5. **Quality** Report

5.1. Statement by the Chief Executive

This is the second Quality Account published by the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to accompany our Annual Report.

The Trust has had a busy and successful year and has met all the relevant national standards and targets. In addition, there has been a strong emphasis on improving the quality and accessibility of the services we provide, which remains a centre piece of our Strategy and the "Putting Patients First" initiative.

In this report we have outlined some of the quality activities which have taken place in the Trust over 2009/10. There are particular success stories to tell in respect of some improvements in patient safety, service transformation and our Staff Survey results. We have also continued to perform exceptionally well in respect of Healthcare Acquired Infections. Local patients can be reassured that we continue to have some of the lowest rates for MRSA and Clostridium difficile infections in the country. In addition we gained accreditation at Level 2 of the National Health Service Litigation Authority Maternity standards in November 2009, and in December 2009 we were delighted to win the Health Service Journal Award for Acute Organisation of the Year.

Our quality program has also been enhanced by wide ranging patient safety initiatives which covers a large range of specialties and topics. We are actively participating in the NHS South West Patient Safety & Quality Improvement Program which enables us to share our experiences, ideas and learning on patient safety initiatives with colleagues across the region.

The report outlines our priorities for 20010/11 and within these, patient safety and continuing to improve the patient experience will feature prominently. In addition a large number of initiatives will be undertaken in conjunction with our commissioners - NHS Bournemouth and Poole and NHS Dorset. We welcome the opportunity to work with them on a number of projects aimed at providing seamless care for our patients across primary and secondary care.

Finally, it has not been possible to include all of the quality initiatives that we have been or will be engaged in, within this report, which can at best, be a snapshot of what is taking place. However, we hope that it will fulfill the purpose it sets out to - provide an accurate account of quality activity in the Trust and to demonstrate the clear commitment of the Board to "Putting Patients First".

5.2 Priorities for Improvement and Statements of Assurance

5.2.1 2009/10 Quality Objectives

In line with the Trust's vision: "Putting patients first while striving to deliver the best quality healthcare," the Trust Board agreed a comprehensive set of strategic goals and objectives for 2009/10. The key goals for quality were:

- To offer patient centered services through the provision of high quality, responsive, accessible, safe, effective and timely care.
- To promote and improve the quality of life of our patients.

Quality Report

- To strive towards excellence in the services and care we provide.
- To work collaboratively with partner organisations to improve the health of local people.

External Review of Our Services

The Trust received a score of excellent for both parts of the Care Quality Commission (CQC) Annual Health Check - Quality of Services and Quality of Financial Management. Of the 16 specific areas assessed as part of the Quality of Services review the Trust achieved maximum scores in all areas. The Annual Health Check for the Trust included contributions from the Foundation Trust Council of Governors, Dorset Health Scrutiny Panel, Bournemouth Health Scrutiny Panel, Poole Health Scrutiny Panel, the Local Safeguarding Children's Board, Health Action Group (re Learning Disabilities) and NHS South West.

During the year the Trust received an unannounced visit by the Care Quality Commission of our compliance with the code of practice for the prevention and control of infections. As a result of this inspection one requirement and two recommendations were made. A detailed plan for remedial action was implemented, and follow up visit by the CQC in early 2010 showed the Trust to be compliant with the Code, with no breaches identified.

The Trust holds Level 2 accreditation with the NHS Litigation Authority (gained in 2008). A detailed action plan is in place to achieve Level 3 accreditation with assessment planned for early 2011. During this year accreditation at Level 2 has been obtained for the Trust's Maternity Service, which became the first midwife-led service to attain this level. The Maternity Service also gained accreditation at Level 2 of the Baby Friendly initiative to promote breast feeding.

In 2009 the Trust received a number of alerts from the Care Quality Commission (CQC) triggered by data produced by the Dr Foster organisation relating to Hospital Standardised Mortality Rates (HSMR). These were fully investigated and reported to the CQC, who were satisfied with the outcomes and required no further action in all cases.

To strengthen our review of HSMR the Medical Director has instigated a Mortality Review Group which meets monthly and proactively reviews the HSMR data for the organisation. All potential alerts are fully investigated and the results reported to the Clinical Governance and Risk Committee.

The Trust submitted the required Information Governance Toolkit Assessment to the NHS Information Authority and was accredited at Level 2 for all core standards. Further detail of this is provided in the appropriate section of this report.

Performance against key national priorities - Operating Framework and against Core Standards

The Trust declared full compliance against the 24 Core Standards for Better Health in the Care Quality Commissions Annual Health Check for 2009/10, following a systematic and thorough review of its services, policies and

Quality Report

procedures and the evidence available to assure the Board of Directors of the integrity of these. The self assessment was supported by the Trust's Quality & Risk Profile report supplied by the Care Quality Commission.

In addition the Trust has achieved unconditional registration with the Care Quality Commission. The Trust is registered for:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Maternity and midwifery services
- Termination of pregnancies
- Family Planning

Following further guidance from the CQC application was subsequently made to add the following two regulated activities to the Trust's registration:

- Assessment or medical treatment for people detained under the Mental Health Act
- Management and supply of blood and blood derived products

Performance against national priorities 2009/10

National Priority	2008/9	2009/10
Clostridium difficile year on year reduction	Exceeded	Exceeded
MRSA - target of 12 cases	Exceeded	Exceeded
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	Achieved	Achieved
Maximum waiting time of 62 days from all referrals to treatment for all cancers	Achieved	Achieved
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Achieved	Achieved
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	Achieved	Achieved
18-week maximum wait. Admitted patients: maximum time of 18 weeks from point of referral to treatment	Exceeded	Achieved
18-week maximum wait. Non-admitted patients: maximum time of 18 weeks from point of referral to treatment	Exceeded	Achieved
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	Achieved	Achieved
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack	Achieved	Achieved

Quality Report

Progress against Quality Improvement Plans for 2009/10

During 2008/09 the Trust made considerable progress with the development of a number of quality initiatives. These plans were identified in the Trust's Quality Account for 2008/9 and carried forward into 2009/10 as part of an ambitious overall quality improvement program which has the full commitment of the Board.

The program took account of a number of internally and externally driven requirements and initiatives:

- The Trust's Strategy for 2008 - 2012 "A Healthy Future".
- Feedback from patient engagement, our Patient Panel and local stakeholder groups.
- The extensive quality improvement program agreed with our commissioners including Commissioning for Quality and Innovation Scheme initiatives (CQUINs).
- National initiatives such as the Patient Safety First Campaign.
- The requirements of regulators and assessors i.e. Monitor, the Care Quality Commission, the NHS Litigation Authority.

The Trust's aspirations for quality improvement in 2009/10 were:

- Continue to improve the patient experience.
- Maximise patient safety
- Improve clinical effectiveness and clinical outcomes.
- Aim to further reduce hospital acquired infection.
- Achieve zero tolerance for "never events".
- Improve health and wellbeing.
- Further develop Ward to Board reporting.

Progress made against the quality objectives set for 2009/10 and plans for further development in 2011/12 are set out below:

Performance against quality objectives 2009/10

	09/10 objective setout in 08/09 Quality Account.	Progress against objective.	Action Plan for 2010/11.
Patient Experience	Implement real time monitoring against five key questions derived from patient consultation and focus groups.	Patient Survey group established with representation from governors, volunteers, PALS, service development, nursing and clinical governance. High priorities areas and strategy presented to Board of Directors.	Implement program of real time monitoring focusing on the five priority questions from the National survey methodology and internal Trust consultation exercise.

Quality Report

	09/10 objective setout in 08/09 Quality Account.	Progress against objective.	Action Plan for 2010/11.
Patient Safety	Implement the National Patient Safety First Campaign across the organisation.	Active participation in the South West SHA Patient Safety & Quality Improvement Program. The program workstreams superseded the NPSA campaign. Clinical engagement in each workstream. Over 50% of the identified quality indicators are currently being recorded with action plans in place to address gaps in collection, analysis and/or assurance.	Continue to participate in program and present monthly data to Board of Directors. Program aims are to reduce hospital mortality by 15% and adverse events by 30% by 2014.
	Develop the leadership intervention to demonstrate visible commitment from the Board to patient safety to include regular patient safety walkabouts.	Program of Executive walkrounds in place.	To formalise walkabouts to include NPSA methodology and ensure structured discussion and action for patient safety.
	Aim to improve early recognition of patient deterioration by effective use of the Medical Early Warning Scoring System (MEWS).	MEWs chart revised and routine monthly audit implemented.	Further revision to MEWs policy and procedures to ensure effective and timely response to trigger events.
	Highlight procedures required to prevent NPSA "Never Events" and ensure compliance.	Implemented. No "Never events" reported in 2009/10.	Ongoing reporting and investigation of adverse events. Implementation of the updated Never Events framework
Clinical Effectiveness	Improved management and patient centered treatment through the introduction of procedure specific PROMs.	PROMS implemented in all four national PROMS areas (Hips, Knees, Varicose Veins and Hernia).	Ongoing implementation.
	Aim for a 65% return rate of PROM surveys for patients treated in year.	Return rate of over 80% achieved in all 4 areas.	Ongoing implementation.
	Undertake regular reviews of PROMs scores by clinical specialty.	Awaiting publication of clinical data by National team.	Review clinical data following publication by PROMS team.
Hospital acquired infection	Achieve a target of no more than eight hospital acquired MRSA case in 2009/10.	Only three cases reported.	Sustain achievement.
	Achieve a target of no more than 83 hospital acquired Clostridium difficile cases in 2009/10.	Only 44 cases reported.	Sustain achievement.
	Maintain compliance with Care Quality Commission registration.	Achieved.	Sustain achievement.

Quality Report

	09/10 objective setout in 08/09 Quality Account.	Progress against objective.	Action Plan for 2010/11.
Improve health and wellbeing	Increase breast feeding initiation rates to achieve a minimum rate of 85%.	Rate achieved.	Sustain achievement.
	Achieve UNICEF "Baby Friendly" status in Maternity Services.	Level 2 achieved.	Action plan in place to achieve Level 3.
	Aim to achieve increased referrals of smokers to local smoking cessation services. Refer a minimum of 500 patients in year.	Action taken to increase number of referrals. Audit of referrals undertaken in the Medical Directorate.	Further work to increase the number of referrals. Audit the availability of local smoking cessation services to identify any unmet need or resource requirement.
Governance	Develop a comprehensive Ward to Board reporting matrix which will include a range of metrics reflecting patient experience, patient safety and clinical effectiveness.	Reporting matrix developed following consultation.	Development of an electronic format for Ward to Board reporting to enhance real time quality data collection, analysis and reporting across all levels of the Trust.

Service transformation objectives for 2009/10

The Trust has also embarked upon a wide reaching efficiency and effectiveness program - Better Care, Better Value - which has a substantial quality work stream, launched at a workshop for senior managers and clinicians in March 2009.

Elements of this program which relate to specific quality initiatives include:

- Reducing length of stay
- Theatre utilisation
- Re-configuration of wards to follow patient pathways e.g. stroke care

You can read more details on page 27.

Commissioning for Quality and Innovation (CQUIN) objectives and achievements for 2009/10

During 2009/10 the Trust agreed several Commissioning for Quality and Innovation (CQUIN) schemes with NHS Bournemouth and Poole. These included:

- Increasing the number of referrals to local Smoking Cessation Services to reduce smoking prevalence.
- Promoting healthy eating by advising patients of levels of fat, sugar and salt in hospital food to enable healthy choices of food, auditing the completion of menu cards and carrying out food satisfaction surveys.
- Improving health outcomes for children and young people by implementing the Unicef Baby Friendly Programme which aims to increase the initiation rate for breast feeding. The Maternity Unit was successful in gaining accreditation at Level 2 of the Baby Friendly

Quality Report

programme during the year and is now working towards Level 3.

- Improving access to and the effectiveness of planned care - utilising Patient Related Outcome Measures (PROMs). The Trust participated in four PROMs audits with an excellent participation rate by patients. At the time of writing this report the first outcomes of the PROMs audits are awaited from the national coordinating centre.
- Improving the mental health of the local community with specific reference to the development of a dementia care pathway. This has recently been completed, led by one of the Trust's Medicine for the Elderly consultants and a Dementia Strategy Steering Group is overseeing its implementation.
- Improving patient experience especially in respect of being treated with dignity and respect. In particular the Trust has continued to work on eliminating mixed sex accommodation in line with Department of Health requirements. Of note the reconfiguration of some of our wards has enabled the provision of five completely single sex wards and further work will be ongoing to monitor this area and make other adaptations and provision as necessary.
- Improving end-of-life care in line with the National End-of-Life Care Strategy. This work is being led by our palliative care clinicians and a new steering group has been formed to oversee implementation of the strategy in the Trust.

Data quality and information Governance

All NHS Trusts are required to complete an annual information governance assessment, via the Information Governance Toolkit (IGT). The self assessment must be submitted to Connection for Health by the 31st March and the results are shared with the Care Quality Commission, Audit Commission, Monitor and the National Information Governance Board.

In 2008/09 the overall score for the Trust was 67% (amber) which has increased to 71% (green) in 2009/10. In addition, the Trust was able to demonstrate the required level 2 scores for the 25 core standards in the Information Governance Toolkit.

Examples of actions taken to improve arrangements for information governance in 09/10 have included:

- Introduction of mandatory training programme covering information governance for both clinical and non-clinical staff
- Improved publicity for patients on how the Trust handles confidential information
- Encrypted removable media including memory sticks and laptops and the establishment of encrypted e-mail system with third parties
- Adoption of the Dorset protocol on information sharing

Whilst improvements were made, the Trust recognises that actions are still required to further embed information governance policies and procedures

Quality Report

within the Trust. A key objective for 2011/12 will be in relation to Corporate Information Assurance. This will include reviewing procedures and policies for corporate information and implementation of standard corporate record filing and retrieval systems.

During 2009/10 the Trust submitted records to the Secondary User Service (SUS) and reviewed data quality to ensure that the published data included the patients valid NHS number. For admitted patient care and outpatient patient care the Trusts compliance score was 100%.

In addition to the use of NHS number, data quality requires that published data includes the patients GP registration code. For admitted patient care and outpatient care the Trust's compliance score was 100%.

The Trust was subject to a Payment by Results clinical coding audit by the Audit Commission in the year 09/10. The error rates reported in the latest published audit for that period for diagnosis and treatment coding was 24%. This was an increase from 08/09 (16%) but reflects changes in HRG coding. The Trust has set up an action group to improve diagnosis and treatment coding in 2010/11, particularly in relation to consultant allocation and transfers. An additional data quality post has been appointed for a 12 month period to provide education and training to clinical staff.

5.3 Patient Safety

5.3.1 Reporting and management of adverse events

The Trust promotes a culture of reporting and learning from potential and actual adverse events. Staff are encouraged to report near misses and patient safety incidents. All reports are formally investigated and action plans are developed to reduce the risk of recurrence. Lessons learnt are widely shared across the organisation and, where relevant, with the local health community.

While the numbers of reported incidents can be seen to have increased over the last few years this is viewed as a positive indicator demonstrating a culture where staff feel able to report incidents and have confidence that appropriate actions will be taken. As more no harm events are reported, the potential to reduce or prevent actual harm events from occurring increases. This is because they can lead to investigation and learning.

Number of reported patient safety incidents

The Trust routinely reports all patient safety incidents to the National Patient Safety Agency (NPSA) National Reporting and Learning Centre.

The Trust has a very positive reporting culture, as evidence by our staff survey results (see later) and all staff are encouraged to report and learn from actual and potential adverse events.

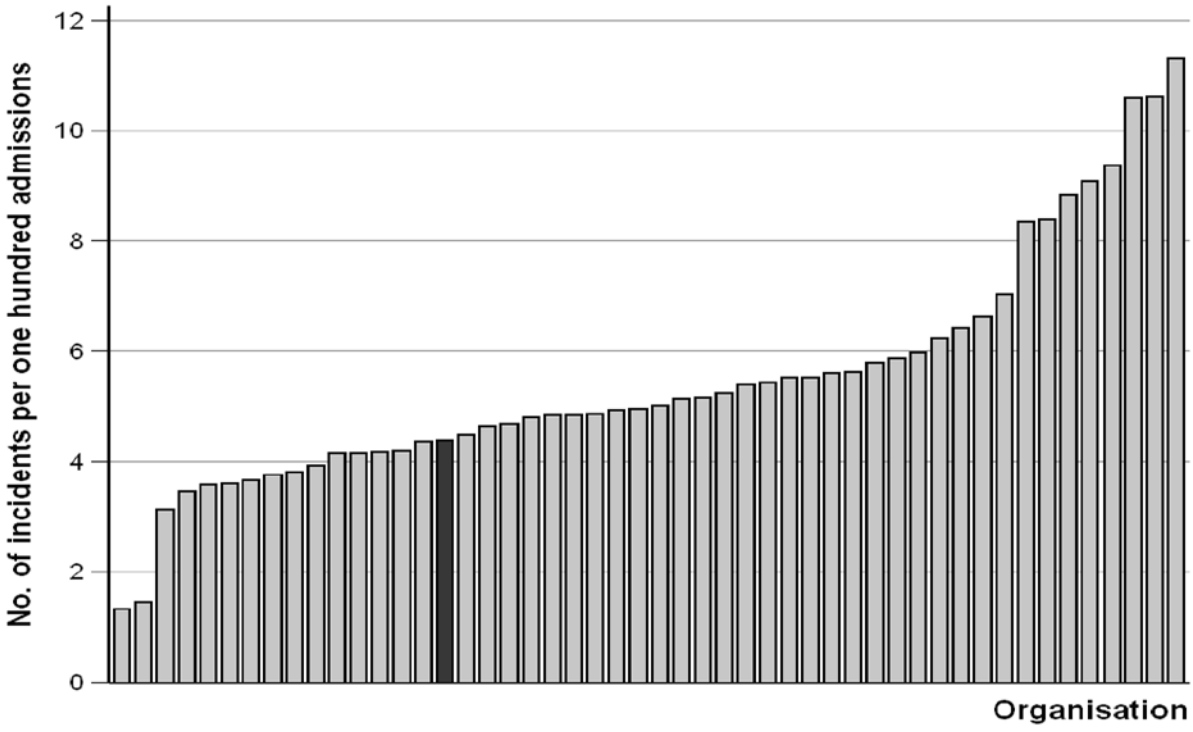
The Figure below shows the rates of NPSA reported patient safety incidents per 100 admissions in the Trust compared to similar Acute Trusts during

Quality Report

the period 1 April 2009 to 30 September 2009. The black bar represents the data from RBCH.

A direct comparison of the number of reports from various organisations can be misleading, as Trusts within the same group can vary considerably in activity levels and patient population.

Figure: Patient Safety Incidents reported to the NPSA National Reporting and Learning System April-Sep09.

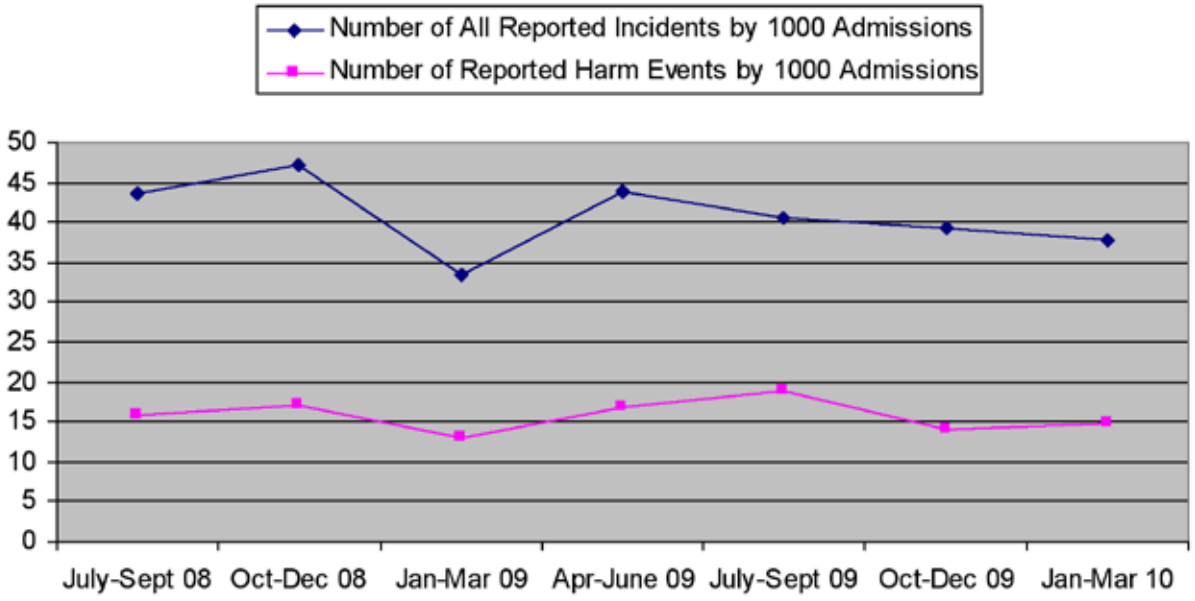


The NPSA suggest that Trusts with a high level of reporting have a strong reporting culture. A middle position in the chart demonstrates that the Trust has a solid reporting platform and a positive quality improvement program that ensures that any risks identified from adverse incidents are resolved quickly and reoccurrences prevented.

Quality Report

Patient Safety Incidents by Severity (Harm, No Harm)

Figure: Patient Safety Incidents reported by 1000 Admissions



Work was undertaken in 2009/10 to develop specific quality metrics using adverse incident reporting data e.g. concerning patient falls and medication incidents. This is particularly relevant to our patient group which contains a relatively high percentage of elderly patients, many of whom have a history of falling and / or are on complicated medication regimes.

Medication Incident Reporting

In relation to Medication Safety a new Medicines Governance Committee, chaired by the Medical Director, has been established to further enhance monitoring of the Trusts strategy to reduce medication errors, comply with national standards for medicines management and implement safe practice.

Patient Safety and Quality Improvement Initiatives to support medication safety and medication incident reduction during 2009/10 have included:

- Implementation of new anticoagulation guidelines and training programme for medical and nursing staff.
- Introduction of purple oral syringes and update of the Trust policy for the safe measurement and administration of liquid medicines. Posters have been displayed throughout clinical areas to highlight good practice and further audits are planned for 2010/11.
- New Medicines on Admission documentation has been introduced and now forms part of the admission process in the Clinical Decision Unit. A Medicines Reconciliation policy has been introduced and e-learning

Quality Report

tools placed on the hospital intranet for staff education and training. Pharmacists are now verifying a patients medical history within 24 hours for approximately 80% of patients. Further work to increase compliance is planned for 2010/11.

- A 50% reduction in insulin related incidents has been achieved through the implementation of a new diabetes chart to aid prescribing and provide clear guidance on correct dose scales.
- Venous Thromboembolism (VTE) prevention. A new VTE risk assessment tool and prescription chart was implemented from 1st March 2010. A Trust wide education programme to support roll out was also introduced.
- Refurbishment of the Pharmacy department started in January 2010 with the installation of an automated dispensing system later in the year.

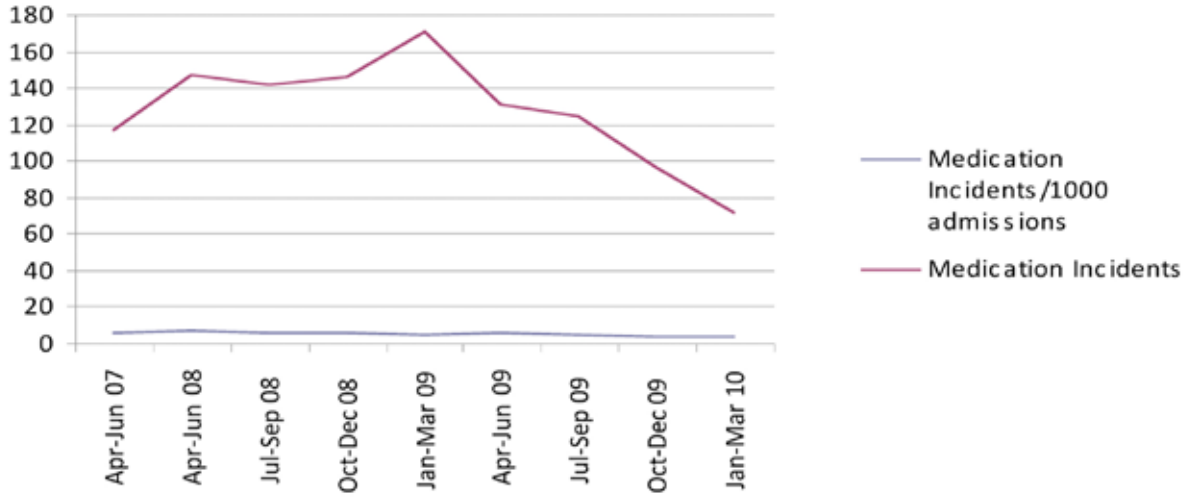
Patient falls reporting

Nationally patient accidents form the largest group of all patient safety incidents reported to the NPSA via the National Reporting and Learning System (NRLS). It is also recognised nationally that a higher incidence of falls occurs in the Elderly.

The NPSA category 'patient accidents' includes any slips, trips or falls by patients. These may be 'no harm' events e.g. a patient has fallen walking along a ward corridor but not sustained an injury, or they may be a 'harm event' when a similar incident has occurred and the patient sustained a bruise, cut or more serious injury.

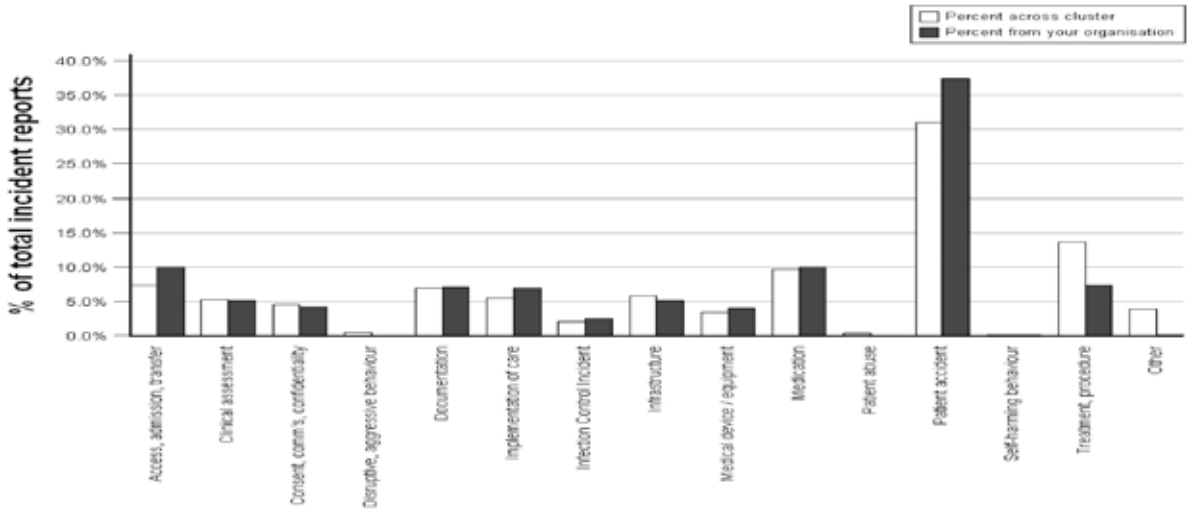
Figures from the NPSA NRLS for April-Sept 09 show the Trust reporting profile in relation to other Acute Trusts. The Trust is shown to report a slightly higher number of patient accidents than the average, however, this is reasonable given the Trusts elderly patient population. In addition, the Trust has robust data validation processes in place and avoids miscoding incidents as "other".

Medication Incidents reported 2007-2010

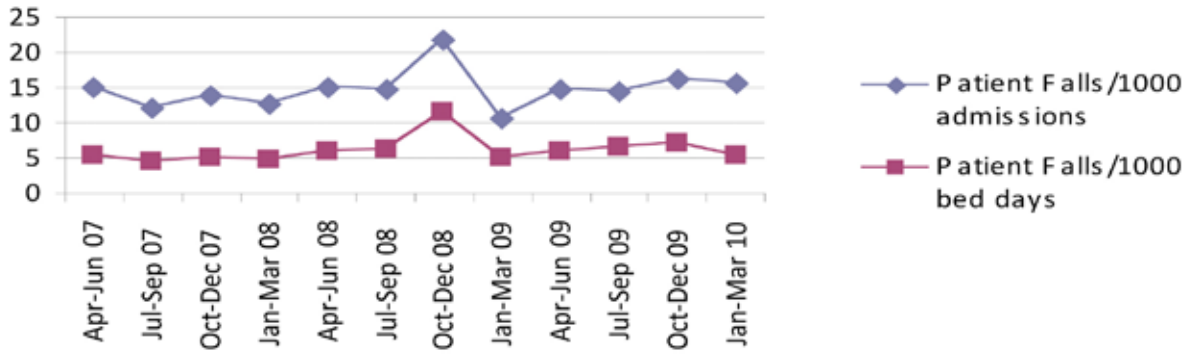


Quality Report

Figure: NPSA NRLS Patient Safety Incidents reported April - September 2009

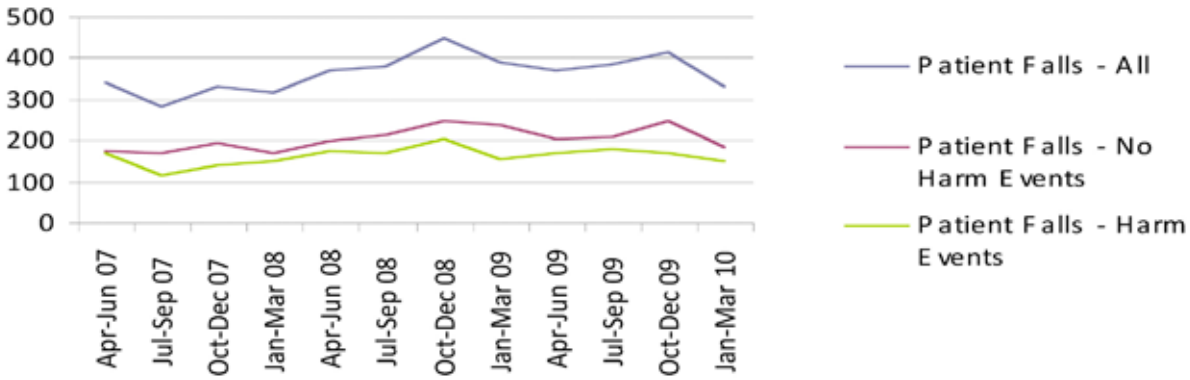


The Trust Falls Prevention Group has undertaken a number of initiatives in 2009/10 to aim to reduce the risk of patients falling whilst in hospital. Falls prevention forms part of mandatory training for all clinical staff and all falls are routinely reported and investigated.



The Trust has continued to invest in equipment and resources to support patient care and reduce the risk of falls. This has included a program to replace all hydraulic beds with new electronic profiling beds and high specification mattresses. Equipment to support safe moving and handling (hoists, specialist slings, and trolleys) have also been provided.

Quality Report



A comprehensive action plan for 2010/11 to look at further reducing the risk of patient falls includes:

- Implementation of the Home Fast Environmental Risk Assessment Tool in inpatient therapy services.
- Implement the Fragility Fracture Risk Assessment Tool for inpatient services on the "Medicine for the Elderly Wards"
- Audit the effectiveness of running a 12 week exercise program in comparison with the previous six week program for patients
- Pilot the use of a generic risk assessment proforma for falls and bone health on the "Medicine for the Elderly" wards at the Royal Bournemouth Hospital
- Undertake routine (at least quarterly) audit of compliance with documentation of osteoporosis risk assessment and appropriate referral of patients to falls clinic etc.
- Implement and audit the effectiveness of an escalation policy for management of patient who is a repeat faller in hospital.

The Trust will also participate in the Royal College of Physicians National Falls & Bone Health Audit in 2010/11.

5.3.2 Infection Prevention and Control

The Trust's Board is committed to infection prevention and control as a key priority at all levels of the organisation and takes a very active interest in the monitoring of infection control performance. The Director of Infection Prevention and Control briefs the Board on a regular basis.

As a result of this energy and enthusiasm there was effective control of C. difficile associated disease, MRSA bacteraemia, and an impressive reduction in all hospital-acquired bacteraemias.

The Trust faced continued scrutiny and accountability in relation to the prevention and control of infection this year and met the challenges well. The Trust has much of which to be proud in relation to its success while, at the same time, rejecting any sense of complacency.

Quality Report

Clean environment

The Patient Environment Action Team (PEAT) program was established to assess NHS hospitals in 2000, and has been managed by the National Patient Safety Agency since 2006. Under the program Acute Trusts are assessed annually and are rated in terms of the quality of the patient environment, including cleanliness. The following table shows the PEAT scores for this Trust for the past five years (including cleanliness and environment)

Year	Royal Bournemouth	Christchurch
2004	Good	Acceptable
2005	Good	Excellent
2006	Acceptable	Excellent
2007	Good	Good
2008	Good	Good
2009	Good	Good

In 2009 Privacy and Dignity assessment was added to the PEAT survey.

Cleanliness and hand hygiene

Compliance with hygiene standards is measured at ward level each month. Results are collated and fed back to directorates and wards. The data is also reported each month to the Trust Management Board. Poor compliance results in increased supervision by the Infection Control Team and increased frequency of audit.

At the start of the year the Trust Infection Control Team reviewed the audit process and raised concerns that the audit tool was open to a large degree of variation of interpretation by clinical staff. A revised audit tool was introduced in June 2009 in order to focus attention and audit on the most clinical relevant areas and to provide immediate feedback on performance over a four week rolling program. A program of peer review in addition to self assessment was also introduced.

The alteration in the audit methodology is felt to provide more relevant data of compliance, although the overall compliance figure appears worse in comparison with that resulting from the previous audit tool. However there has been steady improvement over the year which the Trust hopes to continue to sustain.

An overall figure for safe practice compliance is also reported and represents the proportion on areas where hand hygiene is reported to exceed the minimum 95%. Please see charts on page 64.

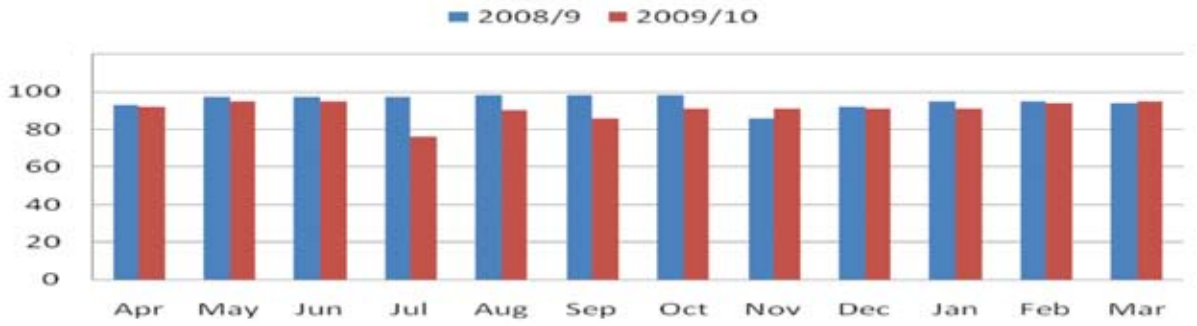
MRSA bacteraemia

We have been successful in reducing our rate of MRSA bacteraemia this year and reported only three cases in the year.

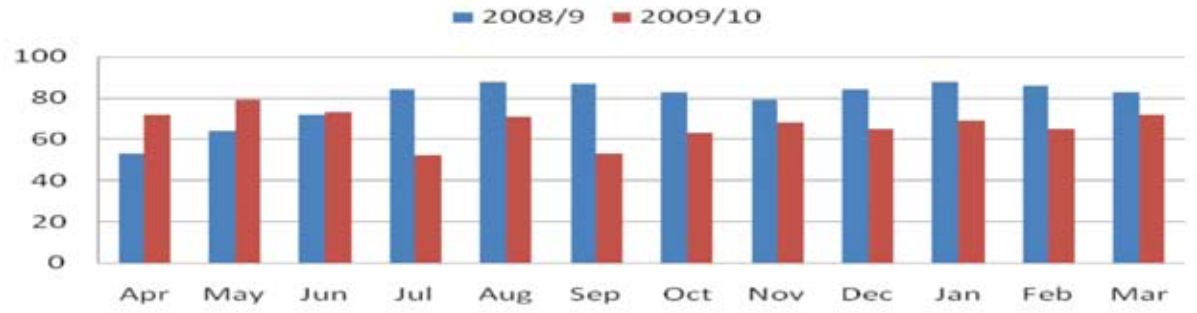
Clinical teams are required to complete a root cause analysis investigation on each hospital-acquired case to ensure adequate risk reduction action plans are put in place and key quality lessons learnt. These are accompanied by an action plan as appropriate and are followed up by the Infection Control Team and Clinical Directorate Leads.

Quality Report

Hand Hygiene Overall Compliance Scores



Hand Hygiene Safe Practice Compliance Scores



Clostridium difficile

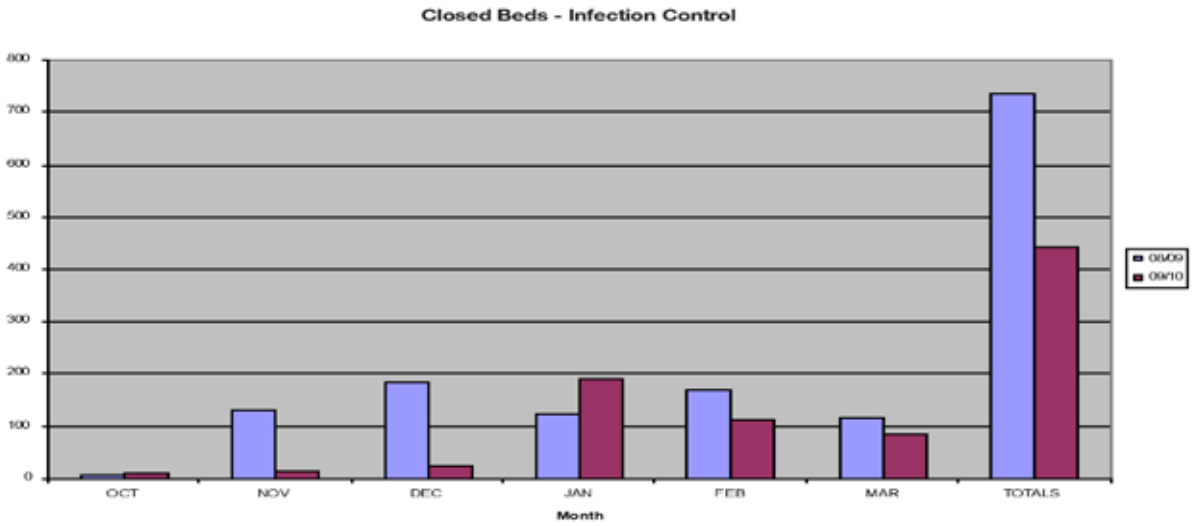
The Trust has had one of the lowest rates in the southwest for each of the past five years. All cases of C. difficile infection at the Trust are reported and investigated. The numbers of cases have been well within the contract target for the entire year. It is probable that good control of the infection is the result of firm adherence to the known preventative factors:

- Prompt isolation of possible cases with rapid laboratory diagnosis
- Rigorous adherence to a sound Antimicrobial prescribing policy
- Scrupulous attention to environmental hygiene
- Appropriate use of personal protective equipment
- Hand hygiene with soap and water rather than alcohol gel

In addition, all hospital cases are reviewed to monitor compliance with policy and to ensure there is appropriate and immediate referral to the gastro-enterology outreach team in severe cases. Reports are presented to the Infection Control Committee and Trust Board of Directors and action plans monitored.

Quality Report

The graphs below illustrate the significant decline of closed beds



Norovirus

In common with previous years the Trust has, like many other healthcare providers, experienced Norovirus outbreaks this year. However due to aggregate work and lessons learnt from previous experiences, the Trust was able to manage these incidents quickly and minimise the impact on the Trust, patients and the public. The number of beds closed for infection control reasons has substantially reduced when compared with last year.

The graph above illustrates the significant decline of closed beds.

Single rooms

The provision of adequate isolation facilities remains an important factor in the control of the spread of infection. Having started with a low base number by contemporary building standards, the Trust continues to try to maximise opportunities for providing additional single room accommodation whenever possible. This year we were able to create 6 additional side rooms - 3 in each of two Medicine for the Elderly wards.

5.4 Staff Safety - What our staff say about us

National Staff Survey 2009

Each year, random selections of staff are asked to take part in the annual staff survey which is carried out by the Care Quality Commission. This year was no different and 440 eligible responses were received, giving a response rate of 53% (the average for all acute trusts was 52%).

The Trust scored well in a number of areas and achieved top ranking results compared to other Acute Trusts (in brackets). These areas included:

- 8% of staff have the intention to leave Trust as soon as they can find another job (14%)
- 22% of staff suffering work-related stress in last 12 months (28%)
- 94% of staff believe Trust provides equal opportunities for career progression or promotion (90%)
- 98% of staff reporting errors, near misses or incidents witnessed in the last month (95%)

Quality Report

In comparison with 2008 staff survey results, there has been a significant improvement in the percentage of staff receiving equality and diversity training in the last 12 months (31% in 2008, compared to 55% in 2009).

However the Trust compared less favorably with other acute trusts in relation to the following areas:

- 14% of staff experiencing physical violence from patients/relatives in last 12 months (11%) 59% of staff appraised in last 12 months (70%)
- 50% of staff appraised with personal development plan in last 12 months (59%)
- 26% of staff having well structured appraisal in last 12 months (30%)

The following tables show the Trust's results from the National Staff Survey 2008 and 2009 in relation to the four NHS staff pledges.

Quality Report

Staff Pledge 1:

To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

	08 Results (against national average)	09 Results (against national average)
% feeling satisfied with the quality of work and patient care they are able to deliver	Best 20%	Above average
% agreeing that their role makes a difference to patients	Best 20%	Above average
% feeling valued by their work colleagues	Best 20%	Best 20%
% agreeing that they have an interesting job	Average	Above average
Quality of job design	Best 20%	Above average
Work pressure felt by staff	Best 20%	Best 20%
% working in a well structured team environment	Best 20%	Above average
Trust commitment to work-life balance	Best 20%	Above average
% working extra hours	Best 20%	Best 20%
% using flexible working options	Best 20%	Average

Quality Report

Staff Pledge 2:
To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.

	08 Results (against national average)	09 Results (against national average)
% feeling there are good opportunities to develop their potential at work	Best 20%	Best 20%
% receiving job-relevant training, learning or development in last 12 months	Best 20%	Best 20%
% appraised in the last 12 months	Below average	Below average
% having well structured appraisals in last 12 months	Above average	Below average
% appraised with personal development plans in last 12 months	Below average	Below average
Support from immediate managers	Best 20%	Above average

Quality Report

Staff Pledge 3:

To provide support and opportunities for staff to maintain their health, well being and safety.

Health and Safety	08 Results (against national average)	09 Results (against national average)
% receiving health and safety training in last 12 months	Above average	Above average
% suffering work-related injury in last 12 months	Best 20%	Above average
% suffering work-related stress in last 12 months	Best 20%	Best 20%
Availability of hand washing materials	Best 20%	Average

Errors and Incidents	08 Results (against national average)	09 Results (against national average)
% witnessing potentially harmful errors, near misses or incidents in last month	Best 20%	Above average
% reporting errors, near misses or incidents witnessed in the last month	Average	Best 20%
Fairness and effectiveness of procedures for reporting errors, near misses or incidents	Best 20%	Best 20%

Violence and Harassment	08 Results (against national average)	09 Results (against national average)
% experiencing physical violence from patients/relatives in last 12 months	Above average	Best 20%
% experiencing physical violence from staff in last 12 months	Average	Average
% experiencing harassment, bullying or abuse from staff in last 12 months	Best 20%	Average
Perceptions of effective action from employer towards violence and harassment	Best 20%	Best 20%

Quality Report

Staff Pledge 4:

To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

	08 Results (against national average)	09 Results (against national average)
% reporting good communication between senior management and staff	Best 20%	Above average
% agreeing that they understand their role and where it fits in	Above average	Average
% able to contribute towards improvements at work	Best 20%	Average
Staff job satisfaction	Best 20%	Best 20%
Staff intention to leave jobs	Best 20%	Best 20%
% that would recommend the trust as a place to work or receive treatment	N/A	Best 20%
% staff motivation at work	N/A	Above average
% having equality and diversity training in last 12 months	Above average	Best 20%
% believing the Trust provides equal opportunities for career progression or promotion	Best 20%	Best 20%

A corporate action plan is being developed to address areas requiring improvement. This will be monitored by the Human Resources Department and Executive team.

Quality Report

5.5 Ensuring clinical effectiveness and quality of care

Reducing hospital mortality

In October 2009, Dr Foster released its Good Hospital Guide and, as part of this, data on Mortality rates.

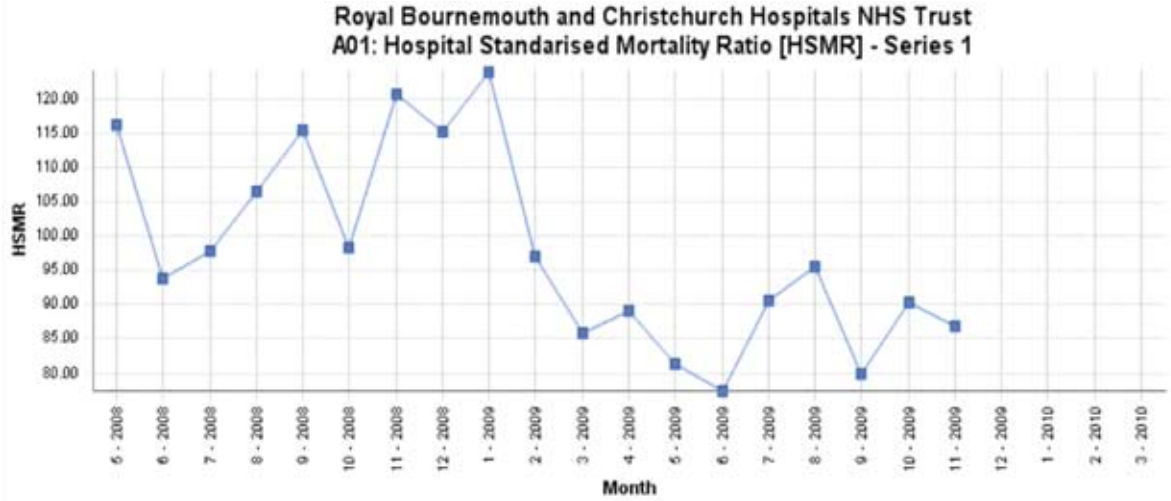
The Dr Foster report used historical data from April 2008 to March 2009. The 2009/10 monthly figures demonstrate a sustained improvement. Since April 2009 the Trust has shown to be consistently below 100 (national average). This demonstrates better, and safer, care than expected.

Dr Foster raised a concern that mortality related to low risk procedures carried out by the Trust were above the national average. As a result we investigated these ratings. We wanted to ensure that there was no underlying clinical issue relating to excess mortality. The medical records of all the patients which Dr Foster had raised concerns about in relation to mortality rates for low risk procedures were reviewed and confirmed that the it was a coding issue and that clinical practice was appropriate. There was no evidence of patients having greater risk of dying from low risk procedures.

The Trust acknowledges that there is clearly no room for complacency. All Trusts are making efforts to improve their mortality rates and we wish to ensure that we remain one of the best performing Trusts in this respect.

From November 2009 the Trust set up a mortality group, under the leadership of the Medical Director, where Dr Foster and Care Quality Commission information is reviewed on a monthly basis. If there are any issues or concerns in the data against the national average then this is referred to the Clinical Governance and Risk Committee and raised with the clinical specialities concerned. The mortality group reports to the Healthcare Assurance Committee which oversees all risk management issues for the Trust and via this to the Board of Directors.

Figure: Hospital Standardised Mortality Rate 2009/10



Quality Report

Participation in National Clinical Audits

The Trust participated in all relevant National clinical audits in 2009/10. These included participation in the following new National audits:

National Audit of Continence Care

This audit required a structured clinical review of:

- 25 cases of urinary incontinence in patients over 65
- 25 cases of urinary incontinence in patients under 65
- 15 cases of faecal incontinence in patients over 65
- 15 cases of faecal incontinence in patients under 65

The Trust submitted all data required. The results of the National audit will be published in 2010/11.

National Diabetes Audit

The audit required a structured clinical review of selected cases. Information was submitted in September 2009 and results have been received. The lead clinicians are currently reviewing the results and revalidating the clinical information submitted for a small number of patients included in the audit. An internal follow up audit looking at patients who were given IV insulin, had hypoglycaemia and were admitted with falls is currently in process. An action plan will be established following completion of this work.

British Thoracic Society Chest Drain National Audit

The Trust submitted data on all chest drains inserted within a specified time period to a national database. National guidance on further involvement is anticipated in 2010/11.

The Trust has also registered to participate in the National Audit of Falls and Bone Health, National Sentinel Stoke Audit, National Dementia Audit and National IBD Audit. Organisational and Clinical data collection will be undertaken during 2010/11.

Meeting local Clinical Audit Standards

The Trust registered 138 new clinical audits during the year across a wide range of clinical specialties. A further 52 patient surveys were registered.

All clinical audits and surveys are approved and monitored via the Clinical Audit Department and regular reports on progress are reported to the Trust Clinical Governance & Risk Management Committee.

Ensuring NICE Guideline compliance

A new system for assessing compliance with NICE Guidance was introduced in the Trust in October 2009 following a reconfiguration of governance arrangements. Guidance published is discussed each month at the Clinical Governance & Risk Committee. The Committee decides whether the guidance is applicable to the Trust. A lead clinician is nominated to produce an action plan to achieve compliance for all applicable guidance. Action plans are then monitored by the Committee and the issue placed on the Trust risk register until full compliance is achieved.

Since October 2009 the Trust has received 34 pieces of published

Quality Report

guidance. Of these 16 were deemed not applicable to the Trust. Of those applicable, the Trust was fully compliant with five and partially compliant with a further four (for which action plans are in place). An additional nine pieces of guidance are still under review.

Ensuring compliance with MHRA safety alerts

A total of 91 Medicines & Healthcare Regulatory Authority (MHRA) Medical Device Alerts were received in the year. Of these 57 applied to medical devices used within the Trust. The Trust ensured compliance with all relevant alerts.

Participation and implementation of National Confidential Enquiry (NCEPOD) reports

The Trust participated in a number of national confidential enquiries in 2009/10.

- Deaths in acute hospitals - 41 out of 49 questionnaires were completed and returned to NCEPOD. The Trust Clinical Governance & Risk Committee is currently reviewing the report to produce an action plan.
- Acute Kidney Injury - five out of five required clinical questionnaires returned (100%). The NCEPOD report has been received and an action plan to implement the report recommendations in place.
- Parenteral Nutrition - eight out of 13 questionnaires were completed and returned to NCEPOD. The results of the national study are due to be published by NCEPOD in 2010/11.
- Elective and Emergency Surgery in the Elderly - six out of nine surgeons questionnaires were completed and returned to NCEPOD. Five out of seven anesthetist questionnaires were completed and returned. The results of the national study are due to be published by NCEPOD in 2010/11.
- Cosmetic Surgery - The Trust did not participate in this study as it was not applicable.
- Surgery in Children - The Trust submitted the NCEPOD organisational questionnaire and notified NCEPOD that there had been no deaths in children under 17 undergoing surgery in study period. Clinical data collection not therefore required. The results of the national study are due to be published by NCEPOD in 2010/11.
- Perioperative Study - 124 forms were completed during data collection week 1-7th March 2010. The study will continue during 2010/11.

In order to enhance and improve coordination and participating in NCEPOD studies in 2010/11 the Trust has identified a consultant lead for NCEPOD activity. The lead clinician will be responsible for ensuring that the Trust submits all clinical information required and ensuring all studies are implemented in a timely manner.

All NCEPOD reports will continue to be presented to the Clinical Governance & Risk Committee who will monitor compliance and completion of any identified action plans.

In addition to participation in new reviews, the Trust also recieved, and acted upon, a number of National Confidential Enquiry and National Audit reports from studies undertaken in 2008/09 and in 2009/10.

Quality Report

- National Comparative Audit of the Use of Fresh Frozen Plasma (FFP). The study highlighted a number of recommendations and actions for the Trust including required improvements to documentation of patients receiving FFP. The Trust Blood Transfusion Committee is monitoring implementation.
- Acute Kidney Injury. The Clinical Governance & Risk Committee has established a sub-group to produce an action plan to ensure compliance with the report recommendations.
- Deaths in Acute Hospitals. The Clinical Governance & Risk Committee has established a sub-group to produce an action plan to ensure compliance with the report recommendations.
- Inflammatory Bowel Disease Audit 2008. The Gastroenterology Department has identified a number of actions to improve documentation and to expand patient involvement. The National Audit will be repeated in 2010/11.
- National Care of the Dying Audit. Improved training in the use of the Liverpool Care Pathway (LCP) has been implemented following publication and review of the report.
- NCEPOD Review of the care of Patients who died within 30 days of receiving systematic anti-cancer therapy.
- National Audit of the Organisation of Services for Falls and Bone Health in Older People (2008). The Trust achieved a high level of compliance against this audit. However, the Trust Falls Group has identified a number of actions required in order to continue to improve services for older people (see page 60).

Research governance

The Trust has been fully compliant with the Research Governance Framework for some years.

In 2009/10 we made some changes to the governance infrastructure to adapt to the new research support system implemented by the UKCLRN. These are summarised below:

1. Research Governance in Dorset has been consolidated by the formation of the Dorset Research Consortium. This allows for pooling of research governance expertise across the county such that we have access to contract law experts and monitoring and audit experts within our organisation.
2. The Western Comprehensive Local Research Network (WCLRN) has now become fully functional and this Trust is a lead organisation in its operations.

Current NHS research strategy requires Trusts to facilitate recruitment to NIHR portfolio studies. To this end we have encouraged local specialist groups and provided specialist facilitation to researchers looking to take part in studies. Our study adoption and recruitment figures place us third in the WCLRN league table. This is despite our Research Management and Governance budget being nearly bottom of the table. This outstanding efficiency is due mainly to our continued policy of ring-fencing

Quality Report

research accounts such that our project costing, contract negotiations and signing off are dealt with by research governance specialists.

Projects approved for 2009/10

In 2009/10 the Trust participated in 166 clinical research studies.

32 new studies were initiated and 893 new patients were recruited.

This data refers to patient intervention studies and our scientific haematology program looking at the genetics of leukaemia. There are a number of studies using laboratory based methodologies which do not recruit patients. We also approve a number of research questionnaires and service development projects which although not strictly research, are required to seek an ethical opinion. We have not included these data.

5.6 Patient Experience

What our patients say about us.

The main systems in place to measure patient satisfaction are:

- National mandatory patient surveys carried out on behalf of the Trust by the Picker Institute covering admitted care and in some years outpatients, maternity and the emergency department.
- Patient Survey cards
- Bespoke patient surveys
- Patient Reported Outcome Measures (PROMS) collected locally but reported nationally covering four national areas: hip and knee replacement, varicose veins and hernias.

National patient survey results

All Acute Trusts are required to participate in a national patient survey each year and this is coordinated by the Care Quality Commission. In 2009/10 the national inpatient survey covered eligible inpatients who were admitted to the Trust during June 2009.

Survey results were published by the Care Quality Commission in May 2010. A total of 850 patients were sent a questionnaire. 478 patients returned the survey giving a response rate of 58%. This was slightly lower than 2008 but still favorably higher than the national average response rate of 52%.

A total of 79 questions were used in the 2009 survey. In comparison to 2008, the Trust scored:

- Significantly better on 0 questions
- Significantly worse on 4 questions
- Showed no difference on 75 questions.

For full results of the survey please visit www.cqc.org.uk.

The Trust is currently in the process of developing an action plan following publication of the survey results. The action plan will be produced following full discussion and consultation with key stakeholders.

Quality Report

Trust patient survey card Results

In addition to responding to national patient surveys, the Trust has an internal patient survey card which is available for all inpatients and outpatients to complete. In 2008/09 3,784 survey cards were completed. In 2009/10 this figures was slightly lower at 2922.

The results are slightly down from the previous year but still demonstrate a high level of patient satisfaction with over 90% of respondents saying that they would recommend the hospital to a friend or relative.

Whilst we will continue with this general survey in 2010/11 we will also aim to undertake more focused "real time monitoring" in specific clinical areas. This will enable greater ownership of the survey results and local responsibility to act and respond to issues raised quickly. The revised strategy will include greater involvement of governors and volunteers and enable patients to have a stronger voice.

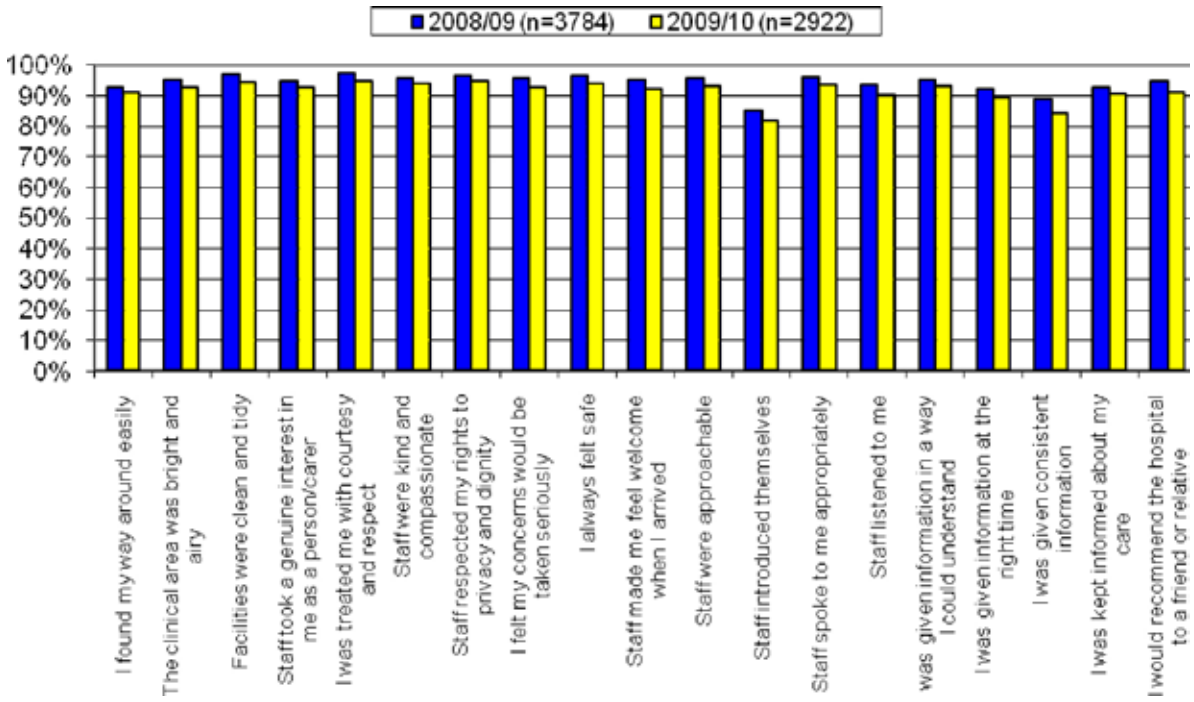
The surveys will focus on five specific questions taken from the National survey and forming national CQUIN requirements. Continued use will enable us to assess changes in the future and driving year on year improvement.

Patient Reported Outcome Measures (PROMS)

The Trust participates in all four National PROMS surveys. Clinical data from national PROMS has yet to be issued.

Groin Hernia Surgery - 361 patients were seen during April 09-March 2010 and 93% consented to participate in PROMS. This compared very well against the national response rate target of 65%.

RBCH Patient Survey Results



Quality Report

Varicose Vein Survey - 269 patients were seen during April 09-March 2010 and 83% consented to participate.

Hip Surgery - This National PROM was launched in October 2009. 607 patients were seen between October 2009 - March 2010, 76% consented to participate.

Knee Survey - This National PROM was launched in October 2009. 525 patients were seen between October 2009 - March 2010, 76% consented to participate.

5.7 Managing complaints

The Trust recognises the importance of responding to formal complaints in a positive and timely manner and ensuring that sufficient resource is given to provide a full and proper review of the issues raised. The Trust has recently strengthened its complaints management function and policies in 2009/10 and now has a dedicated Complaints and Litigation Manager.

Complaint handling

Every complainant is sent a letter (by post or email) on receipt of their complaint, explaining the proposals for investigation, inviting them to contact the complaints manager to discuss this if this has not already happened. Complainants are also advised about clinical confidentiality and the support available to them from the Independent Complaints Advocacy Service (ICAS).

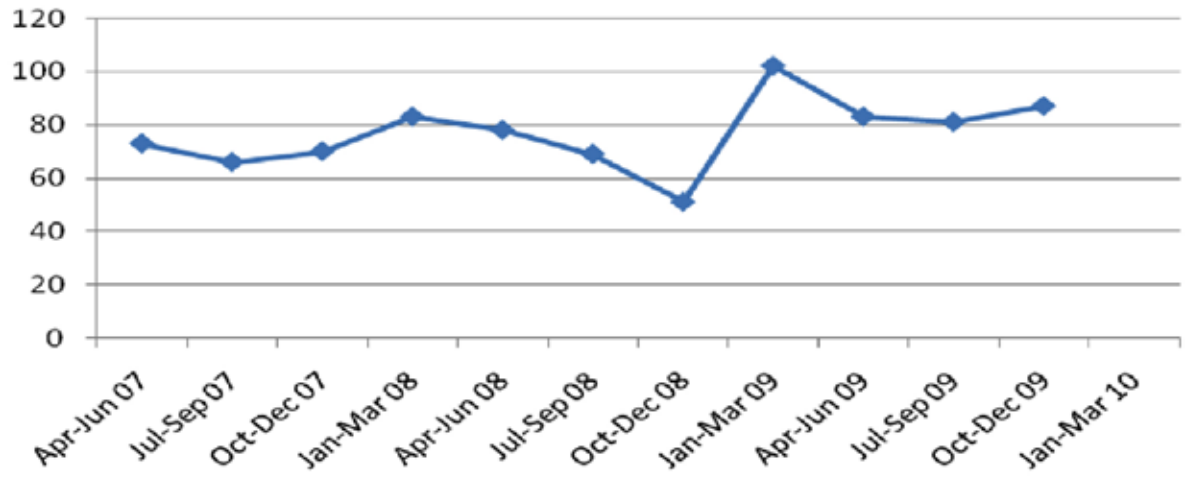
Each complaint is investigated by the Directorates concerned and, where appropriate, the advice of a clinician from another area is obtained. This evidence forms the basis for a response to the complainant from the Chief Executive.

Number of complaints in 2009/10

There were 375 formal complaints from patients or their representatives during the year. This represents an increase of 25% (75 complaints) from last year.

These figures should be seen in context of the overall number of patient encounters, which are over 500,000 a year, when covering admissions, outpatients and diagnostic visits.

Formal Complaints



Quality Report

The increase in the number of complaints is considered to result from a variety of factors. From April 2009, it has been easier to raise a formal complaint through contact details on the Trust's website. The PALS office also relocated to the main entrance of the Royal Bournemouth Hospital in early 2009. People contacting them may now choose to route their concerns through the complaints procedure.

The complaints regulations also require all verbal complaints which are not responded to within 24 hours to be recorded as a complaint and therefore some of the less complex concerns, for example about appointment times, have to be recorded as complaint.

An acknowledgement and explanation of the procedure to be followed was issued within three working days for 91.5% of complaints.

47% of complaints (176 completed investigations) were upheld or partially upheld, with the necessary changes explained and appropriate apologies offered in the letter of response from the Chief Executive.

Subjects of complaints

Themes within these broad categories included:

- Breach of the 18 week waiting time standard.
- Waiting time to be seen by a doctor in the Emergency Department.
- Discharge arrangements, including communication with relatives and carers.

The main categories of complaint were as follows:

Subject	Number	Percentage
Administrative systems	37	9.9
Attitude of staff	41	11
Bed management	2	0.5
Clinical treatment	186	49.6
Communication/information	56	15
Discharge arrangements	29	8
Environment	4	1
Equipment/facilities	3	0.8
Health and safety	8	2
Privacy and dignity	3	0.8
Availability of staff	2	0.5
Theatre management	1	0.2
Transport	1	0.2
Violent/Aggressive behavior	2	0.5

Quality Report

- Information about appointments, including appointment letters and changes to appointments.
- Accuracy and timeliness of clinical diagnosis
- Access to assisted conception services

25 complaint resolution meetings were held with complainants and key staff to assist with resolving complaints.

Changes resulting from complaints

One of the main purposes in investigating complaints is to identify opportunities for learning and change in practice to improve services for patients. Examples of changes brought about through complaints were:

- Review of post operative catheter care procedures.
- Discussion with ward staff in relation to breaking of bad news.
- Diversity training provided to staff and included on induction and mandatory training programmes.
- Change to individual practice threshold for x-ray.
- Discussion with reception staff about managing difficult situations, training provided.
- Review of arrangements for recording appointment cancellations.
- Improved information for relatives about isolation precautions when visiting.
- Improved communication with relatives regarding patients' discharge arrangements.
- Review of policy for checking pre-procedure medications. New patient pathway booklet, including detailed checklist, implemented.
- Staggered orthopaedic surgery admission times to avoid long waits
- Clinical details related to complaints incorporated into medical teaching sessions.

Referrals to the health service ombudsman

Complainants who remain dissatisfied with the response to their complaint at local resolution level were able to request an independent review to be undertaken by the Health Service Ombudsman.

After receiving a response from the Trust, nine people chose to refer their concerns to the Parliamentary and Health Service Ombudsman during 2009/10. Of these, the Ombudsman declined to investigate six and referred one back for further local resolution, which has been completed. A decision on two complaints is awaited from the Ombudsman.

5.8 Single sex accommodation

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust is committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

We are proud to confirm that RBCH has invested in this area substantially over the last two years and mixed sex accommodation has now been virtually eliminated in our hospitals. Patients who are admitted to either of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with

Quality Report

members of the opposite sex will only happen by exception based on clinical need (for example where patients need specialist equipment such as in emergency areas, intensive care and high dependency areas and recovery areas). Nevertheless in these areas patients' rights to privacy and dignity will be fully respected in care delivery.

Our Estates Strategy provides for on-going attention to developing further single sex facilities and our operations policies will also aim to achieve this in any further re-configurations of services. Any new build and refurbished clinical areas will have due consideration to the provision of single sex facilities built into the plans.

We will continue to obtain patient feedback via patient surveys and real-time patient feedback using hand held computer devices. The latter allows us to obtain immediate feedback from patients during their stay with us. The results of these surveys will be regularly reported to the Board of Directors.

Because of the investments we have made in our facilities and the training given to staff, we will expect to see an improvement in the scores attributed to this issue in the annual national patient surveys. Senior nursing staff will also perform spot checks and audits relating to privacy and dignity on an on-going basis.

Patient Information

The Trust has standard procedures in place to ensure the quality and design of patient information leaflets. The Trust has a multi-disciplinary Patient Information Group that meets monthly to review new and revised leaflets. The group includes patient and voluntary services representatives.

In 2008/9 285 new leaflets were approved by the Patient Information Group. In 2009/10 the volume of activity increase and 324 leaflets were approved.

5.9 Priorities for quality improvement 2010/11

The Trust has identified its main clinical quality priorities for the three years, key actions required to deliver these, the risk of delivery and how the Board will measure progress for each and gain appropriate assurance in a reliable and consistent manner. The following key clinical quality objectives reflect not only the Trust's own strategic focus and goals but also those of its commissioners, patients and service users:

- Patient Surveys - Implementation of Real-time feedback project.
- Patient Safety - Continued participation in the South West Strategic Health Authority Patient Safety & Quality Improvement Programme.
- Risk assessment for VTE.
- Medicines management - Compliance with National Patient Safety Agency Alerts.
- Hospital Mortality audit / reporting.
- Infection Control.
- Nutrition.
- Learning from the Francis Report on Mid-Staffordshire NHS Foundation Trust.
- Tissue viability - Pressure sore prevention.

Quality Report

Clinical quality priorities	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11, 2011/12, 2012/13
Patient Surveys	Implementation of programme of real time monitoring and targeted patient surveys in relation to high priority issues and areas.	Care Quality Commission Inpatient survey 2009. Internal patient survey card results - 2922 patients participated in 09/10. 90% of respondents said they would recommend the hospital to a friend or relative.	Quality reporting of real time patient monitoring to the Trust Marketing Committee and Board of Directors. Patient surveys included in annual quality objectives and contract quality indicators. Putting Patients First programme.
Patient Safety - Involvement in the South West Strategic Health Authority Patient Safety & Quality Improvement Programme	Continued participation in the workstreams for the life of the NHS SW programme.	The Trust joined this new programme at its conception in Oct 2009. The programme has a three year plan to reduce mortality rates and adverse incident rates across the whole South West SHA. The Trust is now monitoring and reporting on over 50% of the new quality indicators. This is in line with the SW SHA programme timetable and in line with other participating Trusts. Winner of CHKS Patient Safety Award 2010.	Quarterly reporting to the Trust Clinical Governance Committee, Healthcare Assurance Committee and Board of Directors. Reporting of indicators to NHS SW Patient Safety Project.
VTE Risk Assessment	Implementation of VTE risk assessment and VTE prophylaxis policy and procedures. Implementation of IT solution to ensure routine data capture of completion to ensure verification of compliance with Department of Health and CQUIN targets. Clarification from Department of Health still required in relation to whether the target includes all day case patients.	New VTE risk assessment tool designed in compliance with Department of Health guidelines. Education and training programme developed to support implementation. I.T. solution procured.	Quarterly report to Board of Directors on compliance. Reports to commissioners re national CQUIN compliance.

Quality Report

Clinical quality priorities	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11, 2011/12, 2012/13
Medicines Management - Compliance with National Patient Safety Agency Alerts	Further work to ensure compliance with all relevant NPSA Alerts relating to medicines management. On going work to ensure reduction in medication errors and risks.	Established a new Medication Governance Committee to oversee the Trusts medicines management strategy. Implementation of several new policies and procedures relating to medicines management e.g. medicines reconciliation, insulin management, anticoagulation and controlled drugs. Successful investment in specific training to reduce errors e.g. insulin prescribing and administration.	Quarterly report to Healthcare Assurance Committee by medication Governance Committee. Quarterly reporting on NPSA Alert compliance, medication incident rtes and medication risk issues to Clinical Governance & Risk Committee, Healthcare Assurance Committee and Board of Directors.
Reducing Hospital Mortality Rates	Further work to review the quality and accuracy of death certification and clinical coding. Review of mortality rates monthly via Mortality review group.	Established a new Mortality Steering Group chaired by the Medical Director. Review of clinical coding, with specific reference to high mortality in low mortality risk groups. Implementation of training programme for Doctors to ensure accurate recording of death certification. Achievement of HSMR below 100 for April 09-March 2010.	Quarterly reporting to Healthcare Assurance Committee and Board of Directors.
Maintaining high standards of Infection Control	Ongoing implementation to maintain current high standards of infection control.	Targets for MRSA and c.difficile achieved. Only four cases of MRSA reported in year. Improvements in the management of Norovirus and reduction in bed days lost.	Monthly reporting to Board of Directors. Bi-monthly reporting to Infection Control Committee. Monthly reporting to commissioners.
Ensuring patients receive good nutritional care	Continued implementation of catering surveys and use of malnutrition screening tool (MUST). Complete implementation of Protected Mealtimes initiative. Appointment of nutrition nurse specialist for education and audit.	PEAT score for food improved. Patient satisfaction survey re catering. Successful partial implementation of protected mealtimes initiative and implementation of the Productive Ward Nutrition module.	Annual PEAT scores. Catering surveys. Audits of screening tool. Report to Board of Directors quarterly.

Quality Report

Clinical quality priorities	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11, 2011/12, 2012/13
Ensuring learning from the Francis Report on Mid Staffordshire NHS Foundation Trust	Implementation of a Trust wide action plan to ensure compliance with report recommendations, and local departmental action plans where relevant. Monitoring by Healthcare Assurance Committee.	Report discussed in full by Board of Directors.	Quarterly report to Board of Directors on compliance with action plan targets and objectives. Monitored by Healthcare Assurance Committee.
Ensuring high standards for pressure ulcer prevention and management	Implementation of routine monitoring of hospital acquired pressure ulcers. Implementation routine monitoring and audit of compliance with Trust policy for the prevention and management of hospital acquired pressure ulcers. Provision of pressure ulcer management as a core component of clinical mandatory training.	design and testing of routine audit tool	Quarterly report to Clinical Governance & Risk Committee

5.10 Consultation Process

The Quality Account has been produced following consultation with the following external groups:

Local Involvement Network (LINks)

LINks Comment for Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust

Quality Account 2010

Bournemouth LINk welcomes this opportunity to comment on their work with Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust over the last year.

Infection Control

Bournemouth, Poole & Dorset LINks worked with NHS Bournemouth & Poole and the Infection Control Matrons from Bournemouth & Poole Hospitals in 2009 to improve public information about infection control.

For more information about this project, go to the LINks Winter 2009 Newsletter: http://www.madesachange.org.uk/cms/site/docs/B,P%20&20D%20Newsletter%20Issue%209%20Dec%2009%20Winter.pdf

Promotion

Bournemouth LINk has posters and information leaflets around the Hospital.

The LINk has also held promotional stands in the Hospital.

Joint Working

The LINk has regular contact with the Patient Advice & Liaison Services (PALS) and is looking forward to working more closely with the Hospital over the coming year.

Quality Report

Dorset Health Scrutiny Committee

Response received:

"At its meeting yesterday (20 May) the Dorset Health Scrutiny Committee resolved that it would not be commenting on the Quality Accounts submitted by Trusts this year.

The Committee has decided that over the coming year individual members who act in a liaison capacity with individual Trusts will endeavour to strengthen this role and develop their engagement so that next year the Committee is better placed to comment. It is envisaged that we will set up a task and finish group to look at the accounts next year so that we can start the process earlier and not be tied into the Committee timetable which may make the process easier and less pressured for everyone.

May I take this opportunity to thank you for submitting your Quality Accounts as requested.

If you would like to discuss any aspect of this with me please do not hesitate to contact me.

Kind regards

Health Partnerships Officer
Adult and Community Services
Directorate Dorset County Council."

Bournemouth Health Overview and Scrutiny Panel -

No comments received:

Poole Health and Social Care Overview and Scrutiny Committee

No comments received:

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 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:

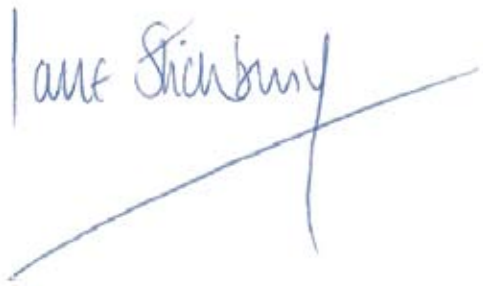
- the quality report presents a balanced picture of the Foundation Trust's. performance over the period covered.
- the performance information reported in the Quality Report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance 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

Quality Report

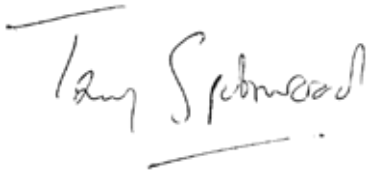
Monitor's annual reporting guidance (which incorporates the Quality Account regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/nnualreportingmanual)).

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



Jane Stichbury
Chair
Date: 4th June, 2010



Tony Spotswood
Chief Executive
Date: 4th June, 2010