excellent care for every patient, every day, everywhere

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Quality Report 2013/14

Quality Report 2013/14

Part 1:

This is the sixth 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 2013/14.

Our quality program has been supported 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 15 acute foundation trusts across England to promote and improve patient safety. This year NHS QUEST work has concentrated on creating a shared quality dashboard, and a programme of peer reviews and clinical collaboratives to enable us to work closely together to tackle common issues such as patient falls, pressure damage and surgical safety.

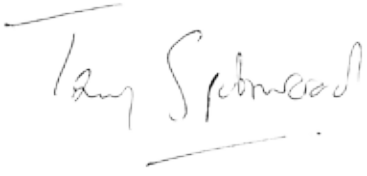
There were a number of inspections during the year, the most important of which was a formal inspection by the Care Quality Commission (CQC) which identified that we needed to improve on our standards in areas such as privacy and dignity and nutrition and hydration. We have worked with external and internal stakeholders to develop a robust action plan for 2014/15 to improve core standards across all areas of the Trust and ensure our patients, carers and visitors that safety is at the heart of everything we do. The action plan has also informed decisions on our action plans and quality improvement programme for the year ahead.

It is acknowledged that we set ourselves ambitious quality and safety targets for 2013/14 and, whilst progress is positive, we did not meet all of our aspirations. Where this is the case we have highlighted this in the 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 2014/15. We have chosen to continue with our "harm free" care programme for 2014/15 alongside our comprehensive CQC action plan. 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 and patient safety initiatives that we have been or will be engaged in within this report. We have considered the comments made by our external stakeholders during the consultation process and amended the final version of the report to provide additional information where appropriate. We hope that the report demonstrates 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

Focus on quality

In June 2014 we launched a new Quality Strategy focusing on safety, effectiveness and experience. A Quality Toolkit was developed to engage staff in quality improvement. Case studies are used to promote examples of good practice, celebrate innovation and improvement and share ideas for spread and learning.

Weekly 'Focus on quality' bulletins are produced to inform staff about progress against our CQC action plans; highlight important 'SEE Quality Strategy' objectives.

The quality bulletins are also shared with members of the public via our website, on patient information screens in waiting areas at the hospital and displayed on noticeboards in the main atrium. Key quality messages are displayed on screensavers that appear across our hospitals, visible to both staff and patients. For each quality story, we aim to see what impact it is having on our staff and patients, so include quotes from those who are putting our quality strategy into action, and those who are seeing the benefits

Monthly Core Brief cascade briefings with leaders across the organisation, led by the Executive Director team, are used to promote and share quality strategy communication to all staff. The Core Brief briefings are filmed and placed on the intranet so that staff who are unable to attend do not miss out on important information. The message is that we want to deliver excellent care for every patient, every day, everywhere and everyone in the organisation has an equally important role to play to support this.

Focus on quality

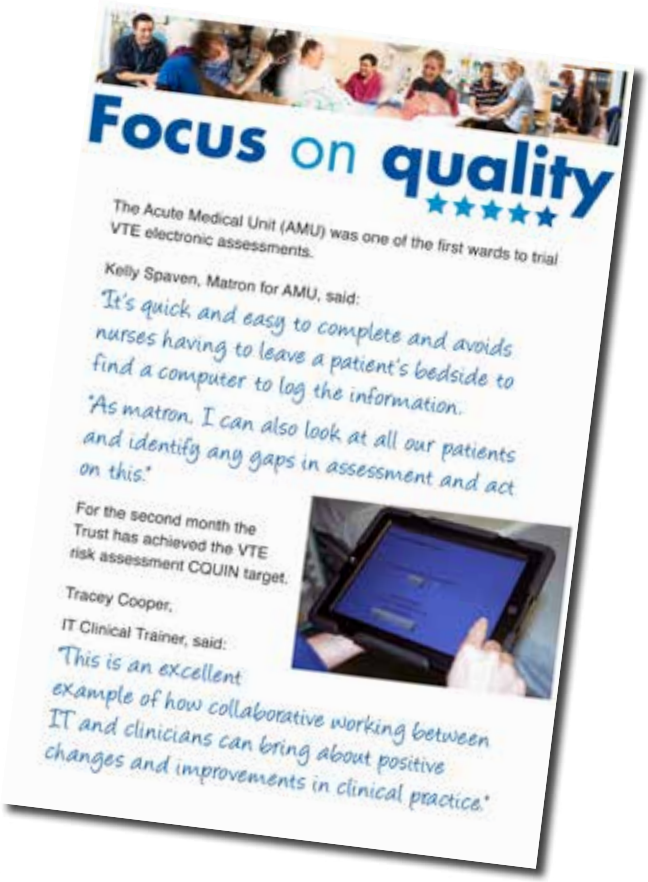
Praise from visiting Trust

Our hospitals have received a glowing report from the Heart of England NHS Foundation Trust following a recent visit by them.

The organisation is currently undergoing a re-structure and visited us to find out how we have become more efficient and to learn about the successes of ongoing initiatives.

They visited our Sandbourne Suite, Treatment and Investigation Unit (TIU), short-stay wards and various other departments. They were impressed by patients being admitted to a central point and walking to theatre, the innovative DVT clinic moving to TIU, and the efficiency of both SSU and theatres.

They were also particularly impressed with our one-stop pre-assessment service, the amount of nurse lead discharges we carry out, the high percentage of day case procedures we do and the volume of patients and quality of care given in the orthopaedic walkabout clinics.



Focus on quality

The Acute Medical Unit (AMU) was one of the first wards to trial VTE electronic assessments.

Kelly Spaven, Matron for AMU, said:

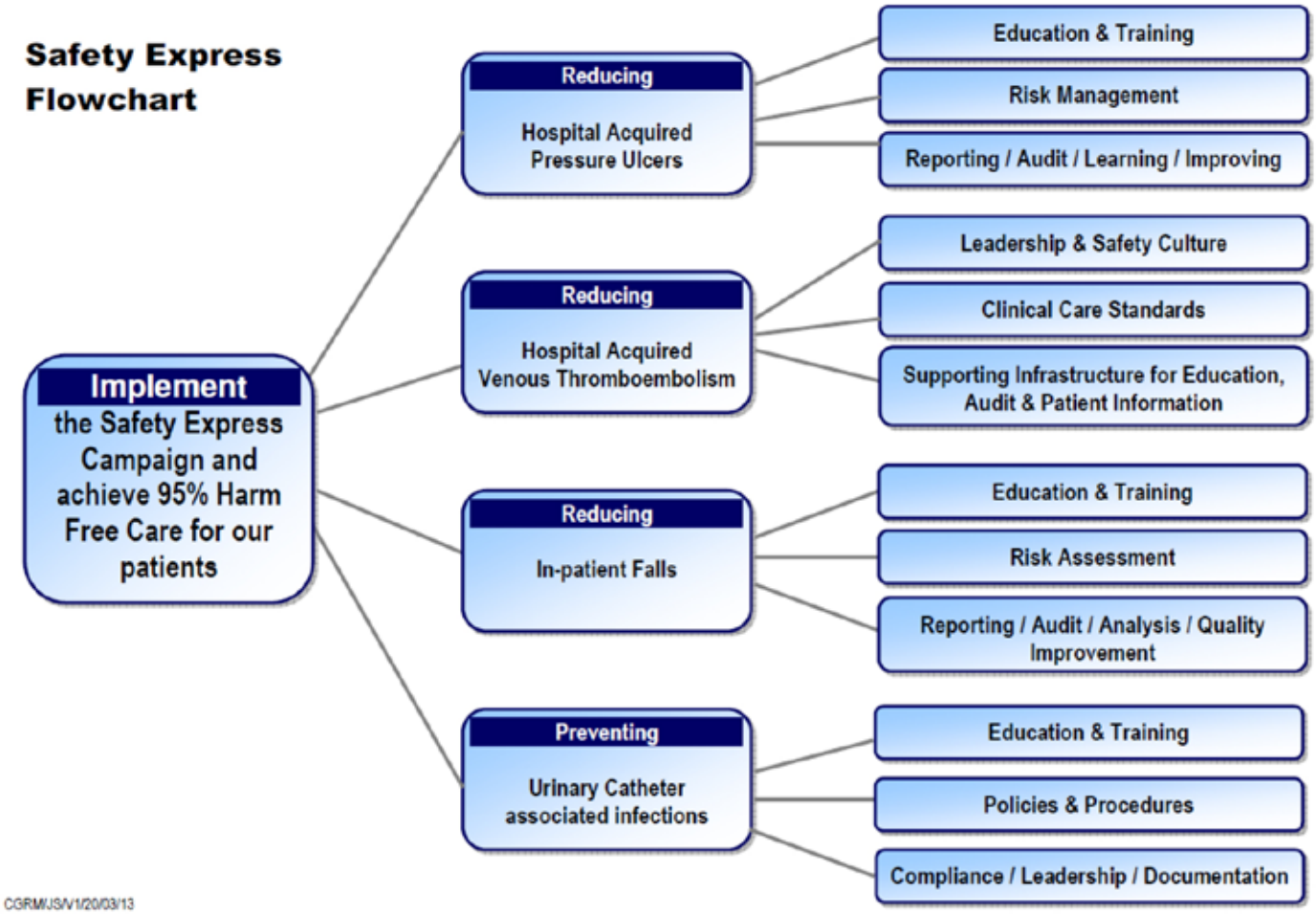
"It's quick and easy to complete and avoids nurses having to leave a patient's bedside to find a computer to log the information.

"As matron, I can also look at all our patients and identify any gaps in assessment and act on this."

For the second month the Trust has achieved the VTE risk assessment CQUIN target.

Tracey Cooper, IT Clinical Trainer, said:

"This is an excellent example of how collaborative working between IT and clinicians can bring about positive changes and improvements in clinical practice."



Part 2:

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

2.1 Progress against quality priorities set out in last year's Quality Report for 2013/14

The 2012/13 Quality Report identified 'harm free care' as the specific quality improvement priority to be monitored in 2013/14, as measured by the national NHS Safety Express programme and NHS Safety Thermometer tool.

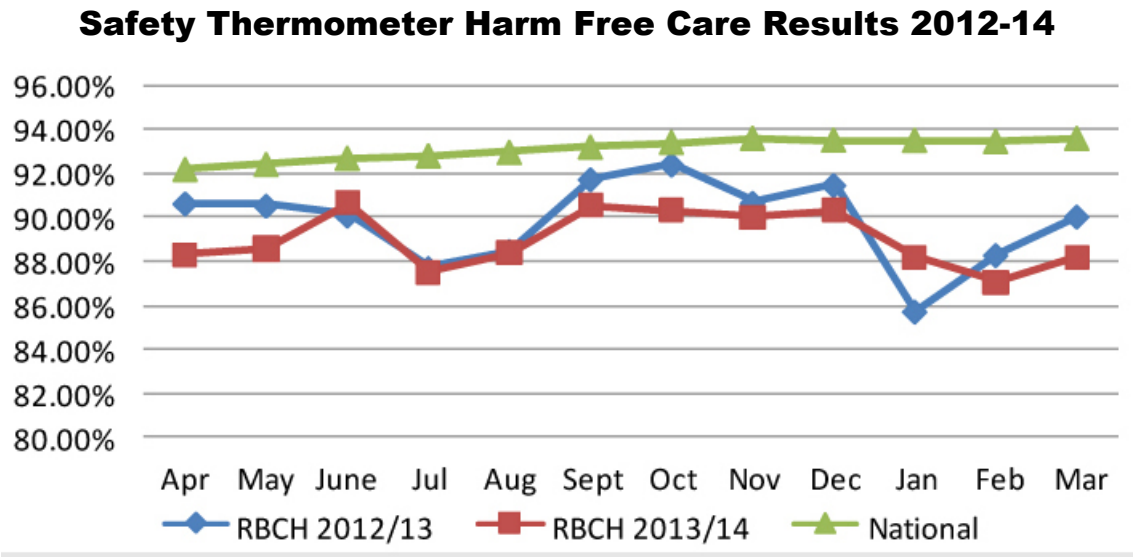
The main quality objective for the year (2013/2014) was the completion of the safety thermometer across all wards areas with an over arching aim: "to deliver harm free care as defined by the absence of pressure ulcers, harm from falls, catheter acquired urinary tract infection (CA-UTI) and Veno-thrombosis (VTE)".

A patient is identified as having 'harm free care' if they have not had a pressure ulcer (either before or during admission), an inpatient fall, a catheter related urinary tract infection or a hospital acquired venous thromboembolism (blood clot).

'Harm free care' is measured monthly via a standard NHS Safety Thermometer methodology that requires wards to record 'harms' for all inpatients on the ward on the monthly data collection day. 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 2013/14, we achieved an average of 89% harm free care (90% in 2012/13). This is below what we set out to achieve (95%) and worse that the national average score for 2013/14 for acute trusts which was 93%. We aim to improve significantly on this in 2014/15.

Chart: NHS Safety Thermometer - Harm Free care scores for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust 2013/2014



Our score for 2013/14 is worse than the national average as a result of a higher number of patients being admitted to hospital with an existing pressure ulcer and a higher number of internal hospital acquired pressure ulcers. We are currently working with community colleagues to support pressure ulcer prevention initiatives and training across the whole health economy.

Quality initiatives undertaken in 2013/14 for each 'harm free care' patient safety objective are outlined in the following sections of the quality report.

Hospital acquired pressure ulcers

On average 2.2% of the hospital inpatients surveyed in 2013/2014, using the National NHS Safety Thermometer tool, had a reported hospital acquired pressure ulcer. We are disappointed in these results as they are higher than last year and also worse than the national average.

The national reporting methodology for hospital acquired pressure ulcers includes patients who had pressure ulcers healed or acquired the previous month. Our submitted data has been externally reviewed and we are assured we have met the national data set for 2013/14. We are subsequently working with our clinical commissioning groups, neighbouring trusts and NHS England to ensure there is consistent reporting across Wessex for 2014/15.

Our higher than expected pressure ulcer figures for 2013/14 were principally concentrated to a number of specific incident peaks in a few individual areas. Detailed action plans have been implemented in year for these areas and encouragingly we have seen a significant reduction in these areas in the last few months. We have also implemented a number of Trust-wide pressure ulcer prevention strategies in year and have extensive improvement plans to take these further in 2014/2015. We aim to achieve a 50% reduction in our avoidable hospital acquired pressure ulcers in 2014/15.

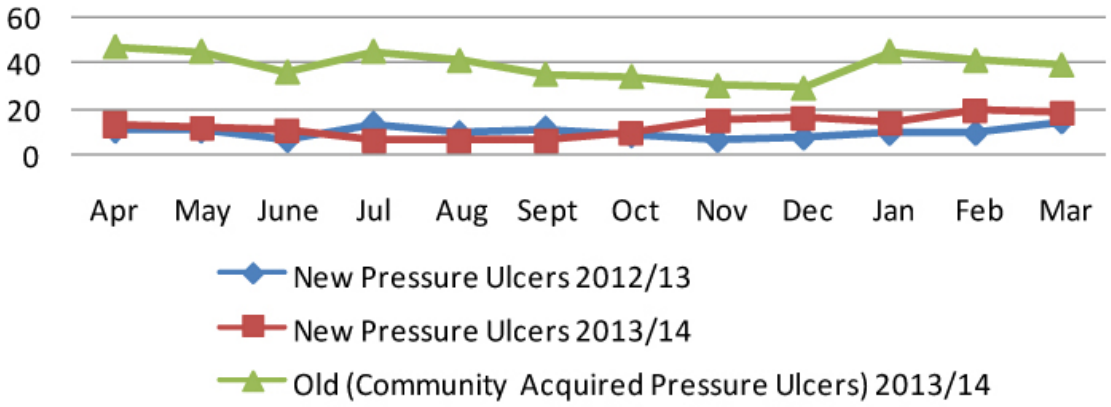
The number of patients being admitted with existing pressure damage from the community is also worse than the national average, this impacted significantly on the overall harm free care score for the Trust. We are working closely with community and commissioning group colleagues across Dorset and Hampshire to improve pressure ulcer prevention.

NHS Dorset Clinical Commissioning Group has established a multi-agency Dorset Pressure Ulcer Strategy Group to review pressure area care and management across all care boundaries in the county. We are a key stakeholder in this group and a joint action plan has been developed.

National Safety Thermometer results for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (Source: Health and Social Care Information Centre)

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of all patients surveyed with a community or hospital acquired pressure ulcer	10.17	9.69	7.96	10.62	8.97	7.61	8.13	8.64	8.88	10.75	11.11	10.54
% of patients surveyed with a hospital acquired pressure ulcer	2.2	1.9	1.73	1.46	1.15	1.11	1.7	2.88	3.16	2.55	3.52	3.33

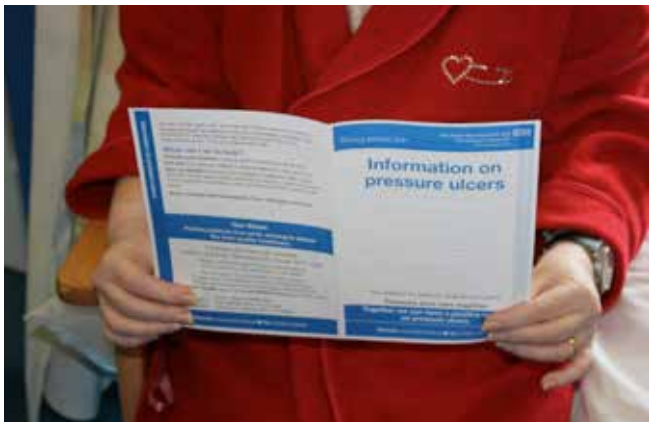
Hospital aquired and community acquired pressure ulcer numbers collected via the Safety Thermometer Tool for 2012/13 and 2013/14



Quality Improvements implemented in 2013/2014

- the Tissue Viability Team has been expanded this year to include a new full time tissue viability healthcare assistant. The remit of this post includes:
  - supporting the implementation of the pressure ulcer policy
  - referring incidents of pressure ulcer policy non concordance to the ward co-ordinator, ward resource nurse and tissue viability
  - supporting the Trust adverse incident reporting process i.e. to assist wards in investigating, action and learning from reported pressure ulcer incidence
  - assisting in the planning and provision of clinical audits and supporting implementation of recommended changes from audit reports
- implementation of new Standard operating procedures developed for; Stock dressings, Heelift suspension boot use, pressure relieving cushion provision, skin care for incontinent patients and pressure ulcer ward rounds
- provision of enhanced ward based training, including dedicated training sessions for stroke and Acute Medical Unit staff
- implementation of a number of additional clinical audits to routinely monitor policy compliance e.g. monthly risk assessment and wound care documentation audits.
- implementation of specific tissue viability ward rounds
- Pressure Area Care Together (PACT) is the pressure ulcer prevention and management strategy for the Trust and was launched in January 2014. It has been designed so that all relevant documentation and supporting information can be easily accessible to all staff. Each clinical area will have a PACT folder containing trust guidance, standard operating procedures for both tissue viability and nutrition and dietetics departments

- a pressure ulcer patient information leaflet has been developed to compliment the Pressure Area Care Together strategy. This has been designed to explain the associated risk factors, how pressure damage can develop and what patients can expect during their hospital stay.



- the Trust IT Department and the Tissue Viability Team have been working together to develop an interactive risk assessment application (eWaterlow app). The eWaterlow app will help to streamline the completion and updates of the pressure ulcer risk assessment tool. Using the iPads, qualified staff can be guided through the risk assessment tool. Timeframes for reassessment based on the patients' level of risk are set, highlighting to ward staff when they are due to be reviewed. Automatic electronic referrals to specialist teams and pressure relieving equipment requests can be initiated via the application. The pilot phase is due to commence in May 2014.

- NHS England, Wessex region hosted a Pressure Ulcer Quality Summit in March 2014 to share best practice in pressure area care across the region. The Trust Tissue Viability Team presented a session on the implementation of the pressure ulcer ward rounds at the summit.

Action plan priorities for 2014/15

- maintain and strengthen our existing relationships with providers across all care boundaries. Focus on sharing good practice and learning from others with regards to reducing hospital acquired pressure damage
- pilot and implement across the Trust the eWaterlow risk assessment application
- hold a Trust Tissue Viability study day. In April a study day for 60 delegates will be held focusing on pressure area care prevention and management within the Trust. The programme include scenario based workshops and learning shared from Serious Incident events
- continue to embed and expand the Trust wide Pressure Area Care Together (PACT) strategy, to share areas of learning and good practice across the organisation
- commence evaluations of novel pressure relieving equipment systems including Hybrid mattresses (static foam and dynamic air cell technology) and non-patient specific heel protectors

Inpatient falls

Less than 1% of hospital in patients surveyed in 2013/2014 using the national NHS Safety Thermometer tool had a fall resulting in harm whilst admitted to hospital.

The number of falls recorded using the Safety Thermometer methodology was better than the national average.

Quality improvements implemented in 2013/14

- ongoing education with ward staff regarding falls prevention and the introduction of falls prevention toolkit folders for all wards

- Risk Assessment Documentation Audits have been integrated into monthly safety Thermometer data collection and results presented to ward sisters and senior nurses. Results for the last six months show that on average 90% of falls, bed rails and mobility risk assessments are completed in a timely manner. While encouraging, there is ongoing work needed to further improve nursing assessment documentation and care planning. This will be a priority action for 2014/15
- updated Care Round Documentation has been implemented and is in use across all inpatient areas. Training on extended 14 Day Care Plan has been provided at ward level and will be a focus for continued review and improvement in 2014/15
- to improve communication and learning, ward teams present case presentations at the Trust Falls Steering Group. Teams are able to feedback on individual patient stories and share experiences, good practice, improvements and learning

- a new in-house falls management video has been “story boarded” with the Risk Management Department, Therapy Team and Falls Steering Group
- new gripper socks to improve patient footwear and reduce the risk of falls have been made available across the Trust

- a number of falls prevention initiatives have focused on dementia care and, working with the Specialist Dementia team, the Falls Group have looked at:
  - reducing busy patterns on ward walls and flooring to assist independent safe walking
  - removal or replacement of mirrors and shiny surfaces to reduce risk
  - improving signage on all the wards by using pictures and appropriate colours
  - creating dementia friendly ward environments.
- as part of the NHS QUEST Collaborative, the Trust is participating in a specific work programme to look at reducing patient falls. The Collaborative is currently working on a shared action plan and quality improvement programme.

- the Trust is currently participating in the Royal College of Physicians national pilot of Inpatient Falls.

Action plan priorities for 2014/15

- maintain and increase the number of Ward based training sessions delivered
- provide additional study days to focus on falls prevention and management. The planned programme will include workshops and case studies to enable wider learning from adverse events
- implementation of e-assessments for nursing and patient assessments to aid completion, documentation and care planning

New Hospital Acquired Venous Thromboembolism (VTE)

On average less than 0.2% of hospital inpatients surveyed using the National NHS Safety Thermometer tool in 2013/14 had a new hospital acquired venous thromboembolism (a "blood clot") during admission. This is much better than the result for 2012/13 which was 0.45%. It is also much better (i.e. lower) than the national average value of 0.51%.

The Trust also demonstrated a VTE risk assessment rate of 98.62% using the NHS Safety Thermometer data collection tool compared to the national average of 70.21% and a thromboprophylaxis rate of 92.31% compared to national rate of 66.05%. In both cases the Trust level of compliance was much better than the National average.

Electronic VTE assessments rolled out across our wards

An electronic system which speeds up venous thromboembolism (VTE) assessments has been rolled out across our wards following a successful pilot.

All patients admitted to our hospital are required to have VTE assessments due to an increased risk of blood clots, particularly after surgery, or for patients who may be bedbound for longer than usual.

Historically, the VTE assessment data was captured on all clinical computers once a day. However in February 2014, a new system using iPads was designed which created a live data report, enabling earlier identification of any patient who required a VTE assessment.

Action plan priorities for 2014/14

- improve the consensus data capture for VTE risk assessment to consistently above 95%
- update the patient information leaflets on preventing blood clots in hospital and perform regular audit on patient information and knowledge on VTE.
- implement new National Institute for Health and Clinical Excellence (NICE) Guidance relating to VTE prevention for patients admitted with an acute stroke.
- continue to complete root cause analysis on all hospital acquired venous thromboembolism analysing data for trends.
- apply for national recognition of the outstanding work on VTE by applying for exemplar status.

Reducing Catheter Associated Urinary Tract Infections (CA UTI)

The average numbers of CA UTIs (from National Safety Thermometer data) for the Trust in 2013/4 was 0.47%. This is better than the National average score of 0.56%.

During the year, a review of urinary catheter procedures and documentation was undertaken to ensure compliance with Evidence Based Practice in Infection Control (EPIC3) guidelines. The review highlighted the need to amend existing policy and procedures to ensure best practice. New criteria for urinary catheter use were established and documentation now includes expected duration of use; planned date of removal; daily recording or rationale for use/insertion; compliance with bag fill levels and ensuring the position of the catheter bag is correct.

To further improve the standards for the insertion, care and management of catheters

insertion sticker labels were introduced at the start of the year. Post implementation an audit was undertaken which confirmed that there had been significant improvement in documentation following implementation and use of the new labels in medical notes.

2.2 Our quality priorities for 2014/15

In order to identify priorities for quality improvement in 2014/15, 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 and surveys
- collating information from claims, complaints and adverse incidents
- 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
- risk reports
- listened to what staff have told us during executive director patient safety walkrounds
- vision and values staff and patient workshops

We have taken into account the comments made by the CQC inspection team in its final report. Our action plan focuses on ensuring we meet four essential standards covering assessment and meeting patients' needs, dignity and respect, and improving quality and staffing. We have reviewed our CQC action plan as part of setting our principle quality priorities and improvement objectives for 2014/15.

We have also 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 Clinical Commissioning Groups and other acute trusts as part of NHS QUEST to look at how joint initiatives may be undertaken and best practice developed together.

We have formally consulted with key stakeholders (general public, staff, patients, governors and commissioners) to help identify quality improvement priorities for 2014/15. Priorities have been considered with clinical staff as part of service delivery and clinical governance meetings.

Following consultation, the Board of Directors has agreed that the specific patient safety priorities for 2014/15 should be further improvement in the fundamentals of good nursing care:

- reducing harm from inpatient falls
- reducing harm from hospital acquired pressure ulcers
- reducing urinary tract infections caused by catheters
- reducing hospital acquired venous thromboembolism (VTE blood clots)
- ensuring privacy and dignity at all times
- ensuring completion of all appropriate nursing risk assessments and care plans

A specific objective is to improve on 2013/14 compliance and achieve an average of 95% 'harm free care' for 2014/15. A further objective is to reduce the 2013/14 NHS Safety Thermometer baseline number of hospital-acquired severe harms from pressure ulcers by 50% in 2014/15.

We 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, we will review compliance against published national and local benchmarking.

The rationale for adopting the same priorities for 2014/15 as 2013/14 has been endorsed by the Board of Directors and Council of Governors and is to ensure effective implementation of current quality initiatives and to focus on embedding and sustaining change.

Ensuring consistency was a key finding of the CQC inspection in October 2013.

In addition to these specific quality objectives, we will continue to implement and monitor our CQC action plans at organisational and directorate level. We will also maintain with our wider Trust and NHS quest quality improvement plans with specific focus on issues such as sepsis, acute kidney injury, deterioration and palliative end of life care. We will continue to collect, report, monitor and act on specific quality indicators for patient safety, clinical effectiveness and patient experience agreed with our Clinical Commissioning Groups. Performance will be monitored internally and also externally via joint quality meetings with commissioners.

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.

Review of services

During 2013/14 the Trust provided eight 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 2013/14 represents 100% of the total income generated from the provision of NHS services by the Trust for 2013/14

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, adverse incident reports, quality dashboards and quality and risk data. This information is discussed routinely at Trust and Directorate quality, risk and 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 Quality and Risk Committee, Healthcare Assurance Committee, Trust Management Board and, Board of Directors each month. Many of the reports are also reported monthly and/or quarterly to our commissioners as part of our requirement to provide assurance on contract and quality performance compliance.

Participation in clinical audit

During 2013/14, 31 national clinical audits and six national confidential enquiries covered NHS services that the Trust provides.

During 2013/14, the Trust participated in 90% (28/31) of national audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that the Trust was eligible to participate in during 2013/14 are shown in the tables below.

The national audits and national confidential enquires that the Trust participated in and for which data collection was completed during 2013/14, 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.

The reports of two national audits published in 2013/14 were reviewed by the Trust in 2013/14 and the Trust intends to take the following actions to improve the quality of healthcare provided:

■ - yes ■ - no ■ - not applicable

National Clinical Audits for Inclusion in Quality Report 2012/13	Eligible to Participate	Participated in 2013/14	Data Collection completed in 2013/14	Rate of case ascertainment (%)
Acute coronary syndrome or Acute myocardial infarction (MINAP)	■	■	■	100%
Adult Cardiac Surgery Audit	■	■	■	■
Adult Community Acquired Pneumonia	■	■	■	■
Adult Critical Care Case Mix Programme (ICNARC)	■	■	■	100%
Bowel Cancer (NBOCAP)	■	■	■	98%
Bronchiectasis	■	■	■	■
Cardiac Arrhythmia	■	■	■	100%
Chronic Kidney Disease in Primary Care	■	■	■	■
Chronic Obstructive Pulmonary Disease	■	■	■	■
Congenital Heart Disease (Paediatric Cardiac Surgery)	■	■	■	■
Coronary Angioplasty	■	■	■	100%
Diabetes (Adult) - National Diabetes Inpatient Audit (NADIA)	■	■	■	55 cases
Diabetes (Paediatric)	■	■	■	■
Elective Surgery (National PROMS programme)	■	■	■	80.1%
Emergency Use of Oxygen	■	■	■	419 patients
Epilepsy 12 audit (Childhood Epilepsy)	■	■	■	■
Falls and Fragility Fractures Audit Programme, includes National Hip Fracture Database	■	■	■	100% (40 cases submitted to pilot inpatient falls audit)
Head and Neck Oncology (DAHNO)	■	■	■	■
Heart Failure	■	■	■	47.9%

Inflammatory Bowel Disease	■	■	■	132 cases submitted to biological therapies audit 42 cases to 4th Round main audit
Lung Cancer (NLCA)	■	■	■	63%
Moderate or Severe Asthma in Children (care provided in emergency departments)	■	■	■	Data collecting still in progress - ends May 14
National Audit of Dementia	■	■	■	100%
National Audit of Schizophrenia	■	■	■	■
National Audit of Seizure Management (NASH)	■	■	■	30 cases submitted
National Cardiac Arrest Audit	■	■	■	Data collecting still in progress - ends May 14
National Comparative Audit of Blood Transfusion	■	■	■	100%
National Emergency Laparotomy Audit	■	■	■	100%
National Joint Registry	■	■	■	93% of patients consented
National Vascular Registry (including CIA and elements of NVD)	■	■	■	
Neonatal Intensive and Special Care	■	■	■	■
Non-invasive Ventilation - Adults	■	■	■	■
Oesophago-gastric cancer (NAOGC)	■	■	■	60-80%
Ophthalmology	■	■	■	Data collection not started in 2013-14
Paediatric Asthma	■	■	■	■
Paediatric Intensive Care	■	■	■	■
Paracetamol Overdose (care in the Emergency Dept)	■	■	■	Data collecting to end May 2014
Prescribing Observatory for Mental Health (POMH-UK)	■	■	■	■
Prostate Cancer	■	■	■	Data collection started Oct 13, still in progress
Pulmonary hypertension	■	■	■	■
Renal replacement registry (Renal Registry)	■	■	■	■
Rheumatoid and Early Inflammatory Arthritis	■	■	■	Data collection started Feb 14, still in progress

Sentinel Stroke Audit Programme (SSNAP)	■	■	■	April-June 13 90%, Jul13-April14 100%
Severe sepsis and septic shock	■	■	■	Data collection to end May 2014
Severe trauma (Trauma Audit and Research Network)				
Specialist rehabilitation for patients with complex needs				

National Confidential Enquiries for Inclusion in Quality Report 2013/14	Eligible to Participate	Participated in 2013/14	Data Collection completed in 2013/14	Rate of case ascertainment (%)
Sub Arachnoid Haemorrhage	■	■	■	100%
Alcohol Related Liver Disease	■	■	■	100%
Tracheostomy Care	■	■	■	100%
Lower Limb Amputation	■	■	■	100%
Gastrointestinal Haemorrhage	■	■		
Sepsis	■	■		

Centre for Maternal and Child Death Enquires for Inclusion in Quality Report 2013/14	Eligible to Participate	Participated in 2013/14	Data Collection completed in 2013/14	Rate of case ascertainment (%)
Sub Arachnoid Haemorrhage	■	■	■	No cases to report
Alcohol Related Liver Disease	■	■	■	No cases to report

The reports of two national audits published in 2013/14 were reviewed by the Trust in 2013/14 and we intend to take the following actions to improve the quality of healthcare provided:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Sub Arachnoid Haemorrhage Study

- to develop more formal links with our tertiary centre at Southampton and develop shared policies and procedures
- to review availability of X-ray Computed Tomography scans out of hours to facilitate diagnosis

Sentinel Stroke Audit Programme (SSNAP)

- to improve access to the Stroke Unit within four hours
- to increase the number of nurses who are competent to perform swallow tests
- to improve the quality of data collection especially the clinical indicators
- to review and improve access and treatment times for stroke patients

The Trust did not participate in three national audits this year - non-invasive ventilation, adult community acquired pneumonia and bronchiectasis. A decision was made to focus on more local clinical and audit priorities.

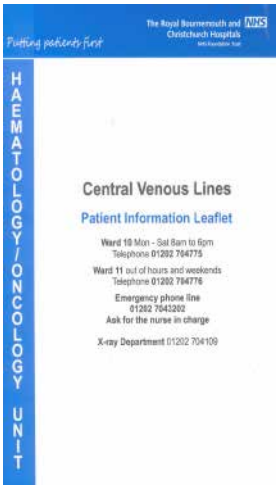
Results of local clinical audits are reviewed within the directorates and at directorate clinical governance committees. A summary of actions noted from clinical audits is reviewed quarterly by the Trust's Quality and Risk Committee and by the Healthcare Assurance Committee.

The Trust has developed a detailed clinical audit plan for 2014/15 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 212 local clinical audits were reviewed by the Trust in 2013/14 and we intend to take the following actions to improve the quality of healthcare provided:

Following an audit of health records by nurses and allied health professionals, a yellow plastic page marker is now inserted into the current inpatient episode with a reminder of the key items to be recorded with every entry. The new divider makes it much easier for staff to find the most recent admission documentation for the patient and has helped to ensure a consistent approach to documentation standards.

- new wrap around gowns have been procured following an audit of privacy and dignity undertaken by the Surgical Directorate
- an audit of patients starting on the Fermentable Oligo-Di-Monosaccharides and Polyols (FODMAP) diet recommended that all patents should have screening for coeliac disease before starting the diet. This diet is used to alleviate the symptoms of irritable bowel syndrome by introducing a diet low in FODMAPs
- a nurse led transfusion clinic has been set up as a result of an audit of the Haematology/Oncology Homecare Service which enables large numbers of patients to be seen without the need for a home visit. Nurses also now undertake some telephone clinics
- following an audit of NICE Guidance CG126 Stable Angina, new forms designed to provide better documentation of medical therapy were introduced.
- plated meals were introduced to all wards in October 2013 following a review of catering satisfaction
- patients who care for their own central venous catheter lines at home are to be given a central venous catheter record book on the day of insertion and an advice booklet is to be written following an audit of central venous catheter line patient information and line care



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 1182 (April 2013 - March 2014). This compares to the 2012/13 value of 1157 and therefore represents a slight increase in activity for the year.

In 2013/14 we achieved 109% of the National Institute for Health Research (NIHR) recruitment target despite a near 25% cut in NIHR Clinical Research Network (CRN) NHS Service Support funding. Our ability to achieve this was, in part, as a result of improvements in the research structure and appointments of a Lead Research Nurse and Senior Research Nurses. This allows us to better manage research teams and distribute resources in support of Principal Investigators leading on clinical trials and research studies.

Our recruitment total for 2013/14 is categorised by:

- interventional Band 3 studies - 219
- observational Band 2 studies - 282
- observational Band 1 studies - 514
- commercial studies - 185

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has the second highest number of NIHR recruiting commercial studies in the Wessex Clinical Research Network (CRN). Our non-NIHR commercial research is supported by our partnership agreement with Quintiles, which is now reaping rewards and we have been offered “named” investigator studies in areas new to research. The partnership has helped to stimulate research in dermatology and has the potential to help revitalise research in rheumatology. We are in a strong position to respond to quintiles’ pipeline activity particularly in CVA/Diabetes and infectious diseases/hepatology. Our stroke team has engaged consultants in elderly care to broaden their portfolio and encourage cross-speciality research collaboration. We are one of only three quintiles partner sites in the south of England.

This year four clinicians at the Trust have been selected as UK Chief Investigators, leading on five international studies in the areas of orthopaedics, oncology and cardiology.

Recent highlights from the research community include:

- Dr Sally Killick - recognised as Myelodysplastic Syndrome (MDS) Centre of Excellence. One of only nine centres in the UK
- Dr Helen McCarthy - one of the worldwide top recruiters to RESONATE, a chronic lymphocytic leukaemia/small lymphocytic lymphoma commercial study
- Anita Immanuel, haematology research nurse, awarded a Churchill Fellowship from the prestigious Winston Churchill Memorial Fund
- vascular research study AARDVARK - Mr Rittoo and Sara Baker. Top UK recruiter.
- cardiac research team reaching the finals of the Pharma Times Research Team of the Year 2013
- cardiac research study VENTURE AF - Top UK and world recruiter, first out of 44 centres (achieved 383% of target recruitment)
- cardiac research leaders free study - top UK recruiter, seventh out of 55 sites in world (achieved 420% of target recruitment)

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

The Trust’s income in 2013/14 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because of the agreement reached with the Clinical Commissioning Group (CCG) to use the CQUIN payment to source a fund available non recurrently to protect the quality of care and safety of the service with a particular focus on areas that are giving rise to the CQUIN areas. The Trust agreed use of this fund directly with the CCG.

Statements from the Care Quality Commission (CQC)

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

The Care Quality Commission has not taken any enforcement action against the Trust during 2013/14.

The Trust has participated in one review or investigation by the CQC relating to its licence in 2013/14.

The CQC inspected the Royal Bournemouth Hospital on the 24, 25 and 30 October 2013 using their new inspection model for NHS hospitals. The full report on the inspection was issued by the CQC on 18 December 2013 and identified a number of areas where inspectors felt that services were not always safe, effective, responsive, caring or well led. The CQC highlighted three specific compliance breaches relating to care and welfare of patients (Regulation 9), monitoring the quality of service provision (Regulation 10) and respecting the dignity of patients (Regulation 17).

The CQC report highlighted four MUST do actions relating to where they considered that essential standards of quality and safety were not being met. The four 'MUST take action to improve' requirements were as follows:

- all patients need to have their needs assessed and care delivered safely and in a timely manner by staff who are skilled to do so.
- at all times, patients must be treated with the dignity and respect they deserve and basic care needs must be met.
- the Trust must reassure itself and stakeholders that all opportunities to drive quality improvement and quality assurance are taken
- the Trust must ensure that the required number of staff are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet peoples needs.

The report did highlight outstanding areas of care, for example in critical care, end of life care and maternity.

We have fully accepted the CQC's report and have taken its findings seriously and used the report to identify our priorities for 2014/15 and supplement these with our extensive CQC action plan work started in October 2014.

The CQC report cited examples where patients have reported to the CQC a poor experience at the Royal Bournemouth Hospital. Every patient is important to us and we need to put right areas where we are not providing the standard of care we expect for all patients.

Work began before the CQC inspection on increasing staffing levels. We have recruited 57 newly qualified nurses, who are already working on our wards, and we have been building our ward teams. We look at staffing on a shift by shift basis to ensure levels are matched to patient needs.

We are absolutely focused on building upon and maintaining the improvements we have made. We have a large elderly population locally and, ultimately, we want to be recognised as a centre of excellence in elderly care and provide a patient experience that all patients and their families can have confidence in.

Areas where we have acted and are acting to improve include:

- Trust-wide actions on privacy and dignity, including call bell audits, new patient gowns and better communication have been implemented. We are working closely with the Patients Association and Healthwatch to ensure patients concerns are identified and addressed and standards continually improved

Bay nursing improves patient communication

Knowing our patients and their individual needs is essential to safe and effective nursing care. Bay-based nursing stations have been introduced on all of our medical and care of the elderly wards at the Royal Bournemouth Hospital providing a greater nurse presence and reducing patient anxiety.

A nurse is allocated to each bay on the ward at the start of each shift. That nurse is responsible for the delivery of care to those patients (up to seven patients and supported by a health care assistant) for the duration of their shift.

The nursing stations are stocked with materials based on the acuity and needs of the patients on that bay. This leads to more effective nursing by ensuring they have the right equipment to hand.

The nurse becomes the expert on those patients in that bay and is able to support doctors' ward rounds. They can provide more proactive, consistent and timely individual care and improved communication between staff, carers and families.

Staff nurse, Bridget Bush from Ward 17, said: "It has improved communication between staff and patients and is more efficient. I love it. It is simple but effective and has made such a difference."

- implemented a new pathway for quick access to our Stroke Unit. This provides our patients with the best possible chance of making a good recovery
- expanded our acute clinics so that urgent care patients are reviewed and triaged in a more timely manner and discharged earlier if an hospital admission is not required.
- implemented a new pathway that enables elderly care consultants to now take direct calls from GPs for advice and guidance about possible admissions.
- provided additional wound care and pressure ulcer prevention training for ward staff
- implemented a specific training programme for staff working in elderly care and we are also working with the Kings Fund to redesign a number of our elderly care wards so they are a dementia friendly environment
- expanded our volunteers as patient companions at meal times
- extended visiting times

We have extended the visiting times on our wards to benefit patients, families, friends and carers. We wanted to make visiting times less restrictive for those who may have previously been unable to see a friend or loved one.

The extended times (varying on wards from 1.30-7.30pm or 2-8pm) mean patients, visitors and carers have more opportunities to liaise with doctors, nurses and therapists about their care.

Families and carers are also able to assist patients at meal times if they wish to, with support from hospital staff. Protected mealtimes, aimed at ensuring patients can eat without being interrupted, still apply on hospital wards. Visitors are politely requested to respect this time unless they are supporting feeding.

Ellen Bull, Deputy Director of Nursing, said: "As a hospital, we absolutely want our patients to get the valued support they receive from their relatives, carers and friends through more flexible visiting times.

"Some patients are happier having a relative or friend assisting them with feeding, rather than a nurse, and this gives them that opportunity if they wish."

- appointed additional nursing staff (all grades) and recruiting an additional 17 consultants in areas such as Emergency Department, the Acute Medical Unit, care of the elderly and general surgery
- launched a new staff listening and engagement programme
- created a Elderly Care Directorate to focus on this important specialty for our patients

- promoted the importance of learning and sharing, from adverse incident reporting (AIRS), mortality reviews and best practice
- improved security arrangements in the Emergency Department
- improved consent process for interventional radiology procedures
- introduced a new x-ray booking system and improved waiting times in outpatient clinics

You can read more about how we are responding to the CQC's report at www.rbch.nhs.uk/cqc

Data quality

The Trust submitted records during 2013/14 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 99.7% for admitted patient care: 99.9% for outpatient care; and 97.5% 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: 99.9% for outpatient care; and 99.9% for accident and emergency care.

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
- supports safer patient identification practices
- 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 next.

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 the Health and Social Care Information Centre, with all evidence uploaded by 31 March 2014.

The Trust's Information Governance Toolkit Version 11 assessment attained an overall score for 2013/14 of 74% and was graded as Satisfactory and green. A score of at least a Level 2 was attained in all of the 45 requirements; this overall score included 10 standards graded at Level 3, which is the maximum score that can be attained on any standard.

The Trust's overall score of 74% with a 'satisfactory' rating represents an improvement from its 2012/13 Version 10 submission, which had been graded as 'not satisfactory'.

During 2013/14 the Trust has enhanced its Information Governance arrangements by progressing the work around the identification of Information Asset Owners. This project is now entering the second phase, whereby flows of personal data are being identified and risk assessed to ensure that they are adequately protected. Work will also be undertaken to embed and sustain the current compliance with the Information Governance Toolkit.

During 2012/13, the Trust did not meet a Level 2 target within the Information Governance Toolkit, in relation to Clinical Coding. 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 had taken the decision to adhere to the Charlson Index - a comorbidity coding standard required by Dr Foster. During 2013/14, the Trust has ceased to use the Charlson Index, and now uses a Clinical Coding Audit Methodology which is in line with the requirements set out by the Health and Social Care Information Centre within the Information Governance Toolkit. Level 2 assurance is now provided for this standard and a recent audit demonstrated the impact of this decision on coding error rates

with improved percentage accuracy levels in all areas of attainment specified in the IG toolkit (i.e. primary and secondary diagnosis and primary and secondary procedures).

There has been a decrease in the number of information governance incidents reported during 2013/14; this includes a decrease in serious incidents. During 2013/14, one serious incident was reported and has 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.

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 8%, an improvement on the previous years figure of 12.5%.

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

- 20 FCE'S from Healthcare Resource Group (HRG) EA49Z
- 20 FCE'S from Healthcare Resource Group EA36A
- 20 FCE'S from Healthcare Resource Group WA18V and WA22V
- 40 FCE'S from Healthcare Resource Group SA04D,SA09D,SA12D and SA13A

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.

Action taken by the Trust to improve data quality in 2013/14 has included improvement in the clarity of discharge summaries by clinicians to enable easier coding. The Trust is also in the process of implementation of new program to scan all notes and move to an Electronic Document Management System. This will enable coders to view more clinical information when coding patient care episodes. The Trust has also reviewed and validated its coding procedures in year to ensure that the coding of diagnosis and procedures is in line with National standards.

2.4 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report against a set of core indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

For each indicator the number, percentage, value, score or rate (as applicable) for the last two reporting periods (where available) are presented in the table below. In addition, where the required data has been made available by the HSCIC, a comparison with the national average and the highest and lowest national values for the same indicator has been included. The Trust considers that the data presented is as described for the reason of provenance as the data has been extracted from available Department of Health information sources.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Summary hospital level mortality indicator (SHMI)	Health and Social Care Information Centre (HSCIC)	June 12-June 13 107.4 Oct 11 - Sept 12 101	100 100	118.6 121.0	63.0 68.5
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust considers that the data presented is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission to HSCIS. The data has been extracted from available Department of Health information sources.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by routinely monitoring mortality rates. This includes looking at mortality rates by speciality diagnosis and procedure. A systematic approach is adopted whenever an early warning of a potential problem is detected - this includes external review where appropriate. The Trust Mortality Group, chaired by the Medical Director routinely reviews mortality data and initiates quality improvement actions where appropriate.					
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust	HSCIC	June 12-June 13 33.8% Oct 11-Sept12 24.28%	21.3% 19%	44.9% 43.3%	0% 0.2%
The Trust considers that the data presented is as described for the following reason. The data has been extracted from available Department of Health information sources.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services to end of life patients, by: (i) Increasing the specialist palliative service available for patients at the main RBH site, including extra palliative nursing and medical time in the Acute Admissions Unit (ii) Greater accuracy of recording of this information, arising from review of mortality reporting. This is part of the routine review of all deaths at RBCH, linked to the roll out of the e-mortality process so learning and trends can be analysed across the Trust. (iii) More proactive end of life discharge planning to enable patients to go home, or to hospice care, where this is appropriate, again resulting in more accurate recording of end of life care in the records. These actions, alongside the fact the Trust has one of the largest Palliative care units in an acute hospital trust, means we would expect our palliative care coding rate to increase and be higher than the national average. We are also working on improving the quality of palliative care within the Trust via a comprehensive approach which was recognised by the CQC hospital inspections as good practice.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
% of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period (i) aged 0 to 14 (ii) aged 15 or over	HSCIC	2012/13 (i) = 0 (ii) = 4176 (10.96%) 2013/14 (i) = 0 (ii) = 3298 (9.82%)	Not available	Not available	Not available
The Trust considers that the data presented is as described for the following reasons. The source data for this indicator is routinely audited prior to submission. The figures submitted for the number of readmissions has been independently scrutinised by external auditors. The figures for 2012/13 have been amended from those published in the 2012/13 Quality Report to allow a like-for-like comparison using the same counting methodology. This approach is in line with the NHS Information Centre's recommended approach, rather than that used previously which was in line with the NHS PBR guidance. There are numerous possible ways of reporting re-admission rates, with case note audits by clinical experts being perhaps the most insightful for understanding true reasons for re-admissions and whether these were avoidable, and clinically related to the original presenting condition. As a result the Trust continues to facilitate GP led audits of this subject, as well as to use benchmarking to identify any significant issues. Overall the downward trend is positive, and this is predominately due to the changes in the Emergency Department pathways of care.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate by routine monitoring of performance data and root cause analysis investigations where appropriate.					
Responsiveness to the personal needs of patients	National Inpatient Survey 2013	77%	76.9%	87%	67.1%
The Trust considers that the data presented is as described for the following reason. The data source is produced by the Care Quality Commission.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate: An action plan that addresses the issues raised in the report has been developed and will be overseen by Patient Experience and Communications Committee, which is a sub committee of the Board of Directors. High-lights of this include regular feedback and ward based actions from the Friends and Family Test, as well as the Patient's Association CARE audits.					
Staff who would recommend the Trust to family or friends	National Staff Survey 2013	71.37%	67.1%	93.92%	39.57%
The Trust considers that the data presented is as described for the following reason. The exercise is undertaken by an external organisation with adherence to strict national criteria and protocols.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this percentage: The results of the survey have been presented to the Workforce Committee and Board and key actions have been agreed, including the implementation of the Quality strategy, improved staffing levels and better communications.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Patient Reported Outcome measures (PROMS) - Case mix adjusted average health gains i) groin hernia ii) varicose vein iii) hip replacement iv) knee replacement	PROMs Full data release covering April13-Dec13 (published May 2014)	(i) 0.069 (ii) NA (iii) 0.435 (iv) 0.308	(i) 0.086 (ii) 0.101 (iii) 0.438 (iv) 0.330	(i) 0.157 (ii) 0.158 (iii) 0.527 (iv) 0.416	(i) 0.014 (ii) 0.020 (iii) 0.301 (iv) 0.193
The Trust considers that the data presented is as described for the following reason. The number of patients eligible to participate in PROMs survey is monitored each month and the number of procedures undertaken by the Trust is cross tabulated with the number of patient questionnaires used.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate by reviewing relevant patient pathways.					
% of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)	HSCIC	2012/13 = 94.4% 2013/14 = 93.9%	Not available	Not available	Not available
The Trust considers that the data presented is as described for the following reason. The VTE Score is based on the Department of Health definition and agreed by the local commissioners for CQUIN purposes. The source data for this indicator is routinely audited prior to submission.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate by the implementation of an IT application to support easier data collection and compliance.					
The rate per 100,000 bed days of cases of Clostridium difficile infection reported within the trust during the reporting period	HSCIC	2012/13 0.14 / 100,000 bed days (31 confirmed) 2013/14 0.07 / 100,000 bed days (14 confirmed)	Not available	Not available	Not available
The Trust considers that the data presented is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission. All cases of Clostridium difficile infection at the Trust are reported and investigated by the Infection Control Team and reported monthly to the Board of Directors. Reporting is in line with the requirements of the Health Protection Agency (HPA) and Monitor. The figures submitted for the number of Clostridium difficile cases has been independently scrutinised by external auditors.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has achieved C. difficile reduction targets for the year. The number of hospital acquired cases reported for 2013/14 was 14 against the annual maximum of 29 which was set by the Department of Health. This year shows a sustained improvement in the Trust's clostridium difficile (c.difficile) rate per 100 000 bed days which was lower than the national and south west average for 2013/14.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Number of patient safety incidents reported during the reporting period	NRLS	3239 (Oct12 - Mar13) 3119 (April 13-Sept 13)	Not available	5272	631
Rate of patient safety incidents reported during the reporting period	NRLS	6.6 per 100 admissions (Oct12 - Mar13) 6.12 per 100 admissions (Apr 13 - Sept 13)	7.2 per 100 admissions 7.23 per 100 admissions	16.7 per 100 admissions	1.7 per 100 admissions
Number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	18 (Oct12 - Mar13) 19 (Apr 13 - Sept 13)	Not available	64	2
% of total number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	0.56% (Oct12 - Mar13) 0.50% (Apr 13 - Sept 13)	0.70% 0.60%	4.7%	0.1%

The Trust considers that the data presented is as described for the following reasons. All data is validated prior to submission to the National Reporting and Learning System. The NRLS enables all patient safety incident reports, including near miss and no harm events, 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.

The data presented is from the most recent NRLS report.

The Trust is in the lowest 25% of reporters for reporting when compared to all other medium acute against reporting rate per 100 admissions. The Trust is in the highest 25% of reporters when comparing total number of adverse incidents (including no harm and near miss events) reported. Trusts.

The Trust supports an open culture for incident reporting and investigation and will be implementing a new web based incident reporting system in 2014/15 to increase opportunities for reporting and further improve feedback and learning pathways.

Nationally under 1% of NRLS patient safety incidents were reported as severe harm or death. The Trust percentage lower than this at 0.5%. All incidents resulting in severe harm are fully investigated and a report is shared with our commissioners.

Part 3:

Review of quality performance in 2013/2014

The following section provides an overview of the performance in 2013/14 against additional key quality indicators selected by the Board of Directors in consultation with stakeholders. The indicators have been selected to demonstrate our commitment to patient safety, clinical effectiveness and enhancing the patient experience. The indicators provide continuity to data presented in the 2012/13 Quality Report and have also been selected on the basis of data collection, accuracy and clarity.

The top 10 key messages in this section of the report are:

1. harm from medication errors has reduced
2. low levels of hospital acquired infections achieved
3. improved infection control practice across the Trust
4. low rates of surgical site infections
5. the Hospital Standardised Mortality Rate has significantly reduced in the year as a result of improvements in patient safety, clinical care and quality
6. incident reporting and learning has improved
7. effective review and implementation of national clinical guidelines
8. improvement in overall national inpatient survey results
9. positive Friends and Family Test scores for inpatient wards. The Emergency Department was rated 4th nationally
10. increased number of complaints recorded in year. Greater focus on early local resolution, better communication with complainants and evidence of organisational learning following a complaint investigation

SAFETY

see
safety • effectiveness • experience

1. The Trust's safety culture has improved. More near miss and no harm events have been reported. Staff are encouraged to speak out, report, reflect and learn.

Reducing adverse events

We support an open culture for reporting and learning from adverse events and near miss patient safety incidents. We promote an open reporting culture through the Adverse Incident Policy and standard Adverse Incident Report (AIR) Form.

Encouraging staff to speak out safely

The Trust has signed up to the Nursing Times Speak Out Safely campaign. This means we encourage any staff member who has a patient safety concern to raise it at the earliest opportunity. We promise that where staff identify a genuine patient safety concern, we shall not treat them with prejudice and they will not suffer any detriment to their career.
Instead, we will support them, fully investigate and, if appropriate, act on their concern.

You can read our full pledge on our website **www.rbch.nhs.uk**

SOS
SPEAKOUTSAFELY

Table: Patient safety incidents reported to NPSA via the national reporting and learning system - April 2013 to March 2014

Severity of Incident Reported	Total Number Reported 2013/2014	% of Incidents Reported 2013/2014	Total Number Reported 2012/2013	% of Incidents Reported 2012/2013
No Harm	4865	70.69%	3415	56.8%
Minor / Low	1802	26.17%	2451	40.8%
Moderate	178	2.59%	115	1.90%
Major / Severe	41	0.55%	30	0.50%
Total:	6886		6011	

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.

Nationally 0.70% of patient safety incidents reported to the National Reporting and Learning System are recorded as having caused major or severe harm or death. The Trust's percentages for each of 2011/12, 2012/13 and 2013/14 are much lower at 0.55%, 0.5% and 0.6% 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
- introduction of new transfer and handover checklists
- letters requesting patients to attend for outpatient procedures amended to include warning about driving following appointment
- development of guidance for treatment of underage patients admitted following drug overdose
- improved referral process to reduce inpatient waiting times for therapy services
- new IT system for Portering services to support timely allocation and prioritisation of tasks
- improved information governance procedures for research trials
- provision of additional equipment to support patient handling and the prevention of pressure damage
- amendments to the Trust mandatory training programme to include falls awareness and dementia awareness
- pilot and implementation of a Radio Frequency Identification (RFID) tagging system to improve tracking, provision and maintenance of essential medical devices.
- new transportation boxes/bags purchased to improve security/integrity of specimens in transit.

Never events

The Department of Health has defined a list of specific events that are considered unacceptable and eminently preventable. These are called "Never Events".

In 2013/14 the Trust reported two Never Events. Both incidents related to surgical procedures. Although on both occasions the patient did not come to harm, detailed investigations concluded that routine safety procedures were not followed robustly. As a result of the incident reviews relevant safety procedures have been amended and improved and key learning points shared across the organisation.

Medication safety

2. Harm from medication errors has reduced.

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

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

In 2013/14 a total of 745 medication related adverse incidents were reported and investigated. This compares to 2012/13 (753) and 2011/12 (679) and reflects our promotion and support for open and honest reporting. Of the 745 adverse incidents reported 87% represented no harm events. This is better than previous year's results (2012/13 - 73%, 2011/12 - 75% 2010/11 - 73%).

We have implemented a number of patient safety and quality improvement initiatives in 2013/2014 in year to support medication safety. These have included:

- cages installed for medication deliveries from pharmacy and medication to be returned from wards
- separate 'in' and 'out' cages reduce missed doses and time wasted searching for delivered medication
- wards return medication which has been stopped or expired
- pharmacy staff sort returns for entering back to stock and re-use or destruction

- colour fobs for medication keys have been standardised to reduce time wasted to find correct key
- aide memoire of side-effects of top 100 drugs
- developed and attached to all drug trolleys
- useful resource for nurses to improve information given to patients
- transfer check-list revised and implemented on AMU, leading to improved transfer of;
  - patient's own drugs by 29%
  - drug charts by 50%
  - and, of reduced missed doses on transfer ward
- the pharmacy risk team have
  - developed induction session and film on 'what can go wrong' for new staff
  - introduce a risk notice board for education and training
  - raised awareness of the issues, learning from mistakes and how to report incidents

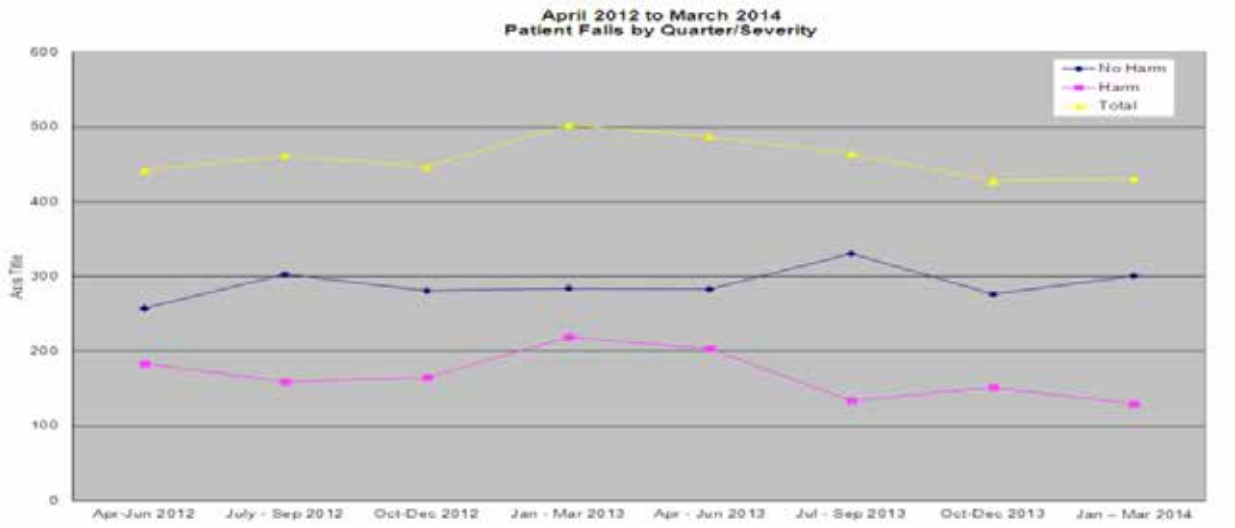
We are in the process of procuring an Electronic Prescribing and Medications Administration system. The procurement is expected to be completed by the end of this financial year (2014/15) and the implementation will start during 2015/16.

In line with the published evidence on e-prescribing systems* it is expected that this system will transform the prescribing and administration process by replacing the paper with electronic records (and hence handwriting/reading errors), implement checks and alerts to support decisions that clinician's take, provide instant access to data for review and audit and have the overall effect of reducing the number and severity of medication related incidents.

* Prescribing errors before and after introduction of electronic charts, Clinical Pharmacist, 2012

* Effects of two commercial electronic prescribing systems on prescribing error rates in hospital inpatients: a before and after study, PloSMed, 2012

RBCH reported patient falls (all events) - 2012/13/14



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.

We have 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:

A total of 1828 patient falls were reported in 2013/14 compared to 1892 in 2012/13 and 1,505 in 2011/12.

1.0% of reported incidents in 2013/14 resulted in severe harm to a patient, this compares to 1.2% in 2012/13 and 1.5% in 2011/12.

The number of patient falls reported as serious incidents in 2013/14 was 13 compared to 21 in 2012/13 and 24 in 2011/12. This represents a significant improvement.

As a year average, the Trust reported 9.0 patient falls/1000 bed days, compared to an acute Trust average (2009, NPSA data) of 5.6/1000 bed days. This is slightly lower than 2012/13 value of 9.18 patient falls/1000 bed days.

All patient falls incidents are reported and investigated to ensure actions and learning points are identified. Incidents resulting in moderate severity undergo a full root cause analysis (RCA) investigation and serious incident RCAs are discussed at multidisciplinary panel meetings chaired by the Director of Nursing.

Examples of themed learning points and actions from root cause analysis investigations held in 2013/14 include:

- ensuring nursing documentation includes accurate and timely risk assessment information
- additional ward based training sessions
- a programme on monthly audit and additional spot checks on care standards
- provision of falls prevention resource folders to all wards
- amending clinical mandatory training sessions to include falls risk assessment skills and case studies
- provision of additional equipment to aid patient moving and handling
- improvements to the ward environment for dementia care and reduce the risk of patient falls

Ensuring high standards of infection prevention and control

3. Low levels of hospital acquired infections achieved

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

There has been one Trust attributed MRSA bacteraemia for the year 2013/14.

Case Study:

A full root cause analysis investigation noted that there had been a delay in the initial screening of the patient. The initial screen was negative and a subsequent screen later in the admission, when the patient had a high temperature, also showed as negative. Following a positive blood culture result a repeat screen was then undertaken which showed MRSA

colonisation in the patients nose and groin. As a result of learning from the investigation, the ward have added due dates for MRSA screening to their daily handover sheet and introduced magnetic stickers for patient boards to remind staff when screens are due. This learning has been shared Trust wide.

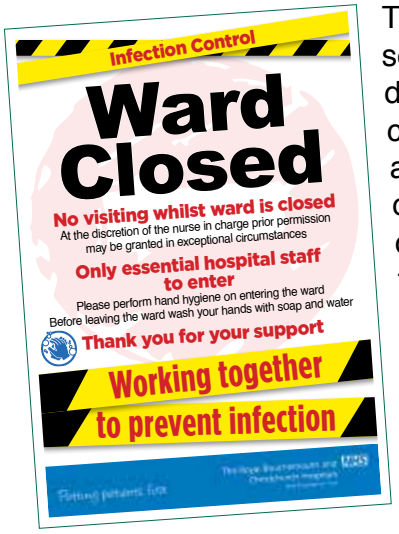
Infection prevention - clean environment

4. Improved infection control practice across the Trust

As part of the ongoing Infection Control Team initiatives, to provide a safe environment, the Trust has invested in disposable curtains that are bacteriostatic having new silver technology which does not support bacterial growth. This is part of a wider ongoing initiative in improving the environment of the elderly care wards.

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. The overall combined compliance was 83%, however there have been areas of concern highlighted by Clinical Commissioning Group, Care Quality Commission and our own internal infection control audits. The issues raised have been addressed or are in the process of being resolved with a multidisciplinary approach and good staff engagement.

The design and purchase of six pull up ward closure posters this winter during the outbreak season ensured a heightened awareness to staff, patients and visitors of the enhanced precautions required on a closed ward to prevent the spread of infection.



The Trust has seen a measurable decrease in the closure of wards and bays as a result of an infection control incident for 2013/14. This is as a result of improvement in infection control practices across the Trust.

Reducing orthopaedic Surgical Site Infections (SSIs)

5. Low rates of surgical site infections

Public Health England (PHE) has highlighted that compared to other participating hospitals, the Trusts incidence of surgical site infections for hip and knee replacement surgery is significantly lower rate. This in part reflects the very high standards of care at our hospital.

To reduce the risk of readmission data being under reported, the Trust Infection Control Team examined the feasibility of introducing patient pocket cards which would identify the carrier as being on a surveillance programme. This has been positively endorsed by Public Health England and a card is now given to each patient who undergoes hip or knee replacement within the Trust. If the patient is readmitted to the hospital, or other care provider, the card is shown prompting the healthcare professional to contact the Trust Infection Control Team. This enables detailed infection control surgical site surveillance records to be maintained.

Infection Control Environment Pods (ICEpods)

Following attendance at a national conference where the new technology was shown, news of advances in the development of the Infection Control Environment pods (ICEpods) manufactured by the Andover company Bioquell, was bought back to Trust. The Infection Control Team then contacted the company and discussed the potential benefits for infection prevention and control.
A business case was developed and approved and following detailed planning and manufacture, pods now are already in use in Wards 2 and 14, with further installations taking place in Wards 15 and 3.

The made to measure ICEpod units completely enclose regular bed spaces to provide additional isolation environments and also enhance facilities for privacy and dignity. Infection control standards have been further enhanced by the installation of individual clinical washbasins within each pod.

Installation of the leased pods has increased our ability to appropriately place and care for patients with specific needs. The use of the pods is being assessed and monitored during the agreed trial period of use. Initial feedback from staff and patients is positive.

“The ICEpod provides flexibility for a protected environment for infectious conditions but can also be utilised to offer accommodation for privacy, dignity or social purposes. This is a new innovation for our Trust and we are offering staff, patients and visitors the opportunity to complete a questionnaire to gain their views on the new installations”. (Trust Infection Control Team)

“The introduction of these pods enables faster isolation of infected patients and this is vital as the hospital looks to minimise the risk of bugs spreading. They are high-tech and don’t compromise privacy.” (Staff Nurse)

“The pods are extremely quiet and well ventilated which makes being inside one comfortable, but the biggest positive is the privacy it offers me.” (Ward Patient)

The Infection Control Team routinely invites Governors to attend Infection control walkabouts, which involves surveillance and audit of the standards of cleanliness of the environment and equipment.

In September 2013, the ICT held their annual Infection Control Study Day. The event is held to provide update education and training for ward and department Infection Control resource staff. The Governors’ were also invited to attend the event, to find out current policies and procedures, new innovations, case studies and current infection control issues for the Trust and national organisations.

A representative from Public Health England provided a session on their remit and their interaction with both the community and the acute hospital setting. Feedback from all participants was very positive.

EFFECTIVENESS

Reducing hospital mortality

6. The Trust's mortality rate has significantly reduced in the year as a result of improvements in patient safety, clinical care and quality. The Trust's Hospital Standardised Mortality rate (HSMR) is now better than the national average.

The Trust has a multi-disciplinary Mortality Group, chaired by the Medical Director, to review the Trust's HSMR (Hospital Standardised Mortality Ratio) and Dr Foster Intelligence Unit mortality 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. An HSMR value of 100 represents an average "expected" value and therefore a score below 100 demonstrates a better than average position.

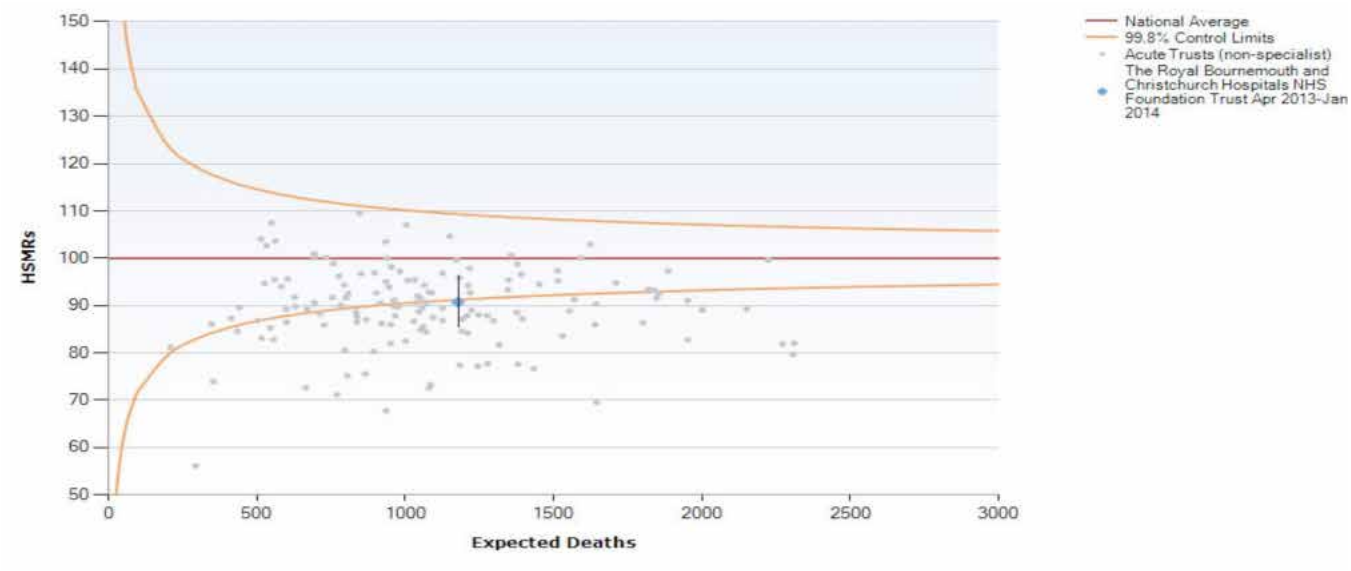
The chart below shows the most recent report available for the Trust and a comparison against the National Average. The HSMR for the Trust for the period February 2013 - January 2014 was 94.3. The figure for January 2014 was 78.7. Both results demonstrate that the Trust has a much lower mortality rate than expected and a mortality rate lower than the National average.

HSMR data for 2013/14 shows a significant improvement. The figures has been discussed with Dr Foster analysts and they can find no data reason for trend and therefore attribute the change to quality, patient safety and service improvements that we have made in year.

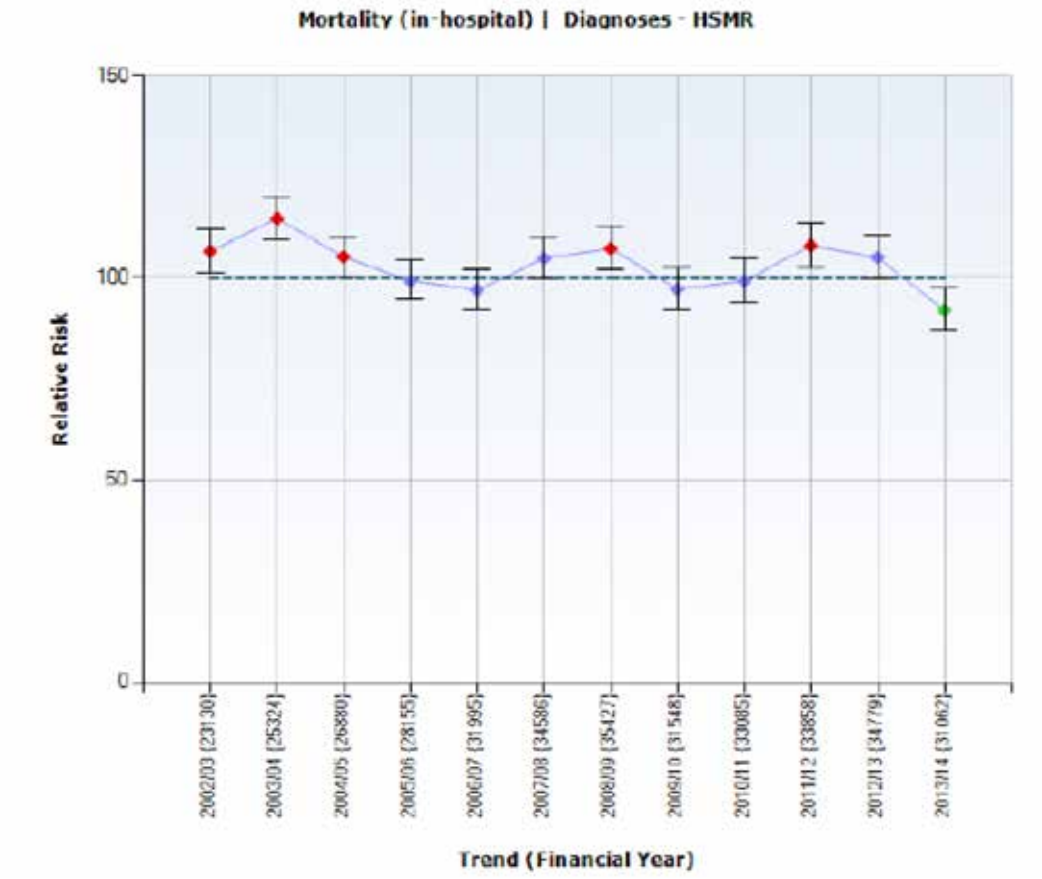
The Trust has continued its review of mortality via the Mortality Improvement through Clinical Engagement (MICE) Group, chaired by the Director of Nursing and Midwifery. The programme draws together several significant strands of work including the work of the Mortality Group described above. The other programmes drawn under this umbrella include seven day working, end of life care, the deteriorating patient and specialist mortality reviews.

Successful initiatives introduced this year have included:

- implementation of an IT system (VitalPAC) to support the accurate and timely recording of patient observations. VitalPAC also allows the proactive identification of patients requiring critical care outreach team or senior review e.g. as the result of clinical deterioration or sepsis
- implementation of a specific simulation training programme 'Management of the Critically ill patient' led by ITU consultants, Critical Care Outreach Team and the Trust's simulation lead



Hospital Standardised Mortality Ratio (HSMR) rates for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust 2000/2014.



- improved end of life care documentation, education and training. In addition to staff training, the lead clinical in End of Life Care held a public Understanding Health event on the topic in January 2014
- development and provision of a comprehensive palliative care education and training programme for all clinical staff
- improvements to seven day working pathways and services across the Trust, to include additional consultant provision in emergency care and elderly care, weekend and out of hours radiology services and senior nurse site cover at weekends

- implementation of a Trust wide process to standardise clinical reviews of all inpatients deaths to ensure all reviews are used as an opportunity to share, learn and improve quality of care for our patients
- establishment of the Acute Kidney Injury (AKI) group to focus on the implementation of early recognition and management of patients with AKI
- improving the management of patient fluids including a review and implementation of new standard fluid charts and, improved medical education on fluid requirements
  - improving the treatment of sepsis patients via:
  - simulated sepsis management sessions with junior doctors
  - modification of hospital drug chart to facilitate better antimicrobial prescribing
  - primary care sepsis training day for GPs
  - involvement in national audits and research trials.
  - review, republication and repromotion of a standard sepsis proforma
  - redeveloped and reissue of sepsis prompt cards to nursing and medical staff
  - use of VitalPac to support the identification of sepsis patients
  - planning the production of an in house training video on sepsis

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

7. Effective review and implementation of national clinical guidelines

The Trust Clinical Governance and Risk Committee (CGRC) reviews compliance with all new National Institute for Health and Care Excellence (NICE) Guidance issued each month. For the period from April 2013 to March 2014 the CGRC reviewed a total of 129 newly issued guidance documents. Compliance rates are shown in the following table:

Type of Guidance	Published	Applicable	Compliant	Partially Compliant	Non Compliant	Under Review
Clinical Guidelines	20	17	6	4	0	7
Technology Appraisals	31	24	11	1	0	12
Interventional Procedures	34	4	2	0	0	2
Public Health Guidance	8	3	0	1	0	2
Medical Technology Guidance	4	1	0	0	1	0
Quality Standards	28	23	8	9	0	6
Diagnostics Guidance	4	3	2	0	0	1
Total	**129**	**75**	**29**	**15**	**1**	**30**

Where non or partial compliance has been identified this is reported to the Trust quality and Risk Committee and an appropriate action plan agreed. The majority of guidelines noted in the above table as “under review” related to those issued during January-March 2014.

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 outcome measure is sent to the patient six 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 four 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 became a pilot site for Electronic Data Capture (EDC). The PROMS questionnaires are completed, by patients, through hand held tablets, similar to iPads. A volunteer has been recruited to assist patients with the technology and one of the biggest advantages is that patients, on completion of their questionnaire will receive immediate acknowledgement and feedback.

During December 2013 and January 2014 an audit was undertaken to assess whether perceived technophobia would be a barrier to patients completing PROMs electronically. Orthopaedic nurse practitioners were divided into 2 groups, one solely collecting paper

PROMs and the other solely collecting electronic PROMs and the compliance rate was collected. Positively 98% of patients asked to complete PROMs electronically completed their outcome measures via the Electronic data capture. 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. For 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 2011/12	Compliance Rate 2012/13	Compliance rate Apr13-Dec13*	National Average Apr13-Dec13*
PROMS for Groin Hernia	59%	117.7%*	58.3%	59.2%
PROMS for Varicose Veins	17%	9.8%	28.0%	39.8%
PROMS for Total Knee replacement	95%	96.5%	94.3%	93.3%
PROMS for Total Hip replacement	97%	96.5%	82.0%	83.4%

\+ Current available figures from PROMS

* 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.

Improving outcome results for knee replacement patients

Following below average health gain results on the Oxford Knee Score for 2011/12 (reported in 2012/13), the orthopaedics department implemented a detailed action plan to improve standards and outcome for patients. The action plan included;

- offering every post-operative knee replacement patient the opportunity to practice on a set of stairs
- offering every post-operative knee replacement patient the opportunity to practice a simulated practice transfer in and out of a car
- standardised total knee replacement operative protocol and follow up protocol introduced to ensure the highest standards of care, regardless of operating surgeon.

Encouragingly, 2012/2013 results for the Oxford Knee Score show a significant improvement from below average to average.

PROMS Outcome Measures

Hip

Measure	RBCH	England	Highest	Lowest
Oxford Hip Score	22.387	21.363	27.571	14.486
EQ-5D	0.444	0.261	0.179	0.641
EQ-VAS	12.131	11.663	42.167	-1.5

Knee

Measure	RBCH	England	Highest	Lowest
Oxford Knee Score	15.673	16.414	22.857	9.5
EQ-5D	0.324	0.33	0.028	0.573
EQ-VAS	5.671	5.8	18.433	-12.5

Other news:

At the Royal Bournemouth and Christchurch hospitals we have some outstanding services that have been recognised for their excellent clinical outcomes, innovation and patient care this year. For example:

- Toshiba has chosen the Royal Bournemouth Hospital (RBH) as the first site for installation of its latest CT scanner - the first of its type in the world
- our Bournemouth Transplant Unit is JACIE accredited which means we are compliant with several hundred quality standards, all of which strive to ensure that a patient having a stem cell transplant has a safe procedure
- in orthopaedics we are the third largest joint centre in the UK with some of the shortest lengths of stay and lowest rates of infection
- our cardiologists have the lowest levels of major adverse cardiac events in the country

Measuring patient experience for improvement is essential 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 current status of patient experience work at the Trust can be summarised in the following areas:

- Trust level benchmarking - e.g. national annual inpatient surveys, cancer patient surveys, Friends and Family test, National patient CQUINS including Dementia. Stroke patient experience survey completed in partnership with The Picker Institute and Oxford University
- in year progress on local priorities and internal benchmarking - e.g. patient experience cards, real time patient feedback, care campaign audit in collaboration with the Patients Association, carers cafes
- 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, web based free text comments, ward scorecards and staff surveys. Also national forums for patient feedback (including NHS choices and Patient Opinion) that we respond to within 24 hours wherever possible and often include mini investigation. For example, in one case a patient comment about staff attitude was made on the Patient Opinion website. The complaint was shared with managerial staff the same day and a response produced which included an invite for the patient to come in via PALS for further discussion
- personal insights - e.g. patient stories, letters and compliments, video vox pops, patient diaries, experience based design interviews, one to one interviews with complaints to understand their experience of the Trust complaints process and to identify opportunities for reducing formal complaints via proactive local resolution
- in depth reviews - e.g. focus groups, local surveys and audits e.g. call Bell audits, privacy and dignity audits, stakeholder events, local forums e.g. young persons, learning disability, dementia and carer events
- education - e.g. patient story by patient at Board of Directors' meetings. The Trust is also currently developing video clips to highlight the patient experience from specific disability groups to enhance understanding and provision of care for a wide variety of disabilities
- specific project groups - e.g. Learning Disabilities, Dementia, Patients Association, CARE audit, Healthwatch quality audits, Volunteers and patient advocates support for improvement projects e.g. meal time companions. Disability forum in partnership with Clinical Commissioning Group and Poole Hospital NHS Foundation Trust

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

Key improvements in patient care are centred both around direct interventions which positively impact on all aspects of quality. Actions taken in 2013/14 include:

- implementation of a Trust-wide Privacy and Dignity Policy to uphold privacy and dignity for all patients
- purchase of new improved dignity gowns for patients
- provision of new disposable curtains to aid correct closure to uphold dignity

- formal adoption of the Code of Conduct for healthcare support workers to ensure consistent practice and patient care for the unregistered nurse workforce
- purchase of specific equipment for patients to aid and assist with eating, such as wide handled cutlery, plate guards, and drinking implements
- revision of patient menus and the provision of snackbags for patients who miss a meal. Food parcels are also provided for patients at the point of discharge who are returning home alone
- expansion of volunteer roles including more trained mealtime companions.
- implementation of the Friends and Family Test through the inpatient services and Emergency Department attenders
- stakeholder events
- carers' cafes and carers audits to support and understand needs of carers
- changes to visiting times to aid patients and relatives carers and visitors

National Care Quality Commission Inpatient Survey

8. Improvement in overall National Inpatient Survey results

The annual Care Quality Commission (CQC) national inpatient survey is a public determinant of patient experience; a regulatory measure performance analysed by the CQC and a local performance measure monitored by our local Clinical Commissioning Groups. The 11th annual CQC in-patient survey includes responses from in excess of 62,400 patients from 156 acute trusts with a response rate of 49%. RBCH had a response rate of 53.1% from a sample of 831 eligible patients who were in the Trust overnight during July 2013. There were 441 responses completed.

The data analysis is based on an 'expected range' when compared to other trusts and is standardised by age, gender and method of admission to ensure the results are fair regardless of demographic. The numerical score is 0 (worst) - 10 (best).

National comparison results

Results are displayed when compared with other trusts as:

- better than most other trusts (coloured green)
- about the same as most other trusts (coloured amber)
- worse than most other trusts (coloured red)

Survey questions are segmented into 10 sections to reflect key aspects of the patient journey or quality of care by professional disciplines. There are a total of 60 questions in total. Performance results for the 2013 survey (completed July 2013) are displayed in the table on the following page;

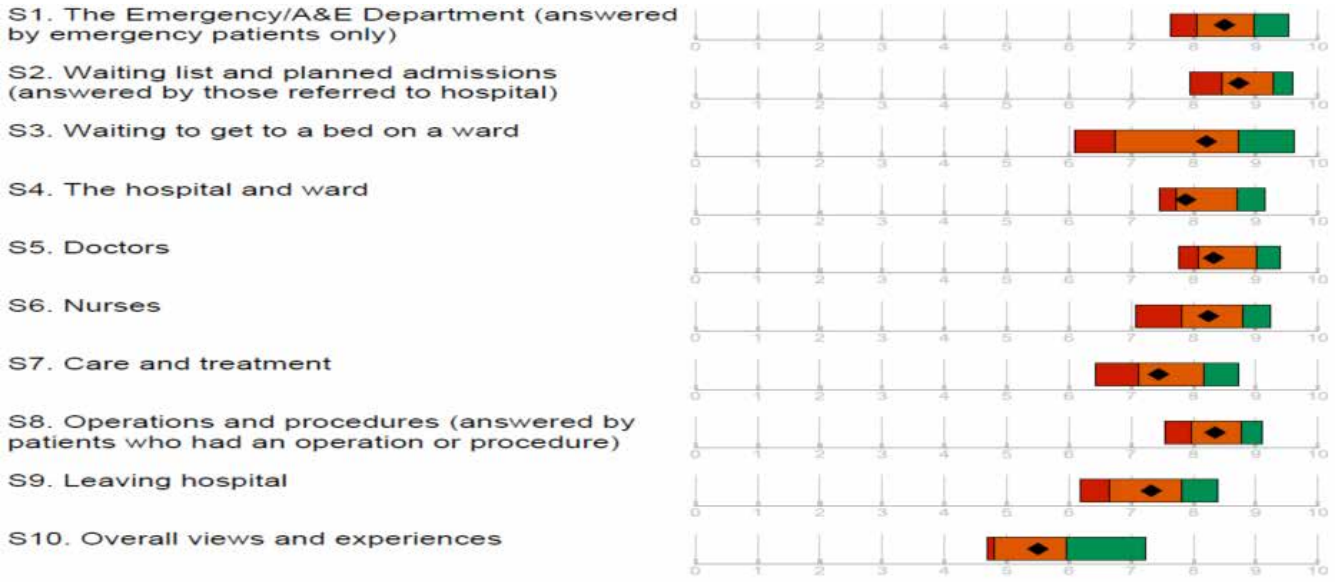
It is very positive to see that the 'overall' score demonstrates good improvement from last year.

We improved on last year's performance in the following categories; Emergency Department, waiting to get a bed on a ward, nurses, care and treatment, and operations and procedures. The Trust is also identified as one of the "better performing trusts when compared to most other Trusts" for providing printed information to patients on "what to do when discharged".

However the report did highlight that we need to make progress in reducing the actual and perceived occasions where patients have to share an area with a patient of the opposite sex.

The results presented in the report are a combined response to two questions that cover sharing a sleeping area when first admitted i.e. Acute Medical Unit (AMU) and, when moved to another ward. Due to changes in the survey design the results for 2013 cannot be compared with previous survey data in 2012.

We have made a number of major design changes to the AMU to improve standards for single sex accommodation and patients' privacy and dignity and will continue to monitor closely.



Comparison with 2012 results

Comparison with 2012 performance demonstrates:

- improvement in 20 questions
- eight questions have remained the same
- deterioration in 29 questions

The results to the question "Were you asked to give your views on the quality of your care?" was statistically better" than last year.

In addition, in 2012 we had the lowest score for the question on privacy when being examined or treated. Encouragingly the results for 2013 demonstrate good improvement and the Trust is now rated as amber at 9.4 from a possible score of 10, this is an improvement by 0.3.

Three questions had results that indicated scores "statistical lower" than last year when compared internally were:

- did you ever share a sleeping area with patients of the opposite sex. Whilst this is shown in the report as a statistical drop, there is a caveat advising to ignore due to reliability of the question following changes to the wording. It does however offer an indicator to patient views.
- delayed discharge due to waiting for medicines/ to see the doctor or waiting for an ambulance. Last year the score was 6.8 which dropped to 6.1 for 2013.
- were you given clear and printed information about your medicines? Last year the score was 8.2 which has dropped to 7.4

In summary, performance against the Trust's 2012 demonstrates good improvement in questions relating to privacy and dignity, discharge information and, asking patients their views. The 'overall' category performance score has improved together with the section performance in the emergency department, waiting to get a bed on a ward, nurses, care and treatment, and operations and procedures categories. Improvement projects are already underway to improve performance across all questions and specifically in areas where we scored less than expected.

Trust Patient Experience Card (PEC) results

In addition to responding to national patient surveys, the Trust has an internal patient experience card (PEC) 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 six questions on one side, chosen in parallel with 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 2013/14, 22,514 cards were completed by patients across our hospitals of which 21,024 completed the Friends and Family Test question.

Friends and Family Test (FFT)

9. High Friends and Family Test Scores for Inpatient Wards and the Emergency Department. ED has achieved 4th Highest Score (NHS England data)

The national Friends and Family Test (FFT) aims to provide a simple headline metric which, when combined with other patient experience feedback, provides a tool to ensure transparency, celebrate success and galvanise improvement.

The implementation of the FFT across all NHS services is an integral part of Putting Patients First, NHS England's Business Plan for 2013/14 - 2015/16, and is designed to help service users, commissioners and practitioners.

Since April 2013, the FFT question has been asked in all NHS Inpatient and emergency departments across England and, from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care:

"How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?" with answers on a scale of extremely likely to extremely unlikely.
The national directive to implement the Friends and Family Test question has been cascaded throughout the Trust. The use of the patient experience card (PEC) has enabled the standard questions to be included and a free text on the back of the cards. The free text section produces approximately 1,000 comments per month of which over 80% are positive and 8% negative, 12% are either mixed or unrecorded.

The results are reviewed through Patient Experience and Communications Committee and actioned where required. The use of the PEC has quadrupled in two years in the number of returns from 5,300 in a year (2011/12) to in excess of 22,000 in 2014. This data is collated and submitted to NHS England in accordance with strict guidlines. The data is also made publically available throughout the Trust for patients and the public in accordance with NHS England guidelines.

The Friends and Family Test score is calculated using 'Net Promoter Score' methodology. Scores are calculated as follows:

Proportion of respondents who would be extremely likely to recommend (response category: 'extremely likely') MINUS the proportion of respondents who would not recommend (response categories: 'neither likely nor unlikely', 'unlikely' and 'extremely unlikely'). This gives a FFT score of between -100 and +100.

The table on page 103 provides the data Trust-wide for the Family and Friends Test.

In addition to the patient experience FFT card we have introduced a token system which has improved our compliance rates in the emergency departments.

We have attained the fourth highest score of 80 based on the NHS England website data for our emergency departments.

Since October the FFT has also been rolled out to include Maternity. This is likely to be further expanded to Out Patient areas in 2014/15.

Number of cards from your area during the above period =	22514

The Friends and Family Test Score for
April 2013 to March 2014
For
Overall Trust (all areas included Inpt/ED/OPD etc)
This is based on 21145 responses

Extremely likely	16626
Likely	3466
Neither likely/nor unlikely	437
Unlikely	208
Extremely unlikely	287
TOTAL	21024
FFT Score	**75**

Real Time Patient Feedback (RTPF)

Real Time Patient Feedback (RTPF) has been facilitated through the Trust by trained volunteers and 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 has been provided by an external provider; however this has been superseded since January 2014 by the Patient Association CARE Campaign audit.

Care Campaign Audit

In partnership with the Patient Association, the care campaign audit has been designed to ensure robust feedback on a daily basis from participating Elderly Care and Medical wards. The audits are facilitated by trained volunteers and public Governors and review:

- Section 1 - Communicating with care and compassion
- Section 2 - Assistance - Ensuring Dignity
- Section 3 - Relieving pain effectively
- Section 4 - Ensuring adequate nutrition
- Section 5 - Your Expectations

The completed audits forms are returned to the Patient Experience Team and reviewed individually on a daily basis. If issues are identified the ward is contacted immediately and informed of the area of concern and an action plan is sent to the ward to be reviewed and completed within two weeks.

Working in partnership

During 2013/14 we have worked in stronger partnerships with carer's forums to develop a carers café which run in collaboration with Dorset County Council, Healthwatch to assist with quality of care audits, and a local disability forum set up in collaboration with Poole Hospital with meetings across both sites. This innovative group is in the process of developing a training package using patient experience stories to educate staff through training and induction.

We have held annual stakeholder events in partnership with our local clinical commisioning groups (CCG's), Health watch, learning disabilities and other key stakeholders.

A stroke patient experience survey was undertaken in partnership with Dorset Healthcare Trust, Bournemouth, Dorchester and Poole hospitals. The questionnaire used for the survey was developed by Picker Institute Europe, University of Oxford and staff from participating organisations. Over 600 patients were surveyed. The Trust scored well in respect to involving family and carers in decisions about condition and treatment; ensuring patients and carers had an opportunity to discuss worries and fears.

Other partnership events have included:

- specialist workshops to review patient pathways, which have included CCG and GP's e.g. Urology Cancer pathway
- rheumatology focus group with members from the National Rheumatoid Arthritis Society (NRAS)
- endoscopy focus groups
- annual Trust open day in June 2013
- interview with Hospital Radio Bedside
- young persons' forum at St Peter's School
- vox pop interviews with various patient groups, bariatric, maternity, cardiac, elderly care,

The Patient Experience Performance Group (which reports to the Board of Director's subcommittee Patient Experience and Communications Committee) monitor patient feedback through triangulation of data and ensure robust and rapid response and action plans are completed where required. The group also reviews the national and local data and ensures that information is cascaded via grand round to medical colleagues for information and action.

Working with our volunteers to support patient experience

We are extremely fortunate to receive the support of over 800 volunteers including partnership volunteer organisations. Over the last 12 months the Trust has been reviewing and extending the number and roles of our valuable volunteers. Partnership agencies that support the Trust and in addition to the Trust Bluecoat volunteers include:

- Royal Voluntary Services
- Chaplins
- League of Friends Christchurch
- League of Friends Bournemouth
- Friends of the Bournemouth Eye Unit
- Hospital Radio Bedside
- Red Cross
- Headstrong
- Macmillan

Bluecoat volunteers duties are extensive and include:

- main receptions meet and greet
- ward support offering tea and coffees
- patient companions, who have dementia awareness training
- administration support throughout the Trust
- driving the indoor train to help patients and visitors around the hospital
- surveying patients for real time patient feedback
- meal time companions to help support those in need of minimal support to eat
- meal time assistants to help prepare the food environment and sit and talk with patients
- gardening
- medical photography escort
- audit support

We continue to recruit volunteers who are happy to provide support during the day, evenings or weekends. The Board of Directors is very grateful for all the excellent work the volunteers provide and would like to publically thank them all for their continued support to our patients and the organisation.

Learning from and reducing complaints

10. Increase in complaints in the year but greater focus on early local resolution, improved communication with complaints and organisational learning following complaints investigations

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 370 formal complaints from patients or their representatives during the year. This represents an increase of 22% (67 complaints) from last year's total of 303 complaints. This increase was apparent

throughout the year and was not related to one or a small number of areas or subjects but was multi-factorial. The wider environment for the NHS has included the publication of the Francis report into Mid-Staffordshire Hospitals which may have lowered the threshold for people to complain.

The focus of the Patient Advice and Liaison Service in resolving concerns informally with front line staff has been constructive and there has been a greater focus within the Trust on addressing complaints of all types at a local level as soon as possible.

Of the 370 formal complaints, 173 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, 37 complaint investigations were still to be concluded and a decision on whether they were well founded had not been reached.

Subjects of complaints

The 10 main categories of complaint in 2013/14 were as follows:

21 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:

- hand hygiene audit and regular infection control visit to ensure compliance and provide education
- equipment moved and new staff recruited to biochemistry to improve timeliness of results
- specific form developed to avoid confusion in endoscopy procedures
- medical staff reminded about referral protocol for fracture clinic
- medical staff in the Emergency Department to have a lower threshold for requesting spinal imaging in addition to clinical assessment

Subject	Number in 2013/14	Percentage in 2013/14	Number in 2012/13	Percentage in 2012/13
Administrative systems	26	7%	19	6.2%
Attitude of staff	35	10%	38	12.5%
Bed management	8	2%	4	1.3%
Clinical treatment	197	52%	172	56.7%
Communication/information	43	12%	35	11.5%
Discharge arrangements	21	6%	15	4.9%
Environment	6	2%	4	1.3%
Health and safety	6	2%	3	0.9%
Privacy and dignity	5	1%	2	0.6%
Medication	15	4%	5	1.6%

- review of age protocols with cardiologists to ensure not restricting young people access to our services
- listing of orthopaedic patients for small joint arthroscopies reviewed to avoid a shortage of instrument sets on the day of procedures
- correct process for booking patient transport discussed with ward staff
- nasogastric feed protocol rewritten and published on the Trust intranet
- changes to anaesthetic protocol to prevent antibiotics being drawn up until patient is present with anaesthetist
- the need for catheterisation to be completed promptly reinforced
- standard of nursing conduct reviewed by Deputy Director of Nursing following complaint investigation
- discussion with surgical ward team about communication with relatives/carers of vulnerable patients.
- call bell audit undertaken and spot checks being undertaken by ward sisters and senior nurses
- discharge planner cascade to all staff to ensure that at least two contact details are obtained and check these details are correct on every admission
- reduced fetal movement and missed appointments polices in maternity reviewed and updated
- confirmation that escalation beds are no longer used
- monthly meeting between the Ward Sister of theatre recovery and the surgical ward to improve communications and work together in reviewing practices and processes between the two areas. The expectation is that teams support one another to achieve better care along the patient pathway
- the bed management team are linking in on a daily basis with the surgical lead to identify any potential for delays in transferring patients from recovery to the wards.
- review of Do Not Attempt Resuscitation (DNAR) form completion and communication with relatives. Guidance issued by Medical Director
- pharmacy meetings with ward staff to include reference to scope for wards to check pharmacy system and availability for drugs to be collected
- the physiotherapy referral protocol has been amended with the letter being sent to patients inviting them to contact the department within a maximum period of 48 hours of the referral being received
- currently establishing electronic systems to replace the current paper ones which will both reduce the risk of misplacing or delaying paper forms, and provide a full audit trail of the request and subsequent actions.

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, six people chose to refer their concerns to the Parliamentary and Health Service Ombudsman during 2013/14 compared to 10 in 2012/13. The Ombudsman referred one complaint back to the Trust for further local resolution, and completed two investigations. One of these was upheld and an action plan was devised and shared with the complainant as a result. The other investigation did not uphold the complaint and there was therefore no action required of the Trust. Three complaints were still being investigated by the Ombudsman at the end of the year.

Complaints focus group

We have held in two specific focus groups this year for those who have made an official complaint against the Trust. The aim was to learn about complaints views on the complaints process and ensure that we make improvements to communication and feedback procedures wherever possible. The sessions have been facilitated and those who could not attend but did want to provide feedback have been met on a one of one basis. We plan to run further groups in 2014/15.

Performance against National priorities in 2013/14

The Trust measures many aspects of its performance and this data is regularly reviewed throughout the organisation. At Board of Directors 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 2013/14 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	2010/11	2011/12	2012/13	2013/14 Target	2013/14 Target
18 week referral to treatment waiting times - admitted	n/a *	17.7 weeks	94.5%	90%	90.8%
18 week referral to treatment waiting times - non admitted	n/a *	14.2 weeks	98.9%	95%	98.4%
18 week referral to treatment waiting times - patients on an incomplete pathway	n/a *	14.2 weeks	97.1%	92%	96.2%
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	99%	97%	97.2%	95%	95.5%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	89.71%	87.3%	88.6%	85%	80.3%
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	97.00%	94.6%	98.6%	90%	93.4%
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	99.56%	96.7%	96.4%	96%	95.7%
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	99.6%	99.2%	98.8%	94%	95.1%
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 two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93.60%	94.2%	93.6%	85%	93.8%
Two week wait for breast symptoms (where cancer was not initially suspected)	98.58%	99.1%	97.0%	93%	98.0%
Clostridium difficile year on year reduction	46	62	31	29	14
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	n/a	Compliance certified	Compliance certified	Compliance certified	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.

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:

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

Comments received were as follows:

NHS Dorset Clinical Commissioning Group

Re: Quality Account 2013/14

In 2013/14 The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust pursued achievement of the key quality priorities identified in the 2012/13 quality account. We can confirm that we have no reason to believe this Quality Account is not an accurate representation of the performance of the organisation during 2013/14. The CCG recognise the areas of strength described in the Quality account and the priority areas for quality improvement. The CCG monitor quality and performance at the Trust throughout the year. There are monthly quality meetings and there is frequent ongoing dialogue as issues arise. The information contained within this Quality Account is consistent with information supplied to commissioners throughout the year. Over the year the Trust has shown consistent use of the Patient safety thermometer to collate safety information. Whilst it is pleasing to note the low level of harm in relation to patient falls and catheter associated infections, there are clearly improvements required in relation to hospital acquired pressure ulcers and maintaining compliance with Venous Thromboembolism risk assessments.

The Hospital Trust has experienced a challenging year most significantly in relation the Care Quality Commission (CQC) inspection report findings published in December 2013. The CCG would have expected to see a reframing of the application of quality priorities for 2014/15 in response the CQC report and subsequent Trust action plan. The CCG has not been actively engaged in the development of the Quality Improvement Priorities that the Trust has set for 2014/15 however will work with The Royal Bournemouth Hospital NHS Foundation Trust over the coming year to ensure all quality standards are monitored as set out in the reporting requirements of the NHS Contract and local quality schedules. “

NHS West Hampshire Clinical Commissioning Group

Re: The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Quality Account 2013/14

Thank you for sharing the Trust’s Quality Account for 2013/14.

West Hampshire Clinical Commissioning Group (CCG) would like to thank The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT) for the opportunity to review and provide a statement response to their 2013/14 Quality Account.

The trust should be congratulated on the efforts made on improving outcomes for patients with the reduction of infections and the continued improvement in patient experience as demonstrated through the implementation of the Friends and Family test. Despite this, however, the Care Quality Commission identified a number of areas of concern on their visit in October 2013 and we are pleased to see that a number of actions were taken immediately to put things right and a comprehensive plan is underway to address the remaining areas.

The CCG acknowledges the improvements made in the reduction of patient falls, however the reporting rate remains above the national average per 1000 bed days, and initiatives continue to be made to work towards a reduction.

The CCG supports the priorities identified for 2014/15 especially the continued focus on reducing hospital acquired pressure ulcers and patient harm as a result of a fall. However, we would have expected to see more focus around the recommendations from the CQC visit i.e. regarding out patients, the care of the older patient and security issues at the A&E department.

Reviewing the quality account the CCG confirms that as far as it can be ascertained the quality account complies with the national requirements for such a report and the following are of specific note:

- The report provides information across the three domains of quality- patient safety, clinical effectiveness and patient experience.
- The mandated elements are incorporated into the report.
- There is evidence within the report that the Trust has used both internal and external assurance mechanisms.
- Commissioners are satisfied with the accuracy of the quality account, as far as they can be based on the information available to them.

Commissioners would have expected the Trust to have made mention of the two Never Events that were reported during the year which have been subject to full investigations.

Overall West Hampshire Clinical Commissioning Group is satisfied that the plans outlined in the Trust's quality account will maintain and further improve the quality of services delivered to patients and the CCG looks forward to working closely with the Trust over the coming year to further improve the quality of local health services.

Councillor The Revd. Charles K. Meachin

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May 7th 2014

Health and Social Care Overview and Scrutiny Committee (HASCOSC) response to The Royal Bournemouth and Christchurch Hospitals (RBCH) NHS Foundation Trust's Quality Account 2013/14

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 the Quality Account for 2013/14 as well as for the very helpful visit on 2nd May in which members were able to clarify and gain a better understanding of a number of key issues.

Overall, we felt that the Trust's Quality Account gave a comprehensive account of activities undertaken to improve services over the financial year and that areas for improvement were also identified.

Members appreciate that Quality Accounts follow a nationally prescribed format and were concerned that this format might make it more difficult for people outside the health system to understand some of the key messages; this is, therefore, an issue that we would like to raise for possible consideration by Monitor, the

Regulator of NHS Foundation Trusts, once all Trusts have produced their Quality Accounts.

Given the above, members appreciated the Trust's efforts to improve "accessibility" to the information through the inclusion of pictures (e.g. of the ICEpods and the Gripper socks). It was felt that accessibility could be further enhanced through clarification as to whether "exceeding the target" reflects good or poor performance, the routine inclusion of the previous year's performance and national comparators (where these are available) as well as actual numbers (rather than just percentages). The inclusion of a contents and glossary section would also be useful.

In terms of progress against 2013/14's priorities for improvement outlined in last year's Quality Report the Trust's main aim was "to deliver harm-free care" across 4 specific harms: the reduction in hospital-acquired pressure ulcers, harm from falls and veno-thrombosis, and the prevention of catheter-acquired urinary tract infections.

We note with concern that the Trust's 'harm-free score' of 89% is below the national average of 93%, due to the admission of more patients with an existing pressure ulcer as well as a higher number of those acquiring pressure ulcers in hospital. Whilst members understand that a significant proportion of patients had acquired the condition in the community (rather than in the RBCH), the Trust is still falling short on this vital area; members note actions already undertaken and those planned to improve the situation in the year ahead and would ask for an update on progress against targets at the half year stage. This is one of the instances where specific numbers, data from last year and national comparators would have been particularly helpful.

Members were pleased with the reduction in new catheter-related urinary tract infections in 2013/14 (0.57% compared with 1.25% in the previous year) whilst recognizing that this is still short of the average national acute Trust score of 0.47% - again we would ask for an update on progress half way through the year.

In terms of the other harms, members commend the Trust on having fewer inpatient falls, and significantly fewer venous thromboembolisms than the national average as a result of the proactive steps taken. Changes made to the Dementia care wards to reduce falls were particularly impressive.

In terms of the priorities for quality improvement for 2014/15, we are pleased that the Trust has been mindful of feedback from a range of stakeholders including patients, carers, the public, commissioners and staff as well as other sources of information. We note that the Board of Directors have agreed that the Trust will continue to strive for improvements across the 4 harms above, with the aim of achieving 95% harm-free care. Since this was also the stated intention in last year's Quality Account and was clearly not achieved, we would ask for an update on progress to be presented to Members half-way through the year, together with the Trust's progress against the other "harms," particularly the objective to reduce hospital-acquired pressure ulcers by 50%.

We note the Trust's participation in local and national clinical audits and national confidential enquiries and understand the reasons for non-participation in 3 national audits. The resultant improvements to the quality of healthcare, including measures to improve dignity through new wrap around gowns and the use of yellow markers to ensure a more consistent approach to admission documentation, were particularly commended.

In terms of medication safety, we commend the Trust for the measures it has taken (including the use of "cages" for deliveries) which has seen a rise to 87% (compared to 73% last year) of reported adverse incidents representing no harm events. We are also pleased to see the measurable decrease in the closure of wards and bays indicating an improvement in infection control practices across the Trust as well as Improved Communication (eg new ward closure signs). Members were particularly impressed by the very innovative Infection Control Environment Pods (ICEpods) which contribute to both the reduction in the spread of infection and privacy.

Members note the two measures of counting Hospital Mortality rates, acknowledging that one (HMSR) shows a substantial reduction in hospital mortality which Doctor foster has

attributed to service improvements you have made; the other measure (SHMI) shows a significant increase but latest data is from June. Members would therefore value an update later in the year.

We commend the Trust on the changes which resulted from some of the 370 formal complaints received and would urge the Trust to continue use complaints as a further driver to improve patient safety and clinical effectiveness. We would be interested in receiving a summary of key issues and changes at the half year stage especially how you have communicated these changes to the public.

In terms of the Care Quality Commission's (CQC) inspection of the Trust in October, Members were extremely concerned to learn that a number of specific issues had been identified where essential standards of quality and safety were not being met - in short that services were not always safe, effective, responsive, caring or well-led. We view CQC's findings that the Trust had not taken account of the experience of patients and staff to improve service provision, that patients were not being supported to eat and drink on the ward and that there were instances where dignity and respect was not given sufficient consideration, as being of a very serious nature. We understand that you are committed to making improvements and have already put a number of actions in place particularly in terms of addressing staffing levels, improving privacy and dignity and working with various relevant stakeholder groups - we urge you to implement the required changes as quickly as possible and would ask for an update on progress halfway through the year.

We would also be keen to have sight of sight of the Performance against Key National Priorities - Quality Indicators, once the complete data set is available.

In summary, we would wish to state that Members are extremely pleased to learn of the Trust's many successes and improvements. We are, however, concerned that there were a number of aspects of care which fell below the standards that the CQC the people of Poole and members would expect to see. We commend the plans for improvement that you have put in place and would request a brief update of progress against key aspects reported in the 2014/15 Quality Account at the mid year stage.

Thank you once again for the opportunity to comment on what we felt was an interesting Quality Account and please pass on out special thanks to Joanne Sims, Assistant Director for Clinical Governance and Paula Shobbrook - Director of Nursing who went out of their way to help us better understand the key issues during our visit and who were very open to receiving our feedback on the day.

Yours sincerely

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

Bournemouth Borough Council

I am able to confirm that in respect of the Quality Account for 2013/14, representatives from the Bournemouth Health and Adult Social Care Overview and Scrutiny Panel met with the Trust and colleagues from the Borough of Poole to study the Quality Account and provide feedback.

Please accept the written feedback submitted by the Borough of Poole Council as a joint response, formulated from the discussions at the above mentioned meeting. I understand that a number of verbal comments made by Members were also acknowledged by the Trust.

Matthew Wisdom
Democratic and Overview & Scrutiny Officer
Legal & Democratic

Commentary on The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Quality Account 2013-2014

Healthwatch Dorset welcomes the opportunity to comment on the quality of services provided by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Healthwatch Dorset is one of around 150 local Healthwatch organisations that were established throughout England in 2013. The dual role of local Healthwatch is to champion the rights of users of health and social care services and to hold the system to account for how well it engages with the public. We collect feedback on services through our attendance at community events and our contact with community groups; through the 10 Citizens Advice Bureaux in our area; through our comment cards and feedback forms which people send to us in the post; online through our web site and social media, and from callers to our telephone helpline.

Of the feedback we hold about the Trust in the period covered by this Quality Account, 42% is positive, 43% is negative, 12% is mixed and 3% is neutral.
The greatest numbers of positive comments were related to quality of service (37%), staff (29%) and patient pathway (26%). The greatest numbers of negative comments were related to patient pathway (22%), quality of service (19%), staff (16%) and environment (15%).

The past year has been a challenging time for the Trust. A formal inspection by the CQC (Care Quality Commission) found some aspects of care (particular around dignity, privacy, nutrition and hydration) fell below acceptable standards. We welcome the plan of action that the Trust has put in place to remedy these failings and look forward to seeing the evidence that they have done so.
We welcome, too, that following the CQC report the Trust has agreed a number of initiatives whereby Healthwatch Dorset is gathering feedback from people in the public areas of the hospital; working with the Trust to promote Healthwatch as an independent organisation to which staff can take any concerns; facilitating focus groups to explore public perception of the hospital; and supporting the Trust in the recruitment and retention of volunteers.

It is good to see a section in the Quality Account about learning from complaints, and an account of improvements that have been made as a result of learning from complaints. But at this stage the Trust should, in one sense, be aiming not so much to decrease the number of complaints as to increase them. For complaints are “gold dust” in the sense that they are one of the best ways of understanding the true quality of services and driving forward improvements.

An omission in this Quality Account which we would like to see rectified in future years is a report on equality issues in service provision, with information on how the Trust’s services aim to cater to the needs of ethnic, faith and other minority and socially excluded groups, such as people with learning disabilities.

Quality Accounts are intended for a broad range of audiences and aim to meet the twin goals of local quality improvement and public accountability. We believe that they should be published in forms that enable interpretation and comparison. We recommend that the Trust produce next year’s in a form that will be more accessible to the general public, and in an “easy read” format.

There are areas of excellence in the Trust’s services, which should be acknowledged and built on, and areas where improvements are needed. The Trust’s goal should be to raise all services to the level of the best. To achieve this, it will need a clear vision, a culture of openness and honesty, and strong leadership to inspire everyone to work together in a common purpose, driving forward a clear plan of action that will instill confidence and trust in local people.

We look forward to working with the Trust in the coming year as their “critical friend”, supporting them to reach their stated goal of “putting patients first”.

healthwatch Dorset

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

The Council of Governors has welcomed 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 process has been supported again this year by a survey seeking the Governors' views on the consultation process for setting the 2013/14 quality priorities for the Trust and on the way the Trust has performed and reported against these.

The Council of Governors supports the quality priorities which have been set for 2014/15 and the continuing focus on these key benchmarks of good quality nursing care in order to improve the Trust's performance and meet the objectives which the Trust has set for itself. The Council of Governors has emphasised the importance of remaining focused on reducing the number of patients with pressure ulcers and has asked the external auditors to review the data in relation to pressure ulcers as part of their assurance on the Trust's quality indicators. The external auditors will carry out sample testing to provide additional assurance on the data and report to the Council of Governors.

The Council of Governors wrote to members of the Trust in early 2014 following the Care Quality's Commission report on the results of inspection of the Trust in 2014. The CQC had identified a number of areas where inspectors felt that services were not always safe, effective, responsive, caring or well led. We accept the CQC's report and have taken its findings seriously. We apologised for the examples of poor quality care highlighted in the report and remain committed to eradicating poor quality care in the future. While there has been a great deal of progress since the report we continue to monitor and provide challenge to the Board of Directors on the delivery of the actions which the Trust has committed to in its response to the report. The report also provided a catalyst for us to improve the way we communicate and engage with members, patients and the wider community about important issues around the care and services which the Trust provides and we have committed to a comprehensive programme of engagement including the involvement of local Healthwatch.

The Council of Governors, through its Governors' 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 the hospital at night presented during 2013/14.

Annex B

Statement of directors' responsibilities in respect of the Quality Report

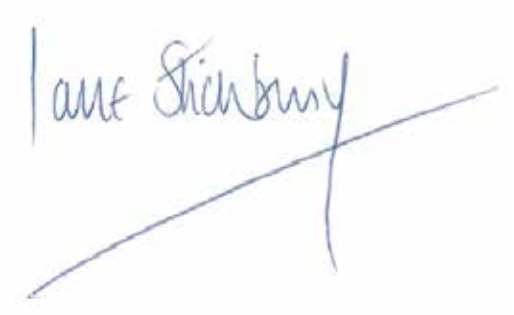
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate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

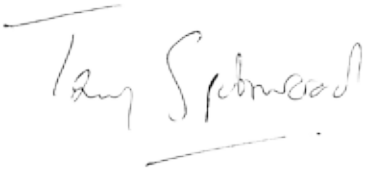
- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14
- the content of the quality report is not inconsistent with internal and external sources of information including:-
  - board minutes and papers for the period 1 April 2013 to 23 May 2014
  - papers relating to quality reported to the Board over the period 1 April 2013 to 23 May 2014
  - feedback from commissioners dated 9th May 2014 and 12th May 2014
  - feedback from governors dated 19 May 2014
  - feedback from Local Healthwatch organisations dated 12 May 2014
  - the trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014
  - the latest national in patient survey dated 2013/14
  - the latest national staff survey dated 2013
  - the Head of Internal Audit annual opinion over the Trusts control environment dated 27 May 1014
  - Care Quality Commission quality and risk profiles published during April 2013 - March 2014
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account regulations) (published at http://www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/sites/all/modules/fckeditor/plugins/ktbrower/openTKFile.php?id=3275)

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
27 May 2014



Mr A Spotswood
Chief Executive
27 May 2014

Annex C

2013/14 limited assurance report on the content of the quality reports and mandated performance indicators

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 2014 (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 2014, 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, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- emergency readmissions within 28 days of discharge from hospital;
- number of Clostridium difficile cases

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
- 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:

- board minutes for the period 1 April 2013 to 23 May 2014
- papers relating to quality reported to the board over the period 1 April 2013 to 23 May 2014
- feedback from the Commissioners dated 9 May 2014 and 12 May 2014
- feedback from governors dated 19 May 2014
- feedback from local Healthwatch organisations dated 12 May 2014
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014
- the 2014 national inpatient survey dated March 2014
- the 2013 national staff survey dated 2013
- Care Quality Commission quality and risk profiles published between April 2013 and March 2014
- the Head of Internal Audit's annual opinion over the trust's control environment dated 23 May 2014
- any other information included in our review.

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.
- 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 affect 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 of these criteria, 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 2014:

- 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
Chartered Accountants
Reading
27 May 2014

Glossary of Terms

Healthcare Resource Group (HRG)
A HRG is a coding grouping consisting of patient events that have been judged to consume a similar level of NHS resource. For example, there are different knee related procedures that all require a similar level of resource; they are therefore assigned to one HRG. HRG codes are set out by the National Case Mix Office which is part of the NHS Health and Social Care Information Centre.

Finished Consultant Episode (FCE)
An NHS Term used for a consultant episode (period of care) that has ended e.g. patient has been discharged or transferred from the consultants care.

Dr Foster Intelligence
Dr Foster is an organisation founded as a joint venture with the Department of Health to collect and publish healthcare information to support patient care. The Dr Foster Unit at Imperial College London collates and produces reports on hospital mortality rates. 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

Patient Reported Outcome Measure Scores
Patient reported outcome measures (PROMS) are recorded for groin hernia, varicose vein, hip replacement and knee replacement surgery.

National data (HSCIS) 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, CCG and NHS Treatment Centre data. Private hospital data is omitted.

EQ-VAS
is a 0-100 scale measuring patients pain, with scores closest to 0 representing least pain experienced by the patient.

EQ-5D
is a scale of 0-1 measuring a patients 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.

The Oxford Hip and Oxford Knee Score
measures of a patients experience of their functional ability specific to patients who experience osteoarthritis. The measure is a scale of 0-48 and records the patient ability to perform tasks such as kneeling, limping, shopping and stair climbing. The closer the score is to 48 the more functionally able the patient perceives themselves to be.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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Copies of the Annual Report and Accounts can be found online at **www.rbch.nhs.uk**

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