Putting patients first

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Quality Report
2010/11

Quality Report 2010/11

1. Statement by the Chief Executive

This is the third Quality Report 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 with a strong emphasis on improving the quality and accessibility of the services we provide and maintaining our commitment to our "Putting Patients First" initiative.

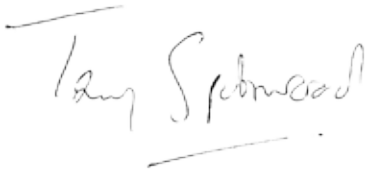
In this report we have outlined some of the quality activities which have taken place in the Trust over 2010/11. There are particular success stories to tell in respect of some improvements in patient and staff safety and quality improvement. We have also continued to perform exceptionally well in respect 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.

Our quality programme has also been enhanced by wide ranging patient safety initiatives which covers a large range of specialties and topics. We continue to participate in the NHS South West Patient Safety & Quality Improvement Programme 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 2011/12 and within these, patient safety and continuing to improve the patient experience will feature prominently. We welcome the opportunity to work with patients, carers, Foundation Trust members and the public on a number of patient experiences and equality and diversity projects this year.

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".

To the best of my knowledge the information contained within this report is accurate.



Tony Spotswood
Chief Executive

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2. Priorities for Improvement and Statements of Assurance on the Quality of Services Provided

2010/11 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 2010/11. 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.
- To strive towards excellence in the services and care we provide.
- To work collaboratively with partner organisations to improve the health of local people.

Progress against Quality Improvement Plans for 2010/11

During 2009/10 the Trust made considerable progress with the development of a number of quality initiatives. These plans were identified in the Trust's Quality Report for 2009/10 and carried forward into 2010/11 as part of an overall quality improvement programme which had the full commitment of the Board.

Progress made against the quality objectives set for 2010/11 are set out below:

Performance against national priorities 2009/10

	Action Plan for 2010/11 as set out in 09/10 Quality Report	Progress against objective in 10/11
Patient Experience	Implement programme of real time monitoring focusing on the 5 priority questions from the National Survey methodology and internal Trust consultation exercise.	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. Internal patient survey card results - patients participated in 10/11. 62% of respondents saying that they rated the hospital as "excellent" (graded 10/10).
Patient Safety	Continue to participate in South West SHA Patient Safety Programme and present monthly data to Board of Directors. Programme aims are to reduce hospital mortality by 15% by 2015 and adverse events by 30% by 2015.	Participation ongoing. Use of Global Trigger Tool to identify actual and potential adverse events undertaken monthly and learning points reported to the Clinical Governance & Risk Committee.
	To formalise walkabouts to include NPSA methodology and ensure structured discussion and action for patient safety.	Executive team walkabouts include patient safety although not formally recorded. Executive Team walkabouts at night initiated in year.
	Further revision to Modified Early Warning System (MEWs) policy and procedures to ensure effective and timely response to trigger events.	MEWS policy updated, routine audit and reporting in place.

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	Ongoing reporting and investigation of adverse events. Implementation of the updated Never Events framework	Ongoing
	Ensuring learning from the Francis Report on Mid-Staffordshire NHS Foundation Trust.	Report on progress to Board of Directors in July 2010. Action plan was expanded to include the recommendations of the Airedale Report. All ward staffing templates reviewed in February 2010. Patient dependency audit undertaken in October 2010. Board walkabouts undertaken to several clinical areas including at night.
	Ensuring high standards for pressure ulcer prevention and management	Pressure ulcer prevention included within mandatory training programme. Audit tool implemented. Links with Adult Safeguarding Team established.
	Medicines Management - compliance with National Patient Safety Agency alerts.	Work of Medication Governance Committee continues. Robust action plans in place for NPSA alert compliance.
	Reducing hospital mortality rates.	Mortality Group well established and meets monthly. Improvements to coding made. Regular case reviews undertaken.
	Sustain achievement in reduction of Hospital Acquired Infections	Sustained
Clinical Effectiveness	Review clinical data following publication by Patient Reported Outcome Measures (PROMS) team.	No clinical data available from National PROMS Team at this stage.
	Implementation of Venous Thromboembolism (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	VTE risk assessment tool designed, implemented and monitored in compliance with Department of Health guidelines. Education and training provided to support implementation. IT solution designed to enable routine data capture of compliance. June 2010 - March 2011 results presented monthly to Trust Board of Directors. Compliance for March 2011 was 94.87%
	Improve use of Malnutrition Screening Tool (MUST). Fully implement Protected Mealtimes (PMT) initiative. Appoint nutrition nurse specialist for education and audit.	Nutritional nurse specialist in post. MUST audit completed 2010. 71% of eligible patients had a form completed although accuracy of recording was lower. Ward based training provided. PMT audit completed 2010. 18% of patients surveyed experienced one or more interruption (non urgent) during their meal (figure was 50% prior to the introduction of PMT). Use of PMT also shown to improve patients' energy (kcal) intake per meal. Reports presented to Clinical Governance Committee.

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	Audit the availability of local smoking cessation services to identify any resource requirement.	Completed and appropriate action taken to review services.
Overall Governance	Action plan in place to achieve NHS Litigation Authority (NHSLA) Risk Management Standards Level 3.	Level 3 Assessment held February 2011. Trust failed to achieve Level 3 but sustained Level 2 accreditation.
	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.	Quarterly report to Board of Directors amended to reflect new safety and quality indicators. Monthly quality dashboard currently under development.

Priorities for Quality Improvement 2011/12 - Clinical Outcomes Framework

The government's plans for reform across the NHS, public health and adult social care are designed to enable services to deliver improved outcomes across 5 key areas (domains). The Clinical Outcomes Framework establishes five domains, each to be defined by a series of National Institute of Health and Clinical Effectiveness (NICE) quality standards and quality indicators. The framework will be embedded into existing mechanisms to drive improvement (i.e. tariffs, contract decisions, CQUIN standards and GP Quality Outcome Framework (QOF).

The final version of the framework and details of the quality indicator definitions and data sources will be clarified by the Department of Health over the next two years and the Trust will ensure that it has sound governance arrangements in place to implement effectively.

With reference to the NHS Outcomes Framework, the Board of Directors has identified a number of quality objectives for 2011/12. The rationale for selection of these objectives takes into account:

- The Trust's Strategy for 2008 - 2012 "A Healthy Future".
- Feedback from patient engagement and surveys, local stakeholder groups, Trust Open Days and Trust governors, constituency events, governor scrutiny and feedback.
- Feedback from public consultations including Local Authority Health Scrutiny Panels.
- The extensive quality improvement programme agreed with our commissioners
- National and local quality initiatives such as the South West SHA Patient Safety Improvement Programme.
- The requirements of regulators and assessors i.e. Monitor, the Care Quality Commission, the NHS Litigation Authority.

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	Indicator	Quality Improvement Objective 2011/12	Monitoring arrangements for 2011/12
Effectiveness	Preventing people from dying prematurely	• Reducing the mortality rate from cardiovascular disease; respiratory disease and liver disease	Monthly monitoring via Mortality Group chaired by Medical Director
	Helping people to recover from episodes of ill health or following injury	• Maintain high standards of care for stroke patients • Reduce emergency readmissions within 28 days of discharge from hospital	Stroke and emergency readmissions monitored monthly by Board of Directors
Experience	Ensuring that people have a positive experience of care	• Improve patients experience of outpatient care (National and local survey results) • Improve patients experience of emergency care (National and local survey results) • Implement End of Life Care Strategy and action plan • Implement action plan following National Dementia Care Audit	Implementation of real time monitoring of patient experience, quarterly reporting to Board of Directors and Council of Governors (CoG). Survey reports to Board of Directors and CoG. End of Life care and Dementia care action plan reports to Healthcare Assurance Committee and NHS South West
Safety	Treating and caring for people in a safe environment and protecting them from avoidable harm	• Continue to reduce inpatient falls • Reduce incidence of hospital related VTE • Continue to reduce levels of hospital acquired infections (MRSA, MSSA and C difficile) • Measure, monitor and reduce incidence of hospital acquired category 3 and 4 pressure ulcers • Comply with NPSA Alerts for Medicines management and prevent medication errors causing severe harm. • Prevent all Never Events • Reduce the number of adverse events resulting in severe harm	Quarterly reporting to Healthcare Assurance Committee and Board of Directors Infection control reports monthly to Health Protection Unit and Board of Directors

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Review of Our Services

During 2010/11 the Trust provided 8 NHS Services in accordance with its license with the Care Quality Commission:

- Management of supply of blood and blood derived products
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Maternity and midwifery services
- Family planning
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

The Trust has reviewed all the data available to it on the quality of care in services provided. This has included data available from the Care Quality Commission, external reviews, participation in National Audits and National Confidential Enquiries and internal clinical audits.

The income generated by the NHS Services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Trust for 2010/11.

Participation in National Clinical Audits

During 2010/11, 54 National clinical audits covered NHS Services (www.dh.gov.uk/qualityaccounts). During that period the Trust participated in 79% of national audits which it was eligible to participate in.

The National clinical audits that the Trust was eligible to participate in during 2010/11 are shown in the table below. The national audits that the Trust participated in, and for which data collection was completed during 2010/11 are listed alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Participation	% Cases Submitted
Children Audits		
Paediatric pneumonia (British Thoracic Society) (BTS)	Not applicable to Trust	
Paediatric asthma (BTS)	Not applicable to Trust	
Childhood epilepsy	Not applicable to Trust	
Paediatric Intensive Care	Not applicable to Trust	
Paediatric Cardiac Surgery	Not applicable to Trust	
Paediatric Diabetes	Not applicable to Trust	
Paediatric Fever - College of Emergency Medicine	Yes.	100% of appropriate data submitted.
Peri-Neonatal Audits		
Neonatal Intensive and Special Care (NNAP)	Not applicable to Trust	
Perinatal Mortality (CEMACH)	Yes	100% of applicable cases submitted.

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Audit Title	Participation	% Cases Submitted
Acute Care Audits		
Emergency Use of Oxygen (BTS)	Did not participate	More specific local audits undertaken by Thoracic Team
Adult Community Acquired Pneumonia (BTS)	Did not participate	
Non Invasive Ventilation (BTS)	Did not participate	
Pleural Procedures (BTS)	Did not participate	
National Cardiac Arrest Audit	Yes	100% of applicable cases submitted
Vital Signs in Majors - College of Emergency Medicine	Yes	96% of cases submitted
Adult Critical Care (Case Mix Programme)	Yes	100% of applicable cases submitted through ICNARC
Potential Donor Audit (NHS Blood and Transplant)	Yes	100% of applicable cases submitted
Long Term Conditions Audits		
National Diabetes Audit	Yes	100% of applicable cases submitted
Heavy Menstrual Bleeding Audit - (RCOG)	Yes	Data collection in progress
Chronic Pain Audit (National Pain Audit)	Yes	Data collection - (PROMS format) currently in progress
Ulcerative colitis and Crohn's Disease (National IBD Audit)	Yes	Data collection in progress
Parkinson's Disease Audit	Did not participate	The Trust missed the deadline date for the 2010 national audit but are registered to participate in 2011
European COPD audit (BTS)	Yes	Data collection in progress
Adult Asthma (BTS)	Did not participate	More specific local audits undertaken by Thoracic Team
Bronchiectasis (BTS)	Did not participate	
Elective Procedure Audits		
National Joint Registry (hip, knee and ankle replacements)	Yes	Routine data collection and reporting - 100% of applicable data submitted
Elective Surgery - National PROMS programme	Yes	Routine data collection and reporting - 100% of applicable data submitted
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	Not applicable to Trust	
Liver Transplantation (NHSBT UK Transplant Registry)	Not applicable to Trust	
Coronary Angioplasty (NICOR adult cardiac interventions audit)	Yes	100% of applicable data collected and will be transferred to NICOR database in 2011

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Audit Title	Participation	% Cases Submitted
Peripheral valvular surgery (VSGBI Vascular Surgery Database)	Yes	100% of applicable data submitted
Carotid Interventions Audit	Yes	100% of applicable data submitted
CABG and Valvular Surgery (Adult Cardiac Surgery Audit)	Not applicable to Trust	
Cardiovascular Disease Audits		
Familial Hypercholesterolemia	Yes	100% of applicable data submitted
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Routine data collection and reporting - 100% of applicable data submitted
Heart Failure Audit	Not applicable to Trust	
Pulmonary Hypertension Audit	Not applicable to Trust	
Acute Stroke (SINAP)	Yes	100% of applicable data collected. Trust to submit to SINAP when local database compatible
Stroke Care (Sentinel Stroke Audit)	Yes	100% of applicable data submitted
Renal Disease Audits		
Renal replacement therapy	Not applicable to Trust	
Renal transplantation	Not applicable to Trust	
Patient Transport	Not applicable to Trust	
Renal Colic	Not applicable to Trust	
Cancer Audits		
Lung Cancer	Yes	100% of applicable data submitted
Bowel Cancer	Yes	100% of applicable data submitted
Head & Neck Cancer	Not applicable to Trust	
Trauma Audits		
Hip Fracture (National Hip Fracture Database)	Yes	100% of applicable data submitted
Severe Trauma	Not applicable to Trust	
Falls and Non-Hip Fractures (National Falls and Bone Health Audit)	Yes	97% of cases submitted
Psychological Conditions Audits		
Depression and Anxiety	Not applicable to Trust	
Prescribing in Mental Health Services	Not applicable to Trust	
National Audit of Schizophrenia	Not applicable to Trust	

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Audit Title	Participation	% Cases Submitted
National Dementia Audit	Yes	97% of clinical cases submitted, 50% of staff questionnaires submitted
Blood Transfusion Audits		
O Neg Blood Use (National Comparative Audit of Blood Transfusion)	Yes	100%
Platelet Use (National Comparative Audit of Blood Transfusion)	Yes	100%

The reports of 4 National Audits were published in 2010/11 and reviewed by the Trust. The Trust intends to take the following actions to improve the quality of healthcare provided in these areas as follows:

- **Dementia** - A lead consultant and a Dementia strategy group have been set up to implement the report action plan. The group are due to present to the Clinical Governance and Risk Committee in May 2011. The audit of standards of dementia care in line with the National Dementia Strategy was completed in full at the end of March 2011, and the required action plan will be developed within the required timescale of June 2011.
- **Continence** - A lead consultant has been appointed and an action plan has been presented to Clinical Governance & Risk Committee. The action plan includes review of current policies and procedures. The Trust participated in the national review of continence care in 2010.
- **Familial Hypercholesterolemia** An action plan from the report recommendations is currently being produced and will be reported to and monitored by the Clinical Governance & Risk Committee.
- **Stroke Care (Sentinel Stroke Audit)** An action plan from the report recommendations is currently being produced and will be reported to and monitored by the Clinical Governance & Risk Committee.

Meeting local Clinical Audit Standards

The reports of 74 local clinical audits were reviewed by the Trust in 2010/11. Examples of audits that have led to the Trust making a change to current practice and ensuring continuous improvement in the quality of healthcare and services provided include:

Audit	Change to Practice
Patients with early inflammatory arthritis	Rheumatologists to make more referrals to Multi Disciplinary Team (MDT) and aim for combination treatments in all sero-positive patients without contra-indications
Eye Unit Patient Satisfaction Survey	Eye Unit to implement staggered admission times for patients attending for surgery as patients felt waiting times were too long

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Audit	Change to Practice
NICE Guidance on Management of Self Harm	Psychiatric Liaison Team to deliver training to Emergency Department staff and improve the current psychiatric proforma to aid staff to undertake comprehensive assessments
Audit of Post Operative Temperature	Theatres to ensure Intra-operative monitoring and heating systems are used more widely
Non-administration of medicines audit	A new "Don't miss doses" flow chart has been put on all drug trolleys to encourage further action after a missed dose code has been used. A new inpatient drug chart has also been introduced with missed dose pages to highlight reasons for non-administration
Audit of catheter use and documentation	Implemented use of a catheter insertion sticker in the medical notes
Audit of problem with patients self removing NG tubes on Stroke Unit	The Unit are developing a daily checklist for safe and appropriate use of mittens
Vaccine Cold Storage Audit	Cool boxes and packs to be supplied to areas for use when transporting cold storage items and defrosting fridges. Stand alone max/min thermometers provided for each area that stores cold chain pharmaceuticals
Audit of Surviving Sepsis Campaign	Sepsis proforma has been put on the Emergency Department record system to aid use, implementation and audit.
Audit of lumbar puncture	Implementation of a new Trust wide proforma to follow when performing lumbar puncture. Accompanying guidance also implemented.
Outstanding warfarin doses by ward	Change of timing of warfarin dosing introduced across the Trust

Participation and Implementation of National Confidential Enquiry (NCEPOD) reports

During 2010/11, 4 applicable National Confidential Enquiry (NCEPOD) reviews covered NHS Services. During that period the Trust participated in 100% national confidential enquiries which it was eligible to participate in.

The National Confidential Enquiries that the Trust was eligible to participate in during 2010/11 are listed below. The reviews that the Trust participated in, and for which data collection was completed during 2010/11 are listed alongside the number of cases submitted to each review as a percentage of the number of registered cases required by the terms of that enquiry.

Between April 2010 and March 2011 the Trust submitted data to the following National Confidential Enquiries:

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Title	Participation	% Cases Submitted
NCEPOD		
Parenteral Nutrition Study	Yes	62% of case questionnaires returned (13 cases selected for study)
Cosmetic Surgery Study	Not applicable to the Trust	
Elective & Emergency Surgery in the Elderly Study	Yes	100% of required surgical questionnaires and 78% of anaesthetic questionnaires returned. (9 cases in study period)
Peri-operative Care Study	Yes	100% of required data submitted (189 cases in study period)
Surgery in Children Study	Yes	100% compliance with study request
Cardiac Arrest Study	Yes	100% of required data submitted (6 cases in study period)
CMACE		
Perinatal Mortality Study	Yes	100% compliance, ongoing data submission

Between April 2010 and March 2011 the Trust also received the following reports:

NCEPOD	Action Taken
Acute Kidney Injury - "Adding Insult to Injury"	Lead Consultant appointed. Action plan in place and further audits completed in medicine and surgery to review progress.
Parenteral Nutrition - "A Mixed Bag"	Lead Consultant appointed. Gastroenterology Working Group established to take forward recommendations.
Deaths in Acute Hospitals - "Caring to the End?"	Lead Consultant appointed. Working Group established which led to review of acute services particularly handover procedures. Admission documentation has been revised and extended to surgical patients. End of Life Strategy Group established to take forward a number of specific report recommendations.
Emergency and Elective Surgery in the Elderly - "An Age Old Problem"	Lead Consultant appointed. Working Group established and currently considering how to improve Medicine for the Elderly (MFE) input into care of elderly surgical patients
Cosmetic Surgery - "On the Face of It"	This report was reviewed by the Clinical Governance & Risk Committee. There were no relevant recommendations for the Trust.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	This report was reviewed by the Clinical Governance and Risk Committee and Consultant Lead for Liaison Psychiatry Team. There were no recommendations applicable to the Trust.
CMACE	
Perinatal Mortality 2008 (published July 2010)	The report has been reviewed by the Maternity Unit and an action plan is in place. In accordance with the national report recommendations, a guideline is to be formulated for babies delivered at less than 22 weeks gestation.
Review of Maternal Deaths in the United Kingdom related to A/H1N1 2009 Influenza	This report has been considered by the Maternity Unit and appropriate protocols and procedures are in place

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NCEPOD	Action Taken
Maternal Obesity in the UK	The report was reviewed by the Maternity Unit and guidelines were already in place for antenatal care and the management of diabetes in pregnancy. These have subsequently been updated and new Obesity Guidelines implemented in accordance with the report recommendations.
CMACE Emergent Theme Briefing 1 - Genital Tract Sepsis	The report was reviewed by the Maternity Unit and existing Postnatal care guidelines were found to be compliant with the majority of the report recommendations. The guidelines have been subsequently updated to include an updated list of symptoms of serious infection. In addition, an action plan is in place to update antenatal and postnatal care patient information and stress the importance of good personal and perineal hygiene.

Research Governance

The Trust continues to take a leading role in local and regional research initiatives and is the largest recruiter to clinical trials in the South West region outside the teaching hospitals.

In 2010/11 the Trust had 161 open projects, of these 69 were new projects for 2010/11. All 69 new projects received approval from the relevant Ethics Committee. 56% of both open and new projects are cancer trials.

We recruited 1010 new patients to National Institute for Health Research (NIHR) adopted studies which is a 10% increase on last year.

National policy now dictates that we concentrate solely on NIHR studies. However we are able to continue to support our rich tradition of own account research because our healthy industry liaison generates the income to do so.

In previous years, our portfolio of NIHR adopted studies was almost exclusively cancer trials coordinated through the Dorset Cancer Research Network. While this remains strong, investment in research infrastructure within the Trust is now showing increased recruitment to cardiology, stroke, vascular and rheumatology trials. We intend to continue this strategy with an aim of broadening the range of our portfolio in order to comply with the DH 5 year target of doubling our recruitment by 2015. By 2011/12 we should have enough data to show trends in graphical form.

The trend to local collaboration with Bournemouth University and the other Acute Trusts has become less of a priority due to the financial pressures. As a lead Trust with a healthy portfolio, we need to ensure our collaborations do not prove a drain on our management and financial resources.

The Trust was inspected by the Medicines & Healthcare Regulatory Authority (MHRA) in October 2010 to ensure our Research Governance systems conformed to statutory directives. The report encouraged us to continue sponsoring clinical trials of medicinal products and suggested modifications to our pharmacovigilance and quality management systems which have been implemented. The report also highlighted a need for increased investment in monitoring especially of the clinical involvement of local investigators. This will be addressed in 2011.

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Commissioning for Quality and Innovation (CQUIN) objectives and Achievements for 2010/11

Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust income for 2010/11 was not conditional on achieving quality improvements and innovation goals through the Commissioning for Quality and Innovation Framework. As an alternative the provider and the lead commissioner agreed an extensive set of quality and performance indicators, including the national CQUIN indicators and these were formally monitored throughout the year on a monthly basis.

Care Quality Commission Registration

The Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The CQC has not taken any enforcement action against the Trust during 2010/11.

The Trust has not participated in any special reviews or investigations by the CQC relating to its license in 2010/11.

The Trust receives monthly reports on quality and patient safety from the Care Quality Commission (QRP reports). The report is reviewed in detail by the lead director and any significant changes reported to the Healthcare Assurance Committee for action. The report is also used to identify any areas for further scrutiny, for example by Internal Audit, patient survey and/or Council of Governors feedback. The March 2011 QRP report provided assurance that the Trust was rated as having a low risk of non compliance with its Care Quality Commission registration.

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, with all evidence uploaded, to Connection for Health by the 31st March 2011. The results are shared with the Care Quality Commission, Audit Commission, Monitor and the National Information Governance Board.

The overall score for the Trust in 2010/11 is 68% (Green). The Trust was able to demonstrate the required level 2 score for the 22 key requirements, and level 2 for all remaining requirements of the Information Governance Toolkit.

Examples of actions taken to improve arrangements for information governance in 2010/11 have included:

- Appointment of a dedicated Information Governance and Freedom of Information Officer
- Information Governance training for all staff
- Full audit of evidence uploaded for all requirements

Whilst improvements were made, the Trust recognises that actions are still required to further embed information governance policies and procedures within the Trust. An action plan to reach Level 3 across all requirements by 31st March 2012 will be implemented following the March 2011 submission.

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Data Quality

During 2010/11 the Trust has continued to review the data quality of records submitted to the Secondary User Service (SUS) to ensure our published data is as complete and accurate as possible. For admitted patient care and outpatients we have exceeded the required information governance standards for the core data quality indicators (i.e. patient's NHS number, registered GP and postcode).

Activity Type	Data Quality Indicator	Data Quality Target	RBCH (Apr 09 - Mar 10)	National (Apr 09 - Mar 10)
Inpatients	NHS number	98.0%	99.7%	98.5%
Inpatients	Registered GP	99.0%	100.0%	99.8%
Inpatients	Postcode	100.0%	100.0%	99.8%
Outpatients	NHS number	98.0%	99.9%	98.8%
Outpatients	Registered GP	99.0%	100.0%	99.8%
Outpatients	Postcode	100.0%	100.0%	99.7%
A&E	NHS number		96.7%	91.9%
A&E	Registered GP		100.0%	99.7%
A&E	Postcode		99.9%	99.7%

In 2010/11 the Trust was subject to a Payment by Results (PbR) clinical coding audit by the Audit Commission. The PbR audit covered 300 Finished Consultant Episodes (FCEs). 200 were selected from an area audited as a national theme, General Medicine (100) and Cardiology (100).The remaining 100 FCEs were selected based on discussions with our local commissioners.

Area audited	Specialty/ Sub-chapter/ HRG	Sample size
Speciality A	General Medicine	100
Speciality B	Cardiology	100
Sub-chapter	JC - Skin surgery	70
HRG	EB01Z Non interventional acquired cardiac conditions 19 years and over	30

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The error rate reported in the latest published audit for diagnosis and treatment coding is 10% which is a significant improvement compared to the previous year error rate of 24%. The Trust is performing close to the national average (9.1%) when compared to the overall performance of trusts in 2009/10. The results should not be extrapolated further than the actual sample audited. The speciality's audited are listed above.

The Trust is continuing to improve the quality of the source documents for coding which will help to reduce our coding error rate below the national average. The Coding improvement work has seen much better accuracy on primary and secondary diagnosis and procedure codes.

The vast majority of issues identified in the Audit have already been rectified as relatively straight forward issues, leaving the Trust well positioned for extremely high accuracy rates next year. To further improve coding accuracy, the move away from READ coding, planned for 11/12, will ultimately reduce error rates. This will make a more meaningful comparison to the national average rates, as most Trusts do not have to deal with the handicap of coding in a separate system (READ) and translating into International Classification of diseases version 10 (ICD10) and Office of Population Census & Surveys (OPCS) classification of surgical operations and procedures version 4.5.

These measures combined with ongoing clinical engagement and the move to electronic notes give assurance that coding accuracy is improving.

The net effect of these coding adjustments was zero pounds, i.e. there was no gain or loss to any organisation as a result of the audit.

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3. Other Information

The following section provides an overview of the care offered by the Trust based on performance in 2010/11 against key quality indicators selected by the Board in consultation with stakeholders. The indicators selected demonstrate the Trusts commitment to patient safety, clinical effectiveness and enhancing the patient experience. The rationale for selection of these indicators is on the basis of data collection, accuracy and clarity as well as the feedback mechanisms previously outlined on page 5.

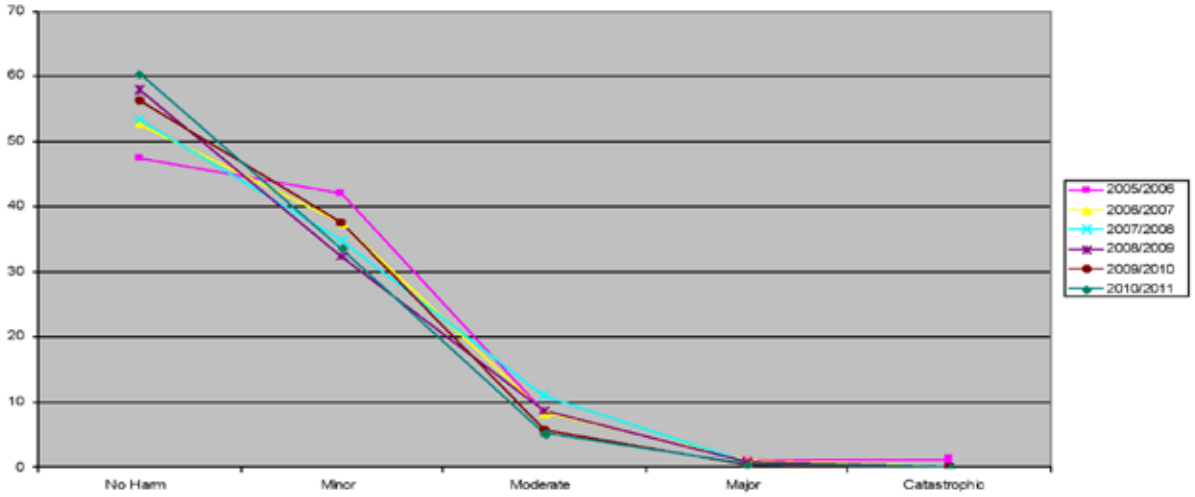
Patient Safety Reporting and Management of Adverse Events

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 non harm events are reported the potential to reduce or prevent actual harm events from occurring increases as a result of investigation and learning and this can be seen below:

The graph below clearly shows that the positive reporting culture within the organisation has resulted in an overall increase in reported incidents and a decrease in the number of moderate, major and catastrophic severity events.

All incidents Reported - April 2004 to March 2011
Severity as % of Total



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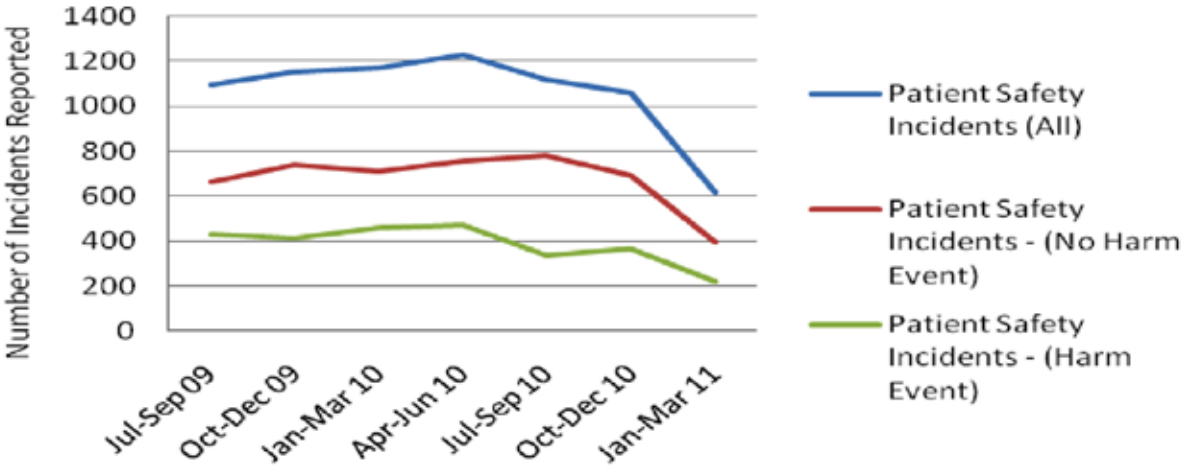
Patient Safety Incidents Reported 2009/10, 2010/11



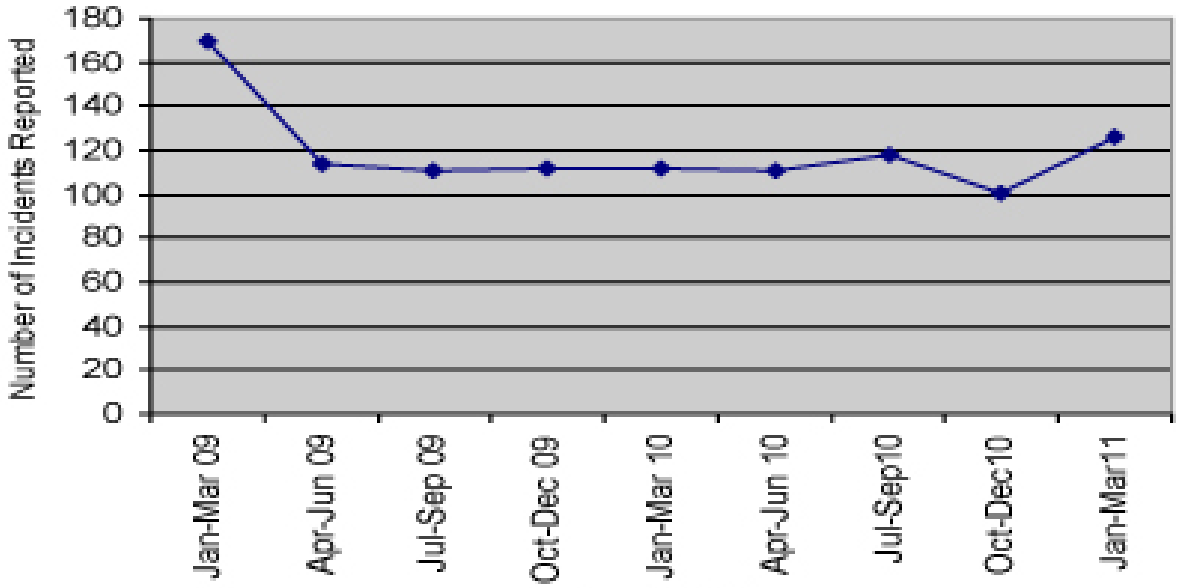
The Trust routinely reports all patient safety incidents to the National Patient Safety Agency and the National Reporting and Learning System (NRLS). Benchmarking show the rates of NRLS reported patient safety incidents per 100 admissions in the Trust compared to similar Acute Trusts during the period April 2010 to November 2010. The Trust has a rate of 4 per 100 admissions which is around the average for all medium Acute Trusts.

Reducing Medication Incidents and Improving Safety

The Trust's Medicines Governance Committee is chaired by the Medical Director and its remit is to enhance and monitor the Trust's strategy to reduce medication errors, compliance with national standards for medicines management and ensuring implementation of safe practice alerts and reports.

Medication Incidents (all events including near misses and no harm events) reported 2010/11

Medication Incidents Reported 2009/11



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Patient Safety and Quality Improvement Initiatives to support medication safety and medication incident reduction during 2010/11 have included:

Omitted or delayed doses

New resources to reduce the number of missed or delayed doses of medication have been written and implemented in 2010/11. In particular, the Trust prescription chart has been revised to enable accurate recording of omitted doses. Resource material to support mandatory training has been developed and small group training sessions have been held on wards led by our Medicines Management Nurse.

Medicines reconciliation

In 2010/11 there has been continued work to improve documentation and encourage doctors to resolve medication discrepancies identified by pharmacists in a timely way. Liaison with primary care ensures that action taken on changes to medication in hospital is communicated in discharge letters to GP surgeries. Audits to monitor progress are routinely undertaken and reported to the Medicines Governance Committee.

Oral liquids

Teaching sessions on the correct administration of oral liquid medication using purple syringes have been held on the wards by the Trust Medicines Management Nurse. Routine audit of practice has also been implemented to monitor compliance.

Safer lithium therapy

Working with Development Dorset Healthcare Trust the Trust has produced Trust-wide guidelines - “Lithium in the acute hospital setting”. A newsletter highlighting safe practice has been circulated and resources added to the Medicines Management Intranet page.

Safer administration of insulin

Guidelines, teaching materials and an amended Diabetes Prescription Chart (incorporating new NPSA guidance) were implemented in 2010/11.

The Trust has also established a Medication Incident Review Group which is multidisciplinary and meets monthly to review reported adverse incidents (actual and potential) relating to medicines, to monitor trends and recommend further action or communication of learning points where appropriate. The Medication Incident Review Group reports to Medicines Governance Committee.

Reducing Patient Falls

Patient Accidents form the largest group of all patient safety incidents reported to the NPSA via the National Reporting and Learning System (NRLS).

The NPSA category “patient accidents” includes any slips, trips or falls by patients. These may be non harm events e.g. a patient has fallen walking along a ward corridor but not sustained an injury, or a harm event when a similar incident has occurred and the patient sustained a bruise, cut or more serious injury.

The Trust has invested heavily in staff training and equipment provision over the past three years in order to reduce the number of patient falls.

In 2010/11 the Trust completed a total bed and mattress replacement programme which has resulted in all patients now being treated on an electronic profiling bed and high

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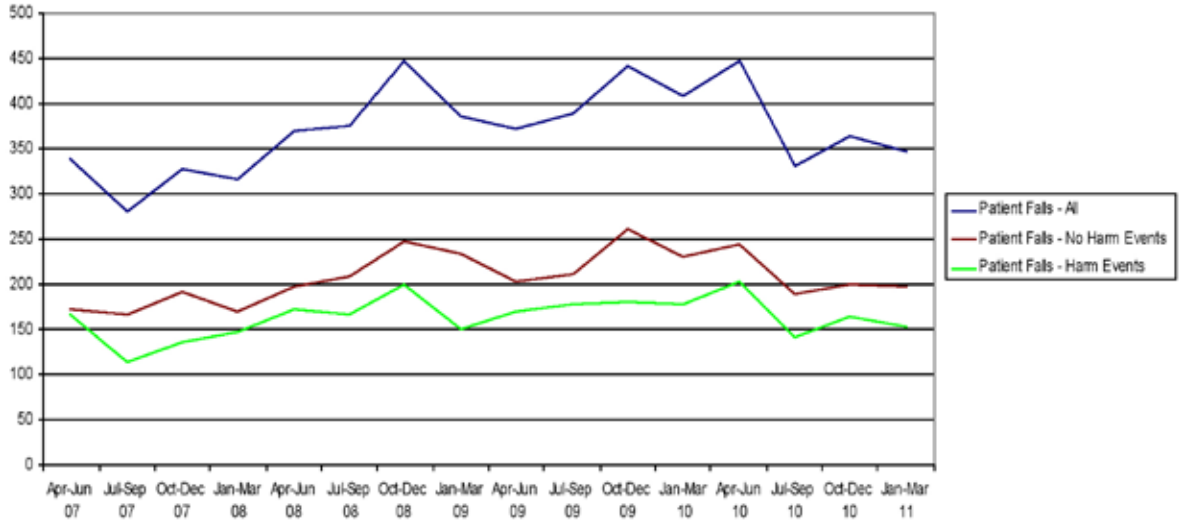
RBCH Reported Patient Falls (all events) - 2010/11



specification mattress. In addition, new equipment for moving and handling patients has been purchased and training provided within clinical mandatory training days and ward based updates. Further work to improve patient mobility and bedrail risk assessment documentation is programmed for 2011/12 and will be monitored by the Trust Falls Prevention Group.

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 Nursing who acts as the Director of Infection Prevention and Control (DIPC) briefs the Board on a regular basis.

The Trust publishes a detailed Infection Control Annual Report which is released publically and available on the Trust website.

Clean Environment

The Patient Environment Action Team (PEAT) programme was established to assess NHS hospitals in 2000, and has been managed by the National Patient Safety Agency since 2006. Under the programme 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. The results for 2010 identified an improvement to the Food and Privacy & Dignity Scores for Christchurch Hospital.

MRSA bacteraemia

The Trust has been successful in reducing our rate of MRSA bacteraemia this year and reported no cases in the year.

MRSA Screening

The Trust continues to meet the MRSA screening target for elective patients. Achievement over 100% occurs as this target is calculated by dividing the

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Year	Site	Environment Score	Food Score	Privacy & Dignity Score
2011	Christchurch Hospital	Good	Excellent	Good
	Bournemouth Hospital	Good	Good	Excellent
2010	Christchurch Hospital	Good	Excellent	Excellent
	Bournemouth Hospital	Good	Good	Good
2009	Christchurch Hospital	Good	Acceptable	Good
	Bournemouth Hospital	Good	Good	Good
2008	Christchurch Hospital	Good	Excellent	N/A
	Bournemouth Hospital	Good	Good	N/A
2007	Christchurch Hospital	Good	Excellent	N/A
	Bournemouth Hospital	Good	Excellent	N/A
2006	Christchurch Hospital	Excellent	Excellent	N/A
	Bournemouth Hospital	Acceptable	Good	N/A

number of admissions by the number of screens. Some admitted patients receive more than one screen.

Clostridium Difficile

The Trust has had the lowest rate in the southwest for each of the past five years. All cases of C.difficile infection at this Trust are reported and investigated. The numbers of cases have been well within the contract target for the entire year.

Clinical Effectiveness and Quality of Care

Reducing Hospital Mortality

The Medical Director chairs a Mortality Review Group which meets monthly and proactively reviews mortality data for the Trust. All potential alerts are fully investigated by a lead clinician and this means that potential coding issues are identified and resolved earlier and before an alert is issued by the Care Quality Commission.

Two Alerts have been issued by the CQC in 2010/11 and on each occasion the Trust had already identified the risk group and had initiated an internal notes review. The CQC Alerts related to Pulmonary heart disease, and, Coronary Atherosclerosis and other heart disease.

The Medical Director provided a full written report to the CQC for each alert. In all cases, coding errors were identified which have now been resolved. The reviews did not identify concerns about the clinical management of the patients.

In order to improve coding, the Mortality Group has led on a number of initiatives this year. This has included implementation of an improved electronic immediate discharge form (eIDF); training for junior doctors on death certification and producing discharge letters; direct consultant involvement in confirming appropriate death certification; proactive case note reviews and clarity on clinical coding definitions.

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Ensuring NICE Guideline compliance

The Trust Clinical Governance & Risk Committee (CGRC) reviews compliance with all new NICE Guidance issued each month. For the period April 2010 - March 2011 the CGRC reviewed a total of 110 newly issued guidance.

Compliance rates are shown in the following table.

Where partial or non compliance is highlighted the issue is placed on the Trust risk register with a time bound action plan to resolve. Outstanding issues are reviewed regularly by the Clinical Governance & Risk Committee.

Ensuring compliance with MHRA Safety Alerts

A total of 103 Medicines & Healthcare Regulatory Authority (MHRA) Medical Device Alerts were issued and received in the year. Of these 35 applied to medical devices used within the Trust. The Trust ensured compliance with all relevant alerts.

In addition, 13 NHS Estates Alerts were issued and received in the year. Of these, 10 were applicable to the Trust, six required action but are completed and four currently have action plans in place. Where actions are still required these issues are highlighted on the Trust risk register and implementation monitored via the Trust's governance framework.

The National Patient Safety Agency (NPSA) also issued 12 new Alerts in 2010/11. One alert was not applicable to the Trust, three required action that has been completed and eight have appropriate action plans in place. Where actions are still required these issues are highlighted on the Trust risk register and implementation monitored via the Trust Clinical Governance & Risk Committee and, where applicable, the Medicines Governance Committee. For each Alert a senior manager consultant has been appointed to coordinate compliance.

Type of Guidance	Published	Applicable	Compliant	Partially Compliant	Non Compliant
Clinical Guidelines (CG)	24	19	3	9	1
Technology Appraisals (TA)	34	27	20	4	3
Interventional Procedures (IP)	50	11	5	0	0
Public Health Guidance (PH)	11	11	2	5	0
Medical Technology (MT) Guidance	2	1	1	0	0
Cancer Services Guidance	1	1	0	1	0
Quality Standards	4	3	0	3	0

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Patient Experience

The main systems in place to measure patient satisfaction are:

- National mandatory patient surveys
- Trust wide Patient Survey cards and Bespoke patient surveys including Real-Time Patient Feedback
- Patient complaints

National Patient Survey Results

The Trust participated in the Care Quality Commission National Inpatient Survey 2010. A total of 850 patients from the Trust were sent a copy of the questionnaire, of which 467 were returned, giving a response rate of 57%. The national average response rate was 50%.

The survey highlighted many positive aspects of the patient experience and was highlighted as one of the top 20% of Trusts for:

- Providing patients with assistance with their meals
- The availability of nursing staff, confidence and trust in nursing staff and understanding information provided by nursing staff
- Involving patients in decisions about their care and providing information about their treatment or condition, including the risks and benefits.
- Providing patients with written information about what to do when they left hospital, including the purpose of any medications to take home and any symptoms to look out for.
- Pain control
- Privacy and dignity

The Trust scored below national average scores (lowest 20% of Trusts) for patients perception of:

- Patients using bath or shower area who shared it with opposite sex
- Availability of posters or leaflets about hand wash and use of hand wash gels
- Availability of hand wash gels
- Privacy and dignity when being examined in the Emergency Department
- Patients family having enough time to talk to a doctor and patients themselves having someone to talk to about their worries or fears.

The report from the Care Quality Commission was issued in April 2011 and the Trust is currently developing an action plan to address issues raised within the survey 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. The results of the survey cards are reviewed quarterly and information feedback to relevant clinical areas in order to support and maintain best practice. A summary of the results for 2010/11 are shown above.

In September 2010 a new Patient Experience Card was also introduced as part of a new initiative to gain real time monitoring of patients views. The survey card is facilitated through the Trust's excellent pool of volunteers and public governors. Patients are asked a series of standard questions.

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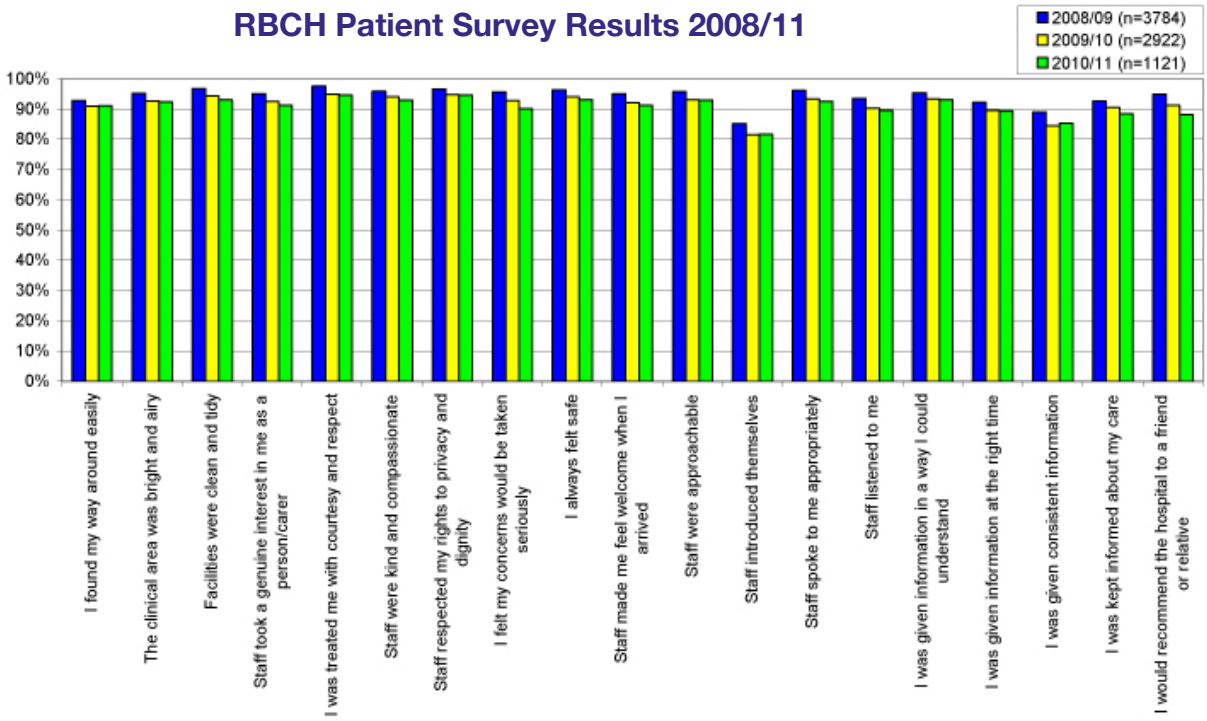

From September 2010 to March 2011, 614 patients have completed the survey and the recorded results were as follows:

	All of the time	Most of the time	Some of the time	None of the time
Were you involved as much as you wanted to be in decisions about your care and treatment?	74%	20%	4%	2%
Did you find someone on the hospital staff to talk to about your worries and fears?	70%	20%	7%	3%
Were you given enough privacy when discussing your condition or treatment?	84%	12%	2%	1%

	Yes	No
Did a member of staff tell you about medication side effects to watch for when you went home?	84%	16%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	85%	15%
Were you treated as an individual at all times?	97%	3%

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If you were admitted to hospital did you ever:	Yes	No
a) Share a sleeping area, for example a room or a bay, with patients of the opposite sex?	15%	85%
b) Use the same bathroom/shower or toilet area as the patients of the opposite sex?	25%	75%
Did you feel safe during your visit?	98%	2%

	Excellent ..... Poor									
	10	9	8	7	6	5	4	3	2	1
How would you rate your overall visit?	62%	17%	11%	3%	1%	2%	0%	1%	1%	1%
How likely would you be to recommend us?	71%	12%	7%	3%	1%	2%	1%	0%	0%	1%

The results are directly used to improve patient care in the areas surveyed. The results of the survey are fedback to staff through team meetings and briefings and in many areas displayed on notice boards. Issues such as staff not wearing name bands or appropriately introducing themselves have been highlighted and this has resulted in improved practice. Another change in practice following survey feedback has been a trial of ear plugs and eye masks for those patients who find it hard to sleep in the hospital at night.

Managing Complaints

Complaints made to the Trust are managed within the terms of the Trust's complaints procedure and national complaint regulations for the NHS. The overriding objective is to resolve each complaint with the complainant through explanation and discussion.

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.

There were 313 formal complaints from patients or their representatives during the year. This represents a decrease of 16.5% (62 complaints) from last year's total of 375 complaints.

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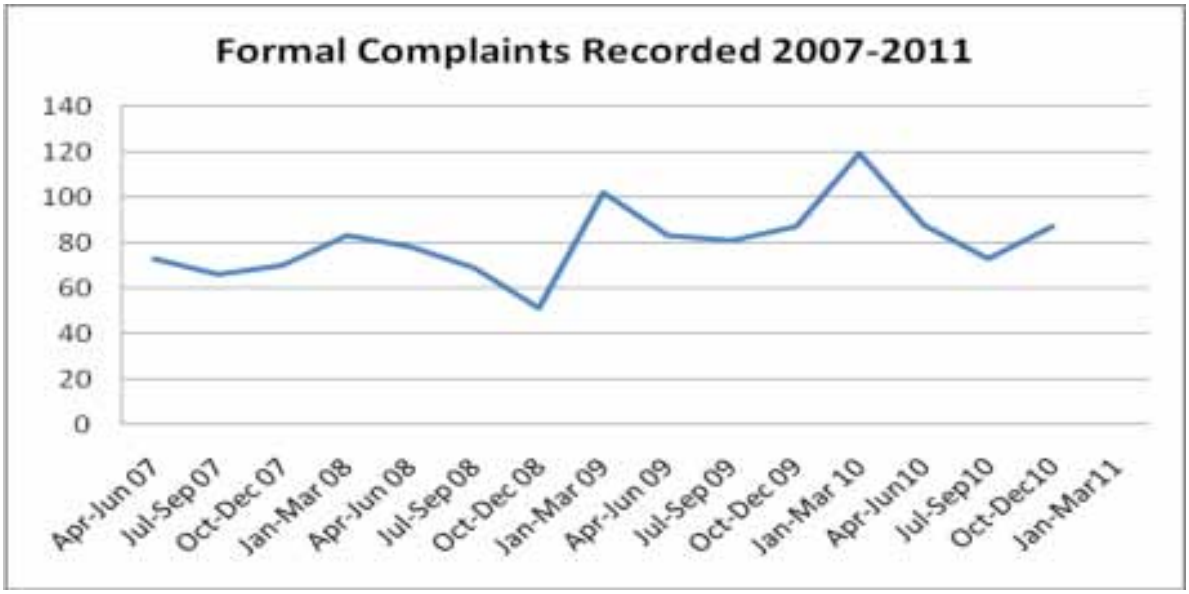
Number of complaints in 2007/2011



Of these, 145 of the 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. At the time of preparing this report, 22 complaint investigations were still to be concluded and a decision on whether they were well founded had not been reached.

An acknowledgement and explanation of the procedure to be followed was issued within 3 working days for 95% of complaints.

Subjects of complaints

The main categories of complaint were as follows:

Subject	Number	Percentage
Administrative systems	31	10
Attitude of staff	23	7
Bed management	1	0.3
Clinical treatment	161	51
Communication/ information	62	20
Discharge arrangements	11	4
Environment	2	0.6
Equipment/facilities	2	0.6
Health and safety	9	3
Privacy and dignity	4	1.2
Availability of staff	3	1
Policies and procedures	3	1
Violent/Aggressive behaviour	1	0.3
Total	**313**	**100**

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

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 in order to safeguard their privacy and dignity at all times.

The Trust has invested in this area substantially over the last few 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 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 and the results of these surveys will be regularly reported to the Board of Directors. Senior nursing staff will also perform spot checks and audits relating to privacy and dignity on an on-going basis.

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:

- Emergency Department to run a daily report to show all referrals to fracture clinic to confirm all details forwarded to Poole Hospital
- Nursing staff in Emergency Department advised against putting confused patients in side rooms unless infection risk
- Nursing staff re-educated on correct fitting of anti-embolic stocking
- Review and update of thoracic appointment re-book letters
- Spot checks of completion of drug charts
- Policy formulated for following up rejected blood samples for inclusion in ante-natal pathway
- Maternity policies updated and change to computer system
- Training for nursing and junior medical staff re pain scores/control
- Training for nursing staff on Achilles injuries and follow up

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- More time allowed between sending appointment letter and appointment date. Staff reminded to check name and other feature e.g. PMI number, DOB etc to ensure correct notes are collected and prepared for clinic
- Revised checking procedure for fracture clinic referrals
- Review undertaken to identify any known outpatient appointment letter delivery problems and procedures amended where necessary
- Outpatient IT system amended to avoid appointment time errors

Referrals to the Health Service Ombudsman

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

After receiving a response from the Trust, 22 people chose to refer their concerns to the Parliamentary and Health Service Ombudsman during 2010/11.

Of these, the Ombudsman declined to investigate 10; referred 4 back for further local resolution, and undertook one investigation of a complaint made in 2010/11. Two investigations of complaints started but not completed in 2009/10 were also received. Together, each of these three investigations was upheld by the Ombudsman and action plans will be completed in line with Ombudsman recommendations. One investigation is continuing and five complaints are still being assessed by the Ombudsman.

Performance against key National Priorities for 2010/11

The following table provides an overview of performance in 2010/11 against the key national priorities from the Department of Health's Operating Framework and against Department of Health's Core Standards. The table includes performance against the relevant indicators and performance thresholds set out in Appendix B of the Compliance Framework.

National Priority	2009/10	2010/11 Target	2010/11 Actual
Clostridium difficile year on year reduction	44	87	46
MRSA - hospital acquired	3	6	0
Maximum waiting time of 31 days from decision to treat to start of treatment	97.71%	96%	99.56%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment	99.78%	96%	100%
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	96.30%	90%	97.00%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	88.26%	85%	89.71%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	94.11%	93%	93.60%
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	86.26%	93%	98.58%

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National Priority	2009/10	2010/11 Target	2010/11 Actual
18-week maximum wait. Admitted patients: maximum time of 18 weeks from point of referral to treatment	96%	90%	97%
18-week maximum wait. Non-admitted patients: maximum time of 18 weeks from point of referral to treatment	99%	95%	99%
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	99%	95%	99%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	81%	68%	94%
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Complete	Completed
Screening all elective in-patients for MRSA	N/A	100%	100%

Achievement over 100% occurs as this target is calculated by dividing the number of admissions by the number of screens.

Participation in External Reviews

The Trust has participated in the following external reviews in 2010/11:

External Review	Key Findings
Mental Health Commission Review of Mental Health Services (undertaken on behalf of the Care Quality Commission (CQC))	The review by the Mental Health Commissioner was a routine visit on behalf of the CQC. The inspector reviewed the Trust policies and procedures and concluded that "the Trust arrangements that are in place appear to be effective in meeting the requirements of the Mental Health Act". Two minor recommendations were noted and these have been completed.
UNICEF Baby Friendly Accreditation Review	Level 3 Accreditation attained for Maternity Services.
CQC/Ofsted Review of Child Protection Provision	The Trust received an inspection as part of a wider review of Bournemouth Services by the CQC and Ofsted. As part of the review, inspectors looked at child protection arrangements in place in the Trust's Emergency Department and Maternity Unit. The inspections found that processes were adequate but made several recommendations including one that dedicated funded time for safeguarding be identified. The full report has now been received (April 2011) and an action plan has been developed to address the recommendations in conjunction with relevant local agencies.
South West Acute Hospitals Learning Disability Review	NHS South West, in partnership with local commissioners, undertook a series of peer reviews in Autumn 2010 to identify acute hospitals' ability to meet the needs of people with learning disabilities. The review highlighted a number of areas of good practice, including the use of Easy Read information in preadmission and the Emergency Department. In addition, the use of individual care plans and documentation was commended and also the level of individualised medication advice provided by pharmacy. Recommendations for further improvements were made by the review team and these are currently being implemented as part of the Trust Learning Disability Strategy. A report has been made to the Board of Directors and a further update will be provided in September 2011.

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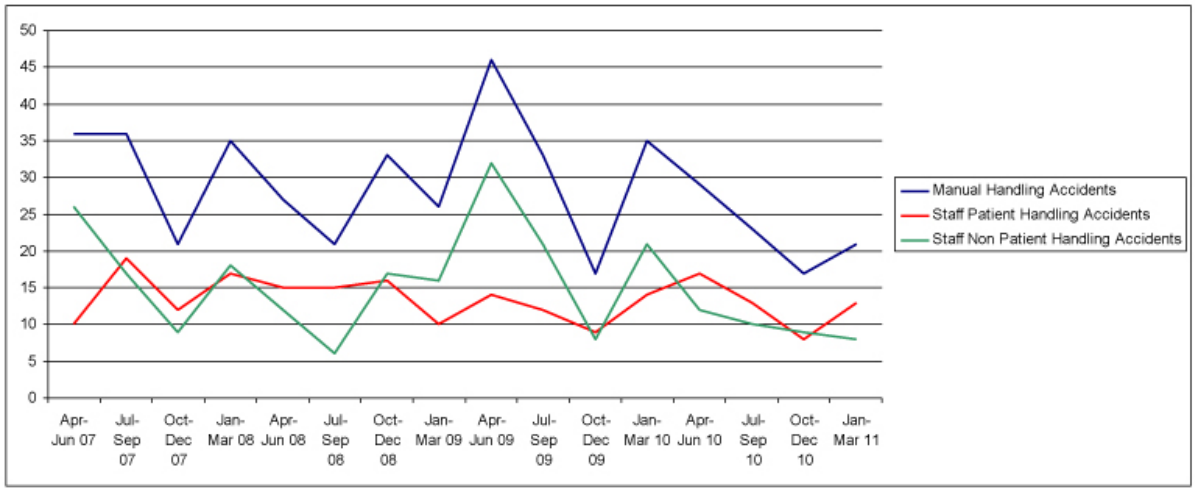
Human Tissue Act - Accreditation Assessment	The Trust was inspected in March 2011. The inspectors only commented on 3 minor issues and were assured that the Trust met all the requirements of its license under the Act.
MHRA Inspection - Research Governance Procedures & Compliance	The Trust was inspected by the MHRA in October 2010 to ensure our Research Governance systems conformed to statutory directives. The report encouraged us to continue sponsoring clinical trials of medicinal products. The report suggested a number of minor modifications to our pharmacovigilance and quality management systems which have all been implemented.
NHS Litigation Authority Assessment	Level 2 Accreditation attained.
Health & Safety Executive - Routine review of Procedure to control Legionella	The Trust had a routine visit by the HSE in March 2011 (as part of a South West audit) in relation to the Control of Legionella. The HSE inspected arrangements in place for risk management and quality assurance in relation to water testing; safe water systems and temperature control. As a result of the visit, two Improvement Notices have been issued and a full action plan is in place to achieve full compliance by the required date of October 2011. A full report has been received by the Board of Directors which will continue to monitor progress against the recommendations.

Staff Safety - Reducing Staff Accidents

Staff accidents are reported via the Trust Adverse Incident Reporting Policy and Form. All accidents (potential and actual) are investigated and trends, key learning points and actions for sharing are routinely discussed at the Trust Health and Safety Committee.

In 2010/11, the Trust has particularly concentrated on looking at the overall numbers of recorded manual handling incidents, the type and severity of injuries occurring and the reasoning behind the positive reduction in numbers.

Manual Handling Accidents Reported by Staff in 2010/11



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The provision of manual handling mandatory training for all staff, additional training on wards and, the introduction of specialist equipment has had a direct impact on the decrease in incidents. Embedding best practice techniques into the every day tasks of staff on the Wards via ward based training sessions and the support of the Link Trainers has demonstrated great improvements.

In addition, work was completed in September 2010 to provide all wards with new electric profiling beds. Previously staff had to mobilise patients manually in and around the bed, the profiling function on the new electric profiling beds has reduced this need and has significantly reduced the need for direct patient handling. The Trust has also invested in the provision of other specialist equipment (slings, hoisting systems, trolleys) which has also improved staff and patient safety.

The Trust participated in the national Staff survey during 2010 -2011. The full results of this are contained within the Annual Report.

Service Transformation Objectives & Achievements for 2010/11

The Trust has a wide reaching efficiency and effectiveness programme - Better Care, Better Value monitored by the Performance Management Office (PMO). The Transformation Programme covers a number of projects including Theatre Efficiency, Length of Stay, and e-Rostering. Significant progress has been made in a number of areas which has improved patient flow and turnaround time in theatres which is both beneficial to the patient and provides efficiency savings for the Trust.

The Electronic Rostering system first introduced in 2009/10, is now installed in the majority of wards and supports the objectives of ensuring safe and fair staffing on the wards as well as efficient use of available resources.

The Length of Stay project continues to work on improving the patient pathway. Part of this process has involved piloting a dedicated medical investigation unit which has reduced the patient length of stay for investigations, and provided increased capacity on inpatient wards.

Consultation Process

The following groups have had sight of the Quality Report and have been offered the opportunity to comment:

- NHS Bournemouth & Poole
- NHS Dorset
- Bournemouth & Poole LINKs
- Dorset LINKs
- Dorset Health Scrutiny Panel
- Bournemouth Health Scrutiny Panel
- Poole Health Scrutiny Panel
- RBCH Council of Governors

Comments received for publication were as follows:

"The Dorset Health Scrutiny Committee and the Dorset LINk had limited engagement with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on the Quality Report during 2010-11 and they had discussed the Quality Report with the Trust and agreed the summary of priorities. The Trust were complimented on the fullness of the Quality Report for 2010/11 and for patient consultation undertaken and the introduction of real time feedback."

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"NHS Bournemouth and Poole is happy to provide comment on the Quality Reports for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. On reviewing the report and working with the Trust over the last year, the PCT notes that the overall quality of care provided remains at a consistently good level."

"During 2010/11, the Trust had no incidents of MRSA Bacteraemia and a reduced number of Clostridium Difficile cases. The Trust is known to be a high reporter of incidents, which denotes an organisation with a positive reporting culture focusing on safety. The PCT also notes the decrease in harm following incidents occurring over the last year."

"The PCT fully supports the priorities for 2011/12 and would endorse the focus on patient feedback and experience, a key indicator for identifying quality services."

"Bournemouth LINks are pleased to comment on their work with the Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust over the last year.

LINks welcome the Trusts implementation of a program of real time monitoring and targeted patient surveys in relation to high priority issues and areas.

We also encourage the Trust to be more pro-active about gathering service user feedback and using it to plan and design services. The Trusts plan to gather real time feedback by electronic questionnaire devices is very welcome. They may wish to consider using kiosks, in key locations such as the main atrium and A & E to gather information from a wider customer base.

One of the most common issues raised by local people to LINks is 'access to information'. LINks would be pleased to help the Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust over the coming year to produce an easier to read Quality Report, thus improving access to this information for service users, carers and the public.

Another of the Trusts priorities for the coming year should be working with the LINks, as they evolve into HealthWatch, to improve patient and public engagement. We would also expect them to develop an information sharing policy to formally enable them to share their customer experiences with the LINk, as the LINk has done with them.

Joint Working
The Bournemouth LINk was invited to attend the Hospitals Open Day in 2010. This enabled both hospital staff and patients to understand the ongoing value that the LINk has to offer.

The hospital have included a piece of LINks literature in their bedside folder.

A representative of the LINk, regularly attends the PALS Liaison Group; Disability Forum and the Trusts Board of Governors meetings.

The LINk regularly attends the Trusts Understanding Health Talks and is given the opportunity to talk to the attendees. The LINks are very interested in working on a 'leaving hospital' project and this may involve some joint work with the Trust during the year.

For more information about the Bournemouth LINks, please go to: ***www.makesachange.org.uk****"*

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Independent Assurance Report to the Council of Governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Council of Governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- 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 5 May 2011;
- feedback from the Council of Governors dated 19 April 2011;
- feedback from LINKS dated 11 April 2011, 5 May 2011 and 23 May 2011;
- the Trust's annual complaints data reported quarterly to the Board;
- the 2010 national patient survey;
- the 2010 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 1 April 2011; and
- Care Quality Commission quality and risk profiles dated March 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended

Quality Report 2010/11

31 March 2011, to enable the Council of Governors to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents listed previously.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Patrick Jarvis
Officer of the Audit Commission
Collins House
Bishopstoke Road
Eastleigh
Hampshire
SO50 6AD
3 June 2011

Quality Report 2010/11

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 Reports) Regulations 2010 to prepare Quality Reports for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

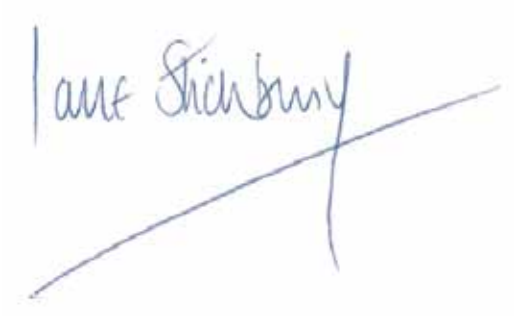
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010/11
- the content of the Quality Report is consistent with internal and external sources of information including:-
  - Board minutes and papers for the period April 2010 - June 2011
  - Papers relating to quality reported to the Board over the period April 2010 - June 2011
  - Feedback from commissioners dated 05/05/2011
  - Feedback from governors dated 19/04/2011
  - Feedback from LINks dated 11/04/2011, 05/05/2011 and 23/05/2011
  - The Trust's complaints reported quarterly to the Board of Directors
  - The 2010 national patient survey
  - The 2010 national staff survey
  - The Head of Internal Audits annual opinion over the Trust's control environment dated 01/04/2011
  - CQC quality and risk profiles dated March 2011
- 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 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/annualreportingmanual)

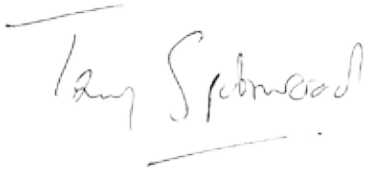
Quality Report 2010/11

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
Chairman
Date: 03.06.11



Tony Spotswood
Chief Executive
Date: 03.06.11

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

The Royal Bournemouth Hospital
Castle Lane East
Bournemouth
BH7 7DW

Christchurch Hospital
Fairmile Road
Christchurch
BH23 2JX

Further copies of this Report can be found on line at **www.rbch.nhs.uk**

If you would like a copy of the Quality Report in a different format please contact the Communications Department on **01202 704271**.