



Derbyshire Community Health Services NHS Foundation Trust

Annual Quality Report 2018/19

DRAFT 24/04/2019

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Part 1 - Introduction

Welcome to the 2018/19 Annual Quality Report

It is my pleasure to introduce our Annual Quality Report for 2018/19. This report describes in detail the work we have been undertaking during the year to improve the quality of the services we provide and achieve our vision of being the best provider of local healthcare and a great place to work.

Within our Clinical Strategy 2018, the term "Quadruple Aim" is used to describe a vision of 'simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing the per capita cost of care for the benefit of communities; whilst ensuring staff have the best possible experience of work.' This provides a framework for the work described within this Quality Account.

2018/19 has seen increasing pressure on our health and social care community. We continue to be challenged with increasing patient numbers and pressure on our resources and therefore it becomes more and more important that we have a strong focus on quality assurance and continuous quality improvement.

During the year we have continued to embed our Quality Always clinical assessment accreditation programme and it is always rewarding to hear the patient focused initiatives teams have led to achieve their gold awards. This programme allows us to drive quality improvements from a frontline service level and ensure that changes are sustainable. 2018/19 saw the creation and launch of the DCHS Quality Improvement Faculty which to date has 75 members, the Faculty are colleagues from all parts of DCHS who have an interest in, and dedication to improving services for our patients.

The management of chronic wounds including pressure ulcers, leg ulcers, diabetic foot wounds and complex surgical wounds continues to utilise a significant amount of our community nursing teams and it is therefore gratifying to see that the impact that the introduction of the Time to Heal chronic wound management programme is having on patients and staff. The programme was the overall winner of the 2018 Leading Healthcare Award.

Other highlights of the year have included:

- 98.3% of the 26,778 patients we surveyed recommending our Trust to their family and friends
- Achieving a score above the national average for all 6 elements of the Patient Led Assessments of the Care Environment (PLACE) audit
- Our 'Time to Heal' programme tackling chronic wounds and in particular significantly reducing healing times for patients with debilitating leg ulcers
- Implementing the agreed changes following the Clinical Commissioning Group led Better Care Closer to Home consultation, minimising the impact of change on patients, their families and our staff
- Once again being recognised as a great place to work, as reported by our staff within the national NHS Staff Survey where our colleagues reported performance that was average or above average against 9/10 key areas, compared with our peer community trusts
- A score of 7.2 out of 10 for overall staff engagement compared to a national average for Community Trusts of 7.1 out of 10 despite the significant changes in services in year
- The launch of the new staff wellbeing strategy aiming to create a step change for staff experience at DCHS. The strategy focuses on three key areas; prevention, resilience and support.

This report reflects on our achievements and challenges in improving quality during 2018/19 and where we have not always got things right how we have learned from this.

We hope that you will agree that much progress has been made as a result of the great commitment of our staff and I would like to take this opportunity to recognise and thank them for their continued dedication.

As we look forward to 2019/20 we recognise that there continues to be significant change ahead and an ongoing fiscal challenge. We will continue to strive to improve services for our local people and support our most valuable asset, our staff.

Quality Always, our clinical quality assessment and accreditation programme and Outstanding Way, our approach to service improvement, will be fundamental in how we monitor and assess our progress and provide assurance that the Trust continues to provide the very best quality of care for its patients.

Our staff are our greatest asset and we recognise that to provide great services we need to look after them well and to continue to recruit the very best calibre staff. During 2019/20 we will continue to develop our leadership strategy and use the findings from the annual NHS Staff Survey to work with our teams to build on our vision of being a great place to work.

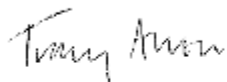
I can confirm on behalf of the Trust's Board that to the best of our knowledge and belief, the information contained in this Annual Quality Report is accurate and represents our performance in 2018/19 and our priorities for continuously improving quality in 2019/20.

Tracy Allen, Chief Executive

29/04/19

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 - Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

This quality report demonstrates our achievements for the year 2018/19, describes the areas where we would still like to make improvements and our quality objectives for the coming year.

Each year Derbyshire Community Health Services NHS Foundation Trust (DCHS) sets itself stretching improvement targets referred to as the Big 9. The Big 9 are split into three domains - Quality People, Quality Service, and Quality Business - in line with the DCHS Way.

During 2018/19 we set three new quality priorities focusing the whole organisation on quality improvement in areas of patient safety, clinical effectiveness and patient experience. Progress on all three objectives was monitored through the Big 9 report section of the performance report to the Board of Directors.

These priorities in detail were:

Priority 1 Patient Safety - Reduction in the number of chronic leg ulcers being managed across community services through improved training of clinical staff.

Rationale: Audit results and staff activity analysis (BRAVO) have highlighted that leg ulcers account for the most significant element of community nursing team work (10%). Leg ulcers can be very debilitating for patients and if not managed effectively can become chronic in nature, causing loss of independence and costing significant amounts in terms of dressings and staff resources. The tissue viability team has developed a care pathway to ensure that all patients receive optimum treatment.

Target: To train 240 community nurses in optimum leg ulcer management.
Twenty registered community nurses per month to undertake two-day training in the care and treatment of leg ulcers.

Monthly trajectory: 20 nurses per month to successfully complete leg ulcer management training.

Priority 2 Clinical Effectiveness - To increase the proportion of services adopting patient related outcome measures.

Rationale: 2017/18 was the first year the Trust had worked to develop a broad range of patient related outcome measures with a target of 37 adopting specific measures. Good progress was made during 2017/18 however embedding of this as routine practice has yet to be established.

We are proposing continuing this priority for a second year to ensure that improvements can be sustained.

Target: An additional 45 teams will implement the systematic use of patient related outcome measures.

Table 1: Monthly trajectory for team to implement patient related outcome measures

Month	1	2	3	4	5	6	7	8	9	10	11	12
Trajectory cumulative number of teams including baseline 37 2017/18	Consolidation of year 1 work			40	45	52	55	60	67	70	75	82

Priority 3 Patient Experience - To establish breast feeding friendly facilities across our services in Derbyshire and Derby City.

Rationale: The 0-19 year's team have worked hard for us to be recognised as UNICEF breast feeding friendly organisation and on 7th March 2019 successfully applied for the Quality Always Gold accreditation.

In support of this, and recognising that breast feeding mothers can access any part of our service, we are proposing running an internal breast feeding friendly accreditation scheme. Identified areas would be asked to identify a suitable area to offer a breast feeding mother, reception staff would have support training and on satisfactory completion of both the area would be designated breast feeding friendly and a certificate/poster awarded. This proposal compliments our inclusion agenda.

Target: A total of 40 sites based on seven hospitals, 29 health centres and four general practice sites.

- Year-end target is to have all 40 sites registered.

Table 2: Monthly trajectory for breast feeding friendly accreditation

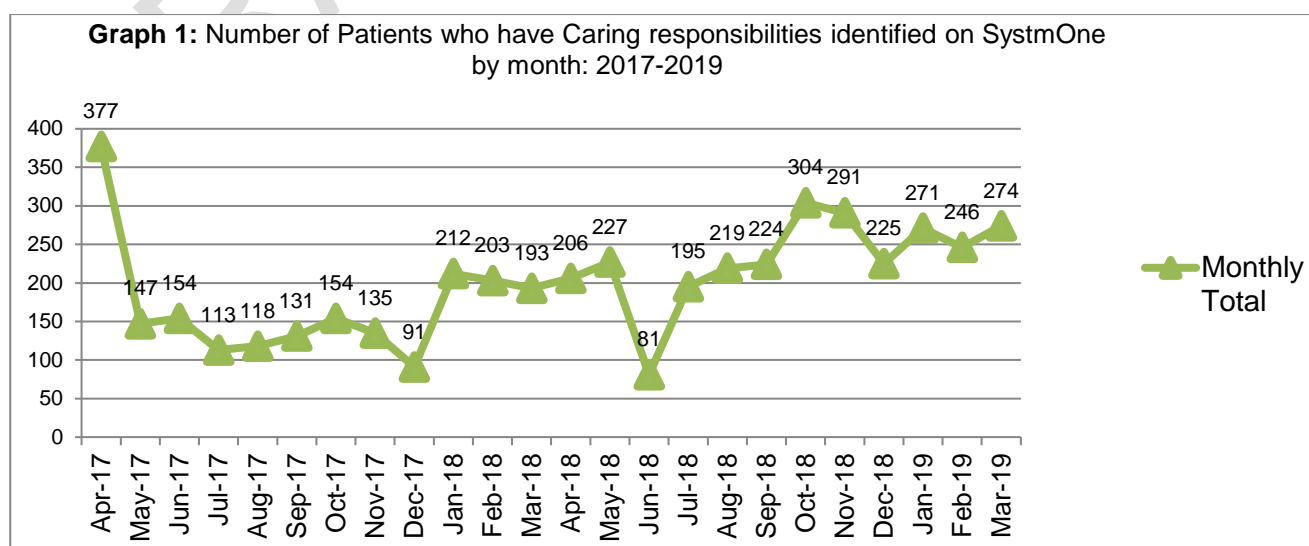
April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Implementation phase			5	8	12	18	23	28	33	38	40	40

Table 3: Quality Big 3

Quality Big 3	Objective	Priorities	Target	Achieved end Mar	Forecast year end
Quality Service	To deliver high quality and sustainable services that echo the values and aspirations of the community we serve	Targeted increase in community nursing staff trained in best practice management of chronic leg ulcers	240 community nurses to be trained in optimum leg ulcer management	286 (119%) GREEN	286 (119%) GREEN
		Increase the proportion of services adopting patient related outcome measures	Additional 45 teams will implement the systematic use of patient related outcome measures	45 (100%) GREEN	45 (100%) GREEN
		Establish breast feeding friendly facilities across our services in Derbyshire and Derby City	40 sites to be registered	33 (83%) RED	33 (83%) RED

The establishment of 40 breast feeding friendly areas has proved slightly problematic in a few areas and we did not achieve this target by year end. This is due to some areas originally identified as patient areas now being decommissioned and not having direct management responsibility of staff in other areas where we work as part of a multi-agency team. Opportunities for new areas to be supported in Baby Friendly status continue to be explored.

One of our targets for 2017/18 was to identify 75% of carers who accessed our services. We actually achieved 70% and PEEG has continued to monitor the number of carers each month that have been identified through Systm1 as can be seen in graph 1 below.



2.1.2 Things we want to do better in 2019/20

We are continually striving to improve the quality of the services we provide and to learn from things that did not go so well. In identifying improvement goals for this year we have listened to feedback from our patients, staff and governors about what concerns them and have discussed suggestions made via staff meetings to identify those issues where we feel we can make the most difference. For 2019/20 our Board of Directors has agreed three new strategic quality improvement priorities which will be reported monthly via our Big 9 performance report to Trust Board:

Priority 1 - Patient Safety

Improving the Identification of Sepsis and Recognition of the Deteriorating Patient

Background: Sepsis is a significant cause of death in both Adults and Children. It is estimated that there are 31,000 cases of severe sepsis in England and Wales every year, and the number of cases is rising. Approximately 30% to 50% of people with severe sepsis will die because of the condition. Recognition of sepsis is an important part of the recognition of the deteriorating patient. NEWS 2 has now received formal endorsement from NHS England and NHS Improvement to become the early warning system for identifying acutely ill patients - including those with sepsis - in hospitals in England. It has been agreed that from April 2019 DCHS will be introducing NEWS 2 across Integrated Community Services. NEWS 2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital.

Currently community teams have access to all the relevant equipment to undertake NEWS2 with the exception of pulse oximeters which monitor oxygen saturation. The DCHS Critically Ill Patient Prevention Group has endorsed the move to NEWS2 as it is nationally recognised best practice. The Medical Devices Group is currently working with Procurement to source the most effective Pulse oximeters for use in the community and the funding has been secured via the Capital and Estates Group.

Proposal: The roll out of the pulse oximeters will take place in Q1 & Q2 of 2018/19 with all being issued to community teams by 30/09/19.

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Target	233	233	233	233	233	233

Once the roll out and associated training is complete there will be monthly reporting from Systm1 to determine if the provision of this equipment has increased the number of baseline observations recorded, ensuring oxygen saturations are measured in line with NEWS2. The current position is 0% as the equipment is not used in community and it is proposed that a target of 80% is both stretching and reasonable.

Month	Oct-19	Nov-20	Dec -19	Jan-20	Feb-20	Mar-20
Target	13%	26%	40%	55%	70%	80%

A random audit in Quarter 4 of cases where the where NEWS 2 was 5 or more will be undertaken to ensure that the UK Sepsis Trust Screening tool was completed and actioned.

Priority 2 Clinical Effectiveness

Increasing participation in National Institute for Health Research (NIHR) across DCHS Services

Supporting Information:

- Vision for growing DCHS as a 'researching' Trust (DCHS Strategy)
- NHS Constitution commitment and pledge 'to inform you of research studies in which you may be eligible to participate'
- Inclusion in CQC monitoring and inspection programme – well led domain requirement for integrated clinical research

- Published evidence around the correlation between involvement in high quality research and better patient outcome
- 87% of patients had a good experience of taking part in research (n = 4,312). **NIHR** Report of the Patient Research Experience Survey 2017/18
- 83% of respondents (public) said that health research is very important (n= 1,014). Survey of the general public: attitudes towards health research 2017 Health Research Authority
- Access to £20,000 incentive funding for organisations, Clinical Research Capability funding, for recruiting minimum 500 participants to NIHR research in a financial year.

Table 4: Target: Aspire to recruit minimum 500 participants in total between 01/04/2019-31/03/2020

Month	1	2	3	4	5	6	7	8	9	10	11	12
Target	38	80	122	164	206	248	290	332	374	416	458	500

This is a challenging target and is aimed to achieve the £20,000 research capability incentive. However, it is recognised that this will depend on availability of relevant research studies throughout the year. Therefore a target range of a total annual target between 250 – 500 participants can be set but we would not receive £20,000 if the minimum 500 was not achieved.

In 2017/18, there were 10 potential studies which we could have participated in but were unable to do so for various reasons including a lack of local collaborators and principal investigators. In 2018/19 there are currently 14 studies we could have participated in but have been unable to do so. In 2018/19 we trained 15 research envoys / principal investigators to become research ready.

Process to be set up to support the Big Nine

In 2019/20, we will set up a formal (virtual) research review group involving the research champions, research envoys and principal investigators, service managers etc. Every potential NIHR research study will be reviewed formally by the group and cascaded internally to relevant services with the expectation that every relevant research study will be opened in 2019/20 i.e. we will open approximately 10 – 14 new research studies in 2019/20. Each newly opened research study will have an agreed realistic participant recruitment target. Any relevant research studies that are not opened will need to be formally agreed and recorded following acceptance of valid reasons as not being feasible. There will be an expectation for the review of potential studies and expressions of interest to be conducted within 2 weeks or published deadline. Studies which are opened will need to meet set up target times of 40 days (maximum) and first participant must be recruited within 30 days of recruitment beginning. All agreed study targets will be monitored for achievement.

Please be aware that we cannot ensure that the studies available to us will be evenly spread across DCHS services. It is likely some services will receive more potential research studies than others.

Priority 3 Patient Experience

Improving the Dementia Friendly Environment and Culture across DCHS

Background

People with dementia access all services that are provided to adults in Derbyshire. Community services need to be accessible for people whose cognitive and communication abilities are affected by dementia. Services for children are concerned with the whole family, which may include adults with dementia. Dementia affects people in different ways, and there is no single step that will make a service more accessible for all people with dementia. The principle of making services, information and environments more dementia friendly needs to be considered alongside person centred approaches – asking people ‘What matters to you?’

In response to the Healthwatch Derbyshire dementia report (2018) Health Wellbeing and Inclusion division proposed to address three aspects of dementia friendly-ness:

- Environments
- Accessible information
- Staff awareness

DCHS has resources and advice on each of these areas from dementia lead, care environments lead, patient involvement officer and quality and safe care champions. Although the Big 9 requires a single set of metrics that can be reported on monthly throughout the year, a single approach to improving dementia friendly services is probably not appropriate (there is a different need and baseline for diverse services such as Health Visiting vs Minor Injuries Units or wards).

Proposal

There are over 100 Quality and safe care champions for dementia across DCHS services. We need to cover all services with a dementia champion – this could be achieved by having more champions in services that are regularly used by people with dementia, and champions covering more services where people with dementia are less frequent patients.

1. Target – all services are linked to a dementia champion through Quality Always team. Champions to carry out a brief self-assessment of dementia friendly-ness of their service; environment, information and staff awareness. The self-assessment could include: PLACE assessment criteria, accessible information standard, dementia friends training uptake.
2. Target: all champions have completed the self-assessment and agreed an action that will result in improved experience for people with dementia.
3. Target: all services have submitted a planned improvement action via their champion
4. Target: Champions will audit that their action has been implemented and submit evidence.

Metrics:

Numerator = 97 services

Target = 100% of services (97) will have a completed dementia friendly improvement action by year end.

Metrics: shading has been used to indicate a single reportable measure per month.

Table 5: Targets for dementia friendly improvement action

Month	Baseline Q4	1	2	3	4	5	6	7	8	9	10	11	12
Services with a dementia champion	43	50	70	97									
Services with a dementia friendly improvement action					25	50	97						
Services with a completed dementia friendly action								5	10	20	50	80	97

2.2 Statements of assurance from the Board

2.2.1 Contracted Services

This section of the report includes text and reports mandated by NHS England and NHS Improvement.

- During 2018/19 DCHS provided and/or sub-contracted 41 relevant health services
- DCHS has reviewed all the data available to them on the quality of care in 100% of these relevant health services
- The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by DCHS for 2018/19.

2.2.2 National audits

To ensure that the services we provide achieve meaningful outcomes for patients and carers, we undertake a range of clinical effectiveness activities and clinical audit is one. Our focus is to ensure that all clinical audit activity results in learning, and improvements in care. Participation in clinical audit enables us to provide effective, responsive and safe care.

During 2018/19 8 national clinical audits and two national confidential enquiries covered relevant health services that DCHS provides.

During that period DCHS participated in 86% national clinical audits and 100% 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 2018/19 are below in table 6.

The national and clinical audits and national confidential enquiries that DCHS **participated** in during 2018/19 are below in table 6.

The national clinical audits and national confidential enquiries that DCHS participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 3 national clinical audits were reviewed by the provider in 2018/19 and DCHS intends to take the following actions to improve the quality of healthcare provided. See table 6 below for outcomes and actions.

Table 6: National audits

Title	Participated	% submitted	Actions
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%	1) Mortality Review Group (MRG) receives quarterly LeDeR report from the Derbyshire LeDeR Steering Group 2) Critically Ill Patient prevention Group (CIPP) continuing to scope training for Learning Disability staff on sepsis 3) DCHS continuing to develop IT updates for identifying patients with Learning Disability on Systm1.
National Audit of Care at the End of Life (NACEL)	Yes	100%	Report not available until May 2019
National Audit of Intermediate Care (NAIC)	No	0%	Organisational decision not to take part due to burden it would add to clinicians work load

Title	Participated	% submitted	Actions
National Diabetes Foot Care Audit	Yes	100%	1) Discharge Reason: Review how this is recorded, including separating DNAs, deaths and outcomes. 2) Deep dive on interval from referral to appointment
National Core Diabetes Audit	Yes	100%	National report not yet available
National Diabetes Transition	Yes	100%	National report not yet available
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%	CCG aware of lack of 6 month assessment - Derby City ESD are due to participate in the Compass research study which will explore psychology provision for ESSD for cognitive support - recruitment of staff - Amber Valley, Erewash Team Leader is going to reflect on case studies that were carried on beyond the 6-week period to demonstrate the gap in specialist services and ongoing therapy patient needs in context of the current waiting times for neurology outpatient services
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%	National enquiry – no report produced
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology)	Yes	100%	Ensure training package on PD UK is linked to Neuro Portal when this goes live in DCHS - need to develop PD group in HP& Dales - need to develop and advertise specialist neuro interest group in DCHS to ensure access to specialist advice - Need to clarify and agree consistent process across teams for discharge process - Guidelines for newly diagnosed pathway implemented and Follow up audit in 2019 should demonstrate reduction in number of years from diagnosis to therapy intervention - Group agreed that BERG and Lindop should be used as standard OMs for all areas for PT and aim to use PDQ39 for all review patients.

The reports of 22 local Clinical audits were reviewed by the provider during 2018/19 and DCHS intends to take the following actions to improve the quality of healthcare provided. See table 7 below for outcomes and actions.

Clinical Effectiveness and Audit Programme 2018/19

The programme of 48 clinical effectiveness projects has progressed well in 2018/19 with 20 projects undertaking a full cycle through to the successful completion of the improvement action plan. The remaining 28 audits are all progressing as planned. The 20 completed projects are listed in table 7 below.

The Clinical Effectiveness and Audit Programme consists of clinical projects which review the quality of the services that we provide. These projects include a blended methodology of audit, questionnaire, surveys and focus groups. We compare practice against agreed and recognised standards to ensure our patients receive care of the highest quality. These projects also include participation in the national audit programmes including adult diabetes, diabetic foot care, stroke and dementia. Projects to date include the following:

Table 7: clinical audit programme

	Project Title	Purpose	Outcome	Actions
1	003.3 Q1 2018/19 Controlled Drugs Audit	To ensure safe storage and management of controlled drugs	100% compliance with all security questions Administrative errors found in CD registers	<ol style="list-style-type: none"> 1) Audit report has been shared with all wards, MIU and Diagnostic and Treatment Centre. 2) Ward Manager to check registers on weekly basis for 1 month 3) Ward manager to discuss at team meeting 4) Ward manager to speak to individuals 5) Pharmacy to produce information / education poster to be displayed on CD cupboard.
2	005.2 Q1&2 Omitted Doses (part of the Treatment Card Audit)	To ensure safe administration of medication	Alton, Baron, Butterley, Fenton, Heanor, Hopewell, Oker and Okeover are on Systm1 and achieved 100% for omitted codes. Hillside Ward also achieved 100%. Walton Unit did have some missing omitted dose codes but a system has been introduced to drug rounds which should help reduce these in future. Out of 362 regular doses only 8 (2%) had no code or signature in the administration box.	<ol style="list-style-type: none"> 1) Audit report has been shared with all wards 2) Continue to follow up on individual ward action plans 3) Ensure the process for checking "due medication" at the end of every drug round on e-prescribing wards 4) Consider expanding the audit to look at approved codes for omitted doses eg out of stock, patient refused etc.
3	016.3 18/19 Emergency Equipment Audit	To ensure standardised provision of well-maintained emergency equipment	<ul style="list-style-type: none"> • Overall compliance for DCHS is 96.27%, which is an improvement from the January 2018 Audit when it was 95.36%. -Of the 77 audits of Emergency Equipment 39 (51%) achieved 100% compliance • 38 (49%) sites were less than 100% compliant but the vast majority of issues reducing compliance was minor and posed no clinical risk. 	<ol style="list-style-type: none"> 1) complete a spot check audit of non-compliant areas in January to ensure action has been taken 2) Info-graph to include instructions about the need to document on the weekly check that there is a procedure in place for the checking of emergency call bells. 3) Info-graph to include instructions about the need to add a sticker to items with no printed expiry date to state expiry is 3 years hence date of manufacture

	Project Title	Purpose	Outcome	Actions
				4) Info-graph to be sent to all GMs and to the named responsible clinician and responsible equipment checker
4	022.2 Mental Capacity Act Phase 2 Re-Audit (Adult Rehab Wards and Day Hospitals)	To monitor compliance with the mental capacity Act	<ul style="list-style-type: none"> a) Capacity Assessments: Slightly fewer were correctly recorded in the clinical notes. b) Independent Mental Capacity Advocates (IMCA): Where a Best Interests Decision met the criteria for involvement of an IMCA a referral to the IMCA service was not made. c) Past preference: Recording this decreased in the Adult Rehab Wards. d) Least Restrictive Decision: Recording this decreased in the Day Hospitals. e) Deprivation of Liberty rationale: Recording why an application should not be made when a Best Interests Decision included degrees of restriction was missing for several cases. f) Deprivation of Liberty Applications: The Local Authority had not responded to any of the applications in this sample. 	<ul style="list-style-type: none"> 1) Communicate the results and improvement actions to staff 2) Escalate Local Authority delays in approving DoLs applications 3) Ensure Mental Capacity Act (MCA) documentation is rolled out to all Systm1 users in a fully reportable format, with staff training available, before a new audit is set up.
5	037.1 Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Implementation Evaluation	The project will provide data to support the implementation of the ReSPECT documentation, and to evaluate the effectiveness of its roll-out and use with patients.	<ul style="list-style-type: none"> a) some entries suggest a ReSPECT form is in place but that the patient declined discussions about emergency health care planning. b) report cannot show outcomes of discussions or detail of free text entered by clinicians. c) further work needed to evaluate the content and quality of ReSPECT forms. 	<ul style="list-style-type: none"> 1) Re-audit the use of the ReSPECT template on Systm1 in both inpatient and community settings. 2) Share findings and learning from Systm1 audit and staff survey with relevant staff groups across DCHS 3) Develop case notes review to assess the quality of the content of ReSPECT forms which have been completed in DCHS.
6	036.1 Audit of referrals made by DCHS GP practices to Live Life Better Derbyshire Smoking Cessation Service	There is a risk to population health through the failure to fully embed public health principles within DCHS service delivery impacting on the ability to reduce inequalities in access and outcomes for our populations	No specific improvement actions identified. Governance group agreed to close project but CET to work with division to create clearer project which identifies with the Quality Conversations agenda	Whilst the audit provided useful information, it identified a need to refine the audit question to gather more detailed information in future. There is work on-going in the division around Quality Conversations which is due to be rolled out in DCHS GP practices in Feb 2019
7	001.3 Improving the Assessment of Wounds Commissioning for	Failure to complete a full assessment can contribute to ineffective treatment which therefore delays the rate of	Documentation of information given to patients regarding their wound care has reduced to 52% compared with 61% in Q4	1) Results to be broken down by team to enable targeted training & support

	Project Title	Purpose	Outcome	Actions
	Quality and Innovation (CQUIN) Audit Q2 2018/19	wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal. Aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment	2017/18, despite including this element in the manual notes review as well as the Systm1 report to capture any information being documented elsewhere in the patient record. Completion of the clinician's declaration that "all fields have been considered" has fallen to 91% this quarter, compared with 100% in Q4. Only 36 of the 150 patient records had 100% of the required information completed, but a further 57 records were only missing 1 element of information	2) Share audit findings with participating teams, to support development/improvement 3) Tissue Viability Matron to liaise with Deputy Chief Nurse to develop a communication to Integrated Community Manager (ICM) and Integrated Community Team Lead (ICTL) to gain their support and ask them to identify any barriers to compliance.
8	002.1 Pilot survey of people who have recently experienced the death of a significant person in the care of DCHS community nursing teams	DCHS priority to provide qualitative information relating to the patients and their families experience of end of life care.	17 respondents felt that community staff gave them appropriate advice regarding what to do after the death.- All respondents said that the care provided was delivered with dignity and respect.- 22 respondents said that they and the person being cared for felt involved in decisions about the treatment and care being delivered at home by the community nursing team.- several respondents have made additional comments, referring to the professionalism and care of the teams supporting them.- 2 people have specifically commented on the positivity of their loved one being able to be cared for at home.	1) DCHS to complete the pilot bereavement survey in the community, and the Clinical Effectiveness Team to interview participating teams to identify concerns or benefits to the project, prior to a decision regarding how to consult bereaved relatives in the future. 2) Decision made at End of Life (EoL) Group that an appropriate person will be identified to conduct a deep dive records review where respondents to the survey have given negative comments.
9	006.5 Q1 2018/19 End of Life Audit	Identify unexpected deaths and trigger an in depth review of the circumstance by MRG. Identify areas where practice can be improved and share the findings across the services. Identify areas of good practice and share this across the service. Start to review qualitative information relating to the patients and their families experience of end of life care Triangulate end of life information with other sources – Quality Always, training, friends and family test, complaints and comments.	Need to ensure lessons learned from the EoL audit including thematic analysis is shared with front line staff - 25 auditors report not being aware of GP palliative care meeting - Inpatient Clinical teams will be encouraged to consider how the needs of the family can be better documented - Decline in the response rate for community teams	1) Audit report, improvement plan and info graphic to be shared with Quality Always team, ICM & Matrons meeting, DN forum and to all auditors 2) Q&SCC to create "you said, we did" boards to evidence how they change practice as a result of lessons learnt. 3) Work with teams and service leads to identify issues with attending palliative care meetings 4) Identify lead to help encourage teams to consider & document the needs of the family. 5) Devise communications plan to inform community teams when, how and why to complete an end of life audit -

	Project Title	Purpose	Outcome	Actions
10	006.6 Q2 2018/19 End of Life Audit	<p>Identify unexpected deaths and trigger an in depth review of the circumstance by MRG.</p> <p>Identify areas where practice can be improved and share the findings across the services.</p> <p>Identify areas of good practice and share this across the service.</p> <p>Start to review qualitative information relating to the patients and their families experience of end of life care</p> <p>Triangulate end of life information with other sources – Quality Always, training, friends and family test, complaints and comments.</p>	<p>Inpatients- Communication with patients and carers has continued to improve- 97% of patients had an individualised care plan</p> <p>Community- overall response rate increased to 40.9%- 92% of patients who died were on the GP palliative care register. Improvement in communication between staff and patient and involvement in decision making.</p>	<ol style="list-style-type: none"> 1) Info-graph and end of life training to include reminders to staff to explicitly document that they have had discussions with patients and families/carers about their care. 2) Work with IT team to add functionality on audit tool that helps improve data quality for the audit. 3) Feedback to quality lead for EoL at CCG that we are informed that GP palliative care meetings are not being held with required frequency. 4) Attendance and reasons for non-attendance at palliative care meetings to be reported team by team in future.
11	009.1 Susceptibility to Medications	To reduce the number of falls caused by effects or side effects of medication	59% of patients audited had a primary reason of fall for admission. Of these patients 19% suffered a fall during admission. 12.2% of all the patients audited had presented with a new onset of confusion. Results are limited due to lack of evidence related to medication reviews.	<ol style="list-style-type: none"> 1) Inclusion of the clinical records audit within the monitoring section of the policy. This is a key area of monitoring compliance with falls documentation 2) Policy clarification added regarding exemption of mobility wristbands for LD and OPMH services in regards to documentation 3) Updated policy regarding consideration of foot care to reflect amendments to policy documentation and current NICE guidance. 4) Audit findings and written report to be shared with OPMH inpatient matrons and ward managers 5) Cascaded for action for all clinical staff including medical.
12	024.1 Frailty Audit	Audit the effectiveness of the frail elderly early discharge and admission avoidance pilot between the DCHS, the Chesterfield Royal Hospital and the North Derbyshire and Hardwick CCG.	<ol style="list-style-type: none"> a) There is a wide diversity of community referrers b) Teams respond very quickly to acute referrals c) There is an 80% level of success in achieving admission avoidance or facilitated discharge (D2AM) d) Adoption of a standard frailty assessment tool. DCHS has now adopted the 	<ol style="list-style-type: none"> 1) Share infographic with participating teams 2) Feedback specific data & results to relevant groups 3) Rockwood scale: Feedback scores data from uptake report to frailty strategy group. Informatics Team to be asked to improve reporting of this data for Jan 2019 meeting, then to make this a direct report to the group.

	Project Title	Purpose	Outcome	Actions
			<p>Rockwood frailty measure. This was a DCHS Big 9 strategic objective for 16/17.</p> <p>e) Effective care plans: Making sure that care plans in Systm1 are:</p> <p>f) Specific to the patient's individual requirements and reflecting their assessments.</p> <p>g) Clear, realistic & measurable patient led outcomes</p> <p>h) Achievable within a clear time frame with recovery plans if the time limit may slip.</p> <p>i) Providing clarity of how patients are using appropriate pathways for their presenting problems e.g. falls, continence, medication reviews delirium and end of life pathways.</p> <p>j) Personal Care Plans: Making sure care plans reflect the patient's wishes and objectives, and in easy to understand language</p>	<p>4) Re-audit to be planned once frailty view on Systm1 is in place</p>
13	025.1 Pressure Ulcer - SSKIN self-assessment	Audit of compliance against key standards for DCHS Prevention and Management of pressure ulcer policy and the SSKIN bundle pressure ulcer prevention plan/pathway	<p>Overall engagement with the Trust-wide audit appears to have improved, with a particularly significant increase in returns from community teams.</p> <p>More work is needed relating to the documentation of advice and discussion with patients in both inpatient and community. Further work is needed in community teams to document discussions with patients/carers to demonstrate they are involved in planning their care and treatment.</p> <p>Documentation needs to demonstrate that patients understand the information they are given.</p>	<p>1) Improve documentation and compliance with Key Standards.</p> <p>2) Reduce inconsistencies in approaches to meeting prevention and wound management standards.</p> <p>3) Support pressure ulcer improvement groups (PUIGs) to monitor progress, celebrate good practice and focus on areas for improvement</p> <p>4) Work with Information Management and Technology (IM&T) colleagues to develop a means of monitoring key standards and run reports from Systm1 during 2019.</p>
14	028.1 A Re-audit to measure the impact of improvement actions on the diagnosis and management of Catheter Acquired Urinary Tract Infections (CAUTI).	To measure compliance with NICE guidelines for the diagnosis, management and treatment of CAUTI.	Out of 33 DATIX incidents, 29 CAUTI patients had a set of observations documented, 4 had their pain assessed, 4 had a bowel review, 1 had their blood sugars measured and 19 were advised to increase their fluid intake. The re audit indicated that urinalysis dipstick is still being used within DCHS to help diagnose a CAUTI. The reporting suggests overall	Continue to respond to all DATIX but not to focus on the use of dipstick urinalysis if the catheter has been changed, a CSU taken from the clean catheter and the CSU has been sent for culture.

	Project Title	Purpose	Outcome	Actions
			reduction in the number of clinicians performing urinalysis. These figures should not be taken in isolation as it is evident that the overall management of patients with a CAUTI has improved immensely. Clinicians are changing the catheter, obtaining a Catheter Specimen Urine (CSU) from the clean catheter which is sent to microbiology for culture prior to commencing antibiotics. 90% of CAUTI's reported during Q3 2017/18 were treated with antibiotics. It should be noted that the DATIX report does indicate that all of these infections were symptomatic.	
15	038.1 Use of personalised goal questions in the assessment of patients with Venous Leg Ulcer wounds (CQUIN) Q2 2018/19	Enable individuals living with a wound to achieve their potential and improve the overall experience.	<ul style="list-style-type: none"> 8 of the 27 patients had not received a lower limb assessment. No other rationale for diagnosis found. Some of the issues identified from the manual notes review where the lower limb template (LLT) was not completed are as follows: <ul style="list-style-type: none"> Patient declined any assessments – it is not clear whether the staff member discussed further with the patient to attempt to understand their reason for declining. LLT completed in April 2018, VLU diagnosed, but patient admitted to hospital in the interim. Wound was not reassessed and LLT was not reviewed when the patient was discharged and came back under community care. Diagnosis appears to have been taken from original LLT in April. Two instances where patient is also under the care of another service, e.g. dermatology, who have diagnosed VLU, but no rationale from our community nursing team re diagnosis, and no evidence of any liaison with the dermatology team. 	<ol style="list-style-type: none"> 1) Tissue Viability Team to continue to provide targeted training & support for staff to understand how to complete outcomes of goals 2) Improve staff understanding of aetiology of wounds, the importance of reviewing a wound if there is any change or interruption in care, & importance of demonstrating clinical reasoning. 3) Develop roll-out plan to other community nursing teams and leg ulcer clinic 4) Plan improvement trajectory, for re-audit to be completed in Q4

	Project Title	Purpose	Outcome	Actions
			<ul style="list-style-type: none"> Notes and wound assessment suggestive of a different diagnosis but VLU still selected. No LLT. 	
16	011.1 Stopping Over-Medication of Patients with Learning Disabilities (STOMPwLD) Review	The aim of this audit is to establish a baseline of current prescribing practice of all psychotropic medication in our specialist Learning Disability Service (OP and Inpatient)	<p>Prescriptions were generally not backed up by documentation of the process standards. The best score of 24% compliance was for recording clinical indicators.</p> <p>No assurance can be taken from the results for recording the process standards when initiating or reviewing a prescription.</p>	<ol style="list-style-type: none"> 1) Design an 'aide memoire' for all outpatient consultations and inpatient review meetings involving psychotropic medication, to improve recording of prescribing standards in medical notes. 2) Include next planned psychotropic medication review date in next outpatient meeting form, and include as a medication review flag on Systm1. 3) Investigate whether Specialist Pharmacy support for psychotropic medication is available.
17	017.1 Identifying Disability	demonstrate that reasonable adjustments are made for people with a learning disability to allow improved access to all DCHS community services	<ol style="list-style-type: none"> a) Only 6.5 % of first contacts in Systm1 in Oct 2016 had an E&D Questionnaire started. b) Of the audit sample of 80 started E&D Questionnaires, 8 (10%) failed to answer Q3 about disabilities, but 56 (70%) identified at least one disability, suggesting that staff do not complete the questionnaire unless they see a disability. c) A total of 79 disabilities were identified, but there was evidence of some staff confusing long term medical conditions with disabilities. d) In 40 out of the 56 (71%) the record ended there, with no account of what sort of adjustment was needed. For 5 patients it was clear that no adjustments were needed for identified disabilities. Only 11 records had an entry for a reasonable adjustment. e) Care planning for reasonable adjustments and evaluation of the care plan actions was non-existent in the audit sample. f) This is similar to the results of the previous two years results from the Identifying Learning Disability Audit. 	<ol style="list-style-type: none"> 1) Review the E&D Questionnaire. 2) Staff Training

	Project Title	Purpose	Outcome	Actions
18	020.1 National Audit of Dementia (Community Hospitals Pilot)	This will also allow us to measure our performance against the national standards for inpatient dementia services.	<ul style="list-style-type: none"> a) no dementia lead b) no pathway for dementia c) staff very positive about personalized care d) dementia training strategy embedded 	<ul style="list-style-type: none"> 1) Dementia flag to be introduced to electronic patient record to support identification of patients who have dementia 2) Development of DCHS dementia strategy is underway 3) New dementia training pathway has been developed 4) Work progressing to include patient/carer representatives at Dementia and Frailty Group meetings
19	027.1 VTE Podiatric Surgery	<p>To ensure that all relevant planned care patients are risk assessed for VTE and a clinical decision made and documented as to the necessity for prophylaxis taking into account the overall risks and benefits for individual patients.</p> <p>To ensure that patients have been treated appropriately following the VTE risk assessment.</p> <p>To identify if any areas have not followed the NICE Guidance and DCHS VTE Policy</p>	<ul style="list-style-type: none"> • Limited evidence of quality of verbal advice given to patients. • Lack of clarity of term "prophylaxis" and what form this might take - could be advice, pharmaceutical or mechanical. • Limited scope of audit, no comparable data from other services. • 95% of patients were offered verbal and written information on VTE prevention as part of the pre-surgical assessment process. 63% of patients were documented to have received an assessment of their VTE and bleeding risk prior to surgery. 90% of patients at risk of VTE were offered VTE prophylaxis. 	<ul style="list-style-type: none"> 1) Ensure all staff/services are using the updated screening form and that any older versions are removed 2) Discuss with teams regarding clear documentation of advice given to patients 3) Review definition of "prophylaxis" and update screening tool to identify the type of prophylaxis given 4) Audit to be rolled out to other podiatric surgery services in DCHS in March 2019.
20	039.1 VTE screening audit Diagnostic & Treatment Centre (DTC)	<p>To ensure that all relevant planned care patients are risk assessed for VTE and a clinical decision made and documented as to the necessity for prophylaxis taking into account the overall risks and benefits for individual patients.</p> <p>To ensure that patients have been treated appropriately following the VTE risk assessment.</p> <p>To identify if any areas have not followed the NICE Guidance and DCHS VTE Policy</p>	<ul style="list-style-type: none"> • None of the screening tools which were audited were fully completed – none had any information completed on page 2 of the screening tool. • There is some evidence that verbal and written advice is given to patients about VTE and how to reduce risk, but this is limited and further work is needed to encourage staff to provide evidence in patient records that they have discussed this with patients/carers. • Out of date screening forms were widely in use, and had not been updated. 	<ul style="list-style-type: none"> 1) Communications to staff to inform of importance of completing the tool fully. 2) Communication and sharing of the DCHS VTE Prophylaxis policy and screening tool with consultant team to ensure visiting consultants are aware of the process. 3) Clear process of who should complete each element of the screening tool, and when, to be agreed across the Outpatients and DTC teams and shared with all relevant staff as a Standard Operating Procedure (SOP). 4) Ensure the correct, up-to-date version of the screening tool is being used in all

	Project Title	Purpose	Outcome	Actions
				areas and any out of date forms are removed.

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2.2.3 Research

The number of patients receiving relevant health services provided or sub-contracted by DCHS in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee is 145; this is 6 less recruits when compared to 2017/18 activity.

2.2.4 Commissioning for Quality and Innovation (CQUIN)

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. The targets support ongoing innovation and improvement in care across our clinical services.

During 2018/19 we agreed 5 CQUIN measures; the themes for our CQUINs included:

- Health and Wellbeing: Staff survey, health food, flu vaccination uptake
- Prevent ill health through risky behaviours (i.e. alcohol and tobacco)
- Improving the assessment of wounds
- Improving the degree of personalised care planning for patients with long term conditions
- Using personalised patient goals in the treatment of patients with venous leg wounds (local).

A proportion of DCHS's income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between DCHS and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2018/19 and the for the following 12 month period are available in section 3.

The total CQUIN value available for 2018/19 was £3,416,478 and this was agreed as part of the block contract for DCHS. The monetary total for the associated payment in 2017/18 was £3.42m.

Areas of under achievement

We have continued to evaluate staff wellbeing through the annual staff survey, with the CQUIN focusing on responses to those questions related to positive action on health and well-being, and work-related stress. Despite a dedicated programme of wellbeing support being made available to staff, the results of the 2018/19 survey did not demonstrate the 5% point improvement required in these particular areas. This may be indicative of the high level of organisational change staff have experienced over the past 2 years.

The uptake of flu vaccinations for frontline clinical staff was 64.1%. This is a deterioration from the 2017/18 position (68.5%) and below the national target of 75%. Work to support uptake of the vaccination will continue and will be monitored through the DCHS Quality Schedule in 2019/20.

Performance against the Preventing Ill Health CQUIN saw an achievement in the majority of indicators; however, due to the low number of patients involved, the threshold for one indicator was missed by a small percentage. This CQUIN has an acute pathway focus which was challenging to fit within a community inpatient service. It should be noted that data capture has continued to improve in terms of achievement and accuracy over the 2 years of this CQUIN.

Healthy eating options for staff and visitors have been successfully implemented across all Trust sites. All DCHS Trust sites complied with the targets related to providing reduced levels of food and drink high in fat, sugar and salt. DCHS has also signed up to the national sugar-sweetened beverage reduction scheme.

This year the Personalised Care Planning CQUIN involved a number of key staff receiving personalised care training, and their associated patients receiving dedicated care and support planning conversations and interventions. DCHS achieved 100% of the training target and the average activation score of the relevant patient cohort increased from 0.96 to 1.46, indicating a positive impact on patients' engagement with, and confidence in, their own health and wellbeing.

The Improving Wound Care CQUIN continued the roll out of the national chronic wound assessment across frontline community services. Compliance of its use has been measured through a bi-annual audit, with a stretched target of 60% for Q2 and 80% for Q4. Whilst the final audit result did not meet

the 80% compliance target, in many cases the audit found that only one element prevented the assessment from being 100% completed, and the overall quality of wound assessments has significantly increased, demonstrating the value that support from the tissue viability team has added to clinical interventions.

In addition to the national personalised care CQUIN, DCHS, in conjunction with the CCG, also developed a local CQUIN on personalised goal setting for patients with a venous leg ulcer. Following a programme of training for staff in a pilot area of community nursing, a total of 50% patients had personalised goals set against an improvement target of 75% following a baseline audit. The implementation plan and wider roll-out of this CQUIN is now being refined and developed, as part of the 2019/20 CQUIN programme

2.2.5 Care Quality Commission (CQC)

DCHS is required to register with the CQC and its current registration status is registered. DCHS has no conditions on registration.

The CQC has not taken enforcement action against DCHS during 2018/19.

DCHS has not participated in any special reviews or investigations by the CQC during 2018/19.

2.2.6 Ratings for primary care services

The 3 GP practices continue to be rated good overall. See our GP Survey ratings at appendix 2.

2.2.7 Secondary uses service data

DCHS submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data

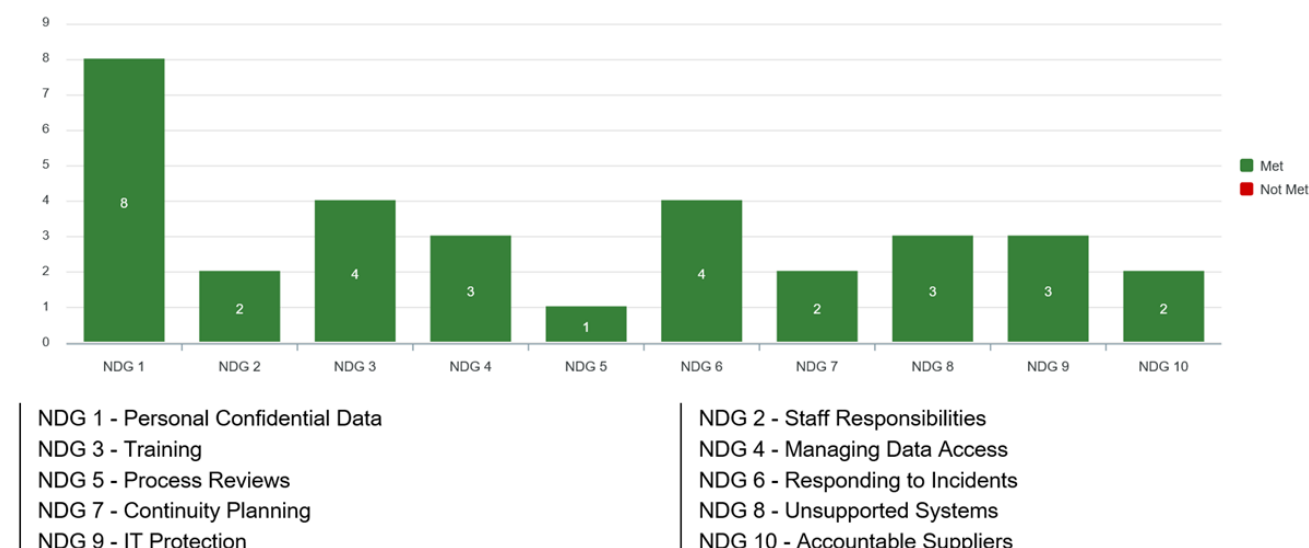
- which included the patient's valid NHS number was:
 - 100% for admitted patient care
 - 100% for outpatient care
 - 100% for accident and emergency care
- which included the patient's valid General Medical Practice Code was:
 - 100% for admitted patient care
 - 100% for outpatient care
 - 100% for accident and emergency care.

2.2.8 Information governance

DCHS' Data Security and Protection Toolkit overall rating for 2018/19 was 'Standards Met' with all mandatory assertions having been completed.

Graph 2 below shows DCHS' compliance against the 10 National Data Guardian Standards detailed in the toolkit:

Graph 2: DCHS compliance



2.2.9 Payment by Results

DCHS were not subject to the Payment by Results clinical coding audit during 2018/19 but did initiate its own internal audit, which measure the accuracy of clinical coding, the results of which are detailed in table 8 below.

Table 8: Clinical coding

Coding Field	DCHS Percentage Correct 2018/19	DCHS Percentage Correct 2017/18	DCHS Percentage Correct 2016/17	IG Req 505 Level 2	IG Req 505 Level 3
Primary diagnosis	91.00%	96.50%	92%	90%	95%
Secondary diagnosis	91.09%	92.26%	93.53%	80%	90%
Primary procedure	93.94%	98.92%	96.84%	90%	95%
Secondary procedure	90.21%	92.66%	93.71%	80%	90%

NB. It is important that results should not be extrapolated beyond the actual sample audited.

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

- The clinicians within the Trust and the Clinical Coding team members will develop an ongoing and regular process for reviewing activity data, how this is best represented in the clinical coding and what measures need to be put in place to ensure this can be maintained and effectively monitored. This will include the development of any local policies required during the process. Another outcome should be an improvement in the documentation that the clinical coders use to extract information from.
- The Department will engage with clinicians to formalise a local policy to support the effective recording of the type of cataracts. This could incorporate a chart for abbreviations and acronyms that are used and the most appropriate code for it. This could also be carried out in conjunction with discussion around the structure of the pro-forma used and how it could be improved to support data quality.

2.2.10 Learning from Deaths Analysis (Schedule 27)

Schedule 27.1

The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

The data provided in this report in relation to number of deaths and case note reviews / investigations are derived from our End of Life care audit, the monthly IT in-patient mortality report to the Clinical Effectiveness team and our mortality tracker respectively.

During 2018/19, 908 of DCHS' patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Table 9: Quarterly reporting of deaths

	Q1	Q2	Q3	Q4
Patient Deaths 2018/19	176	202	220	310

Schedule 27.2

The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

By 31 March 2019, 8 case record reviews and 3 investigations have been carried out in relation to 908 of the deaths included above.

In 1 case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Table 10: quarterly reporting of case reviews

	Q1	Q2	Q3	Q4
Case Note Review	5	3	0	0
Investigation	1	0	1	1

Schedule 27.3

An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

4 representing 0.4% of the patient deaths during the reporting period are judged to have been more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 0 representing 0% for the second quarter; 3 representing 1.4% for the third quarter; 1 representing 0.3% for the fourth quarter.

There is currently no prescribed methodology for case note reviews in community trusts. We have developed a hybrid of the community section of the global trigger tool and a root cause analysis (RCA) tool to be used as a template for the case record reviews. We used the Royal College of Physicians (RCP) structured judgement review avoidability scale to determine the level of avoidability although in year this has been revised to ask whether 'the death is thought to be more likely than not due to a problem in care'.

Schedule 27.4

Information requirement: a summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified:

The information gathered will continue to inform themes and trends as data increases, this information will be shared with the MRG through a bi-annual paper. Patients discussed at the MRG these are the emerging trends:

- Excellent monitoring and timely escalation of when people deteriorate - share excellent example of observations
- HCA exemplary performance - Not performing inappropriate cardiopulmonary resuscitation (CPR)

- Medication reviewed on regular basis and patient needs addressed promptly with additional doses as required
- Good liaison between community team and GP
- Involvement of multi-disciplinary team to address changes in patients' needs
- High quality of record keeping
- Team followed Sepsis guidelines
- Antimicrobial prescriptions in line with antimicrobial prescribing guidelines
- Multidisciplinary review of patient undertaken to support patient's wishes to die at home
- Example of excellent practice – good use of objective tool for validating frailty- Rockwood clinical scale.

Opportunities for Quality Improvement

- Recognising deteriorating patients and escalating care as appropriate
- Wound assessment documentation not completed fully
- Ensuring timely follow up on referrals
- Timely escalation of failed access on planned visits.
- Staff recognising delirium
- Recognition of risk of C Diff and appropriate actions being taken
- Greater level of alertness to monitoring compliance with professional recommendations in care homes subject to safeguarding proceedings.

Schedule 27.5

Information requirement: a description of actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4)

Quality Improvement Actions

1. "Failed Visit" Standard SOP has been developed. SOP is proceeding to Clinical Safety Group (CSG) for approval and will be launched once approved
2. Handover process reviewed to include specific discussion of patients with ongoing diarrhoea symptoms and appropriate mitigation implemented e.g. stool sample, diaries, continence assessment, diet, medication review
3. Summary sheet documentation to be updated to include infection control section to enable issues and specialist requirements to be highlighted to receiving ward/team
4. Delirium Task & Finish Group to continue and conclude all outstanding actions

Schedule 27.6

Information requirement: an assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

Staff are clearer about the mechanisms for seeking and obtaining the additional support and advice as highlighted within the lessons learned. One case was referred to a neighbouring acute trust for further review.

Table 16 in section 3.1.8 Medical Devices shows the increase in staff monitoring base line observations in patients which was identified as an emerging theme through the MRG meetings.

Schedule 27.7

The number of case records or reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.

45 case record reviews and 0 investigations completed after 01/04/2018 which related to deaths which took place before the start of the reporting period.

Schedule 27.8

An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

Five representing 11% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the methodology outlined in 27.3.

Schedule 27.9

A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant documents for that previous reporting period, taking into account of the deaths referred to in item 27.8.

Zero representing 0% of the patient deaths during the previous reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

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2.3 Core indicators

Since 2012/13 all NHS foundation trusts are required to report performance against a set of core indicators using data made available to them by NHS Digital. Many of the core indicators are not relevant to community services. Those that are applicable to DCHS appear in table 11 below. For completeness the full set of core indicators can be found at appendix 6.

Table 11: Core indicators applicable to DCHS

	Prescribed information	Related NHS Outcomes Framework Domain & who will report on them	2016/17	2017/18	2018/19
21	The data made available to the trust by NHS Digital 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 Trusts providing relevant acute services	87.5%	82%	82.8%
DCHS considers that this data is as described for the following reasons: we have worked actively with our staff to engage them in service development and delivery. DCHS has reported consistently excellent staff survey results for the last three years.					
DCHS intends the following actions to improve this percentage score and so the quality of its services, by continuing to actively engage with staff and to build upon its well-developed staff engagement processes and to continue its roll out work related to staff wellbeing.					
Comparative Data taken from NHS England Staff Friends and Family Test website When asked whether, if a friend or relative needed treatment, they would be happy with the standard of care provided by their organisation, 82% of staff agreed or strongly agreed (the average for community trusts is 73%) (data for 2016/17 = 86%).					
21.1	Friends and Family Test – Patient. The data made available to the trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2). <i>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.</i>	4: Ensuring that people have a positive experience of care Trusts providing relevant acute services	98%	97.8%	98.2%
DCHS considers that this data is as described for the following reasons: we have worked with our patients to ensure effective and robust feedback from across the breadth of our services and this is monitored by our patient experience and engagement group.					
DCHS has taken the following actions to improve this percentage score: engage with patients and carers, actively seek feedback, encourage completion of FFT cards, collate the findings from feedback and report on changes through our patient experience and engagement group. Develop patient engagement groups for specific service areas and undertake engagement events on key issues. During 2019/20 DCHS will explore options for electronic recording of patient feedback to increase capture of data.					
Comparative Data taken from NHS England Friends and Family Test data website Data for 2017/18 shows average of 97.8% of patients would recommend their local community services to friends and family.					
23	The data made available to the trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm Trusts providing relevant acute services	99.6%	99.9%	99.6%

	Prescribed information	Related NHS Outcomes Framework Domain & who will report on them	2016/17	2017/18	2018/19	
Derbyshire Community Health Services NHS Foundation Trust considers that this data is as described for the following reasons: Derbyshire Community Health Services NHS Foundation Trust has trained its staff well and has clear clinical policies.						
Derbyshire Community Health Services NHS Foundation Trust has taken the following actions to improve this percentage score and so the quality of its services by reviewing in detail any venous thromboembolism case to ensure any learning is shared throughout the organisation.						
Comparative data for community trusts is not available.						
25	The data made available to the trust by NHS Digital 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.	All trusts 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	Total - Patient Safety Incidents	10,002	10,018	7,221
			Severe harm or death	7	9	4
			% severe harm or death	0.07%	0.08%	0.05%
DCHS considers that this data is as described for the following reasons: DCHS has a culture of high reporting of clinical incidents as reported by National Reporting & Learning Scheme (NRLS). There has been a focus during the year on improving the timeliness of reporting.						
DCHS has taken the following actions to improve this rate and so the quality of its services, by developing a supportive reporting culture and ensuring that lessons learned from clinical incidents are shared organisation wide. Due to the reporting of inherited pressure damage and unwitnessed falls in community no longer requiring reporting there has been a significant drop in the total number of finally approved incidents.						
Comparative data NRLS April – Sept 2017 DCHS remains as having the highest reporting culture rate per 1000 bed days compared with 17 NHS community trusts. <1% of incidents in this period were reported as resulting in severe harm or death.						

Part 3 - Review of quality improvements 2018/19

This section of our annual quality report provides information on performance against our quality and performance indicators agreed internally by the Trust and also performance against relevant indicators and performance thresholds set by our regulators.





The Trust has chosen to include performance against a broad range of quality and performance indicators which are reported to the Board of Directors rather than specifically selecting three patient safety, three clinical effectiveness and three patient experience indicators. Performance against this range of indicators is included in table 12 below. Where possible we have included benchmarking information to show how we compare to other NHS organisations and comparative year on year performance. On a monthly basis a balanced score card of performance indicators is presented to the Board of Directors and where there is underperformance exception reports are provided which include actions that are being taken to improve outcomes.

Data quality kite mark scoring




Accurate information is fundamental to supporting the delivery of high quality care; we therefore strive to ensure all data is as accurate as possible. Our data quality kite mark scoring enables us to ensure that each indicator on the integrated performance summary dashboard is assessed against six dimensions of data quality, given as a summary of the quality of the indicator data. Using data collected following interview sessions with service staff; each system has been marked on the criteria of audit, timeliness, sign off, granularity, completeness and source/process. A system can score as not sufficient, sufficient or exemplary in each of the six areas. These areas make up the outer segments of the data quality kite mark shield e.g. a score of sufficient or exemplary marks the system as green on the kite mark shield for that section; and a score of not sufficient marks the system as red.

Where an indicator has not yet been assessed a white symbol is used. These dimensions and the definitions of the ratings are outlined here:

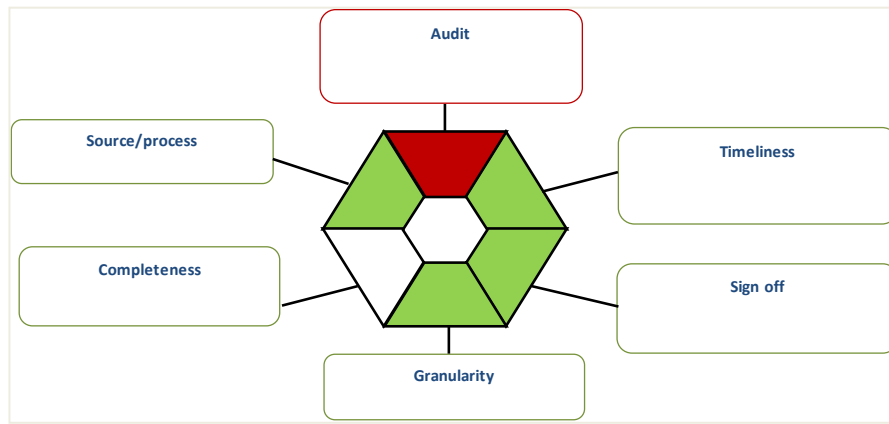
Key to colour coding – data quality kite mark scoring

	Indicator/measure has met or exceeded target
	Indicator/measure has not met target but is within acceptable tolerances. An action plan is in place and is being monitored.
	Indicator/measure has not met target and is beyond accepted tolerances. Immediate action and investigation has been instigated. An action plan is in place and is being monitored.
	Indicator/measure is not available, in development, or not applicable

Key to symbols

	Performance has improved/is above target
	Performance has declined/is below target
	Performance is stable and on target to be delivered

Each system will receive a data confidence score calculated by the total overall scoring given by four key members of staff relating to the specified system from information, performance and within the service. Each contact is asked to give the system a confidence rating out of five to state how accurately the system data reflects service activity, where five is complete confidence and one is no confidence. The total of the four scores will be displayed in the centre of the data quality kite mark shield. The Audit and Assurance Committee (AAC) receives quarterly reports on data quality.



DRAFT 24/04/2019

Table 12: Range of indicators

Key Performance Indicator (KPI)	Primary data source	Data quality score	Target 18/19	Average monthly score 16/17	Average monthly score 17/18	Average monthly score 18/19	Year-end data	Benchmarked performance**
Friends and Family Test scores	Datix	14	98%	97.9%	97.8%	98.3%	98.3%	95.8%
Complaints – number received	Datix	14	No target	11	13	11	131	-
Complaint cases completed within agreed timescale	Datix	14	80%	73%	84%	73%	66.4%	80%
Number of responses from Family and Friends Test	Datix	N/A	No target	2,101	2,428	2,231	26,778	-
Turnover %	ESR	12	14%	9.9%	8.5%	8.9%	8.9%	14.40%
Total sickness rate	ESR	12	3%	4.7%	5.2%	4.9%	4.9%	4.3%
Sickness long term	ESR	12	No target	2.7%	3.2%	2.9%	2.9%	-
Sickness short term	ESR	12	No target	2%	2%	2%	2%	-
Vacancy rate %	ESR	12	No target	6.8%	5.6%			-
Annual reviews (staff appraisals) carried out %	ESR	12	96%	92%	87%	93.6%	93.6%	88.4%
Clinical supervision %	Internal Spread sheet	N/A	100%	59.29%	65.51%***		83%	100%
Mandatory training	ESR	12	96%	96%	89%	97.1%	97.1%	88.4%
Mandatory training - information governance %	ESR	12	96%	93%	95%	95.9%	95.9%	96%
Medication errors causing serious harm (no.)	Datix	14	0	0	0	0	0	-
Never Events (no)	Datix	14	0	0	0	0	1	-
Avoidable grade 2, 3 & 4 pressure ulcers developed or deteriorated in Trust care (no.)	Datix	14	34	5	5	Data no longer collected 2019	30	-
Pressure ulcers which meet SI Criteria	Datix	14	0	n/a	n/a	3	34	34
Clostridium difficile incidence	Internal Spread sheet	N/A	0	0.5	0.2	0.1	1	10
MRSA bacteraemia incidence	Internal Spread sheet	N/A	0	0	0	0	0	0
Total grade 3 & 4 pressure ulcers developed or deteriorated in Trust care (no.)	Datix	14	0	7	4	Data no longer collected 2019	27	-
Safety thermometer all harms - % harm free care *	ST Tool	14	94%	93%	92%	Data no longer collected 2019	--	94%
STEIS serious incident reporting – open serious incidents	STEIS	14	No target	20	18	15.3	184	-
OPMH mental health delayed transfers of care - % attributable to the Trust	BI	14	3.5%	1.7%	3.8%	4.3%	4.3%	3.5%
Inpatients – delayed transfers of care	BI	14	3.5%	10.5%	8%	5.9%	5.5%	3.5%

Key Performance Indicator (KPI)	Primary data source	Data quality score	Target 18/19	Average monthly score 16/17	Average monthly score 17/18	Average monthly score 18/19	Year-end data	Benchmarked performance**
OPMH & Inpatients – delayed transfers of care	BI	14	3.5%	8.4%	7.1%	5.6%	5.3%	3.5%
A&E 4 hour wait for A&E attendances (%) (MIUs)	BI	16	95%	100%	99.9%	99.9%	99.9%	95%
RTT waits - admitted patients seen within 18 weeks - (2a) (%)	Systm1	16	No target	93%	95%	86.1%	86.1%	-
RTT waits - non admitted patients seen within 18 weeks - 95% (target) (1B)	Systm1	16	95%	95.2%	93.4%	91.1%	91.1%	n/a
RTT waits - incomplete pathway - 92% (target) (2) (%)	Systm1	16	92%	96%	95%	95%	95%	96.7%
Minimising mental health delayed transfers of care	BI	16	3.5%	1.7%	3.8%	5.6%	5.3%	3.5%
Mental health data completeness: identifiers	Systm1	16	97%	100%	100%	100%	100%	-
Certification against compliance with requirements regarding access to health care for people with a learning disability	EDILF report	n/a	Yes	Yes	Yes	Yes	Yes	Yes
Data completeness: community services - referral to treatment information	CIDS	16	95%	92%	97%	100%	100%	95%
Data completeness: community services - referral information	CIDS	16	95%	91%	96%	99.2%	99.2%	95%
Data completeness: community services - Treatment activity information	CIDS	16	95%	91%	96%	99.2%	99.2%	95%

*Data not collected

**Benchmarked Performance Data taken from October 2016 Aspirant FT Benchmarking Group

***Clinical supervision data is currently not available for Q3 & Q4, the process for collection changed mid-year. From 1st April 2018 this data is being collected via ESR.

Trust risk ratings (single oversight framework (SOF))

As a foundation trust we are 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. From 1 April 2016 to 30th September 2016 Continuity of service was measured on a scale of 1-4 with 1 being the highest risk and 4 the lowest risk
- From 1 October 2016 a new SOF became effective and replaced the previous continuity of services risk rating with a finance and use of resources metric. A rating of 1 now represents the lowest financial risk with a score of 4 being the highest 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). This rating was in place from 1 April 2016 to 30 September 2016.
- From 1 October 2016, under the new SOF, the governance rating was replaced with a segment rating. Trusts are segmented based upon the scale of issues faced by individual providers, with segment 1 providers having maximum autonomy, and segment 4 providers being those in special measures

We are given a rating for continuity of services / use of resources and a rating for governance / segment to indicate where there is a cause of concern and to determine the extent of any intervention required by NHS Improvement.

We have performed in line with our annual plan during 2018/19 and have achieved consistently good ratings and continue the success of the previous year see table 13.

There have been no formal interventions in year.

Table 13: Table of analysis

2018/19	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	Low risk	1	1	1	1
Finance and use of resources	Low risk	1	1	1	1
Governance rating	Green	Green	Green	Green	Green
Segment	Segment 1	Segment 1	Segment 1	Segment 1	Segment 1

2017/18	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	Low risk	1	1	1	1
Finance and use of resources	Low risk	1	1	1	1
Governance rating	Green	Green	Green	Green	Green
Segment	Segment 1	Segment 1	Segment 1	Segment 1	Segment 1

2016/17	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	Low risk	4	4		
Finance and use of resources	Low risk			1	1
Governance rating	Green	Green	Green		
Segment	Segment 1			Segment 1	Segment 1

3.1 What have we done to improve patient safety?

The provision of healthcare by its nature is a risky business and so one of our key clinical governance priorities is the provision of safe care and the management of risk. The following section provides examples of work undertaken by the patient safety team during the year to improve and monitor patient safety across the trust.

3.1.1 Sign up to Safety

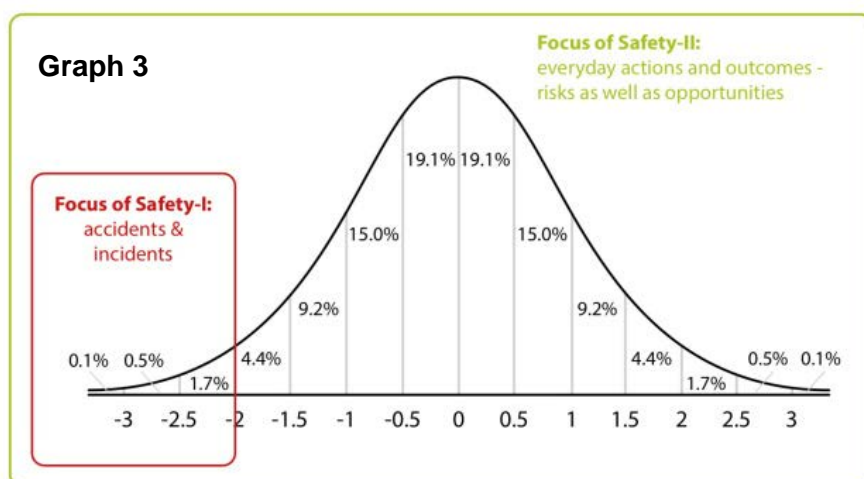
Sign up to Safety is a national patient safety campaign intended to harness the commitment of staff across the NHS in England to make care safer for patients. We formally signed up to the campaign on 3rd July 2015. The national campaign officially ended on 31st March 2019; however, DCHS have committed to continue to work towards the pledges made. The continuing Sign up to Safety pledges are listed in table 14.

The focus of Sign up to Safety has evolved over the years with the realisation of the importance and influences of human factors, staff health and well-being having a pivotal role in keeping patients safe. In addition we have emphasised the importance of learning from all care and not just when there has been an error. This is something that has been and continues to be embraced and built on in DCHS with the following initiatives:

- **Appreciative Inquiry** was used as the basis for staff team discussions (Mini Kitchen table discussions) held with teams across DCHS throughout 2017/18. Building on this during 2018/19 we have introduced '3I Dialogue Forums'. The 3I's stand for Included, Involved and Inspired evidence shows that staff who are included and involved are become inspired. '3I' has also been used with Allied Health Professions (AHPs) colleagues when setting the vision for their contribution to service in DCHS.
- **Shout Out** was launched in September 2018 to facilitate all staff being able to capture and celebrate excellence occurring across the trust. Any staff member can submit a "Shout Out" for a colleague or team who have delivered an excellent service within DCHS. From these submissions, issues where the organisation can learn from excellence are selected and shared with the Lessons Learnt Panel to share best practice organisationally. This enables us to shift the focus of learning to that of all care and not just when errors have occurred.
- **Safety I to Safety II** The patient safety team has embraced the need to move from Safety I to Safety II (Erik Hollnagel, November 01 2015).

Safety-I represents a concern for managing events with unacceptable outcomes. This is done by trying to explain how things go wrong in order to prevent any reoccurrence. The current focus on things that go wrong in practice excludes everything else. The Datix system and NRLS lends itself to this and even though we should be uncovering the Lessons Learnt, because it is only triggered from a Patient Safety Incident, the learning is limited to that area depicted in red in graph 3.

There is national recognition of the need for further focus on learning from incidents. This has led to the current development of a new database, Patient Safety Incident Management System, to replace both the NRLS and StEIS. The launch date of which is yet to be confirmed.



Safety-II looks at all events regardless of their outcomes, but in particular at the events that occur frequently that lead to the expected outcomes and which therefore are seen as 'normal' (in Safety-I these are, ironically, described as situations where 'nothing happens').

Table 14: Sign up to Safety pledges and progress to date

Pledge	Progress made
Pledge 1 Putting safety first - commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.	<p>Continence services have been working in collaboration with NHS Improvement on two initiatives to improve the care of patients with an indwelling catheter.</p> <ol style="list-style-type: none"> 1) to reduce the number of catheters within the University Hospitals Derby & Burton UHDB by implementing the HOUDINI (a catheter removal protocol). 2) to develop national documents for use with patients with a catheter. These include a National Patient Catheter Passport and catheter documents to use within the hospital setting. <p>Additionally the continence team have reviewed the education / training for catheters and are facilitating two days per month inclusive of the Foundations in Care. This includes a clinical skills session on catheterisation and catheter management and addresses their initial pledge to address inappropriate use of antibiotics for UTI's.</p> <p>Through the DCHS Falls Prevention Strategy the safe care movement team aimed to achieve a 5% reduction in the rate of harmful falls per 1000 occupied bed days in a hospital inpatient setting during the period of 2018/19.</p> <p>Tissue viability team's Time to Heal programme has achieved astounding results for patient's requiring chronic wound management – see item 3.1.17.</p>
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 the safety of our services.	<p>All patient safety incidents are reviewed by the patient safety team and all staff incidents are reviewed by the health and safety team to ensure that as an organisation we learn from the incidents investigated. Feedback is given to the Lessons Learned Panel, as well as to the investigating manager so that local and trust wide dissemination of information can occur.</p>
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.	<p>The patient safety team continues to ensure that duty of candour is exercised when serious harm occurs and those patients and their advocates are informed of any lessons learnt. The RCA training now incorporates patient experience and duty of candour elements to provide an insight into the relationship between being open and honest and its reduction in possible complaints.</p>

Pledge	Progress made
Pledge 4 Collaborate - work closely with our commissioner stakeholders and the serious incident network so that wider learning can occur. Actively consult with our workforce and nurture an open attitude to health and safety issues, encouraging staff to identify and report and suggest innovative solutions so that we can all contribute to creating and maintaining a safe working environment.	<p>The patient safety team meets regularly with the commissioner stakeholders and the serious incident networks to ensure wider learning occurs.</p> <p>The Medical Devices group have pledged to ensure that all frontline community staff are equipped with standardised equipment to take clinical observations (BP, temperature, oxygen saturations) to meet the requirement of NEWS2</p>
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	<p>We continue to strive to create a positive health culture. This is embedded into our policies and procedures. Human Contributory Factors is incorporated into RCA training so that during incident investigations there is further understanding of the crux of the problem and our staff are provided with training, support and confidence to learn and improve.</p>

3.1.2 Risk management

Reporting and managing risks effectively helps us to recognise issues, which pose either a threat or an opportunity for improvement, and helps us to track new or under-recognised safety issues. Clusters of patient safety incidents particularly those occurring more frequently may represent an important trend that needs a response (e.g. more transport or admissions-related problems). The Patient Safety team monitors incident trends to ensure that any related risk has been considered and registered on our risk management system (Datix) and that there are robust governance processes in place to address associated concerns.

3.1.3 Risk review

Risks are reviewed on a regular basis by managers through established governance meetings in accordance with our risk policy. To assist rating of a risk, a 5 x 5 risk grading matrix (see table 15) is used to identify the likelihood of a risk occurring against its resulting consequence.

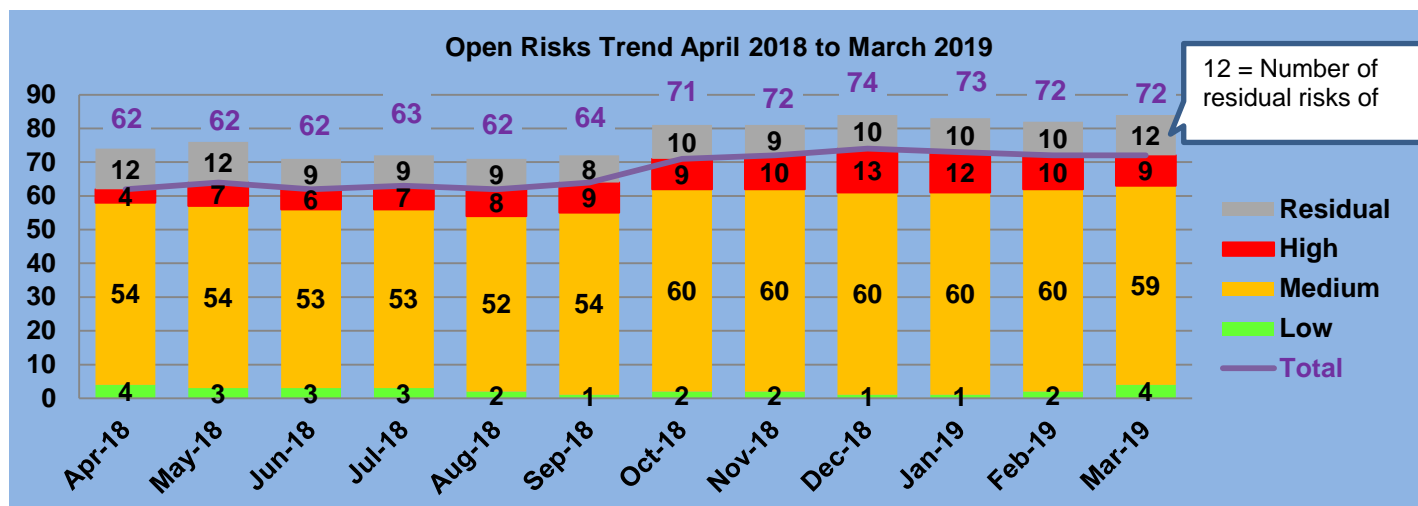
Table 15: Risk grading matrix

LIKELIHOOD	Almost certain	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	15
	Unlikely	2	4	6	8	10
	Rare	1	2	3	4	5
		INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
CONSEQUENCE						

To ensure overview of all risks the Trust's Board review all risks rated 10 and above on a monthly basis, the Quality Service Committee (QSC) review all risks rated 10 and above bi-monthly. Risks 9 and below are reviewed by the QSC on a quarterly basis.

There have been no risks overdue a review for 23 consecutive months at the final review and reporting stage. Risks form a standing agenda item are discussed at each divisional governance meeting. An overall trend line of risks through the financial year is shown in graph 4.

Graph 4: Risk trend line April 2018 to March 2019



3.1.4 Risk assurance

The Trust's Board have taken significant assurance regarding risk management throughout the year. DCHS has effective mechanisms in place to ensure that risks are identified and managed right across the organisation. The risk management team continue to provide support and guidance as and when required. The effectiveness of the risk management strategy and policy have been recognised by the Board, Deloitte in the Well Led Review (2018) and the CQC during their last inspection.

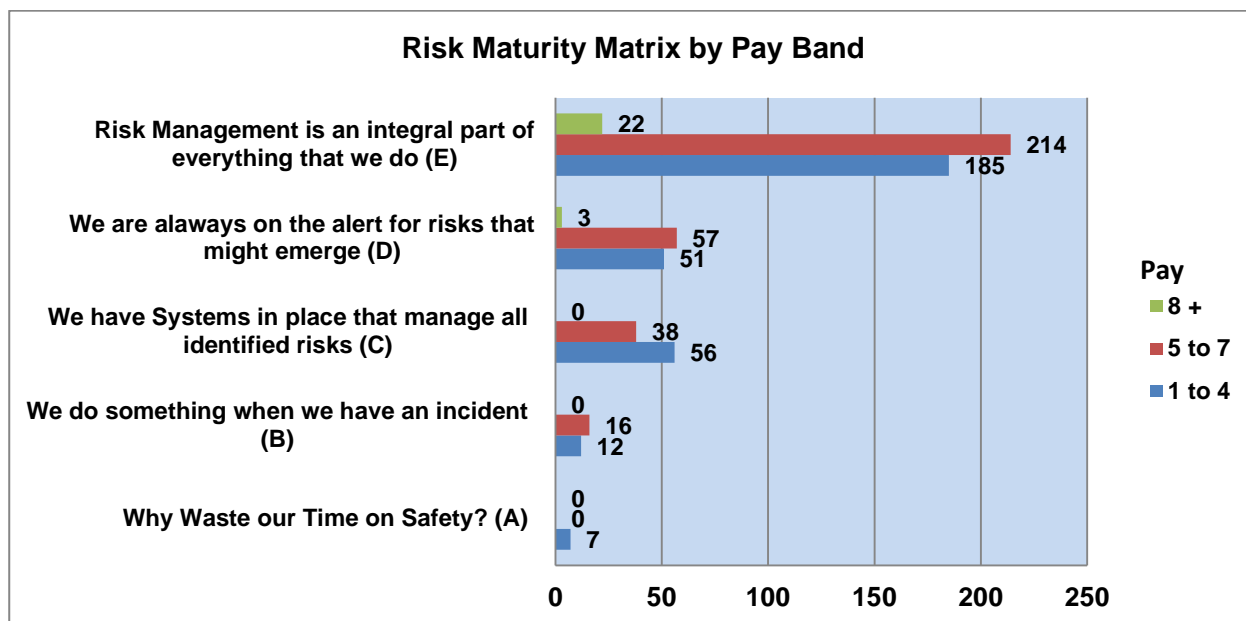
3.1.5 Risk maturity

There is evidence of increasing risk maturity across DCHS. This was remarked on positively during the Deloitte 'Well Led' visit. The maturity is demonstrated regularly within the risk register i.e. risks appear more fluid and better described in the controls and further controls sections when compared to previous years.

For 2018/19 the aim was to continue to promote and provide further support improved awareness of risk management across the Trust with particular emphasis on improving awareness of risk management at a more junior team level. From 1st April 2017 the risk management team have used a simple matrix of 5 questions to gain staff responses in terms of levels of risk maturity as detailed in table 16. This provides staff an opportunity to identify and indicate what importance is placed on risk management in their workplace.

Measurements are now well established and provide the risk management team an opportunity to bolster training and conversations around specific aspects of risk management. The data yielded in 2018/19, (consisting of 661 responses from 777 issued questionnaires) shows that there is a positive culture to risk management. The responses yielded an 85% return and of these 64% rated risk management as an integral part of everything that we do. This data enables the risk management team to identify the effectiveness of existing risk management training and awareness.

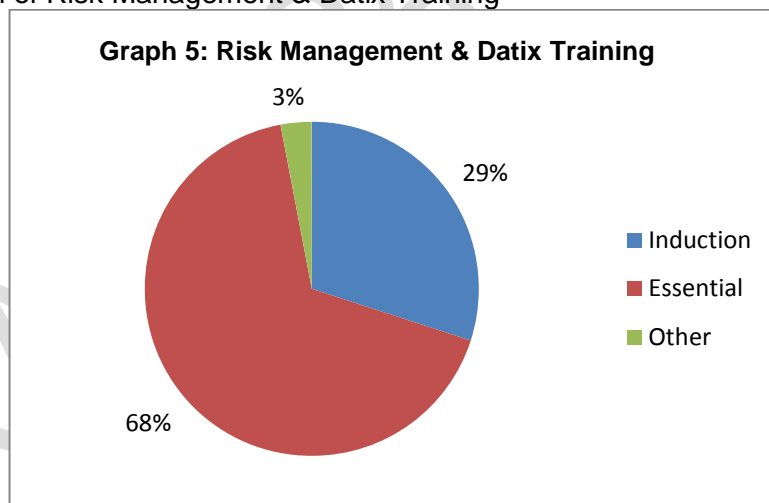
Table 16: Responses during April 2018 to March 2019



3.1.6 Risk training

During 2018/19 the risk management team provided risk management training to 1322 members of staff. This is approximately 30% of staff employed by DCHS. This is based on a total of 4,416 substantive staff as recorded in the 2017/18 annual quality report. Training includes induction, essential, preceptorship and risk management training. This is supplemented by bespoke individual or team training.

Graph 5: Breakdown of Risk Management & Datix Training



3.1.7 Clinical policies, guidelines and procedures (referred to as ‘clinical documentation’)

Clinical documentation is at the core of every patient encounter. In order to be meaningful it must be accurate, timely, and reflect the scope of services provided. For this report the different type of documents that are identified in table 17 will be referred to generically as ‘clinical documentation’.

DCHS recognises its public accountability, and has established and maintains two central “clinical documentation” sites to ensure compliance with relevant legislation, taking into account professional guidance and standards and reflecting best practice; these two sites [clinical policies site](#) and [clinical documentation site](#) are managed by the Safe Care Team.

It is of paramount importance to ensure information is efficiently managed, and that all clinical documentation has gone through the correct governance and approval process as this together with

management accountability and structures provide a robust governance framework for information management.

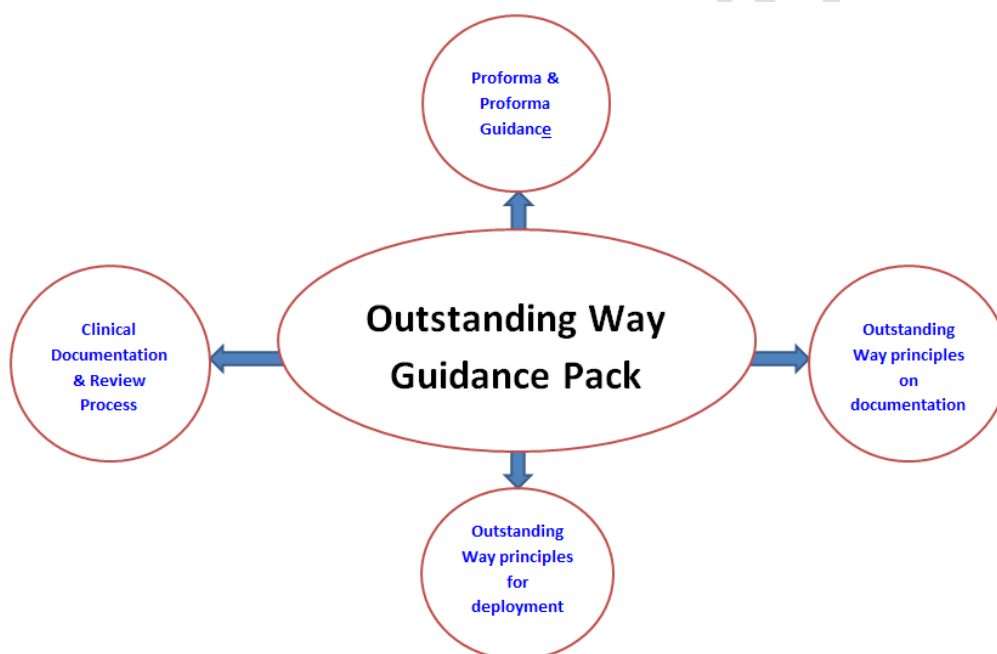
3.1.7.i Current numbers of all clinical documentation

Table 17: Clinical documentation numbers

Type of document	DCHS Stand-alone clinical document	Appendix in another document	None DCHS document	Total	Pending archiving
Policies	66	0	0	66	0
Guidelines	43	26	0	69	0
Procedures & Protocols	31	14	0	45	0
Leaflets	120	60	2	182	0
Forms	13	0	0	13	0
Documentation Paper	172	104	34	310	13

3.1.7.ii Documentation Review Process

The review of clinical documentation is a dynamic process and the numerous changes that occur due to new documents being developed and older ones archived or replaced are actioned within a timely manner. The outstanding way guidance pack below has been developed to support clinicians with the agreed process.



Clinical documentation is generally approved for three years and the safe care team advises teams 9 months prior to the review date that they are due for review, to achieve this a rolling clinical documentation database has been created which monitors review dates.

The clinical documentation group is well established and has been running since 2014. The overall aim of the group is to provide assurance to CSG that the trust is meeting its contractual obligations and expectations of external bodies such as the CQC, NHS Resolution and NICE in respect to clinical policies and guidance (collectively known as clinical documentation). The group will support DCHS to improve the quality and safety of care across services by ensuring that clinical documents are effective, safe and in line with best national practice and that professional standards are clearly outlined and embedded in clinical records and documentation to prevent harm.

The clinical leaflets group was established in July 2018 and is a sub group of the clinical documentation group. The group's overall aims is to provide assurance to the clinical documentation group and its parent group, CSG, that the Trust is meeting its contractual obligations and the expectations of external bodies such as the CQC, NHS Resolution and NICE in respect to clinical leaflets.

3.1.7.iii Compliance

Currently 100% of all clinical documentation has been reviewed and are within their review date.

3.1.7.iv Number of clinical documentation approved / archived and new between March 2018 – March 2019

Table 18: Clinical documentation approved / archived / new

Type of document	Approved	Archived	New
Policies	14	10	2
Guidelines	28	14	10
Procedures & Protocols	20	9	14
Leaflets	87	7	45
Forms	1	0	1
Documentation Paper	62	72	11

3.1.7.v Governance of DCHS's Information Systems

The Data Security and Protection toolkit (DSP) (formerly the IG Toolkit) is completed annually, with backing evidence confirming compliance, and submitted by 31st March each financial year. The toolkit contains several assertions related to the governance and security assurance of our electronic information systems:

- **Managing Data Access** - Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on Information Technology (IT) systems can be attributed to individuals.
- **Unsupported Systems** - No unsupported operating systems, software or internet browsers are used within the IT estate.
- **IT Protection** - A strategy is in place for protecting IT systems from cyber threats which are based on a proven cyber security framework such as cyber essentials. This is reviewed at least annually.
- **Accountable Suppliers** - IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

The Information Governance (IG) Team are reviewing and updating DCHS's information asset register (a list of our information systems) to ensure this information is evidenced and held centrally for each system.

DCHS's DSP toolkit compliance is monitored by the IG & Records Management Group and the IM&T Strategy Group. A full action plan is taken to each meeting of the IG & Records Management Group and compliance is reported through to QSC in the summary report following each meeting.

DCHS is also audited annually on our DSP Toolkit compliance; the audit by KPMG took place in November 2018 and reported to Audit and Assurance Committee.

3.1.8 Medical Devices

There has been extensive work completed with regards to the standardisation of medical devices within community teams to ensure that all staff working in the trust have access to standardised equipment, which has been approved through a well governed process.

The provision of baseline kit (tympanic thermometer and sphygmomanometer) for community nurses and therapists was commenced in September 2017 and continued through 2018. This resulted in a truly significant year on year increase in baseline observations (taking into account the 10% increase in clinically-relevant patients during 2018) as detailed in table 19.

Table 19: Vital signs reporting 2017/18

Community Nursing			Community Therapists		
% increase on vital signs reporting from previous year			% increase on vital signs reporting from previous year		
Observation:	2017	2018	Observation:	2017	2018
Lying diastolic blood pressure	169.84	70.60	Lying diastolic blood pressure	147.97	25.15
Lying systolic blood pressure	186.33	61.97	Lying systolic blood pressure	149.45	24.26
O/E - pulse rate	133.50	37.07	O/E - pulse rate	128.83	60.7
O/E - rate of respiration	132.58	37.83	O/E - rate of respiration	116.33	68.61
Sitting diastolic blood pressure	122.77	34.11	Sitting diastolic blood pressure	104.45	60.50
Sitting systolic blood pressure	123.12	34.16	Sitting systolic blood pressure	104.36	60.31
Standing diastolic blood pressure	235.75	9.65	Standing diastolic blood pressure	109.26	41.72
Standing systolic blood pressure	224.58	8.83	Standing systolic blood pressure	109.20	42.31
Temperature	86.24	64.27	Temperature	120.02	87.37
Grand total	126.78	40.47	Grand total	114.40	58.82

This is being further developed with the provision of pulse oximeters to meet the requirements of the revised national early warning score (NEWS2). This has been recognised in the Quality Big 3: improving the identification of sepsis and recognition of the deteriorating patient and has been detailed in section 2.1.2.

3.1.9 National Reporting & Learning System (NRLS)

All patient safety incidents reported onto Datix which meet the reporting requirements are communicated to NHS England's NRLS 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 feed into national trends and promoting national improvements.

During the period 1 April 2018 to 31 March 2019, there have been a total of 7,994 patient safety incidents reported (excluding 689 rejected reports), of these 7,033 have already been communicated to the NRLS. Please note that the NRLS do not require all patient safety incidents to be communicated to them. At the time of reporting there were 188 (180 last year) patient incidents in the Datix system in the review process i.e. 109 (92 last year) awaiting review by manager, 33 (27 last year) actively being reviewed by manager and 46 (61 last year) waiting follow-up by the patient safety team. This is showing a slight delay in responsiveness by the incident managers, which is reflected on the corporate risk register, but still an improvement compared with 2016/17.

Table 20: Patient incidents in Datix

	April 2016-March 2017	April 2017-March 2018	April 2018-March 2019
In holding area, awaiting review	240	92	109
Being reviewed	70	27	33
Awaiting final approval	94	61	46

Table 21 compares incident rate by severity classification. This is a much improved picture compared with previous years. There have been 0 major harm incidents and a reduction from 9 to 4 catastrophic incidents reported. The mortality review process ensures these are reviewed to determine if our clinicians provided reasonable care in foreseeable situations. Due to the reporting of inherited pressure damage and unwitnessed falls in community no longer requiring reporting, there has been a significant drop in the total number of finally approved incidents.

Table 21: Incidents by severity

Incidents by severity comparable data	2016/17	2017/18	2018/19
No injury or harm	3,574	3,905	3,558
Minor harm/injury	5,897	5,851	4,105

Incidents by severity comparable data	2016/17	2017/18	2018/19
Significant harm/injury	344	253	141
Major harm/injury including permanent disability	2	0	0
Death/multiple deaths or catastrophic event (e.g. flood/fire)	5	9	4
Totals:	10,002	10,018	7,808

The catastrophic events comprise one each of: cardiac arrest on attendance to MIU; suspected suicide in patient's home; subdural haematoma post unwitnessed fall in a care home and an unexpected death in a residential home which has been referred to the Coroner.

3.1.10 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. The revised list was launched in January 2018 where there have been a small number of changes which the patient safety team is in the process of incorporating onto the Datix system. During 2018/19 there has been 1 Never Event reported by the Trust which met the NHS England's Never Events listed fields.

The incident pertained to a dental green pack left in situ when it should have been removed. This was noticed before the end of the procedure in the recovery area and did not cause harm. In the spirit of transparency and learning, DCHS reported this incident as a No Harm, Never Event i.e. that unnoticed this may have caused harm and that the learning was great. The learning was shared through all relevant departments; guidelines were updated and distributed to enhance learning.

Table 22: The top five reported incidents and trends over the past three years

2016 /17		2017/18		2018/19	
Pressure relief care	4,507	Pressure relief care	5,180	Pressure Relief	3,291
Slips, trips and falls (patient)	974	Slips, trips and falls (patient)	931	Slips, trips and falls (patient)	713
Ambulance/taxi/transport issue	603	Medication	699	Medication	634
Medication	545	Discharge Problem	509	Discharge Problem	484
Discharge or transfer problem	419	Safeguarding Adults	469	Safeguarding Adults	444
Totals:	7,048	Totals:	7,788	Totals:	5,566

Part of the impact on the figures for 2018/19 for pressure relief and slips, trips and falls (patient) is attributed to the cessation of incident reporting of inherited pressure damage and unwitnessed falls in community. This change was made because these incidents do not pertain to care delivered by DCHS. These are now captured on the electronic patient record in Systm1.

Managing the transfer of patients safely between different health care facilities is essential. The patient safety team sends details of all discharge / transfer incidents to our acute trust partners. Responses are shared through our risk reporting system to the relevant manager so that any lessons learned are communicated. Due to this focused work the number of discharge / transfer incidents needing to be raised is gradually decreasing year on year.

Safeguarding adults' incidents are those reported by our staff who have raised concerns which they have observed when administering care to patients. These incidents are usually related to influences external to the Trust and as such are not further communicated to the NRLS. The notification system within Datix allows the safeguarding teams to be aware of an incident as soon as it is reported.

3.1.11 Central Alert System and Strategic Executive Information System (STEIS)

The Central Alert System is a national reporting system which distributes alerts from NHS England, alerting health organisations of safety issues. During the financial year of 2018/19 a total of 110 alerts were received compared with 128 in the previous financial year. Each alert is reviewed for its relevance to our Trust and distributed to the services where the alert applies. All alerts were

responded to within the required time frames and the implementation of any required actions is followed up by the patient safety team to ensure it has been executed.

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure there are systematic measures in place to respond. We report incidents under the following severity of harm: no harm / minor / moderate / significant / major / death. Serious incidents are those considered when harm caused is moderate or significant and in the majority of cases, will require further investigation and reporting to commissioners via STEIS. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

The patient safety team processes all serious incidents and checks that, where appropriate, learning is shared across the organisation.

Table 23: Incidents reported on STEIS

Category	STEIS incidents 2016/17	Category	STEIS incidents 2017/18	Category	STEIS incidents 2018/19
Pressure ulcers	60	Pressure ulcers	62	Pressure ulcers	51
Slips / trips / falls	23	Slips / trips / falls	4	Slips / trips / falls	14
Delayed diagnosis	1	Medication	2	Treatment / Diagnosis Delay	2
Pending review	2	Infection prevention and control	1	Medication	1
Medical equipment	1	Sub-optimal care	1	Sub-optimal care	1
Sub-optimal care	1	Pending review	0	Surgical / Invasive procedure	1
				Medical Equipment – Devices	1 Never Event
Total	88		70		71

3.1.12 Serious Incident

During October 2017 we were informed that a serious incident had occurred in the operating theatres at Ilkeston Hospital. A surgeon had received a letter from a pathologist at UHDB informing him that 2 histopathology (tissue) samples had been transposed resulting in surgery being carried out on one patient who did not need surgery and surgery not being carried out on one patient who did need surgery.

The 2 patients had both had elective procedures carried out in Ilkeston and tissue samples were sent from both patients to Derby. These samples revealed that one patient had pre-cancerous changes in the sample and she was booked for further surgery under a general anaesthetic again samples were sent for histological examination in Derby. These samples proved normal and on review of the original samples the transposition was identified.

Both patients had appointments with the surgeon and the surgeon personally notified the patients of the error. The duty of candour process was comprehensive and the patients both received an apology from UHDB. The patients were also able to question a senior doctor from the pathology service. The full incident report has now been received from UHDB and the conclusions shared with the patients. An offer has been made for a further meeting with the Medical Director and Head of Patient Safety.

The investigation confirmed that the multi-organisational pathway of care did not contribute to the error. We have carefully reviewed our procedures for labelling and transporting samples to ensure that these are as safe as possible.

3.1.13 Human factors (HF)

The principles and practices of HF focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment. By acknowledging human limitations, HF offers ways to minimise and mitigate human frailties, so reducing medical error and its consequences. The system-wide adoption of these concepts offers a unique opportunity to support cultural change and empower DCHS to put patient safety and clinical excellence at its core.

The patient safety team are making changes to the report form on Datix to enable the capture of HF from the perspective of the reporter and the incident manager to ensure that all incident investigations consider and address the 12 main areas highlighted in the DuPont's Dirty Dozen of Human Factors which are:

A Lack of: communication, resources, assertiveness, awareness, team work, knowledge

An abundance of: stress, pressure, norms, fatigue, distraction, complacency

It is recognised that when any 1 of these contributory factors are present then an error can occur and that when 3 or more are present significant harm is more likely to be the outcome.

3.1.14 Duty of Candour

We expect that our staff will always be open and honest with the patients and families they care for. This is especially important where care does not go as planned and where serious harm has occurred.

The Trust is committed to providing an open and honest explanation to patients and a sincere apology where serious harm has happened. During the reporting period 2018/19 there has been 71 incidents meeting the duty of candour criteria. Patients have been contacted and a full explanation provided following investigation.

Duty of candour is a thread throughout Trust induction, essential training, RCA training and incident managers Datix training as well as being identified in our Sign up to Safety pledges.

References:

From Safety I to Safety II – A White Paper, Erik Hollnagel, November 01 2015

<https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-white-papr.pdf>

NHS England: Human Factors in Healthcare A Concordat from the National Quality Board

<https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf>

3.1.15 End of life care

We continue to work on the delivery of our 3 year end of life care strategic implementation plan which aims to improve and develop the quality and safety of patient care, supported through the development of our staff or service. In 2018/19 we saw the first end of life care training programme that was bespoke to meet the needs of our AHPs, to value and recognise their contribution to end of life care. We continue to support and develop our safe care quality always end of life care and spirituality champions who support and disseminate best practice in their individual areas. We proactively supported engagement of our staff and services with the key themes during the 2018 National Dying Matters week through local displays and a cross organisation event. Current work streams include the development of a DCHS directory of end of life care services to bring together all services that support end of life care into one easy accessible place for staff to use. Introduction of an Electronic Palliative Care Co-ordination system (EPaCCS) which aims to improve communication and co-ordination of care will be implemented as a pilot in one area of DCHS and then rolled out to further areas across the organisation throughout 2019.

3.1.16 Allied Health Professions and End of Life Care

In DCHS Allied Health Professions contribute significantly to the multidisciplinary and holistic care of patients in their final year of life. This is a relatively new clinical role for these professions. Nationally,

professional bodies have not published role descriptions to inform the development of competency frameworks or training needs.

In 2017, our end of life care strategy group noted the lack of take up of internal end of life training days. The end of life care facilitator was asked to develop an offer that would meet the needs of AHPs. This was co-produced with therapists working in clinical posts, along with local experts in partner organisations.

40 therapists attended a pilot study day delivered in north and south locations in November 2018. Evaluation of the courses took the form of a pre and post course questionnaire to assist the staff to reflect on their own learning.

In response to the question 'Did you feel that the day met your expectations?' 29 out of 40 responded they were fully or partially met. Additional content was suggested to enhance the impact of the day for future attendees.

The new post of specialist lead trainer for end of life care and dementia has a sound foundation on which to develop the contribution of DCHS' AHPs to multi-disciplinary end of life care.

3.1.17 Time to Heal

DCHS's 'Time to Heal' leg ulcer improvement initiative was set up to:

- 1) Expand and redesign existing leg ulcer and wound management training
- 2) Appoint a chronic wound specialist nurse to review patients from the leg ulcer audit who had been on caseloads for more than 200 days.
- 3) Second leg ulcer specialist nurses to support community teams to review patients with lower limb wounds,
- 4) Embed knowledge and skills acquired on training and assess competencies
- 5) Develop a clinical leadership programme which included health coaching to ensure quality conversations and patient focused plans of care.

Patient Outcomes: chronic wound specialist reviews at 12 weeks: 32% healed and discharged. Leg Ulcer Specialist reviews 42% healed and discharged.

Table 24: Patient outcomes

	6 Week Review	12 Week Review	18 Week Review	Total
Wound healed	207 (26%)	91(16%)	61 (18%)	359
Wound improving	272 (34%)	146 (25%)	112 (33%)	530
No change	105 (13%)	99 (17%)	71 (21%)	275
Wound deteriorating	47 (6%)	44 (8%)	20 (6%)	111
Has capacity refusing treatment	25 (3%)	18 (2%)	10 (3%)	53
In Hospital	27 (3%)	21 (4%)	7 (2%)	55
No longer in DCHS care	24 (3%)	19 (3%)	6 (2%)	49
Deceased	24 (3%)	20 (3%)	15 (4%)	59
Impact on Community Nursing Teams	At 6 Weeks	At 12 Weeks	At 18 Weeks	
Reduction in Nursing visits per week	268	165	160	593

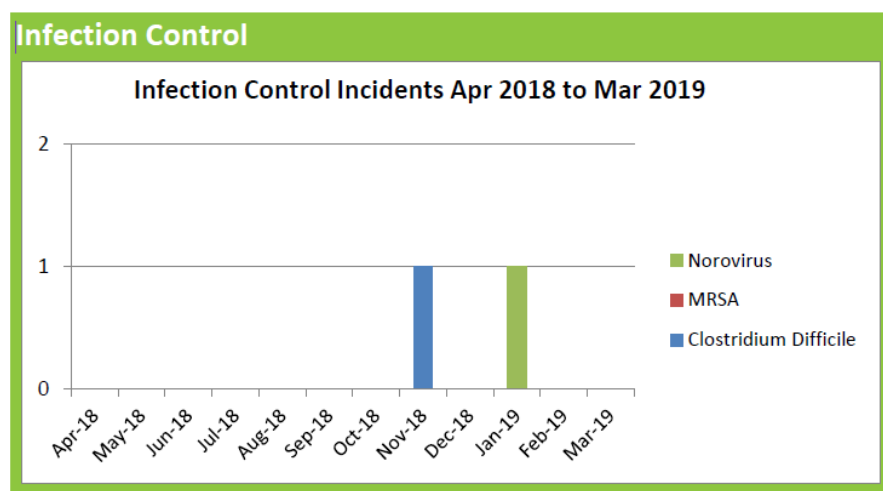
For 138 patients that healed at 6 weeks the suboptimal care cost prior to leg ulcer specialist intervention was £435,646.14. This was reduced to £44,861.04. Potential Cost savings for 138 patients if optimal care pathway was to be followed £390,785.01

3.1.18 Infection prevention and control (IP&C)

Infection, prevention & control remains a high priority for DCHS and our good performance is reliant on the continued commitment of the team in promoting best practice, alongside the commitment of staff, patients and visitors in ensuring that we keep healthcare associated infections (HCAI's) as low

as possible. Again, this year we can report that our infection rates have remained low with 3 cases of *Clostridium difficile* infection and no blood stream infections (bacteraemias) reported.

Graph 6: Infection control incidents April 2018 – March 2019



We have been involved in improving awareness of sepsis across the Trust, including the recognition of early signs and symptoms and its management.

The work to reduce *E. coli* bacteraemia in the community has been ongoing and the IP&C team have continued to collaborate with the CCG and other partners in the wider health economy.

Patient Story – Freddie's Story

Amanda, School Nurse told the story of Freddie, 9 years old. Freddie had poor personal hygiene and low school attendance (82%) due to frequent sickness and diarrhoea. As a subsequence of his absences the relationships with his peers were not as strong as they could have been. Amanda offered him and his family support around handwashing. The initial presentation of the session to the Freddie's family went well with everyone engaging and singing along to a cartoon.

Amanda offered to present a handwashing session to Freddie's school year of around 50 students. This was done with a view to improve Freddie's self-esteem and interaction with his peers and he agreed to be her 'assistant' to present the session.

During the session we had a hands up quiz; used glitter and handshakes to visually demonstrate the transmission of bacteria; used a lightbox to check handwashing techniques which also captured the children's attention. Freddie co-presented the session brilliantly. In addition, a colleague was able to join in and following watching the session they were able to present the second session.

Following the session's that were presented by Freddie, the school reported that absences for diarrhoea and sickness had dramatically declined. Since the training Freddie has only had authorised absences due to medical appointments.

3.1.19 Patient Manual Handling and Bariatric Care

This year the team has supported 159 new patients (bariatric and complex) in community hospitals, transfers to community beds from acute hospitals and in their own homes. Patient records are now managed electronically allowing better communication with clinicians and data collection.

The team works with partner agencies to improve the flow of the patients' journey for people with bariatric needs from acute hospital to community beds or discharge ensuring the availability of appropriate equipment and staff to provide safe, high quality care.

We have been working with IP&C, occupational health, health and safety and tissue viability teams to support community nursing services with equipment and advice to reducing the occurrence of injury to

staff from prolonged poor postures due to low level working for leg dressings in the home and the complex wound clinics.

We have continued to review and audit personal handling equipment throughout the trust to ensure safety and availability. The programme to replace mobile passive hoists is due for completion this financial year and will reduce the risk from different systems. Flat lift equipment (Hovermat and jacks) is being deployed across the trust to enable safer and more comfortable lifting of people from the floor and transferring from bed to bed.

Compliance with mandatory patient manual handling continues to increase through bespoke training to teams and through the key trainer system. E-learning packages are soon to be available for staff for bed rail and bed area training and the provision of further training being provided at Induction.

3.1.20 Falls prevention assessment and care planning

Inpatient areas have been utilising the new falls risk assessment documentation designed to enhance risk identification and improve care planning documentation standards. A follow up audit of falls risk documentation will be carried out, when the implementation of electronic patient records has been rolled out across all inpatient areas. Community services have undergone a transformation of a suite of patient assessments including falls prevention. Falls prevention specialists will continue to support staff across all clinical areas to ensure clinical assessments and interventions are representative of best practice.

3.1.21 Falls management

This year we have focused on the DCHS deliverable elements of the Derbyshire wide falls & fracture pathway, working alongside colleagues in social care, health and voluntary sectors across Derbyshire and Derby City and begun to outline a new service framework to offer to commissioners. We will continue to have a vital role which focuses on providing rehabilitation to improve strength and balance, restore function, independence and minimise the impact of recurrent falls and fall-related injuries on our elderly population across all clinical services.

3.1.22 Food Texture Descriptors

Dysphagia is the medical term for swallowing difficulties and a sign or symptom of disease, which may be neurological, muscular, physiological or structural. Dysphagia affects people of all ages in all types of care setting. Food texture modification is widely accepted as a way to manage dysphagia.

Historically the terms relating to food textures and fluid thickening, such as 'custard thickness', have varied locally. In 2011 a national standard terminology for modified food texture, including terms such as 'fork-mashable' developed and widely adopted by the hospital catering industry and many clinical settings. However, local variations have persisted for food and fluid texture, confusing patients, carers and healthcare staff. In June 2018 a National Safety Alert (NHS/PSA/RE/2018/004) required the following actions; all organisations providing NHS funded-care for patients who have dysphagia or need the texture of their diet modified for other reasons, including acute, mental health and learning disabilities trusts, community services. The campaign was to be started immediately and be completed by 1 April 2019.

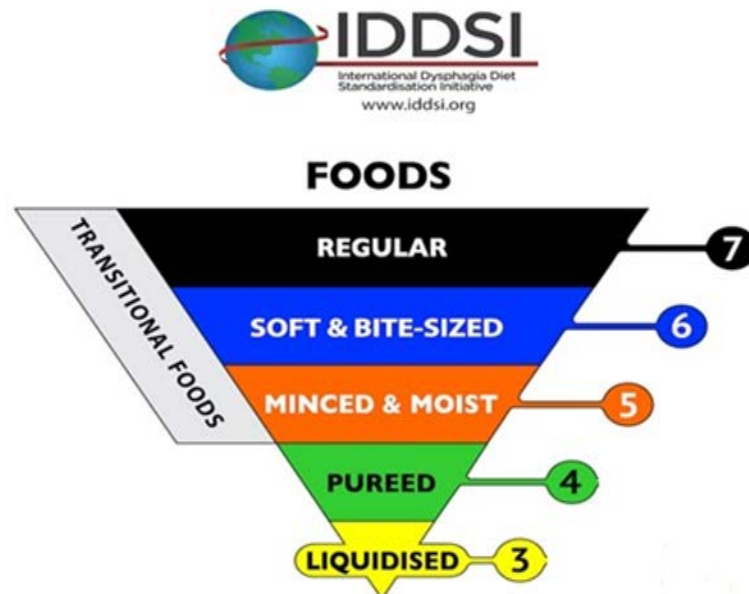
A review of NRLS incidents over a recent two-year period identified seven reports where patients appear to have come to significant harm because of confusion about the meaning of the term 'soft diet'. As a result of the review the International Dysphagia Diet Standardisation Initiative (IDDSI) developed a standard terminology with a colour and numerical index to describe texture modification for food and drink. Manufacturers were required to change their labelling and instructions accordingly, with an aim to complete this by April 2019.

Transition from the current range of food and drink texture descriptors to IDDSI framework for people with dysphagia required careful local planning to ensure it happened as soon and as safely as possible. A senior clinical leader was identified who brought together key individuals (speech and language, therapists, dietitians, nurses, medical staff, pharmacists and catering services) to plan and co-ordinate the safe and effective transition to the IDDSI framework and eliminate use of imprecise terminology including 'soft diet' across DCHS. A local implementation plan was developed, which

included revising systems for ordering diets, amending in patient menus local training, clinical procedures and protocols, posters and guidelines and patient information.

Through a local communications strategy (newsletters and local awareness campaign) all relevant staff were given opportunity to be aware of the IDDSI resources and importance of eliminating imprecise terminology including 'soft diet', and understand. Local posters were created along with resource packs for use by appropriate staff and professionals. This work is now completed.

Graph 7: International Dysphagia Diet Standardisation Initiative



3.1.23 Diabetes Specialist Nurses (DSN)

The specialist nurses have received additional funding from transformational monies to increase their service. This has led to additional joint clinics being run within GP surgeries supporting practice staff to increase their expertise.

Additional specialist nurse support has been given at Whitworth Hospital in the specialist foot clinic supporting patients to improve their diabetes control, improve health outcomes and reduce referral to secondary care services. Average HbA1c* before DSN started treating them was 9.91%, the average latest figures were 8.56% So there was a mean average 1.35% decrease in HbA1c which is a significant improvement. An additional foot clinic is also supported in Buxton.

*HbA1c is your average blood glucose (sugar) levels for the last two to three months

The DSNs have been using 'Flo telehealth' to support patients when starting insulin as a short term intervention; this allows monitoring of glucose levels remotely and potential reduction of face to face contacts.

The DSNs continue to provide training for staff in diabetes and have supported use of new e-learning diabetes education tool - the Cambridge Diabetes Education program.

3.1.24 DCHS Quality Improvement (QI) Faculty

2018 saw the creation and launch of the DCHS Quality Improvement Faculty. Already up to 75 members strong and growing, the Faculty are a band of staff from all parts of DCHS who have an interest in, and dedication to improving services for our patients. Through their experience, commitment and skills they help to support our staff to identify areas for improvement and begin a change cycle to test and embed change. They are aided by a group of Improvement Advocates with extensive knowledge of NHS and social care systems. A DCHS library of Quality Improvement will also ensure that we learn from what has gone before and help spread good practice.



3.1.25 Ligature Management Work

In October 2017 we invited our internal auditors (360 Assurance) to support and advise us in the review and revision of our Ligature Management Policy and associated risk assessment and survey tool which resulted in the following action areas:

- Revision of the 'compound risk' scoring capability to include a score for the ligature point itself reflecting its position and design (i.e. is it 'anti-ligature' or not, is it accessible and weight bearing?)
- Review of the 'Compensation Factors' making up the compound risk in order to establish more robust coherence between room function, security over access and relative 'remoteness' within an area
- The resulting policy needs to incorporate a 'survey tool' for completion
- The new policy and risk survey tool should be widely publicised and accessible
- Staff should be supported in how to use the tool and that '1 or 2 individuals', from an area, should be involved in carrying out the survey (especially important where staff have not had to use this type of survey approach in their areas)
- The identification of an appropriate committee within the DCHS Governance framework which will have oversight and monitoring responsibilities for the implementation of the policy, the associated ligature risk surveys and the progression of any identified 'remedial works' that are recommended. This responsibility will also include an 'escalation route' e.g. in the case of where difficulties are experienced within a service in having remedial works progressed.

The revised policy was presented at the Mental Health Oversight Group (MHOG) in January 2018 where both the policy and the tool were endorsed and subsequently approved by CSG on 2/2/2018. CSG agreed to become the oversight and monitoring committee for this process and routinely receives an update report at its meetings. In parallel with its 'approval' by CSG, work was undertaken with the DCHS communication and engagement team to formally publicise and launch the new policy and survey tool across DCHS utilising the 'My DCHS' intranet pages.

The tool was used for the first time to survey the new Heanor Memorial Health Centre; this enabled a number of functionality issues to be identified in the survey tool and for these to be resolved. A schedule was developed which identified 17 areas of service across DCHS for initial survey. In all, 19 surveys were completed during 2018 across all inpatient services, MIU's and the OPMH Day Hospitals. The remedial works identified from each survey were costed and presented to CSG and the QSC a schedule of works was agreed for 2018/19 with the remaining works agreed for 2019-2020.

3.1.26 Prevention and Management of Violence & Aggression (PMVA)

In December 2017, a working group was assembled to carry out a comprehensive review and revision of the DCHS Management of Violence and Aggression Policy. The initial purpose was to review and revise the current policy in light of a 360 Assurance action plan relating to the policy and its procedures. We undertook our review considering the following guidance:

- Positive and Proactive Care; reducing the need for restrictive interventions (Gov.UK 2014) – reduce uses of Physical Restraint in care settings
- British Institute for Learning Disabilities – adoption of 'Trauma Aware' approaches to PMVA.
- MIND - Movement away from 'Combative' styles of PMVA
- NHS England – outlaw the use of 'Prone Restraint'
- Care Quality Commission – attention on PMVA practices as part of their inspections
- MHA 1983 Code of Practice (2014) – Least restrictive principles
- NICE Guidance NG10 – Short-term Management of Violence and Aggression – Proactive and inclusive care planning
- Positive Behavioural Support Planning
- The Use of Force Act (Mental Health Units) 2018.

The current policy will not be fit for purpose moving forwards and a re-write and review of associated procedural tools has commenced:

- With the oversight of CSG – monitoring the working group
- Consultation with MHAC members
- Consultation with safeguarding colleagues.

Key features of the new policy - The new policy brings with it key robust safeguards for patients:

- Designed to ensure that all uses of physical restraint will only follow after all 'least restrictive' measures have been considered thoroughly
- That during physical restraint, measures are taken to monitor carefully the patient's physical condition so that their safety can be properly supported
- That when used, review of the circumstances which led to its use and the techniques employed will take place as part of a formal investigation process
- That effective debriefing of service users and staff takes place and appropriate support is provided
- That incidents of physical restraint will be effectively recorded and reported so that we can draw on this information to inform over strategic objectives of reducing use.

3.1.27 Safeguarding Service

Safeguarding children, young people and adults from abuse and harm is everybody's business, is an important part of everyday healthcare practice and should be an integral part of patient care. DCHS has a dedicated Safeguarding Team of nurses / health professionals and administration staff to provide advice, support and training to DCHS staff and other care providers within Derbyshire.

All staff working within DCHS who have a responsibility for the care, support and protection of children and vulnerable adults should ensure that those at risk are safe. If staff witness or have suspicions of abuse or neglect, they are under an obligation to report it without delay even if they have not witnessed the abuse or neglect themselves. The Safeguarding Service seeks to protect children, young people and adults through training, supervision and advice.

The Safeguarding Service promotes a 'Think Family' focus throughout all child and adult safeguarding work to promote the importance of listening to the voice of the child so that their experience is heard and for the adult to ensure that safeguarding is made personal.

3.1.27i Key Legislation

The Children's Act 2004 (Section 10 and 11) requires each local authority to make arrangements to promote cooperation between the authority, relevant partners and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are made with a view to improving the well-being of all children in the authority's area, which includes the need to safeguard and protect from harm and neglect.

'Working Together to Safeguard Children' (2018) continues to be the guidance which covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children and provides a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services.

The Care Act of 2014 continues to direct the statutory duties of all agencies in relation to safeguarding adults to ensure that services are reactive, proactive and responsive. There is now increased importance on making safeguarding personal for individuals who require safeguarding advice and support. To achieve this professionals and agencies must work in partnership and promote the well-being of both individuals and their families/carers to reduce inequalities, risk and harm from abuse.

3.1.27ii Quality Assurance

There has been a change in the safeguarding self-assessment; the Markers of Good Practice (MOGP) has been replaced by the Section 11 audit. This audit reflects safeguarding children responsibilities as directed by Section 11 of the Children Act 2004. The outcome of the process informs the Trust Board, CCG and the Derbyshire Safeguarding Children Board (DSCB) of the processes in place to safeguard local children and young people and acts as a benchmark of compliance.

The Section 11 site visit and MOGP for Looked after Children by the CCG was completed on the 7th December 2018. The outcome being that suitable arrangements are in place; consistent with the standards as set out in the national guidance.

The visit / audit reflects the organisational arrangements for looked after children and that the needs of children are being met and identified in line with statutory guidance: Promoting the Health and Well-being of Looked after Children (2015).

The CCG carried out a visit on October 31st 2018 to review the completed Safeguarding Adults Assurance Framework (SAAF). They were reassured that:

“The DCHS safeguarding team continue to provide an excellent service across DCHS. The team has developed a variety of expertise and leadership which act to benefit both clinical and non-clinical staff. There is awareness within the team that safeguarding requires ongoing scrutiny and evaluation. You have continued to seek opportunities to enhance the service and improve outcomes for adults at risk from abusive behaviours and practice”.

The Safeguarding Teams core responsibilities are providing advice and support, delivering training and safeguarding supervision to DCHS and on occasion to partner agencies.

3.1.27iii Training Delivery

The team deliver training to all DCHS staff that has contact with patients, volunteers, and governors. The level of training required is decided by the Intercollegiate Document for Safeguarding Children and Young People January 2019 and Adult Safeguarding August 2018.

Table 25: Safeguarding & Prevent training compliance

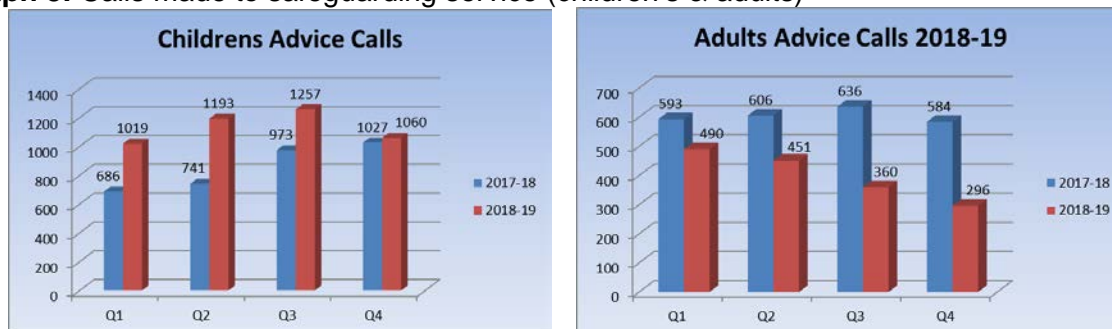
Safeguarding Training Compliance	2018-19
Safeguarding Adults L1	98.00%
Safeguarding Adults Lv2	97.54%
Safeguarding Children L1	97.96%
Safeguarding Children Lv2	97.37%
Safeguarding Children Lv3	86.77%
Safeguarding Children Lv3a	94.59%

Prevent Training Compliance	2018-19
WRAP Training (Clinical Staff Level 2 & Above)	96.7%
BPAT Training (Non Clinical Staff, Level 1)	88.6%

3.1.27 iv Advice & Support

The volume of advice calls to the safeguarding children's team has increased for each quarter from the previous year. The safeguarding adult team's advice call activity has dropped. We are exploring whether this is due to more appropriate recording on the safeguarding electronic record along with improved knowledge of staff through training, increased 'debriefs' with frontline staff and the delivery of safeguarding supervision by the safeguarding adult team. The adult safeguarding team continue to be extremely busy, supporting DCHS staff with an ever increasing number of complex cases.

Graph 8: Calls made to safeguarding service (children's & adults)



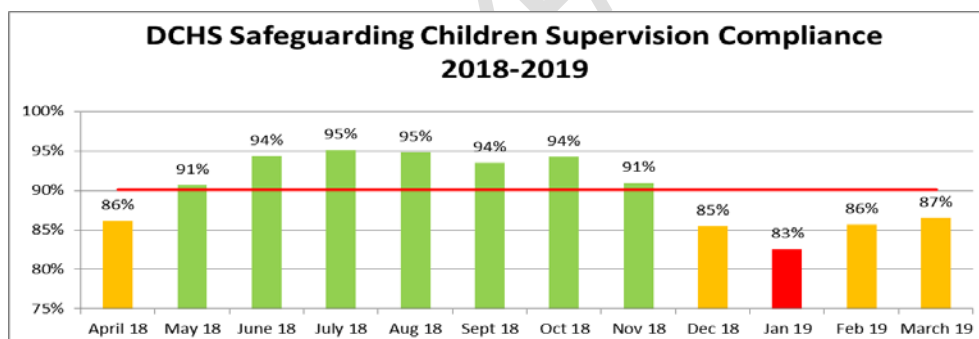
3.1.27v Safeguarding Supervision

The delivery of safeguarding supervision is a statutory requirement for the safeguarding children's team which we record to ensure compliance. The adult safeguarding team provide supervision to teams that are recognised as having 'high risk' clients i.e. learning disability, older people's mental health. Often, when a think family approach is required supervision is delivered jointly by a named nurse safeguarding children and a named nurse safeguarding adult.

December to March 2018/19 saw a decrease in the number of safeguarding supervision sessions delivered by the safeguarding children's team decreased; this was due to sickness within the team and increased activity caused by the writing of Serious Case Reviews and Serious Learning Incident Reviews.

The safeguarding team remain committed to the protection of all children and vulnerable adults within Derbyshire.

Graph9: Safeguarding children supervision compliance



3.1.27 Modern Slavery Statement

This statement is made pursuant to Section 54 of the Modern Slavery Act (2015) and sets out the steps that DCCHS has taken and will continue to take to ensure that modern slavery or human trafficking is not taking place within this organisation or those with whom we are affiliated. Modern slavery encompasses slavery, servitude, human trafficking, forced labour, sexual exploitation and forced criminality. We have zero tolerance to any form of abuse and thus modern slavery is incorporated within both children and adults safeguarding work streams.

We are committed to acting ethically, with integrity, requiring transparency in all our business dealings and putting effective systems and controls in place to safeguard against any form of modern slavery across the NHS and associated sectors.

Through implementation of robust recruitment policies and procedures we ensure that comprehensive checks are in place to negate the likelihood of an individual being employed by the organisation who has been trafficked or who is the victim of modern slavery.

DCHS is responsible for providing a range of health services for people living in Derby and Derbyshire. The care we provide is monitored by the Clinical Commissioning Groups (CCGs) across the area through regular compliance visits and processes to ensure that we are compliant with the Modern Slavery Act (2015). More details about our work in this area can be found on our website www.dchs.nhs.uk.

DRAFT 24/04/2019

3.2 Ensuring services are clinically effective

As well as our developing clinical audit programme we continue to develop mechanisms for improving and evaluating the effectiveness of care of patients. This section provides examples of how we have achieved this across our range of services.

3.2.1 BRAVO

BRAVO is an excel-based tool undertaken annually which captures clinician activity in 10 minute slots, including detailed clinical procedures, travel, and break time. It was developed by DCHS in response to an ever growing requirement to capture detailed information on the type and volume of activity which community nurses and other clinicians undertake: predominantly clinical but also associated non clinical activity. This information includes the acuity and dependency of the patients in our care.

The tool has been used by DCHS over the last 4 years to support local and strategic workforce planning. DCHS have continued to refine the capability of the tool to ensure it remains fit for purpose and has the flexibility to capture the information the organisation needs.

In the past BRAVO data has been used to support the development of leg ulcer clinics and has enabled managers to review and respond to local priorities within clinical teams in terms of skill mix and best practice, supporting the development of staffing for safe caseloads in the community.

During 2018/19 information extracted from the BRAVO audit has supported discussions with commissioners regarding the development of the district nursing specification for 2019/20.

3.2.2 Clinical Effectiveness Showcase

The Clinical Effectiveness Showcase 2018 ("Quality Conversations to Improve Outcomes - Using Clinical Effectiveness to Support Staff and Benefit Patients") took place on Thursday 4th October 2018 at Post Mill Centre. This year we focused on the way in which we can use clinical effectiveness methodologies to improve the outcomes for our patients, with an overarching theme about how we can engage patients by the way we communicate with them. 92 people attended, the day was vibrant and energetic, it evaluated extremely well and led to DCHS staff going on to showcase their work at external Quality Improvement events.

3.2.3 Research and innovation strategy implementation

DCHS has made significant progress in implementing this strategy through the development and delivery of a research programme across the Trust that is rigorously governed and which results in quality improvements for our patient population. DCHS has delivered a variety of studies relevant to the clinical priorities of the research strategy and has begun to develop research competencies with staff across the Trust including developing a research leadership development programme for principal investigators funded in partnership with the Clinical Research Network. The appointment of research champions within each of the three operations divisions has been key to promoting and embedding research which is relevant to our clinical services. DCHS has established a partnership with Derbyshire NHS Library and Knowledge Service. This provides DCHS staff with access to a full and comprehensive service including literature search service, training, knowledge sharing service and access to library resources across three sites.

A research survey was undertaken during 2018 which demonstrated that 15% of staff within operations divisions who responded to the survey had actively engaged in research in the last 2 years. A further 66% of those not yet involved in research expressed an interest to be involved. This demonstrates an appetite within the Trust to further develop research capabilities and opportunities.

The research and innovation strategy was refreshed in February 2019 and outlines the strategic priorities below:

- Increasing patient and public participation, involvement and engagement in the research and innovation agenda
- Ensuring our staff have the skills and support they need to enable them to develop research and innovation capacity and capability

- Promoting and embedding a culture of research and innovation to improve the quality of care in service delivery and to drive a process of continuous quality improvement throughout the Trust
- Using research and innovation to deliver evidence based practice while making the best use of resources
- Working collaboratively with other organisations to identify and develop new opportunities in research and innovation
- Ensuring research and innovation enables us to contribute to an improvement in the health of our population and reduce inequalities.

During 2018/19, we have continued to develop our research capacity and capability. This year the research and innovation team has introduced two new posts: a research nurse and a research assistant. These roles are instrumental in supporting our Research Officer to grow the research ambition at DCHS. The research and innovation team and divisional research champions provide support and mentorship to colleagues who want to become involved in research. They support the uptake of clinical studies and opportunities for staff and patients to participate in research and they facilitate research, resolve barriers and share good practice

Key Research and Innovation success this year include:

- One of our health visitors / practice teacher has become the Institute for Health Visiting Research Champion for the East Midlands
- A Community Dentist has successfully been awarded an NIHR in-practice fellowship
- One of our Speech and Language Therapists has successfully applied for the Health Education England / NIHR Bronze Clinical Scholar Award
- Three Physiotherapists from integrated community services presented their posters at the DCHS Clinical Effectiveness Showcase
- A poster presentation was submitted to the East Midlands Clinical Research Network Research Forum titled "Evaluation of the Training Nursing Associate Pilot in Derbyshire".
- Special Care Dentistry successfully applied for a small grant research prize through the British Society for Disability and Oral Health on the research topic of "*Qualitative assessment of Oral Health related Quality of Life in patients receiving Community- based psychiatric care in Derbyshire*". This grant of up to £5000 will enable the team to pursue a research topic in the area of Special Care Dentistry.
- A health Visitor has successfully presented "The Five Guide" - A training package and approach to support education delivered to women following a caesarean section. This innovation has gained the interest of the Royal College of Nursing and Public Health England.

Collaboration

Another area of development in research this year has focused on building and strengthening our strategic partnerships with research networks, universities and other NHS providers.

- Ongoing work to develop a partnership between DCHS and Huddersfield University
- Research work is continuing between DCHS and researchers from the University of Derby to discuss possibilities for a leg ulcer research proposal
- Exploratory meeting was held with the Health and Social Care Research Centre, University of Derby and members of the research and development team from Derbyshire Healthcare NHS Foundation Trust to discuss collaboration and potential bid development for research projects
- Established links between DCHS and a senior lecturer with an interest in palliative and end of life care at the Health and Social Care Research Centre
- DCHS was represented at the Community Trust Alliance (CHART) meeting in Birmingham which aims to provide a forum for discussion and action to increase research participation in community trusts
- Attendance at the Derbyshire CCGs research forum, which sets out to connect health and social care organisations across Derbyshire and to increase research activity
- Clinical Research Network has invested in research posts and the professional development of our staff.

Research Activity

DCHS Portfolio studies opened in 2018/19: Definition: The National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio is a database of high-quality clinical research studies that are eligible for support from the [NIHR](#) Clinical Research Network

Table 26: Research Studies opened 2018/19

Research title	Research summary
Metronidazole Versus lactic acid for Treating bacterial vaginosis-VITA	A randomised controlled trial to assess the clinical and cost effectiveness of topical lactic acid gel for treating second and subsequent episodes of bacterial vaginosis
PrEP (pre-exposure prophylaxis) Impact Trial	HIV pre-exposure prophylaxis (PrEP) is the use of anti-HIV medicines by HIV negative people in order to prevent them from becoming HIV positive if exposed to HIV. The PrEP Impact Trial will make PrEP available to 10,000 people over three years to help find out how many people will need PrEP, how many will want to take PrEP, and how long they will stay on PrEP.
Development of a patient decision aid and patient information resource for the management of decayed primary teeth: supporting parents and children to make the right choice for them	The aim of the study is to develop a Patient Decision Aid to support parents and children to make the right choice for them for the management of their child's decayed baby teeth. This will be done through conducting interviews with parent/child pairs who have already been referred to Derbyshire Community Dental Service (CDS) and using this information to design a Patient Decision Aid (PDA) which will then be evaluated and adapted by experts, parents and children.
CREATE - Training for OTs in advising on Fitness for Work	Comparing a reusable learning object with face-to-face training for occupational therapists in advising on fitness for work
Scaling the Peaks	Understanding the barriers and drivers to providing and using dementia friendly community services in rural areas: the impact of location, cultures and communities in the Peak District National Park on sustaining service innovations
Finch (Falls in Care Homes)	A multi-centre cluster randomised controlled trial investigating the impact of implementing the Guide to Action Care Home (GtACH) fall prevention programme in old age UK Care homes
The psychosocial impact of diabetes & severe mental illness: DAWN-SMI	A survey of people with severe mental impairment (SMI) and diabetes, their carers and healthcare professionals to examine the psychosocial impact of diabetes in SMI including diabetes distress, quality of life, and factors affecting diabetes self-management.
HCP Training in Assistive Technology	A survey of Healthcare Professionals' knowledge, experiences and training needs in Assistive Technology
Public preferences for vascular treatment: Is health outcome all that matters?	A survey looking at public preferences for vascular treatment and what factors are important in providing that care
Radicalisation and General Practice	A survey to scope current primary care attitudes, awareness and practice in the areas of identifying radicalisation such that the workforce can be better supported in addressing the threat posed to communities by extremism.
RSV and vaccination in pregnancy	A questionnaire-based study of pregnant women and healthcare staff to help identify factors that might affect their understanding of Respiratory Syncytial Virus (RSV) and attitudes to being involved in hypothetical future trials and receiving the RSV vaccination

DCHS Non-Portfolio Research activity - Definition: These are studies that do not meet the criteria for adoption by National Institution for Health Research.

Table 27: Non-Portfolio studies opened in 2018/19

Research Title	Research Summary
How Do School Nurses Identify and Work with Children at Risk of Child Abuse and Neglect?	A mixed-methods design to support a comprehensive understanding of the role of the school health nurse in identifying and working with school-aged children at risk of child abuse and neglect.

Research Title	Research Summary
Cognitive Management Pathways in Stroke Services (COMPASS): The identification and management of cognitive problems by community stroke teams	The identification and management of cognitive problems by community stroke teams
Following up patients who last used the Tier 3 weight management service in Derbyshire over two years ago	Following up patients who last used the Tier 3 weight management service in Derbyshire over two years ago
Micronutrient Supplement Effects on Cognitive Outcomes in TBI	The aim of the study is to investigate the efficacy of low-cost multivitamin supplementation with post-acute head injured patients and potential benefits this may have on cognitive rehabilitation. The study is a trial which will compare cognitive task performance of three matched traumatically brain injured patient groups: one taking a multivitamin supplement, one taking an omega-3 supplement and a control group. The findings should inform nutritional supplementation post head-injury.
Peer mentoring for Acquired brain Injury Study (PAIRS)	Many people don't receive the help they need after brain injury. One way to help is to pair them up with a more experienced brain injury survivor who understands their problems, can provide support and help them take part in activities. This PhD project aims to find out if it is possible to recruit mentors and mentees, match them together, get them to meet and achieve activity goals.
How does the microbiome change in a diabetic foot infection after a week of treatment with antibiotics and is this change a result of the treatment?	Diabetic patients are typically prescribed systemic antibiotics. Often, these antibiotics do not resolve the infection. There will be a collection of tissue from patients who present with diabetic foot infections. Bacteria will be harvested from the tissue and for samples taken after treatment of antibiotics. The data will provide insight on how the bacteria in the foot ulcer change in type and amount after a week of treatment with antibiotics.
What are caregivers experiences of supporting stroke survivors with Graded Repetitive Arm Supplementary Program (GRASP) self-management in the community?	Graded Repetitive Arm Supplementary Program (GRASP) is a homework-based program to improve arm function after stroke.
Attendance at Clinical Health Psychology Appointments	A multilevel analysis of patient-level predictors and therapist effects on attendance at clinical health psychology appointments.

Table 28: showing the current number of participants recruited for participation in portfolio research projects for the year 2018/19.

Research title	Recruitment 2018/19
Metronidazole Versus lactic acid for Treating bacterial vaginosis–VITA	4
PrEP (pre-exposure prophylaxis) Impact Trial	49
Development of a patient decision aid and patient information resource for the management of decayed primary teeth: supporting parents and children to make the right choice for them	74
CREATE - Training for OTs in advising on Fitness for Work	2
Scaling the Peaks	1
Finch (Falls in Care Homes)	0 (non-recruiting)
The psychosocial impact of diabetes & severe mental illness: DAWN-SMI	1

Research title	Recruitment 2018/19
HCP Training in Assistive Technology	2
Public preferences for vascular treatment: Is health outcome all that matters?	12
Radicalisation and General Practice	0
RSV and vaccination in pregnancy	0 (non-recruiting)
	Total 145

Research Governance and Reporting

DCHS has made considerable progress towards meeting the minimum data set targets outlined by the Clinical Research Network. The data set relates to the portfolio management system (EDGE). The minimum data set project is in place to ensure quality and consistency in reporting on the capacity and capability approval process for trusts. There has been a steady rise in compliance to the minimum data set definition from 73% in July 2018 to 99% in January 2019.

3.2.4 Dementia and Frailty

Dementia

The current focus on dementia, both globally and nationally, has highlighted how much has been achieved in the development of dementia care since the launch of the national dementia strategy in 2009/10. However, dementia care remains a national challenge. In response to this, DCHS has worked extensively with our staff, patients and carers of people with dementia to develop the DCHS dementia strategy.

Our Strategic Objectives are to:

- Provide comprehensive education and training for all staff working within the Trust to empower teams to champion and deliver the very best, person-centred, compassionate, safe and effective care
- Provide early specialist support to people who have just been diagnosed with dementia to aid them and their carers to live well with dementia
- Provide targeted support to people with moderate dementia to continue to live well, through the delivery of programmes of cognitive stimulation therapy
- Refresh our approach to communication by listening to, involving and engaging with people with dementia and their carers to improve dementia care
- Care and support for the carers and friends of people with dementia
- Raise the standards of care by promoting activities that improve the well-being of people with dementia and their carers
- Continue to develop our Trust as a 'Dementia Friendly' organisation with environments that promote better outcomes and which are safe
- Continue to develop partnerships to improve collaborative working and improved integration of the pathways of care.

Our strategic objectives will be delivered in keeping with the following principles:

- Parity of esteem between physical and mental health
- Dementia care is everybody's business
- All relevant staff to have generic dementia management skills and competencies
- Dementia friendly environment is embodied not only in concrete buildings and infrastructure but also in the attitude and culture exhibited by staff as we move to a care closer to home model of care delivery
- Reduction in hand-off points in the care of people with dementia
- A clear understanding of the relationship and interdependencies between dementia and the frailty syndromes both in terms of pre-disposition/causation as well as exacerbation.

Frailty:

Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years (Collard *et al*, 2012). The DCHS Frailty Strategy sets out our approach to the care

of older people living with frailty. It will be applicable to all people who are cared for in DCHS inpatient settings, within the community and by DCHS-led primary care services. It is informed by national guidance and is set in the context of the Derbyshire-wide Sustainability and Transformation Plan. It articulates the Trust's strategic aims in response to an ageing population and addresses the unique challenge of frailty: treating older people as individuals who need coordinated, person-centred care rather than as a collection of morbidities.

Our strategy is aligned with the Joined up Care Derbyshire Community Frailty Model with the stated vision of "**Derbyshire Healthier Futures**"

The goal – to enable all older people to live healthy independent lives for as long as possible in their own home or the place they call home reducing the need for escalation of care to non-home settings by 2020.

The DCHS Frailty Strategy has three main objectives:

1. Frailty as a long term condition in its own right, rather than merely a label.
2. Pro-active care through timely identification, comprehensive assessment and person centred, holistic care planning
3. Community based, person centred, coordinated care.

3.3 Caring – understanding and improve the patient experience

Patient story - Phil's Story by Sue from DTC Phil suffers from severe hospital phobia and had not been inside a hospital in twenty years, his mother had died in hospital and he hadn't been able to visit her due to the extent of his phobia. Although his sight was deteriorating rapidly, he felt he could not come to hospital to have his cataract surgery. The team agreed how to gradually expose Phil to the hospital by phone contact initially and after several months he agreed to meet Caroline, the manager, in the car park and then eventually in the hospital café. Over a period of time Phil attended his outpatient tests in the Eye clinic. It was a lengthy process as there were times when Paul felt he simply could not come in.

When Phil first attended the DTC he was introduced to a designated nurse who showed him round the department, into the theatre where he would have his surgery and explained in detail what would happen on the day of his procedure, she assured Phil that she would be with him at every step during his treatment. The team were able to put to rest many of his anticipated anxieties.

On the day of surgery the whole team was united in ensuring Phil had a positive experience. The operation was a success. Cataract surgery has an important and almost immediate impact on the lives of patients and Phil expressed his gratitude to all the staff for achieving 'the impossible'.

None of the above would have happened had we not had in place the pathway for working together closely and the staff with the drive, professionalism and passion to deliver the best service possible to our patients.

It was a pleasure to be able to feed this back to our teams both as a learning outcome but also as a massive success for the patient.

3.3.1 Patient engagement and Involvement

We measure and monitor people's experiences in different ways to help us improve services. This includes general feedback, complaints, concerns, compliments, the NHS Friends and Family Test (FFT), surveys and online sources such as NHS Choices and Care Opinion (previously known as Patient Opinion) as well as social media. We have also heard many patient and carer stories this year.

98.3% of people would recommend our services to their friends or family if they needed similar care or treatment. (*FFT results 2018-19)

3.3.2 The Friends and Family Test (FFT)

The FFT is an important feedback tool that asks a patient **"How likely are you to recommend our (ward/service) to friends and family if they needed similar care or treatment?"** on a scale from Extremely Likely to Extremely Unlikely. The FFT helps us to identify good and poor patient experiences.

Throughout the year we have monitored responses to the FFT and the reasons why people have given higher or lower scores. We follow the national guidance for undertaking and scoring of the FFT results and report on our performance monthly so that we can benchmark our results.

The FFT feedback has been overwhelmingly positive with comments describing high quality services, compassionate and empathetic staff as well as satisfactory overall patient experiences where often expectations are exceeded.

26,778 patients completed the FFT between April 2018 – March 2019 (8% decrease from last year, 29,141 cards). We also continue to perform well above the local and national FFT results.

Whilst the overall feedback given is positive about the care provide to patients, their relatives and carers, we also often get suggestions for improvement. Most typically this has related to improving communication, extending service opening times, reducing waiting times and making some service environments more comfortable (e.g. with better seating and refreshments).

3.3.3 Involvement

We have a network of over 40 groups which consist of local people who use our services. We have worked with these groups to develop our services in the last year. Our most successful example of working in partnership with local people is around the development of our Dementia Strategy. A focus group helped us shape the development of this strategy.

We will continue to work with the General Practice Patient Participation Groups (PPG) to support our three practices and improve opportunities to gather patient feedback and respond to feedback in the GP annual survey.

Service users were involved in the selection of our Chief Nurse and a new Medical Director during the year.

Patient story - From campaigner to 'expert by experience' patient partner – after the loss of his wife Val in 2015 from dementia Keith Horncastle became a great supporter of his local community in Buxton offering support for families with a loved one diagnosed with dementia. When the Better Care Closer to Home (BCCTH) changes in local community hospitals came about, a group of concerned community members from Buxton and High Peak got together and made a film to highlight their concerns - this is on YouTube: <https://www.youtube.com/watch?v=g99JKv3bmXc> and in support of what their needs as families and whose family members may use the new Walton Unit in Chesterfield in future.

After a request from the chair of DCHS' BCCTH implementation group, we contacted Keith as the main spokesperson for the local community group and he agreed to work with us. Keith was able to share with us his own story of caring for his wife with dementia, and their experiences of care in our community Hospital at Buxton. Due to his close links with the community he was also able to share what was most important to families living with dementia. We have been able to develop an understanding of the impact of BCCTH proposals and the following changes are being followed up:

- The Walton Unit has developed a carers support group called Friends and Family group.
- A member of staff is leading on the involvement of any patients from the High Peak locality
- DCHS are developing Information on Services
- Consideration of the importance of continuity of care for patients and carers by both DCHS and Derbyshire Healthcare Trusts.
- Flexibility in visiting times to accommodate individual family needs, which is especially important for those with longer journeys from home.
- Refurbishment of a carers room has been so that family members can make drinks, and stay overnight
- Improvements in signage to make visits to the Walton Unit easier.

We are very proud of our relationship with Keith and delighted that he has continued to work with us.



Keith is now one of our 'expert by experience' network members and he also provides Dementia Friends training for our staff members – **25 staff members have attended Keith's training so far with more sessions booked in for 2019.** Some of the comments we have received from staff :

Everybody in healthcare should attend one of these sessions.

I wanted to let you know how valuable I found the Dementia Awareness Session with Keith, and thank you for letting me attend. It

was very engaging and how he shared his own personal experiences was very humbling

Very informative, I now have a better knowledge, excellent. Helpful for both work + personal

Heartfelt presentation, great insight. Thank you

Clear, informative, interesting, interactive, practical –applicable. Here for personal and work. Thanks for organising the session

Keith was nominated for an Unsung Hero award for 2019.

3.3.4 Responding to patient feedback

The Pulmonary Rehab group is a twice weekly 6 week programme which is delivered in unused ward space at Walton Hospital. Members of the group fed back that the room was 'not really fit for purpose': it got very hot and cramped when doing the various exercises and when the carers joined for the education part, chairs had to be found and moved around. Observations showed that there was insufficient space for all the activities in the room without having to go into the corridor. This compromised dignity and equity of service. Concerns were expressed by patients, carers and staff regarding the room conditions. We reported these concerns through our Patient Engagement and Experience Group (PEEG). A Capital and Estates proposal was approved.

The Patient Involvement Officer, Lisa Brightmore, visited the Pulmonary Rehab group again in November 2018. It was evident that the new space on Peter McCarthy suite at Walton Hospital was a much improved facility. We received feedback regarding other aspects of attending this group such as timing and parking, but not one report of the room being unfit for purpose was received and it was noted that the new room provided a much better area for people to complete their exercises and for the facilitators to deliver their support and education sessions.

The added benefits of providing this programme were expressed by group members as:

- the ability to share stories and information between themselves
- those nearing the completion of the programme described significant improvements to their pulmonary function
- One gentleman in his 80's on the last day of the programme explained how his confidence has grown since starting the programme. He was proud he had managed to cut the lawn once again.

3.3.5 Patient Led Assessments of the Care Environment (PLACE)

PLACE is a system for assessing the quality of the care environment and involves local people and Council of Governor representatives 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 the assessments have covered the ways we can demonstrate that we are meeting the needs of patients with disabilities.

The percentage scores for each category shown in table 29 below have been awarded by the NHS Information Centre based on the information returned by us for our 2018 assessments. All assessments were delivered through self-assessment. The programme was undertaken between March and May 2018.

Table 29: PLACE scores 2016-2018

Hospital	Cleanliness			Food			Privacy and dignity		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Ash Green	100	100	100	96.72	95.44	79.35	91.51	93.86	88.79
Babington	100	99.70	100	98.96	96.13	74.75	86.41	92.5	82.14
Bolsover	100	100	--	96.13	96.40	--	83.91	84.18	--
Cavendish	99.87	100	100	96.6	93.49	79.59	85.9	92.24	85.17
Clay Cross	98.42	99.28	98.56	90.70	94.21	93.81	76.27	82.75	78.13
Ilkeston	99.01	99.59	100	99.09	94.95	98.06	76.41	91.79	83.33
Newholme	99.80	99.91	--	97.9	96.38	--	84.22	78.85	--

Hospital	Cleanliness			Food			Privacy and dignity		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Ripley	100	100	99.62	96.56	94.47	96.73	94.39	91.04	89.80
St Oswald's	98.24	96.92	96.15	98.31	96.10	96.67	84.57	93.75	93.29
Walton	100	99.81	100	95.87	95.98	94.61	91.82	89.72	98.37
Whitworth	100	99.85	100	97.03	94.69	97.06	84.55	83.49	69.83

Hospital	Condition and maintenance			Dementia			Disability		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Ash Green	98.05	98.10	99.05	82.36	82.60	83.44	92.90	87.75	93.94
Babington	98.64	96.57	96.62	82.21	73.57	75.35	92.02	87.06	91.16
Bolsover	97.32	98.99	--	86.61	80.37	--	93.46	88.48	--
Cavendish	98.0	98.54	97.92	77.57	82.73	79.38	85.55	91.84	95.42
Clay Cross	99.01	95.40	96.61	79.7	83.96	82.59	94.05	96.69	96.88
Ilkeston	93.84	98.06	90.93	76.46	81.99	75.28	83.08	91.09	86.20
Newholme	94.57	94.63	--	83.24	69.38	--	81.38	78.13	--
Ripley	98.83	99.25	98.69	79.76	85.76	84.97	85.75	95.25	96.44
St Oswald's	99.36	98.26	100	79.72	90.24	87.57	90.69	94.52	96.98
Walton	99.82	97.89	99.04	86.66	85.59	89.29	91.0	91.93	96.08
Whitworth	100	98.99	99.03	82.64	84.14	82.78	84.85	94.24	94.19

Additional elements were included within all sections of the 2018 assessments and this should be considered when comparing last year's scores against this years.

Some of the elements we look for under Disability within the PLACE assessment include:

- Are there handrails in corridors?
- Is there at least one toilet big enough to allow space for a person in a wheelchair and their carer?
- Where there are steps to the reception area, is there a ramp to assist those with mobility difficulties?
- Is there space in reception areas for people in wheelchairs?
- Is there a hearing loop at the reception desk?
- Where appropriate, have kerbs been adapted to facilitate wheelchair access?
- Are car parking spaces for disabled people appropriately located closest to the building entrances?
- Is there an audible/verbal appointment alert system for people who have visually impairments?
- Is there a visual appointment system for people who have hearing impairments?

The overall scores for our hospitals are shown in table 30.

Table 30: PLACE: DCHS scores against national average scores

	Cleanliness	Food	Privacy and dignity	Condition and maintenance	Dementia	Disability
DCHS 2018	99.35%	91.73%	85.74%	97.21%	82.32%	93.72%
DCHS 2017	99.51%	95.29%	88.63%	97.66%	81.59%	90.57%

DCHS 2016	99.57%	96.65%	84.81%	97.81%	81.47%	88.36%
National Average Score 2018	98.5%	90.2%	84.2%	94.3%	78.9%	84.2%

Data source PLACE audit results

DCHS have achieved a score above the national average for all 6 elements of the PLACE audit.

Some issues that have been identified at various sites during the PLACE audits and require ongoing works are:

- No contrasting fittings in bathroom
- Hand rails in corridors repainting as they do not contrast with the wall colour
- Drain covers made of bricks (trip hazard) to be replaced
- Taps identified as not being dementia friendly
- Alarm bell cord broken
- Walls requiring redecoration
- Yellow lines in car park need relining
- Garden requiring attention and not currently suitable for patient use

An estates action plan has been prepared which is monitored and updated on a regular basis and some items are monitored through contract review meetings.

3.3.6 GP Patient Survey results

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people across the UK. The results show how people feel about their GP practice.

Top lines

- Castle Street was rated above the CCG and national averages in all aspects of the survey.
- Creswell and Ripley had both improved overall; increasing 8% and 9% respectively with patients describing their overall experience of the GP practice as good.
- The aggregate scores for the service were above the national average for 13 out of 18 aspects of the survey.
- Ripley had made excellent progress over the last 12 months in relation to the time patients wait before they are seen. Their score increased by 22% against the previous year (Waited 15 minutes or less after their appointment time to be seen at their last general practice appointment).

3.4 Ensuring our services are responsive to patients' needs

We are continually reviewing the provision of services to understand how we can ensure that our services are responsive to the needs of our patients, and patient stories enable us to do this.

3.4.1 Patient Stories

Patient stories provide a very powerful and human account of the way that the care we deliver impacts on individual people, carers and families. Every meeting of our Trust Board, Quality Services Committee, Council of Governors, Patient Experience and Engagement Group, End of Life Care Group and Dementia and Frailty Group starts with a story. The stories are either told by a member of staff or by a person who used our services. We aim to hear about the positive impact of our services (for example a patient who was supported during their gender transition) as well as where improvements are needed to be made (for example where our services identified improvements in the way we manage and care for pressure ulcers).

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 People Committee also presents 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.

Patient stories - dementia

Lisa from Speech and Language therapy services (SLT) shared three different stories of people with dementia.

Dorothy's story - Dorothy had been living in a care home, with a dementia diagnosis for a number of years. She had been struggling with eating and drinking for some time but no one in the care home recognised this and so she was not referred to the SLT for specialist assessment and advice. This meant that Dorothy often didn't finish her meals or her snacks and had been losing weight over several months. Care home staff tried to encourage her to have her supplement drinks, but she really disliked these and most of them were thrown away. She sometimes coughed and choked when eating and drinking which meant she couldn't enjoy her food and she became frightened to eat and drink as it was so unpleasant for her. She also became isolated from other residents as she was embarrassed to eat in the dining room and someone kept telling her to stop coughing all over them. Dorothy had a few chest infections but no one realised this was because food and drink was going the wrong way, into her lungs. She ended up in hospital twice with aspiration pneumonia, and once after a really frightening choking episode. This was not only distressing for Dorothy but also for the people looking after her. She spent 25 days in hospital in total and had required 6 GP visits in the last 6 months because of her chest infections, dehydration and weight loss. Very sadly, Dorothy died during the last acute hospital admission.

Sid's Story - Sid is a man with long standing dementia, which included significant behaviour issues, and very limited communication. He had with a right sided chest infection and had not been seen by SLT in the past and wasn't on any specific recommendations to support eating and drinking. The SLT assessed Sid and noted that he presented with subtle signs of aspiration; texture and fluid modifications were recommended and advice about the eating environment was provided. He enjoyed his meals more as he was no longer coughing, and was able to eat more during meal times. His chest infection resolved, he remained an in-patient on the ward, due to difficulties identifying an appropriate placement. Sid subsequently deteriorated with regard to his swallowing difficulties, and developed another severe chest infection. However, the staff were quick to notice the signs of deterioration and contacted SLT for further support. Liaison between SLT and other members of the multi-disciplinary team (MDT), including medics resulted in decisions being made regarding a best interest plan which included Sid's family. The family were able to be reassured about the issues relating to his swallowing difficulties and how this could be best supported. Staff were aware of how to support Sid in terms of positioning, how to manage if he coughed, to provide safest consistencies and support an end of life process that enabled Sid to remain comfortable, minimise distress for everyone,

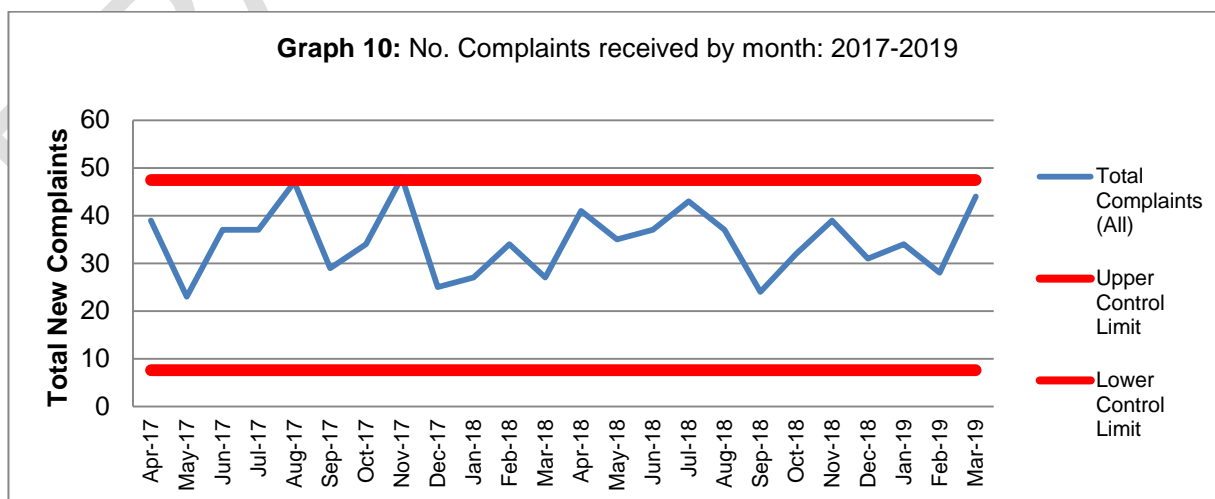
and continue to enjoy the taste of small amounts of food. Sid was able to die in a familiar supportive environment, with minimal distress, both for him the staff and his family.

Terry's Story - Terry was referred to the Adult Community SLT by a Neurologist, asking for some help and information in diagnosing Terry's condition. Terry was experiencing word finding difficulties and slowed cognitive processing and was frightened by his new symptoms. Terry was happy to complete some language and cognition assessments with the SLT and was reassured that someone was interested in helping him. Terry's wife was able to contribute to the assessments and gave valuable information, informing the assessment process. Terry was diagnosed with primary progressive aphasia, a specific form of dementia which involves a progressive loss of language function. Terry and his wife were obviously frightened by this diagnosis and relied on the SLT for information and support. His wife was helped to support and maximise Terry's communication by learning supported conversation techniques. Terry started to use a specialist SLT computer software programme to allow him to practice useful words such as family names and places. This meant that Terry could independently control how much therapy he wanted to do, to help to maintain his retrieval of functional words. Terry and his wife benefitted from finding out about local support services, and met other people for peer support, with the help of the SLT. Terry began to put in place some long term strategies to help him to cope with the progression of his disease, for example, he started to use a diary as a record and communication support tool and started to make a collection of photographs to help him to be able to communicate with new people. Terry and his wife feel able to call the SLT for help with new communication challenges as they occur and Terry said recently 'you are an absolute star and always help me' the last time the SLT saw him.

3.4.2 Complaints and Concerns

We know that sometimes people's experiences may be poorer than expected. This can be as a result of a lot of different factors. It is important for us to hear about people's experiences, so that we have the opportunity to find out what happened and to put things right if needed. We have complaints handling processes to ensure that patients, relatives and carers have the opportunity to tell us about their care and treatment and to let us know when things go wrong. Listening and learning from complaints is very important to us. We make every effort to ensure the complaints process is accessible to all. Complaints can be made by telephone, email, through our website, in writing or in person. Leaflets are available throughout our services describing the process, contact details and support available. When we are contacted by someone who needs help with their complaint, we provide clear contact details for the local NHS complaints advocacy services, which can provide support and make the complaint on a person's behalf. Complaint response letters can be provided in different formats to accommodate needs, for example large fonts and alternative languages.

During 2018/19 a total of 424 complaints (all types) were received, this is a 4% increase compared to the previous year. We have seen a significant increase in type 1 complaints, which do not require a full investigation and these concerns are resolved by services very quickly.



Graph 10 above shows the variation in complaints received each month over a two year period.

We have monitored the increase in complaints throughout the year and we have concluded that the reason for this has been a result of some of the internal changes we have made to our complaints reporting systems as well as greater awareness amongst service users of how to raise their concerns as a result of our marketing and publicity efforts.

Subject/s of complaints

The main reasons for complaints have usually been a result of poor communication. We are trying to address this through greater awareness and staff training around 'words matter' and improving the patient experience. On review of patient experience data year to date the following 3 areas have shown to be the most important to people when sharing their concerns. We will continue to monitor these areas to identify any specific learning for individual teams.

- Clinical Treatment
- Values & Behaviours
- Access to treatment

Learning from Complaints – an example from Minor Injury Units

Investigations often identify learning and suggested improvements that services should implement. A number of complaints about diagnosis of fractures in our Minor Injuries Units were highlighted during the year. Several patients believed that they had not had the appropriate access to x-ray to reach a diagnosis and appropriate treatment. Those complaints were not upheld on investigation. The following learning and an improvement action was identified as follows:

Learning: Patients did not always understand our x-ray protocol and that the initial diagnosis given to them in MIU is tentative pending confirmation by x-ray. Sometimes patients do not retain information given verbally during their attendance at MIU.

Improvement: A leaflet for patients with a suspected fracture or severe sprain explaining the protocol the Minor Injuries Unit and recommendations of how to treat their injury has been developed.

Responding to complaints

We aim to respond to all complaints that require investigation within 40 working days. We identified an inaccuracy in the way we reported our performance against this standard in our last Quality Report (2017/18). This was reported as 84% compliance and it should have been reported as 83%. This year we responded to only 66.4% of complaints in that timeframe. In 2018/19 we are challenging ourselves to provide timely responses to people who have raised a concern with us.

3.4.3 Complaints review panel

In February 2019 DCHS undertook a review of the formal complaints process for the third year. The panel that undertook the review consisted of Chief Nurse, Assistant Director for Patient Experience, and Assistant Director for Integrated Community Services, a Staff Governor, a Public Governor and Patient Involvement Officer. Ten closed and completed complaints were randomly selected and the panel were given specific actions or processes to look for within the record. Although this is a relatively small number of formal complaints that have been managed by the Trust over the previous year it did give evidence of themes that would benefit from further review.

Initial review of the comments showed that there is a consistently high quality approach to how the trust responds to a formal complaint however there are themes identified:

- Quality of the investigation
- Demonstrating learning from the investigation

The outcome of the panel review will be discussed at governance meetings within the organisations and actions will be taken forwards both within Patient Experience Team as well as within teams that undertake the investigations. This review will be repeated annually.

3.4.4 Carers

We acknowledge the significant contribution of informal carers to the health and wellbeing of local people. We recognise the additional efforts that are needed to ensure that carers of our patients and patients with caring responsibilities are met.

2763 people using our services identified that they also have caring responsibilities this year. The graph on page 6 shows that we have a system in place to record this and to signpost them for appropriate support.

3.4.5 Healthwatch

We continue to work in Partnership with both Healthwatch Derbyshire and Healthwatch Derby. Our partners play a valuable role engaging with local communities, particularly those whose voices may not otherwise be heard, and ensuring that the patient perspective is actively shaping our services. We receive regular feedback from Healthwatch; these are shared with the service lead for response.

Examples this year include:

- We continue to support Healthwatch Derbyshire with their training of Enter and View volunteers.
- We have supported the development and sharing of a 'STOP' poster for people with learning disabilities to help them have more control when care may cause them discomfort (for example in our Dental services)
- Healthwatch Derby provided us with valuable feedback on our Integrated Sexual Health Services and on our Derby Specialist Dental services from their own engagement events
- Healthwatch Derbyshire undertook a report on the experiences of people with dementia using the full range of services, including those provided by DCHS.

3.4.6 An inclusive organisation

Over the last year, there has been a strategic shift to embed equality, diversity and inclusion across the Trust. We are working to strengthen shared understanding and accountability across the functions so that we will be able to demonstrate evidence based decision making as business as usual. We have completed all national compliance reports as part of our statutory duties under the Equality Act within deadlines.

That work has begun to embed the national NHS equality improvement tool called the Equality Delivery System2 (EDS2). Equality standards have been used to frame our corporate approach and to evidence continuous improvement across the four goals:

Goal 1: Better health outcomes for all

Goal 2: Improved patient access and experience

Goal 3: representative and engaged workforce

Goal 4: Inclusive leadership & governance at all levels



We have over 40 network groups which consist of local people and service users. We have worked with these groups to co-design and develop our services in the last year. Our most successful example of working in partnership with local people is around the development of our dementia strategy. We held a successful focus group where people had the opportunity to share their experiences and help shape the development of this strategy.

We hope to continue our work with the General Practice Patient Participation Groups (PPG) to develop new initiatives to support our three practices and improve opportunities to gather patient feedback and improve our performance on the annual survey.

3.4.7 Pastoral Care in DCHS

We recognise the importance of meeting people's pastoral and spiritual needs as part of our holistic care of patients. We work in partnership with Derby City Centre chaplaincy who are experienced in providing volunteer chaplains to come alongside people who are using our services. We recognise that life can be challenging and that people are faced with a range of worries and questions especially

at times of loss – for example at times of change in their lives. Volunteer chaplains are available for patients in any locality to provide a comforting and confidential listening ear. Chaplains are supporting patients with end of life care, terminal illness, new diagnoses, living with long term conditions, bereavement, with fears about forthcoming treatments, making difficult decisions or about a desire to connect with family. The service is able to connect patients of any faith, or none, with an appropriate person to support them. The chaplaincy service is also helping DCHS to develop our spiritual care to patients at the ends of their lives.


3.4.8 Minor Injury Unit (MIU) waiting times

We have four MIUs 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. 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.

This data is governed by standard national definitions.

Table 31: MIU 4 hour waits

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
2018/19	100%	100%	100%	100%	100%	99.8%	99.7%	100%	99.8%	99.9%	99.9%	100%	99.9%
2017/18	99.9%	99.9%	100%	99.9%	99.9%	99.9%	99.9%	100%	99.9%	100%	100%	100%	99.9%
2016/17 	100%	100%	99.9%	99.9%	100%	100%	99.9%	100%	100%	100%	100%	100%	100%

Data Source Systm1 PAS

 these figures were independently audited

We will continue to monitor the quality of our services using our Quality Improvement and Assurance Framework. We will work with the wider health community to maintain the high performance within our MIUs.

3.4.9 Comparative data A&E 4 hour wait

It should be noted that our emergency provision is limited to four MIUs and that comparative data includes data from type 1 Accident and Emergency departments.

Table 32: comparative A&E 4 hour wait data

Period	Performance	Rank	Total In cohort	Nat. average	Highest	Lowest
2018/19						
2017/18	100%	Joint 1 st	238	85.0%	58 trusts	Princess Alexandra Hospital NHS Foundation Trust
2016/17	100%	Joint 1 st	241	99.9%	56 trusts	Princess Alexandra Hospital NHS Foundation Trust
2015/16	100%	Joint 1 st	237	91.9%	65 trusts	Tameside Hospital NHS Foundation Trust

Source NHS England February 2019 A&E wait figure




Criteria for percentage of patients with a total time in Minor Injuries Unit of four hours or less from arrival to admission, transfer or discharge
<p>The Trust uses the following criteria for measuring the indicator for inclusion in the quality report:</p> <p>The indicator is expressed as the percentage of unplanned attendances at Minor Injuries Units (whether admitted or not) in the year ended 31 March 2019 that have a total time in Minor Injuries Unit of four hours or less from arrival time (as recorded by the clinician (nurse or doctor) carrying out initial triage, or Minor Injuries Unit reception, whichever is earlier) to admission, transfer or discharge home.</p>

3.4.10 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 Trust's data kite mark quality assurance system.

Table 33: Referral to treatment times (RRT)

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
Referral to treatment times Incomplete pathway (where treatment is part of a pathway) against a standard of 92%													
2018/19	95.4%	96.2%	96.4%	96.1%	95.3%	95.2%	95.4%	95.2%	94.8%	93.3%	92.3%	94.7%	95%
 2017/18	96.9%	97.3%	96.7%	95.8%	93.9%	95.3%	94.7%	93.9%	95.0%	95.1%	95.5%	95.0%	95.4%
 2016/17	97.69%	97.35%	95.66%	93.20%	97.87%	97.24%	95.95%	95.54%	94.58%	94.60%	96.68%	97.60%	96.00%
RTT waits - admitted patients seen within 18 weeks - 90% (target) (%)													
2018/19	91.6%	84%	64.7%	59.2%	78.6%	81.8%	100%	100%	100%	80%	100%	100%	86.1%
2017/18	96.9%	96.5%	96.6%	97.3%	91.4%	92.4%	94.7%	95.5%	93.1%	93.1%	95.2%	92.9%	94.6%
2016/17		95.1%	90.9%	91.4%	94.8%	95.7%	90.7%	87.8%	89.8%	95.0%	94.0%	96.0%	92.8%
RTT waits - non admitted patients seen within 18 weeks - 95% (target) (%)													
2018/19	89.7%	91.2%	90.9%	90.9%	93.7%	92.1%	92.9%	90.7%	91.4%	90.4%	91.1%	86.5%	94.1%
 2017/18	94.9%	94.3%	94.3%	95.0%	95.3%	93.2%	93.6%	93.8%	91.8%	90.8%	92.5%	91.0%	93.4%
2016/17	97.1%	98.9%	95.4%	97.3%	97.4%	95.8%	95.1%	95.3%	93.7%	92.1%	94.3%	91.3%	95.2%

Data Source Systm1 PAS

Criteria for percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The Trust uses the following criteria for measuring the indicator for inclusion in the quality report:

- The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period;
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2018 to March 2019;
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and
- The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

Criteria for Percentage of non-admitted seen within 18 weeks at the end of the reporting period

The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of non-admitted patients seen within 18 weeks for patients on non-admitted pathways at the end of the period;
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2018 to March 2019;
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and
- The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

3.4.11 Delayed transfers of care (DTOC)

A delayed transfer of care (DTOC) occurs when a patient is ready for discharge from one of our community hospitals to home or a residential care setting yet is still occupying one of our hospital beds. We work to minimise DTOC's through effective discharge planning and joint working between services to ensure safe, person-centred transfers. This year we have differentiated between DTOCs resulting from delays identifying ongoing social care and delays which are purely related to NHS care.

We consider 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 is not available.
This data is governed by standard national definitions.

Table 34: Total DTOC: inpatients including Older People's Mental Health (OPMH)

Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
2018/19 3.5%	5.3%	5.1%	4.1%	3.6%	5.8%	8.7%	4.9%	6.7%	5.2%	6.4%	4.5%	3.4%	5.3%
2017/18 3.5%	7.6%	12.4%	9.8%	11.3%	8.8%	4.8%	4.9%	3.8%	5.6%	5.0%	5.3%	5.0%	7.0%
2016/17 5.5%	6%	7.9%	10.1%	7.6%	8.4%	9.5%	6.1%	8.0%	10.6%	7.5%	9.1%	9.8%	8.4%

Data Source Systm1 PAS

Table 35: Total DTOC: OPMH data:

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2018/19 3.5%	1.8%	0.0%	0.0%	1.8%	5.1%	14.9%	2.9%	3.4%	5.1%	4.8%	6.7%	4.8%	4.3%
2017/18 3.5%	0%	1.7%	1.3%	2.0%	7.0%	3.5%	4.0%	2.7%	4.1%	4.8%	13.1%	8.5%	3.8%
2016/17 5.5%	0%	3%	0.9%	0%	1.2%	0%	0%	3.2%	5.7%	3.2%	2.3%	0%	1.7%

Data Source Systm1 PAS

Key	
Less than target	
Greater than target by up to 0.5%	
Greater than target by more than 0.5%	

Although we have not met the revised national target of 3.5% DTOC in 2017/18, working with partners across Derbyshire we have made significant improvements and are currently the best performing health economy in England. During 2017/18 we will be focusing on ensuring a more consistent and robust process for DTOC data collection and to continue to drive improvements in delayed transfers of care.

In an attempt to drive improvements in DTOC's, during 2017/18 we started to specifically performance manage DTOCs in situations where we had direct control of the whole patient pathway. The three tables below illustrate the performance for 2017/18 and compare this with the previous year. The target for 2017/18 set by NHSE remained at 3.5% however we set our own improvement trajectory which it reported against to board each month.

The improvement trajectory is detailed below:

Table 36: DTOC NHS delays improvement trajectory (not sure whether a new trajectory table is required)

Improvement Trajectory	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2017/18	3.5%	3.4%	3.3%	3.2%	3.1%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.5%

Table 37: DTOC: OPMH (NHS delays only):

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2018/19	0.0%	0.0%	0.0%	1.8%	4.6%	14.9%	2.9%	3.4%	5.1%	4.8%	6.7%	4.8%	4.2%
2017/18	0.0%	0.0%	0.7%	1.0%	5.4%	3.0%	2.6%	1.6%	3.5%	4.6%	13.1%	8.5%	3.0%
2016/17	0.0%	1.6%	0.9%	0.0%	1.2%	0.0%	1.0%	1.1%	2.3%	2.7%	0.0%	0.0%	0.9%

Data Source Systm1 PAS

Table 38: DTOC Inpatients (NHS delays only):

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2018/19	3.3%	4.4%	4.6%	1.6%	4.6%	5.4%	3.8%	5.0%	3.6%	5.1%	3.4%	2.7%	4.0%
2017/18	3.7%	6.8%	4.4%	6.1%	5.0%	2.1%	3.7%	3.8%	3.8%	3.0%	2.3%	3.5%	4.0%
2016/17	2.9%	5.4%	7.0%	4.0%	3.6%	4.6%	3.8%	3.1%	3.3%	2.8%	4.9%	4.9%	4.2%

Data Source Systm1 PAS

Table 39: DTOC: OPMH & Inpatients (NHS delays only)

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2018/19	2.8%	3.6%	3.8%	1.7%	4.6%	7.2%	3.7%	4.8%	3.9%	5.0%	3.9%	3.0%	4.0%
2017/18	2.9%	5.2%	3.4%	4.7%	5.1%	2.3%	3.5%	3.3%	3.8%	3.3%	3.8%	4.0%	3.8%
2016/17	2.3%	4.5%	5.5%	3.1%	3.0%	3.4%	3.1%	2.6%	3.0%	2.8%	3.9%	3.9%	3.4%

Data Source Systm1 PAS

3.5 Ensuring our services are well-led

3.5.1 Professional Leadership for Nursing

Nurses form the majority of the diverse clinical workforce across DCHS. Professional leadership is provided by the Chief Nurse and Deputy Chief Nurse.

This year DCHS has been delighted to welcome the first eight registered Nursing Associates (RNA) to the trust with an additional nine in training. This role is a new addition to the nursing family and designed to bridge the gap between health care assistants (HCAs) and registered nurses. The NMC registered RNA role will provide a route into nursing and a career ladder for the health care support workforce; enhancing the quality of hands-on care offered through defined and funded training and development, and strengthening the support available to nursing staff, releasing them to focus on care planning and management, advancing their practice and using their high level skills. RNAs are qualified at level 5 (foundation degree or equivalent) and Nursing Associate (RNA) is a protected title in England, the NMC is clear that the full suite of regulatory functions will apply to RNAs as it does to nurses and midwives.

Revalidation is the way that nurses and midwives show they are meeting their professional obligations and that they continue to be fit to practise. Revalidation will require nurses and midwives to demonstrate every three years, at the point of renewal of their registration, that they are meeting the Nursing and Midwifery Council (NMC) professional standards as laid out in the revised Code (2014).

Revalidation aims to:

- Increase public confidence in nurses and midwives by requiring them to demonstrate on an on-going basis that they are fit to practise.
- Enable nurses and midwives to be accountable for demonstrating their continuing fitness to practise.
- Promote a culture of professionalism and accountability.

The first full cycle of nurse revalidation was completed in March 2019. In 2018/19 410 nurses were due to revalidate and only 4 (0.48%) failed to do so, and now all but one of them is restored to the register. Each of these cases has been as a result of significant ill health and the nurses in each case have been supported through this personally difficult time by line managers and the Deputy Chief Nurse.

DCHS is working to strengthen the development of advanced practice in nursing roles and ensuring that all the roles have competencies which are strongly aligned to practice. As the NHS landscape changes it is essential that the nursing workforce is equipped to deliver the clinical and professional changes that working in integrated care systems will require.

3.5.2 Allied Health Professions

DCHS has a diverse clinical workforce. Over 600 staff are registered with the Health and Care Professions Council as physiotherapists, occupational therapists, speech and language therapists, podiatrists, paramedics or operating department practitioners. These 6 professions are covered by the umbrella of 'Allied Health Professions' or AHPs. Under the professional leadership of an Assistant Director they work operationally across Planned Care and Specialist Services and Integrated Community Services. DCHS recognises the key contributions that AHPs make to patient outcomes and integrated services. In addition a number of AHPs work in advanced practice roles, extending their skills to provide easy patient access to specialist diagnostic and treatment.

In 2018/19 the DCHS Vision for AHPs was co-produced by colleagues across the Trust. This brings together the ambitions of our Clinical Strategy (the Quadruple Aim – reference page 2); the NHS Long Term Plan and AHPs into Action (NHS England's Strategy for AHPs).

The headlines of the AHP Vision are shown below:

DCHS Vision for AHPs

AHPs and our role in improving the health of the population:

- People and communities take up AHP support to improve their health.
- AHPs and the people we serve are able to influence decisions about the future of services to enable better patient outcomes.

AHPs' experience as DCHS employees

- The unique skills of AHPs are utilised to provide excellent services for patients and staff.
- DCHS Leaders value and develop AHPs to provide high quality services.
- DCHS attracts AHPs to pursue their careers in Derbyshire.

AHPs contributing to improving the experiences patients have of healthcare:

- People are empowered to make informed choices about interventions provided by AHPs, and their wider health.
- People have the information they need about AHP services.
- People are able to access AHP interventions as part of flexible, joined up services.

AHPs' role in reducing costs and adding value in delivering care:

- AHPs take responsibility for efficient and effective practice to meet people's needs.
- People living with Long Term Conditions are enabled by AHPs to live the best life they can.
- AHPs use Evidence based interventions, Equipment and Technology to add value and improve outcomes.
- Innovation led by AHPs is shared effectively

Staff Story – Tracy

Tracy initially went into Physiotherapy as a mature student, graduating from Coventry University in 1999. Prior to this she had worked as a Physiotherapy Assistant. Once qualified her rotations were completed in a large inner city hospital. In time her first child came along, followed by twins and more children inevitably meant more challenges. It was at this point that she made the decision to leave physiotherapy.

Tracy had considered returning to physiotherapy in the past, but had not felt ready and though her confidence to return was still low she decided to take a quick look online at what opportunities were available. Tracy realised she needed to do 30 days supervised clinical practice.

Tracy found a link on the Health Education England website which stated 'Thinking of Returning to Practice? Within half an hour she was chatting on the telephone with Paul Chapman who of all places throughout the whole of the UK, was based at Walton Hospital. They talked at length and Paul explained that a pilot programme had been set up supporting potential returnees. Paul also convinced Tracy that she had a lot to offer and that there were many trusts in the area that would like to help her to return. The employment route was immediately attractive as, though she wanted to return, the prospect of a period of time without a wage would be a definite barrier. The intention was to apply for band 5 posts, working her period of supervised practice paid at Band 4. Tracy applied for band 5 posts with Bev (placement support) supporting her from behind the scenes.

Tracy was offered a role by the Amber Valley Integrated Community Based Team, based at Belper. Before she knew it she had completed her return to practice period, she applied to the Health and Care Professions Council for re-registration and it was quickly approved.

Tracy admitted that having ten years away from the NHS brought with it many challenges, but as long as the returnee goes into the process with an open mind, a 'can do' attitude and a good support network it can be done.

3.5.3 Clinical Supervision

DCHS is committed to ensuring Clinical Supervision supports clinical practice and underpins the maintenance and improvement of standards of patient care. DCHS recognises that clinical supervision has an important role to play in contributing to the reduction of clinical risk by ensuring safe clinical practice. DCHS provides opportunities for differing forms of clinical supervision, reflective practice and developmental activities which give staff the opportunity to learn from their experience and develop their expertise within clinical practice, which could contain the following:

- Clinical supervision (group & individual)
- Individual & group reflection sessions
- Restorative supervision
- Development coaching
- Peer review within sessions
- Safeguarding supervision
- Caseload supervision
- Brief and boundaried / action learning
- Reflective practice

The DCHS policy is that all non-medical patient facing staff have a minimum of 3 x 1 hour sessions of clinical supervision in a rolling 12 month period. Medical colleagues do not have dedicated clinical supervision sessions, but have an annual appraisal and regular one to one meetings with their professional lead where matters relating to clinical supervision are discussed. In 2018/19 83% of eligible staff completed their minimum of 3 sessions. In 2019/20 we are committed to improving the data collection methodology to ease reporting.

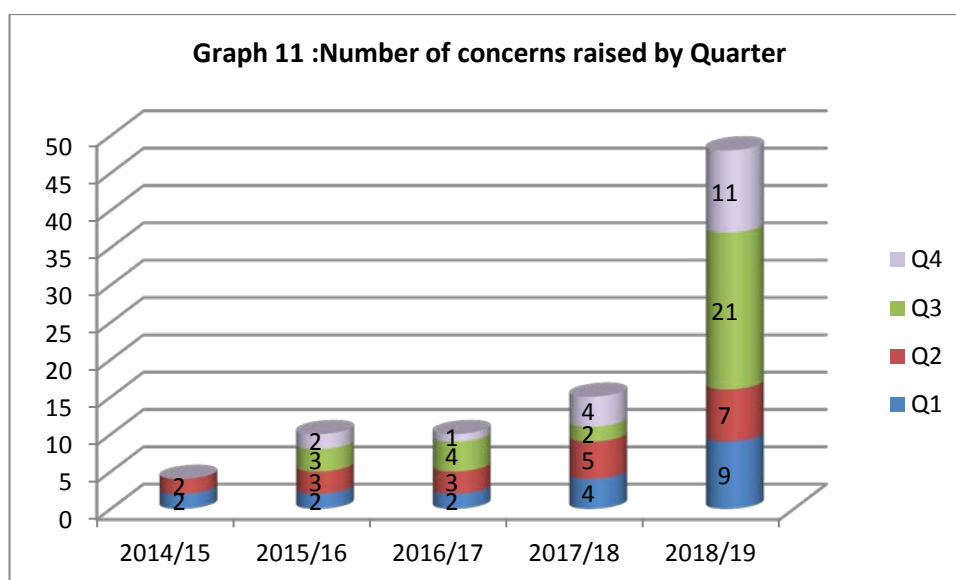
3.5.4 Raising Concerns (Freedom to Speak Up)

In 2018 we were delighted to welcome the National Guardian's Office into the Trust to review our speaking up arrangements, this enabled us to reflect on what we were doing well and areas where we needed to strengthen our arrangements. One of the key outcomes was a new 'Raising Concerns Policy' and we have developed and implemented a robust communications plan to ensure all our staff are aware of how they can raise issues of concern and what they should expect in return.

We have updated our Raising Concerns dedicated website and facilitated drop in sessions across the organisation as well as developing some dedicated training materials. All our staff receive dedicated training as part of their Induction to DCHS.

To help our staff understand the kind of issues they can raise we have created animation videos of five scenarios. These were launched weekly during the first National Speaking Up month in October 2018. During the month we also used social media and local radio to help spread key messages.

During the last year we have seen an increase in the number of issues raised through the Raising Concerns Policy and this can largely be attributed to the huge amount of publicity the initiative has had. The figures are given in graph 11 below.



We have launched a Raising Concerns newsletter, which will enable us to share the learning from issues that staff have raised with us as well as providing key information on a regular basis.

There has been some key learning from the issues that have been reported and this includes:

- Ensuring that staff who are subject to changes in their workplace are provided with continual support and receive consistent messages regarding how the changes will impact on them
- Ensuring our leaders consistently behave in a way that reflects the organisations vision and values
- Ensuring staff are aware of the facilities and equipment that are available to them and that they are used appropriately

One of our priorities for the next year will be to launch our 'Freedom to Speak Up' Strategy: to support its development we held a focus group with key members of staff to explore:

- What currently works well
- What the barriers to staff raising a concern
- What needs to change

The outcomes from the session will be reflected in the final document and will help shape our priorities for the coming year.

3.5.5 Quality Always (QA) – our quality assurance and improvement scheme

We want each person to experience high quality healthcare, whenever they use our services – delivering 'Quality Always.' To support our clinical services to deliver this ambition our trust clinical accreditation scheme known as Quality Always continues to be implemented across the trust:-

1. **Clinical assessment and accreditation scheme (CAAS)** - CAAS is a process of assessment, review and accreditation. An assessment template is used, based on a range of clinical standards. Teams develop and implement an improvement plan and repeat assessments are then carried out, with the frequency being determined by their overall score. Teams can apply for 'Gold' accreditation once the required level of quality has been reached and sustained over a 12 month period.
2. **Quality and safe care champions** - Quality and safe care champions embed best practice identified within the CAAS standards. They are nominated members of front-line staff who receive support to carry out their role throughout the year.
3. **Dashboard** - The dashboard facilitates efficient CAAS assessment and has been developed to identify 'hot spots' and areas of best practice. It also enables in-depth data analysis for staff from board to front-line clinician level. Regular reports run from the dashboard allow identification of the main improvements achieved by the team against the standards and those areas requiring further work or targeted development.

Progress in 2018 - CAAS

- Throughout 2018 the QA team carried out 125 assessments in 69 teams / services covering all DCHS localities and divisions.
- On average during 2018 the team have undertaken ten assessments each month, an increase from 2017 of 2 per month.
- The team were set a KPI of assessing 18 new areas during 2018 and by the end of December 2018, despite carrying out more assessments in 2018, the actual total of new teams assessed was 15. Please see the table 41 below:-

Table 40

Division/Area 2018	ICS Inpatients	ICS Community	Planned Care Outpatients	Planned Care Specialist Services	HWBI Various	HWBI Children's 0-19
Number of assessments	10	48	27	18	14	8
Number of New assessments	0	8	3		2	2
Total per division	58 (ICS)		45 (PC)		22 (HWBI)	

Below is a table summarising assessment ratings to the end of December 2018.

Table 41: CAAS ratings

Division	CAAS rating				
	Red	Amber	Green	Gold	Multiple Gold
ICS	1	16	4	0	6
Planned Care	0	3	9	6	10
HWBI	0	2	6	4	2
Totals (56)	3	21	19	10	18

Gold panels

Six gold accreditation panels have taken place during 2018. Support for the panel process including refining the detail and expectations has been gratefully received from executive and non-executive colleagues, public governors, assistant directors, staff partnership, previous gold award achievers and heads of service and quality.

The teams presenting to the panels have continued to impress with the diversity of their presentations and the commitment to excellence in patient centred quality care. There are a total of 28 teams who are currently achieving the Gold Accreditation standard.

Table 42: New Gold achievers in 2018

Month	Gold accreditation awards in 2018
Jan	Chesterfield and North East Outpatient and MSK Physiotherapy service
March	Fenton Ward
May	Ripley Outpatient Department Diagnostic and Treatment Centre Ilkeston Hospital School age Immunisation and Vaccination Team
July	Okeover Ward Bolsover South 0-19 Children's service Heanor Outpatients Department
September	Amber Valley Outpatient and MSK Physiotherapy Service
December	Wheatbridge Integrated Sexual Health Service



Table 43: Teams Maintaining Gold in 2018

After 12 months of Accreditation	Learning Disabilities Community Team Adult Speech and Language Therapy Service Whitworth Minor Injury Unit Chesterfield and North East Dental service Chesterfield and North East Podiatry Heanor Ward Butterley Ward Hopewell Ward
After 24 months of Accreditation	Valley View Rockley Way Robertson Road Amberley Court Orchard Cottage Baron Ward

Teams who did not retain their gold status

4 teams did not retain their gold status, and one team was deferred by the accreditation panel. All teams have returned to the CAAS assessment process and are currently rated as amber and green.

Quality and responsive summits

During 2018 quality and responsive summits were arranged to support teams and their leaders with the development of a robust plan to move them forwards with their quality improvement journey. The table below shares the details of the team who undertook support from either a quality or responsive summit.

Table 44: Quality / Responsive Summit

Type of Summit	Month 2018	Team
Quality Summit	February	Amber Valley SPA Clay Cross ICT (Integrated Community Team)
	May	Linacre Ward
	December	Derbyshire Dales South ICT
Responsive Summit	January	Dronfield ICT
	April	High Peak and Dales ICT
	May	Erewash 0-19
	June	Belper ICT
	August	Buxton High Risk Podiatry Outpatients and Theatre
	September	Ripley Minor Injury Unit Hillside Ward Oker Ward
	October	Alton Ward Buxton Outpatients South Erewash ICT
	November	Clay Cross ICT East Chesterfield ICT

Quality and safe care champion (QSCC) programme

20 training sessions facilitated by the QA improvement leads and specialist leads / practitioners for safe and person centred care have been held for the champions across the following subjects:



Continence	Infection control and prevention	Nutrition	Patient experience and dignity	Tissue viability
Safeguarding	Falls forum	End of life care and Spirituality	Dementia	Pain

373 champions have attended, estimated to be 40% QSCC registered to attend the sessions provided in 2018 from the total head count of 793 QSCC registered as of December 2018.

QSCC have also become influential members of several key clinical groups in the Trust, such as the nutrition steering group and the end of life care group where their input has been valued.

QSCC hub and Facebook Group

The QA team have developed an on line hub for QSCC to obtain detailed up to date information, examples of service evaluation tools and also to share their ideas with each other, this has been really well received. QSCC continue to engage with Facebook group posting suggestions ideas and examples of the quality improvement developments being implemented.

QA dashboard and reporting tools

Significant progress has been made in 2018 developing the assessment reporting tool on the quality dashboard page and the informatics lead has developed a range of reports that can be accessed by all leaders and teams. This is enabling teams, specialist leads and the QA assessors to drill down on all the data held within the system to identify achievement, hot spots and themes and trends against the clinical standards. Quarterly reports regarding the top rating themes and trends from assessments are now circulated widely across DCHS to inform improvement actions.

National and local events

An article written by the Clinical Lead for QA called “Designing and implementing a trust-wide quality assurance programme” was published in the Journal of Community Nursing in April 2018. The QA team took part in the Trust Clinical Effectiveness Conference.

Seb's Story

In 2017 DCHS were invited by Chesterfield College to offer an internship for 3 learning disability students for a year, to support them with 'real life' business skills, confidence and people skills, whilst learning hands on what qualities someone needs to progress within the world of work. This was the third cohort of such students DCHS had hosted. Of the six candidates interviewed 3 were successful, one being “Seb”.

The wider workforce coordinator arranged for the students to work on a rotational basis with various teams across the Chesterfield area including the patient safety and risk management team. Seb joined the team initially on the 6th and 7th December 2017. Seb continued his further placements within DCHS before requesting to return to the patient safety and risk management team for the remainder of the placement. As a result he re-joined the team for 2 days each week from the 14th March 2018 until the 28th June 2018.

Seb recognised that because of the sensitivity and nature of the work he would have limited opportunity to participate in all areas of work. However, Seb demonstrated an immediate interest in the work he was introduced to and was enthusiastic to assist or be involved in the work where he could. During initial conversations it was identified that Seb has an interest and aptitude for IT work and systems of work. Seb became involved in various work streams and established himself as part of the team whilst Carl Ramsdale, the risk manager, mentored and managed him. Seb's work included the de-commissioning of medical devices, maintenance of training registers and the compilation of community staff clinical baseline kitbags. During his time with the team Seb's confidence grew and together we worked on his communication and presentation skills, initially presenting to individuals and finally progressing to staff groups in excess of thirty people.

At the conclusion of Seb's placement he was recruited to the DCHS staff bank in order that he could continue and complete his work with the Patient Safety and Risk Management team. Seb has also worked with a clinical team providing administrative support. At Chesterfield College Seb has become somewhat of a celebrity through the recognition of his success whilst at DCHS. This was



evident on the 14th June 2018 when Carl was invited to attend the college achievement awards evening in order to present Seb with his college certificate. The majority of staff, parents and students were aware and clearly impressed by Seb as there were frequent references to his achievements.

Carl shared what a pleasure it has been to continue working with Seb and that he has become an outstanding ambassador for DCHS. Seb continues to build on the experience he has gained during the past year and he is confident this has assisted him going forward with his studies and personal development.

Carl Ramsdale was Awarded Leader of the Year – Admin & Clerical at the Unsung Hero Awards on Friday 1st March 2019.

3.5.6 Learning Disability Improvement Standards for NHS Trusts

The new standards have been designed to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both.

There are four standards, which include:

- 1) respecting and protecting rights;
- 2) inclusion and engagement;
- 3) workforce and
- 4) learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

We have undertaken a gap analysis and also contributed to the national survey. In terms of autism we have established a basic awareness programme which 82.82% of staff have completed.

We have also provided staff with easy to use communication guides in the way of posters and cue cards for lanyards

LD services are commissioning a specialist training programme for autism as well.

Patient Story - Max's Story was presented Emma, SLT for Autism. Max is a 6 year old boy. He attends an Enhanced Resource Unit at a local mainstream school, and before this attended a mainstream school and nursery.

When it became apparent that Max was still struggling with his communication the SLT service began to look for an iPad with appropriate software.

Max used pictures to communicate as a pre-schooler. Max was loaned a communication aid which uses a recorded voice and can carry up to 100 messages. Max parents and the SLT Service began to look at sources of funding for devices. Subsequently Max was provided with equipment from the Electronic Assistive Technology Service (EATS) which he can keep for as long as he needs. The iPad has had a profound impact on Max's communication skills and has shown extensive and significant communication skills. After an extremely stressful time for Max's mum, Max has now been placed in a mainstream school where he has been able to thrive. The provision of the iPad has allowed Max to really show his skills. He is a bright boy.

This year Max was able to ask for the kind of birthday party that he wanted, he could tell his mum that he loved her as she dropped him at school, he could develop relationships with wider family as he finally had a system of communication which met his needs and now the icing on the cake, he has two voices, his iPad and his own. Max has recently joined the school choir and is singing his newly learnt songs to his family.

Staff Story - Tim, Healthcare Assistant, shared his story to raise awareness about the challenges people with a stammer encounter in their day to day lives.

Tim started stammering at around 5 years old and doesn't have a memory of speaking without a stammer, so it's all he has ever known. He stammered all the way through school, and back then

times were very different, people really didn't have a lot of awareness about stammering and the support he needed. For Tim, school was about as horrendous as it can get. He was bullied because of his stammer, and people often underestimated the emotional scars this leaves in later life.

Tim's time working in DCHS has been on the whole a very positive experience. He works in a good, close team who even socialise occasionally outside of work. They all have a really good rapport with each other and excellent banter which makes our working environment a great place to be.

Tim doesn't feel that he is treated differently by his team because of his stammer however on occasions he has experienced a clear lack of awareness and understanding around how people communicate with him and is of the opinion that this is an honest ignorance and people are not knowledgeable or aware of how to change their communication to support someone who has a stammer. He has found when speaking to others they will often finish his sentences or jump in with words to complete what he is saying. What they don't realise is that this type of behaviour takes his voice away and discourages him from speaking up.

DRAFT 24/04/2019

Appendix 1 - Workforce - Engaging with our staff

We actively encourage staff to get involved in what's happening across the organisation, to be able to express their views and play an active role in how the culture of the organisation develops - and we also want to be able to thank people.

We have a number of established ways in which we provide information to staff on matters of concern to them as employees and also to encourage involvement by individuals in our organisation's performance.

We have a strong staff representation on our Council of Governors involved in making decisions affecting our workforce and the services we provide.

A quarterly Staff Forum brings together staff representatives with executives to discuss matters of interest and concern to staff, on topics chosen by staff.

Each month we meet with staff partnership/union colleagues in a formal sub-committee of the Trust Board. The aim is to provide assurance that we routinely engage, consult and involve staff in the management of change.

Team Talks and Exec Huddles offer an informal drop-in opportunity for staff to find out more about what's planned and raise any questions face-to-face with an executive.

Big Conversations are bi-monthly bookable three-hour sessions which are open to all staff. The agenda is set before the meeting and covers key issues relating to the current climate.

Leadership Forums are quarterly three-hour sessions for people managers to discuss the latest developments with executives, and then share with their teams.

In addition to these ongoing organisation-wide engagement/information sharing opportunities, we also organise briefing sessions for groups of staff at their places of work to ensure their views can be taken into account on specific developments likely to affect them.

During 2017/18 we held a series of executive-led briefing sessions around the Joined Up Care Belper Review and Better Care Closer to Home Consultation, both commissioner-led projects for the future shape of care with an impact on our staff, which it was important for us to share directly with staff.

We have a strong culture of appraisals, training, learning, development and raising concerns which are all designed to promote our approach to staff engagement. We also hold topic specific engagement events and also arrange for these to be held at locations across the patch.

Saying thank you

We think it is important to celebrate the achievements of individuals and teams who dedication and commitment shines through, including those who devote decades of their working life to the NHS and to our organisation.

This year we launched a new #DCHSTTT – thank you, time and tea party - reward and recognition scheme, hosted by the Board, running every quarter, to celebrate and thank staff by inviting them to take some time out and enjoy tea and cakes with colleagues and friends. Our first 2018 cohort of nominees were a combination of staff who had been nominated, staff who were receiving their long service awards and teams who had retained their Gold Quality Always Accreditation.





We also introduced a new festive initiative leading up to Christmas 'Seasonal Stars', this was a feel good campaign, sponsored by Thornton's, recognising over 80 colleagues split each day throughout December.

During 2018 we which are an recognise those who expectations.



hosted our fifth Extra Mile Awards established event in our calendar, to inspire others and deliver beyond

Staff Story - James

Following an accident, James sustained an injury and Ligament damage to his right hand and right thumb. This involved him having to take time off sick from my job as a Health Care Assistant; working on a ward with patients that have mental ill health and highly challenging behaviours. I was unable to carry out my role as a HCA due to me wearing a splint. I was severely limited with carrying moving and handling safely, I was restricted with carrying out personal care due to me wearing a splint and not being able to employ adequate infection control precautions. Further to this he could compromised work colleagues, patients and himself as he was not able to employ Restraint and or breakaway techniques if and when required.

Following a meeting with his line manager as part of James's managing sickness, a mutually agreed and alternative job role on the ward was found, working with the ward Clerk, carrying out admin work in the office.

The passport and alternative arrangements enabled James to return to work from sickness whilst his hand was recovering in a splint and he worked in the office carrying out admin for three weeks. This prevented him from a protracted length of sickness. By being able to return to work this had had positive impact on his wellbeing; James said "I haven't felt anxious and preoccupied about sickness time or felt guilty for not being able to come to work. I have felt accomplished in my temporary role which has helped to build my self-esteem and confidence. Whilst still being a valued member of the unit team. Further to this I have been able to gain a greater understanding of my peers jobs, namely the work carried out by the RN's and Ward Clerks."

NHS Staff Survey

The 2018 NHS Staff Survey was conducted between Monday 1 October and Friday 30 November 2018. 2,565 DCHS employees completed the survey giving a response rate of 61%, compared to our response rate of 55% in 2017.

The annual NHS Staff Survey provides us with valuable feedback on how individuals feel about the NHS and our organisation in particular as a place to work. The results are widely shared and discussed through all our established staff engagement channels, including Team Talks, Exec Huddles, Leadership Forums and Staff Forum, to ensure staff at all levels have the opportunity to feed into the conversation about what the results tell us.

From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

Scores for each indicator together with that of the survey benchmarking group Community Trusts are presented in table 46 below:

Table 45: Benchmarking group scores

	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity & inclusion	9.4	9.3	9.4	9.3	9.5	9.4
Health & wellbeing	6.2	5.9	6.3	6	6.5	6.1
Immediate managers	7	7	7	7	7.2	6.9
Morale	6.3	6.2	N/A	N/A	N/A	N/A
Quality of appraisals	5.6	5.6	5.7	5.4	5.9	5.6
Quality of care	7.6	7.3	7.6	7.3	7.8	7.5
Safe environment – bullying & harassment	8.5	8.4	8.6	8.4	8.7	8.4
Safe environment – violence	9.6	9.7	9.6	9.7	9.7	9.7
Safety culture	7.1	7	7	6.9	7.1	6.8
Staff Engagement	7.2	7.1	7.2	6.9	7.4	6.9

Full survey results are also shared on our intranet site, My DCHS and via our all staff weekly email, the Weekly Download. All these channels help to feed into the detailed action plan to address areas where the survey shows we need to improve.

Using the findings from the NHS Staff Survey 2018, we are focusing on **seven** key areas for improvement during 2019:

1. Leading for Improvement
2. Employee Wellbeing
3. Appraisals
4. Development Opportunities
5. Bullying and Harassment
6. Raising Concerns
7. Health & Safety of Employees

Progress on a more detailed action plan of our future priorities and targets to improve staff satisfaction in each of these key areas will be reported bi-monthly to our Staff Health, Wellbeing, Safety and Engagement Group and Quality People Committee. We conduct Pulse Checks three times a year. These results give us added opportunities to monitor and improve staff feedback, details of which are included further on in this chapter.

Pulse Check

Pulse Checks were launched in 2013 to give quick anonymous feedback on how well staff feel they are being managed, engaged and supported. This was later linked with our Staff Friends and Family Test. The positive impact high staff engagement can have on other key performance indicators – such as attendance, patient safety and productivity – is recognised and well researched. It also shows leaders how well they are engaging with their teams to deliver the results we need, primarily around quality care for our patients.

We run the Pulse Checks three times a year (2 full census, 1 sample). We encourage all our staff to complete the 9-question Pulse Check (that shouldn't take any longer than 5 minutes to complete) to

test the mood and wellbeing of employees and teams. This helps us pinpoint where and how we need to give extra support and intervention on a rolling basis to maintain staff morale.

The overall engagement scores for each quarter in 2018/ 19 are:

- Q1 April – June: 76%
- Q3 October – December: NHS Staff Survey, no Pulse Check
- Q4 January – March 2019: **TBC – Results are out on Thursday 18th April, not sure on time**

In recent Pulse Checks these are the responses we received to the following Staff Friends and Family Test questions:

How likely are you to recommend Derbyshire Community Health Services NHS Foundation Trust to friends and family if they needed care or treatment?

- Q1 April to June 2018: 90%.
- Q3 October to December: NHS Staff Survey, no Pulse Check
- Q4 January to March 2019: **TBC – Results are out on Thursday 18th April, not sure on time**

How likely are you to recommend Derbyshire Community Health Services NHS Foundation Trust to friends and family as a place to work?

- Q1 April to June 2018: 70%.
- Q3 October to December: NHS Staff Survey, no Pulse Check
- Q4 January to March 2019: **TBC – Results are out on Thursday 18th April, not sure on time**

Staff Wellbeing Update

The launch of the new staff wellbeing strategy aims at creating a step change for staff experience at DCHS. The strategy focuses on three key areas; prevention, resilience and support. The previous model was heavily focused on supporting staff once difficulties had happened, as opposed to tackling up stream issues. The existing support structures, such as Resolve and Occupational Health are continuing to be developed and are linked into the preventative work. The prevention element focuses on staff self-compassion and supports this through staff training and management consultancy offers. There is also a focus on areas where we know things to be more challenging, such as in LD or OPMH services, and are providing bespoke support to these teams.

Wellbeing Figures

The staff wellbeing team have delivered 210 training sessions in the past year, compared to 155 for the same period the previous year. The majority of these sessions focus on stress to resilience or bespoke team building. The sessions receive 98.5% average satisfaction and recommendation scores.

Table 46: wellbeing training sessions

Month	Training sessions delivered 2017	Training sessions delivered 2018
Total	155	210

Resolve Figures

Satisfaction

- 100% of clients rated the overall service received by Resolve as good or excellent.
- 100% of clients felt that the counselling they received helped them to deal more effectively with their issues.
- 98.5% of clients would use the Resolve service again, if they needed to.
- 85.5% of clients reported feeling more productive at work as a result of the counselling they received from Resolve.
- 68% of clients felt that coming to counselling prevented them from taking time off sick.

Table 47: Key Performance Indicators

KPI	Target	2018/19 Half Year	2017/18 Full Year
Uptake of counselling (in % of DCHS workforce headcount)	4%	8.5-9% (projected)	9%
Offer first assessment appointment within 2 weeks (14 calendar days)	100%	89%	83%
Client felt more productive at work	90%	85%	80%
Client would recommend the service / come again	90%	98.5%	99%
Client felt that Resolve counselling helped prevent them from taking sickness absence (where relevant)	90%	68%	72%

Last year there were 408 referrals into Resolve and early indications are that this year will be about the same

2018/19 Flu Campaign

The flu campaign successfully vaccinated 2,226 of 3,473 frontline staff which equates to 64.1%. This is marginally below the 68.5% achieved last year. However a key success of the campaign was ensuring as many clinical staff as possible were vaccinated at the beginning of the campaign, through the use of pre-booked clinic slots. This has resulted in a reduction in absence due to flu of 5% compared to the previous winter.

Appendix 2 - GP Patient Survey results

Table 48: Patient Survey results

Service line request	Castle Street 2018	Castle Street 2017	Creswell 2018	Creswell 2017	Ripley 2018	Ripley 2017	Service total	National Average
Find it easy to get through to this GP practice by phone	86%	91%	81%	86%	71%	73%	79	9
Find the receptionists at this GP practice helpful	93%	91%	90%	84%	91%	82%	91	1
Are satisfied with the general practice appointment times available^	79%	86%	64%	77%	61%	68%	68	2
Usually get to see or speak to their preferred GP when they would like to	65%	81%	25%	40%	33%	29%	41	-9
Were offered a choice of appointment when they last tried to make a general practice appointment*	74%	--	53%	--	52%	--	60	-2
Were satisfied with the type of appointment they were offered*	89%	--	73%	--	66%	--	76	2
Took the appointment they were offered*	97%	--	93%	--	91%	--	94	0
Described their experience of making an appointment as good	82%	92%	57%	71%	63%	58%	67	-2
Waited 15 minutes or less after their appointment time to be seen at their last general practice appointment	80%	79%	69%	70%	62%	40%	70	1
Say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment**	90%	89%	91%	87%	87%	86%	89	2
Say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment**	93%	92%	91%	88%	94%	88%	93	4
Say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment**	88%	94%	94%	89%	91%	87%	91	4
Were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment^^	99%	93%	90%	77%	95%	84%	95	2
Had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment	98%	99%	94%	97%	96%	95%	96	0
Felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment*	91%	--	82%	--	84%	--	86	-1
Felt their needs were met during their last general practice appointment*	100%	--	93%	--	95%	--	96	1

Service line request	Castle Street 2018	Castle Street 2017	Creswell 2018	Creswell 2017	Ripley 2018	Ripley 2017	Service total	National Average
Say they have had enough support in the last 12 months to help manage their long-term condition(s)*	88%	--	60%	--	76%	--	75	-4
Describe their overall experience of this GP practice as good	89%	92%	81%	73%	81%	72%	84	0

* No comparator for 2017

** 2017 data – aggregated from separate GP & Nurse results from 2017

^ 2017 data - % of patients who are satisfied with the surgery's opening hours

^^2017 data - % of patients who say the last GP they saw or spoke to was good at involving them in decisions about their care

Key

Above average	1-10 below average
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Quality Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is a set of 77 quality indicators which indicate how well practices look after people, particularly those with long term conditions such as heart or lung disease. All of our practices have improved their scores during the last year as illustrated below:

Table 49: QOF results 2017 – 2019

Practice	Points (out of 559)	Percentage 2017	Percentage 2018	Percentage 2019
Castle St	538.56	91%	98%	96.3%
Ripley	540.34	98%	99.5%	96.7%
Creswell	553.47	96%	99.2%	99%
Service aggregate is 97.3%				

Appendix 3 - Third party statements – CCGs/Healthwatch



North Derbyshire Clinical Commissioning Group
Southern Derbyshire Clinical Commissioning Group

Commissioner Statement

Sending to CCG on 18th April 2019

Attending Health Scrutiny Committee on 20th May



Derbyshire Community
Health Services
NHS Foundation Trust

Derbyshire Community Health Services NHS Foundation Trust

Governor statement 2019

Being submitted to Quality Sub-Group for 10th May 2019



As an independent organisation which asks local people to share their experiences of services with the aim of helping to improve and better understand overall local Health and Social care, it is important that the service providers are prepared to listen and where necessary act upon patient voice. Healthwatch Derby have found DCHS to be open and responsive to the feedback we have provided throughout the year and the team have found staff very helpful in the planning and outreach work we have undertaken. We especially found this with the work into local emergency dentistry provision and sexual health services. The organisation has acted in a manner which displays that they are interested in improving the experience of their services and are actively searching for ways to engage with their service users. Healthwatch Derby is will continue to work in partnership to help DCHS better understand the impact of their work.

James Moore MBA, Assoc CIPD
Chief Executive Officer
Healthwatch Derby

Healthwatch Derbyshire (HWD) is an independent voice for the people of Derbyshire. We listen to the experiences of Derbyshire residents using health and social care services and give them a stronger say in influencing how local health and social care services are provided. All of the experiences we collect are shared with the providers and commissioners of the services, who have the power to make change happen.

Experiences from patients and members of the public are collected through our engagement team, which is supported by volunteers. We undertake engagement in two ways:

- 1) General engagement in which we collect a variety of different experiences on a number of services. Experiences from our general engagement are shared with providers on a regular basis to provide an independent account of what is working well, and what could be improved.

Anyone who shares an experience with HWD is able to request a response, and we encourage organisations to consider responses carefully and indicate where learning has taken place as a result of someone's experience.

- 2) Themed engagement is where we explore a particular topic in more detail and the findings from our themed engagement are analysed and written up into reports which included recommendations for improvement. Service providers and commissioners are asked to respond to the recommendations outlined in the reports.

All of our reports are published onto our website.

We have read the Quality Account for 2018-19 prepared by the Trust with interest. We have considered if, and how the content reflects some of the themes which have emerged in the feedback that HWD has collected during the past year.

The Quality Account details improving the dementia friendly environment and culture across the Trust. HWD welcomes this priority, following the publication of the HWD Dementia Report in May 2018, patients and members of the public explained how important it is to raise awareness and understanding of dementia and to also, create a culture that is inclusive of all.

The Quality Account also refers to the partnership working between the Trust and HWD. We regularly provide feedback to the Trust in terms of comments and we have also undertaken several pieces of themed engagements, to provide the Trust with independent patient feedback. This includes, the HWD Dementia report, Cataract Report and Enter and View visit reports. DCHS also supported the development and sharing of the 'STOP! I have a learning disability' poster. These provide examples of how HWD and the Trust can work closely together to develop and improve patient experience.

By way of summary, during the period April 2018 - March 2019, a total of 82 comments were received about the Trust with a fairly equal split between positive comments (37), negative comments (23) and mixed comments (22). The most frequent negative comments were regarding information and communication. The most frequently made positive comments were in relation to the quality of treatment, quality of care provided by members of staff and positive and welcoming environments.

Hannah Morton
Intelligence and Insight Manager
Healthwatch Derbyshire

Regulation 5 – No changes have been made to the final quality account after receipt of the statements referred to above.

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Appendix 4 - 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 to prepare Quality Accounts for each financial year.

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

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance;
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - Board minutes for the financial year, April 2018 and up to the date of this statement (the period);
 - Papers relating to quality report reported to the Board over the period April 2018 to the date of this statement;
 - Feedback from the Commissioners dated xxxx;
 - Feedback from Governors dated xxxx;
 - Feedback from Local Healthwatch Derby and Derbyshire organisations dated xxxx;
 - Feedback from Health Scrutiny Committee dated xxxx;
 - The latest national staff survey 2018;
 - Care Quality Commission inspection report, dated 23rd September 2016; and
 - The Head of Internal Audit's annual opinion over the Trust's control environment dated xxxx
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account's regulations) as well as the standards to support data quality for the preparation of the quality report

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

By order of the Board

.....Date.....chairman

.....Date.....chief executive

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Appendix 6 - 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.

Table 49: Complete list of core indicators.

	Prescribed information	Type of trust	2016/17	2017/18	2018/19
12	(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.	Trusts providing relevant acute services	n/a	n/a	n/a
13	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.	Trusts providing relevant mental health services	n/a	n/a	n/a
14	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.	Ambulance trusts	n/a	n/a	n/a
14.1	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.	Ambulance trusts	n/a	n/a	n/a
15	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.	Ambulance trusts	n/a	n/a	n/a
16	The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.	Ambulance trusts	n/a	n/a	n/a
17	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	Trusts providing relevant mental health services	n/a	n/a	n/a
18	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.	Trusts providing relevant acute services	n/a	n/a	n/a
19	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.	All trusts	n/a	n/a	n/a

	Prescribed information	Type of trust	2016/17	2017/18	2018/19
20	The trust's responsiveness to the personal needs of its patients during the reporting period.	Trusts providing relevant acute services	n/a	n/a	n/a
21	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.	Trusts providing relevant acute services	87.5%	82%	82.8%
21.1	<p>Friends and Family Test – patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult 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>	Trusts providing relevant acute services	98%	97.8%	98.2%
22	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.	Trusts providing relevant mental health services	n/a	n/a	n/a
23	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Trusts providing relevant acute services	99.6%	99.9%	99.6%
24	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.	Trusts providing relevant acute services	n/a	n/a	n/a
25	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.	All trusts	10,002 7 0.07%	10,018 9 0.08%	7,221 4 0.05%

Glossary

AHPs	-	Allied Health Professions
BAF	-	Board Assurance Framework
Bariatric	-	Medical terminology for branch of medicine dealing with causes prevention and treatment of obesity
BRAVO	-	Baseline recording of activity for valued outputs
CAS	-	Central Alerting System
CAUTI	-	Catheter Acquired Urinary Tract Infection
CCG	-	Clinical Commissioning Group
CFT	-	Community Foundation Trust
CSG	-	Clinical Safety Group
CQC	-	Care Quality Commission
CQUIN	-	Commissioning for Quality and Innovation
DCHS	-	Derbyshire Community Health Services NHS Foundation Trust
DoLS	-	Deprivation of Liberty Safeguards
DTC	-	Diagnostic and Treatment Centre
EoL	-	End of Life
ERE	-	Erewash
ESR	-	Electronic Staff Record
GP	-	General Practice
HCA	-	Health Care Assistant
HCAI	-	Healthcare Associated Infection
HCCG	-	Hardwick Clinical Commissioning Group
HSE	-	Health and Safety Executive
ICM	-	Integrated Community Manager
ICTL	-	Integrated Community Team Lead
IG	-	Information Governance
IM&T	-	Information Management and Technology
KLOE	-	Key Lines of Enquiry
KPIs	-	Key Performance Indicators
LD	-	Learning Disabilities
LeDeR	-	Learning Disabilities Mortality Review
LoS	-	Length of Stay
MCA	-	Mental Capacity Act
MIU	-	Minor Injury Unit
MoGP	-	Markers of Good Practice
MRG	-	Mortality Review Group
MRSA	-	Methicillin-resistant Staphylococcus aureus
NA	-	Nursing Associate
NDCCG	-	North Derbyshire Clinical Commissioning Group
NACEL	-	National Audit of Care at the End of Life
NAIC	-	National Audit of Intermediate Care
NED	-	North East Derbyshire
NEWS2	-	National Early Warning Score (Revised)
NHS	-	National Health Service
NICE	-	National Institute for Health and Care Excellence
NMC	-	Nursing and Midwifery Council
NRLS	-	National Reporting & Learning Scheme
NUH	-	Nottingham University Hospital
NRLS	-	National reporting and learning scheme
OT	-	Occupational therapist
OPMH	-	Older Peoples Mental Health
PLACE	-	Patient-Led Assessments of the Care Environment
QSC	-	Quality Service Committee
RCA	-	Root Cause Analysis
RN	-	Registered Nurse
RTT	-	Referral to Treatment Times
SDCCG	-	Southern Derbyshire Clinical Commissioning Group

SHOT	-	Serious Hazards of Transfusion
SLT	-	Speech and Language Therapy
SSNAP	-	Sentinel Stroke National Audit programme
STP	-	Sustainability and Transformation Partnership
TV	-	Tissue Viability
UHDB	-	University Hospitals of Derby and Burton NHS Foundation Trust
VTE	-	Venous Thromboembolism
WTE	-	Whole Time Equivalents

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