Putting patients first

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Quality Report
2011/12

Quality Report 2011/12

1. Statement by the Chief Executive

This is the fourth 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.

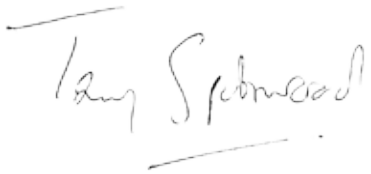
In this report we have outlined some of the quality activities which have taken place in the Trust over 2011/12.

Our quality programme has also been enhanced by wide-ranging patient safety initiatives which covers a large range of specialties and topics. We have joined a new Patient Safety Collaborative “NHS Quest” which combines the shared experiences and learning from 13 Acute Foundation Trusts across the country to promote and improve patient safety.

The report outlines our priorities for 2012/13 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 experience and equality and diversity projects this year.

It has not been possible to include all of the quality improvement and patient safety initiatives that we have been or will be engaged in within this report. I hope that it will fulfill its purpose, providing an accurate account of quality activity in the Trust and demonstrate the clear commitment to quality improvement and patient safety.

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



Tony Spotswood
Chief Executive

2. Priorities for improvement and statements of assurance on the quality of services provided

2011/12 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 2011/12. 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 2011/12

The 2010/11 Quality Report identified the following specific quality improvement priorities to be monitored in 2011/12. Performance against each objective is summarised in the table below:

Quality Improvement Objective 2011/12	Progress in 2011/12	Assurance Source/ Evidence
Reducing the mortality rate from cardiovascular disease; respiratory disease and liver disease.	Mortality rates are monitored monthly via the Mortality Group chaired by the Medical Director. The specific objective noted has been amended in year to focus on a total reduction in the hospital standardised mortality rate (HSMR) through improved coding and clinical pathways. As a result of this wider objective, clinical focus has been around managing the deteriorating patient and managing Sepsis. New project groups have been set up to establish baseline data and relevant quality indicators. This work will continue in 2012/13 as part of a wider NHS Quest collaborative project.	Dr Foster reports, Care Quality Commission Alerts, Trust Mortality Group minutes and reviews.
Maintain high standards of care for stroke patients.	The standard of care was significantly improved for stroke patients during 2011/12 following the opening of the newly refurbished combined Stroke Unit and the development of a pilot scheme for Early Supported Discharge. Improvement has also been seen against a number of the local stroke indicators: 86% of stroke patients (target 80%) spent 90% or more of their time in the hospital on the Unit, of which 85% were directly admitted. This was however, challenging in the latter part of the year due to the level of emergency demand and the extended length of stay required for some patients on the Unit. Improvement work continues to be progressed by the team.	Performance data, Internal monitoring reports.

Reduce emergency readmissions within 28 days of discharge from hospital.	The Trust has been involved in a number of quality projects to review readmissions and establish baseline criteria and information this year. The Trust was one of five Acute Trusts that were commissioned by the Department of Health (DoH) to undertake an audit looking specifically at the rates of avoidable and unavoidable readmissions. The results were not published by the DoH but were used for national policy development. Within the Trust, clinical directorates have formed groups to look at the causes of readmissions and identify interventions that could be put in place to prevent them. This work will continue in 2012/13. In addition, the Trust has joined an NHS Quest collaborative to look at readmissions within specific disease groups with high levels of readmissions. A number of targeted interventions have been introduced which will be rolled out in 2012/13.	NHS Quest Collaborative.
Improve patients' experience of outpatient care (national and local survey results).	The Trust participated in the CQC National Outpatient Survey 2011. The previous survey was in 2009. A total of 62 questions were used in both the 2009 and 2011 surveys. Compared to the 2009 survey, the Trust was significantly better on 12 questions, worse on 0 (zero) questions and the same on 50 questions. The Trust's scores were significantly better than the national average for 32 questions.	Care Quality Commission. Real-time patient feedback monitoring, internal patient surveys, formal and informal complaints.
Improve patients' experience of emergency care (national and local survey results).	There was no national survey undertaken in 2011/12. The Trust has an internal survey using the same questions from previous national surveys. The most recent internal survey was completed by 318 patients and reported in October 2011. Improvement scores were seen in the following areas: safety, privacy and dignity, cleanliness, waiting times (80% of patients saying they were seen within 30 minutes compared to a previous result of 67%). 87% of patients said they would definitely recommend the hospital to family and friends.	Local results via real-time patient feedback monitoring, internal patient surveys, formal and informal complaints.
Implement End of Life Care Strategy and action plan.	A multi-disciplinary End of Life Care Steering Group was formed in 2011/12. The Group developed an action plan incorporating all national documents established, reviewed and prioritised. A Trust wide End of Life Care audit has recently been under-taken and the results will be available in June 2012. The results will be used as a baseline for Trust wide improvement in End of Life Care.	Clinical audit.

Implement action plan following National Dementia Care Audit.	A local action plan was developed in June 2011 incorporating areas for improvement from the results of the South West Dementia Standards for Acute Trust self-assessment review and National Dementia Audit. The action plan was reviewed as part of a Dementia Peer review in November 2011. The Review Team was reassured on the progress that the Trust had made commenting as follows: "Clinical Leadership and strong senior team support were evident across the Trust, and the work plan and reports on the achievements to date were clearly evidenced. The organisation had a good action plan with clearly defined work streams and leads for each element, supported by a Trust Dementia Steering Board and Dementia Strategy Committee". The Trust has been shortlisted for the 2012 Health Service Journal Awards in recognition of the improvements made in dementia care for patients.	National Dementia Audit, Peer review report.
Aim to reduce inpatient falls.	A total of 1505 patient falls were reported in 2011/12 compared to 1498 in 2010/11. In 2011/12, 1.5% (n=22) of reported incidents resulted in severe harm to a patient, this compares to 1.1% (n=16) in 2010/11. Section 3 notes the positive action being taken by the Trust in relation to falls prevention and management.	Adverse Incident Reports, National Patient Safety Agency reports.
Reduce incidence of hospital related VTE.	The Trust monitors VTE readmissions,2007/08 - 57 2008/09 - 66, 2009/10 - 63. 2010/11 - 91 -2011/12 - projected figure 68. The structured education programme introduced in 2010/11 raised patient and staff awareness and increased reporting. The reduction in 2011/12 is thought to be due to improved clinical coding and VTE risk assessment compliance (April 2012 = 94%).	Adverse Incident Reports, Internally validated risk assessment compliance, National benchmarking.
Continue to reduce levels of hospital acquired infections (MRSA, MSSA and C difficile).	The Trust had two cases of healthcare acquired MRSA in 2011/12 which was an increase from 2010/11 (0).	Internal reporting, Health Protection Agency reporting, Internal and external validation.
Measure, monitor and reduce incidence of hospital acquired category 3 and 4 pressure ulcers.	The Trust has implemented a standard process for categorising, reporting and recording hospital acquired pressure ulcers in year. In 2011, 13 patients were reported as acquiring a category 3 or 4 pressure ulcer during their admission. 4 of these cases were determined to be unavoidable due to the patients existing condition. The Trust is committed to a target to reduce category 3 and 4 pressure ulcers by 50% in 2012/13. Awareness of reporting has been raised and training included on clinical core induction and mandatory study days in 2011/12.	Adverse Incident Reporting, Quarterly reporting to commissioners, Mandatory Training compliance reporting to directorates.

Comply with NPSA Alerts for Medicines management and prevent medication errors causing severe harm.	The focus in 2011/12 has been on the importance of reporting and learning from adverse events, including near miss and non harm events. The total number of reported incidents has increased, 679 compared to 509 in 2010/11. In 2010/11 73% of reported incidents were no harm events, this figure has increased to 75% in 2011/12.	Central Alert System (DoH) reporting, Adverse Incident Reports, National Patient Safety Agency reports, Medicines Governance Committee minutes.
Prevent all Never Events.	No Never Events reported in 2010/11 and 2011/12.	Adverse Incident Reports, National Patient Safety Agency reports.
Reduce the number of adverse events resulting in severe harm.	44 Serious Incidents (SI) reported in 2011/12. This figure cannot be viewed against 2010/11 figures (7) because national SI reporting definitions were changed in year and a much wider group of incidents included. All incidents are reported and investigated in accordance with Trust and DoH guidelines. All incidents are validated as an SI by the Medical Director. All incidents investigated using Root Cause Analysis and are reported to the Trust Clinical Governance and Risk Committee and the Board of Directors.	Adverse Incident Reports, National Patient Safety Agency reports.

Priorities for quality improvement 2012/13 - Clinical outcomes framework

In order to identify priorities for quality improvement in 2012/13, we have used a wide range of information sources to help determine our approach. These include gathering the views of patients, public and carers using real-time feedback; collating information from claims, complaints and adverse incidents; and using the results of internal and external clinical audits and patient surveys to tell us how we are doing in relation to patient care, experience and safety. We have also used risk reports and listened to what staff have told us during Meet the Executive sessions and Executive Director Patient Safety Walkrounds.

We have considered the results of the National Staff Survey to help us decide where we need to focus our quality improvement efforts and actions. We have also taken on board the national picture for patient safety and collaborated with other acute trusts (as part of South West networks and the NHS Quest Collaborative) to look at how joint initiatives may be undertaken and best practice developed together.

The Trust has also formally consulted with key stakeholders (general public, foundation trust members, governors, LiNks, commissioners) to help identity quality improvement priorities for 2012/13. Priorities have been considered with clinical staff as part of service delivery and clinical governance meetings.

Following consultation, the Board of Directors have agreed the following priorities for 2012/13:

- Reducing harm from inpatient falls
- Reducing harm from hospital acquired pressure ulcers
- Reducing urinary tract infections caused by catheters
- Reducing hospital acquired venous thromoboembolism (VTE blood clots)

The Trust's objective is to ensure at least 95% harm free care across all 4 harms in line with the national harm free care target.

The Trust is committed to monitoring "Harm Free Care" using the Safety Express "Safety Thermometer" tool across all ward and inpatient areas. All inpatient areas will complete the Safety Thermometer tool each month. Data collection and Harm free care performance will be reported monthly to the Trust's Healthcare Assurance Committee and the Board of Directors as part of a Quality Dashboard. Where possible the Trust will review compliance against published national and local benchmarking.

Statement of Assurance from the Board

During 2011/12 the Trust provided eight NHS Services in accordance with its licence 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 all of these NHS 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 2011/12 represents 100% of the total income generated from the provision of NHS services by the Trust for 2011/12.

The data reviewed for the Quality Report covers the three dimensions of quality - patient safety, clinical effectiveness and patient experience. Information reviewed included directorate clinical governance reports, risk register reports, clinical audit reports, patient survey feedback, real time monitoring comments, complaints, compliments and adverse incident reports, quality dashboards and, quarterly clinical governance data. This information is discussed routinely at Trust Clinical Governance and Risk Committee meetings. There is a clear quality reporting structure where scheduled reports are presented from directorates and specialist risk or quality sub-groups to the Clinical Governance and Risk Committee each month. Many of the reports are also reported quarterly to our commissioners as part of our requirement to provide assurance on contract and quality performance compliance.

Participation in national clinical audits

During 2011/12, 34 National clinical audits covered NHS Services (www.dh.gov.uk/qualityaccounts) that the Trust provides. During 2011/12 the Trust participated in 82% of national audits which it was eligible to participate in.

The National clinical audits that the Trust was eligible to participate in during 2011/12 are shown in the table below. The national audits that the Trust participated in, and for which data collection was completed during 2011/12, 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 (where applicable).

Audit Title	Participation	Cases Submitted
Peri and Neonatal		
Perinatal Mortality (MBRRACE-UK)	Yes	Maternity Unit regularly contributes data where applicable
Children		
Pain Management (College of Emergency Medicine)	Yes	50 cases submitted
Acute Care		
Emergency Use of Oxygen (British Thoracic Society)	Yes	36 cases within specified time period (15/08/11 - 01/11/11)
Adult Community Acquired Pneumonia (British Thoracic Society)	No	Local audit of 78 cases undertaken
Non-Invasive Ventilation - adults (British Thoracic Society)	No	The Trust has registered for the 2012 Audit
Pleural Procedures (British Thoracic Society)	No	Local audit of 200 chest drain insertions undertaken
Cardiac Arrest (National Cardiac Arrest Audit)	Yes	174 cases submitted to 1/3/12. Data collection ongoing
Severe Sepsis and Septic Shock (College of Emergency Medicine)	Yes	30 cases submitted
Adult Critical Care (ICNARC CMPD)	Yes	Data submitted through ICNARC by ITU department
Potential Donor Audit (NHS Blood and Transplant)	Yes	96 cases submitted (April - December 2011)
Seizure Management (National Audit of Seizure Management)	Yes	30 cases submitted (100%)
Long Term Conditions		
Diabetes (National Diabetes Audit)	Yes	73 cases submitted
Heavy Menstrual Bleeding Audit (RCOG National Audit of HMB)	Yes	100 cases submitted
Chronic Pain (National Pain Audit)	Yes	95 cases submitted
Ulcerative Colitis and Crohn's Disease (UK IBD Audit)	Yes	100% required cases submitted
Parkinson's Disease (National Parkinson's Audit)	Yes	20 cases (100%) submitted for MFE and AHP sections of audit. 3 cases (15%) submitted for neurology
Adult Asthma (British Thoracic Society)	No	
Bronchiectasis (British Thoracic Society)	No	Local audit of 26/50 cases in 2011/12

Audit Title	Participation	Cases Submitted
Elective Procedures		
Hip, Knee and Ankle Replacements (National Joint Registry)	Yes	Routine data collection ongoing
Elective Surgery (National PROMS Programme)	Yes	Routine data collection ongoing
Coronary Angioplasty (NICOR Adult cardiac interventions audit)	Yes	The Trust contributes regular data to this as required.
Peripheral Vascular Surgery (VSGBI Vascular Surgery Database)	Yes	71 cases submitted (90%)
Carotid Interventions (Carotid Interventions Audit)	Yes	77 cases submitted (93%)
Cardiovascular Disease		
Acute Myocardial Infarction and other ACS (MINAP)	Yes	Ongoing data collection by Cardiology Dept
Acute Stroke (SINAP)	Yes	Data collected to mirror SINAP database across Dorset - will submit to SINAP when local database compatible
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	Data submitted to this audit on an ongoing basis as required.
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	All required data submitted
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	All required data submitted
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	All required data submitted
Trauma		
Hip Fracture (National Hip Fracture Database)	Yes	Data submitted where appropriate
Blood Transfusion		
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Yes	40 cases submitted
Medical Use of Blood (National Comparative Audit of Blood Transfusion)	Yes	23 cases submitted
Health Promotion		
Risk Factors (National Health Promotion in Hospitals Audit)	No	
End of Life		
Care of Dying in Hospital (NCDAH)	Yes	47 cases submitted

The reports of eight national clinical audits were reviewed by the Trust in 2011/12 and the Trust intends to take the following actions to improve the quality of healthcare provided in these areas as follows:

Audit	Actions Intended
BTS Emergency Oxygen Audit 2011	• Improvement to oxygen prescription. • All doctors in department to be given copy of report and to be made aware of programme to implement change.
National Audit of Seizure Management	• Action plan being developed.
Pain management (CEM)	• Action plan being developed.
Severe sepsis and Septic Shock (CEM)	• Action plan being developed.
National Diabetes Inpatient Audit Day 2010	• All trained staff and doctors to do 'Safe Use of Insulin' e-learning module. • E-learning module to be added to medical staff induction.
UK Irritable Bowel Disease (IBD) Audit 3rd Round	• To improve the rate of prescribing bone protection agents alongside steroids when used in the management of IBD. • To improve the use of Malnutrition Universal Screening Tool (MUST) to identify at risk patients and subsequent referral to dieticians when in hospital. • To increase the number of inpatients with IBD seen by an IBD nurse during their admission.
National Parkinson's Disease Audit	• Avoid cancelling new patients in reduced clinics to reduce waiting time for new patients. • Introduction of a standard tick box review form for follow up to improve documentation. • Raise awareness of end of life care, in those with end stage disease, in order to help care planning and lessen expectations of drug treatment.
Bedside transfusion (National Comparative Audit of Blood Transfusion)	• Continue to address importance of 15 minute vital signs once transfusion in progress in transfusion training sessions. (ongoing) • Discuss at Hospital Transfusion Committee in December 2011. (completed)

Meeting local clinical audit standards

The reports of 272 local clinical audits were reviewed by the Trust in 2011/12 and as a selection the Trust intends to take the following actions to improve the quality of healthcare provided:

Audit	Change to Practice
An Audit of Anaesthetic Technique and Postoperative Analgesia as Part of Enhanced Recovery in Open and Laparoscopic Colorectal Surgery	As a result of auditing the enhanced recovery pathway for colorectal surgery the Anaesthetics Directorate are amending procedures to increase the intrathecal morphine dose. The enhanced recovery nurse specialist will also set up a database with the lead surgeon to facilitate future audits of the pathway.
National Diabetes Inpatient Audit Day 2010	An e-learning module is to be added to the doctor's induction following the National Diabetes Inpatient Audit.
Gentamicin Use Audit	An audit of gentamicin across the Trust has informed the new policy for the use of gentamicin. The revised policy highlights the importance of taking drug levels within appropriate time windows and that renal function should be considered when choosing gentamicin.
Cardiac Rehabilitation Exit Survey	Following a recent cardiac rehabilitation exit survey it has been decided to hold two additional classes in the east of the region to provide a better service to this group of patients.
Audit of Chest Physician Performed Ultrasound (US)	An audit of chest physician performed ultrasound demonstrated that chest physician ultrasound can be performed on the ward by a trained physician if they are available.
Transient Ischaemic Attack (TIA): Vital Signs	Following an audit of TIA vital signs monitoring provision of a weekend service is to be agreed across the network. Acute stroke unit staff nurse training will be completed to ensure that the TIA nurse is covered during study and annual leave.
Maternity Audits	Audits of several topics in the Maternity Unit have led to improvements in the design of hand-held notes and inclusion of a new admission sheet with space for recording risk assessment and observations. Training for midwifery care assistants on use of the Dynamap has been introduced. Low apgar score reporting has also been enhanced. Following an audit of maternity patient information provision, an information checklist has been introduced to ensure women are given appropriate information at the right time.
Extended venous thromboembolism reducing the risk (VTE) prophylaxis after oesophagogastric cancer surgery	A survey of patients having extended VTE prophylaxis after oesophagogastric cancer surgery indicated that they felt they were not given enough instruction and information about self administration of injections. Patient education and teaching is now started much earlier in the inpatient stay and patients are given specific written information at pre-assessment and in clinic.

Use of sedation in ventilated patients on ITU	An audit of use of sedation in ITU demonstrated that patients did not always receive a sedation break when indicated. All patients now have a sedation break at 8.30am unless otherwise documented. The appropriateness of a sedation break is now decided on the evening ward round and documented on the patient's chart.
Customer evaluation of the catering service	The Catering Department introduced price promotions via the internet following a customer evaluation of their service.
Patient falls - Patients with fractured neck of femur	Following an audit of patients with fractured neck of femur, additional training was put in place regarding completion of falls risk assessment paperwork and additional equipment was purchased to assist post falls management.
Safeguarding children and safeguarding children training audit	A robust supervision model is being introduced for staff following a trust wide audit of Safeguarding Children
National Sentinel Audit of Stroke 2010	Following the National Sentinel Audit of Stroke, seven day working was introduced for therapy teams to enable more patients to receive an assessment within 72 hours. Occupational Therapy (OT) and Physiotherapy initial assessments were also combined to address an indentified delay in OT assessment.
Audit of diabetic patients admitted with new or ongoing diabetic foot problems	Following an audit of NICE CG119 new ward paperwork is being introduced to facilitate assessment of a patient's diabetes including an assessment of their feet on admission.
Safeguarding children - ophthalmology	An audit of safeguarding children in ophthalmology found that there was no place to record the person who accompanied the child to hospital in the records. Funding has been identified to upgrade the IT system to include a mandatory field to be filled in for all children attending clinic.
Recording amputees' weight at clinically relevant time points	An audit of amputees weight at clinically relevant time points identified that this was not being done often enough in clinically obese patients. An obesity measure has been introduced to monitor their co-morbidity risk and a six monthly review by the multi-disciplinary team (MDT) for all patients over 125kg has been commenced in clinics. New guidelines have also been written for the weighing of patients and new weighting scales purchased throughout the Trust.
Patient safety audit	Following an audit of nurse interruptions during drug rounds, a ward job book was introduced to enable staff to leave messages for nurses instead of interrupting them.
Carotid artery disease and endarterectomy in TIA and minor stroke	Following this audit, a patient pathway was developed where patients with significant artery disease should have surgery within two weeks in collaboration with vascular surgery team.

Audit of Do Not Attempt Resuscitation (DNAR) Forms	Following an audit of DNAR documentation the DNAR form and audit tool are being revised to enhance ease and accuracy of completion in future.
Audit of Inpatient Falls	Additional guidance and training has been provided for staff following an Audit of Inpatient Falls. A series of in-house training videos and e-learning has also been developed to support safe practice.
Audit of Patient information Leaflet Racks	An Audit of Patient Information Leaflet Racks has resulted in the identification of leaflet rack leads to ensure that only approved leaflets are displayed. A list of approved external organisations has also been developed and placed on the intranet as a reference source for staff.
Audit of Maternal Antenatal Screening Tests and Fetal Abnormalities	Following an Audit of Maternal Antenatal Screening Tests and Fetal Abnormalities a business case is to be submitted to allow for screening of positive women's partners by 11weeks six days.
An Audit of Urgent Brain Imaging for Stroke Patients	An Audit of Urgent Brain Imaging for Stroke Patients has led to the Stroke Team liaising with Radiology to develop a pathway for urgent brain imaging and a plan for urgent out of hours brain imaging is to be developed at Trust level.
Review of Cost Savings, Length of Stay and Readmission Rates by Implementing an OPAL Outreach Care Service	Following a Review of Cost Savings, Length of Stay and Readmission Rates by Implementing an OPAL Outreach Care Service it has been decided to employ an OPAL Outreach therapist to pilot a Rapid Assessment Clinic and increase care hours to include Dorset.

The Trust has developed a detailed clinical audit plan for 2012/13 to include national, corporate and local clinical audit priorities and this will be monitored via directorate clinical governance committees and the Trust Clinical Governance and Risk Committee. Progress is also reported quarterly to the Healthcare Assurance Committee and the Board of Directors.

Participation and Implementation of National Confidential Enquiry (NCEPOD) reports

During 2011/12 four (4) National Confidential Enquiry (NCEPOD) reviews covered NHS services that the Trust provides.

During 2011/12 the Trust participated in 100% of National Confidential Enquiries which it was eligible to participate in.

The National Confidential Enquiries that the Trust was eligible to participate in during 2011/12 are listed below.

The National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2011/12 are listed below alongside the number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry.

Title	Participation	% Cases Submitted
Bariatric Surgery	Clinical questionnaire and case note collection	100% (6 cases)
Cardiac Arrest Procedures	Organisational questionnaire, clinical questionnaire and case note collection	100% (6 cases)
Peri-Operative Care	Organisational questionnaire, clinical questionnaire and case note collection	100% (6 cases)
Surgery in Children	Organisational questionnaire returned	Not applicable

The reports of three National Confidential Enquiries were reviewed by the Trust in 2011/12 and the Trust intends to take the following actions to improve the quality of healthcare provided in these areas as follows:

Confidential Enquiry Report	Action Taken
Emergency and Elective Surgery in the Elderly - An Age Old Problem 2010	A pilot project was set up whereby a registrar from MFE was available daily to see surgical patients with medical problems on request. A working Group was set up with representatives from surgery, anaesthetics and MFE chaired by an MFE consultant to identify further actions.
Surgery in Children - Are We There Yet? 2011	The report was reviewed by a paediatric anaesthetist within the Trust and it was concluded that no action was required as there is evidence that the Trust is meeting all relevant recommendations.
Perioperative Care - Knowing the Risk? 2011	The Clinical Director for Surgery has renewed the report and the recommendations from this report will be taken into account during the Acute Surgical Review taking place in the Trust.

Research governance

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during 2011/12 period to participate in research approved by a research ethics committee was 1452.

Commissioning for Quality and Innovation (CQUIN) objectives and achievements for 2011/12

Income in 2010/11 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because the contract agreed with commissioners was not able to afford CQUIN for 2011/12. However the Trust fully achieved the national VTE requirements and a wide range of quality improvements.

Care Quality Commission registration

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

The CQC has not taken any enforcement action against the Trust during 2011/12.

The Trust has participated in three special reviews or investigations by the CQC relating to its license in 2011/12.

The CQC issued two minor and one moderate concern against the Trust during 2011/12.

Date	Scope of Inspection	CQC Report
June 2011	CQC Dignity and Nutrition Report. This inspection was part of a routine inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. In particular the CQC focused on whether patients are treated with dignity and respect and whether their nutritional needs are met.	The CQC found that the Trust was meeting both of the essential standards of quality and safety reviewed.
October 2011	CQC Inspection of Christchurch Hospital.	The CQC found that Christchurch Hospital met all the essential standards of quality and safety.

November 2011	CQC Inspection of Royal Bournemouth Hospital.	The CQC found that the Royal Bournemouth Hospital met all essential standard for Outcome 7,14 and 16. The CQC found that improvements were needed for the essential standard Outcome 9 - People should be given the medicines they need when they need them and in a safe way. A CQC moderate concern was raised. The CQC also raised a minor concern for Outcome 1 and Outcome 4 relating to standards of documentation for Do Not Attempt Resuscitation (DNAR) and fluid monitoring respectively. In each case the CQC reported that the Royal Bournemouth Hospital was meeting the essential standard but, to maintain this, they suggested that some improvements were made.

The Trust implemented a formal action plan to address medicines management concerns raised by the Care Quality Commission including improvements to medication storage, documentation and administration. The action plan was approved and monitored by the Board of Directors.

The Trust has made full progress against the action plan and completed all actions by 31 March 2012. Compliance with the action plan has been verified by self-assessment and independent review by the Council of Governors and Internal Audit. Completion of the action plan has been reported to Monitor and the Trust Governance risk rating returned to Green.

Action plans to address the 2 minor concerns have also been put in place and auditing will be undertaken in 2012/13 in order to review on going compliance.

Data quality and information Governance

Data quality

The Trust submitted records during 2011/12 to the Secondary Users Service (SUS) for inclusion in the Hospital Episode statistics which are included in the latest published data.

The percentage of records in the published data which included the patients valid NHS number was 99.6% for admitted patient care: 99.9% for outpatient care; and 96.8% for accident and emergency care.

The percentage of records in the published data which included the valid General Practitioner Registration Code was 100% for admitted patient care: 100% for outpatient care; and 100% for accident and emergency care.

Information governance

All NHS Trusts are required to complete an annual Information Governance assessment via the Information Governance Toolkit. The self-assessment must be submitted to Connecting for Health, with all evidence uploaded by 31st March 2012.

The Trust's Information Governance Toolkit Version 9 assessment overall score for 2011/12 was 72% and was graded Green. In order to attain this grade, the Trust has achieved a score of at least Level 2 in all of the 45 requirements. This overall score includes 8 standards graded at Level 3, which is the maximum score that can be attained on any standard.

During 2011/12, the Trust has enhanced its Information Governance arrangements by appointing a dedicated Information Governance Manager, and also by maintaining the approach implemented during 2010/11 to ensure that all staff are comprehensively trained in Information Governance.

Further improvements are expected in 2012/13. A realistic and attainable action plan to achieve an increase in the Trust's overall IG Toolkit compliance score will be implemented following the release of Version 10 of the IG Toolkit during summer 2012. Further work will also be undertaken to continue to embed the principles of good Information Governance within the organisation and supplement training provided to staff through an Information Governance awareness campaign.

Clinical coding

The Trust was subject to a Payment by Results (PbR) clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period of diagnosis and treatment coding (clinical coding) were 11.4%.

The results should not be extrapolated further than the actual sample audited; the services that were reviewed within the sample were urology and a random selection from SUS.

3.0 Other information

The following section provides an overview of the care offered by the Trust based on performance in 2011/12 against key quality indicators selected by the Board in consultation with stakeholders. The indicators have been selected to demonstrate the Trust's commitment to patient safety, clinical effectiveness and enhancing the patient experience. The indicators have also been selected on the basis of data collection, accuracy and clarity.

3.1 Patient safety

3.1.1 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 Trusts strategy to reduce medication errors, compliance with national standards for medicines management and ensuring implementation of safe practice alerts and reports.

Patient Safety and Quality Improvement Initiatives to support medication safety and medication incident reduction during 2011/12 have included:

- Audit of clinical processes in the delivery of medications to patients
- Spot checks of nursing staff clinical practice
- Review of storage facilities for medications in wards, departments and during transfer of the patient
- Updating staff and reminders relating to the medicines policies and procedures
- Review of CQC compliance evidence and assurance from Senior Nurse meetings and directorates regarding arrangements in place for safe delivery of medications

- Review of medication incident reports, trends and action plans via Medication Incident Review Group. Awareness raised about reporting near miss and no harm events to maximise learning opportunities and risk reduction
- Assurance and monitoring processes overseen and reviewed by the Medicines Governance Committee.

The focus in 2011/12 has also been on the importance of reporting and learning from adverse events, including near miss and non harm events. All events are a learning opportunity and can lead to a reduction in actual incidents through personal and organisational development, quality improvement and risk reduction action. Pharmacy, Senior Nurses, Clinical leaders and Consultants have all been encouraged to report near miss incidents and observations of poor practice relating to medicines management.

All reported incidents are stored on a central database (Datix) and standard National Patient Safety Agency (NPSA) coding used to record incident type and severity.

As can be seen from the graph below, as a result of the focus on reporting no harm events the total number of reported incidents has increased in 2011/12 (679 compared to 509 in 2010/11) However, the number of serious harm events has not significantly increased. In addition, in 2011/12 75% of reported incidents were no harm events, compared to 73% in 2010/11.

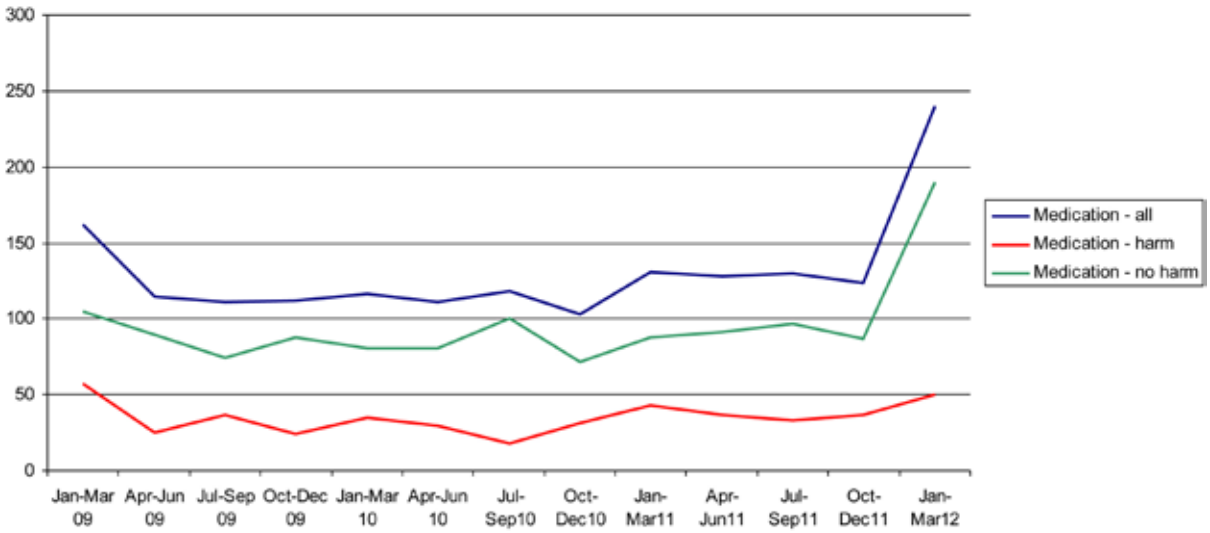
This data is also sent to the NPSA National Learning and Reporting Centre (NRLS). This gives the Trust the opportunity to compare itself with data from all other acute Trusts. Using the most recent NRLS data (April-September 2011) the Trust reported 0.64 medication incidents (including no harm events)/100 admissions, compared to an acute Trust average of 0.65/100 admissions.

3.1.2 Reducing patient falls

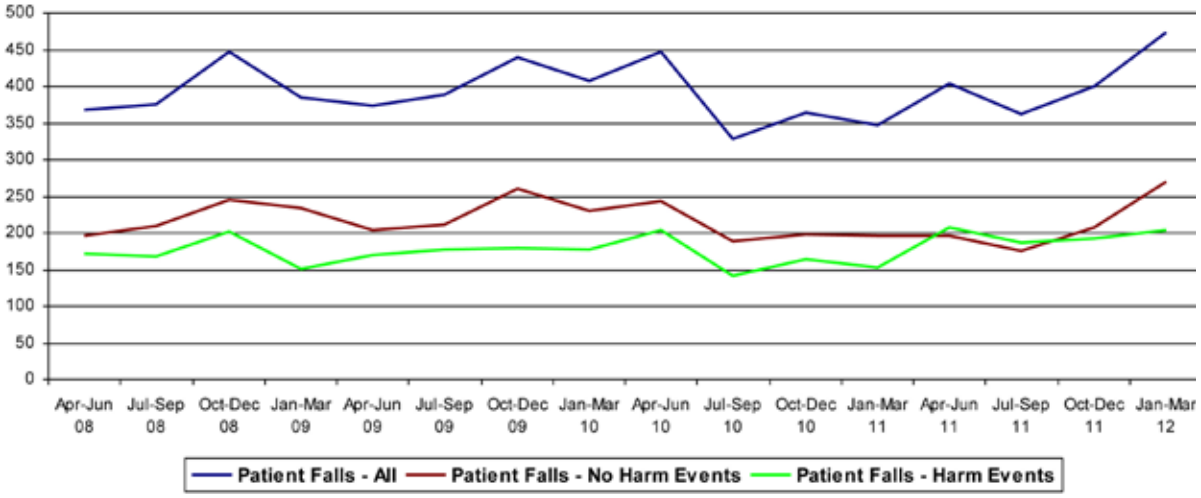
Patient accidents form the largest group of all patient safety incidents reported to the NPSA via the NRLS.

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 a harm event when a similar incident has occurred and the patient sustained a bruise, cut or more serious injury.

Medication incidents (all events including near misses and no harm events) reported 2011/12



Reported patient falls (all events) - 2011/12



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

A total of 1,505 patient falls were reported in 2011/12 compared to 1,498 in 2010/11. In 2011/12, 1.5% of reported incidents resulted in severe harm to a patient, this compares to 1.1% in 2010/11.

The classification of severe incidents was redefined in year.

As a year average, the Trust reported 5.3 patient falls/1,000 bed days, compared to an acute trust average (2009, NPSA data) of 5.6/1000 bed days.

The total number of falls remains fairly static in year. Trust-wide quality improvement measures in 2011/12 included:

- Implementation of a patient falls toolkit on each ward/clinical area. The toolkit provides guidance and information on the management of patient falls.
- Revision of patient risk assessment documentation, including a post falls checklist.
- Provision of new dynamic mattress systems across the Trust that includes a patient egress safety function
- In house e-learning Videos on falls management
- Implementation of a Neck of Femur (NOF) pathway
- Clear criteria for the provision of non-slip slippers for patients and a trial of TED stockings with grippers pads on the soles (still in progress)
- Launch of the Safety Express Initiative with a focus on delivering harm free care as defined by the reduction of serious injury from falls.
- Pilot of intentional rounding - an initiative to establish routine active “well-being” checks for patients assessed as having a greater risk of falls.
- Audits of falls and bed rails risk assessment documentation and feedback to clinical areas to raise awareness about compliance standards
- Trials of patient falls alarms for beds and chairs (ongoing)
- Work with Pharmacy Department to develop guidelines for staff on medications associated with falls risk factors.

3.1.3 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 and Midwifery 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 publicly and available on the Trust website.

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. 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 2012 identified an improvement in privacy and dignity provision at Christchurch Hospital.

MRSA bacteraemia

The Trust has maintained a low rate of MRSA bacteraemia in 2011/12 reporting two healthcare aquired cases in the year.

Clostridium difficile

All cases of C. difficile infection at this Trust are reported and investigated. The numbers of cases reported for 2011/12 was over the national target but within the contract target for the year.

3.2 Clinical effectiveness and quality of care

3.2.1 Reducing hospital mortality

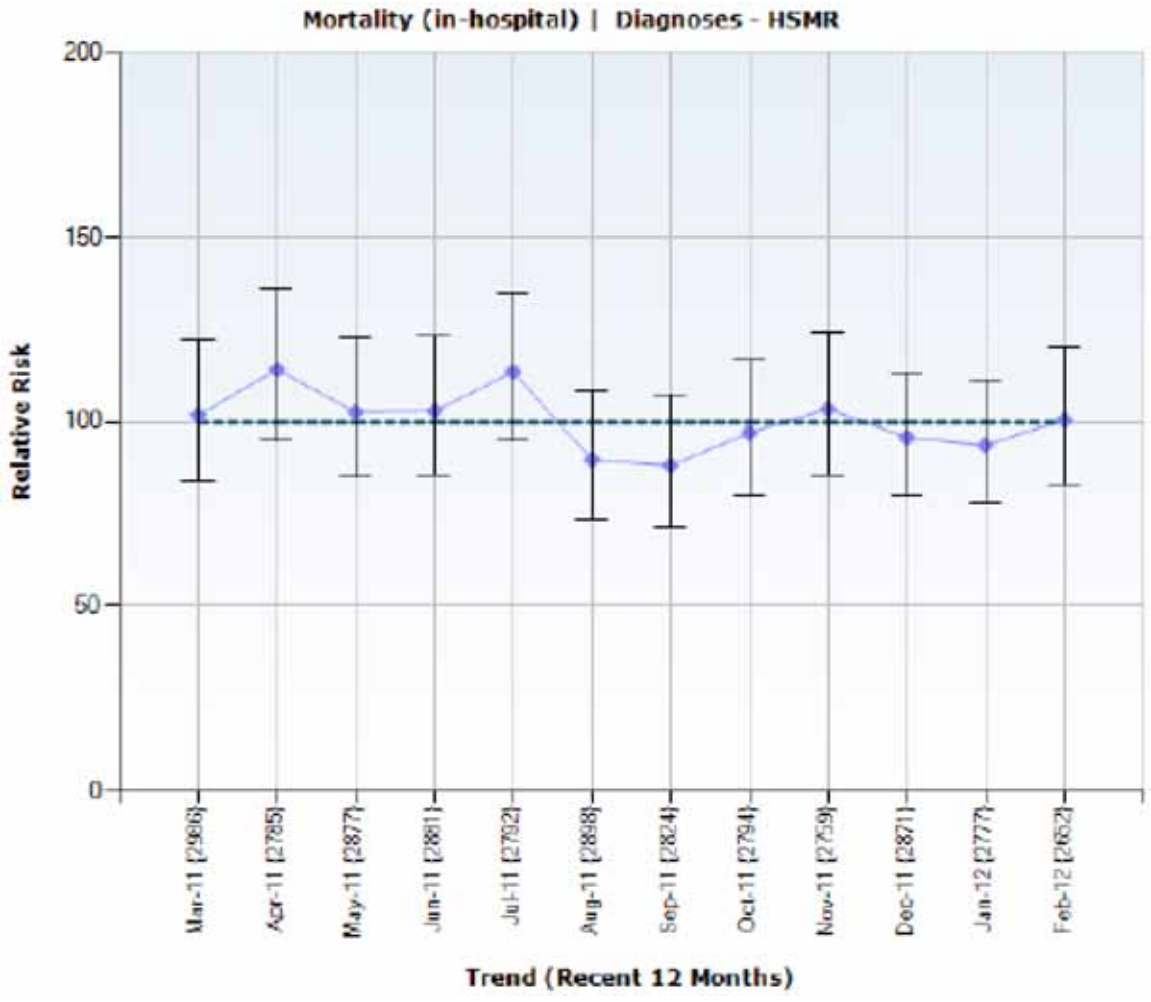
In December 2009, the Trust set up a multidisciplinary Mortality Group, chaired by the Medical Director, to review the Trust's HSMR (Hospital Standardised Mortality Ratio) and Dr Foster Cummulative Summary and relative risk reports on a monthly basis. The group also reviews death certification and electronic Immediate Discharge Forms (e-IDF) to ensure accuracy of coding. The group discusses areas of potential concern regarding clinical care or coding issues and identifies further work, including detailed case note review and presentations from relevant specialties.

Year	Site	Environment Score	Food Score	Privacy and Dignity Score
2012	Christchurch Hospital	Good	Excellent	Excellent
	Bournemouth Hospital	Good	Good	Excellent
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

Mortality data alerts may be triggered by Dr Foster analysis, through Imperial College, or from Care Quality Commission data analysis. Dr Foster is a leading provider of comparative information on health and social care services. Their online tools and consumer guides are used by both health and social care organisations to inform the operation of their services. Dr Foster produces an annual hospital guide and one metric within this, known as HSMR, has become a recognised way of assessing hospital mortality. It is generally accepted that there are difficulties with all methods of comparative mortality data. The Department of Health has recently produced their own equivalent - Summary Hospital Mortality Indicator (SHMI) which also includes deaths in the 30 day period following discharge from an acute hospital.

In 2011, The Trust received 3 CQC Alerts relating to Septicaemia, Peritonitis and intestinal abscess and Chronic Renal Failure.

When an alert is received a full investigation is undertaken and a report submitted to the CQC. Reports have continued to identify problems with coding (wrong primary diagnosis, use of non-specific codes, poor coding of co-morbidities) but there has been continuing education with regard to the completion of death certificates and coding and this has improved substantially. In general we have found many of the deceased patients have been very elderly, with major co-morbidities and generally we have found no or little evidence of poor care that would have changed outcome - i.e. death was inevitable. Each review focuses on the quality of the care given, and whether death could have been prevented, as well



as on evidence of good communication with patient and family, the quality of the documentation, and whether end of life care was well managed, with specific review of use of the Liverpool Care Pathway for the dying and Do Not Attempt Resuscitation discussions.

3.2.2 Ensuring NICE guideline compliance

The Trust Clinical Governance and Risk Committee (CGRC) reviews compliance with all new NICE Guidance issued each month. For the period April 2011 - March 2012 the CGRC reviewed a total of 106 items of newly issued guidance.

Compliance rates are shown in the table below:

3.2.3 Ensuring compliance with safety alerts

A total of 99 Medicines and Healthcare Regulatory Authority (MHRA) Medical Device Alerts were issued and received in the year. Of these 25 applied to medical devices used within the Trust. The Trust ensured compliance with all relevant alerts.

In addition, 11 NHS Estates Alerts were issued and received in the year. Of these 10 were applicable to the Trust, seven required action but are completed and three 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 3 new Alerts in 2011/12. One Alert was not applicable to the Trust and two still have action plans in place. Where actions are still required these issues are highlighted on the Trust risk register and implementation

Type of Guidance	Published	Applicable	Compliant	Partially Compliant	Non Compliant
Clinical Guidelines	19	13	4	4	1 (3 still under review)
Technology Appraisals	31	21	16	1	0 (4 still under review)
Interventional Procedures	35	5	4	0	0 (1 still under review)
Public Health Guidance	2	1	0	0	0 (1 still under review)
Medical Technology Guidance	7	2	0	1	0 (1 still under review)
Cancer Services Guidance	0	0	0	0	0
Quality Standards	9	8	0	2	0 (6 still under review)
Diagnostics Guidance	3	2	2	0	0

monitored via the Trust Clinical Governance and Risk Committee and, where applicable, the Medicines Governance Committee. For each Alert a lead consultant has been appointed to coordinate compliance.

3.3 Patient experience

The main systems in place to measure patient satisfaction are:

- National mandatory patient surveys both Inpatient and outpatient survey
- Trust wide patient experience cards and 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
- Patient complaints.

3.3.1 National patient survey results

Inpatient survey

The Trust participated in the Picker Institute Inpatient Survey 2011. The raw data from the survey is analysed separately by the CQC as part of the National Inpatient Survey 2011.

A total of 850 patients from the Trust were sent a copy of the questionnaire, of which 499 were returned, giving a response rate of 60%. The national average response rate was 57%.

The survey highlighted many positive aspects of the patient experience. The Trust was significantly better than average on 28% (n=27) questions.

Most patients were highly appreciative of the care they received. However, the survey results did identify some areas for

Your results were significantly better than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Planned admission: should have been admitted sooner	17 %	23 %
Planned admission: admission date changed by hospital	14 %	19 %
Planned admission: not given printed information about condition or treatment	14 %	20 %
Admission: process not at all or fairly organised	23 %	32 %
Admission: had to wait long time to get to bed on ward	26 %	31 %
Hospital: toilets not very or not at all clean	4 %	6 %
Hospital: nowhere to keep personal belongings safely	55 %	63 %
Hospital: food was fair or poor	36 %	43 %
Hospital: did not always get enough help from staff to eat meals	24 %	33 %
Doctors: did not always wash or clean hands between touching patients	9 %	11 %
Nurses: sometimes, rarely or never enough on duty	33 %	40 %
Care: staff contradict each other	27 %	33 %
Care: not always enough emotional support from hospital staff	37 %	44 %
Care: more than 5 minutes to answer call button	12 %	17 %
Surgery: what would be done during operation not fully explained	18 %	25 %
Surgery: questions beforehand not fully answered	17 %	22 %
Discharge: was delayed	33 %	40 %
Discharge: not given any written/printed information about what they should or should not do after leaving hospital	27 %	34 %
Discharge: family not given enough information to help	43 %	50 %
Discharge: not told when to resume usual activities	39 %	50 %
Discharge: not told who to contact if worried	15 %	20 %
Discharge: did not receive copies of letters sent between hospital doctors and GP	29 %	34 %
Overall: doctors and nurses working together fair or poor	5 %	8 %
Overall: worried about security of personal information held by the hospital	4 %	7 %
Overall: would not recommend this hospital to family/friends	3 %	6 %
Overall: no posters/leaflets seen explaining how to complain about care	35 %	39 %
Overall: wanted to complain about care received	4 %	7 %

improving the patient experience. In particular, asking patients to give their views on the quality of their care, discharge delays and needing somewhere to keep their belongings safe.

One area where the Trust was statistically lower than national average scores was patients who had moved ward and were bothered by sharing sleeping areas with the opposite sex. This was noted by 23 patients (out of a total of 499) which is a small sample size.

The Trust has developed and is refining an action plan to address issues raised within the survey report and to incorporate the recent CQC publication of their analysis. The CQC analysis of the data demonstrates we are largely average with one green (which demonstrates that we are in the top 20% of trusts) and the rest orange and no red scores.

Due to changes in the CQC survey analysis methodology the CQC results can not be compared with the previous CQC years' scores.

Outpatient survey

The Trust participated in the CQC National Outpatient Survey 2011. A total of 850 outpatient surveys were sent with 489 received back. This represented a response rate of 58% against the national average for the trusts surveyed by Picker of 49%.

Your results were significantly better than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Not given name of person that appointment would be with	22 %	28 %
Appointment not with person told it would be with	16 %	21 %
Could not find a convenient place to park	14 %	35 %
Not easy to find way to Outpatients Department	9 %	17 %
Courtesy of receptionist was fair, poor or very poor	3 %	7 %
Appointment started more than 15 minutes after stated time	27 %	40 %
Nobody apologised for the delay when waiting to be seen	35 %	47 %
Unable to immediately find a place to sit in waiting area	2 %	4 %
No suitable magazines or newspapers provided in the waiting area	20 %	32 %
Outpatients Department not clean	0 %	1 %
Toilets at the Outpatients Department not clean	2 %	5 %
No leaflets or posters about hand washing	2 %	6 %
Hand-wash gels not available or empty	6 %	10 %
Patients unable to get suitable food or drink	13 %	20 %
Did not have enough time to discuss medical problem with other health professional	18 %	25 %
Other member of staff did not fully explain reasons for treatment/ action	14 %	21 %
Other member of staff did not listen fully to what patient had to say	12 %	18 %
Other member of staff did not always give clear answers to questions	17 %	23 %
Did not have full confidence and trust in other member of staff	10 %	16 %
Other member of staff did not know enough about medical history	9 %	15 %
Did not completely discuss worries or fears with other health professional	26 %	34 %
Not all staff introduced themselves	20 %	28 %
Not enough or no information given about condition or treatment	11 %	16 %
Not given complete privacy when discussing condition / treatment	10 %	13 %
Not given complete privacy when being examined or treated	6 %	9 %
Not fully involved in decisions about care or treatment	22 %	27 %
Patient not given information on who to contact	28 %	32 %
Reason for visit not dealt with completely to patients satisfaction	19 %	25 %
Overall - Outpatients Department not at all/fairly organised	24 %	38 %
Overall - not always treated with respect or dignity	8 %	12 %
Overall - care rated as fair or poor	2 %	5 %
Overall - would not recommend this Outpatients Department to family and friends	1 %	3 %

Out of 74 questions, the Trust's scores were significantly better than the national average for 32 (43%) questions.

There were only two questions where the Trust's performance was worse than the national average:

- Patients not told when they would find out test results, we were 7% worse than the national average.
- Patients did not receive copies of letters sent between hospital doctors and family doctor (GP).

An action plan is being developed to address these areas of concern.

The results of the survey 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 noise at night, information regarding medicines on discharge and involving carer's appropriately, have been highlighted and this has resulted in improved practice. Another change in practice following survey feedback has been ensuring that patients receive more information regarding their operations and procedures, improved pain control and general information regarding the ward or how to speak with a doctor about their care.

3.3.2 Trust patient experience card results

Patient experience card results

In addition to responding to national patient surveys, the Trust has an internal patient experience card which is available in all inpatient and outpatient areas for patients, relatives and/or carers to complete. There are 11 questions on one side, chosen in parallel with the CQC and CQUIN questions. The other side is a freetext space for qualitative comments. The results are available to staff via a shared drive and are collated and fedback quarterly to all participating areas. A summary of the cumulative value since the introduction of the cards is shown below (September 2010 to March 2011, and April 2011- March 2012):

From September 2010 to March 2011 Number received:	614
From April 2011 to March 2012 Number received:	3639

		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?	2010/11	74%	20%	4%	2%
	2011/12	75%	20%	5%	1%
Did you find someone on the hospital staff to talk to about your worries and fears?	2010/11	71%	20%	7%	3%
	2011/12	71%	19%	7%	3%
Were you given enough privacy when discussing your condition or treatment?	2010/11	84%	12%	2%	1%
	2011/12	85%	11%	3%	1%

		Yes	No
Did a member of staff tell you about medication side effects to watch for when you went home?	2010/11	84%	16%
	2011/12	88%	12%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	2010/11	85%	15%
	2011/12	91%	9%
Were you treated as an individual at all times?	2010/11	97%	3%
	2011/12	98%	3%

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?	2010/11	15%	85%
	2011/12	8%	92%
b) Use the same bathroom/shower or toilet area as the patients of the opposite sex?	2010/11	25%	75%
	2011/12	16%	84%
Did you feel safe during your visit?	2010/11	98%	2%
	2011/12	98%	2%

In 2011/12, 63% of patients completing the patient experience card rated the Trust as “excellent” and 98 % said they felt safe whilst in our care.

		Excellent ..... Poor									
		10	9	8	7	6	5	4	3	2	1
How would rate your overall visit?	2010/11	62%	17%	11%	3%	1%	2%	0%	1%	1%	1%
	2011/12	63%	16%	11%	3%	2%	1%	1%	1%	0%	2%
How likely would you be to recommend us?	2010/11	71%	12%	7%	3%	1%	2%	1%	0%	0%	1%
	2011/12	73%	11%	8%	2%	1%	1%	0%	0%	0%	2%

A comparison to 2011 performance, noting that the cards have been in use only half a year effect in 2010/11 and a significantly lower number of patient experience cards had been received, shows small improvements. The exception is delivering same sex accomodation, which shows a greater improvement.

Overall, 73% of patients, relatives and carers rated the Trust as excellent, with a further 11% ranking us as 9/10 on the above scale.

Real-time Patient Feedback (RTPF)

RTPF is facilitated through the Trust's trained volunteers and public governors. Patients are asked a series of standard questions through face-to-face interviews and patient stories and views are collected.

Total accrual of the RTPF bedside survey has reached 6000. This has been achieved with the tremendous support of the excellent volunteers and public governors.

The RTPF surveys include specific areas that patients access services through, inpatients, daycases, the emergency department, including major and minor areas, and four outpatient departments. The surveys have been customised for their areas. The results are shared through a shared file with access for all clinical areas involved, and will be incorporated into their clinical dashboards which are currently in development. Actions for improvement of these methodologies is currently through directorates and a review of this to ensure the public can view the actions taken against their views and experiences is currently in progress. This service is also available online.

Patient experience telephone line

A dedicated telephone line is available for leaving messages or texting messages to. This dedicated line provides PALS access information. Any issues are picked up and the clinical areas are informed. Any positive comments are also passed on.

3.3.3 Patient Reported Outcome Measures (PROMS)

All NHS patients who are having hip or knee replacements, varicose vein surgery or groin hernia surgery are being invited to fill in Patient Reported Outcome Measure (PROMs) questionnaires. PROMs is a method of measuring the functional activity level of a patient as recorded by the patient. The same outcome measure is sent to the patient six months post-operation and the two scores are recorded by an external organisation Quality Health (on behalf of the Department of Health), with the aim of helping the NHS to measure and improve the quality of the care it provides. The Trust participates in all 4 National PROM surveys. All patients who come into hospital for one of the above procedures are asked to fill in a PROMS questionnaire before their operation.

The Trust is judged on how well patients are asked and the overall uptake rate. In Orthopaedics reports are published weekly, monthly, quarterly and annually to give regular feedback to the members of staff collecting the scores and to encourage some healthy competition and pride in maintaining high levels of compliance. In March 2012 the data recorded was extended to include a portion of the PROMs score to enable the quality of data to be measured alongside quantity. These measures have led to the annual Orthopaedic PROMS compliance rates increasing to 95% and 97% for knees and hips respectively with a further improvement, over the first quarter, to 100% and 118%.

	Compliance Rate 2010/11	Compliance Rate 2011/12	Compliance Rate Jan-Mar 2012
PROMS for Groin Hernia	90%	59%	81%
PROMS for Varicose Veins	86%	17%	22%
PROMS for Total Knee replacement	79%	95%	100%
PROMS for Total Hip replacement	76%	97%	118%

The national average participation rate (as provided by Quality Health for the Department of Health) at April 2012 is 75%.

The fall in the compliance rate for varicose veins is indicative of a fall in the number of operations performed in the Trust. Quality Health, when calculating percentages use a dominator based on the previous year's (2010/11) clinical activity. For varicose veins this was 30 per month in 2010/11 but due to changes in clinical activity and demand, the actual value is approximately seven procedures per month. The same issue applies to groin hernia operations.

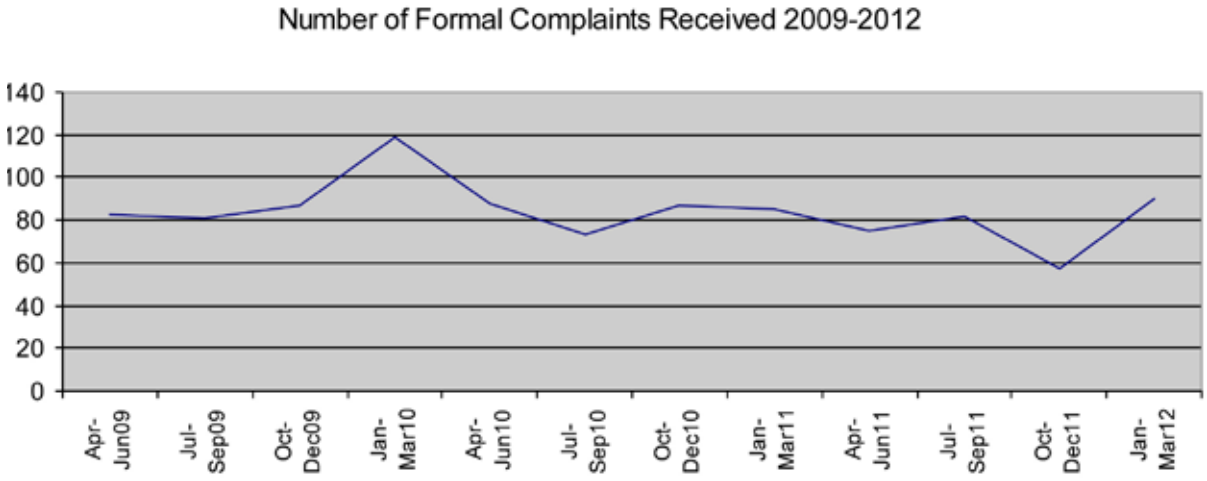
3.3.4 Managing complaints

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.

There were 304 formal complaints from patients or their representatives during the year. This represents a decrease of 2.8% (nine complaints) from last year's total of 313 complaints.

Of the 304 formal complaints, 156 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.

Table: Number of complaints in 2011/12



Subjects of complaints

The main categories of complaint were as follows:

Subject	Number in 2010/11	Number in 2011/12	Percentage in 2010/11	Percentage in 2011/12
Administrative systems	31	19	10%	6.3%
Attitude of staff	23	32	7%	10.5%
Bed management	1	1	0.3%	0.3%
Clinical treatment	161	177	51%	58.2%
Communication/information	62	44	20%	14.5%
Discharge arrangements	11	14	4%	4.6%
Environment	2	2	0.6%	0.6%
Equipment/facilities	2	0	0.6%	0
Health and safety	9	7	3%	2.3%
Privacy and dignity	4	2	1.2%	0.7%
Availability of staff	3	1	1%	0.3%
Policies and procedures	3	1	1%	0.3%
Violent/Aggressive behaviours	1	0	0.3%	0
Transport	0	1	0	0.3%
Theatre Management	0	3	0	1.0%
Total	313	304	100%	100%

15 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:

- Improvements to systems for follow up appointments
- Ensuring GP electronic details added to Pathology database
- Implementation of a new telephone handover checklist between the Royal Bournemouth Hospital and Christ-church hospitals.
- A review of ward environment to meet needs of dementia patients
- Additional staff training on cannulation skills, venepuncture and drug administration
- Electronic screens in eye unit outpatients updated with information about delays and advice to patients if they have any concerns about their appointments
- Improvements in the Endoscopy department to ensure that all necessary medical records and authorisation of bowel preparation medications are in place in advance of patient admission
- Pharmacy and medical team shared learning on assessing patient's medication history together with their condition in order to review the patient holistically

- Nursing staff firmly reminded of the importance of maintaining good standards of cleanliness in ward bathrooms
- Standards of documentation and importance of informing next of kin of discharge arrangements when this has previously been agreed with the patient addressed with nursing staff
- Maternity staff reviewed procedures, training and awareness of tongue tie checks in new borns
- Revision to information leaflet provided to patients in discharge lounge
- LCD screens reviewed to provide information on potential outpatient delays

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, 19 people chose to refer their concerns to the Parliamentary and Health Service Ombudsman during 2011/12 compared to 22 in 2010/11. The Ombudsman declined to investigate 13, referred two back for further local resolution, and undertook one investigation of a complaint, the decision in which was not to uphold. Three complaints are still being assessed by the Ombudsman.

3.4 Performance against key national priorities for 2011/12

The following table provides an overview of performance in 2011/12 against the key national priorities from the Department of Health's Operating Framework. 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	2011/12 Target	2011/12 Actual
Clostridium difficile year on year reduction	44	46	87	62
MRSA - hospital acquired	3	0	6	2
Maximum waiting time of 31 days from decision to treat to start of treatment	97.71%	99.56%	96%	96.7%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	99.2%	99.6%	94%	99.2%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti cancer drug treatment	100%	100%	98%	100%
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	96.30%	97.00%	90%	94.6%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	88.26%	89.71%	85%	87.3%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	94.11%	93.60%	93%	94.2%

National Priority	2009/10	2010/11	2011/12 Target	2011/12 Actual
Two week wait for breast symptoms (where cancer was not initially suspected)	86.26%	98.58%	93%	99.1%
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	99%	99%	95%	97%
18 week referral to treatment waiting times - admitted (95th percentile)	n/a *	n/a *	23 weeks	17.7 weeks
18 week referral to treatment waiting times - non admitted (95th percentile)	n/a *	n/a *	18.3 weeks	14.2 weeks
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	n/a	n/a	n/a	Compliance certified

*Note - Prior to 2011/12 the Department of Health set percentage thresholds for 18 weeks RTT monitoring.

Annex A - Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees

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

Comments received were as follows:

2011/12 Quality Account comment from Health Overview and Scrutiny Panel

I am writing on behalf of the Chairman of the Health Overview and Scrutiny Panel in Bournemouth, to confirm that the Panel will not be commenting on the Quality Account this year. I am hoping to engage members in the process at a much earlier stage in order for a meaningful comment to be provided this time next year.

Many thanks,

Democratic Services Officer
Democratic and Member Support Services
Bournemouth Borough Council

NHS Bournemouth and Poole and NHS Dorset statement for Royal Bournemouth and Christchurch Hospitals Quality Account 2011/12

NHS Bournemouth and Poole and NHS Dorset Cluster (the PCT Cluster) are pleased to comment on the Quality Account for Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

"From reviewing the Quality Account and from the ongoing monitoring of the Trust throughout 2011/2012, the PCT Cluster has seen a number of improvements in the provision of quality care, these include the opening of a newly refurbished stroke unit, actions taken to reduce patients falling, implementation of actions to improve care for patients with dementia, increased patient's satisfaction in outpatients and a high compliance level of VTE (Venous-thrombo embolism) risk assessments being undertaken, which has led to a reduction in the overall incidences of VTE. The national inpatient survey results also demonstrated that 8.9 out of ten patients felt that they were treated with dignity and respect during their admission.

An unannounced visit by the Care Quality Commission in November 2011 highlighted that, although the Trust met the essential standards for quality, improvements were required around essential standard Outcome 1, 4 and 9. The Trust took on board all the CQC findings and developed a robust action plan to ensure that it continues to provide the highest quality care.

The Cluster PCT will continue to monitor infection rates closely during 2012/13 to ensure a continual decrease in the overall number of hospital acquired infections in the local area and will work with the Trust over the coming year to enable a reduction in mortality rate as well.

NHS Bournemouth and Poole and NHS Dorset Cluster are pleased to support the quality improvement areas priority identified by Royal Bournemouth and Christchurch Hospitals for 2012/2013 relating to "Harm Free Care".

Your voice on local health and social care

2011/12 Quality Account comment from LINks

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

Hospital Radio Bedside received a LINks community chest grant, which has funded information banners. These are situated throughout Bournemouth Hospital.

Bedside Information Booklet

Information about the Bournemouth LINk was included in the bedside booklet.

Information Sharing

It is unfortunate that Royal Bournemouth Hospital were unable to agree to share their PALS comments with the LINk, even though the LINk formally asked for this information.

We are looking forward to receiving the data generated from the Real Time Patient Feedback and distilled data from PALS, on a regular basis throughout this forthcoming year.

The merger of the RBH and Poole Hospital

We were consulted on the merger of the RBH and Poole Hospital.

The LINk has received a small number of comments about the Poole and Bournemouth Hospitals merger. All the comments we've received (5 in total) have been about hospital services. Most people were concerned that the merger would result in the closure of Poole A&E department or that services would be moved to Bournemouth, making access difficult for people in Poole.

The Bournemouth LINk is looking forward to undertaking an Enter and View visit to the Hospital in 2012 as a result of patient feedback.

We believe that one 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 in light of the ongoing NHS reforms.

For more information about the Bournemouth, Poole and Dorset LINks, please go to: www.makesachange.org.uk

2011/12 Quality Report comment from the Council of Governors

The Council of Governors has appreciated that its views on the quality priorities for the Trust and the Quality Account itself are being requested at an earlier stage so that it has greater opportunity to make a meaningful contribution through the consultation process. The Council of Governors supports the quality priorities which have been set for 2012/13. The Council of Governors, through its Scrutiny Group, has also contributed to the quality assurance process at the Trust through its own audits and was pleased to see the recommendations of both audits presented during 2011/12 adopted by the Trust.

The Scrutiny Group of the Council of Governors has undertaken audits of certain areas in the past few years, taking topics which are aligned with the Trust's Annual Plan to either follow progress throughout the year or to take a view at a fixed point. The results of the reviews are then reported to the Council of Governors and the Board of Directors. In 2011/12 the Scrutiny Group reported on two audits:

1. Patient nutrition and hydration and all aspects of the meal service given its high national profile following The Mid-Staffordshire NHS Foundation Trust Inquiry led by Robert Francis QC.
2. The patients' bedside booklets to ascertain whether they were widely used and appreciated in the Trust hospitals and whether they were up to date and clean and also how they could be improved. The Scrutiny Group believed that this was important as clear information at a time of stress for patients is an essential part of improving the patient's experience of their stay, and ensuring this Trust strives for that is central to the Governor role.

The Trust also supported both audits as being valuable to the Trust.

For the audit of patient nutrition the kitchens were visited, meal services were observed and clinical leader and patient surveys were carried out in five wards. The audit of patients' bedside booklets involved surveying clinical leaders and patients and a review of the booklets in use on the wards by members of the Scrutiny Group.

The recommendations from the audit of patient nutrition and hydration were:

- Better education around and utilisation of the MUST system is essential.
- Food should be ordered on the same day it is to be eaten.
- All hot food should be served hot, including desserts.
- All patients who require help to eat must get it.
- A dedicated member(s) of staff for each ward should be responsible for serving the food.
- Ward staff should ensure that patients have cleaned their hands before eating.
- Used urine bottles and commodes must be cleared prior to food service and surfaces cleaned accordingly.
- Better communication around food options is needed.

These recommendations were adopted by the Board.

At the conclusion of the audit of patient bedside booklets, the Scrutiny Group recommended that the booklets should be withdrawn as they appeared to be of limited value and patients preferred direct communication. The Trust was asked to investigate ways of imparting simple information relevant to the ward area to each patient or carer either at preadmission or on admission. The Director of Nursing and Midwifery agreed that the new process would need to be embedded before the booklets were withdrawn.

Annex B - Statement of directors' responsibilities in respect of the Quality Report

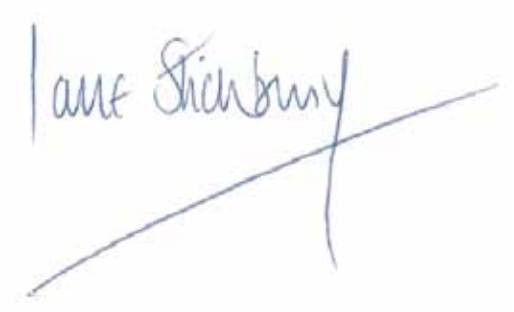
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust Boards on the form and content of annual Quality Reports (which incorporate 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:

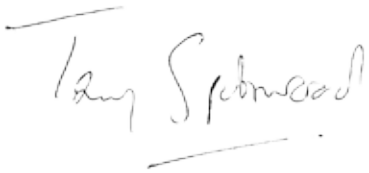
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12
- the content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 - May 2012
  - Papers relating to quality reported to the Board over the period April 2011 - May 2012
  - Feedback from commissioners dated 21/05/2012
  - Feedback from governors dated 23/05/2012
  - Feedback from LINks dated 21/05/2012
  - The Foundation Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11/05/2012
  - The latest national out patient survey dated 14/02/2012
  - The latest national inpatient survey April 2012
  - The Head of Internal Audit annual opinion over the Foundation Trust's control environment dated April 2012
  - Care Quality Commission quality and risk profiles dated 21/04/2011 - 10/04/2012
- 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 Report regulations) (published at http://www.monitor-nhsft.gov.uk/annualreporting manual) 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)).

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
29 May 2012



Mr A Spotswood
Chief Executive
29 May 2012

Annex C - Independent Auditor's 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 Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

I refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the Directors and auditors

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 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 Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011/12; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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

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

- Board minutes for the period April 2011 to May 2012;
- Papers relating to quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the Commissioners dated 21/05/2012;
- Feedback from Governors dated 23/05/2012
- Feedback from LINKs dated 21/05/2012;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11/05/2012;
- The national patient survey dated 14/02/2012;
- The national inpatients survey dated April 2012
- Care Quality Commission quality and risk profiles dated 21/04/2011-10/04/2012;
- The Head of Internal Audit's annual opinion over the trust's control environment dated April 2012; and
- Any other information included in our review.

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

I am in compliance with the applicable independence and competency requirements of the Association of Chartered Certified Accountants (ACCA) Code of Ethics and Conduct. My team comprised assurance practitioners and relevant subject matter experts.

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 31 March 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- 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 above under the respective responsibilities of the Directors and auditors.

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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

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 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011/12; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

Simon Garlick
Officer of the Audit Commission
Collins House
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SO50 6AD
29 May 2012

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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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**.