focused where appropriate.

See ***Local Demographic Data & Findings*** section of this report for further details.

Priority 2: We said…..

We would improve the number of (and quality of) GP Health Action Plans

We did…..

The Strategic Health Facilitation Team have offered quality checks to GP practices which have been further adapted to include lifestyle factors and health promotion with a focus of including these in health action plans. See ***What's been done in Derbyshire in 2023/24*** section of this report for further details.

Priority 3: We said….

We would reduce the number of learning disability annual health checks not attended

We did…

The Strategic Health Facilitation team produced a survey to find out more from individuals and their carers as to why people have not been attending their annual health checks. The results from this have been shared and discussed further and solutions considered. See ***What's been done in Derbyshire in 2023/24*** section of this report for further details.

Priority 4: We said….

We would make services are made aware where the LeDeR review has evidenced poor sharing of information

We did….

This is part of LeDeR processes when issues have been identified in LeDeR reviews.

Priority 5: We said…

We would escalate the need for care coordination of individuals, particularly those with a mild learning disability who do not have the support they need to manage and understand their health appointments

We did…

This area of work has not been completed this year and will move into priorities for 2024/25

Priority 6: We said…

We would promote LeDeR and the notifying of deaths, both for autism only reviews and those with a learning disability.

We did…

The LeDeR programme has been promoted across health and social care throughout the year and we have seen an increase in number of notifications this year. See ***Local Demographic Data & Findings*** section of this report for further details.

Priority 7: We said…

We would work with the new Minority Ethnic lead for LeDeR to increase awareness across all agencies and communities of the role of LeDeR and why notifying LeDeR of deaths is a first important step. To further raise awareness of the even poorer health outcomes for some members of minority ethnic communities who have learning disabilities, sharing the learning from LeDeR.

We did…

This area of work has not been completed this year and will move into priorities for 2024/25

Priority 8: We said…

We would continue to identify issues found in relation to those individuals with epilepsy and highlight the importance of an Epilepsy Lead across the system.

We did…

Although this has continued to be highlighted across the System there is still further work to do here and this will move into priorities for 2024/25

Priority 9: We said…

We would set up a DNACPR working group and share learning across the system, identifying any gaps or training issues.

We did…

This was completed and the group met in September 2024. Further work has been completed in relation to this throughout the year. However, there is still areas of work to complete here and this will move into priorities for 2024/25.

See ***What's been done in Derbyshire in 2023/24*** section of this report for further details.

LeDeR High Impact Actions 2023/24

Across the NHS England Midlands Region there have been 6 high impact actions agreed. Here's what's been done in Derbyshire to address the 6 actions:-

1. **Reduce avoidable mortality in the 3 clinical priority areas (respiratory, cancer & heart diseases) for Learning Disability and Autism**

   Please see section *What work has been happening in Derbyshire in 2023/24* of this report for work we have done across Derbyshire priority areas, with particular reference to Aspiration Pneumonia and cancer bowel screening.

2. **Focus on co-morbidities associated with premature death and DNACPR/RESPECT**

   In Derbyshire DNACPR/ReSPECT is one of our priority areas. We also review each death that is notified to us bearing in mind whether the death was avoidable and premature as part of our decision making as to whether the review should be completed as focused.

3. **Assure and Sustain Performance**

   a. **LeDeR review completion within 6-month KPI (Understanding, addressing and monitoring variation in performance across the region)**

   Performance of the LeDeR programme in Derbyshire is monitored and we aim to complete all reviews in a timely way where possible meeting the 6 month KPI. There are challenges to this due to capacity within the team. See Appendix 1 for the LeDeR Performance report as at 31st March 2024.

4. **Improve the quality of LeDeR reviews and actions from learning**

   a. **Facilitate peer review opportunities**

   In Derbyshire we have been involved in the peer review meetings set up across the Midlands to share feedback of completed reviews, discuss and learn from each other about how improvements could be made. This learning is being used as part of work we are doing locally in Derbyshire to discuss how we can improve reviews.

5. **Improve access and understanding of importance of LeDeR reviews**

   a. **Communicating more with stakeholders encouraging referrals to LeDeR to better understand the experience of LeDeR for families and relevant others particularly minority ethnic groups and autistic people**

   Promoting LeDeR and working with stakeholders across the Derbyshire System is a key part of the role of the Derbyshire Local Area Contact (LAC). Throughout the year this has included working closely with health and social care colleagues to promote LeDeR and the notification of deaths, delivering presentations at partnership meetings, nurse training events, care home forums and social care team meetings.

6. **Improve accuracy of Learning Disability Registers & Increase the quality and uptake of the annual health check**
    a. **To support continued improvements in data accuracy for thematic analysis**
    b. **Improve the quality of annual health checks**

Please see section *What work has been happening in Derbyshire in 2023/24* of this report for work that has been done in relation to annual health checks.

Our Local Priorities for 2024/25

Aspiration Pneumonia – the 6 month collection of data through LeDeR reviews in relation to aspiration pneumonia deaths will be completed during August/September 2024. The information will be reviewed and themes/learning identified along with next steps to be considered based on this learning.

Care Coordination - We will continue to use LeDeR to evidence the need for care coordination of individuals, particularly those with a mild learning disability who do not have the support they need to manage and understand their health appointments.

Epilepsy – We will continue to identify issues found in relation to those individuals with epilepsy and highlight the importance of an Epilepsy Lead across the system.

Managing Deterioration – based on learning through LeDeR in 2023/24 we will be considering where the information and learning can be shared across the System to encourage better understanding of managing deterioration.

Mental Capacity Act - An emerging theme is that of mental capacity for people with a learning disability and autistic people. LeDeR has found some evidence to suggest that capacity is assumed, and the individual is making an unwise decision but without the necessary professional curiosity. We will continue to monitor this through LeDeR.

Minority ethnic communities – We will continue to work with the Minority Ethnic leads for LeDeR to increase awareness across all agencies and communities of the role of LeDeR and why notifying LeDeR of deaths is a first important step. To further raise awareness of the even poorer health outcomes for some members of minority ethnic communities who have learning disabilities, sharing the learning from LeDeR.

ReSPECT/DNACPR – the information included in this report in relation to ReSPECT and DNACPR will be shared as detailed and used as appropriate to promote learning.

Special thanks to the following people who have been involved in producing this report and the easy read version of the report:-

Our experts by experience – particularly Denise B and Dan W and the Derbyshire Reps on Board

LeDeR team

LeDeR Steering Group and Governance Panel members across the Derbyshire system

References

National LeDeR Policy 2021

Derbyshire LeDeR Strategy 2021

Joined Up Care Derbyshire (JUCD) website

Office of National Statistics, 2021 Census

NHS – Bowel cancer screening

Population and Person insight data/dashboard

Appendix 1 – Derbyshire LeDeR Performance Report (4 pages)

LeDeR Performance Report

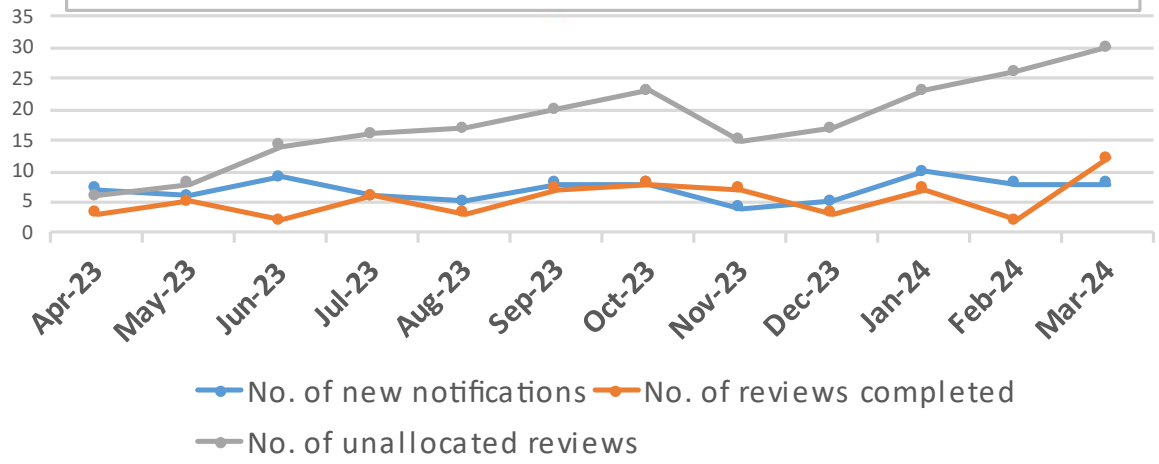
Joined Up Care Derbyshire

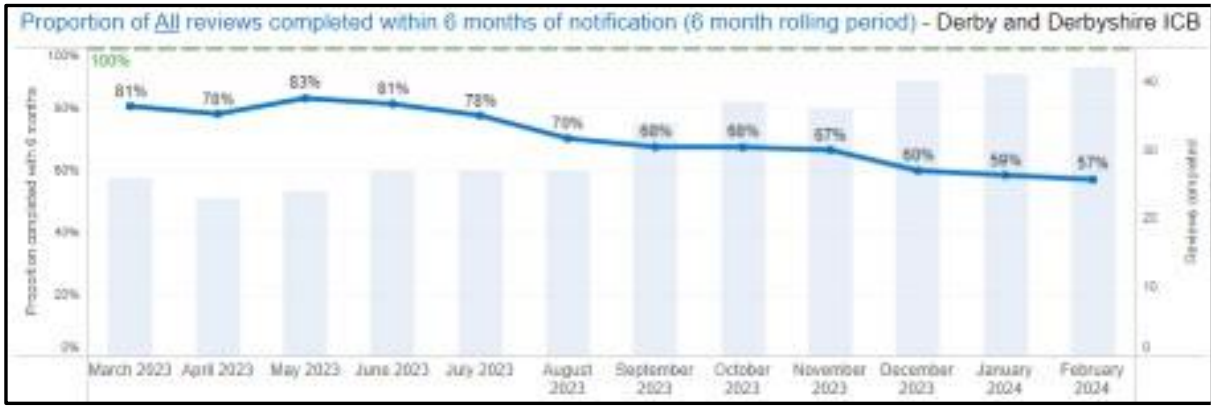
NHS Derby and Derbyshire Integrated Care Board

Data to 31st March 2024

Key Highlights/Issues	Details	Mitigations
INCREASE IN UNALLOCATED REVIEWS – NOW 30 unallocated	**NOT ENOUGH REVIEWER CAPACITY LEADING TO INCREASE IN NUMBER OF UNALLOCATED REVIEWS**	Global shout out to ICB staff to be LeDeR Reviewers - No volunteers Previously had some funding to use external reviewers -funding now fully spent Escalated through LeDeR Steering Group/Governance Panel - no system solutions found Escalated at MH/LDA Board in February 2024
35% of reviews to be completed as focused reviews (NHSE target)	Latest performance as per NHSE for Derbyshire is 21%.	
100% of reviews to be completed in 6 months (NHSE target) is decreasing due to limited number of reviewers.	Currently at 57% (this is taken from NHSE figures– latest data available at 29/2/24) there has been a gradual decline of this percentage since May 2023– see graph	

Number of new notifications received (blue line) compared to number of reviews completed (orange line) - top grey line highlighting the increasing number of unallocated reviews





Date of extraction

31/03/2024

Executive Summary

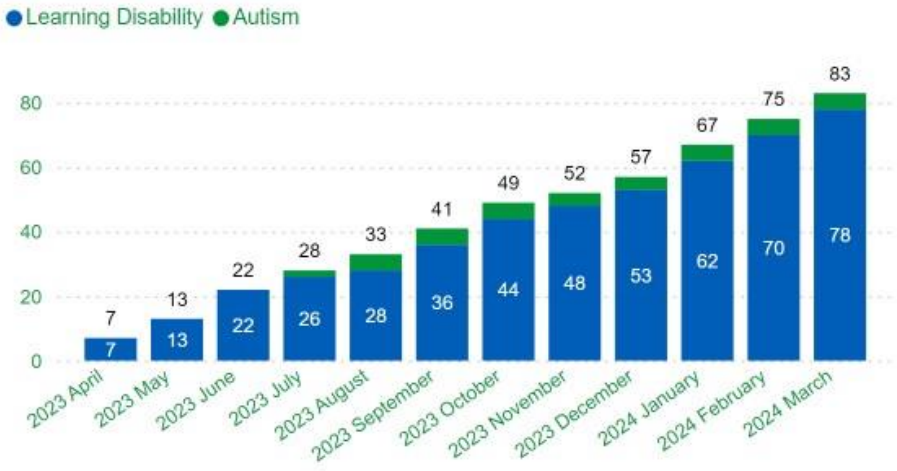
Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

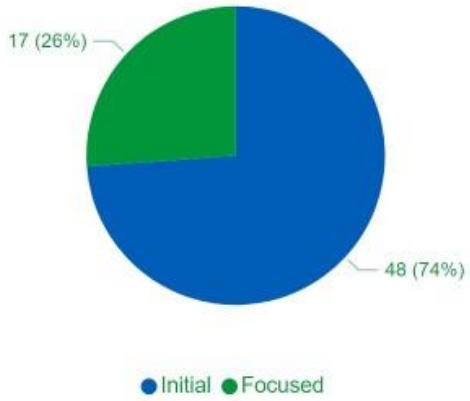
Current Totals for the 23/24 year – from April 2023

83	65	38	58%
Total Notifications 23/24	Total Completed 23/24	Total Completed in 6 months 23/24	% Completed in 6 months

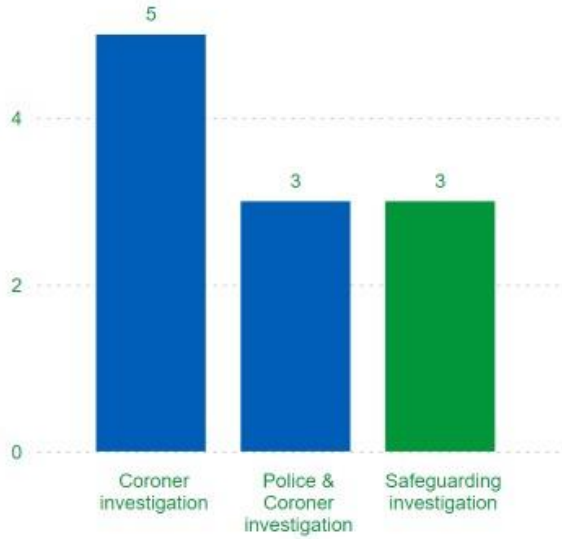
Notifications received from April 2023 split by Autism only and LD



Total number of completed reviews from April 2023



Reason for on hold



Date of extraction

31/03/2024

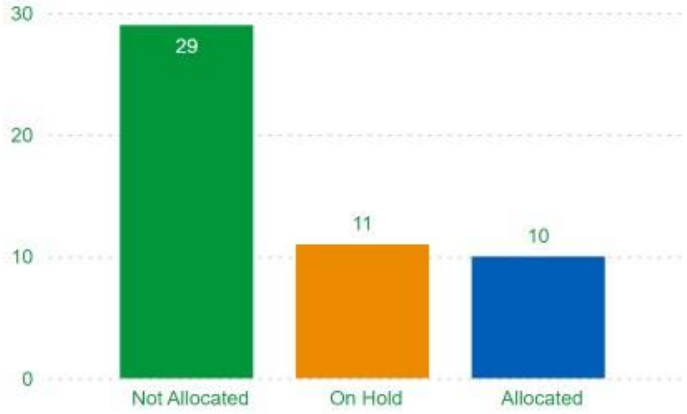
Introduction of new LeDeR Platform since March 21

Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

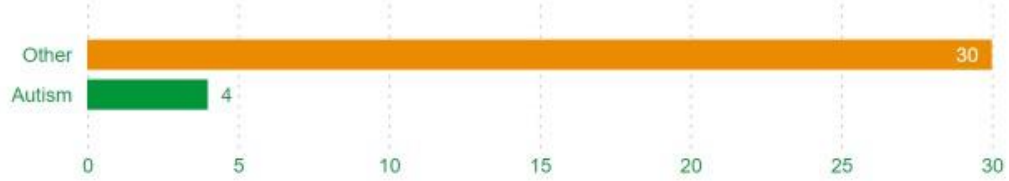
Current Status of Reviews by Reviewer

Current reviews by status

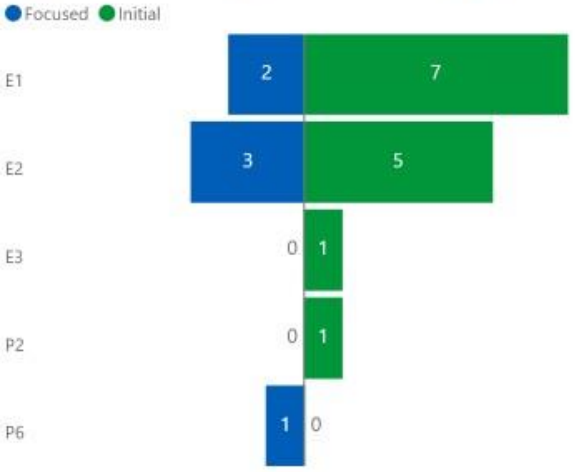


All Reviews (completed and in progress) since March 2021

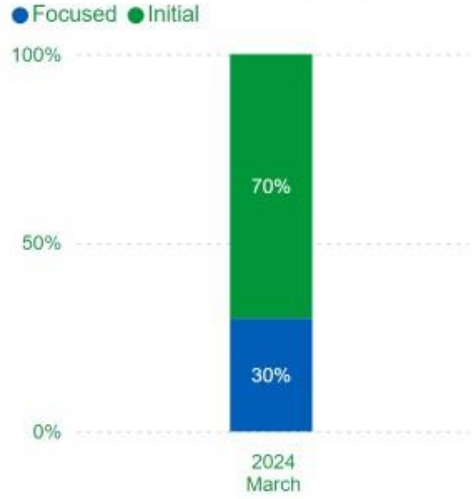
Breakdown of completed and in progress focused reviews since March 2021



Type of Review by Reviewer in progress



Reviews currently in progress



Date of extraction

31/03/2024

Overall Position

Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

Since 2017 the start of the LeDeR program

425

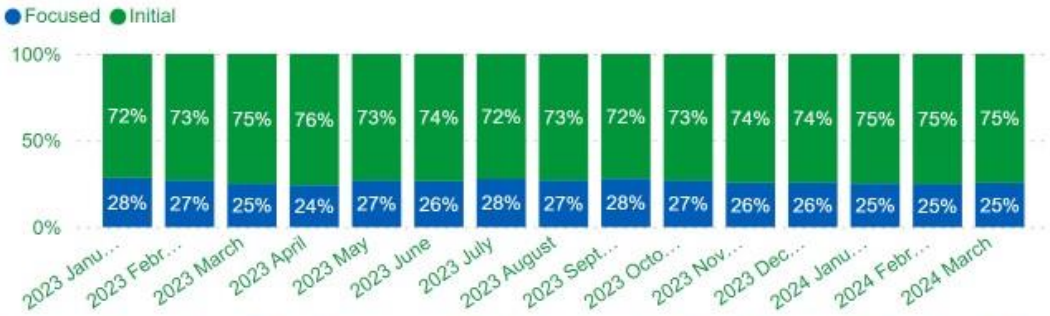
Total Number of notifications since 2017

374

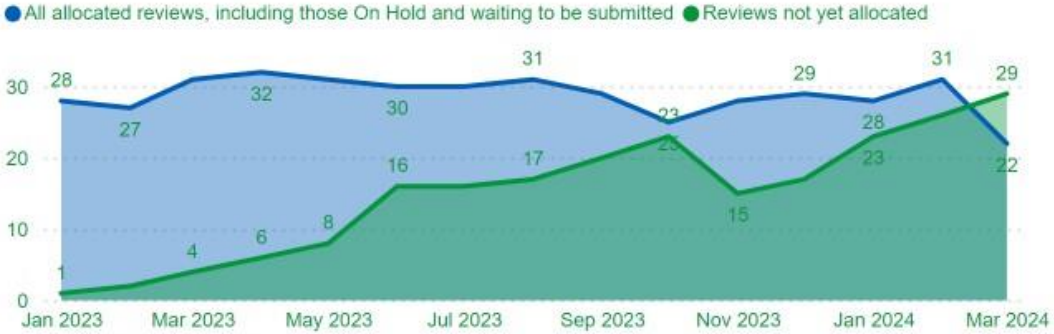
Total Completed since 2017

Graphs show a rolling 12 months but can be amended with the Date of extract filter >>

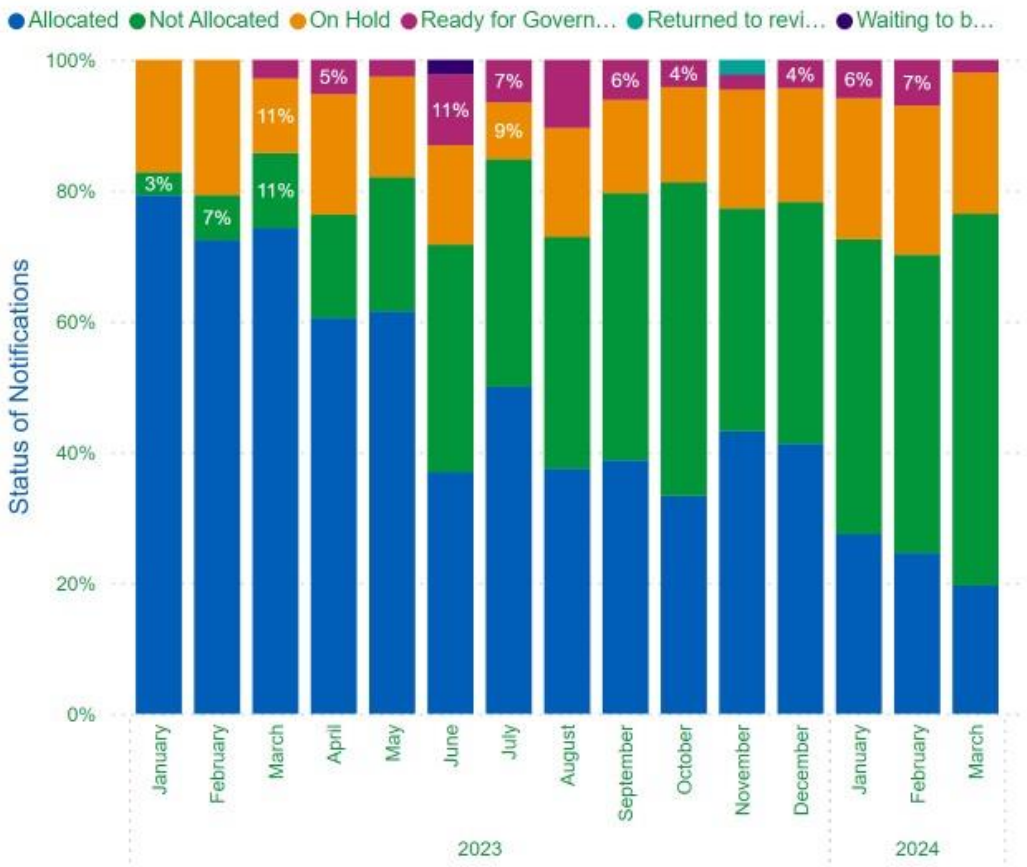
Type of Review Completed since March 2021



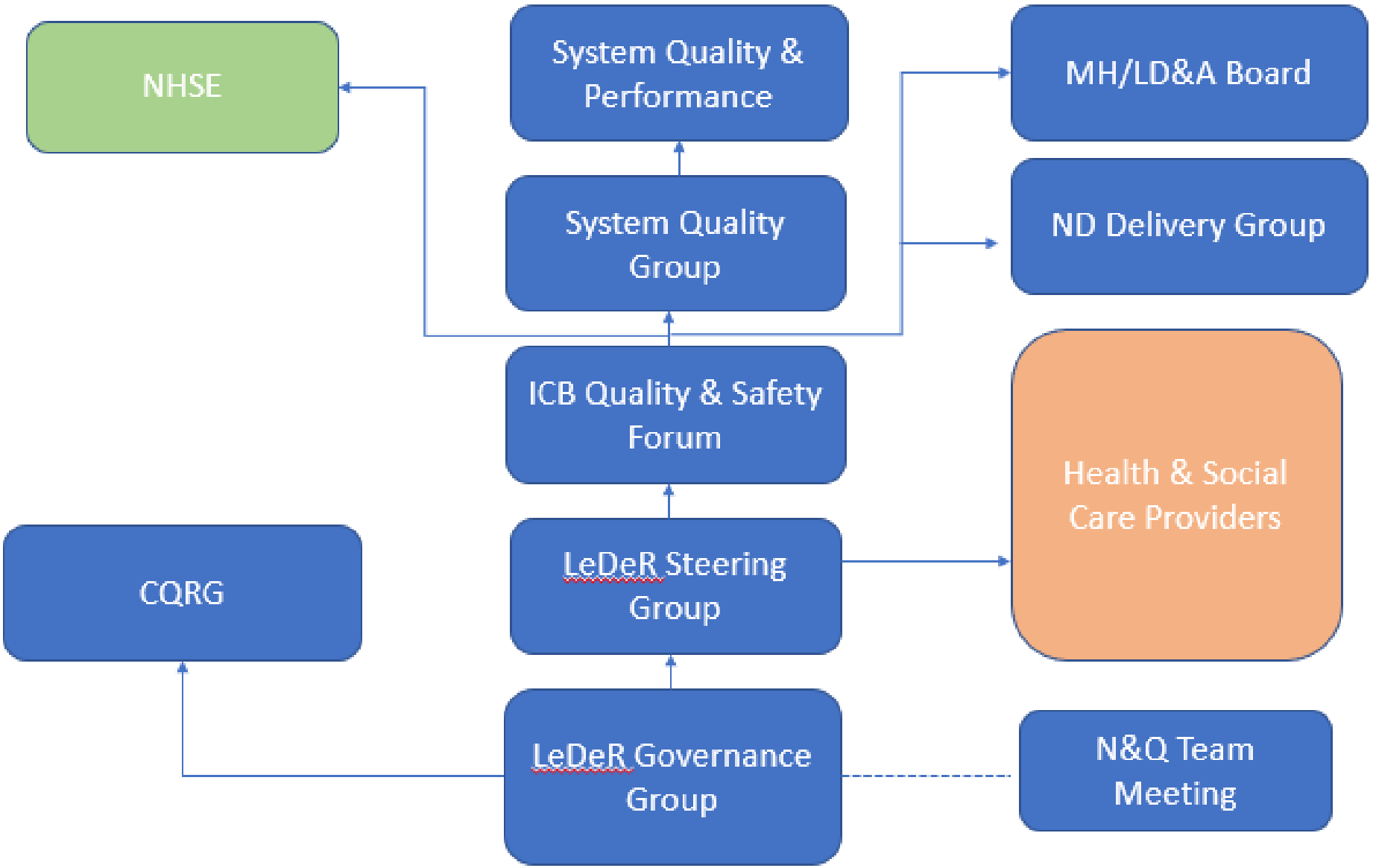
Comparison of notifications received but not yet allocated against allocated reviews (including On Hold reviews)



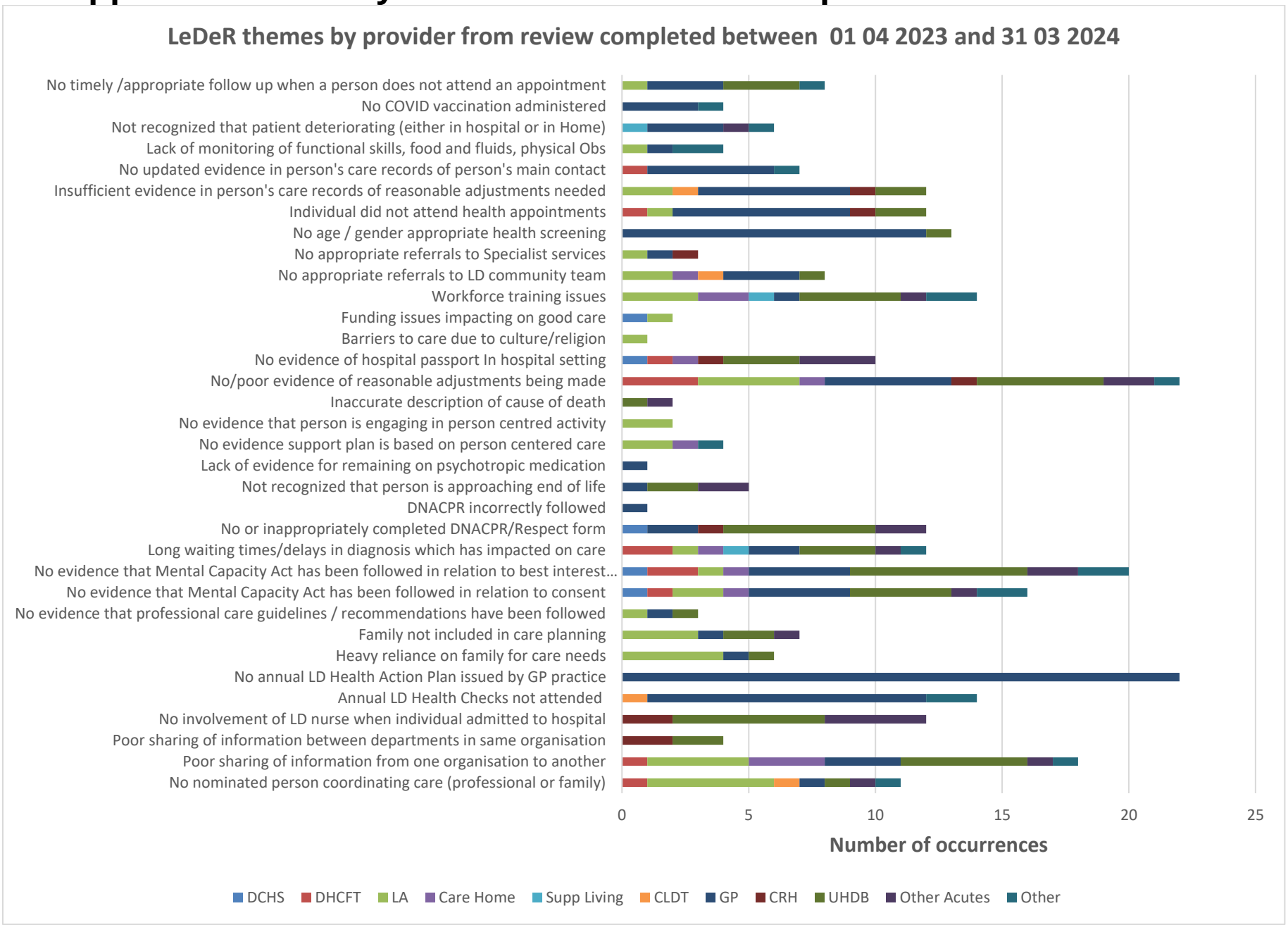
Current Reviews by Status



Appendix 2 – LeDeR Governance Structure



Appendix 3 – Derbyshire LeDeR Themes Graph



Joined Up Care Derbyshire

NHS
Derby and Derbyshire
Integrated Care Board

Learning from Lives and Deaths – people with a Learning Disability and Autistic People

The LeDeR Programme

Derbyshire Quarterly Performance Report

2024/25 Quarter 2

July 2024 – September 2024

Contents

Executive Summary

This is the Derbyshire Quarterly report to summarise the recent progress made in Derbyshire. This report covers the Quarter 2 period for 2024/25 from 1st July 2024 to 30th September 2024.

LeDeR is a service improvement programme and this report aims to show the changes that have and will be made as a result of LeDeR.

Summary of notifications in Quarter 2: There was a total of 15 new notifications of learning disability deaths to the LeDeR programme for Derbyshire during Quarter 2 - 2024/25. In addition, there was also 1 notification for an individual who had a clinical diagnosis of autism (with no learning disability) in this quarter. There were no notifications received for individuals from a minority ethnic background.

Summary of completed reviews in Quarter 2: There were 15 reviews completed for people with learning disabilities in Quarter 2. 11 were completed as "Initial Reviews" and 4 completed as the more detailed "Focused" review (ie. 27% were completed as focused reviews). There were no Autism only (no Learning Disability) reviews completed in this quarter. During the quarter the top reasons for death were aspiration pneumonia (with 3 deaths) and respiratory infections (with 3 deaths) listed as the main reasons for death on the death certificate (1a on the death certificate).

It is difficult to capture any trends over such small numbers, but the report aims to show areas we have identified through actions and learning and the review of health conditions. The report also identifies priority areas for the next quarter in relation to addressing inequalities.

We have been asked to provide an overall RAG status for our Action from Learning progress as part of this report. Based on this the Derbyshire LeDeR programme is currently rag rated as *Amber – Some Concerns* due to resource issues that is resulting in us unable to continue to meet performance targets and progress action from learning.

Introduction & Background

The "Learning from lives and deaths – people with a learning disability and autistic people (LeDeR) policy" was introduced in March 2021 to serve as a guide to professionals working in all parts of the health and social care system on their roles in delivering LeDeR. The policy includes NHS England's (NHSE) delivery expectations of local areas, which includes a quarterly report from the local ICS to identify performance against local actions that have been found through the LeDeR programme. This report is the Derbyshire quarterly report to cover Quarter 2 of 2024-25, from 1st July to 30th September 2024.

As a service improvement programme, we are working locally across the Derbyshire Integrated Care system (ICS), Joined Up Care Derbyshire (JUCD), to use the learning found through LeDeR to improve our local services for people with a learning disability and autistic people.

Our Local Population in Derbyshire

Estimates of people with a learning disability for Derby and Derbyshire are slightly more than 2% of the population, which is approximately four times the proportion of the population who are known to services. It is estimated that there are 15,250 people in Derbyshire and 4,950 people in Derby with a learning disability (people with mild to severe learning disability). (Reference: JUCD website)

It is estimated that 1% of the population have autism. Research has identified between 44% and 52% of people with autism may have a learning disability and between 48% and 56% do not have a learning disability. Data from GPs in Derby and Derbyshire show there are 3,358 people with autism (who have no learning disability). (Reference: JUCD website)

Background and Findings - LeDeR in Derbyshire

Work started on the LeDeR programme in Derbyshire early 2017. The first LeDeR Steering Group ran in February 2017 and the first reviews started in April 2017. Since that date we have received 474 in scope notifications for those age 18+, of which 401 have had a review undertaken and completed (data taken as at 30th September 2024).

Learning from individual reviews is collated through an action tracker. Good practice is acknowledged and shared with organisations and individual actions are agreed and discussed at the Derbyshire LeDeR Governance Panel and fed back up to organisations through their members that attend the meetings.

Themes are also collated from each review and the theme form is reviewed alongside the review as part of the quality review process. The themes are broken down by the responsible care provider. Themes are collated and reviewed to identify areas where commissioning concerns may need to be identified. These themes are shared with organisations via the Derbyshire LeDeR Steering Group to enable them to see themed areas of work that are relevant to them for potential review and for discussion as a wider Derbyshire system.

Deaths in Derbyshire – Quarter 2, 2024/25

	Gender		Total new notifications
	Male	Female	
Total number of Learning Disability notifications 01/07/24 to 30/09/2024	8	7	15
	Gender		Total new notifications
	Male	Female	
Total number of Autism only (no learning disability) notifications 01/07/24 to 30/09/2024	1	0	1

There were no Learning Disability notifications received for people from minority ethnic communities.

There were no Autism only (no learning disability) notifications from minority ethnic communities.

Overall, there were **15** (8 male, 7 female) reviews completed in Quarter 2. 11 reviews were completed as "Initial Reviews" and 4 completed as the more detailed "Focused" review. There were no reviews completed for people who were autistic with no learning disability.

This equates to 27% of reviews being completed as Focused during this quarter.

Type of review	Month review completed			Total
	July 2024	August 2024	September 2024	
Initial	3	5	3	11
Focused	2	2	0	4
Focused (Autism only)	0	0	0	0

The top reasons for death were Aspiration Pneumonia and Respiratory infections.

There were no completed reviews for deaths of autistic people but no learning disability in this quarter.

All reasons for death during this period are listed below.

Reason for death	No. of occurrences
Aspiration Pneumonia	3
Respiratory infections	3
Heart Conditions	2
Cancers	2
Dementia	1
Multi Organ Failure	1
Frailty	1
Foreign Body obstruction of airway	1
Hypoxic Brain Injury	1

NB. The information in the above table all relates to reasons for death shown on section 1a of the death certificate.

Completed LeDeR Reviews in Quarter 2 2024-25 and Action Status

Appendix 1 shows a breakdown of the LeDeR reviews completed in Derbyshire in Quarter 2, the good practice and issues identified and any actions that were agreed. The table is also RAG rated to show the status of the actions.

Actions taken in Quarter 2 2024/25: Update of the Derbyshire Local Action Plan

Below is the local action plan as produced in the Derbyshire 3 Year Strategy. This has been updated with a current status column to highlight progress.

Key Deliverables	Outcomes	Key performance measures	Responsibility	Frequency of collection (if appropriate)	Date for completion	Current Status at Quarter 2 2024-25
1) A robust plan will be in place to ensure that reviews are completed within six months of the notification of death.	100% of reviews (both initial and focused) are completed within six months of notification except those that go to external investigation.	Monthly dataset shows ICS completion of eligible reviews within six months of notification.	LAC	Monthly	Ongoing	Performance Report produced to monitor review status ongoing
2) An annual LeDeR report demonstrating how the ICS is delivering on local actions addressing those areas identified in LeDeR reviews. It will demonstrate effective delivery of actions from learning from LeDeR reviews.	Published report and available to the public	The report will be approved via the JUCD MH/LDA Board	LAC	Published in June until 2024 when due date amended by NHSE to September 2024	Completed - September 2024	A new report for 2023/24 for Derbyshire has been produced and now available on the JUCD website
3) ICS will demonstrate how they are narrowing the gap in health inequalities and premature mortality for those who have a learning disability in their local area	• A reduction in the repetition of recurrent themes found in LeDeR reviews in a local area. • Reduced levels of concern and areas for improvement • Reduced frequency of deaths that were potentially avoidable or amenable to good quality healthcare.	Through LeDeR reporting and analysis	ICS	Annually	Next due September 2024	Ongoing reporting & tracking

4) Clear and effective governance in place which includes LeDeR governance within mainstream ICS quality surveillance and governance arrangements.			ICS	Annually	Operational from 1st July 2022	Complete
5) Increased reporting of deaths from people from relevant Black, Asian and Minority Ethnic communities within the ICS proportionate and relative to the communities living within that geography	Increase in number of notifications received through the LeDeR platform	Captured through LeDeR reporting	LAC & Minority Ethnic lead	Weekly reporting	Ongoing	In Progress
6) Clear strategy for meaningful involvement of people with lived experience in LeDeR governance	Membership at LeDeR Steering Group	Attendance captured in minutes of meeting	LAC	Meetings held quarterly	September 2021	Completed
7) Senior ICS leaders, including local authority partners are involved in governance meetings where issues found in local reviews are discussed and actions agreed collaboratively, to support joined-up actions to improve services, reduce health inequalities and reduce premature mortality.	Membership at LeDeR Governance Panel	Attendance captured in minutes of meeting	LAC	Meetings held monthly	April 2022	Completed
8) To be prepared to begin the reviews of deaths of autistic people once this	100% of reviews are completed within 6 months of notification	Monthly dataset shows ICS completion of eligible reviews within	LAC	Monthly	December 2021	Completed

goes live		six months of notification.				
9) To ensure that reviews are completed and quality assured to an acceptable standard	The programme can share and use learning to make meaningful changes to the lives of individuals with learning disabilities.	• Training of reviewers will be monitored to ensure training provided by the programme is attended • The LAC and Senior Reviewer will meet regularly to quality assure reviews and refer to the LeDeR Governance Panel where wider quality review is required. • Quality Checklist form to be completed for each completed review	Reviewers/LAC/ Senior Reviewer	Training monitored 6 monthly Regular meetings LAC & Senior Reviewer & reviewers	Ongoing Following each completed review	Completed – ongoing
10) To continue to work with partners as part of Joined Up Care Derbyshire ICS in relation to the LeDeR programme	To enable service improvements to be agreed, developed and made together across the whole system	• To review the terms of reference and attendees for the LeDeR Steering Group to ensure correct membership in order that system change can be discussed and agreed based on learning from LeDeR	LAC/ICS	Annually - ToR for Steering Group reviewed regularly	Ongoing	Ongoing

		• To escalate risks and issues through Joined Up Care Derbyshire Mental Health/Learning Disability/Autism Board to ensure LeDeR is an ICS responsibility • To continue to work closely with health and social care partners through the LeDeR Steering Group, sharing learning and discussing and implementing change through the sharing of themes and reviewing of good practice • LeDeR LAC is also workstream lead for Health Inequalities at a Neurodevelopment Delivery Group held monthly across the Derbyshire system. A Health Inequalities Working Group has been set up as part of this workstream to ensure partners		Monthly – as needed Quarterly		

		are meeting together to share learning, identify gaps and share work that is in progress across the system. Such things as learning from LeDeR, work on LD annual health checks, STOMP STAMP and recommendations from the Clive Treacey report are part of the areas of work shared and discussed. This work continues and is fed back in a monthly highlight report to the Neurodevelopment Delivery Group.				
11) To promote LeDeR and share learning from LeDeR across Derbyshire learning disability forums and with learning disability services and care providers.	Increase in notifications made to the LeDeR programme Increased awareness of the LeDeR programme and its aims	Increase in notifications through monthly performance monitoring	LAC/Reviewers	Monthly monitoring	Ongoing	Ongoing

What's been done in Quarter 2 – LeDeR and wider System working

Learning from LeDeR continues to be shared across the System and is discussed at LeDeR Steering Group. In addition the LAC continues to work to improve LeDeR processes and work with other organisations across the Derbyshire System. This includes working with the Mortality Review Facilitator at DCHS to produce regular reports which includes LeDeR learning that is then fed back to the Mortality Group, working with Safeguarding Leads at Derbyshire County Council to look at specific themes that are raised as part of actions and recommendations from the LeDeR reviews and working closely with Adult Care colleagues to ensure LeDeR processes are appropriate to ensure information is gathered in a timely manner for LeDeR reviews and themes and learning are fed back to Social Care for them to use any learning.

Aspiration Pneumonia

The project to look at aspiration pneumonia deaths through LeDeR ended in August. A meeting took place towards the end of Quarter 2 to start to pull the information and learning together that has been collated as part of the project. This work has continued into Quarter 3.

DNACPR/ReSPECT

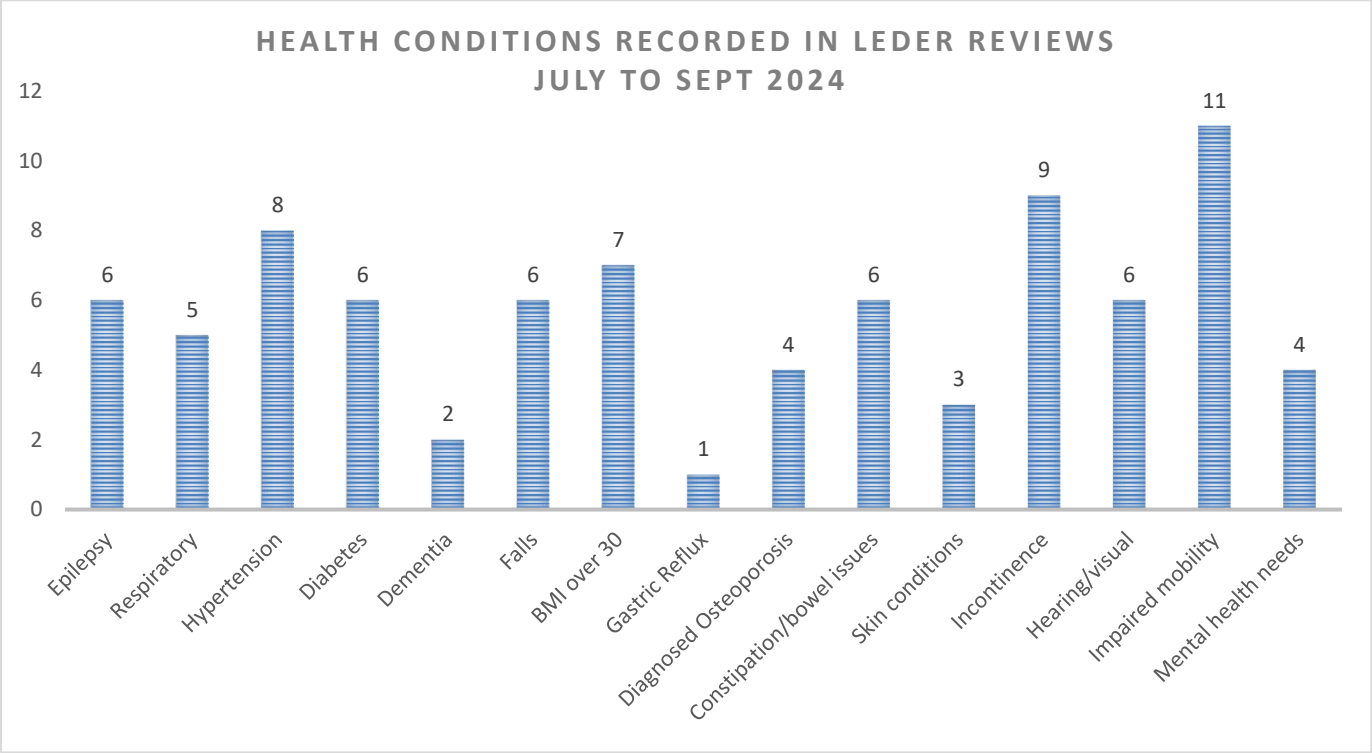
A paper has now been produced based on learning from LeDeR across 2023/24 which has been incorporated into the LeDeR Annual Report for Derbyshire 23/24. Next steps have been incorporated into this report and will be worked on in Quarter 3.

Health Conditions

Data continues to be collected locally of the health conditions of everyone who receives a LeDeR review. This information is reviewed regularly to enable us to identify possible areas of work.

A graph for Quarter 2 is shown below identifying the health conditions and the number of times each condition was identified. This information is taken from the 15 completed LeDeR reviews during that period. The top most common health condition was Impaired Mobility, which was a health condition in 73% of the 15 completed reviews, followed by Incontinence at 60% and Hypertension at 53%. We have started to monitor and collate BMI over 30 which is showing for this quarter as our fourth highest health condition at 47%.

Constipation/bowel conditions was a health condition for 40% of the 15 completed reviews and mental health needs 27%. This is a reduction from the quarter 1 report but we will continue to monitor this throughout the year. Hypertension is an increase from the quarter 1 report and this will also continue to be monitored throughout the year.



LeDeR Annual Report for Derbyshire 2023/24

The LeDeR Annual Report for Derbyshire 23/24 has been completed throughout Quarter 2 and is now published and available on the Joined Up Care Derbyshire website at Learning disabilities and autism » Joined Up Care Derbyshire.

Performance reporting

The LeDeR performance report continues to be produced on a monthly basis and will be included in these reports each quarter. These reports are shared across the System, including within the ICB Nursing and Quality Team, at LeDeR Steering Group meetings and with the System Mental Health LDA Board. The report as at 30th September 2024 is included in Appendix 2.

Next Quarter LeDeR Actions & Priorities

Particular focus is being given in the next quarter in relation to the following priority areas.

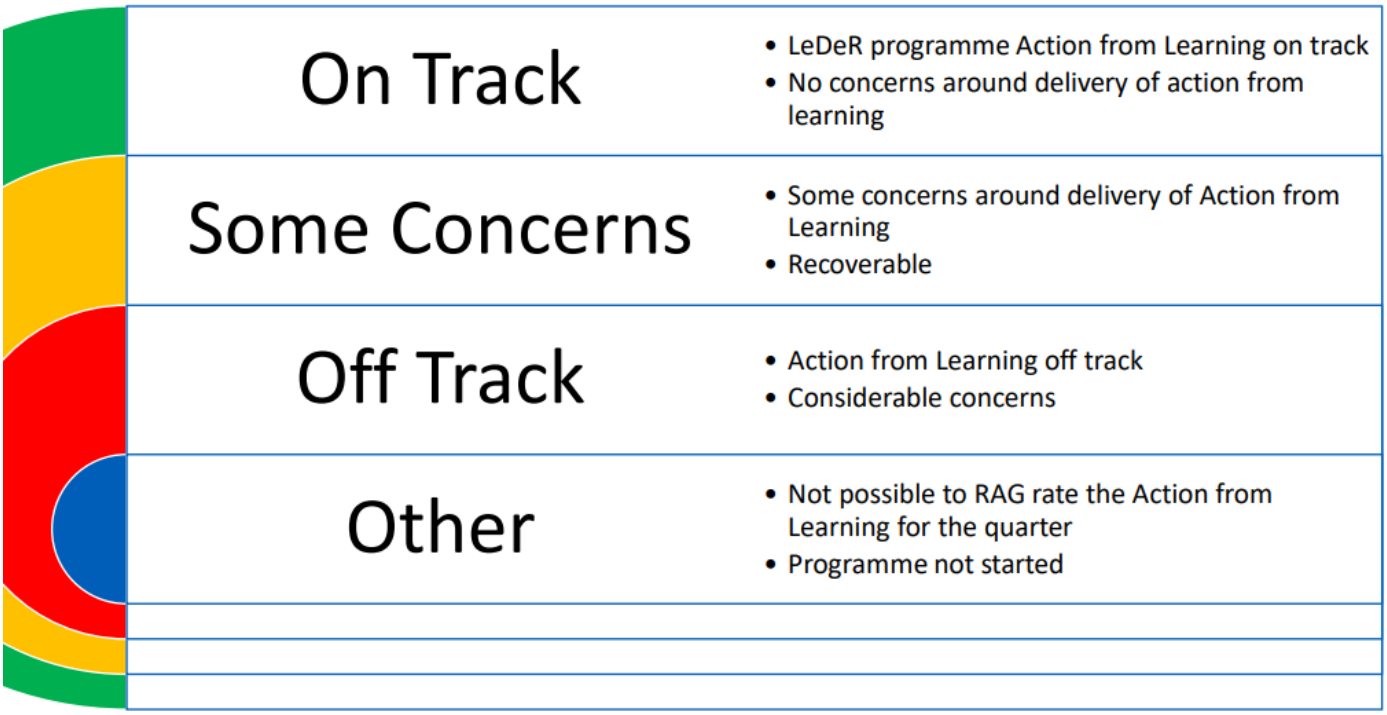
Aspiration Pneumonia –the project ended in Quarter 2 and the learning will be collated in Quarter 3 and next steps agreed.

ReSPECT/DNACPR – next steps as detailed in the LeDeR Annual Report will be worked on throughout Quarter 3.

LeDeR Annual Report – as this report has now been published focus will also be given to the priority areas included in the report.

RAG Rating for the LeDeR programme in Derbyshire

We have been asked to provide an overall RAG status for our Action from Learning progress as part of this report based on the following ratings.



For the period that this report covers there are still concerns in relation to the workforce available to continue to deliver the LeDeR programme. Based on this the Derbyshire LeDeR programme is currently still rag rated as *Amber – Some Concerns*: -

- At present we have a team of 2 reviewers (who work 0.5 wte each, ie 1.0 wte total). We have trained a member of the Nursing & Quality ICB staff as an additional reviewer and have taken this issue to the LeDeR Steering Group to see if there are any ideas as to how this issue could be resolved while working within the terms of the LeDeR Policy 2021. This has been raised as a risk through the ICB Quality & Safety Forum and at the Mental Health/Learning Disability & Autism/Children & Young People Board.

Appendix 1 – Completed LeDeR Reviews in Quarter 2 2024-25 and Action Status

Review ID	M/F	Age at Death	Ethnic Grouping as per LeDeR Programme	Main Reason for Death (1a on Death Certificate)	Additional information on Death Certificate	Current Status	Good Practice Identified	Issues/learning identified	Status of actions
25639	M	75	A	Cardiac Arrest	Aspiration of food	Completed as a focused review due to issues found	None identified	x choked on food which was not prepared according to SLT eating and guidelines. Safe-and-Well checks and SLT referrals for all residents with eating and drinking guidelines were requested .	Complete. S42 in house Dysphagia Training has taken place through CLDT SLT Team.
20715	M	54	A	Left ventricular failure	Obesity associated Cardiomyopathy	Completed as a focused review due to issues found	Person centred approach provided by SLT. Excellent support by social worker.	Better working together as an MDT from the start would have led to conversations being held where the MDT could have agreed where mental capacity assessments were needed.	Complete. Concerns shared with MDT. Good practice shared with SLT
27524	M	62	A	Multiple organ failure	Pneumonia	Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	GP offered consolidated appointments to reduce visits.Good support from CLDT nursing team with medication monitoring, easy read, arranging hospital transport and supporting hospital appointments.	None identified	Complete. Good practice shared with GP and CLDT.
24657	F	66	A	Aspiration Pneumonia	Ischaemic Stroke	Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	None identified	Day services stopped due to covid, no evidence that this was reconsidered as restrictions lifted. There was no evidence that this was explained to X or if she was involved in these conversations.	Complete. Issue shared with Adult Care .

26428	F	80	A	Dementia		Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	None identified	A safeguarding referral was made due to a choking episode where X had not been observed whilst eating.Appropriate care plans and risk assessments have been updated at the Care Home.	Complete. Issue shared with Care Home and Adult Care .
28466	M	56	A	Aspiration Pneumonia		Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	GP from Ageing Well Team offered a debrief to staff due to events surrounding death. Step mum felt that the quality of care he received from the care home was exceptional and the staff were like his extended family.	None identified	Complete. Good practice shared with Ageing Well Team and the Care Home.
28074	M	57	A	Aspiration pneumonia, Type 2 Myocardial Infarction	Acute necrotising Pancreatitis	Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	Reasonable adjustments made by hospital consultant	Support staff to x could have been made to feel more welcome by hospital staff in their role as advocates and with their knowledge of how to support X in the best way.	Complete. Good practice and hospital issues shared with Notts LAC to share with QMC, Notts.
26073	M	90	A	Frailty of old age		Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	None identified	The LD Dementia care pathway does not indicate that people with mild LD are expected to access Mainstream Services	Complete. Issue shared with Area service Manager of Neurodevelopmental Services
28879	F	79	A	Endometrial Cancer		Completed as a focused review due to issues found	Excellent observation of learning disability awareness and implementation of reasonable adjustments in hospital team	Failed hospital discharge plan: No home equipment in place when discharged .No evidence of proactive referrals to palliative care	Complete. Good practice and Issue shared with hospital
26380	F	46	A	Pneumonia		Completed as a focused review due to issues found	Adult care worker provided a comprehensive adult care review.Thera Trust provided excellent support and advocated for X in all aspects of her life.	Wheelchair services closed the referral whilst x in hospital. Hospital did not refer to the home oxygen team on discharge when NIV given.Training needs agreed for hospital staff.	Complete. Concerns raised with hospital and wheelchair services.

29871	M	52	A	Metastatic bowel cancer		Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	Good practice by surgeon in copying in Learning Disability Liaison Nurse to the GP letter where capacity and IMCA (Independent Mental Capacity Advocate) was advised.	None identified	Complete. Good practice shared with hospital
27092	M	61	A	Foreign body obstruction of airway		Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	Accessible Health Action plan and Reasonable Adjustments used by GP.	Care coordinator referred x for Shared Lives assessment but no evidence assessment took place	Complete. Issue shared with Adult Care.
27045	M	79	A	Bilateral Aspiration Pneumonia	Severe Learning Disability	Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	None identified	Inappropriate cause of death (severe learning disability) added to 1b on death certificate	In progress
27431	M	51	A	Respiratory Failure	Bronchopneumonia	Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	Good communication between SLTs in community and hospital teams to coordinate dysphagia assessment.Excellent care at hospital and care home.	Accepted for weight management Tier 3 in June 2023, not seen before time of death in January 2024.Also delay in respiratory follow up	In progress
26498	M	64	A	Hypoxic brain injury and multiple organ failure	Out of hospital cardiac arrest	Completed as an initial review. Quality Assured and actions agreed by Senior reviewer and LAC	None identified	None identified	Complete

Appendix 2 – LeDeR Performance Report as at 30th September 2024 (4 pages)

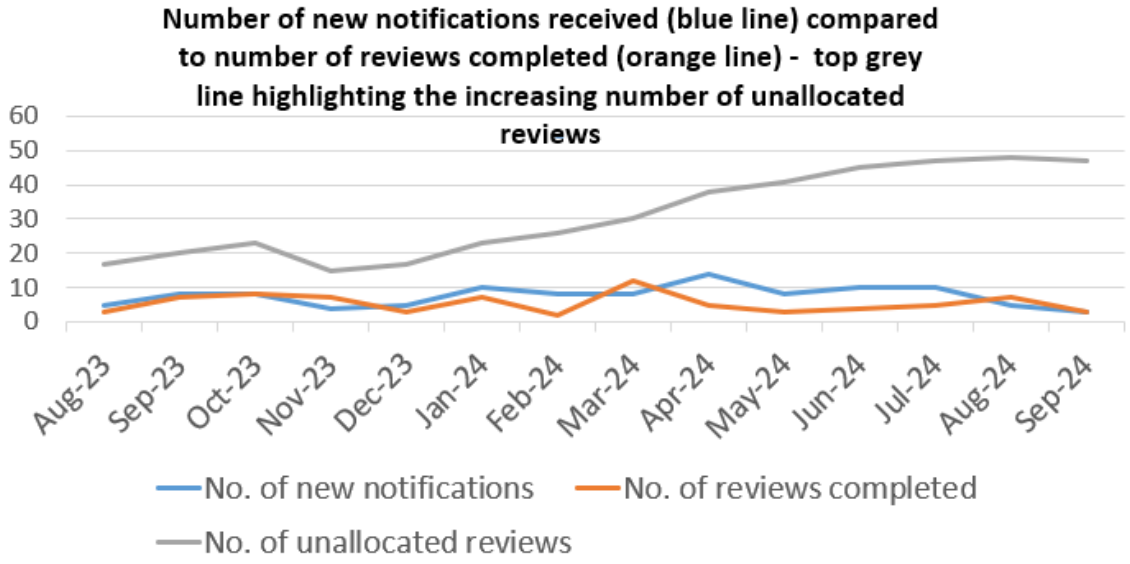
LeDeR Performance Report

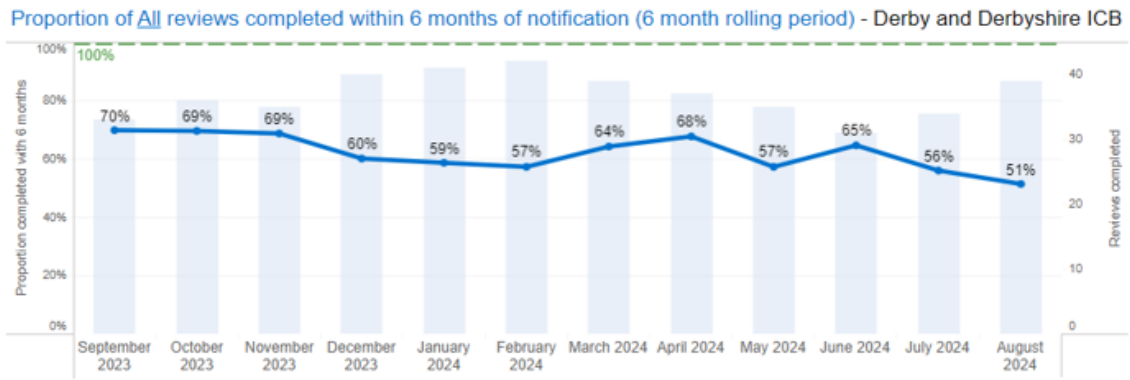
Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

Data to 30th September 2024

Key Highlights/Issues	Details	Mitigations
INCREASE IN UNALLOCATED REVIEWS – @ 30/9/24 there are 47 unallocated reviews	**NOT ENOUGH REVIEWER CAPACITY LEADING TO INCREASE IN NUMBER OF UNALLOCATED REVIEWS**	Global shout out to ICB staff to be LeDeR Reviewers - No volunteers Previously had some funding to use external reviewers -funding now fully spent Escalated through LeDeR Steering Group/Governance Panel - no system solutions found Escalated at MH/LDA Board in February 2024
35% of reviews to be completed as focused reviews (NHSE target)	Latest performance as per NHSE for Derbyshire is 28%. Latest info available as at 31/8/24.	
100% of reviews to be completed in 6 months (NHSE target) – unable to meet target due to limited number of reviewers and increasing numbers of unallocated reviews	Currently at 51% (this is taken from NHSE figures – latest data available at 31/8/24)	





Date of extraction

30/09/2024

Executive Summary

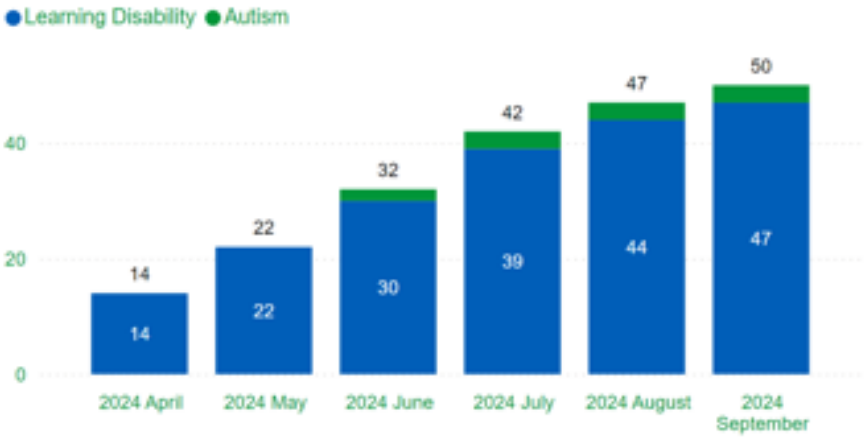
Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

Current Totals for the 24/25 year – from April 2024

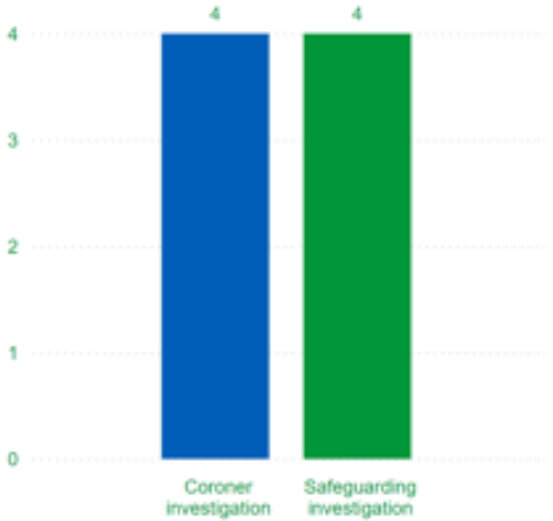
50	27	12	44%
Total Notifications 24/25	Total Completed 24/25	Total Completed in 6 months 24/25	% Completed in 6 months

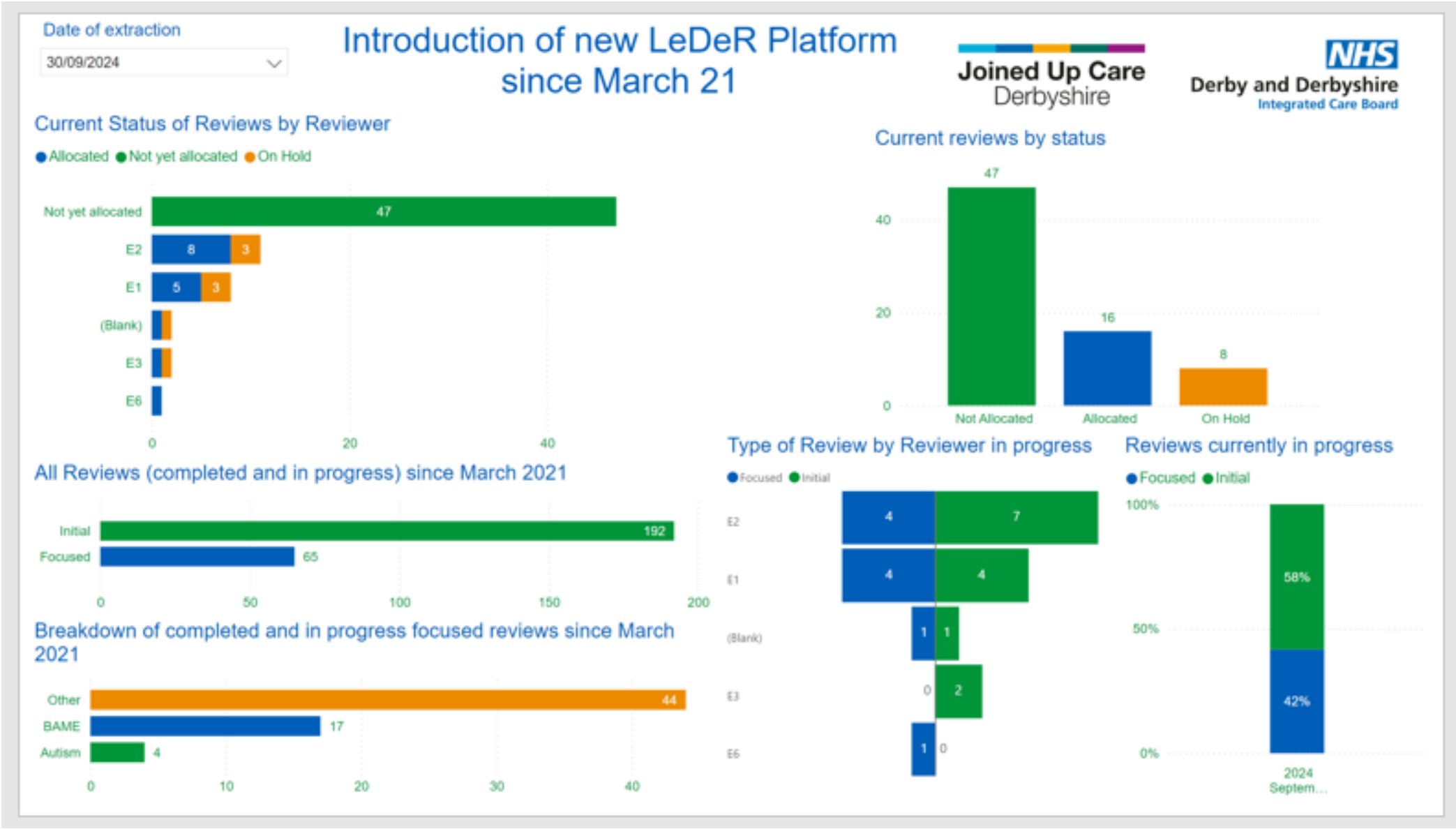
Cumulative Total of Notifications received from April 2024 split by Autism only and LD



Total number of completed reviews from April 2024

Reason for on hold




Date of extraction
30/09/2024
Introduction of new LeDeR Platform since March 21
Joined Up Care Derbyshire
NHS
Derby and Derbyshire
Integrated Care Board
Current Status of Reviews by Reviewer
Allocated
Not yet allocated
On Hold
Not yet allocated
47
E2
8
3
E1
5
3
(Blank)
E3
E6
0
20
40
Current reviews by status
47
40
20
16
8
0
Not Allocated
Allocated
On Hold
All Reviews (completed and in progress) since March 2021
Initial
192
Focused
65
0
50
100
150
200
Type of Review by Reviewer in progress
Focused
Initial
E2
4
7
E1
4
4
(Blank)
1
1
E3
0
2
E6
1
0
Reviews currently in progress
Focused
Initial
100%
50%
0%
58%
42%
2024 Septem...
Breakdown of completed and in progress focused reviews since March 2021
Other
44
BAME
17
Autism
4
0
10
20
30
40

Date of extraction

30/09/2024

Overall Position

Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

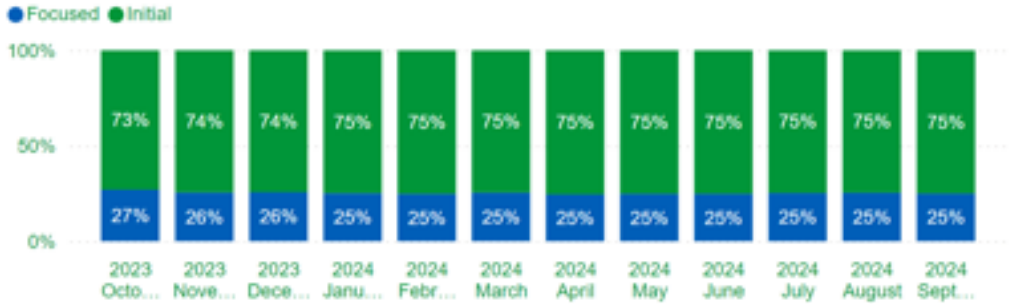
Since 2017 the start of the LeDeR program

474 Total Number of notifications since 2017

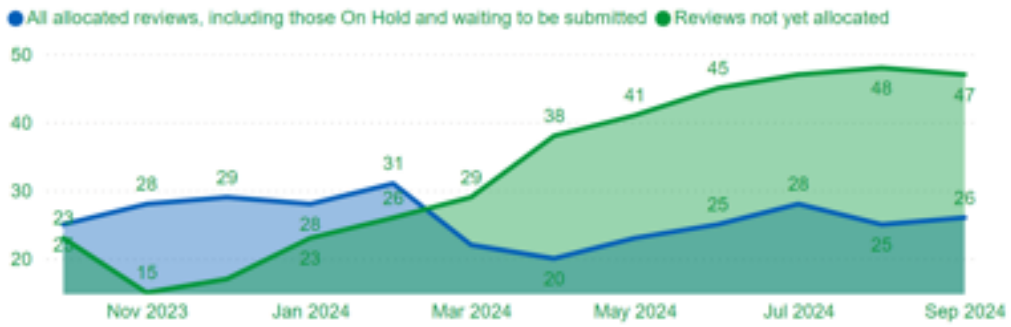
401 Total Completed since 2017

Graphs show a rolling 12 months but can be amended with the Date of extract filter >>

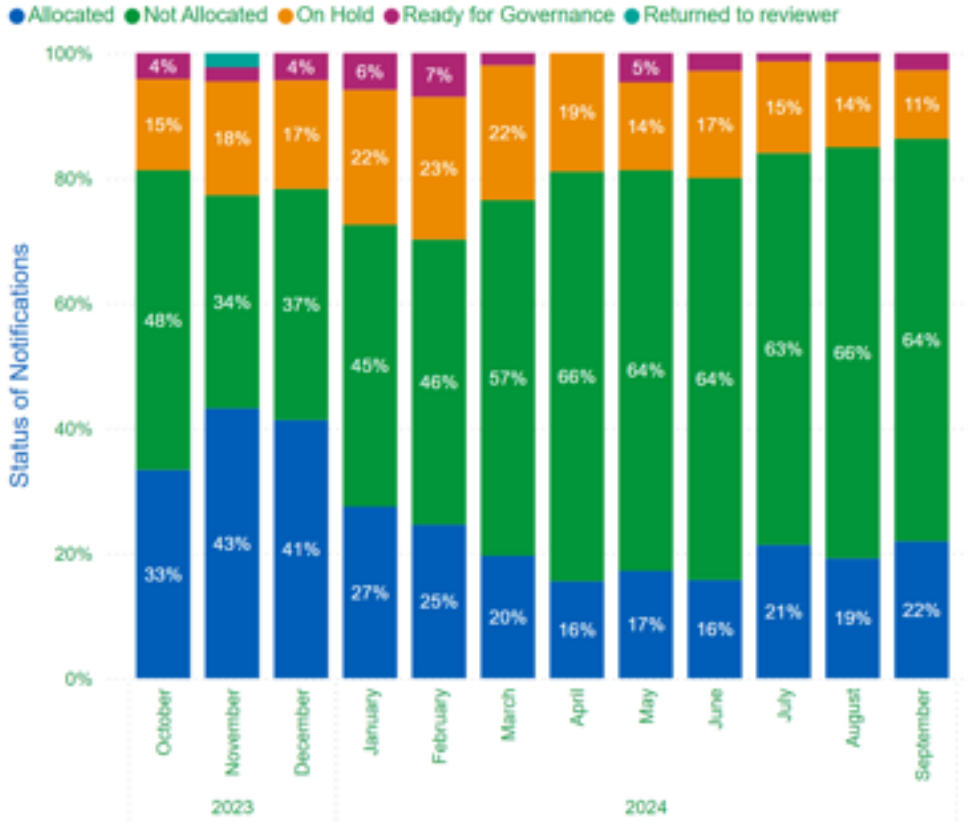
Type of Review Completed since March 2021



Comparison of notifications received but not yet allocated against allocated reviews (including On Hold reviews)



Current Reviews by Status



Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 14 January 2025

Guardian of Safe Working Hours (GoSWH) Report (quarterly) (December 2024)

Purpose of Report

This quarterly report from the Trust's Guardian of Safe Working (GoSWH) provides data about the number of resident doctors in the Trust, full transition to the 2016 Resident Doctor contract (Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016) and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Executive Summary

The Board of Directors is requested to note:

1. Exception reports during this period were for non-resident on call (NROC) rest requirement breaches (six in total). These attract a payment to the doctor and a fine levied against the Trust. All were on the south registrar rota tier.
2. Hours monitoring for the out of hours rotas is currently taking place (complete for consultants – being analysed, and complete for resident doctors – data being collated). This is for baseline purposes given the planned expansion of provision (the Making Room For Dignity project). The south rota is a particular concern as it is already generating NROC rest requirement breaches. The proposed expansion will likely increase the number of Section 136 MHA assessments, as well as seclusion reviews, leading to more NROC rest requirement breaches.
3. A further exception report from a Foundation Year resident doctor was given time off in lieu (TOIL). However, further correspondence with this doctor highlighted difficulties they were having with the placement. Efforts were made with further correspondence with this doctor to no avail. The GoSWH discussed this with the Directors of Medical Education for how to take this forward. An option was suggested of the resident doctor raising their concern formally as they rotated out of the Trust. This has been offered to the resident doctor, as well as further discussions in confidence. However, there has been no response. This highlights the cultural barriers exception reporting faces and is consistent with what is seen nationally.
4. Discussions are ongoing between NHS Employers and the British Medical Association (BMA) to agree changes to the exception reporting system as per the pay deal for resident doctors. It is expected for these to be finalised by the end of the calendar year, and then implemented later in 2025.
5. The GoSWH continues to chair the task and finish group for 'Improving the Working Lives of Doctors in Training'. The end of this report contains the current work plan.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

This report from the Trust's GoSWH, provides data about the number of resident doctors in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

The GoSWH has shared the previous annual report with the Quality and Safeguarding Committee, with the Joint Local Negotiating Committee, the Trust Medical Training Committee, the Resident Doctor Forum and its constituent resident doctors. Following presentation to the Quality and Safeguarding Committee on 10 December 2024, this report will be shared at the next Resident Doctor Forum and its constituent resident doctors.

Governance or Legal Issues

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

None.

Recommendations

The Board of Directors is requested to note the scrutiny and significant assurance received at the Quality and Safeguarding Committee that the duties and requirements as set out in the 2016 Resident Doctor contract are being met.

Report presented and prepared by:	**Dr Kaanthan Jawahar** **Guardian of Safe Working Hours**

GUARDIAN OF SAFE WORKING HOURS REPORT (QUARTERLY)
December 2024

1. Resident doctor data

Extended information supplied from 9 October 2024 to 30 November 2024.

Numbers in post for resident doctors

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	3	5
GP ST	4.10 (headcount 5)	6.4 (headcount 7)
CT	10.4 (headcount 11)	12.8 (headcount 13)
HSTs	8	7.6 (headcount 8)
Paediatrics ST	0	2 (headcount 2)

Key

CT = Core trainee years 1-3
FY1/FY2 = Foundation year trainee (years 1 and 2)
HST = Specialty trainee (ST) years 4-7
GP ST = General practice specialty trainee
Paediatrics ST = Paediatrics specialty trainee (year 4+)

2. Exception Reports

Covering the period 9 October 2024 to 30 November 2024. Total number of exception reports =

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	1	1	0
South	6	6	0
Total	**7**	**7**	**0**

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	0	0	0
ST4-7	6	6	0
GP	0	0	0
Foundation	1	1	0
Total	**7**	**7**	**0**

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	0	1	0	0
South	5	1	0	0
Total	**5**	**2**	**0**	**0**

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	0	0	0
Foundation	0	1	0	0
ST4-7	6	0	0	0
GP	0	0	0	0

3. Work schedule reviews

No formal work schedule reviews during the period 9 October 2024 to 30 November 2024.

4. Fines

- The current total of fines available for the RDF to spend is £3,383.84 through cost code G62762
- Fines' money set aside for a Board-supported away day for resident doctors.

5. Locum/Bank Shifts covered (9 October to 30 November 2024)

	North	Cost	South	Cost
Locum/bank shifts covered	19	£10,980	18	£9,320
Agency locum shifts covered	0	0	0	0

6. Agency Locum

Nil during the current financial year.

7. Vacancies (9 October 2024 to 30 November 2024)

	North	South
CT1-CT3	0.4	0.2
ST4-7	3	0
GP Trainees	0.4	0.6
Foundation	0	0

8. Qualitative information

- Exception reports during this period were for non-resident on call (NROC) rest requirement breaches (six in total). These attract a payment to the doctor and a fine levied against the Trust. All were on the South registrar rota tier
- Hours monitoring for the out of hours rotas is currently taking place (complete for consultants – being analysed, and complete for resident doctors – data being collated). This is for baseline purposes given the planned expansion of provision (the Making Room For Dignity project). The South rota is a particular concern as it is already generating NROC rest requirement breaches – the proposed expansion will likely increase the number of Section 136 MHA assessments, as well as seclusion reviews, leading to more NROC rest requirement breaches
- A further exception report from a Foundation Year resident doctor was given TOIL, however further correspondence with this doctor highlighted difficulties they were having with the placement. Efforts were made with further correspondence with this doctor to no avail. The GoSWH discussed this with the Directors of Medical Education for how to take this forward. An option was suggested of the resident doctor raising their concern formally as they rotated out of the Trust. This has been offered to the resident doctor, as well as further discussions in confidence. However, there has been no response. This highlights the cultural barriers exception reporting faces and is consistent with what is seen nationally
- Discussions are ongoing between NHS Employers and the BMA to agree changes to the exception reporting system as per the pay deal for resident doctors. It is expected for these to be finalised by the end of the calendar year, and then implemented later in 2025
- The GoSWH continues to chair the task and finish group for ‘Improving the Working Lives of Doctors in Training’. The end of this report contains the current work plan.

9. Compliance of rotas

Current work schedules are compliant with the 2016 resident doctor contract.

10. Other concerns raised with the Guardian of Safe Working (GoSWH)

None that are not already covered in section 8.

IMPROVING WORKING LIVES OF RESIDENT DOCTORS ACTION PLAN				
Item	**Narrative**	**Actions**	**Lead**	**Expected Completion/ Timescales**
Rota Coordinator	Currently this role is fulfilled through a combination of Medical Education and Medical Staffing. It is recognised that the ideal scenario is to have dedicated resource for this.	• Create a job description specific to DHCFT by codifying what work is currently done by whom re: rota management in the Trust	Medical Staffing and Medical Education	December 2024.
Payroll accuracy	Rotating doctors are more at risk of such errors. Board governance framework for monitoring payroll errors has been asked for. Policies/procedures to identify and swiftly correct payroll errors.	• **Pay arrangements for resident doctors** Foundation and GP trainees are paid under lead employer arrangements. GP trainees by Mersey and West Lancs teaching hospitals and foundation trainee south by UHDB and north by Chesterfield Royal Hospital. There is no lead employer arrangement for cores and higher psychiatry trainees. The doctors rotate between DHcFT, Notts HC and Lincoln and are paid by the relevant Trust where they are working on placement. • Exploration on whether a board governance framework already exists (Liam Carrier approached).	Medical Staffing	December 2024 for Board Governance Framework to include procedures to decrease delays/errors.
Onboarding processes	Ensuring these are swift and efficient. Provision of practical information, such as rest facilities, parking and similar.	• Induction content can be looked at with Medical Education	Resident doctors (led by Dr Omesili), supported by Medical Education and the GoSWH	December 2024.

		• Onboarding can be looked at with Medical Staffing and Medical Education • Elizabeth has also shared a document from Medical Education for residents that join 'out of sync'. Focusses more on general rather than local induction, but very useful content • Resident doctors have reviewed both general and local inductions. Suggestion of re-working previous DME communications to supervisors, and development of crib sheet for CS local inductions.		
Stat-mand training.	Ensure rotating doctors' learning passports are aligned with the CSTF. Using e-LfH/ESR as the default. Adopting the NHS Digital Staff passport.	• In addition to the CSTF (Statutory and Mandatory Training - elearning for healthcare (e-lfh.org.uk)), DHcFT asks for Medicine Management 3, NEWS2, COMHAD and SCRs • Meeting had with Karen Johnson within the ICB (workforce officer) and Liam Carrier within DHcFT. Functionality of the Staff Passport requires all relevant organisations to be enrolled, meaning its use in the region is unlikely to work. ESR with current functionality should be able to do this (inter-authority transfer), and Liam Carrier confirmed with our	GoSWH, with resident doctor reps and Medical Education support.	December 2024.

		ESR team that this does already happen (?prospectively test this with new residents in December).		
NETS and GMC surveys.	Parity with Friends and Family Test.	• Embed Board-reporting and sanctioned action plans • Explore with Medical Education what currently happens now (potentially a TMTC item).	Medical Education.	December 2024.
Reversing payments for course fees during study leave.	Currently doctors pay course fees up front and a reimbursed after attending the course. NHS England have put this down as an action for them rather than for trusts. However, DHcFT was exploring this beforehand and wishes to pursue this independently.	• GOSWH has liaised with the Deanery. National steering group looking at this. The direction of travel is for reimbursement at the point of booking in the first instance, moving to direct procurement. This will sit with providers and not centrally • Process mapping by Medical Education and Finance (2 options)  Process Map.xlsx	Finance and Medical Education.	December 2024.

Completed

Item	Narrative	Actions	Lead	Expected Completion/ Timescales
Work schedules at eight weeks and rosters by six weeks.	Work schedules (determines pay and repeating pattern of shifts) drawn up by Medical Staffing. Rosters (live rotas) drawn up by Medical Education.	• Targets are met by medical staffing in line with the HEE code of practice • Delays (rare) are due to not being given details of the resident from the Deanery • For LTFT residents, the Good Rostering Guide is followed (NHSE-BMA-Good-rostering-170518-final_0.pdf (nhsemployers.org)) • To be included in the final report.	Medical Staffing and Medical Education.	November 2024.
Live rotas.	Rotas are already live for south resident doctors, but this piece of work could galvanise the remainder of rotas also going live.	• Live rota rolled out for north residents – all residents now have access to live rotas via Teams channels • This group may then consider supporting the rest of the trust to deliver the same for psychiatry consultant rotas • To be included into the final report.	Medical Education.	November 2024.
Protecting training time.	Rotating doctors will have specific training requirements for their programmes (eg portfolio, mandatory training, regional teaching etc).	• Discussions had on whether this can be built for each resident – workload not viable, and likely to miss nuance • Personalised work schedules as an enabler • To be included into the final report.	Medical Education and GoSWH.	December 2024.

Better rota management.	Example given of self-rostering (locally this could be picking rota lines?).	• Self-rostering is perhaps not relevant to this setting • Induction considerations. Assigned to rota lines. LTFT considerations • An assigned resident doctor to co-ordinate but with protected time, resource and mentoring.	Medical Staffing.	November 2024.
BMA Wellbeing guidance.	Five priorities for improving wellbeing in the workplace (bma.org.uk).	• JLNC and RDF (formerly JDF) discussed and actioned these items in 2021. Builds on DHcFT's agreement to the Fatigue and Facilities Charter in 2018 • Above to be incorporated into the final report.	GoSWH.	December 2024.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 14 January 2025

Patient and Carer Race Equality Framework (PCREF)
Governance, Oversight and Delivery

Purpose of Report

To provide a briefing on the requirements of PCREF and how they align with the current function of Board Committees and the need for central oversight.

Executive Summary

Patient and Carer Race Equality Framework is mandated for all Mental Health trusts following the recommendations of Independent Review of the Mental Health Act (MHA), published on 6 December 2018.

This report is a briefing on the implementation of this requirement in the context of resource constraints.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	

Risks and Assurances

CQC compliance.

Consultation

- Chief Delivery Officer
- Quality and Safeguarding Committee, 10 December 2024
- Mental Health Act Committee, 13 December 2024

Governance or Legal Issues

Delivery of this requirement will need input from most of the Board committees apart from the Audit and Risk Committee.

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 focusses on addressing inequalities arising from ethnicity.

Recommendations

The Board of Directors is requested to:

1. Note the three domains of deliverables and key components and their relationship with Committee functions
2. Note the plan for mobilising dedicated resource in the context of current capacity constraints
3. Note the scrutiny this briefing received at the Quality and Safeguarding and Mental Health Act Committees.

Report prepared and presented by: **Arun Chidambaram**
Medical Director

Patient and Carer Race Equality Framework (PCERF)

What does the Patient and Carer Race Equality Framework mean in practice?

The PCREF is split into three core components:

- **Part 1** - **Leadership and Governance**– these are national expectations on all NHS Mental Health Trusts in fulfilling their statutory duties under core pieces of legislation, such as the *Health and Social Care Act 2012*, and the *Equality Act 2010*
- **Part 2** – **National Organisational Competencies,** in line with the original vision in the Independent Review of the Mental Health Act, these are the competencies trusts can develop and ideas on how to do so, in line with local priorities
- **Part 3 - The Patient and Carers Feedback Mechanism,** which seeks to embed patient and carer voice at the heart of the planning, implementation and learning cycle.

The PCREF applies to **all mental health pathways** for older adults (65 plus), adults (18-64), children and young people (0-25). Trusts must also ensure that the intersectional needs of racialised and ethnically and culturally diverse communities are attended to i.e. developing plans that considers people's overlapping identities and experiences to understand the complexities racialised and ethnically and culturally diverse communities face when accessing mental health services.

Each NHS Mental Health Trust is expected to develop a local PCREF plan which encompasses the three core components above, detailing actions, timeframes and intended outcomes. Importantly, the development, implementation, and review of local PCREF plans must be done in equal partnership with racialised and ethnically and culturally diverse communities.

Part 1 Leadership and Governance

To deliver Part 1 of the PCREF, there are six specific key legislative and regulatory requirements which trusts are required to fulfil to meet their obligations. Within each of these requirements, there are specific duties relating to racialised and ethnically and culturally diverse communities.

Review of restrictive practices and understanding how they affect racialised communities is key to this requirement. The data that requires to be disaggregated by ethnicity includes (not exhaustive):

- Detention by Mental Health Act
- Seclusion and segregation
- Restraint (physical, mechanical, and chemical)
- Physical health checks for adults with SMI
- Access rates for children and young people to children's mental health services

Trusts are required to provide a narrative on data trends and have plans to reduce inequalities.

Patients' rights information, access to advocacy and complaints should be accessible by racialised communities.

- Patient safety incidents and near misses need to be reviewed for any impact by ethnicity
- Complaints from ethnic minority patients should be actioned appropriately
- Equality impact of policies should be assessed by ethnicity and other protected characteristics
- Consideration of Advanced Choice Directives
- Care provided by the Trust should be informed by cultural competency.

These requirements would mean that the Mental Health Act Committee and Quality and Safeguarding Committee would have a particular focus on ethnicity. The People and Culture Committee could be monitoring cultural competency.

The outputs from the committee will be submitted to Board, either through their individual assurances or through a collective summary on PCREF.

Part 2 National Organisation Competencies

The six most consistent areas of focus for developing the national organisational competency in improving the experience of racialised and ethnically and culturally diverse communities were identified as:

- Cultural Awareness
- Staff Knowledge and Awareness
- Partnership Working
- Co-production
- Workforce
- Co-Learning.

There is a guide with examples of grades – developing, good and outstanding for each of this metric.

These actions can be enabled by EDI lead (staff element). Other elements can be implemented by ensuring that existing workstreams strengthen their ethnic diversity and focus.

Part 3 Patient and Carers Feedback Mechanism

This domain aims to improve **the experiences and outcomes** of racialised and ethnically and culturally diverse communities.

These tools are options for us to consider:

Patient and Carer experience tools	Outcomes tools
• NHSE&I - The Friends and Family Test • Complaints, compliments and safeguarding reports • Patient and Family centred tool kit (PFCC) • Experience Base Co-Design tool kit (EBCD) • CQC Community mental health survey 2022 • Patient Advice and Liaison Service • Tackling inequalities and Discrimination in health services (Tides) • MH Trusts local patient and carer surveys • MH Trusts staff self-assessment tool • Feedback from VCSE partners • Experts by experience feedback from patient and carers	• Mental Health Outcomes • NHSE&I - Patient Reported Outcomes Measures (PROMS) • DIALOG+ | East London NHS Foundation Trust (elft.nhs.uk) • ReQoL: OVERVIEW

We are already considering Dialog plus as the vehicle for CPA transformation and this strengthens carers involvement and aligning outcomes that are meaningful for the patient.

We already use Community Mental Health survey and PALS data.

Review of these two domains will be best delivered by Quality and Safeguarding Committee.

Summary

The Mental Health Act Committee would be the lead committee to receive assurance on the delivery of high impact actions. The Quality and Safeguarding Committee and People and Culture Committee will have an equally strong role in providing Board assurance for the other elements.

There is a need for dedicated resource to oversee the operational delivery of these requirements. The EDI lead will play a supportive role. The PCREF lead will need to have data literacy and will work closely with the Nursing and Quality team leading on CQC compliance. I would suggest that the respective Committee Chairs meet with Executive triumvirates to discuss the practical implementation of how the assurance will be shared between committees and how this will be presented to Board.

FORWARD PLAN - BOARD - 2024/25		07-May-2024	02-Jul-2024	01-Oct-2024	05-Nov-2024	14-Jan-2025	04-Mar-2025
	Deadline for Approved Papers	**25-Apr-2024**	**21-Jun-2024**	**18-Sep-2024**	**24-Oct-2024**	**02-Jan-2025**	**20-Feb-2025**
DOCA/TS	Declarations of Interest	X	X	X	X	X	X
DON	Patient/Staff Story	X		X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board Review of Effectiveness of Meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors Meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DCEO/CDO	Trust Strategy Progress update (on approval, launch Nov-2024)	X		X	X	X	X
DPODI	Staff Survey Results (following assurance at People and Culture Committee)						X
DPODI	Annual Gender Pay Gap Report for approval (following assurance at People and Culture Committee)	X					
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC Sep			X			
MD	Patient and Carers Race Equality Framework					X	
DPODI	Annual Approval of Modern Slavery Statement (following assurance at People and Culture Committee Mar - to be published on Trust website on approval)	X					
DPODI	2024/25 Flu Campaign	Summary of 2023/24 campaign		X			
DOCA/TS	Corporate Governance Report	X					
DOCA/TS	Year-end Governance Reporting from Board Committees and Approval of ToRs (within Corp Gov report)	X					
DOCA/TS	Trust Sealings (six monthly - for information - also within May Corp Gov report)	X			X		
DOCA/TS	Annual Review of Register of Interests	X					
DOCA/TS	Board Assurance Framework Update	X		X	X		X
FTSUG	Freedom to Speak Up Guardian Report (six monthly)			X			X
CHAIR	Fit and Proper Person Declaration		X				
DOF/DCEO/CDO/ DPODI	Planning Update	X (Finances)		X (Ops)			
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
DoF	Standing Financial Instructions (following assurance at ARC)			X			
OPERATIONAL PERFORMANCE							
DCEO/CDO/DON/ DOF/DPODI	Integrated Performance and Activity Report to include Finance, People performance and Quality	X	X	X		X	X
DCEO/CDO/DON	Focused Performance Report (in lieu of Integrated Performance and Activity Report)				X		
DCEO/CDO	ICB Joint Forward Plan (included in CEO Update)			Deferred to Jan-2025		X	
CEO	East Midlands Collaborative					X	
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
Prog Director	Making Room for Dignity progress	X			Included with CEO's update		
DON/MD	Safer Staffing Annual Review (following assurance at QSC Jul)			X			
DPODI	Workforce Plan Annual Review (following assurance at PCC Jul)			X			
QUALITY GOVERNANCE							
DON	Fundamental Standards of Care Report					X	
MD	Learning from Deaths Mortality Report on Assurance from Quality and Safeguarding Committee		AR		X	X	X
MD	Guardian of Safe Working Report on Assurance from Quality and Safeguarding Committee		AR		X	X	
MD	Improving the Working Lives of Doctors in Training		X				
DON	Receipt of Annual Reports on Assurance from Quality and Safeguarding Committee: - Annual Looked After Children (QSC Sep) - Annual Safeguarding Children and Adults at Risk (QSC Sep) - Annual Special Educational Needs and Disabilities (SEND) (QSC May/Jun) - Quality Account (Jul)		X		X		
DCEO/CDO	Transformation and Continuous Improvement (Sign off of Strategy/Plan Mar-2025)						X
DON	Infection Prevention and Control Annual Report and IPC BAF (QSC Oct)				AR		
MD	Re-validation of Doctors Compliance Statement (PCC May)		X				
DON	Outcome of Patient Stories - every two years - due Mar-2026						
POLICY REVIEW							
DOF	Standing Financial Instructions Policy and Procedures (Jul 2024)		Deferred to Oct-2024	X			

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AfC	Agenda for Change
AHP	Allied Health Professional
AI	Artificial Intelligence
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
AOVPN	AlwaysOn VPD (secure network access)
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BCO	Building Control Officer
BCP	Business Continuity Plan
BIA	Business Impact Analysis
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CBRN	Chemical, Biological, Radiological and Nuclear
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
CD-LIN	Controlled Drug Local Intelligence Network
CDM	Construction Design and Management
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CER	Clinical Establishment Review
CESR	Certificate of Eligibility for Specialist Registration

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CGA	Comprehensive Geriatric Assessment
CHANNEL	Confidential, voluntary, multi-agency safeguarding programme that provides early intervention to protect vulnerable children and adults who might be susceptible to being radicalised
CHPPD	Care Hours Per Patient Day
CIC	Children in Care
CIN	Children in Need
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Care Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CROMS	Clinician Reported Outcome Measures
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSC	Commonwealth Scholarship Commission
CSDS	Community Services Data Set
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAR	Divisional Assurance Review
DASP	Drug and Alcohol Strategic Partnership
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DHR	Domestic Homicide Review
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour
DOF	Director of Finance
DoH	Department of Health
DOL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DON	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPR	Divisional Performance Review
DPS	Date Protection and Security
DQMR	Data Quality Maturity Index
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSAB	Derby and Derbyshire Safeguarding Adult Board
DSP	Data Security and Protection
DSCB	Derby and Derbyshire Safeguarding children Board
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DV	Domestic Violence
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
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 and Reprocessing Therapy
EMR	Electronic Medical Record
EPC	Energy Performance Certificate
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GMP	Guaranteed Maximum Price
GoSWH	Guardian of Safe Working Hours
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HV	Health Visitor
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMST	Information Management Systems and Technology
IMT	Incident Management Team
IMT&R	Information Management, Technology and Records
INQUEST	
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IRHTT	In-reach Home Treatment Team
IRT	Incident Review Tool
J	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learn from Patient Safety Events
LHP	Local Health Plan
LHRP	Local Health Resilience Partnership
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
LTS	Long Term Segregation
LWSTO	Living Well Short-Term Offer
M	
MADE	Multi-agency Discharge Event
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
	Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MAST	Management and Supervision Tool
MAU	Medical Assessment Unit
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
M&E	Mechanical and Electrical
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
MMC	Medicines Management Committee
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MST	Multisystemic Therapy
MSU	Medium Secure Unit
MTFP	Medium Term Financial Plan
N	
NAI	Non-Accidental Injury
NCRS	National Cancer Registration Service
ND	Neuro-development
NED	Non-Executive Director
NETS	National Educational Training Survey
NHS	National Health Service
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NPS	National Probation Service
NQB	National Quality Board

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
NR	Non-Recurrent
NROC	Non-Resident On-Call
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OT	Occupational Therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PDC	Public Dividend Capital
PDSA	Plan, Do, Study, Act
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PFR	Provider Finance Return
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHSCC	Population Health and Strategic Commissioning Committee
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position of Trust
PJF	Professional Judgement Framework
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PMO	Project Management Office
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPN	Public Protection Notice
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measures
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Review Framework
PSQG	Patient Safety and Quality Group

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PYE	Part Year Effect
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
ROM	Reported Outcome Measure
RRP	Recruitment Retention Proposal
RTT	Referral to Treatment
S	
s132	Section 132 of the Mental Health Act: As soon as a patient is detained under the Act the patient must be given their rights orally and in writing unless it is not practicable at that time. If this is the case, it must be documented in the patient's electronic care record
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework
SAR	Safeguarding Adult Review
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOC	Strategic Options Case
SOF	Single Operating Framework
SOP	Standard Operating Procedure
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SystmOne	Electronic patient record system
T	
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VFM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

January 2025

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 14 January 2025

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 5 November 2024. The meeting was conducted as a hybrid meeting.

Matters Arising and Action Matrix

An update on wait times for the Memory Assessment Service was presented to the Council. It was noted that wait times have improved.

Chief Executive's Update

The Chief Executives update focused on:

- Lord Darzi's independent review of the NHS and the development of the new 10-Year Health Plan for the NHS
- Review of Community Mental Health
- National Oversight Framework (NOF)
- Improving Access to Psychological Therapies – the Trust has taken the difficult decision not to enter a bid to provide talking therapy services (IAPT) for 2025-2030. Unfortunately, the reduced financial envelope outlined in the new tender means it is no longer possible for the Trust to provide these services
- Approval by the Trust Board of the new four year Trust Strategy
- Update on the Mental Health, Learning Disabilities and Autism Board.

Council of Governors Annual Effectiveness Survey

The Membership and Involvement Manger presented the results of the Annual Effectiveness Survey of the Council of Governors. Initially the results were presented and discussed in full at the Governance Committee on 15 October 2024. The results overall were positive. Actions developed in response to the results were shared.

Non-Executive Directors Report

The Non-Executive Director (NED) who Chairs the Quality and Safeguarding Committee presented her report which summarised her activities as a NED from October 2023 to November 2024. The report focused on the work of the Quality and Safeguarding Committee.

Escalation item to the Council of Governors from the Governance Committee

The Non-Executive Director (NED) who Chairs the Quality and Safeguarding Committee provided governors with assurance that the Trust involves the relevant external agencies (where they would be the primary investigator) with patient safety incidents investigations; and that all relevant outcomes are shared across partners to support system learning.

Brief update on performance

A summary of performance was provided by the NEDs. It was noted that the Integrated Performance Report was included in the 1 October Public Board papers.

Making Room for Dignity Programme Update

The Finance Director gave an in-depth update on the Making Room for Dignity programme (MRFD) which included: costs, progress and pauses.

Annual Members Meeting feedback

The Membership and Involvement Manager provided feedback on the Annual Members Meeting (AMM) which took place on 26 September 2024. It had been a very positive event which focused on the health or our children and young people. A governor's task and finish group is being established to plan next year's AMM which is taking place on 2 October 2025.

Forthcoming governor elections

The Membership and Involvement Manager gave an update on the elections which included:

- Confirmation of public governor and staff governor vacancies
- Timescale for the elections including nominations, voting and declaration of results
- Plans for promoting the elections.

Newly elected governors' terms of office will begin on 1 February 2025.

Update on Non-Executive Director Recruitment

The Trust Chair confirmed that the Trust will be managing the recruitment process this year without the assistance of an external recruitment consultancy. The Trust's Recruitment Manager will assist the Director of Corporate Affairs and Trust Secretary with the process.

Governance Committee Report

The Co-Chair of the Governance Committee presented a report of the meeting held on 15 October 2024. The Council of Governors approved in principle the Membership Plan 2025-2028 noting that the sections on the Trust Strategy and vision and values need to be updated with the new Trust Strategy, vision and values approved by the Board today.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 5 November 2024.