providing the excellent care we would expect for our own families

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Quality Accounts 2014-15

Contents

If you require any further information about the 2014/15 Quality Accounts please contact: Joanne Sims (Associate Director Quality and Risk) at Joanne.Sims@rbch.nhs.uk

2014/15 Achievements

Patient Information Standard
Trust achieves National Information Standard for high quality patient information

Eye Unit
Nominated by patients as an 'outstanding service' at the Macular Society's Awards for excellence

Falls
50% reduction in serious falls this year

Serious incidents
30% reduction in serious incidents this year

Infection control
No MRSA bacteraemia

CQC
All non-compliance actions removed

Trust shortlisted for National Patient Safety Award

Sign up to Safety
Five Sign up to Safety pledges submitted

Pathology
Pathology services received CPA accreditation

Wessex Quality
Improvement Fellowships awarded to three specialist registrars

Excellent care for every patient, every day, everywhere

Part 1

Statement on quality from the Chief Executive

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

In this report we have outlined patient safety and quality improvement projects and activities which have taken place in the Trust over the last 12 months.

Our quality improvement programme has been supported by wide-ranging patient safety initiatives which cover a large range of specialties and topics.

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 had made significant improvement following its full inspection in 2013. We could not have made this improvement without the dedication and skill of our staff and the support from patients, carers and other public stakeholders. We also recognise that we are on a continuous journey and have further improvements to make, embed and sustain.

This year the overarching objectives agreed by the Board of Directors aim to provide a central framework and become the basis for individual objective setting across the whole organisation. It is expected that every member of staff will agree objectives which reflect the key themes of quality, improvement, personal and professional development, teamwork and performance.

There is an important balance to be struck when considering the objectives we set for the Trust. We need to consider the need for these to be clear and measurable against the importance of not over-specifying to the point they fail to be relevant to staff, or lack ownership and connectivity due to their relevance to small defined areas of the Trust. We have sought to establish the balance necessary between the two positions. In summary our work and focus for 2015/2016 will be on:

- quality - providing safe, effective and compassionate care
- improvement - using a standard methodology to support achievement of the Trust's quality priorities
- strategy and partnerships - to have a clear strategy for maintaining viable high-quality services
- staff - focusing on positive development and learning culture, strong leadership and teamwork
- performance - delivering the performance required to maintain access to elective diagnostic and emergency services
- value for money - staying within budget using resources wisely and cutting waste to allow the maximum funding to go to front line patient care

The views of our various stakeholders including patients, governors, staff and the wider public have been very important to the development of our specific quality objectives and priorities for 2015/16. We have engaged with staff through workshops, management briefing sessions, executive team walkabouts and informal drop in sessions. We have talked to patients and carers through our extensive programme of patient surveys and have held specific focus groups, cafes and open days. We have also invited patients and relatives to attend serious incident panel meetings to ensure we focus on everyone's questions and issues. Improving patient safety and patient experience is a prominent agenda item for the Board of Directors and we value the opportunity to work with patients, carers, foundation trust members and the public on a wide range of patient experience and patient safety initiatives.

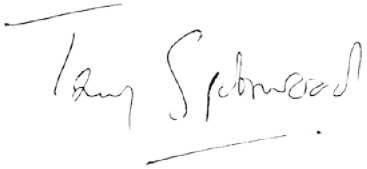
It has not been possible to include all of the quality and patient safety initiatives that we have been, or will be engaged in, within this report. We have considered the comments made by our external stakeholders during the consultation process and amended the

final version of the report to provide additional information where appropriate. We hope the report demonstrates our clear commitment to quality improvement and patient safety.

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in our internal audit's programme of work each year
- data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently
- national data definitions do not necessarily cover all circumstances, and local interpretations may differ
- data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data

The Trust and its Board of Directors have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate.



Tony Spotswood
Chief Executive
28 May 2015

Focus on quality

Focus on Quality Operational Review

The key principles of our Quality Strategy are Safety, Effectiveness and Experience. We want everyone to SEE quality in everything we do.

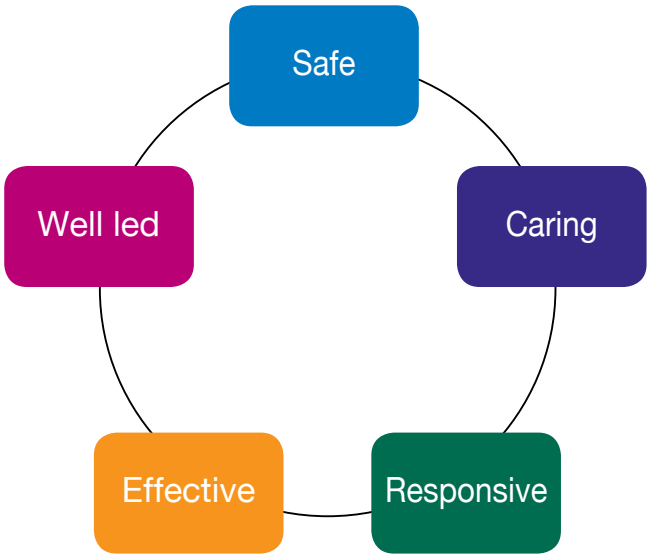
Our 'Quality Toolkit' supports staff engagement in quality improvement. Our weekly 'Focus on Quality' bulletins are produced to inform staff about progress against our Care Quality Commission (CQC) action plans and highlight important 'SEE Quality Strategy' objectives. Case studies are used to promote examples of good practice, celebrate innovation and improvement and share ideas for learning.

The 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 used 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.

Quality is monitored in many different ways, through:

- what we see from ward and department inspections, spot checks and audits
- what we hear from staff, patients, carers, visitors and external stakeholders
- what we learn from internal and external reports, data collection and reviews

To support monitoring and learning we have implemented an internal peer review process and we were pleased the CQC commended this approach when it inspected the Trust in August 2014.



We have trained over 50 managers, matrons, consultants and allied health professionals to participate in internal peer review visits to clinical and non-clinical areas.

The internal clinical quality review process involves a small team of three reviewers visiting a ward/department for approximately two hours, following a patient journey and viewing this from a patient perspective against the CQC fundamental standards.

Observations and interviews with patients and staff are triangulated by the reviewers, with a summary sheet completed against the CQC standards.

The visits are unannounced and are a joint opportunity for learning and sharing best practice across the Trust.

Case Facilitator for Adult Safeguarding and Learning Disabilities, Debbie Hopper:

"From my perspective the peer review process is very useful for risk management and quality. It provides assurances to ward staff that they are complying and completing documentation accurately and the ward area is safe and effective. The ward staff get instant feedback on good practice and areas for improvement.

It is good to carry out peer reviews with different reviewers as everyone has different priorities. It has been a learning opportunity for myself as a reviewer. It has helped me identify areas I need to visit to provide additional awareness training in line with my role."

Matron for Anaesthetics and Day Surgery Services, Sue Langlois:

"It allows an opportunity to empower our staff and recognise that an immense amount of hard work has been done. By giving positive feedback it gives an opportunity to allow them to concentrate on any area that requires further improvement."

Associate Director of Operations, BJ Waltho:

"It is good to have an objective systematic format for these peer reviews. It is excellent to visit a ward to see the progress they have made."

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.

Wessex Quality Improvement Fellowships

Health Education Wessex and the Thames Valley Wessex Leadership Academy have recruited three members of staff from RBCH to participate in a 12-month Quality Improvement Fellowship programme.

These three members of staff will be released from their current roles for two days each week to participate in the scheme.

One of the programmes participants, Ed Hewertson, a specialist registrar in geriatric medicine at RBCH said:

"I have been actively involved in quality improvement for the last two years. This fellowship is a fantastic opportunity for me to improve my skills and methodology. I hope it will allow me to make a signi cant contribution to RBCH during my time here. One of my aims is to disseminate my learning to staff within the organisation and throughout Wessex."

In addition, seven members of our medical staff have been successful with their applications for the SAS (staff grade and associate specialist) doctors' programme, which is the largest cohort across Wessex.

Part 2

Progress against quality priorities set out in last year's quality account for 2014/15

In the 2013/14 Quality Account, we identified seven key areas for improvement in 2014/15. These were:

- harm free care
- inpatient falls
- hospital acquired pressure ulcers
- infection prevention and control
- new hospital acquired venous thromboembolism (VTE)
- privacy and dignity
- nursing risk assessments and care plans

Monitoring of progress against each of these priorities has been undertaken via the Board of Directors and specific sub groups, including the Healthcare Assurance Committee, Quality and Risk Committee and Infection Prevention and Control Committee. Where relevant, quality metrics have been incorporated into 'ward to board' quality dashboards and quality reporting processes.

The following pages provide details of the report provide details of our achievement against the priorities we set ourselves.

Harm free care

The 2013/14 Quality Report published in May 2014, identified 'harm free care' as one of the quality improvement priorities to continue to be monitored in 2014/15.

Harm free care is a national (NHS England) quality indicator and is measured monthly via a standard NHS Safety Thermometer data collection tool. The methodology requires all ward areas 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 on to the national electronic standard safety thermometer data collection.

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

A quality objective for the year 2014/15 was the completion of the NHS Safety Thermometer across all wards areas with the simple aim to be above the national average for inpatient harm free care.

In 2014/15, we achieved an average of 97.18% new harm free care (96.68% in 2013/14). Our score for 2014/15 compared to the national average of 97.59%.

Inpatient falls

Less than 0.3% of hospital inpatients surveyed in 2014/15 using the NHS Safety Thermometer tool had a fall resulting in harm after being admitted to hospital.

We had a lower number of inpatient falls (as recorded using the NHS Safety Thermometer methodology) than the national average.

Falls numbers reported 2013/14 and 2014/15

2013/14 total number of falls reported = 1,836

2014/15 total number of falls reported = 1,727

The number of falls in 2014/15 therefore fell by 6% compared to the Trust's performance in 2013/14.

In addition to the improved Trust performance with respect to patient falls, there has been a significant reduction (50%) in the number of reported moderate and severe injuries following a fall this year.

2013/14 = 52

2014/15 = 26

Quality improvements in 2014/15:

- development of new short stay and 14 day care plans - review of falls, mobility and bed rail assessment documentation
- development of e-Nurse app for falls, mobility and bed rails risk assessments
- development of a fragility risk assessment to meet National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines
- design and implementation of eLearning programmes for staff
- local training needs identified in high risk of falls areas
- appointment of a new Trust falls lead
- Trust falls lead working with the clinical educators to provide bespoke local training
- Trust falls lead providing local training, to high risk of falls areas, on completing documentation accurately
- implementation of a new multi-disciplinary Trust falls steering group

Improvement plan priorities for 2015/6:

- implementation of the e-Nurse app for falls, frailty, mobility and bed rails risk assessments. e-Nurse assessments are due to go live in July 2015. The current falls and bedrails assessment has been completely reconfigured with relevant questions asked to ensure the new NICE guidelines on falls prevention are covered
- implementation of 'daily' repeat fallers list for ward leaders and matrons to assist prioritisation of care plans
- two-yearly mandatory training to include face-to-face training on falls prevention, and a practical session on safe falls management and the use of the hoverjack
- as part of the Trust's duty of candour and our culture of being open, honest and transparent, patients and/or relatives have been invited to attend serious incident panel meetings. This has proven successful in that the relatives have had a clearer understanding of how the incident happened, what measures we put in place to prevent reoccurrence, and how we share this around the Trust. We will continue this for 2015/16
- the falls lead has been working closely with the practice educators to provide bespoke scenario based teaching/training on falls prevention and management using the 'SIM man' (advanced patient simulator)
- develop the role of manual handling and falls champions. They will receive specialised training on how to promote falls prevention within their areas and will be supported with cascading this information to their teams
- bay-based nursing will continue to be promoted in all clinical areas. Bay-based nursing has proven to reduce the number of falls as the patients are easily observed and they also feel safer having a nurse within the bay at all times
- the falls lead is currently liaising with falls leads from other NHS trusts to encourage shared learning and ideas
- we plan to participate in the Royal College of Physicians national audit of inpatient falls (May 2015)

Hospital acquired pressure ulcers

On average less than 2.05% of our hospital inpatients surveyed in 2014/15 using the National NHS Safety Thermometer tool had a reported hospital acquired pressure ulcer. This compared to 2.2% in 2013/14.

Although the result is better than the previous year we are disappointed that the Trust's performance is below the national average.

Our patient profile is such that we have a high proportion of very elderly frail inpatients with often complex and long term health issues. Our patients are often admitted with existing pressure damage or at high risk of early skin deterioration. We have implemented a new prevention strategy at our front door whereby all patients are placed immediately on pressure relieving mattresses. We have also provided additional training to our Emergency Department and Acute Medical Unit staff to highlight the importance of ensuring that

patients have a full skin assessment on admission.

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

All incidents of pressure damage (internally or externally acquired) are reported as adverse incidents. Each incident is formally investigated and in cases of significant pressure damage (a category three or four pressure ulcer) a formal case review meeting is held. The aim of the panel meeting is to identify any gaps in care and/or opportunities for learning. In 2013/14 we reported 31 serious incidents of avoidable category three and four hospital acquired pressure ulcers. In 2014/15 this figure reduced by 39% to only 19 cases.

Quality improvements implemented in 2014/15:

- implementation of new pressure relieving mattress systems. These hybrid mattresses (static foam and dynamic air cell technology) allow us to have a preventative strategy for pressure damage. Patients are automatically placed on a mattress and a pump fitted to provide pressure relieving functionally. A decision is then made to turn the pump off if the patient in assessed as low risk. Previously a patient would have been placed on a static mattress, assessed and then a specialist mattress ordered and delivered to the clinical area if required. Sometimes this meant a delay in provision could occur when areas were busy or had a high demand
- in April 2014 a study day for 60 delegates was held focusing on pressure area care prevention and management within the Trust. The programme included scenario-based workshops and sharing lessons from serious incident events
- promotion of a pressure ulcer patient information leaflet. This has been designed to explain the associated risk factors, how pressure damage can develop and what patients can expect during their hospital stay
- development of 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 iPads, qualified staff can be guided through the completion 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
- development of e-learning programmes for staff
- external review. An external review of the Trust Pressure Ulcer Strategy was undertaken by an expert from Wound UK. The external review reported that the Trust had a well-developed strategy and had invested significantly in pressure relieving equipment. The review also noted the Trust had an open and honest approach to reporting pressure damage and adverse events that was not always replicated across other healthcare organisations. The Trust was recognised as having a good learning culture and was able to demonstrate where improvements had been made following investigations

Improvement plan priorities for 2015/16:

- implementation of a competency framework for all clinical staff
- implementation of a new care bundle approach to pressure area care
- reducing the number of avoidable category three and four pressure ulcers acquired in our hospital in 2015/16 by 25%, measured through Adverse Incident Reports

Infection prevention and control

Reducing catheter associated urinary tract infections (CA UTI)

The mean numbers of new CA UTIs (from NHS Safety Thermometer data) for the Trust in 2014/15 was 0.39%. This is slightly above the national mean score of 0.35% but an improvement on the Trust results for 2013/14 (0.47%).

There are a number of factors that influence our results. As a Urology Centre we have a higher number of patients admitted to the Trust with urinary system related illness. There is also a higher percentage of elderly population that this Trust treats.

During the year a Trust-wide point prevalence study of urinary catheters was carried out. This included a review of catheter insertion documentation and ongoing care ensuring compliance with infection control (EPIC3) guidelines.

The study highlighted a need to update the catheter insertion stickers introduced last year to ensure that key issues are documented. This includes 'insertion using aseptic technique', 'planned date for review' and 'number of attempts'. These are now in use within all relevant wards and departments.

Quality improvements in infection control implemented in 2014/15:

- new hand hygiene points in outpatients
- new signs at all entrances to the Trust

- carbapenemase-producing enterobacteriaceae (CPE) action plan introduced
- focused MRSA screening in line with new Department of Health guidance
- clostridium difficile cases under trajectory for 2014/15 - target was less than 25, position at end of March 2015 was 21
- there have been no MRSA health care acquired bacteraemias
- hand hygiene and 'saving lives' infection control audit - overall the trend in the last quarter of 2014/15 has moved up from 93.1% to 95%. Some areas still need to ensure they are submitting data on time with enough observations to ensure the results from this monthly audit are informative
- improved norovirus outbreak control. We have excellent support from ward staff and housekeeping in supporting our actions for norovirus outbreak control. Timely and informative communications between our Clinical Site Team, wards and departments as well as information from the wider community on new and ongoing community outbreaks enabled the Trust to keep ward closures to a minimum

  There were 79 empty bed days in 2014/15 compared to 181 in 2013/14 and 171 in 2012/13. The number of days that a ward had an area closed in 2014/15 was 88 compared to 72 in 2013/14 and 98 in 2012/13.
- a successful Infection Control Resource Group 14th annual away day was held. Infection control resource leads provide a valuable link between the Infection Control

Team (ICT) and their own clinical area. The resource staff act as role models and are visible advocates for infection protection and control. The principle aims of their roles is to motivate and to increase awareness of infection control issues, enable individuals and their teams to learn and develop infection prevention practice while supporting local audit and surveillance.

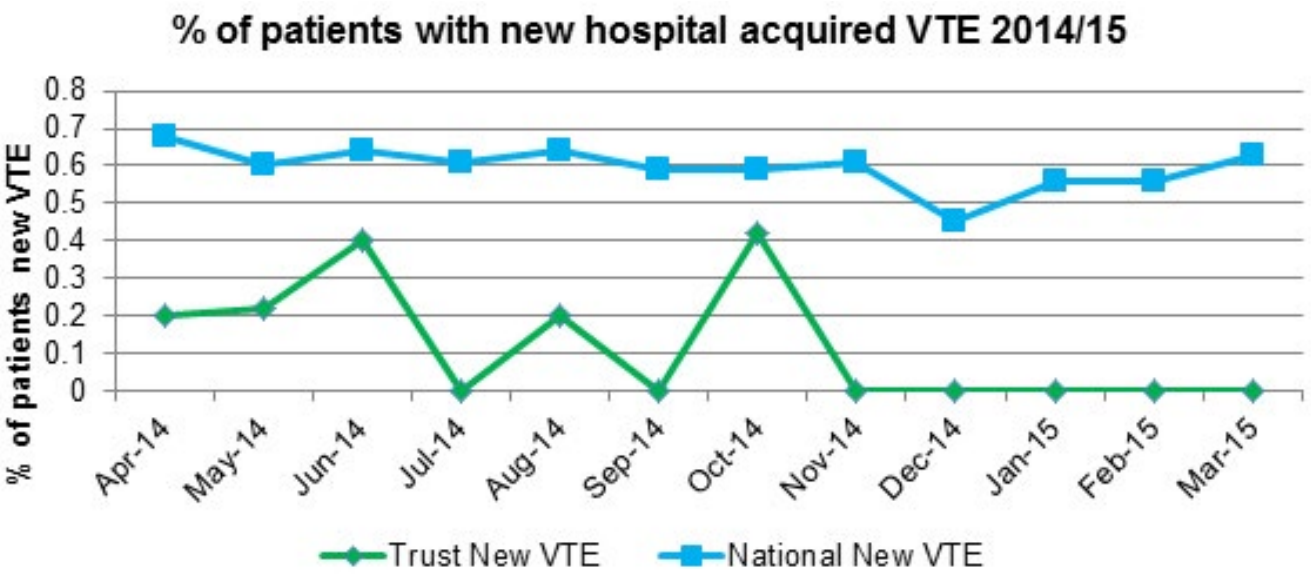
With the date of the away day coinciding with the annual antibiotic awareness day, it was a good opportunity to focus the agenda around resistant organisms, new and emerging organisms, organisms that were in high profile at the time and management of antimicrobial therapy. The day was well attended and staff enjoyed the interactive approach to the learning.

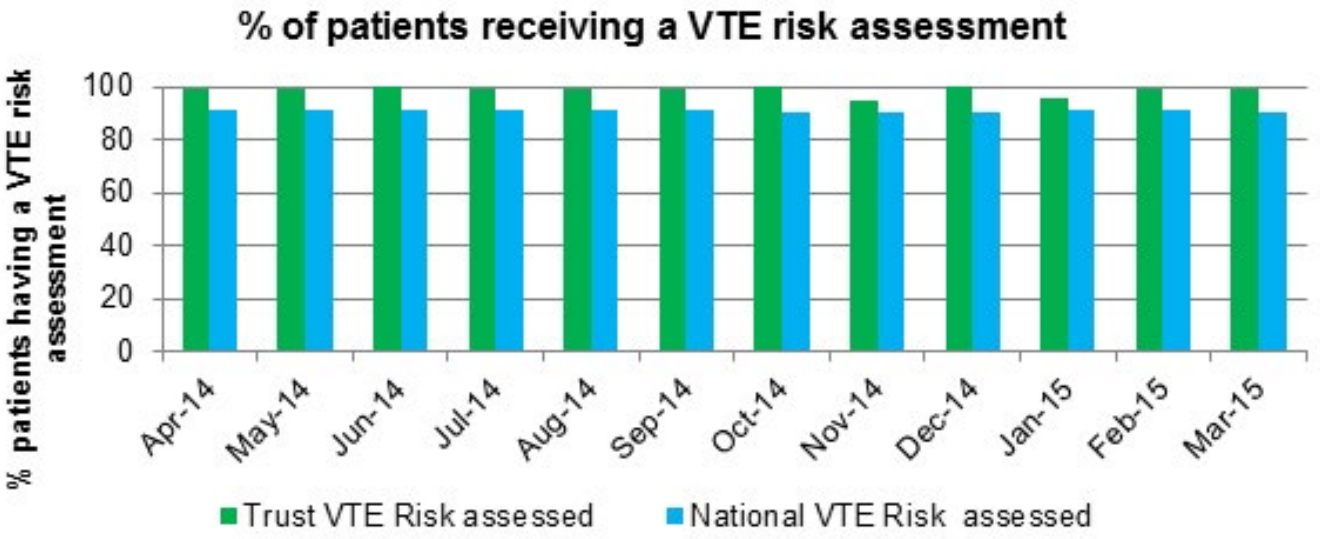
Improvement plan priorities for 2015/16:

- ensuring that there are no MRSA bacteraemia cases and that the Trust achieves its target of no more than 14 clostridium difficile cases

New hospital acquired venous thromboembolism (VTE)

We continue to strive for excellence in the prevention of hospital acquired venous thromboembolism (VTE or a 'blood clot').





On average 0.12% (e.g. 12 patients per 1,000) of hospital inpatients surveyed using the NHS Safety Thermometer tool in 2014/15 had a new hospital acquired venous thromboembolism (a blood clot) during admission. This is much better (i.e. lower) than the national average value of 0.59%.

The Trust also demonstrated a much better VTE risk assessment rate of 98.77% using the NHS Safety Thermometer data collection tool compared to the national average of 90.93%

Electronic VTE assessments

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 less mobile 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.

Mandatory training on VTE for all clinical staff

The Trust has developed a new eLearning module which includes competency assessment and a powerful patient story to provide all clinical staff education on the risk of VTE, the signs and symptoms, how to risk assess and what measures should be taken to prevent VTE. Training is also included for all new staff as part of their corporate induction.

Root cause analysis

A more robust process of checking for hospital acquired VTE has also been developed which includes not only investigating any patient that presents back to the Trust within 90 days of discharge, reviewing all deaths in the community from information sent from the coroner, but also for the past year the Trust has audited the results of all investigation for VTE from a report from X-ray.

Improvement plan priorities for 2015/16:

- improve the consensus data capture for VTE risk assessment to consistently above 95%
- continue to complete root cause analysis on all hospital acquired venous thromboembolism analysing data for trends
- apply for national recognition of its outstanding work on VTE by applying for exemplar status

Privacy and dignity

One of our priority actions has been to improve standards of privacy and dignity for patient care. Action taken in 2014/15 included identification of a core set of privacy and dignity values that all staff should adopt.

I will:

1. introduce myself to patients and visitors at all time
2. acknowledge everyone who visits my clinical area
3. only hold relevant conversations in the clinical and public areas and involve patients and relatives appropriately
4. always ask and address my patients by the name they wish to be called by
5. be sensitive when discussing treatment or diagnosis:
   - use the butterfly sign so others are aware that the room is in use and not to interrupt
   - create the right environment using curtains or a quiet room
6. encourage and help my patients to wear their own clothing when it is appropriate
7. knock before entering a room or call before entering through a curtain
8. offer a chaperone to my patients for examinations and procedures

9. ensure my patients (and their carers) are involved in the decisions about their care
10. ensure my patients have the opportunity to wash their hands after using the toilet, commode, bed pan and prior to meal times
11. ensure my patients' modesty is protected at all times:
    - provide blankets
    - patients are appropriately covered up, while in bed, at bedside, in clinics, transferring to other areas of the hospital
12. ensure curtains or screens are closed properly when my patients are expected to undress
13. ensure I have my patients' permission to be washed or examined

We also encouraged staff to come up with their own ideas for improving privacy and dignity. Following the implementation of new wrap around hospital gowns a new poster was designed for patients. This gives patients instructions on how to put on their hospital gown to ensure their privacy and dignity is maintained at all times.

The poster was the brainchild of radiographer Holly Stevens who noticed patients struggling with putting on the new gowns. She suggested the poster as part of our Staff Leading Improvement programme. The programme encourages staff to come up with positive ways to enhance our services and suggest more efficient ways of working.

Other improvements we made included the provision of new privacy screens in the Outpatient Department and new curtains and clips for ward areas to improve privacy.

We were pleased that the Care Quality Commission (CQC) recognised the improvements that we had made when they re-inspected the Trust in August 2014.

The CQC Report October 2014 noted that "the trust has taken steps to ensure that patients received timely care and that they and their relatives were treated with dignity and respect".

Risk assessments and care plans

A further action from the Care Quality Commission (CQC) inspection report in December 2013 was to ensure that all patients had their needs assessed and care delivered safely and in a timely manner by staff who are skilled to do so. Our focus for 2014/15 has been to improve standards of nursing documentation through education and training and also through innovation and use of information technology.

Additional ward based training sessions have been run throughout the year and updates included as part of clinical induction and essential core skills (mandatory) training. Ward sisters, directorate matrons and care group heads of nursing and quality have routinely promoted good practice and have undertaken regular spot checks of compliance. Internal peer reviews have also been used to review and share improvement stories.

Compliance is monitored monthly and results are given back to ward teams to discuss areas and actions for improvement. Spot checks are also completed by matrons and during internal peer reviews. Results for 2014/15 show improvement from 2013/14.

Average compliance score

Assessment	2013/14	2014/15
Falls risk assessment	89%	90%
Waterlow (pressure ulcer risk assessment	87%	93%
MUST (nutritional risk assessment)	71%	84%
Mobility risk assessment	87%	91%
Bedrails risk assessment	92%	91%

Electronic Nurse Assessments (eNA)

As part of our review of nursing documentation we have also involved our in house IT and information teams to work with clinical leads to design and develop Electronic Nurse Assessments (eNA).

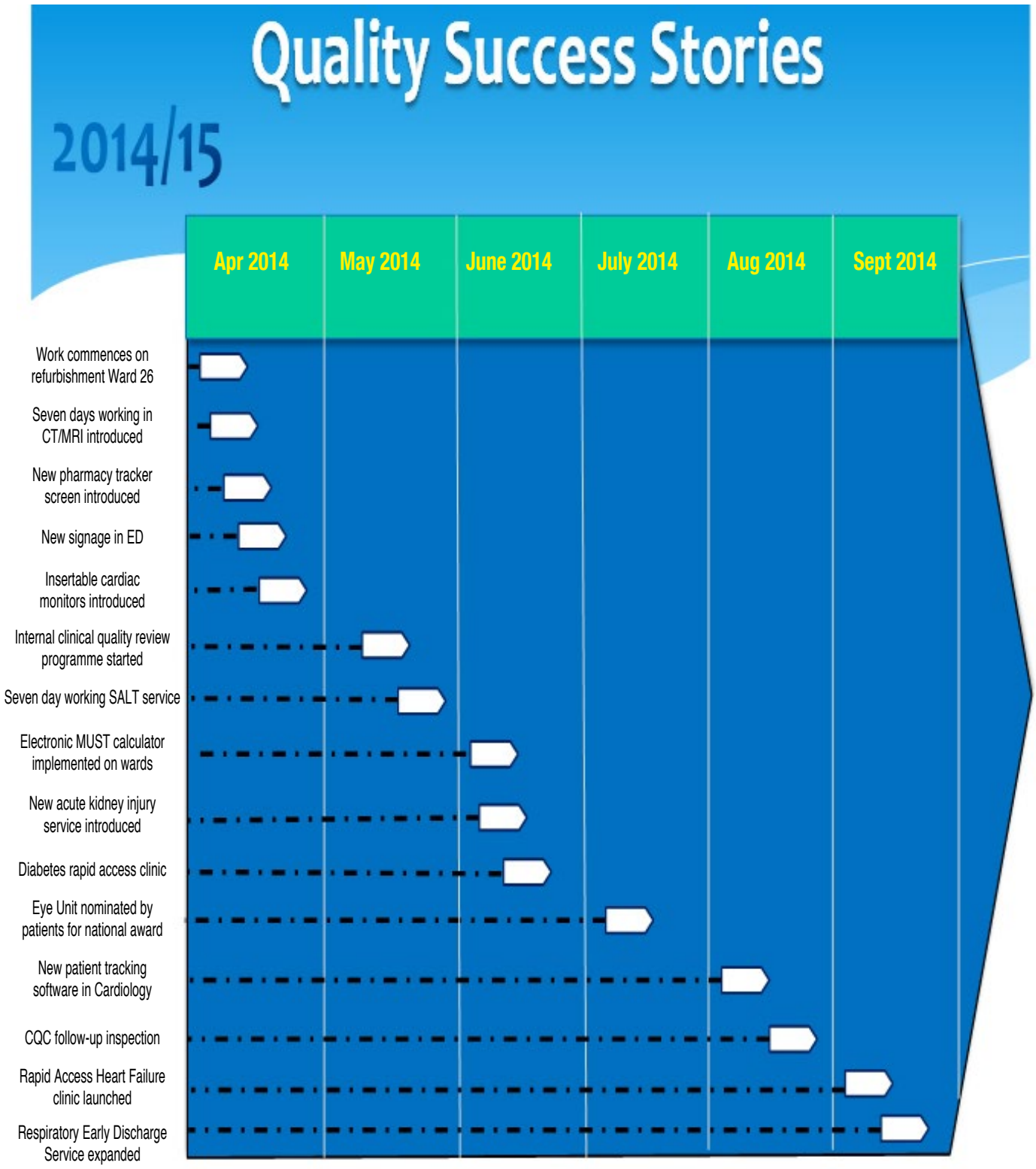
eNA is a mobile solution for use on the ward with 'apps' to allow wards to complete core risk assessments for pressure damage, nutrition, mobility, falls and dementia electronically at the bedside. Wards already use iPod and iPad devices to record basic observations such as temperature and blood pressure so expanding use to nursing risk assessments seemed the next logical step.

Alongside the risk assessment tools, we have developed a 'clinical compass' management function that can display compliance in real time at bay, ward, directorate and care group level. The functionality will enable ward leaders and matrons to see in real time where patient assessments need to be completed or reviewed. The clinical compass will also allow clinical staff to drill down to an individual patient episode and look at trends of risk assessment data over specific time periods.

We have completed initial testing and piloting of the eNA applications and we are aiming to go live from July 2015. This will be in parallel with a roll out of a revised shorter and streamlined version of nursing care plan documentation.

The project aims to deliver the following benefits:

- improved patient safety by increasing compliance with risk assessments and appropriate clinical actions
- reduced human error and improved accuracy through automated calculations
- immediate access to patient risk assessment information
- introduction of real time monitoring of compliance
- reduction in time required to complete nursing documentation
- reduction in unnecessary duplication and double entry of patient data


Quality Success Stories
2014/15
Apr 2014
May 2014
June 2014
July 2014
Aug 2014
Sept 2014
Work commences on refurbishment Ward 26
Seven days working in CT/MRI introduced
New pharmacy tracker screen introduced
New signage in ED
Insertable cardiac monitors introduced
Internal clinical quality review programme started
Seven day working SALT service
Electronic MUST calculator implemented on wards
New acute kidney injury service introduced
Diabetes rapid access clinic
Eye Unit nominated by patients for national award
New patient tracking software in Cardiology
CQC follow-up inspection
Rapid Access Heart Failure clinic launched
Respiratory Early Discharge Service expanded


Quality Success Stories
2014/15
Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
March 2015
25th Anniversary of Cardiac Rehabilitation Service
CQC follow-up inspection published
Resuscitation team receives national prize for audit success
Dedicated heart failure ward opened
Gastroenterology service extended to seven day service
Sign up to safety pledge and plan submitted
Seven day working in US introduced
Electronic bed management system introduced
New Birth Centre opened
New emergency laparotomy pathway introduced
Trust receives Information Standard for patient information (2nd year running)
Datix web roll-out started

Our quality priorities for 2015/16

In order to identify priorities for quality improvement in 2015/16, 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, surveys, focus groups and one to one meetings
- collating information from claims, complaints and adverse incidents
- using the results of clinical audits, inspections and patient surveys to tell us how we are doing in relation to patient care, experience and safety
- considering the views of our commissioners as part of our shared quality and performance meetings and their feedback following formal announced and unannounced inspections
- listening to what staff have told us during executive director patient safety walkrounds, briefing sessions and internal peer reviews
- canvassing the views of staff through our vision and values workshops

We have taken into account the comments made by the Care Quality Commission (CQC) inspection team in its follow up report and in subsequent progress meetings. We have reviewed our current CQC action plan as part of setting our principal quality priorities and improvement objectives for 2015/16.

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 taken on board the national picture for patient safety and collaborated with clinical commissioning groups as part of wider strategy work and clinical service reviews. We have also considered the 2015-2018 priorities of the Wessex Academic Health Science Network and our planned participation in the Wessex Patient Safety Collaborative work streams for sepsis, transfers of care, measurement and leadership.

The Trust has formally consulted with key stakeholders (general public, staff, patients, governors and commissioners) to help identify quality improvement priorities for 2015/16. Priorities have been considered with clinical staff as part of service delivery and clinical governance meetings.

We have also considered any current actions plans in place, for example those forming our response to the Francis Report, our sign up to safety plan and other national reports issued on patient safety and quality.

Our overall aim is to continue to improve the quality of care we provide to our patients ensuring that it is safe, compassionate and effective, while ensuring that it is informed by, and adheres to, best practice and national guidelines. We will drive continued improvements in patient experience, outcome and care across the whole Trust using a standard quality improvement (QI) methodology. We will continue to support and develop our staff so they are able to realise their potential and further develop a Trust culture that encourages engagement, welcomes feedback, and is open and transparent in its communication with staff, patients and the public.

Following consultation, our Board of Directors has agreed that the specific quality priorities for 2015/16 should be:

- achieving consistency in quality of care by a year on year improvement in providing harm free care, measured by a reduction in serious incidents
- ensuring patients are cared for in the correct care setting on wards by improving the flow of patients admitted non electively and reducing the average number of outlying patients and non-clinical patient moves by at least 10%
- reducing the number of avoidable category three and four pressure ulcers acquired in our hospital in 2015/16 by 25%, measured through Adverse Incident Reports
- ensuring that there are no MRSA bacteraemia cases and that the Trust achieves its target of no more than 14 clostridium difficile cases

- improving the management of sepsis, ensuring we implement the six key interventions (high-flow oxygen, fluid bolus, blood cultures, IV antibiotics, monitoring urine output, and measuring lactate) within one hour of patients being identified as having sepsis or being in septic shock
- implementing the Department of Health's best practice guidance for effective discharge and transfer of patients from hospital and intermediate care. These include developing a clinical management plan for every patient within 24 hours of admission; ensuring all patients having an estimated date of discharge within 24-48 hours of admission; undertaking daily discharge board rounds and involving patients and carers in informed decisions about their ongoing care and discharge
- ensuring uniform use of surgical checklists across the whole organisation with the intention that there are no 'never events' associated with failure to use checklist
- implementing the National Institute for Healthcare and Care Excellence (NICE) guidelines for patients referred with suspected GI cancer ensuring patients receive an appointment within two weeks

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

To coordinate implementation of these aims and objectives, we have developed a comprehensive Sign up to Safety Plan. Progress against the plan will be monitored by the Board of Directors, Healthcare Assurance Committee, Workforce Committee and the Quality and Risk Committee.

Statements of assurance from the Board of Directors

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 2014/15 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provided and/or subcontracted eight relevant health 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 them on the quality of care in eight of these relevant health services. This has included data available from the CQC, external reviews, participation in National Clinical Audits and National Confidential Enquiries and internal peer reviews.

The income generated by the relevant health services reviewed in 2014/15 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2014/15.

The data reviewed for the Quality Account 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 2014/15, 31 national clinical audits and four national confidential enquiries covered relevant health services that The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provides.

During 2014/15, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that The Royal Bournemouth and Christchurch Hospitals NHS Foundation was eligible to and did participate in, and for which data collection was completed during 2014/15, are listed on the next page alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

■ yes ■ no ■ not applicable

National Clinical Audits for Inclusion in Quality Report 2014/15	Eligible to Participate	Participated in 2014/15	Data Collection completed in 2014/15	Rate of case ascertainment (%)
Acute coronary syndrome or Acute myocardial infarction (MINAP)	■	■	■	98.9%
Adult Community Acquired Pneumonia	■	■		Data collection ongoing
British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing				
Bowel Cancer (NBOCAP)	■	■	■	100%
Cardiac Rhythm Management (CRM)	■	■	■	732 cases
Case Mix Programme (CMP)	■	■	■	Not available
Chronic Kidney Disease in Primary Care				
Congenital Heart Disease (Paediatric Cardiac Surgery)				
Coronary Angioplasty/National Audit of PCI	■	■	■	Not available
Diabetes (Adult) - National Diabetes Inpatient Audit (NADIA)				
Diabetes (Paediatric)				
Elective Surgery (National PROMS programme)	■	■	■	Data collection ongoing
Epilepsy 12 audit (Childhood Epilepsy)				
Falls and Fragility Fractures Audit Programme Pilot Audit	■	■	■	100% (40 cases)
Fitting child (Care in Emergency Depts)	■			Unable to reach minimum sample size required
Head and Neck Oncology (DAHNO)				
Inflammatory Bowel Disease	■	■	■	Data collection ongoing
Lung Cancer (NLCA)	■	■	■	Data collection ongoing
Major Trauma: the Trauma and Audit Research Network (TARN)				
Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	■	■	■	No relevant cases to submit this year
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	■	■	■	100%

Mental Health (Care in Emergency Departments)	■	■	■	50 cases
National Adult Cardiac Surgery Audit				
National Audit of Dementia	■			Pilot only - Trust not selected to take part
National Audit of Intermediate Care	■			Trust not registered by Commissioners to participate.
National Cardiac Arrest Audit (NCAA)	■	■	■	Data collection ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	■	■	■	71 cases
National Comparative Audit of Blood Transfusion Programme	■	■	■	24 cases
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH)				
National Emergency Laparotomy Audit (NELA)	■	■	■	100%
National Heart Failure Audit	■	■	■	Data collection ongoing
National Joint Registry (NJR)	■	■	■	Data collection ongoing
National Prostate Cancer Audit	■	■	■	Data collection ongoing
National Vascular Registry	■	■	■	Data collection ongoing
Neonatal Intensive and Special Care (NNAP)				
Non-invasive Ventilation - Adults				No National audit data collection in 2014/15
Oesophago-gastric cancer (NAOGC)	■	■	■	Data collection ongoing
Older People (Care in Emergency Departments)	■	■	■	100 cases
Paediatric Intensive Care Audit Network (PICANet)				
Pleural Procedures	■	■	■	11 cases
Prescribing Observatory for Mental Health (POMH-UK)				
Renal replacement therapy (Renal Registry)				
Pulmonary hypertension (Pulmonary hypertension audit)				

Rheumatoid and Early Inflammatory Arthritis	■	■	■	Data collection ongoing
Sentinel Stroke Audit Programme (SSNAP) Post Acute Organisational Audit	■	■	■	>90%
Sentinel Stroke Audit Programme (SSNAP) Clinical Audit	■	■	■	>90%

National Confidential Enquiries for Inclusion in Quality Report 2014/15	Eligible to Participate	Participated in 2014/15	Data Collection completed in 2014/15	Rate of case ascertainment (%)
Gastrointestinal Haemorrhage	■	■	■	100%
Sepsis	■	■	■	100%
Acute Pancreatitis	■	■	■	Data collection ongoing

Centre for Maternal and Child Death Enquires for Inclusion in Quality Report 2014/15	Eligible to Participate	Participated in 2014/15	Data Collection completed in 2014/15	Rate of case ascertainment (%)
Maternal Deaths	■	■	■	No cases to report
Perinatal Deaths	■	■	■	No cases to report

The reports of 22 national clinical audits were reviewed by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- the Trust participated in the national falls audit pilot. The Trust results were better than the national average across all aspects of the audit. However areas for further improvement were identified. The audit resulted in a review of the patient falls leaflet so that it can be made more available to staff, patients and carers. The Trust falls risk assessment tool has also been amended to include the measurement of lying and standing blood pressure
- the National Comparative Audit (NCA) of Blood Transfusion programme audit 2014 highlighted that patients were not always provided with a written information leaflet prior to formal consent. All staff have been reminded to provide the leaflet in addition to verbal information. An additional process step to check consent is also being considered for the electronic hand held devices used for safe blood tracking and administration. Screensavers in clinical areas have also been used to promote good consent practice
- in response to the National Emergency Laparotomy Audit report 2014, the Trust has implemented a laparotomy quality improvement programme for 2015/16
- following a review of the National Chronic Obstructive Pulmonary Disease (COPD) Audit 2014 results, new posters have been displayed at all blood gas machines to remind staff to document how much oxygen a patient receives. The DAIRS team review all COPD patients at weekends and a pharmacist joins post take ward rounds to check oxygen prescriptions. A respiratory/ endocrine consultant is also now available on Sundays to facilitate discharges
- The Maternal Infant and Newborn Programme results identified the need to develop a sepsis pathway for suspected

maternal sepsis. The Trust is also working on a multi-agency evidence based guideline to standardise and improve the care of pregnant and post-partum women with epilepsy

The Trust did not participate in three national audits this year:

- the Trust was not selected to participate in the National Audit of Dementia pilot
- the Trust was unable to reach the minimum sample required for the College of Emergency Medicine Audit on the Fitting Child
- the Trust was not registered by the Commissioners for the National Intermediate Care Audit - providers were unable to register separately for this audit

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 Clinical Audit and Effectiveness Group reviews all submitted audit reports on a monthly basis.

The Trust has developed a detailed clinical audit plan for 2015/16 to include national, corporate and local clinical audit priorities. Progress is monitored via directorate clinical governance committees and the Trust Clinical Effectiveness and Audit Group. Progress is also reported quarterly to the Healthcare Assurance Committee, Audit Committee and Board of Directors.

The reports of 297 local clinical audits were reviewed by the Trust in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- an audit of dementia care standards resulted in improvements to care plan documentation and a review of elderly care pathways. The review resulted in the introduction of a new Short Stay Unit, a Ambulatory Care for the Older Person Clinic and increased geratrician presence at the front door. All inpatient therapy proformas now include the Barthel functional assessment. A structured training programme has also been developed for staff caring for people with dementia
- an audit of support following fetal loss resulted in an amendment to maternity policies to ensure there is always a visit by the named bereavement midwife
- following an audit of neutropenic sepsis in transplant patients, the Trust is to adopt protocol driven administration of antibiotics by nurses to these patients to avoid delays. Prompt reporting of temperature spikes in patients has also been enhanced
- an audit in our Ophthalmology Department has resulted in a tightening of referral criteria to the Acute Referral Clinic and implementation of a new easier referral form
- an audit of seizure management in the Emergency Department resulted in an educational session on first fit pathway being included in the junior doctors core induction

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 1,658. This compares to the 2013/14 value of 1,182 and therefore represents a significant increase in activity for the year.

In 2014/15 the Trust achieved 128% of the National Institute for Health Research (NIHR) recruitment target, testimony in part to the restructuring of research. There has been a complete reorganisation in how research staff are managed, culminating in the development of the Research and Innovation Directorate.

Our recruitment total for 2013/14 is categorised by:

- interventional
  - 50 studies, 494 participants

- observational
  - 33 studies, 967 participants
- large scale
  - 3 studies, 44 participants
- commercial studies
  - 26 studies, 153 participants

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has the third 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 (a clinical research organisation), which is now reaping rewards and we have been offered 'named' investigator studies in areas relatively new to research, e.g. gastroenterology.

We remain in a strong position to respond to Quintiles' pipeline activity particularly in cardiovascular/diabetes and infectious diseases/hepatology.

We have supported the growth of research in orthopaedics with two chief investigators of multi-national studies. In response to the Prime Minister's dementia challenge the lead research nurse, in consultation with the dementia matron, is appointing a dementia research nurse embedded in what will become a research-active dementia nurse team.

Our consultant podiatrist presented her research findings in an international conference on podiatry in 2014.

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

A proportion of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at http://www.england.nhs.uk/wp-comtent/uploads/2014/02/sc-cquin-guid.pdf.

The total income available to the Trust was £4,937,000 against which the Trust achieved income totalling £4,707,000.

Due to the nature of the contractual arrangements in place in the prior year, the Trust's income during 2013/14 was not conditional upon achieving quality improvement and innovation goals.

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. This means that the Trust does not have any current restrictions on its practice or services.

The CQC has not taken any enforcement action against the Trust during 2014/15.

The Trust has participated in special reviews or investigation by the CQC relating to the following areas during 2014/15:

The CQC inspected the Royal Bournemouth Hospital on the 13, 14 and 18 August 2014 as a follow up to the full inspection undertaken in October 2013.

During the inspection in October 2013 the CQC highlighted three specific compliance breaches relation 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 it considered that essential standards of quality and safety were not being met. At the follow up inspection in August 2014, the CQC found that "significant improvement had been made" and all the required actions had been implemented.

The CQC made particular reference to improvement in the following areas:

- greater focus on improving quality

"We found some exceptional examples of care and attention provided by staff at all levels and disciplines across the organisation."

- a strong emphasis on clinical leadership
- strengthened governance structures at all levels
- board members and senior management receiving more robust assurance of quality in all areas

"We found a clear commitment to quality improvement at all levels of the organisation and more robust quality assurance processes."

- significant steps to create an open, transparent and learning culture at all levels of the organisation
- a new assessment ward and pathways that improved the care for older people and the flow of patients through the hospital
- increased staffing levels and support for junior doctors
- improved security arrangements in the Emergency Department
- improved outpatient booking processes and a reduction in unnecessary waits
- the appointment of clinical matrons and support for ward sisters to focus on leadership and supervision of staff and effective care
- improved ongoing assessment, planning and monitoring of care planning, along with support for newly qualified staff

"At follow up inspection we found that all services we visited were caring."

- greater opportunities for staff to attend mandatory training
- privacy and dignity

"The Trust has taken steps to ensure that patients received timely care and that they and their relatives were treated with dignity and respect."

Care Quality Commission
August 2014

The Trust has taken the following action to address the conclusions or requirements reported by the CQC. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has made the following progress by 31 March 2015 in taking such action.

CQC Report recommendation, August 2014	Trust Action
The Trust should increase privacy for patients in the Emergency Department's Majors Department by providing frosted glass or privacy film to the externally facing windows in cubicles	Completed
The Trust should take action to improve the service for stroke patients in line with national benchmarking for stroke patients, particularly for patients admitted at weekends or out of hours	Ongoing
The Trust should ensure that for patients who require their fluid intake and/or output to be monitored that this is accurately recorded	Complete with ongoing review
The Trust should ensure that the records of checks of essential equipment are accurately and consistently recorded on ward areas	Complete with ongoing review
The Alzheimer's Society booklet 'This is Me' should be completed for patients living with dementia	Complete with ongoing review
The Trust should take action to improve the mental health care pathway in the Emergency Department which is not yet a 24-hour service	Additional training provided for Emergency Department (ED) staff. Additional mental health team input to ED commissioned by Dorset Clinical Commissioning Group
The Trust should work with commissioners to clarify admission criteria and suitable locations for 16-17 year olds requiring admission to hospital from the Emergency Department	Complete with ongoing review
The Trust Emergency Department should consider a more robust checking procedure of ensuring that transfer equipment is routinely returned to its base and left in a clean and charged condition ready for immediate use when necessary	Complete
The Trust should take action so that nursing staff who have the skills to provide an outreach stroke service to patients on other wards of the hospital are able to provide this service	Complete
The availability and visibility of hand cleansing gel in the outpatient department should be improved	Complete

A full copy of the August 2014 inspection report is available on the Trust website and also on the CQC website: **www.cqc.org.uk/sites/default/files/new_reports/AAAA1845.pdf**

Data quality

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses 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 97.6% for accident and emergency care. The percentage of records in the published data which included the valid General Medical Practice code was 99.9% for admitted patient care: 99.9% for outpatient care; and 99.8% 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.

The income generated by the relevant health services reviewed in 2014/15 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2014/15.

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 2015.

The Trust's Information Governance Assessment Report overall score for 2014/15 was 37% and was graded as not satisfactory.

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS trust and submitted to the Health and Social Care Information Centre on 31 March each year. The purpose of the IG Toolkit is to provide assurance of an organisation's information governance practices through the provision of evidence around 45 individual requirements.

During 2014/15, the Trust has undertaken a wholly different approach to the completion of its IG Toolkit submission, removing all previous evidence and starting afresh with closer scrutiny of all of the requirements in order to give a higher quality of assurance.

This apparent decline is not indicative of a fall in information governance compliance, but rather more reflective of the approach to evidencing the specific standards within the IG Toolkit audit, some of which are highly prescriptive. In previous years, the Trust has needed to take a pragmatic approach to managing this work which was commensurate with the resource available to carry out the audit. However it is widely recognised that good information governance can be built around the tenets of this audit, and this can only be achieved through a more rigid adherence to these requirements. As such, going forward a greater focus is to be placed on attaining a robust level of compliance with each of these requirements which will in turn give a greater level of assurance of the Trust's information governance practices.

Much of this audit is underpinned by work associated with information risk assurance. Once this work is established and firmly embedded within the Trust, this will inform compliance with many of the requirements within the IG Toolkit. In order to succeed we have identified information asset owners in all areas to ensure that the information systems under their control are compliant with the relevant IG Toolkit requirements.

There has been a reduction, and therefore improvement, in the number of reported breaches of information governance during 2014/15. In 2014/15 only 54 breaches were reported. This compared to 65 breaches in 2013/14.

Coding error rate

The Trust was subject to the 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 9.4%.

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
- 100 FCE'S from Healthcare Resource Group (HRG) BZ
- 100 FCE'S from Healthcare Resource Group DZ

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

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust will be taking the following action to improve data quality in 2014/15. The Trust will aim to make further improvement in the clarity of discharge summaries by clinicians to enable easier coding. The Trust is also in the process of implementing a new program to scan all notes and move to an electronic document management system. This will also allow access to Poole Hospital documents. This enables 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.

Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report against a set of core set of 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)	October 13 - September 14 1.009 June 12 - June 13 107.4	1.00 100	1.198 118.6	0.597 63.0
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission to HSCIC. The data has been extracted from available Department of Health information sources. The SHMI for Oct13-Sep14 are taken from **https://indicators.ic.nhs.uk/nesstar/docs/plot.HTML**.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to continue 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.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust	HSCIC	October 13 - September 14 44.0% June 12 - June 13 33.8%	24.2% 21.3%	49.4% 44.9%	0% 0%
The Trust considers that this data is as described for the following reason. The data has been extracted from available Department of Health information sources. The figures for Oct13-Sep14 are taken from April 2015. Publication of data is found here **https://indicators.ic.nhs.uk/webview/**. Figures reported are 'diagnosis rate' figures and the median average is used for the national value.					
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 the routine review of mortality reports.					

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 • aged 0 to 14 • aged 15 or over	HSCIC	2014/15 (i) = 0 (ii) = 3670 (10.4%) 2013/14 (i) = 0 (ii) = 3298 (9.82%)	Not available	Not available	Not available
The Trust considers that this data is as described for the following reasons. 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, and so the quality of its services, by routine monitoring of performance data and root cause analysis investigations where appropriate.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Responsiveness to the personal needs of patients	National Inpatient Survey	2014 - 54% 2013 - 77%	47% 76.9%	N/A 87%	0% 67.1%
The Trust considers that this data 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 intends to take the following actions to improve this rate, and so the quality of its services. 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.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Staff who would recommend the Trust to family or friends	National Inpatient Survey	2014 - 70.79% 2013 - 71.37%	67.45% 67.11%	89.27% 93.92%	38.17% 39.57%
The Trust considers that this data is as described for the following reason. The exercise is undertaken by an external organisation with adherence to strict national criteria and protocols. Data from question level data here **www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2014-Detailed-Spreadsheets/**.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust intends to take the following action to improve this percentage, and so the quality of its services, by implementation of a detailed action plan. The results of the survey have been presented to the Workforce Committee (a sub committee of the Board of Directors) and key actions agreed.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Friends and Family Test - (i) for inpatients and (ii) for patients discharged from Accident and Emergency (types 1 and 2)	(i) March 2015 Feb 2015 Jan 2015 (ii) March 2015 Feb 2015 Jan 2015	 98% 97% 96% 92% 92% 94%	 95% 95% 94% 87% 88% 88%	 100% 100% 100% 99% 98% 98%	 78% 82% 51% 58% 53% 55%
The Trust considers that this data is as described for the following reason. Data is derived from validated monthly reports collated in accordance with **www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/**					

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	April14 - Sep14 (provisional, published Feb 2015) April13 - Mar14 (provisional, published Feb 2015)	(i) Not yet available (ii) NA (iii) 0.413 (iv) 0.286 (i) 0.074 (ii) NA (iii) 0.431 (iv) 0.309	(i) 0.125 (ii)1.000 (iii) 0.442 (iv) 0.328 (i) 0.085 (ii) 0.093 (iii) 0.436 (iv) 0.323	(i) 0.139 (ii) 0.142 (iii) 0.501 (iv) 0.394 (i) 0.139 (ii) 0.150 (iii) 0.545 (iv) 0.416	(i) 0.009 (ii) 0.054 (iii) 0.350 (iv) 0.249 (i) 0.008 (ii) 0.023 (iii) 0.342 (iv) 0.215
The Trust considers that this data 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, and so the quality of its services, by reviewing relevant patient pathways and undertaking a detailed quality improvement programme.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
% of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)	HSCIC	2014/15 = 95.2% 2013/14 = 93.9%	Not available	Not available	Not available
The Trust considers that this data 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 percentage, and so the quality of its services, by the implementation of an IT application to support easier data collection and compliance.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
The rate per 100,000 bed days of cases of C difficile infection reported within the trust during the reporting period	HSCIC	2014/15 0.10 / 100000 bed days (21confirmed) 2013/14 0.07 / 100000 bed days (14 confirmed) 2012/13 0.14 / 100000 bed days (31 confirmed)	Not available	Not available	Not available
The Trust considers that this data 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 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 ensuring high standards of infection prevention and control are implemented, monitored and maintained.					

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	National Reporting and Learning System (NRLS)	3623 (April 14 - Sept 14) 3239 (Oct 12 - Mar 13)	Not available	12,020 (NRLS Acute Trusts - non specialist)	35
Rate of patient safety incidents reported during the reporting period	NRLS	36.76 per 1000 bed days (April 14 - Sept 14) 39.8 per 1000 bed days (Oct 13 - March 14)	35.1 Not available	74.96 74.9	0.86 5.8
Number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	10 (April14 - Sept 14) 19 (Apr 13 - Sept 13)	Not available Not available	0% Not available	87 Not available
% of total number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	0.2% (April14 - Sept 14) 0.50% (Apr 13 - Sept 13)	0.5% 0.60%	0% Not available	82.8% Not available

The Trust considers that this data 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 April 2014-September 2014.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, supporting an open culture for incident reporting and investigation and has implemented 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 0.2%.

Part 3
Review of quality performance in 2014/15

The following section provides an overview of the performance in 2014/15 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 2013/4 Quality Report and have also been selected on the basis of data collection, accuracy and clarity.

Safety

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.

SPEAKOUTSAFELY

Encouraging staff to speak out safely

The Trust supports the *Nursing Times* Speak Out Safely campaign and the new Freedom to Speak Up Review.

The Trust encourages any staff member with a safety concern to raise it at the earliest opportunity. We recognise that when staff raise concerns it is because they usually know things are not working well and when care could be safer. Staff feedback can help significantly in ensuring high standards of patient care. The Trust has therefore introduced a variety of ways for staff to provide feedback including:

- chatting to the Chief Executive as part of a 'Tony on tour' walkround
- speaking to a matron as part of our 'talk to us' events and communications
- via Board, staff governors or Chairman walkrounds, workshops and drop in sessions

- flagging concerns to their staff side representative
- using the #thank you section on the intranet
- speaking to their line manager, occupational health, human resources or risk management departments

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 70% of incidents reported to the National Reporting and Learning System are recorded as no harm. Nationally just under 1% are reported as severe harm or death. The Trust's percentages for both 2012/13, 2013/14 and 2014/15 are much lower at 0.5%, 0.6% and 0.37% respectively.

Learning from serious incidents

In 2013/14 we reported 66 serious incidents (as defined by NHS England Serious Incident Reporting Framework). In 2014/15 the number of serious incidents reported was 46 - a 30% reduction on the previous year.

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

- provision of additional triage training for Emergency Department staff and provision of additional middle grade cover out of hours
- revision of anticoagulation guidelines
- amendment to clinical pathway to ensure bleeding in a patient with a metal valve is automatically escalated to a cardiology consultant for review
- grand round presentation to all doctors to highlight the importance of acting on abnormal blood results
- changes to cardiac monitoring procedures in Acute Medical Unit
- improvements to decontamination procedures for theatre trays
- provision of additional pressure relieving mattresses for high risk areas

Table: Patient safety incidents reported to NPSA via the National Reporting and Learning System - April 2014 to March 2015

Severity of Incident Reported	Total Number Reported 2014/2015	% of Incidents Reported 2014/2015	Total Number Reported 2013/2014	% of Incidents Reported 2013/2014
No Harm	4,650	66.7%	4,865	70.69%
Minor / Low	2,168	31.0%	1,802	26.17%
Moderate	135	1.93%	178	2.59%
Major / Severe	26	0.37%	41	0.55%
Total:	6,979		6,886	

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 2014/15 the Trust reported four never events. All of these incidents related to surgical procedures. Although on each occasion the patient did not come to serious harm, detailed investigations concluded that routine safety checklist procedures were not followed robustly and the incident should have been avoided. As a result of the incident reviews, a Trust-wide quality improvement programme to improve safety checklist procedures has been established. The group is chaired by the Medical Director and involves clinical champions from all areas undertaking surgical or invasive procedures.

To further improve incident reporting and support an open culture for sharing learning, the Trust is currently in the process of implementing a new web based reporting system. The system offers many benefits including cross department and directorate investigations, the opportunity for the person reporting an incident to request automatic feedback, and an end to paper forms being misplaced or lost. Training is being provided to staff on how to use the system and there has been positive feedback from areas already using the new system.

Improving fluid and hydration

Our Nutrition and Dietetic Department, Dr Jules Cranshaw, Dr Simon McLaughlin and the Practice Development Group led by Ellen Bull (Deputy Director of Nursing) have all worked together to make improvements in fluid and hydration during 2014/15. This has included:

- implementing a new acute fluid monitoring chart revision and a 24 hour fluid accumulative chart
- establishing a new Theory and Clinical Skills training programme for nurses in August 2014
- producing a short six minute training video on 'how to complete' fluid monitoring charts to support implementation of the new charts
- introducing new beverage charts with pictorial vessels and volume measurements for all clinical environments
- purchasing red cups/mugs and red lid jugs to identify patients who require help with fluids and fluid monitoring
- creating new patient information: food and drink patient leaflets have been produced by the Nutrition and Dietetic Department

In addition, in line with recent NICE guidance, the Trust has also produced an intravenous prescribing guide and intravenous fluid prescription chart. Teaching materials and presentations were used to support implementation.

Early safety audit data has shown that there has been a reduction in episodes of hypokalaemia and hyponatraemia since the new IV fluid policy was implemented. Data on fluid management comparing the use of 0.9% saline used by wards during October-December 2013 with that used during the same time period in 2014 has shown that there has been an overall reduction of 66%.

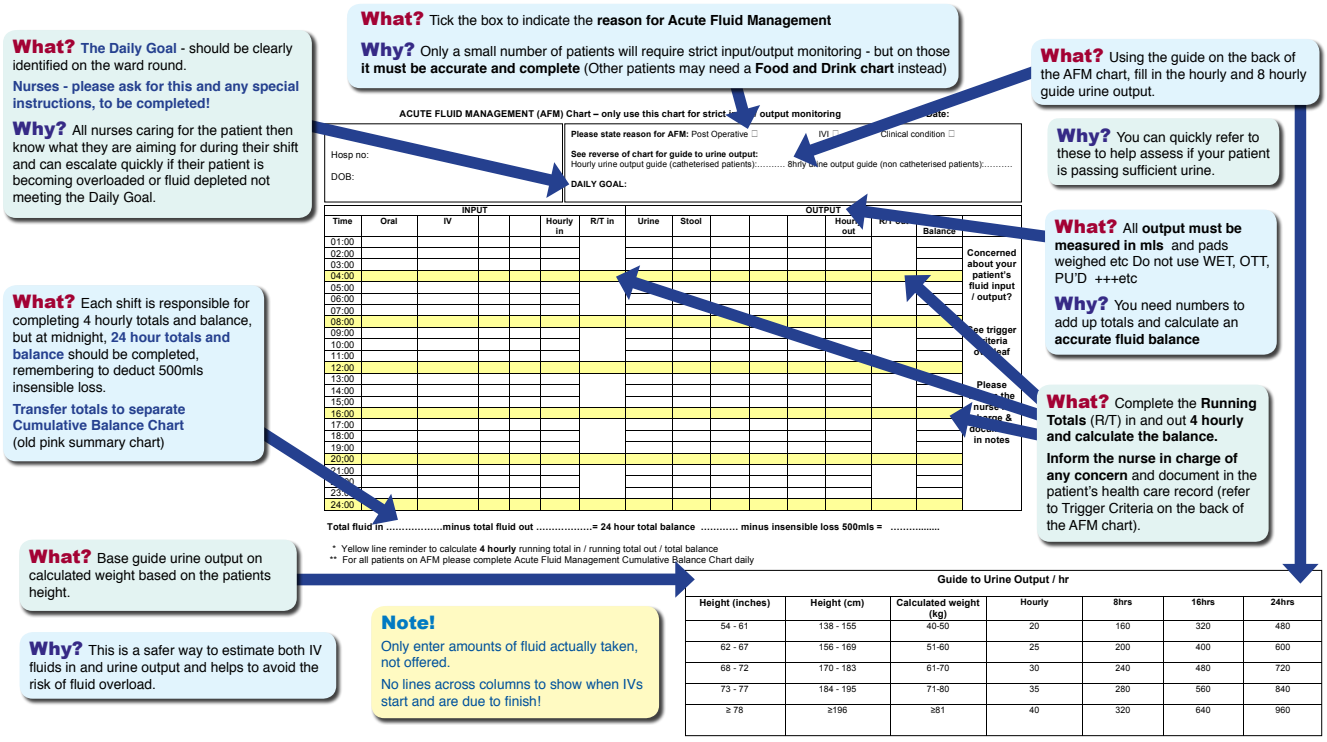
Ward / Dept	Oct-Dec 2013 (Quantity in Litres)	Oct-Dec 2014 (Quantity in Litres)
Total	8,302	2,812

Further monitoring and audit will be undertaken in 2015/16 to measure additional improvements achieved.

Reducing acute kidney injury (AKI)

In response to a National Confidential Enquiry report on Acute Kidney Injury, we implemented a new nurse led AKI service in September 2014. The AKI nurse specialist attends all AKI stage two and three patients on medical and surgical wards to assist with their diagnosis, management and care. The Pharmacy Team is also an integral part of the service and alerts clinicians to the presence of AKI stage one in all the wards around the hospital. We have also introduced AKI alert stickers, new cumulative fluid balance charts, escalation

New Acute Fluid Management (AFM) chart - for strict input / output monitoring



stickers, new AKI care bundles which are on every ward and on the intranet and a new AKI drug awareness sheet also on all wards.

A comparative audit of three months data collection has demonstrated (in a highly selective group of patients) a reduction in mortality, length of stay and re-admission rate in the AKI stages two and three seen by the AKI nurse specialist.

An initial audit of the impact of the new service (three months post implementation) suggests that there have been significant improvements in patient care.

In 2015/16 we are aiming to continue with the service as well as developing additional in house training for ward staff. The AKI Team is also developing an education programme for primary care (including GPs and community pharmacists); an outreach service for primary care and telephone and follow up clinics.

	Audit results before introduction of AKI service	Audit results after introduction of AKI service
No. of AKI patients	188	148
Mortality rate	23 (12%)	8 (5%)
Readmission rate (within 28 days)	45 (24%)	14 (9%)
Mean length of stay	15 days	9 days
No. of patients admitted to ITU	11 (6%)	9 (6%)

Effectiveness

Reducing hospital mortality

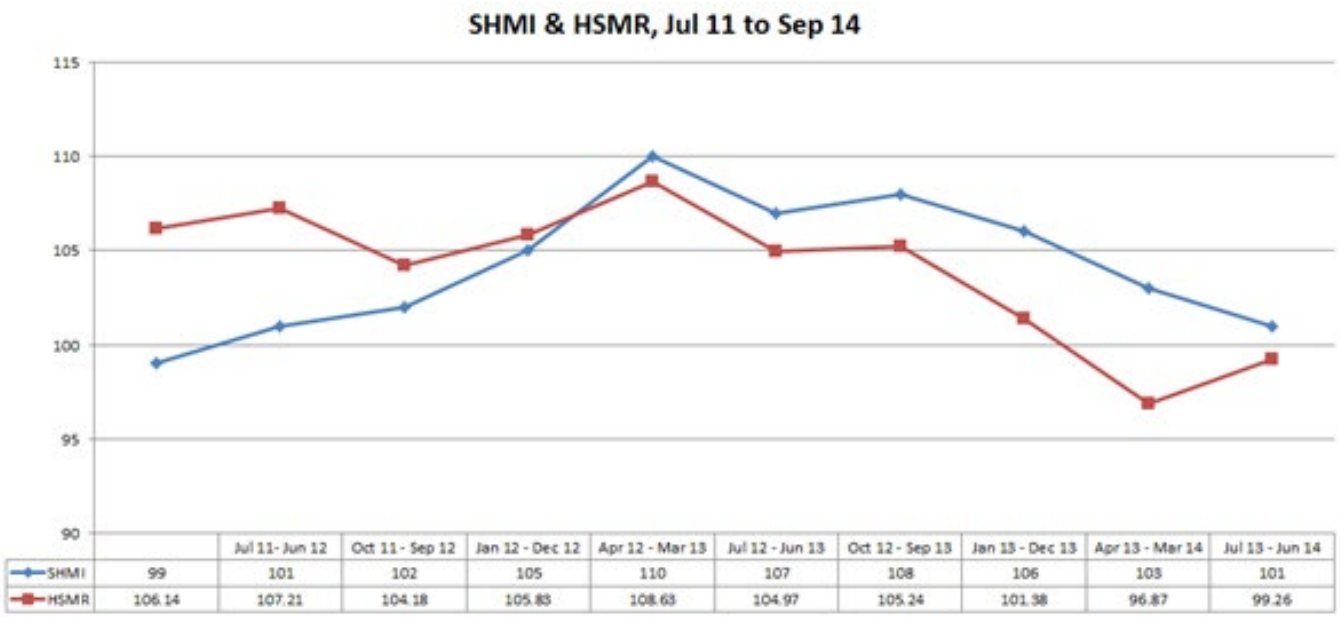
The Trust's mortality rate, as expressed in both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI), continues to lie within the "as expected" category.

The Dr Foster mortality metric, known as 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 NHS, via the Health and Social Care Information Centre, has also developed a slightly different metric SHMI which additionally includes patients that have died within 30 days of being discharged from hospital. SHMI is also calculated slightly differently. Up until now the HSMR figure has been rebased (ie recalibrated against the national average) annually, whereas the SHMI figures is recalibrated each time it is produced. Dr Foster has just changed this which has altered the HSMR figures for this year.

The chart below shows the latest SHMI figures and the comparable HSMR figures. Both are annual figures produced on a quarterly basis. Both figures lie within the 'as expected' categories.

Mortality outlier alerts may be triggered by Dr Foster analysis, through Imperial College, or from the Care Quality Commission data analysis.

The Trust has a multi-disciplinary Mortality Group, chaired by the Medical Director, to review the Trust's HSMR 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. All deaths now get a consultant review against a specific questionnaire and in 2014/15 we developed this further and we now have the chairs of the specialty Mortality and Morbidity Meeting attending the Mortality Group. This therefore ensures that the review of all deaths within the hospital is monitored centrally and ensures the progress of actions, where we have established the potential for improvements. The Trust also has a group - Mortality Improvement through Clinical Engagement (MICE) - that draws together several significant strands of work including the work of the Mortality Group described above. This is chaired by the Director of Nursing and



		Jul 11- Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14
SHMI	99	101	102	105	110	107	108	106	103	101
HSMR	106.14	107.21	104.18	105.83	108.63	104.97	105.24	101.38	96.87	99.26

Midwifery and draws other programmes under its umbrella, including seven-day working, end of life care and managing the deteriorating patient.

Recent actions arising from the work of the group includes:

- the redevelopment and introduction of a fluid chart, together with associated training
- the recruitment of a consultant with an interest in Acute Kidney Injury (AKI) and the provision of a nurse specialist in this speciality and the introduction of AKI flags on the pathology system
- implementation of a Heart Failure Group and action plan, with a multi-disciplinary team (MDT) approach, the recruitment of two heart failure nurses and the cohorting of heart failure patients

Improving heart failure services

A new inpatient Heart Failure Service was set up in December 2013. It currently consists of one full-time heart failure nurse specialist and a heart failure consultant lead.

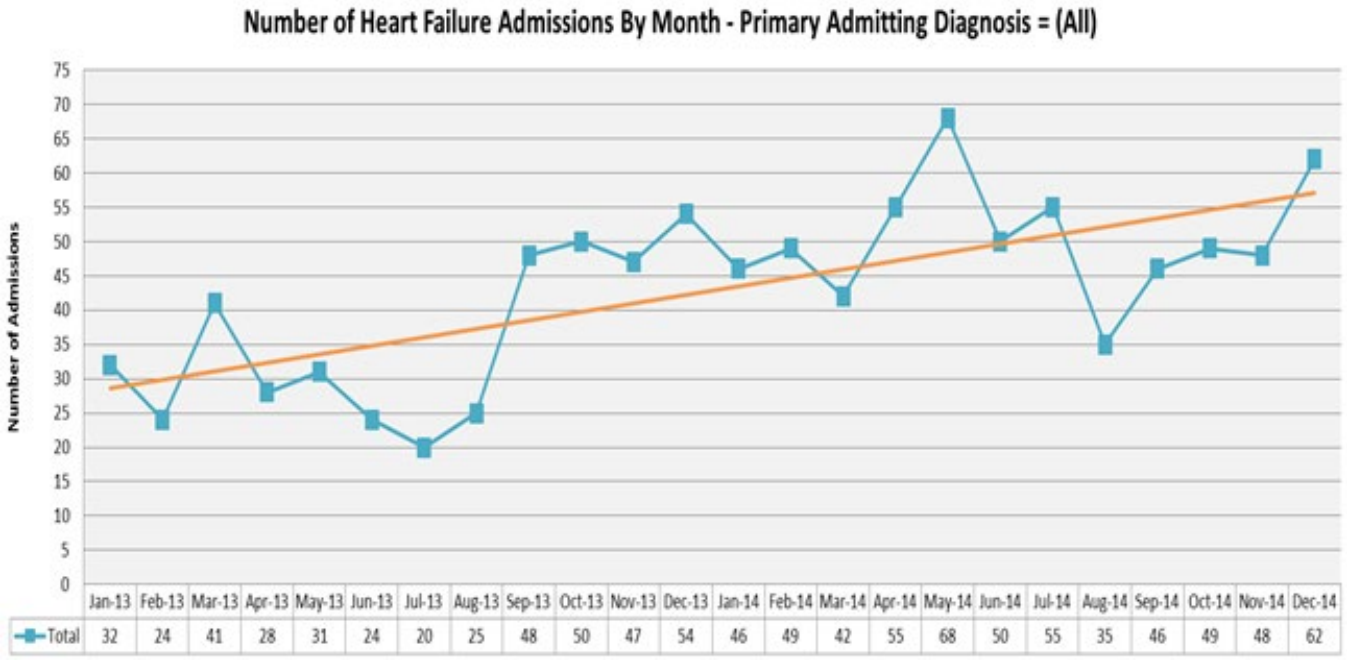
Ward staff are able to make referrals into the service and specific evidence-based heart failure prescribing guidelines have been produced and made available to staff via the intranet.

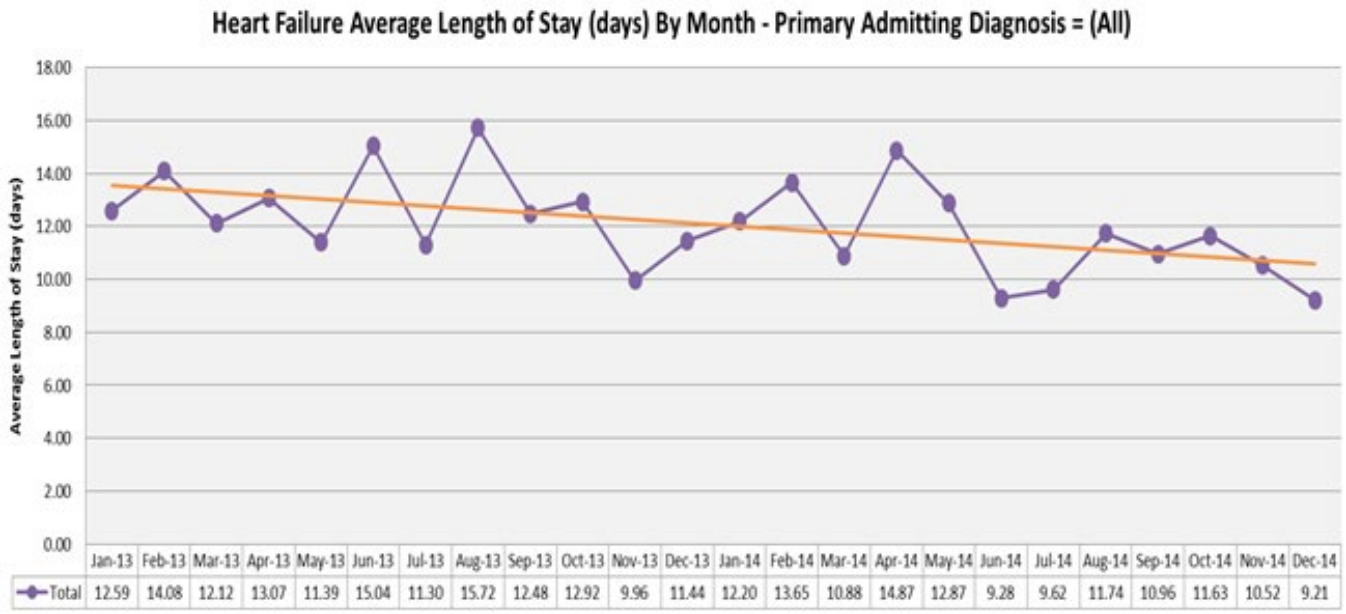
We have set up a small team of consultants from around the Trust with an interest in heart failure to support the identification of patients within the hospital with a primary diagnosis of heart failure. The Heart Failure Team also work closely with older people's medicine, the Palliative Care Team, the Arrhythmia Team and cardiac rehabilitation.

There are monthly educational sessions that are very popular and weekly inpatient MDT meetings on our heart failure unit where each patient is discussed individually and a management plan is agreed.

In order to assess our service and to benchmark with other heart failure services nationally we submit data each month to the National Heart Failure Audit. We are pleased to see that there has already been an improvement in our length of stay figures.

In August 2014 we set up a very successful weekly Rapid Access Heart Function Clinic which is based on referrals from primary care for patients with a high blood-result and heart failure symptoms. All these patients are seen according to NICE guidelines and are given an echocardiogram, full assessment and management plan. We are currently auditing the first six months including a patient satisfaction survey, to assess the impact of this new service.





In November 2014, Ward 21 was re-categorised as a Heart Failure Unit with 12 beds specifically allocated for heart failure patients. This has enabled the staff to develop their skills and knowledge and is beneficial to the heart failure patients to ensure they receive consistent evidence-based care. Once a patient is discharged home they are referred to the community heart failure team for follow up.

Heart failure patients can now also attend specific heart failure cardiac rehabilitation classes to improve their exercise capacity and meet other patients with heart failure. Another recent patient improvement initiative has been to set up a pathway for patients to attend the Treatment Investigation Unit at the Royal Bournemouth Hospital for intravenous frusemide infusions which will prevent readmission into hospital.

We continue to look at additional ways to improve the heart failure service. Our intention is to ensure that all patients admitted to hospital with heart failure are seen by a heart failure specialist nurse within 24 hours of admission, with seven-day working. We also aim for all patients admitted with heart failure to be treated in the specialist Heart Failure Unit. We are developing a heart failure specialist nurse non-medical prescribing policy. This will promote timely provision of discharge treatment.

Improving care for stroke patients

Our stroke service has a combined acute and rehabilitation Stroke Unit with an established reputation of interdisciplinary working striving to provide excellent care and to achieve the best outcomes for our patients. Our purpose-built 36 bedded Stroke Unit includes hyper-acute, acute and rehabilitation beds, neurogym, patients dining and activity room and a therapeutic garden. We have very close working with our colleagues in both the emergency and radiology departments who support the provision of our 24/7 thrombolysis service and initiatives such as our direct door to CT pathway.

We are in the process of implementing our new stroke outreach service which will further streamline the patient pathway to our Stroke Unit and ensure our patients consistently receive early stroke specialist assessments, CT scans and early access to the Stroke Unit. This new team will receive a pre-alert from the ambulance for all suspected stroke patients enabling them to meet the patient in the Emergency Department, or directly at the CT scanner for appropriate patients, undertake all initial assessments and commence early treatment, such as stroke thrombolysis, and facilitate early transfer to the Stroke Unit. We anticipate providing a seven day in-hours service from the end of May 2015 and a seven day 7am-midnight service from mid/end of July 2015.

The Trust admits approximately 750 new stroke patients per annum, making it the busiest stroke service in the Wessex region. As well as our inpatient hyper-acute, acute and rehabilitation provision, we have a stroke Early Supported Discharge (ESD) Team which supports stroke patients with their discharge from hospital. It provides stroke specialist multi-disciplinary rehabilitation in the patients' home setting enabling earlier discharges from hospital. We also provide a seven day rapid access TIA Service seeing approximately 1,000 TIA patients per annum. The TIA Service is another example of excellent collaborative working as the weekend provision is jointly provided with Poole Hospital and Salisbury Hospital. We provide consultant-led stroke follow-up clinics and have an extremely busy and proactive Stroke Research Team undertaking a wide range of stroke research studies.

There is clear national guidance to support interventions and care processes in stroke. These include for CT scanning, access and stay on a Stroke Unit, thrombolysis, therapy and multi-disciplinary working and discharge.

In 2014/15 we have seen a steady and sustained improvement with the proportion of patients having a CT brain scan within 12 hours of arrival to hospital. In April 2015 a new initiative to enable non-consultant staff to request a CT brain scan for acute stroke patients is being introduced which will further reduce delays enabling quicker access to CT brain scans. The stroke outreach service will also ensure that there is earlier identification of stroke patients, again reducing delays and enabling faster access to required interventions and treatments.

SCANNING	Q1	Q2	Q3	Q4
Proportion of patients scanned within 12 hours	76.6% (National Average 87.1%)	81.3% (National Average 87.7%)	82.8% (National Average 88.7%)	85.9% (National Average not available)

All people with suspected stroke should be admitted directly to a specialist acute stroke unit. Throughout 2014/15 we have again maintained our performance and continue to perform above national average. Going forward the new Stroke Outreach Service, by ensuring earlier identification and awareness of stroke patients in the Emergency Department, will enable quicker transfer to the Stroke Unit to be achieved.

STROKE UNIT	Q1	Q2	Q3	Q4
Proportion of patients directly admitted to a Stroke Unit within four hours	64.8% (National Average 58%)	66.7% (National Average 59.8%)	59.8% (National Average 56.9%)	68.2% (National Average not available)

Stroke services should provide early supported discharge to stroke patients who are able to transfer independently or with assistance of one person. Early supported discharge should be considered a specialist stroke service and consist of the same intensity and skill mix as available in hospital, without delay in delivery. Our highly performing stroke Early Supported Discharge (ESD) Service supported 211 patients in 2014/15 and recent patient feedback on the service demonstrated that 92.1% of patients were highly satisfied with the service they received from the stroke ESD Team.

Patient feedback:

"A member of the team came to my home on day of my discharge. The team has been so supportive and helpful in all areas - helped with my walking, making meals, handwriting, and have supported and reassured me emotionally and physically. They are very knowledgeable in all areas and able to answer my questions which helped put my mind at ease, which also helped with my recovery. The whole team were absolutely brilliant while maintaining their professionalism. Thank you so much."

STROKE EARLY SUPPORTED DISCHARGE	Q1	Q2	Q3	Q4
Proportion of patients supported by Stroke ESD on their discharge from hospital	64.5% (National Average 58%)	68.3% (National Average 59.8%)	60% (National Average 56.9%)	68.2% (National Average not available)

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

The Trust Clinical Audit and Effectiveness Group reviews compliance with all new National Institute for Health and Care Excellence (NICE) guidance issued each month. For the period from April 2014 to March 2015 the Clinical Audit and Effectiveness Group reviewed a total of 139 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	16	7	4	0	5
National Guidelines	7	4	0	1	0	3
Technology Appraisals	30	26	16	1	0	9
Interventional Procedures	33	6	4	0	0	2
Public Health Guidance	5	2	1	1	0	0
Medical Technology Guidance	7	1	1	0	0	0
Safe Staffing Guidance	1	1	0	1	0	0
Quality Standards	30	22	9	6	0	7
Diagnostics Guidance	5	4	4	0	0	0
Highly Specialised Technology Guidance	1	0	0	0	0	0
Total	**139**	**82**	**42**	**14**	**0**	**26**

Where non or partial compliance has been identified an appropriate action plan agreed. The majority of guidelines noted in the above table as ‘under review’ relate to those issued during January-March 2015.

Other news

We have some outstanding services that have been recognised for their excellent clinical outcomes, innovation and patient care this year. For example:

- **Improving pre-operative care**

Our nurse led pre-surgical assessment clinic has been recognised by the Royal College of Anaesthetists in their recent guidelines around pre-operative care for improving pre-operative care and reducing length of stay. The service aims to see people with poor diabetes control prior to surgery to ensure their diabetes is adequately managed in order to ensure that their surgery can go ahead.

- **Promoting patients with diabetes**

We have started up a new rapid access clinic, a renal diabetes clinic, a transplant-diabetes clinic and we are in the process of setting up the Wessex Hypoglycaemia Service for people with significant difficulties with hypoglycaemia.

A Diabetes Rapid Access Clinic has been established to facilitate appropriate discharge from hospital and prevent unplanned hospital admissions for people with diabetes. The clinic provides rapid access to specialist advice and is a multi-disciplinary clinic with both a consultant and diabetes nurse specialist present. This allows urgent clinical recommendations (for example starting insulin) to be actioned at the same appointment. The clinic has capacity to see three patients per week and at present the waiting time has not exceeded two weeks.

- **Improving pain management**

Our Pain Management Team has been working with our Communications Team to raise the profile of pain management and support more staff via educational workshops and on the ward advice. A number of wards have subsequently implemented new ideas in best practice, such as giving patients known to be suffering with pain their medication first during rounds.

Lead nurse in acute pain management, Mandy Layzell, says:

"There are a lot of myths surrounding pain management, so staff members who are trying to help a patient may unknowingly undermine their good work. Better pain management means patients are more likely to sleep and eat well, supporting a speedier recovery."

As a result of the campaign, the number of patients per month highlighting the need for better pain management has been halved.

Pathology

It has been a busy and exciting year for developments in pathology. In addition to meeting the increasing needs of our accreditation bodies, the directorate has worked tirelessly to develop and evolve services in line with the needs of our users. There have been several important improvements that have impacted our processes, informatics systems, staffing and estate with benefits in quality, turn-around time and overall productivity. A few examples of service improvements implemented last year are detailed below:

- **Accreditation - maintaining a culture of ongoing quality improvement**

Pathology tests are among the most important aspects of modern medicine and it has recently been estimated that pathology contributes to 60-70% of clinical diagnoses. For many conditions, there is no substitute for pathology tests - for example, high blood cholesterol can be detected by testing long before any physical symptoms appear. Pathology is also relied on to help diagnose a wide range of conditions, and to help monitor the response to treatment.

Consequently there are many processes in place to ensure that pathology does produce reliable, accurate and precise results. These have been instituted by the Government, the Department of Health, pathology professional organisations and individual laboratories themselves to ensure that quality standards are maintained.

Last year pathology at the Royal Bournemouth Hospital was inspected by the Clinical Pathology Accreditation Service when 13 assessors spent 10 days examining the quality of the service. In addition, this year three inspectors from the Human Tissue Authority spent a day reviewing procedures for bone marrow transplants. On both occasions the pathology services and associated working practices were praised and licences to practice retained.

Next year pathology will be inspected by the United Kingdom Accreditation Service (UKAS) as the next stage in evidencing the high quality and accuracy of our service.

- **Clinical haematology - improving outcomes for haematological malignancy**

The Haematological Malignancy Diagnostic Service (HMDS) division of the lab continues to work towards implementation of its bespoke 'Haemosys' software; configuration is being completed by lab, clinical and IT staff who are working in close partnership with the software provider. Once implemented, this will enable compliance with the NICE integrated report format which will draw together all the results from one sample to ensure that all pieces of the diagnostic puzzle are available enabling the clinician to make a robust final diagnosis.

- **Blood transfusion - reducing length of shifts increases quality and reduces errors**

Staff in blood transfusion have historically worked an extended shift. However in December, changes were made to shift patterns to reduce lone working overnight. Other changes included extending the evening shift and implementing a second specialist biomedical scientist until 8.30pm.

Audit reveals that during the last quarter the number of minor procedural errors made while lone working has decreased by over 50% - increasing quality and improving patient safety.

- **Microbiology and infection control - reducing hospital acquired infection**

In line with the recommendations from the Department of Health from February 2015, the Trust moved away from blanket screening of MRSA on all admissions. Instead we only screen those who are at clinical risk of contracting a bacteraemia during their stay. This means certain patients will continue to be screened routinely including admissions to wards 7, 11, 14 and critical care and those undergoing invasive procedures such as major arthroplasties, internal defibrillators and breast implants.

The change has enabled wide use of Octenisan wash which minimises a broad spectrum of bacteria on the skin thereby reducing the overall risk of bacteraemia and hospital acquired infections. This initiative therefore promises to improve patient outcomes and is an excellent example of joined up working, challenging the norm and diverting resources to best meet the needs of the patient.

- **Haematology laboratory - supporting front line services**

Royal College of Pathology performance indictors recommend that 90% of full blood count tests should be reported within 60 minutes of receipt by the laboratory. Biomedical staff and medical laboratory assistants have worked hard to review internal laboratory processes to ensure this target is achievable. The department is pleased to report that the target was comfortably met over the last 12 months and the department continues to improve the responsiveness of the service.

• Phlebotomy - developing a community model

Last year we worked with the Dorset Clinical Commissioning Group to increase phlebotomy access in the community. Five new clinics were opened in north Bournemouth and an additional service began in Highcliffe on 1 April 2015.

This new model for phlebotomy improves patient choice, reduces waiting times at our outpatient services and moves the service closer to the patient. Feedback from patients and GPs has been extremely positive. We are now in discussion with other GP surgeries and exploring the option of opening a service in a local retail outlet.

• Cellular pathology - implementation of electronic workflow management

Cellular pathology has introduced 'Vantage', a system which helps protect patients and staff from serious risks associated with sample misidentification. The system is the first of its kind in the industry and the Bournemouth laboratory is the first in the country to fully install. It has a number of patient benefits and enables staff to:

- virtually eliminate errors with 'one label, one time' slide identification
- maintain positive sample ID with barcode scanners at each workstation
- immediately locate any patient's slide, at any time, from any last scanned location
- easily compile quality reporting documentation
- view a comprehensive dashboard of lab performance at any time
- simplifies workflow
- presents opportunities to improve quality, staffing and efficiencies

• Reception refurbishment - improving the patient experience

Works were recently completed on the refurbishment of the Pathology Reception. New lighting, flooring and furniture have improved this waiting area significantly which had not been refurbished since the original build in 1989. The redesigned reception desks is much more welcoming for patients, particularly those in wheelchairs and has allowed for several operational improvements behind the scenes.

• Demand management - improving stewardship of resources

The Pathology Department has introduced software to prevent the unnecessary repetition of haematology and biochemistry requests. This software has led to a reduction in reagent spend, ensuring that only clinical relevant requests are processed by the laboratory. Since its implementation the Trust has benefited from significant savings on consumables and has reduced turn-around times for key laboratory investigations.

• Palliative care

Despite a significant growth in referrals and minimal increase in resources, the specialist Palliative Care Team has continued to maintain high quality, patient-centred care. The service has seen a 71% increase in referrals over the last five years and 21% increase last year alone, however the unit continues to receive excellent feedback from patients and friends and family surveys.

The Royal Bournemouth Hospital end of life steering group has proven to be dynamic and highly effective. Led by the Associate Medical Director, this group is helping to bring about improvements in end of life care throughout the Trust, especially using tools such as the AMBER care bundle, and the RBCH personalised care plan for the last days of life. A seven day hospital Palliative Care Team will launch later in 2015 which will further improve end of life care and provide additional support for patients and families.

The unit continue to return good performance in various Dorset-wide clinical audits - for example looking at time between referral and telephone contact and face to face assessment, and at concordance with patients' preferred and actual place of death.

Last year the 'do not attempt cardio-pulmonary resuscitation' form was replaced by the new pan-Dorset 'allow a natural death' policy and form. The new form is recognised by all health and social care providers in the county, meaning that the resuscitation status of patients moving between settings is clearer for staff, and that this issue does not need to be repeatedly discussed with patients and families.

• Haematology

Last year there were multiple haematology consultant research publications in peer reviewed journals. This ongoing effort is testament to the team's dedication and quality of clinical research carried out at the Trust's Haematology Department. In addition the department was selected as one of the Myeloma UK clinical research network sites.

• Ward 10 and 11

JACIE (Joint Accreditation Committee ISCT EBMT) re-accreditation was achieved this year evidencing the high standard of care we deliver to our transplant patients.

The unit continues to have excellent compliance with education and training standards which supports team morale and internal peer review results. This is supported by outstanding leadership on the ward with nurse-led audit, nurse-led clinics and a multidisciplinary team approach including research.

Plans are well underway to relocate to the new Jigsaw Building. The new facility will significantly improve the patient experience in terms of privacy, dignity and patient flow, while being a more welcoming, modern and spacious environment in which to receive treatment.

Patient experience

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 an opportunity to comment on the quality of the services they receive.

Patient experience work at the Trust over the last year has included:

- national annual inpatient surveys, national cancer patient surveys, national Friends and Family Test monitoring
- internal feedback via the use of: patient experience cards, real time patient feedback, the care campaign audit (undertaken in collaboration with the Patients Association) and governor audits
- monitoring for any emerging issues via: patient comment cards, formal and informal complaints, issues raised by letters and compliments from patients, carers, relatives and the public

> One patient noted that when visiting the hospital the gel dispenser at a main entrance was empty at a weekend. This was highlighted due to the importance of infection control and the system amended. Housekeeping supervisors now review daily and sign to identify the check has been made and refill dispensers as appropriate.

- collating and using individual patient stories. Patient stories are shared monthly with the Trust Board, shared with staff at ward level and used for staff education. Patient diaries, experience based design interviews and one to one interviews with complainants are also used to identify opportunities for learning and improvement
- holding specific focus groups, stakeholder events and locum forums to discuss local issues for our patients. Specific project groups have included learning disabilities, Healthwatch quality audits, volunteers and patient advocates support for mealtime companions and a disability forum in partnership with Dorset Clinical Commissioning Group and Poole Hospital NHS Foundation Trust

Key improvements in patient care are centred both around direct interventions which positively impact on all aspects of quality. Actions taken in 2014/15 include:

- implementation of a carer's audit
- protected nights scheme
- dignity pledge
- bed curtains replaced Trust-wide for improved dignity and privacy
- promotion of the #hellomynameis campaign
- pain management education plan and analgesia proforma
- pilot site for healthcare assistant Care Certificate education programme - this has led to an established programme for all newly employed healthcare assistants to attend
- staff and volunteers training to support patients using the Hospedia system, with focus on menus and meal ordering
- Property Management Policy to reduce the number of items lost developed for launch in 2015/16
- working with local council to improve traffic flow enabling greater access for patients and visitors
- Interim Care Team supporting the provision of interim care beds for patients ready for discharge
- GP led transitional care unit to support patients fit for discharge
- expansion of volunteer roles including dementia care companions
- implementation of the Friends and Family Test into outpatient and day case areas
- stakeholder events and annual focus groups to support service reviews and changes

Care Quality Commission national inpatient survey

> **Improvement in overall national inpatient survey results**

The 12th annual Care Quality Commission national inpatient survey includes responses from in excess of 59,000 patients from 154 acute trusts. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

had a response rate of 54% (the national response rate was 47%) with 447 responses completed from a sample of 830 eligible patients. The eligible sample (as defined by the national methodology) were all patients who had stayed in the Trust overnight during July 2014.

The national 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 11 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.

Comparison with 2013 results

It is positive to see that the 'overall' score demonstrates improvement from last year. The overall score has improved from 7.9 in 2013 to 8.1 in 2014.

Comparison with 2013 performance demonstrates:

- we made improvement in 42 questions in 2014 (20 questions in 2013)
- eight questions show statistical improvement (one in 2013)
- six questions have remained the same (eight in 2013)

Section scores

- there was a deterioration in the results of 10 questions (29 in 2013)

We improved on last year's performance in the following categories: hospital and ward, nurses, doctors, care and treatment, operations and procedures and leaving hospital.

It was pleasing to note that we made improvement in our patients' perception of having to share mixed-sex sleeping areas (last year the Trust was placed in the bottom 20% for mixed-sex sleeping areas, this has improved from a score of 8.2 in 2013 to 8.8 in 2014). However there is work still to do as the report highlighted that we need to make progress in our patients' perception of not having gender specific shower or bathroom facilities (the Trust is in the bottom 20% of all acute trusts for this question). We are planning to review signage and communications during the year ahead.

National comparison

The results place the Trust in the top 20% of trusts (green) in the following four questions:

- Q8 The hospital specialist had all relevant information from referring specialist
- Q48 Anaesthetist providing information regarding induction and pain management
- Q55 Written information on discharge
- Q60 Staff telling of danger signals to be aware of after discharge

The Trust was only in the top 20% of trusts for one question in 2013.

In 2012 we had one of the lowest scores for the question relating to privacy when being examined or treated. Pleasingly the results for 2014 demonstrate further evidence of significant improvement. The Trust is now rated as amber at 9.7. The highest national score was 9.9.

The 2014 results did not indicate any areas where the Trust was significantly worse (lower) than the national average. In 2013 we had three areas where we were red, so the 2014 show positive improvement.

In summary, performance against the Trust's 2013 demonstrates excellent improvement. We have significantly improved in four questions placing the Trust in the top 20% of the country and have also shown improvement in a further 41 questions. We aim to continue this success in 2015/15 and will introduce via the care group heads of nursing a number of new and ongoing improvement initiatives across all areas.

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.

There are six questions on one side, chosen in parallel with national inpatient survey 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. On review areas for improvement are themed and actioned through improvement plans.

In 2014/15, there has been a significant increase in the number of completed cards; 34,644 cards completed Trust wide (22,514 in 2013/14) by patients across our hospitals. Overall patient satisfaction was high with 96.3% recommending the Trust and only 2% not recommending.

Friends and Family Test

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 stimulate 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, the Trust has included maternity services.

"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.

(National FFT Question)

The Friends and Family Test score is calculated using 'Net Promoter Score' methodology. The methodology results in a FFT score of between -100 and +100.
The national directive to implement the FFT question has been cascaded throughout the Trust via the use of the patient experience card (PEC).

The results are reviewed through the Patient Experience Committee and actioned where required. This data is collated and submitted to NHS England in accordance with strict guidelines. The data is also made publically available throughout the Trust for patients and the public in accordance with NHS England guidelines.

In line with the NHS England directive, the FFT has been extended to include 40 outpatient and day case areas in addition to inpatient areas.

When compared with the previous year there has been an increase (improvement) of the FFT score on aggregate from 75 to FFT Score 77.

FFT April 13 - March 14 (all areas)		FFT April 14 - March 15 (all areas)	
Extremely likely responses	16,626	Extremely likely responses	25,711
Likely	3,466	Likely	5,013
Neither likely/nor unlikely	437	Neither likely/nor unlikely	569
Unlikely	208	Unlikely	246
Extremely unlikely	287	Extremely unlikely	380
Total	21,024	Total	31,919
FFT SCORE 2013/14	**75**	**FFT SCORE 2014/15**	**77**

1st April 2014 to 31st March 2015	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know	No answer	No FFT responses	FFT Score	Recommended %	Not Recommended %
All inpatient depts.	8429	1733	191	67	68	64	408	10552	77	96.3%	1.3%
All ED depts	4933	815	91	68	170	32	124	6109	76	94.1%	3.9%
All Maternity depts	681	191	10	4	2	1	18	889	75	98.1%	0.7%

Children's FFT card

A new FFT card specifically for younger patients was introduced in January 2015. The cards were developed to support the NHS England directive to provide feedback opportunities for those over five years of age. Results for the first three months of data collection indicate that 98.9% of young people who completed this card would recommend the Trust.

Real Time Patient Feedback (RTPF)

Real Time Patient Feedback (RTPF) is facilitated through the Trust by trained volunteers. Patients are asked a series of standard questions through face-to-face interviews. The survey data collection and analysis process is managed by the Head of Patient Engagement.

Results are shared with clinical teams to highlight best practice and indicate areas for improvement.

One of the main RTPF audits this year has been the 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 older peoples' medicine and medical wards. The audits are facilitated by trained volunteers and review five key objectives:

- communicating with care and compassion
- assistance - ensuring dignity
- relieving pain effectively
- ensuring adequate nutrition
- managing 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 put in place for improvement. The audits have led to improvement in privacy and dignity, communication, pain control and mealtime assistance.

Care Campaign Question	April 2014 Score	March 2015 Score
Section 1 Communicate with care and compassion (total of all questions) e.g.	88%	90%
Did staff ask you what name you preferred to be known by/called?	89%	92%
Do staff use your preferred name when they speak to you?	92%	95%
Section 2 Assistance and ensuring dignity (total of all questions)	92%	94%
Section 3 Relieve pain effectively (total of all questions) e.g.	79%	84%
Do staff use other methods to relieve your pain?	72%	83%
Section 4 Ensuing adequate nutrition (total of all questions)	89%	94%
Are the meals provided enough for you?	80%	87%
If you are unable to eat a full meal were you offered regular snacks and drinks?	76%	89%
If you need assistance to eat your meal is it given?	61%	94%
Are you supported to eat your meals without interruption?	76%	93%
Section 5 - Managing expectations (total of all questions)	-	91%
Overall %	**87%**	**91%**

Patient focus groups

Patient focus groups are run throughout the year. This year 11 events have taken place, including in rheumatology, orthopaedics, oncology, endoscopy and physiotherapy. The focus groups are an excellent way of using the views and recommendations of patients in the development of new or existing services.

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 we have 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
- Chaplains
- League of Friends Christchurch
- League of Friends Bournemouth
- Friends of the Bournemouth Eye Unit
- Hospital Radio Bedside
- Red Cross
- Headstrong
- Macmillan
- Healthwatch
- Patients Association

Bluecoat volunteer duties are extensive include:

- main reception 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

The Trust has developed a volunteers major incident policy to ensure that appropriately identified and trained volunteers would be available to offer support if required. The Lampard report recommendations following the Savile Investigation has been reviewed to provide Board and stakeholder assurance of compliance.

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 complaints and concerns

A key focus for the Trust is to ensure that we have robust systems in place to enable early local resolution of concerns and clear communication with all stakeholders about the actions we have taken following complaints investigations. Our overriding objective is to learn from each complaint and resolve each complaint with the complainant through explanation and discussion.

In 2014/2015 we received 360 formal complaints from patients or their representatives. This represents a small decrease of 2.7% (10 complaints) from last year's total of 370 complaints.

Of the 360 formal complaints received, 190 of the completed investigations were upheld or partially upheld, with the necessary changes explained and appropriate apologies offered. Where appropriate complaint resolution meetings were held with complainants and relevant staff to assist with feedback, closure and learning

The main categories of complaint in 2014/15 were as follows:

Subject	Number in 2014/15	Percentage in 2014/15	Number in 2013/14	Percentage in 2013/14
Administrative systems	28	8%	26	7%
Attitude of staff	44	12%	35	10%
Bed management	6	2%	8	2%
Clinical treatment	168	46%	197	53%
Communication/information	56	15%	43	12%
Discharge arrangements	27	6%	21	6%
Environment	3	1%	6	2%
Equipment/facilities	2	1%	1	0.2%
Health and safety	6	2%	6	1.1%
Privacy and dignity	1	0.2%	5	1%
Medication	10	4%	15	4%
Availability of staff	6	1.8%	1	0.2%
Theatre Management	3	1%	2	0.5%
Other	0	0	4	1
Total	360	1000	370	100

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, seven people chose to refer their concerns to the Parliamentary and Health Service Ombudsman during 2014/15. At the time of this report, the Ombudsman partly upheld two complaints, did not uphold two with a further three complaints still under investigation.

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:

- endoscopy office telephone opening times extended, with telephone lines open until 6.30pm
- a cover-sheet/log has been introduced to patients' notes to ensure a record is made to confirm that letters are sent to patients as appropriate to advise them when to stop taking warfarin. A communication will be sent to local GPs to remind them of the recommended timeframes for stopping warfarin prior to undergoing surgery
- training in management of suspected spinal injuries provided in the Emergency Department as direct result of a complaint
- Emergency Department now records all referrals to urology admissions so that we can ensure that they have been sent
- new ward discharge checklist implemented to ensure care home advised of discharge and patient provided with suitable clothing
- agency staff manual handling training made consistent with Trust standards
- training for reception staff updated to ensure they know to bring a patient's notes to the attention of the medical staff if a patient contacts them to advise they are waiting for their biopsy results. Pathway mapping exercise completed to identify potential areas for delays in histology results. This has allowed us to ensure that record retrieval, results reviewing and typing of letters is streamlined and that patients receive results with a minimum of delay
- ward shift co-ordinator (nurse-in-charge) guidelines updated to incorporate continence checks and pressure relieving management in the four times a day full ward rounding. An action plan has been implemented to strengthen a drive for improvement in relation to motivational leadership, accountability for individual actions and the provision of quality care by quantifying areas for improvement and setting the expectations of staff

Details of the improvements made following comments are posted monthly on the Trust website.
www.rbch.nhs.uk/patients_visitors/when_things_dont_go_to_plan.php for further details

Other news

We have some outstanding services that have been recognised for their excellent clinical outcomes, innovation and patient care this year. For example:

• Improving patient information

The Trust was awarded the Information Standard Quality Mark for Patient Information following a rigorous assessment of its patient information processes by the Royal Society for Public Health in October 2014. This is the second time the Trust has been awarded accreditation and means that all of our patient information leaflets can continue to carry the official Information Standard quality mark - a clear indication that it is accurate, evidence based, up to date and reliable.

Matron Jenny House:

"It is essential that our patients get accurate written information about their condition, operation and procedure in a format they can understand. Our lea ets are also just as important for carers and families, as the information we provide keeps then better informed helping to allay any fears or concerns they may have."

• Providing a better environment for maternity

The Royal Bournemouth Hospital celebrated the official opening of the Bournemouth Birth Centre in November 2014 - its new midwifery-led maternity unit.

Hosting two spacious birthing suites with en-suite bathrooms, 'quick-fill' birthing pools and an additional overnight room, the new unit is a demonstration of our commitment to providing high quality 'home from home' births for new mums. The purpose-built facility boasts hidden technology, sound proofing, air conditioning and variable lighting to create a welcoming atmosphere. The more homely surroundings support our natural birth ethos, where midwives assist low risk mothers in using alternative birthing techniques to avoid unnecessary drugs during labour.

The unit has dedicated car parking bays for parents and visitors and pull-out beds so dads and birthing partners can stay overnight. Its location next to the hospital's road also allows for fast patient transfers by ambulance.

• Cardiology

An audit of length of stay and inpatient waits for angiography for patients admitted with Acute Coronary Syndrome (ACS)/ Non ST elevation Myocardial infarction (NSTEMI) was completed in June 2014 to look at the steps in the existing pathway and where potential delays were occurring.

NICE guidance in 2013 suggested a sign of a high quality service would be for patients to have an angiography (angio)/percutaneous coronary intervention (PCI) within 72 hours of admission if intermediate or high risk.

The European Society of Cardiology recommends patients having an angio/PCI in less than 72 hours for low risk and less than 24 hour for high risk. The Wessex Strategic Clinical Network involving clinicians and local clinical commissioning groups have suggested a separate target of 80% of these patients having an angio/PCI within 60 hours of admission. Nationally, 53% of these patients have angio/PCI within 72 hours of admission and 67% within 96 hours.

An internal audit undertaken in June 2014 showed a median time from presentation to angio/PCI for patients transferred to the Royal Bournemouth Hospital (RBH) for treatment of 167 hours and 135 hours for RBH patients. As a result, a working group was established to create a new pathway and process to speed up the transfer of patients and reduce time to procedure and reduce overall length of stay. The new pathway was created and commenced on 1 December 2014.

The new pathway now involves the advanced nurse practitioner attending the Acute Admissions Unit at 8am each day and reviewing all cardiac referrals. This includes taking a clinical history and examination from patients meeting specific criteria; discussing any patient who is suitable for same day angioplasty with the consultant in the catheter lab and arranging for them to be listed for a procedure on the same day if clinically

appropriate; allocating a space on a cardiac ward or trolley in our Cardiac Intervention Unit and moving the patient promptly to the department to further reduce any delays.

A repeat audit was undertaken in February 2015 which showed improved admission to procedure times for RBH patients. Patients had only waited 90 hours in comparison to 134 hours in June 2014. This represents a 12% improvement with the 96 hour target suggested by NICE.

The directorate is planning further changes to continue this improvement progress and is looking at specific quality improvement projects for 2015/16 with regard to length of stay, timely access to the catheter labs and providing early cardiology support and intervention to patients presenting to the front door.

- **Radiology**

Seven-day working in CT/MRI commenced formally in April 2014. This extended service includes:

- a radiologist on site until 9pm daily and Saturday/Sunday
- an extended scanning day 8am-8pm, Monday-Thursday CT and MRI
- Saturday/Sunday scanning 9am-5pm -inpatient/emergencies and some OPD

A seven-day ultrasound service also commenced in December 2014.

- **Ambulatory Care**

Serving a population of 550,000, our Emergency Department (ED) sees on average 200 patients per day with an average take of 91 patients. The ambulatory care project has been part of a wider improvement project for unscheduled care focusing on ED, integrated care, discharge and flow.

Our aim is to prevent unnecessary hospital admissions and improve patient experience. Our initial goal was to convert 25% (excluding ED observation ward) of our take to an ambulatory care setting.

Working with the clinical teams we mapped our existing pathways of care and the network advised us to break down the pathway by length of stay (LOS) to help us understand where our target group of patients were.

Creation of flow diagram helped us to understand our flow, identify opportunities and develop a plan. We could see only 12% of patients were being treated in ambulatory care and that ED was not accessing the service. We therefore needed to develop a new model of care which put ambulatory care as the first option for patients and we quickly gained clinical consensus for a new model of care to streamline flow.

In order to make rapid progress the project teams met every week. The challenges we had along the way were swiftly resolved through weekly checkpoint meetings with a senior team. We are still facing challenges but the project has been a great success. It has helped us to manage a 13% surge in activity and unprecedented growth in demand for our emergency and urgent care services over the past year.

Challenge	Solution
Communicate - Say it, hear it!	Improve - Change it!
Too many short stay patients being admitted to a bed	Developed a new model of care with patients treated as ambulatory until proven otherwise a key principle
Identifying and streaming patients early in the pathway	New model of care includes in-reach to ED from a multi-disciplinary team

Dr Naveed Bhatti (centre) - Consultant Physician:

"As an acute physician I am very passionate about ambulatory care - a passion to improve the quality of emergency care for patients. It is providing clinical care safely, effectively and ef ciently as day-case and could be provided across the primary/secondary care interface. It is about upholding good medical practice, improving patient experience, maintainingsafetyandmaximisingef ciency. Right area, right decision, right care."

To monitor progress we have developed a dashboard of metrics to measure and monitor improvement. We can demonstrate that the conversion rate to ambulatory care improved from 28% (160 patients per week) to 35% (215 patients per week) excluding follow ups.

Next steps

We are very excited to be working with a team of local GPs to extend our service later into the evening and weekends and also provide better integrated care. Work is also underway with our Estates Department to expand and improve the current clinical areas so that we can do even more. Our Older People Ambulatory Care Team is developing links with other innovative projects such as the virtual ward pilot to help older patients stay out of hospital. We continue to use ambulatory care to provide early supported discharge for patients. In Medicine for Older People this has contributed towards a reduction in our average length of stay from 17 to 11 days over a 12 month period.

Dr Ravin Ramtohal - GP, Highcliffe Surgery:

"As a local GP, I am delighted to be part of this innovative project to integrate primary and secondary care. A team of local GPs, alongside the Acute Admissions Team, assess a range of emergency admissions to the Trust. Together we can facilitate effective and timely investigations, outpatient treatment and follow up and community support, prioritising same day discharge."

Sonia Mahmoud - Nurse, Ambulatory Care:

"It's so nice to spend time with patients and see them through from start to nish and I am proud of the service we offer to patients."

• Improving dementia care

Major renovation work took place on Ward 26 to improve the environment for patients who have dementia and the quality of their care

The bays, reception area, facilities and staff offices were transformed over a period of six weeks by staff who attended specialist courses to learn what design changes would make wards safer and less confusing for those with dementia.

Performance against national priorities 2014/15

National Priority	2011/12	2012/13	2013/14	2014/15 Target	2014/15 Actual
18 week referral to treatment waiting times - admitted	17.7 weeks	94.5%	97.1%	90.0%	88.9%
18 week referral to treatment waiting times - non admitted	14.2 weeks	98.9%	98.4%	90.8%	95.6%
18 week referral to treatment waiting times - patients on an incomplete pathway	14.2 weeks	97.1%	96.2%	92.0%	94.3%
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	97%	97.2%	95.5%	95.0%	93.3%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	87.3%	88.6%	80.3%	85%	84%
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	94.6%	98.6%	93.4%	90%	93.1%
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	96.7%	96.4%	95.1%	96%	95.8%
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	99.2%	98.8%	95.1%	100%	92.5%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti cancer drug treatment	100%	100%	100%	100%	100%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	94.2%	93.6%	93.8%	93%	87.1%
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	99.1%	97.0%	98.0%	93%	91.1%
Clostridium difficile year on year reduction	62	31	14	25	21
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance certified	Compliance certified	Compliance certified	Compliance certified	Compliance certified

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 West Hampshire Clinical Commissioning Group
- Borough of Poole's Health and Social Care Overview and Scrutiny Committee
- Bournemouth Borough Council Health and Adult Social Care Overview and Scrutiny Panel
- Healthwatch Dorset
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Council of Governorss

Comments received were as follows:

NHS
Dorset
Clinical Commisioning Group

Statement from the Dorset Clinical Commissioning Group
7 May 2015

In 2014/15 The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust pursued achievement of the key quality priorities identified in the 2013/14 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 2014/15. The CCG recognises the areas of strength described in the Quality Account which were also identified by the Care Quality Commission who undertook a further inspection this year. 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 reducing levels of harm in relation to patient falls, catheter associated infections and compliance with Venous Thromboembolism risk assessments, there are clearly further improvements required in relation to hospital acquired pressure ulcers. It is also evident that compliance with Information Governance requirements is an area of priority for improvement.

The CCG were asked to comment on the quality priorities for 2015/16 at an early stage and is supportive of the areas identified particularly in relation to the reduction of avoidable pressure ulcers. The CCG will continue to work with 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.

West Hampshire Clinical Commisioning Group

Statement from the West Hampshire Clinical Commissioning Group
14 May 2015

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 2014/15 Quality Account.

It is clear that the Trust puts quality care high on its agenda with the various quality improvement initiatives implemented throughout the year, in particular the internal peer review process combined with the analysis of other information such as complaints and incident data, allows staff and managers to scrutinise all aspects of care and provide constructive feedback to staff. It is pleasing to note that this was also acknowledged by the Care Quality Commission during their last visit in August 2015 who also gave a more positive report than the previous one in 2013.

The Trust should be congratulated on the efforts made on improving outcomes for patients with the reduction in number and severity of inpatient falls. In addition, the Trust has worked to reduce hospital acquired infections, particularly those associated with urinary catheters, which is also a key quality indicator in the 2015/16 contract with West Hampshire CCG.

However, we are concerned that there has not been any significant improvement in the number of hospital acquired pressure ulcers during the past year and are pleased to see this as a key priority in 2015/16 with an internal reduction target of 25%.

The Trust failed to achieve the targets for management of patients being admitted with a stroke, and this was also identified by the CQC in their report; however West Hampshire CCG acknowledges that there has been an improvement in the proportion of patients scanned within 12 hours, over the year and we are keen to see the impact of the stroke outreach team once this fully implemented in 2015. The Stroke Unit has been a subject of concern for the CCG and, in particular, our GPs, throughout the year. Whilst we have had assurances from the Trust in the form of a performance and development plan, clinical presentations to the Clinical Quality Review Meetings and clinical visits to the unit including discussions with staff and patients, this still remains a concern. We are pleased that you have assured us that significant improvements will be made during 2015/16 and we will be monitoring this closely over the coming months.

The Trust has not met the Commissioning for Quality and Innovation (CQUIN) targets for the identification of patients over the age of 75 years with dementia and their subsequent assessment and referral and it is disappointing to find little reference to this in the Quality Account; however it is recognised that the Trust has undertaken actions to enhance the environment and improvements to care plan documentation, improved staff training and a review of the elderly care pathways.
We look forward to seeing how the implementation of the e-NURSE app will impact on patient care and experience during 2015/16.The CCG has seen at first hand the implementation of bay-based nursing which staff have, positively, commented on.

In accordance with national requirements, the Trust has included monthly reports on their planned versus actual nursing/midwifery hours and have had a challenging year in terms of recruitment; however, they have undertaken many initiatives to improve recruitment in order to ensure their patients are looked after safely.

The CCG supports the priorities identified for 2015/16 and 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, as far as we can be, with the accuracy of the quality account, based on the information available to us

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.

Heather Hauschild (Mrs)
Chief Officer

BOROUGH OF POOLE

Statement from the Poole Health and Social Care Overview and Scrutiny Committee

Members 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 an early draft of the Quality Account for 2014/15. This response is based on a PowerPoint presentation delivered to Members on 9th March 2015; we had also received a very helpful update during a visit in November. Comments from the interim visit have already been shared with the Trust; comments in this document refer to information presented in the latest meeting.

Members particularly wanted to reflect that the regular meetings with Trust staff over the past year had been very useful in building a good working relationship and also felt that the careful and reflective preparation Trust staff had put into the summaries as well as the opportunities to explore the issues in greater detail face to face were particularly valued. These visits have already led to the opportunity for additional shared working between the council, RBCH and other NHS Trusts on falls prevention and greater awareness of the key issues facing the Trust in all of the quality priority areas.

Members were very pleased to note that feedback they had given regarding last year's Quality Account has resulted in a number of changes to the way evidence is presented eg a glossary page, comparative national data, actual numbers as well as percentages where possible etc. This was evidenced in both the interim and end of year presentations making the information presented clearer and more meaningful. We would encourage the Trust to further develop this good practice to make your Quality Account increasingly intelligible to the wider public.

The end of year presentation clearly set out progress against the Quality Priorities for 2014/15, namely harm free care which reduces the harm from inpatient falls, hospital acquired pressure ulcers and catheter caused urinary tract infections as well as ensuring privacy and dignity and ensuring completion of nursing risk assessments and care plans. As stated above, Members appreciated the trend data, national comparators and clear actions and look forward to this being incorporated increasingly in future published Quality Accounts.
In terms of Harm Free Care, the safety thermometer metric shows that although performance improved from October to December, at 90.4% it still lags behind the national average of 94% for acutes, although there is a small improvement on the 89% outturn for 2013/14. Various reasons for this were discussed at the meeting as well as the actions being taken to improve it. It is good to see that the metric for new harms only is in line with the national average at December. Members would encourage the Trust to work with staff, patients and other stakeholders to continue to improve performance and would ask for a progress update at the half year meeting in the autumn.

Patient falls - Members were pleased to note that at December 14 falls with harm were significantly lower than the national average although performance has declined since the

interim visit (5 falls with major severe harm compared to 0 in the previous quarter). We were reassured that whilst this is unfortunate on an individual basis, the Trust have a robust process in place to ascertain whether more could have been done to prevent the incident, including root cause analysis, discussions with relatives etc. It is also reassuring to note that the vast majority of falls have no harm or only minor harm (445/454).The Trust have appointed a Falls Lead who has been invited to be part of a working group comprising health and social care partners across Dorset led by Borough of Poole - the first meeting is due to take place in April. Members would be interested to receive an update at the interim meeting on any resulting developments.

Pressure ulcers - Members remain extremely concerned about the high incidence of pressure ulcers within the Trust compared to the national average (8.35 compared with 4.31 respectively as at December 14). Whilst we note that the number of patients admitted with existing pressure damage continues to increase and that a number of the Category 3 and 4 ulcers were subsequently deemed to be unavoidable, we would urge the Trust to implement all the identified measures (eg the SSKIN bundle, e-Nurse, additional staff, staff learning and additional Hybrid mattresses) swiftly and comprehensively. Members would expect to see the anticipated 25% reduction in avoidable ulcers achieved in 2014/15 and would request a comprehensive update as to how the above measures have worked to improve performance at the mid year meeting.

Catheter-related Urinary Tract Infections - members would wish to commend the Trust on their performance as at December regarding catheters and new UTIs (0.0 compared to the national average of 0.30) and note the actions taken to achieve the good performance. We look forward to seeing this good performance maintained over the year.

Privacy and Dignity - Members would like to praise the Trust for your approach to improving the patient experience in this vital area as noted by CQC in their October report. We particularly liked the very tangible, pragmatic steps taken to help with issues such as putting on a hospital gown and were even more impressed that the RBCH culture had enabled a member of staff in the radiography department to design a “Putting on your hospital gown” poster as part of a Staff Leading Improvement event. We commend and encourage you to continue to develop this approach in staff across the Trust.

Nursing risk assessments - Members noted the risk assessment compliance metrics and were interested to hear how the introduction of an electronic MUST calculator tool (to measure nutrition and weight) in June was helping to improve compliance in an effective manner. It would be helpful on this chart to know whether 100% was the expected standard of compliance and also how RBCH performance compared with other acute Trusts and last year’s performance.

Looking ahead to 2015/16, Members noted plans for the implementation of e-Nurse risk assessments and the implementation of a new 14 day care plan. We also noted statements of assurance and the Clinical Audit details.

In terms of the Care Quality Commission (CQC) follow up inspection in August 2014, Members had been given an early sight of the findings and their comments are recorded in the notes of the interim meeting in November. In summary, both Cllrs. Wilson and Matthews stated that the Trust and its staff were to be commended for the excellent performance recognised by Inspectors including: “exceptional examples of care and attention provided by staff at all levels and disciplines,” a “clear commitment to dignity improvement at all levels” and patients receiving “timely care” and being treated with “dignity and respect”. Members were also pleased to learn that all compliance actions from the CQC inspection in October 2013 had been met.

The presentation in March provided other useful information including an update on efforts to reduce mortality, and how the Trust was working hard to develop its culture and encourage staff to incorporate its values (including an open and honest reporting culture) into everything they did. Other developments such as the award of the Information Standard quality mark and the use of an internal peer review process to look at services against CQC fundamental standards

and then triangulate findings with staff and patient interviews were also commended by Members for "making improvement real" for staff.

In terms of patient experience, Members were impressed with work to renovate Ward 26 for dementia patients and also with the Trust's commitment to encouraging inpatient participation, for example through the use of a new patient safety film.

Members noted the statistics regarding learning from complaints and were pleased to hear the example of "Lily" where learning from a complaint resulted in a clear presentation of the changes made and their impact on a new member of staff. This style of reporting complaints is particularly powerful and Members would be interested to learn of more examples of how complaints have tangibly changed practice.

In terms of priorities for 2015/16, Members agreed that the "Sign up to Safety" diagram gave a clear representation of what the Trust wanted to achieve. They also welcomed early sight of the draft Quality Priorities (ie Sepsis, Surgical Safety checklists, simple discharge planning/transitions, reducing hospital acquired pressure ulcers and implementing various IT systems in support of patient safety), and appreciated the opportunity to comment and give feedback on them. They felt that the above list reflected the Trust's ambitions and ongoing commitment to focus on the patient's experience / feedback and the need for culture change.

In summary, therefore, we would wish to state that Members are extremely pleased to learn of the Trust's many successes and developments; whilst there are still some areas of performance which require further improvement, it is clear that over the past year the Trust has put significant effort and thought into making improvements that bring real change to the quality of patients' experiences as well as clinical outcomes. This has been recognised both by CQC and by individual staff and patients as part of the overall drive to embed culture change in the organisation.

Thank you for the opportunity to comment on performance - we look forward to reading the published version of your Quality Account but please take this letter as Borough of Poole's response to that document based on performance reported to Members in early March 2015. We are particularly grateful to Paula Shobbrook (Director of Nursing), Jo Sims (Assistant Director of Governance) and Nikki Greenall (Project Manager) for going out of your way to help us understand key issues and successes.

We would welcome the opportunity for a follow up visit in the autumn. I am sure Gabrielle Longdin will let you know the name of the 'new' Chairman of HASCOSC.

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

Bournemouth BOROUGH COUNCIL

Building a Better Bournemouth

Bournemouth Borough Council Health and Adult Social Care Overview and Scrutiny Panel

I am able to confirm that in respect of the Quality Account for 2014/15, representatives from the Bournemouth Health and Adult Social Care Overview and Scrutiny Panel met with the Trust and colleagues from the Borough of Poole on two occasions 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 meetings. I understand that a number of verbal comments made by Members were also acknowledged by the Trust.

Matthew Wisdom
Democratic and Overview and Scrutiny Officer

healthwatch Dorset

Statement from Healthwatch Dorset
7 May 2015

In the past year Healthwatch Dorset has received feedback about the Trust's services from patients, relatives, carers and professionals. We've worked with the Trust throughout the year, holding Healthwatch information stands in Bournemouth Hospital, making our leaflets available to patients, visitors and staff and working with the hospital's public governors to gather feedback from inpatients for the Healthwatch England special inquiry project.

Our 2014 report "Every One Matters" highlighted the wide variation in the standard of care received at hospitals in Dorset. We will be monitoring the outcomes from the Trust's response to our report in 2015/16.

The positive feedback we gather often relates to staff attitudes and the high quality of care and compassion patients receive.

However, we are still receiving concerns about lack of communication especially regarding discharge (unsure of times, waiting for paperwork and medication, not being kept informed of what's happening, feelings of being discharged too early and discharged without appropriate support in place) so we are pleased to note that this area is being recognised as a priority for 2015/16.

The 2014 Emergency Department National Patient Survey highlighted 12 areas for improvement. The Trust has stated that an action plan is in place to address the key findings. It would be useful to have sight of the plan and details of the actions and timescales. Feedback received by Healthwatch Dorset relating to the Emergency Department has improved over the past year but we still receive comments about long waiting times and poor communication.

We are pleased to note that the Trust continues to prioritise issues regarding dementia and dementia awareness/staff training. We have received feedback from carers and relatives highlighting concerns about perceived staff lack of awareness of the needs of someone with dementia and their unwillingness to listen to the carer who knows them best. This is an issue especially when dementia patients are brought in as an emergency.

Our Community Investment Projects have gathered feedback from people and communities whose views might otherwise be under-represented when it comes to matters of health and social care. We'll be producing a report of these projects in 2015 and there will be opportunities for the Trust to respond to issues raised.

We note that issues about infection control are being picked up with daily checks on hand gel dispensers. We welcome this initiative as a number of patients have informed us of empty dispensers around the hospital.

We would like to acknowledge the work being undertaken to encourage patient feedback through a variety of methods but it would be useful to have further information about how patient feedback contributes to affecting change. The "My Dignity Pledge" is also an area where information about how it has worked and how it is monitored would be appreciated.

We acknowledge and welcome the Trust's openness in discussing with us our findings - both from our report "Every One Matters" and from the feedback patients and visitors shared with us at our information stands in the hospital - and the very full responses they have given, together with their action plans to address areas of concern. We look forward to continuing to work with the Trust to ensure that people's feedback on the Trust's services, both good and bad, is welcomed, listened to, learned from and drives forward improvements.

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

The Council of Governors welcomes the opportunity to make a meaningful contribution through the consultation process on the quality priorities for the Trust in 2015/16 and to express its views on the Quality Report for 2014/15.

This process has been supported by a consultation seeking the Governors' views on the 2014/15 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 2015/16 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 is concerned at the ongoing under-performance in the treatment of stroke and has asked the external auditors to review the data in relation to stroke as part of their assurance on the Trust's quality indicators. The external auditors will carry out sample testing of the 2014/15 stroke data to provide additional assurance on the data and report to the Council of Governors.

The Council of Governors continues to monitor and provide challenge to the Board of Directors on the delivery of care in line with the targets set by Monitor, particularly around four hour waits in the Emergency Department and the completion of treatment within 18 weeks of referral.

The Council of Governors continues 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.

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.

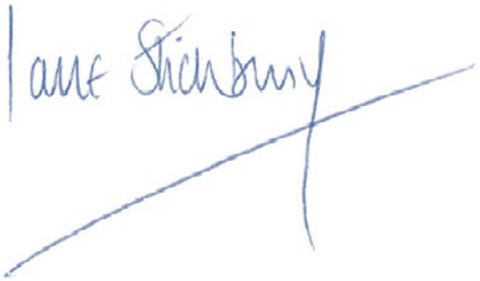
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

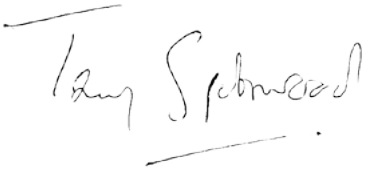
- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including -
    - board minutes and papers for the period April 2014 to May 2015
    - papers relating to quality reported to the Board over the period April 2014 to May 2015
    - feedback from commissioners dated 7 May 2015 and 14 May 2015
    - feedback from governors dated 6 May 2015
    - feedback from Local Healthwatch organisations dated 7 May 2015
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2014
    - the latest national in patient survey dated May 2015
    - the latest national staff survey dated February 2015
    - the Head of Internal Audit annual opinion over the Trusts control environment dated April 2015
    - Care Quality Commission Intelligent Monitoring Report dated July 2014 and December 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
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account regulations) (published at **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/annualreportingmanual**)

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

By order of the Board



Jane Stichbury
Chairman
28 May 2015



Mr A Spotswood
Chief Executive
28 May 2015

Annex C

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

We have been engaged by the council of governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (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 2015, 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 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18 week referral to treatment waiting times - patients on an incomplete pathway
- maximum waiting time of 62 days from urgent referral to treatment for all cancers

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 detailed guidance provided by Monitor
- 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 2014 to the date of signing the limited assurance opinion
- papers relating to quality reported to the board over the period 1 April 2014 to the date of signing of the limited assurance opinion
- feedback from commissioners
- feedback from governors
- feedback from local Healthwatch organisations dated 7 May 2015
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015
- the 2014 National Patient Survey
- the 2014 National Staff Survey
- Care Quality Commission Intelligent Monitoring Report dated December 2014
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2015
- 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 testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

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 2015:

- 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 2014/15
- 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
28 May 2015

Glossary of Terms

CA UTI
Catheter Associated Urinary Tract Infections

CPA
Clinical Pathology Accreditation

CPE
Carbapenemase-producing Enterobacteriaceae

eNA
Electronic nurse assessments

EPIC3 Guidelines
National Evidence Based Guidelines for preventing healthcare associated infections in NHS Hospitals in England. These Department of Health guidelines provide comprehensive recommendations for preventing healthcare infections in hospital and other acute care settings based on best available evidence.

ESD
Early supported Discharge

Harm Free Care
Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system improvement. The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' on the day of data collection. Further details are available at **http://harmfreecare.org/measurement/nhs-safety-thermometer/**

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.

Healthcare Quality Improvement Partnership (HQIP)
was established in April 2008 to promote quality in UK health services, by increasing the impact that clinical audit has on healthcare quality in England and Wales.

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.

JACIE
Joint Accreditation Committee ISCT EBMT (haematopoietic stem cell transplant assessor)

MRSA
meticillin-resistant staphylococcus aureusis. MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

MUST
Malnutritional Universal Screening Tool

National Institute for Health and Care Excellence (NICE)
NICE is sponsored by the Department of Health to provide national guidance and advice to improve health and social care. NICE produce evidence based guidance and advice and develop quality standards and performance metrics for organisations providing and commissioning health, public health and social care services.

NHS Safety Thermometer

The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

Never Event

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. Never Events include incidents such as wrong site surgery, retained instrument post operation and wrong route administration of chemotherapy. The full list of Never Events is available on the NHS England website.

NCEPOD

National Confidential Enquiry into Patient Outcome and Death

NICE

National Institute for Health and Care Excellence

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

The Oxford Hip and Oxford Knee Score measures of a patient's experience of their functional ability specific to patients who experience osteoarthritis. The measure is a scale of 0-48 and records the patient 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.

Point Prevalence

A point prevalence survey or audit gives a figure for a factor at a single point in time only.

SALT

Speech and Language Therapy

SAS

Staff Grade and Associate Specialist

Serious Incident

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. In general terms, a serious incident must be declared for where acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) result in:

- Unexpected or avoidable death of one or more people.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- A Never Event

Full details of the NHS England Serious Incident Reporting Framework can be found on the NHS England website.

Sign up to Safety campaign

The NHS England Sign up to Safety campaign was launched in June 2014. It is designed to help realise the aim of making the NHS the safest healthcare system in the world by creating a system devoted to continuous improvement. The NHS England campaign has a 3 year objective to reduce avoidable harm by 50% and save 6000 lives. Healthcare organisations have been encouraged to sign up to five pledges and create a three-five year plan for safety. To find out more about the Trust's pledge go to: **www.rbch.nhs.uk**

US

Ultrasound

Venous Thromboembolism (VTE)

VTE is the collective name for:

- deep vein thrombosis (DVT) - a blood clot in in one of the deep veins in the body, usually in one of the legs
- pulmonary embolism - a blood clot in the blood vessel that carries blood from the heart to the lungs

Waterlow Score

The Waterlow pressure ulcer risk assessment/ prevention policy tool is the most frequently used system in the UK for estimating the risk for the development of a pressure sore in a given patient. The tool was developed in 1985 by Judy Waterlow.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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Bournemouth
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Christchurch Hospital
Fairmile Road
Christchurch
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Further copies of this report can be found online at **www.rbch.nhs.uk**

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