



**Derbyshire Community Health Services NHS Foundation Trust**

**Annual Quality Report 2015/16  
(draft for consultation)**

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## Part 1

### Introduction

Welcome to our Quality Report for 2015/16 which sets out what we have done to safeguard and improve the quality of our services during the year, where we still need to make improvements and what we want to achieve in 2016/17.

Here at Derbyshire Community Health Services NHS Foundation Trust (DCHS) our vision is to be the best provider of local healthcare and a great place to work. During the year we have implemented a wide range of service developments and quality improvements in support of this vision. This report is an important part of discharging our accountability to the local communities that we serve and describing the progress we have made.

This report covers the quality of our services across the entire 2015/16 year and illustrates how we have continued to develop our approach to quality assurance and service development despite working in an environment that is constantly changing and where resources are increasingly challenged.

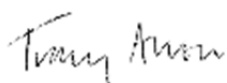
2015/16 has seen some important changes to the portfolio services we manage for our local population including the addition of primary care services in some areas. This is an important step for us and we anticipate will help us to strengthen the integrated primary and community healthcare arrangements for the populations in these areas.

We feel that we have made good progress in the year in continuing to improve the safety and effectiveness of our services, as well as the experience of our care, for everyone that we support. The progress we continue to make has been recognised by external agencies including NHS England and Health Education England (East Midlands). Independent reviews of our services have shown that the Trust continues to provide safe care delivered by staff who are dedicated and compassionate and who demonstrate excellent commitment in providing the best care they can and by putting patients' needs at the centre of their care.

**Tracy Allen, Chief Executive and Prem Singh, Chairman**

### Declaration of Accuracy

I confirm that to the best of my knowledge the information presented in our Annual Quality Report is accurate



Signature

Tracy Allen, Chief Executive

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## Part 2

### Driving quality improvements

#### 2.1 Priorities for improvement

##### 2015/16 Quality priorities

This quality report demonstrates our achievements for the year 2015/16, describes the areas where we would still like to make improvements and our quality objectives for the coming year.

Our quality improvement priorities are identified within the Trust's overarching annual objectives, known as the Big 9, three related to quality services, three pertaining to quality people and three quality business targets.

During 2015/16 our three key quality priorities focused the whole organisation on quality improvement in areas of patient safety, clinical effectiveness and patient experience. These priorities were:

- To improve information sharing – ensuring clinicians have up-to-date information regarding their patients
- To increase the number of referrals to Smoking Cessation services made by DCHS Staff
- To identify where patients with a learning disability access our services equitably

### DCHS BIG 3

Quality Service	Objective	Priorities 2015/16	Aims for this year	Plans to end of Dec	Achieved to end of Dec	Forecast
	To deliver high quality and sustainable services that echo the values and aspirations of the community we serve	• Patient Safety - Improvement in information sharing	90%	82%	76.47% (RED)	90% (GREEN)
		• Clinical Effectiveness - To increase the number of referrals to Smoking Cessation services made by DCHS staff	153	82	46 (RED)	80 (RED)
		• Patient Experience - Identify where patients with a learning disability access our services	100%	85%	33% (RED)	50% (RED)

Whilst progress has been made against all three of these stretch quality improvements we are disappointed that we have not achieved the targets that we set ourselves.

- **Improvements in information sharing.** We set out to improve access to health records by asking our staff to ask their patients at each contact for permission for their health records being shared with other health practitioners to ensure better continuity of care. Many services have made good improvements with this target and some have excelled although there is still room for improvement. Significant progress has also been made across the health and social care community with the development and agreement of information sharing protocols which allow the sharing of information between health professionals where it is in the patients best interest and meets stringent information governance standards. Further work is required to develop our information technology infrastructure to improve data flows and information accessibility. This work will be continued during 2016/17
- **Increase the number of referrals to smoking cessation services.** This target has proved most challenging in terms of data capture again due to our information systems not having the facility to easily capture smoking cessation referrals. We will continue to work with our staff to make improvements and to use the Making Every Count framework (MEC) the mechanism by which we achieve this.
- **Identify where patients with a learning disability access our services.** This target was chosen in an attempt to better understand where patients with a LD access DCHS services so that we can ensure access to appropriately trained staff and information. It has proven difficult to capture this information due to the broad spectrum of learning disability and some

patients not declaring a particular need when accessing the services. Through our equality, diversity and inclusion forum we will continue to work toward improving our data capture and have a particular workstream regarding development of more accessible information.

In addition to our organisation-wide quality improvement targets in 2015/16 we have been working to achieve a combination of quality objectives and service improvements which we set ourselves, together with quality targets which are set out in our contract with local health service commissioners. These are reported in more detail in the body of this report.

Our quality priorities build upon what we already know about our services, what our patients have told us are important to them and in response both to commissioners' and national priorities. We also place a great emphasis on learning from our staff who are at the frontline of care delivery and we have developed an effective network of ways to engage with them and hear their feedback. We are particularly proud of our annual staff survey results 2015, which listed us as one of the best performing trusts, based on feedback from our staff.

### **Things we want to do better in 2016/17**

We are continually striving to improve the quality of the services we provide and to learn from things that did not go so well.

For 2016/17 our Board of Directors has agreed three strategic quality improvement objectives:

- 1) Patient Safety – to decrease the overall burden of pressure damage within our health community by a reduction of pressure ulcer incidents as a percentage of patients looked after by our services
- 2) Clinical Effectiveness – to introduce across our services a nationally recognised measure of frailty which will help us to identify patients at risk and proactively manage their care
- 3) Patient Experience – to improve our performance in relation to complaint response rates ensuring that patients receive a response to any concerns raised within a reasonable timeframe

These three quality improvements have been chosen following feedback from our board of directors, our governors, our staff and most importantly our patients. Pressure ulcers and increasing frailty have been identified as significant issues within our local population needs and account for a large percentage of our overall budget. Ensuring services are appropriately aligned for these issues will enable us to ensure that our services are delivered as effectively and efficiently as possible. Metrics for each of these improvements will be identified and will be measured on and reported on a monthly basis as part of our performance monitoring to the board.

In addition we will continue to strengthen our internal processes for quality improvement and assurance using our Quality Improvement and Assurance Framework.

### **Monitoring and measuring quality**

We are actively committed to being able to demonstrate the consistency and quality of our services. We want our patients and their families to feel safe and well looked after.

We recognise the need for a continuous focus on improving our quality assurance measures. During 2015/16 we have developed further processes for assuring the quality of our services and are very proud of the work we have completed towards our clinical assessment and accreditation peer review – Quality Always/

### **Our services in 2015/16**

During 2015/16 DCHS provided and/or sub-contracted 36 relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by DCHS for 2015/16.

Of these services, 30 were NHS commissioned services and a further 6 were commissioned by local authorities. Services included rehabilitation, community nursing, health visiting, school nursing, sexual health services, community dental services for patients with mental health problems and learning disabilities, as well as a wide range of planned care services such as podiatry, physiotherapy, speech and language therapy and occupational therapy. Strategically we have continued to redesign our services with an aim to support our patients as close to home as possible.

As part of our duty of care we continuously review the quality of all our services. DCHS has reviewed all the data available to them on the quality of care in all of these NHS services.

It is important that we focus carefully on the way we spend the money allocated to us for provision of our services. We need to ensure we are able to deliver best value for money at all times, whilst also striving to provide the very best care for people in our local community.

### **Commissioning for Quality and Innovation (CQUIN)**

2.5% of DCHS's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between DCHS and North Derbyshire Clinical Commissioning Group (CCG) as the lead commissioner on behalf of our four CCGs. This was part of our contract for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Total CQUIN contract value for 2015/16 was £3,181,922 and we are predicted to earn approximately 97% of this value, this indicates a total CQUIN payment of £3,086,464

During 2015/16 we agreed nine CQUIN measures, and acquired a further two CQUINs in October 2015 in association with the Derby City Community Services transfer to DCHS as part of our Strategic Shift programme.

We achieved 97% of our CQUIN targets during the year. (we have conservatively estimated achieving 97% although we may achieve 100% depending on the results for the dementia CQUIN in February and March – we have already met the target for January)

Further details of the agreed goals for 2015/16 and for the following 12 month period are available in section 3.

### **Care Quality Commission (CQC)**

DCHS is required to register with the CQC and its current registration status is: registered with the CQC with no conditions attached to registration. The CQC has not taken enforcement action against DCHS during 2015/16.

DCHS has participated in the specialist Looked After Children review conducted in Derby City during 2015/16. There were no specific recommendations for DCHS as a consequence of this review.

DCHS is subject to periodic reviews by the CQC and the last comprehensive inspection was between 26 February and 4 March 2014, where DCHS volunteered to be in the first wave of new style CQC inspections, with a further focused inspection between 11 and 12 November 2014. The CQC's assessment following that review was that the Trust is fully compliant with all essential standards. As a pilot site within the new inspection regime we were not awarded a service rating.

DCHS is scheduled for a further inspection by the Care Quality Commission from 9<sup>th</sup>-13<sup>th</sup> May 2016 with formal reporting back on this inspection planned for autumn 2016.

During 2015 DCHS assumed responsibility for delivery of adult community care services in the Derby City area. At the point of transfer these services had been inspected by the CQC as part of the Royal Derby Teaching Hospitals NHSFT CQC inspection. At this time the adult community services were found to be non-compliant in three areas:

- Numbers of community nurses to deliver services
- Mandatory training for community teams
- Access to adequate numbers of computers

Compliance actions were not transferred to DCHS, however, we have as would be expected continued to work with the clinical teams to address these deficits.

### **Secondary uses service data**

DCHS submitted records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data up to and including March 2015: (currently data is for April 15 to Dec 15 inclusive):

- which included the patient's valid NHS number was:

99.9% for admitted patient care

99.9% for outpatient care

99.4% for accident and emergency care

- which included the patient's valid General Medical Practice Code was:

99.4% for admitted patient care

99.9% for outpatient care

100.0% for accident and emergency care

### **Payment by Results**

DCHS was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission but we did initiate our own internal audit:

<b>Coding Field</b>	<b>Percentage Correct</b>	<b>IG Req 505 Level 2</b>	<b>IG Req 505 Level 3</b>
Primary diagnosis	93.5%	90%	95%
Secondary diagnosis	94.6%	80%	90%
Primary procedure	95.3%	90%	95%
Secondary procedure	91.6%	80%	90%

DCHS will be taking the following actions to improve data quality:

- Collate all existing clinical coding policies and procedures into a single policy
- Create a table of abbreviations used by all clinicians, to ensure clinical coders are translating abbreviations appropriately
- Undertake regular audits of respite care records, in order to ensure the information collected is sufficient to adequately code
- Introduce bi-monthly internal audits, ensuring all sites have received one audit per year



### **Information governance**

DCHS' Information Governance Assessment Report overall score for 2015/16 was 71% and was graded amber from the IGT grading scheme. 91% of staff completed information governance training in year against a target of 95%. (total as of 03/03/2016) It is anticipated that we will meet the 89% target by the year end.

Further detail on our information governance toolkit score can be found at appendix 3.

### **Emergency Preparedness, Resilience and Response (EPRR)**

In line with the Civil Contingencies Act 2004 and NHS England's national programme for Emergency Preparedness, Resilience and Response (EPRR), we are actively engaged in developing and reviewing plans which ensure our ability to respond to incidents, both internally and out in the communities which we serve. As part of this process plans go to the Quality Business Committee, a sub-group of our Board, for review and approval. We have a named Accountable Emergency Officer (Chief Operating Officer) who is a member of the Local Health Resilience Partnership (LHRP). The LHRP provides a strategic forum for joint planning across the local health community and supports the local health community's contribution to wider multi-agency planning. In 2015, the Trust was awarded full assurance against NHS England's Core Standards for EPRR, following a peer review from the lead CCG.

During the last year the Trust has faced a number of minor operational challenges, such as a flood at Ilkeston Hospital, telecommunications outage affecting Walton Hospital, and the Junior Doctors' industrial action. Contingency arrangements were put in place for each of these incidents and the affected services were either speedily recovered or redirected to alternative facilities until the affected areas and equipment were recovered and declared safe to operate.

## **Part 3**

### **Review of quality improvements for 2015/16**

#### **Commissioning for Quality and Innovation (CQUIN)**

##### **CQUIN targets**

CQUINs are quality-related goals which are agreed with our commissioners each year. The goals are linked to a proportion of our income which we receive on achievement of the targets. CQUIN stands for Commissioning for Quality and Innovation and the targets support ongoing innovation and improvement in care across our clinical services.

During 2015/16 we agreed nine CQUIN measures, and acquired a further two CQUINs in October 2015 in association with the Derby City Community Services transfer to DCHS as part of our Strategic Shift programme. We achieved 97% (we have conservatively estimated achieving 97% although we may achieve 100% depending on the results for the dementia CQUIN in February and March – we have already met the target for January) of our CQUIN targets during the year.

The themes for our CQUINs covered:

- Patient assessment and refer for dementia (national target)
- Training in dementia awareness (national target)
- Support for carers of dementia (national target)
- Improving urgent care (national target)
- Pressure ulcers (local target)
- Compassion and culture (local target)
- End of life care (local target)
- Community nursing, staffing for quality (local target)
- Patient Flow and Discharge planning Stockport model) ( (local target)
- Transition of services (local CQUIN)
- Therapy Outcomes (local target – Derby City)

##### **Reasons for not achieving 100% of CQUIN target**

DCHS faced significant challenge in capturing information for the Dementia 'Assess, Refer, Inform' CQUIN, particularly in relation to information being shared with GPs on discharge. The CQUIN was reliant on manual data collection, and difficulties were encountered in accessing patient notes to obtain this data on a monthly basis through a variable admission and discharge pathway. Work is ongoing to automate data collection through the introduction of an electronic patient record system, and the CQUIN team have continued to work closely with our Ward Clerks and Advanced Nurse Practitioners to ensure data is submitted in a timely and accurate way.

## **Developing services responsive to our patients' needs**

### **Evidence of quality improvements for 2015/16**

This section describes in more detail our successes during the last year. We are also keen to present examples of where we could do better, to ensure we give an open and balanced account. To help understand this information we have presented this in the following sections:

## **What have we done to improve patient safety?**

### **Safety Thermometer**

The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The safety thermometer measures performance against a number of key patient safety indicators including pressure ulcers, falls, urinary tract infections and venous thrombo embolism (deep vein thrombosis).

This prevalence data is effectively population data and provides a snapshot on a single day each month within Derbyshire. The tool was designed to measure local improvement over time and should not be used to compare organisations due to differences in patient mix and data collection methods.

During 2015/16 DCHS set itself a Harm Free Care stretch target of 94%.

January 2016 Harm Free Care (HFC) Score across all Services – 92.65% down from 92.9% in December. 2015/16 Harm Free Care (HFC) Score across all Services (Year to Date) – 92.92%. We set ourselves an internal stretched target of 94%.

2014/15	Harm free care scores 2014/15 (Target for year 93%)	Harm free care scores 2015/16 as of Jan 2016 (Target for year 94%)	Performance in year
<b>Across DCHS</b>	92.37%	92.92%	↑
Rehabilitation wards	87.22%	88.61%	↑
Older people's mental health wards(OPMH)	100%	99.39%	↑
District nursing	92.65%	92.96%	↑
Learning disability services	100%	100%	↔

Whilst we did not achieve our stretched improvement target there was improvement in our overall score and in two service areas. Learning disability services continue to perform at 100%.

### Sign up to Safety Campaign

Sign up to Safety is a national Patient Safety campaign intended to harness the commitment of staff across the NHS in England to make care safer. It is one of a set of national initiatives to help the NHS improve the safety of patient care. Collectively and cumulatively these initiatives aim to reduce avoidable harm by 50% and support the ambition to save 6,000 lives. The campaign requires that organisations commit to **five safety pledges**.

DCHS formally signed up to the Campaign in February 2016. Making this commitment will bring the pledges to life and help staff understand their role in this initiative and build upon existing collaborative working to create the right conditions for safer care. Monitoring of the pledges, the associated actions and its progress will occur through the Clinical Safety Group and inform the Quality Service Committee.

We will report on our pledges in our annual quality report 2016/17

### DCHS Pledges

#### **Pledge 1: Putting Safety First - Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans**

- Ensure a Patient Safety culture where serious harm is minimised and preventable harm in health care is eliminated.
- Reduce the number of low harm medication incidents.
- Reduce the number of pressure ulcers resulting from lapses of care.
- Reduce the number of falls resulting from lapses of care.
- Ensure if patients require restraint, that this is in line with the Mental Health Act and NICE guidance.
- Ensure a zero harm environment where our staff, visitors, contractors and members of the public go home safely at the end of each and every day.
- Ensure that continence clinic venues across our Trust have risk assessments in place to ensure that they are fit for delivering safe care.

- Ensure that Medical Devices (NB either electrical or requiring calibration) have a planned preventative maintenance process in place and that staff are deemed competent in their use.

**Pledge 2: Continually learning– Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are**

- Ensure that the Duty of Candour is exercised when serious harm occurs and those patients or their advocates are informed of any lessons learned. That any lessons are communicated to operational staff via the Trust's 'Learning the Lessons' process.

**Pledge 3: Being Honest– be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong**

- Ensure that the Duty of Candour is exercised when serious harm occurs and those patients or their advocates are informed of any lessons learned.

**Pledge 4: Collaborating– take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use**

- Work closely with our Commissioner stakeholders and the Serious Incident Network so that wider learning can occur.
- We will actively consult with our workforce and nurture an open attitude to health and safety issues, encouraging staff to identify and report hazards and suggest innovative solutions so that we can all contribute to creating and maintaining a safe working environment.

**Pledge 5: Being Supportive– Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress**

- Adopt a Human Factors approach to understand the crux of a problem and provide our staff with the training, support and confidence to learn and improve.
- Strive to create a positive health and safety culture, providing the right conditions to create a just culture where employees are not punished for health and safety actions, omissions or decisions taken by them which are commensurate with their experience and training, but where gross negligence, wilful violations, deliberate acts or breaches are not tolerated.

**Quality Always Accreditation and Assessment Scheme**

DCHS is committed to providing high quality care throughout the full range of the services delivered by the organisation. The Quality Always scheme is an important way to make sustainable quality improvements and provide assurance about the standards of care. There are two key facets of our Quality Always approach.

**Clinical Assessment and Accreditation Scheme (CAAS)**

We have developed a comprehensive suite of quality standards based upon the Care Quality Commissions fundamental standards. These standards have been developed on a bespoke basis for specialist teams. Teams are responsible for ensuring that they meet the standards set through a process of self-assessment and clinical audit. Independent peer assessment is undertaken by the Quality Always core team who undertake unannounced reviews against the core standards. On completion of a peer review teams receive a rating and a detailed report so they can develop a quality improvement plan. Their rating dictates the frequency of the next assessment. (Red, reassess in 2 months, Amber reassess in 4 months, Green reassess in 8 months, following accreditation reassess in 12 months).

To become an accredited Quality Always area a team must be able to sustain a green rating over 2 successive reviews and undergo a panel assessment of the quality of their care. This process is expected to take teams a minimum of 16 months to achieve. We now have several teams achieving

their first green rating. The charts in appendix 4 demonstrate the progression of improvements and progress of the scheme.

### Leadership Development Scheme

A cornerstone of DCHS' vision and values is the development of a workforce who support clinical excellence. Clinical leaders directly influence the quality of patient care and their development is seen as key in achieving our Quality Always goals.

As part of this development clinical team leaders are assessed on strengths and development areas, in relation to the 5 key behaviours (NHS Leadership Academy Framework):

- managing services,
- working with others,
- setting direction,
- leading change, and
- demonstrating personal qualities.

A development centre approach has been developed comprising:

- 360 degree appraisal and feedback,
- staff appraisal
- Development Centre day
- detailed feedback based on the development day, appraisal and 360° appraisal
- a personal development plan for each leader

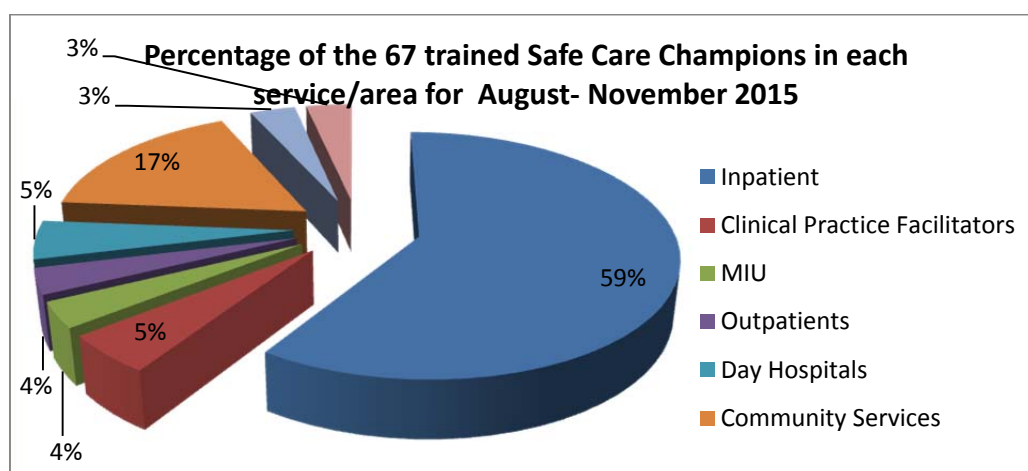
To date 86 clinical leaders have taken part.

It is anticipated that this approach will facilitate clinical leaders in the change management skills needed to sustain clinical improvement in their area of responsibility.

### Quality Safecare Champions

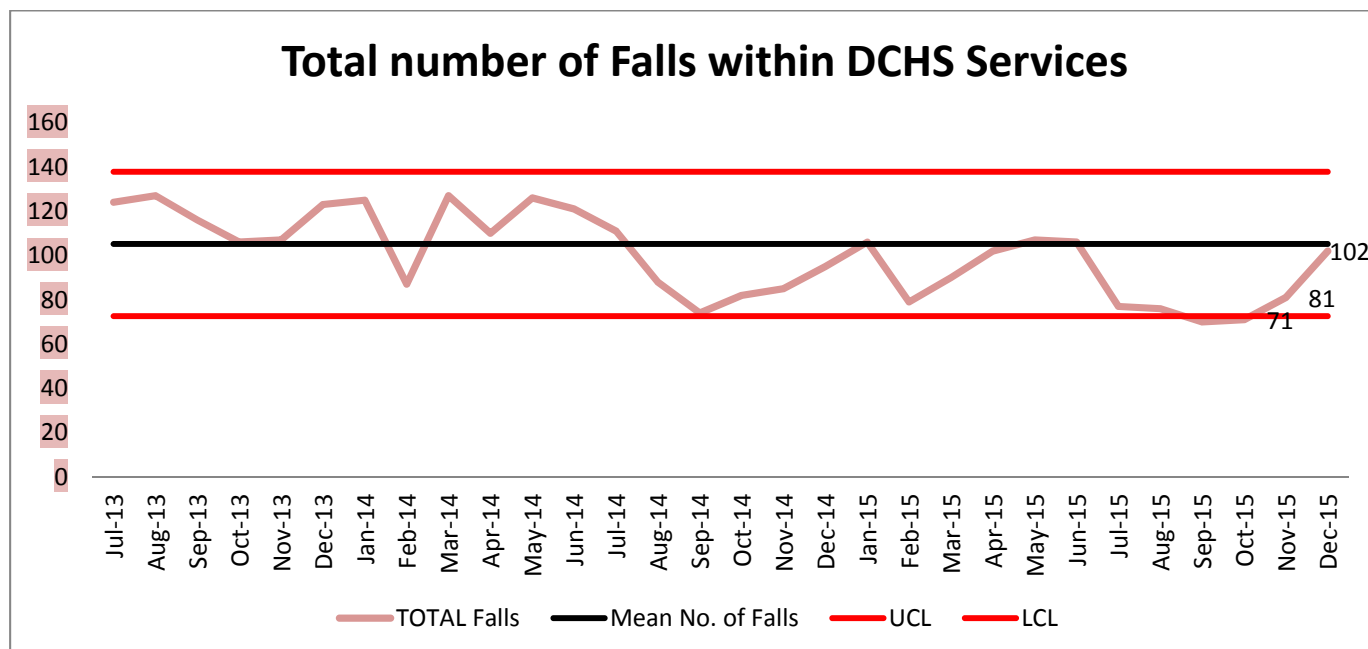
Quality and Safe Care Champions (QSC champions) keep teams up to date with the latest professional standards and evidence base.

During 2015/16 67 staff from a range of clinical back grounds and services have participated in the appropriate training to become recognised as Safe Care Champions.



### Falls

Many of our services are focused on rehabilitation of elderly patients. Obtaining optimal independence is not without risk and on occasion patients fall. Our aim is to reduce the overall number of falls and especially those that result in patient harm. During 2015/16, we have made significant progress in establishing and refining the pathways of care and governance for falls management. We have seen a continuation in the decrease in the number of falls incidents within inpatient care during this period.



We know that the annual incidence of falls in patients with dementia is twice that of older people who are not cognitively impaired. In the last year, we have:

- Introduced two robotic seal devices. Research has demonstrated that robotic seals reduce anxiety and agitation and therefore the risk of falls where patients with cognitive impairment are deemed at higher risk.
- Dedicated Physiotherapy support across all Older Person's Mental Health wards.
- Implemented the coloured wristband scheme to rehabilitation wards. The wristbands identify patients in need of mobility support.
- Provided mandatory falls awareness training for all Registered Nurses, additional awareness training is also available for other clinical staff to embed knowledge across all services (non-mandatory).
- Appointed a Falls Prevention Lead, working across all clinical settings.
- Developed and approved the DCHS falls strategy which outlines our actions to continue to reduce falls and the impact of falls amongst DCHS care, with focused work to identify and reduce falls and associated injuries which occur in a patient's home.

A broader health communities falls strategy is to be developed in conjunction with the wider work being undertaken on frailty management across the health community.

### Pressure ulcers

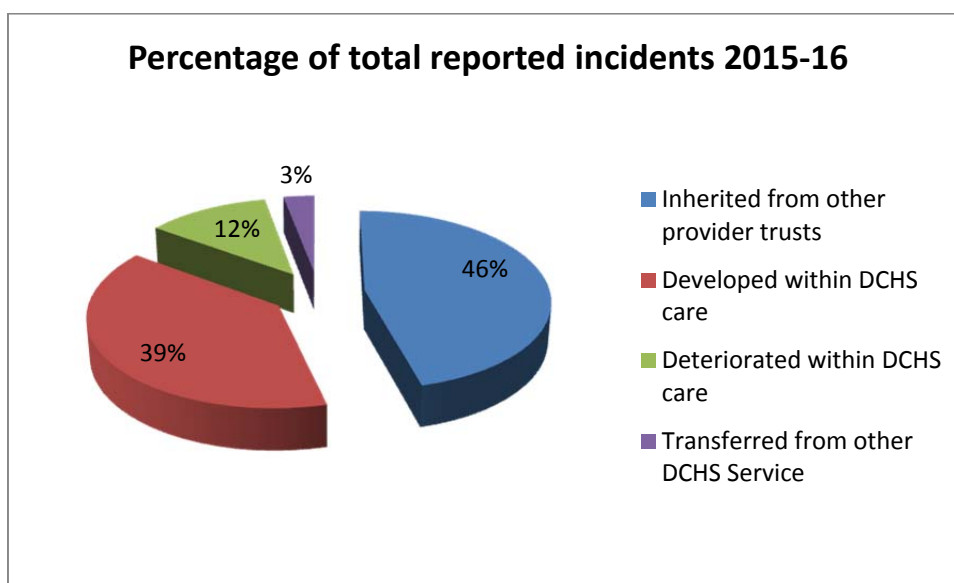
Pressure ulcers affecting skin integrity continue to be one of the most challenging areas of quality improvement for our clinical teams. There are a wide range of influencing factors which impact on our prevention strategy, including input from a variety of care teams across the health and social care community, patient choice and compliance, ability to monitor and supervise care delivered by other care providers in a home setting, use and availability of equipment. In addition there are the increasing challenges of an ageing and frail population, the rising incidence of long-term conditions and the drive to move from hospital based services into the community.

One of the key priority areas relating to quality improvement in 2015/16 was to reduce the number of pressure ulcers developing and/or deteriorating while patients are in the care of our staff. Whilst we are continuing to see a downward trend in severity of the pressure ulcers developing within our care, the overall numbers reported remain a concern and are believed to be associated with an increased reporting culture, increased frailty of our patients and an upward trend of more complex patients on our caseloads as a result of earlier discharges from acute hospitals.

Whilst we have seen improvements in a number of service areas unfortunately we have not yet achieved zero avoidable pressure ulcers across all of our services. Operational managers at all levels and clinical teams were required to engage fully in the harm free care agenda – understanding their roles and responsibilities and to provide evidence to both our Trust Board and the wider health community.

### Pressure Ulcers Reported DCHS 2015/16

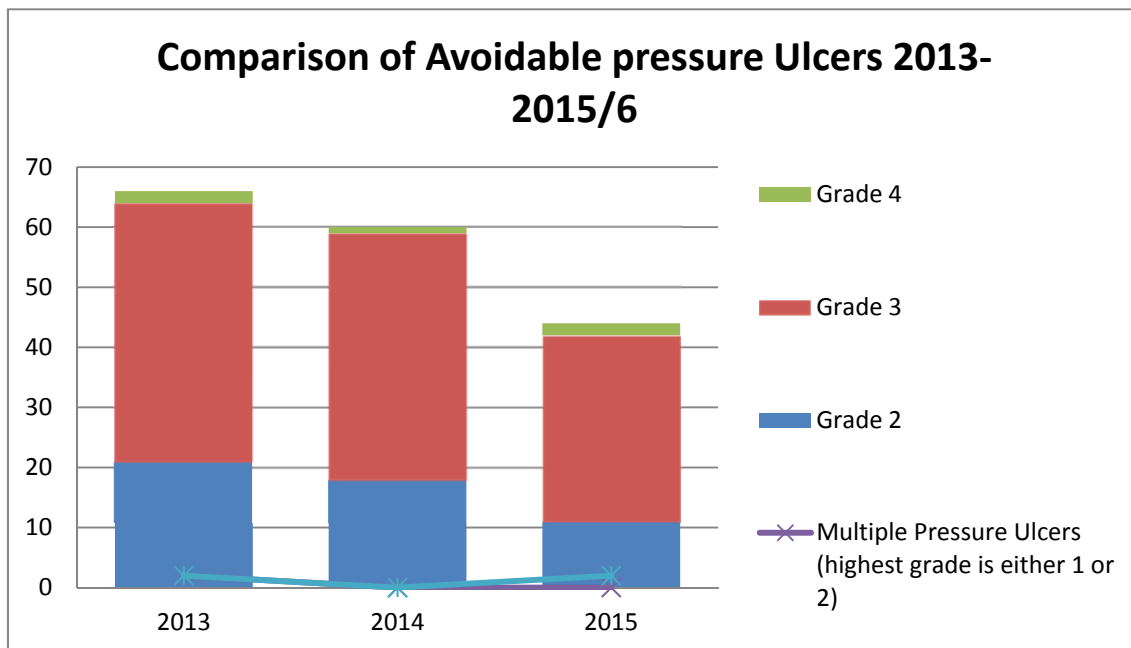
The chart below provides a breakdown of where the reported incidents of pressure damage within DCHS have occurred. We are working with other healthcare providers to identify how the number of patients referred to our services with existing pressure damage can be reduced. This has included collaborative work with other agencies including a training day for 90 care home staff, and the development of a patient information leaflet which will help to increase awareness and ownership of the problem throughout the wider health community.



The majority of pressure damage reported within DCHS occurs within our community-based services where there is less control of the patient's environment. Our community services are working closely with patients, carers, family members and other organisations to increase awareness of how to prevent pressure damage occurring. This work is starting to take effect as the severity and size of the pressure damage has reduced over the last year.

There has also been a reduction in the incidence of pressure ulcers within community hospitals from last year where 6% of incidents occurred within the hospital setting. Whilst the incidence remains small, we are mindful that this is a controlled environment and ongoing work is required to continue to reduce this number even further.

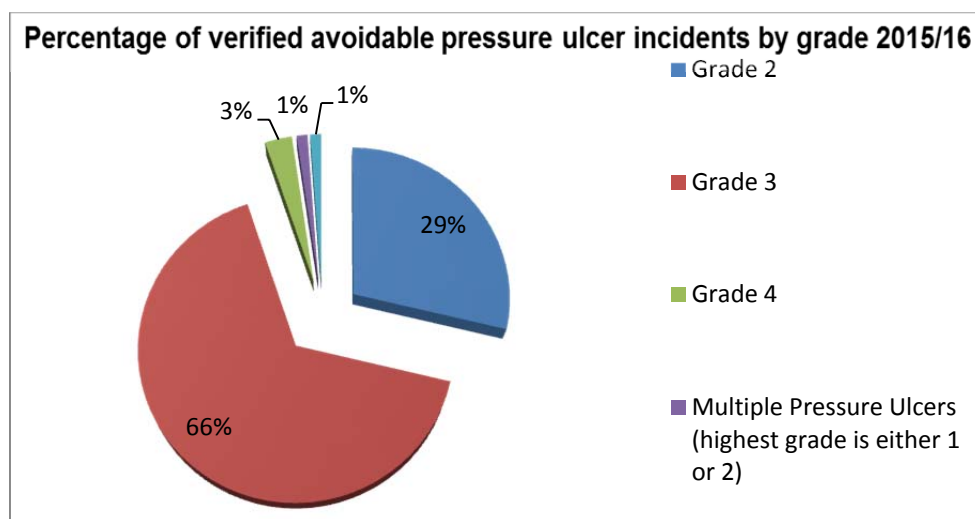
The graphs below compares the numbers of ulcers by grades categorised as being Avoidable following root cause investigations undertaken between 2013- 2015/16



The data demonstrates a sustained reduction in avoidable pressure ulcers, over the past 2 years confirming that clinical teams are demonstrating a more consistent approach to delivering preventative care standards.

DCHS undertakes detailed investigation of all grade 3 and 4 pressure ulcers as well as grade 2 or multiple ulcers where there may be concerns regarding any lapses in care using a tool called root cause analysis. Investigation has highlighted that avoidable pressure damage usually occurs when:

- staff do not respond in a timely manner to a change in the patient's condition and therefore, the plan of care does not always reflect the patient's actual needs or
- staff have not checked the patient's skin on a regular basis which would highlight any early signs of skin damage.



The Trust has introduced additional training to support staff in recognising the deteriorating patient. The teams involved in these patients are working to improve their response time and ensure that care reflects patient needs.



## Venous thromboembolism (VTE)

Venous thromboembolisms are blood clots in major veins which can lead to serious complications. As a service we ensure all our patients at risk of VTE undergo an appropriate risk assessment and have a personalised care plan in place for avoidance of VTE. During 2014/15 and 2015/16 we have seen very few VTEs, suggesting that our risk management strategies are appropriate. There is an increase in sample size in November 2015 due to Derby City teams joining DCHS.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
New VTE's	1	1	0	1	2	0	1	3	0	5		
%	0.06	0.06	0	0.06	0.13	0	0.06	0.13	0	0.22		
Sample size	1619	1672	1680	1662	1563	1581	1685	2259	2253	2287		

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
New VTE's	2	0	2	3	2	2	1	0	1	1	2	0
%	0.12	0	0.13	0.18	0.13	0.12	0.06	0	0.06	0.06	0.12	0
Sample size	1651	1618	1551	1647	1510	1622	1662	1617	1672	1677	1633	1614

## Catheter related infections

Some of our patients need help with continence which is supported by the use of a catheter. Catheters bypass the body's natural defences against infection and therefore, if not managed carefully, can be a source of patient harm. At DCHS we minimise the use of catheters as far as possible, and where infections do occur we ensure that each case is carefully investigated to understand the cause. During 2013/14 there were 94 cases of catheter related infections and in 2014/15 this number had reduced to 55 cases. For the current year 2015/16 we have had 80 reported cases of cauti, the majority of which have been classed as unavoidable. This equates to a cauti rate of 0.27% overall which is well below the target limit of 1.5%.

## Medicines management

The use of medicines to support and improve patients' health is the most common medical intervention used within the NHS and as such we have a responsibility that this is undertaken by staff who have been adequately trained and who can practice safely. In DCHS we pride ourselves on the fact that we have a rigorous process in place that provides us with assurance that our staff follow safe medicines practice.

Given the very large volume of medicines prescribed, dispensed and administered each day across our service it is inevitable that some errors do occur. Our high level of reporting in relation to errors is important and demonstrates that our staff understand the significance of errors and the opportunity to learn from errors when shared with colleagues. We are pleased to report that during 2015/16 at DCHS we have had no medication errors resulting in significant harm to a patient and that we have an excellent reputation for the reporting of near-misses from which we can review policies, procedures and training.

Medication Incidents	2014/15	2015/16
Total number of incidents	613	614
Significant harm to patient	1*	0
Minor or no harm to patient	612	614

*\*The one incident that caused significant harm (W35405 – 3.4.14) was reported from the Ophthalmic outpatients department at Market Harborough hospital and was due to a patient having a severe reaction to an eye drop used in clinic (oxypropacaine 0.4% eye drops) when used as intended.*

Our community staff in north and south Derbyshire administer intravenous (IV) antibiotics to patients in their own home to prevent them needing to be admitted into an acute hospital for this procedure, which is of benefit to the patient and frees up valuable hospital beds. This service is provided in conjunction with both Chesterfield Royal Hospital and Royal Derby Hospital.

DCHS employs more non-medical prescribers, mainly nurses, than any of the other NHS Trusts in Derbyshire and in April we hosted our annual non-medical prescribing conference, attended by over 120 prescribers. The roles undertaken by non-medical prescribers now includes Community matrons, Advanced Nurse Practitioners, Emergency Care practitioners, Sexual Health practitioners, podiatric surgeons and specialists working with patients who have diabetes, respiratory problems or Parkinson's Disease.

A bimonthly newsletter continues to be produced and distributed to clinical teams to update them of all current medication-related issues and lessons learned from investigations into medication errors. These include local and national guidance, updated local policies or procedures and articles relating to medication training or audits undertaken.

### Antimicrobial prescribing

Audits of antimicrobial prescribing are carried out in the Community Hospitals of DCHS twice yearly to ensure continued compliance with national guidance. The guidance helps practitioners ensure optimal patient care and safety by reducing inappropriate antibiotic prescribing to prevent health care associated infections and contribute to slowing the development of antimicrobial resistance.

The results for the last two years of audits are summarised in the table below which focus on all courses of antibiotics prescribed on each ward on the day of the audit:

Antimicrobial Prescribing Audit	July-Aug 2015 % for 20 courses	July-Sept 2014 for 19 courses
Stop/review date recorded on the treatment card	100%	94.7%
Allergy status recorded on the treatment card	100%	100%
Indication recorded on the treatment card	85%	68.4%
Indication recorded in the medical notes	100%	100%
Antibiotic prescribed / dose / frequency / course length recorded in medical notes	85% - Antibiotic 85% - Dose/frequency 85% - Course length	100% - Antibiotic 52.6% - Dose/frequency 36.8% - Course length
Courses prescribed which follow the Antimicrobial Treatment Guidelines	100% - Dose 100% - Frequency 100% - Course length	100% - Dose 100% - Frequency 100% - Course length

	Purpose	2015 Results
<b>Audit of the DCHS Minor injury departments (MIUs)</b>	An annual audit of antimicrobials supplied via Patient Group Directions (PGDs) is carried out to ensure the continued safe and appropriate supply of antimicrobials via PGD in the DCHS MIUs	Results of the September 2015 showed that for 170 courses supplied 100% followed the PGD inclusion criteria. This compares favourably with the 2014 results where of 151 courses supplied, 100% followed the PGD inclusion criteria.
<b>Audit of prophylactic</b>	Best practice surgical antibiotic	Results of the February 2015 audit

<b>antibiotics used in Ilkeston Diagnostic and Treatment Centre,</b>	prophylaxis guidelines for upper gastrointestinal (GI) surgery state that doses should be given within 60 minutes before knife to skin as recommended in DOH Antimicrobial Stewardship: "Start Smart - then Focus" guidance - November 2011	show that three prophylactic antibiotics given by surgical staff from Queens Medical Centre Nottingham follow the Nottingham University Hospitals NHS Trust
<b>Audit of antibiotics used by the DCHS podiatry service</b>	To demonstrate compliance with the current antimicrobial Patient Group Directions (PGDs) for surgical prophylaxis, diabetic and non-diabetic foot infections and post-operative foot infections.	The results of the February 2015 audit showed that all antibiotics supplied via PGD by the podiatry service follow the PGD inclusion criteria, dose, frequency and recommended course length

#### **New Antimicrobial audits to be completed during 2016:**

- Audit of the Cellulitis pathway for the treatment of Class II cellulitis by the Chesterfield Rapid Response service
- Audit of IV use by the Chesterfield Rapid Response service used as part of their service to enable patients to be treated at home rather than being admitted to the acute hospital setting
- Work with the sexual health service to audit the use of antibiotics by the DCHS sexual health service
- Audit of antimicrobial prescribing by non-medical prescribers in the community setting using e-pact data to look at prescribing patterns and use on antibiotics
- Audit of antimicrobial practice in dental care

#### **National Institute for Health and Care Excellence (NICE) - technology appraisals (TA) relating to medicines**

All NICE technology appraisals relating to medicines are discussed at the Derbyshire Joint Area Prescribing Committee (JAPC), at which all four NHS Trusts and CCGs are represented. A Derbyshire wide decision is made as to the prescribing status of each medicine covered in the TA. That information is then provided to the DCHS NICE Consultation Group. The prescribing decisions are then incorporated into the Derbyshire Medicines Management prescribing traffic light list that is on the CCG website. All DCHS prescribers adhere to this Derbyshire wide traffic light list.

A green listed drug is available to be prescribed in the community by any independent prescriber; a red listed drug is for prescribing by specialists only such as Hospital consultants or specialist nurses within DCHS. Amber listed drugs may only be initiated by a specialist but then prescribing responsibilities may be transferred to GPs and other community prescribers according to a written shared care protocol that states where the responsibility for the clinical monitoring of the patient will lie.

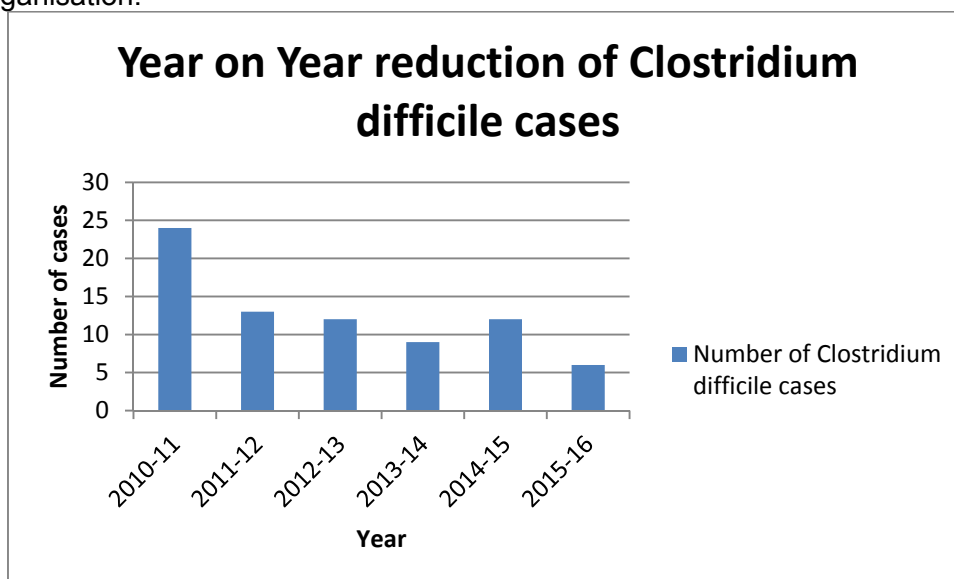
#### **Infection prevention and control**

Reducing the risk of infection and preventing cross infection continues to be an important aspect of our daily work in our hospitals and in the wider community.

We continue to be monitored nationally on the incidence of methicillin resistant staphylococcus aureus (MRSA) blood stream infections (bacteraemia) and clostridium difficile infections. We are pleased to report that for another year there have been no MRSA bacteraemia (blood borne infection) reported within our services.

During 2015/16 we have seen a 50% reduction, from 12 to 6 (Jan 2016) cases of clostridium difficile infection diagnosed within our services. To achieve this we have been working with our clinical teams to ensure that antibiotic prescribing is appropriate and that patient's continence needs are

met e.g. avoiding constipation which can change the bacteria within the bowel making patients more susceptible to infections. This preventative approach has contributed to the reduction in incidents within our organisation.

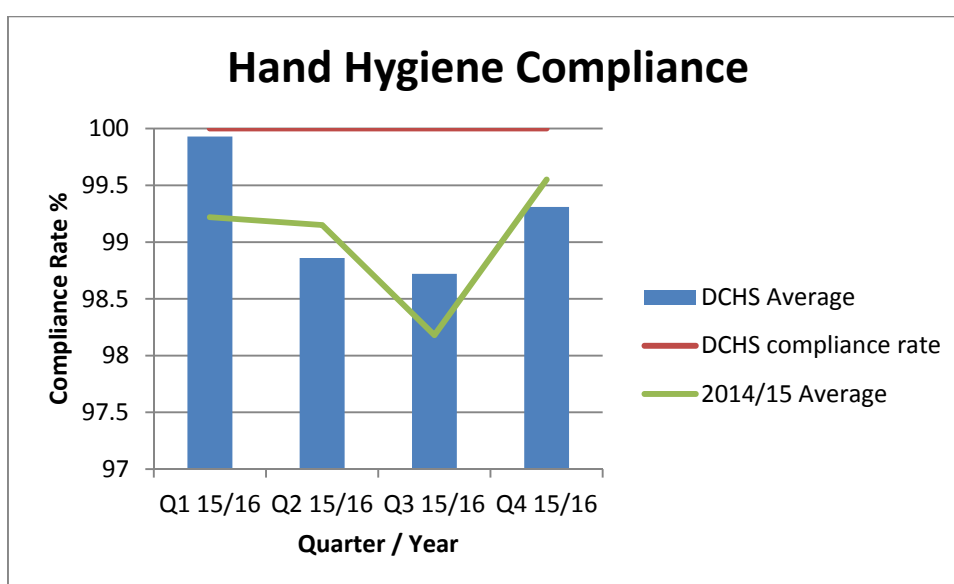


#### Norovirus

We have followed the national trend this year and have only had two incidents of diarrhoea and vomiting caused by Norovirus that resulted in ward closure.

#### Hand hygiene compliance

Our infection control champions have continued to promote good hand washing practice through regular audits and training sessions with their teams. We have seen a slight dip in performance when compared with last year, with the overall compliance rate reporting 99.22% against our target of 100%. We continue to work with the teams and infection control champions to ensure that good practice is consistently adopted across the whole organisation. The infection control champions are now part of the Safe Care Champion programme and will working alongside other specialist champions within their areas promoting quality care and professional standards. To support this we will be providing annual infection control training.



### Patient manual handling team

Our fundamental aim is to ensure that whenever we assist a patient to move, we do so in the safest way possible without causing any harm to the patient, whilst at the same time protecting staff from injury. Our specialist team work with all clinical staff to make sure that they have the correct skills. Training is designed to allow staff to develop skills for their individual roles, and patient manual handling key trainers play a vital role in this process.

This year has continued to see an increase in the referrals of patients with complex needs, both to our in - patient areas, and in the community, particularly bariatric patients. We continue to work closely with the Clinical Navigation team, to ensure that all equipment required to care for and provide rehabilitation for bariatric patients is in place in a timely manner, and that an appropriate environment is prepared prior to admission. A bariatric bed was purchased at the end of the previous financial year along with a set of bed shoe scales. These are moved from site to site as the need is identified, and have been invaluable assets in improving the quality of care for this patient group. This has highlighted the need for a virtual equipment library, and will be a priority for the coming year.

A major component of the work of the team involves ensuring that appropriate equipment and environment is available to be able to assist people to move safely. In response to an MHRA alert on October 2015, all hoist incidents reported within DCHS were examined. The table below shows the number of hoisting incidents and the resulting severity of the injury. Although there was a slight decrease in the number of incidents there was a rise in the incidents resulting in moderate or significant injury.

Year / date	Number of Hoist incidents	Level of Injury				
		No Injury	Minor	Moderate / significant	Major	Death
2013/14	32	10	21	1	0	0
2014/15	29	7	16	6	0	0
2015/16						

Development plans for 2016/17 include:

- To capture all patient manual handling incidents in a timely manner
- To improve reporting of incidents caused or suspected to be caused by slings or any manual handling task.
- Develop closer relationships with Safeguarding Adults to ensure that any safeguarding issues related to the way that people are assisted to move are shared
- Carry out RCA for all incidents reported where there has been a problem with the hoist or sling within DCHS

### Safeguarding children and adults

All staff working within DCHS have a duty to safeguard and promote the welfare of children and vulnerable adults in line with the Children Act 1989 and 2014 and the Health and Social Care Act 2015. We have a large Safeguarding Team comprising specialist nurses and a doctor who work with staff and patients/clients to ensure that as an organisation we discharge this function effectively.

During 2015/16:

- We have delivered Safeguarding Training including PREVENT (counter terrorism strategy) to 1728 staff. We aim for 95% compliance. Year to date - Safeguarding Children and Adult

Training at level 1 is 97%, Safeguarding Children training at level 2 87%, Adult Safeguarding Training at level 2 is 94%

- We have updated our Adult and Children Safeguarding Policies to reflect national and local guidance.
- We have continued to work in partnership with social care to ensure that vulnerable children and adults receive the best care, treatment and outcomes.
- We continue to work with a range of professionals focusing on domestic abuse, substance misuse, child sexual exploitation and all aspects of exploitation and modern slavery
- We have recruited a new Named Nurse for Safeguarding Adults who will be the lead for 'victims of exploitation'.
- We work Monday to Friday (9am to 5pm), to provide an advice function for staff who have concerns regarding children and adults in their care
- We have a robust system in place to provide safeguarding supervision to all staff working with children. Compliance with the agreed plan is currently 91%. Adult Safeguarding supervision is provided on an ad hoc basis to those individual colleagues and teams who require it.
- We have implemented a weekly Deprivation of Liberty reporting process for all DCHS ward areas to ensure that we keep up to date with activity levels. This report goes to our Chief Nurse every week for quality and scrutiny purposes.
- We received a positive report from our commissioners regarding compliance with the Safeguarding Children Markers of Good Practice (2014/15). Two areas required further work (PREVENT training and the Safeguarding Children Training Programme). The Adult Safeguarding Team has rolled out the PREVENT training as part of the Adult Safeguarding level 2 update and the Safeguarding Children training programme was agreed for the training year of April 2014 – March 2015.
- We have supported a pilot of a multi-centre children's referral hub 'Starting Point'. (see below)
- We received positive feedback following the Safeguarding Adult Assessment Framework (SAAF) peer assessment process in July 2015 which highlighted on our ongoing commitment to safeguarding.
- We have updated the safeguarding children and adult training programme for 2016 to ensure it complies with national standards for learning and development.
- We continue to review our current support to teams, in light of new services and staff joining DCHS following the expansion of the Trusts business portfolio.
- We have reviewed DCHS' attendance and role at MARAC (Multi Agency Risk Assessment Conference) to ensure our obligations were met by adopting smarter administration processes.
- We have consulted with key partners both internally and externally to the organisation to review our current LADO (Local Authority Designated Officer) reporting systems. This has resulted in the development of a new pathway for use if safeguarding children allegations are made against staff.

### **Starting Point**

Starting Point is a multi-agency and multi-disciplinary process for ensuring that all referrals into Derbyshire County Council Children's Services (Call Derbyshire) are effectively dealt with and that information between agencies is appropriately shared and assessed in a timely manner. Starting Point provides a seamless approach to a child's journey through early help and safeguarding services and brings together the skills and expertise of a wide variety of staff to ensure the best possible outcomes for Children and Families. Derbyshire Children's Community Health Services (consisting of Specialist Community Public Health Nurses (SCPHN), supported by a community support worker and an administrator), police officers, social workers, family resource workers, youth workers, early years practitioners, business services and customer care assistants all working together to provide an integrated and consistent approach to this very important part of work.

Early indications from this pilot show that:

- co-location of partner agencies sharing the same accommodation and information improves responses to children in need
- relevant information for robust decision making is readily available and prevents delays. Key information shared by health has already been evidenced to influence decision making about future actions or ongoing referrals which ultimately contributes to improved outcomes for the children and young people involved
- the health team have been able to support the triage of domestic abuse referrals working alongside the police and social care.
- The process for undertaking strategy meetings following a safeguarding referral can be undertaken much more quickly if it is considered that a child or young person is at imminent risk of significant harm

### **Patient Safety Incident reporting & culture**

DCHS Staff continue to report a high number of Patient Safety Incidents (PSI), highlighted by NHS England's National Reporting & Learning System (NRLS) as a strong Patient Safety Culture. The high volume of incidents reported sometimes results in managers having incidents which are overdue a review and conversely, this is considered by the NRLS as a potential threat to this strength as assurance is lacking around the vigour of prompt follow up to address required actions.

Serious Incidents are those considered when harm caused is Moderate or Significant and in the majority of cases, will require further reporting to our commissioners. The Patient Safety Team process all serious incidents and check that those which are relevant are reported to the Commissioners within the required timescales. There has been positive feedback from both North and South Commissioners on the timeliness and overall quality of reports received.

### **National Reporting & Learning System (NRLS)**

The majority of Patient Safety Incidents reported onto the DATIX Risk Management System are communicated to NHS England's National Reporting & Learning System through an established coding system (with NRLS guidance) set up within DATIX and administered by the Patient Safety Team.

Incidents shared at this national level are pertinent in determining national trends and promoting national improvements e.g. the 'Four Harms' and the related Patient Safety Thermometer.

During the period April 2015 to February 2016, there have been a total of 8899 Patient Safety Incidents reported. Of these 6245 have already been communicated to the NRLS and a further 37 are in progress. At the time of reporting there were 636 in the DATIX system in the review process i.e. 572 awaiting review by Manager and 63 awaiting follow up by the Patient Safety Team.

### **Duty of Candour**

A Duty of Candour (DoC) policy has been approved in year and its introduction supported by training sessions for staff. The trust is committed to providing an open and honest explanation to patients and an apology where serious harm has occurred. A virtual training package is currently in development to assist leaders to have further discussions with their teams around the Duty of Candour.

### **Duty of Candour Reporting figures since September 2015**

Since September 2015 there have been 125 incidents meeting the Duty of Candour criteria.

DCHS have been embedding this new process into their operational activities since September 2015. The table below provides an account of how many incidents each month had completed the process by the month end. November and December saw the DoC process to be better embedded in the organisation and this now occurs routinely.

Date	Number	Status
September 2015	12	Unknown as process being embedded
October 2015	34	11 Pending 23 Completed
November 2015	36	2 pending 34 Completed
December 2015	20	2 Pending 18 Completed

### Never Events

Never Events are defined as incidents that are wholly preventable. Never Events are revised and relisted on an annual basis by NHS England. During 2015/16 there have been no “Never Events” reported by DCHS which meet the NHS England’s Never Events listed fields.

### Incidents by Severity

**Table 1:** During the reporting period 01/04/15 to 05/02/16, a total of 8,653 patient safety incidents (PSIs) were reported, of which 7984 resulted in No or Minor harm; 624 resulted in Significant harm of these 261 were inherited incidents i.e. pressure ulcer incidents observed on admission to DCHS and 38 resulted in Major harm; these all related to Grade 4 pressure ulcers( the most sever grade), except one where there was delay in diagnosis. There were 7 catastrophic incidents reported, additional details provided in Table below. The three tables below show a) Incidents’ trends by Category b) breakdown of Catastrophic harm incidents reported c) top five reported incidents and trends over the past three years.

Table a : Incidents by Severity	
No injury or harm	3324
Minor harm/injury	4660
Significant harm/injury	624
Major harm/injury including permanent disability	38
Death or multiple deaths or catastrophic event affecting DCHS (e.g. flood/fire)	7
<b>Totals:</b>	<b>8653</b>

Table b: A breakdown of Catastrophic harm incidents reported					
	Cardiac Arrest	Discharged with complications	Exposed to smoke	Ill health	Total
Cardiac Arrest	4	0	0	0	4
Discharge or transfer problem	0	1	0	0	1
Exposure to harmful agent	0	0	1	0	1
Unwell/illness	0	0	0	1	1
<b>Totals:</b>	<b>4</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>7</b>

Table c Shows the top five reported incidents and trends over the past three years. Incidents by Category NB Data for 2015/16 only to Feb 2016					
	2015/2016		2014/2015		2013/2014
Pressure relief care	3759	Pressure relief care	3,941	Pressure relief care	3,705
Slips, trips and	933	Slips, trips and	1,186	Slips, trips and falls	1,456



falls (patient)		falls (patient)		(patient)	
Medication	477	Injury or damage to skin (not pressure ulcer)	573	Ambulance/taxi transport issue	659
Injury or Damage to Skin (not Pressure ulcer)	475	Medication	457	Violence/abuse/harassment	615
Discharge or transfer problem	382	Ambulance/taxi transport issue	398	Medication	528
Totals:	6026	Totals:	6,555	Totals:	6,963

**Pressure Ulcer Management** – see pressure ulcer management section

**Ambulance/transport /taxi issues** - there has been a significant decrease in reported incidents and this category no longer features in the top 5 incidents. Work is currently in progress with ambulance providers to review the standard provision of equipment on vehicles due to recent concern around the provision of headrests. Partnership work continues on a regular basis.

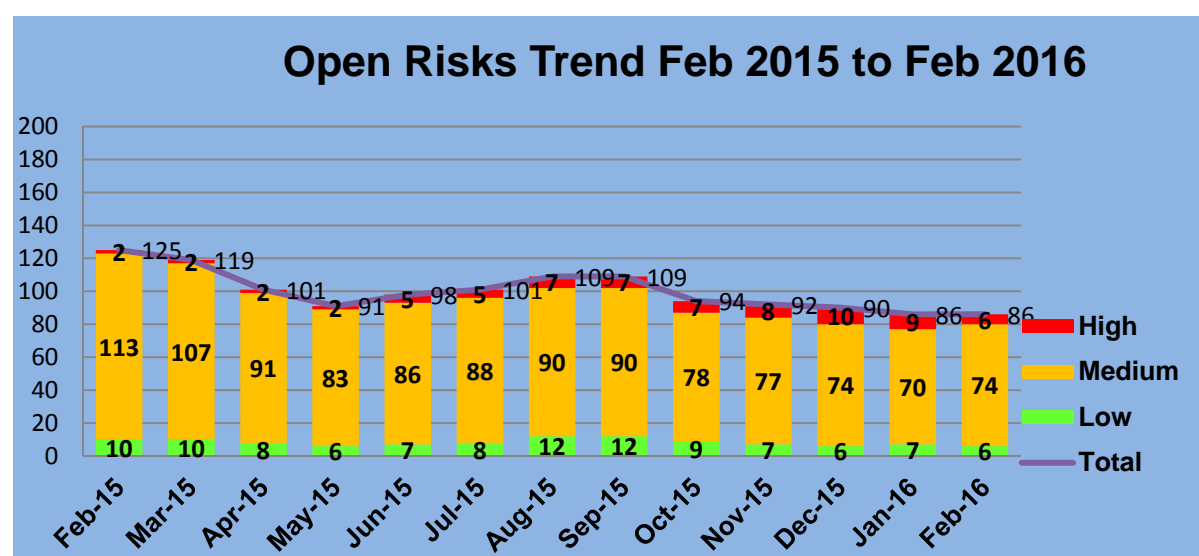
**Violence/abuse/harassment** - there has been further decrease in reported incidents related to patient violence and aggression. This is attributed to improved staff/patient ratios, resulting in improved levels of observation by staff, increased anticipatory/intervention measures and a reduction in the numbers of inpatients. This category no longer features in the top 5.

**Slips, Trips and Falls** – see falls management section

### Risk Management and other governance

Identification and mitigation of risks is a core element of our governance processes. Risks are reviewed on a regular basis by managers and all high risks are reviewed at least monthly by the senior operational and management teams and the Quality Services committee (QSC). The whole risk register is reviewed on a quarterly basis by the QSC.

The graph below provides a trend line for period February 2015 to February 2016.



### Training & other patient safety resources

Following popular and very good evaluation, Root Cause Analysis and Risk Management training continued to be provided by the Patient Safety Team during 2015/16 and will continue to be available on a monthly basis with additional and bespoke sessions arranged as required. An e-learning package has been developed in line with NHS Learning.

#### **Central Alert System (CAS) & STEIS**

The Central Alert System (CAS) is a national reporting system which distributes alerts from NHS England, alerting health organisations to safety issues. During April 2015 to February 2016 a total of 60 alerts were received. Each alert is reviewed for its relevance to DCHS and distributed to the services where the alert applies. All alerts were responded to within the required timeframes.

## Ensuring services are clinically effective

### Clinical Effectiveness

We ensure that the services we provide achieve meaningful outcomes for patients and carers in a variety of ways. Clinical Audit is one part of these. Our focus is to ensure that all clinical audit activity results in learning. We aim to demonstrate the clear links between clinical effectiveness measurement and improvements in patient care. We value participation in clinical audit to ensure that the care we provide is effective, responsive and safe.

### National clinical audits

We participate in National Audits that are appropriate to the community we serve and which will provide learning and outcomes that will benefit patients. During 2015/16 6 national clinical audits and 0 confidential enquiries covered relevant health services that DCHS provides. During that period DCHS participated in 50% of the national clinical audits and 0% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that DCHS was eligible to participate in during 2015/16 are as follows:

The national clinical audits that DCHS participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by terms of that audit or enquiry.

Title	Eligible	Participated	% Submitted
<b>National Chronic Obstructive Pulmonary Disease (COPD) Audit</b>	Yes	Yes	100%
<b>Elective Surgery (National PROMs Programme)</b>	Yes	Yes	62.5%
<b>UK Parkinson's Audit</b>	Yes	Yes	100%
<b>National Audit of Intermediate Care</b>	Yes	Did not participate due to capacity, data collection requirements and expected outcomes. Participation in this audit will be reviewed during 2016.	N/A
<b>Sentinel Stroke National Audit Programme (SSNAP)</b>	Yes	Postponed until 2016/17	N/A
<b>National Diabetes Foot Care Audit (Part of the National Diabetes Audit)</b>	Yes	Postponed until 2016/17 data collection is being integrated into the organisations Electronic Patient Record in 2016/17.	N/A

The table below outlines the 24 audits that are part of our DCHS Priority Audit Programme. It demonstrates the focus of the audit and learning outcomes identified.

### Priority Audit Programme – Audit Focus and Outcomes

No	Title	Outcome
1	<b>National Chronic Obstructive Pulmonary Disease (COPD) Audit</b>	This is a two part national audit, with a clinical audit reviewing service delivery and quality and a snap shot audit of resources and organisation of COPD services in secondary care and pulmonary rehabilitation. Results demonstrate that DCHS provides high quality pulmonary rehabilitation in line with national expectations. Improvement actions identified include: review and enhance referral pathway, review patient information leaflets, consider patient video's to educate others about the service. Review venue provision.
2	<b>Sentinel Stroke National Audit Programme (SSNAP)</b>	This is a two part national audit, with an organisational audit of post-acute stroke services to establish what services are commissioned and a clinical audit of patient pathway from admission to 6 months after discharge. The

No	Title	Outcome
		organisational audit is complete for Southern Derbyshire. All appropriate services have been identified and will be registered for the clinical audit in January. Our Electronic Patient Record is being configured to collect data for this audit.
3	<b>Elective Surgery (National PROMs – Patient Reported Outcome Measures Programme)</b>	This national audit seeks patient feedback regarding outcomes of selected surgical interventions, and measures health gain for patients via pre and post-surgery questionnaires. DCHS recruits Groin Hernia surgery patients to this audit. We have achieved a significant increase in patient recruitment in recent returns from less than 30% to 71.1%. Results show that 45.5% of our patients improved compared to a national average of 51%. Patient recruitment needs to increase further to support clinical learning as our activity for these procedures is small compared to acute trusts.
4	<b>National Diabetes Foot Care Audit</b> (Part of the National Diabetes Audit)	This national audit enables services to measure their performance against NICE clinical guidelines and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease. Before completing this audit a costing exercise was undertaken and we are now configuring our Electronic Patient Record (ESR) to record the audit data as part of clinician patient contact and plan to be participating fully from April 2016.
5	<b>UK Parkinson's Disease Audit</b>	This national audit assists healthcare professionals to measure their service against national guidelines. We have completed our data collection. Reports will be available in April 2016.
6	<b>Mental Capacity Act</b>	The goal for this audit is to make sure that people who lack the capacity to make decisions are cared for in a way that is consistent with their known wishes, and supported in the least restrictive and safe way. We are implementing the audit improvement plan re Deprivation of Liberties (DoLs) guidance for staff from last year's baseline audit for Older Peoples Mental Health Wards and Learning Disability Wards, before setting the re-audit date and a rollout plan for all other inpatient wards and other clinical services.
7	<b>Clinical Records</b>	The audit aims to ensure that optimum patient care is supported by clinical records that meet our standards. All clinical services participate on a rolling basis. The overall results for the last quarter are the highest since the July 2013 re-launch of the audit, which may in part be due to the rollout of our Electronic Patient Record to many clinical teams and services.
8	<b>End of life - Mortality audit</b>	The goal of this audit is ensuring that patients and carers have the right support and care at the end of their life according to the 5 Priorities of Care is. The overall results for Oct to Dec 2015 (the latest period reported) shows that there has been a significant improvement in addressing social and spiritual needs of our patients. A review of unexpected deaths did not identify any failings in care. We are addressing the problems some community teams have in participating in the audit, but for the majority who are participating, standards remain high. Triangulation with Quality Always data suggests that some resuscitation discussions with family members are not always recorded. We are strengthening feedback of results to clinical teams and promoting discussion about resuscitation with patients and carers. Death classified as unexpected will be reviewed urgently. The audit tool questions are being reviewed to ensure that they reflect all aspects of care.
9	<b>Identifying Learning Disability</b>	The objective of this audit is to ensure that people with a Learning Disability using any DCHS service are identified so that reasonable adjustments are made to personalise their care. Initial half year results indicate that significant work is required to utilise our Electronic Clinical Record effectively for this purpose. A communication plan will be developed to educate staff about the need for this information and how it can relate to improvements in patient care.
10	<b>Equality and Diversity</b>	This audit aims to ensure that patients' cultural, religious, gender and disability needs are documented sensitively, so that adjustments are made to ensure accessibility to our services. Data for this audit is collected via Clinical Records Audit sample, and will report at the end of the financial

No	Title	Outcome
		year.
11	<b>Pressure ulcers</b>	This is a baseline audit of key standards for prevention and management of pressure ulcers. This includes the capture of clinicians' perceived barriers to the delivery of consistent care, and links with the introduction and evaluation of Motivational Interviewing training. The staff consultation is now complete and the clinical records audit is on schedule. The findings have been widely shared and improvement actions planned include a review to free up Tissue Viability Team time to work more closely with teams (e.g. looking at how Skype could be used for consultations) and the development of Electronic Patient Record templates.
12	<b>Escalation of Care</b>	The goal of this audit is to ensure that patients receive the correct clinical intervention when their conditions deteriorate and are transferred appropriately is. Findings to date indicate that the Early Warning Score Tool was used correctly. Patients were transferred appropriately and in a timely fashion.
13	<b>Diabetes – Flo tele health</b>	This is an audit of the extended roll out of the Flo tele health project which supports people with Diabetes through smartphone messaging. A patient experience evaluation is planned for January 2016. Final report due in March 2016.
14	<b>Falls Prevention - Wrist Bands Evaluation</b>	The prevention of falls for those at risk is an essential part of maintaining the independence of people and avoiding further health problems. This audit is to review the impact of the coloured wrist bands project on inpatient wards. The results for July to September 2015 (the latest period reported) indicate that there were less inpatient falls than the same period in 2014. Inconsistencies between wards using wristbands and those that did not suggest that this needs a longer period to validate. The audit is ongoing.
15	<b>Falls Prevention - Assessment and Care Planning</b>	This is an audit of the falls assessment and care planning data collected as part of the Clinical Records Audit. The provisional data analysis for the half year shows an overall improvement in scores compared to the previous two years.
16	<b>Frail Elderly</b>	The aim of this audit is to look at the clinical effectiveness of admission avoidance/early acute discharge services for the frail elderly population. Audit taking place in Quarter 4.
17	<b>Treatment Cards (Medicine management)</b>	The objective of this audit is to ensure that all inpatients receive the correct medication to enhance their recovery and that medication treatment cards comply with prescribing and administration requirements on our wards.
18	<b>Omitted Doses (Medicine management)</b>	In this audit the standard to be measured is that prescribed medicines not given to inpatients for any reason are correctly recorded, to ensure that patient care is safe and effective.
19	<b>Community Prescribers</b>	The goal of this audit is to ensure that patients in the community receive safe and effective care from community prescribers. Audit currently taking place within Heart Failure and Minor Injury Units.
21	<b>Antipsychotic Prescribing</b>	The aim for this audit is to ensure that all inpatients on Older People's Mental Health wards are prescribed medication that complies with NICE Antipsychotic Prescribing Guidance. The audit is shared with the Derbyshire Healthcare NHS FT.
22	<b>Control of infection – Hand Hygiene</b>	This audit checks that staff prevent cross infection to patients by appropriate hand washing. In the most recently reported results 93.75% of services achieved 100% hand hygiene compliance which is a decrease of 3.85% from the previous quarter.
23	<b>Assess school readiness of children</b>	This audit is to examine the impact of children's services on school readiness. Report due in March 2016.
24	<b>UTI and catheter management in Community Nursing</b>	This audit is to measure practice against Urinary Tract Infection and Catheter Management standards. The aim is to reduce inappropriate prescribing of antibiotics and develop nurses' knowledge of catheter management and adherence to policy. Clear learning needs have been identified around the use of antibiotics in catheterised patients. An action

No	Title	Outcome
		<p>plan has been completed, including:</p> <ul style="list-style-type: none"> <li>• Adding training to Clinical Essential training</li> <li>• Follow up with individuals when incident reports identify incorrect practice.</li> <li>• Training of safe care champions.</li> <li>• A publicity strategy to circulate information to nursing staff</li> <li>• Provision of thermometers to the nurses within the continence team to check patient's temperature and a section to be added on DATIX form regarding recording the patient's temperature.</li> <li>• Re-Audit 2016/17</li> </ul>

To complement the priority audits we also have a service level audit programme. The table below gives examples of outcomes from a sample of audits from each division

#### Service Level Audits - Examples of outcomes from each division

Directorate / Service	Audit Title	Outcome
Health Wellbeing & Inclusion  Psychology	Health Psychology Service: Routine audit of impact of service on clients	<p>88.2% of those asked felt that their aims had been completely and mostly met. Satisfaction impact remains extremely high; quality of life and ability to cope are experienced as improved in excess of 90% of respondents; and over half of respondents report that they are reducing medical visits. There were 95 respondents. Of these 29.5% (28) hoped to reduce medication and, following treatment, 64.3% (18) of those who wanted to had done so. Occasional comments about waiting times not being satisfactory. An action plan has been completed including:</p> <ul style="list-style-type: none"> <li>• patients opt-in for first appointment,</li> <li>• institute a robust but compassionate DNA and cancellation policy,</li> <li>• offer immediate assessments give priority to the most urgent cases</li> <li>• offer a variety of "active wait" options (including providing advice, direction and signposting; offering relaxation skills training from our assistants; providing a distance-learning mindfulness course, offering a 2 session group intervention with an assistant)</li> </ul>
Planned Care  Speech & Language Therapy	Dosage of therapy delivered by Speech and Language Therapists (SLT) to children with Speech Disorders	<p>The audit has shown that more intensive therapy for speech sound disorders led to quicker achievement of therapy aims for the selected children. An action plan has been completed including:</p> <ul style="list-style-type: none"> <li>• Disseminate audit findings and discuss offering intensive sessions for children with speech disorders at team meetings in city and county</li> <li>• SLTs consider factors that indicate whether child is suitable e.g. maturity levels of child, child's resilience, motivation; level of engagement from school and family.</li> <li>• SLTs to plan diary time when offering intensive sessions.</li> <li>• SLTs consider needs of whole caseload before offering intensive sessions and consider that child may be discharged in a quicker timescale</li> </ul>
Planned Care  Physiotherapy & Occupational Therapy	To review compliance with injection policy and clinical reasoning for choice of injection	<p>The aim of the audit was to ensure that injecting service are as effective and efficient as possible in order to maximise the benefits for our patients. Results - 83% of known outcomes were improved. Timing of outcomes was recorded as there is much literature indicating that injections have better short term outcomes. The outcomes from this sample indicate that outcomes can be improved &gt;12weeks post injection A Final outcome was recorded for 94% of clinicians. When the notes were assessed none of the urgent cases had referred themselves back to either the MSK or physiotherapy injection services so it is possible that the injections had a good long term outcome. An action plan has been completed including:</p>



Directorate / Service	Audit Title	Outcome
		<ul style="list-style-type: none"> <li>Audit report to be shared and discussed with all clinicians who were audited and the DCHS injection special interest group</li> <li>Patient Management pathways to be reviewed to ensure that patients are referred to the correct clinician</li> <li>Audit to be rolled out to other injecting clinicians in DCHS</li> </ul>
Integrated Community Based Services (ICBS)  Erewash & Amber Valley (Babington)	Audit of patient feedback from the 4 harms group	<p>Most patients chose the informative, useful or enjoyable box. 1 patient in the last 6 months found the session not enjoyable (no comments why). A range of topics are effectively covered including pressure sores, falls, urine infections and blood clots.</p> <p>The size of the group has always been "good", An action plan has been completed including:</p> <ul style="list-style-type: none"> <li>Trying to do the groups more regularly for appropriate patients.</li> <li>staff from different community hospitals have been offered to come and shadow the groups.</li> </ul>
ICBS / South Derbyshire & Community Amber valley	Leg Ulcer Audit	The results from this audit have enabled the auditors to identify the most appropriate place of care for different diagnoses of leg ulcer and as a result a leg ulcer care pathway was developed to identify which patients should be cared for by DCHS and which should be cared for by Primary Care.

### Research and development

DCHS is committed to developing its research capacity and capability. Our Research Team provides support to staff across the Trust and works in partnership with other key research organisations in Derbyshire.

In 2015-16 DCHS patients have been recruited to the following national research studies which were approved by a Research Ethics Committee:

- Dementia and Imagination 11 (2014/15) 27
- Behavioural Activation Therapy for Depression after Stroke (BEADS): 7
- Cost effectiveness of aphasia computer treatment versus usual stimulation or attention control long term post stroke 12
- Development of a guided self-help Cognitive Behavioural Therapy Resource for the reduction of dental anxiety in young people aged 9-16 years 11

All these studies are on the National Institute of Health Research portfolio which means that this research is seen as having national significance.

Our participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. It means that our clinical staff are more likely to stay up to date with the latest possible treatments and active participation in research leads to successful patient outcomes. A Strategy for further development of research activity in DCHS has been approved by our Trust Board.

### Speech and language therapy – improving outcomes for patients

An important area of patient safety for the speech and language therapy service is the harm that can arise from eating/drinking and swallowing difficulties (dysphagia), including chest infections, malnutrition and dehydration. Speech and language therapists work with people who have dysphagia (and their carers) to increase their ability to eat and drink safely and effectively.

This year has seen the implementation of our new Early Intervention model, which allows adults with dysphagia to get help from our service much more quickly. This followed a period of higher than average referrals, which lead to longer waiting times for patients. We now triage and prioritise patients differently, and have employed some additional staff.

As a result, our average waiting time for an appointment has reduced from 49 days in January 2013, to 8 days in July 2015. The longest wait has reduced from 223 days in January 2014, to 26 days in July 2015. This is despite a continuing significant increase in referrals (increase of 34% between July 2014 and July 2015). Patients and carers have commented positively on our speedy responses.

We have also trained key staff in Community Hospitals to deliver basic awareness training in Dysphagia to their colleagues, so that all ward staff understand the impact of dysphagia on patients and how to ensure their patients can eat and drink as safely and effectively as possible.

We have worked with our colleagues in Community Paediatrics to develop a pathway for the referral and assessment of children with suspected autism, with more specialised staff undertaking the more complex assessments, to ensure a more coordinated approach and smoother journey through the complex multi-disciplinary assessment process, in line with NICE Guidance.

We have recently adopted the new technique of Voice-Banking for patients with Motor Neurone Disease. The patient records their own voice at an early stage, and this is then programmed into a computerised communication aid for use when they are no longer able to use speech, meaning they can continue to 'talk' with their own voice even though they are using a communication aid.

### **Insight visits**

As part of the DCHS Assurance model; our newly designed Insight visits commenced in July 2015 and superseded our quality and safety visits. The visits take place in all care settings across the trust. Insight teams include a senior staff manager from the visited service, a member of the Trust Board and a public Governor. The Insight visits offer a great opportunity for staff to share successes, achievements, suggestions and the day to day challenges they face; as well as to showcase the area which staff work. As part of the visit the Insight team talks to patients and clients, to find out more about their experiences.



## What we have done to improve patient experience?

### Caring Always – The DCHS Experience

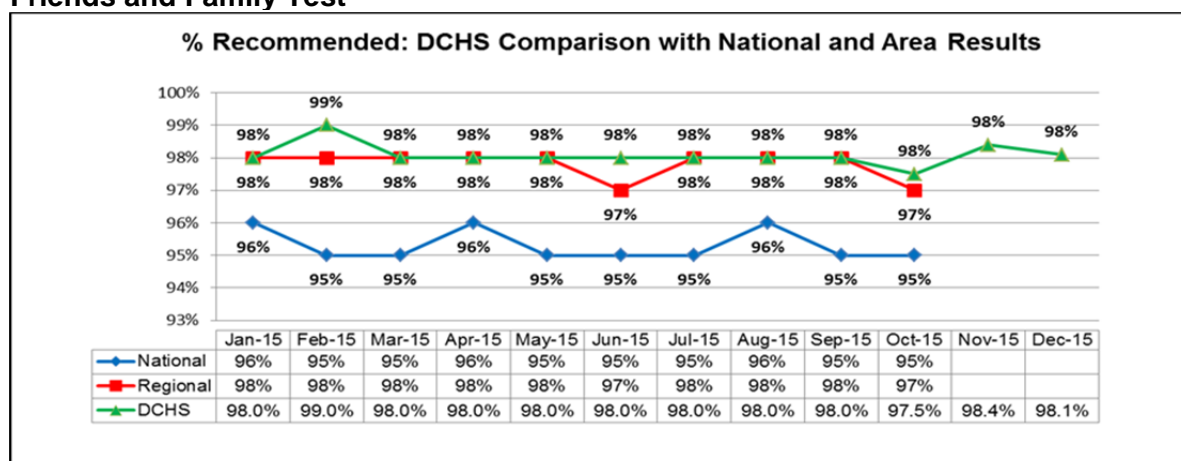
We have made 8 promises about what it should feel like to use our services. We call these promises 'Caring Always'.

1. During your time with us you will feel welcomed and valued. You will feel that your care meets your individual needs.
2. You will have the opportunity to discuss with us what is going to happen at every stage.
3. You will understand the choices that you can make about your care. You will be supported to make the best choices for you.
4. You will have all the support you need to feel comfortable and safe.
5. You will know who is providing your care and what to expect. You will have clear information about how and when they can be contacted.
6. You will feel confident that you are being looked after by well trained staff who have the time to care.
7. You will feel able to choose how much we involve your family, friends and carers.
8. You will feel able to tell us how we could improve.

### Feedback

The promises tell patients and their families how it should feel when they access our services. We ask for comments about how we keep these promises and we use this feedback to make improvements. There is a range of ways for people to give us that feedback.

### Friends and Family Test



16801 patients completed the Friends and Family Test this year and 98% would recommend DCHS to friends and family. This compares with 97% in the previous year. We also ask patients to tell us about their experiences and how we could improve the services they used. The comments we receive are used to make improvements in local services and are shared across the organisation through "You Said, We Did".

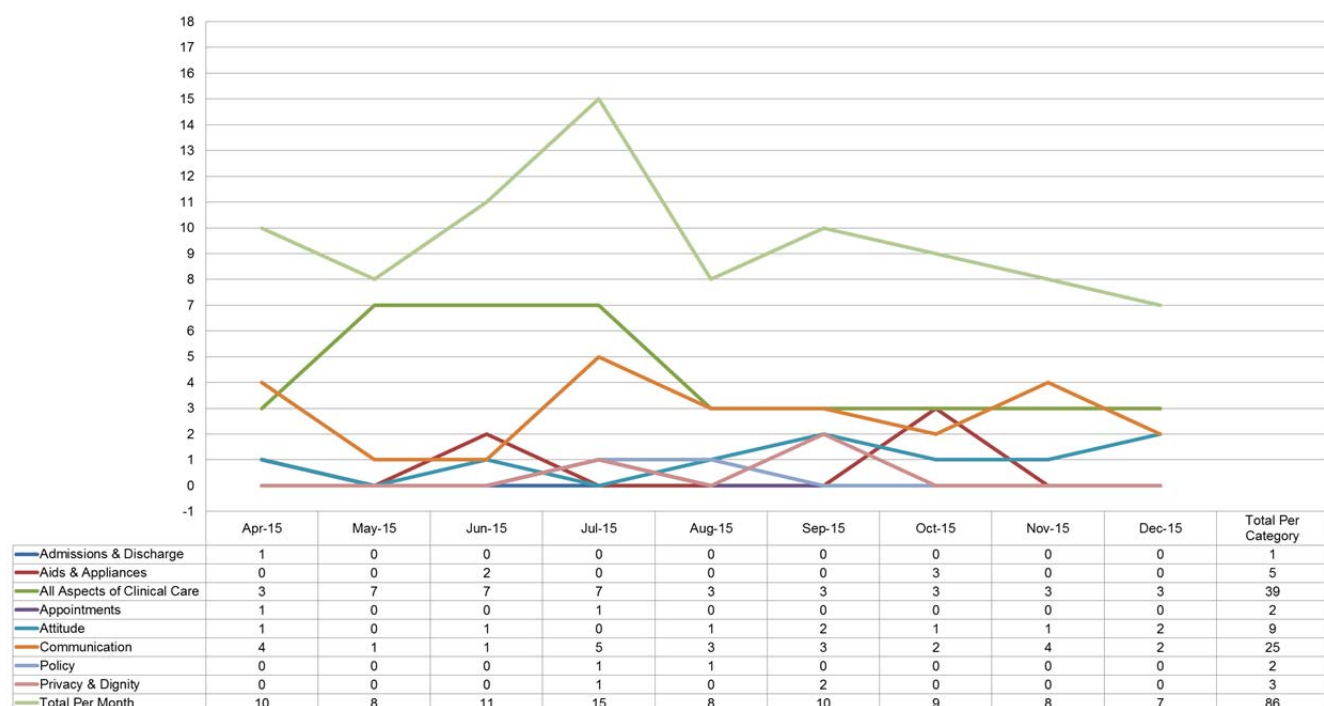
Examples of Improvements are given below:



### Complaints

During Quarters 1-3 in 2015/16 the Patient Experience Team received and responded to 386 enquiries, concerns and complaints compared with 583 in (full year) 2014/15 (these figures have not been adjusted for any change in our service or activity). Of these, 86 complaints required an investigation under the NHS complaints process. Two complaints were referred to the Parliamentary and Health Service Ombudsman, one of which has not been upheld and one was partially upheld.

DCHS Complaints (Level 2, 3, 4) Trends and Themes by Subject (April 2015 to December 2016)



## Patient Led Assessments of the Care Environment (PLACE)

### Results summary for DCHS for 2015

PLACE is a system for assessing the quality of the care environment and involve local people working alongside trust staff in assessing the quality of patient areas across a range of criteria including privacy and dignity, food cleanliness and general building maintenance> for the first time this year assessments of the environment meeting the needs of patients with dementia have been included

The **percentage scores** for each category below have been awarded by the NHS Information Centre based on the information returned by us for our 2015 assessments. All assessments were delivered through self-assessment. The programme was undertaken between March and June 2015.

Hospital	Cleanliness		Food		Privacy & Dignity		Condition & Maintenance		Dementia	
	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015
Ash Green	99.91	100	92.86	93.62	86.93	96.77	97.59	94.85	*	73.48
Babington	98.76	99.79	97.47	94.79	91.83	90.45	91.88	91.96	*	82.92
Bolsover	99.60	99.18	97.45	87.79	59.22	86.16	98.00	96.64	*	82.92
Cavendish	99.78	100	94.89	96.97	81.80	87.81	95.92	94.48	*	72.80
Clay Cross	99.72	98.83	96.61	96.93	80.47	71.35	96.15	92.65	*	72.80
Ilkeston	98.75	99.15	96.06	97.23	91.83	81.40	98.29	89.88	*	74.31
Newholme	99.79	100	96.88	97.16	87.20	83.12	95.63	94.44	*	81.77
Ripley	99.35	100	93.54	93.66	92.61	92.71	96.97	96.09	*	79.93
St Oswalds	100	99.61	94.99	97.21	94.15	92.19	98.71	100	*	80.16
Walton	100	99.86	90.83	83.51	92.42	89.68	95.08	95.45	*	85.67
Whitworth	99.78	100	93.13	97.39	85.20	90.19	98.40	97.06	*	86.60

*\*Dementia 2014 – not reported on in 2014, new for 2015*

**Dementia-Friendly Environment** – this element is drawn up from environmental assessments produced by The King's Fund and Sterling University. The assessment covers: flooring, toilets, toilet signage, general signage, décor and catering for patients with Dementia.

The overall scores for our hospitals were very favourable, as indicated below:

	Cleanliness	Food	Privacy & Dignity	Condition & Maintenance	Dementia
2015	96.67%	94.13%	87.43%	94.86%	79.73%
2014	99.59%	94.97%	88.51%	96.60%	Not reported on

	Cleanliness	Food	Privacy & Dignity	Condition & Maintenance	Dementia
National Average Score 2015	97.57	88.49	86.03	90.11	74.51
DCHS Scores 2015	99.67	84.13	87.43	94.86	79.73

DCHS Hospitals have achieved a score above the National Average for Cleanliness, Food, Condition and Maintenance, Privacy & Dignity and Dementia.

### **Dementia friendly environments**

This was the first year that the hospitals were scored against the Dementia Environment standards, the OPMH wards fared better than the general medical wards and the out-patient areas.

Some of the areas DCHS scored low on were:

- That the flooring in most areas has either a pattern or fleck in the design
- A lot of wards and out-patient areas did not always use contrasting colours for the hand rails in corridors and contrasting toilet seats / hand rails in the bathrooms and toilets.
- Most of the ward areas didn't have the name of the hospital displayed (only the ward name)
- Signage was not always at a recommended height of 1.21 metres
- Toilet doors are not always painted in a single distinctive colour (yellow is the normal colour used)

The trust is committed to significantly improving its score in this area and will be working with the estates team during the coming year to address deficits

### **Equality, Diversity, Inclusion and Human Rights**

DCHS is committed to achieving equality, celebrating diversity, fostering a culture of inclusion and respecting Human Rights. As an NHS organisation, we have both a legal and moral duty to demonstrate fairness and equality to our patients and services users, their carers and families, and to our employees.

We understand and appreciate that everyone is an individual, with different needs and requirements. People have very different life experiences and sometimes face many challenges and barriers to accessing our services and opportunities.

We also recognise that it isn't simply access to our services that's a challenge – it's important to ensure that people get equitable outcomes from the care they receive from us. We want to provide a wide range of quality health services that are designed to meet people's individual needs. We are committed to personalising our services to ensure that the most positive outcome is achieved for all.

We take seriously our duties under the Equality Act to eliminate the unlawful discrimination of both our staff and service users, to advance equality of opportunity for all and to foster good relations between all people. We are implementing NHS England's Equality Delivery System 2 (EDS2), which provides a framework for us to monitor and improve our equalities practice.

Board members have established an Equalities Forum which enables employees from under-represented groups a direct line to the Trusts most senior leaders, to raise issues and concerns and to secure support. They are also mentoring members of the Trusts Employee Network Groups. We are establishing our 'Equality Allies' programme to engage the whole workforce, Governors and Board in the agenda and to ensure we achieve positive and sustainable change

During 2015/16 DCHS has:

- Continued to embed our equalities strategy
- Developed staff, Public Governors' and Board members' understanding and build competencies around Equality, Diversity, Inclusion and Human Rights
- Improved access to our buildings
- Produced and published annual workforce equality data and used this to work with our staff on what is important to them
- Used our Equality, Diversity and Inclusion Leadership Forum (EDILF) to coordinate action across the Trust
- Continued to work with our Access to Healthcare Forum (A2HC), which is representative group of service users with protected characteristics.
- Utilised our award winning equalities forum theatre group to train our staff and raise awareness nationally
- continued to support our three Employee Network Groups for our BME, LGB&T and disabled staff and their allies
- improved our ranking in the Stonewall Workplace Equality Index to 171st
- begun to implement our Internship Programme for people with a Learning Disability, in collaboration with Chesterfield College, as part of NHS England's programme to increase the employment of adults with a learning disability across the NHS

### **Our future plans**

Over the coming 12 months, we will focus on:

- improving the collection of information about our employees and our service users; we need to ensure that we always know what people's individual needs are and that we can meet them
- ensuring that we provide information and communication in an accessible way that needs the meets the needs of individual service users and employees
- Implementing actions to achieve a more diverse workforce, including tackling unconscious bias in our recruitment and selection processes
- continuing to build cultural competence and raising awareness around equality, diversity, inclusion and Human Rights across the whole organisation at every level.

### **Healthcare for All (HC4A)**

Healthcare For All (HC4A) was the title of the report from the independent inquiry into access to healthcare for people with learning disabilities, led by Sir Jonathan Michael.

The inquiry found that people with learning disabilities...

- Generally have worse health than everyone else
- Find it harder to get treatment for health problems that are nothing to do with their learning disability
- Health services often do not adjust the way they do things to make it easier for people who find it hard to communicate or understand
- Parents and carers of people with learning disabilities often struggle to make themselves heard even though they have the best information about the people they support
- Staff who work in general health centres often do not know enough about disability
- The different parts of the health service often don't communicate with each other very well

There are six criteria for Monitor's Risk Assessment Framework (MRAF) and these are:

- 1) Criteria 1 - Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?
- 2) Criteria 2 - Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: i) treatment options; ii) complaints procedures and iii) appointments?
- 3) Criteria 3 - Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?
- 4) Criteria 4 - Does the NHS foundation trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?
- 5) Criteria 5 - Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?
- 6) Criteria 6 - Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings?

DCHS can confirm

- it is compliant with all MRAF in relation to its 6 criteria that relate to people with learning disabilities who use any of our services
- the completion of equality monitoring information is now a key performance indicator for the Trust, with 100% achievement target by end March 2016
- that work is progressing to understand the needs of our service users and to ensure we make all reasonable adjustments required
- we are now part of NHS England's Learning Disability Employment Project, which aims to increase the employment of learning disabled adults in NHS organisations.

#### **Areas for further development:**

A key priority for the trust this year is to improve our equality monitoring of patients. Current completion data shows that only 33.3% of services are completing the equality monitoring questionnaire on TPP / SystemOne. The original year end trajectory target was 100% of services. This features as one of our Big 3 quality targets and will continue as one in 2016/17. The Equalities Task Group is leading the improvement of this and has created an action plan.

An Inclusive Communication project has been proposed through the Patient Experience and Engagement Group that will equip employees to make adjustments to the way information is provided, face to face communication is conducted and how best to support involvement for any person with a communication barrier. Work being undertaken on implementation of the Accessible Information Standard (AIS) will support this piece of work and ensure that the information we have is made accessible to all through formats such as Easy Read and British Sign Language (BSL).

Greater emphasis on learning disabilities will be incorporated into our learning and development sessions at both Induction and Essential Learning. This could form part of the current Equality, Diversity and Inclusion sessions which are being allocated more time to ensure adequate coverage of this important subject. The Equalities Forum Theatre Group, with its diverse membership, could

be used more effectively across the organisation to communicate how to identify poor practice and what actions should be taken to improve users' experiences

### **Making every contact count**

Making every contact count (MECC) has been a successful initiative across DCHS since 2010, raising staff awareness of their responsibility to help patients, carers, families, friends and colleagues to adopt a healthier lifestyle. We have increased staff awareness of MECC by providing training and awareness raising sessions to over 3,500 DCHS staff. We have amended our documentation to make sure we can identify and audit MECC activity, which helps patients and staff to address lifestyle choices that are impacting on their personal health. The initiative is now truly embedded in the culture and ethos of the Trust with staff seeing MECC as part of their role.

### **Older people's mental health**

**OPMHS dedicated physiotherapy service** – Following agreement to fund 2 senior physiotherapist posts, dedicated to reducing the risks of patient falls in our inpatient services, we have successfully employed 2 suitably experienced and highly motivated physiotherapists. Whilst it is too early to draw definite conclusions from the evaluation of the impacts of their service on reducing patient falls carried out so far, early indications are positive both in terms of the effective management of the risks of patient falls as well as positive patient experience of these services overall. Plans are in place to, along with the DCHS falls leads, continue to develop and evaluate the service impacts and to identify and share with other DCHS, the good practice lessons that we identify as part of the evaluation exercises.

### **(LD/OPMH) Implementation and integration into DCHS governance and practice, the requirements of the new Mental Health Act Code of Practice ( MHA CoP), published April 2015**

The new MHA CoP, published in April 2015, in its development, underwent extensive review and revision with the inputs of both mental health professionals, lay people as well as users of mental health services; including those individuals with direct experience of being treated for mental ill-health under the provisions of the MHA 1983.

DCHS Service leads from LD and OPMH have worked throughout 2015 in order to ensure that the mental health care we provide is of the highest quality, is safe and of course, is lawful. In order to achieve this, we have undertaken comprehensive and exhaustive review and revision of our mental health care governance framework to ensure that it is fully compliant with the changes that have been made to the new MHA CoP. Included in this review we have reviewed areas of policy and procedures which guides the practice of our clinicians, and 'Mental Health Act Managers. In addition, we have identified a number of significant areas of 'Essential Learning' required by our clinical staff and Mental Health Act Managers which the new MHA CoP makes specific and particular reference too. These areas of essential learning include re-designed Mental Health Act process training and the training of clinical staff in support of them understanding and deploying the principles of Positive Behaviour Support planning (PBSP).

PBSP is a vitally important tool in care planning for individuals who have 'behaviours that challenge' as a feature of their mental ill-health. As an approach, it ensures that the individual is a partner in planning their care and therefore at the centre of the process and that through this approach, care can be delivered which supports the principles of high quality safe care which is least restrictive.

### **Specialist Learning Disability services**

#### **Transforming Care**

The Department of Health, Winterbourne Review, Transforming Care Concordat commits to a programme for change to transform health and care services and improve the quality of the care to ensure better care outcomes for people with a learning disability.

DCHS specialist learning disability services are actively involved in the Derbyshire wide Transforming Care project. We attend the joint 'Transforming Care' Operational group to review each of the cases and assist in the development of plans for those service users who are moving back into North Derbyshire. Where service users move back and require on-going support from specialist services we work jointly to develop patient centred plans that meet individuals needs.

A number of people have returned to North Derbyshire communities and our Community Learning Disability Teams (CLDT) have played a key role in their ongoing management and support of their individual plans. Our learning disability staff are continuing to develop the Challenging Behaviour Pathway which is in line with Positive Behavioural Support and the Department of Health's guidance on positive and proactive care.

Care and treatment reviews (CTR'S) have taken place for all individuals who meet the Transforming Care criteria and for those people who have required an in-patient admission. This is National identified good practice which we have embedded into our operating procedures.

### **Unveiling of new sensory rooms at Ashgreen**

In May 2015 Service users and their families, along with staff and governors celebrated the reopening and official naming of the Robert Frederick Sensory Rooms at Ashgreen, Specialist Learning Disability Service.

Following a generous bequest, the sensory rooms underwent a major refurbishment to create state-of-the-art sensory facilities for therapeutic and treatment purposes for people with learning disabilities. The refurbishment allows us to provide a safe environment from which we can provide a quality service and user experience and by providing very specific equipment and systems we are able to respond to the individual needs of service users with sensory integration problems which in turn will help support them in managing their daily lives within the community.

### **Home from Hospital**

This initiative provides 6 weeks of practical support to help patients settle back into a normal routine and to build their confidence and independence after a stay in hospital. Volunteers provide support with activities like shopping, dealing with bills and utility suppliers, making sure pets are looked after, collecting/returning library books, collecting medication, and generally befriending the person when they return home. The project currently has 35 trained volunteers, all having completed a bespoke volunteer training day and having an up to date enhanced DBS certificate in place in line with the requirements of the Lampard report. Since the first visit took place in April 2015 the service has received over 90 patient referrals. The feedback using the Friends and Family Test shows that all the patients that have received volunteer support would be extremely likely to recommend the service. The Home from Hospital project was initially funded by NESTA ( an independent charity that works to increase the innovation capacity of the UK) and the service will continue to develop over the year to come.

### **Patient Stories**

Every meeting of our Trust Board, Quality Services Committee, Council of Governors and Patient Experience and Engagement Group starts with a Patient Story. The stories are either told by a member of staff or by a person who used our services. They provide a very powerful and human account of the way that DCHS care impacts on individual people and families. We aim to hear about the positive impact of our services (for example from a patient who had been empowered to lose over half of her body weight) as well as where improvements have needed to be made (for example where our care fell short of what we expect to provide and how this experience impacted on the patient). Members of the Board or committee that hear the story are often challenged and moved by what they hear, lessons are identified and actions agreed. The telling of the story at the start of the meeting sets the tone for the remainder of the agenda, 'putting the patient in the room', and ensuring that the patient is at the centre of everything we do. Our Quality Services committee



has followed this lead and now present a staff story at the start of each of their meetings these stories help us to better understand the issues and challenges our staff face and how we can support them and become a better employer.

## Improving care for patients at Bolsover

DCHS prides itself on being a learning organisation and we have worked hard to improve our trust wide assurance processes. In the spring of 2015 we identified that care in our inpatient service at Bolsover hospital was falling below the standards we would normally expect. A series of clinical incidents including two serious patient falls and complaints from some of our patients resulted in us undertaking a systematic review of this clinical area. This identified further concerns regarding clinical leadership. Over the course of a number of months our professional standards team worked with staff to review practice standards and to implement an action plan to drive improvements. A change in clinical leadership and focused effort from a reconfigured clinical team is now resulting in consistently high standards of care evidenced through improving Quality Always peer review outcomes and good feedback from patients and carers. A lessons learned exercise was undertaken at the end of the year which identified important learning for the organisation.

## Ensuring our services are responsive to patients' needs

### Minor Injury Unit waiting times

DCHS has four Minor Injury Units providing urgent care as part of the wider out of hours and emergency care pathway across the health community. Ensuring our patients receive timely care is a key priority and this is measured against a four-hour standard set by the Department of Health. As the table below illustrates we have performed well in this area.

**DCHS considers that this data is as described for the following reasons:** there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the trusts data kite mark quality assurance system.

2013/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14 Outturn
4 Hour Wait for A&E Attendances (%)	99.8 %	100.0 %	99.9 %	99.7 %	99.9 %	99.9 %	99.9 %	99.9 %	99.9 %	99.7 %	99.8 %	99.9 %	99.9%

2014/15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Year to Date
4 Hour Wait for A&E Attendances (%)	99.5 %	99.8 %	100.0 %	100.0 %	99.9 %	100.0 %	100.0 %	100.0 %	99.9 %	99.9 %	99.9 %	99.5 %	99.95 %

2015/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Year to Date
4 Hour Wait for A&E Attendances (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%

DCHS will continue to monitor the quality of its services using its Quality improvement and assurance framework and to work with the wider health community to maintain the high percentage performance within its minor injuries departments.

### Comparative Data A&E 4 Hour Wait

It should be noted that DCHS emergency provision is limited to four minor injury units and that comparative data includes data from type 1 accident and emergency departments.

Period	Performance	Rank	Total In Cohort	Nat. Average	Highest	Lowest
Q3 2014/15	99.96%	73	247	95.0%	66 Trusts	Cambridge University Hospitals NHS Trust
Q4 2014/15	99.94%	78	245	94.2%	67 Trusts	Hull & East Yorkshire Hospitals NHS Trust

### Referral to treatment times

When our patients need care we aim to see them and undertake their treatment as quickly as possible. The table below reports on our performance in year against the 18 week referral to treatment times and demonstrates that performance has been consistently good in all areas.

DCHS considers that this data is as described for the following reasons: there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the trusts data kite mark quality assurance system.

2014/15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Year to Date
Referral to Treatment Times Incomplete pathway (where treatment is part of a pathway) against a standard of 92%	99.0 %	99.0 %	100.0 %	98.9 %	99.4%	98.0 %	98.0 %	97.8 %	98.8 %	99.9 %	99.9 %	97.65 %	98.86 %
RTT Waits - admitted patients seen within 18 weeks - 90% (target) (%)	94.0 %	95.0 %	93.3 %	93.1 %	90.1%	94.7 %	95.2 %	92.8 %	95.5 %	93.3 %	92.5 %	94%	93.63 %
RTT Waits - non admitted patients seen within 18 weeks - 95% (target) (%)	99.0 %	99.0 %	99.2%	98.6 %	100.0 %	98.5 %	97.5 %	99.6 %	98.4 %	98.8 %	98.9 %	98.9%	98.87 %

2015/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Year to Date
Referral to	97.9%	99.2%	97.9%	97.6%	97.5%	95.2%	97.6%	98.0%	97.9%	97.7%			

2015/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Year to Date
Treatment Times Incomplete pathway (where treatment is part of a pathway) against a standard of 92%													
RTT Waits - admitted patients seen within 18 weeks - 90% (target) (%)	95.3%	96.5%	95.7%	96.6%	95.0%	97.5%	94.9%	94.9%	94.0%	94.4%			
RTT Waits - non admitted patients seen within 18 weeks - 95% (target) (%)	98.1%	98.4%	97.0%	97.8%	99.9%	97.0%	98.0%	97.3%	97.3%	97.7%			

*Consultant led Referral to Treatment Schedule in Weeks (January 16) Clocks ended in January: Admitted Patient Care (Part 1A – unadjusted)*

Speciality	Total weeks waiting								18 weeks	
	0-6	7-12	13-17	18+	Total Waiters	Max Waiter	>6 week waiter	% waiting over 6 wks	>18 week waiter total	% waiting over 18 weeks
Derbys Dental	33	54	9	0	96	16	63	0%	0	0%
Leics Dental	19	35	15	4	73	38	54	0%	4	0%

*Consultant led Referral to Treatment Schedule in Weeks Clocks still running (Part 2)*

Speciality	Total weeks waiting								18 weeks	
	0-6	7-12	13-17	18+	Total Waiters	Max Waiter	>6 week waiter	% waiting over 6 wks	>18 week waiter total	% waiting over 18 weeks
Derbys Dental	68	49	5	0	122	15	54	0%	0	0%
Leics Dental	68	78	11	3	160	24	92	0%	3	0%

DCHS intends to develop the data collection and validation processes for the RTT indicator for dental pathways in advance of including the figures within the 2015/16 quality report. – need this figure

**Comparative data – Referral to Treatment Times Incomplete Pathway – needs to be update**

Period	Performance	Rank	Total In Cohort	Nat. Average	Highest	Lowest
Feb-15	99.00%	26	187	94.4%	Northamptonshire Healthcare NHS Foundation Trust	North East London NHS Foundation Trust
Mar-15	97.60%	45	186	94.4%	Bradford District Care Trust	North East London NHS Foundation Trust

## Delayed transfers of care

**DCHS considers that this data is as described for the following reasons:** there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the trusts data kite mark quality assurance system.

Comparative data - DTOC Monitor Compliance Calculation

No national comparator data available

2013/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14 Outturn
Delayed Transfers of Care	2.4%	4.9%	6.0%	2.8%	4.5%	8.3%	7.7%	10.0%	10.6%	6.2%	7.8%	7.0%	6.6%

2014/15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Year to Date
Delayed Transfers of Care	7.1%	3.2%	4.6%	4.3%	5.3%	3.8%	8.7%	8.7%	7.9%	4.7%	3.7%	1.0%	6.1%

2015/16	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Year to Date
Delayed Transfers of Care	11.5%	8.1%	8.3%	11.1%	9.0%	11.7%	9.2%	6.7%	9.0%	9.8%			

DCHS has taken the following actions to improve the delayed transfers of care percentage:

- we have reviewed the clinical pathway management within our older peoples mental health wards and
- worked with partners across health and social care to ensure that effective discharge plans are in place for patients.

DCHS has continued to proactively manage the flow of patients across in-patient beds in the Community Hospitals to minimise the overall incidence of Delayed Transfers of Care (DTOC). The rehabilitation wards DTOC figure has risen from 9.00% in December 2015 to 9.8% in January 2016. This has been due to a combination of increased demand for Health and Social Care services across Derbyshire and the complexity of the discharge planning for some individual patients some of which is due to patients waiting for Continuing Health Care Assessments.

### Patient Experience/New Service – Breakfast Club Baron Ward Babington Hospital

Breakfast club is a therapy lead group that is currently run on Baron Ward – 2/3 times per week from 8 - 9.30am – max 4 patients per group session. The group is run by two members of the therapy team with support from housekeeping.

Patients are referred by qualified staff (OT/PT) following ward based assessments, and determination of goals based on need to prepare own breakfast/make hot drinks on discharge. Priority is given to all patients who are approaching discharge. Mobility, functional tasks and equipment are all addressed within the group alongside increasing patient confidence, re-establishing roles and routines the group also offers patients the opportunity to socialise with other patients planning for discharge. Patients must be medically fit to attend the group. Feedback forms are completed with patients after each session and audited monthly. Overall feedback has achieved 100% in most areas, which is very positive.

Following a recent Insight Visit in October 2015 on Baron Ward – Carolyn White (Chief Nurse) highlighted how valuable the Breakfast Club was. Therapists from other DCHS sites have

shadowed the breakfast club and have now implemented the group at Ripley, Ilkeston and St. Oswalds. Therapy staff at Clay Cross also keen to start the group and share information.

### **Discharge Home Visits - Ilkeston**

Discharge home visits have been carried out since 2014. The Occupational Therapist (OT) anticipates equipment, services and support required prior to discharge so that they can assess them in their own home enabling the Therapist to leave them if it is safe to do so.

The Therapist are also carrying out discharge visits using a pool car so there is more flexibility to carry out the visit to fit in with times family, OT and social services are available.

Verbal feedback from the patient has demonstrated that the patient feels confident to remain at home as the OT will go through discharge arrangements such as medication, any follow up by Community Rehab Team or outpatient appointments.

It has also improved the patient's experience as the patients have reported that they feel reassured that they will manage at home and the OT can settle the patient in especially if there are no family/friends present. By carrying out discharge visits it has led to reduced length of stay on the wards as the patient is not waiting for a care package to be arranged following a home assessment.

### **Changes to the 5-19 Public Health Nursing Service.**

School nursing services have faced major change over the last 12 months following the full transfer of public health commissioning to local authority. This generated the tender process of the 0-19 services which resulted in DCHSFT successfully winning the contract to deliver the public health services to children, young people and their families across Derbyshire.

October 2015 saw the start of the contract for the 5-19 school nursing service. Following the transfer of staff from other organisations, DHCSFT became the sole provider of this service and began to deliver elements of the healthy child programme which supports children and young people's health and development.

School nurses, with their teams, are co-ordinating and planning delivery of public health interventions for school-aged children. The nature of their work requires clinical input and effective leadership, which qualified school nurses are equipped to provide. They are the single biggest workforce specifically trained and skilled to deliver public health for school-aged children (5-19). Being in a unique position within community and education settings allows them to support multi-disciplinary teams, provide a link between primary and secondary care, manage relationships between child, family and school settings and are trusted and valued by children and young people.

### **Care Home Advisory Service**

We have worked on developing one to one training on falls prevention for care home managers. This has been personalised care planning on an individual care home basis. This has taken into account the specific needs of each manager, which varies hugely between care homes. The main aim has been to increase each manager's understanding of pre-disposing factors to falls and by this, to try and prevent them occurring.

We have worked with them to review their falls process by: supporting paperwork development, more effective risk assessment, onward referral to other services and staff education. We have also helped to review specific extrinsic factors that could be made safer within the care home environment.

Positive results have included care homes improving their reporting process via staff education to give more specific information for the manager to review. They are able to better identify any patterns of causes of falls, which can then be addressed appropriately for prevention purposes.

Care homes have improved their risk assessment information and analysis in particular to look at those residents who frequently fall. They have also added to their documentation to include monthly checks of extrinsic factors that could cause falls, taking the appropriate actions as needed. Analysis of number and type of falls is on-going.

### **New Services / Development of the Care Home Support Service in Erewash**

After successfully bidding for one of the Prime Minister Challenge fund project commissioned by Erewash CCG we are working with our GP and pharmacy colleagues to provide services to residents in care homes across Erewash.

A team of Advanced Nurse practitioners, care coordinators and staff nurses carry out ward rounds and medical reviews within the care homes on a regular basis and provide an emergency response to residents in crisis. The team can monitor people health needs and offer advice and support to the care home staff and relatives. Our aim is to keep people healthy in their care home, prevent them from going into hospital and free up GP time so they can be more dedicated to people visiting their practice.

Since the project started in October 2014 we believe we have prevented over 350 unnecessary admissions in the 17 care homes we are now working with and we hope to expand to cover the remaining homes in Erewash over the next year.

One GP said –“ the positives of having the Care home support service working with me is that it has reduced the number of visits and phone calls I get ; both of which we used to get daily.”

A care home manager said “The range of care home services and care which has been available directly to the residents through this service to ensure they receive the care they need has been and still is outstanding”

### **New Services - Virtual Ward**

Derby Hospital Foundation Trust, Derbyshire Community Health Services, Derbyshire Healthcare NHS Foundation Trust, Southern Derbyshire Clinical Commissioning Group & Derby and Derbyshire Social Care services have been working together to improve and streamline the care of acute care based patients through the development of a new care pathway called the Virtual Ward.

The virtual ward is a model which provides an enhanced package of health and social care, provided within a patient's own home. The current service model enables existing in-patients to be discharged home from hospital earlier than would have traditionally been possible. It is an alternative pathway for those patients who do not require acute medical in-patient support, but do require on-going intensive therapy and/or nursing care. Whilst on the virtual ward, the medical responsibility is with their own registered GP.

An integrated team of clinical therapy and nursing staff provide care to patients on the virtual ward, with the assistance of support staff. The team aim to support people to leave hospital earlier and prevent any unnecessary readmissions. Every patient on the virtual ward is reviewed on a weekly basis, or more frequently if required, by a senior clinician and discussed with the wider multi-disciplinary team at the 'virtual' ward round.

An initial rapid assessment is undertaken within the patient's own home and includes delivery of an immediate personalised care plan including both health and social care as required. This is supplemented by close monitoring and re-assessment of progress and need, with care packages amended accordingly. Staff provide training and education for patients in order to support self-care and management of any long term conditions, rehabilitation and re-ablement needs, with the aim to discharge or transfer into mainstream community services when intensive support is no longer required.

## **Primary Care**

In 2015 DCHS was asked to manage Creswell and Langwith Medical Centres initially on a caretaker capacity. During February 2016, following a successful tendering process the trust were awarded a contract to manage these services going forward.

Primary care is a new, potentially challenging environment for us as a community provider. We have taken the opportunity to review the staffing skill mix in order to create a multi-specialty primary care team to support the General Practitioners. We anticipate the changes will dovetail well with our integrated community-based care teams, with the potential to bring many further benefits to patients who have easier access to a broader range of services. In addition to Creswell and Langwith practice we are working with Ripley Medical Centre and Castle Street, Bolsover and exploring options for future models of working. Together we are breaking down traditional organisational and professional barriers in order to provide care which is more integrated and flexible in meeting the needs of our patients. Our guiding principles are to deliver better outcomes, safeguard quality and improve value and patient/staff experience.

## **Ensuring our services are well led**

**Strong leadership is at the heart of high quality care services and DCHS continues to invest in its staff to ensure the very best outcomes for patients.**

### **Health Education East Midlands visit to DCHS, Feedback Report – 10th February 2016**

Health Education England Working Across the East Midlands (HEE(EM)) visited Derbyshire Community Health Services (DCHS) NHS Foundation Trust on 10th February 2016. The visiting team reported that they encountered a Trust that demonstrates a culture which truly values education and learning and is keen to train students and support the continuous development of existing members of staff. This culture was evident across all levels of the organisation. DCHS was consistently described as ‘supportive’, ‘welcoming’ and ‘friendly’ by the learners and educators we met. The Trust demonstrated that they are being proactive in transforming its workforce to meet the future needs of its service users. The visiting team heard about several areas of good practice and innovation: in particular the training of staff in using the University of Stirling’s ‘Best Practice in dementia Care’ training package, the ‘Quality Always’ programme of ongoing audit and development and a new face to face forum for students.

## **Appraisals**

At DCHS we provide our staff with an annual appraisal, which not only reviews their progress against their objectives, but also provides an opportunity to assess how they performed their duties in line with the DCHS Way values and behaviours.

In 2015, 90% of our available staff received an Annual Appraisal. We are committed to ensuring this figure increases further in 2016.

We are keen to ensure that appraisals are not only undertaken on time, but are also of a high standard and quality. To understand this even further, in late 2015, we commissioned an independent external audit into our appraisal systems and processes. We shall be acting upon the feedback received through that audit during 2016.

## **Staff Health and Safety**

At DCHS we take Health and Safety very seriously, our objective is to ensure that **ALL** our staff to go home safely at the end of each and every day. Our approach to Staying Safe is simple. We believe that all injuries are preventable and through good leadership and engagement of staff we can create a safety culture in which everyone takes responsibility for health and safety both on a personal and a collective level.

In 2015 we have had 893 reported incidents versus 928 in 2014. Out of the 893 incidents reported there were 485 with no harm or injury, 392 minor injuries and 16 RIDDOR Reportable Injuries.

## **Staff Health and Wellbeing**

At DCHS, we know that if our staff are healthy, they are able to provide better quality care for our patients. We are passionate about creating a healthy workplace for our employees.

2015 has seen us:

- remodel our internal Staff Support and Counselling service (Resolve) including provision of a new out-of-hours helpline;
- launch a new online Emotional Wellbeing Toolkit for staff;
- hold a summer Pedometer Challenge which saw over 500 staff take part;
- start our own Staff Weight Loss programme, facilitated by our Live Life Better Service and attended by over 150 staff.

## **Raising Concerns (Whistleblowing)**

We are committed to encouraging staff to speak up regarding any issues that are concerning them. We have established a small working group consisting of staff side representatives and managers to ensure that DCHS implements all the recommendations in the Freedom to Speak Up Campaign. This year we have extensively reviewed and rewritten our Raising A Concern Policy to make it easier for staff to raise a concern in a way that they feel comfortable with and strengthened our mechanisms for ensuring that any learning from issues raised are implemented. We have identified our Trust Secretary as the 'Local Guardian' for concerns (Whistleblowing) and highlighted in our new policy the numerous different ways staff can both raise a concern and receive support to do so.

Within DCHS our Executive Team have a high visibility with front line staff, this means that they are often able to deal with concerns raised directly when they are out visiting sites and services and very few concerns are raised 'formally'. In the last year we have received 5 formal 'concerns' one of which is still 'on-going'. A number of these issues have been reported anonymously.

Our plans for the following year include:

- implementation of 'Raising A Concern' communications campaign supported by additional training materials including a video which can be accessed from our web site.
- looking at ways to identify whether the low numbers of concerns raised are due to staff's reluctance to speak up or because issues are dealt with effectively by managers.

## **Quality impact assessments**

Assessing the impact that changes we make to our services has on our patients and their carers is an important part of our quality control. Individual service managers are required to assess the impact changes will have against the following categories patient safety, patient experience, clinical effectiveness, impact on staff and other stakeholders. All quality impact assessments are reviewed by the Medical Director, Chef Nurse and a non-executive director who are required to recommend whether the change is progressed as a result of the assessment. Ongoing monitoring of key indicators and risk factors ensure any unforeseen circumstances are identified early. All cost improvements during 2015/16 underwent a quality impact assessment.



## **Celebrating success – the extra mile awards**

Each year the trust celebrates the contribution of its staff in the Extra Mile Awards. excellence

This year the awards attracted 300 entries from which judges selected 51 finalists who were invited to the awards evening. These are individuals and teams who have been nominated by their colleagues for their dedication and caring. One of the awards – for outstanding care and compassion – is also open for patients and families to nominate.

Awards were made in a broad range of categories including:

- |   |   |
|---|---|
| • Healthcare Hero Award                 | Winner: Gill Jones  |
| • Behind the Scenes Hero Award          | Winner: Megan Campbell  |
| • Innovation Award                      | Winner: Welcome Home Service  |
| • Celebrating Diversity Award<br>Forum  | Winner: The Equality & Diversity Theatre                            |
| • Volunteer of the Year                 | Winner: John Hart   |
| • Leadership Excellence Award           | Winner: Jackie Rawlings   |
| • Partnership Working Award             | Winner: Falls Partnership Team                                      |
| • Outstanding Care and Compassion Award | Winner: Gill Jones  |
| • Team of the Year Award                | Winner: Ilkeston & Heanor Inpatients Wards                          |
| • Lifetime Achievement Award            | Winner: Sue Renshaw   |
| • The Chairman's Award                  | Winners: Kay Bradley, Lisa McKenzie, Ruth Keen and Steven Ratcliffe |

## **NHS Board of the Year - East Midlands**

During 2015 the trust board of Derbyshire Community Health Services NHS Foundation Trust was named as the NHS Board of the Year in the East Midlands in December 2015.

The judges commented on the Boards hands-on leadership style, with regular back-to-the-floor sessions, and for making a priority of learning from patient feedback in how services are improved. Every trust board meeting starts with hearing about the experiences of a particular patient.

The team was responsible for leading the organisation to become one the first specialist community foundation trusts in the country, earning the organisation a clean bill of health from the Care Quality Commission inspectorate and a consistently above average position in most national measures.

Further information regarding our workforce can be found in appendix 1

## Appendix 1 - Workforce

### Workforce Summary

As at 31<sup>st</sup> December 2015 DCHS employed 4,529 substantive staff. Two-thirds of our staff are in clinical roles.

In addition to the above we have approximately 1,000 bank staff who support us in keeping agency usage to an absolute minimum, in fact only 1% of our nursing budget is spent on agency staff, significantly lower than the national average. We are committed to staffing our clinical areas wherever possible with DCHS staff as we believe this is the best way to deliver high quality care.

Staff turnover has remained stable over the past 12 months and the rate stands at 9.04% which is significantly lower than the East Midlands NHS turnover average of 14.68% and a national NHS turnover rate of 10.09%. Analysis undertaken on the reasons staff have left DCHS has not highlighted any trends or cause for concern. Currently our vacancy rate is 6.23%. All of this assures us that DCHS has a largely stable workforce which can only serve to allow us to provide high quality care.

Our average absence rate for the last 12 months as at 31<sup>st</sup> December 2015 was 4.49%. National and regional absence figures have not been released since summer 2015, when we were slightly below the national and regional average. The top three reasons for absence remain as stress/anxiety, MSK and gastrointestinal.

### Staff Survey

In 2015 we used the NHS Staff Survey to invite all 4500+ of our staff to take time out to tell us what they thought about the organisation and their working lives. This was performed independently by the Picker Institute Europe which ensured absolute confidentiality and supported detailed analysis. We received a 57% response rate to our full census which enables us to have a rich source of data to look at the key areas we can improve for our staff.

NHS England published its Staff Survey results in February 2016. The key findings for DCHS, benchmarked against other Community NHS Trusts are detailed below:

### Details of key findings from the latest NHS staff survey

#### Response rates

2256 staff at Derbyshire Community Health Services NHS Foundation Trust took part in this survey. This is a response rate of 57% which is above average for community trusts in England, and compares with a response rate of 62% in this trust in the 2014 survey.

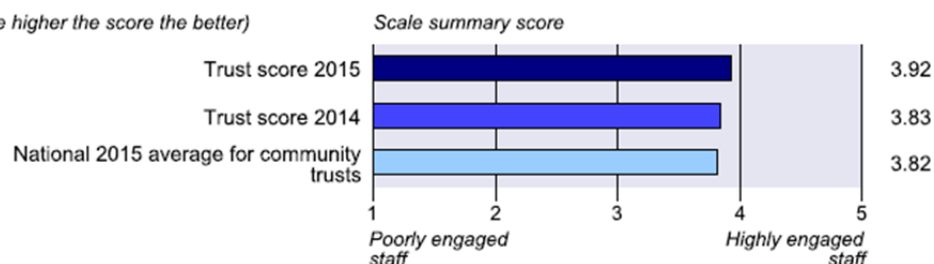
The table below gives a summary of ranking, compared with all Community Trusts in 2015 for the 32 key findings in the survey:

	2014	2015
Above (better than) average	12	17
Below (better than) average	5	7
Average	11	6
Above (worse than) average	1	2
Below (worse than) average	0	0

## Overall staff engagement

### OVERALL STAFF ENGAGEMENT

(the higher the score the better)



The overall staff engagement score for 2015 was 3.92 and was above (better than) average when compared with trusts of a similar type, this has increased from 3.83 in 2014 and was at 3.76 in 2013. It also compares favourably with national average Community Trust engagement score of 3.82 for 2015.

The overall indicator of staff engagement is calculated by NHS England using the questions that make up key findings 7, 4 and 1. These key findings relate to the following aspects of staff engagement:

- Staff members' perceived ability to contribute to improvements at work
- Staff members' willingness to recommend the trust as a place to work or receive treatment
- The extent to which staff feel motivated at work

### Areas of improvement from prior year

There are four Key Findings where staff experiences have improved the most at DCHS since the 2014 survey:

- 1) KF4: Staff motivation at work
- 2) KF25: % of staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months
- 3) KF18: % of staff feeling pressure in the last 3 months to attend work when feeling unwell
- 4) KF28: % of staff witnessing potentially harmful errors, near misses or incidents in the last month

### Areas of deterioration from prior year

There are three Key Findings where staff experiences have deteriorated since the 2014 survey:

- 1) KF27: % of staff/colleagues reporting most recent experience of harassment, bullying or abuse
- 2) KF24: % of staff/colleagues reporting most recent experience of violence
- 3) KF 16: % of staff working extra hours

### Top 4 ranking scores

According to the National NHS England data the four key findings for which DCHS compares most favourably with other Community Trusts in England are:

- KF6: % of staff reporting good communication between senior management and staff
- KF1: staff recommendation of the organisation as a place to work or receive treatment
- KF14: staff satisfaction with resourcing and support
- KF19: organisation and management interest in and action on health and wellbeing

### Bottom 4 ranking areas

According to the National NHS England data the five key findings for which DCHS compares least favourably with other Community Trusts in England are:

KF22: % of staff experiencing physical violence from patients, relatives or the public in the last 12 months

KF23: % of staff experiencing physical violence from staff in the last 12 months

KF27: % of staff/colleagues reporting most recent experience of harassment, bullying or abuse

KF3: % of staff agreeing that their role makes a difference to patients/service users

*The proposed focus areas of action following the 2015 staff survey results are identified in the table below. These have been based on the areas where DCHS were ranked in the bottom against other community trusts and where results have deteriorated the most against the 2014 results.*

*The areas will now be discussed with staff and senior managers for final decision and once agreed, actions aligned and progress tracked.*

Focus Area	2015 results
1) Safety - staff and patients	KF27: 42% of staff/colleagues reporting most recent experience of harassment, bullying or abuse KF24: 64% of staff/colleagues reporting most recent experience of violence KF22: 10% of staff experiencing physical violence from patients, relatives or the public in the last 12 months KF23: 1% of staff experiencing physical violence from staff in the last 12 months
2) Staff able to contribute to improvements at work	KF7: 72% of staff able to contribute towards improvements at work
3) Staff working extra hours	KF16: 71% of staff working extra hours
4) Making a difference	KF3: 91% of staff agreeing that their role makes a difference to patients/service users
5) Recommendation as a place to work	KF1: 3.97 staff recommendation as a place to work or receive treatment

	2014/15		2015/16		Trust improvement / deterioration
Response rate	Trust	National Average	Trust	National Average	
	62%	44%	57%	48%	Increase / decrease in % points -5%

#### Top 4 ranking scores

	2014/15		2015/16		Trust improvement / deterioration
Top 4 ranking scores	Trust	National Average	Trust	National Average	
<b>KF6</b> – Percentage of staff reporting good communication between senior management and staff	42%	33%	40%	30%	Increase / decrease in % points 2% decrease
<b>KF1</b> – Staff recommendation of the organisation as a place to work or receive treatment	3.90	3.66	3.97	3.75	Increase / decrease in % points 0.07 increase
<b>KF14</b> – Staff satisfaction with			3.42	3.27	Increase / decrease in

resourcing and support					% points N/A
<b>KF19</b> – Organisation and management interest in and action on health and wellbeing	–	–	3.81	3.65	Increase / decrease in % points N/A

	2014/15		2015/16		Trust improvement / deterioration
Bottom 4 ranking scores	Trust	National Average	Trust	National Average	
<b>KF22</b> – Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	9%	8%	10%	7%	Increase / decrease in % points 1% increase
<b>KF23</b> – Percentage of staff experiencing physical violence from staff in last 12 months	2%	1%	1%	1%	Increase / decrease in % points 1% decrease
<b>KF27</b> – Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	–	–	42%	43%	Increase / decrease in % points N/A
<b>KF3</b> – Percentage of staff agreeing that their role makes a difference to patients / service users	–	–	91%	91%	Increase / decrease in % points

### Staff Pulse Checks

The DCHS pulse check was launched in July 2013 and provides an indicator throughout the year as to how staff, as employees, are feeling. The pulse checks are run on a quarterly basis and provide an opportunity for staff to give anonymous feedback on how well they feel they are being managed, engaged and supported. This is now linked with our Staff Friends and Family Test.

It allows DCHS leaders to gain valuable insight into how their teams are feeling, and thus the opportunity to work closely with their teams about the issues that are important to them. The way they are structured facilitates swift feedback after the questionnaire has been completed. The positive impact high staff engagement can have on other Trust KPIs - such as attendance, patient safety and productivity - is recognised and well researched. It is also a significant measure for the leader as to how well they are engaging with their teams to deliver the results we need, primarily around quality care for our patients.

**The trust wide response rates for each quarter to date are:**

Jul 13	Oct 13	Jan 14	Apr 14	Jul 14	Jan 15	Apr 15	Jul 15
39%	37%	36%	31%	38%	33%	35%	36%

**The overall engagement scores for each quarter to date are:**

Jul 13	Oct 13	Jan 14	Apr 14	Jul 14	Jan 15	Apr 15	Jul 15
77%	77%	79%	76%	76%	77%	75%	76%

**Our Staff FFT scores for the past 2 Pulse Checks are as follows:**

### **How likely are you to recommend DCHS to friends and family if they needed care or treatment?**

April 2015: 89%

July 2015: 91%

### **How likely are you to recommend DCHS to friends and family as a place to work?**

April 2015: 69%

July 2015: 70%

As a result of the DCHS Pulse Check process/staff engagement it can be confirmed that:

- a review of existing practice has been started
- examples of good practice are being identified and will be shared
- there is a plan to re-energise staff engagement and work specifically with teams with low participation rates/staff engagement scores to foster a new attitudes and improved results.

### **What we will be doing during 2016/17**

1. Review and refresh all the current staff engagement activities including Pulse Check/Staff Survey questions; survey methodology – e.g. frequency, sampling; survey mechanisms – e.g. paper vs online; Staff Forum; recognising talent (EMAs) and supporting innovation.
2. Ensure Pulse Check data hierarchy is correct – improve understanding of match between data held on ESR and teams managed
3. Review staff engagement communication channels, visual identity and messaging
4. Review examples of good practice and identify any that can be shared and mechanisms for spreading the learning
5. Develop the ‘Moving from good to great’ staff engagement strategy;
6. Focus on increasing participation rate in low performing teams through understanding barriers, introducing bespoke action plans and supporting change and improvement
7. Align with other key DCHS programmes – e.g. DCHS Way; Caring Always, Quality Always
8. Evaluate and introduce new initiatives that will support improvement in staff engagement. Focus on four key areas – communication, opportunity to engage, leadership training/development and visibility

### **Training and Development**

Achieving business excellence relies on DCHS having a workforce with the right skills, competencies and professional capabilities to deliver excellent care against a background of unprecedented change both nationally and locally.

DCHS’ ambition is to be ‘the best provider of local healthcare and a great place to work’. Education and training is critical to achieving that vision. In-addition, if we want to fulfil the DCHS Way ‘to build a high performance work environment that engages, involves and supports staff to reach their full potential’ we know that we must ensure staff receive first class training and education and provide the workforce with appropriate development opportunities so as to ensure they acquire the requisite knowledge and skills to provide high quality care and practice at the top of their license.

DCHS currently provides a range of in-house training programmes however, changes in population health needs, service transformation and the move toward integrated care calls for the development of new and or additional workforce skills so as to deliver new models of care.

This will require significant change to the current education and training offer not least an increase in the current portfolio but development of robust quality assurance processes such as achieving the Skills for Health Quality Mark. We recognise that if we want to remain an employer of choice within the local and national labour market, we must go ‘from good to great’ in terms of our training and education offer.

It is our vision '*To become a Centre of Excellence for Training and Education*'.

### **Leadership Development**

During 2015, we have invested in our leaders through the Quality Always Leadership Development Centres (QALDS).

The scheme involves nominated participants undertaking a DCHS 360 review and attendance at a DCHS Development Centre. During 2015, 86 leaders took part in the process and the feedback has been extremely positive, with both participants and observers at the Development Centres commenting how constructive the experience had been. As part of the process we have had 43 senior leaders attend an accredited training programme, so that we have our own pool of in house observers to support the future roll out of QALDS. This training has brought benefits to those leaders beyond supporting QALDS as it has built confidence and competence in observing, evaluating and feeding back on behaviours. This will in turn benefit the quality of appraisals, recruitment etc.

The review of our leadership offer during 2015 has also seen a refresh of our leadership development learning portal ([leadingthedchsway](#)) available for all leaders to access on our intranet. This holds all information that is helpful to leaders e.g. details of all leadership development courses, conferences, coaches, mentors, career case studies, live news feed re NHS leadership etc. We are also about to launch a leadership 'chat room' within the site so that leaders can share best practise and access support from each other. We have also launched a leadership 'twitter' account and weekly email newsletter to market leadership development opportunities.

We have piloted new courses e.g. outward bound team building, social media for engagement, personal impact workshops, better decision making etc. which are externally facilitated along with some basic 'getting to grips' 2 hours information sessions for leaders that are facilitated by 'in house' experts.

## Appendix 2 - Trust Risk Ratings

As a foundation trust DCHS is required to meet certain conditions including those in respect of:

- continuity of services – a measure of financial sustainability and resilience. The purpose of this measure is to identify any significant risks to the financial sustainability of the foundation trust which would endanger the delivery of key services. Continuity of service is measured on a scale of 1-4 with 1 being the highest risk and 4 the lowest risk.
- governance – how a foundation trust oversees care for patients, delivers national standards, and remains efficient, effective and economic. Trusts are rated from Green (low risk) to Red (high risk)

DCHS is given a rating for continuity of services and a rating for governance to indicate where there is a cause of concern and to determine the extent of any intervention required Monitor.

DCHS has performed in line with its annual plan during 2015/16 and has achieved consistently good ratings and continues the success of the previous year.

There have been no formal interventions in year.

### Table of analysis

2015/16	Annual Plan	Q1	Q2	Q3	Q4
Continuity of service rating	4	4	4	4	
Governance rating	Green	Green	Green	Green	

2014/15	Annual Plan	Q1	Q2	Q3	Q4
Continuity of service rating				4	4
Governance rating				Green	Green



### Appendix 3 - Information Governance Toolkit submission for 2015/16

We are required to make sure that the information we hold about patients and staff is held and managed safely and confidentially and that it is used only for the purpose for which it was collected. The Information Governance Group is responsible for maintaining and improving the Information Governance Toolkit scores.

We can confirm that we had no requirements that were not applicable and all requirements were answered.

Assessment	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score (%)
Information Governance Management	0	1	1	3	5	80%
Confidentiality and Data Protection Assurance	0	0	7	2	9	74%
Information Security Assurance	0	0	14	1	15	68%
Clinical Information Assurance	0	0	5	0	5	66%
Secondary Use Assurance	0	0	1	1	2	83%
Corporate Information Assurance	0	0	3	0	3	66%
Overall	0	1	31	7	39	71%

**Appendix 4 - Progression of Quality Always, the DCHS Way**  
Update in April

			Assessment Number				
Inpatients:			A1	A2	A3	A4	A5
Babington Hospital	Baron Ward		A	A	A	G	
Bolsover Hospital	Hudson Ward		*R	R	R	A	A
Cavendish Hospital	Fenton Ward		A	A	A	A	
Cavendish Hospital	Spencer Ward	OPMH	R	A	G		
Clay Cross Hospital	Alton Ward		A	A	A	G	
Ilkeston Community Hospital	Heanor Wards		R	A	A	A	
Ilkeston Community Hospital	Hopewell Ward		R	A	A	A	
Newholme Hospital	Riverside Ward	OPMH	R	A	A	A	A
Newholme Hospital	Rowsley Ward		R	A	A	R	R
Ripley Community Hospital	Butterley Ward		A	A	A	A	
St Oswalds Hospital	Okeover		R	A	A	A	
Walton Hospital	Linacre Ward	OPMH	R	A	G		
Walton Hospital	Melbourne Ward	OPMH	R	R	A	G	
Whitworth Hospital	Oker Ward		R	R	A	A	
Ashgreen Hospital	Valley View		A	A	G		
Ashgreen Hospital	Hillside		A	A	G		
Core Unit	Rockley		A	A	A	G	
Core Unit	Amberley		A	G			
Core Unit	Robertson Road		A	A	G		
Core Unit	Orchard Cottage		A	A	G		
Buxton MIU			A				
Ilkeston MIU			A				
Ripley MIU			A	G			
Whitworth MIU			G				
East Chesterfield integrated teams			R				
Chesterfield Central integrated teams			R				
Lea Hurst Day Unit		OPMH	A				
Health Visiting Team			Pending				
Speech and Language Therapy			Pending				
Chesterfield Podiatry			A				

\*Combined results for Linden and Rowan wards which were replaced by Hudson Ward

## Appendix 5 - Third party statements - CCGs/Healthwatch



North Derbyshire Clinical Commissioning Group



**East Midlands Academic Health Science Network Patient Safety Collaborative  
Quality Account Statement (2016)**



## Appendix 6 - Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Account (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2015 to May 2016
  - Papers relating to quality reported to the board over the period April 2015 to May 2016
  - Feedback from commissioners dated xxxxxx
  - Feedback from Governors dated xxxxxx
  - Feedback from Healthwatch dated xxxxxx
  - Feedback from Overview and Scrutiny Committee, xxxxxx
  - The trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated xxxxxx
  - The national patient survey – n/a to DCHS
  - The national staff survey dated February 2016
  - The Head of Internal Audit's annual opinion over the trust's control environment dated xxxxxx
  - Care Quality Commission Intelligent Monitoring report (not available for community trusts)

The Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered; the performance information reported in the Quality Account is reliable and accurate:

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- Data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account Regulations) (published at [www.monitor-nhsft.gov.uk/annualreportingmanual](http://www.monitor-nhsft.gov.uk/annualreportingmanual)) as well as the standards to support data quality for the preparation of the Quality Account (available at [www.monitor-nhsft.gov.uk/annualreportingmanual](http://www.monitor-nhsft.gov.uk/annualreportingmanual))

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Date: .....  
.....

Chairman:

Date: .....  
Executive:.....

Chief



## Appendix 7 - Independent Auditors





## Appendix 8 - The Core Quality Account Indicators

Where the necessary data is made available to the NHS Trust and Non NHS bodies by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the trust and non NHS bodies (as applicable) should be included for each of those listed in the table with

- a) The national average of the same; and
- b) With those NHS trusts and NHS Foundation Trusts with the highest and lowest of the same for the reporting period.

For each indicator the following statement must be included in NHS Trusts' and non NHS bodies quality accounts:

DCHS considers that this data is as described for the following reasons [insert reasons].

DCHS [intends / has taken] the following actions to improve this [percentage / proportion / score / rate / number] and so the quality of its services, by [insert description of actions].

The data should be presented, in a table format with the [percentage / proportion / score / rate / number] shown for at least the last two reporting periods.

	Prescribed information	Related NHS Outcomes Framework Domain & who will report on them	2014/15	2015/16
12	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to - (a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. <b>*The palliative care indicator is a contextual indicator.</b>	1: Preventing People from dying prematurely 2: Enhancing quality of life for people with long-term conditions  <b>Trusts providing relevant acute services</b>		
13	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	1: Preventing People from dying prematurely 2: Enhancing quality of life for people with long-term conditions  <b>Trusts providing relevant mental health services</b>		
14	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.	1: Preventing People from dying prematurely  <b>Ambulance trusts</b>	n/a	n/a
14.1	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period.	1: Preventing People from dying prematurely  <b>Ambulance trusts</b>	n/a	n/a



	Prescribed information	Related NHS Outcomes Framework Domain & who will report on them	2014/15	2015/16
15	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period.	1: Preventing People from dying prematurely 3: Helping people to recover from episodes of ill health or following injury  <b>Ambulance trusts</b>	n/a	n/a
16	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.	1: Preventing People from dying prematurely 3: Helping people to recover from episodes of ill health or following injury  <b>Ambulance trusts</b>	n/a	n/a
17	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	2: Enhancing quality of life for people with long-term conditions  <b>Trusts providing relevant mental health services</b>	n/a	n/a
18	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's patient reported outcome measures scores for— (i) groin hernia surgery, (ii) varicose vein surgery (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.	3: Helping people to recover from episodes of ill health or following injury  <b>Trusts providing relevant acute services</b>	n/a	n/a
19	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged - (i) 0 to 15; and (ii) 16 or over, Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	3: Helping people to recover from episodes of ill health or following injury  <b>All trusts</b>	n/a	n/a
20	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.	4: Ensuring that people have a positive experience of care  <b>Trusts providing relevant acute services</b>	n/a	n/a
21	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	4: Ensuring that people have a positive experience of care  <b>Trusts providing relevant acute services</b>	89%	91% (Jan 2015)
21.1	Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult	4: Ensuring that people have a positive experience of care	98.7%	98%

	Prescribed information	Related NHS Outcomes Framework Domain & who will report on them	2014/15	2015/16
	<p>NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2).</p> <p>Please note: there is not a statutory requirement to include this indicator in the quality accounts reporting but NHS provider organisations should consider doing so.</p>	<p><b>Trusts providing relevant acute services</b></p> <p><b>Information reported to Unify2 not HSCIC</b></p>		
22	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	<p>2: Enhancing quality of life for people with long-term conditions</p> <p>4: Ensuring that people have a positive experience of care</p> <p><b>Trusts providing relevant mental health services</b></p>	n/a	n/a
23	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	<p>5: Treating and caring for people in a safe environment and protecting them from avoidable harm</p> <p><b>Trusts providing relevant acute services</b></p>	99.30%	99.77%
24	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	<p>5: Treating and caring for people in a safe environment and protecting them from avoidable harm</p> <p><b>Trusts providing relevant acute services</b></p>	n/a	n/a
25	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	<p>5: Treating and caring for people in a safe environment and protecting them from avoidable harm</p> <p><b>All trusts</b></p>	Data needed	Data needed

## Glossary

APO	–	Autonomous Provider Organisation
AQP	–	Any Qualified Provider
ARU	-	Adult Reablement Unit
AV	–	Amber Valley
BAF	–	Board Assurance Framework
CCG	–	Clinical Commissioning Group
CFD	–	Chesterfield
CFT	–	Community Foundation Trust
COPD	-	Chronic Obstructive Pulmonary Disease
CQC	–	Care Quality Commission
CQUIN	–	Commissioning for Quality and Innovation
CRHFT	–	Chesterfield Royal Hospital Foundation Trust
DCC	–	Derbyshire County Council
DCHS	–	Derbyshire Community Health Services NHS Foundation Trust
DHFT	–	Derby Hospitals NHS Foundation Trust
DHU	–	Derbyshire Health United
DTC	–	Diagnostic & Treatment Centre
EoL	–	End of Life
EMU	-	Elderly Medical Unit
ERE	–	Erewash
ESR	-	Electronic Staff Record
FT	–	Foundation Trust
GP	–	General Practice
HCAI	–	Healthcare Associated Infection
HCCG	-	Hardwick Clinical Commissioning Group
KPIs	–	Key Performance Indicators
LD	–	Learning Disabilities
LoS	-	Length of Stay
MIU	–	Minor Injury Unit
MRSA	–	Methicillin-resistant Staphylococcus aureus
NDCCG	–	North Derbyshire Clinical Commissioning Group
NED	–	North East Derbyshire
NHS	–	National Health Service
NICE	–	National Institute for Clinical Excellence
NUH	-	Nottingham University Hospital
OPMH	–	Older Peoples Mental Health
PLACE	–	Patient-Led Assessments of the Care Environment
SDCCG	-	South Derbyshire Clinical Commissioning Group
PROMS	–	Patient Reported Outcome Measures
SLT	–	Speech & Language Therapy
SPA	–	Single Point of Access
VTE	–	Venous-thrombo Embolism
WTE	–	Whole Time Equivalents