Derbyshire Community Health Services NHS Foundation Trust

Quality Report

Derbyshire Community Health Services NHS Foundation Trust
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Date of inspection visit: 09 - 13, 22, 23 May & 10 June 2016
Date of publication: 23/09/2016

Core services inspected	CQC registered location	CQC location ID
Community end of life care Community health inpatient services	Cavendish Hospital	RY8Y8
Community end of life care Community health services for adults Community health inpatient services	Clay Cross Hospital	RY8Y7
Community end of life care Community health services for adults Community Dental Services Community health inpatient services Urgent care services	Ilkeston Hospital	RY846
Community end of life care Community health services for adults	Ripley Hospital	RY8Y4

Summary of findings

Community health services for children and young people Community health inpatient services Urgent care services		
Community health services for adults Community health inpatient services	Newholme Hospital	RY8Y5
Community health services for children and young people Community health inpatient services	Babbington Hospital	RY8Z2
Community health services for children and young people Community health inpatient services Urgent care services	Whitworth Hospital	RY8Y1
Community health inpatient services Sexual health services	St Oswalds Hospital	RY8Y3
Community health inpatient services	Bolsover Hospital	RY8Z2
Mental health wards for older people with mental health problems	Walton Hospital	RY8Y2
Community health inpatient services Mental health and rehabilitation	Ash Green	RY8AK
Primary Medical Services	Creswell and Langwith Primary Care Service	RY8W7
Primary Medical Services	Ripley Medical Centre	RY8Z7
Urgent care Services	Buxton Hospital	RY8Y9

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Outstanding 
Are services responsive?	Good 
Are services well-led?	Good 

Summary of findings

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Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

Derbyshire Community Health Services NHS Foundation Trust cares for patients across a wide range of services, delivered from 133 sites including 13 community hospitals and 28 health centres. It covers the city of Derby, the rural communities of Derbyshire and also provides some services into Leicestershire. It provides care for more than 4,000 patients every day. The trust employs approximately 4,500 staff, serving a patient population of more than one million. The trust was authorised as an NHS Foundation Trust in 2014, being one of the first Community Trusts in England.

This was the trust's second inspection using our comprehensive inspection methodology. We had previously inspected this trust during our pilot testing phase in 2014 but we did not publish any ratings.

We carried out this comprehensive inspection between the 9 and 13 May 2016. We also carried out an unannounced inspection from the 22 to 23 May 2016.

Overall we found the provider was performing at a level which led to the judgement of good, with some elements of outstanding. We inspected 10 core services; two were rated as outstanding, seven were rated as good and one was rated as requiring improvement.

Our key findings were as follows:

Safe

- The trust had a mature patient safety culture and incidents were managed well with evidence of learning across the organisation. We found the sexual health service needed to improve its incident reporting processes. However, this was a service which had been subject to change because of the new way it was being commissioned. There were contractual arrangements that still needed to be made clearer. These issues were hampering the process for incident reporting and learning across the whole service.
- There was a good understanding of safeguarding children and adults amongst staff.
- Staffing levels were generally able to meet the needs of patients, although there were some vacancies in the community adult's service.

Effective

- Evidence based practice was embedded throughout the trust and services followed national guidance.
- A range of audits were undertaken across the trust.
- Multidisciplinary working was well established across the trust.
- Staff were able to demonstrate a good understanding of the principles of mental capacity.We noted the approach to mental capacity assessment, best interest assessment and restraint within the learning disability service was particularly good.

Caring

- Patients were treated with kindness, compassion, dignity and respect throughout all of the services we inspected.
- During our observations of staff and patients interaction we found staff were focused on the individual needs of patients making them feel valued and respected.
- Staff were observed going above and beyond what they were expected to do so they provided the best possible care for their patients.

Responsive

- Services were planned around the needs of individual patients.
- There were a range of services offered to vulnerable groups. There was a flagging system in use within the electronic patient record system to identify patient who had a learning disability.
- Frail elderly patients and children, those living with dementia or a learning disability were prioritised for care in the Minor Injuries Unit (MIU).
- The MIU was providing a very responsive service. It was consistently exceeding targets in respect of time spent in MIU and the time patients waited for treatment.
- We found evidence throughout the trust that people were supported to raise concerns, complaints and compliments.

Well led

- There was a clear vision in place supported by objectives and values which staff understood.

Summary of findings

- The Chief Executive and Chairman worked well together but their relationship had an appropriate balance between high challenge and high support. The Chief Executive and Chairman were visible and many staff commented on the strong leadership they provided.
- We received many positive comments about the non-executive and executive leadership from staff at all levels in the organisation.
- The trust valued its staff, there was a real sense that they cared about them and saw them as their greatest asset. Morale amongst the majority of staff was very good. Staff enjoyed working at the trust and felt valued by the executive team and their line managers. Where morale was not as high it was usually because of the impact from service reconfiguration.
- The trust had an established governance structure which was there to support the provision of assurance to the board.
- The trust had a commercial focus which was also centred on providing the best possible care for patients. This had made the trust well placed to respond and adapt to changes in direction arising from new local and national policy.
- A culture of putting the patient first was evident throughout the organisation.

We saw several areas of outstanding practice including:

- We were extremely impressed with the work the trust had done on transgender. Walton hospital had a display of photographs and quotes from people undergoing transition. This work had been in place for some time. We found the work on display promoted equality and diversity and brought issues of transgender to the fore in a very positive, open and accepting manner.
- The community inpatient services had worked hard to provide a service which was dementia friendly. There were activities being provided across the trust and work had begun to update the wards where possible to be suitable for patients living with dementia. Staff were dementia friends and had completed external training to increase their knowledge and competence in providing care for patients living with dementia.
- The pharmacy service provided on the community inpatient wards was outstanding and integral to the patients' discharge planning.
- Patients were left with comment cards on Oker Ward so they could write down any questions they may have about their care and treatment. The staff on the ward would regularly review these cards and answer the patient's questions.
- We found clinical staff delivered care over and above best practice guidelines in relation to dentistry; this included adaptations to provide individualised special care dentistry, conscious sedation dentistry in primary care, paediatric dentistry and preventive dental care through detailed patient assessment and individualised treatment plans which took into consideration each patient's specific dental and special care needs.
- The community dentistry service coordinated treatment input for patients living with special needs who were undergoing general anaesthesia. This included podiatry, venepuncture and other interventions which would be distressing to the patient. This also reduced the number of health care attendances required by patients.
- The Derbyshire Alliance End of Life Care (Eolc) Toolkit was a readily accessible online toolkit. This comprehensive toolkit provided both professionals and members of the public with access to a range of learning materials polices and Eolc documentation. The toolkit was designed collaboratively by professionals who worked across Derbyshire and had received national recognition. The toolkit provided national guidelines and local Derbyshire- wide guidelines for all agencies offering unified documentation bespoke for staff working in, primary and secondary care settings, including hospices, social care, ambulance services and the voluntarysector. A range of information leaflets were available on the website that staff were able to print and share with patients and carers. Training opportunities were also provided supported by notification of forthcoming events by personal emails and 'training flyers'.
- Staff at Ripley Minor Injuries Unit (MIU) were able to call a "pit stop" in the unit. The "pit stop" was a way of gaining an overview of the units and prioritising patient needs in the unit. All staff would attend the "pit stop" and create a plan.
- The MIUs had adopted safeguarding children supervision. Safeguarding children supervision was a formal process of professional support and learning, which aimed to ensure clinical practice promoted the

child and young person's welfare. This was achieved by staff thinking and talking about what they had observed, heard or read, doing so supported the development of good quality practice and was a way of ensuring staff were up to date and knowledgeable in safeguarding procedures. We saw records of these sessions.

- A nurse led fracture clinic had been set up across all MIUs; led by the Emergency Nurse Practitioners (ENPs) this aimed to reduce the numbers of patients having to transfer to acute hospitals for the management of simple fractures. This benefited patients from the local community as well as visitors to the area. ENPS saw patients with simple fractures; they assessed, diagnosed, treated and followed-up patients in the same hospital. This had shown to be a positive experience and benefit to patients particularly children, as all hospital experiences have the potential to be frightening.
- Patients had access to ENP clinics, patients could book to attend these clinics for follow up treatment or review of conditions such as burns, fractures requiring x-ray, foreign body removal, eye problems and wounds.
- MIU had access to short stay beds on the wards nearest to the unit. The beds could be used for variety of reasons for example, a simple observation period following treatment, application of plaster of paris, awaiting x- ray opening times or for safety concerns whilst awaiting home support. Access to these beds prevented admissions to the acute NHS Trusts.
- Live waiting times for Ripley and Ilkeston MIU were available on the trust's website, local newspaper's, and clinical commissioning group's website. The times were displayed against the current waiting times at the local acute emergency department, this encouraged patients to attend MIU where their conditions allowed and reduce the demand on the local emergency department.
- Staff hours of work in the community learning disability services could adapt in response to the needs of patients. For example, if a patient had an engagement out of hours in the evening or at a weekend, staff would alter their working hours to provide any support required by the patient or their family.
- Staff in the community learning disability services could adapt or design healthcare documents to meet the needs of patients better. A documents group in the trust would review the documents usefulness and safety with a view to ratification and implementation. We saw an excellent example of an adapted ABC chart created by a nurse in the Darley Dales team.
- Staff in the community learning disability services were dedicated and creative about engaging with patients who were reluctant to engage with services. They would devise clever ways of engineering meetings with patients which would appear casual and therefore less threatening.
- Staff in the community learning disability services had developed links with local dentists and the local acute hospital. This meant they were able to offer patients de-sensitisation visits to the dental practices and the acute hospital. Patients were able to spend time in the environments and reduce their fears and anxieties. This service extended to operating theatres where patients could visit and have theatre staff explain all the machinery to them and answer any questions.
- Staff on Riverside, Melbourne and Linacre Wards, facilitated by the Occupational Therapist, were regional partners in the Dementia and Imagination programme understanding art in dementia friendly communities, ran by Bangor University. The aim of this research programme was to explore the use of visual arts within the dementia community.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure there is a robust process for maintaining a register of serial numbers for prescription pads in community health services for adults.
- Ensure medicines are transported in securely sealed or tamper evident containers in community health services for adults.
- The trust must ensure incidents in Integrated Sexual Health Services (ISHS) are reported and investigated in a timely and consistent way.
- The trust must ensure learning from incidents and complaints is shared with all staff in ISHS.
- The trust must ensure that all staff working within Derbyshire Community Health Services ISHS follow the same guidance, policies and procedures in all areas.
- The trust must work towards national guidance for service provision, including return postal addresses for

undelivered mail, management and follow up for patients who did not wait to be seen or did not attend appointments and monitoring of calls that are unanswered on the central booking service.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection

Chair: Elaine Jeffers

Team Leader: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors, inspection managers, pharmacy inspectors, an inspection planner and a variety of specialists including:

Clinical Project Manager, Non-Executive Director, Community Children's Nurses, Community Health Visitors, Dentist, Dietitian, Occupational Therapists, Physiotherapists, Paramedic, Nurse Consultants, District Nurses, Palliative Care Director, GP, Learning Disability Nurses, Specialist Nurses and a Mental Health Act Reviewer.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in May 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew.

We did not hold a public listening event before this inspection as we were looking to assess changes and progress over a defined period; however, we did contact Derbyshire Healthwatch to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of services. We met with the trust executive team both collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades. Prior to the visit, we held 10 focus groups and during the inspection a further six focus groups with a range of staff across Derbyshire who worked within the service. We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were cared for, talked with carers and family members, and reviewed care or treatment records of people who used services. We met with people who used services and carers, who shared their views and experiences of the service.

We carried out unannounced inspection visits from 22 to 23 May and 10 June 2016.

Information about the provider

Derbyshire Community Health Services NHS Foundation Trust cares for patients across a wide range of services, delivered from 133 sites including 13 community hospitals and 28 health centres. It covers the city of Derby, the rural communities of Derbyshire and also provides dental services into Leicestershire. It provides care for more than 4,000 patients every day. The trust employs approximately 4,500 staff, serving a patient population of more than one million.

The trust offers a range of community based services including, inpatient services, community nursing and therapies, urgent care, rehabilitation, older peoples mental health, learning disability services, children's services, podiatry, dental services, sexual health services, health psychology, outpatients and day case surgery.

The trust was authorised as an NHS Foundation Trust in 2014, being one of the first in England. It is forecasting that it will meet all its statutory financial duties for the year

The trust is in receipt of an annual income of approximately £200 million, with the main purchasers of services being the four clinical commissioning groups (CCGs) acting on behalf of patients in Derbyshire:

- NHS Hardwick CCG represents 16 GP practices, acting on behalf of over 100,000 patients living in North Eastern Derbyshire
- NHS North Derbyshire CCG represents 38 GP practices, acting on behalf of over 288,000 patients covering North Derbyshire
- NHS Southern Derbyshire CCG represents 57 GP practices and is responsible for the healthcare of 525,000 people
- NHS Erewash CCG represents 12 GP practices, acting on behalf of 96,000 patients in Ilkeston, Long Eaton and surrounding villages. Since registration Derbyshire Community Health Services NHS Trust has been inspected on eight occasions at five locations.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Actions the provider MUST take to improve

- Ensure there is a robust process for maintaining a register of serial numbers for prescription pads in community health services for adults.
- Ensure medicines are transported in securely sealed or tamper evident containers.
- Ensure incidents in integrated sexual health services (ISHS) are reported and investigated in a timely and consistent way.
- Ensure learning from incidents and complaints is shared with all staff in ISHS.
- Ensure all staff working in ISHS follow the same guidance, policies and procedures in all areas.
- Ensure ISHS staff receive appraisal.
- Work towards national guidance for ISHS provision, including return postal addresses for undelivered mail, monitoring patients who did not wait to be seen and monitoring calls that are unanswered on the central booking service.

Actions the provider SHOULD take to improve

- The trust should ensure that they provide a two-way communication panel within the seclusion room on Hillside Ward.
- The trust should ensure patients are able to lock their bedroom doors within the core living respite units.
- The trust should ensure there are adequate staffing levels within Health visitor teams.
- The trust should ensure all patients have copies of their care plans in Older People's Mental Health Services and Learning Disabilities Services.
- The trust should ensure Older People's Mental Health staff abide by the Mental Health Act Code of Practice's guidance on the completion of leave of absence (Section 17) forms.

- The trust should ensure Older People Mental Health ward staff have access to the computer care recording system so that staff can have read access to all patient information.
- The trust should ensure that signage in team bases is inclusive and accessible for the people using the learning disability service.
- The trust should ensure that patients do not wait for excessive time on waiting lists for the learning disability service.
- The trust should consider reviewing the children's waiting areas to ensure they provide visual and audible separation from the adult waiting areas in line with Intercollegiate Children and Young people in Emergency Care settings standards.
- The trust should ensure the arrangements for managing complaints are operated effectively in the end of life care service.
- The trust should ensure the strategic plan for end of life care services continues to be developed.
- The trust should ensure there are robust governance arrangements in place in order to continue to improve the quality and safety of end of life care services.
- The trust should consider monitoring the provision of out of hours services in end of life care in order to assure themselves patients' needs are responded to in a timely way.
- The trust should consider how the Derby city district nurse liaison service can provide accurate referrals in a timely manner.
- The trust should consider how the ways of working and caseloads for Derby city community nurses can be aligned with Derbyshire Community Health Services in a timely manner.
- The trust should consider monitoring the time taken for the community nurses to see patients once referral has been made.
- The trust should consider developing a consistent approach to monitoring and auditing the quality of the service throughout the community, including obtaining feedback from members of the public.
- The trust should consider developing a consistent approach to monitoring outcome measures for patients, including how rapidly patients are discharged from inpatient services if they wish to be cared for at home in the last days of life.
- The trust should review the provision of therapy on a weekend to maximise a patients' rehabilitation programme.
- The trust should consider how the confidentiality of patient information can be guaranteed when notes are stored at the end of a patient's bed.
- The trust should monitor the number of patients that are transferred to an acute trust following care and treatment at the day treatment centre.
- The community dental service should consider how to improve communication between the Derbyshire and Leicestershire based clinics.
- The trust should consider how to ensure the lone working policy is understood fully amongst the health visitors and ensure the code is known by all staff.
- The trust should ensure written consent is obtained from parents in children's services and not just implied consent where patient information is shared with other professional services.

Derbyshire Community Health Services NHS Foundation Trust

Detailed findings

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Overall, we rated the safety of the services as good.

Key findings were:

- The trust had a mature patient safety culture and incidents were managed well with evidence of learning across the organisation. We found the sexual health service needed to improve its incident reporting processes. However, this was a service which had been subject to change because of the new way it was being commissioned. There were contractual arrangements that still needed to be made clearer. These issues were hampering the process for incident reporting and learning across the whole service.
- There was a good understanding of safeguarding children and adults amongst staff.
- Staffing levels were generally able to meet the needs of patients, although there were some vacancies in the community adult's service.

Our findings

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 was introduced in November 2014.This regulation required the trust to notify the relevant person that an incident has occurred, to provide reasonable support to the relevant person in relation to the incident and to offer an apology.
- The trust had a Duty of Candour policy in place and training sessions had been delivered to staff. The trust's electronic reporting system incorporated a duty of candour element and prompted staff to offer an open and honest explanation to patients if an incident had affected patient care.
- There was a patient safety team helpline for staff where they could raise queries and get additional support and guidance on meeting the requirements of the Duty of Candour.

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- The inspection team found that awareness and understanding of the duty was good across the trust. The understanding of more senior staff, such as ward sister level and above was much more in depth with them being clear on the steps they needed to take.
- The trust recognised the Duty of Candour was a statutory requirement and had identified it as a risk on their corporate risk register with a series of controls to mitigate risk in place.

Safeguarding

- Staff had access to suitable safeguarding adult and children's policies and procedures as well as advice from the trust safeguarding team. Recent reviews of safeguarding procedures had been completed to ensure that female genital mutilation, self-neglect and duty of candour acts of omission were included.
- The trust had dedicated named safeguarding leads for adults and children who were generally well known by staff. Staff told us the leads were accessible to provide advice and guidance. The team of six adult and six children's safeguarding leads were all trainers and had a responsibility to provide advice to all staff at the trust who worked with adults, families and children. A three monthly staff survey was undertaken to get a sense check of how useful the safeguarding training had been and how staff felt about reporting concerns.
- The safeguarding team staff represented the trust at a range of external sub groups and reported excellent multi-agency relationships. Trust staff contributed to Derbyshire Multi Agency Risk Assessment Conferences (MARAC) and Multi Agency Public Protection Arrangements (MAPPA) to share information crucial to the protection of children.
- The safeguarding governance group was reformed in January 2015 and met quarterly. There was a governance structure in place and clear lines of accountability up to the trust board.
- We saw child sexual exploitation (CSE) and female genital mutilation (FGM) were discussed at safeguarding governance meetings. Staff working in sexual health, children's and minor injury services demonstrated a clear understanding of CSE and FGM and what actions they needed to take. Training for staff who were more likely to come into contact with these issues had taken place. Training sessions for all staff were planned but had not been delivered at the time of the inspection.
- The trust policy was that health visitors and school nurses received safeguarding supervision every four to six months. The annual children's safeguarding report showed a decline from 98% in November 2014, to 87% of staff receiving safeguarding supervision in March 2015.
- Between May 2015 and May 2016 there had been three serious case reviews. Two reviews had been completed and were ready to be published; there had been some delays due to criminal court cases which were happening later in 2016. Learning from the reviews had been identified and changes had been implemented and audited by the learning lessons group.
- We witnessed examples during our inspection where staff had recognised possible safeguarding concerns and had taken appropriate action. There was a very good understanding of safeguarding responsibilities amongst all of the staff we came into contact with.
- The required level of safeguarding training had been clearly identified for the different staff groups. Training compliance was monitored monthly as part of a balanced score card. Data indicated compliance was high, with performance in line with the trusts own target of 95%.

Incidents

- The trust had an electronic incident reporting system. Data from this system indicated the trust had a mature safety culture.This was because they were in the top 20% of incident reporters when compared with similar trusts and the number of no or low harm incidents was high. Forty seven per cent of incidents reported between 1 January and 31 December 2015 resulted in no harm, 47.9% resulted in low harm and 4.8% in moderate harm. Severe harm incidents accounted for 0.2% of all incidents and less than 0.1% resulted in death.
- During the period, 1 January 2015 to 31 December 2015, the trust reported 231 serious incidents through the electronic reporting system. Of these: 202 were Pressure Ulcers and 22 were slips, trips and falls.
- The trust had not reported any never events and 59 serious incidents to STEIS between January 1 and December 31 2015.
- The trust had a culture of awareness and reporting of medicine related errors resulting in over 700 being reported during the year 2015-2016. All such errors were reported via the electronic reporting system, to the chief

Good

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pharmacist who was responsible for assessing and assigning severity. A summary of these reports was discussed at the trust's medication operational safety team meetings.

- There was a well-established system for investigating incidents using root cause analysis methodology. Incident reports that we examined were detailed with good depth and rigour being evident. All incident investigations outlined areas for learning. Our inspection teams saw examples of changes that had been introduced as a result of learning from incidents.
- We found the sexual health service needed to improve its incident reporting processes. However, this was a service which had been subject to change because of the new way it was being commissioned. There were contractual arrangements that still needed to be made clearer. These issues were hampering the process for incident reporting and learning across the whole service.
- There was a clear governance structure for monitoring incidents. The Trust board had oversight of trends and learning from incidents.
- Sign up to Safety is a national Patient Safety campaign intended to harness the commitment of staf across the NHS in England to make care safer. It is one of a set of national initiatives to help the NHS improve the safety of patient care. Collectively and cumulatively these initiatives aim to reduce avoidable harm by 50% and support the ambition to save 6,000 lives. The campaign requires that organisations commit to five safety pledges. The trust signed up to the Campaign in February 2016. It made five safety pledges which were monitored through the trusts clinical governance structure.

Staffing

- The trust had a People Plan and a Workforce Strategy. The executive team and trust board monitored staffing vacancies, staff turnover and the use of bank and agency staff through a monthly performance report. We looked at these reports and found them to contain depth and rigour.
- Across the trust we found staffing levels were generally meeting the needs of patients. With the exception of the community nursing service for adults, we received very little feedback from staff that staffing levels were of concern to them.Similarly, we did not receive feedback relating to concerns about staffing levels from patients, relatives or carers.
- In October 2015, the Derby City community nursing team was transferred to the trust from another provider. At the time of the inspection, the trust were aligning teams to be consistent with the rest of the organisation. Caseloads of patients were being reviewed. The risks of the staffing vacancies had been entered onto the corporate risk register with plans in place to mitigate and control the risk to patients and staff.
- In the community nursing teams there was an average of four registered to one unregistered nurse with the exception of a team which had recently joined the trust from an acute trust where the ratio was three to one. The average vacancy factor for community nurses was 7%. We saw evidence that recruitment was on-going and by June 2016 vacancy rates had reduced significantly.
- Inpatient wards were staffed according to bed numbers of 16 with a ratio of one qualified nurse to eight patients. This was in line with the Royal College of Nursing guidance for elderly care wards. Additional staff were available when the dependency and acuity of patients made it necessary. The trust used a responsive staffing model which maximised the use of bank staff and reduced the use of temporary agency staff. Use of agency staff was low at 1.4%.
- Trust wide staff turnover for the period March 2015 to February 2016 was 10%. Staff sickness levels for the same period were 4.5%.
- All trust inpatient areas were led by Advanced Clinical Practitioners (ACPs). The medical director told us they had access to medical support from consultants and GPs on service level agreements (SLAs). The trust was working towards increasing the numbers of advanced clinical practitioners to meet predicted future staffing needs.

Medicines management

- Across the trust, we found efficient medicine management. A recently expanded pharmacy team provided clinical services to inpatient wards to ensure people's medicines were handled safely. The pharmacy

Good

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team produce a bimonthly newsletter which was distributed to all clinical teams. This detailed recent medicine alerts or changes in guidelines. Staff we spoke with were aware of this publication.

- Arrangements for managing medicines and medical gases including storage, security, administration and disposal were safe. However, we found there was not a robust process for maintaining a register of serial numbers for prescription pads in community health services for adults. Medicines were not transported in securely sealed or tamper evident containers in community health services for adults.

Safety of equipment and facilities

- During 2015 it was identified that there was significant redecoration required in many areas. This had been addressed with funding being found to undertake the work.
- The estates department had won an award for its use of energy and waste management. A second award had also been won for the travel and transport systems which included hybrid cars fitted with trackers which enabled them to be directed to the nearest site where works were required.
- The estates team staff were available 365 day per year so could be called out to deal with emergencies.
- The estates department produced quarterly performance monitoring reports. The reports considered a wide range of aspects including performance, training, complaints/compliments and finances.
- We found electrical testing and equipment maintenance was up to date in the areas we inspected. Staff didn't report any concerns about access to the equipment they needed to carry out their job.

Cleanliness and infection control

- The trust had a director of Inspection Prevention and Control who was the executive lead at the trust board.
- There were infection prevention and control policies in place.
- All areas we visited during our inspection were visibly clean. This was supported by most recent patient led assessment of the care environment (PLACE) data which demonstrated a high compliance rate of cleanliness in the ward areas of 99.70% which is above the national average of 97.50%.
- There had been no cases of MRSA bacteraemia in the last 12 months, although the lead for infection prevention and control did tell us that they had seen four MRSA infections between April 2015 and May 2016. As MRSA infections have the potential to escalate in seriousness, the IPC lead asked the ward to complete root cause analysis (RCA) investigation on them. The outcomes of the RCAs identified no lapses in care.
- There had been six cases of C.difficile infection between April 2015 and May 2016. No lapses in care were identified in any of the six cases following a detailed RCA.
- We observed hand hygiene to generally be good, but we did identify some opportunities for improvement.
- There were effective systems in place for monitoring water safety.
- Self-assessment infection prevention and control of infection audits were undertaken for each ward area, mostly undertaken by the ward sister and hotel supervisor. The findings of these were reviewed by the infection and prevention control team and matrons. The standard score to reach was 95%, where scores fell below this an action plan and re-audit was undertaken to monitor progress.

Major incident awareness and training

- The trust had a comprehensive business continuity plan which was available to staff on the trust intranet site. There was also a major incident plan with clearly defined roles for site coordinators or managers. The plan indicated the trust held one live training exercise every three years with annual table top drills and test exercises every six months.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Overall, we rated the effectiveness of the services as good.

Our key findings were:

- Evidence based practice was embedded throughout the trust and services followed national guidance.
- Multidisciplinary working was well established across the trust.
- Staff were able to demonstrate a good understanding of the principles of mental capacity. We noted the approach to mental capacity assessment, best interest assessment and restraint within the learning disability service was particularly good.

Our findings

Evidence-based care and treatment

- Evidence based practice was embedded throughout the trust.Services followed national guidance and standards such as National Institute of Health and Care Excellence (NICE).
- There were a range of clinical policies and procedures in place for staff to follow which reflected current guidance.For example, NICE guidance on Pressure Ulcers (CG029).Staff knew how to access policies and guidelines and they were readily available.
- There was a trust wide governance process to ensure policies and procedures were up to date and in line with best practice.
- The Liverpool Care Pathway (LCP) had been removed. All staff involved in delivering end of life care had access to current guidance through the Derbyshire Alliance End of Life Care Toolkit.This toolkit was based on evidence based guidelines which underpinned aspects of clinical practice.

Nutrition and hydration

- All inpatient sites had meals freshly prepared on site. The quality of food was monitored through the PLACE (Patient led assessment of the care environment). As a result of the audits 'nutritional state at a glance' sheets were placed in kitchens which were reflective of the patient's care plan.This allowed catering staff to have readily available information about each patients' dietary requirements.
- The trust implemented protected mealtimes, which is an initiative to ensure patients are not disturbed when they are eating their meal. Protected meal audits were completed, these assessed if correct water jugs and crockery were in place for those patients who were considered to be at risk of dehydration or malnutrition.
- The three weekly menu cycle was checked by a dietitian and speech and language therapist to ensure it met patients nutritional needs.
- The trust had achieved United National Children's Fund (UNICEF) full baby friendly accreditation in February 2014.

Outcomes of care and treatment

- The trust had eleven Commissioning for Quality and Innovation (CQUIN) measures in place. CQUIN's are quality indicators agreed with the trusts commissioners and are designed to improve services. In 2014/15 the trust achieved 91% of their CQUIN targets and in 2015/16 100%.
- In addition to externally agreed performance targets the trust had their "Big 9".These were nine additional targets to enable them to deliver their vision to provide the best quality care for patients and ensure a good environment for staff. Progress was monitored against these nine areas and was reported through the governance process.
- The trust developed a number of quality standards based upon CQC Fundamental Standards. Teams were responsible for ensuring they met the standards and were assessed through a process of self-assessment and clinical audit. In addition to this the trust had set up a programme of unannounced reviews to all wards and departments and clinical teams.This was part of the Quality Always programme. Teams received a rating and a detailed report to develop a quality improvement plan. The frequency of the next assessment depended on the rating awarded.
- The trust participated in the NHS National Safety Thermometer which is a national prevalence survey that looks at patients one day every month to determine if they had received harm free care. A national target for harm free care is set at 96%. One hundred per cent of patients who were receiving care from the learning

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

disability service received harm free care. During 2015/16 the trust set itself a stretch target to achieve 94% of patients across the trust receiving harm free care. The trust had an overall rate of 93%, however, there was an improvement in this score when compared to 2014/15.

- During 2014/15, the trust participated in 125 local clinical audits. They completed all of the national audits they were eligible for. In our inspection of the various services we found evidence that teams had acted upon audit findings to further improve patient's outcomes. However, in the integrated sexual health services we found a low number of audits were completed. This was a service that the trust recognised needed further development since they took over responsibility following a commissioning change.
- There were a range of care pathways in place to meet the needs of patients with various health conditions. We found these were in line with national guidance.There were a number of patient outcomes in the children and Young people's services which were monitored as part of national outcome measures.

Competent staff

- Many staff told us they had opportunities for training and development in the trust. The trust supported staff to undertake a variety of training including access to master's level study, non-medical prescribing and the specialist district nurse qualification.
- There was a process in place to ensure that doctors undertook revalidation. One hundred percent of the doctors due to revalidate had done so.
- From April 2016, all registered nurses are required to revalidate with the Nursing and Midwifery Council (NMC) in order to continue practising. The trust had arrangements in place to support staff undertaking their revalidation. Nursing staff told us they felt the trust was supporting them with the process and there was a lot of information available to them.
- The trust estates department invested in the training of staff to ensure they were multi skilled and could take on a variety of jobs. The trust also employed and trained apprentices in the estates department, for example electricians.
- The trust target for completion of appraisal was 100% for available staff. At the time of our inspection 94% of available staff had received an appraisal.
- Access to clinical supervision was variable across the trust. Some areas had greater access than others. Staff working in the sexual health services didn't always attend clinical supervision. The trust was supportive of clinical supervision and encouraged staff to attend. Workload pressures were the most common reason for staff not accessing this.

Multi-disciplinary working and co-ordinatation of care pathways

- The trusts Integrated Business Plan 2014-2019 set out how the trust would use an integrated approach to different models of care based around the needs of patients.
- There were integrated community health teams in place which brought together different disciplines of staff to meet patient's needs.
- We found effective multi-disciplinary working took place across the trust. This meant services worked together to provide effective joined up care.
- Staff worked closely with social care in order to improve patient care and outcomes.

Referral, transfer, discharge and transition

- Generally we found patients were referred and transferred appropriately.
- The trust provided generalist end of life care services. Specialist palliative care services were provided by other NHS organisations. Arrangements worked well and we found evidence of good communication between health, social care and voluntary organisations.
- The Integrated Sexual Health Service had direct referral access into the Child and Adolescent Mental Health Service (CAMHS).
- With the exception of Derby City, there was an effective single point of access service for referals to the community nursing service team. Derby city community nursing team had recently been transferred to the trust. There was an outdated system for referrals which relied on a fax and telephone system. The trust recognised this was not effective and were planning to incorporate this team into the single point of access system.

Availability of information

- Policies and procedures were available electronically through the trusts intranet system.
- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way.

Are services effective?

Good

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- The majority of Community nursing staff had access to an electronic system to access patient records. In most cases staff also had access to GP records. There were plans in place to transfer all areas to the electronic system during the remainder of 2016/17.
- Staff generally reported good levels of satisfaction with access to information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Mental Capacity Act policy in place. Staff were able to demonstrate a good understanding of the principles of mental capacity. We noted the approach to mental capacity assessment, best interest assessment and restraint within the learning disability service was particularly good.
- Staff received training in consent, mental capacity and Deprivation of Liberty (DoL's). Compliance with this across the trust was generally good.
- Where relevant staff also received training on the Mental Health Act. Staff had a good understanding of the Mental Health Code of Practice.
- Adherence to the Mental Health Act and Mental Health Code of Practice was good. Records relating to patients detained under the Act were in good order although improvements were needed to section 17 leave records. This was an area of improvement which was raised in our previous inspection.
- Where relevant patients had access to advocacy services.
- We reviewed numerous sets of patient records throughout the inspection. We found records about obtaining consent were generally completed in line with best practice.
- We reviewed a total of 51 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms and found 86% of these to be fully completed. Two of the 51 forms had no record of a mental capacity assessment in place. This demonstrates relatively good performance in this area, although there is still room for more improvement.
- The number of deprivation of liberty referrals were monitored each quarter at the safeguarding governance group. Minutes showed there were delays in local authorities completing assessments after referral had been made. The minutes for February 2016 showed that 10 out of 43 patients were discharged before the assessment process had begun. This delay was outside of the trust's control but it had been raised as a concern.
- Staff working with children demonstrated a good understanding of Gillick competency and Fraser Guidelines. There are nationally recognised guidelines relating to the taking of consent from children.

Outstanding ☆

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Overall we rated the caring for the services in the trust as outstanding.

Our key findings were as follows:

- Patients were treated with kindness, compassion, dignity and respect throughout all of the services we inspected.
- During our observations of staff and patients interaction we found staff were focused on the individual needs of patients making them feel valued and respected.
- Staff were observed going above and beyond what they were expected to do so they provided the best possible care for their patients'.

Our findings

Dignity, respect and compassionate care

- Patients were treated with kindness and compassion throughout all of the services we inspected.
- Staff treated patients with dignity and respect.
- Our inspection teams carried out a number of observations to monitor staff and patient interactions. Without exception, interactions were very positive and staff treated patients with kindness, dignity, respect and compassion.
- We spoke with many patients, relatives and carers during our inspection. They were consistently positive and complimentary about staffs attitude and support. We saw examples of how staff had gone over and above what was expected of them to provide compassionate care.
- We noted that staff provided non-judgemental care to patients.
- The trust scored 12% over the England average for staff who would recommend the trust as a place to receive care. The response rate by staff was three times higher than the England average. This indicated there was a high degree of confidence that the scores were representative of the views of staff working in the trust.
- In relation to privacy, dignity and wellbeing, the 2015 Patient Led Assessment of the Care Environment (PLACE) score for Derbyshire Community Health Services NHS Foundation Trust were slightly above the England average at 87%. PLACE is a system for assessing the quality of the patient care environment. Assessments are carried out in areas which provide NHS funded care. The percentage of respondents, who would recommend the trust as a place to receive treatment, was equal to or above the England average during the six month period from August 2015 to January 2016. The response rate is similar to the England average for the duration of the period.

Patient understanding and involvement

- Overall, patients understood and were involved in their care. We saw some excellent examples of how staff took time to clarify patients understanding of their care and treatment.
- All inpatient wards were promoting "Johns Campaign, "which encourages the involvement of relatives and carers of patients living with dementia. We saw some excellent examples of care for patients living with dementia during our inspection.
- Patient's relatives and carers consistently told us they were involved in care planning and delivery. Many relatives specifically commented to us how involved they were and how much information and support they received from staff.
- In the end of life care service, patients had individualised advanced care plans in place to reflect the choices and preferences of the patient. Records we inspected showed detailed discussions had been held with patients and their families.

Emotional support

- Without exception, we found staff offered emotional support to patients' and their families.
- The trust had worked with Derby Volunteer and Chaplaincy Service. Each integrated community team had a volunteer chaplain linked to them. The trust was in the process of working with a multi faith centre to expand their multi faith service further.
- A carers diary was used in the end of life care service which was part of the Derbyshire Alliance End of Life Care Toolkit. The diary was completed when their loved one was believed to be in the last days of life and used to improve communication between carers and professionals.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Overall we rated responsive for the services in the trust as good.

Our key findings were as follows:

- Services were planned around the needs of individual patients.
- There were a range of services offered to vulnerable groups. There was a flagging system in use within the electronic patient record system to identify patient who had a learning disability.
- Frail elderly patients and children, those living with dementia or a learning disability were prioritised for care in the Minor Injuries Unit (MIU).
- The MIU was providing a very responsive service. It was consistently exceeding targets in respect of time spent in MIU and the time patients' waited for treatment.
- We found evidence throughout the trust that people were supported to raise concerns, complaints and compliments.

Our findings

Planning and delivering services which meet people's needs

- Services were planned around the needs of individual patients.
- The total number of delayed discharges between February 2015 and January 2016 was 238. Thirty four per cent of these delays were due to waiting for care packages in the patient's own home, 24% of the delays were due to patient or family choice, 16% awaiting residential home placement and 14% awaiting nursing home. The number of delays that were the responsibility of social care had increased during 2015 and was higher than delays attributable to NHS responsibility in the final six months of 2015.
- The average trust bed occupancy rate was 74%. With the exception of Alton Ward, bed occupancy had decreased since 2014/15.This reflected the vision of the trust and its commissioners to deliver more care closer to the patient's home, rather than in hospital.

Meeting the needs of people in vulnerable circumstances

- The 'This is me' booklet was used to improve staff awareness of the preferences, lives and personal history of patients living with dementia.
- Ward quality visits were undertaken which considered if wards were dementia friendly. This was recorded on the ward metric system which awarded a rating for each ward assessed. The ratings showed an improving picture of wards being dementia friendly. The changes made had included clearer signage, clocks and painting toilet doors yellow to aid identification.
- Each chef had their own fund which they could use to purchase specific foods for patients if there was an identified need.
- Staff working in the community learning disability service made repeated attempts to contact patients who didn't arrive for appointments. We saw an example of this during our inspection.
- There was a flagging system in use within the electronic patient record system to identify patient who had a learning disability.This meant staff could provide additional support for patients.
- A former patient with a learning disability had created a pictoral guidebook for patients attending the MIU.
- At the time of the inspection the trust had 200 children who were subject to care supervision orders and 702 children who were subject to a child protection plan. We found the staff working with vulnerable children to be knowledgeable about their caseloads.
- There were a range of services offered to vulnerable groups. This included three health visitor roles who specifically worked with women's refuges to support vulnerable women and children.
- Since 2011 there had been 15 deaths of young people and adults due to suicide within Derbyshire. In response to this the trust was working with other agencies to develop the Derbyshire Suicide Prevention Strategic Framework.
- There were arrangements in place for young people attending the sexual health service. There was a flagging system in place which altered staff that a patient was under 18. The trust also used a "C" card. Young people were given a card and would show it at different clinics and the Minor Injury Unit (MIU) across Derbyshire. This

Good

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allowed them to obtain condoms free of charge. We saw this system being used by a young person attending an MIU and found it to be sensitively handled encouraging the young person to use it again.
- We observed how frail elderly patients and children, those living with dementia or a learning disability were prioritised for care in the MIU.

Access to the right care at the right time

- The Minor Injuries Unit (MIU) was providing a very responsive service. It was consistently exceeding targets in respect of time spent in MIU and the time patients waited for treatment. The MIU's were involved in initiatives to direct patients to them, rather than attending emergency departments. This included staff attending local events to raise the profile of the MIU's.
- The sexual health service was able to provide patients with an appointment within two days of the contacting the service. However, the average time between referral received to appointment date was 10.6 days. There were no mechanisms in place to monitor any calls to the sexual health service and how long people were waiting for their call to be answered or how many patients hung up while waiting for their call to be answered.
- Within the community mental health service for people with learning disabilities or autism, we found there were 155 patients on the waiting list. Staff maintained contact with the patients on the list to ensure they were safe and their risks had not increased. There was capacity for 800 patients in total and they were at full capacity at the time of our inspection. Staff managed the waiting list proactively and arranged for patients to be seen as soon as possible.

Complaints handling and learning from feedback

- The trust had an up to date complaints and concerns policy available on the intranet.
- The trust had 118 formal complaints during 2014/15 which was a decrease from 2013/14. The highest number of complaints related to nursing and health visiting.
- We found evidence throughout the trust that people were supported to raise concerns, complaints and compliments. Information was widely available. The trust had an "app" to provide an easy way for patients to submit anonymous feedback electronically. The trusts website contained prominent information about how to get in touch and encouraged patient feedback. We also noted that comments made on the NHS Choices website were responded to by the Patient Experience Team.
- The trust's Patient Experience Team oversaw the complaints procedure. Complaints information was recorded on the electronic risk management system allowing any links between a complaint and a reported incident to be identified. Data from complaints was reported through the trusts clinical governance structure and to the trust board. There was a sense that the trust took a genuine interest in patient feedback.
- We reviewed six complaints and saw they had been managed appropriately, with openness and transparency and according to the policy. All complaint responses offered an apology. All six complaints were graded as satisfactory with four being graded as demonstrating good practice.
- The trust had an external peer review of their complaints process by the Patient Association in November 2015. The review demonstrated the trust had improved its complaints handling during 2015.
- During our inspection of the 12 core services we saw evidence of lessons learnt and action taken to improve services. Further development was required within the sexual health service to ensure staff learnt from complaints.
- The trust board heard a patient story every month. The Chief Executive and Chairman told us it was important for these stories to be heard at the trust board. They were at the start of the agenda so they had the time they needed and were not rushed.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We rated the trust as good for well led because:

- There was a clear vision in place supported by objectives and values which staff understood.
- The Chief Executive and Chairman worked well together but their relationship had an appropriate balance between high challenge and high support. The Chief Executive and Chairman were visible and many staff commented on the strong leadership they provided.
- We received many positive comments about the non-executive and executive leadership from staff at all levels in the organisation.
- The trust valued its staff, there was a real sense that they cared about them and saw them as their greatest asset. Morale amongst the majority of staff was very good. Staff enjoyed working at the trust and felt valued by the executive team and their line managers. Where morale was not as high it was usually because of the impact from service reconfiguration.
- The trust had an established governance structure which was there to support the provision of assurance to the board.
- The trust had a commercial focus which was also centred on providing the best possible care for patients. This had made the trust well placed to respond and adapt to changes in direction arising from new local and national policy.
- A culture of putting the patient first was evident throughout the organisation.

Our findings

Vision and strategy

- The trust had a vision to be the best provider of local healthcare and to be a great place to work. Underpinning the overall vision were four ambitions, three objectives and five trust values. These were presented in a clear and logical way.
- The term "The DCHS Way," was used to describe how staff put the vision and values of the trust into action. It was the trusts pledge to staff and patients which promised how they governed and managed the organisation. There were three elements to the DCHS Way; quality service, quality people and quality business. Without exception, staff knew about the DCHS Way and what it meant to them. We found it was publicised extensively across the organisation, but more importantly we observed staff at all levels displaying the trusts values in their day to day work.
- The trust had a number of strategies, such as quality, risk management and equality and diversity. In addition to the strategies, there was an integrated business plan 2012-2017. The plan focused on different models of care with integration of services at the centre. There were two different narratives of a patient's experience of care to help illustrate what the business plan was trying to achieve. All developments to clinical services were underpinned by key service principles, namely; to provide a single point of access and navigation for patients, to provide care as close to home as appropriate, create integrated services and pathways, ensuring all services promote health and independence and ensuring care is efficient and effective as possible.
- Some groups of staff had been through service reconfiguration which had meant changes to their employer. The trusts leadership team spoke about their actions to help staff feel supported through change. They had learnt from each reconfiguration so they could continually improve and achieve their vision to be a great place to work. We spoke with the staff partnership group which was a group of staff who represented the workforce. Without exception, they spoke positively about the trusts commitment to making the experience of service reconfiguration as smooth as possible to staff.
- The trust operated within a wider health and social care economy and had approximately nine other acute NHS trusts that it worked with. Its main purchases of care were four clinical commissioning groups across Derbyshire. Information received prior to the inspection suggested the trust was well respected by all of these organisations.
- The trust had a commercial focus which was also centred on providing the best possible care for patients. This had made the trust well placed to respond and adapt to changes in direction arising from new local and national policy.

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- The trust was involved in the development of the Sustainability Transformation Plan (STP) for Derbyshire. An STP is a five year shared place based plan focused on driving the implementation of the NHS five year forward view.

Governance, risk management and quality measurement

- The trust had an established governance structure which was there to support the provision of assurance to the board. A range of board sub committees were in place chaired by non-executive directors. These committees reported regularly to the trust board and all had clear terms of reference. There were governance structures in place at a local level which in turn provided assurance through to sub committees and the trust board.
- From our interviews with the senior and executive leaders within the organisation, we could see they were aware of the key quality and performance issues the trust faced.
- The governance arrangements had been extensively reviewed as part of the trusts application to become a Foundation Trust. They were one of the very first community trusts to be authorised as a Foundation Trust in November 2014.
- The trust had a governance rating of “Green", this meant it had met all its risk assurance framework targets set for NHS Foundation trusts.
- The trust had a “Quality Always” programme designed to improve the quality of care but focusing on the accountability for staff working at the front line. Part of this programme was an assessment and accreditation scheme knows as CAAS. This was a process of assessment, review and accreditation for clinical areas and was linked to the care quality commission standards. A team of clinical and non-clinical staff visited areas to carry out an assessment. Observations were also triangulated with data and feedback was given so that quality improvement plans could be put into place. We saw evidence that the programme was being delivered across the trust and plans were being monitored to ensure services were continually improving. We also saw evidence of how the performance monitoring had flagged areas of concern so that more support from clinical leaders could be given.
- There was a quality dashboard in place and although it was not implemented in every clinical service at the time of our inspection, it was a useful tool for the board to monitor performance. It provided a range of performance metrics for the trust board as well as giving information for individual clinical teams.
- The Board Assurance Framework (BAF) and corporate risk register identified the trusts strategic and operational risks. The BAF was reviewed by the board and was linked to the strategic risks. Following a board development session in November 2014, the BAF had just been changed at the time of our inspection. The BAF was reviewed in full by the Audit and Assurance Committee.
- We could see from our review of board papers that the trust reviewed how data was presented to ensure it was not duplicated and it provided the appropriate level of assurance.
- The Council of Governors held the trust board to account. The Governors felt involved in the direction of trust and that the executives and non-executive directors were open and honest. There were formal and informal contacts between governors and the trust board members.
- There was a risk management policy in place. Risk registers were held at divisional level with a process for escalation. Risks were categorised using a risk matrix framework based upon the likelihood of the risk occurring and the severity of the impact. Staff within the core service areas knew what their operational risks were and actions were in place to mitigate those risks.
- The trust had a surplus of £0.34 Million at month 1 2016/17. A year end surplus of £3.4 million was forecast, which assumes full delivery of the service quality improvement programme. The trust had a financial sustainability rating of 4 which was the lowest risk given by NHS Improvement. The trust had a cost improvement plan in place (CIP). Performance against this was reported to the board. All CIPs were assessed for their impact on quality by the Chief Nurse, Medical Director and a non-executive director and would be rejected accordingly.
- The trust board met monthly and the agenda was structured so that patient stories and clinical quality were at the top of the agenda. All board papers had a cover sheet outlining the purpose, recommendations, link to the BAF and financial impact of the subject being presented.

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- A monthly performance report was presented to the trust board and highlighted trust performance in relation to the three "DCHS Way" focus areas of quality people, quality services and quality business. A balanced scorecard approach was used where indicators were given a red, amber or green score. There were no red areas and where there were any amber areas they had exception reports and improvement plans in place.
- The trust had nine CQUIN's (Commissioning for Quality and Innovation). These are measures set by the commissioners of the service to improve the quality of patient care. In 2014/15, the trust achieved 91% of their CQUIN targets and in 2015/16 100%.
- In addition to the CQUIN areas, the trust set themselves the "Big 9," which were a set of quality indicators that linked to the DCHS. Performance against the "Big 9" was good.
- The trust met its referral to treatment time targets in all areas during 2015/16.There were no delayed transfers of care. The average length of stay for patients was 21days which almost met their trust target of 20 days.
- Total harm free care in accordance with the Safety Express programme was very slightly worse than the trust target, 93% against a target of 94%.
- There had been a big focus on the reduction of avoidable grade two, three, and four pressure ulcers across the trust. Performance had significantly improved and the commissioners of care told us they were very satisfied with the work the trust had done to address this.
- The trust had responded positively following an independent NHS England report into the deaths of people with a learning disability or mental health problem by identifying and reviewing the deaths of six patients where death had been considered 'unlikely'. The purpose of the review was to identify any potential adverse incidents that might have contributed to the death. The review concluded that none of the deaths were avoidable; however it was identified that the process for reporting and reviewing mortality could be improved. A monthly, triangulated reporting system was being introduced to address this.

Leadership

- The executive leadership in the trust was very stable. The Chief Executive had been in post for over five years and was very well respected both internally and by external stakeholders. The trust board was led by an equally respected Chairman who had been in post since December 2013.
- The Chief Executive and Chairman worked well together but their relationship had an appropriate balance between high challenge and high support. This was a view that was shared by other senior leaders both within the trust and from the commissioners and other stakeholders. The Chief Executive and Chairman were visible and many staff commented on the strong leadership they provided. The Chief Executives weekly message to all staff was seen as valuable and was a way for staff to feel some connection with the executive team.
- We received many positive comments about the non-executive and executive leadership from staff at all levels in the organisation.
- The trust Medical Director had been in post since November 2014 and the Chief Nurse since September 2013. Staff in many of the core service areas we inspected felt the medical director provided strong clinical leadership and he was visible across the trust. Some staff felt the Chief Nurse was less visible and they looked to the Medical Director for clinical direction.
- The Non-Executive Directors were a skilled and experienced group who had varying backgrounds. We saw evidence of challenge in board and committee meetings.
- Leadership development was a priority for the trust and was an objective in the trusts strategy. There were leadership development programmes in place for varying levels of staff. Eighty six leaders went through a leadership development programme during 2015/16.
- The trust board also undertook board development. In May 2016, the trust held their first leadership conference where 150 staff joined board members.
- We found examples of effective leadership across the organisation. Staff were empowered to make improvements and make suggestions.
- The NHS staff survey 2015 gave the trust a much higher score than the national average for staff reporting good communication between senior management and staff.
- The trust had an effective and highly engaged governing body. The council of governors provided a summary report to the trust board highlighting their work and any

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areas of concern or improvement. Without exception, the governors felt listened too, supported and were able to offer a balance of high challenge whilst being supportive of the trusts leaders.

Culture across the provider

- A culture of putting the patient first was evident throughout the organisation. Generally staff spoke positively about the organisation. Morale was worse in services that had been affected by service re-configuration, such as the sexual health service. The trust board were aware of areas where morale was not as good as they would like.
- We met with the trusts Partnership Forum which included members of recognised trade unions such as Unison and the Royal College of Nursing. They confirmed that the trust had taken steps to ensure it learnt from changes in the commissioning arrangements for services and the impact on staff and attempted to improve it each time it occurred. Senior managers acknowledged that they could always improve and wanted to learn lessons to make a difference for the next time. Staff had been invited to participate in events to seek their views and learn lessons. Staff told our inspection teams they felt listened to.
- The response rate for the trust in the 2015 staff survey was above average for community trusts and had a response rate of 57% but this was a 5% drop from the 2014 survey where the response rate was 62%. The trust performed better than average in 24 of the key findings in the NHS patient Survey. This included staff reporting the trust as a positive place to work, staff being motivated at work and the support they received from their managers.
- There was just one area where the trust scores were worse than the national average of other NHS community trusts which was the percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months. The trust score was 10% with the national average being 7%.
- We spoke with members of the Staff Partnership Forum and asked them about bullying and harassment in the trust. They did not raise any concerns with us about a culture of bullying or harassment.
- The trust set themselves an ambitious target of 100% of staff should have received an appraisal. Ninety two per cent of staff received an appraisal during 2015/16. The trust had set an improvement target of 96% of staff to receive an appraisal and it was a key area of focus.
- The trust had an annual awards ceremony to recognise staff contribution and achievements. They also held afternoon tea ceremonies for staff to receive long service awards.
- Staff turnover in 2015/16 was better than planned, being 9.7% against a plan of 14%.
- The trust offered all staff the living wage. There was a genuine culture in the trust that staff were the trusts greatest asset and it was important to look after their welfare.
- The trust aimed to be a good partner and an organisation that was easy to do business with. They had set out their approach to business and commercial development underpinned by three key principles. One of these principles was public benefit. We saw an example of this in practice where the trust had taken on a GP service with one days' notice. They were conscious that this created major risks to the delivery of a successful organisation but they took the decision in the wider public interest for the benefit of patients.

Fit and proper person requirement

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. The regulation intends to make sure senior directors are of good character and have the right qualifications and experience.
- We looked at the file of four directors. In one file we found the Curriculum Vitae (CV) for another person who was not employed at the trust, we alerted the trust to this and it was removed.
- For some directors who had been in post many years (pre the FPPR regulation in November 2014), recruitment had been undertaken by an external company, this meant that some records, mainly references, were not available in the files we looked at.
- Not all directors had enhanced disclosed and barring service checks in place. The trust had made a decision that where directors were not clinical directors this was sufficient. We did not see evidence that the trust considered informal sources of information about directors in files but were told that this was completed.
- A register of hospitality and gifts received was maintained for each of the board members.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Annual declarations of director's personal interests were on file.

Public and staff engagement

- The overall score for staff engagement in the 2015 NHS staff survey was higher than the national average when compared with similar trusts. They had a score of 3.93 which indicated staff were engaged.
- The trust scored higher when compared with other trusts for staff recommending the organisation as a place to work or receive treatment.
- Scores in the staff survey 2015 suggested that staff motivation at work was good. Our findings from our core service inspections reflect this.
- Generally, staff told us they felt supported and listened too by their managers. We spoke with staff that had been through service re-configuration and feelings varied amongst these staff groups. Many staff told us they felt the trust had done all it could to ensure they were kept informed of change and how this would impact on them. Other staff felt strongly about service re-configuration and were less supportive of change affecting their employment.
- A quarterly staff forum brought together staff and the executive team to discuss workplace issues that had been chosen by staff. Quarterly pulse checks were taken monitor how staff were feeling about work and to flag any areas of concern. Representatives from the staff partnership board met with the director of HR each month and were positive about the support they received from the executive team and other managers.
- The trust promoted the living wage and had reviewed all salaries and paid the living wage to all employees.
- The Staff Friends and Family Test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The trust has scored 12% above the England average for staff who would recommend the trust as a place to receive care. In addition, the response rate is over three times higher than the England average with over a third of eligible staff responding. This shows a high degree of confidence that the scores are representative of the views of the staff at the trust.

Public engagement

- The trust had a membership strategy. Their aim was to maintain the largest practicable membership which reflected the local communities. The objective was to engage the membership in the work of the trust, helping to shape services and to elect a Council of Governors. The trust had over 17000 members. They provided a biannual members newsletter as well as providing information and requests for involvement in different areas of the trusts work.
- The trust had a patient experience strategy. Patient stories were widely used and were included in the majority of committees, board meetings as well as in the monthly staff newsletter. The trust felt patient stories allowed them to monitor how services were being received.
- The trust was part of the Dignity Campaign which was a partnership between the NHS and Derbyshire County Council. It recognised teams who treated patients with dignity and respect. Many services had achieved the bronze and silver awards.
- There was a raising concerns phone application for patients, families and staff to give quick and easy real time feedback and services.

Equality & Diversity

- The trust equality & diversity theatre forum won an internal trust 'Extra Mile Award' in 2015 under the category of celebrating diversity. This forum group produced videos for the DCHS You Tube channel highlighting equality and diversity issues.
- An equality, diversity and inclusion leadership forum (EDILF) met bi monthly with an update of discussions published on the staff intranet.
- As part of our inspection we reviewed how well the trust was adopting the Workforce Race Equality Standard (WRES) and realistically working towards achieving workforce race equality. The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS community providers. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. The trust's WRES report for July 2016 was published on their website and showed 3.17% of their workforce for the period 2013-2014 were from a visibly black and minority (BME) community background. This compared with a

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BME population of Derbyshire at 4%. Data for December 2015 showed the trust's figure had increased slightly to 3.37%. There was a DCHS equalities action plan 2015-16 and the board had identified equalities focus areas.

- During our inspection we spoke with four BME staff. They all told us DCHS was a good environment to work in and the head of equality and diversity was effective and supportive.
- We discussed the WRES with the head of equality and diversity. The trust had collected, reported and published their data on their website. There are nine metrics in the WRES, three on workforce data and five are based on data from national staff survey indicators. The trust had produced a report with actions covering all nine metrics for race / ethnicity.
- There were staff groups for lesbian, gay, bisexual and transgender (LGBT) employees, disabled employees and those with long term health conditions as well as BME. There was one seat for each of these groups on the trust's equality, diversity and leadership forum (EDLF) which met every six months and reported to the trust's quality people committee. An inequalities task group sat under the EDLF. The trust had an innovative equalities forum theatre group where staff could take part in scenarios to help them deal with equalities and diversity situations. Some of these scenarios were recorded and available to staff on the trust's YouTube channel.
- All staff received awareness training in equality and diversity as part of induction and then in mandatory training every two years. We saw examples of some bespoke training for individual teams.
- We were extremely impressed with the work the trust had done on transgender. Walton hospital had a display of photographs and quotes from people undergoing transition. This work had been in place for some time. We found the work on display promoted equality and diversity and brought issues of transgender to the fore in a very positive, open and accepting manner.
- The trust had an equality and diversity theatre group. This group produced videos and performed at conferences to raise the profile of the importance of equality and diversity.

Innovation, improvement and sustainability

- The trust had a thriving in house estates department. This was an innovative team, who were working in new ways to deliver a responsive and very efficient service. Staff morale within the service was excellent. The trust had taken on several apprentices within the estates service.
- The trust ran a fitness to work service to support staff who were off work due to musculoskeletal injuries. This service won an award in the 2015 NHS England Innovation Challenge awards. The prize money had enabled the service to be rolled out across the trust.
- In March 2014 the trust was selected as one of the first national Vanguard sites to receive transformational funds to support the work they were doing in Erewash. The work to deliver this was progressing well and it was supporting new ways of working.
- The trust was working in partnership with other organisations on the development of the Sustainability Transformation Plan (STP) for Derbyshire. An STP is a five year shared place based plan focused on driving the implementation of the NHS five year forward view. There were many implications for service delivery for the trust, but they were well placed to deliver new models of care.
- As a community trust, staff were required to travel to patient's homes to deliver care. The trust had a fleet of low emission pool cars, including electric vehicles. Electric charging points had been installed in all of the trusts hospital car parks. They had also introduced a new lease car policy to encourage staff take up of low emission vehicles to reduce the impact on the environment.
- The trust had invested in sustainable energy sources and had fitted solar panels on two sites. The carbon reduction management plan had exceeded the targets which had been set.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(g) The provider must ensure the proper and safe management of medicines. How the regulation was not being met: The provider did not ensure there was proper and safe management of medicines in community services for adults. Staff did not maintain a record of serial numbers for prescription pads in community services for adults. Staff did not transport medicines in securely sealed or tamper evident containers in community services for adults.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (1) Systems or processes must be established and operated effectively How the regulation was not being met: Not all staff working within integrated sexual health services (ISHS) followed the same guidance, policies and procedures in all areas. Regulation 17(2)(a)(f) Systems or processes must enable the provider to assess, monitor and improve the quality and safety of services provided How the regulation was not being met:

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Requirement notices

Incidents in integrated sexual health services (ISHS) were not always reported and investigated in a timely and consistent way.

The provider did not ensure learning from incidents and complaints was shared with all staff in integrated sexual health services (ISHS).

The provider did not manage or follow up patients who did not wait to be seen or did not attend, monitor unanswered calls on the central booking service and provide return postal addresses for undelivered mail.