Derby Hospitals NHS
NHS Foundation Trust

DRAFT VERSION 3 11.04.14

Quality Report

Year 2013-2014

QUALITY REPORT
FOR THE YEAR ENDED 31 MARCH 2014

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to introduce our Quality Account and to have the opportunity to share the progress we have made with the Trust Quality Strategy and the continued achievements of our staff. This covers the aspect of our service which matters most to all of us –the quality of the care we provide for our patients.

Compassion is at the heart of what we do and in November last year the Trust was the winner of the first national Compassionate Patient Care Award for our work to enhance the care of elderly patients and those with dementia. This includes the befriending scheme by volunteers from local schools, improvements in the patients' environment including the introduction of reminiscence rooms, memory cafes and a home from home environment. This shows that despite the challenges facing the NHS that our staff are committed to improving the quality of care for all patients even when they are busy and under pressure.

Our aim is to continue to build on the aspects of care that matter most to patients. Following a consultation exercise with over 3,000 patients, relatives, carers and staff, we have commenced our 'Making the Moment Matter' initiative to provide what matters most to our patients which fits alongside our Taking Pride in Caring Trust vision and objectives.

The current Quality Strategy ends this year and is currently being reviewed. A new Strategy will be developed which will build on the progress we have made and the priorities for the future. It is essential that feedback from service users continues to influence this work and our continuing commitment to improving patient safety, clinical effectiveness and the quality of care within our Trust.

Please read the report to learn more about the progress we have made.

This statement summarises Derby Hospitals NHS Foundation Trust's view of the quality of the NHS services that it provided or subcontracted during 2013/14To the best of my knowledge the information in the document is accurate and the Trust Board has received and endorsed the details set out in the Quality Report document.

Susan James
Chief Executive
2014

INTRODUCTION TO DERBY HOSPITALS NHS FOUNDATION TRUST QUALITY ACCOUNT

Current view of the Trust's position and status for quality.

This report covers the financial year of 2013/2014 across the Derby Hospitals NHS Foundation Trust.

The first part of the report details how we performed against last year's Quality Report, followed by an overview of organisational quality and patient safety and our performance against national and local metrics in 2013/2014.

The second section identifies our priorities for improving quality, safety, and patient experience for the coming year, and where we believe further improvements are required to enhance patient care.

Our 2012/2013 Quality Report detailed the following quality improvement priorities:

Patient Safety	- Implementation of the post infection Review Toolkit for the investigation of all MRSA bacteraemias Continue zero tolerance to pressure ulcers Roll out of Medical project initiatives. Update the Education Strategy regarding pressure ulcer prevention
Clinical Effectiveness	- To further develop integrated care and new pathways, in particular for the frail elderly Development of the Discharge Hub Continue delivery of the 2 year Nutrition Plan To ensure that all clinical staff have a personal development plan and undergo appropriate continuous professional development.
Patient Experience	- Implement Experience Based Design of Patient Pathways through Transformation Programmes Redesign the elective pathway to improve the experience of our patients Implement a Dementia Framework to improve the quality and experience of people with Dementia using our services and their carers Review our maternity services model to improve patient experience and safety promoting midwifery led care. Work in partnership with health and social care partners to transform our approach to discharge, ensuring it is timely and safe for patients with complex needs Development and Implementation of the "Getting Healthy, Staying Healthy" strategy Continue to develop and monitor the complaints management processes.

PART 2 PRIORITIES FOR IMPROVEMENT

2.1 THE TRUST QUALITY STRATEGY

In September 2011 the Trust Board approved its 3 year Quality Strategy. The Strategy details how the Trust aims to continuously improve the quality of care it provides to patients, staff and key stakeholders.

The Strategy provides a working plan for the Trust to ensure it maintains a focus on its key objectives. It sets out what needs to be done and how our progress will be measured. The Quality Strategy is currently being reviewed and will be re-launched later in 2014, mapping out the Trust's key aims to further improve quality and safety over the next 5 years.

Our Strategy is based on the key principles of patient safety, clinical effectiveness and patient experience and is linked to the Trust's overall PRIDE objectives.

P Putting Patients First

Effectiveness: Continually drive down the Trust Mortality rate
Safety: Improve the safety of patients whilst in the care of the Trust by reducing avoidable harm
Experience: To continue to improve the patient's journey through the Trust and increase the number of patients who would be happy to recommend the Trust

R Right First Time

Effectiveness: Reduce the 30 day readmission rate
Safety: Reduce medication errors
Experience: Ensure that patients who are at the end of life receive the most appropriate care, e.g. End of Life Care, Right Care or the Liverpool Care Pathway.

I Investing our Resources Wisely

Effectiveness: Improving timely discharge to optimise a patient's length of stay
Safety: Invest in appropriate acuity tools to optimise nursing levels across the Trust
Experience: Invest in a ward assurance tool to provide demonstrable evidence of delivery of high standards of clinical care

D Developing our People

Effectiveness Ensure all clinical staff have an annual personal development plan and undergo appropriate continuous professional development
Safety: Work on achievement of mandatory training for all clinical staff in order to standardise practice and empower front line staff to respond positively to every patient concern every time

E Ensuring Value through Partnerships

Effectiveness: To further develop the Integrated Care Pathways for Respiratory, Dementia, End of Life, Falls, and Learning Disabilities and to initiate appropriate new pathways such as Frail Elderly Care

Safety: To improve and sustain discharge communications with GPs and the wider health and social care community

Experience: Through partnerships ensure that the patient pathway and experience of care is seamless through the acute sector and community care

2013/14 is the final year of this Quality Strategy and the remaining objectives identified have been included in reporting this year.

2.1.1 SAFETY

INFECTION PREVENTION AND CONTROL

The Trust remains fully committed to, and takes very seriously, the responsibility for the prevention and control of healthcare associated infections (HCAI), including Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.diff).

Infection Prevention and Control Governance Review
Over the past three years there have been a number of reviews to improve the quality of infection control practice; this has included 2 external reviews. The reviews identified a high level of assurance in the rigour and support being given to the HCAI agenda and confirmed that the Infection Prevention and Control Team are providing an appropriate and effective service.

In July 2013, Professor Wilcox, Public Health England (PHE) national lead for C.diff, was commissioned to lead a review of the prevention and management of Clostridium difficile infections in the Trust. He identified that the Infection Prevention and Control Team is clearly experienced in their discipline and that the documentation surrounding C.diff is generally of good standard.

Professor Wilcox recommended 6 key areas where improvements to practice may be beneficial to the management of C.diff within the Trust. Actions related to these key areas were incorporated into the Trust Clostridium difficile Action Plan. Professor Wilcox returned to the Trust on 23 January 2014 to review the progress made against his previous recommendations and reported on 5 key areas where improvements could be made.

The following section outlines some of the key objectives of the Trust, with particular focus on those infections that form part of the national reporting requirements. A key factor of infection prevention and control is the management of specific infections and their risk.

National Screening Programme for MRSA on Admission to the Trust
The Trust continues to screen all elective and emergency admissions for MRSA in line with the requirements of the Department of Health. Good compliance with MRSA screening continues to be demonstrated.

Key focus on Reducing the Number of MRSA bacteraemia (MRSAb)
The Department of Health adopted a zero tolerance to avoidable MRSA bacteraemia infections for 2013/14. The Trust has had a year-end position of 2 MRSA bacteraemia cases, 1 of these was classed as an avoidable infection.

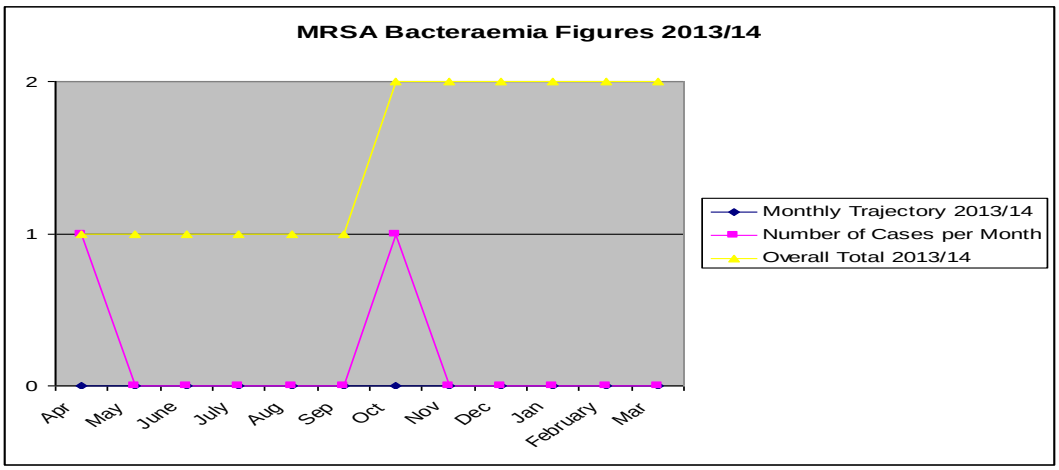
In 2012/13 the Trust was set a target of no more than 2 MRSA bacteraemia cases, but had a year-end position of 3.

All cases of MRSA bacteraemia are reported and investigated as a serious incident. A detailed and full investigation involving all healthcare practitioners involved in the patient's

care, is carried out to consider whether all appropriate actions have been taken and to identify any learning points. All MRSA bacteraemia case investigations and learning points are discussed at the Trust Infection Control Committee.

The graph below shows the monthly trajectory and the incidence of the two cases.

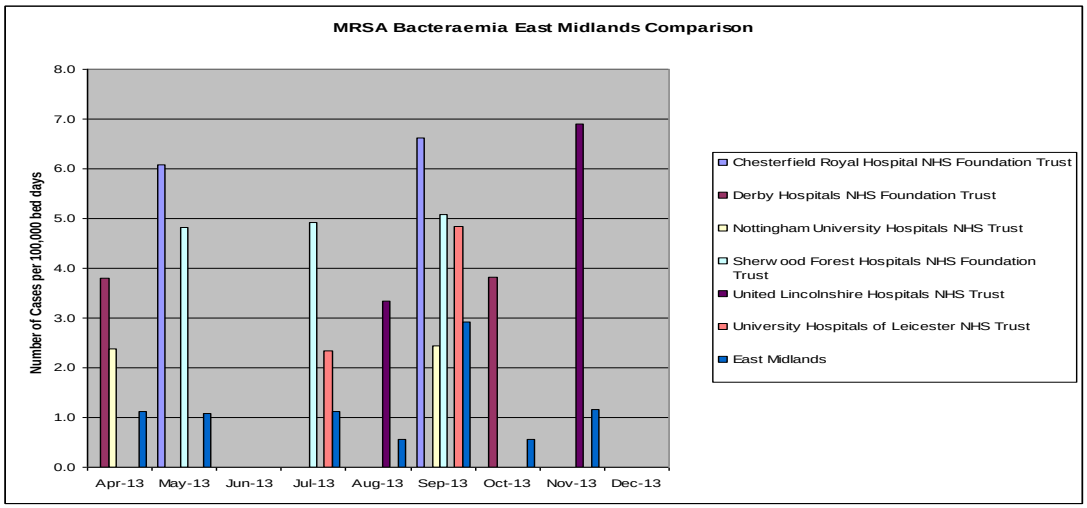
Department of Health MRSA Trajectory and Trust Performance Data 2013/14



The main learning point from the avoidable MRSA bacteraemia case was the necessity of MRSA screening on admission to identify and treat those patients who are colonised with MRSA at the earliest opportunity to prevent serious infections occurring.

Monthly MRSA Bacteraemia Comparison Data

This data is produced by PHE and is reported as a rate of 100,000 bed days to allow comparisons between organisations. The graph below compares Derby Hospitals' performance against the rest of the East Midlands on a monthly basis. It represents one case for Derby Hospitals in April and October 2013. There have been no further cases in the Trust since October 2013 (PHE has not updated the data since December 2013).



Clostridium difficile (C.diff)

C.diff is a bacterium which is found in the intestines of approximately 3% of healthy adults. It does not usually cause problems as it is kept in check by the normal bacterial population of the intestine. However, antibiotics can disturb the balance of bacteria in the gut, allowing the

C.diff bacteria to multiply and produce toxins. These toxins cause illness. It is known certain antibiotics carry a higher risk of C.diff.

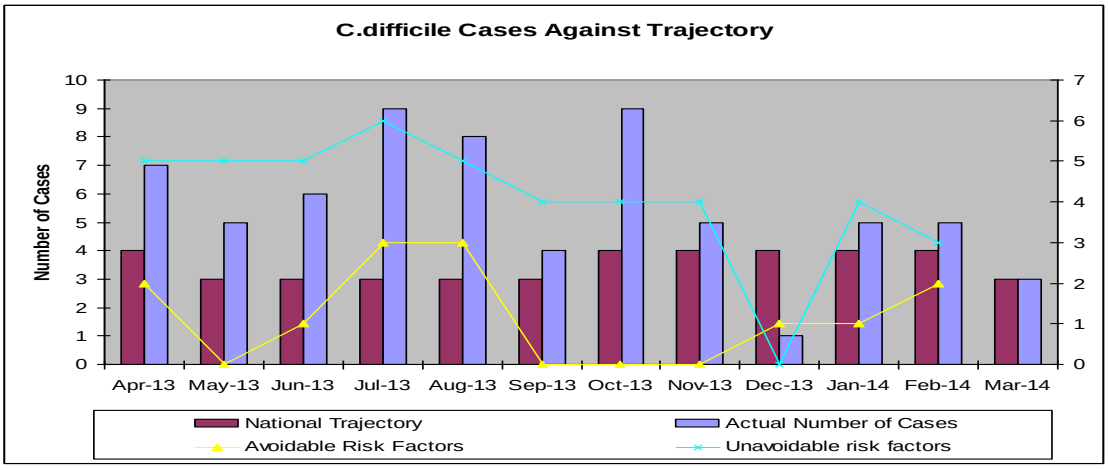
The national target set for the Trust in 2012/13 was 49 cases. The Trust ended the year with a total of 65 cases. This is the first year since the national targets were introduced that the Trust did not achieve.
The target set for 2013/14 was 42 cases. The Trust ended the year with a total of 67 cases.

Continuous assessment and review is crucial to ensure that the Trust is taking all appropriate actions to minimise the risk of patients developing the infection. Root cause analysis is undertaken for each C.diff case by the C.diff Review Group. The group will determine whether all Trust policies and procedures were correctly followed. All findings are shared and discussed with the clinical teams.

The C.diff Review Group grades each case as having unavoidable or avoidable risk factors, e.g. were all Policies and Procedures followed correctly? If a case is determined to have avoidable risk factors an investigation meeting, involving all healthcare practitioners involved in the patients care, is carried out to consider whether all appropriate actions were taken and to identify any learning points. All such cases, including learning points are discussed the Trust Infection Control Committee.

Although a case may have identified avoidable risk factors the C.diff Review Group do not say the case itself is avoidable. Every case gives us the opportunity to learn and improve patient safety.

The graph below shows the Trust monthly performance against the national trajectory and whether the cases identified had any avoidable risk factors.



An external review of the management of C.diff infection in the Trust was undertaken by Professor Wilcox, PHE C.diff lead, in July 2013, with a follow up visit on 23 January 2014. Professor Wilcox acknowledged that progress has been made but there was still opportunity to further optimise the control measures for C.diff infection.

He recommended key areas for focus for the Trust:

1. Optimum use of antibiotics.
2. Proactive isolation of patients with diarrhoea.
3. Clinical leadership of RCA and changes in practice.

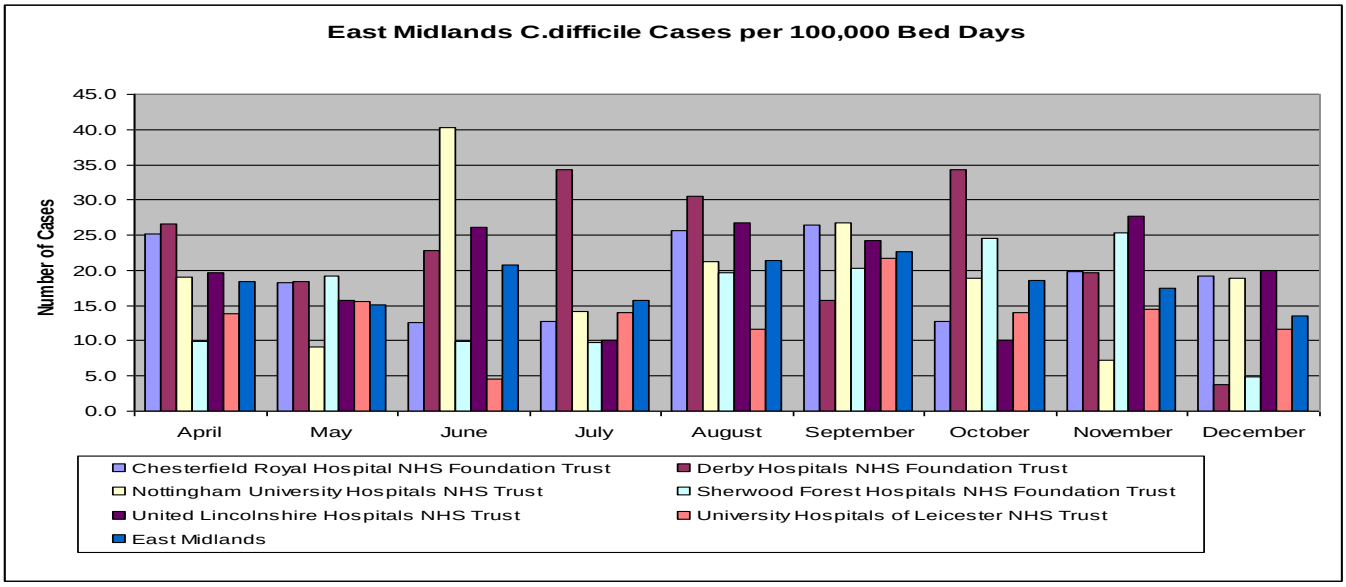
Actions taken:

- Weekly spot check audits by Matrons of infection prevention and control practice, findings reported directly to the Chief Nurse.
- Monthly spot check audits by Heads of Nursing and Clinical Directors / Divisional Medical Directors of infection prevention and control practices and antibiotic prescribing.
- Weekly quality and safety rounds by the Chief Nurse and Medical Director.
- Back to basics focus in the Trust, focussing on hand hygiene, diarrhoea management, challenging poor practice and environmental and equipment cleanliness.
- Weekly antibiotic audits performed by medical teams, results reviewed by lead consultant and quality assured by antimicrobial pharmacist and consultant microbiologists.
- Monthly diarrhoea management audits in all ward areas, standard for isolation changed to 2 hours.
- RCAs now undertaken by clinical teams. All RCAs to be reviewed by the C.diff review meeting, chaired by Medical Director or Chief Nurse.
- Trust C.diff policy updated to reflect the requirement for not repeat testing of stool samples.

The Trust continues to take all steps possible to ensure that its antibiotic prescribing is in line with national best practice, whilst balancing the clinical needs of the patient.

The Trust continues to work closely with PHE with regard to the prevention, diagnosis and management of C.diff. PHE remains assured that the Trust has a comprehensive action plan for the on-going prevention, diagnosis, and management of C.diff within the organisation.

Monthly Clostridium difficile Comparison Data
This data is produced by Public Health England and is reported as a rate of 100,000 bed days to allow comparisons between organisations. The graph below compares Derby Hospitals' performance against the rest of the East Midlands on a monthly basis (PHE has not updated this data since December 2013).



Methicillin Sensitive Staphylococcus aureus (MSSA)
Most strains of Staphylococcus aureus are sensitive to the more commonly used antibiotics and infections can be effectively treated, these are called Methicillin sensitive

Staphylococcus aureus or MSSA. Some Staphylococcus aureus bacteria are more resistant. Those resistant to the antibiotic Methicillin are termed Methicillin-resistant Staphylococcus aureus or MRSA and often require different types of antibiotic to treat them.

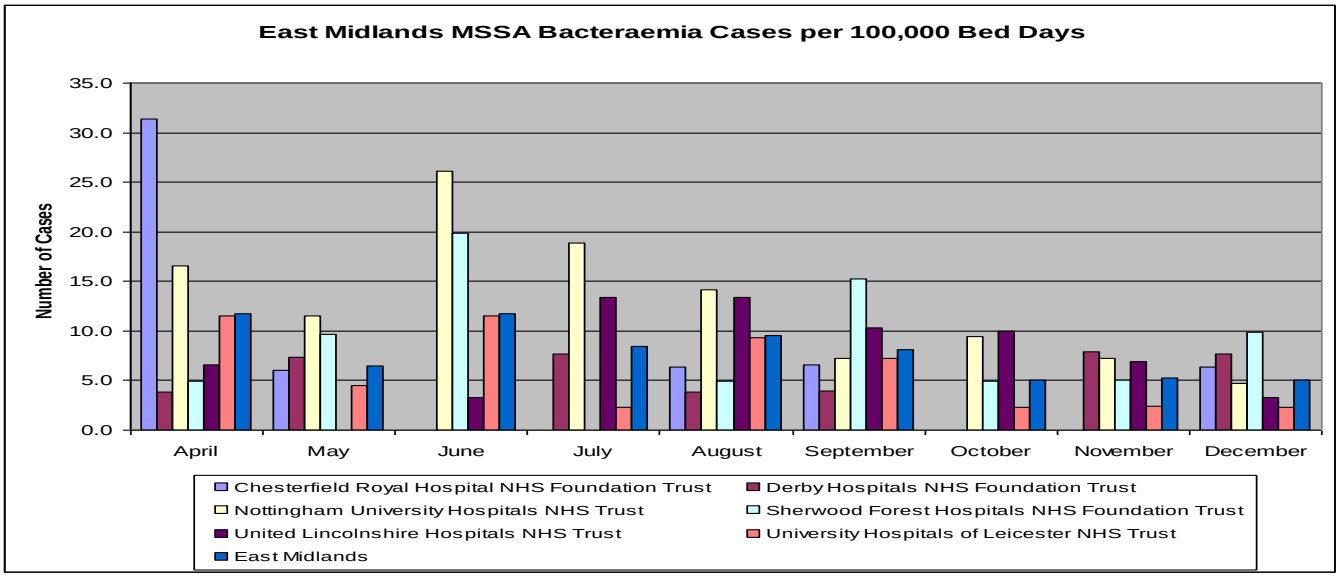
Methicillin-sensitive Staphylococcus aureus is a type of bacteria which lives harmlessly on the skin and in the noses, in approximately one third of people. People who have MSSA on their skin or in their noses are said to be colonised.

MSSA colonisation usually causes no problems, but can cause an infection when it gets the opportunity to enter the body through a surgical wound for example.

It has been mandatory to report all MSSA bacteraemia cases to Public Health England since January 2011. There is no trajectory set against MSSA at this time.

Root cause analysis is undertaken on all Trust acquired cases of MSSA bacteraemia. Since April 2013 there have been 88 cases identified, 15 of these were identified 48 hours or less after admission, meaning the cases were not attributable to Derby Hospitals. This reflects the picture seen nationally.

Monthly MSSA Bacteraemia Comparison Data
This data is produced by PHE and is reported as a rate of 100,000 bed days to allow comparisons between organisations. The graph below compares Derby Hospitals' performance against the rest of the East Midlands on a monthly basis. It shows that Derby Hospitals generally has one of the lowest rates in the East Midlands (PHE have not updated the data since December 2013).



Escherichia coli (E.coli) Bacteraemia
E.coli is a species of bacteria commonly found in the intestine of humans and animals. There are many different types of E.coli and while some live in the intestine quite harmlessly, others may cause a variety of disease. Urinary tract infection is the commonest E.coli infection, the organisms spread from the gut to the urinary tract. E.coli can also cause infection in the intestine, causing diarrhoea, these are usually the result of food poisoning illness.

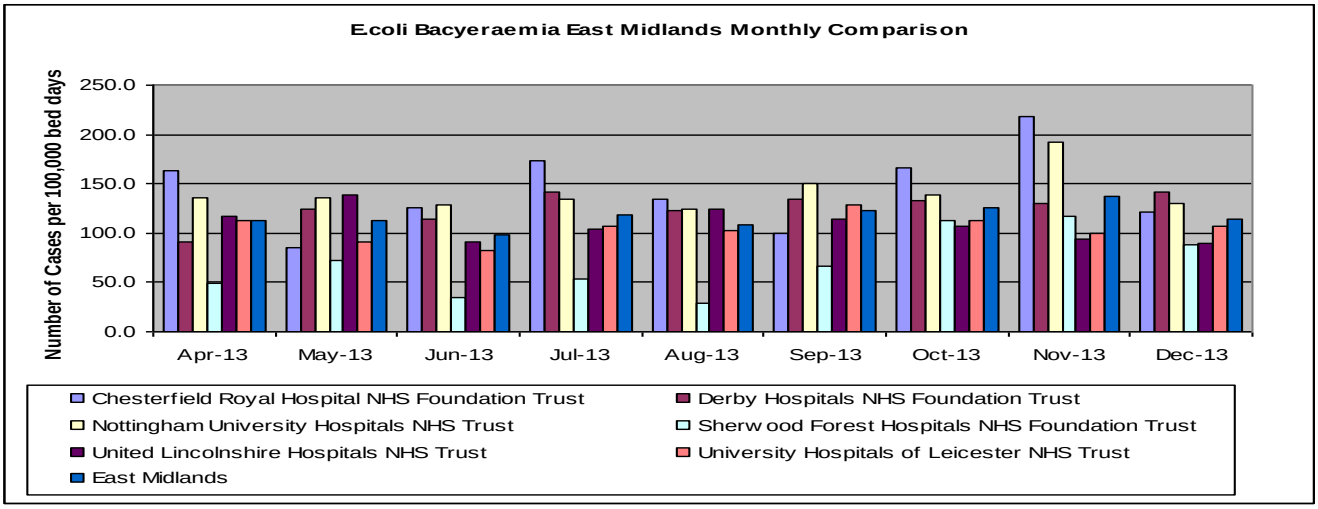
Overspill from the primary infection site into the blood stream can cause blood stream infection. These are referred to as E.coli bacteraemia.

Mandatory reporting of E.coli bacteraemia commenced in June 2011. There is no trajectory set against E.coli bacteraemia at the current time.

Since April 2013 there have been 413 cases identified, 72 of these were identified 48 hours or less after admission, meaning the cases were not attributable to Derby Hospitals. This reflects the picture seen nationally.

Monthly E.coli Bacteraemia Comparison Data
This data is produced by PHE and is reported as the number of cases identified per laboratory, not by 100,000 bed days. The graph below compares Derby Hospitals' performance against the rest of the East Midlands on a monthly basis (PHE have not updated the data since December 2013).

As PHE report E.coli bacteraemia by number of cases the graph does not reflect that the vast majority of E.coli bacteraemia cases are identified 48 hours or less after admission, meaning they are not attributable to Derby Hospitals.



Norovirus
Norovirus is a virus which causes diarrhoea and/or vomiting. Although there is an increase in winter months, cases do occur throughout the year. In general the symptoms last for 24-48 hours. There are no long term effects from Norovirus and a full recovery is usually within 48 hours. Norovirus is extremely infectious, with around 50% of people exposed developing symptoms. The focus within the Trust is to ensure the spread of the illness is minimised.

The table below demonstrates the significant reduction in the number of patients and staff affected by Norovirus in 2013/14 compared to the same time period 2012/13

	Number of areas affected	Number full ward closures	Number confirmed Norovirus	Number patients affected	Number staff affected
2013/2014	12	5	15	82	17
2012/2013	34	8	18	131	38

Winter Preparedness
The Infection Prevention and Control Team put in place additional Norovirus and Influenza training in preparation for the winter season.

In addition a 'winter preparedness week' was held. Information for patients and visitors on Infection Control, Norovirus and Influenza was distributed to all ward areas for patients and

visitors to the Trust. The Infection Prevention and Control team held a number of road shows at the Royal Derby Hospital and the London Road Community Hospitals to provide information for the public.

The Infection Prevention and Control and the Antimicrobial Prescribing intranet sites are updated regularly with the latest information and guidance. The Infection Prevention and control site includes 'top tips' documents for Norovirus and Influenza as quick reference guides for staff.

Hand Hygiene

Hand hygiene is a key measure in controlling the spread of infections in hospitals and remains a key focus for the Trust. Monthly, 20 minute observational hand hygiene audits continue to be undertaken in all clinical areas, assessing compliance against the Hand Hygiene policy. Compliance is monitored by exception on a monthly basis at the Infection Control Operational Group, along with any action plans. Areas of concern are escalated to the Infection Control Committee. In addition all clinical staff are required to undertake a competency assessment of their hand hygiene technique.

The table below demonstrates continued compliance with hand hygiene in all divisions:

Month	Medical Services	Clinical Support Services & Cancer	Surgical Services
April 2013	99%	100%	99%
May 2013	99%	100%	100%
June 2013	99%	100%	100%
July 2013	99%	100%	99%
August 2013	99%	100%	100%
September 2013	100%	100%	98%
October 2013	100%	100%	99%
November 2013	98%	100%	99%
December 2013	98%	100%	100%
January 2014	100%	99%	100%
February 2014	99%	100%	99%
March 2014	99%	100%	99%

Infection Control Accreditation Programme

The Infection Prevention and Control Accreditation programme takes a multifaceted approach to improving patient safety and reducing healthcare associated infections. It sets standards for infection prevention and control practice in Derby Hospitals and is a package of practices likely to reduce infection rates when carried out consistently by clinical teams.

The accreditation programme recognises excellence of practice and that the area has consistently exceeded the high infection prevention and control standards expected by Derby Hospitals. Staff in an accredited area have demonstrated their sustained commitment to patient care, safety, and infection prevention and control standards.

This project was shortlisted for excellence in infection control practice in the 2013 National Nursing Times Awards.

The following areas that have achieved Infection Control Accreditation:

- Sunflower
- Ward 206
- Medical OPD
- Pulvertaft Hand OPD
- Ward 203
- Ward 204
- Ward 205
- Ward 207
- Orthopaedic Outpatients
- Spinal Outpatients
- Ward 307

The Trauma & Orthopaedic Business Unit has been the first business unit to achieve excellence across all of its areas.

The Cleaning Service at Derby Hospitals

In 2013/14 the Royal Derby Hospital has revised the cleaning model across its wards. Working in partnership with ISS, the Trust has implemented a "Team cleaning" approach. The concept is based on a team method with each member of staff having responsibility for specific rooms or tasks. The Health Care Cleaners have been issued with new colour coded uniforms which identify which areas they are responsible for cleaning. The colour coding follows NPSA Guidance. The Team Model was shortlisted for excellence in infection control practice in the National 2013 Nursing Times Awards.

The key to its success was the initial planning and audit process and working closely with the ward sisters and Infection Prevention & Control Team (IPCT). ISS continue to use microfibre for cleaning and these cloths are laundered onsite. The laundry process and the efficacy of the microfibre cloths have been validated to ensure compliance with all national guidance.

All areas of the hospital continue to be audited following the National Standards of Cleanliness 2007:

- Very High risk areas weekly
- High risk areas monthly
- Significant risk areas quarterly
- Low risk areas annually

The audit results are shared with wards and reported on a monthly basis in the Derby Health Care Report to Trust Facilities Management and from this year at the Trust Infection Control Operational Group. Actions are initiated if there are concerns with any cleaning.

The Trust Quality Monitoring Officer continues to verify the environmental standards by undertaking a technical audit which involves ISS Facilities Services and Skanska Facilities Services.

In addition PLACE inspections take place monthly on each site conducted by the Trust Facilities Management Contract Monitoring Officer along with Trust Governor Representation. The inclusion of both Derby Healthwatch and Derbyshire Healthwatch on these inspections has added a real openness about the reporting process.

In 2013/14 Trust Facilities Management purchased 3 Hydrogen Peroxide Vapour (HPV) machines and introduced a decontamination team at the Royal Derby Hospital whose specific role is to deep clean patient equipment and subject to HPV . On instruction of the Infection Prevention Control Team the Decontamination Team will also HPV isolation rooms. The HPV is a proving to be very effective method of sterilising fixtures, fittings and equipment. By using the Trust's own "Derby Door" we are able to create a decontamination room on any ward in the Trust, which allows for the decontamination of large amounts of equipment.

Trust FM and IPCT have introduced enhanced auditing using a ultra violet pen and torch, which allows us to measure the quality of cleaning undertaken by health care cleaning and nursing. This is currently being programmed on a weekly basis

In December 2013 Trust FM and ISS started a deep cleaning schedule for all wards. The process is dependent on the availability of empty bed spaces, and activity on the wards, to date the Medical Admissions Unit, Surgical Admissions Unit, and Wards 401 and 402 have been deep cleaned and where possible the HPV machine has been used. The programme to complete all wards will take over a year and will become part of our annual cleaning programme.

TISSUE VIABILITY – PRESSURE ULCER MANAGEMENT

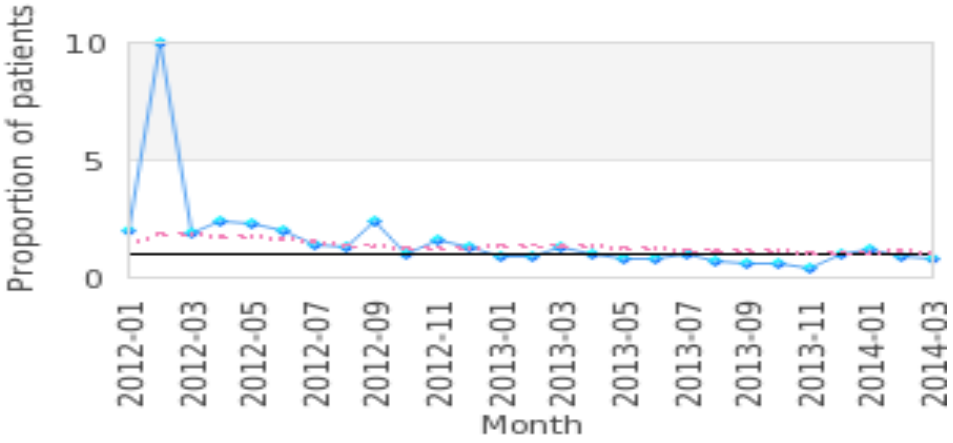
It is nationally recognised that the incidence of pressure ulcers is a key quality indicator and that 95% are deemed preventable. Pressure ulcers are painful and distressing for the patient, and require increased support and input to the patient from a health care perspective.

The Trust is participating in a significant national project to 'Stop the Pressure' and reduce the incidence and prevalence of pressure ulcers. The numbers of patients with pressure ulcers are monitored through the prevalence and incident reporting systems. The Trust has taken a zero tolerance stance to hospital acquired avoidable pressure ulcers. We have not achieved our target of zero avoidable pressure ulcers. However, there continues to be a significant change in the delivery of care in relation to key pressure ulcer prevention standards. The culture and positive attitudes towards prevention has become the norm in many areas and this is evidenced in both our prevalence and incidence data.

The Patient Safety Thermometer measures prevalence rates in pressure ulcers, nationally. The total Pressure Ulcers prevalence for Derby Hospitals Foundation Trust (including admitted and acquired all stage pressure ulcers) had a mean of 5.% in 2013 which compares favorably against a performance range of regional as well as national prevalence rates.

The graph below represents prevalence of Trust acquired new pressure ulcers (acute and community) and demonstrates a sustained reduction in the total of new Trust acquired pressure ulcers since 2012. From March 2012 our prevalence rate was just above the regional and national prevalence rates at 2.5%. It is apparent from January 2013 our total prevalence rate, in line with regional prevalence rates has dipped below national prevalence rates, and since April 2013 this reduction fell below 1% and has remained below median rates through to March 2014.

New Trust Acquired Prevalence (Acute and Community)



median line **national line** **DHFT line**

Trust Acquired Pressure Ulcers Reported as Serious Incidents

The Trust (acute and community) reported 161 stage 3 and 4 pressure ulcers on the National STEIS system during 2013, of which 94 incidents (58%) were confirmed as unavoidable and 67 incidents (42%) were found to have some omissions in care and therefore classified as being avoidable.

There were 14 incidents (9%) categorized as avoidable in the Community. The ambition of eliminating avoidable 2, 3 and 4 Pressure Ulcers is a particular challenge in the community settings, especially where District Nursing services may only be visiting once or twice a week and the care is delegated to family, Social Care agencies, or to carers within residential homes.

The implementation of an effective and sustained pressure ulcer prevention strategy described in brief below has been instrumental in steering the Trust Pressure Ulcer Prevention Group (PUPG) and works collaboratively with other disciplines and all divisions to influence elements of pressure ulcer prevention for patients across Primary and Secondary Care.

- Excellence audit data from Divisions is scrutinized and hot spots are targeted where there is indication of poor compliance to standards. To assist in this work, the Tissue Viability Team have recently started attending Divisional monthly Senior Sisters Meetings and give an overview of the common themes, reinforce what could have been done to prevent the damage from occurring in the first place, and hold staff to account where it is evident that harm has occurred as a result of omissions of care. It also provides an opportunity to share good practice between clinical areas as well as promoting ownership of issues raised.

- Root Cause Analysis is carried out for all Stage 3 and 4 pressure ulcers. Overall learning from these Serious Incidents (SIs) are being addressed through education, monitoring the implementation of action plans to reinforce implementation of standards.

- Improved access and standardisation of training on the SSKIN Bundle (Surface, Skin Inspection, Keep moving, Incontinence, Nutrition) for all disciplines (essential to role) as well as more emphasis being placed on how care is delivered; through raising awareness on the principles of “Time to Care” which will help prompt all disciplines to ensure patients

are comfortable, repositioned to stop the pressure, have access to a drink, the call bell system, toilet etc.

- A Zero Tolerance Poster Campaign was launched in November 2013 to raise awareness of common themes, including timely risk and skin assessments, appropriate surfaces , medical devices, keep patients moving, incontinence skin care protocol as well as a heel device, nutrition and hydration and discharge planning posters. A recent audit of staff as well as patients indicates this has been successful in that it has improved staff awareness as well as communications with patients on the need to keep moving.

Genuine sustained improvements have and are being made from embedding the above approaches in our efforts to prevent pressure ulcer development and assist healing of those present. Raising awareness to all staff disciplines is promoting a change of culture by challenging practice as well as motivating staff within clinical areas to discuss and find solutions as to how they can ensure key elements of care are given timely and consistently to all our patients.

NUTRITION AND HYDRATION

The Nutrition and Hydration steering group (NHSG) has worked proactively over the last year to ensure that food and drink remains on every ones agenda. Not only have they worked for patients within the Trust but also with other elements of malnutrition prevention in the wider community, to ensure that patients receive the right care and management at any point in their pathway.

Patients continue to be risk assessed on admission to identify those that will require closer monitoring. This is monitored through the Ward Assurance audit on a monthly basis and reported back to NHSG. Action plans are presented from those wards who are not achieving the target.

Initiatives highlighted in last year's report have moved forward in the following way

- The "Nil By Mouth" pathway has been piloted and is now ready to be presented to the Guidelines Group for ratification, prior to implementation across the Trust.
- There is now a more streamlined approach to accessing snacks and special diets with better communication between ISS, the wards and the dietitians.
- The National Descriptors training was successfully cascaded to all the wards.
- E-referrals have successfully been implemented for both Dietetics and the Nutrition Team. This has led to a more timely receipt of referral enabling priority patients to be identified more quickly.

The Nutrition Ambition Plan for 2014 – 2015 has been agreed and will be concentrating on the following areas:

- An audit will be conducted to ensure the meals provided to patients with dysphagia correspond with the National Descriptors.
- An audit of the National Patient Safety Agency (NPSA) guidance to facilitate the safe management of Nasogastric Tubes to ensure compliance within the Trust.
- Nutrition to form part of the "Fundamental Aspects of Care" programme and continued delivery of the training "Enabling patients to eat and drink safely".
- Review of the Trust Nutrition section of the Intranet.
- Development of innovative ideas for promoting nutrition and hydration.
- Changes to the presentation of patient meals to improve the appearance.

- Continued close working between ISS and Dietetics on patient menus, regularly reviewing range and quality.

LEADING IMPROVEMENTS IN PATIENT SAFETY (LIPS)

The Trust commenced the Leading Improvements in Patient Safety programme run by the NHS Institute of Innovation at the end of 2010/11.

The Medical Director is the programme lead and has established a Patient Safety Team to lead and sustain change across the Trust. The team comprises a Consultant Physician, a Consultant Surgeon, a Nurse Consultant, a Patient Safety Pharmacist and the Head of Patient Safety.

Harm is measured by the use of the trigger tool, a process that involves retrospective records review looking for defined trigger events that are often associated with preventable harm (although for a proportion of patients this harm is a recognised side effect of treatment). Using this methodology we have demonstrated a reduction in harm from a baseline of 67 harm events per 1000 (67/1000) beds days to a median of 30.6/1000 in 2011 and 21/1000 in 2012 and 19/1000 in 2013.

Our aim for 2013/14 has been to sustain harm reduction and further reduce significant harm. Work streams continue to take forward improvements in the areas of standardisation and zero tolerance to outliers.

Progress of Note

- A continued reduction in hospital cardiac arrests with a further 10% reduction during 2013.

- The Trust has successfully bid for funding to support implementation of an electronic observation recording system which alerts medical and specialist teams to signs of patient deterioration thus supporting a prompt response. This system will be implemented across the Trust during 2014.

- The Trust has standardised nursing handovers to adopt SBAR (Situation, Background, Assessment, Recommendation) principles. This is a communication methodology which prompts staff to present information in a logical and standard way thus reducing the potential for omitting to handover information.

- Embedding of the enhanced discharge programme for patients identified at risk of re-admission in Cardiology and Respiratory occurred in 2013/14. To date over 500 patients have been enrolled with a 20% reduction of avoidable re-admissions seen in this patient group. Implementation will now spread into Diabetes and Elderly Care Wards.

- Continued promotion of key safety checks within operating theatres has led to a 100% record of completion with these being led by the Operating Surgeon (therefore re-enforcing the importance) over 70% of the time. Observational audit and on-going promotion will continue during 2014.

- Following completion of a staff perception survey on patient safety which demonstrated favourable scoring when benchmarked for team work, job satisfaction and safety climate (safety awareness, feeling confident to voice concerns and that these would be responded to) the Trust wanted to further strengthen and monitor the culture through the introduction of Safety Walks. Safety Walks involve two or three members of the Patient Safety Team visiting areas unannounced to discuss safety culture and issues with staff.

This has been received favourably and has informed further safety work and initiatives, including the introduction of a Patient Safety 10 campaign in 2014 to ensure our staff consider all key aspects of care which can impact on our patient's safety. All wards will have had a Safety Walk visit during 2013/ 2014 and additional Safety Walks are to be introduced by local management teams to ensure all areas receive six monthly visits.

- Each month we undertake the Patient Safety Thermometer audit which is a prevalence audit measuring harm from falls, pressure ulcers, catheter associated urinary tract infections and venous thrombo emboli. This indicates more than 98% of our patients do not experience these harms whilst in our care and is an improvement from 95% when auditing began in March 2012 and 97% at the end of 2012/13.

2.1.2 CLINICAL EFFECTIVENESS

CONTINUE TO DRIVE DOWN TRUST MORTALITY

Mortality rates are a key measure of the clinical outcomes of a Trust. The established measurement across the country and published in the Dr Foster Good Hospital Guide is the Hospital Standardised Mortality Rate (HSMR). The HSMR is a method of comparing mortality levels taking account of differences in population structure and accounts for approximately 80% of all deaths in hospital. The Department of Health has also developed a national Summary Hospital-Level Mortality Indicator and national index, shortened to SHMI.

SHMI includes all deaths in hospital and those within 30 days of discharge. For both measures 100 is the average for hospitals.

The HSMR reported in the Dr Foster Hospital Guide for 2012/13 was 103.1 and was "within the expected range". The Trust was banded as expected for all the mortality metrics produced by Dr Foster in the Good Hospital Guide. The SHMI value reported by the Department of Health for April 2012 to March 2013 was 110 and was banded within the 95% control limits trimmed for over-dispersion. The palliative care coding rate at Derby Hospitals was 29.06% within the time period.

The Trust scrutinises all issues relating to mortality with great care. Following a recent revision of the Quality Governance structure the Terms of Reference, chairmanship and membership of the Mortality Committee (previously the Mortality Review Group) has been strengthened. This Committee receives data on all hospital deaths and chooses certain cases to review often with valuable clinical lessons which have led to genuine changes in care. Dr Foster analysis of Trust data is examined monthly and appropriate audits undertaken to examine any areas of concern. The Medical Director leads this work which is reported monthly to Board.

REDUCE THE 30 DAY ADMISSION RATE

Work on the reduction of our re-admission rate has been focused on two main areas over the last 6 months: the implementation of the AMBER care bundle across medical and cancer wards, and pilot of the Enhanced Discharge of high risk patients within our Respiratory and Cardiology specialities. The AMBER care bundle contributes to people being treated with dignity and respect, and enables them to receive consistent information from their healthcare team. It helps people and their carers to be fully involved in making decisions and knowing what is happening with their care.

The Enhanced Discharge Model involves:

- Risk assessment

- Teach-back, a three day education and support programme pre-discharge focussing on medicines understanding, self-care and recognition of deterioration designed to help patients understand their medical condition and the impact it has on their everyday life
- Hot Handover: a verbal hand over to community teams to highlight patient discharge and needs ensuring other health professionals know what specific needs a patient may have
- Post Discharge Follow Up Call: 48-72 hours after discharge to identify any issues and support solutions which may arise post-discharge.

This model is now being rolled out across our Cardiology, Respiratory, Diabetes and DME specialities.

The Enhanced Discharge Approach has seen a 20% reduction in re-admission rates for those patients who have gone through the programme.

REDUCING MEDICATION ERRORS

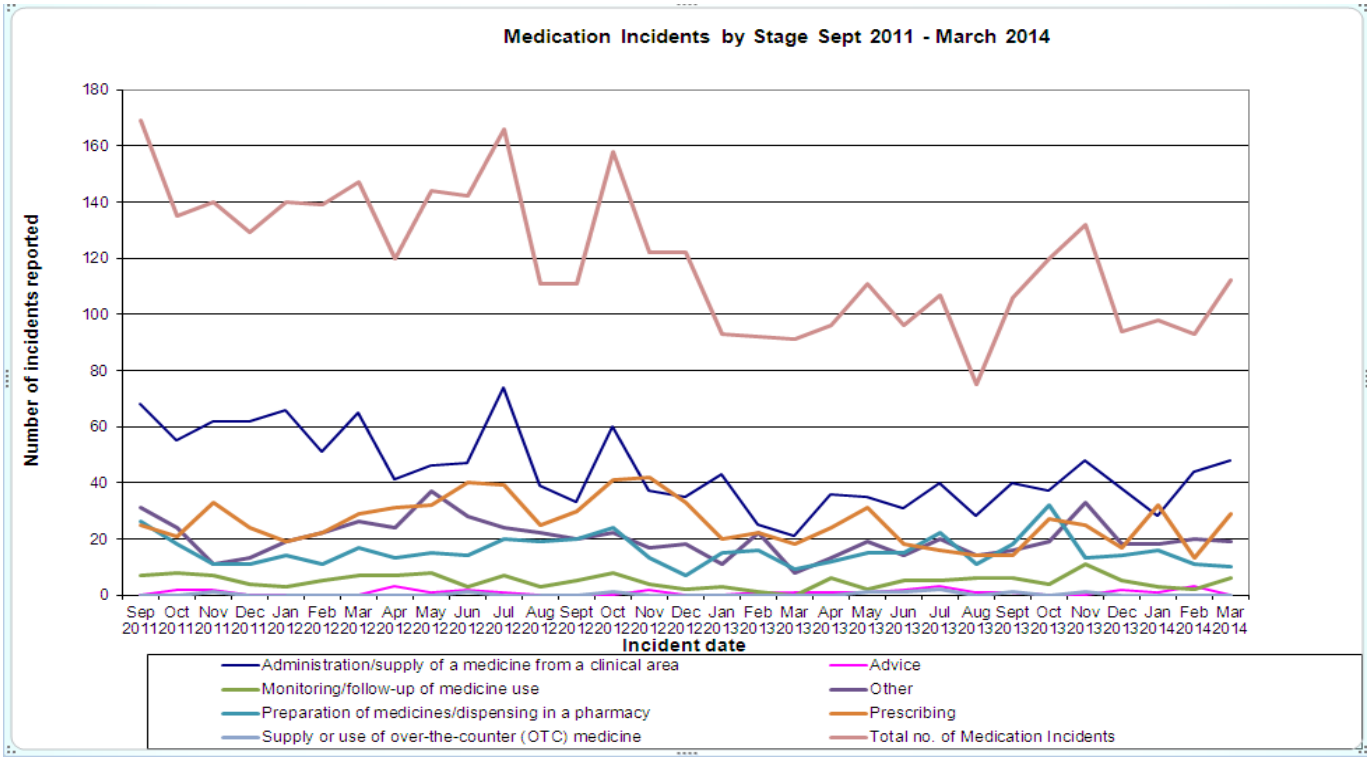
Priorities for Improvement section: 'Right First time' Reduce medication errors

The Trust promotes a positive safety culture and encourages incident reporting, placing the Trust in the top quartile of acute hospitals reporting to the National Reporting and Learning System (NRLS). There is widely published evidence of reduced harm in industries and organisations which have a positive reporting and learning culture.

Medication Errors

Following a 40% reduction in the number of medication incidents reported over the last two years, 2013/14 has seen the number of reports plateau at an average of 100pcm (from ~160 pcm in 2010/11).

This reflects the 40% reduction in medication error reports over the past two years due in part, to a focus on reducing avoidable harm within the Leading Improvements for Patient Safety (LIPs) programme, and the rollout of electronic Prescribing and Medication Administration (ePMA).



The latest data released by the National Reporting and Learning (NRLS) system covers incidents reported between Oct 2012 and March 2013. The data shows that Derby Hospitals still has a healthy reporting culture, with 8.1 incidents/100 admissions reported (E Midlands acute average 7.9). Medication errors were 9.9% (down from 11.9%) of all incidents reported (Large acute average 10.2%).

At Derby Hospitals over 98% of incidents lead to low or no harm (large acute average 93.8%) with incidents leading to severe harm or death (0.1%) reported during this period at rates lower than the large acute (0.7%) and regional (0.6%) average.

There are nine ‘medication events’ included in the NHS list of ‘Never events’. No ‘Never events' involving medication occurred at Derby hospitals in 2013/14.

This year we have introduced weekly ‘newsletter’ e-mails to all junior doctors on safe prescribing practice. Written by an experienced pharmacist the newsletters focus on sharing learning from real prescribing incidents or near misses and have been well received by junior doctors.

Electronic Prescribing and Medicines Administration (ePMA)

ePMA is now live in all adult inpatient areas within the RDH and LRCH, with the exception of Ward 101, Labour ward and ITU. Approximately 80,000 prescribing activities are conducted within iCM each month.

In December 2013 the iCM discharge module was implemented, which avoids the need for prescribers to ‘transcribe’ discharge medications into a separate system. The accuracy of prescribing on discharge prescriptions has improved. Baseline data from pharmacy indicated that 60% of TTO prescriptions needed correcting using the ‘old’ Bedweb system, but with discharge prescriptions being generated within iCM the proportion requiring correction has dropped to 20%.

‘Order sets’ are used within the ePMA system to standardise prescribing and reduce unwarranted clinical variation. The EPMA team have worked closely with clinicians to continually develop and implement relevant ‘order sets’ (of which there are now approximately 100 in use).

FRAIL ELDERLY CARE

Work has progressed well on the design and implementation of the Acute Frail Elderly Pathway. The screening tool is now fully implemented in the Emergency Department and Medical Assessment Unit.

The Frail Elderly Assessment Team is fully implemented 7 days a week, 8am to 8pm, providing a Comprehensive Geriatric Assessment across Medical Assessment Unit. The team have developed joint Multidisciplinary Team documentation which is shared with GPs and used as the referral data for Community Services within City and County. The next phase of the development of the pathway is due to start in April 2014 concentrating on the transfer out of the acute setting to community services ensuring the delivery of Comprehensive Geriatric Assessment.

LONG TERM CONDITIONS

Implementation of Community Support Teams and recruitment of a Care Co-ordinator role within GP practices is helping to develop a more integrated pathway for patients with long Term conditions across southern Derbyshire.

IMPLEMENT EXPERIENCE BASED DESIGN OF PATIENT PATHWAYS THROUGH TRANSFORMATION PROGRAMMES

During 2013/14 the Transformation Team have integrated with the Patient Experience Lead to ensure that all projects have a Quality Impact Assessment carried out at the very start of the project. This has to be signed off by the Medical Director and Chief Nurse. The use of Patient Panels and patient surveys have led to informed decisions about the changes required to ensure our services are fit for purpose and as appropriate for our current healthcare market as possible whilst recognising the needs of our patients.

REDESIGN THE ELECTIVE PATHWAY TO IMPROVE THE EXPERIENCE OF OUR PATIENTS

The work this year has concentrated on the following pathways:

- Implementation of Outpatient Parenteral Antibiotic Therapy (OPAT) service delivering intravenous antibiotics at home rather than having to stay in hospital.
- Identified sessions to move cases from general theatre to day case – to provide a better experience for patients in the right setting
- Piloting a revised pre-op pathway
- A revised admission pathway for breast patients providing a better pre-theatre environment

GETTING HEALTHY STAYING HEALTHY

In January 2014 the new "Get Healthy, Stay Health" programme was launched. This programme aligns the workplace health agenda, Making Every Contact Count (MECC), and NICE Guidelines for workplace health to ensure that the Trust strategic objectives are met and patients, staff, and visitors receive a consistent and positive message.

The overarching aim of the programme is to help staff make positive lifestyle choices, in addition to ensuring staff are able to support and sign post patients to the appropriate services.

The launch of the programme was supported by a comprehensive communication plan including road shows, team brief, target emails, poster campaign, launch of new intranet pages and signpost. In the first week over 3000 hits were measured on the intranet pages and over 40 individual e mails received from staff wanting to find out more about the services on offer.

The key topics that the programme covers are:

- Physical Activity
- Healthy Eating
- Stop Smoking
- Alcohol Awareness

In addition to the January launch there are several high profile campaigns planned throughout the year, which staff, patients and visitors are welcome to attend.

This programme will be further enhanced in March 2014 with the launch of the new Live Well programme, which is provided by Derby City Council.

IMPROVEMENTS IN TIMELY DISCHARGE AND COMMUNICATION TO OPTIMISE A PATIENT'S LENGTH OF STAY

Delayed Transfer of Care (DTOC) – Integrated Model

At the start of January 2013 Derby Hospitals NHS Foundation Trust applied a weekday system to support any patients that had gone over their Expected Date of Discharge. The daily process was supported by representatives from Derby City Adult Social Care and Greater East Midlands Commissioning Support Unit (Continuing Healthcare) supporting the daily DTOC meeting.

The vision is an integrated model to enable people to maintain the maximum possible level of independence, choice and control, whilst listening and supporting people to express their needs and wants. This increases positive self-esteem. Dignity in Care (2013).

Through the year DTOC levels were reported and overall there was a reduction in numbers of patients delayed.

Integrated Team

The Trust has a unique opportunity to develop and lead a multi-disciplinary team approach to managing complex discharge. The team incorporates strategic leadership and oversight of complex discharge progress, but also includes direct support to wards from a team experienced in all aspects of complex discharge i.e. equipment, over-border partners, continuing health care and social care support.

The strategic leadership is provided through the General Manager of Integrated Care & Discharge.

Having an integrated team has enabled:

1. Caseload management of patients on the Temporary Placement in Exceptional Circumstances; following the patient in to their temporary placement within the Southern Derbyshire locality.
2. Supporting the transfer of patients to a residential setting by undertaking comprehensive 'health and social care assessments' to facilitate the patient's safe transfer.
3. Support the management of complex patient cases and reduce delays to a minimum level.
4. To co-ordinate an Integrated Discharge Team within the proposed locality model to ensure smooth handover and care at discharge from hospital. This also supports case management of complex discharges within a non-acute setting.

Transformation- improving the quality of the patient discharge
The Home to Assess strategy has been monitored and reported through a Transformation scheme called Work-Stream 4 - Better Handover to Primary Care.

During 2013/14 transformation work has been led by Derby Hospitals delivering the following:

Launching the 5-a-day strategy- 'Providing safe and timely patient care 'enabling all staff to take proactive planned actions in order to optimise the patient experience. Focus has been given to earlier discharge planning, focused daily board/ward rounds using the See Home Other Plan (SHOP) principles, pulling from assessment areas early and utilisation of the discharge lounge. In addition all patient discharge information has been reviewed to optimise the opportunity for earlier communication with the patient and their significant others.

The strategy has been supported by:

- Development of a Discharge Standard Operating Procedure – rewriting the Discharge Policy, defining clear roles and responsibilities for the multi-disciplinary team and linking these with agreed internal professional standards.
- Establishing the Discharge Support Officer role and its clear link with the Community Support Teams.

This transformation work has been achieved through partnership working across the health and social community, including the Clinical Commissioning Group.

Discharge Lounge
Derby Hospitals currently has a Discharge Lounge facility located on level 2, adjacent to ward 206. The facility accommodates 3 bed spaces and 18 chair spaces.

The Discharge Lounge operates Monday to Friday from 8am until 8pm. To maximise the patient experience on the last day of their inpatient stay the workforce model has been revised to now include dedicated leadership and a designated level of portering and hostess support. Additionally there are plans to enhance the patient environment. The impact of these changes will be closely monitored through a patient experience survey.

Service Navigation – admission avoidance
Service Navigation is a committed service provided to patients who attend the Emergency Department, Medical Assessment Unit, Short-stay medical ward and Surgical Assessment Unit. The service supports patients found to be medically stable, but require assistance in facilitating their discharge or transfer, for example temporary support or respite care or rehabilitation in the community.

The Service Navigation operates:

- Monday to Friday from 8.00am until 8.00pm
- Weekend days from 8.00am until 4.00pm

DERBY BIRTH CENTRE

The Birth Centre was officially opened on Tuesday 11 March 2014 by Professor Cathy Warwick, CBE, who is the Chief Executive of the Royal College of Midwives. The opening was attended by representation from the Maternity Services Liaison Committee, the Southern Derbyshire Clinical Commissioning Group, The Trust Chairman and Executive Directors, and included midwifery and support staff from the maternity service.

The Birth Centre aims to provide a welcoming, relaxed, comfortable, and supportive environment for women and their families. Women experiencing a straightforward pregnancy and anticipating a normal birth are cared for by enthusiastic midwives. The Midwives in the Birth Centre view childbirth as a positive life experience which enhances the long term physical and emotional wellbeing of women and their families.

The feedback from women and their families has been extremely positive, and the midwifery team led by the Senior Midwife for Low Risk is working very hard to improve the women's experiences of the birth process.

INVEST IN A WARD ASSURANCE TOOL TO PROVIDE DEMONSTRABLE EVIDENCE OF DELIVERY OF HIGH STANDARDS OF CLINICAL CARE

Derby Hospitals currently has a significant challenge in managing patient flow. Demand in the emergency department has increased and there is good evidence that admitted non-elective patients are more complex. This has had a number of consequences in the hospital including an increased length of stay and increasingly complex discharges.

This year a need was identified for an electronic patient flow system that operates in real time giving quick access to vital, clinically relevant information. This system will play a vital role as the vehicle to support daily, high quality, multidisciplinary board and ward rounds. It will help facilitate decision making crucial to appropriate admission and timely discharge. The system is available on every computer in the Trust and utilizes a large touchscreen on every ward which is used as the basis of our daily board rounds.

The system that most closely met the operational requirements of Derby Hospitals was the Hospedia Extramed system.

It has been implemented across all of our medical wards (completed in December 2013) and we have plans in place to complete the implementation (across our surgical wards) by June 2014.

We are very pleased and excited with the system and will continue to develop it further help us manage care to the benefit of our patients.

TO IMPROVE AND SUSTAIN DISCHARGE COMMUNICATIONS WITH GPs AND THE WIDER HEALTH AND SOCIAL CARE COMMUNITY

ePMA and e-Discharge summaries have been successfully rolled out across both RDH and LRCH sites.
e-signing and e-sending of outpatient letters to GPs has now been implemented across 30 specialties.
The roll-out will be completed following our transfer over to our new IT system Lorenzo, which will support all patient information systems.

We are still working to ensure that all specialties send letters within 14 calendar days of discharge.

The Trust has worked in partnership with primary care colleagues to develop an e-portal and call handling service for primary care clinicians to report issues with prescribing information on discharge letters/receive appropriate response. This is to be implemented during 2014.

ENSURE ALL CLINICAL STAFF HAVE AN ANNUAL PERSONAL DEVELOPMENT PLAN AND UNDERGO APPROPRIATE CONTINUOUS PROFESSIONAL DEVELOPMENT

Every employee should meet with their line manager to identify and prioritise their learning and development needs for the next year in a Personal Development Plan (PDP). This is presented in an annual training needs analysis and informs the Trusts' annual workforce development plan. In identifying the priorities reviewers and / or managers consider the following:

- What training, development and or learning do individual employees need to achieve the requirements of their job description
- Does the training, development, and/or learning, reflect the agreed SMART objectives set from the annual development plan (Specific Measurable Achievable Realistic Timely);
- What training, development, and/or learning, do individual employees require to meet planned service developments, transformation developments;
- What training, development and or learning do individual employees need to reflect changing work roles and ways of working;
- What training, development and or learning do individual employees require who have been talent spotted or to support succession planning and career development;
- Consider the wider resources available including time and funding to support training, development and learning;
- How will the individual employee disseminate knowledge and skills from training, development and learning activity?

Evidence of appraisal activity is recorded with the Electronic Staff Record (ESR). Evidence of PDP is retained by the individual employee in their records (paper and or electronic versions) and by their manager.

WORK ON ACHIEVEMENT OF MANDATORY TRAINING FOR ALL CLINICAL STAFF IN ORDER TO STANDARDISE PRACTICE AND EMPOWER FRONT LINE STAFF TO RESPOND POSITIVELY TO EVERY PATIENT CONCERN EVERY TIME

Derby Hospitals are working with Skills for Health and Derbyshire Health and Social Care Organisations to agree minimum standards for Mandatory Training. This will enable the agreement of Core Skills Framework Standards.

At Derby Hospitals we have a blended approach to learning, with dedicated training rooms, and e-Learning which is available in the workplace, or accessible from home.

All staff have the opportunity to access their own Training Passport, which is a web based App, highlighting their mandatory training status. This is designed to run on all SmartPhones, Tablet Devices and desktop / laptop computers (PC and MAC). The Training Passport equips our staff and trainers to access the appropriate tools to manage their own learning and education, empowering individuals to work flexibly and efficiently through learning at work.

The App displays the mandatory training activities relevant to staff job roles, using a red, amber and green (RAG) model.

The App highlights which mandatory training activities are:

- in date (Green)
- need refreshing within the next 90 days (Amber)
- out of date (Red)

Reports are generated monthly to detail staff compliance and bi-monthly exception reports are produced to identify to managers which staff are non-compliant. This information on training allows staff to be booked on relevant e-Learning courses via the Training Passport; this is available at work or at home to all Trust staff 24/7. This information is required as part of Appraisal and Development Review and for Incremental Pay Progression purposes from April 2014.

Train the trainer (cascade training) is available for some subjects, to enable senior staff to deliver training and ensure competence in subject areas that are mandatory and essential to service within their working areas.

2.1.3 PATIENT EXPERIENCE

In 2012/13 the Trust has reviewed its Patient Experience Framework to shape and guide the Trust on its priorities to continue to build on its vision to deliver PRICE in caring and put the patient at the heart of all that we do..

The 10 point approach to this Framework looked at all aspects of care. The importance of ensuring the organisation grows with both the NHS and the people that it serves is vital if we are to understand the needs of our ever changing Healthcare economy.

During 2013 Derby Hospitals began a campaign called "Making Your Moment Matter" based on the Patient Experience Framework set out in 12/13. This Framework aimed for us to provide “Always Events” and during the course of the project development and after discussion with patient groups we decided to Brand this project “Making Your Moment Matter”.

We know from the feedback we receive that the small things that we do often make a big difference to patients, their carers and their families. We want to understand the things that make the difference to our patients, and to the member of staff caring for them. The aim of the project is to ensure that we listen to both our patients and staff and that this consultation exercise fitted alongside our Taking Pride in Caring Trust vision and objectives, as well as the National Nursing 6 C’s - Developing a Culture of Compassionate Care.

We wanted staff, patients and their families to help us develop a set of statements which are right for both our organisation and our patients.

23 statements were drawn from some of the feedback we receive from patients, their carers, and their families. Also information gained from our Friends and Family Test.

This was a large scale consultation with a target audience of 3000 people. Data from the consultation was gathered using a variety of methods including the listening events which proved to such a success that the Trust has set a calendar of listening events for 14/15 which will be set out later in this report. Other methods included:

- hard copy feedback forms which included an option to leave contact details if the patient/carer would be happy for their hospital experience to be used as a patient story;
- an online feedback form;
- feedback forms translated into the top 8 languages used at Derby hospitals by our interpreting service (Latvian, Polish, Punjabi, Russian, Slovak, Urdu, Arabic and Kurdish) and were made available for download on the Trust website;
- staff forums; and
- direct consultation with partnership organisations.

The methodology ensured we had a wide range of responses that meant something to both staff and service users which when published could be related to or be recognised as a direct comment from them.

The following Top 5 " Moments " have been recorded from this consultation:
We will treat you as a person, not just a patient, with dignity and respect at all times.
We will give you the best possible treatment that is available to you.
We will understand your needs by listening, empathising with you, and keeping you informed.
We will make the place you are treated in clean, safe and the environment as caring as possible.
We will give you information in a way that you can understand, to help make decisions about your care.

The statements set out the Trust's Pledge to its patients , visitors and carers to ensure that we deliver the best possible patient experience by not just doing the " Big Stuff" but ensuring we get the smallest interaction with a patient right first time.

This campaign will be rolled out across the Trust during 2014/15 through embedding this into every aspect of teaching we do in the Trust induction and in conversations during staff appraisals both medical and non-medical, ensuring we touch every member of staff delivering care in all its forms.

The Fundamentals of Care (FC)

This is an innovative flexible programme that engages staff in a meaningful conversation about what people want from our services. Through activities and the use of a variety of media, staff are invited to explore their own values, the Trust values, and the kind of care they would want for those people important to them.

Films and patient stories punctuate an interactive experience that discusses both the emotional needs (module FC1) and physical needs (module FC2) of those who require our care.

Themes included in FC1 are: Reflections on own values and the needs of those important to us, Public perception including the media, Francis Report, Keogh Review, The 6 Cs and Care Makers, PRIDE, CARE, Communication skills and Patient Stories.

Themes included in FC2 are: Meaningful interactions and 'rounding', tissue viability, nutrition and hydration, pain management and falls prevention.

The programme was launched in September 2013 and was delivered to the Trust senior nursing team as well as approximately 100 of our Sisters, Charge nurses and lead therapists. Both of which demonstrate the level of priority the Trust has given to this project and the patient experience in turn.

We are providing monthly sessions from February of 2014 and this will reach in excess of 200 of our clinical staff by the end of the schedule. The programme has also been included in our inductions for newly qualified nursing staff so that all those who begin their nursing career with us will see that the patient experience is at the centre of what Derby Hospitals delivers across all its services.

Person Centred Care project

Personalisation is a programme designed to embed person centred care into the culture on the wards. This is achieved by the use of a variety of tools that enable the staff caring for the patient to find out about and understand the person behind the patient and how to better support them and engage with them whilst they are in hospital.

The 1 page profile is like a mini 'this is me' document and details what and who are important to the patient. It also lets us know what their interests are etc.

Staff also complete a mini one page profile that will be displayed on the ward. This is so that patients and family can begin to know the person behind the uniform. By staff and patients knowing a little bit about each other and their interests it will be easier to strike up conversations about mutual interests etc.

Where possible every patient will be asked at the beginning of every day what small thing needs to happen on the ward that day in order for it to be a good day for them. At the end of the day staff ask the patient if their good day has been achieved.

Half way through the patients' stay on the ward, the senior nurse will sit down with them and discuss what is working well and what is not going so well. If this can be rectified at the time it will be. This information will be collated and reviewed every few months to identify any themes and the art of the possible with regard to addressing them.

Highlights from National Inpatient Survey 2013

The majority of results from this survey present the care delivered at Derby Hospitals in a very positive light. In most aspects, Derby Hospitals also fairs better than the national average scores. The most positive findings were that over 80% felt they were always treated with dignity and respect (a slight improvement on last year); 84% rated their overall experience as 7 out of 10 or above; 85% of planned admissions felt they were admitted in a reasonable timeframe and few experienced changes to appointments; over 70% thought the hospital, including toilets and bathing areas, were very clean; 84% felt they had the right

amount of information about their care; and the vast majority had confidence in the staff caring for them (85% confidence in doctors, 78% confidence in nurses).

Whilst there were very few negatives, a number of improvement areas have been identified. Around 30% felt there were only enough nursing staff some of the time; however, this may be simply down to perception. On questions regarding the quality of information given at various stages of care, although most reported they were given information in a clear and understandable way, around a quarter of patients either didn't feel they had any clear information or reported that it was only clear some of the time. In line with trends from complaints, almost half the respondents reported delays to discharge (47%), and of these, 56% reported that the delay was caused by a delay in receiving medicines. Furthermore, 35% of patients who'd received an operation or procedure said that how they would feel afterwards either hadn't been explained at all or had been only explained to some extent.

In relation to those negative elements found in the report the Trust is looking at the following key actions:

1. To develop the work with our patient panel to try and understand how we can make information sharing easier for the patient given that a lot of the information supplied can be of a complex nature.
2. The Patient Experience Team will be carrying out induction training for the new junior doctors in 2014/15 and this will be a theme of that training.
3. The Trust discharge project will have a key focus to improve the delay in receiving.
4. The Patient Experience Team will be working with surgical colleagues to look at the type of information supplied at the time of consultation, in relation to both the after effects of the surgery they are about to undergo, but also the general rehabilitation period expected.

Respondents
In the 2013 National Inpatient Survey, 431 patients responded from a sample of 900, which represents a good response rate of 48%. This compares to 476 in 2012, a response rate of 53%, so our response rate has gone down slightly.

Of those that responded, the vast majority were the actual patient. In some cases, a friend or relative completed the survey, and a number of patients were assisted in completing the survey.

Overall experience
In terms of patients' overall experiences, most felt they were treated with dignity and respect, most felt they had been given opportunities for feeding back their experiences, and many people were aware of how to make a formal complaint. Most ratings of overall experience were 8 out of 10 or above.

National Cancer Patient Experience 2012/13
The Cancer Patient Experience Survey 2012/13 (CPES) follows on from the implementation of the CPES in 2010 and 2012. The CPES provides information that can used to drive local quality improvements by the Trust and Commissioners; there is a plan to repeat the survey.

155 acute NHS Trusts participated in the survey which included all adult patients (aged 16 yrs and over) with a primary diagnosis of cancer who had been admitted into hospital as an inpatient or as a day case and was discharged between 1st September 2012 and 30th November 2012. The response rate at the RDH was 68% (national 64%) which was 743 questionnaires being returned. Where numbers of respondents in a particular tumour group were less than 20 (representing rare cancers), the individual tumour data is not available.

The survey has 15 categories which comprises of between 3 and 8 questions (overall 64 questions).

Who responded by tumour group?

Tumour Group	Number of respondents
Breast	143
Colorectal/lower Gastrointestinal	112
lung	35
prostate	42
Brain/Central Nervous System	2
Gynaecological	66
Haematological	103
Head and Neck	30
Sarcoma	0
Skin	36
Urology	113
Upper Gastrointestinal	49
other	12

Where we are doing well?
Derby Hospitals had 23 question responses that were in the top 20% category (compared to15 in the 2012 National Cancer Survey), with a statistical improvement being noted in 8 of these questions.

Listed below are the themes:

- * Patients' views being taken into account by doctors and nurses discussing treatments.
- * Given the right amount of information about condition and treatment.
- * Clinical Nurse Specialists listened carefully and patients felt they got understandable answers to important questions most of the time.
- * Staff explaining what would be done during tests and easy to understand written information being given to support this, alongside being given a complete explanation of test results in an understandable way.
- Patients feeling that they are given enough privacy when discussing condition/treatment, being examined and being treated.
- Patients feeling that the hospital staff did everything to help control pain all of the time.
- Written information about:
  - cancer type
  - explaining possible side effects
  - discharge written information and who to contact if worried post discharge

* demonstrates a statistical improvement from the National Cancer Survey results 2012

Where might we need to improve?
The Trust was placed in the bottom 20% for 3 questions (compared to 7 in the 2012 National Cancer Survey). The bottom 20% range is a comparative range with other Trust and is measured on a scale. Whilst it may seem rather negative to be in the bottom 20% on a particular question, in some cases the margin of tolerance between being 'in' or 'out' of the bottom 20% is very small.

The 3 questions were:

- Patients being given a choice of different treatments
- Staff did everything they could to control the side effects of chemotherapy
- When rating the NHS care over all 'patients being offered written assessment and care plan'

Developing Real Time Patient Feedback

The Trust has been committed to gathering real time patient feedback this year using a varying array of methods including the use of both performing and visual artists.

Listening to the patient on a one to one basis is so important. It is what we then do with the information to effect change.

An example of this type of real time listening can be seen through the "Singing Chefs" food project.

In the 12 /13 inpatient survey the Trust found that its scores in relation to food had dropped by a small amount on the previous year and in an effort to find out what the problems were the Facilities Team in conjunction with the Arts Co-ordinator drew up a project that saw two performing artists survey patients out on the ward about their experience of the food served at the Royal Derby site. During this interview patients were asked to score five themes out of five, those being Taste, Texture, Choice, Temperature and Amount. Once rated out of five this rating was placed on a music stave board and the tune played back to the patient using a violin. So if your selection was say 1 the note would be low and if scoring 5 it would produce a high note. This form of interaction was all noted and the music recording produced was given to the patient as a keepsake of their eating experience. The real value of this exercise was seen in the fun the patient had giving feedback and this led to a more open approach that just filling in a survey card.

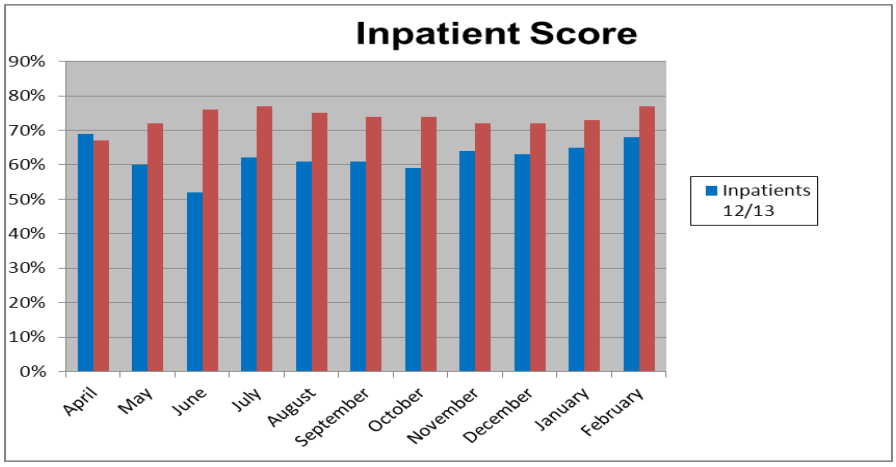
These themes have been fed back to the Catering Team and real improvements made in the last two menu changes at the Royal Derby site. Changes which have seen smaller portion sizes available to patients, changes in our light bites menu and the introduction of "Wraps" as well as sandwiches as a new choice. This just demonstrates the power of listening differently and what achievements can be made.

The Trust will continue using new and varied ways of getting this real time feedback which will be made all the easier with the introduction of our Electronic Friends and Family Test.

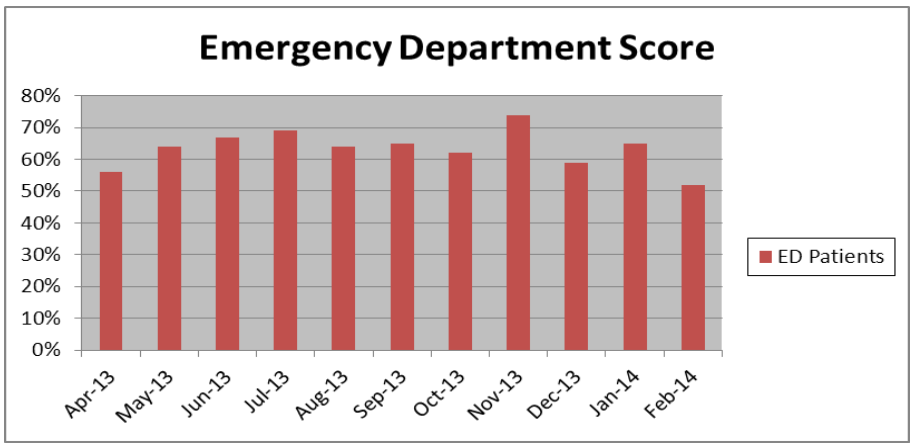
Friends and Family Test

Response rates for our Friends and Family Test are still variable across the Trust and this is constantly challenged at department level. However the Trust Score against Friends and Family are some of the best in the region.

Over the last year compared with 12/13 the Trust has seen a steady rise in its Friends and Family test score for inpatient Services.



Emergency Department (ED) Friends and Family Scores have been variable over the last year with a trend that reflects the times in which we have seen higher activity in the area. Since the collection of ED scores via text messaging in November 14 after a low early response rates recorded we have seen these pick up.



Maternity Services were added to the Friends and Family Test in October 2013 and are now in their fifth month of reporting with some really good scores being achieved. Maternity Services saw increases in both scores and response rates in January 2014 and with the addition of a electronic web based input portal we hope to increase the response rates further

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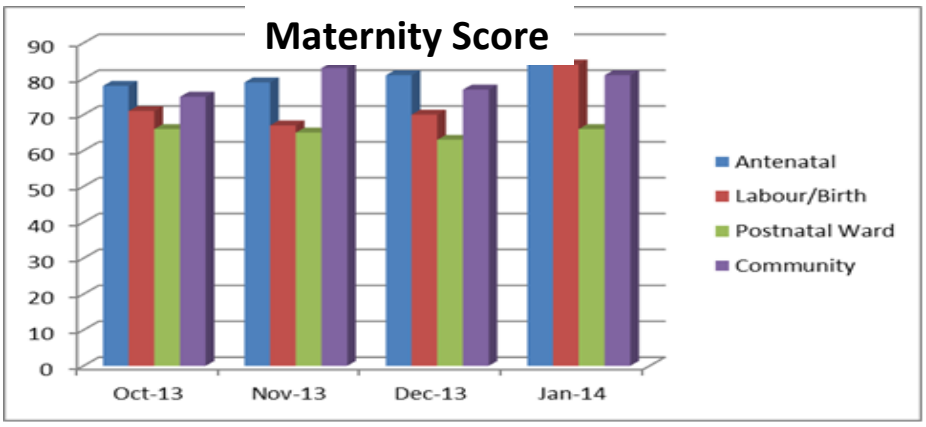


The Friends and Family Test is due to be rolled out further to Community Services and Outpatient areas as well as to staff in December 2014, October 2014 and April 2014 respectively. The Trust is developing plans on how to capture this data.

Currently we use 3 methods to capture the Friends & Family Test data: our "Your Views Matter" Cards, Text Messaging in ED and via an Electronic portal which we rolled out in March 2014, This will allow for a on line portal to be available to all patients, visitors, and carers, This will allow us to correlate feedback between both staff and patient experience.

The challenge to the Trust in 14/15 will be to ensure we keep the flow of information from all of these formats available for the organisation to learn from and adapt to the comments made about services if appropriate

The Your Views Matter Campaign was designed to support and enhance the Family and Friends Test. The campaign was set up to raise awareness of the different ways in which people could tell us about their experiences. This continues with a great deal of success. To support this, a new 'postcard' style feedback card was designed which incorporated the Family and Friends question, plus 4 further questions which focused on safety, information and communication. There is also a section for people to leave comments or suggestions on where we are doing well or where we could improve.

As part of the campaign posters on who to speak to on the ward if someone has a concern have been put up in inpatient areas. Banners advertising the campaign have been placed across the Trust and information for staff and patients has been put onto the Intranet and Internet.

The outcomes to date have been very positive with the majority of people responding to the additional questions identifying that they have had a positive experience, with particular focus on the positive and caring attitude of staff.

Positive comments are passed onto staff and also our communications and marketing department to ensure that information is shared.

As many of the comment cards carry a positive message (currently 85% of comments made) these are now scanned directly into the database and are e-mailed back to the Ward / Department to the senior nurse for display / onward communication.

Health Service Journal (HSJ) Awards
Health Secretary Jeremy Hunt encouraged all organisations to enter a new HSJ Award category which was backed by the Department of Health.

The Compassionate Patient Care category showcased the ways in which the health service has built on the recommendations of the Francis Report, and highlight organisations at the forefront of the patient centered care agenda.

The HSJ Awards are the largest celebration of healthcare excellence and Compassionate Patient Care joined 21 other categories. Health Minister Norman Lamb, on behalf of Health Secretary Jeremy Hunt, awarded Derby Hospitals Foundation Trust this inaugural award for its integrated partnership working over elderly patient care. Saying the breadth of project demonstrated at the judging stage showed that the words compassion and care was a constant throughout those projects in place.

COMPLAINTS AND COMPLIMENTS

In 2013/14 the Trust has continued to welcome patient feedback. Following a review of the Complaints Policy, there has been a continuing focus to ensure that we effectively and efficiently answer concerns and continually use this information to improve our services.

	2011/12	2012/13	2013/14
Number of Complaints	573	602	670
Number of Concerns	798	808	1072

Although we do not wish there to be more Concerns and Complaints, the increase continues to be encouraging as more people are telling us about their experience. The increase is felt to be due to the heightened awareness amongst the public about the option to complain. This trend reflects the local and national picture, and our own internal campaign related to 'Your Views Matter'. Proportionately, there have been a higher number of concerns this year and we have made significant effort to resolve peoples' concerns quickly, reducing the need for them to follow the formal complaints process.

The Trust has assessed itself against the National Complaints Report '*A Review of the NHS Hospitals Complaints System. Putting Patients back in the picture – Clwyd and Hart, October 2013'* and improvement work is well established as a result of this.

The key areas of focus are;

- Ensuring that staff are trained to deal effectively and efficiently with concerns
- Embedding systems to make sure that learning and improvements from complaints are part of our core activity
- Consolidating the use of the electronic information system to ensure that complaints and concerns are responded to in a timely manner

We have established a Complaints Review Group to carry out monthly reviews of the quality of our complaint responses. Consisting of Non-Executive, Governor and staff members, the group feed back to staff to ensure that learning takes place. The Trust has also enlisted the support of the Patients Association in surveying all people who make a complaint about their experience of the complaints process. Learning from complaints takes place at several different levels of the Trust, at Board, Divisional, Business Unit and local ward and department levels.

Complaints Received by the Health Service Ombudsman

A person may refer to the Health Service Ombudsman (HSO) if they do not feel that the Trust has responded to all of their concerns, or they are unhappy with the way in which we have dealt with their complaint. The HSO gives the Trust the opportunity to ensure that all local resolution has taken place to try and resolve the issues. The HSO will give an independent view view on the complaint.

In 2013/14 there were 7 new referrals received by the HSO which is a reduction from the previous year (18). This is encouraging because it means that more complaints are successfully resolved by the Trust.

Compliments
The Trust has widened the ways by which compliments are received, with the comments from Friends & Family and NHS choices website adding a rich source of information to the compliments received in writing by the Trust. The high number of compliments received is very encouraging and are fed back to the department teams to reinforce good practice.

Source of feedback	In writing	NHS choices website	Friends & Family
Number of Compliments	359	32*	8838**

* Data collected from September 2013
** Data collected from June 2013

DEMENTIA CARE

The Trust is continuing to develop the Framework for improving the experience of patients with Dementia as part of the overall approach to enhancing the quality of care for frail elderly people.

There is now a range of training and development programmes to improve Dementia awareness and a new E-Learning package has been developed. Dementia training has been rolled out via our One Stop Shops. This has been very well attended and we now have 2,500 staff having received general Dementia Awareness training.

13 senior members of nursing staff have also been trained in delivering a 'Best Practice in Dementia Care' course. This training has enabled them to become qualified facilitators of the same training so that they are now able to lead others within the Trust through the programme.

A very successful Dementia event took place in September 2013 to look at we can further improve how we care for patients with dementia. This involved a wide range of hospital staff and many of our community partners' action plans have been developed as a response to suggestions given on the day.

In wards that specifically have high numbers of elderly patients and those with a diagnosis of Dementia a number of initiatives have taken place, this has included the introduction of the 'Memory Cafes' which are designed as rooms which replicate certain eras and offer patients a place of consistency and calm whilst in the hospital setting. Environment changes have been made on some of our key wards, including painting individual bays different colours, better signage and a room being changed to become a dining/activity space. We are currently looking at the further environmental improvements we need to make.

The Trust has participated in the 'Enhancing the Healing Environment' programme provided by the Kings Fund. This training now enables staff members to undertake specialised environmental audits to enable the Trust to further improve the environment for people with dementia.

There is now a Psychiatric Liaison Team within the acute Trust available 7 days a week, 24 hours a day comprising of Mental Health Nurses, Consultant Psychiatrists, Psychologist and a Social Worker, who are supporting the assessment of patients with confusion and Dementia and advising on best care for patients.

As part of the Commissioning for Quality and Innovation (CQUIN) programme of work there has been a dedicated CQUIN focusing on early diagnosis, and referral for people over the

age of 75. The Trust has consistently made these targets which have improved the recognition, assessment and referral for specialist care of patients with a diagnosis of Dementia.

The Trust Board have signed up to the national 'The Right Care' campaign and have submitted our pledges towards getting it right, this will be available and published on the internet along with all the other acute hospitals pledges.

The Trust's priorities for the coming year will be;

- To increase the numbers of staff who have specialist training, particularly for those who directly care for patients with Dementia
- To continue to enhance our environment to make them more therapeutic for people with Dementia
- To further develop our individualised care plans for patients with Dementia, in close collaboration with community colleagues

LEARNING DISABILITIES

The Learning Disability Liaison Nurse continues to support the patients, carers and staff in improving the experience of this patient group. Assessing the care needs and advising on specific requirements including communication techniques, complex behaviours, and reasonable adjustments to assist the trust in effectively meeting the healthcare needs of people with a learning disability.

Support for pre- operative appointments has increased; this enables the planning to be discussed and the reasonable adjustments to be made prior to admission for surgery.

A photographic journey has also helped with this to show the patient and carers where they will be going and who they will meet. This reduces the anxiety for the patient and the carers, which leads to a positive hospital experience.

The Traffic Light Assessment continues to be well received by people with a learning disability and their carers, and is now recognised by the staff that come into contact with this patient group.

Alerts / patient flags continue to be imputed onto the PAS / Lorenzo systems; clearly identifying the person has a learning disability.

The short films on the web site have been used within training and within the community, and we are looking to do more filming for other departments within the hospital.

DEVELOPMENT AND IMPLEMENTATION OF WARD ASSURANCE TOOL

The Ward Assurance Tool is currently being reviewed in line with best practice and other organisations.
From 1st March 2014 indicators will be restricted to red or green, ie compliant or non-compliant. This will remove the potential risk of complacency. The ward assurance indicators will be reported against other safety measures through the Trust Quality Review Committee.

A performance management process will be developed to support the new approach. This will include a period of increased supervision and audit for those areas consistently falling below 95%. The process will also identify, reward, and give recognition to the most improved wards.

ENSURING THAT PATIENTS WHO ARE AT THE END OF LIFE RECEIVE THE MOST APPROPRIATE CARE

The Trust remains committed to providing high quality care to patients who are at the end of their life, and their loved ones. In 2013, we have been one of 71 Trusts participating in the national programme 'Transforming End of Life Care in Acute Hospitals'. This programme has been designed to enable more people to live and die well in their preferred place and encourages staff to use tools and resources, in particular five key enablers which are highlighted below. Delivery of this programme in Derby is being led by the End of Life Team, within the department of Palliative Medicine.

Advance Care Planning

Advance Care Plans record patients' wishes and preferences for end of life care. Throughout 2013, the End of Life Team provided training for community staff on the use of the *Gold Record,* a locally designed patient-held booklet in which advance care plans may be documented. These booklets are now in use in the community, given out by a range of community staff working with patients at the end of life. The Gold Record is a Trust Commissioning for Quality and Innovation (CQUIN) to secure improvements in quality of services and better outcomes for patients. The CQUIN enables the Trust to monitor the number of advance care planning discussions with patients using the Gold Record.

Electronic Palliative Care Co-ordination Systems (EPaCCS)

A system enabling key information to be communicated between healthcare professionals will improve coordination of care so that patients' wishes can be achieved wherever possible. Since 2013 the Trust has worked with Southern Derbyshire Clinical Commissioning Group (SDCCG) to introduce a common system that can be implemented across all providers involved in the care of patients at the end of life.

Amber Care Bundle (ACB)

The AMBER care bundle encourages clinical teams to identify critically ill hospital patients whose recovery is uncertain and who are at risk of dying in the next one to two months. This leads to better involvement of patients and their families in discussions about treatment and future care. The success the Trust has had with the implementation of this programme to date has led to the Trust being labelled as a 'faculty hospital'. All of the medical wards and the Medical Assessment Unit are now using this approach. As a baseline for 2013/14 55% of patients supported by the tool should have a documented discussion about their clinical uncertainty, this is currently recorded for 84% of patients. Work continues to implement the AMBER care bundle across all other wards in 2014/15.

Rapid Discharge Home to Die

Most patients say they would prefer to die at home, yet many die in hospitals. During 2013 we commenced a project, led by a facilitator, assessing the obstacles that may make it difficult for us to respond to an urgent request from a dying hospital patient to die at home.

Liverpool Care Pathway

Following an independent review led by Baroness Neuberger of the Liverpool Care Pathway, (LCP) it was recommended that that the LCP be withdrawn by July 14th 2014. The Trust has issued guidance regarding use of the LCP in caring for dying patients during the interim period and will be directed by forthcoming national guidance as we move forward.

The Leadership Alliance for the Care of Dying People (LACDP) has produced further interim guidance regarding the LCP and we continue to await the final formal guidance. The interim guidance highlights that the Neuberger report had 44 recommendations, of which withdrawing the LCP was only one. The LACDP (a group made up of about 20 organisations)

has to respond to all of them to come up with a comprehensive response on quality in end of life care.

The priority areas within the interim guidance for care in the last days of life are as follows:

- Recognising and communicating the possibility that a person may die within hours/days and reviewing this decision and plan regularly
- Communication with patient and family at this time
- Involving patient and family in decisions at this time
- Identifying needs of patient and family at this time
- Creating an individual plan of care for these days

The development of an "Individualised End of Life Care Plan" is still under discussion. Derby Hospitals are working with the local CCG's to develop documentation encompassing all of the above priorities. The above changes will need to be held within a framework of robust education for staff working both in Primary and Secondary Care.

Further Trust initiatives in End of Life Care

The National Bereavement Survey (VOICES)

The National End of Life Care Strategy (DOH, 2008) set out a commitment to promote high quality care for all adults at the End of Life stating that outcomes of End of Life care would be monitored through surveys of bereaved relatives.

The National Bereavement Survey (VOICES) commissioned by the Department of Health and administered by the Office for National Statistics (ONS, 2011) used a questionnaire which was completed by bereaved relatives as a method of evaluating these experiences.

This questionnaire has been re-designed to provide a mechanism for assessing the quality of care provided to people at the End of Life within Derby Hospitals and has been used within the Trust since January 2013.

Through the use of the VOICES questionnaire the team are able to measure the quality of care given to patients at the End of Life, their families/close friends and carers, and to use the results to plan and improve the quality of the care provided.

Carers Diary

The Trust has also introduced a Carers Diary for loved ones of patients in the last in the last days of life. Relatives and carers are encouraged to write down comments and questions regarding processes at the end of life. Concerns may also be raised.

This information is read by staff and acted upon as necessary. The Carers Diary is now used across the Trust.

A review of the Carers Diary identified two themes: observations on care and expressions of thanks and appreciation. To date there have been no concerns regarding personal care needs not being met.

2.2 PRIORITIES FOR IMPROVEMENT DURING 2014/15

The Trust continues to ensure that the Quality Strategy is embedded throughout the organisation and that these objectives are achieved. These objectives were developed through organisational learning, patient feedback and surveys. Wider engagement was not undertaken when those objectives were developed.

Staff views were taken into account following work developed as part of the Quality in Action event which all leadership staff from the Trust Business Units and Corporate Teams attended.

From 2014 objectives and targets will form part of the performance management arrangements for each Division within the Trust and be subject to regular review and scrutiny by the Quality Committee and Trust Board.

Monitoring and measurement of progress will be undertaken with the appropriate Trust committees and groups. These will report into the Quality Review Committee, Quality Committee, and the Trust Board. The priorities for 2014/15 have taken into account feedback and engagement with staff and patients through our:

- Dementia workshops
- Francis Listening Events
- Making your Moments Matter

Consultation with:

- Quality Committee
- Governors Workshops

Patient Safety:	Protect patients from C.Difficile Continue to drive down mortality rates Implement speciality level mortality review groups Introduce public ward staffing and safety information
Clinical Effectiveness:	Develop "toolkit" of quality assurance methods ie risk and quality reviews and safety walks Embed Trust inter-professional standards Reduce opportunities for clinical variation
Patient Experience:	Embed “Making Your Moment Matter” as a key caregivers strategy Roll out Fundamentals of Care education programme to all staff groups Implement year 2 of the Dementia Strategy continuing to improve the environment for patients Enhance opportunities to use real time patient experience feedback to drive improvements Ensure our complaints process is responsive and demonstrates the shift to a learning organisation

2.3 REVIEW OF SERVICES

The Trust provides a wide range of secondary care NHS services and since April 2011 has continued to provide the Adult Community Services across the City Centre.

During 2013/14 Derby Hospitals NHS Foundation Trust provided and/or sub-contracted 102 relevant health services. The Derby Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 102 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100% per cent of the total income generated from the provision of relevant health services by the Derby Hospitals NHS Foundation Trust for 2013/14.

2.4 PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

Audit is integral to providing evidence that the Trust is meeting national targets and demonstrating compliance with the recommendations and guidance from the National Confidential Enquiries of Patient Outcome and Death (NCEPOD), the National Institute for Health and Clinical Excellence (NICE) and the Department of Health.

The Trust Audit Group has an important role in assisting Divisions in the prioritisation of audits and monitoring progress against the Divisional Annual Audit Programmes and Action Plans when improvements are indicated and checking that re-audits are carried out. The Trust Audit Strategy and Audit Policy are available for staff on the Trust Intranet.

During 2013/14 39 national clinical audits and 2 national confidential enquiries covered relevant health services that Derby Hospitals NHS Foundation Trust provides. The Audits and Enquiries for which data collection was completed during 2013/14 are shown in the tables below. This data includes the number of cases submitted to each audit or enquiry as a percentage of the number of cases required by the terms of that Audit or Enquiry.

During 2013/14 Derby Hospitals NHS Foundation Trust participated in 77% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

NATIONAL CONFIDENTIAL ENQUIRIES INTO PATIENT OUTCOME AND DEATH (NCEPOD) REPORTS

The aim of NCEPOD audits is to maintain and improve standards of patient care in all specialties by reviewing the care of patients in confidential surveys and making the results and recommendations available to the Trust and relevant Clinicians and Departments. The Trust has an NCEPOD Ambassador who is responsible for the formalised process of review and management of National Confidential Enquiry reports and recommendations. The process includes identification of a designated Clinical Lead and a robust reporting structure via reports to the Mortality Review Group, Clinical Audit and Effectiveness Committee.

The national clinical audits and national confidential enquiries that the Derby Hospitals NHS Foundation
Trust was eligible to participate in during 2013/2014 are as follows:

National Confidential Enquiries					
Title		**Participated During 2013/14**	**Completed**	**Cases Submitted**	**% of Required/Eligible Cases**
Subarachnoid Haemorrhage	NCEPOD	✓	✓	1	100%
Alcohol Related Liver Disease	NCEPOD	✓	✓	3	100%
Tracheostomy Care	NCEPOD	✓	✓	3	100%
Lower Limb Amputation	NCEPOD	✓	✓	7	100%

The following NCEPOD Reports were received in 2013/14 and reviewed by the appropriate sub-committee of the Board.

Measuring the Units: A Review of Patients who Died with Alcohol Related Liver Disease

The aim of this study was to identify remedial factors in the quality of care given to patients who died from Alcohol related Liver Disease (ARLD) and the following recommendations were made.

Key Recommendations

- All patients should be screened for alcohol misuse. An alcohol history including weekly units drunk, patterns and recent drinking behaviour, time of last drink, indicators of dependence and risk of withdrawal should be documented.
- All patients with a history of potentially harmful drinking should be referred to alcohol support services for physical and mental assessment. The patient's GP should be informed re the referral and outcomes.
- Each hospital should have a 7day Alcohol Specialist Nurse service with a liver specialist and psychiatry liaison nurses for assessment, brief interventions and access to services within 24hours of admission.
- Each acute hospital should have an MDT Alcohol Care Team led by a Consultant with dedicated sessions.
- All patients with decompensated alcohol related liver disease should be seen by a gastroenterologist/hepatologist. This should be within 24 hours and no longer than 72hours after admission.
- Escalation of care for patients with alcohol related liver disease, whose background functional status is good, should be actively pursued and there should be close liaison with medical and critical care teams when making these decisions.
- Robust guidelines should be available and all clinicians should be familiar with them and trained in their use.

Trust Self Assessment

The Trust was compliant in 14 of the 27 recommendations, partially compliant in 7, not compliant in 4 and actions planned for 2, and these will be addressed through a monitored action plan.

Managing the Flow: Aneurysmal Subarachnoid Haemorrhage

This study examined the pathway of care from presentation to hospital, the initial management, surgical intervention, rehabilitation and discharge for patients suffering an aneurysmal subarachnoid haemorrhage (aSAH), and the following recommendations were made:

Key National Recommendations

- Formal networks of care should be established in secondary care, that include standard protocols for the initial assessment and management of aSAH patients in secondary care and their care during transfer.
- Accepted methods of establishing priorities for treatment should be established across networks.
- Standard operating procedures for the management of aSAH patients (including for their peri-operative care) should be established.
- Nationally agreed specifications and appropriate funding are required to ensure that aSAH patients receive optimum rehabilitation and support post-operatively and post discharge.
- The clinical presentation of aSAH needs to be highlighted in primary and secondary care education programmes, observing the guidelines for the management of lone acute, severe headache published by the College of Emergency Medicine.

- Standard operating procedures in secondary care facilities to improve the diagnosis, stabilisation, management, referral, and transfer of patients with an aSAHto neurosurgical centres should be introduced nationally.
- Improvements in organ donation rates from non-survivors of aSAH will require the development of hospital policies and audit.

Trust Self-Assessment
The Trust was compliant in 1 out of the 10 recommendations and partially compliant in 2; 4 were not applicable to the acute Trust.

Actions include:
- Audit of the management of aSAH will be carried out in the Emergency Department
- Assessment of the proportion of patients with headache having a full neurological examination will be part of the audit.
- Development of a protocol for the management of aSAH which will include the use of Nimodipine.
- Organ donation rates will continue to be monitored by the Trust Organ Donation lead

Current Studies

Study	Report Due Date
Lower Limb Amputation	Spring 2014
Tracheostomy Care	2014
Gastro Intestinal Haemorrhage	June 2015

NATIONAL AUDITS

Participation in National Audits 2013/14
The national clinical audits and national confidential enquiries that Derby Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. The chart also identifies audits for which data collection is continuous.

Title	Acronym	Participated in 2013/14	Completed	Cases Submitted	% of required/ eligible cases submitted
Trust Wide					
National Audit of Dementia NAD	NAD	✓	completed	40	100%
Children					
Childhood Epilepsy RCPH National Childhood Epilepsy Audit		✓	Ends May 14	10	100%
Diabetes RCPH National Paediatric Diabetes Audit	PNDA	✓	On going	145	100%
Paediatric Asthma British Thoracic Society		✓	On going	48	100%
Moderate or severe Asthma in Children (Emergency Departments) Colledge of Emergency Medicine		✓	In progress	50	-
Acute Care					
Emergency Use of Oxygen British Thoracic Society		✓	yes	755	100%

Adult Community Acquired Pneumonia British Thoracic Society		✓	Data collection started 01.12.14	-	-

Title	Acronym	Participated in 2013/14	Completed	Cases Submitted	% of required/ eligible cases submitted
Cardiac Arrest National Cardiac Arrest Audit	NCAA	✓	yes	91	100%
Adult Critical Care ICNARC CMPD	ICNARC	✓	on going	1071 cases from 01.01.13 to 4.12.13	100% (yearly cycle not yet completed)
Potential Donor Audit NHS Blood & Transplant Audit		✓			100%
Rheumatology & Early Inflammatory Arthritis		✓	Starts Feb 14	-	-
Inflammatory Bowel Disease	IBD	✓	Starts Feb 14	-	-
Chronic Obstructive Pulmonary Disease	COPD	✓	Starts Feb 14	-	-
Sentinel Stroke national Audit Royal Colledge of Physicians	SSNAP	✓	On going	60	Started Sept 13 data collection still active
Immediate Management of the Patient with Rupture: Open versus Endovascular Repair	IMPROVE	✓	yes	17	15 eligible = 88%
Carotid Interventions Audit	UKCAE	✓	completed	75	100%
National Vascular Database	NVDb	✓	completed	489	100%
Severe Sepsis and Shock Colledge of Emergency Medicine		✓	On going	-	-
National Emergency Laparotomy Audit Royal Colledge of Anaesthetists	NELA	✓	On going	-	Started Dec 13
Long-term Conditions					
Diabetes National Diabetes Audit	ANDA	✓	3023	1381	46%
Adult Asthma British Thoracic Society		✓	On going	-	-
Elective Procedures					
Hip, Knee & Ankle Replacements National Joint Registry	NJR	✓			
Heavy Menstrual Bleeding	RCOG	✓	On going	156	
National PROMs Programme	PROMs	✓	On going	1128	78.80%
Liver Transplantation NHSBT UK Transplant	NHSBT	✓			

Registry					
Peripheral Vascular Surgery National Vascular Database	VSGBI	✓			
Cardiovascular Disease					
Acute Myocardial Infarction & Other ACS MINAP	MINAP	✓	✓	-	100%

Title	Acronym	Participated in 2013/14	Completed	Cases Submitted	% of required/ eligible cases submitted
Heart Failure Heart Failure Audit	HF	✓	On going	229	100%
Coronary Angioplasty		✓	✓	-	100%
Renal Disease					
Renal Replacement Therapy Renal Registry		✓	On going	-	100%
Renal Transplantation NHSBT UK Transplant Registry		✓	On going	181	100%
Cancer					
Lung Cancer National Lung Cancer Audit	NLCA	✓	✓	300	100%
Bowel Cancer National Bowel Cancer Audit Programme	NBOCAP	✓	✓	100	100%
Head & Neck Cancer DAHNO	DHANO	✓	✓	100	100%
Oesopho-gastric Cancer National OG Cancer Audit	NAOGC	✓	✓	180	100%
Trauma					
Hip Fracture National Hip Fracture Database	NHFD	✓	✓	566	100%
Fractured Neck of Femur College of Emergency Medicine		✓		50	
Blood Sampling & Labelling NCA of Blood Transfusion		✓	On going	24	100%
End of Life					
Care of the Dying NCDAH		✓	✓	50	77%

National Audit Reports 2013-14

The reports of 5 national clinical audits were reviewed by the Derby Hospitals NHS Foundation Trust in 2013/2014 and the Derby Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

1 The Effectiveness of Prophylactic Granulocyte Colony Stimulating Factor (GCFS) in reducing Neutropenic Sepsis (NS) with adjuvant Chemotherapy for primary breast cancer

Background

Chemotherapy for breast cancer can affect the body's ability to fight infection since the bone marrow that produces our body's defence cells, as well as the breast cancer cells,

are affected by it. This study looked at the use of a treatment (GCSF) that boosts the bone marrow's ability to produce the white blood cell defence cells.

Recommendations
GCSF is a cost effective therapy that should be used in combination with certain chemotherapy regimes.

2 Heavy Menstrual Bleeding (HMB)

HMB is a relatively common condition that affects women's physical, emotional, social and material quality of life. This third Annual Report focuses on the experiences and health outcomes of women with HMB once they have been referred to the NHS outpatient clinics.

The report recommended a focus on younger women including those with non-white ethnicity and those in severe pain, or poor health, as these were highlighted as being less satisfied with their care.

3 National Paediatric Diabetes Audit (NPDA) 2011-12

The NPDA is commissioned and sponsored by the Healthcare Quality Improvement Partnership (HQIP) as part of the national clinical audit programme. Participation is now a mandatory standard for a Paediatric Diabetes Unit (PDU) to receive Best Practice Tariff (BPT). Over the last few years there has been a move towards intensification of therapy including carbohydrate counting, multiple daily injections and continuous subcutaneous insulin infusions.

The NPDA will act as a measuring tool for the implementation of such initiatives. The NPDA covers the components of the National Service Framework for Diabetes and includes details on the number of children and young people with Diabetes in England and Wales, the care processes they receive and outcome measures, including inpatient admissions for Diabetic Ketoacidosis (DKA). Individual data is available for each PDU for care processes and treatment targets. Only national data is available for admissions.

Key findings: care processes and treatment target

1. England: Overall significant improvement in number of children and young people achieving HbA1c<7.5%
2. Derby PDU: Improvement in number achieving HbA1c<7.5%, median HbA1c and mean HbA1c during 2011-12 compared to 2010-11. Local data better than the overall national data (see below).

	England 2010-11	England 2011-12	East Midlands 2011-12	Derby PDU 2009-10	**Derby PDU 2011-12**
Mean HbA1c		73 mmol/mol (8.8%)	70 mmol/mol (8.6%)	75 mmol/mol (9.0%)	**70 mmol/mol (8.6%)**
Median HbA1c		71mmol/mol (8.6%)	68 mmol/mol (8.4%)		**68 mmol/mol (8.4%)**
% HbA1c < 58 mmol/mol (7.5%)	15.7%	17.4%		16.6%	**21%**

3. England and Wales: only 6.7% of all children and young people over 12 years had all care processes recorded (HbA1c, BMI, BP, urinary albumin, cholesterol, eye screening and for examination.)
4. Derby PDU: 75.9% did not have all care processes recorded. This was due to lack of foot examination only.

Key findings for hospital admissions: national data

- Incidence of DKA remains high but evidence that it has declined slightly in some age groups and especially girls
- 15.7% were in DKA at diagnosis
- 1 in 10 due to hypoglycaemia
- In over half cause of admission unknown

Recommendations:

Treatment target (HbA1c)

1. Introduction of local high HbA1c (above 9.0%) policy with focussed action plan for these individuals.
2. Revision of new patient guideline : Higher starting doses of insulin for new patients, more aggressive correction of high blood sugars from the beginning aiming to get Hba1c <7.5% within 3 months of diagnosis.
3. Pump service: Further expansion of insulin pump service planned. -currently approximately 50 patients out of 240, following NICE guidance.

Care processes

1. Foot examination is now part of annual screening so all individuals should have all care processes performed.
2. Improved quality of data input -Band 4 diabetes assistant practitioner appointed 2013 now inputting all data.

Hospital admissions

1. Aim to reduce the incidence of delayed diagnosis in primary care and DKA at diagnosis: New guideline for GPs on shared care Pathology website accessible by GPs, recent education session at GP refresher course,
2. Coding of hospital admissions: Working with coders to ensure coding accurate.

4 United Kingdom Obstetric Surveillance Survey (UKOSS)

A United Kingdom Obstetric Surveillance System to describe the epidemiology of a variety of uncommon disorders of pregnancy. This includes: Thrombocytopaenia, Cardiac Arrest, and Advanced Maternal Age. Information from these studies may be used for the development of clinical guidelines, prevention and treatment, counselling for women, and may influence service planning and the management of safety issues. This report will be discussed at Governance meetings and areas of concern will be discussed and relevant actions planned.

5 National Bowel Cancer Audit (NBOCA) 2013

The report refers to patients diagnosed from 01 April 2011 - 31 March 2012 and data was submitted prior to December 2012.

There is a concern that the data is unreliable as insufficient numbers of our cases have been included.

Trust v National Results

	National Average (%)	Royal Derby Hospital (%)
Case ascertainment *		92
Discussed at MDT	98	82
Seen by clinical nurse specialist	88	86
Staging CT reported	89	81
Surgery reported	58.6	14
Median Lymph node harvest	16	16
Lap rates	49	19
30 day mortality (adjusted)	2.9	0
90 day mortality (adjusted)	4.5	2.4
2 year mortality (adj)	24.5	16.5
MR performed for rectal cancer	86	82
Radiotherapy for rectal cancer	35	45
APER rate for rectal cancer	24	9
Stoma present at 18 months for rectal cancer	51	33
Stay > 5/7	69	64
Readmission at 90 days	20	17

* case ascertainment and data completeness refers to data on age/sex/ASA/TNM and site of cancer being reported, but does not mean operative data is reported.

6 National Cardiac Arrest Audit

The National Cardiac Arrest Audit (NCAA) is the National Clinical Audit for in-hospital cardiac arrest. The purpose of NCAA is to promote local performance management through the provision of timely, validated comparative data to participating hospitals. NCAA is a joint initiative between the Resuscitation Council (UK) and Intensive Care National Audit & Research Centre (ICNARC).

NCAA monitors and reports on the incidence of and outcome from, in-hospital cardiac arrests and aims to identify and foster improvements, where necessary, in the prevention, care delivery and outcome from cardiac arrest. This Trust collects and enters data according to the NCAA data collection scope and comprehensive dataset specification. The NCAA dataset was developed to ensure that all hospitals collect the same standardised data, so that accurate comparisons can be made.

The NCAA Report provides an overview of the completeness of the data that the Royal Derby Hospital has reported. To include analysis of activity; stratified analysis of activity (drawing comparisons between this Trust and national data); and basic, anonymised comparative analysis (risk adjusted).

Trust Findings

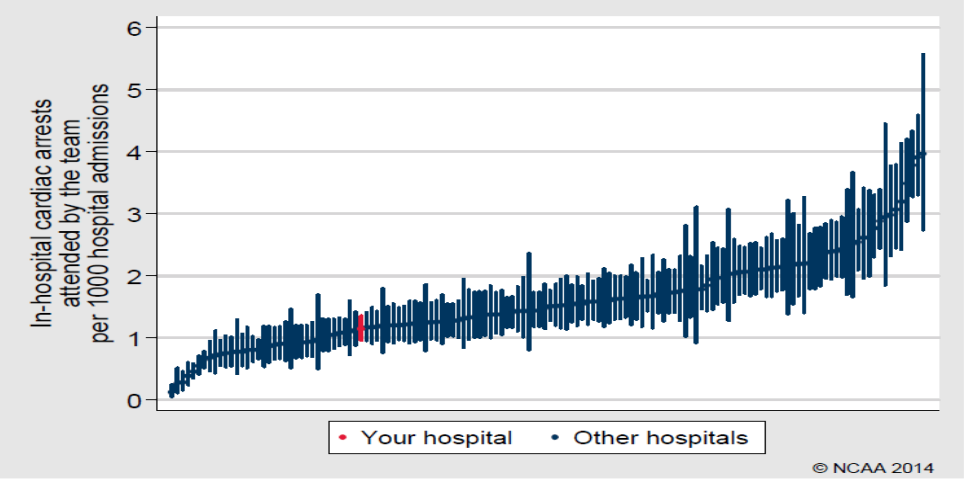
The Trust entered into the NCAA and commenced submitting data from April 2012. The most recent report which has been received is the third quarter report for the period April - December 2013.

The following graph represents the reported number of cardiac arrests per 1,000 hospital admissions for adult, acute hospitals in NCAA (for the period that this Report covers).

Comparison Reporting from NCAA Audit for In-hospital Cardiac Arrest

Rate of in-hospital cardiac arrests

The following graph presents the reported number of in-hospital cardiac arrests attended by the team (i.e. pre-hospital arrests are excluded) per 1,000 hospital admissions for adult, acute hospitals in NCAA.



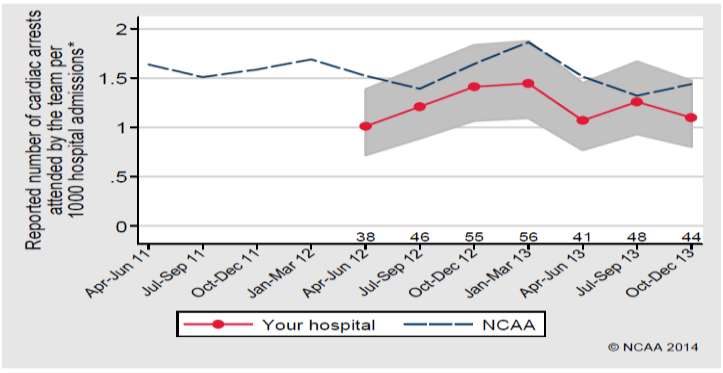
In the graph above, data for Royal Derby Hospital is presented in red, and data for other hospitals are presented in blue (for the period that this report covers).The Confidence Interval (CI) gives an idea of how accurately the value has been estimated. A narrow CI indicates a more accurate value.

The interpretation of the data is subject to:

- the inclusion of the most recent nine months of validated data for all adult acute hospitals participating in NCAA;
- the inclusion of hospitals with at least five in-hospital cardiac arrests attended by the team and at least three months data in the given financial year;
- an assumption that all hospitals are capturing the numerator and denominator data accurately; and
- variation across hospitals of type of admissions included in denominator data.

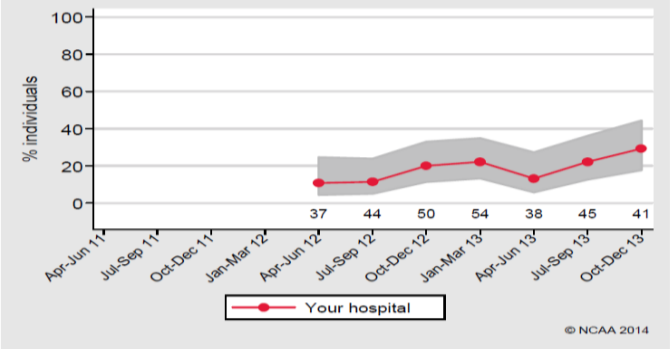
Results

Rate of cardiac arrests attended by the team per 1000 hospital admissions - trended



*Total includes elective, non-elective, and day cases (excludes babies born in your hospital and neonates)

Status at hospital discharge (alive) – trended



Note: NCAA comparator data are not plotted as these data are not risk adjusted
n = 0 individuals recorded as "patient still in your hospital" (excluded)

As a comparison RDH total number of cardiac arrests during 2011/12 was – 247, In 2012/13 the total number of cardiac arrest have been reduced to 202 resulting in a significant reduction of 18%. There has been a further reduction 2013/14 with an unconfirmed total of 183 cardiac arrests. It has been noted that the survival to hospital discharge in the 3rd quarter NCAA report has also improved compared to the same period 2012/13.

Trust Key Actions

- To continue with the quality of data collection and maintain the speed of data collection/entry.
- Compare outcomes with the other NCAA participating hospitals and examine what other factors (e.g. age, etc.) might be causing any variations seen.
- Examine survival rates following cardiac arrests and if they fall under the NCAA scope, review any unexpected patterns in patient outcome.
- To continue to identify and review specific resuscitation team calls for unexpected patterns in patient outcome, escalation or issues surrounding resuscitation status.
- To continue to circulate the NCAA reports to key individuals within the Trust, Medical Director, groups and committees.

DIVISIONAL AUDIT ACTIVITY

The Clinical Audit Department within the Trust continues to promote and support adherence to the approved Clinical Audit process to ensure the provision of accurate clinical audit information for the Trust and external organisations. Clinical audit also identifies improvements in patient care, good practice and excellence in the services provided by the Trust.

The Clinical Audit Department works closely with the Post Graduate Medical Education Centre and Foundation Programme Director to co-ordinate the Foundation House Officer, Year 2 of training (F2) Audit Programme. This ensures active involvement of junior doctors in the audit process and their ability to select and complete a clinical audit that is of value to patient care within the trust and add to their professional development.

Each Division develops a local Clinical Audit Forward Programme that is monitored by the Audit Department as part of the overall Trust Clinical Audit Forward Programme. Topics include, National Guidelines, NICE Guidance, National Service Frameworks, Clinical Risk and Clinical Indicators.

The Clinical Audit Department provides support and resources to facilitate audits throughout the Trust. All audits are registered and monitored through to completion.

Local Clinical Audit Activity by Division

		In Progress	% In Progress	Completed	% Completed	Continuous	% Continuous	Abandoned	% Abandoned	National Audits	% National Audits	Audits Against NICE	% Audits Against NICE
Medicine	Emergency Dept	13	0	1	7%	0	0	0	0	1	7%	3	21%
	MAU	5	100%	0	0	0	0	0	0	0	0	2	40%
	Medicine	74	80%	9	10%	9	2%	0	0	14	15%	4	4%
	Rehabilitation	4	100%	0	0	0	0	0	0	0	0	0	0
	Paediatrics	18	62%	6	3%	1	3%	4	14%	3	10%	5	17%
Clinical Support Services & Cancer	Critical Care	22	40%	14	25%	7	13%	12	22%	3	5%	1	2%
	Cancer Services	20	77%	3	12%	3	12%	0	0	4	15%	4	15%
	Imaging	16	53%	10	33%	4	13%	0	0	1	3%	0	0
	Pharmacy	5	21%	0	0	0	0	0	0	0	0	1	4%
	Pathology	8	40%	7	35%	3	15%	2	10%	7	35%	2	10%
Surgery	Surgery	32	86%	3	8%	2	5%	0	0	3	8%	6	16%
	T&O / Hands	51	96%	0	0	0	0	2	4%	1	2%	6	11%
	GUM	4	44%	5	56%	0	0	0	0	1	11%	0	0
	Obs & Gynae	38	72%	9	17%	6	11%	0	0	13	25%	8	15%
OVERALL		305	68%	67	15%	35	8%	20	4%	51	11%	42	9%

The reports of 17 local clinical audits were reviewed by the provider in 2013/14 and Derby Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Title of Audit	Aim	Key Findings	Actions
Management of epileptic women in pregnancy	To assess the care pre-conception	Not all women had appropriate pre-conception counselling in the ante-natal period.	Liaise with GPs and neurologists in providing pre-conception counselling and develop protocol and patient information leaflet
Patient satisfaction survey following day case shoulder surgery under regional anaesthesia.	To review patient complaints /dissatisfactions in order to improve patient care		Patients to receive a patient information leaflet regarding regional anaesthesia
Respiratory Action Plan for Chronic Obstructive Pulmonary Disease (COPD) patients	To assess the use of self-management for exacerbations of COPD	Plans were useful in 60% of cases. 40% had not used them or relied on health professionals for support.	The results were in line with other studies that show not all patients want or have the ability to self-manage. For re-audit next year.
To assess compliance with current bone health assessment in patients attending the Falls Clinic	To optimise management of Vitamin D deficiency	60% had a low Vitamin D level. 40% required increased dose Vitamin D loading. No single or	Compliance section on drug history chart if patient taking Vitamin D and calcium supplements.

		combination of risk fracture factors predicted deficient patients	Liaison with Pharmacy to develop a protocol for Vitamin D loading in all suitable patients attending Falls Clinics.
Peri-Splenectomy care	To assess performance with British Committee for Standards in Haematology	Overall vaccination performance had improved and antibiotic prophylaxis performance had been maintained.	Development of a checklist to improve performance and development of an automated letter to E Mail to the GP when the decision for splenectomy is made.
Re-Audit of the World Health Organisation (WHO) STOP moment	To audit performance against National Patent Safety Guidelines introduced in 2011	The STOP moment was performed in 88% of cases and there was an increase in the proportion of checks but a reduction in completeness.	Consultant led STOP checks and re-audit.
Re-Audit of Steroid prescribing in Palliative Care	To determine if steroid prompt stickers are being used on treatment charts and how effective they are.	There was an increase in compliance but inconsistent use of stickers. Excellent steroid treatment plans. Patients admitted on steroids don't have stickers and may have been clerked by non (NMU) doctors	Re-audit

Title of Audit	**Aim**	**Key Findings**	**Actions**
Analgesia following arthroscopic ankle arthrodesis prior to the use of popliteal catheters.	To consider the effectiveness of other modes of analgesia following arthrodesis		Patients having this procedure should be given Patient Controlled Analgesia (PCA) or sub-cutaneous Morphine. Better documentation of pain control. Suitable patients should have popliteal catheter local anaesthetic infusions.
Occupational Therapy Patient Satisfaction Study	To determine if patients found the service beneficial in enabling them to manage safely at home following discharge	No significant change from last year's audit. Most patients were satisfied with the support they received.	Re-audit
Patient satisfaction with care provided by the Adult Respiratory Team	To evaluate service user comments to help shape and improve future service provision.	The majority of the study findings were very positive and indicated a high level of satisfaction.	Review of a complex case highlighted in the study. Re-audit to include clinic availability and

			running to time.
Timely checking of Specialist Registrar Computerised Tomography (CT) reports pending Consultant review.	To assess if the current standard for senior review by 100hrs the next day and the documentation of communication of significant findings are realistic/achievable.	Almost all reports were available to the clinical team according to the standard. Written documentation of communication of major findings fell below the standard	Protocol revised. For re-audit in 6 months
Cholestasis in pregnancy		Half of patients would not meet new diagnostic criteria. No difference in delivery or neonatal outcome.	New Guidance in line with other Units nationally. Vitamin K use only with prolonged Prothrombin Time. Trainee education and discussion at Multidisciplinary forums.
Management of epileptic women in pregnancy	14 Maternal death 2006-2008 attributed to epilepsy. To assess the antenatal management of pregnant women with epilepsy	Good at providing multidisciplinary care Vitamin K prescription inappropriate 3/2. Overall good maternal and perinatal outcomes in well controlled epileptics	Liaise with GPs and neurologists in providing pre-conception counselling Proforma in ANC to prompt special aspects of ANC for pregnant women with epilepsy Access to patient information leaflet regarding postnatal care and advice in the ANC(*epilepsyaction*)

Title of Audit	**Aim**	**Key Findings**	**Actions**
Cholestasis in pregnancy	To review local practices and identify if there was over intervention.	Found that half of patients would not meet new diagnostic criteria. No difference in delivery or neonatal outcome in women induced early vs expectant management	New Action limit of BA 14 for diagnosis of OC -implemented in 2013 Review of guidance in line with other Units nationally to include Vitamin K use only with prolonged Prothrombin time - implemented in 2013. Trainee education and discussion at multi-disciplinary forums to ensure consistent rationalisation of investigations.

Laparoscopic surgery for endometrial cancer.	To review our practice against NICE national standards.	Conversion to TAH small and in keeping with the national average. Less blood loss noted than TAH. Complication rates between TLH and BSO, and TAH and BSO comparable	For Endometrial Ca to be treated laparoscopically if no exception criteria. Audit of 5 year survival rate in RDH patients.
Hypertension in Pregnancy – Aspirin uptake	To review our practice against NICE guidelines.	Aspirin was not given as recommended in a timely manner to those women at risk.	To raise awareness in all clinical areas and community bases. Refer identified women sooner in the pregnancy – high risk women to be booked with a Consultant at 12 weeks gestation – implemented 2014.
Intrauterine insemination at the fertility clinic.	To compare IUI treatment outcomes against the national average (HFEA).	Higher number of pregnancies where cycles were stimulated with HMG. No pregnancies when post wash motile sperm count is less than 2 million.	Proposed we develop a business case to support the use of HMG for ovarian stimulation.

DERBY CANCER AUDIT

Background and reason for Audit

The Dr Foster organisation monitors several outcomes of health care including mortality. It assigns a risk of death during a patient's hospital admission based on the admission diagnoses and co- morbidities. From this risk calculation Dr Foster generates an expected number of deaths and compares the expected number with the actual (observed) number of deaths in a diagnostic group. A score of 100 means the observed and expected deaths are the same; a score of above 100 indicates more deaths than Dr Foster would expect.

For cancer deaths, particularly secondary cancers, the number of deaths within Derby Hospitals has consistently exceeded the number that Dr Foster has predicted, so a thorough audit was carried out and covered all areas of the patient's pathway:

- Method, urgency and source of admission
- Initial grade of admitting doctor
- Time to consultant review
- Number of wards visited by the patient
- Number of consultants involved in care
- Final place of death
- Likelihood of death (by opinion)
- Details of metastatic spread
- Recorded Cause of Death and the Cause of Death that a consultant would have written
- Any Palliative or Terminal Care pathway provided
- Any discussion with HM Coroner and any post mortem undertaken

Conclusions: Data, Diagnoses and Dr Foster

Dr Foster data missed half of the actual number of cases, but this was because they had not been coded fully. Our data showed that the actual number of deaths was the same as the Dr Foster expected value per month.

The main areas for improvement are:

- Medical record keeping
- Consultant involvement early in the patient's admission, as well as in determining the death certificate entry and the subsequent clinical coding.
- Mortality meetings to review every death in the speciality
- Computerised mortality database]
- Consistent involvement of cancer specialists or palliative care team as indicated

2.5 PARTICIPATION IN CLINICAL RESEARCH AND INNOVATION

The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered, and supported.
(Principle 3 of the NHS Constitution, 26 March 2013)

The importance of innovation and medical research is underscored by this Principle as integral to driving improvements in healthcare services for patients.
(Handbook to the NHS Constitution, 26 March 2013)

The promotion and conduct of research continues to be a core NHS function and continued commitment to research is vital if we are to address future challenges. Further action is needed to embed a culture that encourages and values research throughout the NHS.
(Quality, 2.4., The Operating Framework for the NHS in England 2012-13)

RESEARCH

Derby Hospitals NHS Foundation Trust is a research-active teaching hospital with research taking place in most disease areas and specialties across the organisation. Activity in clinical research is a hallmark of high quality service and it places our Trust at the leading edge of patient care and treatment.

In 2013-14, research studies and clinical trials took place in obstetrics, maternity and gynaecology, paediatrics, cardiology, dermatology, hepatology, gastroenterology, renal medicine, cancer and palliative care, lymphoedema, diabetes, stroke, rheumatology and musculoskeletal disease (including physiotherapy), hand surgery, vascular surgery, ophthalmology, neurology and Parkinson's Disease, general surgery, respiratory medicine, rehabilitation and accident and emergency.

The number of patients receiving relevant health services provided or sub-contracted by Derby Hospitels NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 3,856.

Recruitment to a number of studies has been notable, including a study in renal medicine, "Defining the long-term consequences of acute kidney injury: the AKI Risk in Derby (ARID) study" which recruited 268 patients in the first 10 months of the year. Acute Kidney Injury (AKI) refers to an abrupt decline in kidney function and is often seen in unwell patients. The ARID study, led by Dr Nick Selby, Consultant Nephrologist, is designed to address the lack of good quality research in this area.

The "UK Aneurysm Growth Study" opened at Derby Hospitals NHS Foundation Trust at the start of 2013-14 and, in the just first 10 months of the year, it has provided the opportunity for 621 patients to participate in research.

The study aims to find out more about abdominal aortic aneurysms (AAA). An AAA is a condition where the main artery in the body swells up and there is a risk of it bursting as a result. These AAAs can be identified when they are small, but there is no treatment for them other than high-risk surgery. Recently, a national screening programme (the NHS Abdominal Aortic Aneurysm Screening Programme) has been established and patients attending for screening are invited to participate in the study. The AAA Screening Programme at Derby Hospitals NHS Foundation Trust is led by Mr John Quarmby, Consultant Vascular Surgeon and managed by Mr David Miller.

In 2013/14, the Trust was involved in conducting 311 clinical research studies and approximately 122 new studies were given permission to start in the Trust. This level of participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinicians stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes. Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques.

A number of applications have been made by Chief Investigators within the Trust for National Institute for Health Research (NIHR) and other high quality research funding. Applications have been made to NIHR Research for Patient Benefit; British Renal Society; BMA; BUPA; Dunhill Medical Trust; Pfizer; NIHR Health Technology Assessment (HTA); Kidney Research UK; Medical Research Council (MRC) DPFS.

A number of these research funding applications have been successful and this is a further indication of the high quality research environment within the Trust which supports the delivery of high quality patient care.

Research grant awards made in 2013/14 include:

1 £2.9 million awarded to Mr Amit Goyal, Consultant Oncoplastic Breast Surgeon, by NIHR HTA for a 10 year, multi-centre trial:

"POSNOC – Positive Sentinel Node: adjuvant therapy alone versus adjuvant therapy plus clearance or axillary radiotherapy. A randomised, controlled trial of axillary treatment in women with early stage breast cancer who have metastases in one or two sentinel nodes".

Women with early breast cancer usually have this removed either by wide local excision (lumpectomy)or removal of the whole breast (mastectomy). During the operation, one or two lymph nodes (glands) are removed from the armpit (axilla) to check if the cancer has spread to them, a procedure called sentinel node biopsy. A quarter of women, have cancer in these nodes. Current practice is to offer these women chemotherapy and/or hormone therapy, plus axillary treatment. Axillary treatment is either further surgery to remove all the remaining nodes from the armpit (axillary node clearance) or axillary radiotherapy.

Our study will recruit almost 1900 women diagnosed with early breast cancer and cancer in their sentinel node biopsy. Patients will be randomised either to adjuvant therapy alone, or to adjuvant therapy plus axillary treatment (axillary lymph node clearance or axillary radiotherapy). Adjuvant therapy is systemic chemotherapy and/or hormone therapy, with radiotherapy to the breast or chest wall if indicated.

2 £300,000 awarded to Professor Maarten Taal, Consultant in Renal Medicine, by the Dunhill Medical Trust for a study entitled: "Clinical impact of adopting a new equation utilising cystatin C and creatinine to estimate glomerular filtration rate for diagnosis and risk prediction in older people with chronic kidney disease in primary care", which is part of the larger Renal Risk in Derby (RRID) study.

Measurement of creatinine, a blood chemical cleared by the kidneys, is used to estimate how well the kidneys are working (glomerular filtration rate, GFR) and diagnose chronic kidney disease (CKD). Creatinine levels are, however, influenced by other factors that may result in lower GFR values and over-diagnosis of CKD, particularly in older people who are more commonly labelled as having CKD. This study evaluates the impact of using creatinine, together with another marker of kidney function called cystatin-C to more accurately diagnose kidney disease.

3 £108,000 awarded to Dr Vaughan Keeley, Consultant in Palliative Medicine, Dr Lorraine Pinnington, Associate Professor and Professor Christine Moffatt, Professor of Clinical Nursing Research by the Multiple Sclerosis Society for a study entitled:

"Chronic Lower Limb Oedema in people with Multiple Sclerosis: prevalence, precipitating factors and secondary consequences".

People with Multiple Sclerosis (pwMS) can experience leg swelling which does not go away easily. This form of Chronic Lower Limb Oedema (CLLO) is generally thought to arise as a result of reduced mobility, blood pooling, and impaired lymphatic flow.

This study will estimate the prevalence of CLLO in multiple sclerosis patients of Derby Hospitals NHS Foundation Trust; it will describe the severity, causes, and secondary consequences of CLLO.

4 £22,000 awarded to Ms Fiona Willingham, Team Leader Dietician, by the British Renal Society for a study entitled:

"Pre-emptive rehabilitation to prevent dialysis-associated morbidity (PREHAB)"

Chronic kidney disease is associated with general lethargy and muscle wasting, which can affect day-to-day life. This study continues our assessment of a programme of weekly sessions of exercise, education, and support to reduce the impact on quality of life.

RAISING THE PROFILE OF RESEARCH

Each year, we celebrate International Clinical Trials Day by placing a number of posters and stands, manned by Research & Department staff, in key locations around the Trust where they can be seen and visited by patients, staff and visitors to the Trust.

The aim of International clinical Trials Day is to raise awareness of health research and to highlight “It’s OK to ask” about clinical research.

INNOVATION
Derby Hospitals NHS Foundation Trust continues to enhance the quality of its services and develop new sources of income through its innovative staff and the support provided by the Research & Development Department. The Trust has an Innovation and Horizon Scanning Group, which identifies and develops any potential clinical and technological developments which may impact on clinical services within the Trust and to link these to the Trust Strategy.

Innovation is about developing new ideas and “inventions”, to generate new products or services (product innovation) and new ways of working (process innovation).

Product Innovation & Intellectual Property
NHS Innovation Hub Membership
In January 2012, the Trust became a member of Health Enterprise East Ltd, a NHS Innovations Hub which provides financial support and personnel to enable the Trust to take forward, commercialise and disseminate its innovations.

In the last year, colleagues from Health Enterprise East have held monthly innovation surgeries within the Trust as well as travelling to meet with Trust staff who have raised ideas about innovations with the Trust’s Assistant Director of Research & Development. The appropriate Intellectual Property Rights (IPR) for the various inventions are being put in place and commercialisation opportunities are being investigated. There new innovations identified in the last 12 months include various software programmes, e-learning packages and training courses as well as innovative healthcare products.

Trademarks
The Trust has trademark protected the use of “Pulvertaft” for the Hand Unit and “Jenny O’Neill” for the Diabetes Centre.

Patents
Patent protection, including US Patent protection, has been granted for a limb disinfection sleeve which was invented by Mr Chris Bainbridge, Consultant Hand Surgeon. A new licensee is also being sought for the limb disinfection device to improve the commercial return on this product. Discussions with interested parties are underway. Avenues of commercialisation other than via licensing are also being explored.

Design Rights and Collaborations

The Derby Door which won the Best Interior Product Award and the Patients' Choice Award at the Building Better Healthcare Awards 2011, is an inflatable barrier which fits flush against walls and ceilings on hospital wards to form a complete seal. This innovative product was invented by Mr Paul Brooks, Head of Facilities and Director of Patient Experience. The Derby door is produced and manufactured by AirQuee Ltd in Bristol, an inflatables manufacturer. Derby Hospitals will share the net profit from these sales and as part of the manufacturing agreement the Trust received 10 Derby Doors.

Other NHS Trusts have also purchased the Derby Door and sales are starting to rise. The Trust will be taking the lead on marketing the Derby Door with AirQuee Ltd taking on the roles of manufacturing and sales. Discussions are taking place with the East Midlands Academic Health Science Network regarding their support in disseminating the uptake and spread of this innovative product which was awarded the East Midlands Academic Health Science Network award for Patient Safety in the Health Enterprise East 2013 Innovation Competition.

Spin Out Company
Derby Hospitals NHS Foundation Trust is a significant share-holder and partner in iQudos Medical Services. iQudos Medical Services provides a nurse-led service for management of benign prostate disease. The company is in the process of setting up a similar service for stable prostate cancer and other disease domains. In June iQudos was runner-up in the Outstanding Achievement Awards category of the Medilink East Midlands Innovation Awards 2013. iQudos was also a finalist in the "Efficiency in Medical Technology" category of the HSJ Efficiency Awards announced in September 2013. The company is looking to increase its geographical coverage and is in discussions (under a CDA) to investigate this further. This is an on-going action.

2.6 GOALS AGREED WITH COMMISSIONERS

CLINICAL QUALITY AND INNOVATIONS MEASURES (CQUIN)

A proportion of Derby Hospitals NHS Foundation Trust income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between Derby Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Payment of £ tbc was made by the NHS Derby City (the Co-ordinating Commissioner) and this included East Midlands Specialist Commissioners.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: (tbc)

Year		£000's	CQUIN	
2012/13	Tariff Income	£270,915	£6,237	
	Non-Tariff Income	£107,778	£2,487	
	Total Income	£378,693	£8,724	2.30%
2013/14	Tariff Income			
	Non-Tariff Income			
	Total Income			

Derby Hospitals CQUIN Year-End Position 2013/14
Acute Services

Goal Type	Goal Number	Indicator Number	Indicator Name	**Indicator Weighting** (% of CQUIN scheme available) **and Expected Financial value of indicator** (£)	Year End Result
National	**1**	1a	Friends and Family Test – Phased expansion	0.0250% = £77,939	**Achieved**
		1b	Friends and Family Test – Increased Response Rate	0.0500% = £155,878	**On target to achieve** (confirmed data not available until May 2014)
		1c	Friends and Family Test – Improved performance on the Staff Survey FFT	0.0500% = £155,878	**Achieved**
National	**2**	2	NHS Safety Thermometer – Data collection	0.1250% = £389,695	**On target to achieve** (confirmed data not available until April 2014)
National	**3**	3a	Dementia – Find, Assess, Investigate and Refer	0.0750% = £233,817	**Achieved**
		3b	Dementia – Clinical Leadership	0.0125% = £38,969	**On target to achieve** (confirmed data not available until April 2014)
		3c	Dementia – Supporting Carers	0.0375% = £116,908	**Achievement to be verified through the May 2014 Contract Management Board as** (partially achieved within the year)
Local	**4**	4	Local Dementia – Improve the management and care of patients with dementia receiving hospital care	0.864% = £269,357	**On target to achieve** (confirmed data not available until April 2014)
National	**5**	5a	Venous Thromboembolism – Risk Assessment	0.0625% = £194,847	**Partially achieved**
		5b	Venous Thromboembolism – Root Cause Analyses	0.0625% = £194,847	**On target to achieve** (confirmed data not available until April 2014)

Local	**6**	6a	End of Life - Implementation of Amber Care Bundle	0.1037% = £323,291	**On target to achieve** (confirmed data not available until April 2014)
		6b	End of Life - Discussions as End of Life approaches	0.1037% = £323,291	**On target to achieve** (confirmed data not available until April 2014)
		6c	End of Life - Improve care of patient and support for family in the last few days of life	0.1037% = £323,291	**On target to achieve** (confirmed data not available until April 2014)
National	**7**	**7**	High Impact Innovations - Progress for achieving the relevant High Impact Innovations identified at the pre-qualification stage	0.2591%= £807,760	**On target to achieve** (confirmed data not available until April 2014)
National	**8**	8	MECC - All patients in contact with frontline staff who wish to make lifestyle changes are identified through Making Every Contact Count and provided with Brief advice/ Brief Intervention	0.0864% = £269,357	**On target to achieve** (confirmed data not available until April 2014)
National	**9**	9	CNO Strategy – improve standards of care by implementing the Chief Nursing Officer strategy 'Compassion in Practice'	0.3111% = £269,357	**On target to achieve** (confirmed data not available until April 2014)
National	**10**	10	Clinical Information - Improving patient level clinical information	0.2591% = £811,813	**TMG Indicators on target to achieve** (to be discussed at May 2014 Contract Management Board)
National	**11**	11a	Discharges – Improving Patient Flow	0.1727% = £538,403	
		11b	Discharges – Forward planning discharge	0.3400% = £1,059,970	
		11c	Discharges - Developing Discharge MDT	0.0864% = £269.357	
		11d	Discharges – Non weight bearing patients	0.0864% = £269.357	
			Totals	**100.00% = £7,793,900**	

COMMUNITY INDICATORS					
National	**1**	1	NHS Safety Thermometer – Data Collection	0.50% = £47,977	**On target to achieve** (confirmed data not available until April 2014)
Local	**2**	2a	End of Life – Improve communication and co-ordination of patient care at the End of Life	0.47% = £45,098.5	**On target to achieve** (confirmed data not available until April 2014)
		2b	End of Life – discussions as End of Life approaches	0.47% = £45,098.5	**On target to achieve** (confirmed data not available until April 2014)
Local	**3**	3	MECC – All patients in contact with frontline staff who wish to make lifestyle changes are identified through Making Every Contact Count and provided with brief advice/brief intervention	0.53% = £50,856	**On target to achieve** (confirmed data not available until April 2014)
Local	**4**	4	CNO Strategy – improve standards of care by implementing the Chief Nursing Officer strategy 'Compassion in Practice'	0.53% = £50,856	**On target to achieve** (confirmed data not available until April 2014)
			Totals:	**100.00%**	

2.7 REGISTRATION WITH THE CARE QUALITY COMMISSION (CQC)

Derby Hospitals NHS Foundation Trust is required to register with the CQC and its current registration status is registered without any conditions. During the year the Trust received 2 visits from the Care Quality Commission.

The Care Quality Commission has not taken any enforcement action against Derby Hospitals NHS Foundation Trust during 2013/14.

Derby Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission. Derby Hospitals NHS Foundation Trust has made the following progress by 31st March 2014 in taking such action.

2.7.1 DERBY HOSPITALS PERIODIC REVIEW-RETURN VISIT

The CQC visited the Trust on the 15th and 16th of July 2013 in order to check that the Trust had taken action to meet the following essential standards for Complaints and Records identified in a periodic review on the 16th and 17th of October 2012. The visit involved 2 medical and 2 surgical wards. Patients said they were generally satisfied with their care and the service and commented on how well they were treated and looked after.

Complaints
The Trust had identified that that the systems for tracking and recording progress in dealing with a complaint were not effective and did not meet the standard. A detailed review and re-organisation of the Trust complaints policy has been undertaken with key performance indicators monitored directly through Trust Board each month.

The CQC judged that the Trust still did not meet the standard as the complaints procedure was not understood by patients and visitors, and not well publicised. Also not all complaints were being responded to in a timely and appropriate way as the recently approved and updated Trust policy on the management of complaints was not fully embedded within the organisation. This would have a minor impact on services.

A complaints improvements plan focusses on responsiveness and organisational learning is in place and is monitored through the Trust Quality Review Committee
.
There was evidence that:

- Ward staff were trying to resolve complaints at an early stage through meetings and discussions.
- There was evidence of learning from complaints on 3 out of 4 wards visited by the inspection team.

Records
On the previous visit in October 2012 the Trust was found to be not meeting the CQC standard as the nursing care records did not give an accurate reflection of all care and treatment needs for each patient.

The Trust still did not meet the standard on the July 2013 visit as, although generally the patient nursing records had appropriate information about the patient's care and treatment, there were some nursing care records that did not provide an accurate and complete account. The lack of information meant patients were not protected against the risks of unsafe care and treatment. This would have a minor impact on services. The Trust's nursing documentation was reviewed and re-launched in 2013. This is monitored through the monthly ward assurance audits.

- There were improvements in recording of information including, food and fluid charts and discharge plans

- A Trust-wide audit of the new care plan document was carried out in January 2014. Results showed that there were good to excellent evaluations of care, and further amendments to nursing documents are to be made to minimise replication. There is to be an ongoing training update for all staff with continuous monitoring by Ward Sisters and further audit following the release of updated documents.

Accordingly, the Trust has enacted plans to address the concerns raised by the CQC and is awaiting a re-inspection to formally confirm our compliance.

2.7.2 OPHTHALMOLOGY OUTPATIENTS

There was an unannounced visit to the Ophthalmology Outpatient Department on December 16th and 17th which was initiated from a concern raised anonymously to the CQC. The visit focused on regulation 9 care and welfare reviewing the patient pathway to ensure that patients were receiving the appropriate treatment and follow up.

Whilst the final report is dependent on the CQC receiving additional reports and analysis of patient records the review was described as broadly positive. They spoke highly of the team as a whole and commented on the positive respect and understanding between all staff.

During the review a list of 20 sets of records were reviewed by the a member of the team who raised concern that there was potentially information contained in the medical records related to pre-existing conditions that had not been taken into account. As the member of the CQC was not qualified to validate the information the Trust was requested to review the notes.

The Trust has since commissioned an expert Ophthalmology Consultant from Leicester to review the total list of 48 patients and we await the outcome of the report.

The CQC has also requested further audit information to be submitted related to clinic throughput and discharge rates by clinic code.

2.7.3 SOUTHERN DERBYSHIRE CLINICAL COMMISSIONING GROUP (CCG) QUALITY VISITS

These visits are undertaken as part of the CCG's quality assurance process with the aim to understand how the services are operated and delivered within the Trust, and to gain assurance that the care given is high quality and evidence based.
There have been 6 visits.

- **MATERNITY SERVICES VISIT 24.06.2013**
  The purpose of this visit was to understand the ways in which the service supports the transition through pregnancy to family life through partnership working. The team found staff were enthusiastic and committed and demonstrated pride in their role. The quality of services was good and there were no serious concerns reported.

  Recommendations included:
  - A review of out of hours cover
  - To continue the Breast Feeding initiative with the introduction of the Unicef framework
  - Review of the Screening Co-ordinator role

- **OLDER PEOPLES SERVICES VISIT 22.08.2013**
  This visit included the Medical Admissions Unit, Medical Outpatients Department, Wards 401,405, 403, 216 and 205 and the Specialist Assessment and Rehabilitation Centre at the London Road Community Hospital. The team found staff who were very skilled and enthusiastic about the care of older people. There was strong leadership and care pathways were evident between sites. The Frail Elderly Patient initiative had enormous potential to form partnerships with other services.

  Recommendations included:
  - The development of an Information Pack for patients explaining what to expect from their care and how they could engage with this.
  - The staff should ensure that the patient falls assessment links to the patient's individual care plan.
  - Consideration of communication with the Mental Health Services and Care Homes to improve discharge planning.

- **END OF LIFE CARE VISIT 01.10.2013**
  The aim of this visit was to find out how End of Life Care was put into action. The visit included community care and the Nightingale Macmillan Unit at the Royal Derby Hospital. It was reported that the District Nursing teams give a great service and there is good

support for End of Life care in Care Homes. There is also a 24 hour service from GPs and District Nurses for patients with life limiting disease.

The Community Palliative Care Team
It was noted that there had been a 50% increase in referrals to the Community Palliative Care Team between 2008 and 2011 but no increase in capacity. This had led to a reduction in the service at weekends. There is also a lack of experienced District Nurses throughout the service and there have been failures of home care packages and subsequent hospital admissions.

Within the Nightingale Macmillan Unit the team were impressed by the environment of care and friendly staff. They also highlighted the rotation of community nurses into the Unit.

The team were impressed by the leadership and roll out of the Amber Care Bundle programme and concluded that there had been a behavioural shift in practice, assessment and recording of care.

Recommendations included:
- The role of the Amber Care Bundle Facilitator should be reviewed and a permanent post considered.
- Communication needs to be strengthened between secondary care and primary care in relation to patients who have been on Amber care during inpatient episodes.
- CCG to update staff on the roll out of Virtual Hospice and Rapid Response Projects.
- The Community Palliative Care team should have access to SystmOne.

- **OPHTHALMOLOGY THEATRE VISIT 02.12.2013**

The purpose of the day was for the team to understand how the service operated and gain assurance that high quality evidenced care was being delivered against the background of two serious incidents that occurred in 2012. There are 3 day Case Units dealing with approximately 3,500 cases per year. There is also flexibility for emergency cases.

Overall the patient experience was positive and all patients seemed to be well informed about the process. There was good communication, reassurance and post-operative checks and in theatre each patient's hand was held and could inform the anaesthetist if there was a problem.

The patient waiting area served as a clinical area for the installation of eye drops and admission details checks. Although the inspectors appreciated the rapid throughput there were concerns about patient privacy and dignity.

Recommendation:
The theatre team to consider improvements that could be made to improve the privacy and dignity of patients within the waiting area.

- **DERBYSHIRE CHILDRENS HOSPITAL VISIT 09.01.2014**

The aim of the visit was to gain an overview of the children's services and assurance that high quality evidence based care was being delivered.

The team reported a strong culture of self-improvement which was very child centred and linked to the Think Family initiative. Strong teamwork was evident in all departments.

Future plans include the facility for observation beds in the Children's Emergency department and the refurbishment of the Outpatients Department.

Recommendations include:

- To increase the visibility of clinical staff outside the Trust to aid integration with social care and the wider health community.
- Review referrals to the Phlebotomy service
- Review the pathway for jaundiced babies.
- Evaluation of shift harmonisation.
- Establish a service improvement group to explore development options for access out of hours.

- **COMPLAINTS AND PALS VISIT 27.01.2014**

The purpose of the visit was for the team to understand how the service was being operated currently and gain assurance that the NHS Complaints Regulations (2009) was being enacted. Also that learning and change from the investigation of complaints was being implemented, particularly in improving the patient experience.

They conducted a review of a sample of complaints and held discussions with key members of staff to understand the process for complaints including any recent system changes. Three reports were requested from the complaints module of DatixWeb (risk management system) as detailed below:

- Complaints and PALS themed report for Business Units grouped by division including numbers.
- Complaint categories – Care Medical, Care other, Attitude and Communication. Breakdown by rag rating for Business Units grouped by Division.
- Response times for complaints closed in September, October and November 2013

Awaiting final report from the CCG at the time of publication of this report.

- **EMERGENCY CARE INTENSIVE SUPPORT TEAM**

Due to difficulties in achieving the 4 hour standard in the Emergency Department, Derby Hospitals invited the Emergency Care Intensive Support Team (ECIST) to review the Trust's urgent care systems and processes and make recommendations for improvement. The team visited the Trust on 15th July 2013 and 5th August 2013 and made a return visit to assess progress on 4th February 2014.

On their first visit the ECIST team reviewed the pathway from the Emergency Department, Medical Assessment Unit, inpatient wards, Care of the Elderly wards and the Discharge Team.. On their second visit in August 2013 the team carried out a length of stay review of all patients with a hospital stay over 7 days in the Acute Trust, London Road Community Hospital and Derbyshire Healthcare Community Services hospitals. The team reported positive progress since 2010 in the Emergency Department and acute Medicine and a number of opportunities for improvement particularly on the Medical inpatient wards.

Following the visit, the recommendations made by ECIST were incorporated into the Emergency Department Recovery and Improvement plan. The programme was organised into 4 work streams, each with a Consultant Lead, a GP Lead and operational staff supported by the Transformation Team. A programme management structure has been used to manage the improvements and a wide range of actions have been taken across the Urgent Care Pathway to improve the patient journey. The work has been overseen by the Urgent Care Clinical Oversight Executive.

When ECIST reviewed progress on 4 February 2014, they recognised that good progress had been made and that there was effective working between Operations, Transformation and clinical staff. The formal report has not yet been received, but the team recommended the following priority areas for further improvement on the day of their visit:

Recommendations Included:

- Continue to develop and embed early senior decision making in the Emergency Department
- Consider developing a 7 day work stream to explore reasons why Sunday discharges are still significantly lower and short/medium and longer term actions
- Apply the same improvement approach to Surgery to explore and resolve Pathway issues particularly with the Surgical Assessment Unit.
- Continue work on internal delays to increase the number of patients discharged earlier in the day
- Develop an improvement work stream for Therapy Services. Front load therapists in the Emergency Department, taking handover from ambulance staff and starting collateral history.
- Increase use of home based discharge pathways.

2.8 DATA QUALITY

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.

INFORMATION GOVERNANCE (IG) TOOLKIT ATTAINMENT LEVELS

The Derby Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2013/2014 was 78% and was graded green as all requirements score a level 2 or above. The score was an improvement on 72% the previous year and reflects the continual refinement and rigour of the requirements each year.

CLINICAL CODING AUDIT

Derby Hospitals NHS Foundation Trust has a regular programme of internal clinical coding audit. These are performed by the Trusts Clinical Coding & Data Quality Manager and her deputy, who are both HSCIC Approved Clinical Coding Auditors and Accredited Clinical Coders. These audits aim to cover a random sample of the coding in all specialties. Auditors must conform to the Auditor's Code of Practice and The Clinical Coding Audit Methodology version 7.0 must be adhered to.

All reports & action plans from audits are submitted by the Clinical Coding & Data Quality Manager to the relevant Information Governance groups for approval.

In addition to the programme of internal audit, Trusts are required to complete an audit of a random sample of 200 Finished Consultant Episodes each year to support Information Governance requirement 505. This year's Information Governance audit was completed in November 2013.

Overall, the results for this Trust showed good quality assurance;

200 FCEs	Primary diagnosis (200 audited, 187 correct)	Secondary diagnosis (755 audited, 702 correct)	Primary procedure (123 audited, 120 correct)	Secondary procedure (182 audited, 176 correct)	Episodes where HRG changed as a result of incorrect coding
August – October 2013	93.50% correct	92.98% correct	97.56% correct	96.7% correct	5

The above table demonstrates that the Trust's coding accuracy has met the required standards for Information Governance Level 2, but it highlighted the need to improve the quality of electronic source data for more robust follow-up of histology and scan results by coders and the need to use the full operational notes for coding elective procedures.

The report findings were submitted to the Information Governance groups and identified actions were put in place. The Trust has identified that our level of coding is lower than other comparable Trusts and this was reflected in the audit outcomes. A Task and Finish Group has been set up to deliver a series of actions to address this.

Depth of clinical coding is a significant priority for the Trust due to the impact it has both financially and clinically. High quality clinical coding ensures that service performance, commissioning, and payment data is accurate.

The lower than National average coding depth at Derby Hospitals Foundation Trust has been identified as an issue since 2008 and has been further emphasised by the recent work by 'Civil Eyes', EPS Research, and the management consultants Price Waterhouse Cooper.

The Dr Foster organisation has repeatedly reported a low depth of coding, variously around 85% compared to comparator and regional trusts.

Over the past 12 months the Trust have been working with 'Civil Eyes', a research project involving 22 Foundation Trust Hospitals which focuses on valuing medical resources. The project team have conducted workshops across a number of key specialties and in each case have identified that our depth of coding is significantly lower than the majority of other Trusts in the cohort. For example across the whole Trust our average diagnosis per Finished Consultant Episode (FCE) is 3.5 compared with Plymouth where it is 5.6.

Recent analysis by Price Waterhouse Cooper as part of their work with the Trust (to support identification of Transformation schemes for 2014/15 and analyse the financial position of the Trust in line with Monitor requirements) has further highlighted the variance of this Trust against the National average and our peer group. This is seen across all major specialties, with obstetrics showing the least variance and rheumatology showing the greatest.

Ensuring an accurate depth of coding is a significant issue for the Trust due to the impact on mortality and patient outcome statistics (influenced by recording of co-morbidities) and the financial impact.

2.9 DELIVERY OF NATIONAL TARGETS

The following table reflects the national targets the organisation is required to report as part of its board reporting:

Indicator	Target 12-13	12/13 Full Year	Monitor Target 13-14	YTD Target to March 14	Q4 Actual to March 14	Q4 Status to March 14	Actual YTD to Jan 14	Full YTD Status

Incidence of Clostridium difficile	49	49	42	42	66		66	
Cancer: 31Day - Subsequent Treatment - Surgery	94%	94%	94%	94%	%		94.32%	
Cancer: 31Day - Subsequent Treatment - Drugs	98%	98%	98%	98%	%		99.52%	
Cancer: 31Day - Subsequent Treatment - Radiotherapy	94%	94%	94%	94%	%		97.27%	
Cancer: 62 Day Std - Urgent Referral to Treatment	85%	85%	85%	85%	%		80.6%	
Cancer: 62 Day Screening	90%	90%	90%	90%	%		96.06%	
Referral To Treatment - Admitted (95th percentile) - in weeks	90%	90%	90%	90%	%		86.19%	
Referral To Treatment - Non Admitted (95th percentile) - in weeks	95%	95%	95%	95%	%		96.31%	
Referral To Treatment - Incompletes 92% (Snapshot)	92%	92%	92%	92%	%		93.09%	
Cancer: 31 Day Standard	96%	96%	96%	96%	%		96.66%	
Total time in A&E (95% seen within 4 Hours)	95%	95%	95%	95%	%		95.24%	
Cancers: 2 Week Wait - Breast Symptoms	93%	93%	93%	93%	%		96.07%	
Cancer 2 Week Wait	93%	93%	93%	93%	%		92.69%	
Stroke - 90% of time on a stroke ward	80%	80%	80%	80%	80%		69.9%	

ADDITIONAL INDICATORS

Prescribed info	Related NHS Outcomes Framework Domain & Who will report on them		Trust Value	National Average	High Value	Low Value
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health & Social Care Information Centre with regard to:						
(a) the value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period; and	Apr 2012-Mar 2013	Value	1.1027		1.11697	0.6523
		Banding	2	1	1	3
	Jun 2012 – Jun 2013	Value	1.1102		1.1563	0.6259
		Banding	2	1	1	3
(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	Apr 2012-Mar 2013		Treatment Rate: 10.4 Diag. Rate: 29.2 Comb. Rate: 29.4	Treatment Rate: 0.09 Diag. Rate: 1.11 Comb. Rate: 1.12	Treatment Rate: 16.9 Diag Rate: 43.9 Comb Rate: 44	Treatment Rate: 0 Diag Rate: 0.1 Comb Rate: 0.1
	Jun 2012 – Jun 2013		Treatment Rate: 10.4 Diag. Rate: 28.9 Comb. Rate: 29.1	Treatment Rate: 1.74 Diag. Rate: 20.1 Comb. Rate: 20.3	Treatment Rate: 17.4 Diag Rate: 44.1 Comb Rate: 44.1	Treatment Rate: 0 Diag Rate: 0 Comb Rate: 0
(i) groin hernia surgery, (the "EQ-5D Index" has been used: this is a	Apr 2011-Mar 2012		Health Gain: 0.055; % Improved:	Health Gain: 0.087; % Improved:	Health Gain: 0.147; % Improved:	Health Gain: 0.002; % Improved:

combination of five key criteria concerning general health).			40.2	51.0	64.3	30.0
	Apr 2012 – Mar 2013		Health Gain: 0.076; % Improved: 49.1	Health Gain: 0.085; % Improved: 50.2	Health Gain: 0.157; % Improved: 82.9	Health Gain: 0.015; % Improved: 36.6
(ii) varicose vein surgery, (the "EQ-5D Index'' has been used: This is a combination of five key criteria concerning general health).	Apr 2011 – Mar 2012		Health Gain: - ; % Improved: -	Health Gain: 0.095; % Improved: 53.6	Health Gain: 0.167; % Improved: 70.6	Health Gain: 0.049; % Improved 54.3
	Apr 2012 – Mar 2013		Health Gain: - ; % Improved: -	Health Gain: 0.093; % Improved: 52.7	Health Gain: 0.175; % Improved: 71.1	Health Gain: 0.023; % Improved 39.5
(iii) hip replacement surgery, (the "EQ-5D Index" has been used: this is a combination of five key criteria concerning general health).	Apr 2011 – Mar 2012		Health Gain: 0.438; % Improved: 89.9	Health Gain: 0.438; % Improved: 89.7	Health Gain: 0.543; % Improved: 97.7	Health Gain: 0.319; % Improved: 85.3
	Apr 2012 – Mar 2013		Health Gain: 0.412; % Improved: 86.5	Health Gain: 0.416; % Improved: 87.5	Health Gain: 0.499; % Improved: 96.8	Health Gain: 0.306; % Improved: 76.9
(iv) knee replacement surgery, (the "EQ-5D Index" has been used: this is a combination of five key criteria concerning general health).	Apr 2011 – Mar 2012		Health Gain: 0.320; % Improved: 80.1	Health Gain: 0.302; % Improved: 78.8	Health Gain: 0.385; % Improved: 94.4	Health Gain: 0.181; % Improved: 67.5
	Apr 2012 – Mar 2013		Health Gain: 0.321; % Improved: 80.3	Health Gain: 0.319; % Improved: 80.7	Health Gain: 0.409; % Improved: 90.2	Health Gain: 0.195; % Improved: 69.7
(i) 0-15; and 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.	2010 – 11		7.91	10.15	25.8	0
	2011 – 12		7.27	10.9	16.38	0
(ii) 16 or over; and 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.	2010 – 11		12.91	11.42	22.93	0
	2011 – 12		11.54	11.45	41.65	0
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health & Social Care Information Centre with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.	2011 – 12		70.4	67.4	85	56.5
	2012 – 13		70.2	68.1	84.4	57.4
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health & Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2013/14	Q2 (Jul-Sept)	92.34%	95.69%	100%	81.70%
		Q3	94%	95.89%	100%	76%
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health & Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	Apr 2011 / Mar 12		19.30%	22.20%	58.20%	0%
	Apr 2012 / Mar 13		21.30%	17.30%	30.80%	0%
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health & Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the	1/10/11- 31/03/12 - Incidents		6485	4060	6485	859
	- rate per 100 admissions		9.19	6.69	13.61	1.99
	- severe harm – number		3	24	90	0
	- percentage		0	0.63	2.5	0
	death - number		2	6	19	0
	- percentage		0	0.14	0.5	0
	01/10/12-31/03/13 Incidents		5735	4428	7835	1761

Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	- rate per 100 admissions - severe harm - number - percentage - □ death - number - percentage	8.12 3 0.052 3 0.052	7.22 25 0.014 9 0.004	12.73 101 3.35 20 0.42	3.04 0 0 0 0
Friends and Family Test - Question Number 12d – Staff - 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'	2012 / 2013	65	63.25	94.19	35.33
	2013 / 2014	69	64	93.92	39.57
Friends and Family Test – Patient - covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)	Oct. 2013: By Trust By Site	60 60	55 55	93 100	-11 -11
	Nov. 2013: By Trust By Site	58 58	56 56	92 100	9 9

PATIENT REPORTED OUTCOME MEASURES		**2011/12**			**2012/13**			**Change Year on Year**	
Hip Replacement		**ENGLAND**	**Royal Derby**	**Variance**	**ENGLAND**	**Royal Derby**	**Variance**	**ENGLAND**	**Royal Derby**
	Modelled Records	35913	384		12789	137			
EQ-5D	% Improved	87.5%	86.5%	-1.0%	87.8%	92.0%	4.2%	0.3%	5.5%
EQ VAS	% Improved	63.7%	59.9%	-3.8%	63.8%	59.7%	-4.1%	0.1%	-0.2%
Oxford Hip	% Improved	95.9%	96.0%	0.1%	95.7%	96.3%	0.6%	-0.2%	0.3%
Knee Replacement		**ENGLAND**	**Royal Derby**	**Variance**	**ENGLAND**	**Royal Derby**	**Variance**	**ENGLAND**	**Royal Derby**
	Modelled Records	37757	502		12749	173			
EQ-5D	% Improved	78.8%	80.1%	1.3%	79.4%	80.9%	1.5%	0.6%	0.8%
EQ VAS	% Improved	53.9%	56.0%	2.1%	54.8%	54.5%	-0.3%	0.9%	-1.5%
Oxford Knee	% Improved	92.0%	93.9%	1.9%	92.2%	96.2%	4.0%	0.2%	2.3%

Patient Reported Outcome Measures

The Derby Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The EQ-5D Index is a combination of five key criteria concerning general health. The EQ-5D INDEX CHANGE is a calculated average for these five criteria (Mobility, Self-Care, Usual Activities, Pain/Discomfort and Anxiety/Depression)

The EQ VAS is the current state of the patients general health marked on a visual analogue scale 0 - 100. The EQ-VAS INDEX CHANGE is calculated as Q2 result minus Q1 result.

In addition to the EQ indexes, there are additional Hip/Knee Replacement specific questions that were asked of the patients and the score is a calculated average of these 12 questions.

The data has been analysed at consultant level spanning a 2 year period. The results show that apart from a marginal decrease in the EQ-VAS, Royal Derby's Hip and Knee PROMS results have improved year on year. More recently the results have been shared with each of the consultants, and it is anticipated that the results will form part of a discussion for their individual appraisals.

The Derby Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by:

In addition to the PROMS, knee replacement patients are phoned by the physiotherapist 2 days post discharge for support related to mobility and rehabilitation. This may result in a home visit. Patient feedback has resulted in the re-enforcement of prescribing appropriate analgesia.

In addition to the PROMS, hip replacement patients are phone by the senior sister 4 days post discharge for general support and guidance. The patient feedback has resulted in a review of patient information to include coping strategies for patients, for patients to use due to disturbed sleep patterns, which can impact on their health and wellbeing and mobility post operatively. A pilot is also due to commence by the Physiotherapy team to contact the patient at around 3 weeks from discharge to support an increase in the patients' mobility and rehabilitation.

For both varicose veins and groin hernia, the number of procedures carried out within the Trust is relatively small; however, additional training sessions for staff have been organised in year to support an increase in questionnaire response rates.

Mortality Indicator

The Derby Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Derby Hospitals NHS Foundation Trust has a hospice on site and as a consequence has one of the highest rates of palliative care coding in England. In addition, the depth of reporting of co-morbidities by Derby Hospitals NHS Foundation Trust is one of the lowest in the England. These two factors have an impact on the in-hospital mortality rate that forms part of the SHMI calculation.

The Derby Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by:

- Setting up a task and finish group to improve the depth of coding for each spell
- Scrutinising any condition that alerts as high through speciality morbidity and mortality meetings reporting to the Mortality Review Committee and implementing any changes in care as indicated

Readmission Rates

The data made available to Derby Hospitals NHS Foundation Trust by the Health and Social Care Information Centre with regard to:

The percentage of patients aged:

I. 0-14 and
II. 15 or over, readmitted to hospital within 28 days of being discharged from a hospital that forms part of the Trust during the reporting period.

The Derby Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- There has been a slight decrease in the admission rate for both sets of data from 2010/11 to 2011/12
- Derby Hospitals NHS Foundation Trust reports on the 30 day re-admissions according to Payment by Results rules. Overall there is an increase locally however there has been an increased national trend.

For the financial year 2011/12 the Derby Hospitals NHS Foundation Trust's readmission rate was at 5.56%. It then decreased to 5.52% in 2012/13 and increased to 6.11% this year (2013/14)

Derby Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Continued to run re-admission group with a focus within medicine, this is currently being reviewed to work with surgery and cancer.
- Developed a dashboard containing current data which is accessible by key managers within the organisation
- Enhanced discharge project has been rolled out within medicine across all wards
- Undertaking re-admission audits for patients who re-attend at the Emergency Department.
- Amber Care Project for End of Life Care
- Work on Frail Elderly Pathway

Patient Experience

The data made available to the Derby Hospitals NHS Foundation Trust by the Health and Social Care Information Centre with regard to the Trust's responsiveness to the personal needs of patients.

The Derby Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The national goal to improve responsiveness to the personal needs of patients is a CQUIN which focuses on 5 specific questions
- Derby Hospitals is in a cluster with 45 other Trusts. To be considered in the upper quartile this should mean the top 11 out of 45. The Derby Hospitals NHS Foundation Trust's score of 70.2 places Derby Hospitals at point 37 which is within the top ten

Derby Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

In 13/14 the Trust began a campaign called "Making Your Moment Matter" based on the Patient Experience Framework set out in 12/13. This framework looked for us to provide "Always Events" and during the course of the project development, and after discussing with patient groups, we decided to brand this project "Making Your Moment Matter". We wanted staff, patients and their families to help us to come up with a set of statements which are right for both our organisation and our patients, thus demonstrating our listening organisation credentials.

The following Top 5 " Moments " have been recorded from this consultation with a response rate topping 74%, giving us some assurance that these moments are the ones we hold most important from our service users and staff members alike:

We will treat you as a person, not just a patient, with dignity and respect at all times.
We will give you the best possible treatment that is available to you.
We will understand your needs by listening, empathising with you, and keeping you informed.
We will make the place you are treated in clean, safe and the environment as caring as possible.
We will give you information in a way that you can understand, to help make decisions about your care.

This project has helped underpin various projects across the Trust dealing with Discharge, Admission, and how we ensure we inform our patients about the effect of a care episode such as surgery.

The following 5 selected question results demonstrate our performance in these areas:

1 Involvement in decisions about treatment/care: 7.8 /10 - which is “about the same as other Trusts” as defined on the CQC Website.
2 Hospital staff being available to talk about worries/concerns: 6.3 /10 - which is “about the same as other Trusts” as defined on the CQC Website.
3 Privacy when discussing condition/treatment: 8.8/10 - which is “about the same as other Trusts” as defined on the CQC Website.
4 Being informed about side effects of medication: 5.0/10 - which is “about the same as other Trusts” as defined on the CQC Website.
5 Being informed who to contact if worried about condition after leaving hospital: 8.7/10 - which is better than other Trusts” as defined on the CQC Website.

Venous Thromboembolism

The Derby Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- This data demonstrates the percentage of all adult inpatients that have had a VTE risk assessment on admission to hospital using the clinical criteria of the national audit tool. This data is submitted monthly to Unify as part of the national CQUIN requirements.

Derby Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by

- Increasing and sustaining the percentage of recorded risk assessments to 95% in line with National Guidance by:
  - Ensuring doctors carry out the risk assessment prior to prescribing – and reviewing compliance at Business Unit level monthly
  - Working with our electronic prescribing system to force a risk assessment being completed electronically before the prophylaxis is prescribed
  - Reviewing current local policies on prescribing of thromboprophylaxis

Clostridium difficile (C.diff)++

Derby Hospitals Foundation Trust considers that this data is as described for the following reason:

- This data demonstrates the number of patients with a positive test result 72 hours or more after admission.

The target set for 2013/14 was 42 cases. The Trust ended the year with a total of 67 cases, 25 cases over the national trajectory.

The Trust has taken the following actions to improve this score and so the quality of its service by:

- Continuous assessment and review to ensure that all actions to minimise the risk of patients developing the infection have been undertaken.
- Root causes analysis is undertaken for each Trust acquired case of C.diff. The outcomes of these are shared with the clinical teams and action plans put into place.

- The C.diff Review Group reviews all patients with C.diff infection to ensure optimum treatment and supporting care to patients is given. The group also develops and assists with the implementation of the C.diff policy.
- Learning points from the C.diff cases are presented at the Trust Infection Control Committee.

Safety Incidents

The data made available to the Trust by the Health and Social Care Information Centre with regard to –the number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

The Derby Hospitals Foundation Trust considers that this data is as described for the following reasons:

- 6 monthly retrospective reports are published by the NHS Commissioning Board and are monitored closely
- The Trust supports an effective safety culture via the increased reporting of incidents
- Increase in incident reporting against the same period last year which reflects the Derby Hospitals NHS Foundation Trust's position of 13th highest incident reporter out of 39 large acute organisations listed by the NHS Commissioning Board.

Derby Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services:

- Continue to monitor and review all classification of incidents to ensure correct rating
- Ensure Datix is updated appropriately.

Staff Experience

The Derby Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Our Organisational Development approach is to continue to develop our service line management infrastructure, build upon our leadership/team behaviours, and ensure we have in place talent and succession planning processes.

Our aim is to create a positive and supporting culture of continuous learning, where openness and transparency is encouraged to ultimately improve both the experience of patients and staff. We want all staff to feel empowered to put forward ways to deliver better and safer services.

'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'

The data made available to DHFT by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contact to the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

In 2013 national staff survey there was an improvement in score from 65 to 69 (6% improvement).

Derby Hospitals NHS Foundation Trust is taking the following actions to continue to improve this score and so the quality of its services, by:

- Continuing to build upon our existing engagement structures *(eg face2face, surveys, team meetings)* exploring ways how we can engage more staff in the improvement of services, patient feedback, learning from complaints and incidents.
- Undertaking quarterly mini impression staff surveys throughout 2014/2015, which will be broken down to business unit level (and department level where response rates are high enough). This will enable a more in depth analysis of staff experience in different areas across the Trust, which in turn will feed action planning for improvement. As well as asking the family and friends questions, we will be asking for feedback on key areas for development eg in the first quarter we are exploring raising concerns.

Friends & Family Test

The Derby Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The Derby Hospitals NHS Foundation Trust intends has taken the following actions to improve this score and so the quality of its services, by:

Over the last year, compared with 12/13, the Trust has seen a steady rise in its Friends and Family test score for inpatient Services. The Trust will continue using new and varied ways of getting this real time feedback, which will be made all the easier with the introduction of our Electronic Friends and Family Test.

Currently we use 3 methods:
- our "Your Views Matter" cards;
- text messaging in ED; and
- via an electronic portal which we rolled out in March 14 - this will allow for a on line portal to be available to all patients, visitors, and carers. This is the sister system to that currently used by our Human Resources Team so that integration between both staff surveys and patient feedback will be able to be carried out.

Assurance over mandated indicators

MAXIMUM WAITING TIME OF 62 DAYS FROM URGENT GP REFERRAL TO FIRST TREATMENT FOR ALL CANCERS

Indicator requirement as per Monitor Guidance:

Detailed descriptor: PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

Date definition: all cancer two month urgent referral to treatment wait.

Denominator: total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

All of the values for the numerator and denominator should be for financial year 2012/13 (from 1st April 2012 to 31 March 2013).

Trust 62d standard compliance for FY 12/13	
Numerator:	977.5
Denominator:	1180

Trust 62d standard compliance for FY 13/14	
Numerator:	
Denominator:	

Compliance rate:	82.84%

Compliance rate:	%

EMERGENCY READMISSIONS WITH 28 DAYS OF DISCHARGE FROM HOSPITAL

Indicator description: Percentage of emergency admissions occurring within 28 days of the last, previous discharge from hospital.

Indicator requirement as per Monitor Guidance:

Numerator: The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0-27 days (inclusive) of the last, previous discharge from hospital (see denominator).
Including: those where the patient dies
Excluding: those with a main speciality upon readmission coded under obstetric; and those where the re-admitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell

Denominator: The number of finished continuous inpatient spells within selected medical and surgical specialities, with a discharge date up to 31 March within the year of analysis.
Excluding: day cases, spells with a discharge coded as death, maternity spells (based on speciality, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are also excluded.

Trust readmission rate for FY 12/13	
Number of admissions:	49206
Number of readmissions:	4812
Readmission rate:	9.8%

Trust readmission rate for FY 13/14
Number of admissions:
Number of readmissions:
Readmission rate:

READMISSIONS WITHIN 30 DAYS OF DISCHARGE FROM HOSPITAL

Indicator description:
Readmissions within 30 days of discharge from hospital
Numerator:
Denominator

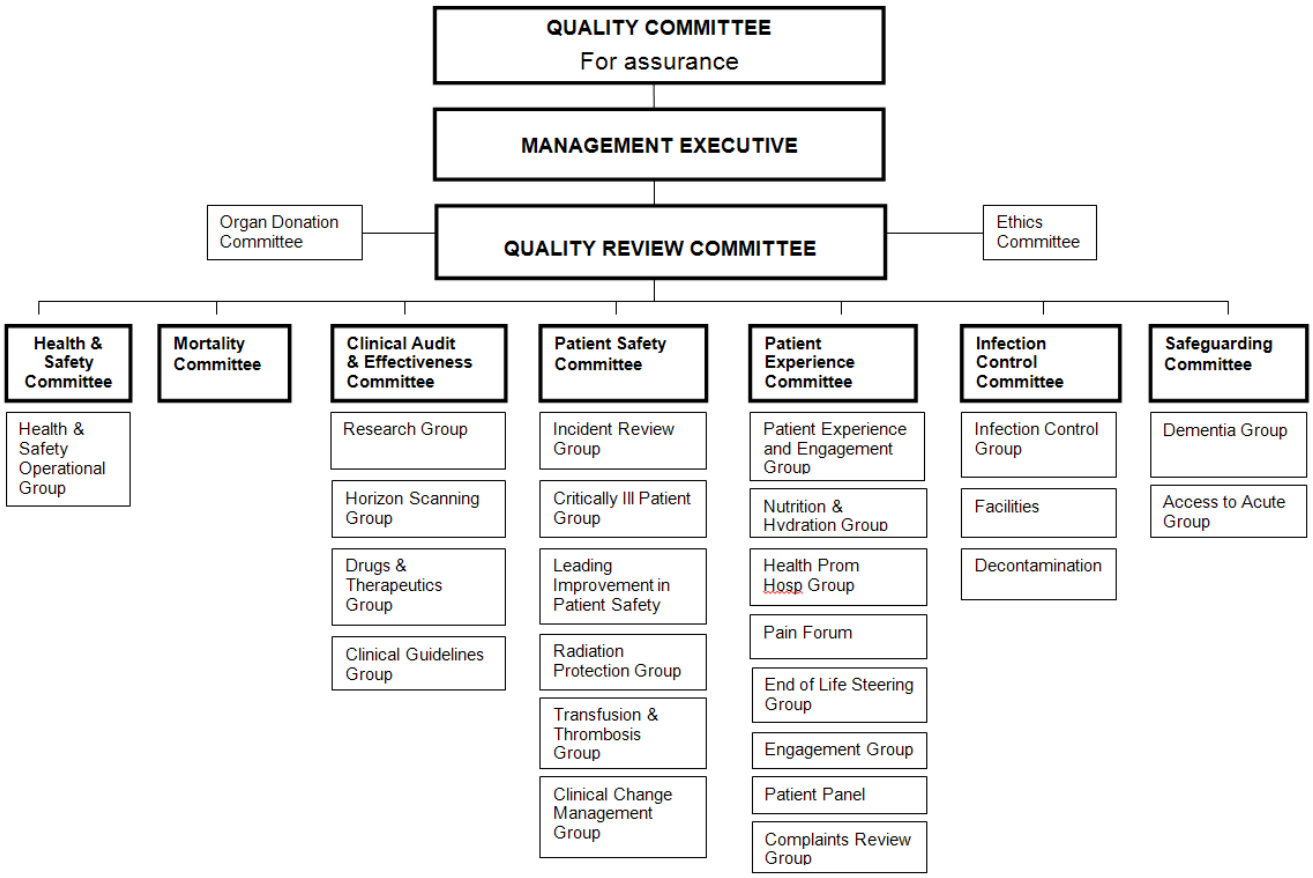
PART 3 QUALITY PERFORMANCE GOVERNANCE ARRANGEMENTS

The Trust has a robust structure of groups and committees (see quality governance structure below) which feed into the Executive Quality Review Committee (QRC), along with quality reports from the Divisions. This allows triangulation of information and an ability to develop recommendations and action for any issues. QRC reports through performance and scrutiny management meetings and also to the sub-Board Quality Committee. This is being further enhanced through our divisional performance management meetings which will include a quality focus on the meeting agenda, a quality dashboard used by Business units, our Management Executive, and Trust Board to actively monitor quality metrics in line with the 5 CQC domains of safe, caring, effective, responsive and well led.

We have on two occasions, carried out the Monitor's Quality Governance Framework Self-Assessment. This intensive self-assessment process, which required detailed and thorough reflection and deliberation, demonstrated that the Trust Board had acquired an increased emphasis on quality governance and has robust mechanisms in place to monitor quality.

Internal and external auditors routinely incorporate quality assurance into their annual audit plans. All internal audit reports are reported to Board committees and to the Board by audit committee minutes. The Trust's annual quality report is audited by PwC.

Quality Governance Structure



3.1. BOARD TO WARD PROGRAMME

The Board to Ward programme was launched in November 2011, since March 2013 42 visits have been
undertaken. An Executive and Non-Executive Board Member carry out each visit jointly. The focus of the programme is:

- **Relationship Development** - the visiting team will have the opportunity to meet with staff, patients and carers in the clinical area. Two way communication during these visits means that both teams will be able to share key messages. It is also a time when the care environment can demonstrate areas of good practice.
- **Visible Leadership** - this programme supports the clear message that the delivery of high quality care across the organisation is important to the Trust Board. This is the message that is important internally for patients and staff, and externally for the public and key stakeholder organisations.
- **Supporting the embedding of the Quality Strategy** - the visits provide the forum to ensure that there is a wide understanding of the strategy across the organisation, the Executive/Non-Executive receive an update on the current clinical delivery, and it brings to the life for the team some of the areas that are being demonstrated in the reports at Trust Board Meetings.
- **Seeking further understanding and assurance of Patient Experience** – where appropriate the team explore the experience of the patient through informal discussion

The format of the Board to Ward visit is structured around the 15 Steps Audit Tool. This tool helps the team to gain an understanding of how patients and service users feel about the care provided and what gives them confidence. It helps to identify the key components of high quality care that are important to patients and carers from their first contact with a care setting.

The audit focuses on 4 key areas and includes if the ward /department is:

- Welcoming
- Safe
- Caring and Involves Patients
- Well organized and calm

Themes from the visits include:

- Good team working
- Positive leadership
- Positive feedback from patients/families/Carers
- Staffing Levels
- Discharge Planning

Annex 1:

STATEMENTS FROM CLINICAL COMMISSIONING GROUPS, HEALTHWATCH DERBYSHIRE,
IMPROVEMENT AND SCRUTINY COMMITTEES, AND THE TRUST COUNCIL OF GOVERNORS

STATEMENT FROM COUNCIL OF GOVERNORS DERBY HOSPITALS NHS FOUNDATION TRUST

STATEMENT FROM CLINICAL COMMISSIONING GROUP

STATEMENT FROM HEALTHWATCH DERBY

STATEMENT FROM HEALTHWATCH DERBYSHIRE

STATEMENT FROM DERBYSHIRE COUNTY COUNCIL IMPROVEMENT AND SCRUTINY COMMITTEE

STATEMENTS FROM HEALTH AND WELLBEING BOARDS

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 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that 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 2013/14;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2013 to June 2014
    - papers relating to Quality reported to the Board over the period April 2013 to June 2014
    - feedback from the commissioners dated
    - feedback from the Governors dated
    - Feedback from local Healthwatch organisations dated
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated
    - latest national patient survey published
    - latest national staff survey published
    - the head of internal audit's annual opinion over the trust's control environment dated
    - CQC quality and risk profiles dated
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reporting 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 measure of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Date 2014 . . . . . .Chairman

Date 2014 . . . . . .Chief Executive

Annex 3:

INDEPENDENT ASSURANCE REPORT

Independent Auditor's Limited Assurance Report to the Council of Governors of Derby Hospitals NHS Foundation Trust on the Annual Quality Report

ABBREVIATIONS USED:

Abbreviation Used	In Full
AKI	Acute Kidney Injury
ANTT	Aseptic Non Touch Technique
BMI	Body Mass Index
C.diff	Clostridium difficile
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CDS	Commissioning Data Set
CLRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised Tomography
CVC	Central Venous Catheter
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
E.coli	Escherichia coli
ED	Emergency Department
EMCSN	East Midlands Cardiac and Stroke Network
EWS	Early Warning Score
EPMA	Electronic Prescribing and Medicines Administration
GP	General Practitioner
IBD	Inflammatory Bowel Disease
ICOG	Infection Control Operational Group
ICNARC	Intensive Care National Audit and Research Centre
HRS	Health Research Sectors
HSMR	Hospital Standardised Mortality Rate
HPA	Health Protection Agency
HTA	Health Technology Assessment
KPI	Key Performance Indicator
LCP	Liverpool Care Pathway
LGBT	Lesbian, Gay, Bisexual and Transgender
LIPS	Leading Improvements in Patient Safety
MAU	Medical Admissions Unit
MRC	Medical Research Council
MRSA	Methicillin Resistant Staphylococcus Aureus
MRSAb	Methicillin Resistant Staphylococcus Aureus bacteraemia
MSSA	Methicillin Sensitive Staphylococcus Aureus
NCEPOD	National Confidential Enquiries of Patient Outcomes and Death
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NMBR	National Mastectomy and Breast Reconstruction
NNAP	National Neonatal Audit Programme
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PbR	Payment by Results
PDSA	Plan, Do, Study, Act
PEAT	Patient Experience Assessment Team

PLACE	Patient Led Assessment for the Care Environment
PROMS	Patient Reported Outcomes Measures
PUPG	Pressure Ulcer prevention Group
QIPP	Quality, Innovation, Productivity and Prevention
RCA	Root Cause Analysis
RCP	Royal College of Physicians
SBAR	Situation, Background, Assessment , Recommendation
SHMI	Summary Hospital Level Mortality Index
SLAM	Service Level Activity Monitoring
SUS	Secondary User Service
VTE	Venous Thrombo Embolus