Our Vision:

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

DCHS Clinical Strategy (2019/22)
Annual Quality Report 2019/20

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

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.

Derbyshire Community Health Services NHS Foundation Trust
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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 Derbyshire Community Health Services (DCHS) as “Outstanding” overall. You can read more about the inspection on Page 16.

But the year was extraordinary for another reason. It will be marked as the year the NHS 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. We rapidly implemented new ways of working, 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 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 on-going 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.

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 the NHS Long Term Plan and here at DCHS we have a role to play in supporting the delivery of the majority of priority areas identified within it, 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 (STP), 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 have undertaken during the year to improve the quality of the services we provide, to achieve our vision of being the best provider of sustainable local healthcare and be 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, (overleaf), that we have placed at the heart of our organisational strategy and vision.
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 and innovation.

During the year we have continued to embed our Quality Always Clinical Assessment and Accreditation Scheme. This scheme 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 World Union of Wound Healing Societies Awards for cost effective care with the winners to be announced in September 2020 (see page 39).

Other highlights of the year have included:

- We were identified as one of the ten trusts with the highest score in the Freedom to Speak Up index 2020 (page 72)
- 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 (page 54)
- We achieved an increased response rate in the NHS Staff Survey, 62.4%, compared to our response rate of 61% in 2018
- Within the Staff Friends and Family Test (FFT) 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 DCHS, placing us as the best Trust within that category when scores are measured against similar organisations
• Keeping our patients and staff safe 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 received the Gold Award in the Defence Employer Recognition Scheme (ERS)
• We scored higher than the CCG average in the GP Practice survey and showed significant improvement in the recognition and understanding of mental health needs (appendix 4).

This report reflects on our achievements and challenges in improving quality during 2019/20, where we have not always got things right and 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: 1st October 2020

Are we accessible to you? This publication is available on request in other formats (for example, large print, easy read, Braille or audio version) and languages. For free translation and/or other formats please call 01246 515224, or email us at: DCHST.communications@nhs.net.

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

Our vision

To be the best provider of sustainable local healthcare and 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: ‘everyone matters’

Our strategic priorities

- To embed a culture and practice of continuous service improvement across all areas of our Trust
- To recognise that we are entering a period of change, build upon our success of attracting, retaining and empowering people and developing leadership to embrace a culture of high support, strong performance and quality improvement
- To ensure that we continuously look for opportunities to improve value for money through innovation, transformation and elimination of unwarranted variation
- To take a leadership role in the Derbyshire health and care system, working with partners to maximise the system’s contribution to improving the experience of care, improving the health of the population and reducing the per capita cost of care

Each year 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 reports 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

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr 19</th>
<th>May 19</th>
<th>Jun 19</th>
<th>Jul 19</th>
<th>Aug 19</th>
<th>Sep 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>233</td>
<td>233</td>
<td>233</td>
<td>233</td>
<td>233</td>
<td>233</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Month</th>
<th>Oct 19</th>
<th>Nov 19</th>
<th>Dec 19</th>
<th>Jan 20</th>
<th>Feb 20</th>
<th>Mar 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>13%</td>
<td>26%</td>
<td>40%</td>
<td>55%</td>
<td>70%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Month</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
</table>
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

<table>
<thead>
<tr>
<th>Month</th>
<th>Baseline Q4</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services with a dementia champion</td>
<td>43</td>
<td>50</td>
<td>70</td>
<td>97</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services with a dementia friendly improvement action</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25</td>
<td>50</td>
<td>97</td>
</tr>
<tr>
<td>Services with a completed dementia friendly action</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

### Table 5: Achievement of Quality Big 3

<table>
<thead>
<tr>
<th>Quality Big 3</th>
<th>Objective</th>
<th>Priorities</th>
<th>Target</th>
<th>Achieved end Mar</th>
<th>Forecast year end</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Service</td>
<td>To deliver high quality and sustainable services that echo the values and aspirations of the community we serve</td>
<td>1. Improving the identification of sepsis and recognition of the deteriorating patient</td>
<td>(i) Roll out of pulse oximeters to all community teams by 30 September 2019 (ii) SystmOne baseline observations to be 80% by March 2020, starting October 2019 (iii) Clinical records audit to ensure appropriate response to NEWS2 score 5 and above</td>
<td>(100%) GREEN</td>
<td>(100%) GREEN</td>
</tr>
</tbody>
</table>

| | | | 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 |
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 3 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. physiotherapist or occupational therapist) to visit as part of the care plan then quite reasonably baseline observations are not done and therefore not recorded. 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. 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 submitted via the quality performance report quarterly to the Quality Service Committee (QSC) 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 friendly 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 the 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, conversations have taken place with staff, governors and Board members which have 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 avoidable 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 avoidable 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

<table>
<thead>
<tr>
<th>Needle stick Injuries 2019/20</th>
<th>Needle stick Injuries 2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>7</td>
</tr>
</tbody>
</table>

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 review 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 Derby and Derbyshire. 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 of 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 Derby and Derbyshire 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

<table>
<thead>
<tr>
<th>Month 2020/21</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly target for no. of patient records flagged</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>150</td>
<td>150</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Month 2020/21</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint files to be reviewed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Complaint files to be reviewed (cumulative)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
<td>18</td>
<td>21</td>
<td>24</td>
<td>27</td>
</tr>
</tbody>
</table>
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>
<thead>
<tr>
<th>Table 9: National audits and confidential enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL) 2018</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL) 2019</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
</tr>
<tr>
<td>UK Parkinson’s Audit: (incorporating Occupational Therapy Speech and Language Therapy (SLT), Physiotherapy, Elderly care and neurology)</td>
</tr>
<tr>
<td>National Asthma and COPD Audit Programme: Pulmonary Rehabilitation</td>
</tr>
<tr>
<td>National Falls and Fragility Fractures Audit</td>
</tr>
<tr>
<td>National Diabetes Foot Care Audit</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
</tr>
<tr>
<td>National cancer diagnosis audit</td>
</tr>
<tr>
<td>Core National Diabetes Audit – Adults</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>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.</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL) 2018</td>
<td>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.</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL) 2019</td>
<td>Report not available until 2020</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>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 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.</td>
</tr>
<tr>
<td>UK Parkinson's Audit: (incorporating Occupational Therapy, SLT, Physiotherapy Elderly care and neurology)</td>
<td>Report due to be published at the end of March 2020.</td>
</tr>
<tr>
<td>National Asthma and COPD Audit Programme: Pulmonary Rehabilitation</td>
<td>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.</td>
</tr>
<tr>
<td>National Falls and Fragility Fractures Audit</td>
<td>No patients in our inpatient area have had a fall resulting in a hip fracture since we joined the audit in April 2019</td>
</tr>
<tr>
<td>National Diabetes Foot Care Audit</td>
<td>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.</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>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.</td>
</tr>
<tr>
<td>Title</td>
<td>Actions</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>National cancer diagnosis audit</td>
<td>Report not yet available, date to be published unknown.</td>
</tr>
<tr>
<td>Core National Diabetes Audit—Adults</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 CQUIN 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>
<thead>
<tr>
<th>CQUIN Title</th>
<th>Summary Outline</th>
<th>Final Position</th>
</tr>
</thead>
<tbody>
<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>Indicator                                                                                                                             Q1 results</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lying and standing BP                                                                                                      1.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication and rationale                                                                                                   3.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mobility assessment and aid provision                                                                                      5.8%</td>
</tr>
</tbody>
</table>
| LOCAL - Personalised Goals for Patients with Venous Leg Ulcer             | Implementation of personalised goal setting for patients with venous leg ulcer across the DCHS wound clinic hubs (75% target for audit sample) | 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. |

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)

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

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**

Tracy Allen, Chief Executive on DCHS achieving outstanding:

“I am so proud of everyone who works here for helping us to achieve this fantastic result. It shows the commitment energy and effort all our staff put into their roles every day in ensuring we do the best we can for our patient and for each other.”
Table 14: CQC ratings - service

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health services for adults</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Community health sexual health services</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Community health services for children, young people and families</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Words for people with a learning disability or autism</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Community urgent care services</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Words for older people with mental health problems</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Community mental health services with learning disabilities or autism</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Community dental services</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Community health inpatient services</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

Last rated 12 September 2019
2.2.6 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

2.2.7 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:

2.2.8 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 overleaf.
### Table 15: Clinical coding

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

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.

### 2.2.9 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 or 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 patients who had received care from DCHS died. This comprised the following number of deaths which occurred in each quarter of the reporting period:
Table 16: Quarterly reporting of deaths

<table>
<thead>
<tr>
<th>Reporting Quarter 2019/20</th>
<th>Total number of deaths reported by DCHS via SystmOne</th>
<th>Number of deaths notifications received via the triggers to MRG</th>
<th>Number of death notifications received appropriate for full case note review by MRG following the IDR screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>1611</td>
<td>33</td>
<td>27</td>
</tr>
<tr>
<td>Q2</td>
<td>2059</td>
<td>21</td>
<td>14</td>
</tr>
<tr>
<td>Q3</td>
<td>1607</td>
<td>29</td>
<td>22</td>
</tr>
<tr>
<td>Q4</td>
<td>1822</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>7099</td>
<td>122</td>
<td>91</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case note reviews</td>
<td>7</td>
<td>7</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>Investigations</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Deaths</td>
<td>1611</td>
<td>2059</td>
<td>1607</td>
<td>1822</td>
</tr>
<tr>
<td>Number and (%) deaths judged to be more likely than not to have been due to problems in the care provided to the patient</td>
<td>3 (0.16)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>
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, root cause analysis (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 QSC.

**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, internal teams 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 19 below. For completeness the full set of core indicators can be found in appendix 1.

Table 19: Core indicators applicable to DCHS

<table>
<thead>
<tr>
<th>Prescribed information</th>
<th>Related NHS outcomes framework domain and who will report on them</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>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.</td>
<td>4: Ensuring that people have a positive experience of care</td>
<td>82%</td>
<td>82.8%</td>
</tr>
<tr>
<td></td>
<td><strong>Trusts providing relevant acute services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparative data taken from NHS England Staff Friends and Family Test website</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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%).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.1</td>
<td>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).</td>
<td>4: Ensuring that people have a positive experience of care</td>
<td>97.8%</td>
<td>98.2%</td>
</tr>
<tr>
<td></td>
<td><strong>Trusts providing relevant acute services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparative data taken from NHS England Friends and Family Test data website</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data for 2018/19 shows average of 97.8% of patients would recommend their local community services to friends and family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Prescribed information

<table>
<thead>
<tr>
<th>Prescribed information</th>
<th>Related NHS outcomes framework domain and who will report on them</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>5: Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>99.9%</td>
<td>99.6%</td>
<td>99.7%</td>
</tr>
</tbody>
</table>

**Trusts providing relevant acute services**

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.

<table>
<thead>
<tr>
<th>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.</th>
<th>All trusts 5: Treating and caring for people in a safe environment and protecting them from avoidable harm</th>
<th>Total - Patient safety incidents</th>
<th>10,018</th>
<th>7,221</th>
<th>7,171</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All trusts</td>
<td>Severe harm or death</td>
<td>9</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>% severe harm or death</td>
<td></td>
<td>0.08%</td>
<td>0.05%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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 and 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 20 below. Where possible we have included benchmarking information to show how we compare to other NHS organisations and comparative year on year performance.

### Table 20: Range of indicators

<table>
<thead>
<tr>
<th>Key performance indicator (KPI)</th>
<th>Primary data source</th>
<th>Data quality score</th>
<th>Target 19/20</th>
<th>Average monthly score 17/18</th>
<th>Average monthly score 18/19</th>
<th>Average monthly score 19/20</th>
<th>Year-end data</th>
<th>Benchmarked performance**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends and Family Test scores</td>
<td>Datix</td>
<td>14</td>
<td>98%</td>
<td>97.8%</td>
<td>98.3%</td>
<td>98.2%</td>
<td>98.2%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Complaints – number received</td>
<td>Datix</td>
<td>14</td>
<td>No target</td>
<td>13</td>
<td>11</td>
<td>10</td>
<td>122</td>
<td>-</td>
</tr>
<tr>
<td>Complaint cases completed within agreed timescale</td>
<td>Datix</td>
<td>14</td>
<td>80%</td>
<td>84%</td>
<td>66.4%</td>
<td>93%</td>
<td>93%</td>
<td>80%</td>
</tr>
<tr>
<td>Number of responses from Friends and Family Test</td>
<td>Datix</td>
<td>N/A</td>
<td>No target</td>
<td>2,428</td>
<td>2,231</td>
<td>1,792</td>
<td>22,540</td>
<td>-</td>
</tr>
<tr>
<td>Turnover %</td>
<td>ESR</td>
<td>12</td>
<td>14%</td>
<td>8.5%</td>
<td>8.9%</td>
<td>9%</td>
<td>9%</td>
<td>14.40%</td>
</tr>
<tr>
<td>Total sickness rate</td>
<td>ESR</td>
<td>12</td>
<td>4.5%</td>
<td>5.2%</td>
<td>4.9%</td>
<td>5%</td>
<td>5%</td>
<td>4.98%</td>
</tr>
<tr>
<td>Sickness long term</td>
<td>ESR</td>
<td>12</td>
<td>No target</td>
<td>3.2%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>-</td>
</tr>
<tr>
<td>Sickness short term</td>
<td>ESR</td>
<td>12</td>
<td>No target</td>
<td>2%</td>
<td>2%</td>
<td>2.6%</td>
<td>2.6%</td>
<td>-</td>
</tr>
<tr>
<td>Vacancy rate %</td>
<td>ESR</td>
<td>12</td>
<td>No target</td>
<td>5.6%</td>
<td>5.8%</td>
<td>5.1%</td>
<td>5.1%</td>
<td>-</td>
</tr>
<tr>
<td>Annual reviews (staff appraisals) carried out %</td>
<td>ESR</td>
<td>12</td>
<td>96%</td>
<td>87%</td>
<td>93.6%</td>
<td>91%</td>
<td>91%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Mandatory training</td>
<td>ESR</td>
<td>12</td>
<td>96%</td>
<td>89%</td>
<td>97.1%</td>
<td>98%</td>
<td>98%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Mandatory training - information governance %</td>
<td>ESR</td>
<td>12</td>
<td>96%</td>
<td>95%</td>
<td>95.9%</td>
<td>98%</td>
<td>98%</td>
<td>96%</td>
</tr>
<tr>
<td>Medication errors causing serious harm (no.)</td>
<td>Datix</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Never Events (no.)</td>
<td>Datix</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Key performance indicator (KPI)</td>
<td>Primary data source</td>
<td>Data quality score</td>
<td>Target 19/20</td>
<td>Average monthly score 17/18</td>
<td>Average monthly score 18/19</td>
<td>Average monthly score 19/20</td>
<td>Year-end data</td>
<td>Benchmarked performance**</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>--------------</td>
<td>------------------------------</td>
<td>------------------------------</td>
<td>------------------------------</td>
<td>--------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Pressure ulcers which meet SI criteria</td>
<td>Datix</td>
<td>14</td>
<td>0</td>
<td>n/a</td>
<td>3</td>
<td>1.9</td>
<td>23</td>
<td>34</td>
</tr>
<tr>
<td>Clostridium difficile incidence</td>
<td>Internal spread sheet</td>
<td>N/A</td>
<td>0</td>
<td>0.2</td>
<td>0.1</td>
<td>0.6</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>MRSA bacteraemia incidence</td>
<td>Internal spread sheet</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>STEIS serious incident reporting – open serious incidents</td>
<td>STEIS</td>
<td>14</td>
<td>No target</td>
<td>18</td>
<td>15.3</td>
<td>11</td>
<td>128</td>
<td>-</td>
</tr>
<tr>
<td>Older Peoples Mental Health (OPMH) delayed transfers of care - % attributable to the Trust</td>
<td>BI</td>
<td>14</td>
<td>3.5%</td>
<td>3.8%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Inpatients – delayed transfers of care</td>
<td>BI</td>
<td>14</td>
<td>3.5%</td>
<td>8%</td>
<td>5.5%</td>
<td>4.7%</td>
<td>4.7%</td>
<td>3.5%</td>
</tr>
<tr>
<td>OPMH and inpatients – delayed transfers of care</td>
<td>BI</td>
<td>14</td>
<td>3.5%</td>
<td>7.1%</td>
<td>5.3%</td>
<td>4.6%</td>
<td>4.6%</td>
<td>3.5%</td>
</tr>
<tr>
<td>AandE 4 hour wait for AandE attendances (%) (MIUs)</td>
<td>BI</td>
<td>16</td>
<td>95%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>95%</td>
</tr>
<tr>
<td>RTT waits - admitted patients seen within 18 weeks - (2a) (%)</td>
<td>SystmOne</td>
<td>16</td>
<td>No target</td>
<td>95%</td>
<td>86.1%</td>
<td>100% at Q3</td>
<td>n/a</td>
<td>Services moved provider</td>
</tr>
<tr>
<td>RTT waits - non admitted patients seen within 18 weeks - 95% (target) (1B)</td>
<td>SystmOne</td>
<td>16</td>
<td>95%</td>
<td>93.4%</td>
<td>91.1%</td>
<td>90% at Q3</td>
<td>n/a</td>
<td>Services moved provider</td>
</tr>
<tr>
<td>RTT waits - incomplete pathway - 92% (target) (2) (%)</td>
<td>SystmOne</td>
<td>16</td>
<td>92%</td>
<td>95%</td>
<td>95%</td>
<td>95% at Q3</td>
<td>n/a</td>
<td>Services moved provider</td>
</tr>
<tr>
<td>Minimising mental health delayed transfers of care</td>
<td>BI</td>
<td>16</td>
<td>3.5%</td>
<td>3.8%</td>
<td>5.6%</td>
<td>4.6%</td>
<td>4.6%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Mental health data completeness: identifiers</td>
<td>SystmOne</td>
<td>16</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>Replaced with DQMI</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Certification against compliance with requirements regarding access to health care for people with a learning disability</td>
<td>EDILF report</td>
<td>n/a</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Data completeness: community services - referral to treatment information</td>
<td>CIDS</td>
<td>16</td>
<td>95%</td>
<td>97%</td>
<td>100%</td>
<td>Replaced with DQMI</td>
<td>n/a</td>
<td>95%</td>
</tr>
</tbody>
</table>
The data quality maturity index (DQMI) 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, SystmOne is not complete and therefore not a true representation of DCHS activity currently. Work is underway to resolve this. 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 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.
Mechanisms for receiving assurance on quality of services

- **DCHS Quality Improvement and Assurance Framework**
  Quality improvement is the driving force behind the work of DCHS 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 curious and compassionate culture is a core element of the DCHS QI ambition. This will ensure that learning is shared 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.

In 2019/20 a total of 109 CAAS assessments were conducted throughout DCHS 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 there were 14 triangulation events across the organisation.
A QA dashboard continues to be developed to provide detailed assurance information across the Trust. This enables us to analyse the themes and trends collated through clinical assessment to inform quality and operational teams of areas of particular good practice or areas needing specific attention for growth and development.

During the year a number of table top reviews have been undertaken for teams who have been in an 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 of 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 is a network of Quality and Safe Care Champions (QSCC) across the organisation. There are currently 1,35 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 1,235 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 management, safeguarding, tissue viability and lifestyle.

- **Leader Back to the Floor Visits**
Back to the floor visits provide leaders, including our executives, across the organisation with dedicated time to work with teams to observe and share best practice. They also help to 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.

- **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.
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 are 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 on 31st March 2019 but DCHS has continued to stay committed to the 5 pledges of:

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Putting safety first</td>
<td>Continually learning</td>
<td>Being honest</td>
<td>Collaborative</td>
<td>Being supportive</td>
</tr>
</tbody>
</table>

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 the 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 trends or a 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 and 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 (table 22).

To ensure qualitative management is maintained and 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 – QSC, Quality Business and Quality People Committee (QBC and QPC). In addition, executives are expected to review their allocated risks with their teams prior to the Board reporting.
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 and 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 and accurate further control planning and 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 and Assurance Committee is the body responsible for risk assurance in DCHS.

Risk strategy and 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, well managed platform to promote and 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 and departments who carry out and 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 1,400 staff in 2018/19. A further 1,400 pulse oximeters have been provided to staff in 2019 to complement the existing kit bags. This will help to 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. This is through an established coding system (with NRLS guidance) set up within Datix and administered by the patient safety team. Incidents shared at this national level are pertinent in determining national trends and promoting national improvements.

During the period 1 April 2019 to 31 March 2020, there have been a total of 7,171 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.

Table 23: Patient safety incidents on Datix

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In holding area, awaiting review</td>
<td>92</td>
<td>109</td>
<td>194</td>
</tr>
<tr>
<td>Being reviewed</td>
<td>27</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Awaiting final approval</td>
<td>61</td>
<td>46</td>
<td>43</td>
</tr>
</tbody>
</table>

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)

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

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 incorporated 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 lesson learnt from the investigation was 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>
<thead>
<tr>
<th>Table 25: The top five reported incidents and trends over the past three years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2017/18</strong></td>
</tr>
<tr>
<td>Pressure relief care</td>
</tr>
<tr>
<td>Slips, trips and falls (patient)</td>
</tr>
<tr>
<td>Medication</td>
</tr>
<tr>
<td>Discharge problem</td>
</tr>
<tr>
<td>Safeguarding adults</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
</tr>
</tbody>
</table>

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 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

<table>
<thead>
<tr>
<th>Category</th>
<th>STEIS incidents 2017/18</th>
<th>Category</th>
<th>STEIS incidents 2018/19</th>
<th>Category</th>
<th>STEIS incidents 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcers</td>
<td>62</td>
<td>Pressure ulcers</td>
<td>51</td>
<td>Pressure ulcers</td>
<td>20</td>
</tr>
<tr>
<td>Slips, trips and falls</td>
<td>4</td>
<td>Slips, trips and falls</td>
<td>14</td>
<td>Slips, trips and falls</td>
<td>7</td>
</tr>
<tr>
<td>Medication</td>
<td>2</td>
<td>Treatment / diagnosis delay</td>
<td>2</td>
<td>MRG identified sub-optimal care</td>
<td>4</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>1</td>
<td>Medication</td>
<td>1</td>
<td>Sub-optimal care</td>
<td>2</td>
</tr>
<tr>
<td>Sub-optimal care</td>
<td>1</td>
<td>Sub-optimal care</td>
<td>1</td>
<td>Treatment / diagnosis delay</td>
<td>1</td>
</tr>
<tr>
<td>Pending review</td>
<td>0</td>
<td>Surgical / invasive procedure</td>
<td>1</td>
<td>Medical equipment – devices</td>
<td>1 Never Event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical equipment – devices</td>
<td></td>
<td>Wrong site surgery</td>
<td>1 Never Event</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>70</strong></td>
<td></td>
<td></td>
<td><strong>71</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

### 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 HF 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 HF’s 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’, DCHS 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 or where serious harm has occurred. During the reporting period 2019/20, 36 incidents met 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 2019/20 the Trust has continued the shift to Safety II by:

- **3I Dialogue** (Included / Involved / Inspired: 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 conference in Derbyshire 2019
- **Shout Out** has continued to gain strength and informs the Lessons Learnt panel to allow the Trust to learn from excellence. During 2019/20 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 and 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 and 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 times 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 World 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 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 remain a high priority for us. 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 only 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 requirements. We have identified challenges within the pathway 2 strategy for plus size and bariatric patients and are working with Derbyshire County Council (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 and safety, occupational health and staff some environmental issues have been addressed and have identified equipment that may help reduce musculoskeletal (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 and 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 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 were completed in accordance with policy and 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
- Independent survey assessments have been carried out in full by an external organisation on all anti-ligature device fittings, and we have responded swiftly to findings, requirements and remediation where necessary
- Review and assessment of all rooms where anti-ligature device re fits are required for Walton Hospital and Ash Green have been completed ahead of schedule.

DCHS continues to maintain a high standard of on-site ligature risk assessment and anti-ligature device management, awareness and 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 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, seclusion along with aggressive and violent behaviour towards staff policy
- Liaise with the operational service line manager for OPMH regarding any updates that will be required for the work previously undertaken
- Confirm if the policy is up to date, with the inclusion of de-escalation techniques, triggers, staff patient relationships for LD / vulnerable patients, updating if required
- Confirm how restraints are recorded either via local logs or Datix
- Work with service to ensure care plans and their implementation is in line with local policy.

3.1.21 Clinical documentation
During 2019/20 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.

417 documents were reviewed during 2019/20 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 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. We are working with the communications and engagement team to ensure the intranet page MyDCHS does not promote any literature which has not undergone a comprehensive governance process. Another strand of work is exploring a different platform to use instead of SharePoint to improve access and search of documents for staff, reducing the length of documents in use and 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 who seek to protect children, young people and adults through training, supervision and advice by working with DCHS staff and partner agencies.

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 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 proactive, reactive 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 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 24th 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 19th 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 27th February 2020. The site visit was planned for the 31st March 2020.

**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, see graph 4. 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 see graph 5.

Graph 5: Safeguarding children supervision compliance

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. The model of supervision will be reviewed during 2020/21 to identify a plan of improvement.

**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**

<table>
<thead>
<tr>
<th>Safeguarding training compliance</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>98.1%</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>92.6%</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>98.1%</td>
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<td>Safeguarding children level 2</td>
<td>92.2%</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>90.5%</td>
</tr>
<tr>
<td>Safeguarding children level 3a</td>
<td>90.5%</td>
</tr>
<tr>
<td><strong>Prevent training compliance</strong></td>
<td></td>
</tr>
<tr>
<td>WRAP training (clinical staff level 2 and above)</td>
<td>98%</td>
</tr>
<tr>
<td>BPAT training (non-clinical staff level 1)</td>
<td>96.2%</td>
</tr>
</tbody>
</table>

**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, innovation capacity and capability
- Promoting and embedding a culture of research and innovation to improve the quality of care in service delivery, 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 (EbE) 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
National Institute for Care and Excellence (NICE) 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.

The JUCD 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 work stream 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 2) 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 overarching 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.

At the 2019 Extra Mile Awards the Chairman’s Award was presented by Prem Singh, not just to a team from DCHS but to a range of organisations that came together to provide Imogen the care she wanted at the end of her life. They worked expertly together effectively, across disciplines, geographies and organisational boundaries.
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. This will help to improve the healthcare offer and experience for patients, staff and the system. The service also has posts working with our Sexual Health promotion team and linking into the 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.

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%), see graph 6.

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.
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 are with 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 process 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. The patients were given this information on day 2 or 3 post surgery. At this point they will have just got home from hospital and will have been suffering with an increase in pain, reduced mobility and feeling vulnerable. From this feedback provided by a patient we discussed we should also at this point be advising patients that by day 10 they should be more mobile 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 their complaint and they were thankful to the service that their complaint had been listened to and acted upon.

3.3.5 Patient Led Assessments of the Care Environment (PLACE)
PLACE is a system for assessing the quality of the care environment. It 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. These 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

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Cleanliness</th>
<th>Food</th>
<th>Privacy, Dignity and Wellbeing</th>
<th>Condition Appearance and Maintenance</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walton Hospital</td>
<td>99.58%</td>
<td>91.31%</td>
<td>95.59%</td>
<td>98.51%</td>
<td>91.30%</td>
<td>83.53%</td>
</tr>
<tr>
<td>Whitworth Hospital</td>
<td>96.05%</td>
<td>86.21%</td>
<td>87.50%</td>
<td>100%</td>
<td>95.69%</td>
<td>92.39%</td>
</tr>
<tr>
<td>Ash Green</td>
<td>96.91%</td>
<td>85.59%</td>
<td>93.62%</td>
<td>94.34%</td>
<td>93.70%</td>
<td>78.00%</td>
</tr>
<tr>
<td>Babington Hospital</td>
<td>99.54%</td>
<td>86.59%</td>
<td>93.33%</td>
<td>98.11%</td>
<td>91.10%</td>
<td>93.44%</td>
</tr>
<tr>
<td>Cavendish Hospital</td>
<td>100%</td>
<td>89.66%</td>
<td>92.16%</td>
<td>99.33%</td>
<td>89.47%</td>
<td>86.08%</td>
</tr>
<tr>
<td>Clay Cross Hospital</td>
<td>96.55%</td>
<td>91.95%</td>
<td>93.75%</td>
<td>100%</td>
<td>95.65%</td>
<td>90.67%</td>
</tr>
<tr>
<td>Ilkeston Hospital</td>
<td>98.19%</td>
<td>90.08%</td>
<td>89.66%</td>
<td>97.50%</td>
<td>97.81%</td>
<td>93.18%</td>
</tr>
<tr>
<td>Ripley Hospital</td>
<td>99.56%</td>
<td>91.40%</td>
<td>94.87%</td>
<td>98.00%</td>
<td>95.69%</td>
<td>94.44%</td>
</tr>
<tr>
<td>St Oswald’s</td>
<td>100%</td>
<td>90.48%</td>
<td>100%</td>
<td>98.67%</td>
<td>97.40%</td>
<td>96.20%</td>
</tr>
<tr>
<td>National average score 2019</td>
<td>98.60%</td>
<td>92.19%</td>
<td>86.09%</td>
<td>96.44%</td>
<td>80.70%</td>
<td>82.52%</td>
</tr>
<tr>
<td>DCHS Score 2019</td>
<td>98.79%</td>
<td>89.79%</td>
<td>93.90%</td>
<td>98.47%</td>
<td>93.24%</td>
<td>89.85%</td>
</tr>
</tbody>
</table>

(Data source PLACE audit results)
After a national review of the questions by the PLACE team we are unable to compare scores with 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.

Examples of why DCHS scored low in the disability section included:
- Hand rails not in a different colour to contrast with the walls
- Not all corridors had hand rails.

Examples of why DCHS scored low in the privacy and dignity section included:
- 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.

Examples of why DCHS scored low for the dementia friendly environment section included the items below, (specifically identified within our Ashgreen learning disability assessment and treatment unit) where any environmental changes must take account of managing risk:
- 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 a 18 inch face clock and day plus date visible
- Taps clearly marked as hot / cold e.g. by using red and blue colours.

Overall, DCHS have achieved a score above the national average for elements in cleanliness, condition and maintenance, privacy and dignity, dementia and disability. The food element is lower than the national average for all sites and relates to the provision of food out of hours, rather than the quality of food available.

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 to begin.
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** - “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”.

**Clay Cross Hospital** – “Hospital well maintained, good and caring staff”

**Cavendish Hospital** – “Excellent all hands on deck for service of meal”

**St Oswalds** - “Well maintained, welcoming environment”
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, QSC, 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, see Ann and David’s story on page 58).

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. QPC 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 complainant.

5) Link with incidents: we are clear how we can digitally link together a complaint and an incident report 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](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 finalised investigations are 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 a 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 particularly 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 hospital’s policy did not allow self-medicating. 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 through 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. 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 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. The ward 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 order for them to escalate any concerns.

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 JUCD 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.


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, 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. As such, they are valued as a source of learning for the Trust. Where positive comments are 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 7 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 and behaviours – 21%
- Access to treatment – 16%
- **Responding to complaints**
  We have responded to 93% of complaints in fewer than 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 has identified 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 Derby and Healthwatch Derbyshire. 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 and 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 (EDI)

One of DCHS’ strategic aims is to be a ‘positively inclusive’ service provider and employer so everyone can be the best that they can possibly be. To achieve this, our top three EDI priorities for the 2019/20 reporting period are encapsulated in our equality plan on a page 2019/20 as well as our people strategy 2018-20 respectively.
Progress being made across the nine strands of our plan is regularly reviewed, and some of our wide-ranging EDI milestones and achievements in 2019/20 are outlined below:

- The CQC rated DCHS overall as outstanding following an inspection in July 2019 and specifically 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 have an Equalities Board that sets the strategic direction for equality, diversity and inclusion at DCHS. It comprises of the Trust’s Chair, Chief and Deputy Chief Executive and meets quarterly
- At the end of 2019, DHCS had circa 120 QSCC for dignity and inclusion across the Trust. Training was provided at two trust wide events in year and further training is planned. We are seeking more colleagues to sign up to become champions.
- We successfully piloted a reverse mentoring programme to foster inclusive leadership and better understand the lived experiences of our workforces protected groups

![Picture taken at DCHS’ reverse mentoring programme’s cohort 1 celebration event on 4 Feb 2020](image)

- We are 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 the NHS Workforce Disability Equality Standard (WDES) respectively
- 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 our intranet site as well as the GPG website via https://gender-pay-gap.service.gov.uk/.
- Our public sector equality duty annual report received significant assurance by EDILF
- We have convened a multi-faith chaplaincy service comprising a network of volunteer chaplains that offers pastoral care to people of all faiths and none
- Colleagues participated in three faith tours during 2019 which comprised guided tours to a Hindu temple, mosque, gurdwara and church
- We have developed a Spirituality and Faith Framework
- We achieved gold in the Employer Recognition Scheme (ERS) award in recognition of our support to the armed forces community
• We participated in 3 local Pride events (Chesterfield, Belper and Derby)
• We improved our Stonewall Workplace Equality Index 2020 placing (254 from 280)
• We are participating in the NHS rainbow badge Initiative
• We led the initiation and development of a system-wide EDI work stream with JUCD
• EDI features at every corporate induction programme
• During 2019 equality impact analysis training was delivered to the quality team

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. 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 and 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 features in vlogs to talk about a variety of EDI issues. Some of DCHS’ EDI videos are accessible via the intranet.

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.

Throughout the Freedom to speak up month of 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 (see also page 72 for more detail).

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 need it. 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.
Annual Quality Report 2019/20

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 29: MIU four hour waits**

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
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<td>99.9%</td>
<td>99.8%</td>
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<tr>
<td>2018/19</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99.8%</td>
<td>99.7%</td>
<td>100%</td>
<td>99.8%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>100%</td>
<td>99.9%</td>
</tr>
<tr>
<td>2017/18</td>
<td>99.9%</td>
<td>99.9%</td>
<td>100%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>100%</td>
<td>99.9%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

Data Source System1 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 30: Comparative A&E 4 hour wait data**

<table>
<thead>
<tr>
<th>Period</th>
<th>Performance</th>
<th>Rank</th>
<th>Total In cohort</th>
<th>National average</th>
<th>Highest</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>100%</td>
<td>Joint 1st</td>
<td>174</td>
<td>99.1%</td>
<td>73 trusts</td>
<td>King’s College Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>2018/19</td>
<td>100%</td>
<td>Joint 1st</td>
<td>235</td>
<td>86.6%</td>
<td>50 trusts</td>
<td>Norfolk And Norwich University Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>2017/18</td>
<td>100%</td>
<td>Joint 1st</td>
<td>238</td>
<td>85.0%</td>
<td>58 trusts</td>
<td>Princess Alexandra Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>2016/17</td>
<td>100%</td>
<td>Joint 1st</td>
<td>241</td>
<td>99.9%</td>
<td>56 trusts</td>
<td>Princess Alexandra Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>2015/16</td>
<td>100%</td>
<td>Joint 1st</td>
<td>237</td>
<td>91.9%</td>
<td>65 trusts</td>
<td>Tameside Hospital NHS Foundation Trust</td>
</tr>
</tbody>
</table>

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 31: Referral to treatment times (RRT)

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>95.9%</td>
<td>95.8%</td>
<td>95.35%</td>
<td>95.1%</td>
<td>94.8%</td>
<td>94.1%</td>
<td>Change in service provider</td>
<td>95.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>95.4%</td>
<td>96.2%</td>
<td>96.4%</td>
<td>96.1%</td>
<td>95.3%</td>
<td>95.2%</td>
<td>95.4%</td>
<td>95.2%</td>
<td>94.8%</td>
<td>93.3%</td>
<td>92.3%</td>
<td>94.7%</td>
<td>9.5%</td>
</tr>
<tr>
<td>2017/18</td>
<td>96.9%</td>
<td>97.3%</td>
<td>96.7%</td>
<td>95.8%</td>
<td>93.9%</td>
<td>95.3%</td>
<td>94.7%</td>
<td>93.9%</td>
<td>95.0%</td>
<td>95.1%</td>
<td>95.5%</td>
<td>95.0%</td>
<td>95.4%</td>
</tr>
</tbody>
</table>

RTT waits - admitted patients seen within 18 weeks - 90% (target) (%) 

<table>
<thead>
<tr>
<th></th>
<th>2019/20</th>
<th>2018/19</th>
<th>2017/18</th>
<th>Change in service provider</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>96.6%</td>
</tr>
<tr>
<td>2018/19</td>
<td>91.6%</td>
<td>84.7%</td>
<td>94.7%</td>
<td>99.6%</td>
<td>81.8%</td>
</tr>
<tr>
<td>2017/18</td>
<td>96.9%</td>
<td>96.6%</td>
<td>96.6%</td>
<td>97.3%</td>
<td>91.4%</td>
</tr>
</tbody>
</table>

RTT waits - non admitted patients seen within 18 weeks - 95% (target) (%) 

<table>
<thead>
<tr>
<th></th>
<th>2019/20</th>
<th>2018/19</th>
<th>2017/18</th>
<th>Change in service provider</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>86.2%</td>
<td>91.2%</td>
<td>88.8%</td>
<td>88.8%</td>
<td>94.1%</td>
</tr>
<tr>
<td>2018/19</td>
<td>89.7%</td>
<td>91.2%</td>
<td>90.9%</td>
<td>90.9%</td>
<td>93.7%</td>
</tr>
<tr>
<td>2017/18</td>
<td>94.9%</td>
<td>94.3%</td>
<td>94.3%</td>
<td>95.0%</td>
<td>95.3%</td>
</tr>
</tbody>
</table>

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 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 32:** Total DToC: inpatients including older people’s mental health (OPMH) – delays identifying ongoing social care

<table>
<thead>
<tr>
<th>Target</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20 3.5%</td>
<td>1.9%</td>
<td>3.4%</td>
<td>7.1%</td>
<td>3.9%</td>
<td>7.0%</td>
<td>4.9%</td>
<td>4.8%</td>
<td>5.9%</td>
<td>1.6%</td>
<td>5.4%</td>
<td>5.0%</td>
<td>4.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>2018/19 3.5%</td>
<td>5.3%</td>
<td>5.1%</td>
<td>4.1%</td>
<td>3.6%</td>
<td>5.8%</td>
<td>6.7%</td>
<td>4.9%</td>
<td>6.7%</td>
<td>5.2%</td>
<td>6.4%</td>
<td>4.5%</td>
<td>3.4%</td>
<td>5.3%</td>
</tr>
<tr>
<td>2017/18 3.5%</td>
<td>7.8%</td>
<td>12.4%</td>
<td>3.6%</td>
<td>11.2%</td>
<td>5.8%</td>
<td>4.8%</td>
<td>4.9%</td>
<td>3.8%</td>
<td>5.6%</td>
<td>5.0%</td>
<td>5.3%</td>
<td>5.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>2016/17 5.5%</td>
<td>6.0%</td>
<td>7.9%</td>
<td>10.1%</td>
<td>7.8%</td>
<td>8.4%</td>
<td>9.5%</td>
<td>6.1%</td>
<td>9.0%</td>
<td>10.8%</td>
<td>7.5%</td>
<td>9.1%</td>
<td>9.8%</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

Data Source Systm1 PAS

**Table 33:** Total DToC: OPMH data: (NHS delays only)

<table>
<thead>
<tr>
<th>Target</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Full year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>2.7%</td>
<td>3.2%</td>
<td>11.3%</td>
<td>7.6%</td>
<td>9.9%</td>
<td>4.9%</td>
<td>5.9%</td>
<td>2.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>4.2%</td>
</tr>
<tr>
<td>2018/19</td>
<td>1.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.8%</td>
<td>5.1%</td>
<td>14.9%</td>
<td>2.9%</td>
<td>3.4%</td>
<td>5.1%</td>
<td>4.8%</td>
<td>5.7%</td>
<td>4.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>2017/18 3.5%</td>
<td>0.0%</td>
<td>1.7%</td>
<td>1.3%</td>
<td>2.0%</td>
<td>7.0%</td>
<td>3.5%</td>
<td>4.0%</td>
<td>2.7%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>12.1%</td>
<td>8.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>2016/17 5.5%</td>
<td>0.0%</td>
<td>3%</td>
<td>0.9%</td>
<td>0%</td>
<td>1.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.2%</td>
<td>5.7%</td>
<td>3.2%</td>
<td>2.3%</td>
<td>0.0%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

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.

Derbyshire Community Health Services NHS Foundation Trust
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 34: DToC: OPMH (NHS delays only)

<table>
<thead>
<tr>
<th>Year</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Full year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>2.7%</td>
<td>3.2%</td>
<td>11.3%</td>
<td>7.8%</td>
<td>6.9%</td>
<td>4.9%</td>
<td>5.2%</td>
<td>2.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>2018/19</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.8%</td>
<td>3.6%</td>
<td>14.9%</td>
<td>2.9%</td>
<td>3.4%</td>
<td>5.1%</td>
<td>4.8%</td>
<td>6.7%</td>
<td>4.8%</td>
<td>4.2%</td>
</tr>
<tr>
<td>2017/18</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>5.4%</td>
<td>3.0%</td>
<td>2.6%</td>
<td>1.6%</td>
<td>3.5%</td>
<td>4.6%</td>
<td>13.1%</td>
<td>6.9%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

Data Source: Systm1 PAS

### Table 35: DToC Inpatients (NHS delays only)

<table>
<thead>
<tr>
<th>Year</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Full year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>1.8%</td>
<td>3.1%</td>
<td>5.4%</td>
<td>2.6%</td>
<td>5.9%</td>
<td>4.9%</td>
<td>3.9%</td>
<td>5.3%</td>
<td>0.6%</td>
<td>5.7%</td>
<td>4.7%</td>
<td>4.7%</td>
<td>4.8%</td>
</tr>
<tr>
<td>2018/19</td>
<td>3.3%</td>
<td>4.4%</td>
<td>4.6%</td>
<td>1.6%</td>
<td>6.4%</td>
<td>3.8%</td>
<td>5.8%</td>
<td>6.1%</td>
<td>3.6%</td>
<td>5.1%</td>
<td>3.4%</td>
<td>2.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td>2017/18</td>
<td>3.7%</td>
<td>6.8%</td>
<td>4.4%</td>
<td>8.1%</td>
<td>5.0%</td>
<td>2.1%</td>
<td>3.7%</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.0%</td>
<td>2.3%</td>
<td>3.5%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Full year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>1.9%</td>
<td>3.1%</td>
<td>6.6%</td>
<td>3.5%</td>
<td>5.6%</td>
<td>5.2%</td>
<td>6.7%</td>
<td>4.8%</td>
<td>0.5%</td>
<td>4.8%</td>
<td>3.0%</td>
<td>5.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>2018/19</td>
<td>2.8%</td>
<td>3.6%</td>
<td>3.8%</td>
<td>1.7%</td>
<td>6.6%</td>
<td>7.2%</td>
<td>3.7%</td>
<td>4.8%</td>
<td>3.9%</td>
<td>5.0%</td>
<td>3.9%</td>
<td>3.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>2017/18</td>
<td>2.9%</td>
<td>5.2%</td>
<td>3.4%</td>
<td>4.7%</td>
<td>1.1%</td>
<td>2.3%</td>
<td>3.5%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>3.8%</td>
<td>4.0%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

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 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
DCHS employs over 600 Allied Health Professionals (AHPs), 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. Time this year has been spent 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 3). 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.

The Derbyshire AHP Council was set up in May 2019 and enables the AHP workforce (14 professions) to support a workforce of over 1500 AHPs to make its full contribution within the JUCD 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.

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

### 3.5.5 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.

### 3.5.6 Raising concerns (Freedom to Speak Up)

The Freedom to Speak up Index report was published in July 2020 but the data was calculated as the mean average of responses to the following four questions from the NHS Staff Survey taken in 2019:

- % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

<table>
<thead>
<tr>
<th>Name of trust</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridgeshire Community Services NHS Trust</td>
<td>87%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Solent NHS Trust</td>
<td>86.1%</td>
<td>86.1%</td>
</tr>
<tr>
<td>Northamptonshire Healthcare NHS Foundation Trust</td>
<td>84.9%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Hounslow and Richmond Community Health care NHS Trust</td>
<td>85.1%</td>
<td>85%</td>
</tr>
<tr>
<td>Leeds Community Healthcare NHS Trust</td>
<td>84.1%</td>
<td>85%</td>
</tr>
<tr>
<td>Liverpool Heart and Chest Hospital NHS Foundation Trust</td>
<td>85.6%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Wirral Community NHS Foundation Trust</td>
<td>82.5%</td>
<td>84.5%</td>
</tr>
<tr>
<td>Derbyshire Community Health Services NHS Foundation Trust</td>
<td>82.7%</td>
<td>84.4%</td>
</tr>
<tr>
<td>The Royal Marsden NHS Foundation Trust</td>
<td>83.8%</td>
<td>84.3%</td>
</tr>
<tr>
<td>South Warwickshire NHS Foundation Trust</td>
<td>81.6%</td>
<td>84.3%</td>
</tr>
</tbody>
</table>
The Freedom to Speak up agenda has continued to develop during 2019/20. The actions required from the National Guardian Office (NGO) review in 2018 were fully implemented and along with a change of Freedom to Speak Up Guardian (FTSUG) in September 2019 was the opportunity to have defined hours dedicated to the role.

Graph 9: Concerns raised by quarter 2014-2020

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 FTSUG.

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
3.5.7 NHS Staff Survey

The 2019 NHS Staff Survey was conducted between Monday 23 September and Friday 29 November 2019. In total, 2,586 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 and staff forums, 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 38.

<table>
<thead>
<tr>
<th>Table 38: Benchmarking with community trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Equality, diversity and inclusion</td>
</tr>
<tr>
<td>Health and wellbeing</td>
</tr>
<tr>
<td>Immediate managers</td>
</tr>
<tr>
<td>Morale</td>
</tr>
<tr>
<td>Quality of appraisals</td>
</tr>
<tr>
<td>Quality of care</td>
</tr>
<tr>
<td>Safe environment – bullying and harassment</td>
</tr>
<tr>
<td>Safe environment – violence</td>
</tr>
<tr>
<td>Safety culture</td>
</tr>
<tr>
<td>Staff engagement</td>
</tr>
<tr>
<td>Team working</td>
</tr>
</tbody>
</table>

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 and 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 QPC.

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

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
Annual Quality Account 2019/20
Derbyshire Community Health Services NHS FT
Commissioner statement

General Comments
The Derby and Derbyshire Clinical Commissioning Group (DDCCG) welcome the opportunity to provide a statement in response to the presented Quality Account (QA) from Derbyshire Community Healthcare Services NHS Foundation Trust (DCHS). The CCG have worked closely with Derbyshire Community Healthcare Services NHS Foundation Trust throughout 2019/20 to gain assurances that the services delivered were safe, effective and personalised to service users. The data presented has been reviewed and is in line with data provided and reviewed through the regular contractual performance meetings and quality assurance meetings.

The NHS will remember 2019/20 as the year it embarked on its response to the Covid-19 Pandemic. The Trust temporarily suspended some non-critical services while adapting others, in line with a nationally-determined prioritisation framework, and rapidly implemented new ways of work. The Trust’s response played an essential role in managing the pandemic and protecting the residents of Derbyshire. As a key partner of Joined-Up Care Derbyshire, DCHS responded with distinction and DDCCG takes this opportunity to thank the Trust for its valued contribution.

Measuring and Improving Performance
Commissioners agree that the Quality Account provides a good overview of the Trust’s Strategy, Vision, Values and work that is making a difference in services that DCHS provides to the local population. The three quality priorities in 2019/20 were focused on quality improvement in patient safety, clinical effectiveness and patient experience. Commissioners note the development of new roles in the Health Psychology Service and their impact on physical health and mental illness pathway as well as a 5.78% decrease in Trust wide complaints from service users.

Achievements against the national Commissioning for Quality and Innovation (CQUIN) schemes for 2019/20 were in line with a projection for achievement (Commissioners note that no deterioration from Q3 to Q4 was projected).

However, in line with the Covid-19 National Prioritisation Framework Q4 reporting was suspended.

Providing the best outcomes for Patients
The Trust recognises the importance of ensuring that all clinical audit activity is meaningful and purposeful and results in learning, and improvements in care. The vision for continued development of DCHS as a ‘researching’ Trust (DCHS Strategy) is reflected within the organisation’s refresh of its Research and Innovation Strategy.

Commissioners take this opportunity to note the following achievements:

- Defence Employer Recognition Scheme (ERS) – Gold Award
- UNICEF Baby Friendly Initiative – Gold Award
- 48.84% reduction of significant harm pressure ulcer events against a target of 10%  
- The 0-19 year service commenced a new contractual relationship with Derbyshire County Council under section 75 arrangements.

Positive Experience
Patient experience is clearly outlined within the Quality Account and how the Trust measure and monitor patient and carers experiences to help improve services. In 2019/20 the Trust received a Friend and Family Test (FFT) score of 98.24% and 85% of staff would recommend it to their friends and family.
There is an open and transparent culture within the organisation in relation to the reporting of incidents and an appetite to learning from investigations. This is echoed by the appointment of a substantive Freedom to Speak Up Guardian.

Using the national framework the trust has shown transparency and learning to strengthen their internal processes to ensure the safety and wellbeing of patients.

Additional comments

This 2019/20 Quality Account provides an annual report to members of the public with the objective of demonstrating that the Trust is committed to ensuring it assesses and provides a high quality of care across its commissioned services. Within this statement the CCG would like to acknowledge and thank Derbyshire Community Healthcare Services NHS Foundation Trust for working positively and collaboratively with commissioners and key stakeholders to ensure our patients receive a high quality of care at the right time and in the right care setting. We look forward to continuing to work with the Trust and the people it serves over the coming year and beyond.

Brigid Stacey
Chief Nursing Officer
On behalf of Derby and Derbyshire Clinical Commissioning Group
13th July 2020

Healthwatch Derbyshire (HWD) is an independent voice for the people of Derbyshire. We listen to the experiences of Derbyshire residents using health and social care services. This is shared with the providers and commissioners of the services, who have the power to make change happen.

HWD gathers experiences from patients and members of the public using a variety of methods including engagement officers, supported by volunteers, social media and direct feedback to HWD via telephone, website, emails and letters.

Patient experience is fed through to health and care organisations regularly throughout the year to give an independent account of what is working well, and what could be improved. Anyone who shares an experience with HWD can request a response, and we encourage organisations to consider responses carefully and indicate where learning has taken place as a result of someone’s experience. When requested, the Trust (Derbyshire Community Health Service NHS Foundation Trust) replies to these comments thoroughly and with rigour, setting out learning and next steps that will follow.

Themed engagement carried out by HWD is used to explore a particular topic in more detail. The findings of themed engagement work are analysed and written up into reports, which include recommendations for improvement. Service providers and commissioners are then asked to respond to these recommendations. All our reports, including the responses we receive, are published on the HWD website.

HWD has read the Quality Account for 2019/20 prepared by the Trust with great interest. HWD has considered if and how the content reflects some of the topics and issues which have emerged in the feedback that HWD has collected and highlighted during the past year.

HWD welcomed the priority within the 2018/19 Quality Account to improve dementia-friendly environments and culture across DCHS as HWD produced a report in May 2018 detailing the experiences of people living with dementia and their carers. Due to the Coronavirus outbreak, this priority has not been completed but it is reassuring to see within the 2019/20 Quality Account that this work will recommence for within the Trust as part of the recovery phase.
The 2019/20 Quality Account details flagging records of people with learning disability, autism or both as a priority for the coming year, 2020/21. HWD welcomes this priority as recording peoples communication needs as stated within the Accessible Information Standard has been highlighted as an area that if implemented correctly it would lead to an improvement in patient experience as they would get the information they need in an appropriate format.

HWD also welcomes the 2020/21 Quality Account priority to establish an Independent Complaints Review Panel. In the nature of ensuring transparency, the openness of procedures and collaboration, HWD has accepted a place onto the panel.

The Quality Account refers to the partnership working between the Trust and HWD. The Trust supported a mystery shop exercise on their premises which was carried out by HWD volunteer representatives who have learning disabilities. Recommendations which came from the report have been implemented where possible and the Trust truly valued their experience and feedback.

HWD attends the Patient Experience and Engagement Group (PEEG) and is able to be a critical friend at these meetings to champion the importance of implementing patient experience to improve services. HWD welcomes the use of Healthwatch England’s ‘Shifting the Mindset’ paper https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20191126%20Shifting%20the%20mindset%20-%20NHS%20complaints%20.pdf as part of the Trust’s Complaints Review and implementing the recommendations. It is another example of the Trust’s commitment and understanding of the importance of patient experience to deliver a high-quality service.

Further examples of positive partnership working and reflecting DCHS’s commitment to patient experience include:

- HWD being involved in a focus group to discuss ways of improving the capture of feedback of people aged over 75
- Delivering a training session within the training programme for Dementia, End of Life and Frailty Learning Pathway. This was an opportunity to share with frontline staff more information about HWD and the importance and value of patient experience. Up until training had to cease due to the Coronavirus outbreak, HWD had carried out six training sessions. Articles about the programme have been published in the British Geriatric Society and is a reflection of the use of collaboration to develop and improve services for people
- Ongoing support from the Trust to enable HWD staff to gather feedback from people within their premises.

By way of summary, during the period April 2019 - March 2020, a total of 36 comments were received about the Trust with a fairly equal distribution of views.

There were 18 negative comments, ten positive comments, five neutral comments and three mixed comments. The most frequent negative comments were regarding information and communication. The most frequently made positive comments were concerning the quality of treatment and quality of care provided by members of staff.

We look forward to continuing positive working relationships with the Trust in 2020/21.

Helen Henderson-Spoors
Chief Executive Officer
Healthwatch Derbyshire
“The Derbyshire County Council Improvement and Scrutiny – Health Committee, at its meeting on 13 July 2020, was pleased to consider the Quality Report 2019/20 for Derbyshire Community Health Services NHS Foundation Trust. The Committee commented on a number of issues highlighted in the report, including improving the identification of sepsis, proposed participation in the National Falls Audit and joint working with the Council’s Adult Social Care and Health Department. The Committee wished to congratulate the Trust on its report and made particular note of the Trust’s achievement in increasing the uptake of ‘flu vaccines to 80% of its staff, with a further target of 90%-95% planned”

Healthwatch Derby is an independent watchdog for Health and Social Care services in Derby.

Over the past year Healthwatch Derby has worked closely with DCHS. Healthwatch has done regular outreaches across all the services that run within the city and we have developed new reporting processes so the trust gain these experiences on a monthly basis. Over the period of April 19-March-20 Healthwatch Derby received 83 experiences of DCHS services which have been fed back to the trust.

This year Healthwatch published their Diabetic services report and DCHS responded to the report in regards to community podiatry services and circulated amongst the trust for any further learning. Healthwatch worked in partnership with the Integrated Sexual Health Services in the city and developed a survey to engage with patients and published a report in 2019. The Trust provided a detailed response to the report, this response addressed each of the key findings giving Healthwatch Derby assurance that DCHS have heard, and acted upon, the points raised within the published report.

Healthwatch works closely with the patient experience team and have had regular meetings throughout the year to discuss and develop ideas and to gain insight.

Healthwatch Derby attends the Patient Experience and Engagement Group (PEEG) and clearly sees how the trust deals with and acts upon patient feedback and always treats peoples experiences seriously, timely and uses these experiences to improve their services.

Healthwatch looks forward to another year working with the trust.

James Moore MBA, Assoc CIPD
Chief Executive Officer
Healthwatch Derby
DCHS Governor Statement 2019/20

Throughout the year at each meeting of the Council of Governors current status reports are presented on quality and performance of the Trust, presenting Governors with the opportunity to question, scrutinise and challenge these reports. In addition, the Governor Quality Sub Group which consists of both public and staff governor representation is appreciative of the opportunity to review the Quality Account 2019/20 with the opportunity for a confirm and challenge approach. It is through these robust processes that Governors are confident in both monitoring and supporting the Trust in attaining the highest quality services for the benefit patients.

Governors feel involved and informed by the Trust and together with the openness and transparency demonstrated in its reporting mechanisms are confident that despite the significant challenges the NHS faces both locally and nationally are satisfied and assured with its processes, actions and outcomes.

We compliment the staff and authors of this well-constructed comprehensive honest annual report and are grateful as it is an easy, understandable read robustly reflecting all the work that has occurred over the last twelve months. The report provides an excellent overview covering the range of indicators used and work undertaken across a broad breadth of diverse services. There are excellent examples of its successes as well as openness in highlighting those areas that are challenging and require further support. We appreciate how “lesson learnt” are assembled and enacted upon which adds to Governor’s confidence in determining where assurance can be found.

This Quality Account clearly demonstrates the successful and effective triangulation approach providing significant assurance of the work done.

The Council of Governors wish to acknowledge and compliment all staff for the efforts in achieving CQC “Outstanding” status and more importantly the continued efforts to sustain that standard and continued aspirations to improvements in quality care.

We therefore have no hesitation in recommending this annual report.

Lynn Walshaw
Chair of Governor Quality Sub Group
13th July 2020

Bernard Thorpe
Lead Governor
Annex 2 - 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 13th July 2020
  - Feedback from governors dated 13th July 2020
  - Feedback from local Healthwatch Derby and Derbyshire organisations dated 30th June 2020 and 17th July 2020
  - Feedback from Health Scrutiny Committee dated 13th July 2020
  - The Trust’s 2018/19 complaints report (presented to the Patient Experience Engagement Group on 30 June 2020) and bi-monthly 2019/20 complaints reports to the Patient Experience and Engagement Group
  - The 2019 national GP patient survey, dated 9 July 2020
  - The latest NHS Staff Survey 2019
  - 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.
Annual Quality Report 2019/20

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

1st October 2020

[Signature]
Chairman

1st October 2020

[Signature]
Chief Executive
Annex 3 - 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.

<table>
<thead>
<tr>
<th>Prescribed information</th>
<th>Type of trust</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td><strong>Trusts providing relevant acute services</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>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.</td>
<td><strong>Trusts providing relevant mental health services</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>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.</td>
<td><strong>Ambulance trusts</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>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.</td>
<td><strong>Ambulance trusts</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>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.</td>
<td><strong>Ambulance trusts</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>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.</td>
<td><strong>Ambulance trusts</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>17 The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.</td>
<td><strong>Trusts providing relevant mental health services</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>18 The Trust’s patient reported outcome measures scores for— (i) groin hernia surgery (ii) varicose vein surgery (iii) hip replacement surgery, and</td>
<td><strong>Trusts providing relevant acute services</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Prescribed information</td>
<td>Type of trust</td>
<td>2017/18</td>
<td>2018/19</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>(iv) knee replacement surgery, during the reporting period.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 The percentage of patients aged - (i) 0 to 15; and (ii) 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.</td>
<td>All trusts</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>20 The Trust’s responsiveness to the personal needs of its patients during the reporting period.</td>
<td>Trusts providing relevant acute services</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>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.</td>
<td>Trusts providing relevant acute services</td>
<td>82%</td>
<td>82.8%</td>
</tr>
<tr>
<td>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.</td>
<td>Trusts providing relevant acute services</td>
<td>97.8%</td>
<td>98.2%</td>
</tr>
<tr>
<td>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.</td>
<td>Trusts providing relevant mental health services</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>23 The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.</td>
<td>Trusts providing relevant acute services</td>
<td>99.9%</td>
<td>99.6%</td>
</tr>
<tr>
<td>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.</td>
<td>Trusts providing relevant acute services</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>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.</td>
<td>All trusts</td>
<td>10,018</td>
<td>7,221</td>
</tr>
</tbody>
</table>

90
Appendix 2 - Frailty strategy on a page

Frailty Strategy on a page

Healthy ageing
Identification of frailty
Assessment comprehensive geriatric assessment
Integrated intervention with person-centred care planning

Competency & capability

DCHS Frailty Strategy objectives
Managing frailty as a long term condition in its own right.
Providing proactive care through timely identification.
Providing more community-based, person-centred, coordinated care.

Improving the health of the population
- Healthy ageing – through health promotion and preventing and addressing the causes of physical and mental ill health
- Managing frailty as a long term condition
- Providing community-based care and avoiding decline
- Focus on early identification and prevention
- Making the best use of our resources to support the health of the population
- Enabling people to live longer, healthier, happier lives
- Reducing inequalities and improving the wider determinants of health

Improving the experience of care (quality and satisfaction)
- Supporting independence and helping people to live the best lives they can
- Person-centred care ethos and practice
- Community-based coordinated care
- Psychological wellbeing
- Parity of esteem between physical and mental health
- Supporting Primary Care Networks and increasing support to people living in care homes
- Quality Conversations and personalised care planning
- Improving patient experience and engagement and supporting carers.

Improving staff experience
- Increasing job satisfaction
- Competence, confidence and capability
- Flexible working
- Quality Conversations
- A focus on quality improvement
- Promoting and embedding a compassionate culture
- Prioritising staff wellbeing and support.

Reducing the per capita cost of healthcare
- Coordinated care pathways within and across organisations
- Integrated pathways across the pillars of frailty
- Proactive care to reduce emergency admissions
- Avoiding admissions and reducing hospital length of stay
- Reducing delayed transfer of care
- Increasing digitalisation and technology opportunities
- Building improvement capability and capacity
- Ensuring value for money.
Appendix 3 - AHP strategy

DCHS Vision Statements for allied health professions

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 patients.

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 listens value and develops 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:
- Podiatrists
- Operating department practitioners
- Physiotherapists
- Speech and language therapists
- Paramedics
- Occupational therapists

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, sustainability 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.
## Appendix 4 - 2020 GP survey results

National survey undertaken by Ipsos Mori on behalf of NHS England and Improvement

<table>
<thead>
<tr>
<th>Ref</th>
<th>Topic</th>
<th>CCG Avg.</th>
<th>Castle St</th>
<th>Creswell</th>
<th>Ripley</th>
<th>Service Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Find it easy to get through to this GP practice by phone</td>
<td>63%</td>
<td>74%</td>
<td>87%</td>
<td>74%</td>
<td>78%</td>
</tr>
<tr>
<td>2</td>
<td>Find the receptionists at this GP practice helpful</td>
<td>90%</td>
<td>91%</td>
<td>94%</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>3</td>
<td>Are satisfied with the general practice appointment times available</td>
<td>64%</td>
<td>81%</td>
<td>63%</td>
<td>54%</td>
<td>66%</td>
</tr>
<tr>
<td>4</td>
<td>Usually get to see or speak to their preferred GP when they would like to</td>
<td>42%</td>
<td>42%</td>
<td>41%</td>
<td>36%</td>
<td>40%</td>
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<tr>
<td>5</td>
<td>Were offered a choice of appointment when they last tried to make a general practice appointment</td>
<td>60%</td>
<td>82%</td>
<td>70%</td>
<td>61%</td>
<td>71%</td>
</tr>
<tr>
<td>6</td>
<td>Were satisfied with the type of appointment they were offered</td>
<td>75%</td>
<td>83%</td>
<td>78%</td>
<td>73%</td>
<td>78%</td>
</tr>
<tr>
<td>7</td>
<td>Took the appointment they were offered</td>
<td>94%</td>
<td>95%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td>8</td>
<td>Described their experience of making an appointment as good</td>
<td>66%</td>
<td>80%</td>
<td>75%</td>
<td>60%</td>
<td>72%</td>
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<tr>
<td>9</td>
<td>Waited 15 minutes or less after their appointment time to be seen at their last general practice appointment</td>
<td>73%</td>
<td>83%</td>
<td>78%</td>
<td>71%</td>
<td>77%</td>
</tr>
<tr>
<td>10</td>
<td>Say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment</td>
<td>88%</td>
<td>89%</td>
<td>84%</td>
<td>80%</td>
<td>84%</td>
</tr>
<tr>
<td>11</td>
<td>Say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment</td>
<td>90%</td>
<td>89%</td>
<td>88%</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td>12</td>
<td>Say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment</td>
<td>89%</td>
<td>89%</td>
<td>86%</td>
<td>82%</td>
<td>86%</td>
</tr>
<tr>
<td>13</td>
<td>Were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment</td>
<td>94%</td>
<td>95%</td>
<td>97%</td>
<td>82%</td>
<td>91%</td>
</tr>
<tr>
<td>14</td>
<td>Had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>15</td>
<td>Felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment</td>
<td>87%</td>
<td>86%</td>
<td>82%</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>16</td>
<td>Felt their needs were met during their last general practice appointment</td>
<td>95%</td>
<td>92%</td>
<td>94%</td>
<td>96%</td>
<td>94%</td>
</tr>
<tr>
<td>17</td>
<td>Say they have had enough support in the last 12 months to help manage their long-term condition(s)</td>
<td>79%</td>
<td>78%</td>
<td>78%</td>
<td>81%</td>
<td>79%</td>
</tr>
<tr>
<td>18</td>
<td>Describe their overall experience of this GP practice as good</td>
<td>84%</td>
<td>82%</td>
<td>80%</td>
<td>78%</td>
<td>80%</td>
</tr>
</tbody>
</table>

|   | **Average** | 79% | 84% | 82% | 77% | 81% |
**Glossary**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AHPs</td>
<td>Allied Health Professionals</td>
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<tr>
<td>AI</td>
<td>Appreciative Inquiry</td>
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<tr>
<td>AMaT</td>
<td>Audit Management and Tracking</td>
</tr>
<tr>
<td>BAF</td>
<td>Board Assurance Framework</td>
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<tr>
<td>BI</td>
<td>Business Intelligence</td>
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<tr>
<td>CAP</td>
<td>Communit Access Point</td>
</tr>
<tr>
<td>CAS</td>
<td>Central Alerting System</td>
</tr>
<tr>
<td>CAAS</td>
<td>Clinical Assessment and Accreditation Scheme</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CET</td>
<td>Clinical Effectiveness Team</td>
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<td>CSDS</td>
<td>Community Services Data Set</td>
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<tr>
<td>CSG</td>
<td>Clinical Safety Group</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>DDCCG</td>
<td>Derby &amp; Derbyshire Clinical Commissioning Group</td>
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<tr>
<td>DToC</td>
<td>Delayed Transfer of Care</td>
</tr>
<tr>
<td>DQMI</td>
<td>Data Quality Maturity Index</td>
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<tr>
<td>DCHS</td>
<td>Derbyshire Community Health Services NHS Foundation Trust</td>
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<tr>
<td>EbE</td>
<td>Experts by Experience</td>
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<tr>
<td>EDILF</td>
<td>Equality Diversity and Inclusion Leadership Forum</td>
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<tr>
<td>EDR</td>
<td>Electronic Document Review</td>
</tr>
<tr>
<td>EoL</td>
<td>End of Life</td>
</tr>
<tr>
<td>ERiCA</td>
<td>Electronic Report in Care Assurance</td>
</tr>
<tr>
<td>ESR</td>
<td>Electronic Staff Record</td>
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<tr>
<td>FFT</td>
<td>Friends and Family Test</td>
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<tr>
<td>GP</td>
<td>General Practice</td>
</tr>
<tr>
<td>HSE</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>IP&amp;C</td>
<td>Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>IG</td>
<td>Information Governance</td>
</tr>
<tr>
<td>JUCD</td>
<td>Joined up Care Derbyshire</td>
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<tr>
<td>KLOE</td>
<td>Key Line Of Enquiry</td>
</tr>
<tr>
<td>KPIs</td>
<td>Key Performance Indicators</td>
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<tr>
<td>LD</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>LeDeR</td>
<td>Learning Disabilities Mortality Review</td>
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<td>MCA</td>
<td>Mental Capacity Act</td>
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<td>MIU</td>
<td>Minor Injury Unit</td>
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<td>MoGP</td>
<td>Markers of Good Practice</td>
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<td>MRG</td>
<td>Mortality Review Group</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin-resistant Staphylococcus aureus</td>
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<td>MSK</td>
<td>Musculoskeletal</td>
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<td>NACEL</td>
<td>National Audit of Care at the End of Life</td>
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<tr>
<td>NAIC</td>
<td>National Audit of Intermediate Care</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
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<tr>
<td>NEWS2</td>
<td>National Early Warning Score (Revised)</td>
</tr>
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<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
</tr>
<tr>
<td>NRLS</td>
<td>National Reporting and Learning Scheme</td>
</tr>
<tr>
<td>OPMH</td>
<td>Older People’s Mental Health</td>
</tr>
<tr>
<td>PLACE</td>
<td>Patient-Led Assessment of the Care Environment</td>
</tr>
<tr>
<td>PMVA</td>
<td>Prevention and Management of Violence and Aggression</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Always</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>QBC</td>
<td>Quality Business Committee</td>
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<td>QIAF</td>
<td>Quality Improvement Assurance Framework</td>
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<td>QPC</td>
<td>Quality People Committee</td>
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<td>QSC</td>
<td>Quality Service Committee</td>
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<td>QSCC</td>
<td>Quality &amp; Safe Care Champions</td>
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<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
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<td>RTT</td>
<td>Referral to Treatment Times</td>
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<td>SAAF</td>
<td>Safeguarding Adult Assurance Framework</td>
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<td>SLT</td>
<td>Speech and Language Therapy</td>
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<td>SSNAP</td>
<td>Sentinel Stroke National Audit programme</td>
</tr>
<tr>
<td>STEIS</td>
<td>Strategic Executive Information System</td>
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<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
</tr>
<tr>
<td>UHDB</td>
<td>University Hospitals of Derby and Burton NHS Foundation Trust</td>
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