Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors Meeting

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derbyy
1 October 2019 09:30 - 1 October 2019 12:00

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Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 1 OCTOBER 2019
TO COMMENCE AT 9:30am
CONFERENCE ROOMS A & B, CENTRE FOR RESEARCH AND DEVELOPMENT, KINGSWAY, DERBY

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and Register of Interests	Caroline Maley
2.	9:35	Patient Story	Carolyn Green
3.	10:00	Minutes of Board of Directors meeting held on 3 September 2019	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:05	Chair's Update	Caroline Maley
7.	10:10	Chief Executive's Update	Ifti Majid
8.	10:25	STP Refresh Summary and Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY, STRATEGY AND GOVERNANCE			
9.	10:40	Integrated Performance and Activity Report	C Wright/A Rawlings/ C Green/M Powell
11:00 B R E A K			
10.	11:15	Clinical Strategies 2019-22: - Older Adults - Working Age Adults	Gareth Harry
11.	11:25	Looked After Children Annual Report 2018/19	Carolyn Green
12.	11:35	Outcome of Patient Stories	Carolyn Green
13.	11:45	Board Committee Assurance Summaries and Escalations: Mental Health Act Committee 6 September, Quality Committee 10 September, Finance & Performance Committee 17 September 2019 *(minutes of these meetings available upon request)*	Committee Chairs
CLOSING MATTERS			
14.	11:55	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Forward Plan for 2019/20 - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Trust Sealings six month update report			
Summary of Council of Governors Meeting held 3 September 2019			
Glossary of NHS Acronyms			

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner17@nhs.net
The Trust Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct its remaining business in confidence as special reasons apply or because of information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting will be held at 9.30am on 5 November 2019 in
Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision

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

Our values

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

Our Trust values are:

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

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 3 September 2019

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12:40pm

PRESENT	Caroline Maley	Trust Chair
	Richard Wright	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Dr Julia Tabreham	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Ifti Majid	Chief Executive
Up to DHCFT2019/119	Claire Wright	Director of Finance & Deputy Chief Executive
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Medical Director
	Amanda Rawlings	Director of People Services & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
IN ATTENDANCE	Suzanne Overton-Edwards	Incoming Interim Non-Executive Director
	Perminder Heer	NExT Director
	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary
For DHCFT2019/119	Tamera Howard	Freedom to Speak Up Guardian
For DHCFT2019/120	Rachel Kempster	Risk and Assurance Manager
For DHCFT2019/122-123	Harinder Dhaliwal	Head of Equality, Diversity & Inclusion
	Hannah Osgood	IST Manager (shadowing Carolyn Green)
	Kuda Mumvuri	Drug and Alcohol Recovery Service (shadowing Caroline Maley)
VISITORS	Lynda Langley	Lead Governor and Public Governor, Chesterfield
	John Morrissey	Public Governor, Amber Valley
	Jo Foster	Staff Governor, Nursing
	Christine Williamson	Public Governor, Derby City West
	Christopher Williams	Public Governor, Erewash
	Al Munnien	Staff Governor, Nursing
	April Sanders	Staff Governor, Allied Professions
	Sandra Austin	Derby City & South Derbyshire Mental Health Carer's Forum and Trust Volunteer
	Andrew Beaumont	Trust Member
	Rebecca Taylor	Liaison Workforce
	Christopher Hollands	Care Quality Commission (CQC)
	Eddie Bisknell	Derby Telegraph
APOLOGIES	Justine Fitzjohn	Trust Secretary

DHCFT 2019/110	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting. Perminder Heer who joined the Trust on 1 August on a placement through NHS Improvement's NExT Director scheme, which supports the next generation of talented people from BAME (black, Asian and minority ethnic) communities to become Non-Executive Directors in the NHS was welcomed to her first meeting with the Board of Directors. The previous NExT Director Suzanne Overton-Edwards who is to be formally appointed as Interim Non-Executive Director for a period of three months was welcomed back. Introductions were made to Kuda Mumvuri from the Trust's Drug and Alcohol Recovery Service who attended the meeting to shadow the Trust Chair and Hannah Osgood from the Intensive Support Team service who shadowed Director of Nursing and Patient Experience, Carolyn Green. Apologies were noted from the Trust Secretary, Justine Fitzjohn. No declarations of interest in agenda items were raised.
DHCFT 2019/111	**PATIENT STORY** Today's patient story did not take place as the person who had been invited to share their story at today's meeting was unable to attend.
DHCFT 2019/112	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 2 JULY 2019** The minutes of the previous meeting, held on 2 July 2019, were accepted as a correct record of the meeting subject to corrections to be made to DHCFT2019/099 Chief Executive's Update. The beginning of the first sentence of the fourth paragraph is to be corrected to read *"The second Annual Staff Conference took place on 10 June"*. The second sentence should be corrected to read that *"Matters discussed included mental health, workforce and inclusion will also be taken forwards as part of the Trust's strategy development".*
DHCFT 2019/113	**ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads. **MATTERS ARISING** **DHCFT2019/094 Patient Story:** Carolyn Green asked if Caroline Maley or the Chief Executive, Ifti Majid had considered sharing the letter that was read out to the Board from the EQUAL Forum at the previous meeting with the Joined Up Care Derbyshire (JUCD) Board so they can be aware of the effect that lack of person centred care after diagnosis can have on people with autism. Ifti Majid responded that the new STP Chair of JUCD will be introducing patient stories at JUCD Board meetings and that arrangements have been made for the JUCD Board to hear Max's story on the need to improve the package of care for people with autism. **DHCFT2019/103 Revised Trust Strategy:** Caroline Maley was pleased to report that after discussing the revised Trust Strategy with the Council of Governors at

	their meeting on 2 July, feedback received from governors has been included in the newly rolled out Trust Strategy.
DHCFT 2019/114	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** No questions had been received from members of the public or governors in advance of the meeting.
DHCFT 2019/115	**CHAIR'S UPDATE** Caroline Maley's report provided the Board with the Trust Chair's summary of activity and visits to the Trust's services undertaken since the previous Board meeting held on 2 July. Attention was drawn to the Schwartz Round that Caroline had attended at the Radbourne Unit. This session was led by the chaplaincy team and underlined the emotional impact of the work carried out by clinical teams and the importance of providing support to staff. Caroline felt it was clear from this visit that staff felt there is a change taking place in the culture being promoted within the Trust and was important for the Board to hear. The appointment of Non-Executive Director (NED), Richard Wright as Deputy Chair has now been confirmed. Thanks were extended to Julia Tabreham for her support as Deputy Chair since September 2016 and she looked forward to continuing working with her as a NED. Caroline also took the opportunity to formally thank Denise Baxendale for her work in supporting governors to carry out their role and for recruiting members of the public to stand for election as governors. The Chair's report updated the Board on the appointment of an Independent Chair, John MacDonald to JUCD. Key messages from the JUCD Board meetings held in July and August and the JUCD Prevention Strategy were included as appendices to the report. Julia Tabreham was pleased to observe from the Chair's report an improving shift in culture and asked if there were any areas of the Trust Strategy that might help deliver further improvements. It was thought that the new strategic priorities will help achieve a greater culture through staff buying into the Trust's culture from the top of the organisation through to the front line that will bring about the change that the Board is looking for. Ifti Majid added that over the summer he had heard that the revised strategy is resonating with colleagues, particularly the 'people first' message. The promotion of the Trust's vision and values is also attracting people to come and work at the Trust. Deputy Trust Chair, Richard Wright welcomed the introduction of the JUCD Prevention Strategy that was appended to the Chair's report. He emphasised the need to work with local authorities to improve the health of people living in areas of deprivation as this cannot be achieved without the involvement of local authorities and the voluntary sector. **RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 2 July 2019 and the Joined up Care Derbyshire Prevention Strategy.**

DHCFT 2019/116	**CHIEF EXECUTIVE'S UPDATE** Ifti Majid's report provided the Board of Directors with feedback on changes within the national health and social care sector, as well as providing an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders including commissioners, and Trust staff. Ifti drew the Board's attention to the NHS Mental Health Implementation Plan 2019/20 – 2023/24. He outlined how the implementation plan fits with the system planning approach and the areas that will be supported by investment. He was pleased to see a significant investment is being made in mental health that will help services grow faster and felt this would have a positive impact on the development of new models and roles within the Trust's future workforce. The NHS Patient Safety Strategy; safer culture, safer systems, safer patients was referred to. This strategy sets out a new framework to enable a culture transition from blame to learning and takes an approach where patient safety initiatives and responses are based on what can be learned rather than who should be held accountable. Medical Director, Dr John Sykes is the Trust's lead for this initiative and will provide assurance on patient safety through the Quality Committee to Board. Ifti felt these changes were exciting as they will focus on learning rather than blame as they dovetail with the Team Derbyshire Healthcare Just Culture that will enable personal development, growth and learning when responding to incidents, conduct or complaints. Ifti was pleased to report on the recent visit he made to the Roma community in Derby where he discussed working in partnership with the Roma community to help local families engage and have access to mental health and substance misuse services. He hoped this visit would change their reluctance to engage with mental health services and children's services and committed the Trust to work in partnership with Roma Community Care to assist local families receive support when needed. The report also provided an update on recent JUCD meetings and the progress being made with partner organisations in making sustainable changes for the people of Derbyshire. Ifti was pleased to include in his report the reflections of the new JUCD Chair, John MacDonald, particularly as they are aligned to discussions that have occurred during the Trust's previous Board meetings around delivering care in a better way which is a constant driver for the Board. Ifti intends inviting John MacDonald to a future Board meeting. Senior Independent Director, Margaret Gildea commented on her attendance as Caroline's deputy at the JUCD Board meeting held on 15 August. She was pleased to report that she had observed a very well structured and sense of close community at the meeting, particularly when hearing how the ambulance team had transformed its responsiveness to a more effective process. She found it extremely heartening to hear how the system wide elements linked to the Trust's clinically led pathways and felt that now is the right time to promote the Trust's pathway work. She also stressed the importance of NED involvement at JUCD Board meetings. Non-Executive Director, Geoff Lewins echoed Margaret's comment and was pleased to hear that JUCD Chair, John MacDonald agrees that it is important that NEDs play an assurance role in the workstreams and welcomed the engagement of NEDs in these activities.

	Non-Executive Director, Anne Wright asked how the Trust could move to a needs based model rather than a model based on demand as she felt this would help with prevention, particularly as working to a demand led system would create more demand on beds. In response, Director of Business Improvement and Transformation, Gareth Harry updated the Board on the work developing within the refreshed long term plan for Derbyshire. He reported that a significant amount of work has taken place involving stakeholders in pulling together the first draft of the long term mental health plan. He also spoke of ensuring our internal clinical strategies linked to the long term plan and said the first clinical strategies will be brought to the Board from October through to December. Richard Wright noted that Gareth Harry had been appointed Lead Director of the New Care Models for Mental Health as part of the proposed East Midlands mental Health Alliance. He was conscious that the continuous improvement programme work has been led by Gareth within the Trust. He did not want this work to be compromised as it is vital to maintain the impetus that has been achieved. Ifti responded that Gareth's involvement in the Trust's quality improvement approach will complement the work across the east Midlands. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2019/117	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** The Integrated Performance Report (IPR) provided the Board of Directors with an overview of Trust performance at the end of July 2019. This report was issued in a new format, using run charts to review performance over longer periods of time, with a particular focus on whether the Trust consistently achieves agreed targets and / or whether there is variation which needs attention. The report also included an overview of performance across the Acute Care Division. Chief Operating Officer, Mark Powell gave an overview of operational, quality, financial and workforce performance. The Trust continues to perform favourably and most of the measures contained in the report identified a strong and tangible link to the refreshed Trust Strategy. He also reported that the Finance and Performance Committee had met twice recently to address concerns relating to the Trust's financial performance. There are continuing challenges in achieving Cost Improvement Programme (CIP) targets and the Trust is trying to maintain its current agency spend position. The Committee continues to monitor delivery against the Trust's capital expenditure programme. This programme will be driven through the rest of the year to ensure that the challenges being faced in developing the Trust's estate do not drain the capital expenditure plan over the next few months. Deputy Chief Executive and Director of Finance, Claire Wright further outlined the financial aspects of the report. The Trust is forecasting that it can achieve its control total although there are a number of cost pressures that need to be mitigated in order for the Trust to deliver its financial plan. She reminded the Board that the cost pressures were a result of strategic and quality related investments. The Trust is expecting to need to use all its contingency reserves in the year and there also exists the potential for further cost pressures that need to be managed as the year progresses. Accordingly this risk is currently rated as extreme in the Board Assurance Framework (BAF). The report showed that overall from a national standards point of view the Trust is

	performing well. Over the last few months the number of acute out of area (OOA) patients has stabilised. The Trust does not have a PICU (Psychiatric Intensive Care Unit) in Derbyshire. This is why there are a significant amount of PICU patients OOA. From a strategic point of view the work in developing the Estates Strategy is a key priority in providing a PICU service in Derbyshire and this is being worked on with support from commissioners. Mark Powell emphasised that the Trust is determined to deliver its ambition that there will be no OOA by March 2021. The plan to reduce OOA is being overseen by NHS Improvement (NHSI) and is worked on every day to help provide great care on our wards in Derbyshire. The Board discussed ongoing challenges associated with only being commissioned to deliver an autism assessment service. The current waiting time for autism assessment is twelve weeks. The team have worked hard to bring the waiting time down although the growth in the number of individuals waiting for assessments is a real concern. Carolyn Green advised that the Trust is continuing to work with its partners in this domain in order to invest in the development of a learning disability and autism workforce for the future. She was pleased to report that the Trust has obtained a bursary in learning disability and autism that she believes will help maintain waiting lists and improve vacancy rates by maximising opportunities for people who work in these areas in Derbyshire. Julia Tabreham asked how supervision rates can be improved to meet the target. Carolyn Green explained that the key to maximising supervision rates is to fill vacancies. She has seen improvements in the run rates for supervision and this was evident from recent ward visits when she felt encouraged by the improvements being made in supervision being championed from a leadership point of view. In conclusion, the Board agreed that limited assurance was obtained on current performance across the areas presented in the report. It was agreed that the new style of reporting was preferred but more narrative should be provided in reports to identify focussed areas of risk. **ACTION: IPR to include additional narrative identifying focussed areas of risks** **RESOLVED: The Board of Directors received limited assurance on current performance across the areas presented.**
DHCFT 2019/118	**<u>QUALITY REPORT ON USE OF RESOURCES</u>** This report presented by Claire Wright provided the Board with an update regarding the Trust's Use of Resources in support of strategic objective '*Best Use of our Money'* as well as in support of regulator assessment of Use of Resources. The report built on the top ten priorities identified in the report submitted to the Board in 2018 and focussed on current priorities including staff health and wellbeing in terms of putting people first and improving staff wellbeing needs, out of area placements and use of the Trust's estate. Claire highlighted the good news of the significant increase in workforce accessing the enhanced wellbeing support, noting however that the Trust has not yet seen a corresponding reduction in days lost to sickness. Claire also outlined examples of the significant amount of work taking place with leaders and managers and the transformation work piloting innovations and new ways of working to improve efficiency and effectiveness in use of resources.

	Alongside this, a significant amount of focus is taking place around addressing less positive factors and celebrating positive success in the Trust's equality, diversity and inclusion work. The report also set out the programme of work that is focussing on reducing Adult OOA as well as the actions taking place to reduce length of stay. In summary she pointed out that, for many of the priorities, there are green shoots of success but more time is needed to evidence sustained improvement. Geoff Lewins found the benchmarking information useful, he was surprised to note the apparently lower productivity metrics in the community statistics. Claire explained that the most up to date Model Hospital information relates to quarter 3 of 2018/19 and that the mental health metrics and the Model Hospital are fairly new statistics which in time will assist the community mental health team to continue to learn from good practice and drive increased productivity alongside quality improvement outcomes. Carolyn Green outlined recent discussions with the Model Hospital team around variation in community team make-up which affects comparability of benchmarked data. The Board considered the extent to which the Trust has so far addressed its top ten Use of Resources priorities and agreed that it was too early to establish the full strategic impact that this is having on current output as progress could only be established through regular reporting. *Claire Wright left the meeting at this point.* **RESOLVED: The Board of Directors considered and noted the extent to which the Trust has so far addressed its top ten Use of Resources priorities and any associated strategic impact.**
DHCFT 2019119	**<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>** The new Freedom to Speak Up Guardian, Tamera Howard joined the meeting to present her first half yearly report to the Board that outlined Freedom to Speak Up (FTSU) cases raised in the last six months with the FTSU Guardian. The Board recognised that 67% of staff felt it is safe to speak up and noted the themes emerging around patient safety and the need for a compassionate and supportive response where staff have been assaulted by patients and concerns around bullying and harassment. Ifti Majid commented that he had observed from visits to services that Tamera Howard is ever present and accessible and is already making an impact in encouraging people to speak up. He believes that the more people who speak up will mean that the Trust can change and improve and address particular trends. The Board was pleased to see that the FTSU Guardian is working to introduce FTSU champions across the organisation. These champions will undertake regional FTSU Champions training so they can support workers to raise their concerns at the earliest opportunity as well as signposting them to the FTSU Guardian for advice to ensure a greater reach of the FTSU agenda across the Trust. John Sykes had noticed that concerns that come from clinical areas are mainly associated with safety and that in the past staff have feared being disadvantaged if they raised concerns or spoke up. Inhibiting factors need to be understood and John was pleased to see that the FTSU Guardian is working with colleagues to

	help improve the culture of speaking up. The Board was aware that Trust staff are often exposed to racism from patients. The Trust policy is clear that violence and aggression will not be tolerated within the Trust. Discussion took place on using cases studies to show how change can take place and culture improve so that learning can be taken from both positive and negative experiences. The use of case studies would also be useful if used in mainstream leadership training particularly as people might not perceive bullying and harassment in the same way. The Board welcomed the support that the FTSU Guardian is giving to staff across the organisation and fully supported Speaking Up / Raising Concerns training as well as the Speaking Up Strategy for raising awareness of the FTSU agenda. Thanks were also extended to Margaret Gildea for the support she provided to the improving the speaking up culture in her role as FTSU NED lead and to Julia Tabreham who takes over this role from September onwards. **RESOLVED: The Board of Directors:** **1) Discussed and noted the content of the paper** **2) Supported the roll out of Speaking Up / Raising Concerns training, including an in-house e-learning module for all workers** **3) Supported the development of a Speaking Up Strategy which will be shared with key stakeholders, discussed and agreed by the Board, and is linked to or embedded within other relevant strategies** **4) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda.**
DHCFT 2019/120	**<u>BOARD ASSURANCE FRAMEWORK UPDATE – VERSION 3.2</u>** This report presented by Risk and Assurance Manager, Rachel Kempster detailed the third issue of the BAF for 2019/20 which provides assurance on the process of identifying and mitigating risks to achieving the Trust's strategic objectives. Rachel outlined the key headlines to the BAF and was pleased to report that the number of operational risks rated as high has now reduced to 17 due to there being a number of staff related risks that have either been reduced or closed. Attention was drawn to the proposal by the Quality Committee that risk 1a *There is a risk that the Trust will fail to provide standards for safety and effectiveness required by the Board* be escalated from high to extreme due to failings in governance identified in the adult urgent service pathway. An extraordinary Board meeting took place on 7 August to review the assurances required to mitigate this risk. The recommendation from this review was to line up operational risks as high or extreme to make sure they are aligned to other BAF risks. Carolyn Green assured the Board that she has confidence in the substantial improvements that clinical and operational teams have made to the acute services to mitigate risk 1a and that during a review of acute services the CQC was impressed with the work carried out so far in this area. Julia Tabreham asked whether high rated risk 3b *There is a risk that the Trust will fail to influence external drivers such as national policy and Brexit which could impact on its ability to effectively implement its strategy* is rated highly enough. Ifti Majid responded that the Trust is trying to capture the effect of negotiating Brexit and felt confident that this risk has been accurately rated

	Richard Wright added that risk 3a *The risk that the Trust fails to deliver its financial plans* will be affected by achieving CIP (Cost Improvement Plan) targets. He felt it was worth clarifying to the Board that in addition to achieving CIP and the forecast plan, wider STP savings and STP risk sharing is adding to the financial pressure being felt by the Trust this year. In response to Geoff Lewins seeking assurance on risks associated with waiting lists and lack of commissioning in acute inpatient areas in risk 1a, it was agreed that Geoff would discuss this outside of the meeting with Rachel Kempster. Board members approved the third issue of the BAF for 2019/20 and confirmed that they have seen the BAF worked through the Board Committees and are familiar with individual risks. The Board also gave its approval to increasing the rating of risk 1a from high to extreme. As this risk is now an extreme rated risk a deep dive of risk 1a will be held by the Audit & Risk Committee in October. The Board also agreed to continue to receive quarterly updates of the BAF as scheduled in the forward plan. **ACTION: Clarification of risks associated with waiting lists and lack of commissioning in acute inpatient areas to be discussed between Rachel Kempster and Geoff Lewins.** **RESOLVED: The Board of Directors:** **1) Approved the third issue of the BAF for 2019/20 and received significant assurance in 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) Approved Risk 1a to be increased from high to extreme risk** **3) Agreed to continue receive a quarterly update of the 2019/20 BAF risks as outlined in the forward plan.**
DHCFT 2019/121	**<u>PULSE CHECK RESULTS AND STAFF SURVEY PLAN</u>** Director of People Services & Organisational Effectiveness, Amanda Rawlings updated the Board on the recent Pulse Check results, which show the Trust's current position based on the Q1 all staff survey; and shared the plan for the 2019 NHS Staff Survey. The Board was pleased to see that the Pulse Check response rate has risen from 18% – 34% and that the staff Friends and Family Test (FFT) recommending the Trust as a place to work has increased by 10%. It was thought that the significant shift in response could be contributed to the FTSU Guardian's work in helping staff to feel safe to challenge and speak up. The Board was pleased with the overall result of the Pulse Check. It was noted that a focus is being made to support individual teams with lower staff engagement through shared learning from areas with strong engagement. Anne Wright asked why some staff were not participating in the Pulse Check. Amanda responded that small pockets of staff feel that the survey is not anonymised or secure. Therefore work is taking place to make staff feel confident in participating by demonstrating the work carried out over the past year resulting from the survey results that tackled bullying and harassment, investment in leadership development and ensuring colleagues are able to have meaningful appraisals. This work also underpinned the new strategic priorities contained in the

	refreshed Trust Strategy that will help achieve an improved culture within the Trust that will bring about the change staff are looking for, particularly the putting people first value. **RESOLVED: The Board of Directors:** **1) Received and reviewed the Q1 Pulse Check results** **2) Noted and received significant assurance regarding the plan for the 2019 NHS Staff Survey.**
DHCFT 2019/122	**<u>WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT AND ACTION PLAN</u>** Head of Equality, Diversity and Inclusion, Harinder Dhaliwal presented the annual Workforce Race Equality Standards (WRES) 2018/19 to the Board for consideration and approval. The Board recognised that the aim of the WRES is to improve workplace experiences, treatment and employment opportunities for BME colleagues and was disappointed to note that the Trust is rated worse than the national average. The Board committed to taking an organisational development approach to drive change and inclusive leadership through holding leaders to account and tracking performance. This includes the introduction of new BME inclusion targets to achieve a diverse workforce spearheaded by Ifti Majid as Chief Executive and BME Executive Sponsor. Ifti clarified that inclusion targets relate to the draft national People Plan and he recommended that this is accepted by the Board so that results can be reported through information metrics. He looked to the Board to lead this and drive the requirements of the national People Plan forward throughout the Trust. This will enable the Trust to build on the progress and initiatives achieved so far including the reverse mentoring programme and will support BME networks further to create a social movement to enable the Trust to be a better organisation. Julia Tabreham observed that the report contained some worrying comments from BME colleagues who say they have experienced harassment, bullying and abuse and asked if there was data that breaks this down further as bullying seemed to be the most prevalent complaint. Harinder explained that data relating to bullying and harassment is based on the results of the staff survey. This data is used within peer support sessions where concerns are shared and enables an understanding of how these concerns affect our colleagues. Margaret Gildea recognised the significant work that has taken place to improve culture within the Trust and noted that the improvement plan showed positive ways of tackling problems. She urged Board members to help increase pace by driving action through the Board Committees that play a part in pledging that bullying and harassment and discrimination will not be tolerated. Geoff Lewins shared Margaret's view. He was also concerned that the data contained in the NHS England pulse check template report was complicated when describing 'white British' and 'white other'. Ifti Majid spoke of feeling confident from recent discussions held by the Board that there is a desire to change the culture and he felt that the improvement actions contained in the report were appropriate. He proposed that in order to provide further assurance that the Trust is carrying out positive work to achieve the desired results he, Amanda Rawlings and Harinder Dhaliwal will present a simplified action

	plan to the Board for approval that shows action that is more applicable to the Trust rather than the national position. This action plan is to include improved training around diversity that includes stories showing the impact of discrimination so that it feels more real. **ACTION: A revised WRES action plan to be presented to the Board for approval that is applicable to the Trust rather than the national position at the Board meeting to be held on 5 November.** **RESOLVED: The Board of Directors:** **1) Considered and discussed Trust WRES data and journey – organisational performance and improvement actions** **2) Noted the introduction of the new BME Inclusion targets as part of the workforce dashboard.** **3) Approved the WRES 2018/19 template and associated documents prior to publishing on the Trust website on 27 September, 2019 and sharing with commissioners.**
DHCFT 2019/123	**<u>WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORT AND ACTION PLAN</u>** The Workforce Disability Equality Standard (WDES) 2018/19 reporting summary and actions were presented by Harinder Dhaliwal for consideration and approval prior to sharing with lead commissioners and publishing on the Trust's public-facing website by 30 September 2019. This was the first WDES to be submitted to the Board for discussion and approval. The report showed that declaration rates of staff with disabilities in the Trust are low. It was acknowledged that whilst it is important that staff declare non-visible disabilities, the medical model of what determines a disability might be driving an underrepresentation from disabled staff as some people do not regard their long term disabilities necessary to declare. The Board considered that if people disclose their disabilities this gives the Trust permission to support them. This will be achieved by developing a person centred culture so that people do not feel judged by their disability or their needs. The Board approved the WDES report and concluded that the 2018/19 position shows there is considerable work to be done to address the variations in experience, workforce representation, recruitment progression and development for disabled people. It was established that an Inclusion Strategy is being developed that encompasses people's different needs and this will be taken further by Harinder Dhaliwal, and Amanda Rawlings through the People and Culture Committee and wider network groups. **RESOLVED: The Board of Directors:** **1) Noted the findings against the ten performance indicators and the need to improve the disclosure rate so that support colleagues can be supported with reasonable adjustments.** **2) Approved the WDES Report that will be published on the Trust's website by 30 September 2019 and shared with commissioners.**
DHCFT 2019/124	**<u>LEARNING FROM DEATHS MORTALITY REPORT</u>** The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This end of year report

	presented by Dr John Sykes, covered the financial year 1 April 2018 to 31 March 2019 outlines the progress to date. John Sykes outlined how most of the deaths taking place in the community are people who have been in contact with the Trust's services over the last six months. The report shows that people suffering from a mental illness and/or substance misuse or those who have a mental disorder or learning difficulty have a reduced life expectancy compared to the general population without these characteristics. Although there is an absence of concern in most individual cases there is also an assumption based on national data that patients will be dying at a premature age due to comorbid physical illnesses, particularly related to cardio vascular risk factors or substance misuse disorders. Therefore the Trust is introducing the LESTER tool which will enable clinicians to monitor these risk factors and identify where intervention is required. This will become a focus of mortality reviews from October 2019. The Board noted that in addition to the suicide prevention strategy that is being taken forward, a safety plan is being developed with an increasing focus on specific safety plans for individual services which will be linked to the use of suicide prevention assessment tools that is being underpinned with accredited training. Carolyn Green commented that the report would benefit from commentary outlining the effects that the Trust's quality improvement priorities have had on the wider population of the people of Derbyshire. The Board took full assurance from the approach being taken to review learning from deaths and agreed for the report to be published on the Trust's website in line with national guidance. **RESOLVED: The Board of Directors accepted the Mortality Report as assurance of the Trust's approach and noted that it would be published on the Trust's website in line with national guidance.**
DHCFT 2019/125	**<u>CONTROL OF INFECTION REPORT</u>** Carolyn Green presented the Board with the Annual Control of Infection Report that summarised the activity over the preceding twelve months of work related to infection control. Board members were conscious that this report was presented to the Quality Committee in July 2019 when the information was scrutinised and reviewed. The Quality Committee endorsed the report and the required duties under the Health Act. The Board therefore approved the report with good performance being noted and agreed that it provided significant assurance of the system and processes in place within the Trust. **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) Received significant assurance on standards of cleanliness of clinical areas and food preparation areas** **3) Received and approved the report in public session to assure the community on the Trust's infection control standards.**

DHCFT 2019/126	**BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS** Assurance summary reports were received from the Quality, Audit and Risk, Finance and Performance and Safeguarding Committees. Due to time constraints the reports were noted and not discussed. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries.**
DHCFT 2019/127	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** The following issues were noted for inclusion and updating within the BAF: • Gaps in assurance relating to waiting times will be discussed and taken forward outside of the meeting with the Risk and Assurance Manager • Quality improvement on WRES and WDES to be included in the BAF to show how the Trust compares with other organisations • Inclusion for all protected characteristics will be enhanced to enable inclusion around making the Trust a great place to work.
DHCFT 2019/128	**2019/20 BOARD FORWARD PLAN** The 2019/20 forward plan was noted and will continue to be reviewed further by all Board members.
DHCFT 2019/129	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance at today's meeting. Caroline Maley felt that although today's agenda was particularly extensive it contained appropriate matters. The Board always strives to have a patient story heard at the start of each meeting and the effect of a patient story was missed at today's meeting. A report on the impact of patient stories is due to be received at the next meeting in October. Hannah Osgood who shadowed Carolyn Green thanked the Board for inviting her to attend the meeting. She felt heartened to hear the discussions that took place today about work taking place on the wards and within the local communities. Kuda Mumvuri from the Drugs and Alcohol Recovery Service who shadowed Caroline Maley shared the same views as Hannah. He had previously thought there was a disconnect between the Board and front line services but saw from what was discussed today that the Board is heavily involved with the key issues that affect staff on the wards and in the community. Kuda and Hannah both undertook to brief their teams and share these observations.
The next meeting of the Board to be held in public session will take place at 9.30am on Tuesday 1 October 2019 in Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby DE22 3LZ	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - OCTOBER 2019			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
3.9.2019	DHCFT2019/117	Integrated Performance & Activity Report	Mark Powell	IPR to include additional narrative identifying focussed areas of risks	1.10.2019	Further narrative has been provided in this month's report. In addition, a proposal for enhancing the quality indicators is being presented to the Quality Committee for agreement.	Green
3.9.2019	DHCFT2019/120	Board Assurance Framework	Justine Fitzjohn/Rachel Kempster	Clarification of risks associated with waiting lists and lack of commissioning in acute inpatient areas to be discussed between Rachel Kempster and Geoff Lewins	1.10.2019	Discussion at the Executive Leadership Team on 16/09/2019 identified that assurances around community waiting times are in place and will be presented via the next deep dive/position statement to the Board on access and responsiveness. Currently the risks associated were not identified as significantly impacting on risk 1a. ELT will continue to monitor.	Green
3.9.2019	DHCFT2019/122	Workforce Race Equality Standards (WRES) 2018/19	Ifti Majid/ Amanda Rawlings	A revised WRES action plan to be presented to the Board for approval that is applicable to the Trust rather than the national position at the Board meeting to be held on 5 November	5.10.2019	On agenda for November meeting and captured in the forward plan.	Yellow

Resolved	**GREEN**	**2**	**75%**
Action Ongoing/Update Required	**AMBER**	**0**	**0%**
Action Overdue	**RED**	**0**	**0%**
Agenda item for future meeting	**YELLOW**	**1**	**25%**
		3	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 1 October 2019

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 2 September 2019. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

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

2. On 4 September 2019 I visited the Mental Health Liaison team at the Royal Derby Hospital where I spent time observing how the team work, and also walking through the hospital to wards where patients were being treated and supported by our team. It is apparent how difficult it is to gather information from four different systems when our team are reviewing the case history and support required. I was briefed on the challenges the team face when it is not appropriate to see a patient in A&E (for example when person is intoxicated or under the influence of drugs), and how this can cause tension with the hospital staff and family and carers. I was impressed with the caring attitude of staff, and also the way that they work with the hospital staff, both in teaching and training about mental health and substance misuse, but also in terms of supporting patients who might be deemed medically fit for discharge, but where the community (mental health, substance misuse or social care) support may not yet be in place. This visit was led by a member of staff experienced in alcohol and substance misuse.

   On 19 September I visited the Mental Health Liaison team again, but with a focus on the mental health areas of support. I met with staff from the Royal Derby Hospital who have been working on developing care plan for those service users who attend A&E frequently. This work has been able to significantly reduce the number of attendances by these patients, in some cases by up to 70%. I was also able to see details of a service user who has been attending A&E frequently (daily) with violence and abuse to A&E staff. It is evident that this is a challenging environment for all involved.

3. On 25 September I plan to attend the BME Network Conference. I will cover this in my next report along with attending a further Schwartz Round, shadowing a consultant in the community, and visit to CAMHS (Child and Adolescent Mental Health Service) and CAMHs Rise.

Council of Governors

4. On 2 September I chaired the Council of Governors meeting. At this meeting, the Council confirmed the appointment of Dr Sheila Newport as a Non-Executive Director (NED), who will take over from Anne Wright as the clinical NED, and the interim appointment of Suzanne Overton-Edwards whilst the recruitment process

takes place for the appointment of a sixth NED. The Council also received a report on the current position with regard to waiting lists.

5. On 11 September I met with four of our six Staff Governors for a regular quarterly meeting. This was Tony Longbone's last meeting as he has stepped down as he starts his nurse training at the University of Derby. His post will be included in the next round of Governor elections. Areas discussed included the concerns about staff abused by patients, and the support that the Trust provides.

6. Election for new public Governors have commenced in Derby City West and Erewash. Polling closes on 26 September, with the results being announced at the end of September.

7. On 4 September I met with Lynda Langley, Lead Governor. Regular meetings between the Lead Governor and Chair are an important way of building a relationship and understanding of the working of both governing bodies. Outstanding business remains the appointment of a Deputy Lead Governor.

8. On 11 September, we held the Annual Members meeting at the Research and Development Centre at Kingsway. The meeting was preceded by a "market place" where teams were able to showcase the good work that they do. The meeting was well attended, and the writing competition "Looking Back / Looking Forward" winners were announced. The writing competition was the idea of the Council of Governors and had 56 entries of really high quality. The aim was to challenge the stigma around mental ill health, learning disabilities and the wider services provided by the Trust, and to celebrate equality, diversity and inclusion by giving entrants the opportunity to explore these topics. My thanks go to all the members of the Council involved in the planning and delivery of the afternoon, and to the Communications and Involvement team who were helpful in the delivery of a good meeting.

9. The next meeting of the Council of Governors will be on 5 November after the public Board meeting. The next Governance Committee takes place on 10 October. The Nominations and Remuneration Committee will be meeting as required over the course of October and November to appoint a new NED and to receive my appraisal and the appraisal of two of the NEDs.

Board of Directors

10. Board Development on 18 September was focussed on living our values – People First and Respect. The focus was on developing a person centred leadership culture, and using a feedback model to be open and honest in terms of providing feedback – both appreciative and constructive feedback were explored.

11. In September I met with Anne Wright, Margaret Gildea and Geoff Lewins for their regular NED quarterly development meetings. During these meetings we review performances against objectives set at the beginning of the appointment / review cycle, as well as discuss generally mutual views on the progress of the NED and the Trust and any personal development requirements. We have also commenced the gathering of feedback for the Chair and NED appraisals for Julia Tabreham, Margaret Gildea and myself. A new tool is being used to expedite this process.

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

System Collaboration and Working

13. On 13 September, Joined Up Care Derbyshire (JUCD) held a stakeholder engagement event in Matlock. Ifti Majid was one of the presenters, and I facilitated one of eleven tables of attendees. The meeting was attended by some 90 participants and I covered a lot of information about the refresh of the Joined Up Care Derbyshire plan which is due for submission in the Autumn of 2019. I was pleased to see a number of Governors from our Trust in the room.

14. On 20 September I met with the JUCD Independent Chair, John MacDonald.

15. I attended the Joined Up Care Derbyshire Board on 20 September. Attached as Appendix 1 are the key messages noted from this meeting.

Regulators; NHS Providers and NHS Confederation and others

16. On 10 September, Ifti Majid and I attended a regular Chiefs and Chairs meeting hosted by NHS Providers. Speakers at the meeting included a strategy and policy update from Chris Hopson, CEO of NHS Providers; a panel session exploring Primary Care Networks and a Briefing on Brexit planning and the No Deal implications.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work.

With respect to our work with governors - we work actively to encourage a wide range of nominees to our governor elections, and strive that our Council of Governors is representative of the communities they serve. We also provide support to any current or prospective governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings.

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NExT Director scheme we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS. Perminder Heer has started her placement thereby continuing to support the system development of future potential NEDs from diverse backgrounds.

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

Recommendations

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

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

JUCD Board – 20 September 2019 – Key Messages

STP Refresh

Progress is now being made on the collation of material produced as part of the STP refresh. Delivery Boards across the health and care system have been assessing priorities in the context of the NHS Long Term Plana and other local issues. The current draft of the plan was discussed at JUCD Board with further work taking place between now and the initial submission date of 27 September.

Along with clinical engagement, the refreshed plan has also been the subject of extensive engagement, with the first wave culminating in a stakeholder event on Friday 13 September where councillors, MPs, patient reps and staff were able to hear the emerging details from the refresh. The draft plan will continue to be refined with more detail added, including financial and activity based projections, workforce and digital opportunities. The final version will need to be completed by mid-November.

Population Health

Population Health is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. JUCD is an active member of the cohort of organisations developing the approach further and we expect it to be central to the way in which we understand the outcomes we require for Derbyshire people as we deliver the STP Plan. There was a strong commitment from the system to develop and use population health information to inform our future decision making and where appropriate resource allocation.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 October 2019

Chief Executive's Report to the Public Board of Directors

Purpose of Report

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

National Context

1. NHS Providers have released the findings of their annual survey into regulation in the NHS. It is of particular interest this year, as we are in a time of transition, with NHS Improvement and NHS England coming together. I thought the results of the survey were generally optimistic, that the new national structure will be more efficient and better placed to support system leadership, through providing a more joined up perspective. However, the findings indicate that, under the new joint working arrangements with NHS Improvement, there will be a need for NHS England to rapidly develop and demonstrate its understanding of the provider sector. Trust leaders also see opportunity for the national NHS leadership to use this juncture to reset the culture towards one of improvement support and to focus on shared culture, values and behaviours, something we have heard the leaders of the Organisation talking about in a number of settings.

   It is encouraging that most trusts reported a sense of stability in the level of regulatory burden over the last 12 months. This is in contrast to each of the previous four years, in which this annual survey has run, when the majority of trusts have said that the burden had increased. There has also been an improvement in the proportion of trusts who agree that reporting requirements are proportionate to the level of risk they manage. This is reflective of our relationship with the newly developing joint Organisation with our performance review meetings being cancelled in favour of system wide ones. In addition we have seen a lot of 'true' improvement support from NHS Improvement's quality team with our transformation plan for acute services.

2. The NHS Oversight Framework for 2019/20 outlines the joint approach NHS England and NHS Improvement will take to oversee organisational performance and identify where commissioners and providers may need support. The NHS Oversight Framework for 2019/20 has replaced the provider Single Oversight Framework and the Clinical Commissioning Group (CCG) Improvement and Assessment Framework (IAF), and will inform assessment of providers in 2019/20. It is intended as a focal point for joint work, support and dialogue

between NHS England (NHSE) and NHS Improvement (NHSI), CCGs, providers and sustainability and transformation partnerships, and integrated care systems.

Changes to oversight will be characterised by several key principles:

- NHSE and NHSI teams speaking with a single voice, setting consistent expectations of systems and their constituent organisations.
- A greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals.
- Working with and through system leaders, wherever possible, to tackle problems rather than directly with individual organisations.
- Matching accountability for results with improvement support, as appropriate.
- Greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

The existing statutory roles and responsibilities of NHS Improvement and NHSE in relation to providers and commissioners remain unchanged. The key change is the context in which they are applied, which will now reflect the principles set out above. This will serve to identify and address both:

- Performance issues in organisations directly affecting system delivery
- Development issues which may, if not addressed, threaten future performance.

Linked to the new People Plan, leadership and culture in organisations and systems, will form a core part of oversight conversations, as part of the commitment to making the NHS a better place to work.

Oversight will incorporate:

- System review meetings: discussions between the regional team and system leaders, drawing on corporate and national expertise as necessary, informed by a shared set of information and covering:
    - performance against a core set of national requirements at system and/or organisational level. These will include: quality of care, population health, financial performance and sustainability, and delivery of national standards;
    - any emerging organisational health issues that may need addressing;
    - implementation of transformation objectives in the NHS Long Term Plan.

In the absence of material concerns, the default frequency for these meetings will be quarterly, but regional teams will engage more frequently where system or organisational issues make it necessary. There will be more focused engagement with the system and the relevant organisations where specific issues emerge outside these meetings.

Board members will note I fed back on our first system wide performance review meeting at the last Board meeting and since then we have had a focussed meeting on urgent care in Derbyshire – demonstrating the new system is operating already.

Local Context

3. I chaired an extended facilitated session for system leaders on 16 September 2019 looking at how we develop Integrated Care Partnerships (ICPs) in Derbyshire. ICPs are a formal alliance of a number of providers, often including statutory NHS, Local Authorities and the voluntary and independent sector, that come together to deliver an agreed specification for a range of services for an agreed population.

   The meeting reviewed best practice from elsewhere, for example Mid Nottinghamshire ICP, Surry Heartlands ICP, and Greater Manchester ICP, as well as remind us about the need for any ICP development to add value to the quadruple aim for Derbyshire:

   - Improving experience of care
   - Improving population health
   - Improving staff experience and resilience
   - Improving the per capita cost of healthcare

   The meeting enabled us to agree some critical success criteria which will include areas such as (not an exhaustive nor finalised list):

   - Focus on population health
   - Will not focus on health alone - must focus on wider determinants of health and therefore be clear where colleagues from local authorities and public health engage and add value
   - Not dismiss gains already made
   - Not a new organisation
   - Any partnerships/alliance must be relevant to local residents
   - Need to consider capacity to service any new infrastructure.

   The group agreed to consider a range of options for ICP development based around variations on the following:

   - Geographic - linked to Derby City, South and North County
   - Needs and pathways
   - Current PLACE alliances

   Next steps are for a steering group, led by myself, to create a detailed list of success criteria that will allow us to review the full variety of ICP configurations, generated so a short list can be presented through system governance structures and ultimately through to statutory Boards.

4. The Joined up Care Derbyshire (JUCD) Board met on 20 September 2019. The key highlights that I think are relevant to our Organisation are as follows:

   - We received our first Patient story - outreach partnership linked to homelessness called Street Health, led by Sherwood Forest Acute Trust, which makes it unique. The key was linking with existing Council for Voluntary Service (CVS) services, such as the soup kitchen. We heard clear examples of how this programme had reduced admissions to hospital for this cohort of people. I thought a major learning was the fact

we don't need to create complex partnerships to have strong outcomes.

- Agreement that we need to agree the Primary Care Network and ICP structure by November submission.
- We agreed to have a "confirm and challenge" of each of the workstreams over the next few months, which will include looking to see how to simplify the Workstream Structure.
- System finance update - at month 5 we are reporting "off plan" with a circa £45m risk. We agreed we need to create a single joint report that simply updates each statutory Board of system risk and opportunity. A deep dive of month 6 will be the first discussion at the new System Finance Committee.
- The first draft of the refreshed STP submission, due 27 September, with a probable updated submission in October, heading to final 21 November submission to NHSI/E. For the current draft please see the separate paper. We agreed the draft would be shared with all statutory Boards.
- We heard about the development of the new specialist National Rehabilitation Centre at Stanford Hall near Loughborough. Currently going through various gateway approval processes, aiming for approval in March next year, it is hoped this could have a positive impact on local rehabilitation pathways.
- Helpful presentation around population health, its link with the Integrated Care System approach, and a drive to improve inequalities in our local communities. This reminded us that only 30% of the things that impact on the health of populations are based in health Organisations, hence the need to focus resource on the wider determinants of health.

5. The Board will recall last month as part of this report, I spoke about the planned formation of an East Midlands Mental Health and Learning Disability Alliance. You will recall that, as part of developing a new way of working to support the implementation of New Care Models for Mental Health (the management of services previously commissioned by NHSE specialist commissioning hub), the CEOs of the five East Midlands NHS Mental Health Trusts and St Andrew's Healthcare, have agreed to work together to establish a mental health provider alliance in the East Midlands.

   A second meeting of the Alliance CEOs was held in early September. At that meeting, the CEOs considered a number of issues:

   - Feeding in to a draft common Board paper to be used by each member organisation. The content went to our Board last month in my report.
   - A discussion paper on the development of a Memorandum of Understanding between Alliance partners.
   - The establishment of a Strategy Director Group, to implement decisions taken by the CEO Group, and to develop options and recommendations for the CEO Group.
   - A proposal to host the NHS England New Care Model, related to staff together in one Trust, before the CEOs take a collective view on how to deploy them.
   - A proposal to bring in part-time leadership for the Alliance and to support the CEOs.
   - A proposal to take forward a communications plan once each Board has held discussions on this Alliance proposal.

- Concerns about the potential approach to risk and resource transfer, to New Care Models from NHS England, and the need for a strong collective voice.

It is important that through this discussion I am able to indicate our formal support to review the Memorandum of Understanding at our next Board meeting.

Within our Trust

6. The Board will be aware that we received our CQC Provider Information Request on 20 August 2019. Following some great collaboration between the Nursing and Quality Team and the Operations Team, supported by Finance, Workforce, Estates and IM&T (Information Management and Technology), we successfully submitted our completed return by the deadline of 3 September. We have now commenced the next phase of the inspection preparation, which includes answering direct queries from the CQC related to the submission.

7. As an Executive we understand the importance of colleagues throughout the Trust being aware of some of the great initiatives we have undertaken over the last year that have an impact on our culture, leadership, innovation and quality, as well as supporting delivery of our strategy. To this end we have started to produce weekly newsletters entitled *'Making a Positive Difference'* that provide updates to all colleagues in the Trust on the following areas:

Topic	Publication Date	Lead
What are we doing about recruitment?	09/09/2019	Amanda
How are we supporting enhancing retention?	16/09/2019	Amanda
What QI type pilots have we got running (nurse led clinics etc etc)?	23/09/2019	Gareth
Developing our estate strategy	30/09/2019	Mark
Early outcomes from clinical pathway work	07/10/2019	Gareth
Leadership and management offer	14/10/2019	Amanda
Enhancing inclusion	21/10/2019	Claire/Amanda
Speaking up and opportunities for engagement	28/10/2019	Ifti/Anna/Tam
System working	04/11/2019	Ifti
Our financial position/CIP and plans for financial sustainability	11/11/2019	Claire/Gareth
IM&T Developing our Electronic Patient Record	18/11/2019	Mark

Feedback from the first two editions has been very positive and I have attached them for Board members' information.

8. On 9 September myself and Mark Powell hosted a meeting with our Area Service Managers and General Managers. It was really helpful to have an open agenda meeting that enabled us to focus on culture, the impact of our refreshed strategy, and the support our operational managers feel they need in taking their roles forward.

9. 11 September saw our Annual Members' Meeting (AMM) and innovation Market Place. My thanks to all colleagues who took the time to prepare a market place stall showing off their team's innovations and it was fantastic so many stayed through to the main meeting.

The AMM started with an update by representatives from three of our four networks, talking about the developments we have made in the year around inclusion and diversity in its broadest sense, including one of our experts by experience from CAMHS (Child and Adolescent Mental Health Service) reading out a personal account of her experiences. Thanks to colleagues who took part as it is daunting talking in front of a full conference room. This set the tone for the meeting and I think it was a great idea from our Governors to have such a focus, recognising the importance of inclusion to us as a Trust.

This, coupled with the announcing of the winners of the writing competition, created a real sense of being focussed on the people who use our services and their carers throughout the AMM, and brought to life some of the conversation about quality improvements, links with the Trust Strategy and financial performance that are mandatory components of an AMM.

We concluded our AMM by presenting certificates to the category winners of the writing competition and the overall winner, Jill. Jill, who has used our services recently, asked to address the meeting and gave a passionate and emotional thank you to the colleagues who had cared for her during her illness and who are supporting her towards recovery. Jill also endorsed our refreshed strategy, saying looking after the people who would look after her was exactly the right thing to do. I have to say there wasn't a dry eye in the house!!

10. 25 September was our annual BME Network Conference and, as this happened after the Board paper deadline, I shall report on this next month.

11. Communications activities have continued over the month, with a number of positive and proactive features receiving coverage in the local media. This has included the Trust's partnership work with wider local agencies to promote World Suicide Prevention Day and to share the opportunities available to talk to a healthcare professional at football events taking place across the county in September. The Trust also shared its expertise through local features, aimed at supporting children on their return to school and celebrated good news, including fundraising activities raised by teenagers on the National Citizens Service (NCS) for our CAMHS teams in Derby.

    Following last month's Board meeting, I appeared on East Midlands Today on 13 September, to continue the inclusion focused conversations that took place in the September meeting. This focused on the Trust's commitment to prevent any inequality or discrimination on the basis of an individual's race or ethnicity. Following the overwhelming support received from colleagues and wider stakeholders about this approach, the Trust is now considering a wider campaign to confirm that such discrimination will not be tolerated in our services.

    A wider feature about the Trust's approach to supporting people with drug and alcohol misuse towards a gradual recovery also came from the last Board meeting. This article has featured in a number of local newspapers, reflecting the Trust's knowledge and expertise in safely supporting people towards recovery whilst reducing the risks of relapse or accidental death.

    Our social media channels continue to celebrate the Trust's DEED nominees and winners. During the month a number of conversations took place during and following the Trust's attendance at Belper and Derby Pride events, together with

posts and comments regarding the recent AMM. We also shared messages to support teenagers receiving exam results, to encourage nursing as a rewarding career for school leavers, and to promote National Breastfeeding Week. An unexpected highlight of the month was reaching over 1,800 people following a post about two new guinea pigs at Audrey House - and the positive benefits for our patients when looking after animals.

12. On 4 September I was privileged to have been asked to speak at the First Steps Eating Disorder Conference, which attracted people in the specialist field from all over the East Midlands. It was really important to support First Steps, who are key partners for us here in Derbyshire, and I was particularly pleased that the focus was about the style of how we work, focussing on compassion, assets and self-actualisation, rather than a more traditional deficit illness model.

13. During September I have enjoyed getting out and meeting staff through continued engagement visits, for example taking part in the Stoptober event at Kingsway. I have held *Ifti on the Road* engagement events at The Hartington Unit, where I was able to meet some of our acute care colleagues, and at the Ashbourne Centre, Kingsway, as well as carrying out a Quality Visit to Clinical Audit and Library Services. (I am not reporting here on the outcomes from the quality visits).

    On the Road feedback

    - A first for me was that a service user called in to see me at the Hartington Unit, telling me how helpful and supportive our colleagues had been in helping her to find a step down placement before she went home, and how she thought that would really help her recovery.
    - Service users who I met in the Hub at the Hartington Unit also told me how pleased they were with our revised Tobacco Dependence Policy (they didn't refer to is as that!). One person told me that it made her feel like an 'adult' by respecting her choices even when not well.
    - It was great to hear from a couple of colleagues about staffing levels increasing, but noting some pressures on Pleasley Ward and the importance of being able to get offers of employment converted to start dates asap. I picked this specific action up with our recruitment team through Amanda Rawlings.
    - I was reminded of the importance of our ward admin colleagues in bringing calmness and consistency to our wards.

    These issues are logged and cross referenced through conversations with our Freedom to Speak up Guardian.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

This paper demonstrates some strong features of good practice relating to inclusion and diversity in its broadest sense. Working with partners such as First Steps helps to provide a wider funnel of access to our services, knowing that some individuals from local communities either do not trust or historically don't use statutory services.

The feedback from colleagues in our BME, LGBT+ and Disability & Wellness Group at our AMM gives hope to the changing culture in the Organisation and the recognition that, as part of business as usual, we are rolling out best practice. It is also worth noting that some of that best practice, for example the building in of an 'unconscious bias stop' in disciplinary processes, will have a positive effect on all colleagues in the Trust.

There is no doubt that in order to fully understand the best solutions to tackle bias and how it shows itself across recruitment, disciplinary and personal development, we have to create a culture where colleagues feel able to tell us what is happening in the Trust – we have made significant moves forward in this regard and, as our BME Network reminded me this month, the next step is then about co-creating solutions.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken.
2) Seek further assurance around any key issues raised.
3) Approve the move towards agreeing a Memorandum of Understanding with other Mental Health Trusts in the East Midlands.

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

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

MAKING A POSTIVE DIFFERENCE UPDATE

Colleague e-newsletter 16 September 2019
Issue 2

Help colleagues in your area who have limited access to emails: please print and share this bulletin

Message from our Chief Executive, Ifti Majid

Last week we issued the first of a new series of bulletins, reflecting on what we are doing to address our key issues and challenges so that we meet our vision of 'making a positive difference in people's lives by improving health and wellbeing'. At the same time this gives us an opportunity to share progress on the implementation of the 'building blocks' that make up our Trust strategy.

The first bulletin was about recruitment, because we know we need to 'attract new colleagues' to make the Trust a great place to work. If you missed that bulletin, you can find a link to it on the Chief Executive and Chair's page on Connect.

This week Amanda Rawlings, our Director of People Services and Organisational Effectiveness, will look at how we are making a positive difference on our strategic building block of 'retain our colleagues'. Amanda describes some of the ways we are seeking to make Derbyshire Healthcare a great place to work by ensuring that more of our workforce stays with the organisation for longer – which means we give better, more consistent care to our service users and build up a stronger sense of 'team' for all colleagues.

Thank you to everyone who has provided feedback on the first bulletin. Please contact the Communications Team if you have any comments or would like to make a suggestion for a future topic.

Making a positive difference on… enhancing staff retention

Amanda Rawlings
Director of People Services and Organisational Effectiveness

I am 'making a positive difference in people's lives' by…
Focusing on making Derbyshire Healthcare a great place to work so that colleagues want to join and stay with us.

Last week I shared with you the steps we are taking to attract new colleagues to our Trust.

In this bulletin I would like to share some of the things we are doing to retain the amazing colleagues we already employ.

Our turnover levels compare well to other NHS and Mental Health Trusts (the group we are often compared against) and many colleagues have chosen to stay and move to new roles and positions internally. However, we still have work to do to further reduce our turnover and retain more colleagues within our Trust. We have just launched a new exit interview process so we can gather more insight into reasons why colleagues would want to leave the Trust.

We know that to be a 'great place to work' we need to continue to engage and involve staff in the running of the organisation and shaping how it moves forward. I am very proud of how our Staff Forum has grown and flourished in the last year. The group have identified a number of important issues and made significant changes to date. This year we also had an amazing staff conference which helped to shape the next stage of our strategy. We have grown our staff networks; BME, LGBT+, Disability and Wellness and Armed Forces. These groups play a significant role in helping us to be an inclusive place to work and receive care.

In January we reviewed our wellbeing offer and made the decision that we wanted to invest in a local staff support service – Resolve – in addition to the confidential 24-hour telephone support. We have brought Neyber on board to be there for any staff who require financial support. We have worked with Occupational Health to provide rapid access to musculoskeletal (MSK) services and we are launching an NHS-approved 24 hour mental wellbeing app – read Weekly Connect this week for more details.

We are in the process of consulting on new shift times so we can provide breaks during shifts and between shifts to promote the health and well-being of colleagues. We are also introducing 12-week shift rosters to colleagues to help with better work/personal life planning and forward shift planning.

We know we have many fabulous leaders and managers in the Trust but we haven't provided enough support and development to them over recent years. So we have made this a strategic priority in our strategy. Over 500 leaders and managers have spent time with Ifti, Claire Wright and I to discuss leadership and management in our Trust and the development support we are putting into place. I will soon be doing a future bulletin on this topic with more detail.

We have an ongoing ambition to reach full nursing establishment in our adult acute inpatient wards. In order to support this ambition we are introducing a competency-based development programme for all band 5 clinical practitioners in our acute units to progress to a band 6 (should they choose to) over a two-year period. This will be offered firstly to nurses in our acute units as this is the majority of the acute inpatient workforce. We are committed to developing the ward-based OT/AHP route using the same methodology.

I am keen to hear from you of things that you feel we need in place to make DHCFT a great place to work. Please get in touch via amanda.rawlings2@nhs.net

Our staff survey will be out later this month so please take the time to tell us what is going well and what we need to do better. It is totally confidential and non-attributable and I do read all the comments that are made.

The *Making a Positive Difference Bulletin* is a newsletter for all Derbyshire Healthcare NHS Foundation Trust staff.

If you have a topic you would like to include in a future issue please email dhcft.communications@nhs.net.

Follow the Trust on Twitter @derbyshcft and Facebook

NHS
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MAKING A POSTIVE DIFFERENCE UPDATE

Colleague e-newsletter 9 September 2019
Issue 1

Help colleagues in your area who have limited access to emails: please print and share this bulletin

Message from our Chief Executive, Ifti Majid

When I am out 'on the road' across the Trust, or talking to colleagues at meetings or events, there are certain topics that come up regularly. They are often some of the biggest challenges we face and impact on staff working at all levels in the organisation, across different teams and services.

Ahead of our forthcoming inspection by the Care Quality Commission (CQC), members of our Staff Forum have asked if we could outline the Trust's current position on these key issues – how we have developed over the last year and what our plans are going forwards.

In response to this suggestion, I want to take a moment each week to reflect on what we are doing to address those challenges and meet our vision of 'making a positive difference in people's lives by improving health and wellbeing'. This will also provide an opportunity to share progress on the implementation of the 'building blocks' that make up our Trust strategy. We will also colour code the bulletins to show which strategic objective they relate to. I know colleagues are working tremendously hard to change and improve our Trust, and in this short series of weekly updates I would like to acknowledge that. There is no complacency about the work that still needs to be done in the months and years ahead. But I want us all to recognise how far we have come and be confident about our progress when we are meeting with and talking to CQC inspectors.

This week Amanda Rawlings, our Director of People Services and Organisational Effectiveness, will look at how we are making a positive difference on our strategic building block of 'attract new colleagues'. Amanda provides an overview of our focused work over the last year to look at new and innovative ways of attracting people to come to work for Derbyshire Healthcare.

I hope these bulletins are useful. Please contact the Communications Team if you have any comments or would like to make a suggestion for a future topic.

Making a positive difference on… staffing levels

Amanda Rawlings
Director of People Services and Organisational Effectiveness

I am 'making a positive difference in people's lives' by…
Focusing on recruitment to make sure we get the right people into vacant positions to ensure service delivery is maintained and reduce staff pressures

You will hear every day about the national workforce shortage in the NHS. Today there are many professions where there are more roles available than the people trained to fill them. Over the past two years we have worked incredibly hard to improve our reputation as a great place to work. Whilst we know we are not there yet, I am pleased to hear that people are choosing Derbyshire Healthcare as their place to work. We have seen a strong and steady flow of applications over the last year and have been successful at attracting 339 new substantive staff (plus 124 new bank workers). We compare very well for our vacancy rates, times to recruit and applications levels against other Trusts and Mental Health Trusts. However, we know that we need to keep a relentless focus on finding new ways to attract people to the Trust. A summary of the recruitment activity over the past 12 months is outlined below:

Here are some of the things we have done to improve our approach to recruitment over the last year:

- Invested in a recruitment site which has case studies and provides a platform for us to show case what we do: www.derbyshirehealthcarejobs.co.uk
- Attended local and regional recruitment events to promote the Trust and all our vacancies
- Built very strong relationships with universities and schools
- Promoted career pathways from apprenticeships to specialist and senior roles

- Rewritten our adverts to make them more attractive and inclusive
- Increased our social media presence promoting all our key vacancies across Twitter and Facebook.

This is not an exhaustive list, but a summary of the things we have seen to work. We have appreciated the feedback we have had from applicants, new joiners and appointing officers on how we can improve what we do and would welcome any ideas you may have. Please contact DCHST.peopleresourceteam@nhs.net or amanda.rawlings2@nhs.net

The *Making a Positive Difference Bulletin* is a newsletter for all Derbyshire Healthcare NHS Foundation Trust staff.

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Follow the Trust on Twitter @derbyshcft and Facebook

Joined Up Care Derbyshire Board: STP Refresh Summary for Boards and Governing Body						
DATE OF MEETING:	1 October 2019		AGENDA ITEM NO:		8	
DOCUMENT/REPORT TITLE:	**STP Refresh Summary and Update**					
PRESENTER	Ifti Majid, Chief Executive Officer, Derbyshire Healthcare NHS Foundation Trust					
SENIOR RESPONSIBLE OFFICER	Vikki Taylor					
CONTENTS OF PAPER WERE PREVIOUSLY DISCUSSED BY:	Ongoing discussions and updates at the Joined Up Care Derbyshire Board					
AUTHOR/TITLE:	Sukhi Mahil, JUCD STP Assistant Director					
CONTACT EMAIL AND TELEPHONE NUMBER:	sukhi.mahil@nhs.net 07967 252111					
DOCUMENT IS FOR: (MORE THAN ONE BOX CAN BE TICKED)	INFORMATION	☞	DECISION		ASSURANCE	☞

PURPOSE

The purpose of this paper is to provide the Derbyshire Healthcare NHS Foundation Trust with an update in relation to the JUCD STP Refresh, which commenced following approval of the approach agreed at the March meeting.

BACKGROUND

Since the publication of the Joined Up Care Derbyshire Sustainability and Transformation Plan (STP) in October 2016, progress has been made to drive forward the ambitions set out in response to the case for change that was defined at that time.

We are now required to develop 5 year Strategy Delivery Plans in response to the ambitions set out in the NHS Long Term Plan published in January 2019. The submission dates are detailed below.

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

- Has a shift in focus to people not patients
- Localises care delivery, building on progress made since the 2016 plan
- Is outcomes driven to ensure so that the people of Derbyshire ***'have the best start in life, stay healthy, age well and die well'***
- Demonstrates our strive to offer excellent services and make improvements in the key determinants of health leading to improved outcomes for people in Derbyshire; with a stronger focus on prevention, addressing inequalities and population health management

- Ensure our key priority areas support the delivery of our new approach, and will include the wider determinants of health such as housing and air pollution management
- Our transition to becoming an Integrated Care System by April 2021; adopting and implementing our core principles for how we will work together and challenging each other to upholding them
- Demonstrates how commissioners will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at place and make strategic commissioning decisions in the deployment of that budget
- Demonstrates how providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place levels within allocated resources
- The refresh will be informed and developed through strong engagement with people, patients, staff and wider stakeholders – this will drive our approach. In doing so, ALL partners will be involved in developing and subsequently delivering our 5 year plan.

MATTERS FOR CONSIDERATION

The NHS Long Term Plan Implementation Framework (LTP IF)

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

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

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

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

With regards to the strategic narrative, whilst a specific template has not been issued our plan must describe how systems will deliver the required transformation activities to enable the necessary improvements for patients and communities as set out in the Long Term Plan. The following areas are expected to be included:

Section	Content
Outline and plan for achieving key transformation priorities	• Describe local transformation and major service change priorities. This should include plans for integrated care models and service change at place and neighbourhood levels • Overview of approach to delivering LTP foundational commitments (Chapters 2 and 3 of LTP Implementation Framework) • Plans for improving prevention and addressing health inequalities • Plans to develop both the provider and commissioner landscape e.g. provider collaboration, arrangements to streamline commissioning • System approaches to key enablers including workforce, digital and estates • Major milestones and plans for monitoring achievement of plans
System development activities	• Outline of expected trajectory to become an ICS (see Designing Integrated Care Systems recently published) and key activities to support ICS development • Plans to build local partnership coalition and to ensure ongoing engagement including with patients and public • System governance and arrangements for collective decision-making
Key assumptions and supporting narrative for finance, activity and workforce plans	• Outline of key assumptions underpinning finance, activity and workforce plans • Confirmation that system partners have agreed the finance, activity and workforce plans and have a shared commitment to deliver them • Key risks to the delivery of the five-year plan and mitigating actions (including service quality, operational performance, transformation, finance) • Approach to workforce planning
System financial management	• Plans for system financial management, including arrangements to support management of collective financial resources. • Approach to payment reform and description of any planned contractual changes • Plans to agree and drive system-wide efficiency programmes, including how system partners will work together to deliver them

Specific Requirements

Certain phasing of timescales set out in the Long Term Plan Implementation Framework are fixed (chapters 2 and 3), these are the 'foundational commitments' and include:

- Transformed 'out of hospital care' and fully integrated community based services
- Reducing pressures on emergency hospital services
- Giving people more control over their own health and more personalised care
- Digitally enabling primary care and outpatient care
- Better care for major health conditions: improving cancer outcomes
- Better care for major health conditions: improving mental health services
- Better care for major health conditions: shorter waits for planned care
- Increasing the focus on prevention – moving to Integrated Care Systems everywhere

The framework also sets out wider service transformations in relation to prevention (chapter 4) and further progress on care quality and outcomes (chapter 5) in areas including Maternity, Children and Young People, Learning Disabilities and Autism, Cardiovascular Disease, Stroke, Diabetes and Respiratory. These are also key elements of the Long Term Plan, however, they are defined as areas where systems will want to phase activity to reflect local priorities, varying starting points or where national enabling actions are required before they can be implemented at scale. Local phasing of these areas will be more flexible provided it matches our understanding of our population needs; regions will agree trajectories for delivery of these commitments taking this flexibility into account.

A key element to our five year plan is the requirement for the system to become an Integrated Care System by April 2021. System Leaders have participated in a development programme to progress this journey. The output slides from the programme are attached at Appendix 3.

In developing our plan, systems are expected to bring together members organisations and wider partners, adopting a common set of principles and leadership behaviours as they develop and deliver plans. In doing

this, systems will be expected to ensure that plans align with the following principles:

- **Clinically-led**: identify and support senior clinicians to lead on the development of implementation proposals for all LTP commitments that have clinical implications and on the totality of their plan.
- **Locally owned:** ensure local communities can meaningfully input into the development of local plans. Local government will be key partners and are asked to engage throughout the process. Similarly, the voluntary sector and other local partners, including representatives from the most marginalised communities should be involved.
- **Realistic workforce planning:** The interim NHS People Plan sets out the national context. Systems should set out realistic workforce assumptions, matched to activity and their financial envelope. Plans should also show the steps to be taken locally to improve retention and recruitment.
- **Financially balanced:** Systems need to show how they will deliver the commitments in the plans within the resources available to meet the five tests:
  - Test 1: plans will need to include the financial recovery plans for individual organisations in deficit against specified deficit recovery trajectories
  - Test 2: actions to achieve cash releasing savings
  - Test 3: reduction of unwarranted variation
  - Test 4: moderate growth demand
  - Test 5: set out capital investment priorities for capital budgets being agreed through the forthcoming Spending Review
- Delivery of all commitments in the Long Term Plan
- Phased based on local need; with the exception of national 'foundational requirements'
- Using allocated funding to reduce local health inequalities and unwarranted variation
- Focussed on prevention and how to prevent ill health
- Engaged with Local Authorities
- Driving Innovation

Overview of our plan so far

Area	Summary
Case for Change	Framed around the Quadruple Aim so that we improve the health of the population, improve the experience of care, reduce the per capita cost of healthcare and improve staff experience and resilience. The general themes and issues remain the same as the 2016 plan: • Growing over 65 population; • life expectancy is below the national average and no longer improving; • Healthy life expectancy is also relatively static and is significantly lower in Derby than the national average meaning many people are living for years in poor health and often in need of support. • Health inequalities remain across the patch with significant variations in life expectancy, healthy life expectancy, morbidity and lifestyle and behaviours.
5 Strategic Priorities	**Place Based Care:** Our model of care remains valid and is the fulcrum of our plan.

	Prevention and Self-Management: Strategic direction and approach delivered through our prevention strategy which all organisations have now adopted. Embedded within workstreams with specific deliverables in some programmes of work (eg increased Cancer Screening) **Population Outcomes:** Significant recognition of the wider determinants of health including: socio-economic factors; behaviours and lifestyles; healthcare; and environmental factors. This is particularly important as we know that clinical care only directly contributes to 20% of the populations overall health and wellbeing, as demonstrated in the diagram below:  **System Efficiency:** We know the challenges the Derbyshire system is facing and further work will be done ahead of the submission to identify and confirm areas where we have greatest scope to drive forward efficiency opportunities eg estates. Also triangulation of our plans (activity, finance and workforce) will further inform our position. **System Development:** Our journey to becoming an ICS by April 2021 is set out in the plan based on the outputs of the recent development sessions (see Appendix 3).
Priority area plans:	Plans will reflect are key deliverables set out in the LTP implementation framework and work is underway to condense outline business case and triangulate information with finance, activity and workforce which Boards and Governing Body will receive as part of the overall submission.
Ongoing Engagement	Extensive ongoing engagement activities have and continue to take place (for instance the launch of the Citizens Panel); all workstreams organised open meetings with a wide range of stakeholders, including the public. The purpose of these sessions is to inform the development of the 5 year plans for each of the priority areas. Where open meetings have not been possible dedicated challenge and confirm sessions have been held with citizen panel members to inform plans. The comprehensive approach will be reflected in our plans and will continue to form our approach going forward.

Timetable for STP plan approvals and submissions

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

Notes:

(1) The JUCD Board will receive and approve further amendments to the plan to confirm version being taken through organisational governance processes

(2) Due to the scheduling; particularly with regards to feedback from region, it may be necessary for Boards/ Governing Body to receive the final plan which is subject to further amendments (depending on the nature of the feedback). We will need agreement with the direction set out in the plan in principle at this stage.

(3) The EMAS Board date falls after the plan submission and therefore consideration/ agreement is required in relation to interim approach ahead of the plan being published to ensure fit with timescales

(4) Papers will be submitted to the Board one day before final submission to NHSE/I but the Board meeting itself will take place after. Therefore the CEO meeting on 1 November may need to be used to confirm the final submission

(5) Although this is the final submission to NHSE&I discussions will need to take place before this date to ensure plans are agreed with them ahead of actual submission

(6) The JUCD Board will receive the final plan; hopefully with any final feedback from region

RECOMMENDATIONS

Derbyshire Healthcare NHS Foundation Trust is asked to:

- To note the summary of the STP refresh requirements
- To note that owing to the delay in guidance being received and scheduling the draft plan is still in development; Boards and Governing Body are therefore asked acknowledge the submission will come to meetings for approval in October/ early November
- Support the direction of travel set out in the journey to become an ICS by April 2021.

FINANCIAL IMPACT

Any financial implications will be considered as part of the STP refresh
FURTHER INFORMATION AND APPENDICES
Appendix 1: **Additional LTP Funding for specific commitments** Appendix 2: **LTP Metrics** Appendix 3: ICS Development Programme Outputs

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

Appendix 1

Additional LTP Funding for specific commitments

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

Appendix 2

LTP Metrics

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

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

Table 1: Headline Metrics

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

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

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

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

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

Joined Up Care Derbyshire

Becoming An Integrated Care System (ICS)

Outputs of the ICS Development Programme

Which Organisations are Part of the ICS Journey….

PCNs Place Alliances Derbyshire Health United
Derbyshire Healthcare Foundation Trust EMAS
Chesterfield Royal Hospital General Practice
Derbyshire Community Hospitals Services
Derby and Derbyshire CCG GP Provider Alliance
Derby City Council Derbyshire County Council
University Hospitals of Derby and Burton LMC
Voluntary Sector NHS England Direct Commissioning

We are in this together…..

Mission (Why are we here)

To improve population health outcomes for the people and communities we serve

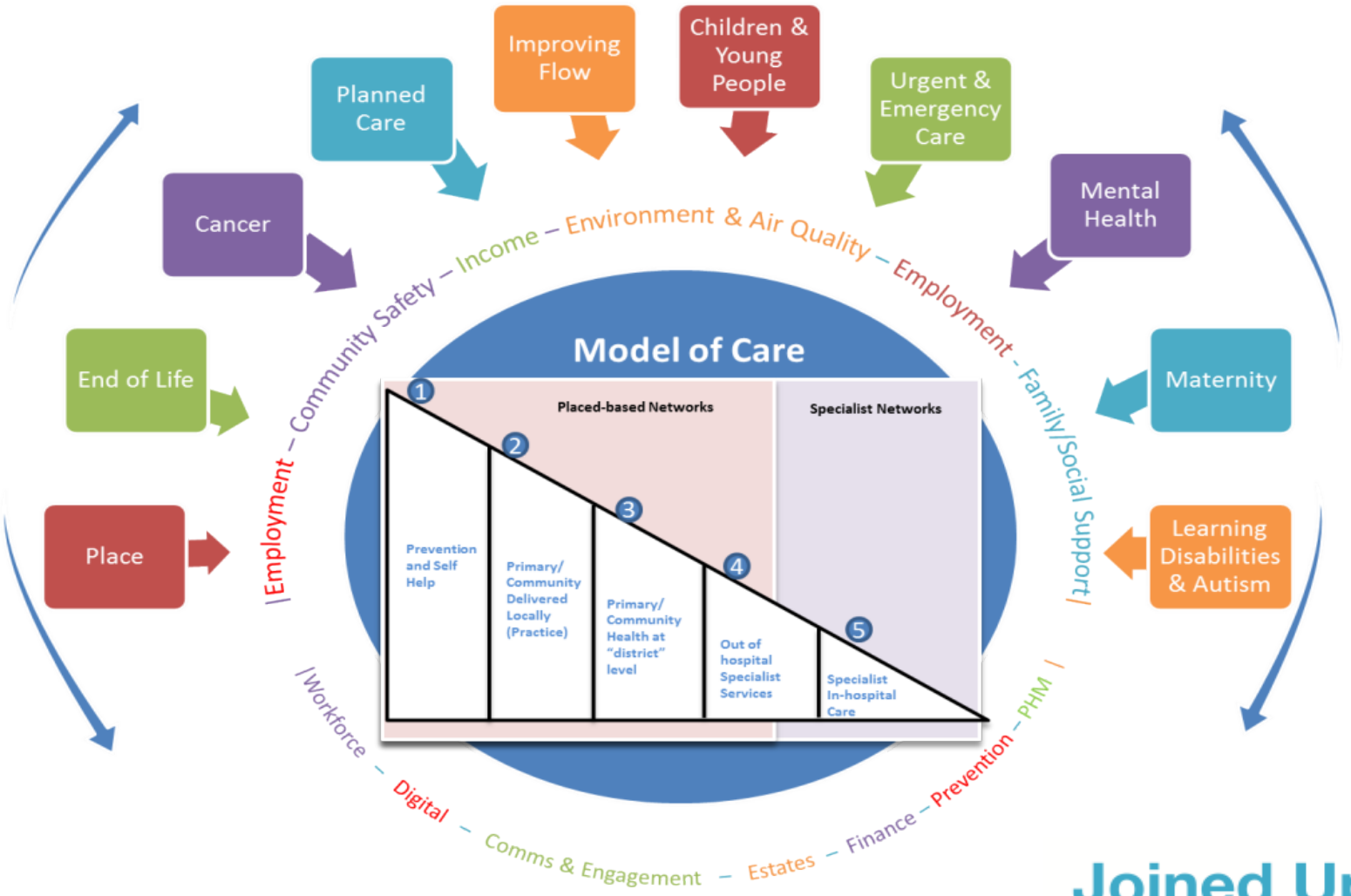
Vision (What do we want to achieve)

For people to have the best start in life, to stay well, age well and die well

We will:

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

Ensuring people have the best start in life, can stay healthy, age well and die well



*What this means…..

- Integrated care teams in each of our Place Alliances enabling more effective care closer to home and contributing a 4.5% reduction in non-elective admissions
- Better cancer screening uptake for Breast (80%), Cervical and Bowel (75%) leading to 62% of all cancers to be diagnosed at an earlier stage by 2020
- More people with dementia and delirium being supported in their own home or in a place they call home
- Provision of 24/7 service for Children and Young People requiring urgent care response for children with mental/emotional behavioural needs
- 30% of non-elective attendances treated as same day emergency care
- A combined primary care and mental health wellbeing service
- Fewer women smoking at time of delivery (11% by 2020, 10% by 2021 and 6% or less by the end of 2022)
- Implementation of a service for High Intensity Users (HIU) with chaotic lifestyles which enables targeted proactive care management

* Based on 2019/20 delivery plans. To be updated as STP Refresh is completed.

Our Approach:

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- **Our new approach will be founded on 'best start in life, staying well, aging well and dying well'**
- **Our key priority areas will support the delivery of our new approach, and will include the wider determinants of health such as housing and air pollution management**
- **We will strive to offer excellent services and make improvements in the key determinants of health leading to improved outcomes for people in Derbyshire**
- **The focus of delivery will be Place Alliances rather than organisations**
- **We will adopt and implement core principles for how we work and challenge each other to upholding them**
- **Our system will jointly plan for the health and social care needs for the population**
- **Commissioners will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at place and make strategic commissioning decisions in the deployment of that budget**
- **Providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place levels within allocated resources**
- **We will establish strong place based alliances to deliver care pathways to meet the local needs of individuals**
- **We will move towards provider alliances being at the heart of Place Alliances**
- **Derbyshire will be a great place to grow up in, work and live**

Derbyshire model for delivering integrated care

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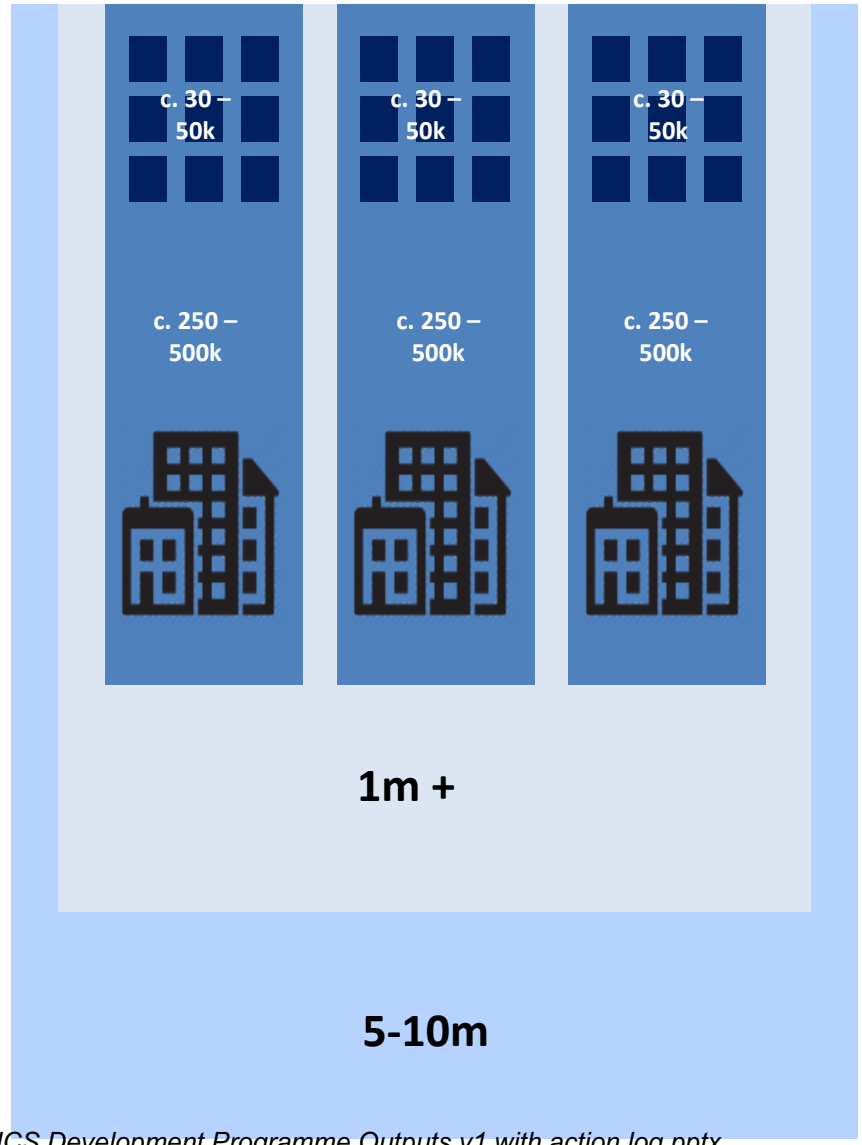

Primary Care Networks (Neighbourhoods)	• 15 Primary Care Networks (PCNs) with services wrapped around populations of circa 30k to 50k • Practices continue to provide core services at scale and work collaboratively with other practices and Health and Social Care partners to deliver integration at a 'neighbourhood' level
Place	• Eight Place Alliances which plan and deliver integration of health and care services • Based on an effective population health management to increase focus on prevention, tackle variation, manage resources and address inequalities. • Includes : PCNs, acute , community mental health, local authority and voluntary sector services to enhance coordinated care delivery and care re-design. • Long Term Plan commitments delivered through local integrated care models in 'hubs' (eg Bakewell, Belper)
System	• Agree the vision and strategy through a Partnership Board • Oversees delivery of the Partnership through effective collaborative working underpinned by an agreed clinical strategy. • Oversee collaboration between providers and development of Integrated Care Partnerships/ Providers • Oversee delivery of long term plan commitments • Streamlined strategic commissioning arrangements
Region	Specialist Networks and Directly Commissioned services: NHS England will continue to directly commission some services at a national and regional level, including most specialised services. The interface with wider clinical networks and alliances will be directly linked at system level (eg Derbyshire links with 3 cancer networks)

JUCD STP Governance: July 2019

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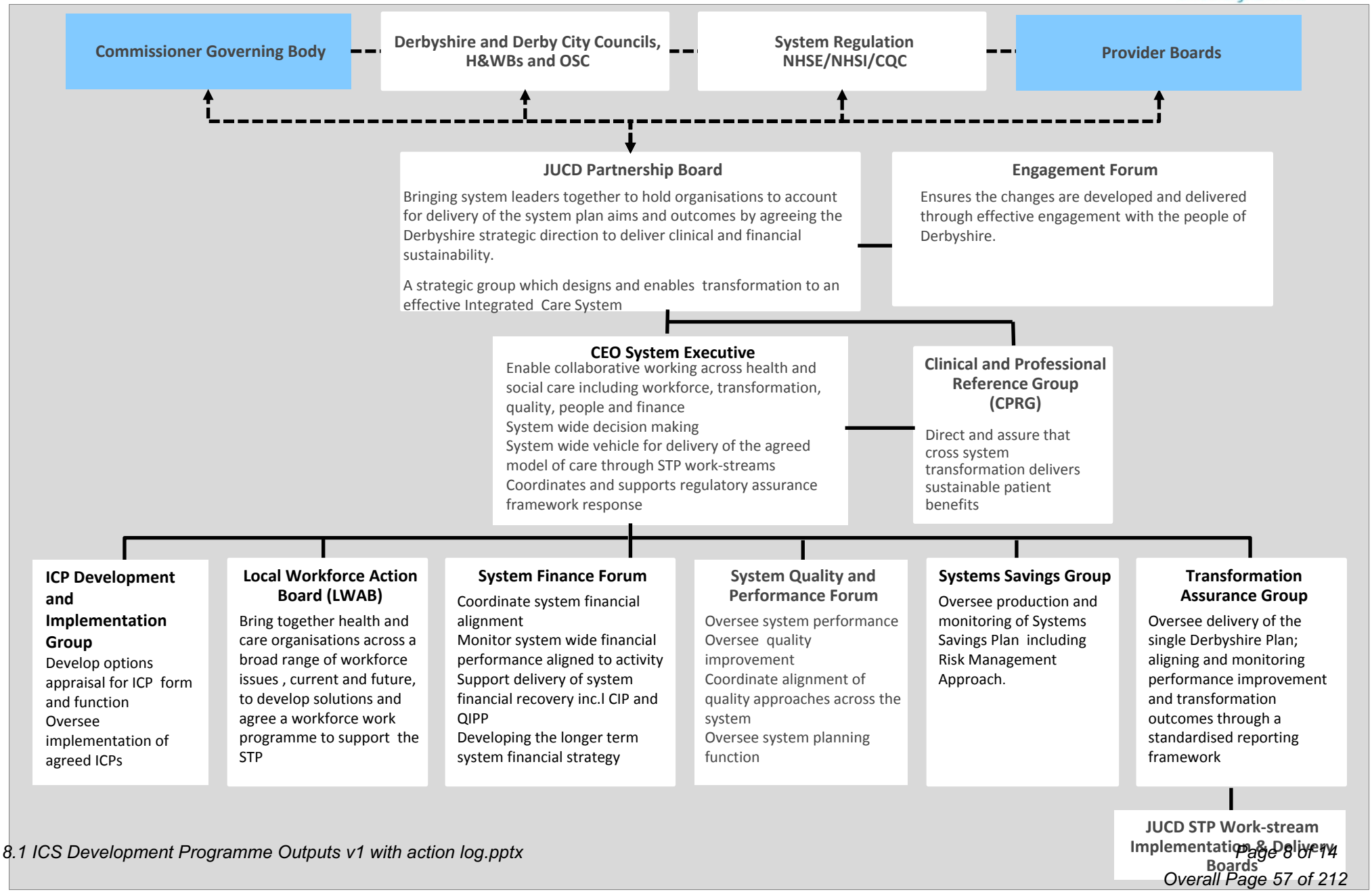

Our aim is to be an Integrated Care System which is built around care close to home, where hospital beds are only used where somebody cannot be cared for safely in their own environment

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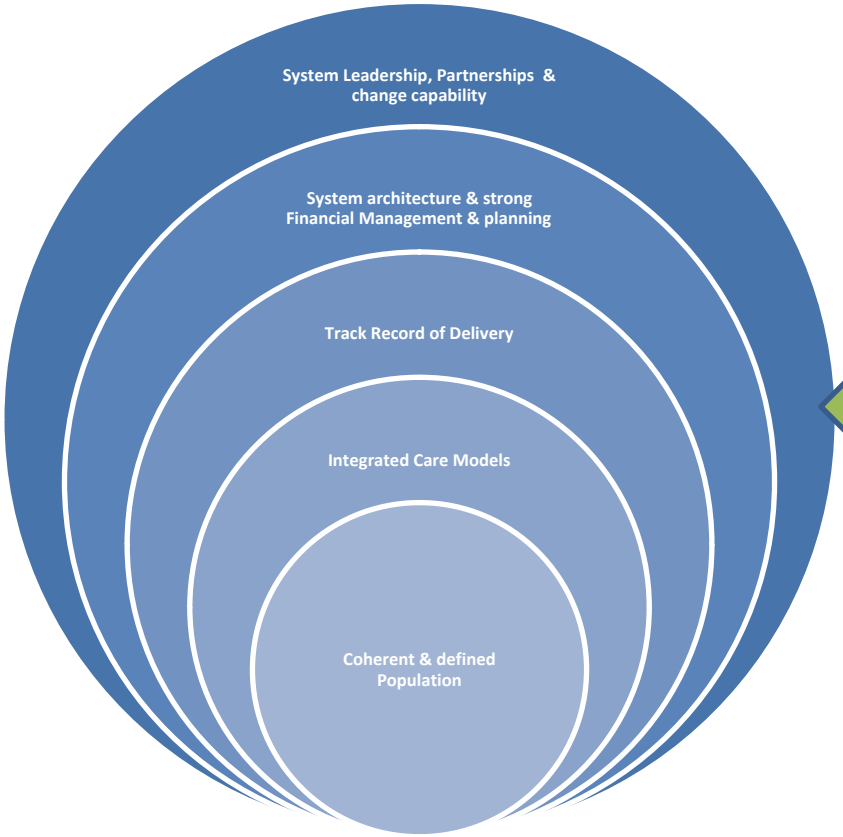
Characteristics of an Integrated Care System



Transformation Work Streams

Planned Care
Improving Flow
Urgent care
Place Alliance
Children & Young People
Maternity
Mental Health
Learning Disabilities
Cancer
End of Life

High level summary of 19/20 enabling work

Enabling development programmes

- ICS Development Programme
- Commissioning Capability Programme
- Population Health Management Programme
- Emerging Joint Board Development Programme

Enabling work

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

ICS Development Action Log

Joined Up Care Derbyshire

Action	Lead	Delivery Date
Set out a programme for engagement with the public to share and embed our vision and strategic narrative Define stakeholder audience segmentation and modes of communication	Sean Thornton	October 2020
Review purpose and function of Joined Up Care Derbyshire (JUCD) Board including revision of agenda and membership	John MacDonald	January 2020
Revise how JUCD Board communicate across the system : 3 key messages /Monthly update to organisations	Vikki Taylor/Sean Thornton	Completed
Agree and implement interim governance arrangements, including: Splitting CEO System Executive/Finance Directors Group to enable the Chief Exec's to focus on system business /Introduction of a Quality and Performance Forum and ICP Development & Implementation Group	Vikki Taylor	Completed
Finalise and agree the future ICS system architecture Agree the process required for each organisational Board to sign off decisions around system architecture	System Executive: CEO Group	March 2020
Ensure PCN representation in system meetings and system development : Place Alliance Board/ICP Development Group Action COMPLETED JUCD Board/System Leadership OD	Clive Newman/Vikki Taylor	October 2020
Undertake appraisal of different ICP options : Establish ICP Development Group	ICP Development Group – Ifti Majid	January 2020
Establish and embed single system PMO: Phase 1: Cross organisational support to SSG ACTION COMPLETED. Phase 2: Agee PMO functions required to support system and implement	Gavin Boyle /Chris Clayton	December 2019
Establish stronger interface between priority transformation work-streams and wider determinants of health work-streams within Health & Wellbeing Boards and how we effectively engage the voluntary sector	Cate Edwyn/Vikki Taylor	January 2020

Joined Up Care Derbyshire

ICS Development Action Log

Action	Lead	Delivery Date
Develop clear system operating plans to support collective prioritisation and decision making, with delivery organised around neighbourhood (PCNs) and Place Alliances 2019/20 Transformation delivery. ACTION COMPLETED STP Refresh: Develop 5 year transformation strategy - or each system transformation priority, detail associated financial, workforce and activity implications	Sukhi Mahil	November 2019
Develop Clinical Care Strategy	CPRG – Avi Bhatia and Steve Lloyd	October 2019
Focus on Place Alliance development and delivery: Demand (NELs) reduction plan and implementation Determine interventions to prevent deterioration of the top 25% of at risk patients (not top 5%)	Place Alliance Board - Penny Blackwell	March 2020
Embed PHM cross the system: Design operational model for BI support to system Agree how to resource BI model Roll out PHM across Place Alliances Agree a system wide data sharing agreement	Dean Wallace/Lee Outhwaite	December 2019
Implement single control total	Finance Forum – Lee Outhwaite	December 2019
Develop collective system financial plan	Finance Forum – Lee Outhwaite	December 2019
Continue roll out of system leaders OD programme: • build a sense of common purpose in the JUCD Board using the frameworks from the Farrar session. • Run further joint NED/ED board development sessions to include a workshop on the STP refresh and response to the Long Term Plan and learning/reflections from the Farrar session • Consider how we engage our staff in "socialising" the idea of collaboration for integration in induction etc Develop a whole system OD programme	Linda Garnett	November 2019
Develop demand and capacity model for the system	Planning Leads Group	November 2019
Fully understand Estates and Capacity requirements across the system and how these impact on location of service delivery and financial sustainability	William Jones/Lee Outhwaite	March 2020

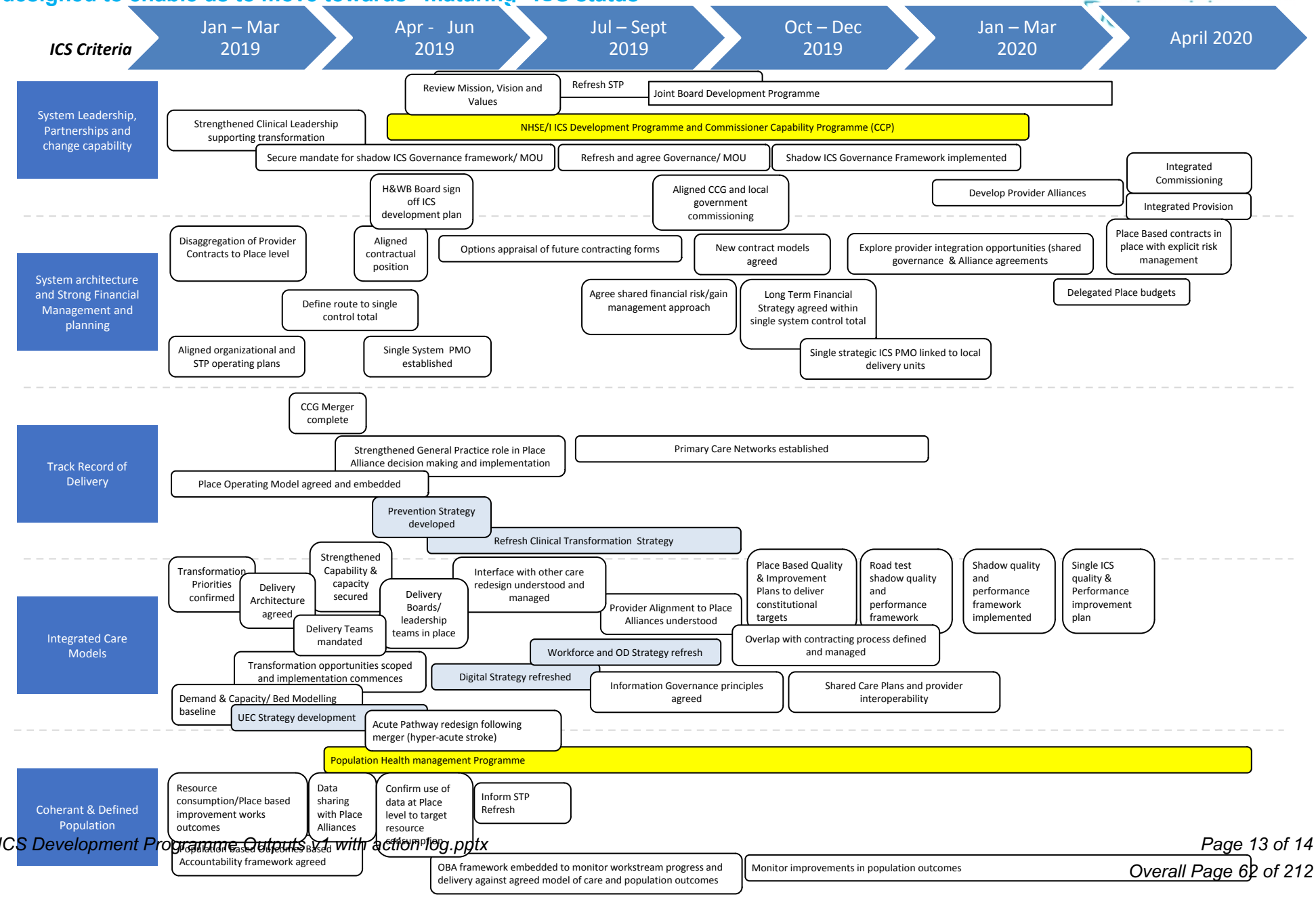
In The Next 6 Months We Will:

- Agree our 5 year system transformation strategy
- Be able to evidence the impact of our transformational change programmes
- Be clear on the role of PCNs and how they work with other community providers
- Continue to build resilience and services provided at Place Alliance level
- Embed population health management at Place Alliance and PCN level
- Describe how many Integrated Community Providers Derbyshire will have and what benefits they will offer our communities
- Implement a system wide Board level OD programme to help organisations increasingly work in the system space
- Develop a shared system financial plan for future years

The following slides set out the work to be completed to enable Derbyshire to become as ICS by April 2021

Roadmap to April 2020 (DRAFT to be updated from ICS Development Programme)Key steps designed to enable us to move towards "maturing" ICS status

Joined Up Care



Roadmap to April 2021 (DRAFT to be updated from ICS Development Programme) Key steps designed to enable us to move towards "maturing" ICS status

Joined Up Care

ICS Criteria	Jan – Mar 2019	Apr - Jun 2019	Jul – Sept 2019	Oct – Dec 2019	Jan – Mar 2020	Apr - Jun 2020	Jul – Sept 2020	Oct – Dec 2020	Jan – Mar 2020	April 2021
System Leadership, Partnerships and change capability	Review Mission, Vision and Values and public consultation. Add shared values	Joint Board Development Programme Refresh STP Further strengthen Clinical Leadership on transformation.CRPG update/review	Aligned strategic commissioning; CCG, & local government	Strategic commissioners to understand how to commission to improve outcomes and reduce inequalities	Start to proactively share roles and open up boards				Shadow ICS Governance Framework implemented	
	Clinical Leadership supporting transformation identified for key system priorities - next step to free up more resource to support	Refresh and agree Governance/ MOU	Releasing & deploying capacity for system work	H&WB Board sign off ICS development plan	Regular (monthly) update to H&WB Board	Set out a programme for engagement with the public and staff to share and agree our vision and strategic narrative (which has already been agreed at board levels across the system)				
	NHSE/I ICS Development Programme and Commissioner Capability Programme (CCP)				Council/District Engagement	Integrated planning across organisations golden thread				
					Alignment with BCF - local democracy/accountability					
System architecture and Strong Financial Management and planning	Aligned contractual position	Options appraisal of future contracting forms - planning group up and running			(Principles and contracts before) new contract models signed				Place Based contracts in place with explicit risk management	
		Single System PMO established (Phase 1)	Single System PMO Phase 2: establish system functions							
		Agree shared financial risk/gain management approach	Define route to single control total							
			"STP Refresh" Long Term Financial Strategy agreed within single system control total -> ongoing workstream to get financial balance							
Track Record of Delivery	CCG Merger complete	Primary Care Networks established. 15 agreed	Define Strategic Commissioner including LAs	PCNs | Provider to contract with. 'Pilot' for a PCN/Place budget						
	Place Operating Model agreed and embedded.	Prevention Strategy developed	Strategic conversation on focus to influence IOP constitutional targets	Road test shadow quality and performance framework	PCN leadership culture and development					
		Strengthened General Practice role in Place Alliance decision making and	Refresh Care Transformation Strategy (start Sept)							
			Define 'Clinical Strategy' ('Care Strategy') and 'population management'.							
Integrated Care Models	Transformation Priorities confirmed	Interface with care workstream redesign understood and managed	Develop ICPs (ongoing)	Align Clinical Strategies		Shadow quality and performance framework implemented			Single ICS quality & Performance improvement plan	
			Strategy - breaking down pathways: community & secondary							
			Workforce and OD Strategy							
		Digital Strategy refreshed	Integrated Care Models - building community integrated care. Framework and outcomes.							
	Demand & Capacity/ Bed Modelling baseline	Transformation opportunities scoped and implementation commences	Information Governance principles agreed							
	Aligned organisational and STP operating plans	UEC Strategy development								
	Population Health management Programme									
Coherent & Defined Population		Data sharing with Place Alliances	Inform STP Refresh	Be clearer about health inequalities and how to utilise resource around Places/ICP & populations						
	Population based outcomes Based Accountability framework agreed	Embed PHM								
		OBA framework embedded to monitor workstream progress and delivery against agreed model of care and population outcomes		Monitor improvements in population outcomes						

Joined Up Care Derbyshire

Joined Up Care Derbyshire

5 Year Strategy Delivery Plan:

2019/20 to 2023/24

DRAFT v1: 27 September 2019 submission

Executive Summary

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

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

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

Towards a Healthier Derbyshire

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

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

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

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

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

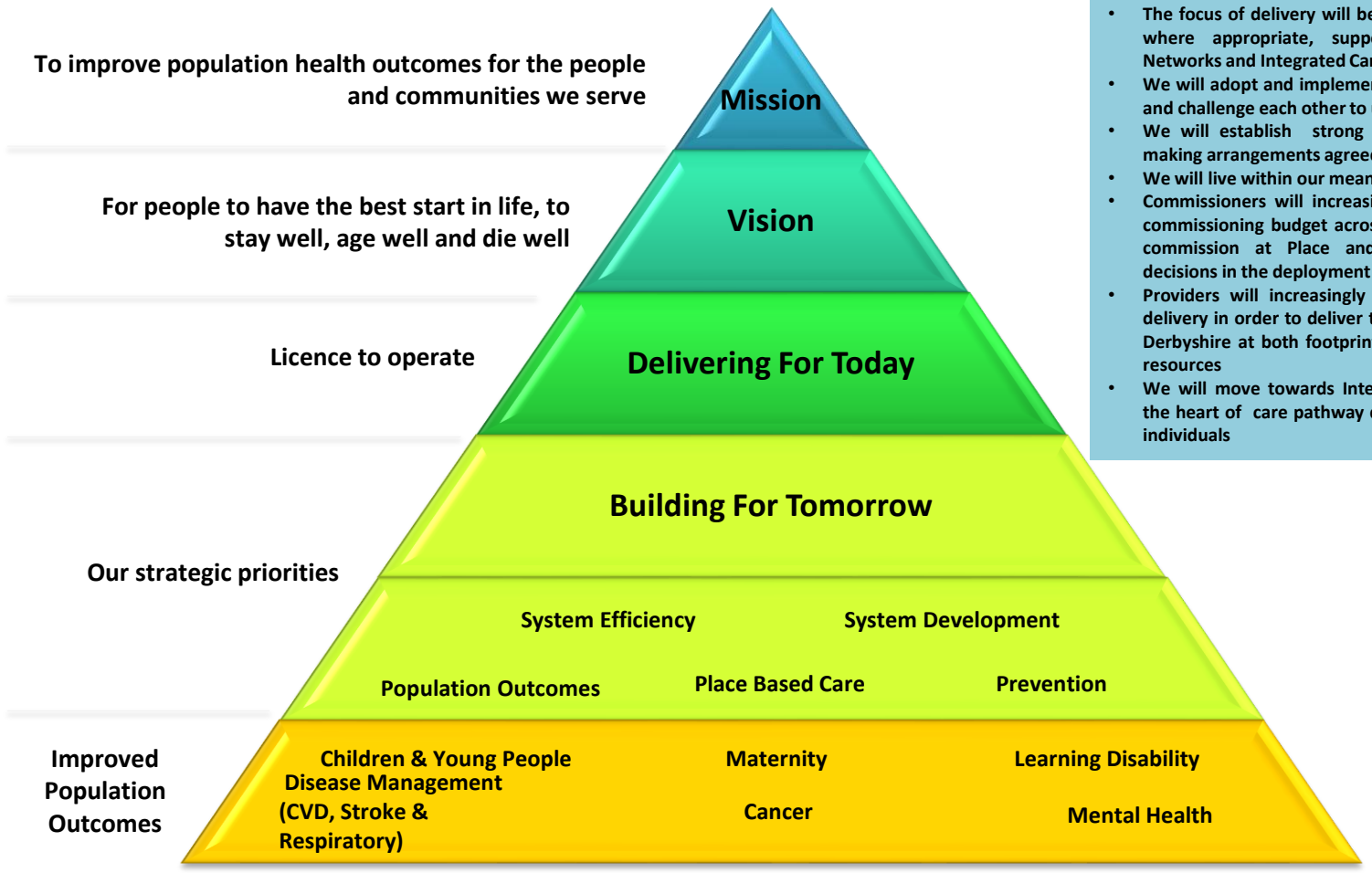
The Derbyshire ambition to deliver the **Quadruple Aim - Improving experience of care (quality & satisfaction), Improving the health of the population, Improving staff experience and resilience, Reducing the per capita cost of healthcare**; will remain at the forefront in our approach and will be underpinned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

Our plan will continue to evolve and there will be opportunities for Derbyshire people to share their views to help make services the best they can be. For more information, and to find out in coming months about how to get involved please visit https://www.joinedupcarederbyshire.co.uk/
Any changes proposed to current services would involve local engagement and, if appropriate, consultation. Any consultation would follow legal guidance, and involve as many local people as possible.

What is Joined Up Care Derbyshire?

DRAFT v1

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



What Will Be Different

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

Our Guiding Principles: We will…

Be driven by the interests of the people and communities we serve

Support each other address barriers to system transformation

Ensure services are provided as close as possible to the places people live

Design health and care services to meet the needs and wants of the people who use them, not the organisations who provide them

Derbyshire STP – 'plan on a page'

DRAFT v1

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

(1) The Quadruple Aim: Challenges

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

- Fundamentally, we know that across Derbyshire people are living longer in ill health and significant inequalities exist; the are areas of significant rurality which create access challenges.
- We have made significant progress with beginning to 'join up care'; however, there remain many opportunities to integrate care more effectively and consistently. We are still overly reliant on bed-based care. Add something ref to LTP re delivering 21C integrated care
- We also know we have significant improvements to make in Primary Care and Urgent Care, as well as ongoing improvements in a number of other areas
- The financial gap for the Derbyshire health system is £219m, with a further £136m (update) gap across the two local authorities (LAs) - there are a number of factors that are driving this position

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

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

(2) Our priorities

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

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

(3) Impact & Implications

Delivering our plan will help us to:

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

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

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

(4) Next steps

Delivering the STP:

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

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Partners involved in Joined Up Care Derbyshire

Primary Care Networks Place Alliances

Derbyshire Health United

Derbyshire Healthcare Foundation Trust EMAS

Chesterfield Royal Hospital General Practice

Derbyshire Community Hospitals Services

Derby and Derbyshire CCG GP Provider Alliance

Derbyshire District and Borough Councils

Derby City Council Derbyshire County Council

University Hospitals of Derby and Burton LMC

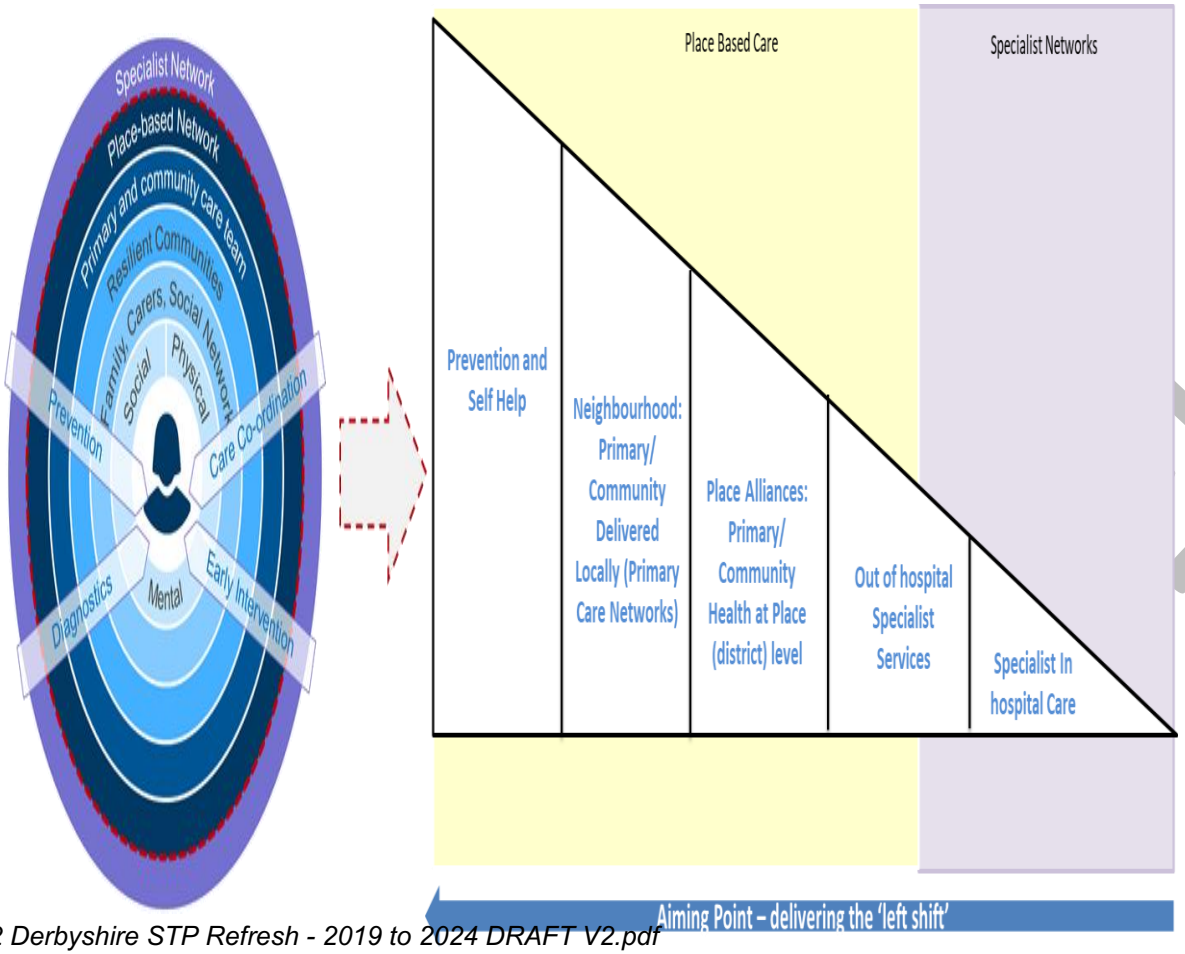
Voluntary Sector NHS England Direct Commissioning

We are in this together…..

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

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

The Derbyshire Model of Care



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

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

... founded on building strong, vibrant communities.

Our plan is underpinned by a system wide Clinical Strategy developed through our Clinical and Professional Reference Group (CPRG). This is based on a set of agreed care principles and standards.

Both Local Authority representatives are members of the Joined Up Care Derbyshire Board and have been fully engaged in the STP to date and are involved at Place level and are SROs for specific workstreams. These relationship and arrangement will continue as part of the future delivery arrangements.

We are actively engaging broader representatives in relation to our plan as we intend to develop our approach in relation to the wider determinants of health and have had early discussion with housing, air pollution leads etc. This work will be led through the Director of Public Health at Derby City on behalf of the system. We have also discussed (and will continue to do so) our plan with both Health and Wellbeing Boards and Health Scrutiny. Local authority representatives have also been actively engaged in wider engagement sessions which have taken place to inform the development of the plan.

Journey So Far (2)

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

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

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

In response we have:

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

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

Challenges and lessons learnt

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

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

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

Overview of the Derbyshire STP Footprint

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

Demography and Diversity

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

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

A wide range of health and care commissioners & providers

The statutory organisations within Derbyshire are:

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

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

Health of our population

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

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

'Out of county' healthcare provision

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

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

Health and care spending

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

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

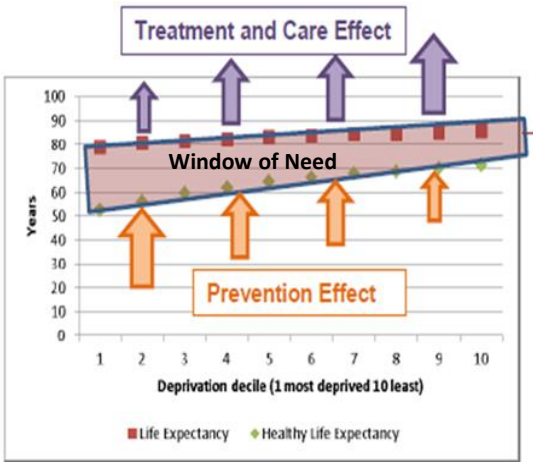
Based on our current assumptions we have a need for additional savings of £32m, £34m, £32m and £39m in 20/21 to 23/24, to live within the current Derbyshire resources.

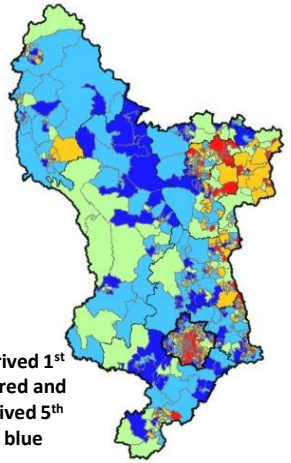
Our plan must tackle and address the forecast growth in health and care service demand

Improving the health of the population

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

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





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

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

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

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

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

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

*affected by suppressed values

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

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

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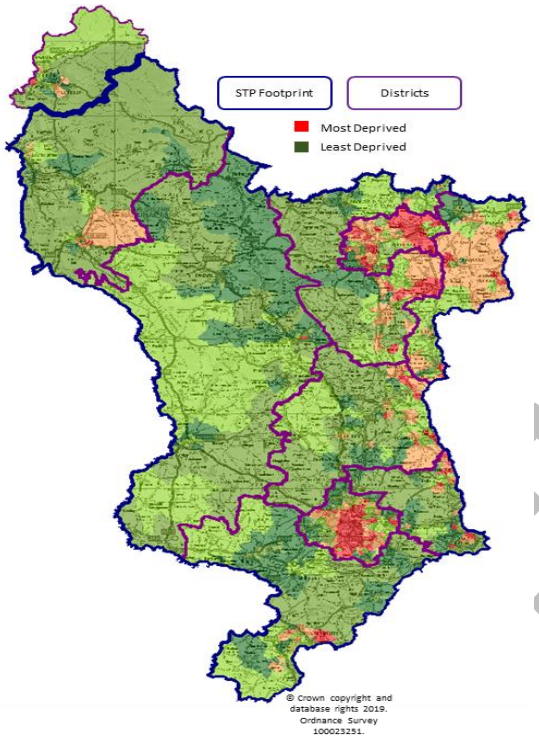
North East Derbyshire - 101K people, ↑ 1.4% next 5 years, 75+ years ↑ to 14K. Largely rural and prosperous area but pockets of deprivation in and around Clay Cross and Grassmoor. 6.6% ESA claimants. Highest adult excess weight in county. Significantly higher rates of hospital admissions for self harm and alcohol.

'Double jeopardy'; we know that far shorter lives are spent in far poorer health in the most deprived areas . Much of the increasing demand for health and care services is for treatment of preventable conditions.

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

Chesterfield - 105K people, ↑ 0.9% next 5 years, 75+ years ↑ to 12K. Clear areas of high deprivation throughout the district. 8% of people claiming employment support benefits and 20% of children in low income families. Average life expectancy significantly lower for men and women. Premature mortality from CVD highest in the county.

High Peak– 92K people, ↑ 0.9% next 5 years, 75+ years ↑ to 10.5K. Sparsely populated areas reflected in above average travel times to key services. Generally better than or similar to England, but alcohol specific hospital admissions remain significantly higher than average. The gap in employment for people with a long-term condition is in the highest 20% in England.



Bolsover – 79K people, ↑ 2.3% next 5 years, 75+ years ↑ to 8.5K. High deprivation, significantly lower average weekly earnings, significantly higher prevalence of health risk behaviours. Reflected in significantly higher premature mortality and significantly lower overall life expectancy. However, the self-rated happiness score is highest in the county.

Amber Valley – 126K people, ↑ 1.9% next 5 years, 75+ years ↑ to 15.5K. Deprivation in and around Alfreton, Somercotes, Ripley and Heanor reflected in stark inequalities in average life expectancy. Gap in life expectancy for females is in the highest 20% nationally. Smoking significantly higher in both R&M occupations and pregnant women.

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

Derbyshire Dales – 71K people, expected 0.6% growth in 5 years, 75+ increase to 11K, around 15% of total population. Though a largely prosperous area, the older population, rurality, inaccessibility to key services and hidden pockets of deprivation present their own challenges.

Derby City – 260K people, 26% 16-34 years. Population ↑ 2% next 5 years, 75+ years ↑ to 23K. Around a quarter of the population from BME groups. Significant areas of deprivation in and around the city centre and higher proportions of children in lower income families and ESA claimants. Significantly lower life expectancy and higher premature mortality from CVD and respiratory disease. Smoking prevalence, alcohol and self-harm admissions all worse than average.

South Derbyshire – 103K people, ↑ 4.3% next 5 years, Two thirds of the population are working age, but the number 65+ will increase by 12% to 21.6K. Relative job density is low and it is the only county district with a significantly higher rate of homelessness. Female life expectancy is significantly below average.

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

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

Erewash – 117K people, ↑ 2.4% next 5 years, 75+ years ↑ to 13K. Deprivation exists around the 2 towns of Ilkeston and Long Eaton. Job density is relatively low for an area with a younger population. 18% of women are smoking at time of delivery, and a quarter of 4-5 year olds are overweight/obese. Self harm admissions are significantly higher.

Improving experience of care (quality & satisfaction)

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

Why do we need to change?

The lack of joined up care results in…

Services which are not integrated effectively:

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

Care is not proactive:

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

Frail elderly patients decompensate:

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

Our system being overly reliant on bed-based care…

Patients are not supported to be independent:

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

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

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

What does this mean for our services and our people?

Urgent & Emergency Care

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

Cancer

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

Mental Health

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

Planned Care

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

Learning Disabilities & Autism

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

Children & Young People

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

Condition Specific:

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

Primary Care:

- Variation in screening, early diagnosis and chronic disease management , means impact on quality of life, independence and life expectancy.
- Patients waiting for access to see GPs quickly is variable,

Our most fundamental challenge is therefore posed not by any individual service, but by the overall shape of the current system and ability to effectively join-up care.

Reducing the per capita cost of healthcare

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Derbyshire STP

LTP - Key Finance Numbers - 27th September Submisison

System Efficiency Target

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

System In Year Underspend/(Deficit)

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

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

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

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

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

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

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

These savings STP Remodelled 2019 to 2024 DRAFT V2.pdf workbook and the key work in the system is now the valuation of the workstreams and the broader redesign initiatives for 20/21 and beyond, adding to and firming up those plans.

Case for Change: Improving staff experience and resilience

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

Recruitment and attraction

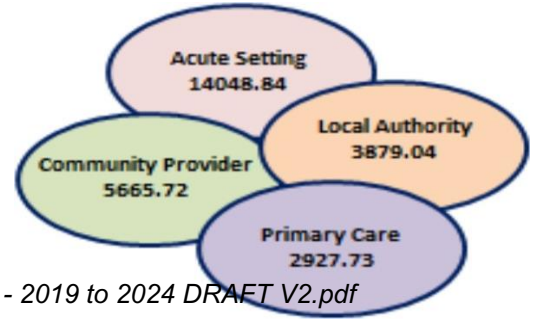
In health and care, we operate in multiple labour markets for different types of staff. In Derbyshire, employment is at 79%, compared to 76% nationally with the number of vacancies steadily increasing across all sectors, so we have to rethink how we can attract people into health and care, to develop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

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

Transforming the way in which staff work

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

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



Changing the skill mix and introducing new roles

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

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

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

Making the NHS a great place to work

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

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

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

Our Strategic Priorities

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

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

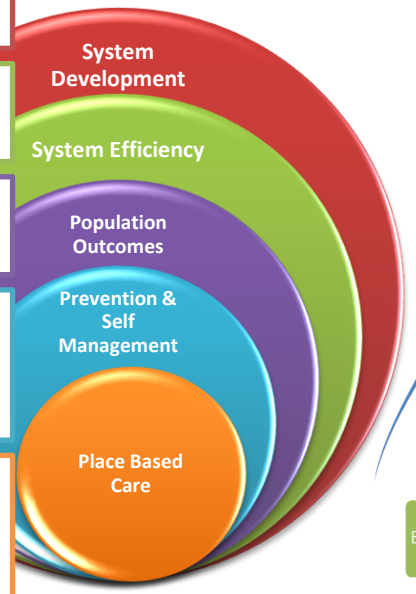
We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

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

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

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

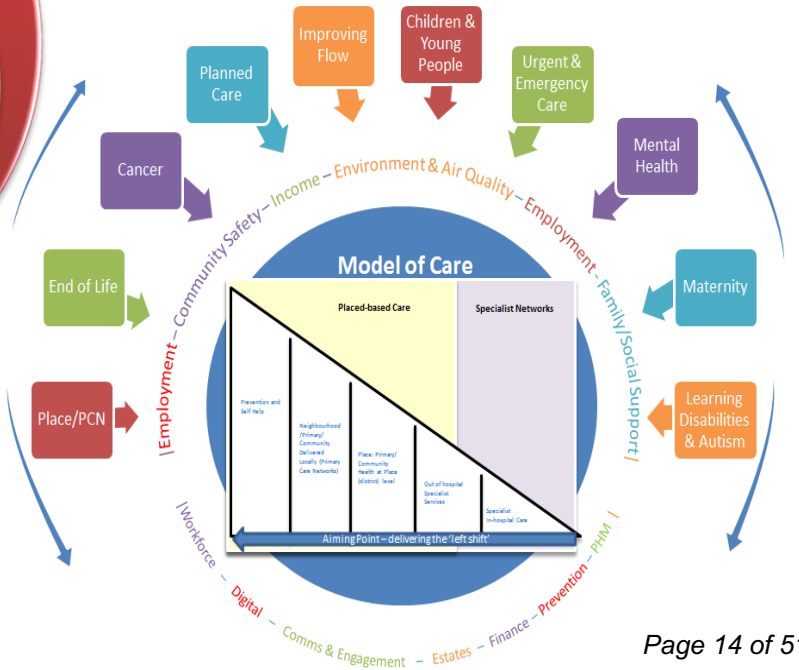
We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. So that services operate as a single team, wrapping care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



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

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

Joined Up Care Derbyshire Programme Areas



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

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

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

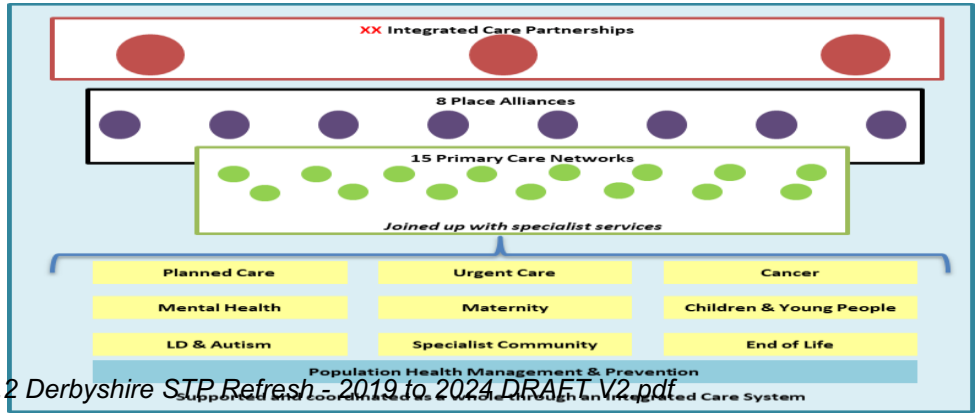
The Derbyshire Model of Care is essentially designed to deliver more localised place based care, whereby we will keep people:

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

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

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

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



Personalised Care

We see personalised care as an enabler for other key priorities set out in our five year plan, as a fundamental element of ensuring effective prevention and in supporting individuals to act independently to make their own free choice and to enable shared decision-making. Personalised care is therefore embedded throughout our priority programmes; a summary snapshot of alignment can be found at Appendix 2.

To achieve the 'step change' in preventing ill health and supporting people to live healthier lives; delivery of our model of care will enable a cultural shift for health and care professionals, to promote 'wellness', in the public and patients in developing the confidence to self-manage and take a lead role in decisions about their health. Our approach is described further in the prevention strategic priority section.

By 2023/24 we are committed to implementation of The NHS Comprehensive Model of Care For Personalised Care's 6 principles of Personalised Care as a universal whole system approach, ensuring we meet the personalised care requirements set out in the Long Term Plan. Specifically:

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

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

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

Primary Care Networks (PCNs)

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

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

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

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

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

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

2. **Support the development of PCNs**
   - The Derbyshire STP is on target to fully meet the requirements for PCNs and their development

3. **Improve the responsiveness of community health crisis response services to deliver the services within two hours of referral, and reablement care within two days of referral**
   - Within the Derbyshire STP there are 4 Rapid Response pilots with the Urgent Care and Mental Health Work streams. The PCNs have identified key link personnel who work directly with these areas to ensure the effective development of rapid response teams.

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

Enhanced Health in Care Homes

Work is underway with PCNs to develop the approach in 2019/20 which will be aligned to the national specification thereafter (anticipated in October/November 2019). We will commission PCNs to work together to develop, at scale, models of pro-active, integrated care to support care homes residents by:

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

Strategic Priority: Prevention and Self-management

DRAFT v1

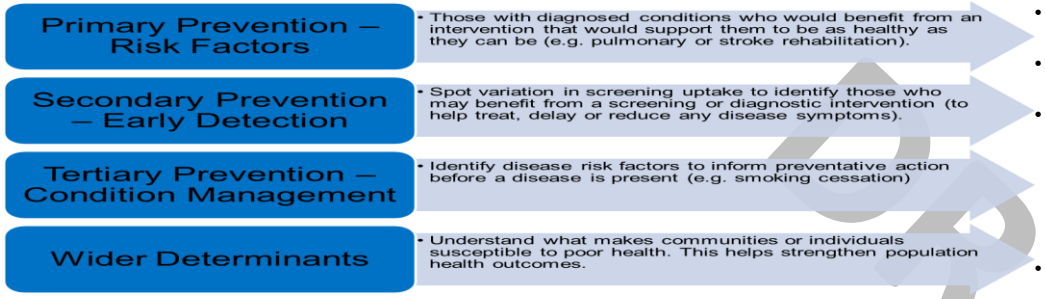
By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand.

Why is this a priority for Joined Up Care Derbyshire?

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

Our Approach

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



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

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

In doing so we will:

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

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

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

Prevention and Place based care

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

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

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

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

Strategic Priority: Prevention and Self-management

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

Delivering national priorities

The NHS Long Term Plan provides a renewed focus on prevention highlighting the need to reduce inequalities and enabling people to stay healthier for longer; setting out the following risk factors as priorities for the prevention agenda; screening and immunisation, smoking, obesity, alcohol, air pollution, anti-microbial resistance (resistance to some anti-biotics). There are also national NHS initiatives that support prevention including Cancer Screening, National Diabetes Prevention programme & NHS Health Checks. Our strategic approach to the key deliverables set out in the LTP are descried below, with more specific prevention deliverables described later in this document and embedded within our respective programmes of work.

Embedding preventative approaches in everything we do, has the potential to make the greatest impact to the overall health and welling of our population, reduce inequalities (geographical and for high risk/use groups) and wider determinants which affect use of our systems finite resources.

Key indicators which will demonstrate our progress can be found in our outcomes based accountability such as life expectancy, healthy life expectancy, mortality under 75 years due to CVD, Emergency admissions due to falls, smoking at time of delivery, population vaccination and screening.

Smoking

We will enable staff, patients and visitors to become smoke-free through:

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

Obesity

We will develop a greater focus on obesity by 'upscaling' support to people who are overweight or obese within a 'whole systems' approach, for example, planning, licencing, access to green space, active travel and policy.

JUCD system organisations will be a leader in enabling staff, patients and visitors to be active and eat healthy through:

- Ensuring organisational policies and infrastructure create an environment that enables healthy eating and active travel
- Ensuring weight management services are promoted and signposting/referring into services is systematic, including links to other programme area deliverables such as the diabetes weight management.
- Utilising nationally developed resources such as fitter, better sooner/stop before any surgical interventions.

Alcohol

Alcohol admissions are significant issue for the City and to some degree the County; we have therefore prioritised this in our prevention strategy to enable healthier choices which result in:

- Increased numbers of adults in Derbyshire drinking within the recommended limits
- Decreased rates of alcohol related admissions
- Increased rates of dependent drinkers accessing services

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

Air Pollution

Engage through our Air Quality Working Group, to focus on protection from pollution and prevention, specifically for people with long term conditions to raise awareness of triggers. Our key areas of focus include:

- Travel behaviours with partners facilitating sustainable and healthy travel options
- Reducing sources of air pollution
- Proportion of people living in a smoke control zone
- Mitigating the health impacts of air pollution

Antimicrobial resistance

We will establish a system wide Antimicrobial Resistance (AMR) steering group, and determine a baseline position from each provider to build upon work undertaken to tackle AMR and related Gram Negative Blood Stream Infection (GNBSI); using this as the forum to fully implement the Governments national action plan 'Tackling Antimicrobial Resistance' to reduce overall antibiotic use, health care associated GNBSI and drug resistant infections. A series of NHSE/I led regional sessions are being held in November 2019 which will inform our planning and approach which will include targeted approaches for high risk populations and areas of high variation.

Effective Population Health Management (PHM) to improve population outcomes

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

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

Our Approach

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

Culture and leadership

- Engaging and supporting change in the system to embed effective PHM.
- Better use of clinical leadership to drive transformation.

Workforce

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

Technical & infrastructure

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

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

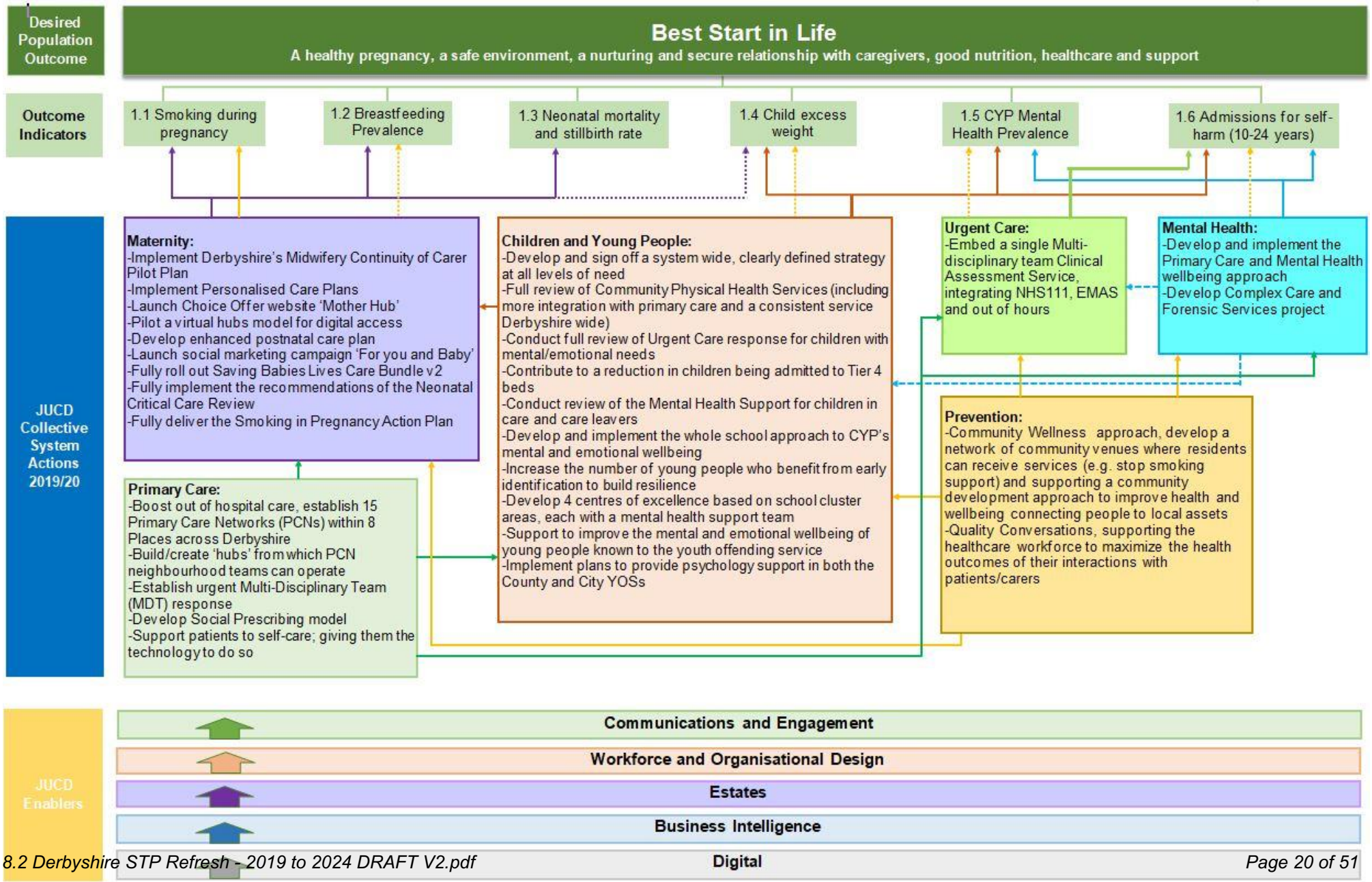
Outcomes Based Accountability (Whole Systems Outcomes)

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

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

We have agreed a set out outcome indicators across our existing programmes which are aligned to improvements in our three overarching population outcomes for people to have the best start in life, stay healthy, age well and die well. These indicators are also consistent with the LTP metrics. Our framework is set out on the following pages.

By delivering the collective transformation programmes as set out in our plan, we will make real improvements in the health outcomes for the people of Derbyshire.


Desired Population Outcome
Best Start in Life
A healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition, healthcare and support
Outcome Indicators
1.1 Smoking during pregnancy
1.2 Breastfeeding Prevalence
1.3 Neonatal mortality and stillbirth rate
1.4 Child excess weight
1.5 CYP Mental Health Prevalence
1.6 Admissions for self-harm (10-24 years)
JUCD Collective System Actions 2019/20
Maternity:
-Implement Derbyshire's Midwifery Continuity of Carer Pilot Plan
-Implement Personalised Care Plans
-Launch Choice Offer website 'Mother Hub'
-Pilot a virtual hubs model for digital access
-Develop enhanced postnatal care plan
-Launch social marketing campaign 'For you and Baby'
-Fully roll out Saving Babies Lives Care Bundle v2
-Fully implement the recommendations of the Neonatal Critical Care Review
-Fully deliver the Smoking in Pregnancy Action Plan
Children and Young People:
-Develop and sign off a system wide, clearly defined strategy at all levels of need
-Full review of Community Physical Health Services (including more integration with primary care and a consistent service Derbyshire wide)
-Conduct full review of Urgent Care response for children with mental/emotional needs
-Contribute to a reduction in children being admitted to Tier 4 beds
-Conduct review of the Mental Health Support for children in care and care leavers
-Develop and implement the whole school approach to CYP's mental and emotional wellbeing
-Increase the number of young people who benefit from early identification to build resilience
-Develop 4 centres of excellence based on school cluster areas, each with a mental health support team
-Support to improve the mental and emotional wellbeing of young people known to the youth offending service
-Implement plans to provide psychology support in both the County and City YOSs
Urgent Care:
-Embed a single Multi-disciplinary team Clinical Assessment Service, integrating NHS111, EMAS and out of hours
Mental Health:
-Develop and implement the Primary Care and Mental Health wellbeing approach
-Develop Complex Care and Forensic Services project
Prevention:
-Community Wellness approach, develop a network of community venues where residents can receive services (e.g. stop smoking support) and supporting a community development approach to improve health and wellbeing connecting people to local assets
-Quality Conversations, supporting the healthcare workforce to maximize the health outcomes of their interactions with patients/carers
Primary Care:
-Boost out of hospital care, establish 15 Primary Care Networks (PCNs) within 8 Places across Derbyshire
-Build/create 'hubs' from which PCN neighbourhood teams can operate
-Establish urgent Multi-Disciplinary Team (MDT) response
-Develop Social Prescribing model
-Support patients to self-care; giving them the technology to do so
JUCD Enablers
Communications and Engagement
Workforce and Organisational Design
Estates
Business Intelligence
Digital

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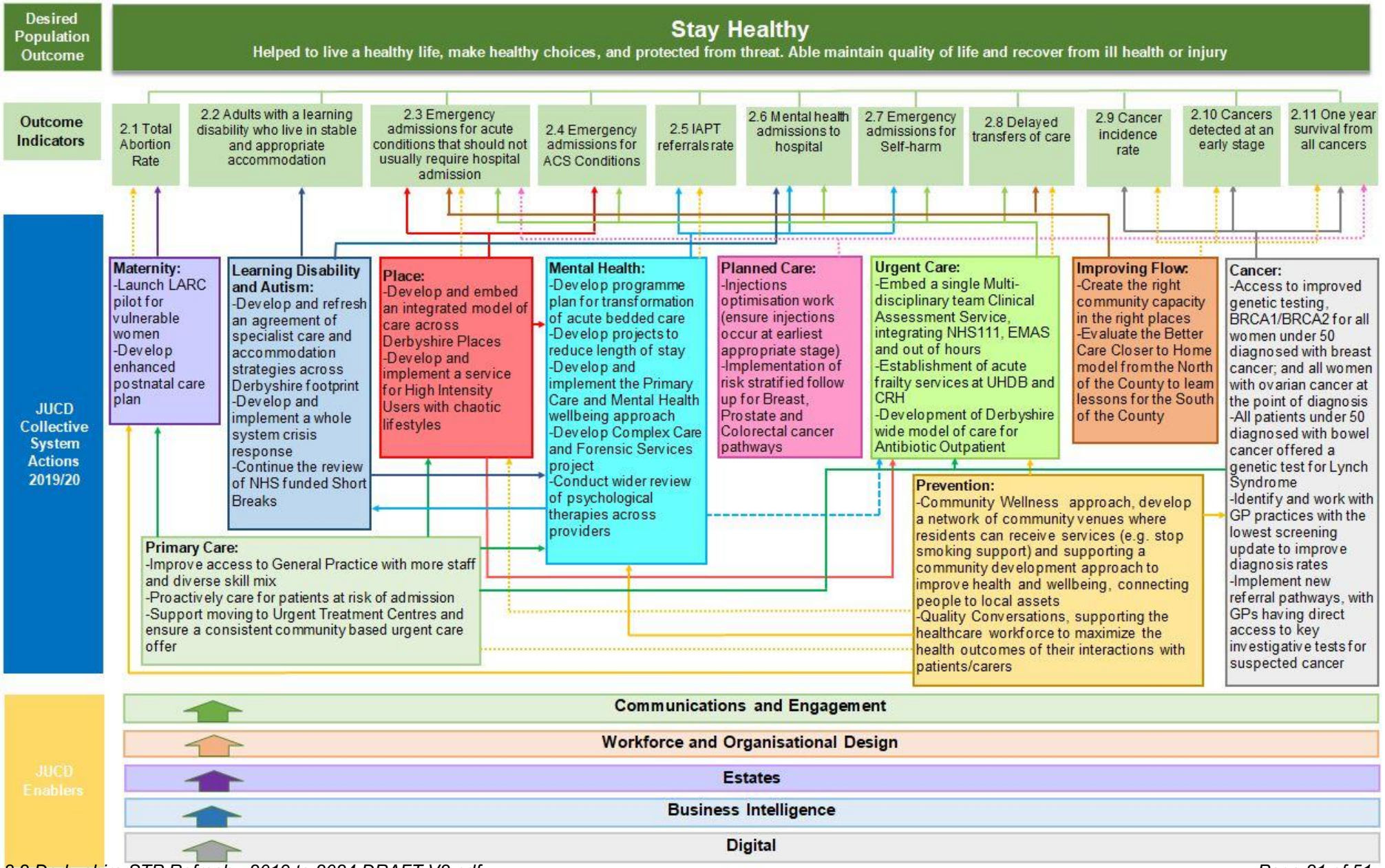
Desired Population Outcome
Stay Healthy
Helped to live a healthy life, make healthy choices, and protected from threat. Able maintain quality of life and recover from ill health or injury
Outcome Indicators
2.1 Total Abortion Rate
2.2 Adults with a learning disability who live in stable and appropriate accommodation
2.3 Emergency admissions for acute conditions that should not usually require hospital admission
2.4 Emergency admissions for ACS Conditions
2.5 IAPT referrals rate
2.6 Mental health admissions to hospital
2.7 Emergency admissions for Self-harm
2.8 Delayed transfers of care
2.9 Cancer incidence rate
2.10 Cancers detected at an early stage
2.11 One year survival from all cancers
JUCD Collective System Actions 2019/20
Maternity:
-Launch LARC pilot for vulnerable women
-Develop enhanced postnatal care plan
Learning Disability and Autism:
-Develop and refresh an agreement of specialist care and accommodation strategies across Derbyshire footprint
-Develop and implement a whole system crisis response
-Continue the review of NHS funded Short Breaks
Place:
-Develop and embed an integrated model of care across Derbyshire Places
-Develop and implement a service for High Intensity Users with chaotic lifestyles
Mental Health:
-Develop programme plan for transformation of acute bedded care
-Develop projects to reduce length of stay
-Develop and implement the Primary Care and Mental Health wellbeing approach
-Develop Complex Care and Forensic Services project
-Conduct wider review of psychological therapies across providers
Planned Care:
-Injections optimisation work (ensure injections occur at earliest appropriate stage)
-Implementation of risk stratified follow up for Breast, Prostate and Colorectal cancer pathways
Urgent Care:
-Embed a single Multi-disciplinary team Clinical Assessment Service, integrating NHS111, EMAS and out of hours
-Establishment of acute frailty services at UHDB and CRH
-Development of Derbyshire wide model of care for Antibiotic Outpatient
Improving Flow:
-Create the right community capacity in the right places
-Evaluate the Better Care Closer to Home model from the North of the County to learn lessons for the South of the County
Cancer:
-Access to improved genetic testing, BRCA1/BRCA2 for all women under 50 diagnosed with breast cancer; and all women with ovarian cancer at the point of diagnosis
-All patients under 50 diagnosed with bowel cancer offered a genetic test for Lynch Syndrome
-Identify and work with GP practices with the lowest screening update to improve diagnosis rates
-Implement new referral pathways, with GPs having direct access to key investigative tests for suspected cancer
Primary Care:
-Improve access to General Practice with more staff and diverse skill mix
-Proactively care for patients at risk of admission
-Support moving to Urgent Treatment Centres and ensure a consistent community based urgent care offer
Prevention:
-Community Wellness approach, develop a network of community venues where residents can receive services (e.g. stop smoking support) and supporting a community development approach to improve health and wellbeing, connecting people to local assets
-Quality Conversations, supporting the healthcare workforce to maximize the health outcomes of their interactions with patients/carers
JUCD Enablers
Communications and Engagement
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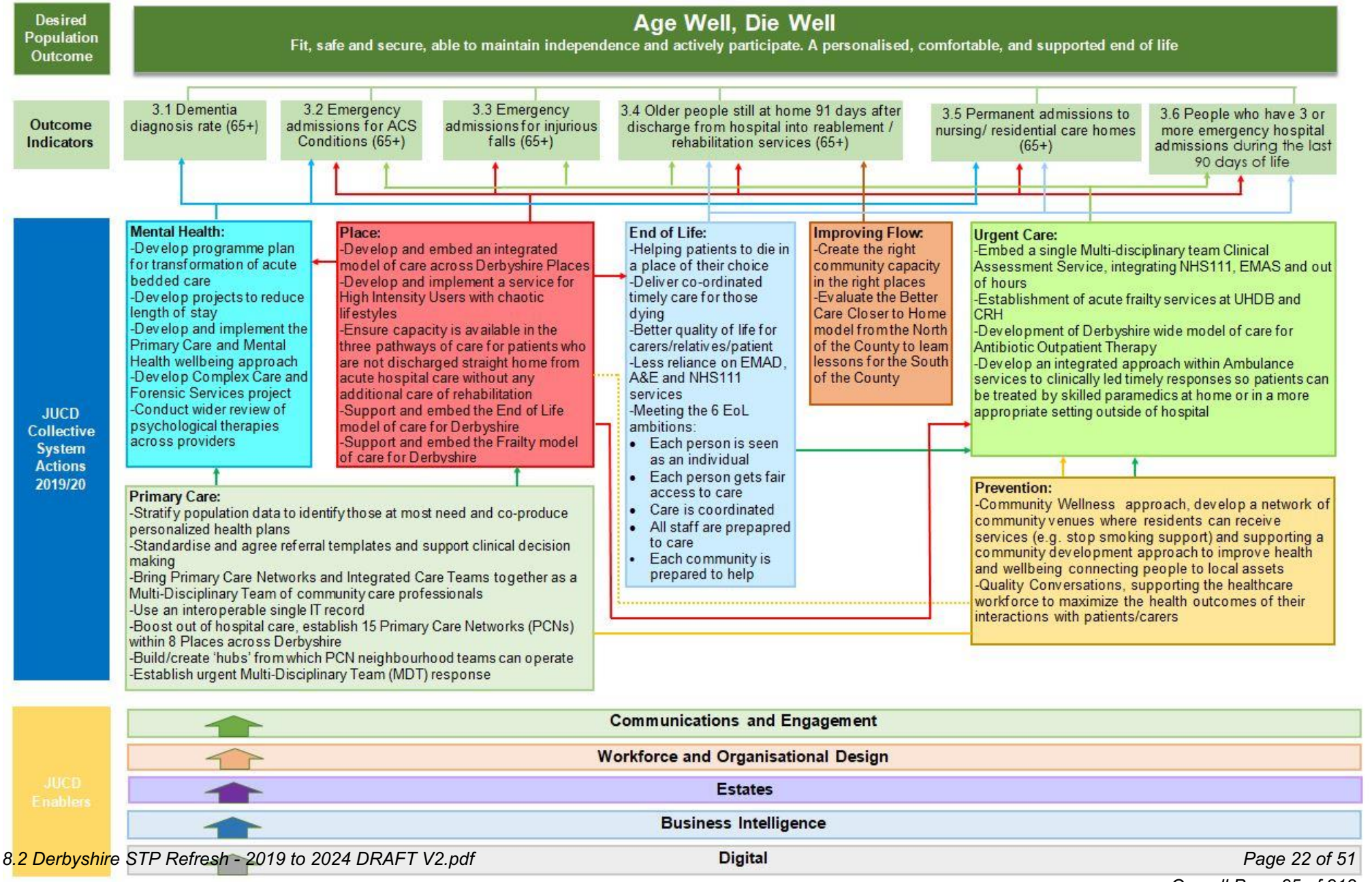
Desired Population Outcome
Age Well, Die Well
Fit, safe and secure, able to maintain independence and actively participate. A personalised, comfortable, and supported end of life
Outcome Indicators
3.1 Dementia diagnosis rate (65+)
3.2 Emergency admissions for ACS Conditions (65+)
3.3 Emergency admissions for injurious falls (65+)
3.4 Older people still at home 91 days after discharge from hospital into reablement / rehabilitation services (65+)
3.5 Permanent admissions to nursing/ residential care homes (65+)
3.6 People who have 3 or more emergency hospital admissions during the last 90 days of life
JUCD Collective System Actions 2019/20
Mental Health:
-Develop programme plan for transformation of acute bedded care
-Develop projects to reduce length of stay
-Develop and implement the Primary Care and Mental Health wellbeing approach
-Develop Complex Care and Forensic Services project
-Conduct wider review of psychological therapies across providers
Place:
-Develop and embed an integrated model of care across Derbyshire Places
-Develop and implement a service for High Intensity Users with chaotic lifestyles
-Ensure capacity is available in the three pathways of care for patients who are not discharged straight home from acute hospital care without any additional care of rehabilitation
-Support and embed the End of Life model of care for Derbyshire
-Support and embed the Frailty model of care for Derbyshire
End of Life:
-Helping patients to die in a place of their choice
-Deliver co-ordinated timely care for those dying
-Better quality of life for carers/relatives/patient
-Less reliance on EMAD, A&E and NHS111 services
-Meeting the 6 EoL ambitions:
• Each person is seen as an individual
• Each person gets fair access to care
• Care is coordinated
• All staff are prepapred to care
• Each community is prepared to help
Improving Flow:
-Create the right community capacity in the right places
-Evaluate the Better Care Closer to Home model from the North of the County to learn lessons for the South of the County
Urgent Care:
-Embed a single Multi-disciplinary team Clinical Assessment Service, integrating NHS111, EMAS and out of hours
-Establishment of acute frailty services at UHDB and CRH
-Development of Derbyshire wide model of care for Antibiotic Outpatient Therapy
-Develop an integrated approach within Ambulance services to clinically led timely responses so patients can be treated by skilled paramedics at home or in a more appropriate setting outside of hospital
Prevention:
-Community Wellness approach, develop a network of community venues where residents can receive services (e.g. stop smoking support) and supporting a community development approach to improve health and wellbeing connecting people to local assets
-Quality Conversations, supporting the healthcare workforce to maximize the health outcomes of their interactions with patients/carers
Primary Care:
-Stratify population data to identify those at most need and co-produce personalized health plans
-Standardise and agree referral templates and support clinical decision making
-Bring Primary Care Networks and Integrated Care Teams together as a Multi-Disciplinary Team of community care professionals
-Use an interoperable single IT record
-Boost out of hospital care, establish 15 Primary Care Networks (PCNs) within 8 Places across Derbyshire
-Build/create 'hubs' from which PCN neighbourhood teams can operate
-Establish urgent Multi-Disciplinary Team (MDT) response
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Digital

Strategic Priority: System Efficiency

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

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

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

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

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

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

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

Strategic Priority: System Development

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

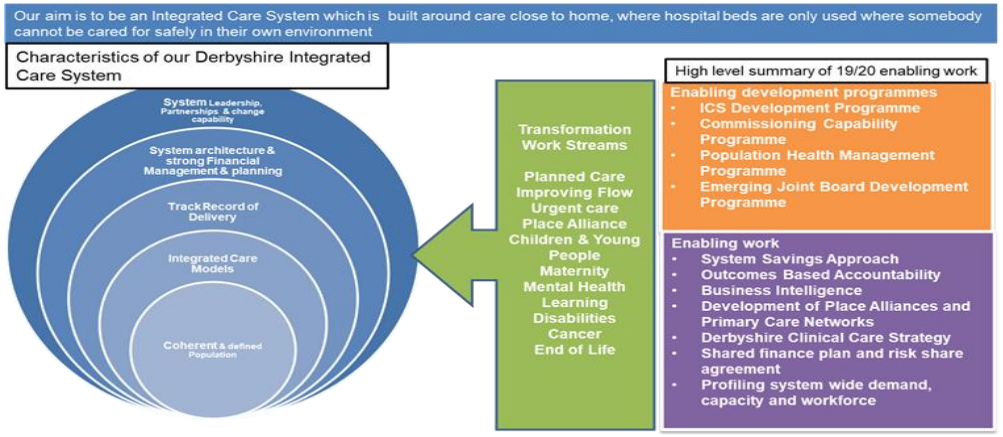
Why is this a priority for Derbyshire?

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

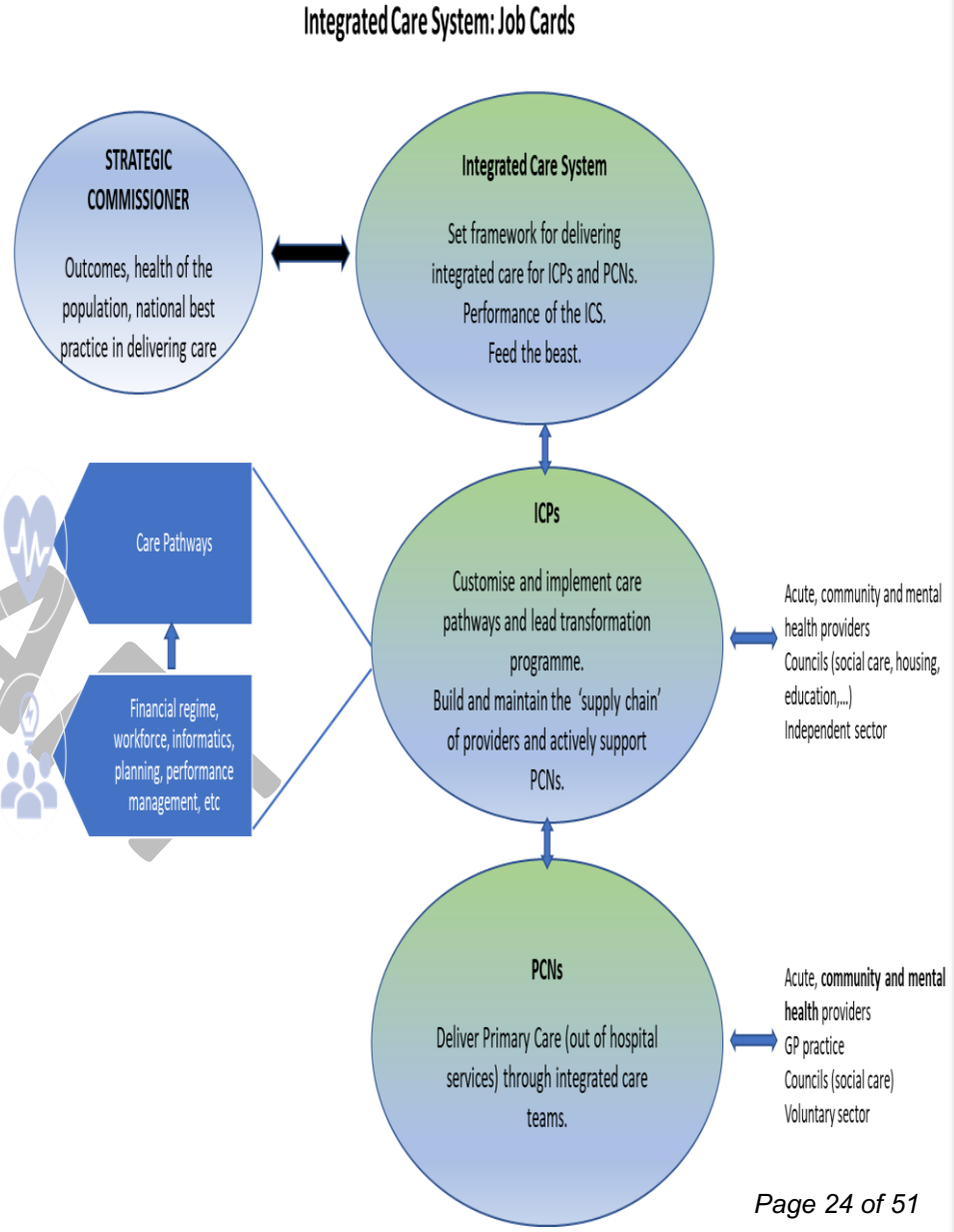
So, we need to ensure that this time we put the arrangements in place to drive sustainable, embedded change. These arrangements must address past barriers to change including the lack of cross-system working, misaligned incentives and the predominant organisational focus over system-wide and patient-centred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

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

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



The following diagrams describe what an ICS means for us in Derbyshire.



Strategic Priority: System Development

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

Our Approach

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

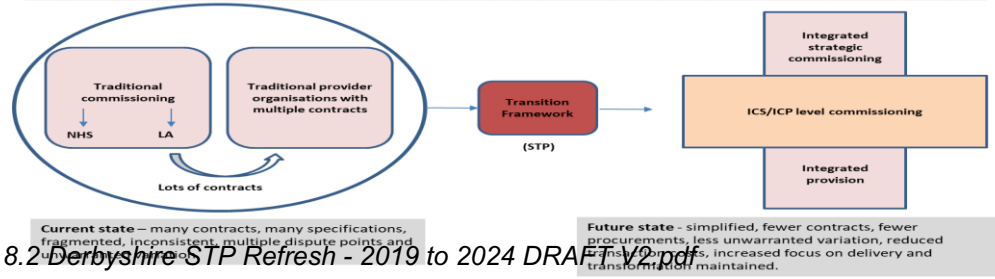
We will develop our partnership to become an ICS by April 2012 which is central to the delivery of the LTP; our future arrangements will include the following components.

Streamlined Strategic Commissioning

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

Strategic commissioning architecture in Derbyshire

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



Current state – many contracts, many specifications, fragmented, inconsistent, multiple dispute points and [illegible]

Future state - simplified, fewer contracts, fewer procurements, less unwarranted variation, reduced transaction costs, increased focus on delivery and transformation maintained.

Streamlined Provision

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

We will confirm our ICP configuration during quarter 3 of 2019/20, the next step will be for Derbyshire to agree a preferred option for implementation from the current long list .

What Derbyshire want ICPs to address/deliver for our population:

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

Delivering further progress on fully integrated Place Based Care

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As described in our strategic priorities, we will deliver transformed out of hospital care; this will be done through place based care, underpinned by our model of care

Key deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Assess and improve integrated community rapid response provision ensuring a 2 hour response is in place where clinically appropriate by 2024					✓
Ensure appropriate capacity is in place and transfers of care are quick and effective to deliver reablement within 2 days of referral by 2024					✓
Progress towards the ambition of an integrated service model available 24/7 as appropriate					✓
Work with PCNs to develop multi-disciplinary teams of community care professionals and review options for greater integration within the emerging ICP structure		✓			
Consistent proactive identification and management of people at risk of unwarranted health outcomes through risk stratification, assessment and care planning in line with the anticipatory care element of 'Ageing Well'	✓	✓			
Improve local provision in line with the Enhanced Care in Care Homes framework		✓			
Implement and review targeted case management approach to the most severe 'high intensity users'. Expand if successful	✓	✓			
Ensure community assets are understood and widen the support available for social prescribing link workers to access in each Place.					
Utilise population health management approaches to understand the use of, and demand for services across the health and care system to inform planning and prioritisation / development of provision for out of hospital care.	✓	✓			
Further develop opportunities to identify and meet the needs of people with 'lower level' mental health needs within the community			✓		
Maximise the benefits of access to the single health care record by integrated community teams and ambulance staff				✓	
Consider the opportunities, and maximise the benefits, of digitally enabled care in the community promoting early adoption		✓			
Contribute to continued reductions in the number / proportion of delayed transfers of care to achieve Derbyshire share of the national target through ensuring appropriate range and capacity of provision to support people leaving hospital	✓	✓			
Leaders will feel equipped to deliver in a collaborative and transformative way agnostic of organisation, with a focus on people and communities	✓	✓			
Ensure continuation of the well-developed wider partnership role in place based working that has been built in Derbyshire to ensure we draw on the widest range of community assets in developing and delivering improvements in care and outcomes	✓	✓			
Support and manage Places in the transition to a new governance structure in the emerging system architecture, ensuring that the structures and frameworks of ICS/ICP enable true integration of planning and delivery of local services.	✓	✓			
Identify where increased resource in community could deliver impact on system; costs, outcomes and experience and agree mechanisms to plan and manage that shift, incentivising preventative and proactive care.	✓	✓			

Reducing pressure on emergency hospital services

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Delivering our vison through the combined deliverables below which are aligned to the LTP commitments will improve Urgent & Emergency Care for our citizens

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

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

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

Better Care for Major Health Conditions: Improving Cancer Outcomes

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We will deliver the foundational commitment in relation to Cancer across the system, by continuing to prioritise improvements across the footprint (including East Staffordshire) through Prevention, Early Diagnosis & Treatment and Living With Cancer in line with the National Ten Year Cancer Plan; working in partnership with the East Midlands Cancer Alliance.

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

Better Care for Major Health Conditions: Improving Cancer Outcomes

DRAFT v1

We will deliver the foundational commitment in relation to Cancer across the system, by continuing to prioritise improvements across the footprint (including East Staffordshire) through Prevention, Early Diagnosis & Treatment and Living With Cancer in line with the National Ten Year Cancer Plan.

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

Better Care for Major Health Conditions: Improving Mental Health Services

DRAFT v1

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

Key Deliverables	Milestones				
We will deliver the foundational commitment in relation to Mental Health across the system; achieving access standards as defined nationally. We will continue development of the Derbyshire Mental Health Alliance to include all statutory and voluntary sector providers and commissioners of mental health services across health and care participate in the emerging regional collaborative around Forensic, CAMHS, Eating Disorder services and future waves, to include Perinatal and LD services.	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Perinatal Mental Health: Derbyshire as lead provider across the region for Tier 4 services will increase access to specialist community perinatal mental health services with performance meeting 5% target of birth rate coverage and Psychological therapy input into the team by 2019/20. Maternity Outreach Clinics will be in place following national testing sites with the care period extended from 12 months to 24 months by 2023/24.	✓				✓
Adult SMI Community Care: We will bolster adult Severe Mental Illnesses (SMI) integrated models of primary and community mental health care with investment in specialist Personality Disorder (PD) support teams in place in Community Mental Health Teams (CMHTs) from 2019/20 onwards. Learning from early waves of testing of new integrated models and implement across Derbyshire by 2023/24. We will maintain national performance standards and sustain fidelity of the model for the Early Intervention Psychosis (EIP) service and Individual Placement and Support (IPS). An IPS wave 2 service will be established in line with national model. Pilots in digital contacts testing model will take place in 2019/20, enabling EIP Level 3 compliance, with roll out of digital contacts subject to evaluation by 2020/21.	✓	✓			✓
Mental Health Primary Care: IAPT services continuing to meet all national targets, with IAPT therapists into integrated PCN teams, Long Term Conditions (LTC) service in place and IAPT accessed by more older people and people in care homes. SMI Physical Health checks at 60%. Wellbeing approaches (Tower Hamlets and GM models) prototyped in two PCN areas 2019/20 and rolled out across the County in 2020/21, engaging fully with communities and the voluntary sector. This will provide individualised opportunities for people to live full and well lives in their communities without recourse to statutory services. Link CMHT staff with GP practices to provide advice and guidance.	✓	✓			
Dementia and Delirium: Integrated Care Homes training package in place, including Frailty, EoL and OPMH training package in place across all providers by 2020/21 to support care staff in identification of delirium and dementia. Consistent and equitable crisis response services (DRRTs and FRRTs) and implementation of Day Services changes to deliver single countywide model across the County in 2019/20. Furthermore we will agree system wide Derbyshire Well Pathway for Dementia as a whole systems approach to Frailty, OPMH and End of Life and sustain transformation of MAS service and continue to meet diagnosis targets.	✓	✓			
Psychological Therapies Review: There will be an improved therapeutic offer to improve patient outcomes and experience of inpatient care, and reduce average length of stay in all adult acute inpatient mental health settings to the current average of 32 days (or fewer) by 2023/24; taking into account need to avoid admissions for people with PD and the need to provide more therapeutic interventions in inpatient settings. Phase 1 of the review will be completed by 2019/20 with increased psychology input into inpatient areas to reduce LoS and Phase 2 of the review completed by 2020/21 with recommendations to feed into plans for future years to reduce LOS by 2023/24.	✓	✓			✓
Mental Health Urgent Care: We will maintain our ambition to eliminate all inappropriate adult acute and Psychiatric Intensive Care Unit (PICU) out of area placements at zero by the end of March 2021 and sustained at very low levels in the future. To ensure care is delivered closer to home there will be a PICU in Derbyshire by 2021/22. The move to single bedrooms and eradication of dormitories, with LoS in line with current national mean of 32 days will result in a smaller acute bed base and will be reflected in our Estates Strategy. Crisis Teams across the county in fidelity with the model across all age groups and alternatives to A&E attendances in place, with 1 alternative to A&E in 2019/20 increasing to two by 2020/21. 100% coverage of 24/7 adult Crisis Resolution and Home Treatment Teams (CRHTTs) operating in line with best practice by 2020/21 and maintaining coverage to 2023/24. These will be accessed via a single point of entry for crisis response via 111 by 2023 and supported by Core 24 Mental Health Liaison Services at CRH and DRH sites and PD specialist resource in place in CMHTs from 2019/20. For people with Personality Disorder, only those with exceptional circumstances will require admission to hospital settings. We will also develop innovative digital alternatives to physical observations (Oxehealth) across all seclusion rooms.	✓	✓			✓
Suicide Reduction and Bereavement Support: We will deliver current plans from the cross-agency Derbyshire Suicide Prevention Forum to put bereavement services in place and to implement actions to reduce suicides in inpatient settings. Trailblazer funding used to establish RTS service with Derbyshire Police and BPT resulting in bereavement support provided within 72 hours in 2019/20 with new services sustained and learning shared with NHSE/I in 2020/21.	✓	✓			

Better Care for Major Health Conditions: Shorter Waits for Planned Care

DRAFT v1

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

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

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

DRAFT v1

Our Maternity Programme of work will continue to deliver the Better Births plan

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Have reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by the end of 2020/21, and are on track to make a 50% reduction by 2025. Including: Supporting establishment of NHS maternal smoking cessation services in 2019/20 Maternal medicine Networks fully operational by 2023/24	✓	✓			✓
Have fully implemented the Saving Babies Lives care bundle (version 1) in full by March 2019 and SBLCB V2 -Full roll out by 2020/21	✓	✓			
We will set up and maintain investigating and learning from incidents, and are sharing this learning through their LMS and with others through a Maternity Quality Review group	✓				
Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Health Safety Collaborative to reduce avoidable admissions of term babies to neonatal unit to no more than 5% by 2019/20	✓				
We will work with operational Delivery Networks to implement fully the recommendations of the Neonatal Critical Care Review in 2019/20	✓				
All pregnant women have a personalised care plan (PCP) 20% with 50% of care delivered through a hubs network by 2020/21		✓			
All women can make choices about their maternity care, during pregnancy, birth and postnatally with 100% care delivered via hubs by & SPOA operational by 2021/22			✓		
Most women receive continuity of the person caring for them during pregnancy, birth and postnatally, with 20% of women booked onto a continuity of carer pathway in 2019/20, increasing to 35% by March 2020. In order to further address inequalities in this area targeted funding will be applied to ensure 75% from vulnerable and BAME Groups in CofC pathway by 2023/24	✓	✓			✓
More women can give birth in midwifery settings (at home and in midwifery units); 19% by 2020/21 increasing to 20% in 2021/22		✓	✓		
All women receive improved postnatal care, in line with a postnatal improvement plan agreed by commissioners and providers, Maternity services deliver UNICEF baby friendly accredited initiative, and support establishment of maternity outreach clinics for women experiencing mental health difficulties arising from ,or related to, the pregnancy or birth experience by October 2019. Postnatal physiotherapy will be offered to women with physical complications because of birth by 2023/24.	✓				✓
Implement learning from electronic Personal Health Record (ePHR) pilot sites for women to access their maternity electronic personal health records in 2019 so by 2023/24 all women have to access ePHR					✓

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

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

DRAFT v1

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

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

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

Delivering Further Progress on Care Quality and Outcomes: Diabetes

DRAFT v1

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

Delivering Further Progress on Care Quality and Outcomes: Diabetes

DRAFT v1

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

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

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

DRAFT v1

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

Giving our staff the backing they need

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

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

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

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

Our Strategic Approach

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

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

Transforming the way in which our staff work

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

Building leadership across all levels

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

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

Improving mental and physical health and enabling flexible working

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

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

Giving our staff the backing they need

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

Enabling transformation and delivering our Model of Care

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

- Further develop our system approach to retention and wellbeing in general practice in collaboration with the LMC overseen by the GP Workforce Steering Group (e.g. first 5 years support, practice manager development programme)
- Explore the opportunity to develop a lead employer model to support increased training and deployment of Advanced Clinical Practitioners in collaboration with Nottinghamshire ICS to strengthen our capability and resilience
- Address shortages in consultants through the introduction in new roles operating in multi disciplinary teams i.e. Physicians Associates who may require significant post qualification training, supervision and assessment which is not funded. This has commenced with local Universities commencing Physician Associate training from September 2019.
- Develop capacity for trainee nursing associate placements in the private, voluntary and independent sector
- We will introduction of new roles e.g. Psychology led services

Changing the Skill Mix and Introducing New Roles

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

We will continue to work closely with the Programme Leads for each of our programme areas to ensure the workforce implications in relation to the key deliverables set out in this plan are genuinely supported; we will identify how they envisage growing and transforming the workforce in line with the LTP ambitions, which will be triangulated with the organisational numerical forecasts. From the strategic planning work we have done to date, we envisage a greater increase at advanced and foundation level roles than in core and extended level practitioners.

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

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

Local metrics

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

The following table summarises our current position against some high level indicators:

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

* Current position reflects our four Foundation Trusts only at this time

In addition the Derbyshire system:

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

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

DRAFT v1

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

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

The core purpose of the LEF is:

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

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

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

The Derbyshire Estate

Acute and Community Care:

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

Primary Care:

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

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

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

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

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

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

Specific areas of LEF focus within the Implementation Plan include:

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

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

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

Delivering Digitally Enabled Care

DRAFT v1

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

Our Vision and Priorities

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

Leadership and Governance

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

Risks, Issues and Constraints

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

2019/20 Operational risks

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

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

Next Steps

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

Delivering Digitally Enabled Care

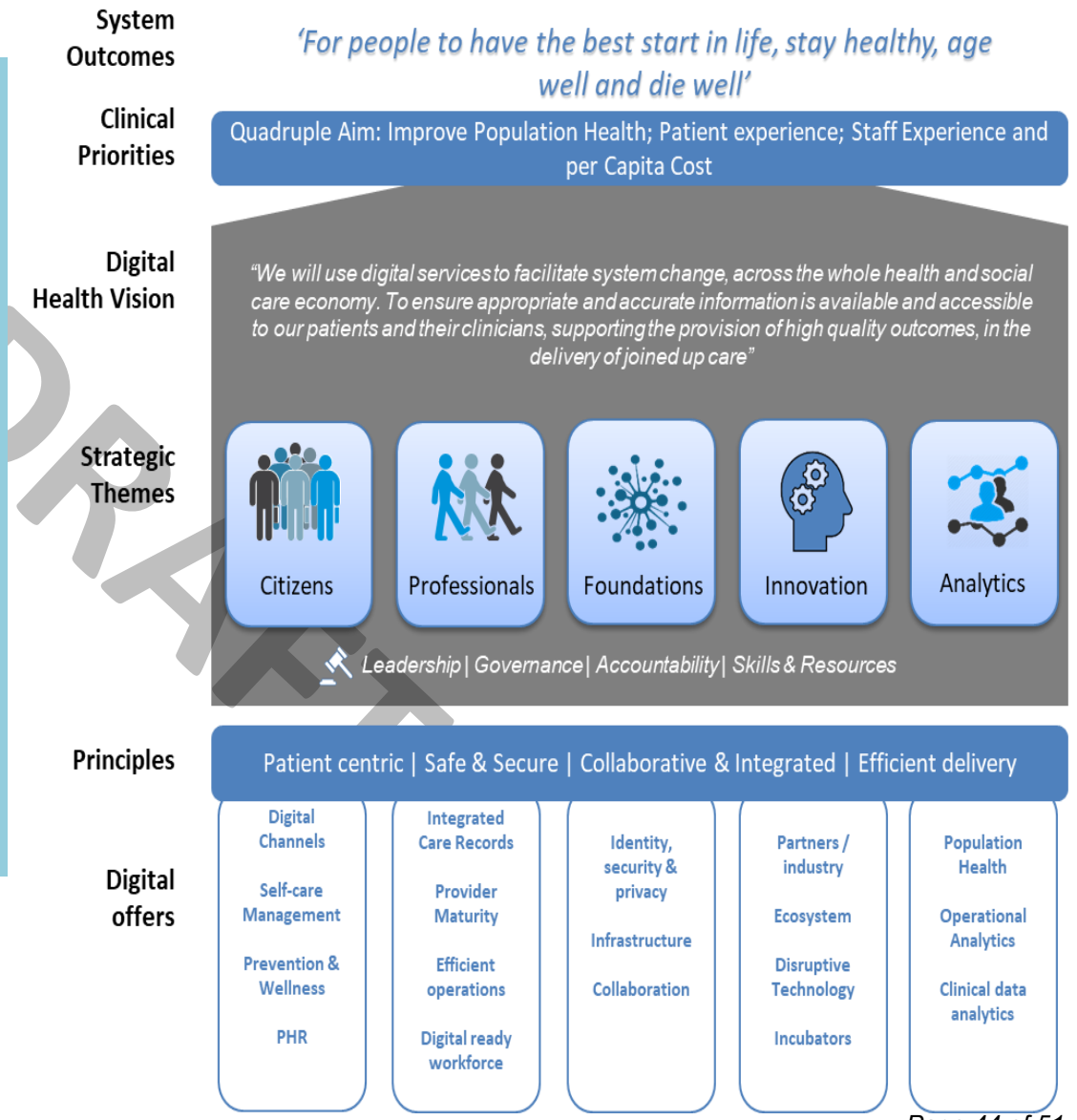
We have made significant progress to date and will further accelerate our approach through our refreshed digital strategy

Our Achievements – the journey so far

- Clear Digital Leadership and Governance
- 28% of patients have electronic access to GP systems, via POLAR project;
- 100% of GP practices are enabled to have access to NHS app;
- 100% of GP practices have patient Wi-Fi available;
- 100% of GP practices offering extended hours appointments;
- 35% of patients already have access to online consultation, with plans to reach 100% by 31/01/20;
- 20% of GP practices are enabled to receive appoints from 111 services, with plans to reach 100% by 31/01/20;
- Preparations in hand for implementing GP futures and Digital first;
- HSCN data networks in deployment;
- Delivery of the MIG Interoperability system;
- Delivery of windows 10 upgrade programme is on track to meet national deadlines Q4 2019/20;
- Strengthening cyber security capabilities;
- Delivery of year 1 HSLI projects;

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

Moving forward enabled by the Joined Up Care Derbyshire Digital Strategy

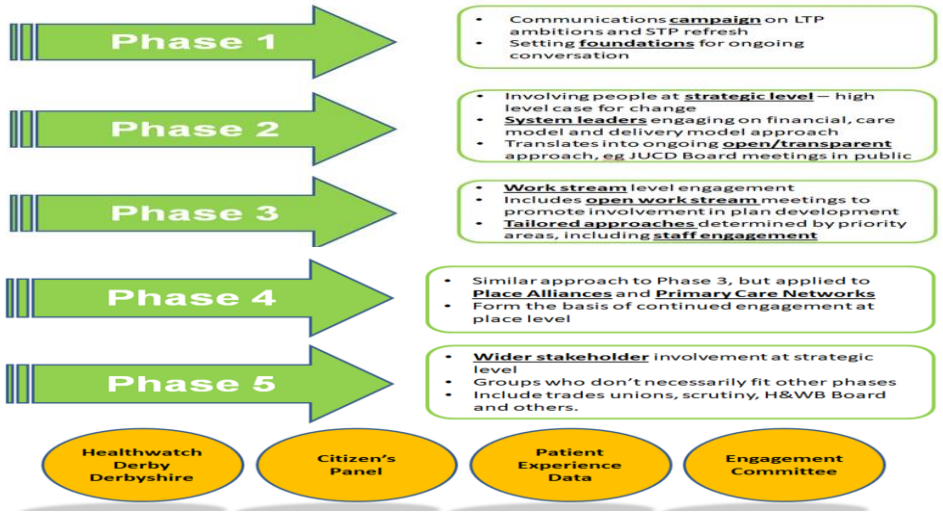


Communication and Engagement Approach

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

Our approach

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



What engagement took place?

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

- 40 members of Citizen's Panel attended confirm and challenge sessions, hearing the details of urgent care, children, Learning Disability and disease management plans
- First Citizen's Panel issued in August on 'online access to health services'.

Governance

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

Key stakeholders

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

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

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

Beginners Guide to JUCD

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

It covers the case for change, the need to consider the wider determinants of health, our priorities, our journey to becoming and Integrated Care System (ICS) and an overview of the work taking place in JUCD work-streams.
It will be available on our website
https://www.joinedupcarederbyshire.co.uk/application/files/3415/6750/5838/Introduction_to_JUCD_leaflet_Sep_2019.pdf

Newsletters

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

Derbyshire STP – financial plan

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

Impact on capacity (including beds)

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

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

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

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

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

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

Investments

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

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

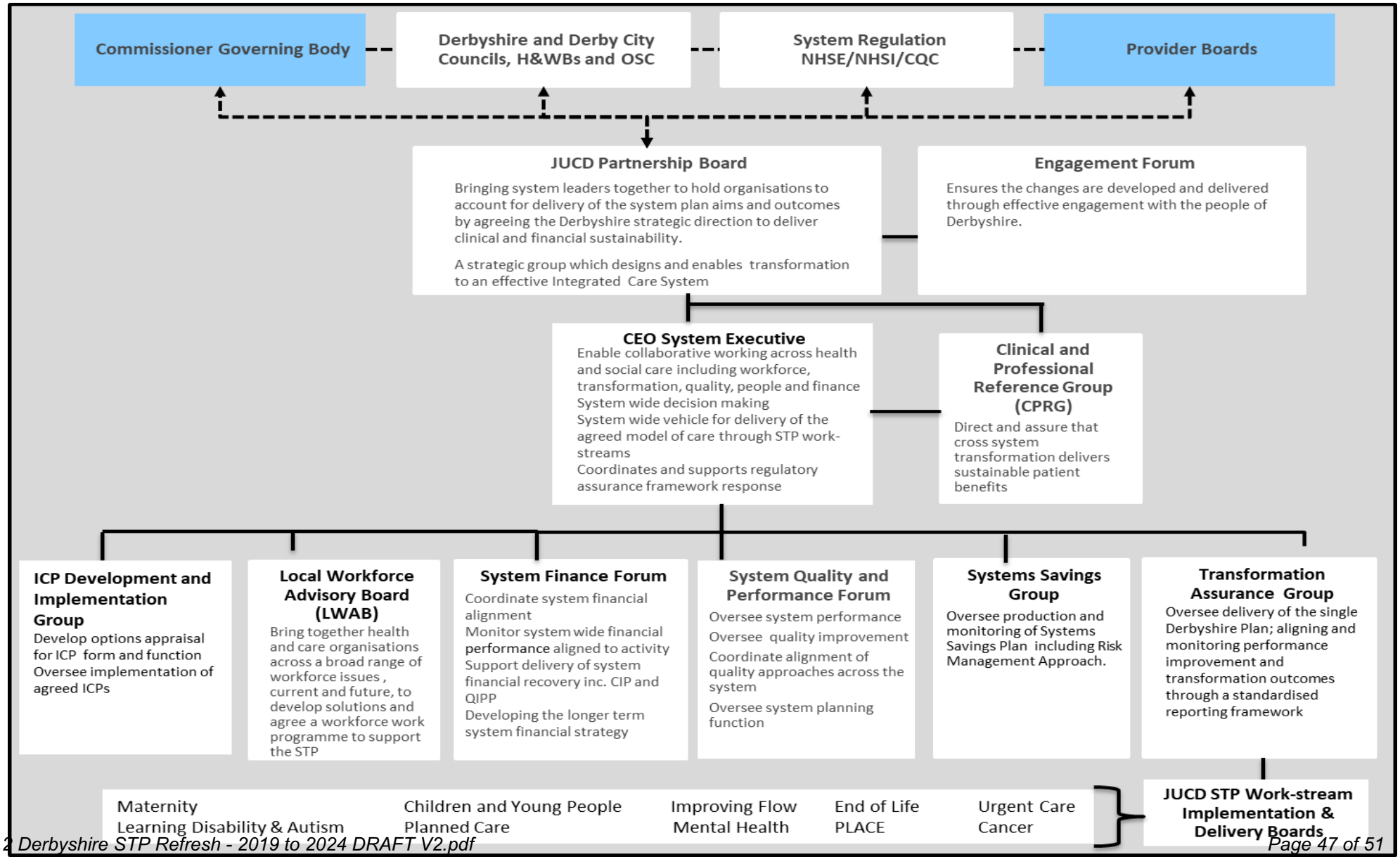
Financial Plan

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

Monitoring Delivery of Our Plan

DRAFT v1

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



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

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

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

Personalised Care

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

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

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

Delivering digitally enabled care

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

Key:

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

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

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

Delivering digitally enabled care

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

Key:

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

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2019

Integrated Performance Report 2019/20

Purpose of Report

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

Executive Summary

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

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

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

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

1. Finance

As at the end of August the surplus of £1.2m is ahead of plan by £0.2m. The forecast assumes the planned surplus of £1.8m is achieved. However there are significant cost pressures and risks to be mitigated. Therefore in order to achieve the planned surplus the forecast assumes the requirement to reduce expected costs by £1.4m during the remainder of the financial year and to mitigate £0.4m of delivery risk on CIP. The financial risk is generated by unfunded cost pressures partially offset by contingency reserves leaving a net cost pressure of £1.5m.

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

The CIP is behind plan year to date but forecast to deliver in full. Capital is behind plan year to date but forecast to spend to plan by the end of the financial year.

2. Operations

Patients placed out of area – PICU (Psychiatric Intensive Care Unit) and adult acute

On behalf of the Mental Health System Delivery Board DHCFT have led two focused task and finish groups to discuss and plan a reduction in out of area PICU and acute placements. The group is represented by commissioners and senior managers responsible for the budgets and monitoring of placements.

Areas discussed:

- Access and egress of out of area placements
- Length of stay and flow of patients in DHCFT acute wards
- Active case management of people placed in out of area placements
- Review of quality of placements out of area

The group agreed actions that could be taken immediately with the case managers and flow coordinators, led by the Improvement Director. Actions were identified that commissioners would take forward as part of a longer term strategy developing a framework of contracting across PICU and acute out of area to achieve greater value from contracted beds that were closer to home for patients.

A follow-up meeting on 9 September noted a significant reduction in both acute and PICU out of area placements. PICU had reduced in 3.5 weeks from 23 to 11 and adult acute had remained at an average of 8 patients from a high of 17 in June. Two key areas that contributed to repatriation of patients was around bed vacancies across the acute wards during August and the case managers and flow coordinators working proactively with both units to return patients, plus discharges direct into the community where clinically assessed as safe.

The out of area patient numbers as of 17 September have continued to be maintained at reduced levels and are monitored daily along with inpatient stays.

The Deputy Director of Operations continues to chair the Bed Optimisation Group with oversight of all services and how future planning of services focus on preventing admissions to inpatient services and how we discharge people in a safe and timely manner.

Waiting list for autistic spectrum disorder (ASD) assessment

There remains a gap between the number of assessments that the Trust is commissioned for and the number of individuals that require an assessment. The result of this is the growing waiting list.

We continue to meet with a stakeholder group of commissioners to review the role and function of the team, but as yet this has not resulted in any changes to the "assessment only model". The number of referrals to the service continues on an increasing trajectory.

This ongoing issue was discussed in some detail at September's Finance and Performance Committee and it was agreed that the executive team would develop a number of options to address the current issues and this would be discussed at the next meeting.

Waiting list for psychology

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

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

On a national basis the demand for psychologists outstrips supply and we have been successful in recruiting 3.8 new psychologists (all of whom should be in post by end of November). It is anticipated that reductions in waiting lists and times will result in Chesterfield (Adult), Derby City and South Dales (Adult and Older Peoples services) by December 2019. Other vacancies are currently out to advert, or being reconfigured prior to advertisement in order to enhance the likelihood of recruitment.

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

Waiting list for Child and adolescent mental health services (CAMHS)

External waits and capacity continue to be a challenge for CAMHS. Vacancy and some sickness has impacted the assessment capacity. All vacancies are now recruited to, with commencement dates being finalised. There has been an internal review of capacity which has identified some opportunity to increase assessment capacity over the coming six months to try to address the backlog. This is being planned at present, and needs to be carefully balanced with follow up capacity also. We await the Clinical Commissioning Group (CCG) release of agreed additional investment into CAMHS for this financial year which will afford us some capacity, in advance of the CCG planning for next year.

Waiting list for community paediatrics

Progress is being made, following a review of caseloads and analysis of wait times by locality. The longest waits are now below 52 weeks, and we continue to focus on those children waiting in excess of 26 weeks. Managing the capacity centrally is a key action, and we are currently recruiting a waiting list coordinator to manage resource and capacity better. Finance and Performance Committee will receive a further update on the agreed action plan at November's meeting.

3. Workforce

Annual appraisals

Divisional People Leads (DPLs) are now supporting Divisions to track and monitor appraisal completion and provide support to signpost when there are issues with ESR inputting. Working with the systems and Information Team to correct due appraisal dates for new starters which can skew the data.

Staff sickness

Increased focus on improving attendance and using support services i.e. Resolve to increase retention of staff rather than being unable to attend work and rollout of the "fast track Physio service" through Occupational Health. Continued focus on long term sickness cases and support is in place to either improve the return to work or where necessary to look at alternative solutions. All line managers reminded to attend the Absence Management masterclass.

Vacancies

A main focus remains on inpatient areas to recruit. In addition, initiatives to recruit and retain now in place. Rolling adverts have been refreshed and application/ interview processes have been enhanced with further "sifting "questions to aid shortlisting.

4. Quality

NHS England and NHH Improvement (NHSE/NHSI) have recently released a change to the single oversight framework. The Nursing and Quality team, working with the performance team, have undertaken an extensive mapping to analyse the reporting systems and required indicators. The Deputy Director of Nursing and Quality Governance has undertaken this in depth piece of work and compared our historical submissions, our current submissions and made recommendations, which will be submitted to the Quality Committee in October. Once agreed the IPR will be updated in advance of November's Trust Board meeting. This will result in a detailed quality section being provided each month.

It was hoped that this may have been available for October, however, limited resources were focused upon the CQC provider information request submissions and the focus will return to this important improvement area including the new changes in October.

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

Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

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

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

1. Assurance Summary

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

[1]The rating symbols were designed by NHS Improvement

Key:

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

2. Detailed Narrative

Finance

As at the end of August the surplus of £1.2m is ahead of plan by £0.2m. The forecast assumes the planned surplus of £1.8m is achieved. However there are significant cost pressures and risks to be mitigated. Therefore in order to achieve the planned surplus the forecast assumes the requirement to reduce expected costs by £1.4m during the remainder of the financial year and to mitigate £0.4m of delivery risk on CIP. The financial risk is generated by unfunded cost pressures partially offset by contingency reserves leaving a net cost pressure of £1.5m.

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

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

The cost improvement programme (CIP) is behind plan year to date but forecast to deliver in full. Capital is behind plan year to date but forecast to spend to plan by the end of the financial year.

Operations

Seven day follow-up

In response to the evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health that people are more vulnerable to suicide in the first two to three days following discharge, and in anticipation of a corresponding CQUIN, DHCFT took part in a pilot project in partnership with NHS England to provide 48 hour follow-up to patients discharged from mental health inpatient units. The pilot was carried out within a quality improvement framework, and was introduced on Morton ward and the associated community mental health teams in March 2019, extended to the rest of the Hartington Unit from July 2019 and across the whole Trust in August 2019. Evaluation of the pilot on Morton demonstrated that a mean of 93% of people were followed-up within 48 hours, and learning from the pilot was valuable in informing how this was subsequently rolled out more widely. Within the NHSE group we developed a quality tool to support clinicians in conducting the follow-up and determining people's future safety needs; this will be shared nationally in due course.

IAPT people completing treatment who move to recovery

Talking Mental Health Derbyshire continues to achieve in excess of its performance targets for both recovery rates (target >50%) and reliable improvement (target >65%) in every month of 2019/20. We monitor both the Trust performance and that of our sub-contractors with regular contract and operational meetings internal to the service and with our partners. Our dashboards update daily so that we can monitor up to date data and react to fluctuations in performance both monthly and in month achieving the national targets. We openly share our performance across the service with clinicians and they can access their own performance data through line managers for regular supervision and case management.

Patients placed out of area – PICU and adult acute

On behalf of the Mental Health System Delivery Board DHCFT have led two focused task and finish groups to discuss and plan a reduction in out of area PICU and acute placements. The group is represented by commissioners and senior managers responsible for the budgets and monitoring of placements.

Areas discussed:

- Access and egress of out of area placements
- Length of stay and flow of patients in DHCFT acute wards
- Active case management of people placed in out of area placements
- Review of quality of placements out of area

The group agreed actions that could be taken immediately with the case managers and flow coordinators, led by the Improvement Director. Actions were identified that commissioners would take forward as part of a longer term strategy developing a framework of contracting across PICU and acute out of area to achieve greater value from contracted beds that were closer to home for patients.

A follow-up meeting on 9 September noted a significant reduction in both acute and PICU out of area placements. PICU had reduced in 3.5 weeks from 23 to 11 and adult acute had remained at an average of 8 patients from a high of 17 in June. Two key areas that contributed to repatriation of patients was around bed vacancies across the acute wards during August and the case managers and flow coordinators working proactively with both units to return patients, plus discharges direct into the community where clinically assessed as safe.

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

In terms of waiting well, we are trying to increase the number of assessment slots available so that individuals who are referred to psychology have been triaged and advice / supervision given to the wider MDT in relation to the individuals psychological needs in a shorter time frame. In addition alongside the routine information offered in relation to waiting well, psychology services are exploring the possibility and value of creating more bespoke advice/ self-help materials which they can offer on assessment.

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External waits and capacity continue to be a challenge for CAMHS. Vacancy and some sickness has impacted the assessment capacity. All vacancies are now recruited to, with commencement dates being finalised. There has been an internal review of capacity which has identified some opportunity to increase assessment capacity over the coming 6 months to try to address the backlog. This is being planned at present, and needs to be carefully balanced with follow up capacity also. We await the CCG release of agreed additional investment into CAMHS for this financial year which will afford us some capacity, in advance of the CCG planning for next year.

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Quality

Staff friends and family test - recommended care

Although the staff friends and family test results have been consistently below the national average, a recent run of 8 months above the Trust mean suggests some improvement in staff views of care provided. Moving forward, we continue to engage staff in quality improvement initiatives, and in particular this has been supported over recent months by the clinically-led strategy development workshops that have been held for all service areas of the Trust.

Workforce

Annual appraisals

Divisional People Leads (DPL's) are now supporting Divisions to track and monitor appraisal completion and provide support to signpost when there are issues with ESR inputting. Working with the systems and Information Team to correct due appraisal dates for new starters which can skew the data.

Turnover

New Exit interview process now embedded in ESR to track leavers and reasons for leaving, Employee Relations team to analyse the data and inform operational teams regarding themes and trends in the feedback to aid retention and reduce turnover.

Compulsory training

Increases in compliance for Mandatory training in 6 out of 8 mandated courses. Continue to track areas where there is low compliance and feedback to managers re DNA's

Staff sickness

Increased focus on improving attendance and using support services i.e. Resolve to increase retention of staff rather than being unable to attend work and rollout of the "fast track Physio service" through Occupational Health. Continued focus on long term sickness cases and support is in place to either improve the return to work or where necessary to look at alternative solutions. All line managers reminded to attend the Absence Management masterclass.

Supervision

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

Vacancies

Focus on inpatient areas to recruit and initiatives to recruit and retain now in place. Rolling adverts have been refreshed and application/ interview processes have been enhanced with further "sifting "questions to aid shortlisting.

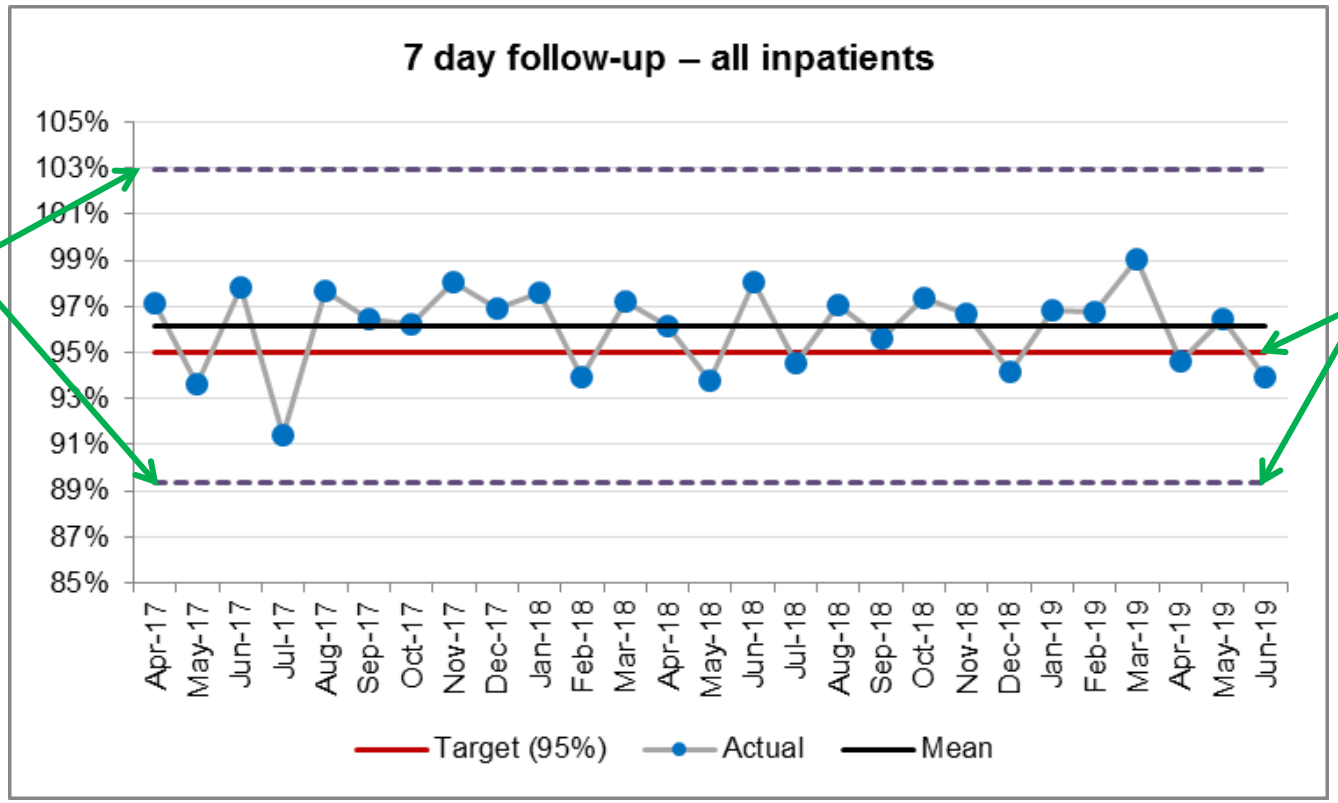
Bank staff use

The current target of 4.98% was set in 2008/9 which was before we brought the bank in house and we encouraged more of our staff were register onto the bank to do additional hours. We have been actively focusing on bank over agency usage in the past 12 months to ensure we can deliver the highest quality of care.

Appendix 1

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

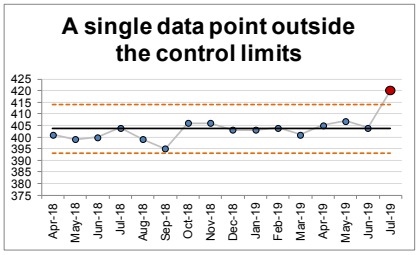
The dotted lines are the "control limits". Any performance between these 2 lines is normal for the current system. This is known as "normal variation"

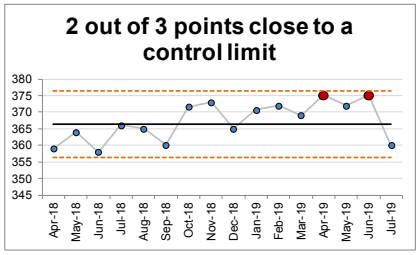


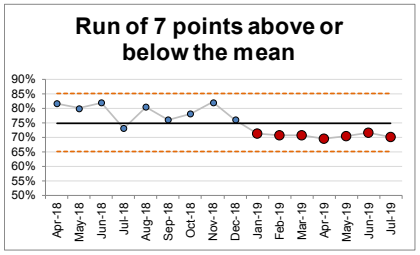
If the system is effective, the **lower** control limit will be above the target line (for targets where higher is better) or the **upper** control limit will be below the target line (for targets where lower is better). In that scenario we have nothing to worry about and can be assured our system is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

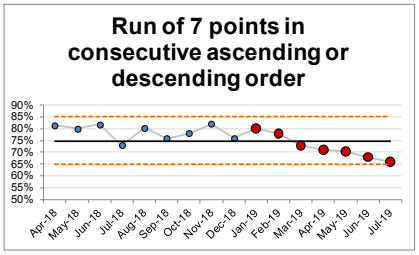
In this case the target line is above the lower control limit which indicates that the system is ineffective.

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



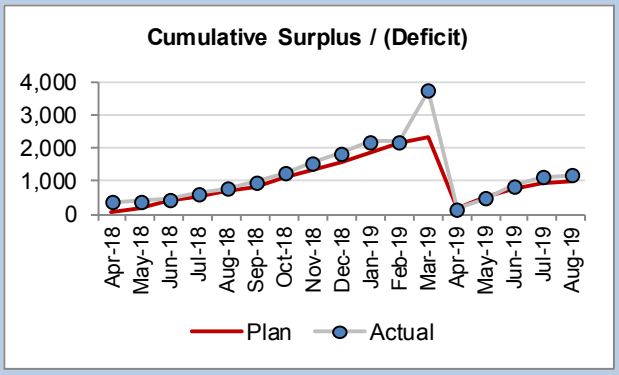


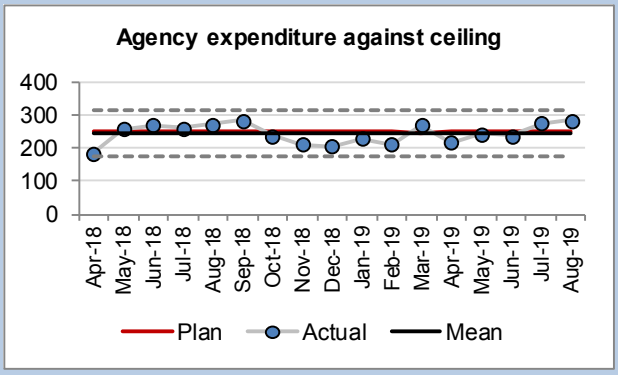


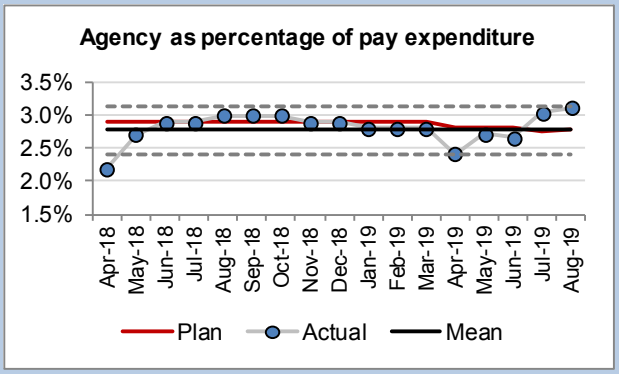


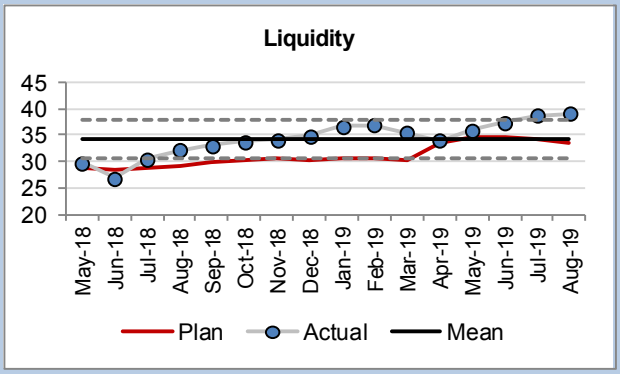
Appendix 2 – Run Charts

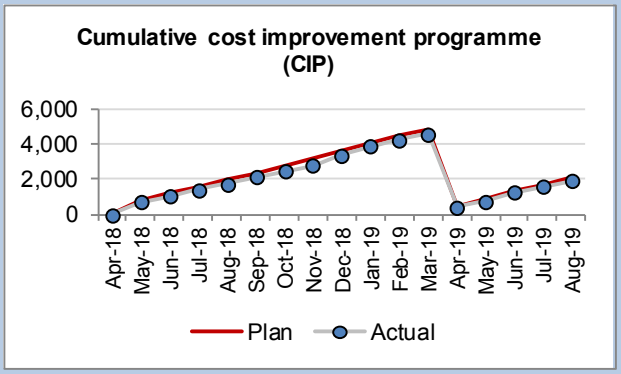
Financial Indicators

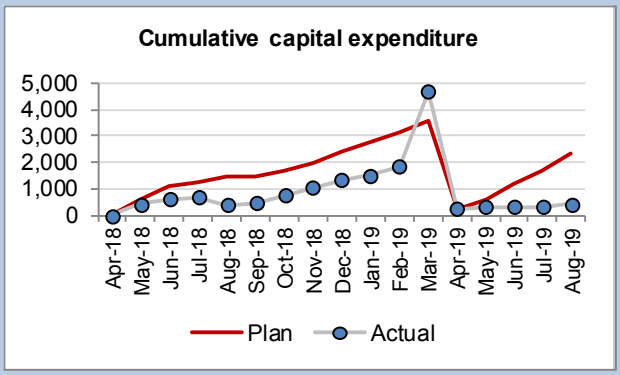


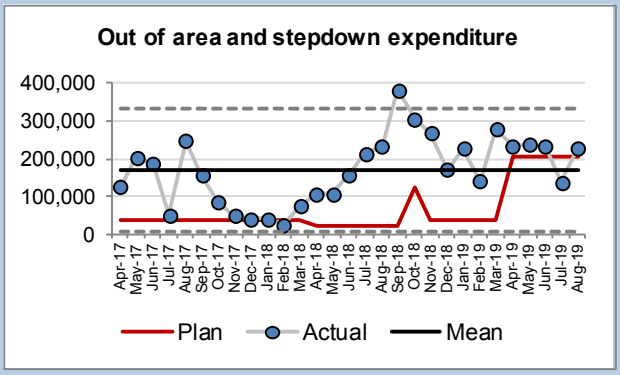






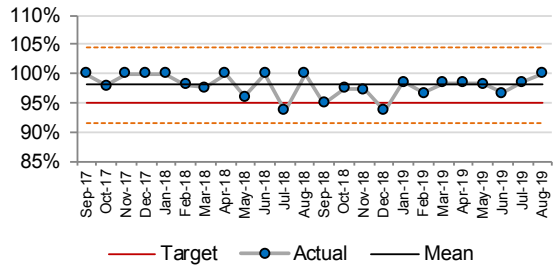




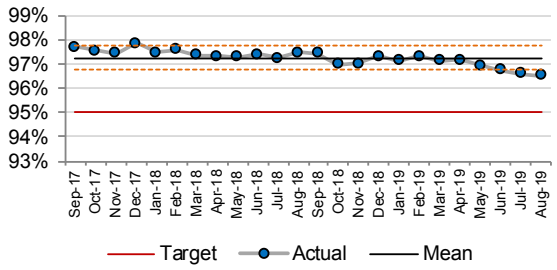


Operational indicators

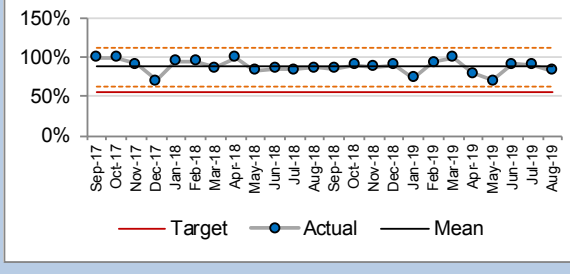
CPA 7 day follow-up



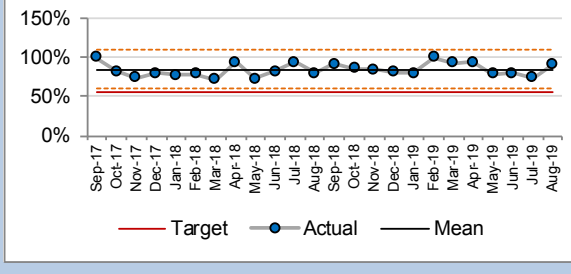
Data quality maturity index



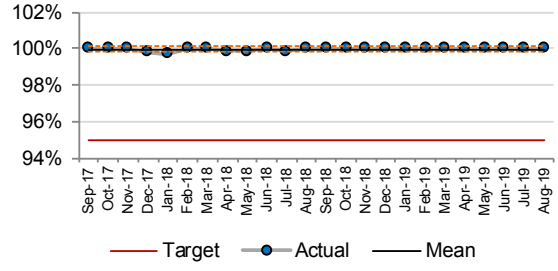
Early intervention 14 day referral to treatment - complete



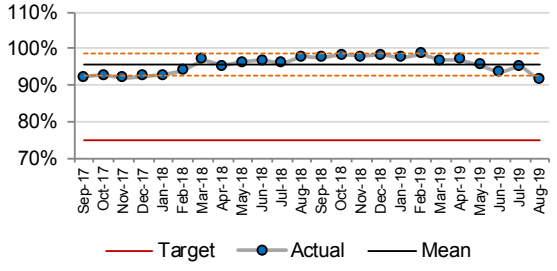
Early intervention 14 day referral to treatment - incomplete



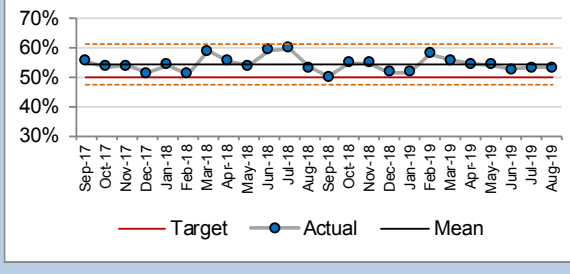
IAPT 18 week referral to treatment



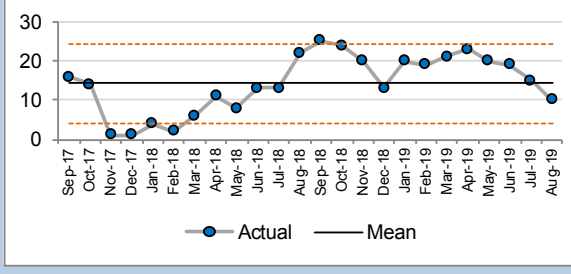
IAPT 6 week referral to treatment



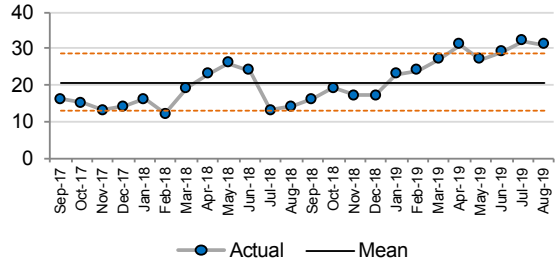
IAPT patients completing treatment who move to recovery



Patients placed out of area - adult acute



Patients placed out of area - PICU



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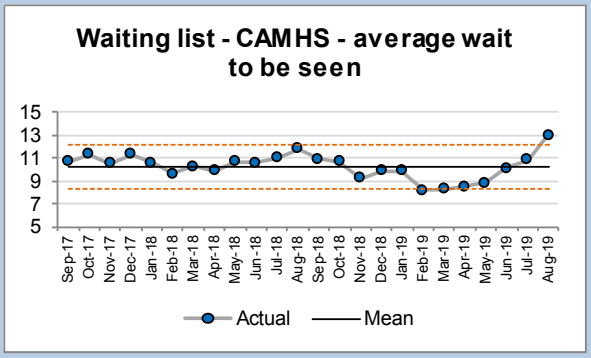
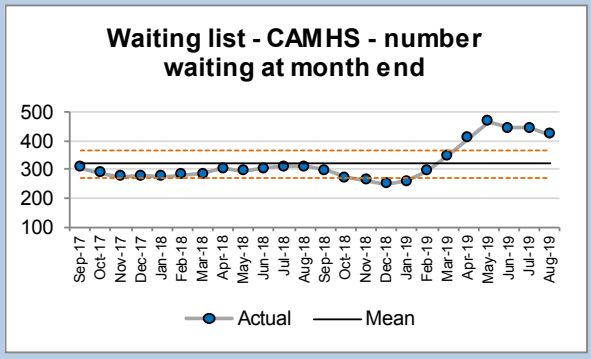
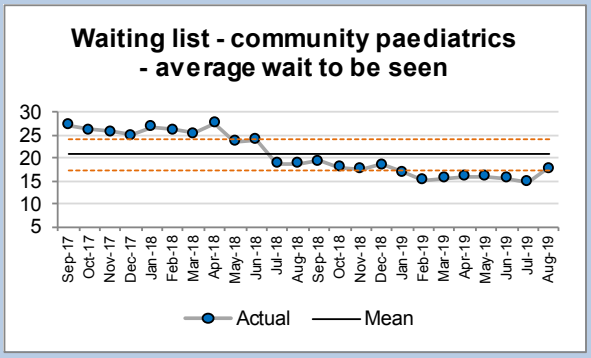
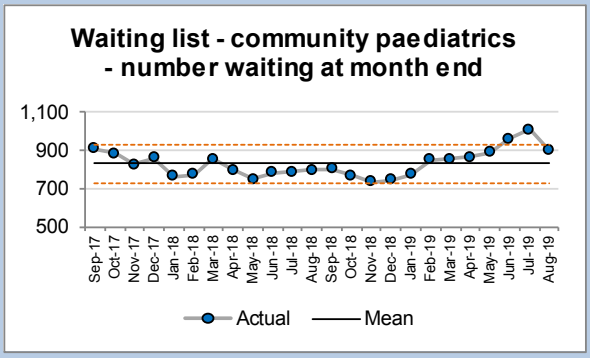
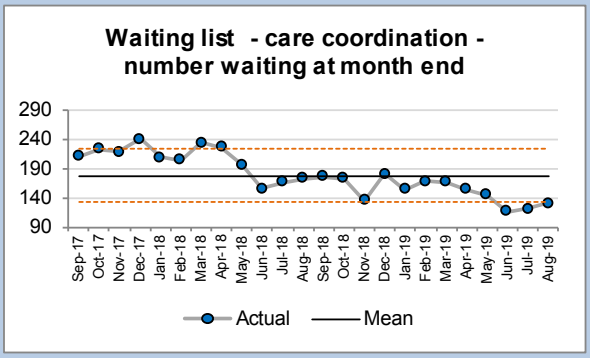
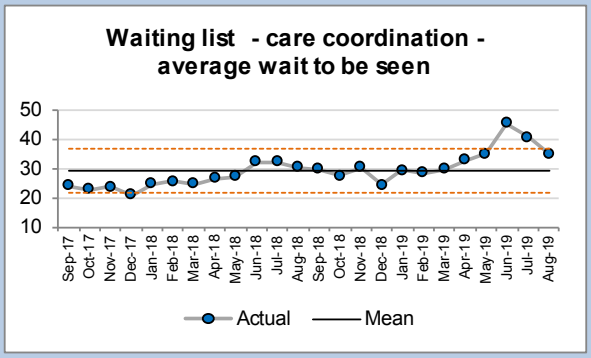


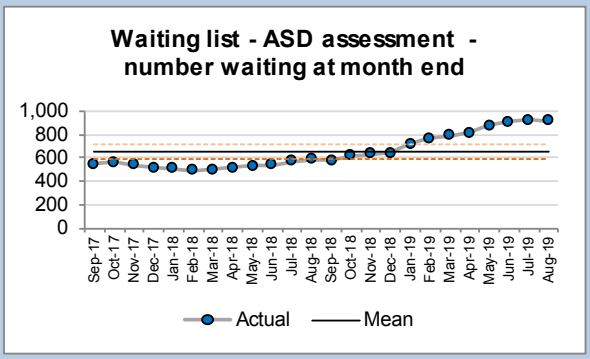


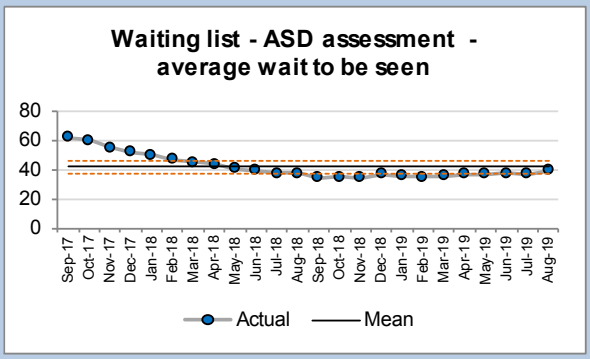


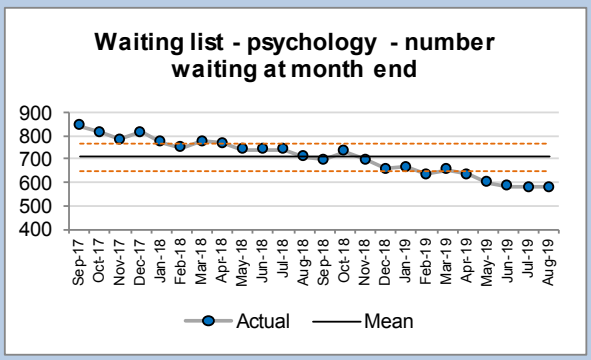


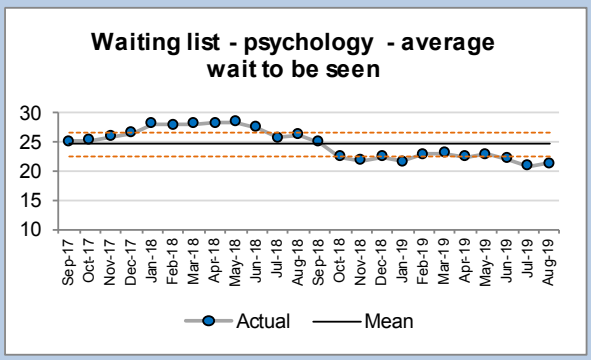






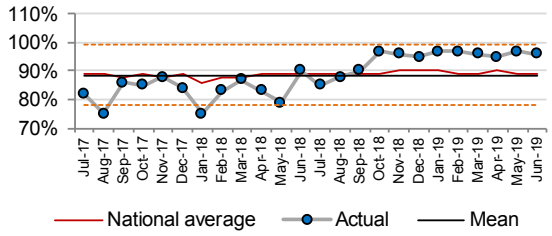




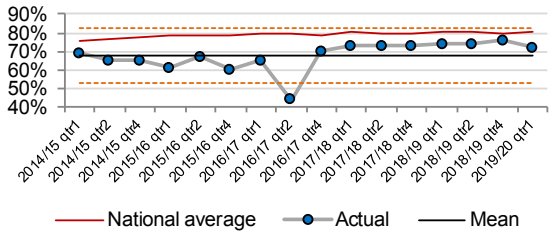


Quality Indicators

Friends and family test - positive responses

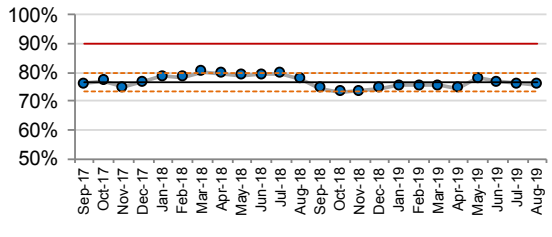


Staff friends and family test - recommending care

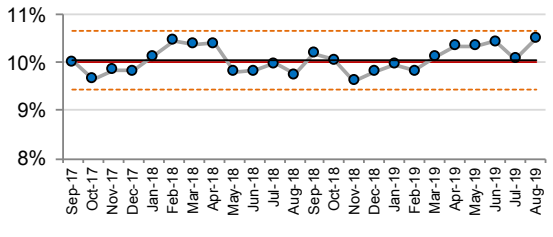


Workforce indicators

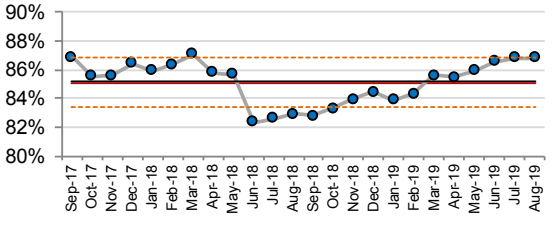
Annual appraisals



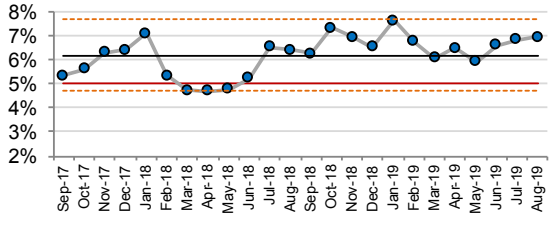
Annual turnover



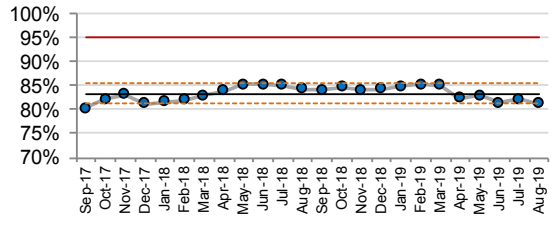
Compulsory training



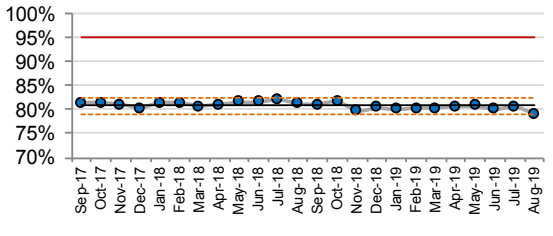
Staff sickness



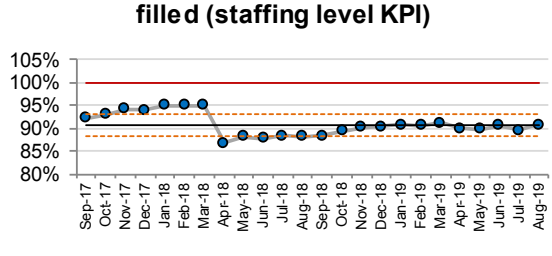
Supervision - clinical



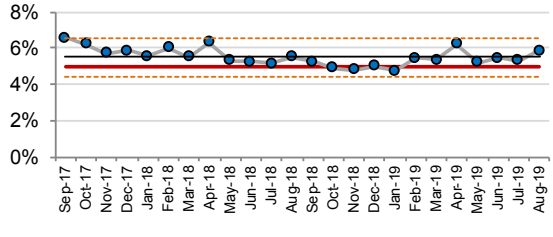
Supervision - managerial



Vacancies - proportion of posts filled (staffing level KPI)



Bank staff use



Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors –1 October 2019

Clinical Service Strategies: Older Age Adult Service; Working Age Adult Service

Purpose of Report

To receive and agree the first two Clinical Service Strategies created through the Clinically-Led Strategy Development (CLSD) process, those for the Older Age Adult Service and Working Age Adult Service.

Executive Summary

The Clinically-Led Strategy Development process has been running since February. The process was designed by a small working group, including Board membership, to maximise the engagement and ownership of frontline clinicians in the development of clinical strategies for each of our eight clinical services in the trust. The aim of the work was to fill the gap between the overarching Trust Strategy and the aims and objectives of individual teams and provide greater coherence and purpose to each service.

Over 500 colleagues from frontline roles, support functions such as finance and estates, alongside a small number of patient and carer representatives have been involved in the development process. The process included a two-day session, interspersed by a week to enable wider engagement from colleagues unable to attend. The products of the sessions were shared widely with all attendees. The products of the sessions were then developed into draft clinical service strategies, which were then shared with participants for comments. The second draft was then shared at specific stakeholder engagement sessions, where a wider group of patients and carers were able to influence the plans, alongside our partners in Local Authorities, the Clinical Commissioning Group (CCG) and the voluntary sector. Further drafts were shared with participants and the Executive Leadership Team (ELT) with comments feeding into the final versions which are attached.

The strategies include a vision of the future service, an outline of the development process, a summary of workforce, estate and Information Management and Technology (IM&T) implications and a more detailed Service Improvement Plan to deliver the strategy.

Each development within the Service Improvement Plan has come directly from ideas developed through the CLSD sessions, the NHS Long-term Plan for Mental Health or the Stakeholder sessions and each link in to a Building Block within the Trust Strategy.

Following the agreement of the Older Adults and Working Age Adults strategies in October, the Eating Disorder and Perinatal Strategies will come to Board in November with the Forensic and Rehab, Substance Misuse, Childrens and Learning Disability strategies coming to Board in December.

A Clinical Services Strategies Transformation Board will be established in October to oversee and assure delivery of the Service Improvement Plans by working groups established for each of the eight service areas.

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

Assurances

- The overarching CLSD process was designed by a small working group including Executive Director and Non-Executive Director Board members.
- Board has received informal updates on progress and emerging themes from the sessions at Board Development sessions in May and June.
- Emerging findings and themes have been shared with those developing our Estates, Workforce and Electronic Patient Record (EPR) strategies.

Consultation

- Over 500 colleagues from across the Trust have been directly involved in the development of the Clinical Service Strategies. Many more have had their ideas included in the process through wider engagement in the week between the two-day sessions.
- Stakeholder sessions were held with a wider group of patients, carers and our partners in Local Authorities, CCG and the Voluntary Sector, where the service improvement plans were shared and comments received and included within the plans.
- Executive Leadership Team have reviewed a draft of the Strategies and the final draft reflects comments received.

Governance or Legal Issues

- Implementation of the Clinical Service Strategies will require the creation of a Transformation Board with Executive and Non-Executive membership to oversee and assure delivery of the plans.
- A service level working group will be established for each of the strategies to deliver the plans, with membership from Clinical Directors, Clinical Leads and other clinical leaders, alongside service managers and service users. Where existing working groups exist, such as the Older Adults and Dementia Board, these will be utilised.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The Clinical Service Strategy for Older Adults should have a positive impact on the experience and outcomes of older people and their carers. It should have a positive impact on those older people with long-term conditions and disabilities, through greater integration between mental health and physical health services for older people.

The Clinical Service Strategy for Working Age Adults should have a positive impact on people with Personality Disorders and with Disabled People and people with long-term conditions.

It is not envisaged that the service improvements detailed in the two strategies would have adverse effects on people with any of the nine protected characteristics.

The Clinical Services Strategies Transformation Board will need to ensure that the implementation of each of the service improvement plans does not adversely impact on people with any of the nine protected characteristics and that the potential benefits to some groups are realised.

Recommendations

The Board of Directors is requested to:

1) Agree the Clinical Service Strategies for Older Adults and Working Age Adults
2) Note the process undertaken to develop the strategies and the extent to which they have been developed by colleagues in frontline service delivery roles
3) Agree to the establishment of the Clinical Services Strategies Transformation Board
4) Note the need for working groups established at clinical service level, reporting to the Clinical Services Strategies Transformation Board, to lead implementation of the service development plans and the importance of leadership in this process of Clinical Directors, Clinical leads and other clinical leaders in delivering

Report presented by: **Gareth Harry, Director of Business Improvement and Transformation**

Report prepared by: **Gareth Harry, Director of Business Improvement and Transformation**

OLDER ADULT CLINICAL SERVICE STRATEGY 2019-2022

Vision of the service in 2023

By 2023 the Older Adults service will be more closely integrated with our partner organisations, able to provide care that wraps around individual older people, taking into account their physical long-term conditions and other factors that might make them frail. Working together with partners, the service will be more closely engaged with care homes and domiciliary care providers to increase the skills and confidence of care workers across the county. The service will be even more responsive, with expansion in crisis related services across organic and functional illnesses. Inpatient services will continue to manage within existing bed stock, despite the increase in older people in the population, due to more work across the pathway to keep people in their homes for as long as possible. Patients and carers will be treated as full partners in the assessment and delivery of care, with compassion-focussed care at the heart of our clinical practice.

Introduction

The Older Adults Service Strategy has been developed in line with the DHcFT values, that by putting our people first, our colleagues, we are able to best meet the needs of the people who use our services. The process undertaken to develop this strategy prioritised the engagement of as wide a number of clinical colleagues working in the service as possible.

Over the same period, DHcFT refreshed its Trust Strategy to focus on three main strategic objectives:

- To provide Great Care;
- To be a Great Place to Work and;
- To make Best Use of our Money.

Underneath each of these strategic objectives, there are a number of building blocks which need to be in place to enable the objectives to be delivered. Each of the improvement ideas contained in this strategy will be linked to these Building Blocks.

Altogether there are eight separate Pathway Strategies that have been developed through this process. The aim is that general themes and common across the strategies and overlapping issues will be linked and where improvement ideas across pathways can be progressed, they are undertaken together in an open and collaborative way, building trust and understanding between services.

The initial development work of the strategy focussed mainly on frontline clinical staff in each of the pathway areas, with some patient and carer representatives at each of the session. The process included a stakeholder session, where an initial draft of the strategy could be shared, tested and improved through engagement with our commissioners, Local Authority and Voluntary Sector partners and a wider group of patients and carers.

Why develop clinically-led pathway and service level strategies?

The Trust operates in an ever changing health and care environment. The NHS Long-term Plan, published in January 2019 outlined a number of commitments and improvements required of health systems alongside significant additional investments into mental health services.
In addition, the ageing population means that there will be a significant growth in the over 80s over the next fifteen years as the generation of the post-war population increase becomes older.

Growth in resource available to health systems and to older people's services is unlikely to keep up with the growth in population. The pressures on local authority funding means that social care availability is more limited than in the past.

All of which, means that if OPMH services are to continue to meet the needs of older people in Derbyshire, then they will need to find ways to continuously improve, to be as efficient and as effective as possible.

The methodology undertaken in developing these strategies enabled frontline clinicians to come together to identify and develop improvement ideas that could be delivered over the next three to five years, supporting the building blocks of the Trust's overall strategy and providing a sustainable base for the provision of services.

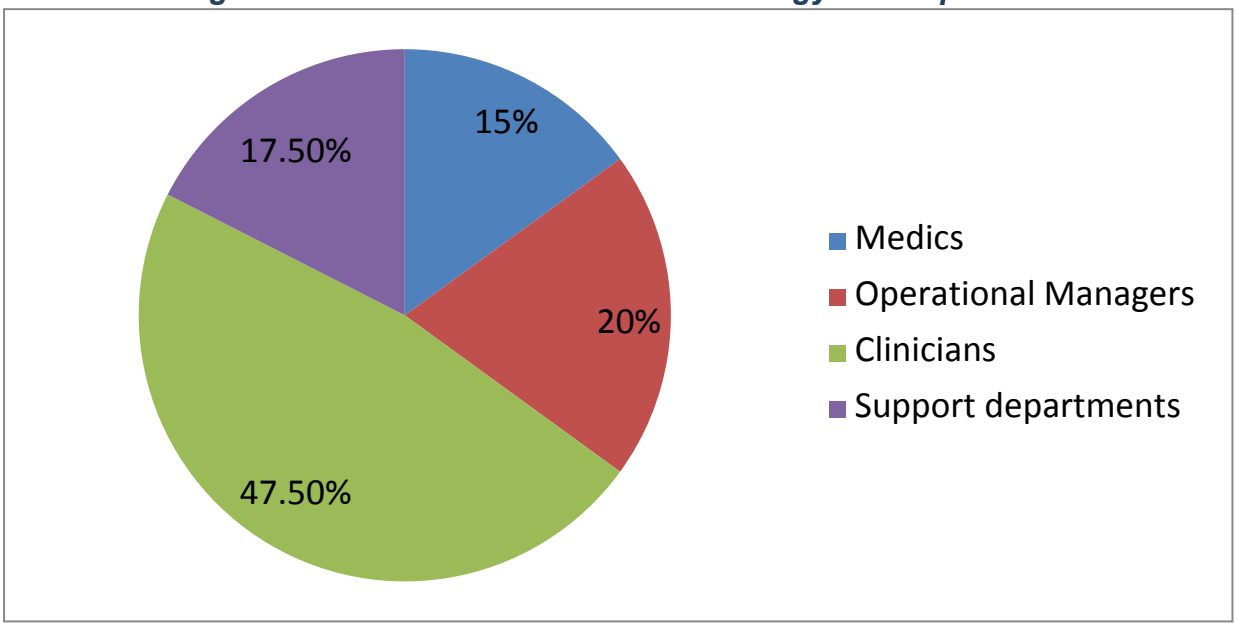
Development Process

Each of the service areas went through the same process of developing their service improvement ideas and strategic development:

- Two day development sessions, held a week apart with intervening time committed for seeking back to base input from team members unable to attend the sessions and feedback
- The direction of travel and the improvement ideas were led by clinical colleagues from all disciplines
- Service user and carer representation
- Support services such as finance, estates, HR, etc., were also engaged with the process.

N.B. When this document uses the term 'clinician', this refers to all our colleagues who are working at the point of care, therefore allied health professional, doctors, nurses, psychologists, and those without a formal professional qualification.

Percentage breakdown of attendances at strategy development sessions



The sessions provided the opportunity for clinicians to come together to acknowledge the good work already being done and also to build on this good work to look at where services could be improved, in line with best evidence and best practice. Time between the development days was built in, specifically to enable the learning from Day 1 to be taken back to the wider teams for discussion and collation of feedback to be put forward for inclusion into the second day and the strategy.

Attendance from clinicians has been prioritised for the sessions, providing a comprehensive understanding of the issues within each pathway and service area. Attendance from staff in support functions such as finance, HR, estates, etc., provided different perspectives and allowed workforce, estates and other strategic considerations to be part of the process.

The Purpose of the Service

The teams thought through a single, cohesive purpose for the service, this in effect providing the strategic direction:

"Putting patients and carers at the heart of what we do; evidence-based practice; combining innovation with engagement and empowering colleagues to problem solve and focus on solutions to support older people in their own homes, wherever possible".

It is clear that there is plenty in Older Adult services that the teams are proud of and clinicians are keen to make the most of the opportunities offered by being their own division under the new Operations structure. Attendees were particularly proud of the way in which their services had expanded into new service areas in the community, such as the Dementia Rapid Response Teams, and the way in which teams had improved their services to provide better access to patients within existing resources, such as the Memory Assessment Service. Team members felt that their teams and service was resilient and resourceful, able to embrace challenge and work in a positive culture.

The teams came up with overarching themes of work where they felt services could be improved:

- Greater help for carers to understand the dementia pathway and functional illnesses in older people;
- Need for a clear entry point to our services for patients, referrers and partners;
- Seamless provision of services throughout the illness trajectory, particularly for dementia;
- Focus on creative solutions to enable older people to self-care, recover and cope;
- Resilient teams;
- Integration with other partners along the functional and organic pathways;
- More effective and efficient use of space and facilities, making our estate work harder and smarter;
- Improved links and closer working with GPs and DCHS community, inpatient and day hospital services;
- Achieve parity and equity of services across the county.

Estate and workforce implications

The expansion of the crisis related services within the NHS Long-term plan and the expansion across the County of the IRHTT will result in the need for additional clinical and office accommodation. Similarly, any expansion in training roles and apprenticeships will require additional staff accommodation. Whilst increased support for agile working may mitigate against some of this demand, it is unlikely to avoid the need for growth in our community estate.

For our inpatient estate, there is scope to co-locate functional inpatient beds at Walton Hospital alongside the DCHS organic inpatient service. There is also scope for similar co-location at Kingsway. Both these proposals would be subject to public engagement and consultation, followed by staff consultation. Both these proposals would assist the move to single bedrooms across the estate.

3-5 Year Service Improvement Plan

Based on the feedback from the wider teams and Day 2 work undertaken by participants, below is an outline Service Improvement Plan of the service improvements the Older Adults Service wants to develop over the next three to five years. Each of these ideas was developed by teams and individuals within the service. An outline project scope is in place for each of these projects, from the work teams did in their Day 2 session. For each idea, there is a reference to NICE Guidelines or other national expectations where available. Some ideas are more locally driven, and will be explored using Quality Improvement methodologies, e.g. the Institute for Health Improvement Model for Improvement, or Lean. This is to ensure a robust structured and evaluated approach, led by the voices of those in our care, their families, and colleagues working at the point of care, as supported by the The Kings Fund document 'Quality improvement in mental health' (https://www.kingsfund.org.uk/publications/quality-improvement-mental-health). This is also in line with the Trust's Quality Improvement Strategy

NICE Guidelines will be a helpful baseline for our alignment against national best practice, and NICE Quality Standards will be a helpful way of prioritising and measuring specific improvement responses to any gaps, again underpinned by Quality Improvement methodologies.

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Greater communication and engagement with carers on care planning and discharge planning. Identification of main carer and provision of information, training and support for the carer, in partnership with the Vol. Sector	Improved resilience and confidence of carers to support care at home	Improve patient and carer experience	Service User Experience in Adult Mental Health: https://www.nice.org.uk/guidance/cg136 https://www.nice.org.uk/guidance/qs14	S11	Marginal impact. Additional non-pay cost of materials.	None	Some additional training may be required	April 2020
Comprehensive approach with partners to enable a good death for people living with dementia	Reduction in avoidable admission to hospital in the last six months of life	Improve clinical outcomes	NICE Guideline for Dementia https://www.nice.org.uk/Guidance/CG42. Care of adults in the last days of life https://www.nice.org.uk/guidance/ng31		Marginal impact. Reprioritisation of staff resource	None	New training packages. New roles covering physical and mental health.	From December 2019

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Expand Care Homes Project to include more homes and evaluation of wider system impact	Reduction in referrals into OA community services. Reduction in admissions to CRH and UHDB,	Improve clinical outcomes			Potential for investment from CCG on an invest to save basis	None	Training packages for care homes staff	From April 2020
Improve engagement with ex-forces groups	More ex-forces Older Adults get the services they need.	Improve access to our services	https://www.armedforcescovenant.gov.uk/	S28	Reprioritisation of staff resource	None	None	From December 2019
Focus on prevention and care of Delirium	Reduction in admission to CRH and UHDB. Resilient and confident workforce in identifying and managing delirium in the community	Improve physical healthcare	Delirium: prevention, diagnosis and management https://www.nice.org.uk/guidance/cg103	B2, B19	Reprioritisation of staff resource. Potential for investment from CCG on an invest to save basis.	None	Additional training packages. Development of new roles covering physical and mental health.	From April 2020
Reduce LoS on all inpatient wards	Reduction in bed base. Improved outcomes for patients.	Improve access to our services	NHS Long Term Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf	S15, B14	Potential for savings from estate reduction. OBC required.	Potential for reduction in estate/ link to single bedrooms/ link to Ward 1 consultation	Potential for shift of staff resource into community teams.	From October 2019.
Adopt Newcastle Model (Compassion	Less patient safety incidents.	Improve safety			None	None	Training and OD support for	From October

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Focussed Care) across all inpatient areas	Better outcomes for patients.						ward teams.	2019
Increased use of Psychologists and Psychologically based approaches across all OA services	Improved therapy input resulting in shorter LoS and improved, recovery focused outcomes for patients.	Improve clinical outcomes	This expectation is within all mental health NICE Guidelines, including for Dementia https://www.nice.org.uk/Guidance/CG42		Internal investment case required linked to benefits of reduced LoS	Potential for reduction in estate/ link to single bedrooms/ link to Ward 1 consultation	None	From April 2020
Specialist staff training package, career mapping and succession planning	Retention of staff improved.	Develop our colleagues	NHS Interim People Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf	S3, S14, S35, S36	Internal investment case required, linked to benefits of increased retention.	None	Development of training package. OD work to develop and communicate career pathways in OA services	By October 2020
Streamline and rationalise assessment documentation across MDTs.	Release staff time for care.	Improve clinical outcomes			Linked to EPR Transformation Programme	None	Training package linked to EPR Transformation Programme	From January 2020
ACP training places and new roles including RGN recruitment into teams	Improved physical healthcare of patients.	Develop our colleagues	NHS Interim People Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf		From existing resources and establishment	None	Development, recruitment and deployment of new roles into OA teams.	From April 2020

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Apprenticeship placements within OA teams	Increased pool of new staff.	Attract new colleagues	NHS Interim People Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf	B11	From existing resources and establishment. Maximisation of levy	Accommodation for training roles in community	Development, recruitment and deployment of apprentices OA teams	From April 2020
Single training package with DCHS, UHDB and CRH across Dementia, Frailty and End of Life Care.	Closer working across providers and pathway. Improved relationships and trusted clinical judgements	Develop our colleagues	NHS Interim People Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf	(B9)	From existing resources	None	Continued development and delivery of joint training packages across teams	From October 2019
Create an equitable service level across the County (e.g. IHRTT in the North)	Patients in the north of the county will have the full range of services available as the south. Admissions avoided.	Improve access to our services	Service User Experience in Adult Mental Health: https://www.nice.org.uk/guidance/cg136 https://www.nice.org.uk/guidance/qs14	S6	NHSE/I Transformation Monies for Crisis Services and CCG Mental Health Investment Standard	Increased accommodation in community teams. Link to potential reduction in bed based estate.	None	From December 2019, by March 2021.
Voice Recognition software to improve and remove administrative processes	Release capacity in clinicians to provide more direct care. Reduction in administrative capacity	Achieve best value from future investment and current resources		S7	Investment in licenses linked to benefits and savings released through Continuous Improvement Programme.	Reduction in office utilisation.	Support and OD for administrative teams.	From October 2019

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Clarify referral criteria and improve communications with GP Practices.	More efficient access process for patients. Reduction in correspondence between services.	Improve access to our services		S8 and Stakeholder Event	None	None	None	From December 2019
Link OA worker with each GP Practice across the City and County, with potential for drop-in sessions	Reduction in referrals from Primary care and improved resilience in primary and community care.	Work with partners to achieve best value across Derbyshire		(S8)	From existing staffing establishment	None	None	From April 2020
Closer integration with DCHS services in the North. Explore joint use of Walton inpatient facilities.	Improved utilisation of estate. Better integration of physical and mental health services and between organic and functional pathways.	Work with partners to achieve best value across Derbyshire		B15	OBC required to consider benefits and potential investments required.	Potential for reduction in estate/ link to single bedrooms.	Potential relocation of staff.	OBC by April 2020
Closer working with UHDB and CRH and explore inreach onto physical health wards	Improved outcomes for patients. Shorter LoS for older people on physical health wards.	Work with partners to achieve best value across Derbyshire		S56	Additional investment on an invest to save basis from CCG/ JUCD.	None for DHcFT	Potential relocation of existing staff and new bases for new posts	OBC by January 2020
Bring Ward 1 onto the Kingsway site,	Improved outcomes for	Achieve best value from		B16/B13	Financial implications	Optimising Kingsway	Potential relocation of	Public consultation

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
exploring the potential for closer linkage with Cubley Unit.	patients. More resilient clinical teams. Savings from optimising estate.	future investments and current resources			already considered.	site. Refurbishment and making good Tissington Ward.	staff and staff consultation subject to pubic consultation.	by end of March 2020.

Governance and implementation

The improvement projects above will be delivered by the OAMH&D Board (Older Adult Mental Health and Dementia Board), which is an existing internal group within DHcFT. The OAMH&D Board agreed to take on this role at its most recent meeting on 13 September and has received previous versions of this strategy for comment. This Board will be accountable to the Clinical Service Strategies Transformation Board, which will be established in October 2019 to oversee and assure the delivery of all the Clinical Service Strategies. The Transformation Board will have Executive Director and Non-Executive Director Trust Board representation and report directly to the Trust Board.

Key to delivery and implementation will be the continued engagement of the Clinical Director(s) and other clinical leads, able to apply a clinical formulation of the workforce implications within the plan. Following agreement of the Strategy by the Board, the OAMH&D Board will meet to prioritise the actions within the service development plan. An early task will be to understand the managerial and clinical capacity required to deliver the plan. The Transformation Board will receive workplans from each area for the year ahead. A balance will need to be struck between central direction and performance management of delivery and implementation with the need for local teams' ownership and commitment to their own continuous quality improvements.

WORKING AGE ADULT CLINICAL SERVICE STRATEGY 2019-2022

Vision of the service in 2023

By 2023, the service will be more closely integrated across the pathway with integrated models of delivery, including psychological therapies and substance misuse services embedded in community teams. The service will link much more closely with GP Practices and Primary Care Networks, with IAPT (Improving Access to Psychological Therapies) services increasingly embedded in primary care provision and Community Mental Health Teams (CMHT) linking with practices and working within the Community Wellbeing approach to support non-clinical interventions, the avoidance of secondary care referrals and active support for recovery in the community. CMHTs will include a much wider range of skills and backgrounds and will use outcomes data to inform risk stratification and their team decisions. Variation across CMHTs will reduce, with single processes for managing capacity and demand and greater compliance to NICE Guidance. The significant expansion in Crisis and Liaison services will make our service more responsive and provide real alternatives to admission, through additional capacity for home treatment and physical alternatives to A&E attendance. Inpatient services will be RCPsych (Royal College of Psychiatrists) accredited, people will stay in their own bedrooms and mean length of stay will be at 32 days. People with personality disorders will be supported in the community, with only exceptional cases requiring unplanned inpatient admissions. Patients and carers will be treated as full partners in the assessment and delivery of care, with an individualised approach to care planning and person-held plans.

Introduction

The Working Age Adult Clinical Service Strategy has been developed in line with the DHcFT values, that by putting our people first, our colleagues, we are able to best meet the needs of the people who use our services. The process undertaken to develop this strategy prioritised the engagement of as wide a number of clinical colleagues working in the service as possible.
Over the same period, DHcFT refreshed its Trust Strategy to focus on three main strategic objectives:

- To provide Great Care
- To be a Great Place to Work
- To make Best Use of our Money

Underneath each of these strategic objectives, there are a number of building blocks which need to be in place to enable the objectives to be delivered. Each of the improvement ideas contained in this strategy will be linked to these Building Blocks.

Altogether there are eight separate Pathway Strategies that have been developed through this process. The aim is that general themes and commonalities across the strategies and overlapping issues will be linked and where improvement ideas across pathways can be progressed, they are undertaken together in an open and collaborative way, building trust and understanding between services.

The initial development work of the strategy focussed mainly on frontline clinical staff in each of the pathway areas, with some patient and carer representatives at each of the session. The process included a stakeholder session, where an initial draft of the strategy could be shared, tested and improved through engagement with our commissioners, Local Authority and Voluntary Sector partners and a wider group of patients and carers.

Why develop clinically led pathway and service level strategies?

The Trust operates in an ever changing health and care environment. The NHS Long-term Plan, published in January 2019 outlined a number of commitments and improvements required of health systems alongside significant additional investments into mental health services.
In addition, demand for mental health services has increased markedly over the last three years, with significant increases in referrals to community teams, increases in inpatient admissions, use of the Mental Health Act and usage of Psychiatric Intensive Care Unit (PICU) beds. DHcFT Acute Inpatient beds have been operating at near to and over 100% capacity over the last two years. At any point in time, there are between 5 and 15 people in out of county acute mental health placements, with similar numbers in PICU placements.

Despite large increases in mental health spending between now and 2023, growth in resource available to health systems and to mental health services is unlikely to keep up with this growth in demand. The pressures on local authority funding means that social care availability is more limited than in the past.

All of which, means that if services for working age adults are to continue to meet the needs of people in Derbyshire, then they will need to find ways to continuously improve, to be as efficient and as effective as possible.

The methodology undertaken in developing these strategies enabled frontline clinicians to come together to identify and develop improvement ideas that could be delivered over the next three to five years, supporting the building blocks of the Trust's overall strategy and providing a sustainable base for the provision of services.

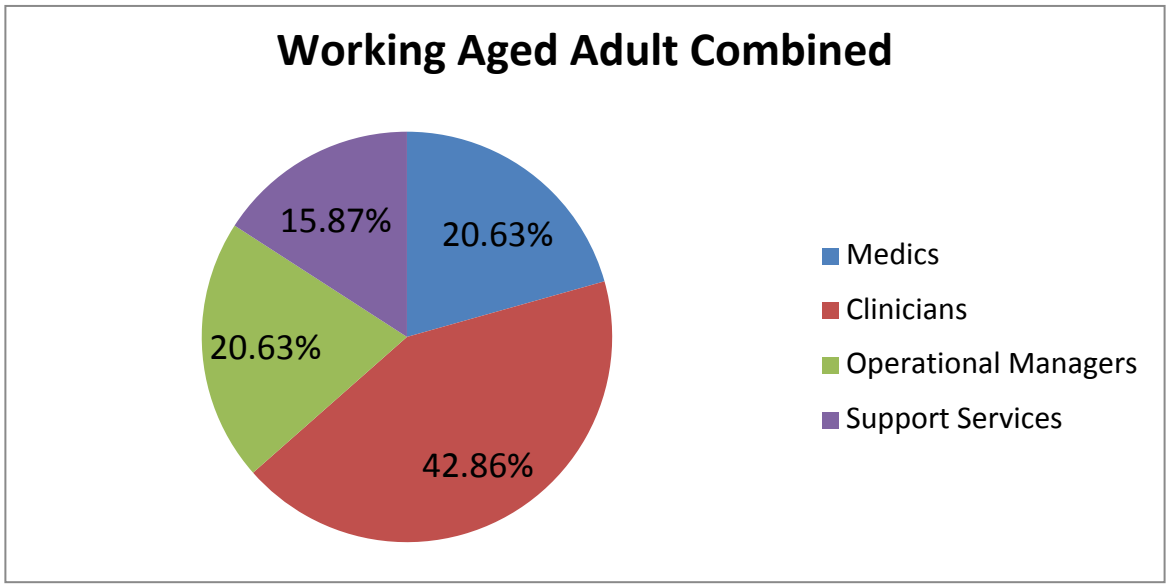
Development Process

Each of the service areas went through the same process of developing their service improvement ideas and strategic development:

- Two day development sessions, held a week apart with intervening time committed for seeking back to base input from team members unable to attend the sessions and feedback
- The direction of travel and the improvement ideas were led by clinical colleagues from all disciplines
- Service user and carer representation
- Support services such as finance, estates, HR, etc., were also engaged with the process.

N.B. When this document uses the term 'clinician', this refers to all our colleagues who are working at the point of care, therefore allied health professional, doctors, nurses, psychologists, and those without a formal professional qualification.

Percentage breakdown of attendances at Working Age Adults strategy development sessions



The sessions provided the opportunity for clinicians to come together to acknowledge the good work already being done and also to build on this good work to look at where services could be improved, in line with best practice and best evidence. Time between the development days was built in, specifically to enable the learning from Day 1 to be taken back to the wider teams for discussion and collation of feedback to be put forward for inclusion into the second day and the strategy.

Attendance from clinicians has been prioritised for the sessions, providing a comprehensive understanding of the issues within each pathway and service area. Attendance from staff in support functions such as finance, HR, estates, etc., provided different perspectives and allowed workforce, estates and other strategic considerations to be part of the process. Each and every session was attended by a small number of service users and carers.

Due to the scale and size of services for Working Age adults, the sessions were planned and delivered over two development session sets. A fifth session was then held, with a smaller group of clinicians, to pull together the work from the four days into a single service strategy.

The Purpose of the Service

The teams thought through a single, cohesive purpose for the service, this in effect providing the strategic direction:

“At the core of our service is how we connect and engage with the community, service users and carers. We want to plan for the future, find new efficient and effective ways of working to address issues felt by service users, carers and staff. We want to support people in their own homes wherever possible and work as a single coherent service across community and inpatient settings and when people are in crisis”.

The Working Age Adult service is proud of the service it provides, the compassion, commitment, ambition and resilience it shows on a daily basis.

The teams came up with overarching themes of work where they wanted to improve services:

People
- Service users integrated in co-production at an individual and service level
- Building value and capacity in clinicians and patients
- Broader use of psychological therapy interventions
- Training and vocational skills improved
- Career development
- Change management training

Structure
- Bed number reduction and delivery of single bedrooms
- Admission avoidance
- Developing outpatients
- Effective and functioning multi-disciplinary teams, including partners and other services
- Links to primary care

Culture and Behaviour
- Communication across entire service
- Sharing improvements, expertise and successes
- Service user involvement
- Connecting people and teams
- Being mindful of staff wellbeing
- Proactive attitudes

Process
- Data and measurement KPIs
- Diagnosis informed pathways
- Risk stratification in managing caseloads
- Multidisciplinary teams (MDT) agreement of workload / caseload
- Tackling unwarranted clinical and process variation

Estates implications

The need to move to single bedrooms across the inpatient estate is well known. By implementing the Out of Area Bed Reduction plan and shortening our current length of stay in our acute wards, there may be the ability to manage future demand growth from within our reduced bed stock. A Business Case for PICU provision in Derbyshire and any and allied estate development will be required.

The service developments outlined below and the significant investments from the NHS Long-term Plan for Mental Health, will result in a large increase in staffing numbers in Crisis, Liaison and CMHTs. Whilst increased support for agile working and digital contacts may mitigate against some of this demand, it is unlikely to avoid the need for growth in our community estate for office and clinical space.

One of the service developments outlined below is the creation of a single booking system for clinical space across the estate. The creation of such a system could assist the optimising of our existing space and would support the future modelling of demand and capacity needed to inform our future need for clinical space with expanded community teams.

Workforce implications

As summarised above, there are significant investments in community services for working age adults required by the implementation of the NHS Long Term Plan for Mental Health. Recruitment to expanded Crisis and Home Treatment Teams has already commenced. Recruitment across the phases of the Long-term plan will need careful management to ensure that recruitment doesn't result in retention issues in other essential services. The investment in CMHTs comes in later years of the plan and may come at a time when workforces shortages in nursing and medical posts are at their most acute. There therefore may be a need to be active planning for alternative roles to be part of that CMHT recruitment to support the role of mental health within a wider MDT suitable for a more integrated service offer in the community. New roles could be in social work, community development, housing support workers and other similar roles, in addition to the wider employment of non-medical prescribers.

IM&T Implications

With the need for greater consistency in practice across the community teams, the new EPR system will need to support the rationalisation of forms, the consistent treatment of referrals, a single waiting process and means to promote adherence to clinical guidance. As teams increasingly demand outcomes data and other information to inform decision making, there will be a need to increase capacity in Business Intelligence functions.

3-5 Year Service Improvement Plan

Based on the feedback from the wider teams and Day 2 work undertaken by participants, below is an outline Service Improvement Plan of the service improvements the Working Age Adults Service wants to develop over the next three to five years. Each of these ideas was developed by teams and individuals within the service. An outline project scope is in place for each of these projects, from the work teams did in their Day 2 sessions.

For each idea, there is a reference to NICE Guidelines or other national expectations where available. Some ideas are more locally driven, and will be explored using Quality Improvement methodologies, e.g. the Institute for Health Improvement Model for Improvement, or Lean. This is to ensure a robust structured and evaluated approach, led by the voices of those in our care, their families, and colleagues working at the point of care, as supported by the The Kings Fund document 'Quality improvement in mental health' (https://www.kingsfund.org.uk/publications/quality-improvement-mental-health). This is also in line with the Trust's Quality Improvement Strategy

NICE Guidelines will be a helpful baseline for our alignment against national best practice, and NICE Quality Standards will be a helpful way of prioritising and measuring specific improvement responses to any gaps, again underpinned by Quality Improvement methodologies.

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement idea Codes and orginators	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Design and build a process of Co-production of care with individual and groups of service users, including care planning and design of service improvements	Service users engaged in their care. Build resilience and improve outcomes	Improve patient and carer experience	Service User Experience in Adult Mental Health: https://www.nice.org.uk/guidance/cg136 https://www.nice.org.uk/guidance/qs14	S58 and Stakeholder Event	Delivered from existing resources. Potential for increase in recruitment of experts by experience and carer volunteers.	None	Potential for increase in training. Potential for increase in recruitments of experts by experience.	Design completed by March 2020.
Broader use of psychological interventions across teams and settings	Avoidance of admissions. Shorter length of stay.	Improve clinical outcomes	This will be found in all mental health NICE Guidelines. With specific reference to		Internal investment in psychological therapies as part of PD plan. Potential case for CCG/JUCD investment and use of NHSE/I	Additional accommodation for enhanced community teams. Potential impact on bed stock/ link to single	None	From October 2019

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement idea Codes and orginators	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
			the diagnosis of personality disorder, this is found at https://www.nice.org.uk/guidance/cg78		Transformation monies.	bedrooms.		
Rolling programme of Change management and Continuous Improvement training provided to all teams	Resilient teams able to manage and lead change and lead service improvement.	Develop our colleagues			Continuous Improvement Plans and recurrent savings idea development.	None	Additional training packages developed and delivered in partnership with Transformation Team	From October 2019
Specialist staff training package, career mapping and succession planning	Retention of staff improved.	Develop our colleagues	NHS Interim People Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf		Internal investment case required, linked to benefits of increased retention.	None	Development of training package. OD work to develop and communicate career pathways in WAA services	By October 2020
Link Working Age Adult colleague with each GP Practice and Primary care Networks across the City and County	Reduction in referrals from Primary care and improved resilience in primary and community care.	Work with partners to achieve best value across Derbyshire		B19, B57, B61	From existing staffing establishment	None	None	From April 2020
Develop alternatives to admission for patients in Crisis	Reductions in admissions.	Improve clinical outcomes	NHS Long Term Plan https://www.l	NHS LTP MH	NHSE/I Transformation Monies and JUCD	Potential lease of additional facilities or service	None.	By March 2021

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement idea Codes and orginators	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
			ongtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf		MHIS investment	agreements with Vol. Sector		
Crisis and Home Treatment teams established in fidelity to the national model	Reductions in admissions. Reductions in out of area placements. Shorter LoS. Improved outcomes for patients	Improve access to our services	NHS Long Term Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf	NHS LTP MH	NHSE/I Transformation Monies and JUCD MHIS investment	Need for additional accommodation for increased staffing.	Additional recruitment. Potential impact on other teams.	By March 2021
Enhanced Community Teams: greater provision for people with PD; caseload levels closer to national benchmarks	Reductions in admissions. Shorter LoS. Improved outcomes for patients. Shorter waiting times.	Improve access to our services	NICE Guideline for personality disorder, found at https://www.nice.org.uk/guidance/cg78	B19, B57, B61	NHSE/I Transformation Monies and JUCD MHIS investment	Need for additional accommodation for increased staffing.	Additional recruitment. Potential impact on other teams	By March 2022
Deliver the five projects within the Urgent Care Improvement Plan	Shorter LoS. Reduction in out of area placements. Admissions reduced.	Improve clinical outcomes	NHS Long Term Plan		Internal investments made or in current financial plans	Potential reduction in bed stock. Link to single bedrooms work.	Already within plans.	Ongoing and complete by March 2021

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement idea Codes and orginators	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
	Improved outcomes for patients.							
Deliver and sustain the actions in the CQC Acute Service Improvement Plan	Shorter LoS. Improved experience for patients.	Improve safety	NHS Long Term Plan. NICE Guideline for Service User Experience in Mental Health		Internal investments made or in current financial plans	Potential reduction in bed stock. Link to single bedrooms work.	Already within current plans.	December 2019 and ongoing.
Caseload management, workload and risk stratification processes in place and to be led by each Community MDT itself.	Greater clinical engagement. Improved team working. Improved and targeted use of resources	Improve access to our services		S3	From existing resource. Potential to source external software packages to assist risk stratification	None	None	Ongoing from January 2020
Increase compliance by CMHTs with NICE Guidance and use of Diagnoses-based pathways where they exist. Improve communication with patients at the onset of care with clear expectations and signposting.	Reduction in clinical variation. Improved team working. Improved and targeted use of resources. Improved patient engagement in care planning.	Improve clinical outcomes	Work is underway to raise the profile of NICE Guidelines and to formally review our alignment with their expectations	S17	Within existing resources and establishment	None.	None	Plan in place by December 2019 for delivery during 20/21
Evaluate impact of Nurse-led clinics and roll out across the county.	Improved and targeted use of resources. Reduction in clinical	Improve access to our services		B2	Within existing resources. Potential savings in line with Continuous	Potential increase in clinical space required in community teams.	None	Pilots evaluated by Sept 2019. Roll out completed by

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement idea Codes and orginators	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
	variation.				Improvement Plans			August 2020.
Single clinical room booking system to be established across the trust.	Improved utilisation of estate. Improved capacity planning. Improved patient experience.	Improve our estate to support our new models of care			OBC to be developed to consider investment and potential benefits of improved utilisation and effective capacity management.	Improved utilisation of resource. Potential risk that more clinical space may be required.	None	October 2020
Digital alternatives to face to face care to be explored, evaluated and rolled out across CMHTs.	Shorter waiting times. Empowered and resilient service users. Improved and targeted use of resources	Improve access to our services		S12, S20, S56 and Stakeholder event	OBC to be developed to consider the investment in new licenses and software with potential benefits.	None	Potential need for training packages for staff and users of digital alternatives.	Plan developed by December 2019.
Greater communication and engagement with carers on care planning and discharge planning.	Shorter length of stay. Improved outcomes for patients.	Improve patient and carer experience	Service User Experience in Adult Mental Health: https://www.nice.org.uk/guidance/cg136 https://www.nice.org.uk/guidance/qs14	Stakeholder event	From existing resource	None	None	Immediate
Identification of main carer and provision of information, training and support for the carer, in partnership with the Vol. Sector	Greater patient and carer resilience. Admissions avoided.	Improve patient and carer experience	Service User Experience in Adult Mental Health: https://www.n	Stakeholder event	Possible training costs for staff. Possible extension of peer support into CMHTs.	None	None	Within six months

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement idea Codes and orginators	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
			ice.org.uk/guidance/cg136 https://www.nice.org.uk/guidance/qs14					

Governance

The improvement projects above will be delivered by a new working group, involving clinicians, operational managers and service users. This working group will be accountable to the Clinical Service Strategies Transformation Board, which will be established in October 2019 to oversee and assure the delivery of all the Clinical Service Strategies. The Transformation Board will have Executive and Non-Executive Trust Board representation and report directly to the Trust Board.

Key to delivery and implementation will be the continued engagement of the Clinical Director(s) and other clinical leads, able to apply a clinical formulation of the workforce implications within the plan. Following agreement of the Strategy by the Board, the new working group will be established and its first task will be to prioritise the actions within the service development plan. Another early task will be to understand the managerial and clinical capacity required to deliver the plan and any financial implications. The Transformation Board will receive workplans from each area for the year ahead. A balance will need to be struck between central direction and performance management of delivery and implementation with the need for local teams' ownership and commitment to their own continuous quality improvements.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2019

Annual Report for Derby City Looked After Children Provision 2018/2019

Purpose of Report

The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHCFT) an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City.

Executive Summary

The report includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live and was reported to the Safeguarding Committee and scrutinised on 16 July 2019:

- The Safeguarding Committee was assured by the sustained and improved performance and governance safeguards in place for our commissioned looked after service and with the significant progress and compliance with statutory duties under the Children Act.
- Key new improvements included a new flowchart for Initial Health Assessments was developed; this is a more structured and robust process to improve clinical information and access.
- A flexible approach in the use of resources by increasing the number of clinic slots to reach the demands of the increase in children entering care and to improve compliance for statutory initial health assessments. The Children in Care (CiC) Specialist Nurses have adapted their way of working with Review Health Assessments by looking at what is required to engage young people to attend their Review Health Assessments working in partnership with the local authority to improve overall health compliance which improved outcues for children
- The Administrator Co-ordinator and the Designated Nurse worked with the local authority to agree on one consent form which incorporated all the previous five consent forms and this has resulted in gaining consent in a more timely fashion, decreasing delay for the child and improved access.
- It is recognised that the Looked after Children health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to foster carers and children's homes
- The adoption process is outlined in the report and an analysis of adoption activity is shown
- Health performance although provisional until submitted in July is the highest it has been in many years. The completion rates for both annual assessments (over 5s) and development assessments (under 5s) are really high and this is very positive. The team is to be commended for this improvement
- Over 2018/19 additional nursing hours have been utilised to capture the requests for review health assessments for the 'Born-out-lives in' (BOLI) children and young people. There have been 36 completed review health

assessments for the BOLI cohort during 2018/19 leading to better outcomes for children.

- The Clinical Commissioning Group have confirmed and have been assured that the Children in Care service provision is overall at a good standard and the Health provider is working in partnership in all areas that have been identified as requiring further progression or improvement.
- Designated Nurse for Looked after Children and the Named Nurse for Children in Care spent a day with the Local Authority Participation Officer and some young people from the Children in Care Council looking at how to develop the Children in Care website and to gather feedback around the proposed new health passport folders. This was a really productive day with lots of ideas from the young people on how to improve the design of the children in care website and the proposed health passport.
- Foster carer drop in health sessions are delivered by the Named Nurse for Children in care and the Designated Nurse for Looked after Children. These sessions are well received by local authority foster carers and feedback is included in the report.
- Priorities for 2018/19 have been set and governance systems to monitor these are in palace and will be scrutinised by the Safeguarding Committee.

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

Assurances

- The compliance for both Initial Health Assessments and Review health assessments have improved over 2018/19 therefore over 2019/20 the Designated Doctor for Looked after Children and the Named Nurse for Children in care will focus on quality of Initial Health assessments and Review Health Assessments. Audits will be completed to ensure the quality of health assessments are consistent across the service
- The organisation will assure measures are put into place in accordance of the service specification
- The statutory timescales have and will be monitored and evidence is provided and scrutinised in order to achieve outcomes in line with our statutory duties
- Training compliance will be scrutinized to ensure competency of staff to the right level again in line with our formal duties

Consultation

- This report has been developed by the Named nurse for Children in Care with information that is held by both provider and local authority
- Various members of the wider Children in Care team have contributed to the report
- A child friendly Annual Report has been developed in a leaflet form.

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:

1. The cohort with the most significant increase is those children coming into care as a result of 'absent parenting' and predominantly Unaccompanied Asylum Seeking Children
2. There is an increase in the 16 years + cohort, this may be as a result of the increased Unaccompanied Asylum seeking Children coming into care (as a direct result of the local dispersal centre that opened in 2018), who have all been aged 16 years or above
3. The Children in Care team have a Child Exploitation Champion who attends relevant multi-agency meetings to gather and share appropriate information with professionals involved, identifying risks using the risk assessment matrix and completing any health actions

Children in care specialist service were originally commissioned as an equalities intervention to reduce the health inequalities and life outcomes for children who were looked after children who had poorer life outcomes than children who were not looked after. This service is designed on that research and that evidence base. By the team delivering this level of performance they are improving life outcomes for our children.

Recommendations

The Board of Directors is requested to:

1) To give appropriate feedback
2) Receive assurance of the work completed in the Safeguarding Committee, the external review by commissioners and the work within DHCFT around looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people
3) To accept the annual report in the public domain as required by the Trust's statutory duties.

Report presented by: **Carolyn Green**
Director of Nursing and Patient Experience

Report prepared by: **Kelly Thompson**
Named Nurse for Children in Care

Derbyshire Healthcare
NHS Foundation Trust

11.1 Annual Report for Derby City CiC

Year: 2018/19

Contributors:

Kelly Thompson (Named Nurse for Children in Care – DHcFT)
Dr A Marudkar (Medical Advisor for Children in Care – DHcFT)
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Maria Moore (Specialist Nurse for Children in Care – DHcFT)
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Emma Fennell (Specialist Nurse for Children in Care – DHcFT)
Jane Mason (Administrator Coordinator – DHcFT)

Section 1: Introduction and context

Introduction

1.1 The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHCFT) an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City. This includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live (see appendix 1 for explanation of the differing cohorts).

1.2 The report will outline how Commissioners, Designated Professionals, Local Authority and health providers have worked together in partnership to meet the health needs of children in care in Derby City; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).

It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2019/20) for looked after children in Derby City.

1.3 This report has been compiled in partnership with the Named Nurse for children in care; Designated Nurse & Designated Doctor for looked after children and the Medical Advisors and Specialist Children in Care Nurses supporting children in care.

1.4 The report contains and analyses the compliance to the statutory framework in respect of timeliness and quality of health assessments and is obtained by the use of snapshot audits.

1.5 Within all national and local policies and guidance the service is known as Looked after Children, however within Derbyshire Healthcare NHS Foundation Trust the service is known as Children in Care.

Context

1.6 **Definition of a looked after child/ child in care**

A child that is being looked after by the Local Authority, they might be living with:

- foster parents
- at home with their parents under the supervision of Children's Social Care
- in residential children's homes
- other residential settings like schools or secure units.

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

1.7 It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

1.8 The Royal College of Paediatrics and Child Health (2015) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, March 2015, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 Children Act (1989)

Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 Adoption and Children Act (2002)

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

2.3 Children and Young People's Act (2008)

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care and services which are focused on and tailored to their needs.

2.4 Children and Families Act (2014)

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs

2.5 Promoting the health and wellbeing of looked after children (March 2015)

This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups, Service Providers and NHS England.

2.6 Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (March 2015)

This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

2.7 The Children and Social Work Act (2017)

Improves decision making and support for looked after and previously looked after children in England and Wales

- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools
-

Section 3: Looked after children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past eight years. There were 75,420 looked after children on 31 March 2018, an increase of 4%, compared to 31 March 2017. The most up to date national figures for 2018/19 are not yet available from the Department for Education (Stats: Looked after Children, Department for Education, 2018), the usual publication date being December 2019.

3.2 Number of children looked after in England at 31 March 2013 to 2018

2013	**68,080**
2014	**68,800**
2015	**69,540**
2016	**70,440**
2017	**72,670**
2018	**75,420**

Ref: Data made available from Derby City Local Authority Informatics Department

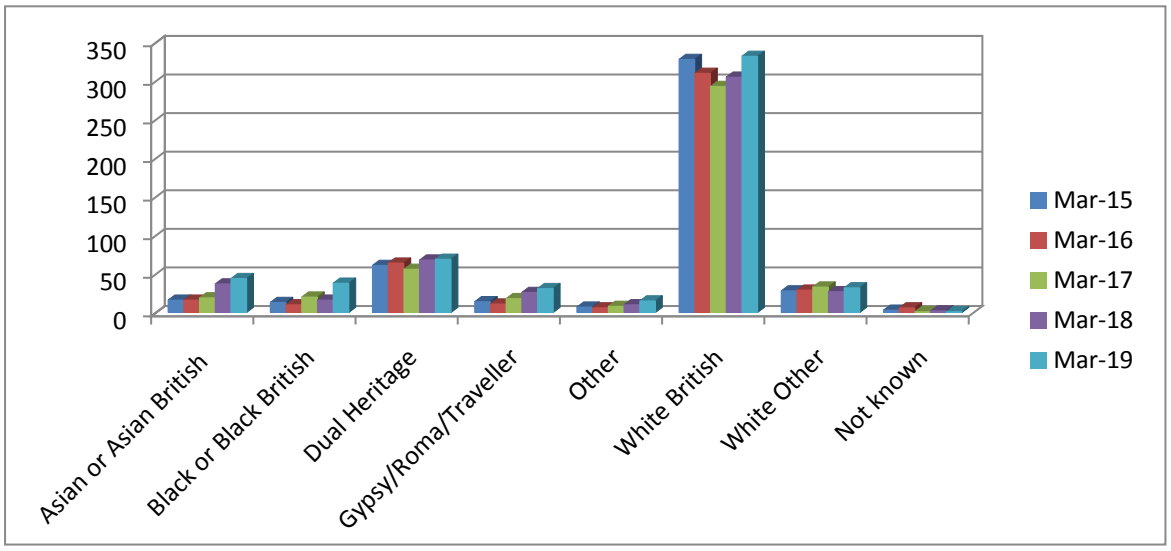
3.3 Number of children looked after in Derby at 31 March 2013 to 31 March 2019

2013	**465**	
2014	445	4% decrease from 2013
2015	470	5% increase from 2014
2016	452	4% decrease from 2015
2017	448	0.8% decrease from 2016
2018	491	8% increase from 2017
2019	562	12% increase from 2018

Ref: Data made available from Derby City Local Authority Informatics Department

Profile of looked after children in Derby City

3.4 Ethnicity comparisons over the last five years:



Ref: Data made available from Derby City Local Authority Informatics Department

On analysing the data, it is clear that there is an increase of looked after children from the Gypsy/Roma/Traveller, Asian/Asian British, Black/Black British and Dual Heritage ethnic group; this reflects the Derby City picture of the diverse demographics within Derby City and the new emerging communities. There have been significant cultural differences found in the new emerging communities, in relation to childcare, parenting, discipline and safety aspects. This has resulted in an increase of cases being referred to Children's Social Care and involvement at all levels of intervention; in some cases children/young people taken into care. The number of White British children coming into care has increased again within this financial year, after a fall over previous years; this may be reflection of the overall increased population changes within Derby City.

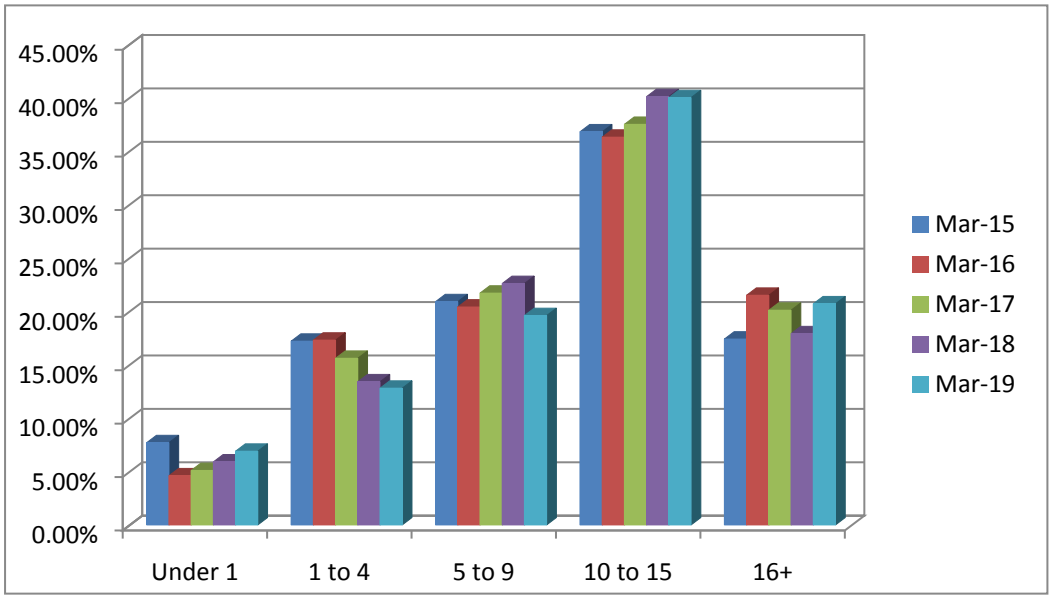
3.5 Gender of looked after children in March 2019

Gender	
Male	57.3%
Female	42.7%

Ref: Data made available from Derby City Local Authority Informatics Department

This data indicates that there is a static gender split between males and females (which mirrors previous years) and the national picture.

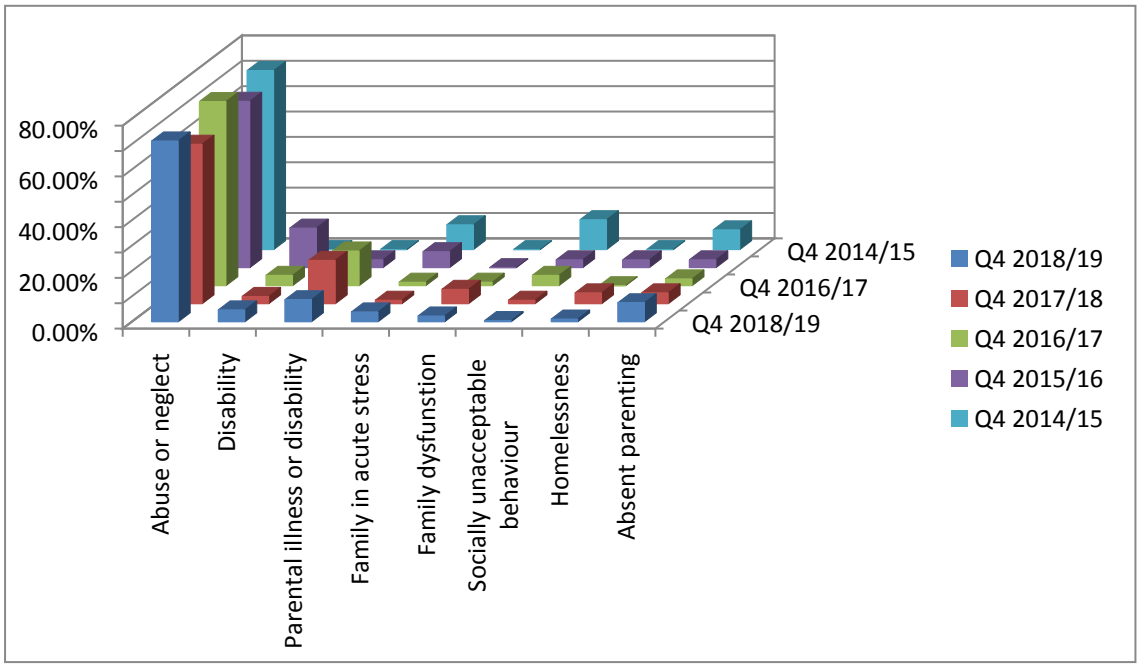
3.6 Age comparisons over the last five years:



Ref: Data made available from Derby City Local Authority Informatics Department

In comparing the data for the past four years, the 10 to 15 year old age group consistently remain the highest number of children/young people coming into care. It is difficult to determine the definitive reasons for this but it may be linked to the increase in socially unacceptable behaviour, abuse/neglect, acute stress within the family home vocalised by children/young people and family dysfunction identified as a reason for coming into care. There is an increase in the 16 years + cohort, this may be as a result of the increased Unaccompanied Asylum seeking Children coming into care (as a direct result of the local dispersal centre that opened in 2018), who have all been aged 16 years or above.

3.7 Reasons for children coming into care – comparison in quarter 4 data over last five years



Ref: Data made available from Derby City Local Authority Informatics Department

Abuse or neglect remains the most dominant reason for children/young people coming into care, with the percentages remaining relatively stable in reason categories reflected in the above data. When making comparisons of a quarter by quarter basis over the past four years, there is a change in the overall trend with more children being taken into care due to homelessness (Local Authority category - low income), disability and family in acute stress. This may in some circumstances be associated to the financial climate within England, changes in benefit systems which is then reflected in family pressures; this is difficult to confirm. The cohort with the most significant increase is those children coming into care as a result of 'absent parenting' and predominantly Unaccompanied Asylum Seeking Children.

3.8 Distribution of Looked after Children placed In and Out of Derby City

	March 2019	March 2018	March 2017	March 2016	March 2015
Within Derby City	39.7%	36.3%	38.6%	42%	46.2%
Outside of Derby City	60.3%	63.7%	61.4%	58%	53.8%

Ref: Data made available from Derby City Local Authority Informatics Department

3.9 The Local Authority has acknowledged that the shift of Looked after Children placed out of Derby City has been increasing over recent years; this is not always in the best interests of the child. Children placed out of Derby City can potentially not receive a timely service or have access to timely specialist services this is due to the child having to be referred to services in the area they are residing in; this clearly needs addressing and resolving as all looked after children should wherever they reside receive services they need in order to meet their individual identified needs. Derby City Local Authority continues to work in partnership with Derby City Foster Carers and Independent Fostering Agencies, in order to increase the level of Foster Carers /placements within the City or placements close to Derby City, which has had a positive impact on the availability of suitable placements within the local area.

3.10 The Local Authority also continues to make progress in placements within a 20/40 mile radius of Derby City and indeed has approximately 78% of Derby City Looked after Children placed within that parameter. The continuation of the Children in Care health team undertaking health assessments at a 20 mile radius of Derby City; has had a positive impact on improved quality and timely health assessments for those living within an approximate 30 mile radius.

Section 4: Summary of achievements in year 2017/18

4.1 During the period of 2019/20 the Children in Care health team have continued to experience significant change and it has been acknowledged despite this the Specialist Nurses, Medical Advisors and Administration Team have shown innovation and marked improvements within their service delivery.

The following are an indication of the progress made and not an exhaustive list of achievements:

4.2 The role of the newly appointed Administrative Coordinator for Children in Care and Adoption commenced during the start of quarter 2. During quarter 2 the Administrative Coordinator and Named Nurse have worked internally with the provider to develop a new Initial Health Assessment Pathway. These changes have resulted in more efficient working, improved compliance with initial health assessment statutory timescales and improved service delivery across administration and clinical areas.

4.3 The provider has used a flexible approach in the use of resources by increasing the number of clinic slots to reach the demands of the increase in children entering care and to improve compliance for statutory initial health assessments. The CiC Specialist Nurses have adapted their way of working with Review Health Assessments by looking at what is required to engage young people to attend their Review Health Assessments working in partnership with the Local Authority to improve overall health compliance.

4.4 Completion of the CCG 'Markers of Good Practice' assurance framework and the implementation of an improvement plan in collaboration with Designated Professionals (detailed in section 10, pages 18-19).

4.5 Review of the service specification took place and agreed between provider and commissioners.

4.6 The Named Nurse for Children in Care and the Designated Nurse for Looked after Children redeveloped the training programme for Foster Carers and Residential Care Workers and this commenced in March 2018 and continued throughout the year 2018/19 (detailed in section 6.14, page 15).

4.7 Action learning sets facilitated by the Designated and Named Nurse have continued within the service. Sessions have focussed on a variety of relevant topics, for example: Serious Case and Learning Reviews in preparation for the Joint Target Area Inspection, smoking cessation and social media and SEND. This also acts as an assurance that the Children in Care health team undertake required specialist training and maintain their skills and knowledge.

4.8 Designated Nurse, Designated Doctor, Named Nurse and the Administrator Coordinator have continued to strengthen existing relationships and networks with key professional, local partners and agencies locally and regionally, which has facilitated information sharing, health outcomes and the voice of the child (including those out of area).

4.9 Health access to Liquid Logic Child Social Care system has been established, which has been proven to improve information sharing between agencies (in the best interest of looked after children) and had a positive impact on the accuracy and validity of health data reportable to Department for Education.

4.10 Health history booklet and process has been improved in partnership with the Provider, Local Authority, leaving care teams (recommended in Ofsted inspection). The Designated Nurse for Looked after Children has secured funding to purchase Health History folders which will follow the child/young person through their time whilst in care.

4.11 Reporting and assurance into the SDCCG (now DDCCG) Quality and Performance Committee have been strengthened via quarterly reporting of performance and quality of the Children in Care service. This has allowed the Named Nurse for Children in Care the opportunity to access and interrogate health data more robustly internally within the Trust, using relevant and useful reporting systems. This in depth provision of evidence has enabled a more robust way of working at both team and service level and influenced improvements.

4.12 Health performance although provisional until submitted in July is the highest it has been in many years. The completion rates for both annual assessments (over 5's) and development assessments (under 5's) are really high and this is very positive.

4.13 The CiCA administration team have worked exceptionally hard over the past 6 months to ensure all the out of area requests for children placed outside of a 20 mile radius are sent out in a timely manner (by 8 weeks of the due date) and this has seen a marked improvement in the amount of review health assessments being sent back within the statutory timescale.

Section 5: Provider and Partnership Working

Below are examples of partnership working within the Children in Care team:

5.1 The Children in Care Team have a champion for Child Sexual Exploitation and Child Criminal Exploitation. Part of the role involves attending Missing Children's Forum, where possible, which take place monthly. This is a multi-professional meeting involving multiple agencies from Health, Education, Police and Local Authority. Intelligence is gathered and shared regarding children who have a pattern of missing episodes; identifying risks, any associates involved and discussions around how any risks can be reduced. Information

sharing is pivotal to ensure the safety of all children and young people in care. If the child is at risk of going missing an alert can be placed on a central database which is a Police based system as well as alerts going out for Health.

5.2 Once a child has been seen by a Social Worker (which is statutory) following a missing episode it is good practice for the worker to complete a Child Sexual Exploitation (CSE) matrix risk assessment form, this consists of a set of indicators and is used to score how high the risk a child or young person is of child exploitation. Any child which is deemed as a high risk, triggers local safeguarding protocols to be followed such as completion of an Operational Liberty Form, Strategy Meetings and an Initial Child Sexual Exploitation Strategy Meeting.

5.3 Part of the role is identifying the various types of exploitation models used, such as, party mode; peer on peer and boyfriend model. In addition to this, it is about using the professional language to identify the abuse and name it for what it is, this is to move away from incorrect terminology which may place the blame or imply the young person is consenting to the exploitation.

5.4 Part of the Specialist Children in Care Nursing role is to raise the profile of exploitation as a public health concern. This can involve working with the young person on recognising healthy/unhealthy relationships and working on the young person's resilience. Direct work involves raising awareness around signs of exploitation and risks to empower the young person to actively report concerns.

5.5 In a July 2016 policy document, Keep on caring, the Department for Education (DfE) concluded that outcomes for care leavers were much worse than their counterparts in the general population. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. Almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs, Promoting the health and wellbeing of looked after children (March 2015).

5.6 The care leaver cohort is also changing, as more children enter care at age 16 and over, and with more unaccompanied asylum seeking children (UASC) entering the care system. These changes could present new challenges for service providers and requires strong collaboration with partner agencies to ensure their needs are fully met.

5.7 It was stipulated within the Children and Social Work Act 2017 mandated Derby and other local authorities to publish a 'Local Offer to Care Leavers. The act also states that a young person who has experienced care can ask for support from the Leaving Care services up to the age of 25, whether you are in education or training.

5.8 In the children in care team there is a champion for care leavers who works closely with the Leaving Care Team.

The benefits of having a champion are:

- Development of stronger links between the children in care nurses and the leaving care team offering support and advice
- Ensure all young people who leave care have a health passport completed, which is accessible to the leaving care team.

- Working more collaboratively with service providers such as ANEW housing, sexual health services and the YMCA offering health advice and support for the young people they work with.
- Improved liaison with care leaving services to support the young person to access their last review health assessment, including different ways of working that is convenient to the young person, such as joint visits with their care worker, home visits or visiting at times that suit the young person due to education or employment.

5.9 The Children in Care team facilitate pre-registration students as a 'spoke' placement and student public health nurses with increasing frequency. We have also supported a number of students completing further professional development visits, providing an opportunity for them to shadow the work completed by the Children in Care Department. The students will learn about the Statutory Service the Children in Care Team provide giving them the opportunity to oversee Initial Health Assessments, Review Health Assessments and visits to the Residential Children's Homes. There is also an opportunity to spend time with the Designated Nurse for Looked after Children to provide an understanding of Commissioning and the importance of quality and audits. This will increase their knowledge and understanding about the service provided to all Children in Care. As a team we have been able to show all students how important the work completed by the Children in Care team is to such a vulnerable population group, and also educate students on how integrated and multi-disciplinary team work is of benefit to all services in meeting health needs.

Section 6: DHcFT service provision for Looked after Children

6.1 The DHcFT Children in Care health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2015). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

6.2 The team have improved their offer for Looked after Children by including; the delivery of health promotion to children and young people, support for care leavers, development of a robust system to collate health histories for care leavers, improved identification of risk of child sexual exploitation (including boys/young men) and provision for children who have special needs and/or disability (revised service specification during 2018/19).

6.3 The staffing levels for the health team at the end of the financial year (March 2019) were as follows:

Designation	Hours	WTE
Designated Doctor	4 hours (1 session)	
Designated Nurse (SDCCG)	37.5 hours	1 (From May 2017)
Named Nurse	30 hours	0.8
Specialist Nurse	14 hours	0.37
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	32 hours	0.85
Specialist Nurse	26 hours	0.7

6.4

Placement	Number of LAC	
Living in Derby and close to Derby City (within 30 mile radius)	350 (approx.)	Total number of children likely to be under direct care of Derby City LAC health team = 350-390
Living close to Derby (between 30-40 miles)	40 (approx.)	
Living at a distance	170 (approx.)	RHAs are completed by an out of area provider under national tariff agreement

On reflection of the distribution of looked after children the Health Provider is deemed to almost have staff in post at a level advised within the Intercollegiate Document (March 2015), being only short of between 0.18-0.58 WTE. It is worth noting that the Health Provider also utilises regular bank Specialist Nurse when required to support busier periods.

However, it has to be acknowledged this document is deemed to be 'gold standard' and one for services to aspire and fulfil as much as possible; to ensure that looked after children receive the healthcare services they require by skilled competent staff and in a timely manner.

6.5 In 2018/19 the service specification for the Children in Care health team was revised, agreed and continues to be implemented to reflect current statutory requirements and completion of health assessments within a 20 mile radius. The Children Commissioners, Designated Nurse and the Provider have and continue to work collaboratively to monitor performance, in line with statutory guidance.

6.6 Over 2018/19 additional nursing hours have been utilised to capture the requests for review health assessments for the 'Born-out-lives in' (BOLI) children and young people. There have been 36 completed review health assessments for the BOLI cohort during 2018/19 and the Provider has received funds at the National Tariff payment rates.

6.7 Over the past year there have been many changes within the Children in Care and Adoption Administration Team. For the first half of the year the team had a vacant post for the Administrator Coordinator therefore the existing administrative team were offered additional hours and an agency administrator was temporarily employed to support the Children in Care Team to cover the required work during this period.

6.8 A successful candidate was appointed as the Administrator Coordinator and started in post in July 2019. Following on from this, the Administrator Coordinator and the Named Nurse for Children in Care worked closely together to ensure improvements were made to improve statutory timescales for Initial and Review Health Assessments.

6.9 A new flowchart for Initial Health Assessments was developed; this is a more structured and robust process which allows the Administrative Coordinator and Administrative Team to be more proactive thus enabling the Administrator Coordinator the ability to professionally challenge the Local Authority enabling the Children in Care Team to increase their compliance and meet their statutory duty.

6.10 The Administrator Coordinator and Children in Care Named Nurse are currently in the process of producing a new Blood Born Virus Test flowchart, thus offering a clearer more robust service to Children/Foster Carers/Social Workers.

6.11 The Administrator Coordinator and Children in Care Named Nurse worked collaboratively with the reporting team to design and produce a reporting process to capture Initial Health Assessment compliance separate to the existing compliance report.

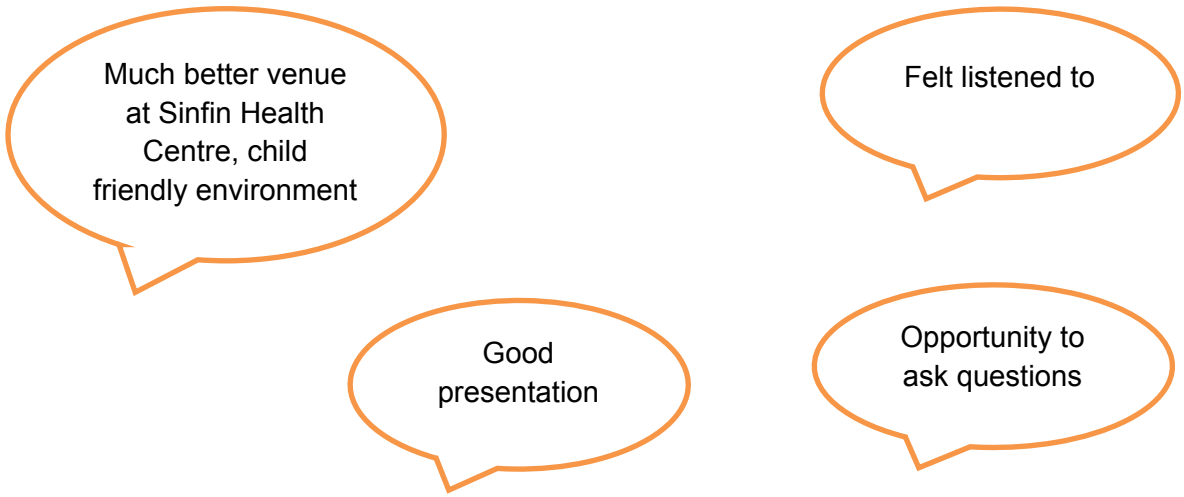
6.12 The Administrator Coordinator and the Designated Nurse worked with the Local Authority to agree on one consent form which incorporated all the previous five consent forms and this has resulted in gaining consent in a more timely fashion, decreasing delay for the child.

6.13 The Administrator Coordinator and Children in Care Named Nurse now organise all Review Health Assessments for children born in Derby City living within 20 miles, these are distributed to Children in Care Nurses for them to manage, book accordingly and increasing the ability to flex to the needs of the child and foster carer. As a result of this the Review Health Assessments for Children who are born in Derby but live out of the area are now organised by an Administrator which has enabled us to reach our compliance.

6.14 The Named Nurse Children in Care and the Designated Nurse for Looked after Children have been commissioned to deliver training to Local Authority foster carers and residential workers twice a year, however the attendance to a planned training day at the beginning of the year had a low attendance and the feedback received from the attendees was that they would prefer regular shorter sessions which covered a particular health theme in the future. Since receiving this feedback, the Named Nurse for Children in Care and Designated Nurse for Looked after Children have been delivering themed sessions to foster carers. The themes covered over the last year were weaning, infant feeding and immunisations. Additional feedback received resulted in a change of venue to a health centre setting due to the previous venue not being a child friendly environment.

6.15 Both the Named Nurse for Children in care and the Designated Nurse for Looked after Children have delivered training to Barnardo's foster carers on request. This was a full day session on various topics covering all age ranges. On reflection and following their feedback from the session the plan for next year is to deliver certain topics chosen by the foster carers.

6.16 Below are some of the comments from the foster carers following on from our training sessions:



Section 7: Strength and Difficulties Questionnaire (SDQ)

7.1 The Local Authority, Designated Nurse and Named Nurse worked together to redevelop the Strengths and Difficulties Questionnaire (SDQ) pathway (see appendix 2), in order to ensure a more robust process and increase the completion rate of the questionnaire. This process ensures that the SDQ score provided by the Local Authority was in line with the Review Health Assessment and supported the Specialist Nurse identifying any emotional or behavioural difficulties of the child/young person and assessing the impact of support provided (or if required). The SDQs are being completed in good time to enable this information to feed into other work, such as the health assessment. An audit was completed by the Named Nurse see appendix 3.

7.2 All data shown below for 2018/19 is provisional until submitted to Department for Education in July;

Year	SDQ received	Percentage of completion rate	Average score (higher the score = higher need)
2016-2017	189	79%	16.3
2017-2018	236	93.6%	16.2
2018-2019	275	92.6%	14.7

7.3 Throughout 2018/19 296 Children in Care required the Strengths and Difficulties Questionnaire completing. From the table above the overall completion rate was 92.9%; this is slightly lower than last year, however much higher than previous national and comparator figures. The average score for 2018-19 was 14.7 which is a significant drop from 15.9. This is our lowest average score ever! This potentially indicates improved emotional health and wellbeing of children and young people in care.

Section 8: Analysis of Adoption and Medical Adviser Activity

This section compiled by Derby City medical advisers Dr A. Marudkar and Dr V. Kapoor, CICA-Derby City

8.1 This section of the report has been prepared based upon the information available from DHCFT data and data provided by the Local Authority regarding adoption related work

Adoption activity:

8.2 There are two medical advisers (Dr Marudkar and Dr. Kapoor) contributing to the Adoption work for Derby city. This includes attending the Adoption panels and preparing the reports for the children coming for adoption panel. The Adult health reports are prepared separately by GP specialist Dr Maclachlan.

8.3 From 1st April 2019, The Adoption services have become regionalised and are now part of Adoption East Midlands.

One adoption panel per month is attended by either of medical adviser in role of panel member, on alternate month basis.

8.4 From 1st April 2018 to 31st March 2019, as per data provided by Derby City social care,

- Number of children matched with adopters - 21.
- Number of children adopted - 30
- Number of separate ADM reports between 1st April 2018 to 31st March 2019 - 7
- Number of Adult medical reports completed by Dr McLachlan - 110
- Number of approved adopters at panel 17
- Number of prospective adopter consultations 20

8.5 The two medical advisers also provide regular training sessions for prospective adopters, foster carers and social workers 3 times a year regarding common clinical issues in adoption scenario, i.e. Impact of maternal smoking, alcohol and drug misuse in pregnancy and Blood borne infection screening in vulnerable and high risk children.

8.6 Dr Kapoor (Medical Advisor) and Named Nurse for Children in Care also deliver a training lecture on Children in Care as apart of GP vocational training course in Derby.

Section 9: Health Data and Performance for Year 2018/19

9.1 Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis and the table below summarises the performance over the last three years:

*please note all health data for 2018/19 is provisional until submitted to the Department for Education in July 2019

Health Data Indicator	Year 2016/17	Year 2017/18	Year 2018/19
Annual health assessments	91.2%	92.7%	96.1%
Dental checks	84.1%	87.6%	91.4%
Immunisations up to date	97.7%	93.9%	92.8%
Development checks (two RHAs in the 12 months for under 5 years old)	81.6%	87.5%	91.9%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more

9.2 Overall performance of the Health Provider's provision continues to improve with the support of both the clinical and administration team and has been acknowledged within the Clinical Commissioning Group, DHcFT and Local Authority.

9.3 The immunisation uptake rate data is noted to have declined over the last three years, however it has been acknowledged that the data in 2015/16 and 2016/17 is likely to be inaccurate. The Local Authority informatics system had undergone a significant change just before 2015 and this may have had an impact on accuracy of the immunisation data. Since the Children in Care team have access and mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The completion rate of immunisations has decreased slightly during 2018/19 from 2017/18, however even after a slight decrease the performance remains higher than the comparator (90.2%) and national averages (85.3%).

Section 10: Markers of Good Practice (MOGP)

10.1 In November 2018 the Children in Care team submitted the Markers of Good Practice – self assessment tool for Children in Care within Derby City. The Markers of Practice tool, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals.

10.2 With the submission of evidence and 'RAG' rating, the tool supports the Children in Care team highlight progress, any gaps or improvements that are required to assure the commissioners our service is working towards a 'gold standard' delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

10.3 Following the MOGP submission, representatives from the Clinical Commissioning Group and Designated Professionals completed a site visit to the Provider in January 2019. A discussion was held between key representatives from DHcFT and the commissioners from both SDCCG and NDCCG (now DDCCG). Each standard was discussed and it was confirmed whether or not the 'RAG' rating provided by the Provider was in line with that of the commissioners' assessment.

10.4 During the MOGP site visit the following was identified by the provider:

- The Trust found the MOGP self-assessment tool easy to understand and were clear around provision of relevant evidence to provide CCG assurance. As the assessment tool was pre-dominantly the same as year 2017/18, allowed benchmarking and opportunity for a stronger and more in depth evidence to be submitted
- The Trust felt that the tool aided them to be 'inspection ready' with regard to CQC
- The Trust found the MOGP process to be an opportunity to reflect, evaluate progress and plan for future improvements
- The Trust found the process to be fair, open, honest and a true reflection of the service
- Discussion took place regarding how to monitor progress year on year and agreements made to utilise the previous year RAG rating within the self-assessment tool and include previous action plans.

10.5 Strengths and challenges were identified, agreed by both parties and an action plan developed for the provider to work through within the year to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice Tool and action plan has been fed back to the Safeguarding Children's Committee by the Head of Safeguarding Children's Service and at the Safeguarding Operational Leads meeting held by the organisation by the Named Nurse Children in Care. The action plan will continually be discussed at the Safeguarding Operational Leads Meeting and with the Designated Nurse for Looked after Children.

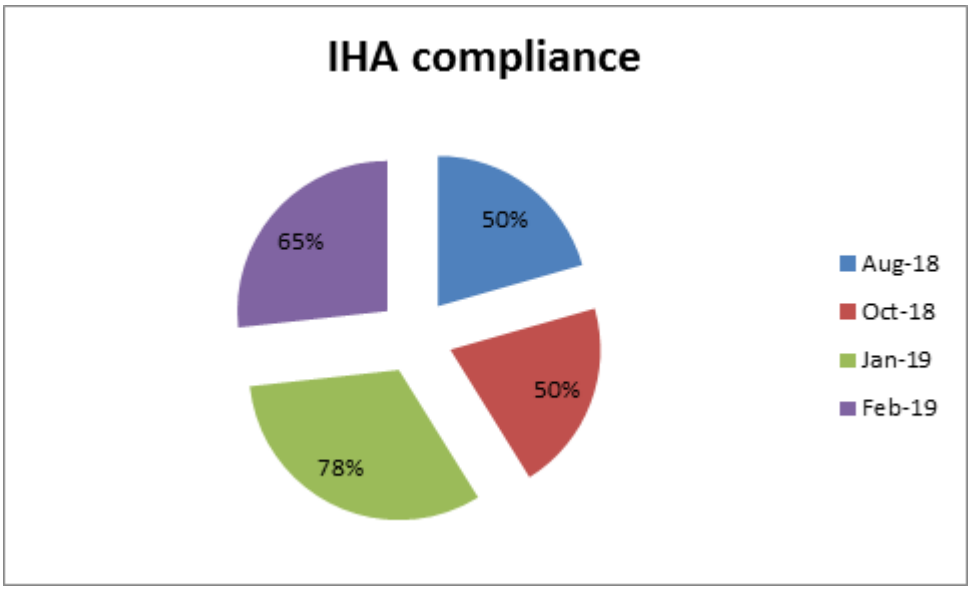
10.6 The Clinical Commissioning Group have been assured that the Children in Care service provision is overall at a good standard and the Health provider is working in partnership in all areas that have been identified as requiring further progression or improvement.

Section 11: Quality Assurance Processes

11.1 From September 2018 the service provision for Initial Health Assessments developed by increasing the number of Initial Health Assessment clinic slots being offered. Prior to this from July to September temporary provision was put in place to carry out a 'mop up' of outstanding Initial Health Assessments.. This resulted in an increase in compliance, during the last 7 months of 2018/19, with the statutory requirement of all children and young people having an Initial Health Assessment and all relevant completed paperwork being sent back to the local authority within 20 working days.

11.2 The Children in Care Administration team worked together with our reporting team to include a reason for delay on the referral to enable the Provider to understand the narrative behind the non-compliance.

11.3 The Designated Nurse for Looked after Children completes a monthly audit on compliance of Initial Health Assessments; this was set up from August 2018. A snapshot of the results is shown below:



11.4 The Children in Care team complete peer record audits on a quarterly basis using a template which captures if health information is included within the review health assessments. The purpose of these audits is to identify best practice and improvements. The results of these are discussed as a team to share learning. The Designated Nurse for Looked after Children also completes a snapshot of quality audits on the review health assessments completed by the children in care team and completes quality audits on all review health assessments completed by out of area provision. A sample of the results taken from 10 review health assessment quality audits completed by the Designated Nurse for Looked after Children are shown below:

Month of audit	Quality level	Timeliness
November 2018	10 - outstanding	70%

There was a narrative for the 20% (2) that were delayed due to 'was not brought' with 10% (1) having no identifiable reason within the health record of the lateness.

Section 12: Voice of the child

12.1 The voice of the child/young person is embedded in all aspects of the Children in Care service development and delivery. It is essential that children and young people are listened to and their views responded to in order to promote and respect the rights of children.

12.2 The voice of the child is obtained through a variety of mechanisms (dependent on their age, capacity, levels of understanding, analysis of non-verbal cues and body language):

- The child/young person is offered the opportunity where age appropriate to be seen alone
- At each appointment confidentiality is explained to the child or young person
- Identification in collaboration with the child/young person of their own strengths, wishes, feelings and their needs
- Use of the evaluation form after health assessments or any individual contact with a child or young person
- Clear documentation of the child's voice by using direct speech quotes or agreed summary of conversations

12.3 Designated Nurse for Looked after Children and the Named Nurse for Children in Care spent a day with the Local Authority Participation Officer and some young people from the Children in Care Council looking at how to develop the Children in Care website and to gather feedback around the proposed new health passport folders. This was a really productive day with lots of ideas from the young people on how to improve the design of the children in care website and the proposed health passport.

Section 13: Special Educational Needs / Disability

13.1 All children in care who have a Special Educational Need or Disability (SEND) have a flag on their electronic records. All children in care who have an Educational, Health and Care Plan (EHCP) have a patient status alert on their electronic records.

13.2 Universal services also have the patient status alert for Education, Health Care Plan (EHCP) and the flag for Special Educational Needs / Disability (SEND). For all children with an EHCP, the Trust has been informed via internal systems (in collaboration with Local Authority) and received a copy of the plan on the child's electronic records. Early identification of any learning concerns can be captured pre-school during Review Health Assessments for example; developmental delay, behavioural issues and school readiness. The graduated response is delivered where low level intervention can be put in place with support before deciding to refer onto specialist services. The graduated response helps providers, specialist and mainstream provision to work together on achieving the best outcomes for children and young people. If the pre-school child does have a confirmed diagnosis we have a team of specialist health visitors who will support the child and their family as appropriate.

13.3 If a child or young person is born in Derby City and placed in Derby City or is born out of Derby City and placed in Derby City the responsibility of the EHCP lies with Derby City Local Authority. For children and young people who are born in Derby City and placed outside of Derby City the responsibility of the EHCP lies with the Local Authority where the child or young person is placed (see extract from the Code of practice below).

13.4 ‘A significant proportion of looked after children live with foster carers or in a children’s home and attend schools in a different local authority area to the local authority that looks after them. Local Authorities who place looked after children in another authority need to be aware of that authority’s Local Offer if the children have SEN. Where an assessment for an EHC plan has been triggered, the authority that carries out the assessment is determined by Section 24 of the Children and Families Act 2014. This means that the assessment must be carried out by the authority where the child lives (i.e. is ordinarily resident), which may not be the same as the authority that looks after the child. If a disagreement arises, the authority that looks after the child, will act as the ‘corporate parent’ in any disagreement resolution.’ (Special educational needs and disability code of practice: 0 to 25 years (2015).

13.5 The Designated Nurse for Looked after Children has worked closely with Derby City Local Authority and other Local Authorities to get a copy of all final Education, Health and Care Plans to be attached to the electronic records of all children in care. This has improved over the past year so that the children in care team have a copy of the final EHCP attached to the electronic records.

13.6 The Children in Care Nurses complete Review Health Assessments (RHA) on all children and young people who are placed in care (by the health team depending on where the child is living). The Review Health Assessment follows on from the Initial Health Assessment for all children under 5yrs they have a RHA every 6 months and for those over 5yrs every year. The nurse carries out a holistic assessment recognising any health needs, a health care plan is developed and referrals on to appropriate specialist services. The plan is to get appropriate services involved early, supporting the child or young person to prevent the issue moving up to EHCP. This is known as the graduated response. The graduated response is monitored whilst the child or young person is in care through the Children in Care review meetings. This is a child focused meeting where the following topics are discussed;

- Care Plan
- Contact
- Placement
- Health
- Education

This is a multi-agency meeting where services in place are identified and achieved outcomes are discussed.

13.7 All nurses in the children in care team have attended a multi-agency SEND training days on writing outcomes for EHCP and the local Graduated Response. The DHCFT SEND coordinator for the Children’s Services has also been out to visit the team to discuss the SEND process and the Local Offer.

13.8 The Children in Care team use a service feedback form which has been adapted to meet the needs of children and young people with special educational needs or disabilities. The Named Nurse for Children in Care and the Designated Nurse for Looked after Children visited one of the Local Authority Children’s Homes specifically for children and young people with special educational needs and disabilities to obtain their feedback on the form before implementing this into practice. The form received positive feedback and is now used to gather the views of the children and young people following their Review Health Assessments.

Section 14: Priorities for Year 2018/19

14.1 **DHcFT Provider key priorities for 2019/20:**

- To roll out and implement the use of the new health passports
- To finalise the staff bio's ensuring they are available to all Children in Care, to be enclosed with each appointment letter
- To develop a dashboard and report activity both internally and externally to the Clinical Commissioning Group on a quarterly basis
- To continue to be part of the CONCORDAT operational meetings to ensure this is adhered to for Children in Care
- To deliver themed health sessions to foster carers bi-monthly
- To pilot new Review Health Assessment forms in conjunction with Derbyshire Children in Care Team with a potential improvement in obtaining the voice of the child
- To continue to deliver quarterly action learning sets for all Children in Care Nurses in collaboration with the Designated Nurse for Looked after Children
- To continue to contribute towards the Children in care website
- To focus on quality of Initial Health assessments and Review Health Assessments

14.2 These key priorities are an overview of some of the on-going work and strong commitment to improving the health and welfare of children in care. The vision continues to be that we ensure all children in care reach their natural potential through the interventions of competent, skilled, compassionate professionals and their drive to make a difference to this vulnerable group of children and young people.

Section 15: References

Keep on Caring: Supporting Young People from Care to Independence, June 2016, Department for Education

Promoting the health and well-being of looked-after children, March 2015, Department of Health and Department of Education

Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, March 2015, Royal College of Paediatrics and Child Health

Stats: looked after children, Department for Education, 2017
https://www.gov.uk/government/collections/statistics-looked-after-children

APPENDICES

Appendix 1 – Looked after Children cohorts explanation

BORN IN, LIVES IN – Looked after Children born in Derby City and reside within the City.

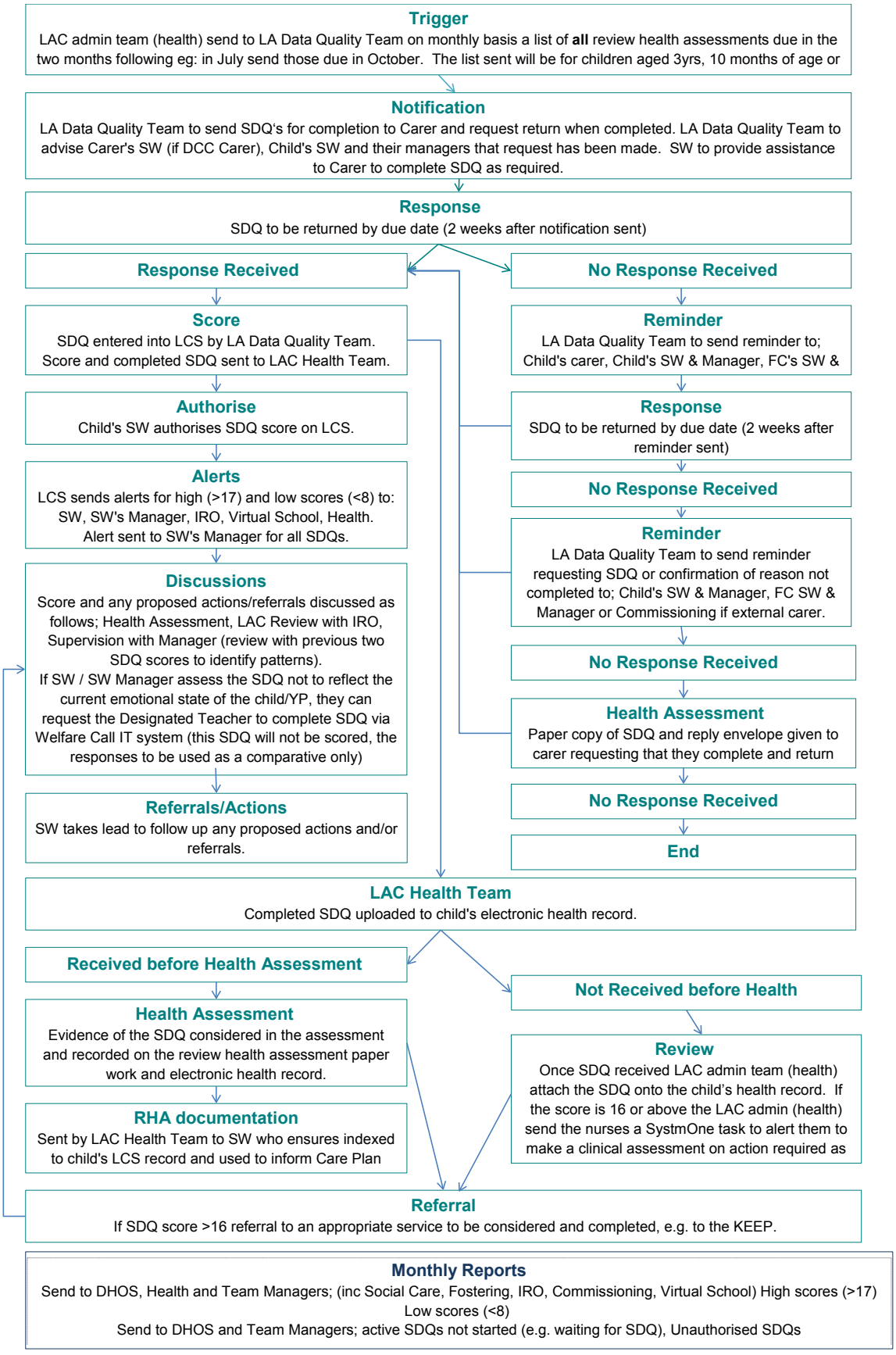
BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City but reside within approximately 20 miles away from Derby City in another Local Authority area.

BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City but reside in Derby City.

Appendix 2

Below is the reviewed and implemented Strengths and Difficulties pathway developed by the Local Authority, Designated Nurse for Looked after Children and Named Nurse for Children in Care.



Appendix 3

Strengths and Difficulties Audit – completed October 2018

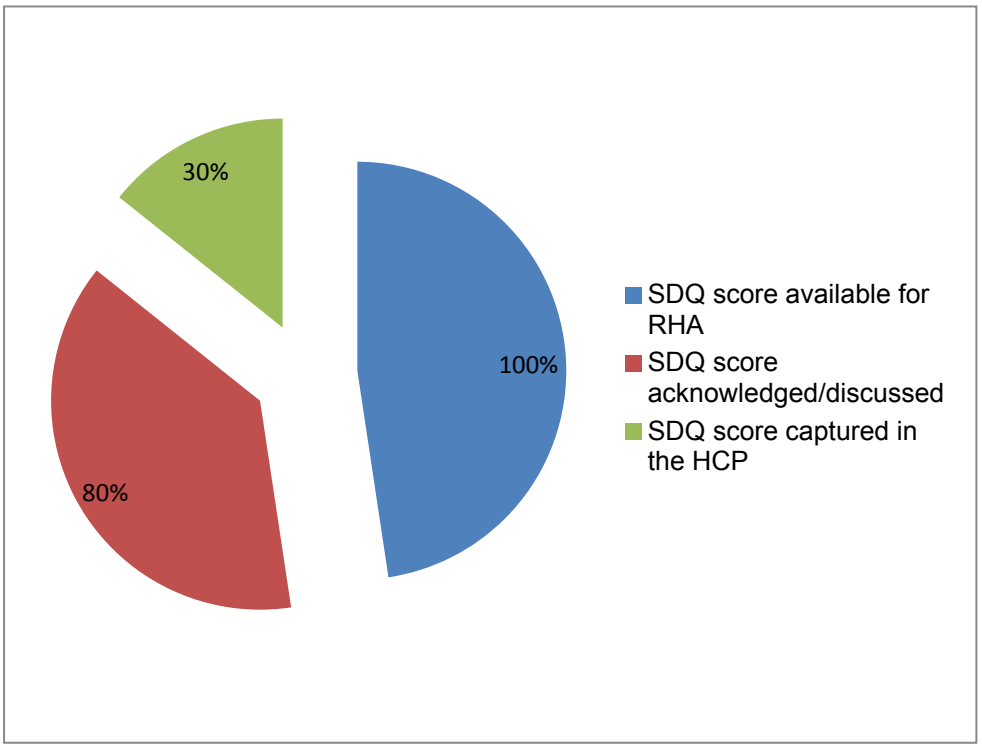
Over the past year DHcFT, SDCCG and the Local Authority have been having regular meetings around the Strengths and Difficulty Questionnaires to develop a process in order to increase the completion rate of the questionnaire. This process ensures that the SDQ score provided by the Local Authority is in line with the review health assessment and supported the Specialist Nurse identifying any emotional or behavioural difficulties of the child/young person and assessing the impact of support provided (or if required).

The completion rate of SDQs is significantly higher within year 2017/18 than previous years and this is a direct result of the newly implemented process and joint efforts from the Children in Care team and Local Authority Business Support Services. Further work is being undertaken in order to ascertain progress and to further develop the meaning/impact of the SDQ score for the child/young person.

I randomly selected 10 children and young people's electronic records to identify whether the process was successful. The three areas I focused on were;

- Was the SDQ score available prior to the RHA appointment
- Was the SDQ score acknowledged and discussed with the child/young person or carer by the nurse
- Was the SDQ score captured in the child or young person's health care plan

Please see below for the results following the audit;



From all the records involved in the audit the SDQ score was available prior to the review health assessment being completed by the Children in Care nurse. If the score is not available at the time of the review health assessment the Specialist Nurse ensures the carer receives a blank copy of the SDQ form, provided by the Local Authority and requests it's submission via a stamped addressed envelope. Once the SDQ score is received by the Children in Care Health team, post review health assessment, the administration team follow a defined process, alerting the Specialist Nurses to high score SDQs. This allows the Children in Care Nurse to make a decision as to whether a referral on to another service is required or any other action is needed.

Overall

This has been a solid year of performance and our thanks go to the Children in care service for their hard work and achievements for our Children in our Community.

Carolyn Green
Director of Nursing and Patient Experience

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2019

A Framework of Quality Assurance for Board Stories – Sharing Service Receiver and Carer Experiences to Trust Board

Purpose of Report

To provide the Trust Board with an overview and assurance regarding patient stories and the impact.

Listening to what is important to the story teller helps the Board to understand why certain issues matter and to make sure that the improvements to the services are based on their respective feedback. The Board demonstrating leadership that they act upon the feedback is key to our collective integrity and to our commitment to our communities

The service receiver or carer can either write down their story or have someone read it aloud, or talk about their experiences. After sharing their experiences, the Board may ask questions and often make commitments to take these experiences into account and improve our services or influence developments to improve patient experience.

In 2019 the NICE Guideline for Patient Experience has been reviewed and the key aspects of this change and the measures are included and the standards have been included wherever possible in these stories.

The five areas that boards should focus on to ensure their organisation is well-led are:

- Inspiring vision – developing a compelling vision and narrative
- Governance – ensuring clear accountabilities and effective processes to measure performance and address concerns
- Leadership, culture and values – developing open and transparent cultures focused on improving quality
- Staff and patient engagement – focusing on engaging all staff and valuing patients' views and experience
- Learning and innovation – focusing on continuous learning, innovation and improvement.

Overall this has been achieved and these experiences have been used to set the Trust strategy, the clinical ambition, in valuing patients' views and experience and focusing on continuous learning and improvement.

In every Board story there has been a change in the area of concern and in some aspects significant impact. There is strong evidence that Board stories do influence the Board in their strategic intent and direction of travel. There is evidence of clinical strategy improvement plans and impacts on services and on individuals.

Some equality gaps remain and are known areas of risk in the Board Assurance Framework with requirements outlined in the Trust strategy to continually improve and reduce this inequality.

Executive Summary

The Board endeavours to make best use of the financial resources and deliver the standards people need, to nationally agreed standards of safety and quality. Each Board meeting will hear a Patient or Carer story.

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

Assurances

Every Board meeting has seen a Ward to Board service receiver attend to give an insight into their experience whilst in care. The Board is listening to the experiences of individuals and using that knowledge to triangulate and to change their strategy and improve performance in these areas.

Consultation

The Director of Nursing and Patient Experience reviewed this paper with the Trust's Chief Executive Officer.

Governance or Legal Issues

The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

The CQC regulates the Trust and when an essential standard is not met, the trust is in legislative breach.

The provider must have plans that ensure they can meet these standards. They must have effective governance and systems to check on the quality and safety of care. These must help the service improve and reduce any risks to people using the service in their health, safety and welfare.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The Trust Board learns from the stories relayed, to hear how incidents have perhaps affected both patients and carers. They also help to shape to make things better whilst patients are in the care of the Trust.

Individuals with protected characteristics have been reviewed.

One significant gap currently highlighted by these experiences are waiting times for individuals with Autism and appropriate follow up treatment. Derbyshire CCG does not commission this service.

Autism spectrum disorder in adults: diagnosis and management (2016)

In order to effectively provide care and support for adults with autism, the local autism multi-agency strategy group[4] should include representation from managers, commissioners and clinicians from adult services, including mental health, learning disability, primary healthcare, social care, housing, educational and employment services, the criminal justice system and the third sector. There should be meaningful representation from people with autism and their families, partners and carers.

1.1.13 In each area a specialist community-based multidisciplinary team for adults with autism (the specialist autism team) should be established. The membership should include: clinical psychologists, nurses, occupational therapists, psychiatrists, social workers, speech and language therapists, support staff (for example, staff supporting access to housing, educational and employment services, financial advice, and personal and community safety skills).

1.1.14 The specialist autism team should have a key role in the delivery and coordination of:

- *specialist diagnostic and assessment services*
- *specialist care and interventions*
- *advice and training to other health and social care professionals on the diagnosis, assessment, care and interventions for adults with autism (as not all may be in the care of a specialist team)*
- *support in accessing, and maintaining contact with, housing, educational and employment services*
- *support to families, partners and carers where appropriate*
- *care and interventions for adults with autism living in specialist residential accommodation*
- *training, support and consultation for staff who care for adults with autism in residential and community settings.*

Waiting times for psychological therapy

1.4.8 Ensure that service users have timely access to the psychological, psychosocial and pharmacological interventions recommended for their mental health problem in NICE guidance.

Waiting times for community mental health assessment.

1.2 Access to care

1.2.1 When people are referred to mental health services, ensure that they are offered a face‑to‑face appointment with a professional in mental health services taking place within three weeks of referral

Recommendations

The Board of Directors is requested to accept the report and make recommendations for further improvement of our model and practice.

Report presented by: **Carolyn Green**
Director of Nursing and Patient Experience

Report prepared by: **Carolyn Green**
Director of Nursing and Patient Experience

Outcome of Patient Stories to the Board

Date of Story	Extract of Story	Actions	What has happened afterwards?
5/10/17	X has experience of mental health since 1975. X has also been in prison. The individual feels that due to a lack of support, communication and transparency from mental health services, a download spiral has occurred resulting in deterioration. The person suffers from BPD.	The report recommendations will be incorporated into a corporate action plan. Provide clear information for patients, friends, families and carers about where to go and what to do in a developing crisis. Work to develop co-ordination and show real ownership of crisis situations. Work to improve patient experience, address. Investment in a personality disorder service	The new Trust website in 2019, has substantially improved the clarity of offer to individuals and carers. The Crisis Team has mixed feedback with substantial levels of compliments and some missed feedback. In 2019, this team will be piloting the new exist questionnaire form service and this service will have feedback to reflect upon its service offer and experience. In 2019, the Trust received investment to develop a personality disorder service, in a trauma informed model and this is in design and recruitment is commencing.
1/11/17	X who is seconded to the Trust talked about his substantive role in operating theatres and the Emergency Department and the ethos displayed by staff when dealing with tragic events. He discussed how they felt, leading to high levels of mental health problems and even suicide	The Board discussed the trauma medical staff experience through deaths at work and acknowledged that clinical staff need to talk to people and require support	A staff Health and Wellbeing strategy has been developed to support staff when they are challenged by stress, anxiety or depression. The Trust's strengthened approach for supporting staff is being taken forward by the Director of People Services and Organisational Effectiveness and in 2019 its Resolve service went live. The Trust continues to develop its interagency suicide prevention work.
31/1/18	A Family First Model was exhibited which	The Board acknowledged the innovative	Continuous improvements have been made

Date of Story	Extract of Story	Actions	What has happened afterwards?
	promotes the voice of the parents, also giving a family perspective of the Trust's Children's service and the Family Nurse and Health Visitor partnership model which works with young parents so that they can identify the specific support that they need relating to their own individual circumstances which works in partnership with Ripplez, a staff-led Community Interest Company (CIC).	practices that have been developed.	and are ongoing. Practitioners also help fathers and grandfathers with literacy problems read to their young children and give them confidence whilst reading aloud to them. The specific feedback was with regard to the Trust maintaining its family inclusive practice approach and listening to the voice of families in service feedback. Extending the role of the Health Visitor into running Family First groups has been achieved. In 2019 EQUAL the Family and Carers forum went live with a Children's vision representative and a parent.
28/02/18	X gave an overview of the group they run in Derby known as PARC (Psychosis and the reduction of Cannabis (and other drugs) is a group run as part of the EI (Early Intervention) programme in Derby. PARC believe in supporting the person as a whole. Their methodology is based on connectivity and this is the motivation for their clients which is the opposite of addiction. They work towards achieving people's aspirations with them through weekly group sessions along with a sharing of life experiences which drives their approach through a 12 week recovery programme.	The Board is keen to improve access and support from one another. It was acknowledged how difficult it is to relay to your GP in 10 minutes how you are feeling. Having support and empathy from psychiatrists and clinicians is important. The common theme is to be listened to as an expert in their own feelings and be allowed to work with psychiatrists towards recovery.	Director of Nursing & Patient Experience will work with PARC and other Trust staff to design a strategy for the dual diagnosis service that will ensure that mental health and physical health is better addressed within the Trust treating the person holistically. This did occur and this work was channelled into the clinical strategy development days with recommended outcomes The co-existing substance misuse work continues and this was a key theme of our days. The Public Health Service undertook a review of co-existing conditions mental health and substance use and asked the Trust to

Date of Story	Extract of Story	Actions	What has happened afterwards?
			reconsider the use of dual diagnosis. The Trust has accepted that challenge. In addition a new strategy and clinical practice standards and outcomes is in design by the Safeguarding Adults Doctor and will be reported on in December 2019.
1/5/18	X reported on the Building Better Opportunities programme and a Y service receiver was present to reflect on this. X works closely with the Trust's consultants who refer service receivers to the programme. Individual Placement and Support Service (IPS) is designed to get people into work as soon as possible and keep them in it.	The Board acknowledged the difference it can make to feel valued and make a contribution to the workplace.	The Board is grateful to have had the opportunity to build the concept of IPS into its own future strategy in order to support service receivers in the community and support them whilst they are in work. The Trust submitted a bid for an IPS service was successful and the posts are being recruited to with appointments made in July 2019.
27/7/18	X is an employee of the Trust and also a carer for her elder sister. X has been experiencing high levels of anxiety, due to the caring aspects and also rigours of the post at work. X found the Crisis Team to be disappointing with appointment mix ups and notes being misplaced	The Board acknowledged that the support had not been as good as it could have been. Also by X being a carer and an employee of the Trust that feedback can be given as to what works well and what does not. The service will be improved and will drive family and carer involvement which will join up services so that carers and their family only have to tell their story once. The service will focus on carers' needs and the value carers bring as they have a wealth of information that can make providing more care effective.	The improvement of family and carers experience is one of the Trust's quality improvement areas and a Patients and Carers promise has been co-produced and will be launched in 2019. The roll out of electronic patient records has substantially reduced this feedback about lost medical information/ clinical notes.
2/10/18	X is a service receiver along with a Senior	The Board congratulated X and considered X	The Board is still encouraging volunteers if

Date of Story	Extract of Story	Actions	What has happened afterwards?
	Occupational Health Therapist. X was embarking on a role as a volunteer after experiencing a prolonged cycle of mental ill health. In 2012 X was working in a medium secure hospital and was severely beaten by a patient. He suffered PTSD (Post Traumatic Stress Disorder) in addition to a stroke. After X lost their job and a suicide attempt X came under the care of the Trust. X felt that recovery was well underway and working as a volunteer was aiding recovery.	to be a strong advocate for the reason why NHS needs to be more connected to a joined up health information system linking all providers.	they are supported by the Trust and mentored, that following recovery if they have the capabilities, willingness and are considered "safe" that they may be considered to have some unpaid work within the Trust. The Board reflected upon its own support of staff and considered the concept of putting staff first and the need to support staff and measured the concept of whether this could this happen in our organisation. The Trust has reviewed all of its staff wellbeing offers and has invested its resources in a new model and strategy.
4/12/18	X was introduced to the Board as a Peer Support Worker (PSW) to discuss the role of PSW's who have 'lived experience' of mental health challenges and have personally accessed mental health services. X now regularly attends volunteer groups and supports service receivers offering ideas about how to take control of their wellbeing.	The Board applauded X for his contribution to the Trust and listened to various ideas regarding ways and means to make contribution to allow those to take control of their well-being to aid recover. The person asked to be involved further in Trust developments and to work toward meaningful activity employment in this area.	X is now working as a volunteer in the Trust one day per week in addition to attending other support and volunteer groups. X has become a regarded person who can actually be seen to be making differences both small and large by launching the "bright ideas" project instigated by the Trust and is a member of the Patient and Carer EQUAL Forum.
2/4/19	The story of X (child) was told through a School Nurse who relayed the experience of a 14 year old girl who disclosed a two year episode of inter-familial sexual abuse. X was referred to a specialised service called "The Keep" and the Board heard how X had found	The Board reflected on the wider and complex issues, urging the importance of listening to people and providing them with appropriate treatment, aligned to person centred care.	The Board will continue to strive for a trauma and person centred approach is provided for young people and ensure the children's services are improved. This person centred and trauma informed

Date of Story	Extract of Story	Actions	What has happened afterwards?
	the treatment extremely difficult as X was not ready to undergo psychological work around the abuse.	School nursing is critical to enable children to make disclosures. A large part of a school nurse's role is spent dealing with students who are suffering from anxiety based issues. The Board will continue to work with multiple agencies and for CAMHS to continue to have access to the Trust.	model has been including in the revised Clinical ambition and Trust strategy.
4/6/19	X'S story was based on a complaint that had been investigated and resolved through the Patient Experience Committee concerning problems in delays in receiving treatment and physical health testing, delays in a smooth and effective access to care with doctors, not writing prescriptions.	The Board recognised that themes emerging from the clinical strategy review were resonated in X's story and that clear communication and remaining engaged whilst service receivers are waiting for results is key. Safe prescribing and having access to GP records so as not to prescribe in isolation was discussed, along with new ways of internal integration to ensure more responsive care, the role of clinical staff in explaining what to expect and why, the future model of working hours and how the services work, the substantial pressure and doubling of outpatient clinic caseload and the need to review this pathway.	This case was reviewed and the learning form this case was considered. Further work on community service pressure, is part of the revised Trust strategy and new investment into mental health teams has been achieved in 2019. Physical health care teams and assessment with the ability to take blood have been rolled out across neighbourhood services. There is further work to meet the outcome of this feedback on shared care and prescribing.
2/7/19	X's story explained how a late diagnosis as an adult of autism had affected life totally. X felt that total change is needed so that person centred care can be provided to adults with autism.	The Board acknowledged that it was unacceptable that X had to wait such a long time and asked what differences could have been made had the diagnosis been given earlier?	Ongoing discussions are taking place with Derbyshire commissioners to explore resource within the current diagnostic ASD (Autism Spectrum Disorder) team to see what can be offered for people who need post diagnostic support. X has now become a member of the Trust's

Date of Story	Extract of Story	Actions	What has happened afterwards?
			expert by experience to the EQUAL Forum and the Board will be responding formally to X's story and commit to making improvements to person-centred care to reduce waiting times for people with autism so that a tailored service can be instigated. The second themed report that is in development is on Autism to the council. The CCG and STP will have this story shared by the Trust CEO due to the impactful nature of person centred care and the important messages. In the development of the STP, the SRO (Senior Responsible Officer) for Autism and Learning Disability and or Autism is our Trust CEO. In 2019 the Quality Committee will receive the reviewed performance against the Learning Disability and Autism standards.

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Summary Report to Trust Board
Mental Health Act Committee (MHAC) - meeting held 6 September 2019

Key items discussed:

- **Minutes from Mental Health Act Committee held 7 June 2019**
  Dr Sheila Newport was welcomed to the Committee as a newly appointed Non-Executive Director. The minutes of the meeting on 7 June 2019 were accepted as an accurate record

- **Matters Arising**.
  Data on the number of seclusions to PICU (Psychiatric Intensive Care Unit) (always out of area as there is no facility in Derbyshire) is not routinely collected and so cannot be reported without a substantial data collection exercise. Whilst it was agreed that this exercise is not currently a priority it will be important to understand what factors determine the demand for PICU placement as we plan and revise the acute care pathway. A report on restrictive practices including seclusion is due at the next MHAC. The Director of Nursing and Patient Experience has reviewed practice with Heads of Nursing as part of the CQC's information returns.

- **Review of Policy Matrix**
  The Adult Inpatient Visiting Policy and Procedure was received and agreed. All other policies are in date. An overarching Restrictive Practice Policy will be received by the Quality Committee in September.

  - **Minutes of MHA Operational Group and Actions Matrix**
    The range of detentions across the country was noted eg Northamptonshire FT (312 beds) 13% detentions, Sheffield Care FT (157 beds) 83%, DHCFT (271 beds) 46%. It was thought that this may reflect demand: bed base ratio but could also be partly due to different clinical pathway models. The MHA Review calls for fewer detentions and so the Operational Group is considering what variables may apply.

    It was noted that the Commissioners were concerned that the S117 aftercare costs were escalating circa £35m per year and rising. It was thought that significant numbers of working age adult patients were being placed in "rehabilitation" nursing homes but not being reviewed with an aim of returning to community living. The CCG is conducting a scoping exercise to gauge the scale of this and members of the Operational Group have joined their working group. Costs of S117 aftercare may escalate further as the right to receive a personal care budget rolls out. In Derbyshire there are about 700 people in receipt of S117 aftercare and about a further 300 who may be eligible. Derbyshire is unusual in not charging for county/county transfers of care which is the norm in many parts of the country which is contributing to a further financial detriment.

    It was agreed that these are important strategic issues for the health community and should be escalated to the Trust Board for further discussion.

    The increasing MHA assessment activity in University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) Emergency Department was noted from the local authority activity report. DHCFT executives and senior managers have met with their counterparts at Royal Derby Hospital and conducted a table top review of cases. One aspect of this is that urgent cases not open to Trust services are generally directed towards the ED following Primary Care/111 contact particularly out of hours. This has implications for planning of integrated care services as part of JUCD.

It was noted that action plans following CQC MHA visits to wards/units had slipped behind trajectory but that remedial action was being taken and was being closely monitored.

Training compliance was still on a "slow crawl" but was less of a priority compared to ILS/Positive and Safe/Safeguarding training for inpatient services. It was agreed that the targets ad trajectories should be reviewed with this in mind and temporary reduction considered.

It was agreed that the time is now right to introduce more mandatory fields into the EPR (Electronic Patient Record) to help maintain high compliance standards.

- **Business case to support review of Mental Health Act and Mental Capacity Act (Amendment) Bill (implementation of changes to MHA and Liberty Protection Safeguards)**
  It was agreed that the proposed reforms to the MHA should be anticipated and taken forward within existing workstreams where possible. It was noted that additional training and quality improvement leads have been requested as part of a business case submitted to the Executive Leadership Team (ELT).

  A decision was deferred pending a review of our overall approach to training.

  Members of the Operational Group are participating in a virtual national working group to develop the Code of Practice for Liberty Protection Safeguards (LPS) (to replace DoLS) which is due to start soon – LPS to be introduced in October 2020.

- **Mental Health Act Manager's Report Quarterly Report**
  It was noted that a QI (quality improvement) approach is being taken to improving practice with rapid tranquillisation – "a vertical observatory" examining the chain from policy to "shop floor" clinical care. It was agreed to present the results at the next MHAC. A similar approach is being taken to reduce other restrictive practices and results will also be presented at the next meeting.

  There was one illegal detention on the Kedleston unit due to a court failing to communicate that a Section 37/41 had been withdrawn. A Section 5(2) and then Section 3 were used to detain the patient on the unit.

  An extended period of seclusion on the same unit is the subject of a SI (serious incident) investigation.

  A breach of S5(4) nurse holding power resulted in the clinician being supported and additional training is being introduced. This was considered to be a "just" response.

  It was agreed that capacity assessments for admission and treatment should now become mandatory fields on the EPR at point of admission.

- **Verbal report on capacity of MHA Office**
  Details of how Liberty Protection Safeguards will be implemented are not currently available but the workload when the Trust becomes the Responsible Body is likely to be significant.

  If all the recommendations of the Mental Health Act review are accepted the increase in workload regarding Tribunal work would be enormous. It is estimated that 3 WTE (whole time equivalent) administrators would be required (two Band 4, one Band 3) but it is difficult to envisage how Responsible Clinicians (consultants) and CPNs (Community Psychiatric Nurse) would cope with the extra reports that would be required.

- **Section 37/41 – verbal update on people affected by Supreme Court Judgement**
  No patients have been adversely affected. A definitive S37/41 register has been constructed. A proactive approach is taken to anticipate discharges into the community and cases triaged in

advance of this so that the appropriate level of forensic service cover is provided so far as is possible given the limited resources available.

- **Verbal update from Associate Hospital Managers (AHM)**
  Seven new AHMs have been appointed.
  Two reviews are outstanding.
  Training was delivered to AHMs after the MHAC.

- **Policy Review – Adult Inpatient Visiting Policy**
  This was agreed and the forward plan reviewed.

- **Issues escalated to Board or transferred to other committees**
  The issue of S117 case reviews is concerning both from the point of view of patient choice and also because of the significant resources involved. This and developing a more appropriate emergency response (rather than ED) to patients not open to our services should be priorities for JUCD.

- **Meeting effectiveness**
  It was splendid to have both the Medical Director and Director of Nursing together to give a comprehensive oversight. The Operational Group notes were thought to be interesting and useful.

Decisions made

- Issues around S117/County:County transfer/urgent out of hours responses for patients not open to the Trust should be escalated to the Board for further discussion and be brought to the attention of JUCD.

- Training compliance targets can be revised downwards but kept under review and the trajectory monitored.

- Mandatory fields should be introduced into the EPR for admission and treatment capacity assessments at the point of admission.

- The recommendations from the MHA Review should be incorporated into existing workstreams wherever possible.

Committee Chair: **Anne Wright**	**Executive Lead:** **John Sykes, Medical Director**

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Quality Committee meeting held 10 September 2019

Key items discussed

- **BAF Risks for Quality Committee**
  Feedback on extreme risk 1a and update on update on the delivery of targeted CQUINs.
  Update on physical healthcare, acute pathway and clinically led strategy days.

- **Quality Dashboard**
  Briefing on the changes, in the Quality Dashboard and areas of scrutiny and monitoring.
  The CQC actions are reduced down to nine actions and improvements, are under review by the Executive Leadership Team to improve the final delivery.

- **Acute Care Pathway Monthly Update**
  Significant discussion on improvements and how they will be achieved
  Limited assurance, but progress behind, key trajectory for training.
  Unannounced visits have taken place to discuss clinical standards performance with patients and colleagues.
  Challenges made on progress and how we ensure improvement.
  Discussion took place on progress and seclusion practice.
  Tobacco dependency policy was discussed as a concern due to review taking place in the USA around the use of vaping and e-cigarettes. .Proposed that policy is deferred pending more information.

- **Reverse Mentoring Report on the health needs and inequalities in the BME population within Derbyshire.**
  Commissioners are engaged in the meetings of the Reverse Commissioning Group. Discussed investment and service improvement in cultural competence training using the medium of seclusion. Exploration of delays in accessing treatment and the impact. Reverse Commissioning Group Terms of reference agreed.

- **Complaints and Compliments Annual Report 2018/19.**
  A review of the data and the indicators and what the data is showing was explored. Executive assurance obtained on the patterns and the data and connections to the Trust strategy.
  Complaints statistically going down and compliments increasing.
  Service improvement information will be included in Quality Improvement plan.
  Overall significant assurance received with implementation, the recommendations and action plan.

- **Annual Health & Safety Report 2018/19**
  Significant assurance obtained on the core required standards. Continued diligence is required going forward to improve reporting any racial harassment or any harassment to staff, as there may be lower levels of reporting of potential incidence. We will continue to support our staff to speak up in this area.

- **Physical Healthcare Gap Analysis against Physical Healthcare Strategy Delivery**
  A full analysis of the risks and practice was identified, and will be rectified with the quality improvement programme and any actions based upon benchmarking and best practice.
  The difference in performance between clinical teams was scrutinised and compared with practice and leadership. Limited assurance was given. Clarity on the standards required was increasingly evident.

- **Chief Pharmacist's Annual Report 2018/19**
  Significant assurance and substantial scrutiny in the annual report with analysis of the last required performance improvement in key services.
  Clarity of standards and needs.
  Discussion took place regarding increasing opioids and increasing use of medicines as a solution and the risk of the long term impact.
  Attendance at the Trust's Medicines Management Committee is variable; the Medical Director is requested to support the Chief Pharmacist in improving performance, or changing the named leads to improve attendance.
  Discussion took place on the impacts on the wider STP and prevention.
  Medical management to review agency and locum prescribing and review standards.

- **Medicines Optimisation Quarterly Update Report**
  Dashboard performance is solid; scrutiny of medicine use is detailed and gives great clarity and impact.
  Accepted significant assurance against trajectory and improvement areas, further exploration of impact of new investment and evidence. Medical Director to meet with Chief Pharmacist and explore support needed to continue to deliver against the strategy.

- **Clinical Audit - Annual Report and Plan**
  The interconnection of continuous and quality improvement plan was endorsed as the correct direction of travel, subject to a business case.
  This paper explored a new model of working, and does not require endorsement.

- **Implementation of Neighbourhood Delivery Model**
  There is significant impact of progress, on the neighbourhood improvement.
  Further sharing of this further investment and agreement in activity is to take place with the Director of Business Improvement and Transformation.

- **Restructure of the Quality Committee**
  Review of terms of reference and improvements

- **Blanket Policy**
  Subject to minor typos and agreed and ratified.

- **Reducing Restrictive Practice Policy**
  Subject to minor improvements by author policy agreed ratified

- **Forward plan and agenda for next meeting**
  Review of the BAF deep dive on BAF 1a to be scheduled.

- **Meeting Effectiveness**
  Valuable discussion took place regarding acute care and the need to inspire the team to explore standards and their impact upon them. Valuable discussion about the measurement and the cultural change of standards.

Assurance/Lack of Assurance Obtained

- BAF Risks for Quality Committee - extreme risk with wider deep dive.
- Quality Dashboard - significant assurance
- Quality dashboard improvement and limited assurance
- Acute Care Pathway - progress. Limited assurance. Significant discussion on improvements and how they will be acheived
- Complaints and Compliments Annual Report 2018/1 - significant assurance
- Annual Health and Safety Report 2018/19. Significant assurance on the core required standards.
- Physical Healthcare Gap Analysis against Physical Healthcare Strategy Delivery Limited

assurance was given. Clarity on the standards required was increasingly evident. • Chief Pharmacist's Annual Report 2018/19 - significant assurance • Medicines Optimisation Quarterly Update Report - accepted significant assurance • Implementation of Neighbourhood Delivery Model - there is significant impact of progress, on the Neighbourhood and improvement	
Meeting Effectiveness • Positive meeting of discussion and briefing	
Decisions made • Blanket Policy - agreed ratified • Reducing Restrictive Practice Policy- agreed ratified	
Escalations to Board or other committee • Decisions on escalation on deep dive.	
Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Finance & Performance Committee – Meeting held 17 September 2019

Key items discussed

Minutes from meeting held on 15 August

- Action matrix - Feedback loop requires closure from the cross referrals from previous meeting to Quality Committee and People and Culture Committee.

Board Assurance Framework – F&P risks for consideration

- Finance plan risk – consideration to be given to articulation of an additional gap that requires action in order to achieve target rating (taking account of the top rated risk in the finance risk table on cost pressures).

Commissioning Interface and Contract Update (QIPP/contract levers/penalties/CQUIN)

- Discussions on recent successful bids and pre-commitments on Mental Health Minimum Investment Standard, discussions at Mental Health Service Delivery Board.
- Clinical Commissioning Group information sharing and working differently.
- Improving Access to Psychological Therapies Services (IAPT) procurement update including tariff.

Operational Performance and KPI Achievement

- Seven day follow-up and 48 hour follow-up pilot success with positive safety impact
- Discussion of the SPC charts including IAPT 6 week RTT (Referral to Treatment) trend and PICU (Psychiatric Intensive Care Unit) and adult out of area improvements. Committee look forward to receiving update on five OOA (Out of Area) reduction interventions next meeting
- Discussion on ASD (autism spectrum disorder) waiting times and being commissioned for assessment only. Referrals increasing.

CIP Delivery and Continuous (Quality) Improvement Delivery Programme

- Discussed the schemes within the residual gap that have not yet been transacted
- Discussed recent ELT (Executive Leadership Team) discussions and the outcomes of the 'forecast deep dives' undertaken since report was written
- Committee considers that the CIP is one part of larger cost reduction requirements and so would like to see it reported within finance paper
- Continuous quality improvement reporting to focus on turning non-recurrent to recurrent and next year's requirements and beyond
- Verbal update on system risk share discussions and information sharing to date.

2019/20 Financial Performance

- Discussed year to date performance and the forecast assumptions. Remains a requirement to deliver significant cost reduction in order to achieve plan (due to cost pressures required for quality and strategic priorities).
- Verbal update from recent forecast deep dives with all finance managers and extended session at ELT on risks and mitigations.

- Finance Risk table discussed in detail, including ratings

- Equality, Diversity and Inclusion (EDI) reporting discussed: both in individual reports to Committee and the collation of a mid-year report in line with Committee EDI objective. CW to meet with RW and consider themes, gap analysis and threads of committee discussions

Review of updated Terms of Reference

- Add CEO's right to attend any meeting

Assurance/lack of assurance obtained

- Commissioning Interface and Contract – significant (given additional context and updates provided in meeting)
- Operational Performance and KPI Achievement – significant assurance of those things under our control
- CIP Delivery and Continuous (Quality) Improvement Delivery Programme – Limited assurance
- 2019/20 Finance Performance – Limited assurance

Key risks identified

- Ongoing risk of not achieving financial plan in light of cost reduction requirements including the residual CIP

Decisions made

- CIP cost reductions to be reported within wider finance report
- To receive a half-year EDI report and for consistency in approach to the consideration of EDI objectives to be discussed at Committee chairs

Escalations to Board or other committee

Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive and Director of Finance**

2019-20 Board Annual Forward Plan

Exec Lead	Item	2 Apr 19	7 May 19	4 Jun 19	2 Jul 19	3 Sep 19	1 Oct 19	5 Nov 19	3 Dec 19	4 Feb 20	3 Mar 20
	Paper deadline	**26 Mar**	**29 Apr**	**28 May**	**24 Jun**	**27 Aug**	**23 Sep**	**28 Oct**	**25 Nov**	**27 Jan**	**24 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X	X	X	X	X
CG	Patient Story	X	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X	X	X	X	X
CM	Board Forward Plan (for information)	X	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE											
CM	Chair's Update	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X	X	X	X	X
MP/CW	NHSI Annual Plan - timing to be confirmed							X			
AR	Staff Survey Results										X
AR	Equality Delivery System2 (EDS2)							X			
AR	Workforce Race Equality Standard (WRES)					X					
AR	Workforce Disability Equality Standard (WDES)					X					
AR	Workforce Standards Formal Submission									X	
AR	Gender Pay Gap Report										X
AR	Public Sector Duty Annual Report									X	
AR	Pulse Check Results and Staff Survey Plan					X					
AR	Flu Campaign for 2019/20							X			X
AR	Workforce Plan			X							
Trust Sec	NHS Improvement Year-End Self-Certification		X								
Trust Sec	Year-End Governance Reporting from Board Committees and approval of ToRs		X								
Trust Sec	Corporate Governance Framework							X			
Trust Sec	Trust Sealings (six monthly)	X					X				
Trust Sec	Annual Review of Register of Interests	X									
Trust Sec	Board Assurance Framework Update	X		X		X		X		X	
IM	Deep Dive BAF Risk 3b - risk that the Trust fails to influence external drivers (such as national policy and BREXIT) which could impact on its ability to effectively implement its strategy								X		

Exec Lead	Item	2 Apr 19	7 May 19	4 Jun 19	2 Jul 19	3 Sep 19	1 Oct 19	5 Nov 19	3 Dec 19	4 Feb 20	3 Mar 20
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)					X					X
Trust Sec	Fit and Proper Person Declaration			X							
Trust Sec	Board Effectiveness Survey Report Policy for Engagement between the Board and COG	X							X		
Trust Sec	Report from Council of Governors Meeting (for info)	X		X		X	X		X	X	
Committee Chairs	Board Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance Committee - Mental Health Act Committee - - Quality Committee - People & Culture Committee - Safeguarding Committee	X	X	X	X	X	X	X	X	X	X
MP	Annual Emergency Planning Report (EPPR)								X		
GH	Business Plan Monitoring close down of 2018/19 (May) Proposal for 2020/21 (June)		X	X				X			
GH	Trust Strategy Review		X		X						
GH	Clinical Strategies 2019-22 - Oct: Older Adult , Working Aged Adult - Nov: Eating Disorders, Perinatal - Dec: Forensic and Rehab, Substance Misuse, LD, Children's						X	X	X		
OPERATIONAL PERFORMANCE											
CG/CW/AR/ MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard		X	X	X	X	X	X	X	X	X
CG/JS/AR/ MP	Workforce Standards Formal Submission/Safer Staffing										X
QUALITY GOVERNANCE											
CG/CW/MP/ GH/JS/AR	Quality Report - focus on CQC domains		Responsive MP	Caring CG		Use of Resources CW		Safety JS	Quality & Strategy GH	Well-led CQC & NHSI Trust Sec	Effective CG AR
JS	Learning from Deaths Mortality report (quarterly publication of information on death) Apr/Jul/Oct/Feb/Apr	X				A		X		X	
JS	Guardian of Safe Working Report			X					A		X
CG/JS	Safeguarding Children & Adults at Risk Annual Report						X				
JS	NHSE Return on Medical Appraisals sign off					X					
CG	Control of Infection Report					A					
JS	Re-validation of Doctors				A						
CG	Annual Review of Recovery Outcomes								X		
CG	Treat Me Well Campaign Update				X						
CG	Annual Looked After Children Report						X				
CG	Outcome of Patient Stories						X				

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2019

Register of Trust Sealings 2019/20

Purpose of Report

This report provides the Trust Board with a six month update of the authorised use of the Trust Seal since the last report to the Board on 2 April 2019.

Executive Summary

In July 2019 Section 8.18 of the Standing Financial Instructions and Standing Orders of the Board of Directors was amended and the contract value for when the Trust seal is required was increased from £100,000 to £500,000. Therefore, every contract which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department (as set out in the Board's Standing Financial Instructions point 8.18).

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A six month report on use of the seal from 2 October 2018 – 2 April 2019 was made to the Board on 2 April. Since then the Trust Seal was affixed twice on 6 August as follows (the contract value for these both transactions were valued at over £500,000):

1. DHCFT68 replacement emergency lighting system
2. DHCFT69 assisted bathroom installation at the Hartington Unit

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

Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There is no direct impact on those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since April 2019 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Report presented by: **Justine Fitzjohn**
Trust Secretary

Report prepared by: **Sue Turner**
Board Secretary

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2019

Report from the Council of Governors Meeting held on 3 September 2019

The Council of Governors met on Tuesday 3 September 2019 at the Centre for Research and Development, Kingsway Hospital site, Derby. The meeting was attended by 16 governors.

Verbal update on Joined Up Care Derbyshire – including the impact of the Long Term NHS Plan

Ifti Majid gave a verbal update on the latest activities within Joined Up Care Derbyshire (JUCD) which included:

- The integration project is moving forward in an inclusive way. The revised Long Term Plan will be presented at the Board meeting in October.
- The Integrated Care System (ICS) should see the expected outcomes agreed and add value as one system rather than as five individual organisations in which to deliver a package of care. The current PLACE system is likely to be developed into Primary Care Networks (PCN's), which link into local populations. The Regulators NHS Improvement (NHSI) and NHS England are working with the partnership to develop the PCN's.
- What does the organisation development mean for the Council of Governors though? Ifti explained that currently governors hold a guardianship role for the Trust. However, going forward it is likely that this will transfer into a role across the system to ensure that services are maintained.

Ifti referred governors to the full details within his Chief Executive's report to the Public Board, which had been enclosed with the Council of Governors papers.

Report from the Governors' Nominations and Remuneration Committee meetings held on 12 July 2019 and 8 August 2019

Governors:

- Approved the appointment of Dr Sheila Newport as Non-Executive Director of the Trust Board at an annual fee of £12,638 for a three year term commencing on the expiry of Dr Anne Wright's term of office (currently 11 January 2020), noting an earlier start date of 1 December 2019 to act in 'shadow form' to allow for handover
- Noted the update and timeline for the recruitment of the sixth Non-Executive Director
- Approved the temporary appointment of Suzanne Overton-Edwards as Non-Executive Director of the Trust Board up until 31 December 2019 on a pro-rata annual fee of £12,638
- Noted that all appointments to the Trust Board are subject to satisfactory completion of the Fit and Proper Persons Tests.

Non-Executive Director deep dive

Anne Wright provided a Deep Dive report into her role as Chair of the Safeguarding Committee and Chair of the Mental Health Act Committee, also her involvement in Joined Up Care Derbyshire and as a member of the Audit and Risk Committee and the Quality Committee. Anne is also the "Learning from Deaths" Non-Executive Director. Anne highlighted her role in holding Executive Directors to account.

Integrated Performance Report
The Integrated Performance Report (IPR) was presented to the Council of Governors to provide an overview of performance as at the end of July 2019. The Non-Executive Director Board Committee Chairs reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

The IPR included new control charts – a training session on the control charts will be arranged for the next Council of Governors meeting for governors to gain an understanding of how to read them.

Review on Waiting Lists
Kath Lane, Deputy Director of Operations presented the review on waiting lists. The paper provided detailed information on the waiting lists for Paediatrics, Autism Spectrum Disorder (ASD), Children and Adolescent Mental Health Services (CAMHS), Psychology and Adult Care Coordination. Governors requested a further update on waiting lists to be presented at the Council of Governors on 7 January 2020.

Governance Committee Report
Kelly Sims, Chair of the Governance Committee presented a report of the meeting held on 6 August 2019. Of note were the following items:

- Governors are encouraged to get involved in engagement events as it is an opportunity for governors to get to know their constituents. Governors are keen to be involved in World Mental Health Day on 10 October
- Feedback from Governor Engagement Activities – governors are reminded to complete the governor engagement template
- Annual Members Meeting – governors were asked to actively promote the AMM within their respective areas
- Governor elections – elections for the vacancies in Derby City West and Erewash will close on 26 September. Results will be declared at the end of September. The next elections will be held in October for vacancies in Amber Valley, Chesterfield, Derby City West, High Peak and Derbyshire Dales and South Derbyshire.

Annual Members' Meeting (AMM) update
An update on the progress of the AMM preparations was given and included information about the governor stall. Governors were reminded that the Annual Members' Meeting is taking place on 11 September 2019 and were asked to keep this date free in their calendars and promote the meeting to their constituents and the public.

Any other business
Council of Governors Annual Effectiveness Survey – all governors were encouraged to complete the survey by 20 September 2019, the results of which will be presented to the Governance Committee in October.

Care Quality Commission (CQC) update – CQC will be attending the next Council of Governors meeting on 5 November 2019 and have requested a meeting with governors which will take place on 5 November from 11.30am-1pm.

Derbyshire Healthcare NHS Foundation Trust

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	Terms in Full
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ACP	Accountable Care Partnership
ACS	Accountable Care System (now known as ICS)
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMHP	Approved Mental Health Professional
AO	Accountable Officer
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BMA	British Medical Association
BAME	Black, Asian & Minority Ethnic group
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care & Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
COG	Council of Governors
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DfE	Department for Education
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early intervention in psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FSR	Full Service Record
FT	Foundation Trust
FTN	Foundation Trust Network
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HEE	Health Education England

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health & Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
IM&T	Information Management and Technology
IPP	Imprisonment for Public Protection
IPR	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSI	National Health Service Improvement
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OP	Out Patient
OSC	Overview and Scrutiny Committee
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
S(U)I	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
W	
WTE	Whole Time Equivalent