Putting patients first

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Quality Report 2012/13

Second best hospital/Trust in England for quality

- based on what matters most to people - Quality Index

Quality Report 2012/13

1. Statement by the Chief Executive

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

In this report we have outlined some of the quality activities which have taken place in the Trust over 2012/13.

Our quality program has also been enhanced by wide-ranging patient safety initiatives which cover a large range of specialties and topics. We continue to be part of a Foundation Trust 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. This year NHS QUEST work has concentrated on patient safety and readmissions; reducing mortality, and improving 'harm free' care.

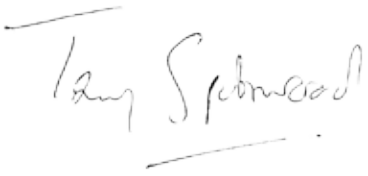
There were a number of successful inspections during the year, the most important of which was a re-inspection by the Care Quality Commission (CQC) which identified that we met outcome standards for areas such as consent, care and welfare, safety and estates. Our midwifery-led maternity services retained NHSLA Level 2 and the Trust was rated the second best hospital in England on quality in an independent report (the MHP Health Mandate Quality Index).

It is acknowledged that we set ourselves ambitious quality and safety targets for 2012/13 and, whilst progress is positive, we did not meet all of our aspirations in all cases. Where this is the case we have highlighted this in the Quality Report and identified the actions we will take in the year ahead to further embed quality initiatives and patient safety programmes.

The views of our various stakeholders have been very important to the development of this report and in the choice of the priorities for 2013/14. We have chosen to continue with our 'harm free' care programme for 2013/14 supported by a new "releasing time to lead" programme for ward clinical leaders. Patient safety and continuing to improve the patient experience will remain a prominent agenda for the Board of Directors and we welcome the opportunity to work with patients, carers, Foundation Trust members and the public on a wide range of patient experience and patient safety initiatives 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. However, we hope that it will fulfill the purpose it sets out to achieve - to provide an accurate account of quality activity in the Foundation Trust and to demonstrate our 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

Our quality improvement priorities in 2012/13 - progress against plan

In line with the Trust's vision: "Putting patients first while striving to deliver the best quality healthcare" the Trust's Board of Directors agreed a comprehensive set of strategic goals and objectives for 2012/13. The key goals for quality were:

- To offer patient centred 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.

The 2011/12 Quality Report identified the following specific quality improvement priorities to be monitored in 2012/13.

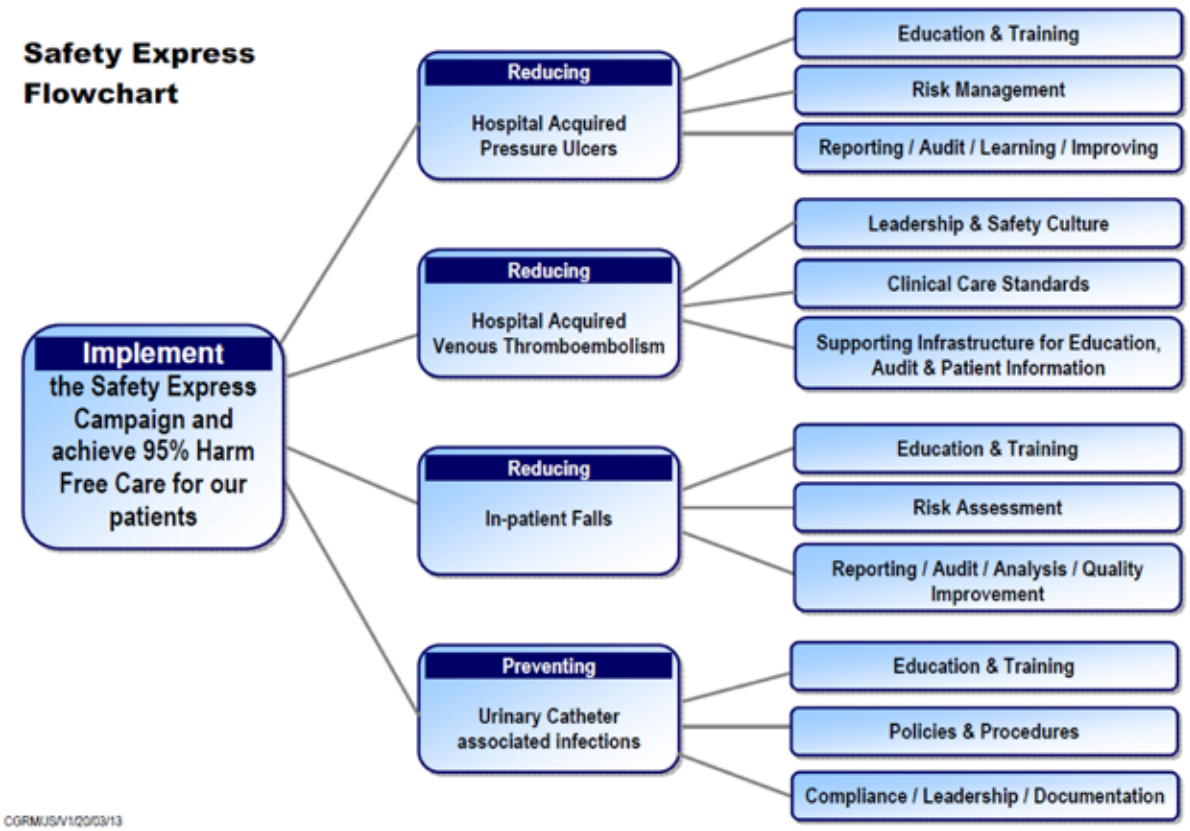
Safety express harm free care

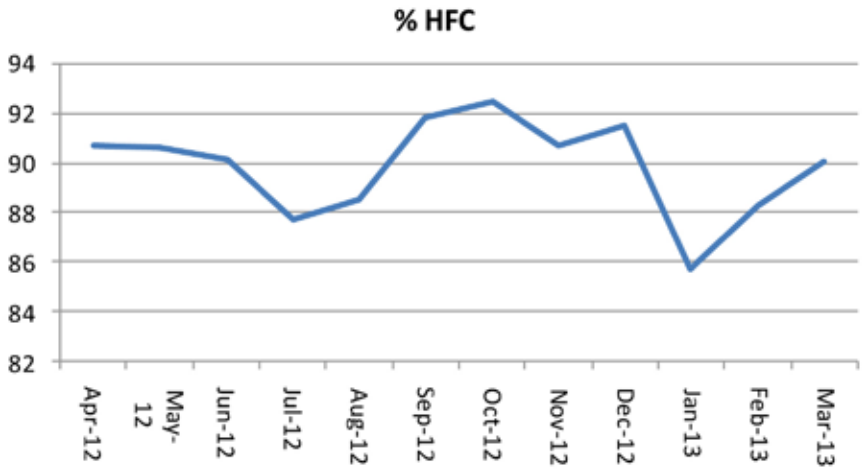
Safety Express is a national Quality, Innovation, Productivity and Prevention (QIPP) safe care initiative and the NHS safety thermometer data collection initiative is a national and local Commissioning for Quality and Innovation (CQUIN) target.

The Trust's Quality Report for 2011/12 set out as the main quality objective for the year completion of the safety thermometer across all wards areas with an over-arching aim: "to deliver harm free care as defined by the absence of pressure ulcers, harm from falls, catheter acquired urinary tract infection (CA-UTI) and Veno-thrombosis (VTE)".

'Harm free' care is measured using a standard NHS Safety Thermometer data collection tool. This requires wards to record 'harms' (hospital acquired pressure ulcer, fall, CA-UTI, hospital acquired VTE) for all patients on the ward each month.

The survey is undertaken on the same day each month on all wards and for all occupied beds.





The data is recorded on a standard audit sheet and results are validated prior to entry onto the national electronic standard safety thermometer data collection.

In 2012/13 the Foundation Trust achieved an average of 90% harm free care. This is slightly lower than the national average for 2012/13 for acute trusts (92%).

The Trust score for 2012/13 is slightly below the national average as a result of a higher number of patients being admitted to hospital with an existing pressure ulcer. The Trust is currently working with community colleagues to support pressure ulcer prevention initiatives and training.

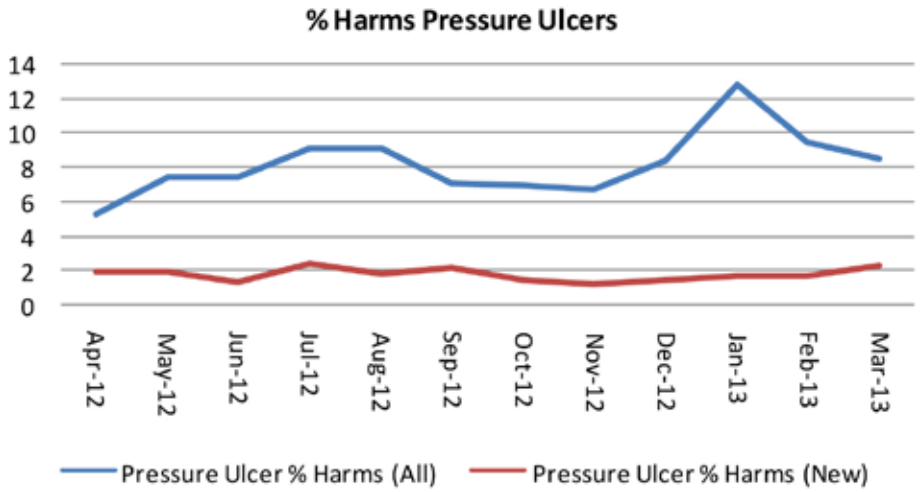
Quality initiatives undertaken in 2012/13 for each safety express patient safety objective are outlined in the following sections of the Quality Report.

Hospital acquired pressure ulcers

98% of hospital inpatients surveyed (6941) using the national NHS Safety Thermometer tool in 2012/13 had 'harm free' care in respect of hospital acquired pressure ulcers.

Quality improvements in year

- Mandatory training compliance increased in year
- In house e-learning film produced
- Link roles on each ward firmly established. 2 study days held in year, monthly meetings established to share learning and good practice
- Clinical leader ward rounds piloted
- Tissue viability lead weekly ward rounds in Medicine for the Elderly implemented
- New templates for safe operating procedures introduced
- Patient information drafted (awaiting approval by the Patient Information Group)



- New criteria for heel lift suspension boots implemented and additional funding provided to support roll out
- New nursing reviews and documentation (called care rounding) developed to record 2 hourly ward rounds

Action plan priorities for 2013/14

- Roll out of new standard operating procedures and nursing documentation
- Increase in ward based training
- Competency standards to be agreed for risk assessment documentation
- Routine documentation audit to be rolled out as part of NHS Safety Thermometer data collection
- Continue pilot of Tissue Viability ward rounds
- Clinical leader wards rounds to be fully established and monitored (Standard operating procedures and audit plan to be implemented to support compliance)
- Mattress availability to be reviewed by Equipment Library (pilot of tracking system to be implemented in 2013/14)

Inpatient falls

Less than 1% of hospital inpatients surveyed (6941) using the national NHS Safety Thermometer tool in 2012/13 had a fall resulting in harm whilst admitted to hospital. 99% of patients surveyed had harm free care.

Quality improvements in year

- Reduction in serious falls in year
- Falls training now part of mandatory clinical training and induction
- E-learning and in house films produced
- Falls Strategy Group enhanced with membership now including Dementia leads for the Trust, allied health professionals, representatives from all clinical directorates and Risk Management team members.
- Risk assessment compliance improved in year
- Slippers provided to all patients assessed at high risk of falls
- Walkrounds with Dementia lead and Estates established. Action plans in place to improve environment for patients at risk

Action plan priorities for 2013/14

- Business case for protected time for ward link staff to support Falls Prevention Strategy
- Routine environment audits planned with Estates and Dementia lead
- Competency standards to be agreed for risk assessment documentation
- Focus on actions to reduce repeated falls in patients and falls at night
- Routine documentation audit to be rolled out as part of the NHS Safety Thermometer data collection

New hospital acquired venous thromboembolism (VTE)

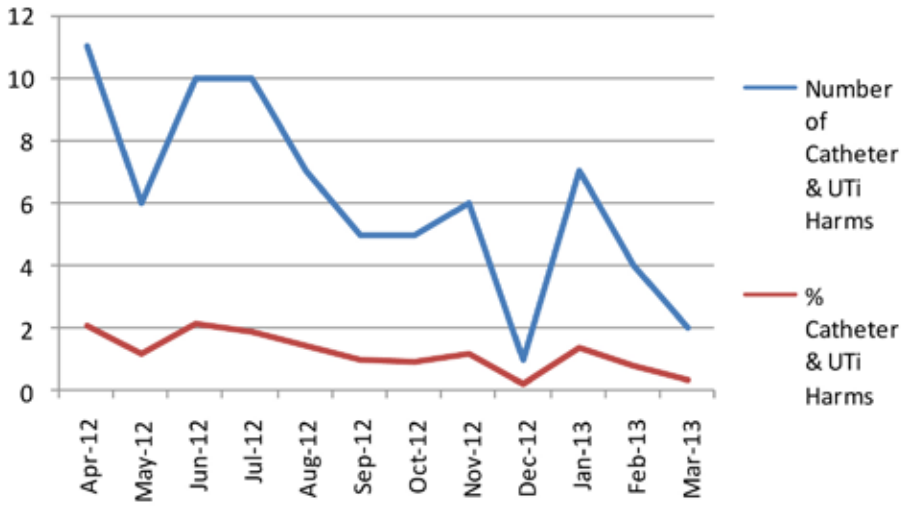
Less than 0.5% (0.45%) of hospital inpatients surveyed using the national NHS Safety Thermometer tool in 2012/13 had a new hospital acquired venous thromboembolism (a “blood clot”) during admission. This compares to a national acute trust average score of 1.17%.

Quality improvements in year

- Local clinical leadership established but gaps in awareness of the need to report hospital acquired VTE remain (focus for 2013/14)
- VTE risk assessment compliance improved to average/month of 93% (national and local target for 2012/13 was 90%)
- Reduction in VTE readmissions
- Decrease in number of hospital acquired VTE root cause analysis investigations required in year
- Only 1 preventable hospital acquired VTE in year

Action plan priorities for 2013/14

- Improve risk assessment compliance to the national target of 95%



- Provide ward scorecard on risk assessment compliance (monthly report to Clinical Leaders meeting)
- Update patient information including patient story film

Reducing catheter associated urinary tract infections

Less than 1.5% (1.25%) of hospital inpatients surveyed using the national NHS Safety Thermometer tool in 2012/13 had a new catheter related urinary tract infection during admission. This compares to a national acute trust average score of 1.56%.

Quality improvements in year and action plan priorities for 2013/14

- Education and training, including ward based training and specific competencies have been improved. Within the Trust there are Nurse Practitioners with well-established practice and competencies for catheter insertion. Further work with the Trust's Professional Development Team and external agencies and healthcare organisations will continue in 2013/14
- Policies for insertion and management of urinary and supra pubic catheters. Workstreams on policy documentation, criteria for urinary tract infections, risk assessments and review/removal procedures have been led by the Infection Control Team. A full review of the Urinary Catheter Management Policy has taken place, and a revised policy approved. The new policy includes the agreed diagnostic criteria and reason for catheter use. Recommendations for review of use and consideration for removal have also been incorporated into the policy. All tenets of the policy are reflected in a new pathway tool, which has also been incorporated into new documentation
- Compliance and documentation. Clinical leadership has been supported by the Continence Group, the Infection Control Directorate Leads and the Clinical Leaders in compliance with the NHS Safety Thermometer scorecard
- Recording. To further improve documentation, and facilitate the audit of compliance, a label to identify information about urinary catheter insertion clearly within the healthcare records has been formatted, and is currently in use. The initial response has been favorable and an audit of use is in progress. Further work is required to gain an overall view of compliance with use of urinary devices

- Recording of urinary tract infection rates. The data that has been provided by the wards as part of the monthly NHS Safety Thermometer data collection is validated by the Infection Control Nurses. The data now provides the Trust with a routine report which will support prevalence of catheter use and infection rates. This also allows further development of Ward to Board reporting, comparison by ward and, also benchmarking with other similar trusts.

Our quality p riorities for 2013/14

In order to identify priorities for quality improvement in 2013/14, 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 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 NHS QUEST) to look at how joint initiatives may be undertaken and best practice developed together.

The Trust has formally consulted with key stakeholders (general public, governors and commissioners) to help identify quality improvement priorities for 2013/14. Priorities have been considered with clinical staff as part of service delivery and clinical governance meetings.

Following consultation, the Board of Directors have agreed that the priorities for 2013/14 should be further improvement in:

- 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 rationale for adopting the same priorities for 2013/14 as 2012/13 has been endorsed by the Board of Directors and Council of Governors and is to ensure effective implementation of all new quality initiatives and to focus on embedding and sustaining change.

A specific objective is to improve on 2012/13 compliance and achieve an average of 95% ‘harm free’ care for 2013/14. A further objective is to reduce the 2012/13 NHS Safety Thermometer baseline number of hospital acquired severe harms from falls and pressure ulcers by 50% in 2013/14.

The Trust will continue to monitor ‘harm free’ care using the Safety Express NHS Safety Thermometer tool across all ward and inpatient areas. All inpatient areas will continue to complete the NHS Safety Thermometer tool each month and this tool will be enhanced to include monthly risk assessment compliance data. Data collection and ‘harm free’ care performance will continue to be reported monthly to the Trust’s Healthcare Assurance Committee and Board of Directors as part of a Quality Dashboard. Where the information is available the Trust will review compliance against published national and local benchmarking.

Statements of Assurance from the Board

This section contains eight statutory statements concerning the quality of services provided by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that provides a local context to the information provided in the statutory statements.

Statement One: Review of Services

During 2012/13 the Trust provided 8 NHS services in accordance with its registration 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 2012/13 represents 100% of the total income generated from the provision of NHS services by the Trust for 2012/13.

Additional Information:

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 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

Statement Two: Participation in Clinical Audit

During 2012/13, 31 National clinical audits and 4 national confidential enquiries covered NHS services that the Trust provides.

During 2012/13 the Trust participated in 84% (26/31) of national audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2012/13 are shown in the tables overleaf.

The national audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2012/13, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

■ - yes ■ - no ■ - not applicable

National Clinical Audits for Inclusion in Quality Report 2012/13	Eligible to Participate	Participated in 2012/13	Data Collection completed in 2012/13	Rate of case ascertainment (%)
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	■	■	■	100%
British Thoracic Society (BTS) Adult Asthma	■	■	■	Local audit in progress
Adult Cardiac Surgery	■	■	■	■
BTS Adult Community Acquired Pneumonia	■	■	■	Local audit undertaken
Adult Critical Care (ICNARC)	■	■	■	100%
Bowel Cancer	■	■	■	100%
BTS Bronchiectasis	■	■	■	■
Cardiac Arrest	■	■	■	79%
Cardiac Arrhythmia	■	■	■	■
Cardiothoracic Transplant	■	■	■	■
Carotid Interventions	■	■	■	93%
Congenital Heart Disease (Paediatric Cardiac Surgery)	■	■	■	■
Comparative Audit of Blood Transfusion	■	■	■	100%
Coronary Angioplasty	■	■	■	100%
Adult Inpatient Diabetes	■	■	■	100%
Diabetes (Paediatric)	■	■	■	■
Emergency Use of Oxygen	■	■	■	100%
Epilepsy 12 (Childhood Epilepsy)	■	■	■	■
Falls And Bone Health	■	■	■	No data collection in 2012-13
Fever in Children	■	■	■	100%
Fractured Neck of Femur	■	■	■	44% (50 cases submitted but only 22 patients eligible)

Head and Neck Oncology	■	■	■	100%
Heart Failure	■	■	■	100%
Health Promotion in Hospitals	■	■	■	The Trust has signed up for health promoting hospital for 2013/14
Heavy Menstrual Bleeding	■	■	■	54%
Hip Fracture Database	■	■	■	■
Inflammatory Bowel Disease	■	■	■	Still open
Lung Cancer	■	■	■	100%
National Joint Registry	■	■	■	100%
Neonatal Intensive and Special Care	■	■	■	■
Non Invasive Ventilation	■	■	■	(8 eligible cases)
Oesophago-Gastric Cancer	■	■	■	100%
Paediatric Asthma	■	■	■	■
Paediatric Intensive Care	■	■	■	■
Paediatric Pneumonia	■	■	■	■
Pain Database	■	■	■	52% (49/95 patients returned both forms)
Parkinson's Disease	■	■	■	100%
Potential Donor	■	■	■	100%
Prescribing Observatory for Mental Health	■	■	■	■
Psychological Therapies	■	■	■	■
Pulmonary Hypertension	■	■	■	■
Renal Colic	■	■	■	100%
Renal Registry	■	■	■	■
Renal Transplantation (NHSBT UK Transplant Registry	■	■	■	■
Schizophrenia	■	■	■	■

Stroke National Audit Pilot Programme (SNAP - combined sentinel and SNAP)	■	■	■	Not involved in pilot
Trauma (TARN)	■	■	■	■
Vascular Surgery Database	■	■	■	100%
National Audit of Dementia	■	■	■	100%

National Confidential Enquiries for Inclusion in Quality Report 2012/13	Eligible to Participate	Participated in 2012/13	Data Collection completed in 2012/13	Rate of case ascertainment (%)
Asthma Deaths (NRAD)	■	■	■	100%
Cardiac Arrest Procedures	■	■	■	100%
Bariatric Surgery	■	■	■	100%
Alcohol Related Liver Disease	■	■	■	100%
Sub Arachnoid Haemorrhage	■	■	■	100%

Centre for Maternal and Child Death Enquiries for Inclusion in Quality Report 2012/13	Eligible to Participate	Participated in 2012/13	Data Collection completed in 2012/13	Rate of case ascertainment (%)
Perinatal Mortality	■	■	■	All relevant cases reported
Maternal Deaths	■	■	■	All relevant cases reported

The reports of 6 National audits published in 2012/13 were reviewed by the Trust in 2012/13 and the Trust intends to take the following actions to improve the quality of healthcare provided:

3rd Round UK Irritable Bowel Disease Audit (UKIBD) Audit

- Following the publication of the 3rd Round UKIBD audit, clinicians will improve the number of patients prescribed bone protection and the use of the Malnutrition Universal Screen Tool (MUST) assessment to inform referral to dietitians as well as increasing the number of patients seen by the IBD nurse specialist

National Outpatients Survey

- The results were positive in that the Trust performed significantly better on 12 questions when compared to its own results from the previous survey in 2009. When compared against other trusts, we performed better than average on 32 questions, average on 4 questions and only below average on 2 questions. The results have been incorporated into the Trust Patient Engagement Strategy

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report - Time to Intervene

- In response to the NCEPOD Report Time to Intervene a business case to provide full supporting care has been discussed with the Trust Management Board and Board of Directors and an audit of surgical acuity requirements has been undertaken to inform this

NCEPOD Report - An Age Old Problem

- Following publication of the NCEPOD Report An Age Old Problem a pilot service providing Medicine for the Elderly support for surgical and orthopaedic patients has proved successful. A business case to set up this new service is being written

Confidential Enquiry into Maternal Deaths in the UK (CEMAC) Report 2011 - Saving Mothers' Lives

- Policies and mandatory training programmes have been updated in maternity in line with the recommendations of the Saving Mothers' Lives (CEMAC 2011) report

Confidential Enquiry into Suicide and Homicide by People with a Mental Illness (CISH)

- The report was considered at the Trust's Clinical Governance and Risk Committee and it was concluded that no additional action was required

Additional Information:

The Trust did not participate in the 3 British Thoracic Society (BTS) audits this year as local audits had already been undertaken on these topics. The Trust will, however, be participating in the BTS Bronchiectasis Audit in the coming year as a new service is being set up.

Results of local clinical audits are reviewed within the directorates and at directorate clinical governance committees. A summary of actions noted from clinical audits is reviewed quarterly by the Trust Clinical Governance and Risk Committee and by the Healthcare Assurance Committee.

The Trust has developed a detailed clinical audit plan for 2013/14 to include national, corporate and local clinical audit priorities. Progress is monitored via directorate clinical governance committees and the Trust Clinical Governance and Risk Committee. Progress is also reported quarterly to the Healthcare Assurance Committee, Audit Committee and Board of Directors.

The reports of 286 local clinical audits were reviewed by the Trust in 2012/13 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- On completion of the annual antimicrobial rolling audit, regular antibiotic ward rounds have been established with robust referral practices from ward pharmacists. The results were presented to the Trust Clinical Governance and Risk Committee who supported implementation of an electronic prescribing platform over the next year to improve the quality of antimicrobial prescribing

- Following a Trust-wide health records audit the Health Records Policy has been amended to stop the use of plastic wallets within the health record and the audit tool has been amended to include the standard relating to ALERT notifications in the record. A "new entry" bookmark has also been successfully trialled
- Dysphagia Awareness training sessions have been organised for nurses, healthcare assistants and housekeepers following an audit of lunchtime feeding practices
- Following an audit of adherence to protected mealtimes policy, link nurses have been redefined for each ward to raise awareness of the updated policy and assist in its implementation on wards
- As a result of an audit of Carotid Artery Disease and Endarterectomy in transient ischaemic attack (TIA) and Minor Stroke all patients who have significant artery stenosis should be referred to a vascular surgeon on the same day of the carotid doppler study. A pathway is also being developed to ensure that patients with significant artery disease have surgery performed within 2 weeks
- Pharmacy attendance at post take ward rounds (PTWR) on the Acute Admissions Unit has been implemented to improve patient safety and medicines management
- An audit of the assessment of feet in patients with diabetes showed the quality of feet assessment in these patients could be improved. A note is now added to the Medical Clerking Proforma to remind doctors to complete these assessments and consultants check these on post take ward rounds
- Following an audit of therapy intervention for patients in Phase 1 cardiac rehabilitation, a new cardiac pathway has been implemented on Wards 21, 23, 24 and Intensive Care to guide therapist input for cardiac patients. A new cardiac screening tool is also being developed to identify patients who are appropriate for therapist input
- Pre-operative education booklets have been introduced and are issued to all enhanced recovery and non-enhanced recovery patients. This resulted from an audit of therapy within the enhanced recovery programme
- The Stroke Team have developed an electronic Multidisciplinary Team (MDT) form and set standards for MDTs using the Manchester model following an audit of Stroke MDT Goals
- Patient information leaflets in Endoscopy have been updated following a patient satisfaction survey.

Statement Three: Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during that period to participate in research approved by a research ethics committee was 1157 (April 2012 - March 2013).

Additional Information:

Data for April 2012 to the end of March 2013 is as follows: Band 1 = 429, Band 2 =266, Band 3 = 377, Commercial = 85. Total 1157. This compares to the 2012/13 value of 1452 and therefore represents a drop in activity for the year. The Trust has taken a number of actions to address this. In addition, we are to be a partner site for Quintiles which we confidently expect will increase commercial activity in 2013/14 despite a predicted global decrease in the UK market over the period.

Statement Four: Use of Commissioning for Quality and Innovation (CQUIN) payment framework

The Trust's income in 2012/13 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework. The Trust agreed a managed contract during 2012/13 to share the risks during the transitional year to the new clinical commissioning groups. As a result the risks of over-performance and the delivery of the CQUIN goals/payments were shared.

Statement Five: Statements from the Care Quality Commission (CQC)

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

The Care Quality Commission has not taken any enforcement action against the Trust during 2012/13.

The Trust has participated in 1 review or investigation by the CQC relating to its registration in 2012/13. The CQC did not issue any concerns against the Trust during 2012/13.

Additional Information:

The CQC inspected the Royal Bournemouth Hospital on the 22 and 23 November 2012. On the first day two inspectors carried out the inspection and on the second day two inspectors and an Expert by Experience attended. The inspectors spoke with patients, relatives and clinical staff. They also undertook a SOFI observational on one ward where patients were not able to tell us about their experiences. The inspections reviewed documentation standards and discussed with staff the systems for managing patients' records. Discussions were also held with the Director of Nursing and Midwifery, senior staff representatives from the Estates Department, Human Resources Department and the Board of Directors Commentary from the inspection report (the full details of which are on the CQC website) notes:

"The patients we spoke with had been fully involved in their treatment. Their consent had been obtained for procedures and operations. Signed consent forms were filed within patients' medical records appropriately. Patients reported that they were happy with their treatment and care. No one raised any concerns with us. They told us that they had been well looked after and were very positive about the staff. We found that the Estates Department had developed highly organised and efficient systems for maintaining a safe environment for patients. Overall, we found that there were efficient systems for management of records. Records we viewed were up to date, accurate and stored securely to maintain people's confidentiality."

The CQC inspection report found that the Trust met CQC standards for:

- Consent to care and treatment
- Care and welfare of people who use services
- Safety and suitability of premises
- Requirements relating to workers
- Records

Statement Six: Data Quality

The Trust submitted records during 2012/13 to the Secondary User 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: 99.8% for outpatient care; and 97.2% 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.

Additional Information:

Collecting the correct NHS number and supplying correct information to SUS (Secondary User Service) is important because:

- It is the only National Unique Patient Identifier
- It supports safer patient identification practices
- It helps create a complete record, linking every episode of care across organisations

This standard covers the specific issue of capture of NHS numbers. The wider data quality measures and assurance on Information Governance are covered under the next standard.

Statement Seven: Information Governance Toolkit Attainment Levels

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 31 March 2013.

The Trust's Information Governance Toolkit Version 10 assessment overall score for 2012/13 was 76% but was graded Not Satisfactory, as the Trust had achieved a score of at least a Level 2 in all but one of the 45 requirements. This overall score includes 14 standards graded at Level 3, which is the maximum score that can be attained on any standard.

Additional Information:

The Trust's overall score of 76% represents an increase in compliance of 4% from its 2011/12 Version 9 submission. However, as noted the Trust's submission was graded Not Satisfactory overall. In order to attain Satisfactory status, organisations are required to achieve a score of at least a Level 2 in all of the 45 requirements. During 2012/13, the Trust did not meet this target in one requirement in relation to Clinical Coding, which was graded at a Level 1. This specific standard required the Trust to evidence a coding error rate based upon the Clinical Coding Audit Methodology set out by the NHS Classifications Service. The Trust has taken the decision to instead adhere to the Charlson Index - the comorbidity coding standards required by Dr Foster. Additional checks have been carried out to confirm that, were the Trust to adhere to the Connecting for Health coding standards, it would be compliant with the requirements of the Information Governance Toolkit. The Trust has contacted the Care Quality Commission and Monitor to explain the reason for this, as well as highlighting the issue with Connecting for Health.

During 2012/13 the Trust has enhanced its Information Governance arrangements by revising all the core policy documents to provide clearer and more practical guidance for staff. The list of Information Asset Owners for the Trust has also been recently updated to ensure that all areas had designated an Information Asset Owner and they were aware of their responsibilities and have undertaken initial/refresher training relevant to the role.

At the same time there has been an increase in the number of Information Governance incidents reported, which demonstrates growing awareness of Information Governance as a result of mandatory training. This included

three serious incidents which have subsequently been reported to the Information Commissioner's Office. This reflects greater awareness of the Information Commissioner's Office thinking on issues of data protection and patient confidentiality following a series of fines of NHS organisations since March 2012.

Further work in 2013/14 will be undertaken to firmly embed the Information Asset Owner roles within the organisation, including a thorough review and risk assessment of flows of data to and from the organisation. Work will also be undertaken to embed and sustain the current 76% compliance with the Information Governance Toolkit.

Statement Eight: Clinical Coding Error Rate

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 12.5%.

The results should not be extrapolated further than the actual sample audited; the services that were reviewed within the sample were 100 Finished Consultant Episodes (FCE'S) in Urology 100 FCE'S randomly selected.

Additional Information:

Clinical coding is the process by which medical terminology written by clinicians to describe a patient's diagnosis, treatment and management is translated into standard, recognised codes in a computer system. It is important to note that the clinical coding error rate refers to the accuracy of this process of translation, and does not mean that the patient's diagnosis or treatment was incorrect in the medical record. Furthermore, in the definition to determine the clinical coding error rate, 'incorrect' most commonly means that a condition or treatment was not coded as specifically as it could have been, rather than there was an error. The Trust's error rate in the previous year's audit was 13.7% against a national average of 9%.

3.0 Review of quality performance 2012/13

The following section provides an overview of the care offered by the Trust based on performance in 2012/13 against key quality indicators selected by the Board of Directors 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.

Reducing adverse events

The Trust supports an open culture for reporting and learning from adverse events and near miss patient safety incidents. The Trust has an Adverse Incident Policy and standard Adverse Incident Report (AIR) Form.

All reported incidents are graded in terms of the actual severity of the incident. Standard gradings set down by the National Patient Safety Agency (NPSA) are applied. All incidents are fully investigated, including near miss and no harm events, and are used as an opportunity for reflective practice, shared learning and quality improvement.

Table: Patient safety incidents reported to NPSA via the national reporting and learning system - April 2012 to March 2013

Severity of Incident Reported	Total Number Reported 2012/2013	% of Incidents Reported 2012/2013	Total Number Reported 2011/2012	% of Incidents Reported 2011/2012
No Harm	3415	56.8%	3115	60.7%
Minor / Low	2451	40.8%	1834	37.5%
Moderate	115	1.9%	150	2.9%
Major / Severe	30	0.5%	31	0.6%
Catastrophic / Death	0	0	0	0
Total:	6011		5130	

Nationally 0.8 % of patient safety incidents reported to the National Reporting and Learning System are recorded as having caused severe harm or death. The Trust's percentages for both 2011/12 and 2012/13 are much lower at 0.6% and 0.5% respectively.

Examples of changes made as a result of incident investigations this year have included:

- Staffing templates reviewed on wards and increased where required to ensure safe staffing levels are provided for all shifts
- Funding for earlier use of heel protection approved and new clinical guideline implemented to support use
- New protocols for gastrointestinal bleed patients have been developed and an update provided at a medical grand round meeting and in the junior doctors' teaching program
- New system of checking anaesthetic machines implemented and new electronic system of recording and following up on missed checks established
- New standard operating procedures in pharmacy for dispensing of medicines and new training programmes introduced. There are also new posters in pharmacy dispensing area to alert patients to the important process of identity checking prior to dispensing medication

Medication 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.

The Trust's Medication Incident Review Group is chaired by the Deputy Director of Nursing and Midwifery. It ensures that Directorates take responsibility for reviewing incidents involving medicines, sharing learning and initiatives to improve safety and reduce risk.

In 2012/13 a total of 753 medication related adverse incidents were reported and investigated. This is an increase from 2011/12 (679) and 2010/11 (509) and reflects the Trust's commitment to encouraging open reporting.

Of the 753 adverse incidents reported 73% represented no harm events. This is consistent with previous years' results (2011/12 - 75%, 2010/11 - 73%).

Patient safety and quality improvement Initiatives to support medication safety and medication incident reduction during 2012/13 have included:

- Wards have completed medicines management self-assessment audits and developed action plans to address the issues raised.
- Wards have completed injectables self-assessment audits with their pharmacist and developed action plans to address the issues raised.
- Slam locks have been fitted to all of the medicines trolleys on the wards to reduce the risk of unauthorised access to medicines.
- Following a successful trial, pharmacists have attended post take ward rounds for medical admissions since October 2012. This continues to show benefits in safer prescribing, reduction in missed doses and reduced risk to patients from medicines.
- An audit of prescriptions for treatment doses of Low Molecular Weight Heparins (NPSA RRR014) was completed in October to December 2012. The results and the need to improve documentation and practice is being discussed with the specialties and at educational meetings.
- Introduction of antidote boxes containing flumazenil and naloxone to clinical areas for treatment of therapeutic overdoses of benzodiazepines and opioids. The boxes also contain a reporting form to encourage reporting as an adverse incident and to allow monitoring and encourage greater care in dosing particularly during conscious sedation.
- Introduced mandatory training on injectable medicines for junior doctors starting work in the Trust.
- Pharmacy implemented new processes (pink supply sheets and yellow bags) to ensure that urgent medicines reach the patient to avoid delayed and missed doses.
- Actions taken to avoid unnecessary omission of aspirin in patients at high risk of blood clots and ensuring that patients take the doses as prescribed and given to them.
- Implementation of a Medication Omissions Audit.
- A focused project commenced in the first quarter of 2013 to improve medication administration with specific outcome goals of reduced medication omission and better patient information. This work will continue through 2013/14.

Reducing patient falls

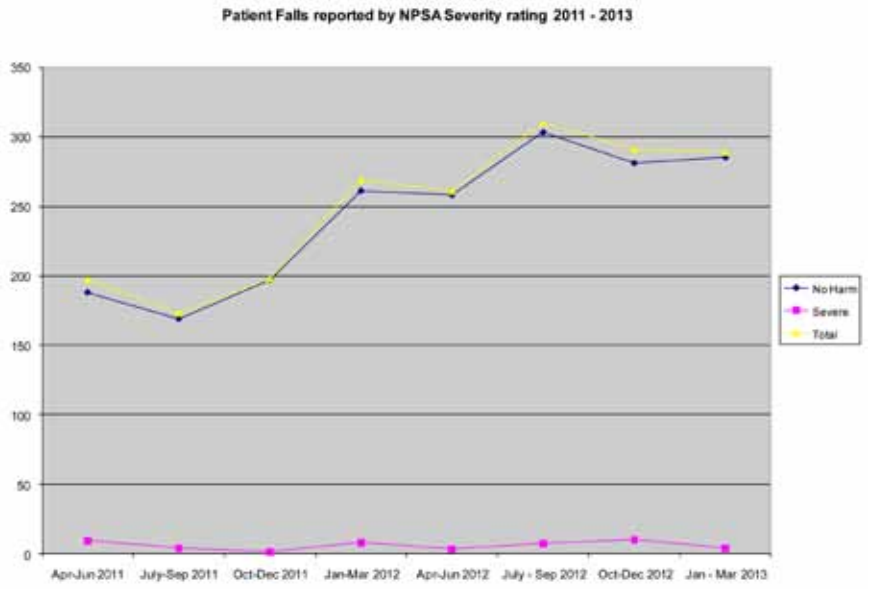
Patient accidents form the largest group of all patient safety incidents reported to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System (NRLS).

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 few years in order to reduce the number of patient falls. As previous noted, quality and patient safety initiatives introduced in year to reduce patient falls have included:

- Implementation of falls training as a part of clinical mandatory training and induction
- Production of e-learning and in-house films for falls prevention and falls management
- Implementation of falls risk assessment documentation
- Slippers provided to all patients assessed at high risk of falls
- Walkrounds with dementia lead and estates established. Action plans in place to improve environment for patients at risk

RBCH Reported Patient Falls (all events) - 2011-13



A total of 1,892 patient falls were reported in 2012/13 compared to 1,505 in 2011/12.

In 2012/13 1.2 % of reported incidents resulted in severe harm to a patient, this compares to 1.5% in 2011/12.

The number of patient falls reported as serious incidents in 2012/13 was 21 compared to 24 in 2011/12.

As a year average, the Trust reported 9.18 patient falls/1000 bed days, compared to an acute Trust average (2009, NPSA data) of 5.6/1000 bed days. This is higher than 2011/12 and reflects the focus in year on reporting all adverse events including no harm and near miss events.

In comparison, as a year average, the Trust reported 3.4 inpatient harm event falls/1000 bed days, compared to an acute Trust average (2012 National Audit data) of 2.5/1000 bed days (the overall range was 0.9-5.4).

Ensuring high standards of infection prevention and control

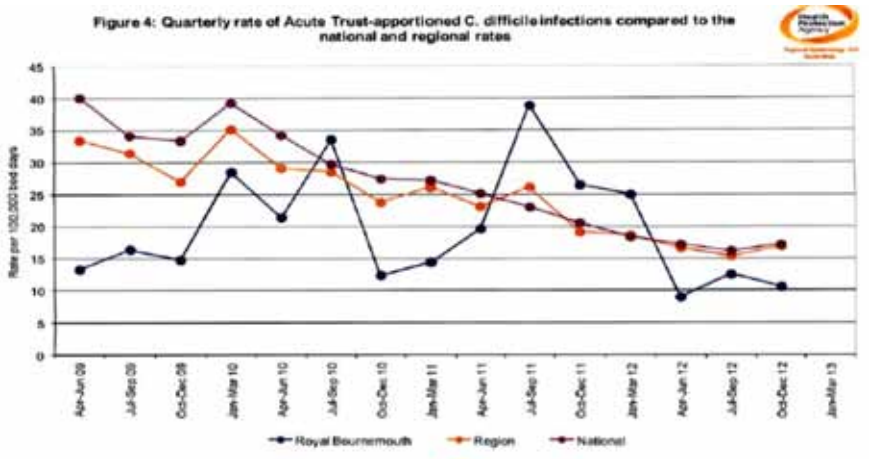
The Trust's Board of Directors is committed to infection prevention and control as a key priority at all levels of the organisation and takes a very active interest in the monitoring of infection control performance. The Director of Nursing and Midwifery, who acts as the Director of Infection Prevention and Control (DIPC), briefs the Board of Directors on a regular basis. The Trust publishes a detailed Infection Control Annual Report which is released publicly and available on the Trust's website.

MRSA Bacteraemia

The Trust has reported no Trust attributed MRSA Bacteraemia for the year 2012/13.

Clostridium difficile

All cases of Clostridium difficile infection at the Trust are reported and investigated. The number of cases reported for 2012/13 was 31; fewer than the annual target of 38, which was set by the Department of Health and was part of the Trust's contract. This year there has been improvement demonstrated by the Trust's clostridium difficile (c.difficile) rate per 1000 bed days which was lower than the national and south west average for 2012/13.



Clean environment

As part of the ongoing Infection Control Team initiatives to provide a safe environment, the Trust has installed eye catching floor and wall poster promoting alcohol gel use. These have been installed in the entrance corridors of all wards. An audit of the use of gels before and after installation showed an increase in usage.

3M Clean-Trace Surface ATP devices have been used in the Trust by the Infection Control and Housekeeping teams, and each directorate, to carry out audit and provide assurance of good standards of cleanliness of the environment and equipment by detecting organic material. The Trust has funded two further hand held devices to support effective audit.

Housekeeping carry out a quality monitoring process which gives compliance percentages monthly to all wards and departments, and work closely with the Infection Control Team and directorate senior nurses. The Infection Control Team, accompanied by representation from housekeeping and governors also undertake regular unannounced inspections.

Housekeeping have taken over some waste removal this year, providing a time efficient service to the wards. They are currently trialling a new method of waste collection from wards using collection bins which will reduce the risks of spillage and be more time-effective. With proposed regular 'trains' the department is working with porters to maintain clear cupboards and reduce the 'road blocks' in the corridors, leaving the areas clear.

The Trust has also approved a business plan, which will enable housekeeping to extend their services to cleaning shared patient equipment, for example hoists, walking aids and weigh scales, which historically has been a nursing task. This will enable nurses to support a high standard of direct patient care and provide agreed standards of cleanliness.

The Infection Control team have led an initiative to improve beverage provision at ward level providing a new light weight and easily cleaned trolley. Trolleys have been purchased with flasks and containers for the benefit of our patients.

Infection control improvements in year

The Trust has seen a measurable decrease in the closure of wards and bays in 2012/13 indicating an improvement in infection control practices across the Trust. Results for 2012/13 compared to the previous year are shown in the table below.

	2012/13	2011/12
Bed closures in days	98	362
Numbers of bays closed and days closed for	14 bays closed - 41 days	69 bays closed -133 days
Number of wards closed and days closed for	12 wards closed - 47 days	34 wards closed -180 days

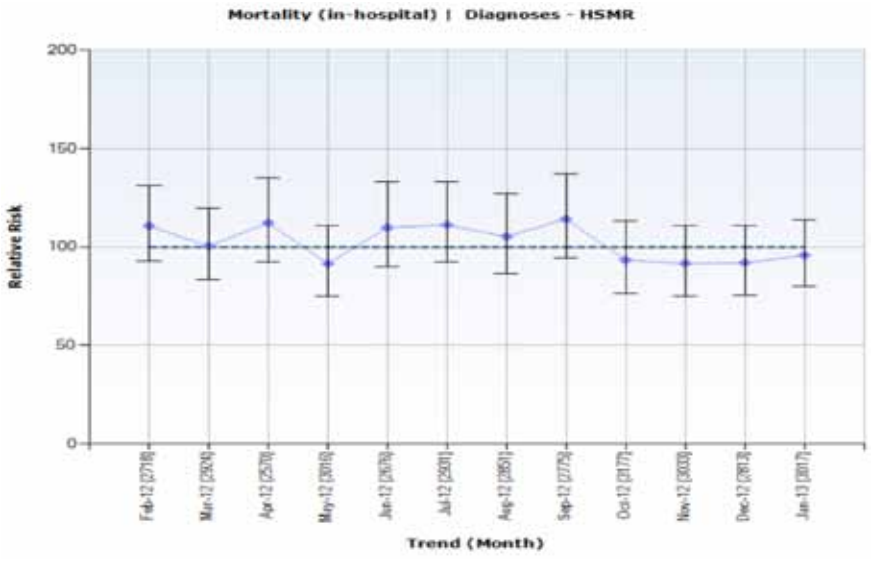
Reducing hospital mortality

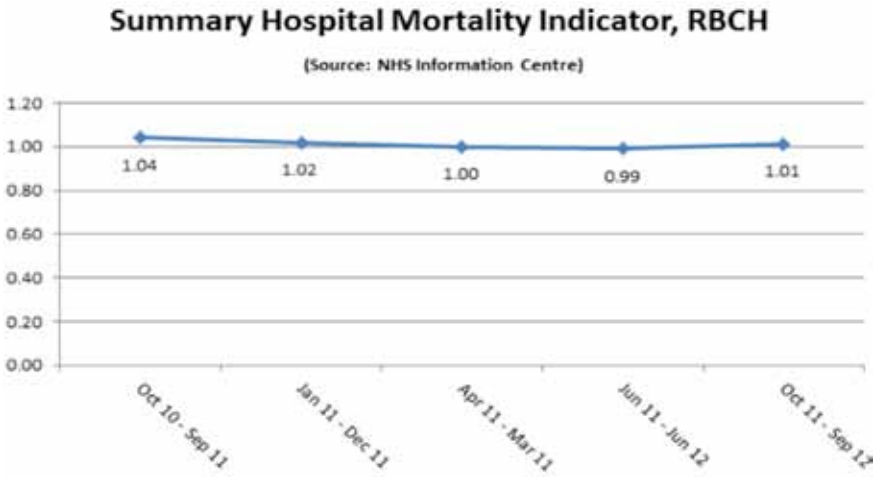
The Trust has a multidisciplinary Mortality Group, chaired by the Medical Director, to review the Trust's HSMR (Hospital Standardised Mortality Ratio) and Dr Foster relative risk reports on a monthly basis. The group also reviews death certification and electronic Immediate Discharge Forms (e-IDF) to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

Mortality outlier alerts may be triggered by Dr Foster analysis, through Imperial College, or from the Care Quality Commission data analysis. Dr Foster is a leading provider of comparative information on health and social care services. Its 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 Hospital Standardised Mortality Ratio (HSMR) has become a recognised way of assessing hospital mortality.

The chart below shows the most recent report available from Dr Foster for the Trust. An HSMR value of 100 represents an average "expected" value and therefore a score below 100 demonstrates a better than average position.





The Department of Health have also recently produced their own equivalent of HSMR - the Summary Hospital Mortality Indicator (SHMI), which includes deaths in the 30 day period following discharge from an acute hospital.

The chart above shows the most recent SHMI report available from the Department of Health for the Trust. A SHMI value of 1 represents an average "expected" value and therefore a score below 1 demonstrates a better than average position.

The Trust has taken the opportunity to widen its review of mortality in 2012/13 and has initiated a Mortality Improvement through Clinical Engagement (MICE) group, chaired by the Director of Nursing and Midwifery. This draws together several significant strands of work including the work of the Mortality Group described above. The other programmes drawn under this umbrella include Seven Day Working, End of Life Care, the Deteriorating Patient and Specialist Mortality Reviews.

The current focus of the latter component has been our work in managing sepsis. A Sepsis Group was formed in early 2012 and has undertaken significant work in a number or areas including:

- Sepsis card introduced
- New fluid chart introduced
- Sepsis added to education programmes for all medical staff

There has been a substantial reduction in mortality attributed to sepsis in 2012/13 in an environment of an increase in the number of patients admitted with sepsis within their diagnosis. To ensure ongoing quality improvement the action plan for the year ahead includes:

- To continue to raise awareness through education and training for clinical staff
- Develop additional continuing multi-professional education and skills lab training
- Audit antibiotic arrangements and sepsis pathway management - with particular focus on Emergency Department procedures
- Development and introduction of a sepsis management pack to support timely patient care
- Arrange a Sepsis Champion forum to enable sharing and dissemination of quality improvement ideas and initiatives
- Undertaken regular audits to review practice

Type of Guidance	Published	Applicable	Compliant	Partially Compliant	Non Compliant	Under Review
Clinical Guidelines	19	13	1	7	1	4
Technology Appraisals	28	22	18	0	1	3
Interventional Procedures	29	3	3	0	0	0
Public Health Guidance	6	4	2	2	0	0
Medical Technology Guidance	4	0	0	0	0	0
Quality Standards	12	11	5	1	0	5
Diagnostics Guidance	4	2	1	0	1	0
Total	**102**	**55**	**30**	**10**	**3**	**12**

Ensuring compliance with National Institute for Health and Care Excellence (NICE) Guidance

The Trust Clinical Governance and Risk Committee (CGRC) reviews compliance with all new NICE Guidance issued each month. For the period from April 2012 to March 2013 the CGRC reviewed a total of 102 newly issued guidance documents. Compliance rates are shown in the table above.

Where non or partial compliance has been identified this is reported to the Trust Clinical Governance and Risk Committee and an appropriate action plan agreed.

Ensuring compliance with safety alerts

A total of 89 Medicines and Healthcare Products Regulatory Agency (MHRA) Medical Device Alerts were issued and received in the year. Of these 27 applied to medical devices used within the Trust. The Trust ensured compliance with all relevant alerts.

In addition, 3 NHS Estates Alerts were issued and received in the year. Of these 3 were applicable to the Trust, 1 required action which was completed and 2 currently have action plans which are being completed within the timescale allowed.

The National Patient Safety Agency (NPSA) did not issue any new alerts in 2012/13.

Patient Reported Outcome Measures (PROMs)

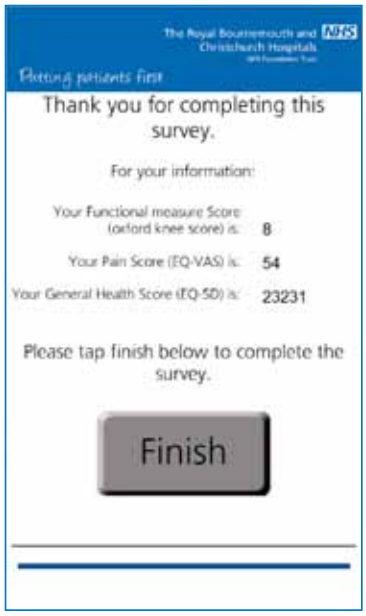
All NHS patients who are having hip or knee replacements, varicose vein surgery or groin hernia surgery are being invited to fill in Patient Recorded Outcome Measure (PROMs) questionnaires. PROMs is a method of measuring the functional activity level of a patient as recorded by the patient. The same questionnaire is sent to the patient 6 months post operation and the two scores are recorded by an external organisation Quality Health (operating 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 PROMs surveys. All patients who come into hospital for one of the above procedures are asked to fill in a PROMs questionnaire before their operation.

In May 2013, the Trust will become a pilot site for Electronic Data Capture. The PROMs questionnaires will be completed, by patients, through hand-held tablets, similar to iPads. A volunteer has already been recruited to assist patients with the technology and one of the biggest advantages is that patients, on completion of their questionnaire will receive feedback, as shown in the picture.

The paper option will still be available for patients who prefer it and they will have equal access to the services of the volunteer.

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.



	Compliance Rate 2010/11	Compliance Rate 2011/12	Compliance Rate 2012/13	National Average 2012/13
PROMs for Groin Hernia	90%	59%	117.7%*1	62.9%
PROMs for Varicose Veins	86%	17%	9.8%*2	33.3%
PROMs for Total Knee replacement	79%	95%	96.5%	86.9%
PROMs for Total Hip replacement	76%	97%	96.5%	79.5%

The national average participation rate (as provided by Quality Health for the Department of Health, April 2012) is 72.6%. The Trust's average participation rate for all 4 PROMs is 80.1%.

*1 Participation rates of greater than 100% occur where the numbers of operations which actually take place are greater than that of the denominator. The denominator is determined as an average of the number of operations performed in the previous year.

*2 The Trust compliance rate for 2012/13 for varicose veins is much lower than the national average. The denominator used in the calculation is the number of operations performed in the previous year. The actual number of procedures performed in 2012/13 was significantly lower than the previous 2 years.

Improving patient experience

Measuring patient experience is paramount for the provision of a high quality service. It is important to ensure that patients and the public are given opportunity to comment on the quality of the services they receive.

The Trust undertook a detailed review of patient engagement and patient experience arrangements in July 2012 and presented a report to the Patient Experience and Communications Committee (a sub-committee of the Board of Directors).

The current status of patient experience work at the Trust can be summarised in the following areas:

- **Trust level benchmarking** - e.g. national annual inpatient and outpatient surveys, cancer patient surveys, Patient Reported Outcome Measures (PROMs) collected locally but reported nationally, Commissioning for Quality and Innovation (CQUIN) Payment Framework patient experience questions
- **In year progress on national and local priorities and internal benchmarking** - e.g. patient experience cards, real time patient feedback
- **Rapid identification of emerging issues** - e.g. real-time patient feedback, Adverse Incident Report forms, patient comment cards, trends in formal and informal complaints, issues raised by letters and compliments from patients, carers, relatives and the public, suggestion box feedback, web based free text comments, ward scorecards, staff survey
- **Personal Insights** - e.g. mystery shopper, patient stories, NHS Choices, letters and compliments, video vignettes, patient diaries, experience based design interviews
- **In depth reviews** - e.g. Focus groups, local surveys, stakeholder events, local forums e.g. young persons, learning disability, dementia and carer events
- **Education** - e.g. patient story by patient at induction training, carer story by carer at induction, patient story by patient at Board of Directors' meetings
- **Specific project groups** - e.g. Learning Disabilities, Dementia, Medicine for the Elderly

Patient experience activity embraces diversity in its entirety within all its actions, for example key stakeholder groups for patients and carers and the carers forum. There is a Trust's commitment to the diversity agenda which is also represented in the Trust Strategy and by the Trust through its Staff Health and Wellbeing Group.

National Inpatient Survey

The annual national patient survey is:

- a public determinant of patient experience
- a regulatory measure performance analysed by the CQC
- a local performance measure included in the CQUIN for our commissioners

The Care Quality Commission Inpatient Survey was undertaken in July 2012. The survey, the 10th annual national inpatient survey, included the results from 156 trusts based on 64,500 patients over the age of 16 years surveyed. There were 70 questions in the survey that relate to the patient experience, and 61 are included in the results. The sample was taken in July 2012 of patients who had spent at least one night at the Trust.

The Trust discharged 2,598 patients in July 2012, of which 850 patients were identified as eligible for the survey. 461 patients returned surveys, a response rate of 55% which is against a national average of 48% (aggregated from 69 trusts using the Picker Institute to administer the surveys).

The Trust's overall performance is amber which identifies that in all 10 sections the Trust results are "about the same as other Trusts in the survey" and amber in all 60 questions with one exception.

The results show that in comparison to 2011 there is:

- improvement on 18 questions
- statistically significant improvement on Q26: Doctors not talking in front of patients (2011 8.1; 2012 8.6)
- statistically significant decrease on Q19: patients feeling threatened by other patients or visitors (2011 9.7; 2012 9.5)
- one question categorised as red, being "worse when compared to other Trusts in the survey ". This question was Q37: 'were you given enough privacy when being examined or treated'. The highest result from all 156 trusts was a score of 9.8 and the lowest result was 9.1 which was the Trust's result. Reviewing the national results there is a 0.5 difference between the red and green categories for this question.

Since the July 2012 survey was performed, the Trust has undertaken a number of actions and inititiatives to improve the patient experience. This has included:

- Implementation of a new patient experience governance framework
- Ensuring accountablity within roles for patient experience
- Establishing a Patient Experience Action Group reporting to the Patient Experience Performance Committee
- Developing and implementing a ward scorecard and establishing regular systematic feedback of patient experience data at ward level
- Presenting a monthly patient experience summary Dashboard to the Trust's Healthcare Assurance Committee and Board of Directors
- Developing and implementing a Trust-wide patient feedback template structure

Focus for 2013/14 will include actions to review:

- Response to call bells
- Reduction in noise at night
- Improved privacy and dignity
- Patients being asked to give their views on the quality of their care
- Information at the point of discharge
- Same sex bathrooms/accomodation
- Patients feeling threatened by other patients or visitors

Action plans will be discussed and agreed through the Patient Experience and Communications Committee.

Commissioning for Quality and Innovation (CQUIN) patient experience questions

The Commissioning for Quality and Innovation (CQUIN) payment framework utilises 5 standard questions from the national inpatient survey. The framework ensures quality is part of every commissioner-provider discussion.

The chart below shows the Trust overall score and a breakdown of each CQUIN question score for 2012.

2012 trust score: The trust score at the end of 2012/13 to be used for payments from the 2012/13 CQUIN scheme	**68.8**

	2003	2005	2006	2007	2008	2009	2010	2011	2012
Your scores	66.5	69.4	65.9	68.5	69.9	68.2	67.9	68.8	**68.8**
SHA cluster	68.3	68.7	67.6	66.6	67.7	67.2	68.0	67.4	68.4
National	67.4	68.2	67.0	66.0	67.1	66.7	67.3	67.4	68.1

Your scores on individual questions, and on the overall indicator	**2012 Score:**
***Q32**: Were you as involved as you wanted to be in decisions about your care and treatment?*	72.3
***Q34**: Did you find someone on the hospital staff to talk to about worries and fears?*	57.3
***Q36**: Were you given enough privacy when discussing your condition or treatment?*	81.1
***Q56**: Did a member of staff tell you about medication side effects to watch for when you went home?*	52.4
***Q62**: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*	80.5

averages out to... → **OVERALL INDICATOR 2012 score out of 100: 68.8**

The Trust's overall indicator score for 2012 is 68.8 out of 100, the same score attained in 2011.

Trust's CQUIN results have been above both the national and South West Strategic Health Authority's average since 2010.

The 2012 results showed that the Trust had improved significantly from 2011 in relation to two of the CQUIN questions:

- Q32 Were you as involved as you wanted to be in decisions about your care and treatment?
- Q56 Did a member of staff tell you about your medication side effects to watch for when you went home?

Picker Inpatient Survey July 2012

The Trust participated in the Picker Institute Inpatient Survey 2012. The raw data from the survey is analysed separately by the CQC as part of the National Inpatient Survey 2012.
A total of 850 patients from the Trust were sent a copy of the questionnaire, of which 461 were returned, giving a response rate of 59%. The national average response rate was 48%.

The survey highlighted many positive aspects of the patient experience. The Trust was significantly better than average on 12 questions in comparison with 68 Trusts administered by Picker.

The first table on the following page indicates the survey questions where the Trust was statistically better than the other participating trusts. The second table indicates the two questions where in comparison to other trusts our scores are statistically lower.

The Trust was statistically lower than national average scores when patients reported having to share bath or shower facilities with members of the opposite sex and they did not feel they were offered enough food choices.

Most patients were highly appreciative of the care they receive. However, the survey results did identify some areas for improving the patient experience. Action plans are in place to improve performance.

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 %

Cancer patient experience

A cancer patient experience survey published in September 2012 demonstrated a wide variety of results in the individual clinical domains. There were 64 questions in the survey across 15 domains. The Trust's performance is summarised below:

- 25 'green' placing us in the top 20% of trusts nationally.
- 5 areas show statistically significant improvement based on the previous survey in 2012.
- 2 'reds' placing the Trust in the lowest scoring 20% of trusts nationally:
  - Patient offered written assessment and care plan
  - Staff explained how the operation had gone in an understandable way

The clinical nurse specialists in each of the specialties have worked with the multi-disciplinary team and made site specific action plans. Key actions to address the two specific areas of concern included:

- Ensuring all clinical nurse specialists and clinicians had attended an 'advanced communication' course. Throughout the autumn individuals were booked and attended the regionally available course and further courses are being provided in 2013/14.
- Identifying a lead and implementing the Information Prescription Programme. This is being led through the cancer nurse practitioner in the Oncology Unit. It is a national programme aspiring to deliver a personalised approach to information giving, based on need. This involves selecting appropriate information from an 'information pathway' relevant for the patient and constructing an individualised 'information prescription'.

The progression of action plans are monitored through the Clinical Nurse Specialist working group and subsequently the Cancer Patient Experience Group chaired by the patient experience lead clinician. A further national Cancer patient experience survey is in progress and another focusing on chemotherapy is being undertaken.

Trust patient survey card Results

Patient experience card (PEC)

In addition to responding to national patient surveys, the Trust has an internal patient experience card which is available for all inpatients and outpatients to complete. The cards are available in all 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 free text space for qualitative comments. The results are available to all staff and are collated and fed back quarterly to all participating areas.

In 2012/13, 63% of patients completing the patient survey card rated the Trust as "excellent" and 98 % said they felt safe whilst in our care. (The 2012/13 results relate to March 2012 to December 2012 data only as the PEC questions were amended in January 2013).

Friends and Family Test (FFT) using the patient experience cards

The implementation of the Friends and Family Test (FFT) has been rolled out throughout the Trust to meet the compliance requirements from the Department of Health. All patients who attend the Emergency Department and those who stay in a ward overnight within the set criteria are offered a Patient Experience Card to complete the FFT. There is an expectation that all clinical areas will be included from October 2013.

The PEC reporting template has been redesigned to ensure that staff have clear visibility of the FFT score in addition to the survey questions. Training sessions on the FFT has been widely available to staff from large group sessions including induction and preceptorship training, to clinical leaders and senior nurses to small ward based and individual sessions. An implementation plan has been activated and wards are aware on a monthly basis of their compliance data. Each clinical area has been visited daily to provide support and advice.

		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%
	2012/13	63%	17%	11%	3%	2%	1%	1%	1%	0%	1%
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%
	2012/13	74%	11%	7%	2%	2%	1%	0%	1%	0%	2%

Real time patient feedback (RTPF)

'Real time patient feedback' is an in-house survey with data collected with hand-held terminals. RTPF is facilitated through the Trusts trained volunteers and public governors. Patients are asked a series of standard questions through face to face interviews and patient stories and views collected. The survey data collection process managed by the Head of Patient Engagement and data analysis is provided by an external provider which is currently commissioned to provide the service.

The RTPF surveys are specific to the areas where patients access services including ward inpatient areas, the Emergency Department and outpatient departments. The surveys have been customised for their areas. The results are shared, 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 is currently in progress. This service is also available online.

Working in partnership

During 2012/13 the Trust has developed stronger partnerships with carers forums, local schools and LINks).

The Trust has welcomed the opportunity to work with Bournemouth LINk on a number of quality reviews this year. Bournemouth LINk have undertaken the following projects:

- "A problem has to fit in one box" - Research with young people in Bournemouth. LINk undertook a survey of young people in Bournemouth, including young carers, asking them for comments about healthcare services that they had accessed or were available. The report (issued in January 2013) provided the Trust with some very helpful feedback and the opportunity to widen our understanding of the needs of young people locally. An action plan has been developed around the responses received and implementation will be coordinated through the Trust Safeguarding Committee and Patient Engagement Team.
- "Enter and View" - LINk visited two inpatient wards at the Royal Bournemouth Hospital in January 2013. LINk were able to observe practice and talk to patients, carers and visitors about their care and treatment and gain feedback about their experience of the Trust. The results were fed back to the Director of Nursing and Midwifery and subsequently shared with ward staff. LINk (Healthwatch Dorset from 1 April 2013) have also been invited to come and discuss their report at a Trust Clinical Leaders meeting.
- "People speak out" - LINk undertook a survey in January-February 2013 of the views of hospital leavers. A standard survey form was used and asked patients to comment about their discharge experience. 500 survey forms were given out with a response rate of 16.4%. It was positive to hear that 91% of people responding said they were happy with the information they received on discharge. However a number of actions to further improve patients' experiences were identified and these are currently being progressed as part of the Trust's wider Patient Engagement Strategy.

The Trust has also held a number of stakeholder style events in 2012/13 including a public feedback event in May 2012 and a learning disability feedback event for patients with a learning disability and their carers. A public and staff event was also held in March 2013 on NHS Change Day with feedback from patients about the care they had received and improvement pledges from staff.

Learning from and reducing 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 303 formal complaints from patients or their representatives during the year. This represents a decrease of 0.3% (1 complaint) from last year's total of 304 complaints.

Of the 303 formal complaints, 159 (52%) 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, 6 complaint investigations were still to be concluded and a decision on whether they were well founded had not been reached.

Subjects of complaints

The main categories of complaint were as follows:

Subject	Number in 2011/12	Percentage in 2011/12	Number in 2012/13	Percentage in 2012/13
Administrative systems	19	6.3%	19	6.2%
Attitude of staff	32	10.5%	38	12.5%
Bed management	1	0.3%	4	1.3%
Clinical treatment	177	58.2%	172	56.7%
Communication/information	44	14.5%	35	11.5%
Discharge arrangements	14	4.6%	15	4.9%
Environment	2	0.6%	4	1.3%
Equipment/facilities	0	0	1	0.3%
Health and safety	7	2.3%	3	0.9%
Privacy and dignity	2	0.7%	2	0.6%
Medication	0	0	5	1.6%
Availability of staff	1	0.3%	1	0.3%
Policies and procedures	1	0.3%	1	0.3%
Violent/Aggressive behaviour	0	0	0	0
Transport	1	0.3%	0	0
Theatre Management	3	1.0%	3	0.9%
Total	304	100%	303	100%

14 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:

- Reception staff reminded by Deputy General Manager of the standards required in speaking to and advising patients
- Provision of suitable changing facilities for disabled patients and others to be considered by Dementia and Learning Disability Group (Dignity in Care)
- Multi-disciplinary action group led by the Clinical Leader set up to change support to patients at mealtimes
- Review of pharmacy waiting area to provide better service to patients
- Plan in place to provide alternative storage for mobility equipment instead of in open ward area. Complaint used as case study with ward team to improve communication.
- Training need identified on the use of specific equipment to transfer patients back to their bed following a fall. Additional equipment and training implemented.
- Protocol introduced to prevent data loss from 24 hour cardiac monitors
- Staff to have conflict resolution training to manage stressful situations
- Education of medical staff on history taking with HIV+ patients
- New cardiology protocol implemented for pathways of post procedure patients
- Appropriate risk assessment of patients requiring escort raised with ward staff
- Patient information leaflet regarding risk of polyhyramnios and cord prolapse to be devised with leaflet for expectant mothers on this subject.

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, 10 people chose to refer their concerns to the Parliamentary and Health Service Ombudsman during 2012/13 compared to 19 in 2011/12. The Ombudsman declined to investigate four complaints, referred three back for further local resolution, and is undertaking one investigation of a complaint which has not concluded. Two complaints are still being assessed by the Ombudsman.

Compliance against national priorities

The Trust measures many aspects of its performance and this data is regularly reviewed throughout the organisation. At Board level patient safety, quality and performance dashboards are reviewed each month and these include key measurements (metrics) for all national and local priorities.

In accordance with statutory reporting requirements, the following section provides an overview of the Trust's performance in 2012/13 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 Monitor's Compliance Framework.

National Priority	2009/10	2010/11	2011/12	2012/13 Target	2012/13 Actual
Clostridium difficile year on year reduction	44	46	62	38	31
MRSA - hospital acquired	3	0	2	6	0
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	97.71%	99.56%	96.7%	96%	96.4%
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	99.2%	99.6%	99.2%	94%	98.8%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti cancer drug treatment	100%	100%	100%	98%	100%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	88.26%	89.71%	87.3%	85%	88.6%
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	96.30%	97.00%	94.6%	90%	98.6%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	94.11%	93.60%	94.2%	93%	93.6%
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	86.26%	98.58%	99.1%	93%	97.0%
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	99%	99%	97%	95%	97.2%
18 week referral to treatment waiting times - admitted	n/a *	n/a *	17.7 weeks	90%	94.5%
18 week referral to treatment waiting times - non admitted	n/a *	n/a *	14.2 weeks	95%	98.9%
18 week referral to treatment waiting times - patients on an incomplete pathway	n/a *	n/a *	14.2 weeks	92%	97.1%
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	n/a	n/a	Compliance certified	n/a	Compliance certified

*__Note__ - In 2011/12 the Department of Health set percentile thresholds for 18 week referral to treatment waiting times monitoring but reverted back to percentages in 2012/13.

Compliance against new Quality Account Core Standards 2012/13

In addition to the above national priorities, for 2012/13 all trusts are required to also report against a set of core standards, using a standardised statement set, identified in the NHS (Quality Accounts) Amendment Regulations 2012.

Quality Indicator	Data Source	percentage/proportion/ score/rate/number for at least the last 2 reporting periods	National average value	Highest value	Lowest value
Summary hospital level mortality indicator (SHMI)	Health and Social Care Information Centre (HSCIC)	Oct 11 - Sep 12: 1.01 Jul 11 - Jun 12: 0.99 Apr 11 - Mar 12: 1.00	1.00	1.21 (Oct 11- Sep 12)	0.6849 (Oct11 - Sep 12)
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust	HSCIC	Palliative Care coding by speciality and/or diagnosis Oct 11- Sep 12: 24.28% Jul 11- Jun 12: 22.26% Apr 11- Mar 12: 21.5%	19% (Oct 11 - Sep 12)	43.3% (Oct 11 - Sep 12)	0.2% (Oct 11- Sep 12)

The Trust considers that the above data is as described for the reason of provenance as the data has been extracted from available Department of Health information sources.

Patient Reported Outcome Measure Scores

Quality Indicator	Data Source
Patient reported outcome measure score for groin hernia surgery	The Trust considers that the data below is as described for the reason of provenance as the data has been extracted from the Department of Health Information Centre HESonline - PROMs. The time periods presented are: 2010-11 - April 2010-March 2011, published August 2012 2012 - April 2012-December 2012, published May 2013 The data compares the post-operative (Q2) values, data collected from the patients at 6 months post-operatively by an external company. The data is not case mix adjusted and includes all NHS Trusts, Foundation Trusts, PCT and NHS Treatment Centre data. Private hospital data is omitted.
Patient reported outcome measure score for varicose vein surgery	
Patient reported outcome measure score for hip replacement surgery	
Patient reported outcome measure score for knee replacement surgery	

Data Definitions and Outcome Measure descriptions used

EQ-VAS

Is a 0-100 scale measuring a patient's pain, with scores closest to 0 representing least pain experienced by the patient.

EQ-5D

Is a scale of 0-1 measuring a patient's general health level and takes into account anxiety/depression, pain/discomfort, mobility, self-care and usual activities. The closer the score is to 1.0 the healthier the patient believes themselves to be.

Oxford Hip and Oxford Knee Score

Measures of a patient's experience of their functional ability specific to patients who experience osteoarthritis. The measure is a scale of 0-48 and records the patient's ability to perform tasks such as kneeling, walking without a limp, shopping and stair climbing. The closer the score is to 48 the more functionally able the patient perceives themselves to be.

	VEINS							
	RBCH 2010-11	National Average	Highest Outcome	Lowest Outcome	RBCH 2012	National Average	Highest Outcome	Lowest Outcome
EQ-VAS	82.630	79.155	69.974	86.075	Data set too small for reporting	78.481	70.194	84.350
EQ-5D	0.862	0.855	0.939	0.716	Data set too small for reporting	0.834	0.903	0.717

	HERNIA							
	RBCH 2010-11	National Average	Highest Outcome	Lowest Outcome	RBCH 2012	National Average	Highest Outcome	Lowest Outcome
EQ-VAS	78.087	79.159	72.200	85.163	81.032	79.505	71.250	85.773
EQ-5D	0.848	0.874	0.934	0.787	0.906	0.874	0.943	0.736

	HIP							
	RBCH 2010-11	National Average	Highest Outcome	Lowest Outcome	RBCH 2012	National Average	Highest Outcome	Lowest Outcome
EQ-VAS	75.668	74.550	64.691	81.672	75.637	75.074	62.308	82.548
EQ-5D	0.782	0.762	0.899	0.583	0.798	0.767	0.899	0.599
Oxford Hip Score	38.358	37.977	43.079	31.307	38.381	38.060	43.837	32.250

	KNEE							
	RBCH 2010-11	National Average	Highest Outcome	Lowest Outcome	RBCH 2012	National Average	Highest Outcome	Lowest Outcome
EQ-VAS	72.771	70.913	60.387	78.246	71.983	71.827	64.094	79.182
EQ-5D	0.727	0.705	0.810	0.539	0.694	0.709	0.822	0.526
Oxford Knee Score	34.208	33.724	38.351	25.531	34.433	33.863	39.225	28.672

Quality Indicator	Data Source	Results for reporting period Oct-Dec 2012	Results for reporting period Jan - Mar 2013	National average value	Highest value	Lowest value
% of patients readmitted to hospital within 28 days of being discharged	HSCIC	Q3 2012-2013 28279 admits 1752 readmits 6.2% readmit rate	Q4 2012-2013 27779 admits 1586 readmits 5.7% readmit rate	Not available	Not available	Not available
% of patients admitted to hospital who were risk assessed for venous thromboembolism	HSCIC	Q3 2012-2013 No. Assessed 26291 Admitted 27827 94.5% Assessed	Q4 2012-2013 No. Assessed 25801 Admitted 27440 94.0% Assessed	Not available	Not available	Not available
C difficile infection rate per 100,000 bed days	HSCIC	Q3 2012-2013 52326 bed days 6 C difficile Rate =11.5	Q4 2012-2013 53939 bed days 13 C difficile Rate = 24.1	Not available	Not available	Not available

The Trust considers that this data is as described for the reason of provenance as the data has been extracted from available Department of Health information sources.

Patient safety incidents

This year is the first time that patient safety incidents resulting in severe harm or death have been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre (HSCIC). The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS trusts to report patient safety incidents under the NRLS's voluntary arrangements.

As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the trusts as this may not be comparable.

The following table and charts provide the results from the most recent NRLS report. The report provides comparative data for April 2012 to September 2012. Full year data is not currently available.

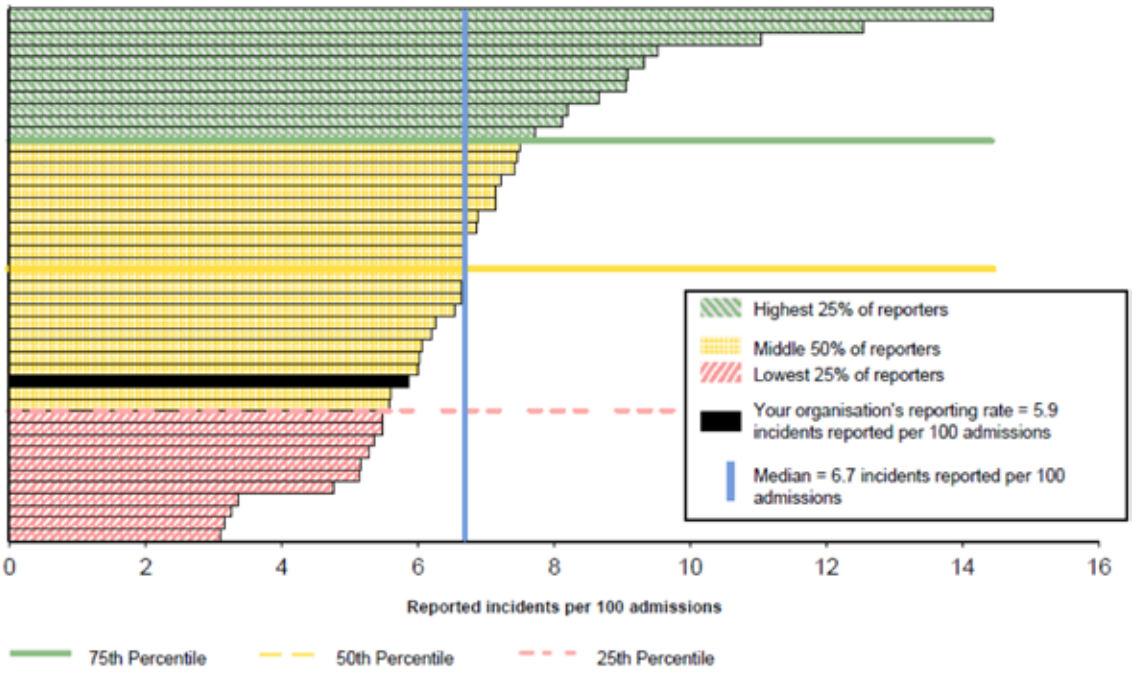
Quality Indicator	Data Source	Trust Results April - Sept 2012	National medium acute Trust average value April-Sept 2012	Highest value April-Sept 2012	Lowest value April-Sept 2012
Number of patient safety incidents reported during the reporting period	NRLS	2876	2603	4552	843
Rate of patient safety incidents reported during the reporting period	NRLS	5.86/100 admissions	6.7/100 admissions	14.44/100 admissions	3.11/100 admissions
Number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	12	19	95	0
% of total number of patient safety incidents reported during the reporting period that resulted in severe harm or death	HSCIC	0.4%	0.8%	3.1%	0

NRLS Report on reporting rate - NRLS Data April 2012 - September 2012

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) between 1 April 2012 and 30 September 2012. 2,876 incidents were reported during this period.

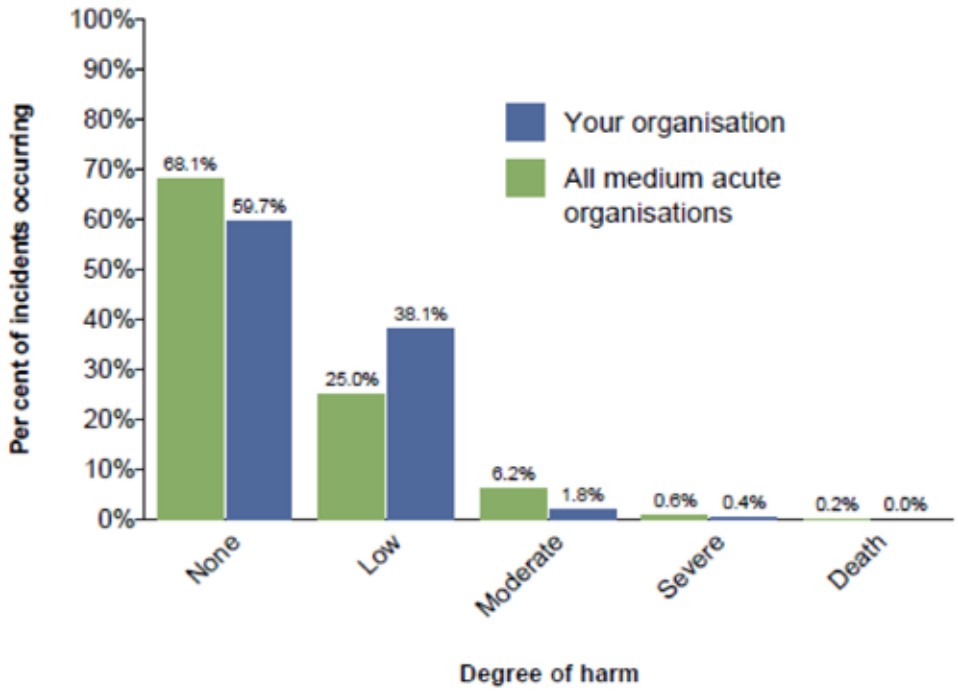
Figure 1: Comparative reporting rate, per 100 admissions, for 45 medium acute organisations.



The Trust is in the middle quartile for reporting when compared to all other medium acute trusts.

The Trust has a similar reporting profile to other medium acute Trusts.

Figure 3: Incidents reported by degree of harm for medium acute organisations



	None	Low	Moderate	Severe	Death
Your figures:	1,718	1,095	51	12	0

Nationally 0.8 % of NRLS patient safety incidents were reported as severe harm or death. The Trust percentage was much lower than this at 0.4%.

The Trust considers that this data is as described for the reason of provenance as the data has been extracted from available Department of Health information sources.

The Trust intends to maintain this position, and so the quality of its services, by continuing to support an open culture for incident reporting and investigation.

Annex A - Statements from commissioners, local Healthwatch organisations and scrutiny committees

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

- Health and Social Care Overview and Scrutiny Committee, Borough of Poole
- Bournemouth Borough Council's Health Overview and Scrutiny Committee
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Council of Governors
- Healthwatch Dorset
- NHS Dorset Clinical Commissioning Group.

Comments received were as follows:

Councillor The Revd. Charles K. Meachin

Borough of Poole, Alderney Ward
7 Hewitt Road, Poole BH15 4QB
Tel: (01202) 682405 Fax: (01202) 681838
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Health and Social Care Overview and Scrutiny Committee response to The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Quality Account 2012/13

Members of Borough of Poole's Health and Social Care Overview and Scrutiny Committee would like to thank the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for the opportunity to comment on their impressive and comprehensive account of activities undertaken to improve services over the 2012/13 financial year. Demonstrating a clear commitment to quality improvement and patient safety

The HSCOSC are encouraged to see that the Trust's quality programme has been enhanced by wide ranging patient safety initiatives and that it continues to be part of a Foundation Trust Patient Safety Collaborative "NHS Quest" combining the shared experiences and learning from 13 Acute Foundation Trusts across the country to promote and improve patient safety.

We note that in addition to patient safety, re-admissions and reducing mortality, the NHS Quest work has concentrated on improving Harm Free Care in particular the delivery of harm free care as defined by "the absence of pressure ulcers, harm from falls, catheter acquired urinary tract infection and veno-thrombosis." We acknowledge the Trust's performance in 2012/13 and the decision to continue with the "Harm free care" programme as a priority in 2013/14 with a view to ensuring at least 95% harm free care across all 4 types of harm in line with the national target as well as a reduction in hospital acquired severe harms from falls and pressure ulcers by 50%. The HSCOSC members would be interested to receive an update on progress in these areas in due course.

We commend the Trust for using a wide range of information sources to help determine their approach in terms of

priorities for the year ahead including 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 inform performance in relation to patient care, experience and safety.

It is pleasing to see that a recent Care Quality Commission re-inspection found the Trust compliant in outcome standards for areas such as consent, care and welfare, safety and estates and that the Trust was rated the second best hospital in England on quality in an independent report.

Thank you once again for the opportunity to comment on a well researched and comprehensive Quality Account.

Yours sincerely

Councillor the Rev. Charles Meachin
Chairman Health and Social Care Overview and Scrutiny Committee
Poole Borough Council

Bournemouth Borough Council's Health Overview and Scrutiny Committee

The Scrutiny Panel would like to thank the Trust for giving them the opportunity to comment on the Trust's Quality Audit, and in so doing engage with them over the future delivery of quality services to the local population.

The Panel would also like to congratulate the Trust on it's achievements in 2012 - 13, and endorse the quality improvement priorities identified for 2013- 14. Through setting out the series of changes that they have put in place during the course of the year, and by listing their detailed action plans for 2013 - 14 the Trust demonstrates that they are an organisation keen to put things right and, are continuing to strive to make improvements to the patient experience.

The Panel was asked to comment on the report content and any omissions that should be included. The response that the Panel is able to give is limited as the draft document contained a number of omissions, and the time given for response was very limited not allowing for time to receive a presentation from, or have any discussions directly with the Trust.

Comments are as follows:

- The document would benefit from having a clear executive summary which gives an overview of how the Trust performed against the areas for improvement they set themselves for 2012 / 13, and then states the outcomes they will be striving to achieve in 2013 / 14. This would also serve as a frame of reference for the rest of the document, giving context to the wealth of information later presented.
- The document might also benefit from having some sort of index.

- At times abbreviations are used and explanations are not close to hand making the text hard to follow.
- The document presents the reader with a wealth of information, at times complex, and it would be helpful if there was more explanatory narrative clarifying how well the Trust was performing against their objectives. At times the comparators are local and at others national, and again this makes the document difficult to interpret, and makes it hard for the reader to assess how well the Trust is performing.
- The language is also quite technical in places and perhaps could be tempered in order to make the document more accessible and easy to read.

The Panel will be giving thought as to how better to engage with the Trust over the course of the year, and will have the Trust's Quality Account as an agenda item at its Autumn meeting. In preparation for that the Panel requests the following:

- To be provided with a final version of the Quality Account 2012-13 as there are a number of gaps in information in the draft version.
- To be appraised of the success of the measures the Trust will be, and has, implemented as a result of the national and local clinical audits they report on in this Quality Audit 2012 - 13, in 6 months time.
- To be informed of the outcome of the Trust's contact with the CQC and Monitor in respect of their decision to adhere to the Charlson Index for the coding standard that caused them to be non compliant when their Information governance assessment was completed.
- To be informed of the outcome of the reports to the Information Commissioner's Office of the 3 serious incidents that are referred to in the Quality Account 2012 -13.
- To be informed as to the number of complaints that were upheld in 2011-2012 and in 2012 - 2013.
- To be informed of the outcome of the complaint that is being investigated by the Ombudsman and of the two currently being assessed.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Council of Governors

The Council of Governors has appreciated that its views on the quality priorities for the Trust and the Quality Report itself are being requested at an earlier stage so that it has greater opportunity to make a meaningful contribution through the consultation process. This year the process also involved a short questionnaire which was sent to the Council of Governors which asked for the Governors' views on the consultation process for setting the 2012/13 quality priorities for the Trust and the Trust's performance and reporting against these. The survey also asked for the Governors' views on potential quality objectives for 2013/14. The Council of Governors supports the quality priorities which have been set and the focus on a smaller number of key priorities. The results of the survey identified that reporting on performance relating to urinary tract infections could be improved and this was referred to the Infection Control Team and also a need for greater awareness of the Trust's performance on implementing an end of life care strategy and this is being developed through training for the Council of Governors in 2013.

However, the Council of Governors was slightly disappointed that the ability of the Council of Governors to set a local indicator to be included in the independent assurance report on the Quality Report to the Council of Governors was been replaced by an indicator mandated by Monitor. The Council of Governors recognised the

importance of gaining assurance on incidents resulting in severe harm to patients with the ability to benchmark data with other foundation trusts, as all foundation trust would be using the same mandated indicator, but did not want to impose the additional administrative burden or cost of selecting a second local indicator.

The Council of Governors, through its Scrutiny Committee, has also contributed to the quality assurance process at the Trust through its own audits and was pleased to gain the support of the Board of Directors for the recommendations following its audit on patient discharge letters presented during 2012/13.

NHS Dorset Clinical Commissioning Group

Over the past year Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has striven to maintain its focus on improving the quality of care provided to individuals. The key priorities identified for 2012/13 focussed upon delivering harm free care. During the year there was a recorded reduction in the number of catheter associated urinary tract infections, with improvement initiatives taking place to reduce harm from falls, pressure ulcers and venous thromboembolism.

The CCG has not been actively engaged in the development of the Quality Improvement Priorities that the Trust has set for 2013/4; these priorities have been agreed following discussion with Governors and Directors. The CCG supports the decision to consolidate upon the quality improvement work undertaken in 2012/13 and looks forward to working with Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust over the coming year.

LINks Your voice on local health and social care

Bournemouth LINks Comment for Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Quality Account 2012

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

LINks welcomed the Trusts commitment to improving the feedback that it received about the Patient Experience, through its own endeavours and by working with the LINk and other organisations, and using this feedback to help it make informed decisions about changes to its services.

In 2011, the LINk encouraged the Trust to be more pro-active about gathering service user feedback and using it to plan and design services.

In 2011 - 2012, the Trust has implemented a program of real time monitoring and targeted patient surveys in relation to high priority issues and areas. We note that the information that has been gathered to date, has been used to as supporting evidence to change the way that services are delivered within the Trust. We feel that by displaying the feedback at the entrance of each ward/ department, shows the transparency of the process and the Trusts commitment to listening and acting upon, the patient's voice.

Working with the Trust

In the 2011 Quality Account - the LINk expressed an interest in undertaking a "leaving hospital survey". This piece of work was successfully undertaken in 2012. The full report can be viewed by visiting **www.makesachange.org.uk** The LINk was very impressed with the Trusts response and action plan.

In 2012 - the Bournemouth LINk undertook an “Enter & View” visit to the Royal Bournemouth Hospital. The report can be found at **www.makesachange.org.uk**

The visit was very well received by both patients and hospital staff. The Trust were very responsive to the recommendations in the report and expressed a desire for Healthwatch to undertake a similar visit in 2012 - 2013.

The LINk undertook a piece of engagement with Young People from 2009 - 2012. Some of the comments that we received were relevant to the Royal Bournemouth Hospital. The report was shared with the Trust who immediately put together a very detailed action plan to deal with the concerns expressed by the young people. The report and action plan can be viewed on the Bournemouth LINks web site **www.makesachange.org.uk**

These three pieces of work are mentioned in this Quality Account on pages 59 & 60.

As we mentioned in the 2011 Quality Account we believe that the Trust should produce an easy read version of the Quality Account, thus improving access to this information for service users, carers and the public. We note that the Trust chose not to do this with the 2010 account and hope that they will produce one for 2012.

In 2011 the LINk suggested that the Trust should engage at an early stage with Healthwatch Dorset. We note that there has been a real effort by the Trust to support Healthwatch Dorset and engage with them as they develop their Healthwatch Champion networks. **www.healthwatchdorset.co.uk**

The Bournemouth LINk has had a good working relationship with the Trust during the last 5 years and is confident that this will continue as it develops its links with Healthwatch Dorset in 2013 and beyond.

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

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

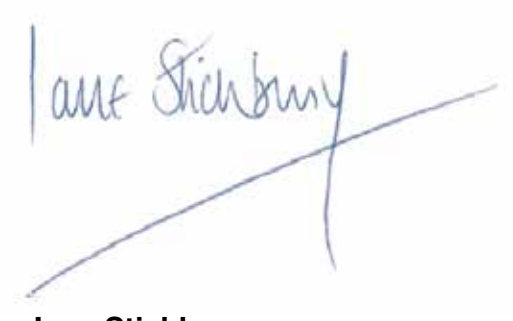
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate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

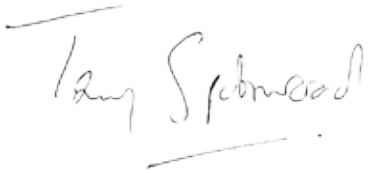
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to June 2013
  - Papers relating to quality reported to the Board over the period April 2012 to June 2013
  - Feedback from commissioners dated 21/05/2013
  - Feedback from governors dated 21/05/2013
  - Feedback from Local Healthwatch organisations dated 22/05/2013
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 20/05/2013
  - The latest national inpatient survey
  - The latest national staff survey
  - The Head of Internal Audits annual opinion over the Trusts control environment dated 24/05/2012
  - CQC quality and risk profiles published April 2012, June 2012, July 2012, August 2012, October 2012, November 2012, December 2012, February 2013, March 2013.
- the Quality Report presents a balanced picture of the 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 **www.monitor-nhsft.gov.uk/annualreportingmanual**) as well as the standards to support data quality for the preparation of the Quality Report (available at **www.monitor-nhsft.gov.uk/annualreportingmanual**).

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

By order of the Board



Jane Stichbury
Chairman
24 May 2013



Mr A Spotswood
Chief Executive
24 May 2013

Annex C - Independent Auditor's Report to the Council of Governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on the Quality Report

We 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 2013 (the "Quality Report") and certain performance indicators contained therein.

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. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we 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 our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor are as follows:

- C Difficile; and
- 62 day cancer wait times from urgent referral until treatment.

We 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 Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us 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 the Detailed Guidance for External Assurance on Quality Reports; 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.

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We 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"). Our 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.
- Analytical procedures.
- 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.
- Reading the documents.

A limited assurance engagement is smaller 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 scope of our 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 our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- 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 the Detailed Guidance for External Assurance on Quality Reports; 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.

Deloitte LLP

Deloitte LLP
Chartered Accountants
Southampton
24 May 2013

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 online at **www.rbch.nhs.uk**

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