Chesterfield Royal Hospital
NHS Foundation Trust

Quality Accounts
2012/13

PART 1

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE NHS FOUNDATION TRUST

As a hospital we exist only to serve our patients. We aim to provide exceptional quality healthcare that our community can have confidence in – because our services are safe, offer the best possible clinical outcomes and a first-class experience for patients. We aim to provide a service built on our "Proud to Care" values of Compassion, Achievement, Relationships and Environment. This is the top priority for our Board of Directors and Council of Governors. Whilst much progress has been made we know that this is a "journey" and there is still much to do.

As North Derbyshire's only acute District General Hospital, serving a population of around 400,000, we take pride in what we do – and our wish is to be the hospital of choice for not only our patients, but for our staff and partners. We are already recognised as being amongst the very best in some specialties (cancer and stroke services for example) but we do not underestimate how much further we need to go – and how much more we need to do.

This report details:

- The Trust's priorities for improvement for 2013/14.
- Statements relating to the quality of services provided by the Trust including involvement in local and national audits and research.
- What others say about us.
- How the Trust has performed over the past year on key indicators of quality.

Many of the Trust's staff have been involved in shaping the content of the report; the priorities reflect what is important to them and our patients; they have helped to measure and monitor our performance and most importantly they have taken, and will continue to take, measures resulting in improvements.

Our Council of Governors receives regular reports on quality and continues to challenge the Trust to continually improve. The Council has given its views on this report and will continue to influence this agenda over the coming years.

In addition views have been sought and received from:

- Our main Clinical Commissioning Group (CCG) - North Derbyshire CCG,
- Derbyshire Healthwatch; and,
- Derbyshire County Council's Overview and Scrutiny Committee.

The views of these groups are reflected in this report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Gavin Boyle
Chief Executive and Accounting Officer
28 May 2013

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

PRIORITIES FOR IMPROVEMENT 2013/14

The Trust has identified three priorities for quality improvement which cover the three areas identified within *High Quality Care for All*:

- Clinical Effectiveness;
- Patient Safety; and,
- Patient Experience.

Progress against each of these priorities will be reported via regular performance reports which are presented to the Board of Directors, Clinical Governance Committee and Council of Governors. In addition, these reports are shared with North Derbyshire Clinical Commissioning Group and Derbyshire Healthwatch.

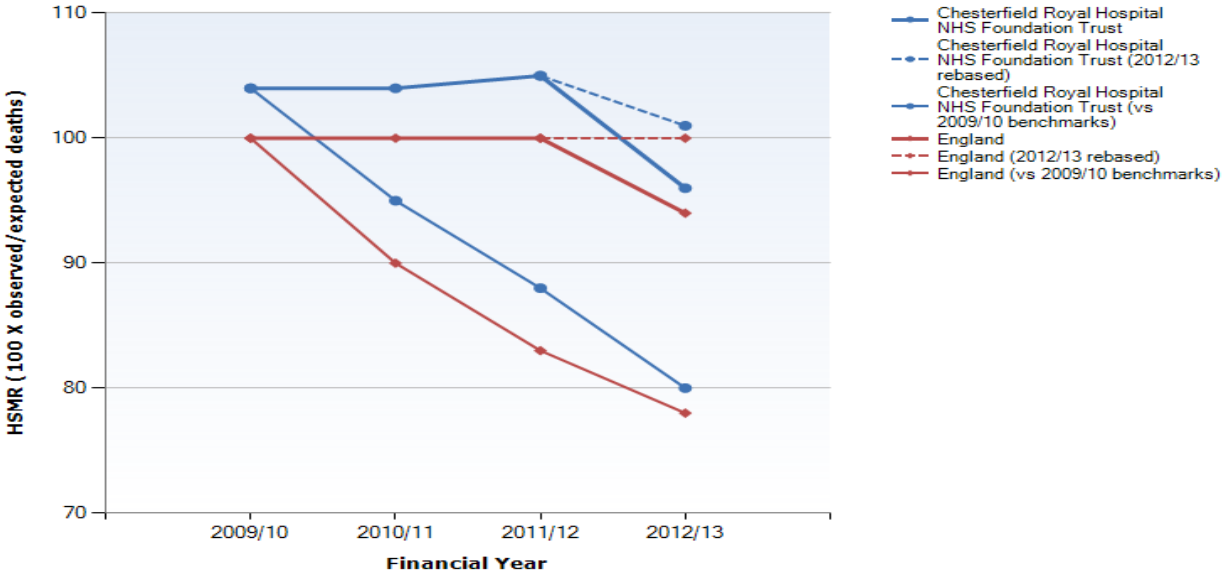
2.1 Clinical Effectiveness

Priority 1: Reduction in Mortality

The Hospital Standardised Mortality Ratio (HSMR) is the key measure we use to monitor our in-hospital mortality. The HSMR sets the mortality rate for England at 100 and hospitals are then compared against this average.

At present the 2012/13 data is compared with 2011/12 (the last year for which there is a full year's data). When the full year's data is available the benchmark will be reset; as nationally the mortality rate is reducing this leads to an increase in the HSMR for every organisation, however during the year we get a prediction of what the HSMR will be when this occurs. The graph below includes both the current HSMR (compared with 2011/12 benchmark) and the predicted HSMR.

Hospital Standardised Mortality Ratio (HSMR)- April 2009 to January 2013



NB 2012/13 data includes discharges during April-December 2012 only; later data not yet available.

As the graph above shows in-hospital mortality rates across England have been dropping year-on-year (the thin red line) and at Chesterfield Royal our mortality rates have mirrored this trend but have for the past three years been slightly (although not statistically significantly) above the national average. In 2012/13, we are pleased to report that our rate of improvement has increased and we are therefore expecting to have a mortality rate close to the national average when the national benchmark is reset.

The other key measure of mortality is the Summary Hospital Mortality Index (SHMI) which includes patients who die while in hospital or within 30 days of discharge. The national baseline SHMI value is one and therefore a Trust would only get a SHMI value of one if the number of patients who die following hospitalisation was exactly the same as the number of patients expected to die based on the SHMI methodology.

To help users of the data understand the SHMI values, Trusts have been categorised into one of the following three bandings:

1 – where the Trust's mortality rate is 'higher than expected'
2 – where the Trust's mortality rate is 'as expected'
3 – where the Trust's mortality rate is 'lower than expected'

SHMI is published quarterly using a rolling 12 months; as the table below shows for the past two reporting periods the Trust has had a rate which is 'as expected'. Unlike HSMR, the calculation for SHMI does not take account of any palliative care input and as the table shows the Trust has a higher proportion of patients who die in hospital who have received Palliative Care input.

Period	Chesterfield Royal	National
Summary Hospital Mortality Index		
Oct'11 – Sept '12	1.06 "as expected"	1.0
July '11 – June '12	1.08 "as expected"	1.0
Apr '11 – Mar '12	1.09 "as expected"	1.0
Proportion of patient deaths with palliative care coded at either diagnosis or specialty level		
Oct'11 – Sept '12	26.4%	18.9%
July '11 – June '12	26.5%	18.4%
Apr '11 – Mar '12	25.0%	17.9%

The publication of the SHMI data runs five to seven months behind the HSMR data and whilst it is usually a few points higher than the HSMR it does follow the same trend. We therefore use HSMR as the key measure because it alerts us of any issues in a more timely manner. In order to understand the difference between the two indicators we are reviewing the SHMI at diagnosis level and will be undertaking further work on any areas of concern.

Chesterfield Royal Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The SHMI methodology does not take account of the proportion of patients who require palliative care input; as the data shows the proportion of these patients is higher at the Trust than it is nationally.
- We have identified some conditions where our mortality is higher than expected and as detailed below we are working to improve these.

Chesterfield Royal Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Establishing a mortality review group, led by the Assistant Medical Director, Dr Gail Collins. This group actively reviews mortality data to identify any themes and trends; the group initiates reviews of practice, and, where issues are identified, ensures that actions are taken to address these. The Trust aims maintain the recent improvements in both HSMR and SHMI during 2013/14.

Data for the HSMR is made available by Dr Foster and SHMI is published by the NHS Information Centre; both indicators use data submitted to HES (Hospital Episodes Statistics) in line with standard national definitions.

2.2 Patient Safety

Priority 2: Reducing Hospital Acquired Pressure Ulcers

Pressure ulcers cause patients long term pain and distress and avoidable pressure ulcers are a key indicator of the quality of nursing care.

In order to monitor the prevalence of pressure ulcers which develop within the hospital the Trust undertakes a monthly audit using a tool called the Safety Thermometer. The Safety Thermometer was developed as part of a national patient safety programme and is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. From April 2012 the Trust has used the Safety Thermometer on all wards every month as prescribed in the national guidance. This has given us some clear baseline data and during 2013/14 we aim to reduce all harms, but we will particularly focus on the number of new (hospital-acquired) pressure ulcers. This will be supported by the embedding of the SSKIN bundle which was introduced across the Trust in August 2012.

The SSKIN bundle combines a number of measures which together help to reduce the risk of patients developing pressure ulcers, as follows:

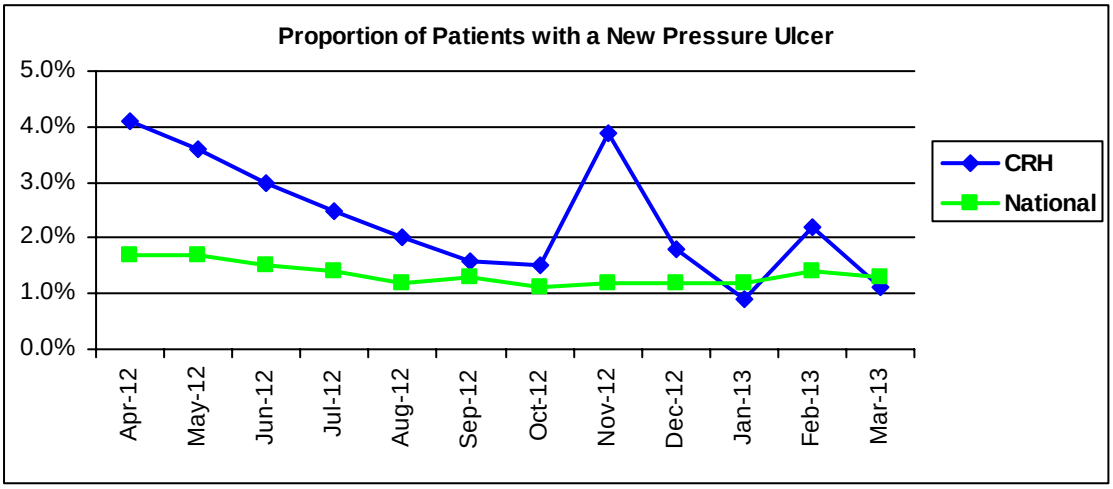
Surface – make sure your patients have the right support (mattress and cushions)
Skin Inspection – early inspection means early detection
Keep your patients moving
Incontinence/moisture – your patients need to be clean and dry
Nutrition/hydration – help patients have the right diet and plenty of fluids.

Safety Thermometer Pressure Ulcer Data – 2012/13

Process

- Staff are asked to record the patient's WORST new pressure ulcer.
- A 'new' pressure ulcer is defined as being a pressure ulcer that developed 72 hours or more after the patient came under our care.

Results



2.3 Patient Experience

Priority 3: Patient Experience – Focus on Care, Compassion and Communication

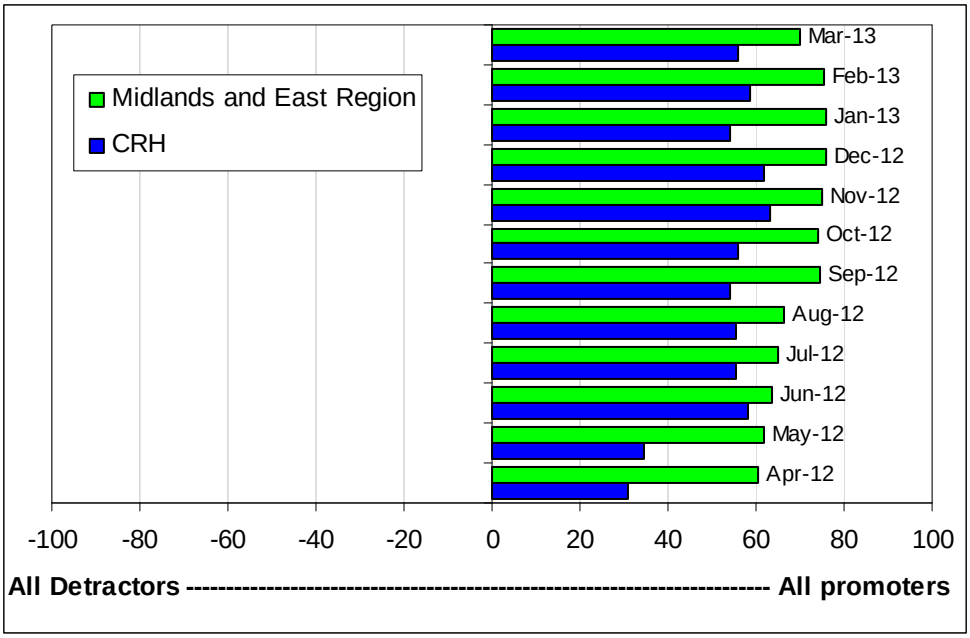
Ensuring that our patients have a good experience is one of our key priorities. In addition, the Francis Inquiry into Mid Staffordshire NHS Foundation Trust ('the Francis Inquiry') highlighted the importance of listening to patient feedback and responding appropriately.

In order to identify whether or not we have achieved this we ask for feedback from our patients. Over the past year, one of the questions we have been asking is the 'friends and family test' whereby we routinely ask *"How likely is it that you would recommend this service to friends and family?".* Based on their responses, patients are categorised into one of three groups:

- Promoters (*extremely likely*),
- Passives (*likely*),
- Detractors (*Neither likely nor unlikely, Unlikely, Extremely Unlikely, Don't know*).

The percentage of Detractors is then subtracted from the percentage of Promoters to obtain a Net Promoter Score (NPS). NPS can be as low as -100 (everybody is a detractor) or as high as +100 (everybody is a promoter).

Patient Revolution – Net Promoter Score



As the graph shows our score has improved over the year. However, it is still below the average for the Midlands and East region. We believe that this is in part due to the differing methodologies adopted by each organisation.

From April 2013, all Trusts will be adopting the 'friends and family' test in line with national methodologies and we will be:

- Giving all in-patients the opportunity to answer the friends and family question at the point of discharge; alongside this question we will be asking a number of key questions to help us assess the quality of care delivered, in line with the Care Strategy.
- Extending the 'friends and family' question to the Emergency Department

From October 2013, the 'friends and family' question will be extended to the Maternity Service.

The information we gain from this process along with feedback gained from complaints and suggestions will be used to continually drive improvements.

2.4 Statements of Assurance from the Board 2012/13

2.4.1 Review of Services

During 2012/13 the Chesterfield Royal Hospital NHS Foundation Trust provided relevant health services across nine clinical directorates.

The Chesterfield Royal Hospital NHS Foundation Trust has reviewed all the data available to them on the Quality of Care in all of these relevant health Services.

The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of relevant health services by the Chesterfield Royal Hospital NHS Foundation Trust for 2012/13.

2.4.2 Participation in Clinical Audits and Confidential Enquiries

We see participation in national audits as an important part of our work seeking to improve services not only at this hospital but across the country. During 2012/13, 34 national clinical audits and four national confidential enquiries covered relevant health services that Chesterfield Royal Hospital NHS Foundation Trust provides.

During 2012/13, Chesterfield Royal Hospital NHS Foundation Trust participated in 89% of national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries in which Chesterfield Royal Hospital NHS Foundation Trust participated, and for which data collection was completed during 2012/13, 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.

National Clinical Audits

National audit title	**Did the Trust participate?**	**No. of cases submitted as a % of the number of cases required for 2012/13**
Adult community acquired pneumonia (British Thoracic Society)	Yes	100%
Adult critical care (ICNARC)	Yes	100%
Emergency use of oxygen (British Thoracic Society)	Yes	100%
National Joint Registry (NJR)	Yes	100%
Renal colic (College of Emergency Medicine)	Yes	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	100%
National Comparative Audit of Blood Transfusion programme	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	100%
Bowel cancer (NBOCAP)	Yes	100%
Head and neck oncology (DAHNO)	Yes	100%
Lung cancer (NLCA)	Yes	100%
Oesophago-gastric cancer (NAOGC)	Yes	100%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
Heart failure (HF)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
Bronchiectasis (British Thoracic Society)	Yes	100%

National audit title	Did the Trust participate?	No. of cases submitted as a % of the number of cases required for 2012/13
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%
Inflammatory bowel disease (IBD)	Yes	100%
National Review of Asthma Deaths (NRAD)	Yes	100%
Pain database	Yes	100%
Fractured neck of femur (CEM)	Yes	100%
Hip fracture database (NHFD)	Yes	100%
National audit of dementia (NAD)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	100%
Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	100%
Paediatric fever (College of Emergency Medicine)	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	100%
Non-invasive ventilation - adults (British Thoracic Society)	No[1]	~
Adult asthma (British Thoracic Society)	No[1]	~
Parkinson's disease (National Parkinson's Audit)	TBC	

National Confidential Enquiries

Study title	Did the Trust participate?	No. of cases submitted as a percentage of the number of cases required for 2012/13
NCEPOD – Subarachnoid Haemorrhage	Yes	100%
NCEPOD – Alcohol Related Liver Disease	Yes	100%
NCEPOD – Bariatric Surgery	Yes	100%
NCEPOD – Cardiac Arrest Procedures	Yes	100%

[1] The Trust has prioritised the British Thoracic Society Audits – as these were completed in 2011/12 it was agreed not to repeat them in 2012/13. Both of these audits will be completed during 2013/14.

The reports of 25 national clinical audits were reviewed by the provider in 2012/13 and Chesterfield Royal Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Awareness has been raised about improved risk scoring and antibiotic prescribing in relation to patients admitted with community acquired pneumonia. In addition, we are looking at introducing a community acquired pneumonia proforma which will incorporate all of the relevant guidelines.
- The audit of emergency oxygen use prompted the development of an oxygen prescription/protocol on the Trust's electronic prescribing systems to ensure that appropriate information is recorded at the time of prescribing.
- Introduction of an electronic blood tracking system to prevent blood transfusion errors.
- The Trust has increased the Specialist Nurse input into the paediatric epilepsy service to ensure that all children with the condition have access to the most appropriate care. In addition an initial assessment proforma has been introduced to ensure consistency of approach.

The reports of 206 local clinical audits were reviewed by the provider in 2012/13 and where appropriate action plans have been developed.

For details of the full programme of completed audits including recommendations please contact the Head of Clinical Governance – see contact details at the end of the report.

2.4.3 Research

Participation in clinical research demonstrates Chesterfield Royal Hospital NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

The hospital is actively involved in clinical research. This helps to provide access to new treatments for local people, but also helps support advancement in clinical care. The number of patients receiving NHS services provided or sub-contracted by Chesterfield Royal Hospital NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 481, across a range of approximately 20 specialties. Of this number 341 were recruited to National Institute for Health Research (NIHR) portfolio studies, exceeding the NIHR target set of 300, with 137 recruited to non-portfolio studies. In addition, three employees of the Trust were recruited to participate in research.

During 2012/13 the number of research projects has continued to increase at Chesterfield Royal Hospital NHS Foundation Trust. Largely due to continued funding from the Trent Comprehensive Local Research Network (TCLRN), the Trust has been able to further grow and develop teams of experienced research nurses, midwives, doctors, allied health professionals and data managers to run a variety of research projects. The Trust continues to host the Trent regional Cardiovascular Research Specialty Interest Group with one of the Royal's Consultant Cardiologists as the lead.

The Trust uses the Department of Health standard clinical trial agreements for research projects and in order to comply with the Human Tissue Act 2004 requirements signed material transfer agreements are always put in place where appropriate.

Although the number of studies approved is slightly lower than last year, the number of participants recruited to trials has increased by 128, demonstrating improved activity.
Of the 48 studies approved during the period from 17 March 2012 to 31 March 2013, 40 (83%) were adopted onto the NIHR portfolio. Of the eight non-portfolio studies, three were for patient identification only, two were academic projects, one was locally developed, one involved primary care and one was a local study in collaboration with University of Derby.

During the period from 1 April 2012 to 31 March 2013, 13 NHS to NHS letters of access were issued to researchers and five letters of access were issued to researchers employed by academic institutions in conjunction with research passports.

The Trust maintains its commitment to contributing to the national and international research agenda and to offering the local community the opportunity to participate in important and relevant quality healthcare research projects.

2.4.4 Goals Agreed with Commissioners

A proportion of Chesterfield Royal Hospital NHS Foundation Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the 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. The 2012/13 goals included:

- Improvements in risk assessment for venous thromboembolism (VTE);
- Improvements in patient experience, including the 'friends and family' test;
- Initial assessment of relevant patients to identify those who may have dementia;
- Increase in the proportion of women breastfeeding;
- Ensure all appropriate patients are being reviewed by the Fragility Fracture Service;
- Ensure that patients with cancer who are admitted as an emergency receive prompt follow-up.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at:

http://www.chesterfieldroyal.nhs.uk/news/annualreport/qualityaccounts?_ts=79792

For 2011/12, the total income dependent upon achieving quality improvement and innovation goals was £2,466k, of which we received £1,757k. For 2012/13 the total income dependent upon achieving quality improvement and innovation goals was £4,187K, of which we received £4,052K.

2.4.5 What Others Say About the Provider

Care Quality Commission Registration

Chesterfield Royal Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is: Registered with No Compliance Conditions.

The Care Quality Commission has not taken enforcement action against Chesterfield Royal Hospital NHS Foundation Trust as of 31 March 2013.

Care Quality Commission Special Reviews/Investigations

Chesterfield Royal Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

During the year the Trust received a routine inspection from the Care Quality Commission, during which we were assessed against five of the outcomes as follows:

- Outcome 1: Dignity and respect – the CQC identified minor non-compliances.
- Outcome 5: Nutrition – the CQC identified moderate non-compliances
- Outcome 7 – Protecting people from abuse – we were fully compliant
- Outcome 13 – Staffing – we were fully compliant.
- Outcome 21 – Healthcare records - the CQC identified minor non-compliances.

Immediate action was taken in all areas where non-compliances were identified and a robust action plan has been developed to address any underlying issues.

2.4.6 Data Quality

Chesterfield Royal Hospital NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was:
  - 99.8% for admitted patient care (national 99.1%);
  - 100% for outpatient care (national 99.3%); and,
  - 98.6% for accident and emergency care (national 94.9%).

- which included the patient's valid General Practitioner Registration Code was:
  - 100% for admitted patient care (national 99.9%);
  - 100% for outpatient care (national 99.9%); and,
  - 100% for accident and emergency care (national 99.7%).

Chesterfield Royal Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2012/13 was 62% and was graded as 'not satisfactory'. In total there are 45 standards and for each standard we are required to evidence our compliance; dependent on the evidence each standard is judged from level 0 (no evidence) to level 3 (evidence of full compliance). We were shown to be level 2 for 39 of the 45 standards and the remaining 6 standards were judged to

be level 1. In order to be satisfactory we needed to achieve a minimum of level 2 for all 45 standards.

Chesterfield Royal Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Continuing to invest in training for clinical and administrative staff;
- Maintain daily 'missing data' checks by the Trust's IT data quality team;
- Review overseas visitors and other groups that do not have NHS numbers;
- Implementing technical improvements in accessing national IT systems;

Chesterfield Royal Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission; and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary diagnoses incorrect 18.0%
- Secondary diagnoses incorrect 18.5%
- Primary procedures incorrect 12.5%
- Secondary procedures incorrect 16.3%

This audit is based on 123 episodes focusing on patients who had been admitted as an emergency and had a length of stay longer than expected. This reflects a small proportion of the Trust's activity and therefore the results should not be extrapolated further that the actual sample audited.

PART 3

REVIEW OF QUALITY PERFORMANCE

This section includes a range of information relating to our quality performance in 2012/13. Whilst this is not an exhaustive list it gives an overview of our performance in both hospital-wide and service specific indicators.

3.1 Clinical Effectiveness Indicators

3.1.1 Cancer Waiting Times

Timely diagnosis and treatment for cancer are key to improving survival rates. To reflect the importance of this there are a range of national standards against which we are monitored as shown in the table below follows:

Standard	Trust Performance			
	Target	2012/13	2011/12	2010/11
Percentage of patients seen by a specialist within two weeks of urgent GP referral for suspected cancer.	93%	**96.1%**	96.7%	96.5%
Percentage of patients seen by a specialist within two weeks of GP referral with any breast symptom except suspected cancer	93%	**96.9%**	95.7%	97.0%
Percentage of patient treated within one month (31 days) of a decision to treat	96%	**99.4%**	99.7%	99.9%
Percentage of patients receiving subsequent surgical treatment within one month (31 days) of a decision to treat	94%	**100%**	100%	100%
Percentage of patients receiving subsequent anti-cancer drug treatment within one month (31 days) of a decision to treat	98%	**100%**	100%	100%
Percentage of patients receiving their first definitive treatment for cancer within two months (62 days) of a GP or dentist urgent referral for suspected cancer[2]	85%	**92.7%**	92.0%	92.6%
Percentage of patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral from a national screening programme[2]	90%	**97.5%**	92.4%	95.4%

As the table shows we have exceeded all of the targets. In order to ensure that this is maintained a weekly meeting takes place between the clinical directorate performance managers, the cancer pathway team leader and the head of cancer services and major incident planning, to enable active monitoring of the patients and a clear treatment plan to take place before their guarantee date.

The data for these indicators are collected from our Patient Administration System, cancer information systems and the national cancer waiting times system (in line with

[2] The calculation of performance against these standards takes account of all cancer patients referred to Chesterfield Royal Hospital irrespective of where their treatment actually takes place, whether it is in Chesterfield or Sheffield.

national definitions) and the process was subject to an external audit in 2012, which did not identify any concerns. We have recently installed the 'Infoflex' Cancer Management system which generates work lists for the Cancer Pathway Staff and helps to maintain an active monitoring of patients against the Cancer Waiting Times targets. There is also a 'target list' of 'potentially problem patients' which are undergoing extensive tests to determine their cancer and as such may delay their pathway.

3.1.2 Maternity Services

We are responsible for maternity services in North Derbyshire, which deliver over 3,000 babies a year. To ensure the quality of these services we use a range of indicators as shown below: (where the target has changed this is shown in brackets):

Target	**Trust Performance**			
	2012/13	**2011/12**	**2010/11**	**2009/10**
Caesarean section rate less than national average of 24%	**22.9%**	21.2%	21.4%	19.6%
Proportion of unassisted deliveries greater than 64.4%	**66.8%**	69.4%	N/A	N/A
More than 75% of mothers initiate breastfeeding	**70.0%**	70.9%	73.0%	71% (target > 68%)
More than 90% of those who initiate breastfeeding are still breastfeeding at five days	**92.3%**			
More than 90% of those who initiate breastfeeding are still breastfeeding at 10 days	**88.0%**	77.2%	N/A	N/A

We are pleased to have maintained positive performance in relation to caesarean section rates. In relation to breastfeeding we are continuously looking at ways to improve the rates we achieve. During the year we have invested in additional midwives to reduce the midwife to birth ratio, which will give midwives more time to support mothers to breastfeed. In addition, we have Maternity Assistants in Antenatal Clinic and in the community bases in Staveley and Darley specifically to discuss infant feeding and encourage initiation.

In addition, we have maintained Baby Friendly accreditation which focuses on implementation and monitoring of the ten steps to successful breastfeeding (related to policies, staff training, information for mothers and audit of practice). The assessment shows that positive steps have been taken to encourage breastfeeding.

There has also been a significant investment in staff training related to infant feeding in the last 12 months and this will continue in 2013/14 until all staff have attended the 'in house' breastfeeding management course.

In 2012 we decided that rather than infant feeding issues being the responsibility of one person (an infant feeding advisor) a team approach should be adopted. We now have a group of staff who have completed advanced training related to infant feeding. This group now have specific responsibility for staff training and act as a resource for other staff.

Data for these indicators is drawn from an internal data collection process using information recorded directly by the midwives; these systems were subject to internal audit in 2011 which did not identify any significant concerns.

3.1.3 Percentage of admitted patients risk-assessed for Venous Thromboembolism

VTE is a condition in which a blood clot (a thrombus) forms in a vein and subsequently dislodges and moves to the heart or the lungs. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. An estimated 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year.

One of the key priorities to reduce the risk of patients developing VTE is to assess all patients on admission to identify those at risk and offer appropriate preventative medication to those assessed as being at increased risk. We have a risk assessment process in place and have been identified as a national exemplar site (a site of best practice) for the work we have undertaken.

Reduction of VTE is a national priority and the proportion of patients being risk assessed on admission was identified as a national Clinical Quality Indicator (CQUIN) for 2012/13. As the table below shows we have made significant progress against this standard and have maintained performance at over 90%.

Period	Chesterfield Royal
Jan-Mar 2013	92.8%
Oct-Dec 2012	91.4%
Jul-Sept 2012	91.1%
Apr-Jun 2012	91.2%
Jul-Sept 2012	91.4%
Oct-Dec 2012	91.6%

Chesterfield Royal Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- A risk assessment is completed for the majority of patients; this target has been met by continuous awareness raising with medical staff to ensure that they complete the risk assessment in a timely manner.

Chesterfield Royal Hospital NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by:

- We are looking to link the electronic VTE risk assessment tool with our electronic prescribing system so that the risk assessment must be completed before any prescribing can be undertaken. This will further increase the proportion of patients for whom the risk assessment is completed.

Data for this indicator is published by the NHS Information Centre, based on submissions from the Trust which is collected in line with standard national definitions.

3.1.4 Re-admissions

The percentage of patients re-admitted to our hospital within 28 days of being discharged.

Period	Chesterfield Royal		National	
	2011/12	2010/11	2011/12	2010/11
Patients aged 16 and over	11.03%	10.64%	11.16%	11.42%
Patients aged 0 to 15	8.96%	8.87%	10.15%	10.18%

Chesterfield Royal Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- We continuously monitor re-admission rates to detect any areas where these are higher than expected and take action to address any concerns identified.

Chesterfield Royal Hospital NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by:

- Reviewing the discharge process to ensure that patients are discharged at the right time with the right package of care in place to support them.

Data for this indicator is published by the NHS Information Centre, using data submitted to HES (Hospital Episodes Statistics) in line with standard national definitions.

3.1.5 Length of Stay

One of our priorities for 2012/13 was to ensure that patients receive timely, well managed care which in turn would reduce the average length of stay. Over the past year much of this work has focused on patients admitted as an emergency for medical conditions i.e. not requiring surgical intervention.

Over the year the average length of stay has reduced from 7.9 days in 2011/12 to 7.6 days in 2012/13; the most significant improvement was in the last six months of 2012/13, when the average length of stay was 7.4 days.

3.2 Patient Safety

3.2.1 Hospital Acquired Infections

Hospital or healthcare acquired infection causes significant harm and is a major concern to patients. There has been very significant decline in rates of bMRSA and C. difficile infection in Chesterfield Royal Hospital in recent years but we are keen to reduce this further. We monitor performance against a range of targets in relation to infection control including:

- C. difficile and MRSA – these are two key hospital-acquired infections.

- Cleanliness and hand hygiene – these are proven to reduce the spread of infection.

The outcome for these indicators are shown in the table below (where the target has changed this is shown in brackets):

Criterion	Target	2012/13	2011/12	2010/11
MRSA	No more than two bacteraemia infections (NHS standard)	**1**	5 bactereamia (target no more than 4)	3 bacteraemia (target no more than 4)
C. difficile	No more than 34 hospital acquired infections	**39**	42 (target no more than 48)	51 (target no more than 50)
Cleanliness Audits	Achievement of minimum scores of 95%	**96.7%**	Average score 96%	Average score 96%
Hand Hygiene	Achievement of minimum scores of 85%	**98.4%**	Overall compliance 96%	Overall compliance 91%

In addition to the information above, data is reported nationally relating to the number of hospital-acquired C. difficile infections per 100,000 bed days, as shown below:

Period	Chesterfield Royal	National
2012/13	**21.8**	**~**
2011/12	23.0	21.8
2010/11	28.5	29.6
2009/10	28.4	36.7

*National data for 2012/13 has not yet been published by the HPA; this figure is taken from data released to the Trust from Public Health England.

The Chesterfield Royal Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- As the data shows we have continued to reduce the number of hospital-acquired infections year-on-year due to a concerted effort by all staff.

The Chesterfield Royal Hospital NHS Foundation Trust has taken the following actions to improve this rate, and therefore the quality of its services, by:

- Sustained programmes to encourage good hand hygiene for staff, patients and visitors.
- All hospital acquired bMRSA and C. difficile infections are thoroughly investigated and any issues identified as a result of these are widely communicated across the Trust to ensure good practice is shared.

- The infection control team undertake regular visits to all of the wards to actively identify any potential issues.
- During the year the infection control team have appointed a clinical educator who works alongside staff in the clinical areas to actively promote good infection control practice.
- Education and ongoing awareness training has been delivered for junior medical staff with respect to antibiotic prescribing.
- External expert advice has been obtained from Professor Mark Wilcox of Leeds University, who is the Public Health England national lead for C. difficile.

The data for these indicators are collected by the infection control team using data from their IT system (ICNET) which links directly to the laboratory information system, and where appropriate, in line with national definitions. The process for infection surveillance was subject to an internal audit in 2009/10 and the process for C. difficile was subject to external audit in April 2011; neither of these audits identified any significant concerns.

3.2.2 Nurse Metrics – Documentation Audit

In order to support our aim to ensure that we deliver high quality nursing care the Chief Nurse introduced nursing metrics at the beginning of September 2009. These measure key aspects of patient care, helping to identify any issues for improvement. The nursing care indicators are measured by auditing nursing documentation and include:

- Patient Observations & Identification: e.g. is temperature and blood pressure monitored as frequently as required? Does the patient have a wristband with all their correct details?
- Pain Management: e.g. has the patient been asked if they are in pain and if they are have staff done anything to control this?
- Risk Assessment: e.g. do patients have all the appropriate risk assessment documentation?
- Falls: e.g. have staff considered the patient's risk of falling and if they are at risk have staff taken appropriate action to reduce the risk?
- Nutrition: e.g. have staff considered the patient's risk of malnutrition and if they are at risk have staff taken appropriate action to reduce the risk?
- Pressure Ulcer Assessment: e.g. have staff considered the patient's risk of developing a pressure ulcer and if they are at risk have staff taken appropriate action to reduce the risk?
- Medication Assessment: e.g. have patients been given all appropriate prescribed medication and does the prescription documentation include all relevant patient details to prevent patients being given someone else medication?
- Infection Control: e.g. have staff considered the patient's risk of having or developing an infection and if they are at risk have staff taken appropriate action to reduce the risk?
- Moving & Handling: e.g. have staff considered what support patients need for moving about the ward and developed a plan to meet these needs?

Nurse metrics audits are now undertaken on all adult inpatients wards (including the emergency management unit), intensive therapy unit, high dependency unit, the paediatric ward and neonatal unit.

	2012/13	2011/12
Patient observations and identification	**97.6%**	98%
Pain management	**98.7%**	99%
Risk assessment booklet	**97.2%**	95%
Falls	**92.5%**	93%
Nutrition	**91.6%**	95%
Pressure ulcers	**93.2%**	97%
Medication assessment	**98.1%**	98%
Infection control	**81.9%**	NA
Personal handling	**89.3%**	NA
Admission/discharge care pathway	**80.1%**	NA

These metrics measure the quality of the information that is recorded in the patient's records, rather than a direct measure of the care given. However, it is important that accurate timely information is recorded for all patients and over the coming months we are developing a ward assurance programme to support those wards who are not achieving these standards and to align this information with other indicators of quality.

This data is collected directly from patient's healthcare records via processes which were the subject of an internal audit review in March 2011 that did not identify any concerns.

3.2.3 Patient Falls

Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year; a significant number of falls result in death or severe or moderate injury, at an estimated cost of £15 million per annum for immediate healthcare treatment alone (NPSA, 2007).

In addition to these financial costs, there are additional costs that are more difficult to quantify. The human cost of falling includes distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to patients, relatives, carers, and hospital staff.

Over the past year we have focused on reducing harm from falls and have established a Falls Group to lead this work.

The table below shows the number of falls reported, per 1000 bed days over the past three years. The first column shows all reported falls and the second column shows the number of reported falls which resulted in any harm to the patient.

	Rate per 1000 bed days	
Year	All falls	Falls resulting in harm
2012/13	**9.1**	**2.6**
2011/12	9.1	2.5
2010/11	7.1	1.0

Whilst it is important to encourage patients to be mobile when in hospital for some patients this presents a risk of falling. To help balance these needs we carry out a risk assessment to minimise the chance of a patient falling. Our nurse metrics audits monitor the risk assessment process and over the year we have shown an increase in compliance in all but one of the trust standards, as shown in the table below:

Measure	**2012/13**	**2011/12**
% of patients who have had a falls risk assessment within 24 hours of admission	**92.9%**	92.5%
% of relevant patients where there is evidence that interventions required to reduce the risk of falling have been considered	**94.3%**	93.5%
% of relevant patients where further assessments have been undertaken as appropriate (minimum weekly)	**91.8%**	90.5%
% of inpatients have had a bedrail assessment	**86.4%**	93.4%

In December 2012, we established a Falls Task and Finish Group led by the senior matron for patient safety. The aim of the group is to implement all aspects of the Fallsafe Care Bundle with a view to reducing the number of in-patient falls, and the harm caused by these. The group is currently reviewing the education package included in the care bundle and how this can be cascaded to all nursing staff. In addition, the group is reviewing the current falls risk assessment documentation and bedrails risk assessment tools. Once the documentation has been agreed, the process for auditing completion of this via the nurse metrics, and the subsequent actions taken in response to the risk assessments will be reviewed.

The falls data is drawn from our incident reporting process which was last subject of an internal audit review in 2011, and the nurse metrics data is collected via processes which were the subject of an internal audit review in March 2011. Neither of these audits identified any significant concerns.

3.2.4 Patient safety incidents

The number and where available the rate of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death

	All incidents reported		Incidents that resulted in severe harm or death	
	No.	Rate per 100 admissions	No.	Rate per 100 admissions
*Oct 12 – Mar 13**	*2751*	*7.4*	*12*	*0.03*
Apr 12 – Sep 12	2442	6.7	9	0.02
Oct 11 - Mar 12	2417	6.7	18	0.05
Apr 11 - Sep 11	2128	5.9	6	0.02
Oct 10 - Mar 11	2236	6.4	6	0.02
Apr 10 - Sep 10	2186	6.2	2	0.01
Oct 09 - Mar 10	2298	6.8	14	0.04
Apr 09 - Sep 09	2063	6.0	17	0.05
Oct 08 - Mar 09	2100	6.2	17	0.05

* Data for this period is not yet available from the NHS Information Centre – this has therefore been calculated internally based on submissions to the National Patient Safety Agency and internal data on admissions.

Chesterfield Royal Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- There has been a continued year-on-year increase in the number of patient safety incidents reported within the Trust, and staff are actively encouraged to report incidents and near misses to enable the organisation to learn from these and therefore reduce harm and improve the patient's experience and safety.
- During 2011/12 there was a marked increase in the number of pressure ulcers reported by staff due to an increased awareness highlighted by the Pressure Ulcer Ambition Campaign, which accounts for some of the increase in the number of severe harm incidents reported.

Chesterfield Royal Hospital NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by:

- Identifying action in response to key types of incidents including patient falls, pressure ulcers and medication errors.
- The latest report published by the NHS Commissioning Board in relation to incidents reported to the national reporting and learning system from April 2012 to September 2012, indicates a reduction in the number of incidents in the severe/death category from 18 in the table above to 9.
- The Patient Safety Team will continue to encourage reporting, and will support the clinical directorates in the investigation of incidents and the identification of root causes to enable changes to practice to be made.

The data is drawn from our incident reporting process which was last subject to internal audit review in 2011; this audit did not identify any concerns.

3.3 Patient Experience

3.3.1 A&E indicators

In April 2011, a set of national A&E Clinical Quality Indicators were issued which are designed to monitor and improve the quality of clinical care given in Emergency Departments. The department has implemented changes in practice and data collection to meet these new indicators, including the introduction of an initial assessment nurse service which runs from 9am – 12 midnight daily to receive all ambulance patients and undertake an initial assessment within 15 minutes of arrival in the department.

	2012/13	2011/12
Percentage of patients spending four hours or less in A&E – aim over 95%	95.7%	97.3%
95th percentile time for patients arriving by ambulance in A&E to start of full initial assessment – aim 15 minutes	21 mins	33 mins
Median waiting time (in minutes) spent for patients arriving at A&E before start of definitive treatment (seeing a decision making clinician) – aim 60 minutes	74 mins	70 mins
Left without being seen – aim less than 5%	2.7%	2.8%

The key national standard is that patients should spend less than four hours in A&E and the hospital has historically performed well against this standard. Over this past year we have found it increasingly challenging to meet the waiting time targets in the Emergency Department (ED), which is partly related to increases in emergency activity across the health community. In order to address this we are reviewing staffing levels and working practices both in ED and across the wider organisation, and reviewing the wider management of urgent care with partner organisations in the health and social care community.

The data for these indicators is collected from our Patient Administration System in line with national definitions.

3.3.2 National In-patient Survey

In line with our aim to be a first class District General Hospital, patient satisfaction and positive feedback is seen as a key indicator of success. We conduct a wide range of patient and public involvement work each year, however the key indicator of patient satisfaction are the national patient surveys. The following table shows the comparative performance for the national in-patient surveys conducted during 2012/13, using three categories:

- **better** than most other Trusts in the survey
- **worse** than most other Trusts in the survey.
- **about the same** as most other Trusts in the survey

Comparative Trust Performance on the National In-patient Survey 2012 vs. 2011 and 2011 (Source: Healthcare Commission/Care Quality Commission Comparative reports)

Performance	2012	2011
Better	1 (2%)	3 (4%)
About the same	56 (93%)	67 (91%)
Worse	3 (5%)	4 (5%)

The key issues identified in this survey related to:

- Communication – the results of the survey were shared with staff and they were reminded of the importance of clear communication and making themselves available to speak to patients and relatives.
- The quality of meals – since the survey we have let a new catering contract and introduced a regular programme of meal observations to ensure food is delivered to all patients at the optimum quality.
- Nurse staffing – during 2012/13 we made an additional £1.5 million investment into nursing staff to increase the numbers of qualified nurses and the skill mix on our wards.
- Noise at night – We have continued to increase the number of single rooms and re-enforce the cut-off time for transfer of patients between wards out-of-hours unless this is required for clinical reasons or due to bed pressures

In addition to the production of the above benchmarking data, key questions from the national in-patient survey are used to produce a responsiveness to in-patients' personal needs score which is used for the national CQUIN. The table below shows the scores for the past three years:

Year	Score
2012/13	66.6
2011/12	63.5
2010/11	66.4

Chesterfield Royal Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- We are pleased to report that following a dip in the score in 2011/12, our score for 2012/13 is more positive. We believe that this is due to the work that we undertook as detailed above.

Chesterfield Royal Hospital NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by:

- Building on the actions described above through our ward assurance programme. This will support individual areas to identify areas where patient experience could be improved; this will be supported by the 'friends and family' test, as described in the priorities.

- The Trust has invested £1.5 million in additional front-line nursing staff on in-patient wards.

The data for these indicators is taken from data published nationally by the Care Quality Commission. This information is drawn from data submitted by organisations in relation to individual responses to patient surveys. We run each of the nationally surveys in line with national guidance and all analysis is conducted nationally by the Picker Institute.

3.3.2 National Staff Surveys

In addition to asking patients how they feel about the services we deliver, the annual staff survey includes a friends and family question, which reflects the proportion of staff who would recommend the Trust as a provider of care to their friends and family.

Period	Chesterfield Royal	National
2012	57%	60%
2011	62%	62%

Chesterfield Royal Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- It is recognised that staff satisfaction mirrors patient satisfaction and whilst patient satisfaction has shown an increase in 2012, it is disappointing that the rating from staff does not match this. This may be due to staff not yet feeling the impact of changes put in place.

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

- Additional investment of £1.5 million in nursing and midwifery staff to increase qualified staff numbers and skill mix in those areas shown to be in greatest need.
- In addition, we intend to take the actions described in the previous section to improve patient experience.

The data for this indicator is taken from data published nationally by the Care Quality Commission. This information is drawn from data submitted by organisations in relation to individual responses to staff surveys. We commission an external organisation to run the national staff survey in line with national guidance.

3.3.3 National Cancer Survey

In addition to the national in-patient survey reported above we also took part in the national survey of cancer patients.

Our results placed us sixth out of 98 Trusts who took part - of the 62 questions relevant to the Trust:
- 40 have results in the top 20% (Green)
- 19 have results in the mid 60% (Amber)
- 3 are in the bottom 20% (Red)

We are pleased to report these results. However, in order to ensure that we continue at this level we have identified a range of actions to further improve these services, including:

- Introduction of an information "prescription" and 'information centre' for cancer patients – the prescription allows clinical staff to identify a range of information that patients require and they can then either access this on-line or visit the information centre where a member of staff can print of the information and offer additional help and support. One key area identified in the survey was a lack of information about getting financial help – this has now been included in all of the information prescriptions.
- Awareness of free prescriptions – in order to ensure that patients are able to access free prescriptions all of our nurses who see patients in clinic are now able to sign the form which gives exemption from prescription charges and information has been included in the information prescription.

The data for these indicators is taken from data published nationally by the Care Quality Commission. The information is drawn from individual responses to a patient survey, which is run on behalf of the Department of Health by an external agency.

3.3.4 Referral to treatment waiting times

In order to ensure that patients receive timely treatment the Trust monitors the following standards:

Target	**2012/13**	**2011/12**	2010/11
95% of admitted patients treated within 18 weeks of referral, including wait for outpatients, diagnostics and inpatient treatment	**97.9%**	99.7%	N/A
95% non-admitted patients treated within 18 weeks of referral, including wait for outpatients and diagnostics	**99.7%**	99.6%	99.9%

The data for these indicators are collected from the Trust's Patient Administration System in line with national definitions and the data is monitored monthly by the Primary Care Trust.

3.3.5 Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) are measures of a patient's health status or health-related quality of life. They are typically short, self-completed questionnaires, which measure the patients' health status or health related quality of life at set points in time i.e. before and after an operation. By comparing the answers given at different points in time we can assess the "success" of treatment from a patient's perspective.

The national PROMs programme was launched in April 2009 and includes patients having the following operations:

- Hip replacements;
- Knee replacement;
- Groin hernia surgery; and,

- Varicose vein surgery.

We are responsible for asking patients to complete a questionnaire before their operation, and providing they give consent, this is followed-up at a set time post-operatively by an independent company who have been commissioned to run PROMs by the Department of Health. National data shows that response rates for the Trust are good with 96% of patients returning the first questionnaire.

For patients where both the pre and post-operative questionnaires are returned, these are analysed to calculate the change in scores as a result of surgery. The table below shows how our results compare with other organisations nationally using the casemix adjusted average health gain as measured by the EQ-5D, which is based on five quality of life questions.

	Year	Chesterfield Royal	National
Groin hernia surgery	2010/11	0.102	0.085
	2011/12	0.062	0.087
	2012/13[3]	0.110	0.091
Hip replacements	2010/11	0.384	0.405
	2011/12	0.372	0.416
	2012/13[3]	N/A[4]	~
Knee replacements	2010/11	0.312	0.299
	2011/12	0.301	0.302
	2012/13[3]	N/A[4]	~
Varicose vein surgery	2010/11	0.097	0.091
	2011/12	0.085	0.094
	2012/13[3]	N/A[4]	~

Chesterfield Royal Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- We are not an outlier for any of the procedures and the results demonstrate that for each of these procedures our patients report a positive health gain.

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

- Continuously reviewing the published data; in addition, we have been investigating ways in which we can use patient level data to identify ways in which we can improve.

[3] Score data for 2012-13 was last updated nationally on 15/02/2013

[4] Data is not available as to date there have been fewer than 30 responses with regard to this procedure.

The data for these indicators is taken from data published nationally by the NHS Information Centre. This information is drawn from individual patient responses to questionnaires administered pre and post surgery. This process is administered by an independent organisation commissioned by the Department of Health.

Statements provided by the North Derbyshire Clinical Commissioning Group, the trust's Council of Governors, Derbyshire Healthwatch and Derbyshire County Council Improvement and Scrutiny Committee

The Trust shared the draft Quality Accounts with North Derbyshire Clinical Commissioning Group, the Trust's Council of Governors, Derbyshire Healthwatch and the Derbyshire County Council Improvement and Scrutiny Committee for comment prior to publication.

Statement from the Trust's Council of Governors

The Council of Governors wishes to comment on the following areas:

- Infection Control – The Trust has performed extremely well with regard to hospital-acquired MRSA bacteraemia (bMRSA), with only one case reported during the year, following a gap of 460 days since the previous case. The Trust has seen a further reduction in the overall number of hospital-acquired C. difficile infections, but unfortunately missed the target, which was extremely challenging. The Trust has sought advice from best performing Trusts and the Health Protection Agency and has implemented changes in practice as a result of these. Key actions have included the introduction of a daily ward round by the Infection Control Team and the Governors have supported continued efforts to reinforce the message about hand hygiene for both visitors and staff, by being on-hand to raise awareness.

- Dementia – The Governors have been pleased to see the increased focus on dementia over the past year. Particularly welcome is the increase in staff training and general awareness raising. In addition, the Trust has sought out additional funding to support the development of dementia-friendly environments.

- Cleanliness – In unannounced visits to wards and departments the Governors have been pleased to note that standards of cleanliness are being maintained. The Governors have also been active involved in piloting the new national Patient-Led Assessments of the Care Environment (PLACE). Their input has led to significant changes to the proposed process and the Governors are now planning to use the revised framework to support a programme of reviews throughout the year, in addition to the required formal annual assessment.

- Nurse staffing – the Governors welcomed a decision by the Trust's Board of Directors to invest an additional £1.5 million in nurse staffing, which has led to the recruitment of an additional 40 nurses and 8 midwives. This investment was based on the findings of a review of staffing, supported by feedback from the Governors following their ward visits. It is hoped that this investment will lead to a decrease in the use of agency staff and improvements in patient experience.

- Nutrition – Governors have been closely involved in the feeding and nutrition working groups, which has led to the appointment of a feeding advocate, whose role is to promote the importance of patient feeding and act as a link between catering and clinical services. In addition, Governors are involved in regular "expectation" meetings with our catering provider and have been active in the meal tasting sessions which the Trust holds to allow patients, visitors and staff to taste the same food served to patients on the day.

- Emergency Department – The Governors have been involved in early discussions with regard to developing the Trust's services for patients who are admitted as an emergency. We look forward to these plans coming to fruition in the coming year.

- Complaints – The Trust's Advice Centre offers a one-stop shop for patients, visitors and carers to ask any queries they may have, pass on their compliment or raise concerns or complaints. The Governors welcome the clinical input into this service which has been increased over the past year, and has led to a more focussed way of reporting, however we remain concerned that the name of the centre does not clearly identify its role in complaints.

- Eye Centre – The Governors are very pleased that during the year the Trust opened its new Eye Centre bringing together services which had previously been delivered over 3 separate sites. Governors were heavily involved in both the planning for the new unit and work to review the patient pathways which ran alongside this. The Governors are impressed with the progress which has been made but recognise that there is further work to be done.

- Links with Care Quality Commission (CQC) – Following their visit to the Trust last August, the Governors have met with representatives from the CQC to clarify the findings of their inspection and as a result of this will now be working together more closely.

Statement from North Derbyshire Clinical Commissioning Group

General Comments

NHS North Derbyshire Clinical Commissioning Group (NDCCG) is responsible for providing the commissioner statement on the quality account provided by Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) and in doing so has taken account of comments made by NHS Hardwick Clinical Commissioning Group as an associate commissioner. Careful consideration has been given to the content and accuracy in line with the national guidance. NDCCG can confirm that CRHFT has produced a Quality Account that meets the required criteria and that the information provided appears to be accurate and representative of the information available to NDCCG through contract monitoring and quality assurance processes during the year.

Measuring and Improving Performance

The Quality Account looks forward and identifies the three local priorities that CRHFT has identified for 2013/14. These are broadly described as patient safety, clinical effectiveness and patient experience.

The Quality Account also describes the quality of services provided this year by CRHFT measured against national, regional and local standards as detailed within the NHS contract and also within the local quality schedule and quality incentive scheme (CQUIN). Areas in which CRHFT has performed very well include the provision of cancer and stroke services.

CRHFT has invested £1.5 million to increase the number of nursing and midwifery staff during the year which will have a very positive impact on the quality of care provided to patients. CRHFT has in place a care strategy to support the provision of

dignity and compassion in patient care. Patient experience measures are detailed through the in-patient survey, patient reported outcomes measures and the 'friends and family' test. Progress has been made as evidenced by the improved 'friends & family' test score. This measure will be used more widely in the Trust in 2013/14 and commissioners would expect to see further improvement in the score and improvements to care as a result of the hospital responding to the comments of patients.

It is recognised that staff satisfaction is related to the quality of patient care. The results of the 2012 staff survey continue to be disappointing to both CRHFT and commissioners. It is anticipated that the investment in staffing and improved leadership from the Board and at all levels in the hospital will deliver better results in 2013/14.

CRHFT was inspected by the Care Quality Commission in August 2012. The Trust was required to make improvements against three of the five outcomes inspected. The Trust took some immediate improvement actions and agreed with CQC an action plan which is also being monitored to completion by the CCG.

This year the Trust has again reduced the number of hospital acquired infections. Whilst the end of year target was exceeded for Clostridium difficile this still represents an improvement on the number of cases in previous years. Audits of cleanliness and hand hygiene continue to show good results and the hospital has invested in many more highly visible hand gel points for the use of visitors. CRHFT continues to take positive action to further improve infection prevention and control by inviting a national leading expert to review processes at the hospital.

Patient safety is also being promoted through the learning from patient safety incidents as well as measures such as the Safety Thermometer and use of mortality data. Commissioners have noted the rise in the number of serious incidents reported. This is related to the new requirement to report all grade 3 & 4 pressure ulcers. The Safety Thermometer measures the prevalence of pressure ulcers, falls, venous thromboembolis and urinary tract infections associated with catheters on a particular day each month to give a measure of harm free care. CRHFT has introduced best practice measures particularly in reducing pressure ulcers with significant improvements. The hospital will continue to focus particularly on falls and pressure ulcer prevention for 2013/14. During 2012/13 one Never Event was reported by the Trust resulting in a contractual penalty but more importantly the learning resulted in improvements in maternity care such as procedures for counting swabs and also increased staffing.

The Trust has made excellent progress against the quality indicators for dementia care and in screening for venous thromboembolism. In 2013/14 Commissioners would like to see improvements in the indicators related to breast feeding which again this year are disappointing. These quality indicators relate to the number of mothers initiating breast feeding and sustaining breast feeding.

Towards the end of this year the Trust has come under considerable pressure in meeting the performance targets related to the care provided in the Emergency Department and is experiencing problems with delayed discharges from hospital. Both of these factors potentially impact on the delivery of planned care and may impact on the quality of care. Commissioners, the Trust and partner agencies are working collaboratively to understand the issues and implement measures to urgently improve.

Additional comments

The Quality Account is an annual report to the public that aims to demonstrate that the Trust is assessing quality across the healthcare services provided. Commissioners acknowledge that some parts of the quality account are mandatory and therefore presented in a specified format. The Quality Account would however be enhanced by the major part being the inclusion of more public friendly, locally determined information describing the improvements made during the year and future developments as suggested in the guidance.

NHS North Derbyshire Clinical Commissioning Group and associate commissioners look forward to continuing to work with the Trust to commission and deliver high quality patient care.

Statement from Derbyshire Healthwatch

In their Quality Accounts for 2012/13, Chesterfield Royal Hospital NHS Foundation Trust set out key priorities for improvement in 2013/14 as Clinical Effectiveness, Patient Safety and Patient Experience.

These are clearly of the utmost importance, and this focus is welcomed by Healthwatch Derbyshire, especially in light of the recently published final report by Robert Francis QC in to the systemic failings at Mid Staffordshire NHS Foundation Trust.

In terms of patient experience, the Trust outline plans to extend and develop the 'friends and family' test, and will continue to use this tool, alongside feedback gained from complaints and suggestions to drive improvements.

It is also worthy of note that a goal for 2012/13 agreed with commissioners related to improvements in patient experience, including the 'friends and family' test. This further embeds this important priority.

It is clear that the National In-patient Survey is also used by the Trust as a mechanism for collecting patient feedback, and this survey has identified key issues of communication, quality of meals, nurse staffing and noise at night.

The Trust goes on to outline steps they have taken to deliver improvements in these areas, and states a commitment to a ward assurance programme to act as a tool for identifying areas requiring further improvement.

Healthwatch Derbyshire would encourage the Trust to take full advantage of the whole range of patient feedback available to them, to help ensure that a complete picture is captured and no voice or experience is overlooked.

Statement from Derbyshire County Council Improvement and Scrutiny

Thank you for sending a copy of the Trust's draft Quality Account 2012/13 for the committee to comment on. Unfortunately, the Committee will not be able to provide a comment to the Trust for inclusion in the year's Quality Account. This is due to the Council being in a pre-election period ahead of the 2 May County Elections and as such there are no meetings of the Committee scheduled before your deadline.

How to provide Feedback on the Quality Accounts

The trust welcomes feedback on the content of its Quality Accounts and suggestions for inclusion in future reports. Comments should be directed to:

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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.

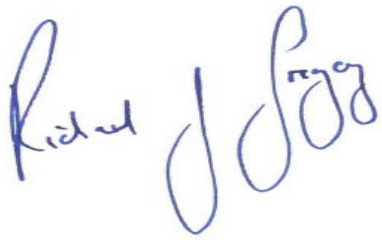
Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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 2011-12;
- 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 2012 to June 2013
    - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
    - Feedback from the commissioners dated 26/04/2013
    - Feedback from Governors dated 31/03/2013
    - Feedback from Local Healthwatch organisations dated 23/04/2013
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/05/2013
    - The latest national patient survey
    - The latest national staff survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 31/03/2013
    - CQC quality and risk profiles received between 1 April 2012 and the 31 March 2013.
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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



Richard Gregory OBE
Chairman
28 May 2013

Gavin Boyle
Chief Executive
28 May 2013

Glossary

Hospital Standardised Mortality Ratio (HSMR) – is a measure of in-hospital mortality, based on 56 diagnosis groups which lead to 80% of all deaths in hospital in England. The Trust uses data calculated by Dr Foster, which is based on data from hospital information systems from all Trusts in England. Dr Foster benchmarks data against the previous full financial year's data, therefore data for 2012/13 is currently being benchmarked against 2011/12. When the full year's data is available the benchmark will be reset; as nationally the mortality rate is reducing this leads to an increase in the HSMR, however during the year Dr Foster gives a prediction of what the HSMR will be when this occurs. This report includes both the current HSMR (compared with 11/12 benchmark) and the predicted HSMR.