

**Chesterfield Royal Hospital NHS
Foundation Trust**

**Quality Accounts
2010/11**

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PART 1

STATEMENT FROM THE CHAIRMAN AND CHIEF EXECUTIVE

Chesterfield Royal Hospital is committed to delivering high quality clinical care, which is safe and effective and places the patient at the centre of everything we do. In order to do this we undertake a wide range of activities to ensure that current high standards are maintained and staff are supported to continually improve quality.

This report details:

- The trust's priorities for improvement for 2011/12.
- Statements relating to the quality of services provided by the trust include the 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.

The report includes information regards the actions the Trust has taken to meet the national priorities outlines in the NHS Operating Framework, which are;

- improving cleanliness and reducing healthcare-associated infections
- improving access through achievement of the 18-week referral to treatment pledge,
- keeping adults and children well, improving their health and reducing health inequalities;
- improving patient experience, and staff satisfaction and engagement; and
- preparing to respond in a state of emergency, such as an outbreak of a new pandemic.

Many of the trust's staff have been involved in influencing 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 commissioning Primary Care Trust; Derbyshire County;
- Derbyshire Local Involvement Network (LINKs); and,
- Derbyshire County Council's Overview and Scrutiny Committee.

The views of these groups are reflected in this report.

In preparing the quality report, directors have satisfied themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010/11;
- 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 2010 to June 2011

- Papers relating to quality reported to the board over the period April 2010 to June 2011
- Feedback from the commissioners dated 27/05/11
- Feedback from governors dated 11/05/2011
- Feedback from LINKs dated 25/05/11
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in the annual report.
- 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 3rd June 2011
- CQC quality and risk profiles issued between April 2010 and March 2011.
- 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.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitornhsft.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.

Richard Gregory OBE
Chairman
3 June 2011

Eric Morton
Chief Executive
3 June 2011

PART 2

PRIORITIES FOR IMPROVEMENT

The trust has identified four 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 the quarterly quality report which is presented to the board of directors, clinical governance committee and council of governors. In addition, this report is shared with Derbyshire County PCT and Derbyshire LINKs.

2.1 Clinical Effectiveness

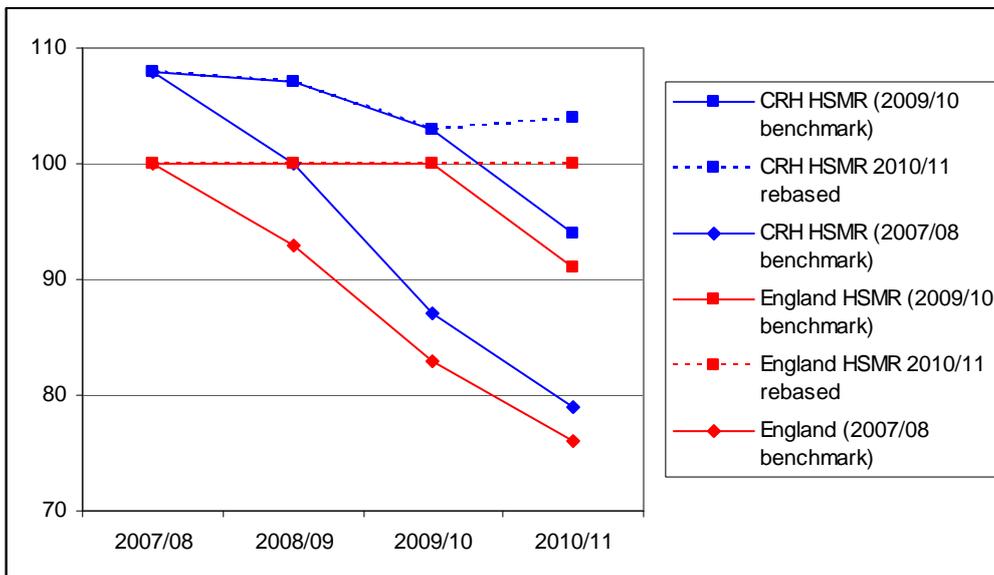
2.1.1 Priority: Reduction in Hospital Standardised Mortality Ratio (HSMR)

Hospital Standardised Mortality Ratio (HSMR) is a way of comparing the number of deaths in hospital between different organisations; HSMRs compare the number of expected deaths with the number of actual deaths. The data are based on the diagnoses that lead to 80 per cent of all deaths and are adjusted for factors statistically associated with hospital death rates, such as age, gender and reason for admission. The expected, i.e. national average, HSMR is set at 100 and Dr Foster resets the benchmark each financial year once they have a full year's data.

Reducing hospital mortality was one of the priority areas identified in our 2009/10 quality accounts when our stated aim was to become one of the best 25% of trusts in relation to HSMR. The graph below shows the trust and national HSMR for the past 4 years:

- Compared with the 2007/08 benchmark
- Rebased year-on-year – with 2010/11 data benchmarked against 2009/10
- The prediction of what will occur when the benchmark for 2010/11 is reset.

Hospital Standardised Mortality Ratio by calendar year



As the graph above demonstrates that whilst the trust has made year-on-year improvements in our mortality rates, we are not improving as quickly as other trusts and when the rebasing calculation is made when the full set of 2010/11 data is available we may in fact show a slight increase in HSMR. Early analysis of this shows that the 'true' figure for this period is likely to be 104 which whilst above average, will still statistically be within the average range. We are disappointed that despite having a robust process in place for investigating alerts generated by the Dr Foster Real Time Monitor tool we have failed to make significant progress towards our aim to become one of the best 25% of trusts in relation to HSMR. We are therefore rolling forward this priority into 2011/12.

Analysis of the data now proves that there are few individual areas that show as significantly different from the nationally calculated expected figures. Therefore we needed to take a different approach.

In order to do this we have worked with Dr Foster, who are nationally recognised for their work on measuring and comparing mortality rates. This has resulted in a mortality project, the first stage of which has been to identify key diagnosis groups where improvements could have a significant impact on the overall mortality rate. We will now undertake an in-depth review of the care delivered to patients with these diagnoses and identify any areas of shortfall. The first four diagnoses we will review are:

- Fractured hips
- Pneumonia
- Urinary Tract Infections
- Stroke

This work will be led by the clinical governance committee and will involve front-line clinical staff responsible for those areas identified. They will be supported by our clinical governance team to identify and audit practice and to make the necessary improvements.

We will continue to use the Dr Foster data to monitor mortality and progress will be reported to the clinical governance committee on a regular basis.

2.2 Patient Safety

2.2.1 Priority: Care Indicators

In order to support the trust's aim to ensure that we deliver high quality nursing care the chief nurse introduced a process of nursing metrics at the beginning of September 2009. 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.

Trustwide Nurse Metrics Results by Category

Adult Inpatients

	Apr-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	Jan-Mar 2011
Patient Observation and Identification	95%	92%	93%	96%
Pain Management	83%	86%	92%	96%
Risk Assessment		83%	91%	94%
Falls	56%	63%	74%	82%
Nutrition	80%	84%	87%	91%
Pressure Ulcer Assessment	80%	81%	88%	93%
Medication Assessment	90%	84%	86%	89%
Infection Control		43%	57%	79%
Personal Handling	77%	82%	87%	91%

Paediatrics

	Apr-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	Jan-Mar 2011
Patient Observation and Identification	91%	94%	93%	94%
Pain Management	59%	83%	83%	97%
Nutrition	87%	81%	80%	87%
Medication Assessment	100%	100%	100%	100%

Neonates

	Apr-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	Jan-Mar 2011
Patient Observation and Identification		95%	98%	98%
Pain Management			98%	93%
Skin assessment			100%	99%
Nutrition		89%	94%	96%
Medication Assessment		98%	98%	98%
Infection Control		99%	99%	100%

Nurse metrics audits are now undertaken on all adult inpatients wards (including the Emergency Management Unit), ITU, HDU, the paediatric ward and neonatal unit. Over the coming year metrics will be rolled out to daycase surgery and a process will be developed for maternity which links to the national risk management standards. In addition, we are planning to develop metrics for medical staff.

As the results show, there have been significant improvements in the results over the past year and we are aiming for all wards to be achieving at least 90% in all categories by the end of 2011/12.

In addition, we have developed a Feedback, Learning and Improvement Programme (FLIP) which brings together the results from the metrics audits, with patient feedback, complaints, incidents, infections, audit and staffing data into a balance scorecard which enables us to gain an overview of each ward. These highlight a range of patient safety issues such as falls, nutrition and pressure ulcers. In the coming months these results will be displayed on each ward, along with a monthly action plan highlighting the three priority areas for improvement.

2.2.2 Priority: Dementia Care

Dementia currently affects over half a million people in England alone and this figure is set to rise considerably as more people live longer. As up to 70% of acute hospital beds are occupied by older people, it is obvious that a large proportion of our patients will have dementia, the majority of whom have been admitted for another condition.

There have been a number of national reports suggesting that acute hospital services for people with dementia need to improve further. To address this the trust will establish a dementia strategy group to support the trust in developing and implementing a dementia strategy in order to improve care for dementia patients in hospital regardless of their reason for admission.

This group will review the quality of care currently delivered for patients with dementia (e.g. via the national dementia audit and NICE Quality Standard for Dementia) to identify gaps in current provision and develop a strategy and action plan to address the shortfalls. The group will also influence the development of CQUIN (Commissioning for Quality and Innovation) standards related to dementia care so that we have an ongoing means of monitoring the quality of care.

Progress will be monitored via the national dementia audit standards and will be reported to the board and clinical governance committee on a quarterly basis via the quality report.

2.3 Patient Experience

2.3.1 Priority: Patient Experience Surveys

In line with the trust's aim to be the hospital of first choice for local people, patient satisfaction and positive feedback is seen as a key indicator of success. The trust conducts a wide range of patient and public involvement work each year, however the key indicator of patient satisfaction is the national patient surveys, in particular the annual inpatient survey.

The results of the 2010 inpatient survey show that there has been deterioration in the number of questions for which the trust was in the top 20% of trusts.

Comparative Trust Performance on the National Inpatient Survey 2010 vs. 2008 and 2009 (Source: Healthcare Commission/Care Quality Commission Comparative reports)

Performance	2010	2009	2008
Top 20%	11 (17%)	40 (63%)	29 (47%)
Mid 60%	47 (73%)	23 (36%)	31 (50%)
Bottom 20%	6 (9%)	1 (2%)	2 (3%)

In order to address these disappointing results the trust has developed a robust action plan to address all areas where our scores have dropped, this includes:

- The cut-off time for transfer of patients between wards at night -hours will be enforced to reduce noise at night.
- The dementia strategy noted above will lead to better management of these patients and hence reduced disruption on the ward.
- Catering key performance indicators are to be introduced in April.
- Protected mealtimes will be re-launched and will include protected breakfasts.
- Staff will be reminded that they need to make themselves available to speak to patients using clear communication and Matrons will be encouraged to be available at visiting times to speak to relatives and patients.
- Ensure staff are aware that patients perceive they are not washing their hands regularly and encourage staff to be more visible whilst washing their hands.
- Continue regular hand hygiene audits and ensure the results are visible at the
- Introduce signage to encourage relatives to ask a member of nursing staff if they wish to speak to a doctor.
- The ongoing internal survey will be amended in May to include all of the benchmarked questions to enable us to monitor progress.

Response to these actions will be monitored via the ongoing patient experience surveys which the trust undertakes on all wards. In addition, members of our council of governors will continue to undertake regular ward visits to talk to patients and gain feedback on their experiences.

2.4 Statements Relating to Quality of NHS Services Provided

2.4.1 Review of Services

During 2010/11 the Chesterfield Royal Hospital NHS Foundation Trust provided NHS 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 NHS Services.

The income generated by the NHS services reviewed in 2010/11 represents 100% per cent of the total income generated from the provision of NHS services by the Chesterfield Royal Hospital NHS Foundation Trust for 2010/11.

2.4.2 Participation in Clinical Audits and Confidential Enquiries

During 2010/11, 32 national clinical audits and 5 national confidential enquiries covered NHS services that Chesterfield Royal Hospital NHS Foundation Trust provides.

During that period Chesterfield Royal Hospital NHS Foundation Trust participated in 75% of national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The tables below detail the national clinical audits and national confidential enquiries that Chesterfield Royal Hospital NHS Foundation Trust:

- Was eligible to participate in during 2010/11.
- Participated in during 2010/11.

The national clinical audit and national confidential enquiries that Chesterfield Royal Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, 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 percentage of the number of cases required for 2010/11
Perinatal mortality (CEMACH)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	100%
Paediatric fever (College of Emergency Medicine)	Yes	100%
College of Emergency Medicine: vital signs in majors	Yes	100%
Adult Critical Care (Case mix programme) ICNARC	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	100%
Heavy Menstrual Bleeding (RCOG National Audit of HMB)	Yes	100%
Adult asthma (British Thoracic Society)	Yes	100%
Familial Hypercholesterolaemia (National Clinical Audit of Mgt of FH)	Yes	100%
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%
Stroke Care (National Sentinel Stroke Audit)	Yes	100%

National audit title	Did the trust participate?	No. of cases submitted as a percentage of the number of cases required for 2010/11
Renal colic (College of Emergency Medicine)	Yes	100%
Lung cancer (National Lung Cancer Audit)	Yes	100%
Severe trauma (Trauma Audit and Research Network)	Yes	100%
National Audit of Dementia	Yes	100%
O negative blood use (National Comparative Audit of Blood Transfusion)	Yes	100%
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	100%
Diabetes (National Diabetes Audit)	Yes	100%
Elective Surgery (National Patient Reported Outcome Measures Programme)	Yes	95%
Heart Failure (Heart Failure Audit)	Yes	94%
Falls and non-hip fractures (National Falls and Bone Health Audit)	Yes	85%
Hip fracture (National Hip Fracture Database)	Yes	75%
Acute Stroke (SINAP)	Yes	50%
Hip, knee and ankle replacements (National Joint Registry)	Yes	37%
Paediatric asthma (British Thoracic Society)	No	~
Emergency use of oxygen (British Thoracic Society)	No	~
Pleural Procedures (British Thoracic Society)	No	~
Cardiac Arrest (National Cardiac Arrest Audit)	No	~
COPD (British Thoracic Society)	No	~
Bronchiectasis (British Thoracic Society)	No	~
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	No	~
Parkinson's Disease (National Parkinson's Audit)	No	~

National Confidential Enquiries

Study title	Did the trust participate?	No. of cases submitted as a percentage of the number of cases required for 2010/11
National Confidential Enquiry into Patient Outcome and Death		
Surgery in Children	Yes	No relevant cases identified – all spreadsheets and organisational questionnaire completed.
Peri-operative Care	Yes	100%
Cardiac Arrest Procedures	Yes	Data collection ongoing
Centre for Maternal and Child Enquiries		
Maternal death enquiry	Yes	Enquiry currently suspended*
Perinatal mortality surveillance	Yes	100%

*the national contract for this enquiry has changed and therefore we have been unable to submit any cases whilst the new service is established.

The reports of all relevant national clinical audits were reviewed by the trust in 2010/11 and where appropriate action plans have been developed to improve the quality of healthcare provided.

The reports of 215 local clinical audits were reviewed by the provider in 2010/11 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

The number of patients receiving NHS services provided or sub-contracted by Chesterfield Royal Hospital NHS Foundation Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 593. Of this number 575 were recruited to studies on the National Institute of Health Research (NIHR) portfolio. No research activity takes place at the trust without research ethics approval and a full research governance check.

Chesterfield Royal Hospital NHS Foundation Trust has continued to increase the quantity and scope of its research activity over the last year. Due to continued funding from the Trent Comprehensive Local Research Network (TCLRN), the trust has been able to further develop teams of experienced research nurses, doctors and allied health professionals. Largely as a result of having local cancer research nurses in post the trust now has the ability to run more cancer research trials as a standalone centre although the trust also continues to act as a recruitment centre for Weston Park Hospital, the specialist cancer hospital in Sheffield. All cancer research projects run at Chesterfield Royal Hospital NHS Foundation Trust have been adopted by the Cancer Research Network.

Of the studies approved during the period from 1 April 2010 to 31 March 2011 only one was established and managed under a trial agreement that varied from the national model agreement. The content of the trial agreement was subject to the same governance and legal review as usual.

Of the forty one studies approved during the period from 1 April 2010 to 31 March 2011, thirty five (85%) were adopted to the NIHR portfolio. Of the six that were not adopted three were academic projects, one project was scientific, one was a surveillance study and one was part of a national screening initiative.

During the period from 1 April 2010 to 31 March 2011, thirteen NHS to NHS letters of access were issued to researchers and eighteen 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 2010/11 was conditional on achieving quality improvement and innovation goals agreed between Chesterfield Royal Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2010/11 and for the following 12 months period are available electronically at:

<http://www.chesterfieldroyal.nhs.uk/news/annualreport/qualityaccounts?ts=79792>

For 2010/11 the value of the CQUIN payment was £2,251,452.

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 with no compliance conditions.

The Care Quality Commission has not taken enforcement action against Chesterfield Royal Hospital NHS Foundation Trust as of 31 March 2011.

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.

2.4.6 Data Quality

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

- A data quality policy has been adopted which specifies who is responsible for the various aspects of this subject. This policy has been shared with commissioners;

- Key data quality measures (e.g. maternity data quality, ethnic coding data quality) are included in the monthly board of directors performance management report. Relevant standards of data quality are defined in the annual corporate objectives process and monitored throughout the year;
- Information and data quality issues are standing items on the joint PCT-trust contract monitoring group (CMG);
- An internal data quality group has been established, with representatives from finance, information and data services teams, which has regular monthly meetings and an action log. Issues are identified and followed up with operational teams;
- Regular independent data quality audits are carried out, and shared with relevant parties (including commissioners). Recent audits have reviewed payment by results (PbR) data and A&E activity;
- Staff training emphasises the importance of ensuring that data is accurately recorded – ‘right first time’, and when issues are identified with individual members of staff, these are promptly followed up;
- A small, dedicated team of data quality staff support initiatives to ensure that data is fit for purpose, and to capture issues that occur outside the normal data collection processes.

Chesterfield Royal Hospital NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episodes 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:
 99.9% for admitted patient care;
 99.6% for outpatient care; and,
 100% for accident and emergency care.

– which include the patient’s valid General Medical Practice Code was:
 100% for admitted patient care;
 100% for outpatient care; and,
 100% for accident and emergency care.

Information Governance Toolkit Attainment Levels

Chesterfield Royal Hospital NHS Foundation Trust’s Information Governance Assessment Report score overall score for 2010/11 was 59% and was graded ‘not satisfactory’.

The trust has achieved all the key standards for the Information Governance Toolkit, except the standard that requires 95% of all trust staff to pass the on-line Information Governance Training tool (IGTT). An action plan has been put in place to ensure that this standard will be met during 2011/12.

Clinical Coding Error Rate

Chesterfield Royal Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

PART 3

REVIEW OF QUALITY PERFORMANCE

This section includes a range of information relating to the trust's quality performance in 2010/11. Whilst this is not an exhaustive list it gives an overview of the trust's performance in both hospital-wide and service specific indicators.

Some of the indicators included in this section appeared in last year's report, whilst others are new, reflecting the changing priorities of the Trust or because we believe they help to give a more rounded picture of performance. In addition, a small number of indicators which appeared last year have been removed as high levels of performance have become standard practice (we continue to monitor these internally to ensure high standards are maintained).

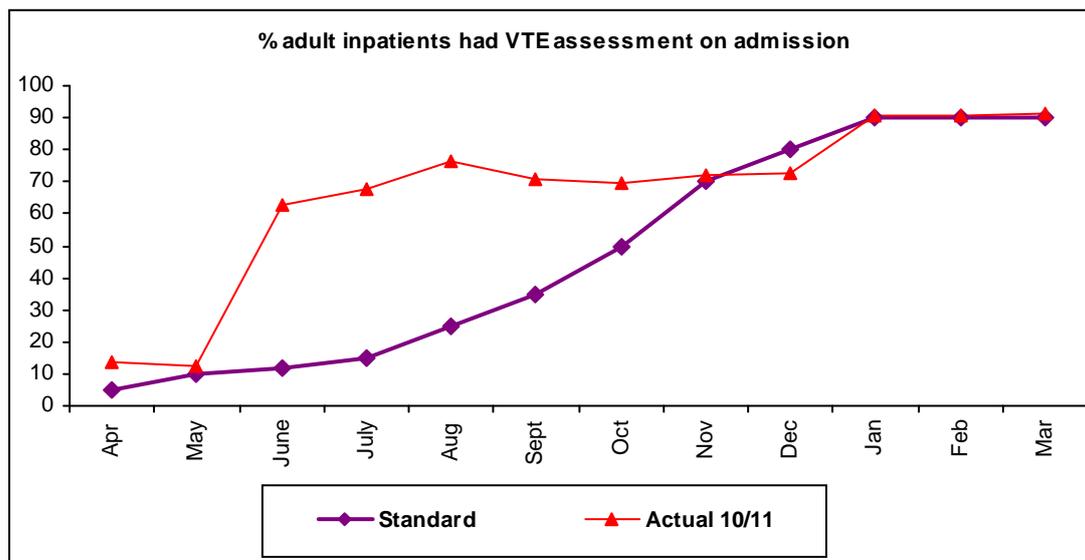
3.1 Clinical Effectiveness Indicators

3.1.1 Reducing the Risk of Venous Thromboembolism (VTE)

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 prophylaxis to those assessed as being at increased risk. The trust has a risk assessment process in place and has 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 2010/11 and was one of the trust's quality account priorities for the year. As the graph below shows the trust has made significant progress against this standard and has achieved the standard of 90% from January 2011 onwards.



The data for this indicator is collected internally as part of the clinical coding process in line with national guidance. The data collection process was subject to an internal audit during 2010/11 which revealed no significant concerns.

3.1.2 Maternity Services

The trust is responsible for maternity services in North Derbyshire, which deliver over 2,000 babies a year. In the past year the trust has invested in the development of a new birth centre aimed at ensuring that women get a “home-from-home” experience. To reflect these areas the trust measures a range of indicators as shown below for 2009/10 and 2010/11 (where the target has changed this is shown in brackets):

Criterion	Target	2010/11	2009/10
Caesarean sections	Caesarean section rate less than national average of 24%	21.4%	19.6%
	Less than 20% of emergency caesarean sections performed under General Anaesthesia	23.9%	24.7%
	More than 90% of elective caesarean sections performed under Regional Anaesthesia	96.8%	99.0%
Home births	Rate of home births above national average of 2%.	1.4%	2.1%
Breastfeeding	More that 75% of mothers initiate breastfeeding	73.0%	71% (target > 68%)

During the year we undertook a review of emergency caesarean sections performed under General Anaesthesia, as this is higher than we would like. This review did not reveal any patient safety concerns or untoward outcomes, however some actions have been identified which may help to decrease the number of emergency caesarean sections performed under General Anaesthesia.

The data for this indicator is collected internally by midwifery staff; the data collection process was subject to an internal audit during 2010/11 which showed no significant concerns.



UNICEF UK Baby Friendly Initiative

The Baby Friendly Initiative accredits maternity facilities that adopt internationally recognised standards of best practice in the care of mothers and babies. In order to achieve full Baby Friendly accreditation trusts have to be externally assessed to prove that they have adopted the ten steps to successful breastfeeding. The trust's facilities (Chesterfield Birth Centre and Darley Maternity Unit) were re-assessed in January 2011 and achieved full accreditation with 32 out of the 34 criteria being met.

The assessment included interviews with 33 women who had recently given birth, interviews with staff and a review of trust policies. In order to achieve re-accreditation:

- All qualified and unqualified maternity, paediatric and neo-natal staff have completed a breastfeeding training day. From April 2011 onwards regular half-day refresher sessions will be held for these staff.
- All documentation and policies were reviewed.
- Ongoing audits of documentation and practice have been introduced.

The trust is awaiting the formal report, but the assessors have identified us as a trust who should be recommended to become a beacon of excellence in relation to practice related to breastfeeding.

3.1.3 Management of Patients with Fractured Neck of Femur

Fragility fractures and their care are a challenge to our health care system and our society. Already in the UK around 300,000 patients with such fractures present each year, and current projections indicate that numbers of hip fracture patients will continue to rise. This picture is reflected at the trust, where the number of patients admitted with a fractured neck of femur has increased by over 50% in the past 10 years.

The evidence-base for hip fracture care is improving rapidly and, in general terms, shows that prompt, effective, multidisciplinary management can improve quality and mortality, and at the same time reduce costs. Key elements of good care are:

- Prompt and appropriate management in the emergency department.
- Reducing the time from admission to surgery.
- Prompt mobilisation following operation.

To reflect these areas the trust measures a range of indicators as shown below for 2009/10 and 2010/11:

Criterion	Target	2010/11	2009/10
Management in ED	Appropriate analgesia provided within 60 minutes of arrival – national average 46%	48%	78%
	Proportion of patients given analgesia within guidelines – national average 72%	100%	72%
	Proportion of patients who had an X-ray within 60 mins of arrival in A&E – national average 42%	82%	66%

Time to operation	45% of patients with fractured neck of femur are operated on within 24 hours of admission	47%	47%
	80% of patients with fractured neck of femur are operated on within 48 hours of admission	80%	84%
Mobilisation	% of patients mobilised within 24 hours post-op.- target 46%	29%	40%
	% of patients assessed for mobilisation within 24 hours	75%	N/A

As the table shows we are not managing to mobilise as many patients as we would like in the first 24 hours after surgery. A review of these patients shows that for many mobilisation within 24 hours is not appropriate and in order to ensure that we are mobilising all appropriate patients we are focusing on ensuring that all patients are assessed within 24 hours.

The data relating to management within the emergency department was collected as part of a national clinical audit managed by the college of emergency medicine. The data for the remaining indicators is collected internally by staff within the orthopaedic directorate and the data collection process was subject to an internal audit during 2010/11 which revealed no significant concerns.

3.1.4 End of Life Care

Each year over 1,000 patients die within the trust and whilst a proportion of these will be sudden death, the greater proportion will be expected deaths. In order to ensure that this latter group receive the most appropriate palliative and supportive care in the last days of their life the trust has worked with other organisations in Derbyshire to develop an end of life care pathway. The aim of the pathway is to ensure a quality multi-disciplinary approach to caring for patients and for their families at the end of their life, sensitive to their changing needs, to ensure a peaceful death.

The care pathway has been in place for sometime, however during 2010/11 we began to proactively monitor its use, which has resulted in an increase as shown in the table below.

Measure	Apr-Jun '10	Jul-Sept '10	Oct-Dec '10	Jan-Mar '11	YTD
Proportion of patients who die in hospital who are on the end of life care pathway	13.3%	26.6%	28.4%	Not yet available	22.1%

The data for this indicator is collected internally by the clinical governance support team and this process will be subject to review by the external auditors during May 2011.

3.1.5 Average Length of Stay and Daycase Rates

Ensuring that patients are treated efficiently and effectively is a key priority for the trust; treating all suitable patients as daycases and minimising the length of stay for others improves patients experience and indicates more effective care. To reflect these priorities two of the regional CQUINs for 2010/11 were:

- Reduction in average length of stay for medical patients to below 8 days.
- Over 85% of specified procedures to be carried out as day cases

The trust achieved both of these targets with:

- An average length of stay for medical patients of 7.4 days
- 85% of specified procedures carried out as day cases

The data for these indicators are collected via the hospital patient administration process and is in line with national definitions.

3.1.6 Stroke Care

Stroke is a preventable and treatable disease; it can present with the sudden onset of any neurological disturbance, including limb weakness or numbness, speech disturbance, visual loss or disturbance of balance. Over the last 20 years, a growing body of evidence has overturned the traditional perception that stroke is simply a consequence of ageing that inevitably results in death or severe disability. Evidence is accumulating that interventions that are effective soon after the onset of symptoms contribute to a better outcome.

In the UK, the National Sentinel Stroke Audits have documented changes in secondary care provision over the last 10 years, with increasing numbers of patients being treated in stroke units, more evidence-based practice, and reduced mortality and length of hospital stay. The table below shows how the trust performed against each of the key standards in the 2010 National Sentinel Stroke Audit.

Standard	Trust Result	Compared with national average
Proportion of patients:		
- admitted directly to a stroke unit	87%	Above average
- having a brain scan within 24 hours of the stroke	92%	Above average
- having screening for swallowing assessment within 24 hours of admission	94%	Above average
- who required a swallowing assessment, who received one within 72 hours	93%	Above average
- having a physiotherapy assessment with 72 hours of admission	100%	Above average
- having an occupational therapy assessment with 4 days of admission	84%	Above average
- being weighed during admission	98%	Above average
- having their mood assessed during admission	91%	Above average
- having rehabilitation goals agreed by discharge	97%	Above average
- having rehabilitation goals agreed within 5 days of admission	94%	Above average
- having aspirin or clopidogrel by 48 hours after the stroke	96%	Above average
- who spent at least 90% of stay on a stroke unit	83%	Above average

These results placed the trust in the top 25% of scores, which is an improvement on the previous audit in 2008 where our results were in the middle 50%.

3.1.7 Cancer Waiting Times

Timely diagnosis and treatment for cancer are key to improving survival rates. The trust is monitored against a range of targets in relation to cancer waiting times as shown in the table below:

Standard	Target	Trust result
Percentage of patients seen by a specialist within 2 weeks of urgent GP referral for suspected cancer.	93%	96.5%
Percentage of patients seen by a specialist within 2 weeks of GP referral with any breast symptom except suspected cancer	93%	97.0%
Percentage of patient treated within one month (31 days) of a decision to treat	96%	99.9%
Percentage of patients receiving subsequent surgical treatment within one month (31 days) of a decision to treat	94%	100%
Percentage of patients receiving subsequent anti-cancer drug treatment within one month (31 days) of a decision to treat	98%	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 ¹	85%	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 ¹	90%	95.4%
Percentage of patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral from a consultant for suspected cancer ¹	~	100%

The data for these indicators are collected in line with national definitions and the process was subject to an internal audit in 2010, which did not identify any significant concerns.

3.1.8 Time spent in the Emergency Department

This standard relates to the total time patients spend in the emergency department from arrival to admission, transfer or discharge. The trust is monitored against both the national standard of 95% of patients spending less than 4 hours in the department and a contract standard of 98%.

Over the year the trust achieved 98.2% compliance, thereby achieving both targets.

The data for these indicators are collected in line with national definitions and the process was subject to an internal audit in 2010, which did not identify any significant concerns.

¹ 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.

3.2 Patient Safety

3.2.1 Hospital Acquired Infections

Health care acquired infection causes significant harm and is a major concern to patients. There has been very significant decline in rates of MRSA and CDiff infection in Chesterfield Royal Hospital in recent years but the Trust is keen to reduce this further.

The trust monitors against a range of targets in relation to infection control including:

- C. difficile and MRSA – these are two key infections cause hospital-acquired infections.
- Cleanliness and hand hygiene – both of which are proven to reduce the spread of infection.
- Staff appearance – by ensuring that staff are appropriately dressed and in particular are not wearing jewellery or watches which may harbour infections we can help to reduce the risk of infections.

The outcome for these indicators are shown in the table below for 2009/10 and 2010/11 (where the target has changed this is shown in brackets)::

Criterion	Target	2010/11	2009/10
C. difficile	No more than 50 hospital acquired infections	51 new isolates	50 new isolates (target no more than 125)
MRSA	No more than 4 bacteraemia infections	3 bacteraemia	3 bacteraemia (target no more than 12)
	No more than 62 hospital acquired non bacteraemia infections	28 non-bacteraemia	42 non-bacteraemia (target no more than 69)
	Screening of all elective inpatients prior to admission	Achieved	N/A
	Screening of all non-elective inpatients (from January 2011)	Under-acheived	N/A
Cleanliness audits	Achievement of minimum scores of 95%	Average score 96%	Average score 96%
Hand Hygiene	Achievement of minimum scores of 85%	Overall compliance 91%	Overall compliance 92%
Staff Appearance	Achievement of minimum scores of 85%	Overall compliance 85%	N/A

The data for these indicators are collected by the infection control team and where appropriate, in line with national definitions. The process for infection surveillance was subject to an internal audit in 2009/10, which did not identify any significant concerns.

3.2.2 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 the trust has focused on reducing harm from falls and has 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, which shows that there has been a steady increase. The second column shows the number of reported falls which resulted in any harm to the patient. This second rate is falling, which suggests that staff are very good at reporting falls, even those where the patient has not sustained any injury. We believe that this is due to the open reporting culture in the Trust and the awareness raising with regard to falls which has taken place in the last year.

Year	Rate per 1000 bed days	
	All falls	Falls resulting in harm
2008/09	5.7	1.8
2009/10	6.6	2.2
2010/11	7.1	1.0

3.2.3 Blood Transfusion Competency - Based Training and Assessment

Blood transfusions involve a complex sequence of activities and, to ensure the right patient receives the right blood, there must be strict checking procedures in place at each stage. In order to reduce the risk of errors occurring all staff are required to have undergone competency based training and assessment.

The trust achieved the aim that 95% of all relevant staff had undergone the relevant assessment(s) by November 2010. The trust will now continue to monitor this standard to ensure that all relevant staff receive their three-yearly updates.

The data for this indicator is collected by the transfusion team who facilitate all of the training and is validated by directorate management teams.

3.3 Patient Experience

3.3.1 Maternity Patient Experience

In addition to the patient experience measures reported in part one of the report the trust also completed the national maternity survey in 2010. In the benchmarking information produced by the Care Quality Commission performance for each question is rated using 3 categories:

- Worst performing 20% of trusts;
- Best performing 20% of trusts; and,
- Intermediate 60% of trusts.

Overall the trust's performance was fairly positive with:

- 4 questions in the best performing 20% of Trusts
- 12 questions in the intermediate 60% of trusts
- 3 questions in the worst performing 20% of Trusts

This is the first time that a benchmark report has been published for a national maternity survey and overall we feel that the results are positive. An action plan has been developed to address those areas where the trust was red and an ongoing maternity experience questionnaire will be introduced from March 2011 to enable us to continuously monitor the areas identified in this survey and hence drive continuous performance.

Comparison with Other Trusts in the East Midlands

Trust	Antenatal Care Score (Rank)	Labour and Birth Score (Rank)	Staff for Labour and Birth Score (Rank)	Hospital Post-natal Care Score (Rank)	Feeding during first few days Score (Rank)	Trust overall rank
Kings Mill	9.4* (1)	7.8 (1)	8.9 (1)	7.7 (1=)	6.8 (2=)	1
Chesterfield Royal	8.5 (3)	7.5 (5=)	8.4 (5=)	7.7 (1=)	7.0 (1)	2
Derby Hospitals	8.3 (5)	7.6 (3=)	8.7 (5=)	7.6 (5)	6.8 (2=)	3
Nottingham University Hospital	8.1 (6=)	7.6 (3=)	8.6 (5=)	7.7 (1=)	5.9 (7)	4=
United Lincolnshire Hospital	8.2 (2)	7.7 (2)	8.4 (5=)	7.1 (7)	6.6 (4)	4=
Leicester University Hospital	7.8 (8)	7.5 (5=)	8.5 (5=)	7.7 (1=)	6.1 (6)	6
Kettering General	8.1(6=)	7.2 (8)	8.0' (5=)	7.3 (6)	6.2 (5)	7
Nottingham General	8.4 (4)	7.4 (7)	8.3 (5=)	6.8 (8)	5.5 (8)	8

3.3.2 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 e.g. 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.

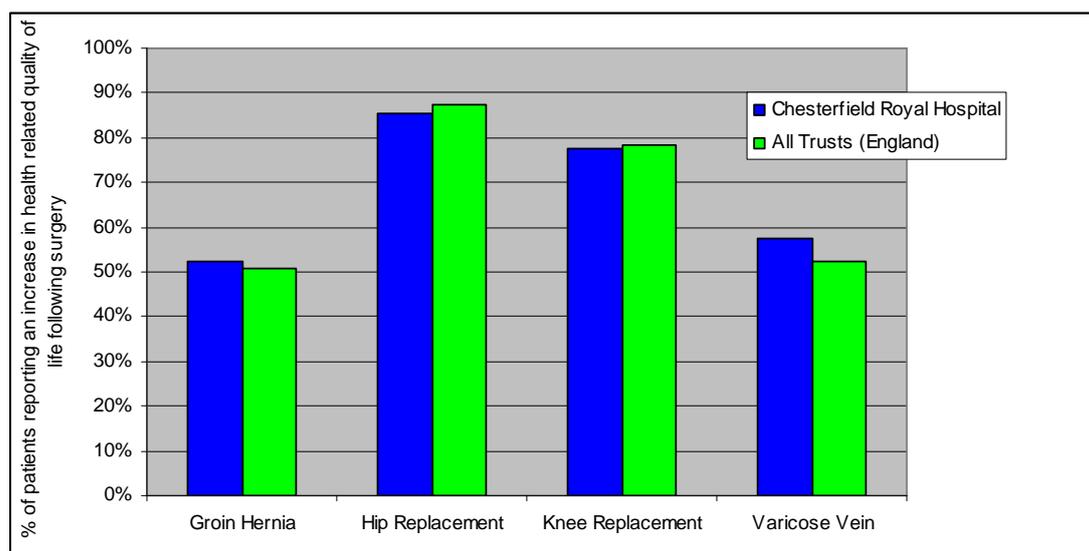
The national PROMs programme was launched in April 2009 and includes patients having the following operations:

- Hip replacements;
- Knee replacement;
- Groin hernia surgery; and,
- Varicose vein surgery.

The trust is 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 very good with 91% 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 graph below shows the proportion of patients, both nationally and for the trust who reported an increase in health-related quality of life following surgery. This suggests that the trust's results are comparable with those gained nationally i.e. we are receiving very similar results to the average across England.

PROMS Results April 2009 – November 2010



3 18 Week Referral-to-Treatment Waiting Times

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

- % inpatients treated within 18 weeks of referral, including wait for outpatients, diagnostics and inpatient treatment – target 90%.
- % non-admitted patients treated within 18 weeks of referral, including wait for outpatients and diagnostics – target 95%.

The table below shows the performance for 2009/10.

Target	Outcome
90% inpatients treated within 18 weeks of referral, including wait for outpatients, diagnostics and inpatient treatment	99.7%
95% non-admitted patients treated within 18 weeks of referral, including wait for outpatients and diagnostics	99.9%

The data for these indicators are collected in line with national definitions and the data is monitored monthly by the Primary Care Trust.

Statements Provided by the Commissioning PCT, the Trust's Council of Governors, Local Involvement Networks (LINKs) and Improvement and Scrutiny Committee

The trust shared the draft Quality Account to Derbyshire County PCT, the trust's Council of Governors, Derbyshire LINK and the Derbyshire County Council Improvement and Scrutiny Committee for comment prior to publication.

Statement from Derbyshire County PCT

General Comments

NHS Derbyshire County (the PCT) believes that Chesterfield Royal Hospital NHS Foundation Trust (the Trust) has produced a quality account which broadly reflects the information received by NHS Derbyshire County through its contract monitoring arrangements.

Measuring & Improving Performance

The PCT has well-established mechanisms in place for checking service quality as part of its contract monitoring arrangements. The PCT has agreed with the trust to monitor quality in a wide range of areas, not all of which can be detailed in this quality account.

As reported in the PCT statement for the trust's 2010 quality account, a set of quality measures were agreed with the trust. A number of these attracted a quality incentive payment. These included care of people suffering a stroke, maintaining independence of people with diabetes, patient safety and assessing the risk of blood clots (VTE or venous thromboembolism).

It is disappointing to note that the trust has not made reference to these as quality incentive measures apart from VTE.

The trust achieved its target for MRSA bloodstream infections and missed the CDiff infections target by 1 case. Both the targets were challenging and continue to be so in 2011/12.

The trust achieved its target of 90% of patients that will be assessed for risk of developing a blood clot (VTE) and this target remains for each month in 2011/12.

In 2010/11 the trust agreed quality measures to improve the care of someone who breaks their hip bone and needs surgery. Getting a person out of bed and moving around within 24 hours helps recovery and the trust had a target of 46% within 24 hours. The trust did not meet this and achieved a rate of 29%.

The 2009/10 National Audit Commission Payment by Results report showed that the trust's coding from inpatient stays in medical records was less than the national mean in several areas. The trust has identified this as a priority and a report is expected during 2011/12 from the Audit Commission with the results of a further audit.

The trust provides a screening service to check the vision of people who have diabetes. The PCT has worked very closely with the trust's managers and clinical staff throughout this last year to try and resolve a backlog of work such as test results.

The performance in this area is of concern as it is a risk to the patient if their eyesight is compromised due to delays in the system.

Additional Comments

Quality accounts are intended to help the general public understand how their local health services are performing and with that in mind they should be written in plain English. The PCT has concerns that the format and language of this quality account does not help local people to understand the level of performance.

Statement from the Trust's Council of Governors

The council of governors has reviewed the draft quality accounts and confirms that the information within the report is consistent with the information it has received over the past year in the quarterly quality reports.

Statement from Derbyshire Local Involvement Network (LINK)

General comments

Derbyshire Local Involvement Networks (LINK) feels that Chesterfield Royal Hospital NHS Foundation Trust (the Trust) has developed a fully comprehensive document that is in most parts is relevant and intelligible for the reader.

LINKs were particularly interested to read about the results of the patient satisfaction survey. LINKs are also pleased to hear that following the last disappointing results, the Trust have planned 'robust action' to address the issues and improve on where they are failing.

It would have been very interesting to see the individual areas in which the patient satisfaction survey looks into and also, as to what areas they are failing.

Patient satisfaction is of utmost importance to Derbyshire LINK and the only thing of equal importance is the Trust working toward improved patient satisfaction.

Derbyshire LINK is very pleased to read the members of the Council of Governors are ready and willing to get involved with the data collection process and gather issues directly from individuals upon the wards. One concern LINK does have in relation to this is that patients may not always be willing or it may not be most appropriate for patients to share their positive, negative or indifferent comments regarding their treatment to a governor of the same Trust. This activity may be best suited to an independent body such as Derbyshire LINK.

LINK therefore considers that the Trust and LINK should work closer on such matters and also be more active in undertaking joint ventures, allowing the public to truly influence *their* local health service.

Derbyshire LINK found the work around UNICEF UK Baby friendly initiative particularly interesting. Having received a number of issues from the public regarding breast feeding and the provision of information surrounding this subject, Derbyshire LINK have already identified this as an area of concern and an area in which needs to be looked into further throughout the county. Derbyshire LINK is pleased to read that the Trust is anticipated to become a beacon of excellence in regards to practice related to breastfeeding. Derbyshire LINK feels that following this accreditation, Chesterfield Royal Hospital NHS Foundation Trust could become a good practice example as to which other trusts should view as a benchmark standard.

Additional comments

Derbyshire LINK does feel the Quality Accounts have come a long way towards becoming more accessible to the general public. One particular accomplishment was

the production of the 'user friendly version' for quality accounts 2009-2010. Direct comments from LINK members have deemed this publication to be particularly useful and also much simpler to absorb.

Trust action

In response to the above comments we have extended the information relating to the national inpatient survey to include details of actions planned in response to the survey.

Statement from Derbyshire County Council Improvement and Scrutiny

Derbyshire County Council Improvement and Scrutiny declined to comment.

How to provide Feedback on the Account

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

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