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PUBLIC

To: Members of Improvement and Scrutiny Committee - Health

Friday 3 July 2020

Dear Councillor

Please attend a meeting of the **Improvement and Scrutiny Committee - Health** to be held virtually on MS Teams at **2.00 pm** on **Monday 13 July 2020**; the agenda for which is set out below.

Yours faithfully

Simon Hobbs
Director of Legal and Democratic Services

A G E N D A

PART I - NON-EXEMPT ITEMS

1. To receive apologies for absence (if any)

2. To receive declarations of interest (if any)

3. Minutes - to confirm the non-exempt minutes of the meeting of the Improvement and Scrutiny Committee - Health held on 9 March 2020 (Pages 1 - 4)

4. Public Questions (30 minutes maximum in total) (Pages 5 - 6)

   (Questions may be submitted to be answered by the Scrutiny Committee, or Council officers who are attending the meeting as witnesses, on any item that is within the scope of the Committee. Please see the procedure for the submission of questions at the end of this agenda.)

5. Services Changes Quality Assurance

6. Derbyshire Community Health Services Quality Account 2019/20 (Pages 7 - 98)

PUBLIC

MINUTES of a meeting of the **IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH** held at County Hall, Matlock on 9 March 2020.

PRESENT

Councillor D Taylor (Chairman)

Councillors D Allen, R Ashton, S Bambrick, S Burfoot, L Grooby and G Musson.

Also in attendance were: Helen Henderson-Spoors from Derbyshire Healthwatch, Richard Chapman, Dave Gardener and Andrew Kemp from Derby and Derbyshire CCG.

Apologies were received from: Councillors S Blank and A Stevenson.

07/20 **MINUTES** **RESOLVED** that the Minutes of the meeting of the Improvement and Scrutiny Committee – Health held on 20 January 2020 be confirmed as a correct record and signed by the Chairman.

08/20 **PUBLIC QUESTIONS** There were no public questions submitted.

09/20 **HEALTHWATCH DERBYSHIRE - OFFENDER HEALTH REPORT** Helen Henderson-Spoors presented the Healthwatch Derbyshire report on the health needs analysis on the experiences of ex-offenders using health services in Derbyshire. It paid specific attention to those who might otherwise struggle to be heard and to understand more about the health services that people had used. The key findings were:

- Most youth offenders had registered with a GP and dental surgery and, although a large proportion of adult ex-offenders had registered with a GP, only half had registered with a dental surgery as this was not viewed as a 'priority';
- Many adult ex-offenders felt there was limited support for people with mental health issues, and felt there should be more emphasis on preventing mental ill health and ensuring people are signposted to appropriate support;
- Some adult ex-offenders felt when they asked for help with their mental health they were often provided with medication, rather than offered support to help deal with any underlying issues;
- Youth offenders appeared to have no difficulties with finding and understanding health related information and support, whereas adult ex-offenders often relied on their probation officer or GP;
- Adult ex-offenders felt there should be more information provided to offenders on release from prison, as many felt unprepared as they were unsure what to do, or where to go with regards to healthcare services;

- Majority of the youth offenders were happy with the health of their lifestyle, however many adult ex-offenders explained they felt unhappy with their lifestyle due to poor diets and mental health.

  Moving forward from the findings, it was agreed:

  1. To ensure that all offenders are provided with clear information and support on all relevant healthcare services prior, and on release from prison;
  2. Improve mental health support;
  3. Ensure that the information provided to offenders on release from prison is in an accessible format; and
  4. Work to improve the health and well-being of ex-offenders:

A sub-group of the Reducing Reoffending, Offending and Offender Health Group had been established, chaired by the Assistant Director of Public Health from Derbyshire County Council, and with a membership that included representatives from commissioners and providers across both criminal justice and health and care. The group welcomed this report which provided additional insight on how organisations can better meet the health needs of offenders in the community.

RESOLVED to accept the report.

10/20 CCG SUMMARY FINANCE AND SAVINGS REPORT 1 APRIL TO 31 DECEMBER 2019 Richard Chapman presented the financial performance of NHS Derby and Derbyshire CCG including delivery of the savings plan for the nine month period ending 31 December 2019. The CCG were reporting a year to date and forecast position in line with its control total and financial plan.

A summary of performance against key CCG financial duties:

Statutory Duty/ Performance	Target	Result	Achieved
Hold a 0.5% risk reserve (inc. PCCC)	£8.112m	£8.112m	✓
YTD achievement of control total in-year deficit (original plan)	(£11.600m)	(£11.484m)	✓
Forecast achievement of control total in-year deficit (original plan adjusted for CSF)	(£18.850m)	(£18.850m)	✓
Forecast delivery of the Savings Target	£69.500m	£47.082m	×
Forecast - remain within the Running Cost Allowance	£22.457m	£16.698m	✓
Underlying Position	(£46.400m)	(£54.951m)	×
Remain within cash limit	Greatest of 1.25% of Drawdown, or £0.25m	0.30%	✓
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8	✓

The Summary Operating Cost Statement showed:

- The year to date and forecast overspend positions of £11.484m and £18.850m respectively were in line with the Commissioner Sustainability Fund (CSF) adjusted control total;
- The year to date position included savings under delivery of £10.620m and the forecast position included savings under delivery of £22.418m;
- £3.572m of the CCG's £8.1m mandated contingencies had been used in the forecast position;
- If the CCG's overall position remained within plan it would receive up to a further £18.850m of CSF. £8.7m relating to quarter 3 was due in month 10.
- Any underspends or spare budget would not be re-committed without the approval of the Chief Finance Officer.

In summary, £3.6m of the CCG's £8.1m mandated contingencies had been used in the forecast position, any overspend or under delivery of savings would be supported by robust mitigation plans or alternative savings and risks of £4.5m were being mitigated by unused contingencies, whilst recovery actions were pursued.

A number of questions were put to Mr Chapman by the Committee Members. Questions were mostly focused around the impact on patients arising from the measures undertaken as part of the Financial Recovery Plan.

The Chairman thanked Mr Chapman and his colleagues for their presentation.

RESOLVED that the Committee would continue to monitor the CCG's Financial Recovery Plan and its impact on patients.

11/20 CONSULTATION ON THE TRANSFER OF ADULT MENTAL HEALTH SERVICES TO KINGSWAY HOSPITAL David Gardener, Derby and Derbyshire CCG presented a report on a public consultation with regards to a proposed move of functional mental health services for older people in the London Road Community Hospital in Derby City Centre to Kingsway Hospital. The Mental Health Commissioning Team and the CCG Communication and Engagement Team welcomed the views and recommendations of the Committee on this proposed relocation and the approach being taken.

The document went on to outline the reasons for the proposed move and details on the consultation process, which would be delivered over a 60-day period. It was proposed that the service would be relocated to an 18-bed facility at Tissington House, based at Kingsway Hospital. This had purpose built

mental health inpatient facilities, single-bed en-suite rooms which were currently empty and a better experience for visitors.

The consultation process would also seek to identify the impact the move would have on current patients, potential future patients, carers and members of the public. It was envisaged that the relocation of the service would be delivered before winter 2020. The proposed consultation document was presented to the Derby City Adult Health Scrutiny and Review Board on 4 February 2019 and they offered their overall support for the proposed consultation.

RESOLVED that the Committee were unanimously in favour of the proposed consultation process to move the functional mental health service for older people to the site at Kingsway Hospital.

The Chairman thanked Mr Gardener for his report.

Procedure for Public Questions at Improvement and Scrutiny Committee meetings

Members of the public who are on the Derbyshire County Council register of electors or are Derbyshire County Council taxpayers or non-domestic taxpayers, may ask questions of the Improvement and Scrutiny Committees, or witnesses who are attending the meeting of the Committee. The maximum period of time allowed for questions by the public at a Committee meeting shall be 30 minutes in total.

Order of Questions

Questions will be asked in the order they were received in accordance with the Notice of Questions requirements, except that the Chairman may group together similar questions.

Notice of Questions

A question may only be asked if notice has been given by delivering it in writing or by email to the Director of Legal Services no later than 12 noon three working days before the Committee meeting (i.e. 12 noon on a Wednesday when the Committee meets on the following Monday). The notice must give the name and address of the questioner and the name of the person to whom the question is to be put.

Questions may be emailed to democratic.services@derbyshire.gov.uk

Number of Questions

At any meeting no person may submit more than one question, and no more than one such question may be asked on behalf of one organisation about a single topic.

Scope of Questions

The Director of Legal Services may reject a question if it:

• Exceeds 200 words in length;

• is not about a matter for which the Committee has a responsibility, or does not affect Derbyshire;

• is defamatory, frivolous or offensive;

• is substantially the same as a question which has been put at a meeting of the Committee in the past six months; or

• requires the disclosure of confidential or exempt information.

Submitting Questions at the Meeting

Questions received by the deadline (see **Notice of Question** section above) will be shared with the respondent with the request for a written response to be provided by 5pm on the last working day before the meeting (i.e. 5 pm on Friday before the meeting on Monday).

It is at the Chairman's discretion whether the questions and responses are read out at the meeting.

Supplementary Question

Anyone who has put a question to the meeting may also put one supplementary question in writing to the person who has replied to his/her original question. A supplementary question must arise directly out of the original question or the reply. The Chairman may reject a supplementary question on any of the grounds detailed in the **Scope of Questions** section above.

Supplementary questions must be emailed to democratic.services@derbyshire.gov.uk

Derbyshire Community Health Services NHS Foundation Trust

Quality report 2019/20

Our Vision:

"To be the best provider of sustainable, local healthcare and a great place to work."

DCHS Clinical Strategy (2019/22)

NHS
Derbyshire Community Health Services
NHS Foundation Trust

the DCHS WAY

Our Vision

'To be the best provider of local healthcare and be a great place to work'

Our Values

- To get the basics right
- To act with compassion and respect
- To make a difference
- To value and develop teamwork
- To value everyone's contribution because everyone matters

Working the DCHS Way

What we can all expect from DCHS:

- Share and support us in understanding our vision, values and priorities
- Be clear as to what is expected of us and what our part is to play in the organisation
- Support us to deliver our job in the best way
- Manage and support us to maximise our performance
- Communicate with us in a timely, open and honest way
- Listen to us and involve us in decision making
- Respect and value diversity

What DCHS can expect from all of us:

- Put patients at the heart of what we are doing, promoting their health and wellbeing at every opportunity
- Go the extra mile for patients, carers, colleagues and the good of the organisation
- Continuously improve our performance and our services
- Eliminate waste and ensure we work as efficiently and flexibly as possible
- Live the DCHS values and behaviours
- Fulfil the requirements of our professional standards
- Take responsibility for promoting the reputation and image of DCHS at every opportunity

We Are	The 'DCHS' Way
Quality Service	To deliver high quality and sustainable services that echo the values and aspirations of the communities that we serve
Quality People	To build a high performance work environment that engages, involves and supports staff to reach their full potential
Quality Business	To ensure an effective, efficient and economical organisation that promotes productive working and which offers good value to its community and commissioners.

Annual report contents

Part 1 - Introduction

It is my pleasure to introduce our Annual Quality Report for 2019/20.

It is presented at the end of an extraordinary year marked by the very positive news that, following an inspection in summer 2019, the Care Quality Commission rated DCHS as Outstanding overall. You can read more about the inspection on page 19.

But the year was extraordinary for another reason. It will be marked as the year the NHS is embarked on its response to the global COVID-19 pandemic. We ended the year playing our part in the national NHS response, adapting quickly to the new clinical issues and challenges it posed for us locally in Derbyshire. We temporarily stopped some of our non-critical services while adapting others, in line with a nationally-determined prioritisation framework, and rapidly implemented new ways of work, including virtual patient consultations and treatment wherever it was safe and appropriate. In parallel we bolstered our staff welfare and well-being offer, doing all we could to support our teams so they could focus on delivering quality patient care. At times of rapid change it is even more important to safeguard quality by ensuring that everyone can voice ideas, issues and concerns so we also made sure our Freedom to Speak up Guardian was part of our Incident Management response and opened up new channels to listen and respond to our colleagues.

Delivering safe, high quality care in the context of an ongoing risk from COVID-19 will be a major challenge for us, as it is for the whole NHS, and a major focus of 2020/21. We are committed to building on the innovation our teams have shown, and delivering services that keep patients and staff safe from Covid-19 infection and begin to tackle the health inequalities that the pandemic has cruelly and clearly made so explicit.

January 2019 saw the publication of the NHS Long Term Plan which set out the priorities for healthcare over the next 10 years, focussing on ensuring we give everyone the best start in life, deliver world-class care for major health problems, such as cancer and heart disease, and helping people to age well.

2019/20 has been a challenging year in planning and delivering healthcare but also one of significant opportunity. Community services are at the heart of NHS Long Term Plan published in Jan 2019 and here at DCHS we have a role to play in supporting the delivery of the majority of priority areas identified within the NHS Long Term Plan, either directly or indirectly, working with our partners in the health and social care system locally. We continue to work as a key partner in Joined Up Care Derbyshire (JUCD), the name given to our system Sustainability and Transformation Partnership, where we work together to make the plan a reality for the people of Derby and Derbyshire.

This 2019/20 report describes in detail the work we undertaken during the year to improve the quality of the services we provide and achieve our vision of being the best provider of sustainable local healthcare and a great place to work. It also describes the importance we place on being an open,

listening organisation – committed to understanding about, and learning from, when things have gone wrong, as a vital part of our quality improvement work.

As in the previous year, we describe how we work as an organisation to support the quadruple aim that we have placed at the heart of our organisational strategy and vision

> 'simultaneously improve the health of the population, enhance the experience and outcomes of the patient, reduce the per capita cost of care for the benefit of communities whilst ensuring staff have the best possible experience of work'
>
> **Quadruple Aim**

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. This programme allows us to support frontline clinical teams to drive locally owned and sustainable quality improvements. We achieved our aspiration of assessing over 16 new teams against the standards and a number of existing teams have retained their gold accreditation. At the end of the year I am pleased to report that we had no teams assessed as 'red' – which highlights concerns regarding quality and safety of our services.

As part of our commitment to Quality Improvement (QI) we continue to support staff to be trained on the use of QI methodologies, e.g. Plan, Do, Study, Act (PDSA) cycle and Appreciative Inquiry to understand what we do well as well as what we could improve. Bringing together all the threads of our QI approach will be the focus of 2020/21 as we revise our Quality Improvement and Assurance Framework (QIAF) to reflect the progress we have made.

During the year we embarked on a new approach to the management of wound care needs of our population by offering a number of wound care clinics across Derbyshire. The successful Time to Heal wound management programme, including quality conversations, has positively supported this development. The programme has now been shortlisted for an international award from the Journal of Wound Care Wound Union of Wound Healing Societies Awards for cost effective care with the winners to be announced in September 2020.

Other highlights of the year have included:

- 98.24% of the 22,612 patients we surveyed recommending our Trust to their family and friends
- We achieved a score above the national average for five out of the six elements within the Patient Led Assessments of the Care Environment (PLACE) audit
- We achieved an increased response rate in the NHS Staff Survey, 62.4%, compared to our response rate of 61% in 2018

- Our Staff Friends and Family Test (FFT) measures placed us as the best Trust within our benchmarking group with 85.5% of colleagues agree/strongly agreeing that if a friend or relative needed treatment they would be happy with the standard of care provided by this organisation
- Keeping our patients and staff save is a priority and over 80% of Trust staff received their 'flu vaccination and through our 'jab for a jab' partnership with UNICEF this means that the Trust has sponsored over 10,000 life-saving vaccines in the developing world
- We were awarded the Gold UNICEF Baby Friendly Initiative
- We achieved a 48.84% reduction of significant harm pressure ulcer events against a target of 10%
- We have been commissioned by the British Geriatrics Society to write a series of articles chronicling the development of the Derbyshire Community Frailty Model, DCHS Frailty Strategy and the common training pathway for frailty / dementia and end of life care
- We received the Gold Award in the Defence Employer Recognition Scheme (ERS)
- We appointed a substantive Freedom to Speak Up Guardian, working closely with our Staff Forum, including Staff Partnership colleagues
- The 0-19 year children's service, which deliver health visiting and school nursing support to parents, carers, families and young children, commenced a new type of contractual arrangement working in partnership with Derbyshire County Council under Section 75 arrangements. This development will enable the service to be much more responsive to the changing needs of this population going forward.

This report reflects on our achievements and challenges in improving quality during 2019/20 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 compassion and commitment to making a positive difference to the people of Derby and Derbyshire.

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 2019/20 and our priorities for continuously improving quality in 2020/21.

Tracy Allen, Chief Executive Date

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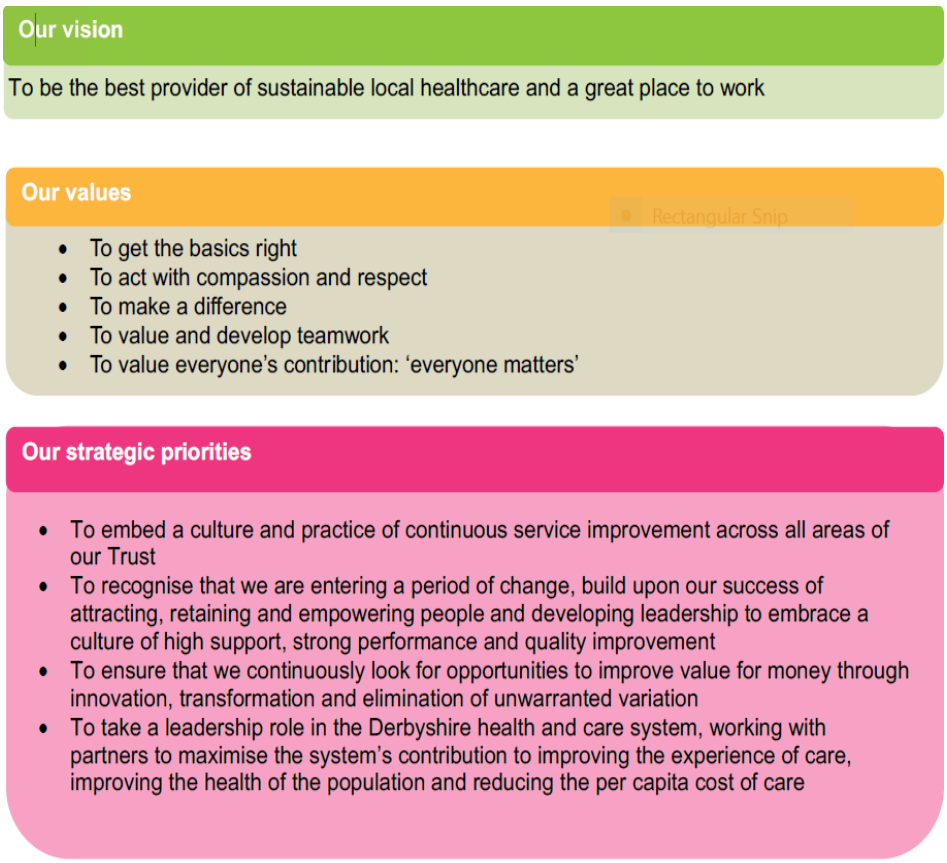
To see the full list of the services we provide, please visit www.dchs.nhs.uk or call us on 01246 565000 for support.

Part 2 - Priorities for Improvement and Statements of Assurance from the Board
2.1 Priorities for Improvement (2019/20)

This quality report demonstrates our achievements for the year 2019/20, describes the areas where we would like to make further improvements and our quality objectives for the coming year. 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 we always listen to feedback from our patients, staff and governors about what concerns them and discuss suggestions made via staff meetings to identify those issues where we feel we can make the most difference.

DCHS Vision, Values and Strategic Priorities



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 performance report to the Board of Directors. These priorities in detail were:

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.

Community teams had access to the relevant equipment to undertake NEWS2 - with the exception of pulse oximeters (which monitor oxygen saturation). The medical devices group worked with procurement to source the most effective pulse oximeters for use in the community and the funding was secured via the capital and estates group.

Target 1: Roll out of pulse oximeters to all community teams by 30 September 2019

Table 1: Target pulse oximeter roll-out

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

Target 2: Once the roll-out and associated training was complete there was monthly reporting from SystmOne to determine if the provision of this equipment increased the number of baseline observations recorded, ensuring oxygen saturations are measured in line with NEWS2.

Table 2: Target for baseline observations

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

Target 3: During quarter four an audit of clinical records to be undertaken to ensure that where NEWS 2 was scored at 5 or more, the UK Sepsis Trust Screening tool was completed and appropriate action taken.

Priority 2 Clinical effectiveness

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

Background: DCHS has a vision to grow as a “research” Trust as outlined in the DCHS Clinical Strategy. There is published evidence of the correlation between involvement in high quality research and better patient outcomes. For those organisations that can recruit a minimum of 500 participants to NIHR research in financial year there is a £20,000 incentive.

Target: Recruit a minimum of 500 participants between 1 April 2019 and 31 March 2020

Table 3: Monthly target for recruits

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

Priority 3 Patient Experience

Improving our dementia friendly environments and culture across DCHS

Background: People with dementia access all services for adults in Derbyshire. Community services need to be accessible for people with cognitive and communication abilities affected by 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?'***

Target: To improve the dementia-friendly environment (environments / accessible information / staff awareness) and to complete a dementia-friendly improvement action plan. All 97 services will have a completed dementia friendly improvement action by year end.

Table 4: 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

Table 5: Achievement of 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	1. Improving the identification of sepsis and recognition of the deteriorating patient	(i) Roll out of pulse oximeters to all community teams by 30 September 2019	**(100%)** **GREEN**	**(100%)** **GREEN**
			(ii) TPP baseline observations to be 80% by March 2020, starting October 2019	**(27.7%)** **RED**	**(28%)** **RED**
			(iii) Clinical records audit to ensure appropriate response to NEWS2 score 5 and above	**(100%)** **GREEN**	**(100%)** **GREEN**
		2. Increasing participation in National Institute for Health Research (NIHR) across DCHS services	Recruitment of 500 participants by March 2020	**651** **(130%)** **GREEN**	**651** **(130%)** **GREEN**
		3. Improving the dementia friendly environment and culture across DCHS	(i) Apr-Aug 19 service champions to be identified	**GREEN**	**GREEN**
			(ii) Aug-Nov 19 Service improvement actions agreed	**GREEN**	**GREEN**
			(iii) Jan-Mar 97 service actions complete	**69/97 Improvement actions** **RED**	**69/97 Actions complete** **RED**

Areas where we still require improvements

Priority 1 – Of the three targets, at year end we have only recorded 28% of baseline observations against our target of 80%. It is disappointing that this target was not met. Once it became clear that the expected trajectory was not going to be met action was taken to try and understand why this was the case when clinicians were reporting that they were undertaking baseline observations. Since this was agreed as a Big 9 target in March 2019 the Community Teams have gone through significant reconfiguration to work as much more integrated community teams. The evidence (both from the data and clinical observation) suggest that baseline observations are taken by Nursing staff on first visit but if they ask other team members (e.g. Physio or Occupational Therapist) to visit as part of the care plan then quite reasonably baseline observations are not done. It is clear from the data that where there is a single visiting clinician (e.g. Community Matron) observations are undertaken as a baseline and this would support the view above. It is not possible to report on this clinical decision making electronically and any further work would require a lengthy and detailed manual trawl of the records.

Improvement action:

1. Monthly data is now provided on a monthly basis to the team leads and managers across the community teams allowing them to monitor individual team performance.
2. The audit will be repeated quarterly in 2020/21 to ensure that there is clinical recognition of our patients at risk of sepsis and improved outcomes. The improvement plans will be monitored through the Quality Performance Report quarterly to the Quality Service Committee to ensure on-going monitoring and sustained improvement.

Priority 3 – This particular priority was separated into three phases (appointing champions, undertaking pledges, reporting on actions) with the final weeks of the financial year being crucial to meeting the final target, i.e. completion of improvement actions. Of the three phases, at year end only 69 of the anticipated 97 improvement actions plans to improve the dementia friend environment and culture across DCHS have been completed. The improvement plans were due to be submitted in the final weeks of March 2020, unfortunately due to response to the pandemic many colleagues involved in collating the plans were diverted into other priorities. We are anticipating that as part of the recovery phase, we will be able to identify examples of where staff have made small or innovative changes to the environments.

2.1.1 Things we want to do better in 2020/21

For 2020/21, similar conversations have taken place with staff, governors and Board members which has led to three agreed strategic quality improvement priorities which will be reported monthly to Trust Board via our Big 9 performance report:

Priority 1 – Patient safety

Reducing Injuries to clinical colleagues from sharps and needle stick injuries

All employers are required under existing Health and Safety law to ensure that risks from sharps injuries are adequately assessed and appropriate control measures put in place. Analysis of the data (Quality Performance Dashboard) shows 29 needle stick or sharps injuries in 2019/20. As a result it is proposed that the Trust will have a real focus on significantly reducing the number of sharps and needle stick injuries throughout 2020/21. The intention is to make needle stick or sharps injuries internal 'Never Events' within DCHS.

Table 6: Yearly reduction trajectories

Needle stick Injuries 2019/20	Needle stick Injuries 2020/21
29	7

During quarter one there will be a focus on planning, education and reminders about clinical practice including: the appropriate use of approved sharps bins, the use of Sharp Safe devices in services as appropriate and individual responsibilities for the disposal of sharps. All sharps and needle stick injuries in 2020/21 will be subject to a detailed Root Cause Analysis (RCA) to enable learning across clinical services. We are being ambitious in aiming to achieve a 75% reduction on the number of avoidable sharps injuries by the end of 2020/21 from the 2019/20 baseline.

Priority 2 – Clinical effectiveness

Flagging records of people with a learning disability, autism or both

There are around 20,000 People with learning disabilities and / or autism within Derbyshire and Derby. People with learning disabilities and/or autism expect high quality care across DCHS services. They should receive treatment, care and support that is safe and personalised and they should have the same access to services and outcomes as people without a disability. In order to do this, we need to be able to identify when a person using any our services has learning difficulties and/or autism so adjustments can be made to meet their individual needs.

We want to develop a 'flag' on our electronic patient record so that their needs from admission through to discharge can be met. Where appropriate, we will share this information as people move through departments and between services. Based on an assumption that 10% of the 20,000 (2,000) people with learning disabilities and / or autism within Derbyshire and Derby will use DCHS services during the year, we will be aiming to ensure that at least 50% (1,000) of these have been identified.

Table 7: Monthly trajectories

Month 2020/21	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Monthly target for no, of patient records flagged	0	0	0	100	100	100	100	100	150	150	100	100

Priority 3 – Patient experience

Establishing an Independent Complaints Review Panel

As part of our approach to continually improve our response to complaints, the intention is to establish an independent complaints review panel to ensure best practice in complaints management.

The Panel will provide independent oversight of randomly selected closed complaints files, considering their management from beginning to end, following the principles of the Patients Association good standards, including timelines, plain English, communication and complainant satisfaction.

By June 2020, the terms of reference will be written and invitations for Panel membership will be sent to stakeholders including Healthwatch Derby, Healthwatch Derbyshire, Public Governors and Operational representatives.

Once established, our target will be to have reviewed 3 complaints files each month from July 2020 onwards.

Table 8: Monthly Trajectories

Month 2020/21	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Complaint Files to be Reviewed	0	0	0	3	3	3	3	3	3	3	3	3
Complaint Files to be Reviewed (cumulative)	0	0	0	3	6	9	12	15	18	21	24	27

2.2 Statements of Assurance from the Board

2.2.1 Contracted Services

During 2019/20 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 2019/20 represents 100% of the total income generated from the provision of relevant health services by DCHS for 2019/20.

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 of these. 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 2019/20 there were 10 national clinical audits and 1 national confidential enquiry covering relevant health services that DCHS provides and DCHS participated in 100% (table 9).

Table 9: National audits and confidential enquiry

Title	Participated	% submitted
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
National Audit of Care at the End of Life (NACEL) 2018	Yes	100%
National Audit of Care at the End of Life (NACEL) 2019	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy (SLT), Physiotherapy, Elderly care and neurology)	Yes	100%
National Asthma and COPD Audit Programme: Pulmonary Rehabilitation	Yes	100%
National Falls & Fragility Fractures Audit	Not yet	0%
National Diabetes Foot Care Audit	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National cancer diagnosis audit	Yes	100%
Core National Diabetes Audit – Adults	Yes	100%

When received, the reports of these clinical audits are reviewed by DCHS. During 2019/20 four reports have been reviewed and the following actions undertaken to improve the quality of healthcare provided (table 10).

Table 10: Actions from clinical audits

Title	Actions
Learning Disability Mortality Review Programme (LeDeR)	1. DCHS now has a process in place to ensure any Learning Disability (LD) deaths are reported to LeDeR for review, and learning from reviews is brought back into the organisation via the Mortality Review Group. 2. In response to learning from the national programme relating to aspiration pneumonia, recognition of sepsis, and constipation, DCHS has rolled out training in the use of NEWS2 and raised awareness with all staff including sharing the LeDeR Learning into Action newsletters, training resources and information posters.
National Audit of Care at the End of Life (NACEL) 2018	1. Findings shared more widely with various forums across DCHS to celebrate the successes of the organisation and support the delivery of improvements. 2. A report has been developed to triangulate the national audit findings with the trust's internal End of Life audit and Bereavement Survey findings, to establish evidence that the needs of families are considered and met. 3. The new End of Life training programme in DCHS will be used as a platform to enhance documentation relating to end of life care. 4. DCHS does not have a specific bereavement policy but this is incorporated into the Learning from Deaths policy. All staff will be signposted to this policy as part of the new End of Life training programme.
National Audit of Care at the End of Life (NACEL) 2019	Report not available until 2020
Sentinel Stroke National Audit Programme (SSNAP)	1. Automatic reporting from SystmOne has been rolled out to all 3 DCHS Early Supported Stroke Discharge (ESSD) teams to support data input to the national audit web-tool and help reduce the burden on staff. 2. The DCHS Early Supported Stroke Discharge (ESSD) teams are working with Integrated Community teams to support the ongoing rehabilitation of patients following stroke and bridge the gap between ESSD and Neuro Outpatients services. 3. The ESSD teams are now using SystmOne to identify patients who may require Psychology and are piloting a recognised mood screening tool to assess patients' mood and identify which patients should trigger a referral to Neuro-Psychology, if a service was available.
UK Parkinson's Audit: (incorporating Occupational Therapy, SLT, Physiotherapy Elderly care and neurology)	Report due to be published at the end of March 2020.
National Asthma and COPD Audit Programme: Pulmonary Rehabilitation	DCHS provides Pulmonary Rehabilitation services at four locations, however due to capacity one location is participating in the national audit, 100% of eligible patients who consented to take part at that site were included. Report not yet available, date to be published unknown.
National Falls & Fragility Fractures Audit	No patients in our inpatient area have had a fall resulting in a hip fracture since we joined the audit in April 2019
National Diabetes Foot Care Audit	1. Further investigation being carried out to understand why there are two parts of the current NICE guidance that DCHS do not provide. 2. Conduct a deep dive to understand why DCHS has a higher than average number of data items missing from the national audit submission. 3. Planning a move to electronic data uploads to the National Audit

Title	Actions
National Audit of Cardiac Rehabilitation	This year we have concentrated on improving our data input processes to support our Cardiac Rehabilitation Team and are planning a move to electronic data uploads to the National Audit. This will give a more reliable basis to plan clinical service improvements based on our results for the period 2020/21.
National cancer diagnosis audit	Report not yet available, date to be published unknown.
Core National Diabetes Audit – Adults	National report was published June 2019, being presented at the GP Governance meeting on 30/03/20 for the development of an improvement action plan.

During 2019/20 the clinical effectiveness team (CET) managed a total of 49 clinical audits, details of which can be provided upon request as can the details of the 15 clinical audits that have been concluded during 2019/20.

The program of clinical effectiveness projects has progressed well in 2019/20 with 23 projects completing at least one full cycle through to the successful completion of the improvement action plan. The remaining 26 are all progressing as planned.

2.2.3 Research

The number of patients receiving relevant health services provided or sub-contracted by DCHS in 2019/20, which were then recruited to participate in research approved by a research ethics committee during this period is 623, this is 478 more recruits when compared to 2018/19 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 2019/20 we had four CQUINs, three set at a national level and one was agreed locally with the CCG:

- Flu vaccination of frontline staff
- Alcohol and tobacco screening and brief advice
- Three high impact actions to prevent inpatient falls
- Using personalised goals in the treatment of patients within wound clinics (local).

A proportion of our income in 2019/20 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 performance against the agreed goals for 2019/20 and the agreed goals for the following 12 month period are outlined in Table 11 and Table 12 respectively.

Due to the impact of the Covid-19 pandemic, all national and local CQUIN work was paused on 17 March 2020, this halted a number of audit activities being undertaken to collect quarter four data for some of the CQUIN indicators. Further national guidance published on 23 March 2020 advised all Trusts to base the final position for CQUINs on the data available and this has therefore been taken from the quarter three position.

Table 11: Final Position against 2019/20 CQUIN

<table>
<tr><th>CQUIN Title</th><th>Summary Outline</th><th>Final Position</th></tr>
<tr><td>NATIONAL - Flu vaccination uptake by frontline staff</td><td>80% target to be delivered in Q4</td><td>DCHS achieved 80.7% of frontline staff being vaccinated against the national target of 80% which was a significant improvement over previous years.</td></tr>
<tr><td>NATIONAL - Alcohol and Tobacco screening and brief advice</td><td>Screening of inpatients 16+ for smoking and drinking and provision of brief advice for those that do. Onward referral for patients to nicotine replacement therapy and/or specialist service for above low level.</td><td>Targets exceeded for Q3 across all indicators:
Alcohol and Tobacco screening – 96% (target 90%)
Smoking Brief Advice – 100% (target 90%)
Alcohol Brief Advice – 100% (target 90%)</td></tr>
<tr><td>NATIONAL - Three High Impact Action to Prevent Hospital Falls</td><td>Three elements:
- Recording of lying and standing Blood Pressure (BP) at least once (80% target)
- No antipsychotics, hypnotics etc. given during stay or rationale recorded (80% target)
- Mobility assessment documented within 24 hours stating aid not required OR aid provided within 24 hours of admission (80% target)</td><td><table><tr><th>Indicator</th><th>Q1 results</th><th>Q2 results</th><th>Q3 results</th></tr><tr><td>Lying and standing BP</td><td>1.5%</td><td>18%</td><td>88%</td></tr><tr><td>Medication and rationale</td><td>3.5%</td><td>3.3.%</td><td>96%</td></tr><tr><td>Mobility assessment and aid provision</td><td>5.8%</td><td>56%</td><td>97%</td></tr></table>
Overall compliance with the target was 81.8%</td></tr>
<tr><td>LOCAL - Personalised Goals for Patients with Venous Leg Ulcer</td><td>Implementation of personalised goal setting for patients with venous leg ulcer across the DCHS wound clinic hubs (75% target for audit sample)</td><td>Staff across all DCHS wound clinic hubs were supported to discuss, and record personalised goals with patients within SystmOne, in relation to their wound care and treatment.

The Q3 position showed that 100% of the relevant wound clinic patients had at least one goal set. A detailed review of the clinical care provided was also undertaken which was then shared with clinic staff to support improved compliance with wound assessments.</td></tr>
</table>

The total CQUIN value available for 2019/20 was £1,703,606 and an 80% fixed contract outturn was agreed during the year with our commissioners. The monetary total for the associated payment in 2019/20 was £1,362,885.

Table 12: Summary of CQUIN (2020/21)

CQUIN Title	Summary Outline
Malnutrition screening and care planning in community hospital inpatients	70% target
Staff flu vaccinations (all frontline staff with patient contact)	90% target
Assessment, diagnosis and treatment of lower leg wounds in Community Nursing services	50% target
Assessment and documentation of pressure ulcer risk for community hospital inpatients	60% target

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. See table 13 and 14 for summary of ratings.

The Trust rated '**outstanding**' overall and '**outstanding**' in its first annual well-led inspection in September 2019. The CQC recorded no areas of improvement actions for the Trust to undertake. The CQC has not taken enforcement action against DCHS during 2019/20. Overall Trust current position against service line can be seen in Table 13.

DCHS has not participated in any special reviews or investigations by the CQC during 2019/20.

Ratings for Primary Care Services

The three GP practices continued to be rated good overall.

Table 13: CQC Ratings – Organisation Summary

Table 14: CQC Ratings - Service

2.2.8 Secondary uses service data

DCHS submitted records during 2019/20 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

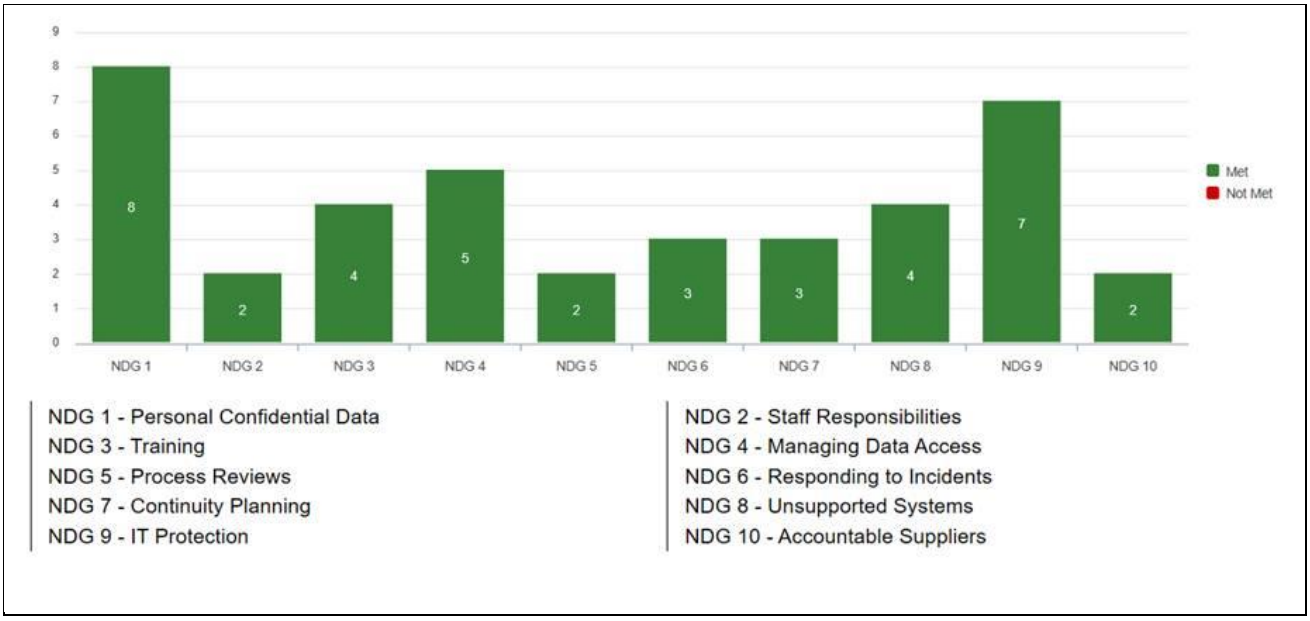
- which included the patient's valid NHS number was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for accident and emergency care.

- 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

2.2.9 Information Governance

DCHS' data security and protection toolkit overall rating for 2019/20 was Standards Met with all mandatory assertions having been completed.

Graph 1: DCHS compliance against the 10 national data guardian standards detailed in the toolkit:



2.2.10–11 Payment by Results

DCHS was not subject to the Payment by Results clinical coding audit during 2019/20 but did initiate its own internal audit, which measured the accuracy of clinical coding, the results of which are detailed in table 15 below.

Table 15: Clinical Coding

Coding Field	DCHS percentage correct 2019/20	DCHS percentage correct 2018/19	DCHS percentage correct 2017/18	IG Req 505 Level 2	IG Req 505 Level 3
Primary diagnosis	92.50%	91.00%	96.50%	90%	95%
Secondary diagnosis	91.02%	91.09%	92.26%	80%	90%
Primary procedure	96.91%	93.94%	98.92%	90%	95%
Secondary procedure	95.17%	90.21%	92.66%	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:

- Greater engagement with clinicians where conflicts in documentation arise
- Clinical coders will regularly attend podiatric surgery team meetings to discuss developing or new surgical procedures, which will increase their knowledge and coding accuracy
- Clinical coders will attend a national standards refresher training course, to ensure clinical coding standards are being maintained.

2.2.12 Learning from deaths analysis (Schedule 27)

The data provided in this section relate to the number of deaths derived from our monthly SystmOne data and relates to any death logged via SystmOne.

It is important to note that the people whose deaths have been included in this report will usually have received care from DCHS as part of a wider health and social care system and DCHS staff involvement in care provision can vary from minimum contact once every 3 months (people receiving Vitamin B12 injections) to daily contact (people in community hospital rehabilitation beds).

The number of death notifications received by the Mortality Review Group (MRG) relates to notifications received for potential review via 5 triggers, if the death is thought to be unexpected or that there is learning for the Trust, these include 1) Datix notification or a serious incident 2) complaint via the patient experience team 3) Coroners reported via the Chief Exec department 4) end of life (EoL) / mortality audit 5) mental health death.

Upon receipt of these death notifications the mortality review facilitator completes the Initial Death Review (IDR) within 5 working days. This tool screens the death notifications received to ensure that they are appropriate for review (introduced as some deaths were deemed inappropriate to review as they were expected deaths but the death may have happened sooner than the clinician expected).

Schedule 27.1

During 2019/20 7,099 of DCHS patients died. This comprised the following number of deaths which occurred in each quarter of the reporting period:

Table 16: Quarterly reporting of deaths

Reporting Quarter 2019/2020	Total number of deaths reported by DCHS via SystmOne	Number of deaths notifications received via the triggers to Mortality Review Group	Number of deaths notifications received appropriate for full case note review by (MRG) following the Initial Death Review (IDR) screen
Q1	1611	33	27
Q2	2059	21	14
Q3	1607	29	22
Q4	1822	39	28
Total	**7099**	**122**	**91**

Schedule 27.2

By 31 March 2020, 58 case record reviews and 4 investigations have been carried out in relation to 58 of the deaths included in 27.1.

In 4 cases 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 17: Quarterly reporting of case reviews

	Q1	Q2	Q3	Q4
Case note reviews	7	7	18	26
Investigations	1	1	1	1*

**Investigation had already been completed prior to the MRG meeting*

Case note review: A review of the clinical notes to determine if there were any problems in care provided to the patient who died.

Investigation: A systematic, in-depth analysis of what happened, how it happened and why. Investigation draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation, in order to identify any problems in care or service delivery that preceded an incident to understand how and why it occurred.

Schedule 27.3

Of the patient deaths during the reporting period, 3, representing 0.04%, are judged to be 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:

Table 18: Quarterly reporting of deaths judged to be more likely than not to have been due to problems in the care provided to the patient.

	Q1	Q2	Q3	Q4
Number of Deaths	1611	2059	1607	1822
Number and (%) deaths judged to be more likely than not to have been due to problems in the care provided to the patient	3 (0.16)	0 (0)	0(0)	0(0)

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, RCA tool and this template

has been used for the case record reviews. We use this methodology to determine whether there were “Problems in Care.”

Our locally determined death classification scale includes Category 1 – these are cases where, following case record review it is deemed that the death was more likely than not to have been contributed to by problems in care. We do not apportion death causation.

Schedule 27.4

The following is a summary of what DCHS has learnt from the case record reviews and investigations conducted in relation to the deaths identified:

- Improvement in end of life care planning
- Clinicians to action the Rockwood frailty score
- Consideration of mental health needs
- Inclusion of family in the patients journey
- Good multidisciplinary team working within DCHS
- Assessing for delirium

The information gathered will continue to inform themes and trends as data increases, this information is shared with the MRG and the Quality Service Committee (sub-committee to the Board).

Schedule 27.5

As a consequence of learning from the case reviews and investigations undertaken, DCHS has taken a number of actions during the reporting period (27.4) and proposes to take the following actions forward after the reporting period:

1. Failed Visit standard operating procedure for clinical community staff
2. After death checklist for community staff
3. Case note review workshops for all staff completing case note reviews
4. Improved processes with external providers and internal team and colleagues
5. Supporting the DCHS bereavement offer and ensuring it meets requirements.

Schedule 27.6

An assessment of the impact of the actions described in (27.5) taken by DCHS during the reporting period have identified the following:

- Improved understanding on management of failed domiciliary visits
- Improved RCA process for category 1 deaths
- Improved escalation process for deteriorating patients and those with suspected sepsis using the sepsis protocol
- Confidence in ability to monitor patients’ conditions due to provision of standard vital signs monitoring kits.

Schedule 27.7

After 1 April 2019, 18 case record reviews and 2 investigations were completed which related to deaths which took place before the start of the reporting period and were not included in 27.2 in the relevant document for the previous reporting period.

Schedule 27.8

From the information included in 27.7, 2 of the patient deaths occurring before the reporting period, representing 0.1%, 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

From the information stated in 27.3 of the relevant documents for the previous reporting period and taking into account the deaths referred to in 27.8, 5 representing 0.4% are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting against 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 13 below. For completeness the full set of core indicators can be found in appendix 8.

Table 19: Core indicators applicable to DCHS

	Prescribed information	Related NHS outcomes framework domain & who will report on them	2017/18	2018/19	2019/20
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**	82%	82.8%	85.5%
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, 85% of staff agreed or strongly agreed (the average for community trusts is 73%) (data for 2018/19 = 82%).					
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).	4: Ensuring that people have a positive experience of care **Trusts providing relevant acute services**	97.8%	98.2%	98.4%
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 2020/21 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 2018/19 shows average of 97.8% of patients would recommend their local community services to friends and family.					

	Prescribed information	Related NHS outcomes framework domain & who will report on them		2017/18	2018/19	2019/20
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**		99.9%	99.6%	99.7%
DCHS considers that this data is as described for the following reasons: DCHS has a robust audit process in place and has clear clinical policies.						
DCHS 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**	10,018	7,221	7,171
			Severe harm or death	9	4	0
			% severe harm or death	0.08%	0.05%	0%
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 the 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 2019) DCHS remains as having the highest reporting culture rate per 1000 bed days compared with 16 NHS community trusts. <1% of incidents in this period were reported as resulting in severe harm or death.						

Part 3 - Review of Quality Improvements 2019/20

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

- **Performance Indicators**

The Trust has chosen to include performance against a broad range of quality and performance indicators which are reported to the Board of Directors monthly rather than specifically selecting three patient safety, three clinical effectiveness and three patient experience indicators. Performance against this range of indicators in included in table 14 below. Where possible we have included benchmarking information to show how we compare to other NHS organisations and comparative year on year performance.

Each service 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.

Table 20: Range of Indicators

Key performance indicator (KPI)	Primary data source	Data quality score	Target 19/20	Average monthly score 17/18	Average monthly score 18/19	Average monthly score 19/20	Year-end data	Benchmarked performance**
Friends and Family Test scores	Datix	14	98%	97.8%	98.3%	98.2%	98.2%	95.5%
Complaints – number received	Datix	14	No target	13	11	10	122	-
Complaint cases completed within agreed timescale	Datix	14	80%	84%	66.4%	93%	93%	80%
Number of responses from Friends and Family Test	Datix	N/A	No target	2,428	2,231	1,792	22,540	-
Turnover %	ESR	12	14%	8.5%	8.9%	9%	9%	14.40%
Total sickness rate	ESR	12	4.5%	5.2%	4.9%	5%	5%	4.98%
Sickness long term	ESR	12	No target	3.2%	2.9%	2.9%	2.9%	-
Sickness short term	ESR	12	No target	2%	2%	2.6%	2.6%	-
Vacancy rate %	ESR	12	No target	5.6%	5.8%	5.1%	5.1%	-

Key performance indicator (KPI)	Primary data source	Data quality score	Target 19/20	Average monthly score 17/18	Average monthly score 18/19	Average monthly score 19/20	Year-end data	Benchmarked performance**
Annual reviews (staff appraisals) carried out %	ESR	12	96%	87%	93.6%	91%	91%	88.4%
Mandatory training	ESR	12	96%	89%	97.1%	98%	98%	88.4%
Mandatory training - information governance %	ESR	12	96%	95%	95.9%	98%	98%	96%
Medication errors causing serious harm (no.)	Datix	14	0	0	0	0	0	-
Never Events (no.)	Datix	14	0	0	0	2	2	-
Pressure ulcers which meet SI criteria	Datix	14	0	n/a	3	1.9	23	34
Clostridium difficile incidence	Internal spread sheet	N/A	0	0.2	0.1	0.6	7	10
MRSA bacteraemia incidence	Internal spread sheet	N/A	0	0	0	0	0	0
STEIS serious incident reporting – open serious incidents	STEIS	14	No target	18	15.3	11	128	-
OPMH mental health delayed transfers of care - % attributable to the Trust	BI	14	3.5%	3.8%	4%	4%	4%	3.5%
Inpatients – delayed transfers of care	BI	14	3.5%	8%	5.5%	4.7%	4.7%	3.5%
OPMH & inpatients – delayed transfers of care	BI	14	3.5%	7.1%	5.3%	4.6%	4.6%	3.5%
A&E 4 hour wait for A&E attendances (%) (MIUs)	BI	16	95%	99.9%	99.9%	99.9%	99.9%	95%
RTT waits - admitted patients seen within 18 weeks - (2a) (%)	SystmOne	16	No target	95%	86.1%	100% at Q3	n/a	Services moved provider
RTT waits - non admitted patients seen within 18 weeks - 95% (target) (1B)	SystmOne	16	95%	93.4%	91.1%	90% at Q3	n/a	Services moved provider
RTT waits - incomplete pathway - 92% (target) (2) (%)	SystmOne	16	92%	95%	95%	95% at Q3	n/a	Services moved provider
Minimising mental health delayed transfers of care	BI	16	3.5%	3.8%	5.6%	4.6%	4.6%	3.5%
Mental health data completeness: identifiers	SystmOne	16	97%	100%	100%	Replaced with DQMI		-
Certification against compliance with requirements regarding	EDILF report	n/a	Yes	Yes	Yes	Yes	Yes	Yes

Key performance indicator (KPI)	Primary data source	Data quality score	Target 19/20	Average monthly score 17/18	Average monthly score 18/19	Average monthly score 19/20	Year-end data	Benchmarked performance**
access to health care for people with a learning disability								
Data completeness: community services - referral to treatment information	CIDS	16	95%	97%	100%	Replaced with DQMI	n/a	95%
Data completeness: community services - referral information	CIDS	16	95%	96%	99.2%	Replaced with DQMI	n/a	95%
Data completeness: community services - Treatment activity information	CIDS	16	95%	96%	99.2%	Replaced with DQMI	n/a	95%
Data Quality Maturity Index (DQMI) compliance A&E (MIU / Urgent Treatment centres)	DQMI		95	n/a	n/a	99.2	99.2	-
DQMI Compliance APC (Admitted Patient Care)	DQMI		95	n/a	n/a	93.4	93.3	-
DQMI Compliance CSDS (Community Services Data Set)	DQMI		95	n/a	n/a	96.9	96.9	-
DQMI Compliance MHMDS (Mental Health Minimum dataset)	DQMI		95	n/a	n/a	74.5	74.9	-

The data quality maturity index is a nationally recognised way of measuring data quality in the NHS. NHS organisations make returns on a regular basis to NHS Digital.

- **CSDS-Community Services Data Set**

For Community services we know that the Current Community Services Data Set (CSDS) extract delivered by our patient record system (TPP) is not complete and therefore not a true representation of DCHS activity currently. Work is underway to resolve. In the meantime DCHS has concluded that to submit an accurate reflection of DCHS provision a local version of the Community Services Data Set is to be built. This is scheduled to be done by April 2020. Prior to that DCHS have identified certain fields that can be coded prior to submission from within the database and this work is now being actioned. This should reflect an increase in DQMI performance in March but the significant improvements will be realised in 2020/21.

- **Trust Risk Ratings (Single Oversight Framework (SOF))**

Trusts are then segmented according to the level of support they require across five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability.

Consistently, the Trust has been allocated in Segment 1, which is maximum autonomy, where although some data will be collected monthly and reviewed as for providers in other segments, NHSE/I will review the segmentation of DCHS on a quarterly basis, unless there is information giving cause for concern

Table 21: Table of analysis

Year	Segment	Q1	Q2	Q3	Q4
2019/20	Segment 1	Segment 1	Segment 1	Segment 1	Segment 1
2018/19	Segment 1	Segment 1	Segment 1	Segment 1	Segment 1
2017/18	Segment 1	Segment 1	Segment 1	Segment 1	Segment 1

Mechanisms for receiving assurance on quality of services

- **DCHS Quality Improvement and Assurance Framework**

Quality improvement is the driving force behind the work of Derbyshire Community Health Services and runs like a ‘golden thread’ through everything that we do. We recognise that the quality of care delivered to our patients is the most important element of our work and that being able to provide assurance to our patients, their families and carers and our commissioners is an essential part of our governance processes.

As an organisation we want to be able to respond to the ever changing needs and priorities of health care. We want to improve the patients’ experience of our services, deliver effective clinical outcomes, enhance the experience of our staff and ensure we are as effective as possible. Quality Improvement (QI) is one essential way to deliver this.

We have an ambition to develop a culture that promotes QI and enables all colleagues to be ‘curious’ and feel that they are supported to improve the way in which they work. We intend to build upon the existing QI work that is taking place within DCHS such as Quality Always, Quality and Safe Care Champions programme, clinical audit, research and patient safety. A learning culture is a core element of the DCHS QI ambition. This will ensure that learning is shared and evolves and that we all feel safe to test new ways of working.

DCHS will commit to providing learning opportunities to develop or enhance QI skills and understanding, to provide a central hub where learning resources can be shared and create a QI community. Our improvement work will support the quadruple aim ensuring that patient care, impact on staff, improvements on health and efficient use of our resources are recognised.

- **Quality Always (QA) Clinical Assessment and Accreditation Scheme (CAAS)**

Based on a set of 13 core standards, reflecting the CQC five domains along with service specific standards where appropriate, this is a scheme which supports the delivery of high quality services across the Trust. Teams are rated Red, Amber, Green or Gold Accredited. By the end of 2019/20 no teams were rated Red.

Throughout 2019/20 a total of 109 CAAS assessments were conducted and this included those teams who have undertaken the earned autonomy process. There were 72 local Key Lines of Enquiry (KLOE) assessments which link in to the CQC assessment framework and 14 triangulation events across the organisation.

A QA dashboard continues to be developed and to provide detailed assurance information across the Trust and to analyse the themes and trends collated through clinical assessment to inform quality and operational teams and responsible leads of areas of particular good practice or areas needing specific attention for growth and development. This information has also been well received via an infographic format by front line clinicians who share the detail in team meetings.

During the year a number of table top reviews have been undertaken amber rating for longer than 12 months. This approach has supported several teams to achieve green and several teams pending gold.

During 2020/21 we will be further developing our quality assurance work, building on the Clinical Governance matrix developed by our Medical Director. The matrix has been developed to support the review the quality, performance, safety, experience and outcomes of services across any service line/pathway. This matrix is a 5x7 table considering the five CQC quality domains alongside the seven pillars of clinical governance.

In support of the QA CAAS there are a network of Quality and Safe Care Champions (QSCC) across the organisation. There are currently 1235 QSCC registered across all divisions of the Trust. Throughout 2019 a program of formal sessions has been delivered by the Quality Improvement Leads with support from Specialist Leads. 327 out of 1235 Champions (27%) have attended these sessions.

There are champions for continence, dementia, dignity and inclusion, end of life, falls, infection prevention and control (IP&C), pain, safeguarding, tissue viability and lifestyle (which commenced in January 2020).

- **15 Steps Board Insight Visits**

Regular Insight Visits, involving members of the Board accompanied by Public Governors with support from senior local managers are undertaken throughout the year and reported through ERICA (see below). During 2019/20 29 Insight visits took place across the organisation.

- **Leader Back to the Floor Visits**

Back to the Floor visits provide leaders including Executives (across the organisation) with dedicated time to work with teams to observe and share best practice and identify issues which inhibit delivery of care and give leaders a more in depth understanding of a service. During 2019/20 27 Back to the Floor visits took place.

- **Electronic Reporting in Care Assurance (ERiCA)**

This Business Intelligence (BI) approach to the collation of assurance findings supports lessons learned and the service improvement methodology. Both local and organisational assurance visits will be recorded in the BI dashboard, thus supporting leaders to have a clear responsive reporting framework in order to guide local assurance. ERiCA is intended to support dissemination of learning, capturing of themes, and identifying overall service improvement opportunities. This dashboard is intended to mimic the functionality and appearance of the Quality Always dashboard ensuring its implementation is eased by offering operational leaders a familiar interface.

3.1 Patient Safety - 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

This national campaign came to an end of 31st March 2019 but DCHS has continued to stay committed to the 5 pledges of:

1	2	3	4	5
Putting safety first	Continually learning	Being honest	Collaborative	Being supportive

The importance of human factors as well as staff health and well-being continue to have a pivotal role in patient safety; as is the need to learn from all care and not just when an error has occurred (Safety I to Safety II).

3.1.2 Risk management

Identifying, reporting and managing risks effectively enable the Trust to reduce likelihood of occurrences that could result in a negative impact. In addition, by horizon scanning for risks, positive opportunities may present that could be utilised as part of continuous improvement. Clusters of incidents, particularly those occurring more frequently, could reflect trend or shortfall in service and are reviewed to ascertain level of risk. The Patient Safety Team continuously monitors incidents to ensure possible risks have been considered, if so, this is raised with the appropriate service and registered on our risk management system (Datix) for which there are robust governance processes in place to mitigate.

3.1.3 Risk reviews

Risks are reviewed weekly by the Risk Management Team and updated on a monthly basis by risk owners through established governance meetings in accordance with risk strategy & policy. To assist with measuring the level of risk, a risk grading matrix is used to identify the likelihood of a risk occurring along with perceived consequence (see table 22).

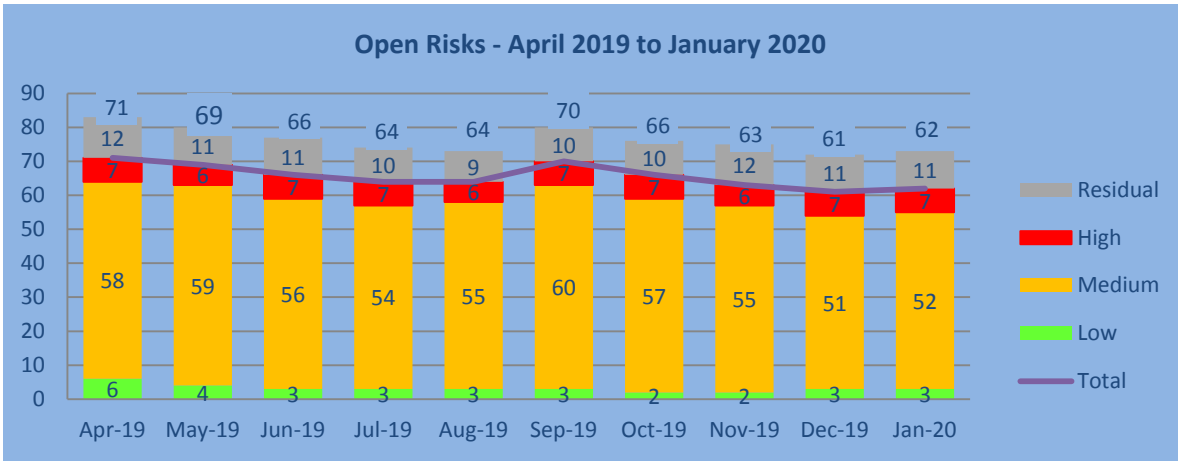
To ensure qualitative management is maintained & monitored at all levels, all risks scored 10+ are reported to Trust Board on a monthly basis and all risks are reviewed at relevant quality sub-committee meetings bimonthly – Quality Services, Quality Business & Quality People Committee (QSC, QBC & QPC). In addition, Executives are expected to review their allocated risks with their teams prior to the Board reporting.

Table 22: Risk grading matrix

LIKELIHOOD							
	Almost certain	5	5	10	15	20	25
	Likely	4	4	8	12	16	20
	Possible	3	3	6	9	12	15
	Unlikely	2	2	4	6	8	10
	Rare	1	1	2	3	4	5
			1	2	3	4	5
			Insignificant	Minor	Moderate	Major	Catastrophic
			CONSEQUENCE				

Risks are a standing agenda item discussed at each divisional governance meeting, with updates captured. An overall trend line of risks through the year is shown in graph 2.

Graph 2: Open Risks - April 2019 to March 2020



3.1.4 Risk controls, further controls and barriers

In December 2019, a new KPI was introduced within the Datix risk register to provide visibility to the Board and enable a measure of effectiveness for risk mitigation when implementing further controls. The threshold for this new KPI is set at 80% of all further controls in place within or on expected implementation date, as set by risk owner.

With introduction of this KPI, additional one to one support & training to all risk owners has been provided to improve understanding of this evolution within risk management across all services.

In particular, promotion of additional analysis by risk owners relating to risk further controls and utilisation of **SMART** methodologies to enable effective & accurate further control planning & mitigation. Further controls need to be:

- **S** – Specific
- **M** – Measurable
- **A** – Achievable
- **R** – Relevant
- **T** – Time based

By applying SMART thinking to risk management, the chance to identify opportunities is enhanced when applying focussed mitigation to risk and supports continuous improvement.

3.1.5 Board Assurance Framework

The Board Assurance Framework (BAF) is a simple but comprehensive method which NHS organisations use for the effective and focused management of principal risks to meeting their corporate objectives.

3.1.6 Risk Assurance

Risk assurance is an evaluated position of confidence, based on evidence gained from review on an organisation's governance, risk management and internal control framework. The Audit & Assurance Committee is the body responsible for risk assurance in DCHS.

Risk strategy & management serves three main purposes for DCHS: 1) it is part of the integrated governance mechanism, ensuring a coherent and well maintained system of internal control; 2) It allows evaluation of risk in terms of strategic impact upon achievement of organisation objectives; 3) Practically it provides an effective and well managed platform to promote & enable effective prioritisation and decision making to manage risk. This is underpinned by swiftly identifying priorities for action and revealing operational or clinical activity for improvement.

3.1.7 Responsibility of Board

The Board has a duty to assure itself that the organisation has properly identified risks; that processes and controls are in place to mitigate those risks that could possibly impact upon the organisation and stakeholders. The Board delegates this duty to quality committees, directorates & departments who carry out & report activities to mitigate risk by:

- Demonstrating personal involvement and support for risk management
- Approval and review of strategies for risk management on an annual basis
- Ensuring there is a structure in place for effective risk management within the organisation
- Authorising directors, assistant directors, heads of service and managers to manage and control risks at a local level, in line with strategy.

3.1.8 Medical Devices

DCHS has made good progress in some areas of medical devices including a medical devices approved list. This is available for staff via SharePoint and shows a list of approved standardised stock for use in the Trust.

The medical devices group has built on the success of the initial baseline kit which was provided to 1400 staff in 2018/19. A further 1400 pulse oximeters have been provided to staff in 2019 to complement existing kit bags which originally provided sphygmomanometer; stethoscope and tympanic thermometer. This will improve the NEWS2 monitoring and assist staff in early recognition of a deteriorating patient.

The patient safety team form part of the National Medical Devices Safety network and receive national updates relating to medical devices. These are reviewed and all relevant detail is further shared with key leads for wider distribution.

3.1.9 National reporting and 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 (risk management software) and administered by the patient safety team. Incidents shared at this national level are pertinent in determining national trends and promoting national improvements.

During the period 1 April 2019 to 31 March 2020, there have been a total of 7,356 patient safety incidents reported (excluding 491 rejected reports). Of these, 6,619 have already been communicated to the NRLS. At the time of reporting there were 194 (188 last year) patient incidents in the Datix system in the review process i.e. 118 (109 last year) awaiting review by manager, 33 (33 last year) actively being reviewed by manager and 43 (46 last year) waiting follow-up by the patient safety team. The current increase of incidents awaiting review is attributed to the current COVID-19 pandemic, where managers are responding to national situation and so unable to review in as timely a manner as in the previous year at this time.

Table 23: Patient safety incidents on Datix

	April 2017-March 2018	April 2018-March 2019	April 2019-March 2020
In holding area, awaiting review	**92**	**109**	**194**
Being reviewed	**27**	**33**	**33**
Awaiting final approval	**61**	**46**	**43**

Table 24 compares incident rate by severity classification. There is a consistently improving picture compared with previous years. There have been zero major harm incidents or catastrophic incidents reported. The mortality review process continues to ensure that where there is a query of whether DCHS care may have contributed to an unexpected death that this is thoroughly reviewed and the lessons learnt disseminated.

Table 24: Incidents by severity (After Final Approval)

Incidents by severity comparable data	2017/18	2018/19	2019/20
No injury or harm	3,905	3,558	3446
Minor harm/injury	5,851	4,105	3649
Significant harm/injury	253	141	76
Major harm/injury including permanent disability	0	0	0
Death/multiple deaths or catastrophic event (e.g. flood/fire)	9	4	0
Totals:	10,018	7,808	7,171

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 which was incorporating onto the Datix system. During 2019/20 there were **two** Never Events reported by the Trust which met the NHS England's Never Events listed fields.

The first incident pertained to wrong site surgery in podiatry. The lessons learnt from the investigation were that the service has recognised the phenomenon of automaticity in the care that it provides. Training of podiatry staff was undertaken to raise awareness of this occurrence and also the development of a nail surgery checklist.

The second was the unintended retention of a foreign object due to the inhalation of the back of a slow hand piece used in dental surgery on an autistic child patient. The outcome of the investigation was that the root cause, in this case, was equipment failure. The investigation highlighted that whilst the maintenance and care of hand-pieces is in line with current practice, improvements could be made to the objectivity of the decommissioning process of hand-pieces.

Table 25: The top five reported incidents and trends over the past three years

2017/18		2018/19		2019/20	
Pressure relief care	**5,180**	Pressure relief care	**3,291**	Pressure Relief Care	**2,806**
Slips, trips and falls (patient)	**931**	Slips, trips and falls (patient)	**713**	Discharge Problem	**551**
Medication	**699**	Medication	**634**	Medication	**550**
Discharge problem	**509**	Discharge problem	**484**	Slips, trips & Falls (patient)	**516**
Safeguarding adults	**469**	Safeguarding adults	**444**	Safeguarding Adults	**400**
Totals:	**7,788**	Totals:	**5,566**	Totals:	**4,823**

Managing the transfer of patients safely between different health care facilities is essential.
The patient safety team continues to send details of all discharge / transfer incidents to our acute Trust partners. Responses are shared through our incident reporting system to the relevant manager so that any lessons learned are communicated.

Safeguarding adult incidents are those reported by our staff who have raised concerns which they have observed when administering care to adult 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 2019/20 a total of 140 alerts were received compared with 110 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.

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. 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. 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 26: Incidents reported on STEIS

Category	STEIS incidents 2017/18	Category	STEIS incidents 2018/19	Category	STEIS incidents 2019/2020
Pressure ulcers	62	Pressure ulcers	51	Pressure Ulcers	20
Slips, trips and falls	4	Slips, trips and falls	14	Slip /trips/falls	7
Medication	2	Treatment/Diagnosis Delay	2	Mortality review identified Sub-optimal care	4
Infection prevention and control	1	Medication	1	Sub-optimal care	2
Sub-optimal care	1	Sub-optimal care	1	Treatment /Diagnosis Delay	1
Pending review	0	Surgical/Invasive procedure	1	Medical Equipment - Devices	1 Never Event
		Medical equipment – devices	1 Never Event	Wrong Site Surgery	1 Never Event
	70		**71**		**36**

3.1.12 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 us to put patient safety and clinical excellence at its core.

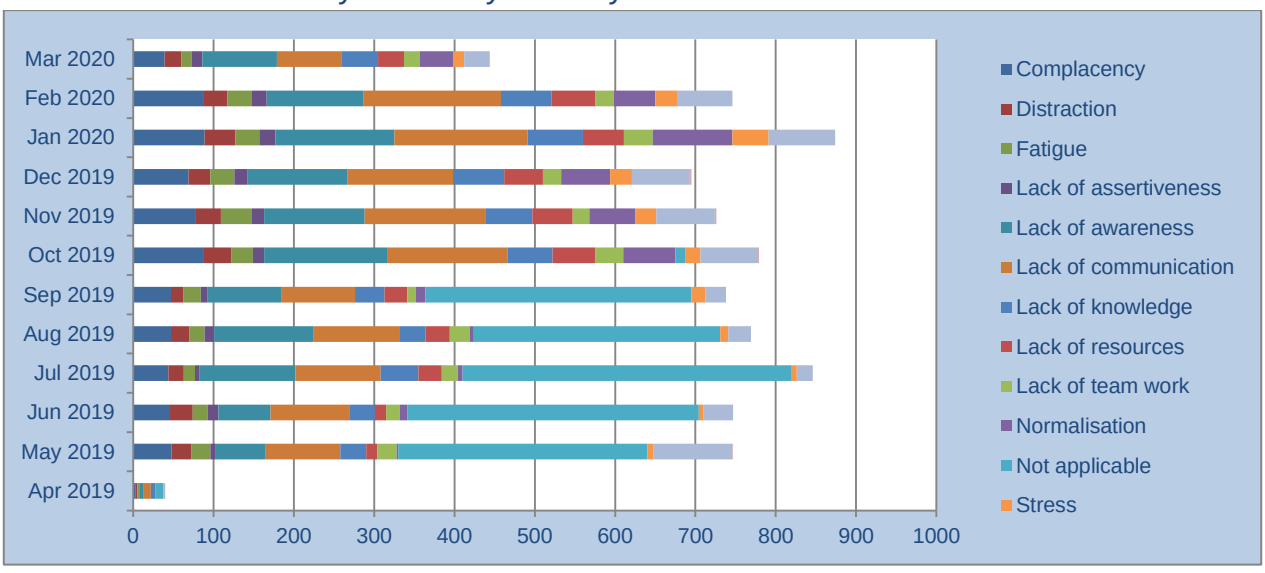
The Patient Safety team made changes to the report form on Datix to enable the capture of HF from the perspective of the reporter and the incident manager to ensure that all incident investigations consider and address the 12 main areas highlighted in the DuPont's Dirty Dozen of Human Factors which are:

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 one of these contributory factors are present then an error can occur and that when three or more are present significant harm is more likely to be the outcome.

As can be seen on Graph 3, initially when HFs were introduced there was an option for 'not applicable' to be selected and many staff were choosing this as their default. The patient safety team removed this option in October 2019 as there are HF's in all incidents. Whilst HF is part of the investigation training delivered by the patient safety manager the patient safety team are to offer further detail to staff throughout 2020 to assist further understanding by frontline staff.

Graph 3: Human contributory factors by month/year



3.1.13 Just Culture

In response to the NHS Resolution document 'New guidance calls on NHS to embed a learning and just culture to support staff, patients and carers', DCSH formed a working group to look at what already existed within the Trust and what else was required. 'Just Culture' looks at being fair: supporting a just and learning culture for staff and patients following incidents in the NHS and

highlights the need for the NHS to involve users of care services and staff in safety investigations. It encourages a more consistent and equitable approach for all, and is supported by the 'Being Fair' charter for all healthcare-related organisations to take forward. A just and learning culture balances fairness, justice, learning – and taking responsibility for actions. The changes regarding the commitment to this culture and ethos will be highlighted in the Trust's disciplinary policy.

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. During the reporting period 2019/20 there were 36 incidents meeting the duty of candour criteria. Patients or the relevant other persons have been contacted and a full explanation provided following investigation.

Duty of candour is a thread throughout trust induction, essential training, investigation training and incident managers' Datix training.

Safety I to Safety II has now been detailed in the NHS Patient Safety Strategy, safer culture, safer systems, safer patients, July 2019. Throughout the year of 2019/20 the Trust has continued the shift to Safety II by:

- **3I Dialogue** (Appreciative Inquiry) which has gained further recognition across the Trust with presentations and workshops at both the Clinical effectiveness Showcase and the Celebration of nursing and midwifery in Derbyshire 2019.
- **Shout Out** has continued to gain strength and informs the Lessons Learnt Panel to allow the Trust to learn from excellence. In the year of 2019/2020 there have been 179 'Shout Out's submitted (50 for teams and 149 individual staff members)
- 17 September 2019 was the first **World Health Organisation Patient Safety Day** which the patient safety team embraced along with our Commissioners at NHS Derby & Derbyshire CCG. To celebrate this, the patient safety team asked all staff across the Trust to advise of one simple thing they do on a regular basis to keep our patients safe, again informing Safety II.

To further bolster the move to Safety II the Patient Safety Team has worked with the Lessons Learnt Panel to broaden the scope of reports it receives and disseminate the learning. This has been captured with a new emblem for the Panel being created to show all the avenues of learning that can input to the panel; these being:

- Shout Out
- Patient Experience
- Raising Concerns
- All Incidents
- Learning from Deaths
- Clinical Effectiveness
- QI Faculty
- Employee Relations & Staff Side

3.1.15 Time to Heal

Our 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.

The Time to Heal programme has now been extended to incorporate the Complex Wound Clinic Leads and continues to run 3 x annually with staff also attending Health Coaching (Quality Conversations) as a separate course.

The Time to Heal programme were overall winners of the Leading Healthcare Awards and the programme has now been shortlisted for an international award from the Journal of Wound Care Wound Union of Wound Healing Societies Awards for cost effective care with the winners to be announced in September 2020.

During 2019/20, the Tissue Viability team were working towards a 10% reduction in significant harm pressure ulcer events and have achieved 48.84% reduction.

Patient Story – Jo's story

Jo a former nurse and full time carer for her husband (who has vascular dementia), has always been very active. Jo slipped and grazed the outside of her leg. Jo thought she could manage the wound herself, however after some time it became evident that the wound was actually getting

worse. Jo sought help from her local GP practice nurse and even though she attended clinic twice a week the wound continued to deteriorate and made Jo miserable.

Jo's GP informed her of a wound clinic at Walton Hospital where she could go for wound care, she was very reluctant but her leg by now was swelling, she was in a lot of pain and her quality of life was seriously affected. Jo attended the clinic and was pleased she went. Jo described the exceptional care she received.

Each time Jo visited the clinic her leg got a little better, she started to feel better in herself, became more independent and she was even able to have a bath again.

Jo, when asked what difference the clinic had made to her advised: …"Absolutely wonderful it's given me my life back – I can bathe, walk out. They're wonderful at that clinic, I can't speak well enough of them. It's a boost to Chesterfield and people should know how good the service is". "Thank you for being there. I don't know why people ever give bad feedback. It's a top service" "Thank you for letting me be part of it…"

3.1.16 Infection prevention and control (IP&C)

Infection, prevention and control remains a high priority for us 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 (HCAIs) as low as possible. Again, this year we can report that our infection rates have remained low with seven cases of Clostridium difficile infection and no blood stream infections (bacteraemia) reported.

3.1.17 Patient manual handling and bariatric care

The team continue to support clinicians with advice and guidance. Referrals have increased in both complex and bariatric fields. Transfers of patients with bariatric and complex patient handling and equipment needs from Chesterfield Royal Hospital have been streamlined with close working with the DCHS Clinical Navigation Team. The pathway is being rolled out to include Derby and Burton Hospitals.

We continue to monitor DCHS ward and facilities regarding the needs of bariatric patients and offer advice regarding equipment needs. We have identified challenges within the pathway 2 strategy for plus size and bariatric patients and are working with DCC adult care and DCHS teams to resolve these.

The team continue to provide patient manual handling training at induction and via the key trainer programme to appropriate staff. Compliance is variable among teams with average compliance at 88%. We have identified challenges that affect specific teams and are looking at ways to support managers to enable improved compliance. The team continue to learn and develop specialist skills and knowledge with academic and peer supported learning and networking.

Working with community nurses the team have reviewed patient handling challenges associated with low level working. Working with health & safety, occupational health and staff some environmental issues have been addressed and have identified equipment that may help reduce MSK risks.

3.1.18 Falls prevention, assessment and care planning

This year through training and incident learning, we have empowered staff to be predictive and responsive to falls risk assessment and management. This has enabled us to provide patient care which is personalised and adaptive for patients with increasingly complex and high risk needs, reducing harm associated with inpatient falls. DCHS is recognised and respected as a key contributor in providing both urgent response and rehabilitation services. This year we have enhanced our partnership working with Age UK Strictly No Falling programme to improve the sustainability of physical activity in the older population.

3.1.19 Ligature management work

Following on from the great work undertaken by DCHS in 2018, the endeavour to reduce risk of self-harm to vulnerable people continues across the Trust. Ownership of ligature management and anti-ligature devices was passed to the patient safety team and with collaborative engagement across all areas:

- All site ligature surveys for 2019/20 have been completed in accordance with policy with clinical staff engaging well to carry out this requirement
- Additional support has been provided by the patient safety team to DCHS sites to assist with use of the assessment tool
- Patient safety team visits to sites to carry out percentage checks of survey reports have been carried out
- Independent survey assessments have been carried out in full by an external organisation on all anti-ligature device fittings, DCHS has responded swiftly to findings, requirement & remediation where necessary
- Review and assessment of all rooms where anti-ligature device re fits are required for Walton Hospital and Ash Green has been completed ahead of schedule.

DCHS will continue to maintain a high standard of on-site ligature risk assessments & anti-ligature device management, awareness & training. To support this, there is an intent to create a short training video for all staff as part of their annual training.

3.1.20 Prevention and Management of Violence and Aggression (PMVA)

In December 2017, a working group was assembled to carry out a comprehensive review and revision of the 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. The head of health and safety and the risk manager are both leading on this collective work stream with clinical input from appropriate colleagues and will:

- Review DCHS polices specifically the management, prevention and reduction of violence and aggression including physical restraint and seclusion and aggressive and violent behaviour towards staff policy
- Liaise and discuss with the operational service line manager for OPMH regarding any updates regarding the work undertaken by the strategic and clinical lead for OPMH and any other recent updates in addition to previous work and policies
- Confirm if the policy is up to date, with the inclusion of de-escalation techniques, triggers, staff patient relationships for LD/vulnerable patients
- Confirm how restraints are recorded either local logs and Datix
- Work with service to ensure care plans and their implementation is in line with local policy.

3.1.21 Clinical documentation

During 2019/2020 there has been a positive trend in the reduction of paper documentation leading instead to an intended increase in the use of electronic templates. There is continued work with GP practices to align some outstanding documents with mainstream governance. Apart from GP practices all other documents have been reviewed within an agreed timeframe. There are no associated risks with any documents currently held in DCHS.

During 2019/20, 417 documents were reviewed and decisions made to either accept or reject any new documents – this is based on their requirement and whether detail is already contained elsewhere. A further 67 clinical policies were reviewed ensuring robust governance measures continue. The group made decisions, supported by the Clinical Safety Group and Clinical Effectiveness Group to approve, archive or reject policies. Policies may be archived either if their content becomes obsolete or is contained in the Royal Marsden Manual; policies will also be rejected if the detail can be found within the Royal Marsden Manual. The Royal Marsden Manual renewal has been extended for a further year.

Ongoing work is currently taking place with DCHS GP practices, to align all documentation in use. Working with the Communications and Engagement team to ensure MyDCHS does not promote any literature which has not undergone a comprehensive governance process. Another strand of work with the Communications and Engagement team is exploring a different platform instead of SharePoint to improve access and search of documents for staff and reducing the length of documents in use making them more reader/user friendly.

3.1.22 Safeguarding Service

Safeguarding children, young people and adults from abuse and harm is an important and integral part of everyday healthcare practice. It is everybody's business. DCHS has a dedicated safeguarding team of nurses, health professionals and administration staff to provide advice, support, supervision 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 by working with DCHS staff and partner agencies.

The safeguarding service promotes a Think Family focus throughout all child and adult safeguarding work. It promotes the importance of listening to the voice of the child and making safeguarding personal for adults at risk, so that their experiences are heard.

Safeguarding 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 wellbeing of all children in the authority's area, which includes the need to safeguard and protect from harm and neglect.

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 placed 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 wellbeing of both individuals and their families/carers to reduce inequalities, risk and harm from abuse.

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 Intercollegiate Documents; Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) provides guidance and expectations regarding safeguarding adult and children training for healthcare staff.

Safeguarding Adults – Quality Assurance

The Safeguarding Adult Assurance Framework (SAAF) reflects the requirements of DCHS as a health provider to demonstrate: safeguarding leadership, expertise and commitment at all levels in the organisation and that DCHS is fully engaged and in support of local accountability and assurance

structures and in regular monitoring meetings with their commissioners, as directed by NHS England Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework (2015).

The SAAF follow up action plan site visit was completed on the 24 October 2019. The outcome being that the CCG were once again assured by the work being done to ensure that DCHS maintains its profile and helps to influence local safeguarding arrangements in Derby and Derbyshire.

Safeguarding Children – Quality Assurance

The safeguarding self-assessment is 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), now the Derby and Derbyshire Safeguarding Children Partnership (DDSCP), of the processes in place to safeguard local children and young people and acts as a benchmark of compliance. The section 11 site visit by the CCG was completed on the 19 December 2019. It was reported that the audit and the site visit has provided assurance, consistent with the standards as set out in the national guidance.

This Markers of Good Practice (MOGP) 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 MOGP Looked after Children audit was completed and submitted on the 27 February 2020. The site visit was planned for the 31 March 2020.

Safeguarding Training

Safeguarding adult and children training is delivered to all DCHS staff, volunteers, governors, and the executive and non-executive teams.

Table 27: Safeguarding and Prevent training compliance

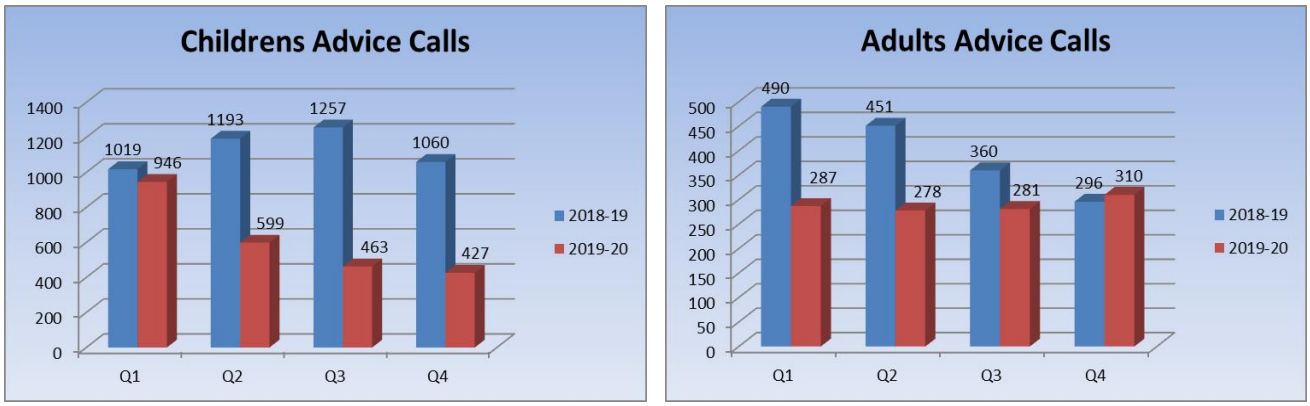
Safeguarding training compliance	2019/20
Safeguarding adults level 1	98.1%
Safeguarding adults level 2	92.6%
Safeguarding children level 1	98.1%
Safeguarding children level 2	92.2%
Safeguarding children level 3	90.5%
Safeguarding children level 3a	90.5%
Prevent training compliance`	**2019/20**
WRAP training (clinical staff level 2 and above)	98%
BPAT training (non-clinical staff level 1)	96.2%

Safeguarding Advice and Support

The activity regarding safeguarding children advice calls has decreased. This has been an expected reduction following a change in the way advice is sought by the starting health team from the safeguarding children team, which was implemented to support autonomy and practitioner experience.

The safeguarding adult team's advice call activity has also decreased. This reflects the more consistent recording on SystmOne and other work streams particularly supervision and training. The safeguarding team continues to be extremely busy, supporting DCHS staff with an ever increasing number of complex cases.

Graph 4: Safeguarding Service Advice Calls; children and adults



Safeguarding Supervision

The delivery of safeguarding supervision is a statutory requirement for the safeguarding children team which is recorded to ensure compliance. The adult safeguarding team provides supervision to teams that are recognised as having 'high risk' clients i.e. learning disability, older people's mental health.

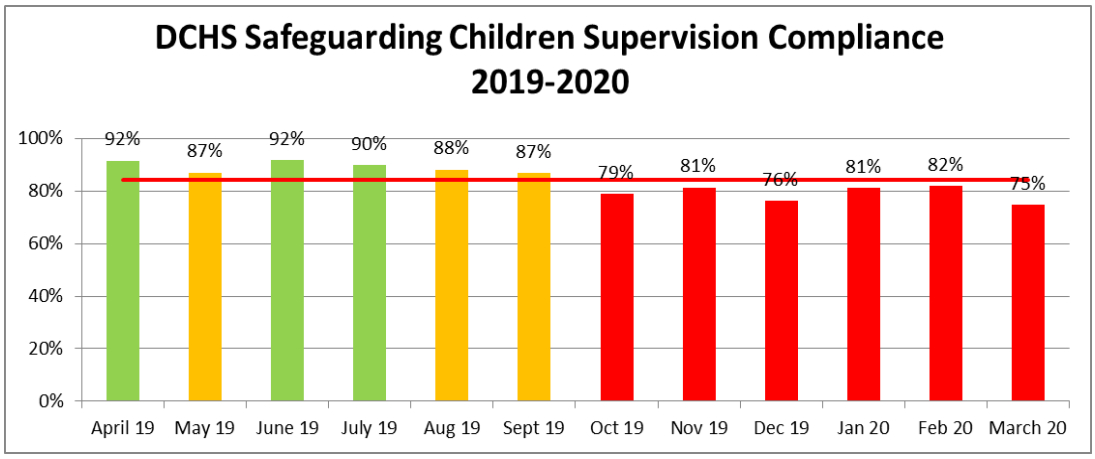
The safeguarding adult supervision is offered to teams approximately 5 to 6 times per year. Additional sessions will be offered to reflect both complex cases and the needs of the practitioner. Starting in quarter 4, sessions will be provided bi-monthly. This will be reviewed following anticipated learning from a serious adult review.

The Safeguarding Team has implemented joint safeguarding adult and children supervision with the Integrated Sexual Health Service and the Minor Injury Units; to reflect the work that these services provide including the Think Family agenda.

It was agreed with the 0-19 Children's Service senior management team that safeguarding children 1 to 1 supervision would be offered 3 monthly regardless of working hours from October 2019, to reflect the increase in child protection/safeguarding cases and surrounding areas supervision models. However from October to March 2019/20 there was a decrease in the number of

safeguarding supervision sessions delivered by the safeguarding children team; contributory factors were vacancies within the safeguarding team, sickness in both the safeguarding team and the 0-19 Children's Service and the impact of the changes to the 0-19 Children's Service. The model of supervision will be reviewed during 2020/21 to identify a plan of improvement.

Graph 5: Safeguarding children supervision compliance



Modern Slavery Statement

This statement is made in accordance with Section 54 of the Modern Slavery Act (2015). It sets out the steps that DCHS 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 DCHS are affiliated.

Modern slavery is defined as the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, and abuse of vulnerability, deception or other means for the purpose of exploitation. It encompasses slavery, servitude, human trafficking, forced labour, sexual exploitation and forced criminality and is a crime under the Modern Slavery Act 2015.

DCHS has **zero tolerance** to any form of abuse and thus modern slavery is incorporated within both children and adults' safeguarding work streams.

DCHS is 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 Group (CCG) 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.

3.2 Clinical Effectiveness - Ensuring Services are Clinically Effective

Clinical Effectiveness is the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum outcomes of care for patients (Department of Health, 1996). To ensure that the services provided by the Trust achieve meaningful outcomes for patients and carers, DCHS undertakes a range of clinical effectiveness activities. These include clinical audit, NICE guidance review and implementation, participation and promotion of research and innovation and the use of clinical and patient-reported outcome measures.

3.2.1 Research and Innovation Strategy

The Research and Innovation Strategy was refreshed in February 2019 and some of the strategic priorities are outlined 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 QI throughout the trust
- Using research and innovation to deliver evidence-based practice while making the best use of resources

Key research and innovation successes this year include (this list is not exhaustive):

- Successfully providing the opportunity for over 500 participants to take part in research studies across DCHS
- Research studies have taken place across many of our services including General Practice, Sexual Health, Dental, Podiatry, Occupational therapy, Speech and Language Therapy, Staff Wellbeing and Physiotherapy services.
- Our GP practices have been successful, for a second year, in achieving the Research Site Initiative Scheme Level 1.

Research activity

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. DCHS portfolio studies opened in 2019/20 can be supplied upon request.

3.2.2 Clinical Effectiveness showcase

DCHS hosts an annual “Clinical Effectiveness Showcase”; this event allows staff to share examples of good practice. Staff present through a variety of media to evidence how they have used research, clinical audit and other Quality Improvement methodologies to improve practice and patient outcomes. In 2019, 145 staff participated in a diverse agenda that included “Appreciative enquiry, a Quality Improvement methodology” and a patient who is also one of our Experts by Experience encouraged the audience to involve patients in their clinical effectiveness projects.

3.2.3 Audit Management and Tracking

DCHS has procured Audit Management and Tracking software called AMaT. This will allow the Trust to gain assurance from a larger portfolio of clinical audits and ensure that all clinical audit activity leads to improvement. The system will support clinicians to view all relevant audit activity, will reduce repetition of activity and will enable the organisation to respond to identified themes and risks.

3.2.4 Implementation of evidence based practice

NICE (National Institute for Care and Excellence) implementation group has reviewed 268 pieces of guidance and disseminated them to the relevant clinical services. The NICE Implementation Group monitors compliance with guidance and provides the Trust with assurance that evidence based guidance is either implemented or notified of action required to improve compliance; this may include change to practice and/or liaison with commissioners.

3.2.5 Effective Documentation Review (EDR)

DCHS has been working to revise the clinical records audit to make it effective, efficient and ensure it supports staff to improve the care of their patients; the revised audit is now called the Effective Documentation Review (EDR).

During 2019 the Clinical Effectiveness Team (CET) has been working with clinicians and the Quality Always team to design suitable audit questions for each service. CET has also developed questionnaires within electronic patient records that will enable Equality and Diversity monitoring to be audited.

The procurement of AMaT will assist the implementation of a revised EDR on a service by service basis.

3.2.6 Dementia and Frailty

Frailty is a common condition which becomes more prevalent with age. It is thought to affect 25-50% of people over 80, and about 10% of those over 60. Frailty is not a normal part of ageing and patients who are becoming frail can be proactively identified, as it develops over a 5-15 year period. However, patients often present in crisis, without prior warning, to urgent or emergency care services with one of the frailty syndromes (falls, delirium, immobility, etc). The population aged 85 and over (i.e. the ‘oldest old’) is the fastest growing age group in the UK population, and represents 2.1% of the total population.

Older people living with frailty are the highest users of health and social care services, and have the highest number of unplanned admissions to hospital. Daily average emergency admissions to English acute hospitals for the over 65 age group doubled between 2005 and 2012. 80% of emergency admissions who stay for more than two weeks are patients aged over 65, and just over 30% are over 85 years old.

The effects of frailty can be mitigated if problems are identified early. However, those affected are not always reliably identified, or are only identified when advanced frailty has developed. This means

opportunities are missed to support people more effectively, which in turn leads to a poor patient experience and avoidable care costs. Identifying people living with frailty can help improve outcomes both in relation to a specific intervention as well as with the long-term management of health needs. Simple assessments can be used to identify frailty but should be followed up by a more detailed clinical assessment where necessary.

Joined-up Care Derbyshire (JuCD) Sustainability and Transformation Partnership's (STP) mission is to improve population health outcomes for the people and communities of Derby and Derbyshire with a vision for people to have the best start in life, to stay well, age well and die well. The Frailty Workstream of the STP is a multi-professional, multi-agency group comprising providers, commissioners, Local Authority and voluntary sector representatives. Their goal is to enable all older people in Derbyshire to live healthy, independent lives at home or the place where they call home for as long as possible by reducing the need for escalation of care to non-home settings by 2020.

To support the delivery of the Derbyshire frailty model, DCHS frailty strategy (see appendix 3) sets out our approach to the care of older people living with frailty. It has relevance and application to all people who are cared for within inpatient settings, community and General Practice.

There is an End of Life Care strategy and dementia strategy (in development), to support our over-arching DCHS Clinical strategy. The strategy incorporates our 'quadruple aim' and our strategic objectives are to manage frailty as a long term condition in its own right; provide pro-active care through timely identification and deliver more community based, person centred, coordinated care.

In recognition of the quality, clinical, business and operational ramifications of the frailty agenda there is a need for a comprehensive framework. Consideration has been given to raising awareness and workforce training to meet the demands of a changing population profile and wider system priorities.

The British Geriatrics Society have commissioned DCHS to write a series of articles which chronicle the development of the Derbyshire Community Frailty Model, DCHS Frailty Strategy and the common training pathway for frailty / dementia and end of life care.

Patient Story (end of life): Imogen's Story

Imogen was diagnosed with Ewing Sarcoma aged 15, resulting in amputation. As her disease progressed she developed pulmonary metastases, and was admitted to hospital in May 2018 (age 17). Her treatment was now palliative rather than curative but she was stable enough to be discharged home which was her preferred place of death.

Imogen was almost 18 and chose to be treated as an adult. We were ideally placed, with our expertise in End of Life care, to support her wish to die at home. The nurses were very keen to be involved, although wary as they had never looked after a teenager before. The Teenage and Young Adult Clinical Nurse Specialist coordinated with multiple teams; Oncology at Sheffield Children's Hospital, Community Nursing, GP, Community Pharmacy, Bluebell Wood Children's Hospice and Derbyshire Health United out of hours.

Imogen was supported to live and die at home with no further admissions to hospital. She managed initially to go out on trips and attended a wedding. Her friends frequently had sleepovers.

She passed away on 03/10/18 Imogen's mother felt Imogen would not have been able to be at home if not for all the teams involved in her end of life care.

3.3 Patient Experience – Understanding and Improving the Patient Experience

Patient Experience – Health Psychology
The Health Psychology Service has developed new roles to work with the impact of mental illness within physical health pathways. The service is providing dedicated Clinical Psychologist time to increase the confidence, knowledge and experience of front-line staff working with patients with complex co-morbidities in two of our integrated care systems to improve the healthcare offer and experienced for patients, staff and the system. The service also has posts working with our Sexual Health promotion team and linking into Derbyshire Public Health department to bring psychological knowledge and a behavioural science approach to service delivery design and patient care.

3.3.1 Patient Engagement and Involvement

We measure and monitor people's experiences in lots of different ways to help us improve services. This includes general feedback, complaints, concerns, compliments, the NHS Friends and Family Test (FFT), surveys and online options (NHS UK, Care Opinion and social media). We have also shared many patient and carer stories this year.

3.3.2 Friends and Family Test (FFT)

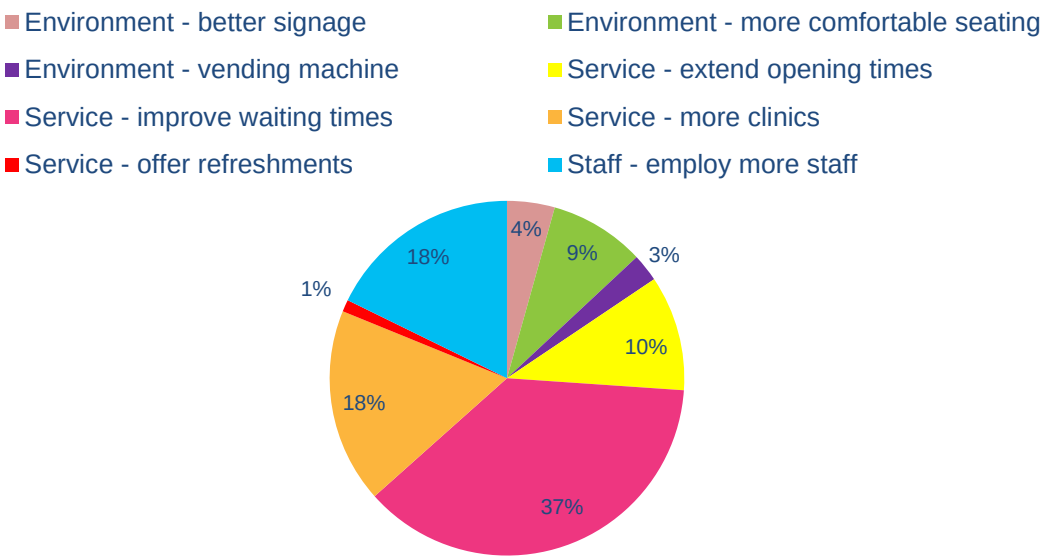
The FFT is an important feedback tool that asks a patient "How likely are you to recommend our (ward/service) to friends and family if they needed similar care or treatment?" on a scale from Extremely Likely to Extremely Unlikely. The FFT helps us to identify good and poor patient experiences. The FFT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

Throughout the year we have monitored responses to the FTT 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. 22,540 Patients completed the FFT April 2019 – March 2020 this is a 13% decrease from last year, (26,778 cards) although we continue to perform well above the local and national FFT results.

Whilst the overall feedback about the care provided to patients, their relatives and carers, has been positive, we always welcome suggestions for improvement. The majority of suggestions relate to improving waiting times (37%), offering more clinics (18%) and employing more staff (18%).

35% of the suggestions for improvement came from Sexual Health Services of which the majority of citizens asked the service to improve waiting times. The Sexual Health Matters website is regularly updated and explains the appointment process and if there are any issues in booking an appointment. More clinics have been put in place with extended opening hours.

Graph 6: Suggestions for improvement



3.3.3 Involvement

We have developed a partnership network of over 40 groups, which includes DCHS specific services: stroke support, learning disabilities, pain management and respiratory rehab, as well as partners across Derbyshire and our Expert by Experience members (EbE). We have worked with the network to co-design and develop many of our services in the last year such as:

- Focus group to look at ways to improve how we capture feedback from patients over the age of 75, through our community nursing services.
- Influenced the dementia and end of life training pathways by supporting the delivery of training to DCHS staff
- Being a key member of the Derbyshire Carer collaborative, influencing the Derbyshire wide carers' strategy; sharing what we have heard from our patients, service users and families through feedback and engagement activities
- Co-design of various questionnaires, leaflets and patient information

3.3.4 Responding to Patient Feedback

The Community Access Point (CAP) now takes all referrals for community nursing across the county and has replaced the District Nurse Call Centre and liaison services (which previously operated in the south of the county only). After initial screening, the referrals are electronically sent to a locality triage point where a clinician triages them. If they are urgent then a community nurse will respond within 4 – 24 hours depending on the need. Routine referrals are passed to the core nursing teams. Previously each core team would have responded to their own urgent referrals, the new process allows them to plan and manage their day better and for the patient to get a timely response when needed.

As with any process change there has been some negative patient feedback, most issues have been responded to as concerns and a few as low level complaints. Most concerns regard a

breakdown in communication or process resulting in a delay for the patient. Learning from each one has supported the development of clear consistent pre-set processes to avoid future re-occurrences. The example below shows how feedback about the triage service was used to make an improvement:

Post hip replacement. Referrals are often sent to triage from acute trusts for removal of sutures 10 days post op. Our nurses had a process in place to advise these patients to attend the practice nurse for this procedure. What came from this was the patients were told this on day 2 or 3 post surgery. At this point they had just got home from hospital and were evidently suffering with increase in pain and reduced mobility and feeling vulnerable. From this feedback we discussed we should also at this point be advising patients that by day 10 they should be more able and able to attend the practice with a backup that if they do not feel any better by day 8 to contact CAP for referral for a District Nurse to visit. We fed back to the patient what we had implemented following this and he was thankful to the service.

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 six broad categories, which include cleanliness, food and hydration, condition, appearance and maintenance, privacy and dignity, dementia friendly environment and how well the organisation caters for the needs of patients / visitors with disabilities.

Table 28: PLACE scores 2019

Site Name	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Walton Hospital	99.58%	91.31%	95.59%	98.51%	91.30%	83.53%
Whitworth Hospital	96.05%	86.21%	87.50%	100%	95.69%	92.39%
Ash Green	96.91%	86.59%	93.62%	94.34%	73.75%	75.00%
Babington Hospital	99.54%	85.56%	93.33%	98.11%	91.10%	93.44%
Cavendish Hospital	100%	89.66%	92.16%	99.33%	89.47%	86.08%
Clay Cross Hospital	96.55%	91.95%	93.75%	100%	95.65%	90.67%
Ilkeston Hospital	98.19%	90.08%	89.66%	97.50%	97.81%	93.18%
Ripley Hospital	99.56%	91.40%	94.87%	98.00%	95.69%	94.44%
St Oswald's	100%	90.48%	100%	98.67%	97.40%	96.20%

After a national review of the questions by the PLACE team we are unable to compare scores from previous years PLACE assessments. We received further notification from PLACE on 19/12/2019 that as part of the validation process, the PLACE team have undertaken some corrections to the

scoring system for a small number of questions which may result in some small changes to our provisional scores.

The disability elements that DCHS scored low in were:

- Hand rails not in a different colour to contrast with the walls
- Not all corridors had hand rails

DCHS scored low in the privacy and dignity section as highlighted below:

- Not all rooms are single occupancy rooms with en-suite facilities
- Not all toilets and bathrooms had privacy curtains
- Not all wards have a separate treatment room for minor procedures and dressings

Areas for improvement for the dementia friendly environment include:

- Ensuring that walls and handrails are of a contrasting colour
- Clear signage prominently displayed, showing the hospital name and ward / outpatients name
- Not all areas had an 18 inch face clock and day plus date visible
- Taps clearly marked as hot/cold e.g. by using red and blue colours

DCHS Hospitals have achieved a score above the national average for elements in cleanliness, condition and maintenance, privacy & dignity, dementia and disability. The food element is slightly lower than the national average. Following the assessment programme action plans have been compiled and forwarded to the facilities managers for action. Progress against these reports will be obtained in June 2020 in preparation for the next PLACE assessment programme.

Table 29: Overall Organisational Scores 2019

DCHS	Cleanliness	Food	Privacy, dignity and well-being	Condition, appearance and maintenance	Dementia	Disability
	98.79%	89.79%	93.90%	98.47%	93.24%	89.85%

Table 30: PLACE: DCHS scores against national average scores

	Cleanliness	Food	Privacy, dignity and well-being	Condition, appearance and maintenance	Dementia	Disability
National average score 2019	98.60%	92.19%	86.09%	96.44%	80.70%	82.52%
DCHS Score 2019	**98.79%**	**89.79%**	**93.90%**	**98.47%**	**93.24%**	**89.85%**

(Data source PLACE audit results)

DCHS achieved a score above the national average for elements in cleanliness, condition and maintenance, privacy and dignity, dementia and disability. The food element is slightly lower than the national average.

As part of the assessment process, the patient representatives were asked to provide a summary which they felt accurately reflected the Hospitals, as a whole. These are some of their comments;

Babington Hospital - *"All Staff very welcoming and gardeners to be proud of the work they have done to the outside social space".*

Ilkeston Community Hospital - *"This is a well-kept and managed site where patient welfare is paramount. Staff assumes ownership of their environment and care for it to the best of their ability".*

Ripley Hospital - *"Building is well maintained, modern with recent additional physio extension underway. Pleasant and welcoming ambience. Patients were treated with dignity at all times".*

St Oswalds Hospital - *"Well maintained, welcoming environment." "Pleasant and helpful staff."*

3.4 Patient Experience - Ensuring our services are responsive to patients' needs

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 and Patient Experience and Engagement 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 mother was supported to enable her to breastfeed her baby following a traumatic birth) 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 patients medication timings on the ward and to listen to family members).

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.

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.

3.4.1 Complaints Review

As part of our Trust's annual Internal Audit Programme, KPMG were commissioned to undertake a review of our complaints handling. The report and recommendations were received in April 2019. DCHS accepted the recommendations and agreed the timescales for the improvements that are needed. The final report was presented to QSC in January 2020.

In response to the review DCHS has made the following improvements to the way we handle complaints from patients and their families:

Recommendations

1) Roles within the Patient Experience Team have been reviewed
2) Management of action plans arising from complaint investigations and sharing the learning is being improved so that we can evidence any service improvements that were made in response to the findings of any complaint investigations. Our Quality Improvement resources will support this. Through divisional governance meetings and the Lessons Learned Panel any new insights we gain from investigating complaints, will be disseminated across services.
3) Data quality and reporting: From April 2020, complaints data will be included in our Business Intelligence system. This will enable operational managers to see their own complaints reports and identify any trends or themes
4) Escalation process: there is now a process that will help us prevent delays in the investigation of complaints which will mean we can respond more promptly to the person who complained.

5) Link with incidents: we are clear how we can digitally link together a complaint and an incident report on when they relate to the same original incident
6) Quality of response letters: a complaint response template has been approved. This provides the basis for all response letters and addresses unwarranted variation in style and content. The key principles from the Patient's Association good practice guidance are applied to all letters https://www.patients-association.org.uk
7) Training of investigators: an updated list of everyone who has completed the internal investigation skills training has been provided to senior operational managers, so that they can allocate complaints investigations to those with the skills to complete them
8) Quality review process for investigations: the Patient Experience Team have an explicit list of criteria against which each completed investigation is rated on completion. Feedback is provided to the investigator for their development, and to the senior leader who allocates future complaints.
9) Review of Complaints and Concerns policy: The changes above have been included in an interim update of the Complaints and Concerns Policy. This was approved by QSC in January 2020. A full scheduled review of the policy will be undertaken in December 2020.

Patient Story: Ann and David's story

Ann had been unwell for 2 to 3 years with spinal stenosis and Parkinson's disease diagnosis was made which resulted in the prescription of a long list of medications. Within 3 months Ann was back on her feet walking, talking and carrying out her own care independently. All was going relatively well until Ann suddenly collapsed, she became so unwell she ended up with an emergency hospital admission and underwent emergency surgery.

Ann started self-medicating at Ilkeston Hospital but after the first 3 days the administration of her medication was taken over by the ward because the hospitals policy did not allow self-medication. David provided the ward staff with a copy of Ann's medications which included the times at which they were to be administered.

Ann's condition was starting to deteriorate after just a couple of days. Ann was not really aware of what was happening she was very confused and in an agitated state. Her Parkinson's symptoms were starting to get worse. One evening the ward rang David and asked if he could come in to the ward and help to calm Ann, she was in such a state he stayed with her though the night holding her hand. There were several such incidents over the coming nights.

David informed the ward manager he was sure that Ann was not getting her medications in the prescribed manner and having spent so much time on the ward he was present when the medications were being administered and had observed that Ann's medication was regularly being given at the wrong times. David was told that this could not possibly be happening on her ward.

He was so concerned about this he went to his GP for advice but was told that he was powerless to intervene as his practice did not cover a community hospital. At this point he considered taking a

wheelchair in and bringing Ann home. David really did think that Ann was going to die if her treatment did not change.

David asked again but was informed that it would not be possible to allow him access to Ann's medicines cupboard for security reasons and it was against hospital policy. In desperation he spoke to the physiotherapists and expressed his concerns that Ann was just getting worse. They had the ability to discharge Ann if they were happy that Ann could be looked after safely at home. After two days and an inspection of their home David was able to take Ann home.

Ann has made a good recovery and is now receiving her medications at the correct time but it has taken several months of effort on her part. David stated that because of the serious nature of these events Ann might never have recovered and that is why he decided to make an official complaint to try to ensure there is no repeat of this dreadful state of affairs.

Following the investigation and review of policies the ward realised that they could have assessed David's ability to give Ann her medication. They advised that they were not aware of the procedure for the self-administration of medication.

A poster with Matrons contact details is now prominent for all patients and visitors.

In January 2020, we received the Healthwatch report 'Shifting the Mind-set: A Closer Look at NHS Complaints'. Having reviewed our current complaints handling in the light of the report, we can become more open about our complaints and what we have learned from them.

- Improved Annual Complaints report (2019/20) with more focus on learning and service improvements will be published on our website
- More patient stories which illustrate learning from complaints will be published on our website
- Explore how we can share learning across the Joined Up Care Derbyshire system
- Extended use of 'You said. We did' posters on our sites and website
- Assure ourselves that people with a protected characteristic have equal opportunity to make complaints and are satisfied with their experience
- Consider adopting the Parliamentary and Health Services Ombudsman's complaints standards framework when it is published.

https://www.healthwatch.co.uk/report/2020-01-15/shifting-mindset-closer-look-complaints

3.4.2 Complaints and Concerns

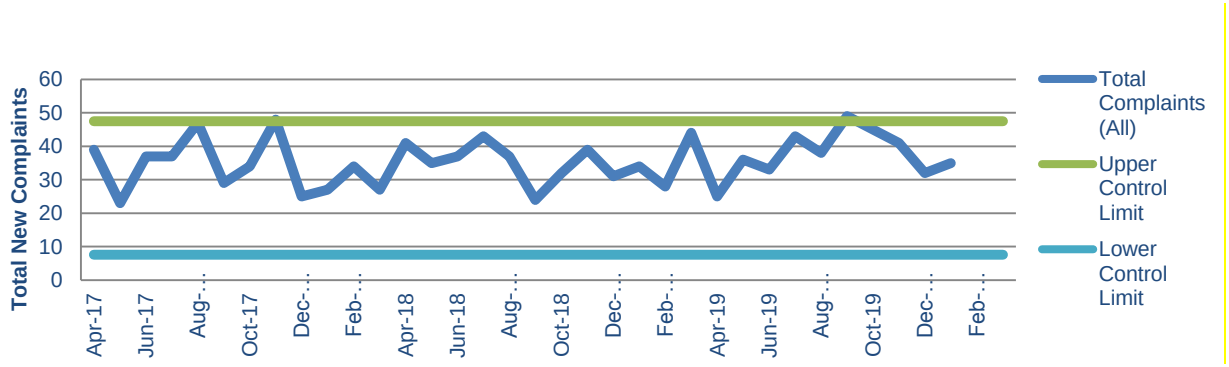
DCHS is committed to ensuring there are opportunities for everyone who uses our services to give feedback about their experience or seek information or advice. This feedback may include raising concerns or making a complaint. Service users or their relatives and carers need to know how to do this. We want them to feel confident that we will listen to their concerns and that they will be taken seriously and any future care we provide will not be compromised.

The Trust recognises that concerns and complaints offer us the opportunity to review issues that are causing concern and highlight practice which could be improved and, as such, they are valued as a source of learning for the Trust. Where positive comments are also received these enable the Trust to identify and disseminate good practice

During 2019/20 a total of **450** complaints (all types) were received, this is a 5.78% decrease compared to the previous year. We have seen a slight increase in Type 1 complaints, which do not require a full investigation and these concerns are resolved by services very quickly.

Graph 9 below shows an upward trend in the overall complaints activity over time. The number of Type 2 complaints investigated (under NHS regulations) has decreased by 11.66% to 122 (2019/20) compared to 138 (2018/19). The decrease in Type 2 complaints in correlation with the slight increase in Type 1 complaints shows the efforts within the team to deescalate concerns and assist services in finding resolution to complaints at a local level.

Graph 7: Complaints activity 2017-2020



- **Subject/s of complaints**

In previous years a higher proportion of complaints related to communication. We have continued to address this through greater awareness and staff training around 'words matter' and improving the patient experience has been significant in reducing these complaints. On review of the complaints we received, 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 – 41%
- Values & Behaviours – 21%
- Access to Treatment – 16%

- **Responding to complaints**

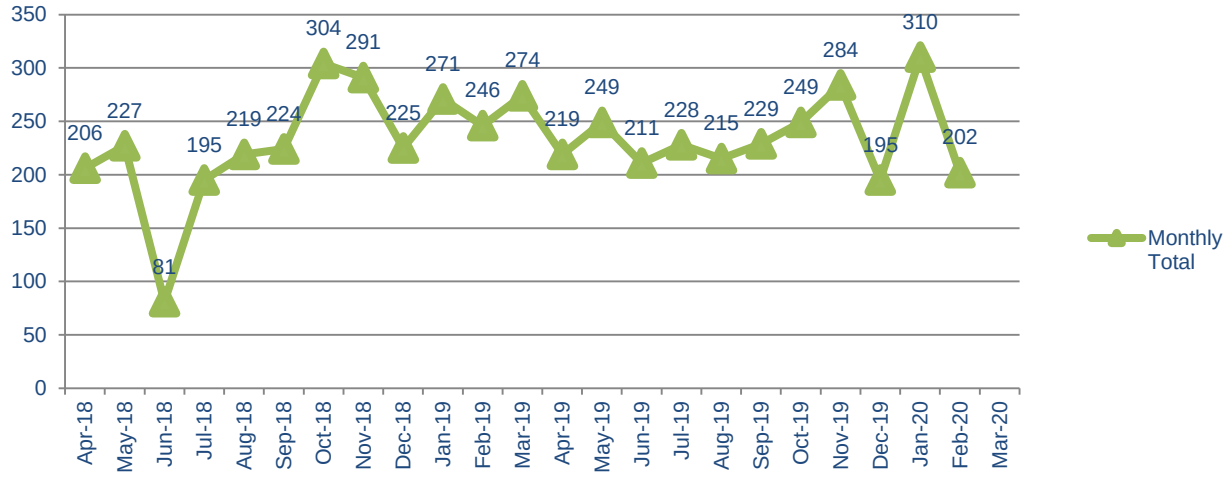
We have responded to **93%** of complaints in under 40 working days, which is a 29% increase from the previous year where we responded to 66% of complaints within this timescale. 28% of the response letters were sent out under 25 working days.

3.4.3 Carers

DCHS recognises that caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care. The Trust recognises the importance of supporting unpaid carers and has been instrumental in this support.

2,591 carers have come into contact with a health professional in the last year. Once a member of staff has identified someone using the service as a carer, there is an expectation that the member of staff records this information, engages with the patient, and if appropriate gives signposting information for local support and information. This is in line with the Ask, Record, Engage (A.R.E) first introduced in a targeted communications campaign in January 2018.

Graph 8: Total number of carers on SystmOne (monthly) 2018-2020



3.4.4 Healthwatch

We continue to work in Partnership with both Healthwatch Derbyshire and Healthwatch Derby. Areas of partnership successes over the past year include a mystery shop exercise; we worked with Healthwatch Derbyshire to facilitate this. This was developed as a direct response to feedback from the Good Health Learning Disability Group that patients who have learning disabilities might not be receiving the same quality of experience as the rest of our patients when accessing phlebotomy services in Ripley Hospital. Two Healthwatch Derbyshire Learning Disabilities (LD) representatives conducted the mystery shop and provided a comprehensive report. We continue to support work on the action plan with the services involved.

3.4.5 Learning Disability Improvement Standards for NHS Trusts

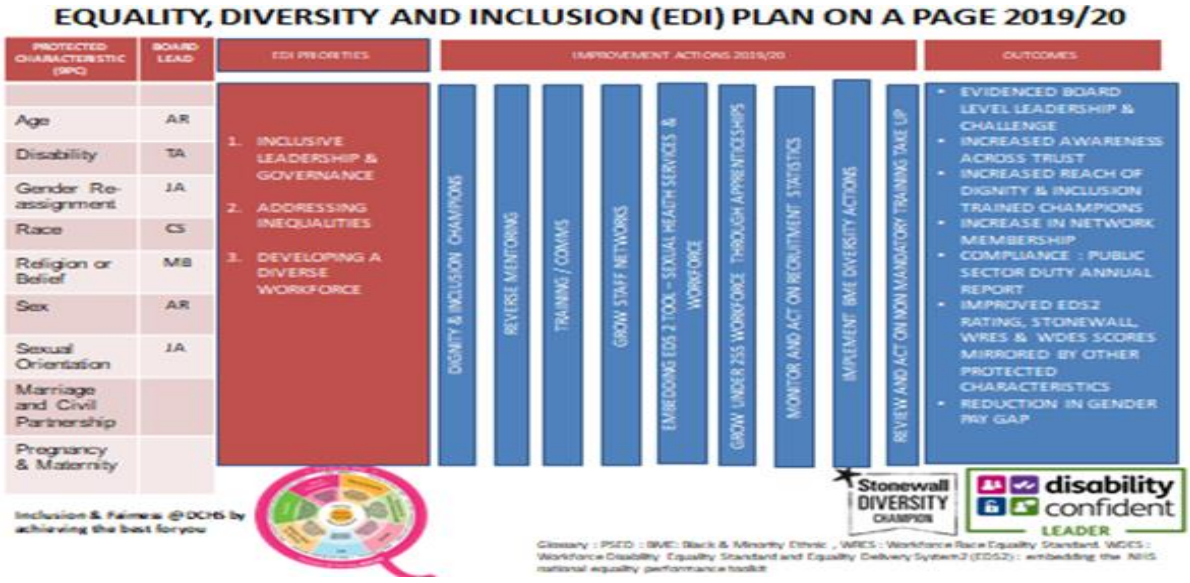
The Learning Disability Improvement Standards (NHSE 2018) – The Learning Disability & Autism improvement standards for NHS trusts were introduced in 2018. We are taking an organisation-wide approach, as well as specifically looking at specialist learning disability services, to evidence that

care is best provided closer to home for people living with learning disabilities and autism. An organisational audit measured compliance against these standards and identified specific areas where improvement and development is required. A task group is overseeing the implementation of these improvements and is seeking assurance that the standards are consistently embedded in the Trust.

The Trust participated in the NHSE national benchmarking for learning disabilities which comprised a comprehensive data return including staff and patient surveys. DCHS will utilise these findings to further measure and improve our provision of care to patients with a learning disability and autism who use our services.

3.4.6 Equality, Diversity and Inclusivity

One of DCHS' strategic aims is to be a 'positively inclusive' service provider and employer so everyone could be the best that they can possibly be. To achieve this, our top three EDI priorities for the 2019/2020 reporting period are encapsulated in our Equality Plan on a Page 2019/2020 (*pictured below*) as well as our People Strategy 2018-2020 respectively.



Progress being made across the nine strands of our Equality Plan on a Page is regularly reviewed, and some of our wide-ranging EDI milestones and achievements in 2019/2020 are outlined below:

The Care Quality Commission rated DCHS overall as outstanding following an inspection in July 2019 and the CQC report published 12 September 2019 (https://www.cqc.org.uk/provider/RY8/reports) commented on our commitment to equality, diversity and inclusion.
We have effective EDI governance and assurance frameworks, which involve Equality Diversity and Inclusion Leadership Forum (EDILF) that convenes bi-monthly meetings.

We also have an Equalities Board that sets the strategic direction for equality, diversity and inclusion at DCHS and it comprises of the Trust's Chair, Chief and Deputy Chief Executive to name a few, and meets quarterly.

At the end of 2019, DHCS had circa 120 Quality and Safe Care Champions for Dignity and Inclusion, otherwise known as Dignity and Inclusion Champions, across the Trust, for whom equalities training was provided on 8 August 2019 and 6 February 2020 with further training planned for the future, and we are still seeking more colleagues to sign up to become Champions.

EDI features at every corporate induction programme. On 2 December 2019, equality impact analysis training was delivered to the Quality Team to increase their understanding of:

- when and how to complete an Equality Impact Assessment when undertaking a policy review;
- the implications of the "Has an Equality Impact Assessment been completed?" section of Board committees and formal groups' report template and
- how often to formally review equality and diversity information with patients.

Our EDI Team's work programme includes improving equality data and diversity monitoring information to build an accurate picture of the diversity of the Trust's patients/service users' profile and workforce respectively.

DCHS successfully piloted a Reverse Mentoring Programme to foster inclusive leadership and enable better understanding of the lived work experiences of our workforce's protected groups. Cohort 1 concluded with an evaluation of the programme on 19th September 2019 followed by a celebration event on 4 February 2020. Plans in place to launch the next cohort.

Picture taken at DCHS' reverse mentoring programme's cohort 1 celebration event on 4 Feb 2020

DCHS is compliant with the NHS Standard Contract in respect of the implementation of the NHS Equality Delivery System (EDS), NHS Workforce Race Equality Standard (WRES) and NHS Workforce Disability Equality Standard (WDES) respectively. We undertook EDS self-assessment and grading of one of our services, Integrated Sexual Health Service, as well as the Trust's

workforce. We also developed WDES and WRES improvement action plans to close or narrow any disproportionate gap highlighted from our workforce's equality data.

We are also compliant with the Equality Act 2010 in respect of Gender Pay Gap (GPG) reporting. Our 2019/2020 GPG report for data as of 31 March 2019 is accessible via http://www.dchs.nhs.uk/assets/public/Equality/DCHS-Gender-Pay-Gap-Report-2019-2020-Data-Extract-As-Of-31-March-2019.pdf as well as the GPG website via https://gender-pay-gap.service.gov.uk/.

The latest instalment of our Public Sector Equality Duty annual report was received significant assurance by EDILF on 31 January 2020. It would be duly published on our public-facing website after the Trust Board's approval.

DCHS also has **a multi-faith Chaplaincy Service** comprising a network of volunteer chaplains serving localities in Derby and Derbyshire. This service offers pastoral care to people, including DCHS patients, of all faiths and none. There are strong links with Derby Multi-Faith Centre. Further details about the service are on the Trust's public-facing website, http://www.dchs.nhs.uk/home/our-services/find_services_by_topic/chaplaincy/.

Numerous colleagues participated in three faith tours for which the itinerary comprised guided tours to a Hindu Temple, Mosque, Gurdwara and Church in Derby on 29 April, 22 July and 14 October 2019 respectively. In July 2019, DCHS **developed a** Spirituality and Faith Framework approved by o**ur Equality, Diversity and Inclusion Leadership Forum (**EDILF).
It is publicly accessible via http://www.dchs.nhs.uk/assets/Our-Services/Services-By-Topic/dchs_framework_for_spirituality_and_faith_2.pdf.

In September 2019, DCHS topped the Silver Employer Recognition Scheme (ERS) Award received in November 2018 with Gold in recognition of our support of the Armed Forces Community through armed forces-friendly policies and practices. The award was presented during the ERS Gold Award ceremony at the National Army Museum in London on 12 November 2019.

In 2019, we participated in three local Pride events, with our EDI Team setting up stalls at the Chesterfield Pride on 21 July, Belper Pride on 3 August and Derby Pride on 7 September. DCHS moved up to 254 (rise of 26 points) on the Stonewall Workplace Equality Index 2020 after submitting the latest application on 9 September 2019. This is an achievement given the additional requirements and upsurge in the number of Stonewall applications to 502 in 2019 from 445 organisations in 2018 when we ranked 280. On 24 February 2020, our EDI Team convened a feedback meeting with internal stakeholders and Stonewall's Client Manager, with a view to securing improvement with future submission.

DCHS is participating in the NHS Rainbow Badge Initiative, which gives colleagues a way to visibly show that we offer open, non-judgemental and inclusive care for people (patients/service users,

their families and colleagues) who identify as LGBT+. Colleagues are asked to sign a pledge prior to being issued with a rainbow badge.

DCHS led the initiation and development of system-wide EDI work stream with local partner organisations under the auspices of Joined Up Care Derbyshire, also known as Derbyshire's Sustainability and Transformation Partnership, which brings together health and social care organisations. DCHS met with system partners on 27 November and 14 January 2020, with future meetings planned.

Our Staff Networks are pivotal to embedding equality, diversity and inclusion as well as driving DCHS' equality performance. Currently, we have three active networks:
Black, Asian and Minority Ethnicity Staff Network,
Disability & Long-Term Conditions Staff Network and
LGBT+ Staff Network

Membership of these networks is growing in an attempt to foster an inclusive workplace where people can be themselves, thrive and progress. Additionally, colleagues are welcome to join any of the networks as an 'ally' even if they do not have the protected characteristics associated with any of them. Each network has an Executive sponsor, who featured in vlogs to talk about a variety of EDI issues. Some of DCHS' EDI videos are accessible via:

- https://youtu.be/tEJA9N5Aa5o
- http://www.dchs.nhs.uk/home/about/equalityand_diversity/videos
- https://youtu.be/AO-8f8c6FLM
- https://youtu.be/96tSZ2tJ610
- https://youtu.be/RROXfAvPZTw
- https://youtu.be/tgz1l4tYZEI?list=PLjqlD5DO3gsI3HXsVR4KA6D_Pl7abP4Rd.

We are committed to consistently delivering person-centred care, being a great place to work and a place where everyone feels safe to speak up and raise concerns on various issues, including equality, diversity and inclusion. Our EDI Team partners with the Freedom To Speak up Guardian (FTSUG) to ensure that the Raising Concern Feedback Form is used to capture equality data whenever colleagues raise concerns. This is intended to improve accessibility to and use of the Trust's Raising Concerns process by all staff groups, ensure that reports on raising concerns are disaggregated by demographics and to identify as well as close or narrow any disproportionate gap. In October 2018, a series of animation videos, one of which focuses on raising concerns about diversity, was created to promote the Trust's Freedom to Speak Up campaign.

Throughout the Freedom Speak up month in February 2020, DCHS promoted its new FTSUG through visits to numerous sites for introductory meetings, for colleagues to find out more about ways to raise concerns and talk about concerns or agree separate meeting times.

3.4.7 Pastoral care

We recognise the importance of meeting people's spiritual and pastoral needs as part of our holistic care of patients. We continue to 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.

During 2019/20 the chaplaincy service has worked with our trainers and end of life champions to enhance the training we offer staff about their spirituality and meeting the spiritual needs of their patients. The Trust developed a Framework for Spirituality and Faith, and identified the Chief Nurse as the Executive Champion for Spirituality and Faith.

Patient Story: Chaplaincy – Rev Anita Matthews and Caroline Carr

Caroline Carr, Volunteer Chaplain visited a lady that required support after losing her husband some months before. The couple had been married for a long time and shared lots of time with each other especially after her husband retired. Her husband's death came very quickly without a great deal of warning or ill health previously, so this was a real devastating blow to her.

She does have family and they have been a huge support to her but following our discussion she said she felt a huge benefit from spending this hour and a half with me. I guess because she could off load easier to me as I had had no emotional connection to her husband or family. I offered to see her again if she would like to but she declined saying she had really felt very much better emotionally after our chat. So I left leaving my card should she wish to contact me in the future.

Some weeks later I met her again as I happened to be volunteering in my fire service Chaplain Role, she came to me and was very affirming of my visit with her. She said she was sleeping better and really engaging in life's activities again. Then her daughter joined us and said a huge

thank you to me for helping her mum through a difficult time and felt her mum was coping so much better.

A second lady I visit is an end of life lady. She and her husband require spiritual support as they no longer have a Church fellowship to belong to. I sadly saw this lady deteriorating but she and husband value the time we share together. I have visited her during her stay in hospital. I have had the privilege of taking Holy Communion to them, and praying with them and helping her by listening as she engages in end of life conversations based around faith.

These are two different stories of my role as a DCHS Chaplain one about the secular role of supporting in our community and the other being able to provide spiritual support to those who most needed it. Both are of equal value visits to undertake and I feel very privileged to serve as a Chaplain in this way.

3.4.8 Minor injuries 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 four hour waits Ⓐ

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
2019/20	100	100	99.9	99.9	99.9	99.9	99.8	99.9	100	99.8	99.9	99.9	99.9
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

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.

Comparative data A&E four 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	National average	Highest	Lowest
2019/20	100%	Joint 1st	174	99.1%	73 trusts	King's College Hospital NHS Foundation Trust
2018/19	100%	Joint 1st	235	86.6%	50 trusts	Norfolk And Norwich University Hospitals NHS Foundation Trust
2017/18	100%	Joint 1st	238	85.0%	58 trusts	Princess Alexandra Hospital NHS Foundation Trust
2016/17	100%	Joint 1st	241	99.9%	56 trusts	Princess Alexandra Hospital NHS Foundation Trust
2015/16	100%	Joint 1st	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
The Trust uses the following criteria for measuring the indicator for inclusion in the quality report: The indicator is expressed as the percentage of unplanned attendances at minor injuries units (whether admitted or not) in the year ended 31 March 2020 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.

3.4.9 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%													
2019/20	95.9	95.8	95.3	95.1	94.8	94.1	Change in service provider						95.1
2018/19 (A)	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 (A)	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
RTT waits - admitted patients seen within 18 weeks - 90% (target) (%)													
2019/20	80	100	100	100	100	100	Change in service provider						96.6
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
RTT waits - non admitted patients seen within 18 weeks - 95% (target) (%)													
2019/20	86.2	91.2	88.8	88.8	89.4	87.4	89.9	Change in service provider					88.8
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 (A)	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

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 **Criteria for percentage of non-admitted seen within 18 weeks at the end of the reporting period**
These services have now transferred from DCHS. For data completeness we have included the figures to October / November when the services moved. We will no longer be reporting on these figures.

3.4.10 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 DToCs 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
2019/20 3.5%	1.9	3.4	7.1	3.9	7.0	4.9	4.8	5.9	1.6	5.4	5.0	4.4	4.6
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
2019/20	2.7%	3.2%	11.3%	7.6%	9.9%	4.9%	5.9%	2.4%	0.0%	0.0%	0.0%	0.0%	4.2%
2018/19	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 2019/20 for the year in totality, working with partners across Derbyshire we have made further significant improvements and are currently one of the leading health economies for DToC in England.

During 2018/19 we introduced statistical process control analysis to better analyse and understand our position and in tandem with real time reports to key stakeholders we achieved the 3.5% target in March 2019 and this position has continued into early 2019/20. This improvement has been achieved against a backdrop of reduced bed capacity which has amplified the impact of any patients in delay across our inpatient setting.

Table 36: DToC: OPMH (NHS delays only)

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2019/20	2.7%	3.2%	11.3%	7.6%	9.9%	4.9%	5.2%	2.4%	0.0%	0.0%	0.0%	0.0%	4.1%
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%

Data Source Systm1 PAS

Table 37: DToC Inpatients (NHS delays only)

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2019/20	1.8	3.1	5.4	2.6	5.8	4.0	3.9	5.3	0.6	5.7	4.7	4.7	4.0
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%

Table 38: DToC: OPMH and inpatients (NHS delays only) line 36

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2019/20	1.9	3.1	6.5	3.5	6.6	4.2	4.1	4.8	0.5	4.8	3.9	3.8	4.0
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%

Data Source Systm1 PAS

Criteria for Delayed Transfers of Care (DToCs)

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

- A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed
- A patient is ready for discharge / transfer when: 1) a clinical decision has been made that the patient is ready for transfer and 2) a multi-disciplinary team decision has been made that the patient is ready for transfer and 3) a decision has been made that the patient is safe to transfer
- The numerator is the number of delayed bed days for acute and non-acute patients whose transfer of care was delayed in the month
- The denominator is the total number of occupied bed days in the month.

3.5 Staff Experience - Ensuring our services are well led

3.5.1 Quality Conversations

DCHS has led on a new health coaching approach for the Derby and Derbyshire Sustainability and Transformation Partnership's (STP). During 2019/20 we trained over 400 staff from DCHS and other partner agencies developing their skills and confidence in using a health coaching approach with patients to help them to take control of their health and wellbeing. Due to success of this pilot work we now have a network of staff able to drive forward this work into their teams and will be commencing a programme of over 70 more Quality Conversations training course in 2020/21.

3.5.2 Allied Health Professions (AHPs)

DCHS employs over 600 Allied Health Professionals, each registered with the Health and Care Professions Council (HCPC). The AHPs employed within DCHS are: physiotherapists, occupational therapists, podiatrists, speech and language therapists and paramedics (operating department practitioners until November 2019).

In line with the recommendations of 'Leadership of allied health professions in trusts: what exists and what matters' (NHS Improvement, June 2018) https://improvement.nhs.uk DCHS has a senior leader with strategic focus. The Assistant Director for AHPs, reports directly to the Chief Nurse, to ensure the Trust Board is informed about the AHP workforce and its contribution to the current and future challenges in the Trust. She has spent time this year with AHP colleagues providing guidance and coaching on career and professional development in line with 'Developing AHP Leaders' from NHS Improvement October 2019. https://improvement.nhs.uk/developing leaders

In May 2019, the Trust launched its first AHP Vision which outlines the direction and priorities for the five professions. The Vision was co-produced by around 100 colleagues across the Trust (see appendix 4). Priorities for immediate focus include: career pathways and learning opportunities, joined up patient pathways, enabling patients to manage their own health, promoting the unique offer of each profession and use of technology to improve efficiency and effectiveness.

DCHS AHPs promoted their roles and contribution to the health and care of Derbyshire people on 14th October 2019 – which was the second ever national AHPs Day. Each of our board members spent time with a different AHP service.

In May 2019, the Derbyshire AHP Council was set up and enables the AHP workforce (14 professions) to support a workforce of over 1500 AHPs to make its full contribution within the Joined Up Care Derbyshire system. The Assistant Director of AHPs is Chair of the Council and sits on the Midlands and East of England Regional AHP Council, representing Derbyshire. This provides the DCHS AHP workforce with access to the latest policy and provides a voice nationally on AHP related issues.

The Speech and Language Therapy (SLT) Care Homes training package included in the NHSE Commissioning "Quick Guide: Allied Health Professions enhancing Health in care homes" is a joint

publication with NHS Improvement and AHPs and is a supporting publication for the AHPs into Action programme. The document supports AHPs and service leaders to meet the priorities and ambitions for care home residents detailed in the NHS long term plan. The NHS long term plan details 4 strategic priorities for community health services, one of which was the roll out of the Enhancing Health in Care Homes Framework.

3.5.3 Outpatient Physiotherapy and MSK Services – Workforce Development

Effective management of musculoskeletal (MSK) conditions is one of the key priorities of the Derbyshire healthcare system. Physiotherapists with advanced skills can manage many musculoskeletal conditions, preventing patients from needing to see a GP or consultant. Advanced Physiotherapy Practitioners can also work in First Contact Practitioner (FCP) roles to assess patients who would otherwise present to the GP. This provides patients with direct access to a specialist in MSK conditions and GP time is released to focus on other patients.

In order to upskill the physiotherapy workforce to work in these advanced practice roles the service mapped the existing outpatient MSK workforce against national competency frameworks and secured funding from Health Education England to procure MSc level training packages. Working with Sheffield Hallam University a package of training was co-designed to include diagnostic imaging, injections and prescribing. Additional Personalised Care training was delivered to support physiotherapists in having shared decision making conversations with patients.

This training has enabled outpatient physiotherapists to develop into advanced practice roles and has provided a defined career pathway within the service. Further advanced level training is planned for 2020.

3.5.4 Health Psychology Service

The Health Psychology Service has developed new roles to work with the impact of mental illness within physical health pathways. The service is providing dedicated Clinical Psychologist time to increase the confidence, knowledge and experience of front-line staff working with patients with complex co-morbidities in two of our integrated care systems to improve the healthcare offer and experienced for patients, staff and the system. The service also has posts working with our Sexual Health promotion team and linking into Derbyshire Public Health department to bring psychological knowledge and a behavioural science approach to service delivery design and patient care.

3.5.5 Clinical Supervision

We are 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.

We provide 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 and individual)	Individual and 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 three x one 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.

3.5.6 Raising concerns (Freedom to Speak Up)

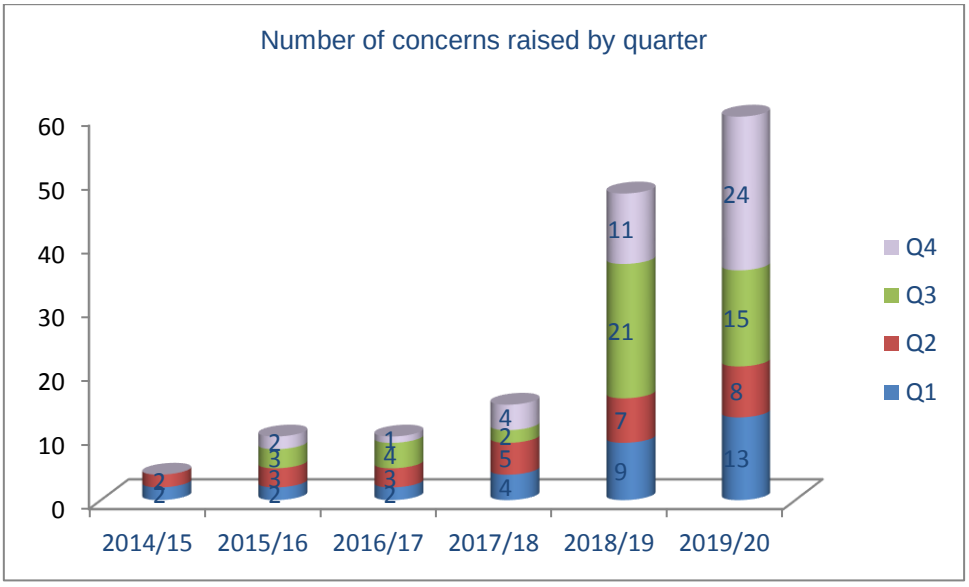
The Freedom to Speak up agenda has continued to develop during 2019/20.
The actions required from the National Guardian Office review in 2018 were fully implemented and along with a change of Freedom to Speak up Guardian in September 2019 was the opportunity to have defined hours dedicated to the role.
Promotional material has been updated and the Guardian has undertaken a series of site and service visits to publicise the role and support staff to have the confidence to raise concerns through the variety of routes available. This is reflected in the year on year increase of reported concerns through the Freedom to Speak up Guardian.

Raising Concerns activity undertaken during 2019/20

- Appointment of new FTSUG
- FTSUG has become a member of the DCHS Staff Forum
- Review of FTSU Executive Lead role with the transfer of this to the Chief Nurse
- Revision of Raising Concerns communication material
- Article in ‘Voice’ on new FTSUG
- Development of local FTSUG links across STP footprint
- Roll out of Raising Concerns - learning
- DCHS FTSU month - Feb 2020 (due to limited capacity of new FTSUG to support national FTSU month October 2019)
- Review of FTSU feedback form in line with NGO requirements
- Raising Concerns drop in sessions across DCHS sites
- FTSUG is an active member of the East Midlands regional network

- FTSUG regularly reviews national FTSU activity to identify and implement relevant learning to DCHS
- Initial consideration to the development of FTSU ambassador network to be further developed in 20/21.

Graph 9: Concerns raised by quarter 2014-2020



3.5.7 NHS Staff Survey

The 2019 NHS Staff Survey was conducted between Monday 23 September and Friday 29 November 2019. In total, 2586 DCHS employees completed the survey giving a response rate of 62.4%, compared to our response rate of 61% in 2018.

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 eleven 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 below in table 32.

Table 39: Benchmarking with community trusts

	2019/20		2018/18		2017/18	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity & inclusion	9.5	9.4	9.4	9.3	9.4	9.4
Health & wellbeing	6.3	6.0	6.2	5.9	6.3	6.3
Immediate managers	7.2	7.2	7	7	7	7
Morale	6.5	6.3	6.3	6.2	N/A	N/A
Quality of appraisals	5.8	5.8	5.6	5.6	5.7	5.7
Quality of care	7.7	7.4	7.6	7.3	7.6	7.6
Safe environment – bullying & harassment	8.6	8.4	8.5	8.4	8.6	8.6
Safe environment – violence	9.6	9.7	9.6	9.7	9.6	9.6
Safety culture	7.2	7.0	7.1	7	7	7
Staff Engagement	7.3	7.2	7.2	7.1	7.2	7.2
Team Working	6.9	7.0	6.9	6.9	6.9	6.8

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 focussed on the following areas 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.

Upon publication and analysis of the 2019 NHS Staff Survey results, all focus areas for improvement during 2020 are to be put on hold during the COVID-19 pandemic.

3.5.8 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.

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

In additional 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.

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.

3.5.9 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.

Now into its second year, #DCHSTTT – thank you, time and tea party - reward and recognition scheme continues. Hosted by the Board, in 2019, we held 9 parties to celebrate and thank staff by inviting them to take some time out and enjoy tea and cakes with colleagues and friends. Nominees are 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 held again our 'Seasonal Stars' festive initiative leading up to Christmas. This feel good campaign began in 2018 and is sponsored in part by Thornton's. In 2019, we recognised over 200 colleagues. Where we were able to, they were featured on our social media channels throughout December.

The Extra Mile Awards has become an established event in our calendar. In 2019, we held our sixth awards ceremony that seeks to recognise those who inspire others and deliver beyond expectations.
We received a record breaking amount of nominations this year, with over 400!

3.5.10 Staff wellbeing

The Staff Wellbeing Strategy has now been implemented with key highlights for 2019/20 including:

- Achieving the staff flu CQUIN with over 80% of trust staff receiving their vaccination. Through our 'jab for a jab' partnership with UNICEF this also means the trust has sponsored over 10,000 life-saving vaccines in the developing world too.
- The launch of a comprehensive mental health support pathway including Wellness Action Plans, a mental health self-care app, phone line support, Resolve in-house counselling service and Clinical Psychologist input through Occupational Health.
- The creation of a new role dedicated to our Women's Health Project, researching and introducing support and interventions across a broad range of wellbeing challenges from menopause to fertility to maternity.
- The expansion of our training offering which now includes 12 months of pre-bookable sessions covering all aspects of individual wellbeing and tied to an annual planner of awareness days and monthly challenges.
- Launching a new team support referral process to offer bespoke support to teams from the full breadth of the Organisational Development service.
- Investing in our mediation provision to have 20 trained mediators which allows for earlier intervention.
- The expansion of the Resolve service to also provide counselling support for DHCFT staff, which increases capacity and safeguards the service for DCHS staff also.
- Launching the STP staff wellbeing project team to identify opportunities for collaborative working and resource sharing across the Derbyshire STP members.

Part 4 - Assurance Process

In order to assure ourselves that the information presented is accurate, and that the services described and the priorities for improvement are representative of DCHS, the Trust Board designated the Chief Nurse/Director of Quality to lead the process of developing the Quality Report for 2019/20. She has ensured that DCHS main stakeholders were given the opportunity to comment and provide an objective view around the content of this Quality Report and the goals it set itself for improvement for the coming year.

A copy of the draft Quality Report 2019/20 has been shared with the Council of Governors, Healthwatch (Derby and Derbyshire), Local Authority Overview and Scrutiny Committee and our Commissioners to ensure that the Quality Report presents a balanced view of the quality of care delivered by DCHS and their responses can be found in Annex 1.

All of the comments have been considered and changes have been made where appropriate. Consultation with staff, and Public Governors has taken place through DCHS committee structures including the Council of Governors, Governor Quality sub-group with the whole process being overseen by the Quality Service Committee.

Due to the COVID-19 pandemic, external assurance was not gained through external auditors, although the content of the quality report was matched against the requirements of NHSE/I published guidance 2019/20.

In addition, again due to the COVID-19 pandemic, the mandated indicators and the one indicator chosen by the Council of Governors have not been tested.

Annex 1 - Third Party Statements

To be included from Healthwatch Derby / Derbyshire / CCG / Oversight Scrutiny Committee

Annex 1 - Statement of Directors Responsibilities in Respect of the Quality Report

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 2019/20 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 2019 and up to the date of this statement
    - Papers relating to quality report reported to the Board over the period April 2019 to the date of this statement
    - Feedback from the commissioners dated ??
    - Feedback from governors dated ??
    - Feedback from local Healthwatch Derby and Derbyshire organisations dated ??
    - Feedback from Health Scrutiny Committee dated ??
    - The Trust's 2018/19 complaints report (presented to the Patient Experience Engagement Group on xx) and bi-monthly 2019/20 complaints reports to the Patient Experience and Engagement Group
    - The 2019 national GP patient survey, dated xxxx
    - The latest NHS Staff Survey 2019
    - The head of internal audit's annual opinion over the Trust's control environment, dated xxxx
    - Care Quality Commission inspection report, dated 2019
- 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
- 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

Annex 2 - Independent Auditors

Due to COVID-19 NHS Improvement issued an update to the Quality Accounts guidance to state that NHS providers are no longer expected to obtain assurance on their quality account / quality report for 2019/20. The requirement to produce the quality report remains.

Charlotte Wood
PwC | Senior Manager

Appendix 1 - 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.

	Prescribed information	Type of trust	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	**All trusts**	n/a	n/a	n/a

	Prescribed information	Type of trust	2017/18	2018/19	
	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.				
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**	82%	82.8%	85.5%
21.1	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). 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.	**Trusts providing relevant acute services**	97.8%	98.2%	98.4%
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**	99.9%	99.6%	99.7%
24	The rate per 100,000 bed days of cases of C difficile infection reported within the Trust amongst patients aged two 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**	10,018 9 0.08%	7,221 4 0.05%	7,171 0 0%

Appendix 2 - Frailty Strategy on a page

Appendix 3 - AHP Strategy

DCHS Vision Statements for *allied health professions*

NHS Derbyshire Community Health Services NHS Foundation Trust

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

People and communities access AHP support to improve their health and wellbeing.

AHPs and the people we serve are able to influence decisions about the future of our services to enable better outcomes for patient.

AHPs contributing to improving the experiences patients have of healthcare:

People are empowered to make informed choices about interventions offered by AHPs, and about 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' 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' 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.

The Allied Health Professions (AHPs) are the third largest workforce in the NHS:

DCHS employs 6 different disciplines of allied health professions:

AHPs work with colleagues across healthcare, social care, housing, education and independent and voluntary sectors within Derbyshire:

- Assess
- Diagnose
- Treat.

Through adopting a holistic approach to healthcare, AHPs are able to help manage people's care throughout their life course.

Their focus is on prevention and improvement of health and wellbeing to maximise the potential for individuals to live full and active lives within their family circles, social networks, education/training and the workplace.

The DCHS vision for AHPs highlights the current and future contribution and needs of the AHP workforce. It sets out these top priorities for improvement:

1. Develop clear career pathways and enable access to learning opportunities to attract and retain AHPs.
2. Join up patient pathways across the system to improve ease of access to AHP services .
3. Enable people who use AHP services to manage their own health and care better.
4. Describe clearly what is the unique offer of each profession (clinical care, sustanablity and public health approaches) to optimise impact.
5. Improve effectiveness and efficiency through the appropriate use of equipment and technology to benefit patients, staff and the system.

Glossary

AHPs	-	Allied Health Professions
AMaT	-	Audit Management and Tracking
BAF	-	Board Assurance Framework
BI	-	Business Intelligence
CAS	-	Central Alerting System
CAAS	-	Clinical Assessment and Accreditation Scheme
CCG	-	Clinical Commissioning Group
CET	-	Clinical Effectiveness Team
CSG	-	Clinical Safety Group
CQC	-	Care Quality Commission
CQUIN	-	Commissioning for Quality and Innovation
DQMI	-	Data Quality Maturity Index
DCHS	-	Derbyshire Community Health Services NHS Foundation Trust
EDR	-	Electronic Document Review
EoL	-	End of Life
ESR	-	Electronic Staff Record
GP	-	General Practice
HSE	-	Health and Safety Executive
IG	-	Information Governance
JUCD	-	Joined up Care Derbyshire
KPIs	-	Key Performance Indicators
LD	-	Learning Disabilities
LeDeR	-	Learning Disabilities Mortality Review
MCA	-	Mental Capacity Act
MIU	-	Minor Injury Unit
MoGP	-	Markers of Good Practice
MRG	-	Mortality Review Group
MRSA	-	Methicillin-resistant Staphylococcus aureus
NDCCG	-	North Derbyshire Clinical Commissioning Group
NACEL	-	National Audit of Care at the End of Life
NAIC	-	National Audit of Intermediate Care
NEWS2	-	National Early Warning Score (Revised)
NHS	-	National Health Service
NICE	-	National Institute for Health and Care Excellence
NIHR	-	National Institute for Health Research
NRLS	-	National Reporting and Learning Scheme
OPMH	-	Older People's Mental Health
PLACE	-	Patient-Led Assessment of the Care Environment
QA	-	Quality Always
QI	-	Quality Improvement
QBC	-	Quality Business Committee

QPC	-	Quality People Committee
QSC	-	Quality Service Committee
RCA	-	Root Cause Analysis
RTT	-	Referral to Treatment Times
SAAF	-	Safeguarding Adult Assurance Framework
SDCCG	-	Southern Derbyshire Clinical Commissioning Group
SLT	-	Speech and Language Therapy
SSNAP	-	Sentinel Stroke National Audit programme
STP	-	Sustainability and Transformation Partnership
UHDB	-	University Hospitals of Derby and Burton NHS Foundation Trust

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