providing the excellent care we would expect for our own families

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Quality Accounts 2015-16

Contents

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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

Our quality strategy this year has been supported by wide-ranging quality improvement and patient safety initiatives which cover a large range of specialties and topics. In this report we have outlined some of these activities.

This year we have been able to report a positive improvement in providing harm free care, preventing hospital acquired pressure ulcers and reducing serious patient safety incidents. We have developed a more open and honest culture, encouraging staff to speak out and take part in internal peer reviews and share learning from errors and mistakes. A particular success was our first Patient Safety and Quality Conference held in September 2015 where over 500 staff shared patient safety and quality improvement stories, case studies, ideas and innovations.

There were a number of inspections during the year, the most important of which was a formal inspection by the Care Quality Commission (CQC). It was therefore positive to receive confirmation from the CQC that we had made significant improvement following their previous inspection in 2013. We could not have made this improvement without the dedication and skill of our staff and the support from patients, carers, governors and other public stakeholders. We also recognised 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 aim to provide a central framework and the basis for individual objectives 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, team work and performance.

There is an important balance to be struck when considering the objectives we set for the Trust between the need for these to be clear and measurable against the importance of not over-specifying to the point that 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 2016/2017 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 team work
- 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 2016/17.

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, feedback sessions 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.

Care Quality Commission (CQC) Inspection Report - February 2016

The CQC inspected the Royal Bournemouth Hospital and Christchurch Hospital on the 20-22 and 26 October 2015 and 4 and 9 November 2015.

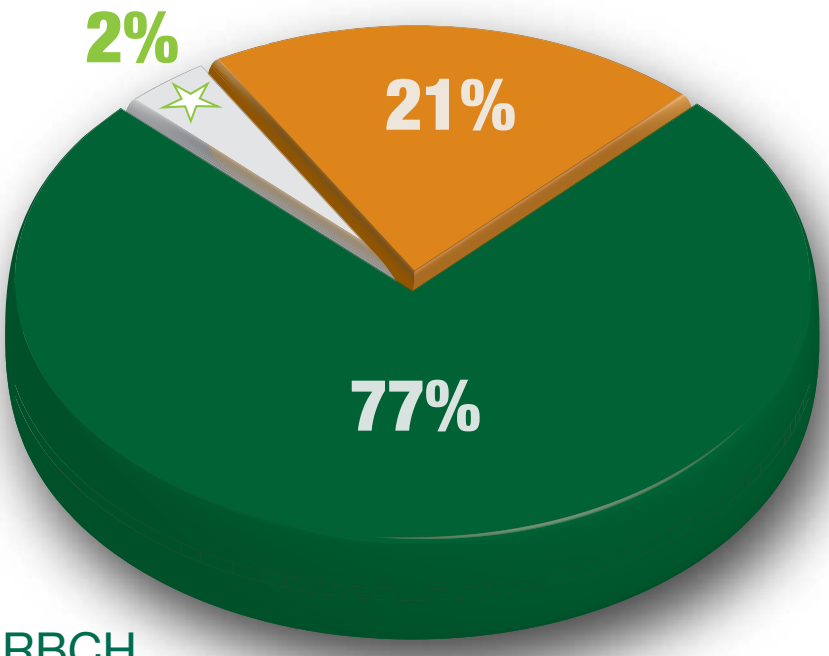
Following the Care Quality Commission's inspection of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, nearly 80 per cent of our services received individual ratings of "good" or better.

Two areas of the Trust were praised by the CQC as being examples of 'outstanding practice' and all services at Christchurch Hospital were rated as good, with the CQC reporting that our staff were caring and compassionate and treated patients with dignity and respect. The CQC also noted that our staff were 'motivated to offer care that was kind, supportive, and open' and this is in line with the mission of our Trust to give the standards of care we would want for our own families."

At the Royal Bournemouth Hospital, we were rated by the CQC as "good" for five services: critical care; surgery; outpatient and diagnostic services; end of life care and children's and young people's services. Three services were rated "requiring improvement": urgent and emergency services; medical care and maternity and gynaecology. The care of children and young people was rated as "outstanding".

The CQC report has highlighted areas that we need to improve on and our actions to address them are summarised in the quality report. The action plan sits alongside an ambitious programme of quality improvement initiatives across the Trust which combined with the hard work and dedication of our staff are both helping with the advancement recognised in this report and beyond.

It has not been possible to include all of the quality and patient safety initiatives that we have been or will be engaged in within this report. We have considered the comments made by our external stakeholders during the consultation process and amended the final version of the report to provide additional information where appropriate. We hope that the report demonstrates our clear commitment to quality improvement and patient safety.



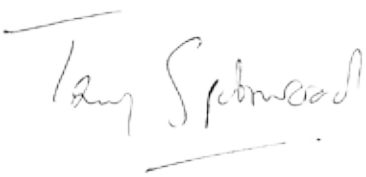
Breakdown of CQC results for services at RBCH

☆ Outstanding Good Requires improvement

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

- 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 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 recognise 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
25 May 2016

Part 2

Progress against quality priorities set out in last year's quality account for 2015/16

In the 2014/15 Quality Account the Trust identified the following key areas for improvement in 2015/16:

- 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 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 Serious Incident Reports
- ensuring that there are no Methicillin-resistant Staphylococcus aureus (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.
- 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

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 our achievement against the priorities we set ourselves.

Harm free care

The 2014/15 Quality Report published in May 2015 identified "harm free care" as one of the quality improvement metrics to continue to be monitored in 2015/2016.

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 the results are validated prior to entry on to the national electronic data collection database.

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

A quality objective for the year 2015/2016 was to complete the NHS Safety Thermometer across all wards with the simple aim of being better than the national average for harm free care.

In 2015/2016, based on a survey of 5812 in-patients, we achieved an average of 97.5% new harm free care (97.2% in 2014/15 and 96.7% in 2013/14). Our score for 2015/16 compared to a national average of 97.8%.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16 Average
National New Harm Free Care %	97.70%	97.78%	97.79%	97.80%	97.74%	97.92%	97.90%	97.87%	97.90%	97.95%	97.89%	97.83%	**97.84%**
RBCH New Harm Free Care %	96.78%	97.86%	98.95%	97.64%	97.89%	96.58%	97.77%	98.08%	97.10%	96.62%	98.35%	96.77%	**97.53%**
National New Pressure Ulcers %	0.99%	0.99%	0.93%	0.98%	0.93%	0.87%	0.88%	0.91%	0.91%	0.93%	0.91%	0.95%	**0.93%**
RBCH New Pressure Ulcers %	2.41%	1.28%	0.63%	1.72%	1.69%	2.99%	1.21%	1.28%	1.93%	2.58%	1.03%	2.63%	**1.78%**
National Falls with Harm %	0.63%	0.61%	0.67%	0.59%	0.65%	0.58%	0.58%	0.59%	0.56%	0.52%	0.57%	0.58%	**0.59%**
RBCH Falls with Harm %	0.40%	0.43%	0.21%	0.43%	0.42%	0.00%	0.61%	0.64%	0.58%	0.80%	0.41%	0.20%	**0.43%**
National New Catheters and New UTi %	0.31%	0.31%	0.30%	0.30%	0.33%	0.31%	0.30%	0.32%	0.30%	0.28%	0.30%	0.28%	**0.30%**
RBCH New Catheters and UTi %	0.40%	0.43%	0.21%	0.21%	0.00%	0.21%	0.20%	0.00%	0.39%	0.00%	0.00%	0.40%	**0.20%**
National New VTE %	0.41%	0.38%	0.36%	0.37%	0.39%	0.36%	0.37%	0.35%	0.37%	0.35%	0.37%	0.39%	**0.37%**
RBCH New VTE %	0.00%	0.00%	0.00%	0.00%	0.00%	0.21%	0.20%	0.00%	0.00%	0.00%	0.21%	0.00%	**0.05%**

Data Source: Safety Thermometer, NHS Information Centre.

Reducing non-clinical patient moves

A quality objective for 2015/2016 was to reduce the number of times patients were moved multiple times during their admission for non-clinical reasons.

The table below show the results for 2014/2015 and 2015/2016 for patients, by number of moves during2014/2015 and 2015/2016 episode, based on admission date.

Number of moves	Apr-June 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	TOTAL 2014/15
6 or more	0	1	1	1	3
5	1	0	2	0	3
4	5	7	13	5	30
Total	**6**	**8**	**16**	**6**	**36**

Number of moves	Apr-June 2015	Jul-Sep 2015	Oct-Dec 2015	Jan-Mar 2016	TOTAL 2015/16
6 or more	0	2	2	0	4
5	1	3	1	1	6
4	5	4	6	10	25
Total	**6**	**9**	**9**	**11**	**35**

The above information shows the number of recorded patient moves for each patient admission on the hospital electronic system. A case note review is currently in progress to review the clinical appropriateness of each recorded move for 2015/16.

The un-validated results for 2015/2016 show slight improvement in year despite a background of higher number of admissions and activity at front door during the year. It is likely that the 2015/16 validated results will highlight further improvement.

Quality improvements implemented in 2015/16

The following actions were undertaken in 2015/16 to reduce the number of inappropriate patient moves and improve the reliability of our data on patient moves:

- Standard operating procedure agreed with Clinical Site team, Ward Sisters and Matrons, Risk Management and Infection control team with agreement on the clinical criteria for ward transfers.
- Amendment of inpatient 7 day care plan documentation to enable date, time and rationale for a ward move to be clearly documented in the patient's notes.
- Improvement in accuracy of data input at ward level.

- Record of all patients who are placed on a ward outside of their specialty recorded and maintained by Clinical Site team and the rationale for the move recorded

Improvement priorities for 2016/17

- Maintain focus on the importance of accurate clear documentation and discussion, including communication with patients and families, about moves.
- Reconfiguration of beds and in particular the development of the acute frailty unit will ensure that that the bed capacity within a specialty matches more closely the demand for those specialty beds.
- Implementation of the electronic new bed management system to aid improved patient flow and identification of bed availability

Reducing Hospital Acquired Pressure Ulcers

On average less than 1.78% of the hospital inpatients surveyed in 2015/16 using the National NHS Safety Thermometer tool had a reported hospital acquired pressure ulcer. This compared to 2.00% in 2014/15 and 2.20% in 2013/14.

The result is slightly higher than the national average of 0.93%.

Our patient profile is such that we have a high proportion of very elderly frail inpatient population with often complex and long term health issues. Our patients are often admitted with existing pressure damage (community acquired cases are much higher than the national average) or at a high risk of early skin deterioration. We have therefore focussed on embedding a proactive prevention strategy at our front door whereby all patients are placed immediately on pressure relieving mattresses. Nursing staff in our Emergency Department and Acute Medical Unit staff also ensure that patients have a full skin assessment on admission. We are working closely with NHS England and our 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 30 serious incidents of avoidable category three and four hospital acquired pressure ulcers. In 2014/15 this figure reduced by 33% to only 20 cases. In 2015/16 this reduced by 70% to only 6 cases being reported as Serious Incidents.

Quality improvements implemented in 2015/16

- Developed and implemented an electronic risk assessment application including pressure ulcer risk assessment tool
- 50 additional specialist hybrid mattresses purchased during the year which takes us to just over 50% bed base coverage.
- 20 additional hybrid cushions purchased for high risk areas.
- Provision of training courses has been increased. Basic wound care workshops are now delivered twice monthly instead of once every other month and opened to outside providers.
- Poster presentation at the European Pressure Ulcer Advisory Panel conference in Belgium in September 2015. Following this we have shared our learning and information with other Trusts around the country.
- Additional full time Tissue Viability Staff Nurse post appointed (to commence April 2016).

Improvement priorities for 2016/17

- Implement a tailored competency framework for qualified staff focussing on pressure ulcer prevention and management
- Continue to work towards 100% bed base coverage of hybrid mattresses (inpatient areas)
- Continue working with our NHS England and commissioning colleagues to establish a core training standard across the area for all care providers

Infection control

Clostridium Difficile.

There were 26 cases of clostridium.difficile reported from the Trust in 2015-16. 17 of these cases were attributed to 'lapses in care' processes, against an NHS England target of 14. This is comparable to previous years in terms of the percentage of total cases reported.

Lessons learnt from the cases where there were lapses in care processes included; ensuring that specimens are sent as soon as possible which will support the timeliness of isolation and to continue the focus on accurate documentation and hand hygiene. When compared nationally, the Trust has low rates of clostridium difficile and we will continue to strive for further improvements.

The Trust works closely with healthcare providers and commissioners in Dorset and Hampshire to continuously improve patient safety in this area.

Methicillin-Resistant Staphylococcus Aureus (MRSA)

No hospital acquired MRSA bacteraemia's were recorded at the Trust during 2015/2016.

Methicillin-Sensitive Staphylococcus Aureus (MSSA)

The trust has a line working group which works closely with members of the Trust and community to ensure that policy and protocol are followed across the health care sector in Dorset. An electronic assessment tool for patients with vascular access devices is in development at the Trust.

Norovirus

Outbreaks of Norovirus were confirmed within the Trust during January and February 2016. Whilst every effort is made to prevent the spread of this virus it is difficult to prevent it from coming into the Trust. Media messages and communications are currently our best defence against this.

Catheter related urinary tract infections (CA UTIs)

The average Harm Free care score relating to new CA UTIs (from NHS Safety Thermometer data) for the Trust in 2015/16 was 0.20% compared to 0.39% in 2014/15 and 0.47% in 2013/14.

This is slightly better than the national average score of 0.3% and a significant improvement on the previous two years results.

Improvement priorities for 2015/16

- Participation in World Hand Hygiene day in May 2016
- Hold an annual infection control study day for staff
- Continue infection control audit programme, including routine hand hygiene audits
- Review of new and novel methods to improve infection control within the Trust

Sepsis Management

The aim of the Trust Sepsis Quality Improvement project for 2015/2016 was to deliver the Sepsis 6 bundle to all patients admitted with severe sepsis and/or septic shock within 1 hour.

A project group was formed comprising quality improvement specialists, data analysts, clinicians (consultant and registrars) from emergency medical, acute medical and surgical specialities, senior nursing staff, and a member of the Communications team. The team worked collaboratively across the Emergency Department (ED), Acute Medical Unit (AMU) and Surgical Admission Unit (SAU), mirroring practises across all three units.

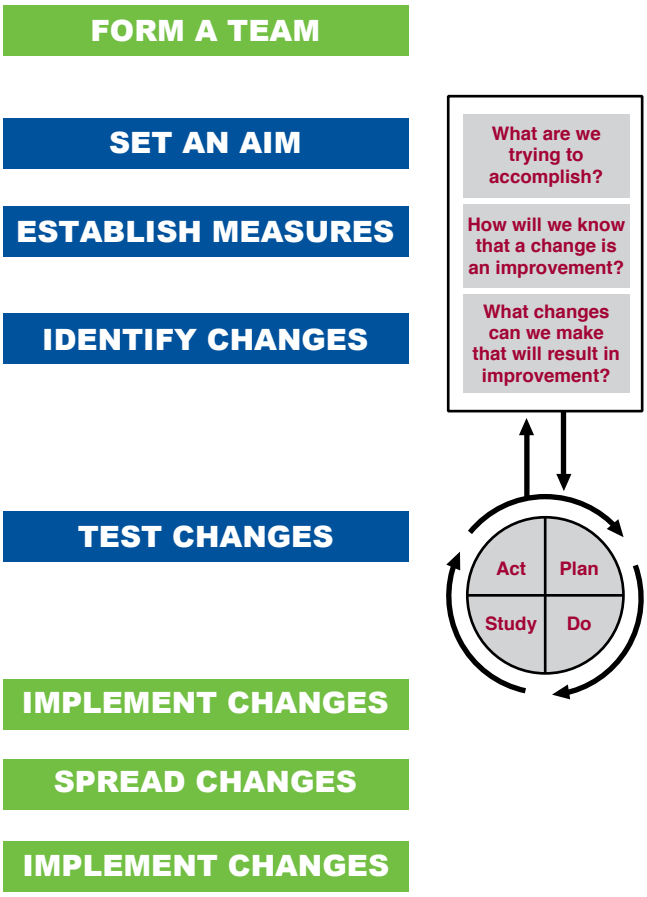
As part of our patient engagement, the team asked a patient and his wife to tell us about their experiences which were then integrated into the education package for all staff. The patient story has also formed an integral part of a video that the Trust is producing to highlight the importance of timely sepsis treatment.

Using the Trust quality improvement model (see diagram), allowed the team to focus on setting an aim, establish measures and identify possible changes.

The Trust Model for Improvement uses Plan-Do-Study-Act (PDSA) cycles to test changes in real work settings. Teams use quantitative measures to determine whether they lead to an improvement and the PDSA cycle guides the testing of a change to determine whether or not it results in an improvement. Each change idea is tested using one or more PDSA cycles.

The team completed two PDSA cycles that have measured the introduction of sepsis stickers, lanyards and cards to see if they helped decrease the time between arrival and administration of antibiotics. The team also completed a PDSA cycle which looked at the availability and types of intravenous antibiotics that were being prescribed in the organisation's emergency admitting areas to see if all antibiotics were available when prescribed. The results of this PDSA showed that all antibiotics prescribed during the cycle were available at ward level.

RBCH Quality Improvement Model



The team are currently preparing their fourth PDSA, looking at availability and appropriate usage of IV antibiotics.

Quality Improvements implemented in 2015/16

- During the year the Sepsis team have improved the one hour delivery of antibiotics to sepsis patients from 26% to 67%.
- Introduced a new policy in line with UK Sepsis Trust to address delivery of care to patient with suspected sepsis
- Developed a 'Sepsis Sticker' checklist to support policy implementation
- Undertaken a Trust wide poster campaign allied to lanyards and sepsis prompt cards, to aid early sepsis screening, identification and management.
- Develop branding of the Trust Sepsis Campaign to increase awareness within the Trust. The branding has been identified as an area of excellent practice by the Wessex Patient Safety Collaborative.

- Provided feedback to staff on current performance and areas for improvement.
- Engaged with Wessex Patient Safety Collaborative to develop a region-wide strategy for Sepsis
- Introduced an education package to be used to increase the sepsis awareness of our staff

Improvement priorities for 2016/2017

The Sepsis team have identified some future aims as they work to spread their success including:

- Adapting a protocol with consideration given to pre-mixing of antibiotics
- Improving communication with pre hospital and primary care teams to improve reception of septic patients
- Adapt to the national re-definition of sepsis and treatment pathways (expected April/ May 2016) and re-educate the Trust
- Develop an electronic clinical decision aid/audit tool to monitor care for inpatient sepsis and at admission
- Continue to review and improve time between prescribing and administration of intravenous (IV) antibiotics
- Continue with regional engagement around sepsis management within Wessex
- Produce a patient story video for staff education

Safety Checklists

During 2015/2016 the Trust has implemented a specific quality improvement project focusing on implementation of the World Health Organisation (WHO) Surgical Safety Checklist for all surgical and interventional procedures across the Trust. The project is led by the Medical Director and the project group includes representatives from across the Trust, senior nursing staff, clinical governance and risk management, information, informatics and communication departments.

The project team have met at least monthly to discuss progress, improvement cycles, actions and plans.

Quality Improvements implemented in 2015/16

- Implementation of new Standard Operating Procedures and Checklists for Theatres, Opthalmology, Interventional Radiology, Radiology, Dermatology, Cardiology, Oncology, Out-patients and Endoscopy
- Checklist champions implemented in all areas
- Compliance and observations audits
- Communications strategy branded and implemented “NEVER get to NEVER” campaign.

- Amendments to theatre data collection made to enable compliance reports by Theatre and by individual lead surgeon. Compliance is recorded for all 5 stages of the WHO checklist (pre start brief, sign in, time out, sign out, post debrief). All stages must be completed to achieve a compliance score. Compliance is recorded for all Theatre procedures and the results are displayed outside each theatre & all theatres aware of their compliance.

- Safety Checklist film launched and commended in Patient Safety category at the National Health Business Awards 2015. The film features real patient stories and is available to watch on the Trust website, facebook page and on YouTube **www.youtube.com/watch?v=vhlDmlxu0P4**

Basil Fozard, Trust Medical Director and executive sponsor of the 'Never get to Never' campaign, said: *"We are absolutely delighted to have been commended for the 'Never get to Never' patient safety campaign at the Health Business Awards this year. Patient safety is our Trust's utmost priority, so we have to recognise human errors are a possibility so that we can discuss them, improve our practice, support our staff to work at their best, and ensure our patients are the safest they can possibly be. Research shows the WHO Safety Checklist dramatically reduces the margin for human error during a procedure, which is why we have made our hospitals 'Safety Checklist zones".*

Improvement priorities for 2016/17

- Implementation of an electronic solution to capture checklist compliance across the Trust. This will be undertaken in a phased way, beginning with Theatres, Endoscopy, Cardiology and Interventional Radiology. Currently the project group is working up the system specification through specialty group discussions
- Implementation of Local Safety Standards for all areas undertaking invasive procedures to meet new National Safety Standards for Invasive Procedures (NatSSIP). The national deadline for completion is September 2016 and the project group is confident of meeting this timescale.
- Develop a patient leaflet covering how and why safety checklists are used for invasive procedures and the steps taken within clinical teams to ensure patient safety.
- Continue awareness and education on the Trust "Never get to Never" campaign and celebrate successful "safety catches" i.e. where use of the safety checklist has ensured patient safety.
- Implementation of a Trust wide faculty to deliver and support human factors training across the organisation, establishing a train the trainers programme for all checklist areas. A programme is already in place for Theatres, the plan is to build on this success and expand Trust wide.

Our quality priorities for 2016/17

In order to identify priorities for quality improvement in 2016/17, 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, concerns, risks, 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 their inspection report and wider stakeholder views at the Quality Summit in March 2016. We have triangulated our principal quality priorities and improvement objectives for 2016/17 with our CQC action plan.

We have also considered the results of the national staff survey to help us decide where we need to focus our quality improvement efforts and actions. We have also taken on board the national picture for patient safety and collaborated with Clinical Commissioning Groups (CCG) as part of wider strategy work and clinical service reviews. We have included the 2015-2018 priorities of the Wessex Academic Health Science Network and our on continued participation in the Wessex Patient Safety Collaborative work streams for Sepsis, Transfers of Care and Dementia.

The Trust has formally consulted with key stakeholders (general public, staff, patients, governors and commissioners) to help identify quality improvement priorities for 2016/17. Priorities have been considered with clinical staff as part of service delivery and clinical governance meetings.

We have considered any current actions plans in place, for example those forming our sign up to safety plan and our responses to 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, whilst 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, the Board of Directors has agreed that the overall quality objective for 2016/17 should be to continue to improve the quality of care we provide to our patients ensuring that it is safe, compassionate and effective, driving down variations in care whilst ensuring that it is informed by, and adheres to, best practice and national guidelines.

Our specific quality priorities are:

- Creating a fair and just culture; being transparent when things go wrong and embedding learning, measured by a reduction in Serious Incidents and avoidance of Never Events
- Promoting the recognition of avoidable mortality and potential links to deficiencies in care by improved and comprehensive mortality reviews and ensuring any learning points are disseminated.
- Ensuring patients are cared for in the most appropriate place for their needs by:
  - Improving the flow of patients and reducing the average number of non-clinical patient moves by at least 10%.
  - Supporting more patients who want to die at home to achieve this.
- To deliver consistent standards in quality care for our patients demonstrated by further improvements in reducing the number of avoidable pressure ulcers and falls which happen in our hospital in 2016/17 by a further 10%, measured through Serious Incident Reports
- To ensure that there are no MRSA cases and that the Trust achieves its target of no more than 14 Clostridium Difficile cases due to lapses in care
- To be within the top quartile of hospital reported patient satisfaction via the Family and Friends Test
- To address all issues highlighted within the CQC Report during 2016/17

To coordinate implementation of these aims and objectives, the Trust has developed a comprehensive quality strategy and monitoring 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

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.

1. Review of services

During 2015/16 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 Care Quality Commission, 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 2015/16 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2015/16.

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.

2. Participation in clinical audit

During 2015/16, 32 national clinical audits and four national confidential enquiries covered relevant health services that the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provides.

During 2015/16, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust participated in 94% 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 2015/16, are listed below 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 2015/16	Eligible to Participate	Participated in 2015/16	Data Collection completed in 2015/16	Rate of case ascertainment (%)
Case Mix Programme (ICNARC)	■	■	■	Awaiting end of year results
National Cardiac Arrest Audit (NCAA)	■	■	■	Awaiting end of year results
National Emergency Laparotomy Audit (Year 2)	■	■	■	97.62% as at Feb 2016
Acute Coronary Syndrome or Acute MI (MINAP)	■	■	■	98.9% (last published report)
Cardiac Rhythm Management	■	■	■	99% (last published report)
Coronary Angioplasty/National Audit of Percutaneous Coronary Intervention (PCI)	■	■	■	99.85%
National Heart Failure Audit	■	■	■	No data available - awaiting report
Sentinel Stroke National Audit Programme (SSNAP)	■	■	■	No data available - awaiting report
UK Parkinsons Audit	■	■	■	No data available - awaiting report
Adult Asthma	■	■	■	National Audit did not run in year
Diabetes Footcare Audit	■	■	■	56 cases submitted (second quartile)
Pregnancy in Diabetes Audit	■	■	■	19 cases submitted
National Diabetes Inpatient Audit	■	■	■	No data available - awaiting report
National Diabetes Audit (Adults)	■	■	■	No data available - awaiting report
Emergency Use of Oxygen	■	■	■	427 cases
Inflammatory Bowel Disease (IBD) 3rd Round Biologics Audit	■	■	■	No data available - awaiting report
Lung Cancer (Lucada)	■	■	■	No case ascertainment data available
National Chronic Obstructive Pulmonary Disease (COPD) Audit	■	■	■	76 cases
Pulmonary Rehabilitation	■	■	■	95% (38/40)

Non Invasive Ventilation				National audit did not run in year
Procedural Sedation in Adults	■			Unable to achieve minimum required sample size
Vital Signs in Children	■	■	■	Awaiting national report
Venous Thromboembolism (VTE) Risk in Lower Limb Immobilisation	■	■	■	48 cases
National Ophthalmology Audit	■	■	■	Data collection started March 2016
Falls and Fragility Fracture Audit programme (FFFAP) Hip Fracture Database				Not applicable to Trust
National Joint Registry	■	■	■	2014-15 971 hip cases (primary and revisions)
National Comparative Audit of Blood Transfusion (NCABT) - Blood Management in Scheduled Surgery	■	■	■	891 knee cases (primary and revisions)
NCABT - Audit of Use of Blood In Lower GI Bleeding	■	■	■	Deadline missed for participation
NCABT - Audit of Use of Blood in Haematology	■	■	■	Awaiting report
End of Life Care Audit	■	■	■	80 cases (100%)
Rheumatoid and Early Inflammatory Arthritis	■	■	■	No Trust level figure available
Bowel Cancer (NBOCAP)	■	■	■	100%
Elective Surgery (PROMS)	■	■	■	No data available
Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK (MBBRACE UK)	■	■	■	100% required
National Complicated Diverticulitis Audit	■	■	■	Unable to participate due to other clinical demands

National Confidential Enquiries for Inclusion in Quality Report 2015/16	Eligible to Participate	Participated in 2015/16	Data Collection completed in 2015/16	Rate of case ascertainment (%)
NCEPOD Acute Pancreatitis Study	■	■	■	100%
NCEPOD Mental Health in General Hospitals Study	■	■	▫	Data collection not yet completed
NCEPOD Non Invasive Ventilation Study	■	■	▫	Data collection not yet completed
NCEPOD Chronic Neurodisability Study	▫	▫	▫	Not applicable to Trust
NCEPOD Young Peoples Mental Health Study	■	■	▫	Data collection not yet completed

Centre for Maternal and Child Death Enquires for Inclusion in Quality Report 2015/16	Eligible to Participate	Participated in 2015/16	Data Collection completed in 2015/16	Rate of case ascertainment (%)
Saving Lives 2015	■	■	■	No data available
Perinatal Mortality - Antepartum Stillbirths 2015	■	■	■	No data available

The reports of 25 national clinical audits were reviewed by the Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust in 2015/16 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- Measurement of blood glucose on admission has been improved for patients admitted with Acute Coronary Syndrome or Acute Myocardial Infarction (MI) as a result of the Myocardial Ischaemia National Audit Project (MINAP).
- A clinical pathway for emergency laparotomy has been developed, following the first round of the National Laparotomy Audit. The Trust has joined a collaborative of 20 hospitals in the south of England and set up a quality improvement project looking at the 'acute abdomen' patient.
- National Heart Failure Audit - appointment of consultant with interest in heart failure as part of Heart Failure Team also additional Heart Failure Nurse Specialist and creation of Heart Failure Unit
- NCEPOD Sepsis report - adopt UK Sepsis Trust standard patient leaflet on sepsis. Review services for patients discharged from intensive care and introduce surgical site bundle. Formalise approach to consultation with microbiology consultants regarding sepsis cases and review the standardised sepsis proforma across the Wessex Collaborative
- National Diabetes Audit - Invite all patients with Type 1 Diabetes to a 3 yearly structured education session.
- National Audit of Inpatient Falls -production of new patient information leaflets on falls. Amendment of nursing risk assessment tool (eNA) to include lying and standing blood pressure.

The Trust did not participate in 2 national audits this year:

- National Complicated Diverticulitis Audit
- NCABT - 2015 Audit of Use of Blood In Lower GI Bleeding

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 now reviews all submitted audit reports on a monthly basis.

The Trust has developed a detailed clinical audit plan for 2016/17 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 279 local clinical audits (including patient surveys) were reviewed by the Trust in 2015/16 and the Trust intends to take the following actions to improve the quality of healthcare provided:

The following improvements to practice were made as a result of audit activity this year:

- Following the College of Emergency Medicine Audit of Paracetamol Overdose education of nursing staff has taken place to reduce unnecessary early blood tests and a poster giving guidance has been put up in Emergency Department.
- A new Emergency Department (ED) psychiatry proforma is being developed in conjunction with the Liaison Psychiatry Team following an Audit of Mental Health Care in ED.
- A proforma has been introduced by Maternity to highlight issues discussed with women prescribed anti-depressants/mood stabilisers in the antenatal period following an audit of Maternal Mental Health.
- The results of an audit of Peripheral Arterial Disease Assessment in Amputees were discussed across Wessex Amputee Services in the context of varying practices to develop an inclusive pathway whist demonstrating compliance with guidance.
- A recent audit of the Management of Pulmonary Embolism (PE) found that Wells Scores were being underutilised. As a result of this audit a presentation on the Wells Score is to be undertaken at Grand Round. Posters have been placed in the Admissions Unit showing the algorithm for PE diagnoses and a link placed on the intranet to aid the calculation of Wells Scores.
- Following an Audit of Obesity in Pregnancy and Birth, a Bariatric Clinic has been set up for pregnant women with raised Body Mass Index (BMI).
- As a result of auditing platelet requests for haematology patients over a one month period, a new patient request form is to be made available on the intranet with guidance for its use.
- Following an Audit of Trust Awareness of the Major Incident Plan, an e-learning package is being developed for Major Incidents as part of mandatory training.
- Following an Audit of Criteria for Referral to the Dietician for a Low Fodmap Diet gastroenterologists and GPs must confirm a normal colonoscopy or faecal calprotectin and exclude a diagnosis of coeliac disease.
- Appropriate forms are now included in midwifery admission packs following an Audit of Venous Thromboembolism (VTE) Assessment in Pregnancy.
- A new pathway is to be created with gastroenterology so that patients are referred straight to the dietician preventing the need for a gastroenterology appointment following a Re-audit of Patients with Newly Diagnosed Coeliac Disease.
- An audit of Use of Exercise Tests in the Rapid Access Chest Pain Clinic has led to a new pathway and referral form being introduced in to the clinic with improved access to functional imaging.

- Following a Survey of Patients in the Department of Sexual Health staff are developing a new information leaflet showing common drug side effects.
- An End Stage Parkinson's Disease Clinic is to be established following an audit of deaths in Patients with Parkinson's Disease.
- National Comparative Audit of Blood Management in Scheduled Surgery - Hospital Transfusion Committee to work with Commissioners to formalise integrated pathways for referral of patients found to be anaemic during surgical workup.
- Improving Understanding of Discharge Waits on the Stroke Unit - The data has been used to inform meetings with West Hampshire CCG and Lymington Hospital regarding use of their inpatient beds and numbers of patients who have been referred.
- Stable Patient Quality Indicator Monitoring and New Treatment Quality Indicator Monitoring Audit (HIV Patients) - to update paperwork and clarify pathways for secondary care services and introduce reminder system for partner notification
- RBH Inpatients Ward Assessment of Fluid Chart Completion - development of av specimen chart highlighting necessary parts of fluid chart that must be completed on commencement of chart and display on staff notice boards.
- Podiatry Patient Group Directive (PDG) Audit 2015 - Podiatrists now keep details of occasions where doctors have prescribed an alternative antibiotic to enable expanding of the number of future antibiotics available to issue via a PGD.

3. Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during that period to participate in research approved by a research ethics committee and NIHR portfolio adopted was 1305 (April 2015 - March 2016). This compares to the 2013/14 value of 1182 and 1658 in 2014/15.

Bournemouth is the second highest recruiting site to commercial trials in the Clinical Research Network: Wessex region, closely behind Southampton Hospital.

Research success stories in 2015/16

- Bournemouth was the first UK site to recruit patients to three cancer studies:
  - The Xilonix trial; preliminary evidence suggests that Xilonix treatment can improve the quality of life of patients with colorectal cancer, to the point that some patients have managed a return to a working life;
  - The AB12005 trial evaluating Mastinib, a type of drug which can block the malfunctioning of particular enzymes and can therefore help in treating certain diseases such as pancreatic cancer;
  - The Colet trial comparing the effects of cobimetinib, a drug that may prevent cancer cells from becoming resistant to a type of chemotherapy drug commonly given to patients with breast cancer.
- High recruitment to the Bournemouth-sponsored Lym1 study, collecting samples to investigate the mechanisms of disease progression in B-cell chronic lymphoproliferative disorders. This led to Wessex coming third out of the 15 Clinical Research Networks in England in recruitment to cancer trials.
- Top UK recruiter to the Master SL total hip replacement study.
- The first edition of the Clinical Researchinforming patients, public and staff about research at the hospitals

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

The Trust's income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because of the agreement reached with the Clinical Commissioning Group (CCG) to use the CQUIN payment to source a fund available non recurrently to protect the quality of care and safety of the service with a particular focus on areas that are giving rise to the CQUIN areas. The Trust agreed use of this fund directly with the CCG.

5. 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 Care Quality Commission has not taken enforcement action against the Trust during 2015/16.

The Trust has participated in special reviews or investigation by the CQC relating to the following areas during 2015/16:

The CQC inspected the Royal Bournemouth Hospital and Christchurch Hospital on the 20-22 and 26 October 2015 and 4 and 9 November 2015.

Following the Care Quality Commission's inspection of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, nearly 80 per cent of our services received individual ratings of "good" or better.

Overview of ratings

Our ratings for Christchurch Hospitals are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for The Royal Bournemouth Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Requires improvement	Good	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

The CQC inspection report (published on the 26/02/2016) highlighted five specific breaches in relation to fundamental standards:

Regulated Activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred Care. Regulation 9 (1) (3)(a)(b) How the regulation was not being met: • Patients in the emergency department did not always receive timely assessment, care and treatment to meet their needs.
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect. Regulation 10 (1) (2)(a) How the regulation was not being met: • Patients did not consistently receive care in a way that respected their privacy and dignity.

Regulated Activity	Regulation
Regulated activity Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment. Regulation 12 (1) (2)(a),(b),(c),(d),(e),(g) How the regulation was not being met: • Patients in the emergency department were not assessed and treated according to nationally agreed standards, particularly for sepsis and fractured neck of femur. • There was no up-to-date protocol on managing the removal of a collapsed woman from a birthing pool. All staff had not had training in the use of the equipment provided. • There was not a safe route for patients between main ward areas and the Derwent suite. • Medicines were not stored at safe temperatures and staff did not follow trust policy when disposing of controlled drugs. Staff did not collect medicine reconciliation data to demonstrate that patients received the correct medicines when admitted. Medicines were not always administered correctly. • Not all theatre areas were clean. Contaminated equipment was not always disposed of safely. Staff did not always adhere to best practice in infection prevention and control. • Transfer equipment in emergency department was not checked and ready for use. Internal audits showed that emergency trolleys were not consistently checked daily, equipment on some trolleys was missing and some equipment was not charged and ready to use.
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance. Regulation 17 (1), (2), (a), (b), (f) How the regulation was not being met: • There were not effective processes to identify, assess, monitor and improve the quality and safety of the maternity and gynaecology services. • Hospital escalation procedures were not always effectively implemented to minimise delays to ambulance patients • Departmental risk registers did not always reflect all the risks identified by staff.
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) How the regulation was not being met: • Staffing numbers were not consistently maintained at a safe level to meet the identified needs of patients.

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 the 31st March 2016 in taking such action.

Trust Actions

The Emergency Department (ED) is evaluating the feasibility of a revision to patient flow that will see a consistent patient flow 24 hours a day into the Rapid Assessment and Treatment area (RAT) that currently operates 10:00 - 22:00. This will facilitate consistent senior nursing and medical assessment, triage, prioritisation and pathway signposting on arrival, including commencing medical management where indicated, i.e. Sepsis. All staff are aware that they must conduct and record an initial assessment of all patients on arrival.

The Trust now has a policy in place for patients with fractured neck of femur. The Trust is working closely with our partners from South Western Ambulance, Poole Hospital NHS Foundation Trust and Dorset Clinical Commissioning Group (CCG) to establish a clear clinical pathway for patients with suspected or confirmed fractured neck of femur.

The Emergency Department has added Early Warning Score observations (NEWS) and Pain Score to the electronic whiteboard (Symphony) and is investigating the feasibility of electronic observation recording in the department.

A detailed review of the environment within Emergency Department and Older Persons Medicine is being undertaken to identify any factors which can be improved or adapted to support privacy and dignity for patients. The Trust is reviewing and refining the Dignity Policy and this will then be summarised and re launched into a new Dignity Pledge. Core Induction and Local Induction procedures will also be reviewed following update of Dignity Policy and Pledge. As part of their daily walk around Matrons reinforce the key messages around Privacy and Dignity and challenge poor practice. We now have a multi-faith dignity gown available to female patients of different faiths and cultures. Staff continue to use blue butterfly signs in clinical areas to indicate sensitive and confidential conversations are taking place.

Electronic Nurse Assessment (eNA) has been successfully rolled out to all inpatient areas and embedding of the new system is well underway. Patients core nursing risk assessments are now monitored and reported on routinely via the Clinical Compass. eNA enables Ward Sisters/Charge Nurses and Matrons to monitor the timely assessment of patients and ensure appropriate escalation takes place.

Datix web has been successfully rolled out trust wide and this has already led to an increase in reported near miss and no harm incidents. Datix web ensures that once an incident has been closed, the person who reported it will get an email giving feedback. The Trust has also produced a staff briefing sheet highlighting the methods of feedback available to them. Staff survey results will also be used to highlight specific areas that may require additional support or encouragement to report incidents. A Safety Conference is being arranged for Sept 2016 (on the back of a successful event in 2015) and will be used to showcase the learning from incident reporting and the Board support for an open culture.

The existing Birthing Pool policy was updated and ratified immediately post CQC inspection. The Trust had at the time of the visit an on line training video to support the evacuation of the pool and training records have been updated to ensure that all staff have watched the video. The policy and video is now part of the local induction to maternity to ensure all new starters are aware of the evacuation procedures. Additional resources have been secured from DOH funding for simulation and training equipment in maternity and a training lead (practice development midwife) commenced to support training in the department in January 2016.

Plans are in place to improve the corridor between the Derwent suite and the Main hospital building by adding electric doors with exterior sensors on both sides of the entrance to the corridor. These will have exterior sensors to reduce draughts within the route. The central area will be carpeted and the general décor will be improved. The number of deliveries using this route will be reduced by placing bollards outside the doors on the Jigsaw side of the entrance, and improving paving lakeside therefore encouraging deliveries to be made via the lakeside entrance. The site has been reviewed and there are no immediate risks to patients or staff whilst the décor is upgraded.

A detailed review of practice around medicine storage and medicines administration in the ward areas is being undertaken by Ward Sisters / Charge Nurses. Current practice is being appraised alongside Trust policies and procedures. The Medication Incident Review Group (MIRG) will review these outcomes and a report provided to the Medicines Governance Committee (MGC) to give assurance. Medicines management will be monitored through the Peer review programme, medication safety audits, MIRG and Medicine Governance Committee.

A global email has been sent to all clinical areas highlighting the basic standards for medicines storage. Also a monthly medication safety newsletter is produced and published by MIRG and posters have been created to support medicines safety message.

Currently, Monday to Friday, Pharmacists aim to review new admissions for Medicines Reconciliation as part of their ward duties. In the Acute Medical unit, a Pharmacist attends both post-take ward rounds during the week and will attend one per day at weekends. Medicine Reconciliation will be incorporated into the Medicines Optimisation strategy and will be discussed further at the Medicines Governance Committee in April 2016. A plan will be developed to ensure that all prescribers understand their responsibilities and have the skills and resources to take an accurate drug history and use it to treat the patient appropriately.

There are plans in the Emergency Department for all patients to be asked for consent for Summary Care Record (SCR) so that their record and drug history can be printed and added to their notes for prescribers to use. In the Emergency Department drugs previously stored on the transfer equipment have been relocated to the resuscitation room drug storage facilities.

Infection Prevention and Control is covered in Induction and Essential Core skills training for Trust staff. Monitoring occurs via monthly Infection Control Audit and the Peer review programme. Any non-compliance is reported as an adverse incident. The dust and cobweb found by the CQC was rectified immediately. Daily cleaning lists and spot checks are in place.

Equipment checklists are already in place and are included in ward daily safety briefings. This is monitored through the Peer review Programme. There is already a crash trolley audit taking place monthly across the Trust undertaken by the Clinical Audit department. A Transfer Equipment check will be included within this. In the Emergency Department the transfer equipment has been relocated into the resuscitation room and will be encompassed with current checking processes in place to ensure daily checking, which is audited monthly for assurance. Monitoring is reported at directorate governance and Healthcare Assurance Committee.

At the time of inspection Maternity had recognised there were improvements required for risk and governance and had completed a review of the systems in place. Since the inspection a full time Interim Risk/Audit lead midwife has been appointed and there is dedicated time for an obstetric lead consultant. Monthly risk meetings have been scheduled and all staff have the opportunity to attend. The meetings will review incidents, themes, quality reports, audit action plans and the Risk Register. There are 6 joint Obstetric/Maternity Governance meetings scheduled for the calendar year. There is a new appointment of Governance lead for Gynaecology and with the new structure in place the team are establishing regular Governance meetings specifically for Gynaecology.

An action plan is in place to improve the hospital escalation procedures in order to minimise delay to ambulance patients. There are also plans to develop an escalation plan that fully incorporates the Emergency Department and to institute the 4hour commander role.

The Trust Recruitment Meeting will continue to oversee the recruitment process for the Trust which includes all disciplines and is chaired by the Director of Human Resources. Matrons and Heads of Nursing and Quality will continue to examine the current processes of monitoring operationally each shift to ensure staffing levels and skill mix are appropriate and safe under this process and ensure escalation is reported in a timely manner. The Nursing Workforce Transformation Steering Group, chaired by the Director of Nursing is reviewing the skill mix, developing the future workforce plan and examining how best to use the financial envelope.

A full copy of the February 2016 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**

6. Data Quality

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust submitted records during 2015/16 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 99.2% for admitted patient care; 99.9% for outpatient care; and 97.8% for accident and emergency care. The percentage of records in the published data which included the valid General Medical Practice code was100.0% for admitted patient care: 100.0% for outpatient care; and 99.9% for accident and emergency care.

Collecting the correct NHS number and supplying correct information to the 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.

7. 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 2016.

The Trust's Information Governance Assessment Report overall score for 2015/16 was 67% (2014/2015 was recorded as 37%) and was graded as "Satisfactory With Improvement Plan".

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 (HSCIC) on 31st March each year. The purpose of the IG Toolkit is to provide assurance of an organisations information governance practices through the provision of evidence around 45 individual requirements.

The Trust's Information Governance Assessment Report overall score for 2015/16 was 67% (2014/5 was recorded as 37%) and was graded by the HSCIC as "Satisfactory With Improvement Plan".

During 2015/16, the Trust has continued with its comprehensive and holistic approach to the completion of its IG Toolkit submission, undertaking closer scrutiny of all of the requirements in order to give a higher quality of assurance. The significantly increased percentage score for 2015/16 is indicative of an extensive amount of work that has been undertaken within the year to document and provide assurance in relation to the Trust's Information Governance compliance, in the manner required by the IG Toolkit.

As at 31st March 2016, the Trust remains non-compliant to 7 of the 45 requirements. However action plans with completion dates are in place for all of these requirements and these have been approved by the HSCIC as adequate leading to their aforementioned grading.

In 2016/17, work will continue to establish and firmly embed the principles of information risk management and IG throughout the organisation; it is widely recognised that good information governance can be built around the tenets of the IG Toolkit. The Trust will work to maintain the traction that it has gathered on this IG Toolkit during the year in order to firmly imbed the concepts as "business as usual", and enable the submission of a compliant IG Toolkit for 2016/17.

There has been a sharp increase in reported breaches of Information Governance during 2015/16. During 2014/15, 54 breaches and no Serious Incidents Requiring Investigation (SIRIs) were reported, whereas 2015/16 has seen 81 breaches and no SIRIs reported. Whilst seemingly a negative point, this is not necessarily indicative of an increase in incidents within the Trust is expected to be as a result of increased levels of incident reporting following the in-year introduction of DatixWeb electronic incident reporting and greater awareness of IG issues due to the significant increase in training uptake (from 57% at April 2015 to 91% at March 2016). Work will continue during 2016/17 to ensure improvement and learning from any incidents raised.

8. 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 Primary Diagnosis 88.5%, Secondary Diagnosis 87.3%, Primary Procedure 93.7% and Secondary Procedure 85.7%. (*These figures relate to the period April 2015-February 2016)

The results should not be extrapolated further than the actual sample audited; the services that were reviewed within the sample were as follows: A&E, General Medicine, General Surgery, Ophthalmology and Urology

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 2016/17:

- Deliver internal training on the coding of scans reiterating sequencing of therapeutic and diagnostic
- Identify a list of documents that must always be reviewed as a minimum standard
- Carry out regular urology audits
- Review the use of Z95.8 to Z95.5 codes for coronary stents
- Review all partial coding once full clinical record is scanned and available

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 2014 - September 2015 1.020 October 13-September 14 1.009	1.00 1.00	1.177 1.198	0.652 0.597
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 HSCIS. The data has been extracted from available Department of Health information sources. The SHMI data is 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 2014 - September 2015 49.0% October 13-September 14 44.0%	26.6% 24.2%	53.5% 49.4%	0.2% 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. Publication of data is found here **https://indicators.ic.nhs.uk/webview/**. Figures reported are 'diagnosis rate' figures and the published value for England (ENG) 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
Patient Reported Outcome measures (PROMS) - Case mix adjusted average health gains i) groin hernia ii) varicose vein iii) hip replacement iv) knee replacement	April14-Mar15 (provisional, published Feb 2016) April14-Sep14 (published Feb 2015)	(i) 0.084 (ii) NA (iii) 0.447 (iv) 0.319 (i) Not yet available (ii) NA (iii) 0.413 (iv) 0.286	(i) 0.084 (ii) 0.095 (iii) 0.437 (iv) 0.315 (i) 0.125 (ii)1.000 (iii) 0.442 (iv) 0.328	(i) 0.154 (ii) 0.154 (iii) 0.524 (iv) 0.418 (i) 0.139 (ii) 0.142 (iii) 0.501 (iv) 0.394	(i) 0.000 (ii) -0.002 (iii) 0.331 (iv) 0.204 (i) 0.009 (ii) 0.054 (iii) 0.350 (iv) 0.249
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 & 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 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period (i) aged 0 to 15 (ii) aged 16 or over	HSCIC	2015/16 (i) = 0 (ii) = 3973 (10.9%) 2014/15 (i) = 0 (ii) = 3670 (10.4%)	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	2015 - not yet available 2014 - 54% 2013 - 77%	not yet available 47% 76.9%	not yet available N/A 87%	not yet available 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 Healthcare Assurance Committee, which is a subcommittee 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 Staff Survey	2015 - 75.49% 2014 - 70.79% 2013 - 71.37%	69.17%% 67.45% 67.11%	88.98% 89.27% 93.92%	45.73% 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/Caches/Files/NHS%20Staff%20Survey%202015%20organisation_sheet8_mean-1.xls**.					
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 subcommittee 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) Feb 2016 Jan 2016 Dec 2015 (ii) Feb 2016 Jan 2016 Dec 2015	 98% 98% 99% 93% 94% 91%	 95% 95% 95% 85% 86% 87%	 100% 100% 100% 100% 100% 100%	 74% 73% 73% 46% 52% 58%
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/ourwork/pe/fft/friends-and-family-test-data/**					

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	2015/16 = 96.13% 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	2015/16 12.89/100,000 bed days (26 confirmed cases) 2014/15 10.44/100,000 bed days (21confirmed) 2013/14 6.92/100,000 bed days (14 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	NRLS	3832 (April 15-Sept15) 3573 (1 Oct 14-March 15)	Not available	12080	1559
Rate of patient safety incidents reported during the reporting period	NRLS	38.89 per 1000 bed days (April 15-Sept 15) 34.82 per 1000 bed days (Oct 14-Mar 15)	38.25 per 1000 bed days 35.34 per 1000 bed days	74.67	18.07
Number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	16 (April15 - Sept 15) v16 (Oct 14 - Mar 16)	Not available	89	1
% of total number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	0.4% (April15 - Sept 15) 0.4% (Oct14-Mar 16)	0.4% 0.5%	2.9%	0.1%
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 issues 19/04/2016.					
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 embedded a new web based incident reporting system in 2015/16 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 was 0.4%..					

Part 3
Review of quality performance in 2015/16

The Trust has a Quality Strategy split into three distinct sections- Patient Safety, Clinical Effectiveness and Patient Experience. This is reviewed and refreshed annually.

The Quality Strategy sets out the strategic quality goals of the Trust in relation to clinical priorities set against the previous year's risk profiles, patient outcomes and new clinically based evidence or published guidance. Each of the three sections has distinct quality patient focussed goals to achieve to deliver the strategic aim, and sets out how this will be monitored and the governance framework within which it will be monitored against. This is developed with key internal and external stakeholders and is approved and monitored by the Healthcare Assurance Committee (HAC) as subcommittee of the Board of Directors. The HAC scrutinises the plans and approves them, monitoring monthly the quality performance, together with the risk profiles and the Trust Assurance Framework. Quality profiles included in this are Pressure Damage, Falls, medications management, Friends and Family Test (FFT), developing patient and public engagement and complaints management, sustaining duty of candour, clinical audit plan compliance and further development of the risk assurance and Trust Assurance process

The following section provides an overview of the performance in 2015/16 against some of the quality indicators selected by the Board of Directors for the year. 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 2014/15 Quality Report and have also been selected on the basis of data collection, accuracy and clarity.

Safety

Reducing adverse events

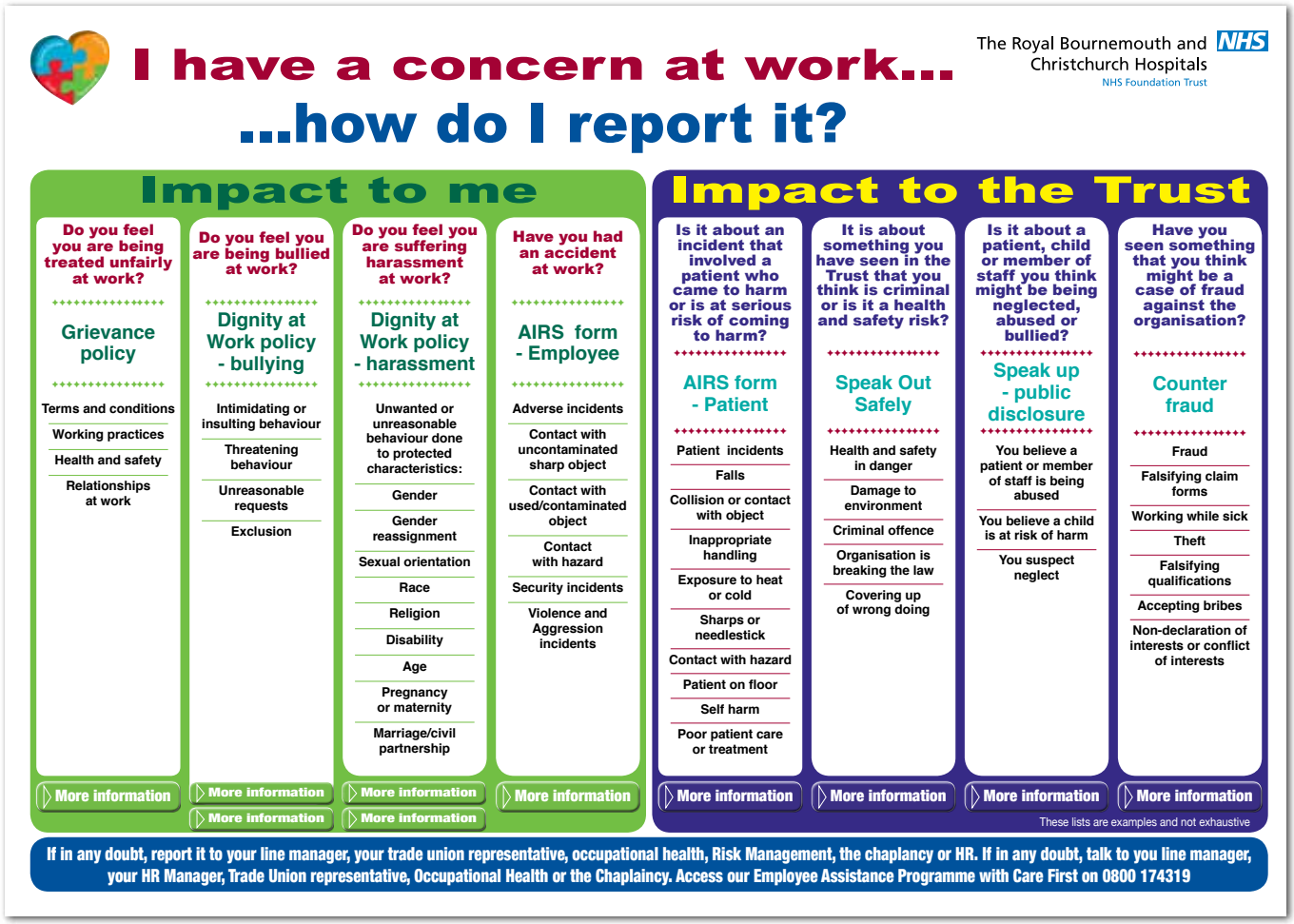
We support an open culture for reporting and learning from adverse events and near miss patient safety incidents. We promote an open reporting culture through the Adverse Incident Policy and standard Adverse Incident Report (AIR) Form.

The Trust fully supports the Secretary of State's "Freedom to Speak Up" review (published February 2015) which emphasises the importance of listening to staff. When staff raise concerns, it's because they usually know where things are not working well and when care is not as safe as it could be.

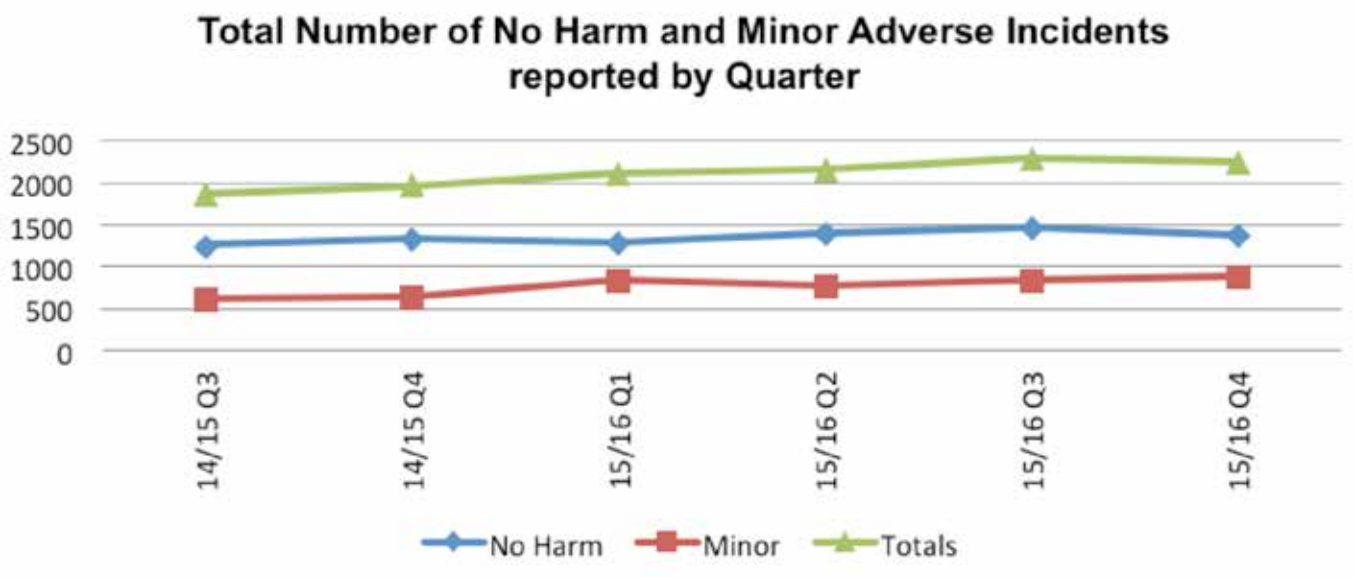
Staff are encouraged to make suggestions or give feedback in a various of ways including:

- speaking to their line manager, matron, staff governor or change champion
- talking to a Human Resources representative
- requesting a 'Tony on Tour' or Executive Patient safety walkround for their department
- using the Core Brief feedback form
- raising concerns to a staff side representative
- attending an open event, workshop or breakfast briefing
- seeking support from Occupational Health and/or the confidential employee assistance service
- via the value based appraisal process
- using the #Thank You section of the intranet
- filling out the staff impressions surveys and the Employee Friends and Family test
- using the improvement ideas suggestion scheme

During 2015/16, we have refreshed the Trust Whistleblowing policy, made this available on our internal intranet site and published a newsletter and poster highlighting the ways in which staff can raise a concern. We have also implemented a detailed freedom to speak up action plan.



The Trust also supports the "Speak out Safely" campaign and as part of our Sign up to Safety plan we have implemented a new online reporting system (Datix web) to make it easier for staff to report adverse events and near misses. Implementation of the new system has led to a 12.5% increase in near miss/no harm reporting between April 2015 and April 2016.



Staff have also been encouraged to engage in feedback from incident reporting for example via daily safety briefings, investigation panels, team meetings, appraisal, peer reviews and directorate and department governance meetings.

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.

Patient safety incidents reported via the national reporting and learning system (NRLS) - April 2015 to March 2016

	Total number reported 2014-2015	% of incidents reported 2014-2015	Total number reported 2015-2016	% of incidents reported 2015-2016
No Harm	4982	69.08%	4931	62.53%
Minor	2063	28.61%	2798	35.48%
Moderate	141	1.96%	120	1.52%
Major	26	0.36%	37	0.47%
Total	**7212**		**7886**	

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 2013/14, 2014/15 and 2015/16 are much lower at 0.60%, 0.36% and 0.47% respectively.

Learning from serious incidents

In 2013/14 the Trust 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. In 2015/16 the number of serious incidents reported was 32 - a further reduction of 30%.

Category of Serious Incident Reported	2013/14	2014/15	2015/16
Patient fall	14	15	15
Hospital Acquired pressure ulcer	30	20	6
Clinical Incident	14	11	11
Other	8	0	0
Total	**66**	**46**	**32**

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 Three Never Events.

Two of these incidents related to surgical procedures and a third involved administration of the wrong dose of insulin due to the use of an incorrect syringe.

In all cases detailed investigations were undertaken and a full action plan implemented to address learning points identified.

To further improve incident reporting and support an open culture for sharing learning, the Trust held its first Safety and Quality Conference in September 2015. One of the principal aims of this week-long event was to share key points of learning widely across all staff groups, so that in the future our patient care is as safe as possible.

The main conference was attended by over 350 members of staff from across the Trust and was a great opportunity to hear very frank and honest talks from a range of clinicians on what happened when things went wrong and what we have learnt from these events.

During the week, over 100 staff attended an additional "Open Space" area which was an opportunity for them to say what more we could all be doing to help improve quality and safety at RBCH, with a range of interactive displays.

Medical Director Basil Fozard said: *"We set ourselves a target to be the most improved hospital by 2017 and that links into safety and quality. Anything we can do to reduce avoidable harm, to reduce mortality, increase safety and to better patient outcomes is vital and I would want that to be the legacy of this conference. We will need to keep up our efforts, and we will need to repeat this conference next year."*

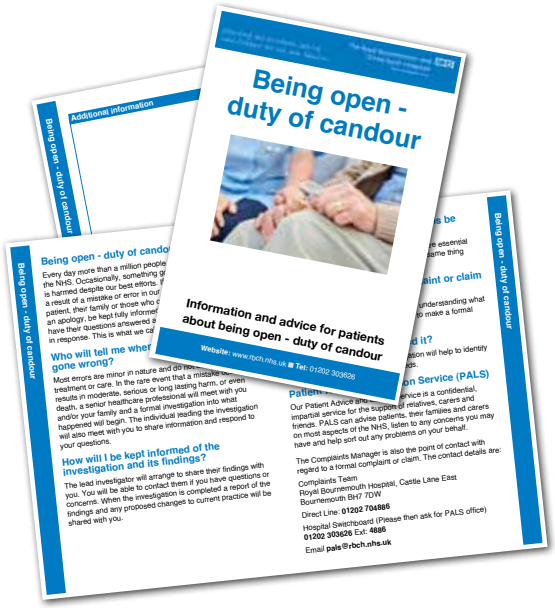
Duty of Candour

The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death.

Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.

As part of our overarching Sign up the Safety plan, the Trust has also implemented revised procedures for the investigation of adverse events to ensure that liaison with patients, families and carers is an integral part of our being open policy.

A patient information leaflet has been produced and new guidance provided for managers and clinicians on how to meet the new statutory duty of candour.



We were pleased that the recent CQC inspection report noted evidence of implementation across the Trust:

"Senior clinical staff were aware of the Duty of Candour regulation and the importance of being open and transparent with patients and families"

"All staff that we spoke with understood the principles of openness and transparency that are encompassed by the Duty of Candour. Senior staff demonstrated detailed knowledge of the practical application of this new responsibility"

"Staff on wards and in theatres understood the principles of Duty of Candour. Incident monitoring reports showed staff were prompted to consider whether incidents required the application of Duty of Candour. Both junior and senior nursing staff provided examples of when the Duty of Candour had been applied".

Staff Survey

The National Staff Survey was undertaken on behalf of the Trust by the Picker Institute, with survey letters being sent directly to all staff via a mixed mode, i.e. staff with an active email address received the survey by email, others by the internal postal system. All staff employed at the Trust on 1st September 2015 were sent a survey questionnaire. This year the Picker Institute were commissioned by a total of 64 Acute Trusts.

Staff completing the survey questionnaire returned it to the Picker Institute. Non-responders were sent a reminder after three and six weeks. Information regarding the survey was distributed in the weekly communications email, on posters around the Trust and at a Health and Wellbeing event.

This year 37.2% of staff returned their survey questionnaire, a total of 1598 staff. In 2014 the response rate was higher at 48.1%, although as only a sample of 850 staff were surveyed, the number of responses was much lower at 409.

The staff survey questionnaire content is agreed nationally. The Trust used the core questions for Acute Trusts. The questionnaire included questions grouped in the following topics:

- Personal Development
- Job
- Management
- The Organisation
- Health, Wellbeing and Safety at work
- Background information

Full details of the staff survey results are included in the Trust Annual Report 2015/2016. The specific results for some of the principle health and wellbeing questions were as follows:

Standard: To provide support and opportunities for staff to maintain their health, well being and safety		
Health and well-being	**Comparison to 2014 survey results**	**Comparison to national average - 2015 results**
% suffering work related stress in last 12 months	N/A	Below (better than national average)
18 % feeling pressure in last 3 months to attend work when feeling unwell	Better than 2014 results	Lowest (best) 20% of Trusts
Organisation and management interest in and action on health/well being	N/A	Above (better than national average)
% reporting most experience of violence	No change from 2014 results	Average
% experiencing harassment, bullying or abuse from patients, relatives of the public in last 12 months	N/A	Below (better than national average)
% experiencing harassment, bullying or abuse from staff in last 12 months	No change from 2014 results	Average
% reporting most recent experience of harassment bullying or abuse	Decrease (worse) than 2014 results	Lowest (worst 20% of Trusts)

Although the overall incidents of staff reporting bullying and harassment have reduced from 2014, however less staff are reporting their concerns. Work is underway to support staff feel confident in reporting any concerns or incidents and communicate the different ways more widely in the organisation.

Overall, the Trust has shown significant improvement since 2014 on 20 questions across a broad spectrum of topics, including satisfaction with job, recognition, communication, and health and well-being. The Trust compares favourably against other Acute Trusts in England in 5 key areas:

- effective use of patient/service user feedback
- effective team working
- % of staff feeling under pressure in the last 3 months to attend work when feeling unwell
- Staff satisfaction with level of responsibility and involvement
- % of staff being able to contribute to improvement at work

A Trust action plan will be drafted and agreed by Trust Board in May 2016. Care Group/ Directorate action plans will be developed and reported at half-yearly reviews and to the Workforce Committee. The full report and a summary of results has been made available to all staff on the intranet, via weekly communications and via department briefings and open presentations. The results will also be used to support Trust objectives and measures for 2016/17.

Effectiveness

Reducing Mortality

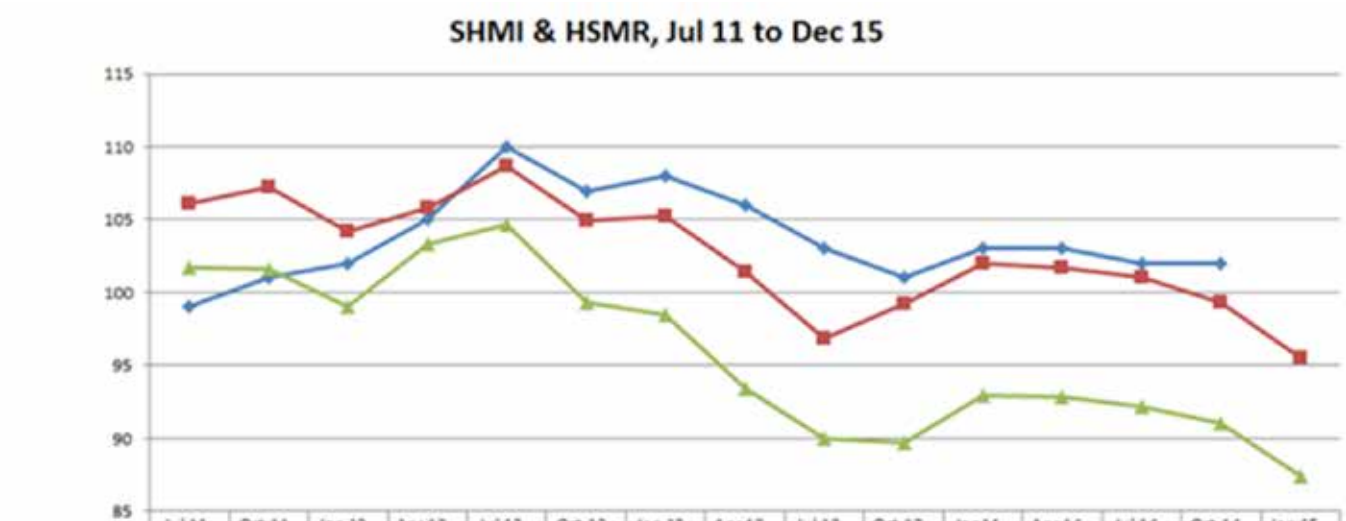
The Trust's mortality rate, as expressed in both HSMR and SHMI, continues to lie within the "as expected" category.

The Dr Foster mortality metric, known as Hospital Standardised Mortality Ratio (HSMR) has become a recognised way of assessing hospital mortality. An HSMR value of 100 represents an average "expected" value and therefore a score below 100 demonstrates a better than average position. The NHS, via the Health and Social Care Information Centre has also developed a slightly different metric Summary Hospital Mortality Indicator (SHMI) which additionally includes patients that have died within 30 days of being discharged from hospital. SHMI is also calculated slightly differently.

The graph below shows the latest SHMI and HSMR figures, the latter both for the whole Trust and for the RBH site alone (which therefore excludes palliative care). The figures lie within the "as expected" categories.

Mortality outlier alerts may be triggered by Dr Foster analysis and/or 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 (Hospital Standardised Mortality Ratio) and Dr Foster Intelligence Unit mortality risk reports on a monthly basis. The group also reviews death certification and electronic Immediate Discharge Forms (e-IDF) to ensure accuracy of coding. The group discusses areas of potential concerns regarding clinical care or coding issues and identifies further work, including detailed case note review and presentations from relevant specialties. All deaths receive a consultant review against a specific questionnaire. Reviews are discussed at specialty Mortality and Morbidity meetings and the chairs of these meetings attend the Trust Mortality Group. This 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.



	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	Oct 13 - Sep 14	Jan14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15
SHMI - All	99	101	102	105	110	107	108	106	103	101	103	103	102	102	
HSMR - All	106.14	107.21	104.18	105.83	108.63	104.97	105.24	101.38	96.87	99.26	102.04	101.73	101.05	99.35	95.53
HSMR - RBH	101.69	101.64	99.08	103.3	104.63	99.3	98.49	93.46	89.99	89.66	92.89	92.85	92.2	90.99	87.42

We have recently reviewed the new guidance from the Department of Health / NHS England (issued February 2016) regarding the process for review of patients' deaths. We have compared the guidance with our existing arrangements and highlighted where there are processes that we amend. Actions for 2016/17 include:

- Providing a monthly report to the public part of the Board of Directors meeting on the outcomes of consultant led mortality reviews and any identified avoidable deaths.
- Ensuring that Junior medical staff discuss death certification of individual patients with the relevant consultant(s)
- Amending the Terms of Reference and membership of the current Mortality Committee to create a new Mortality Surveillance Group (MSG). Invitations will be extended to include Clinical Commissioning Group (CCG) and Governor representatives.
- Making amendments to the current eMortality Form to ensure that the case note reviews consider additional mandatory requirements such as venous thromboembolism and nutrition issues; whether the death was expected at the time of admission and the adoption of the new national mortality classification bandings for unavoidable and avoidable death.
- Undertake an annual notes review of high risk patient groups including pneumonia, congestive heart failure, sepsis, stroke and acute kidney injury. This will entail a detailed notes review and a walk-through of the patients pathways.

Improving care for Stroke patients

The Royal Bournemouth and Christchurch Hospitals 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 (clot-busting treatment) service and initiatives such as our direct door to CT pathway.

In April 2015, we were delighted to implement our new Stroke Outreach service enabling patients with suspected stroke to be seen by Stroke Specialist Practitioners in the Emergency Department immediately on their arrival to hospital. This has enabled us to very effectively streamline the stroke 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 receives a pre-alert from the ambulance crew for all suspected stroke patients eligible for thrombolysis (pre-alert soon to be extended to 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, commence early treatment, such as thrombolysis, and facilitate early transfer to the stroke unit. This new service is available 7-days a week from 7am to midnight and the staff work collaboratively with colleagues in the Emergency Department, Radiography Department, Clinical Site Team and the Stroke Unit multi-disciplinary team. We have also successfully introduced a new innovative protocol enabling all our Stroke Outreach Practitioners and the senior nurses on the Stroke Unit to request CT brain scans for Acute Stroke.

The Trust admits approximately 750 new stroke patients per annum, making it one of the busiest stroke services in the Wessex region. As well as our in-patient hyper-acute, acute and rehabilitation provision, we have a stroke early supported discharge (ESD) team which supports stroke patients with their discharge from hospital. They provide stroke specialist multi-disciplinary rehabilitation in the patient's home setting enabling earlier discharges from hospital. We also provide a seven day rapid access Transient ischemic attack (TIA) service seeing approximately 1000 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 multi-disciplinary stroke follow-up clinics and have a busy and proactive stroke research team undertaking a wide range of stroke research studies.

The quality of stroke services is monitored nationally via the Sentinel Stroke National Audit Programme (SSNAP). SSNAP is a mandatory national stroke audit which collects and analyses near real-time data and measures the quality of care stroke patients receive throughout the whole stroke care pathway. Each stroke service is provided with a quarterly report which includes performance scores for 10 domains of stroke care; case ascertainment; and audit compliance; and a subsequent overall SSNAP Level rating. SSNAP Level A being the highest rating and SSNAP Level E the lowest.

Over the past year we have seen our performance improve from a SSNAP Level D for Q3 of 14/15 to a sustained SSNAP Level B throughout 15/16. The table below provides a summary of our most recent reported SSNAP performance.

Quarter	Jan-March 2015	Apr-June 2015	July-Sept 2015	Oct-Dec 2015	National Average
1. Scanning	C	C	B	C	B
2. Stroke unit	C	C	C	C	C
3. Thrombolysis	C	C	C	C	C
4. Specialist Assessments	D	D	C	C	C
5. Occupational therapy	A	A	A	A	B
6. Physiotherapy	A	B	B	B	B
7. Speech and Language therapy	A	B	B	A	D
8. MDT working	B	B	B	B	C
9. Standards by discharge	B	B	B	A	B
10. Discharge processes	A	A	A	A	B

To put our results in context, for the last SSNAP report we achieved a score of 80 which is a SSNAP Level B, a score of 80.1 or more achieves a SSNAP Level A. Nationally for Q3, only 12% of Trusts achieved a SSNAP Level A which is 26 Trusts and only 29 achieved a score of 80 or more, placing us in the top 13.5% nationally. We are very focused and confident that we will achieve a SSNAP Level A in 16/17.

Claire Stalley, Stroke Services Manager, said: *"This is absolutely fantastic news and reflects the masses of hard work that everyone has put in to improving the service for our patients and their families. This has been a joint effort which has involved several departments, including colleagues in Emergency Department, radiology and Clinical Site Team."*

In 2015/16 we have seen a steady and sustained improvement with the proportion of patients having a CT Brain scan within 12 hours of arrival at hospital. These improvements are a result of our new Stroke Outreach team and new Acute CT request for stroke protocol.

Proportion of patients scanned within 12 hours	Q1	Q2	Q3	Q4
2014/2015	**76.6%** (N.A.87.1%)	**81.3%** (N.A.87.7%)	**82.8%** (N.A 88.7%)	**83.6%** (N.A.89.9%)
2015/2016	**88.2%** (N.A. 90.1%)	**91.9%** (N.A. 91%)	**87.8%** (N.A. 91.8%)	**89.7%*** (N.A. - not yet available)

N.A. is national average and * for Q4 is incomplete data-set

All people with suspected stroke should be admitted directly to a specialist acute stroke unit. Throughout 2015/16 we have again maintained our performance and continue to perform above national average for the proportion of patients directly admitted to a stroke unit within 4 hours of arrival at hospital (or of stroke if patient has stroke whilst an in-patient). We have a number of quality improvement initiatives that the team are working on to further improve our ability to directly admit patients and ensure they remain on the stroke unit until discharge. These initiatives include implementing ambulatory care for stroke, review of multi-disciplinary working together on the stroke unit and implementing a complex nutrition pathway for stroke.

Proportion of patients directly admitted to a Stroke Unit within 4 hours	Q1	Q2	Q3	Q4
2014/2015	**64.5%** (N.A.58%)	**68.3%** (N.A.59.8%)	**60%** (N.A.56.9%)	**68.2%** (N.A.53.6%)
2015/2016	**65.7%** (N.A. 58.7%)	**75.9%** (N.A. 61.8%)	**68.6%** (N.A. 59.8%)	**71.4%*** (N.A. - not yet available)

N.A. is national average and * for Q4 is incomplete data-set

Patient feedback:
"I was taken from the ambulance to the Stroke Unit. On arrival I was immediately taken to a scanner. The attention I received was excellent as were the Doctors and Nurses and could not be faulted. I would like to say thank you to all concerned"

"The admission was expedient and I was kept informed and offered choices over my treatment."

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 ESD service supported 180 patients (data complete as of end of Feb discharges) in 2015/16; this is significantly higher than national average.

Proportion of patients supported by Stroke ESD on their discharge from hospital	Q1	Q2	Q3	Q4
2014/2015	**46.7%** (N.A.25.7%)	**48.6%** (N.A.26.9%)	**45.8%** (N.A.29.3%)	**48.1%** (N.A. 31%)
2015/2016	**49.6%** (N.A. 31.7%)	**41.1%** (N.A. 31.8%)	**46.5%** (N.A. 33.7%)	**33.8%*** (N.A. - not yet 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 2015 to March 2016 the CAEG reviewed a total of 175 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	5	3	0	1	0	2
National Guidelines	39	30	5	5	0	20
Technology Appraisals	49	35	18	3	0	14
Interventional Procedures	34	7	1	0	0	6
Public Health Guidance	1	1	0	0	0	1
Medical Technology Guidance	4	2	1	0	0	1
Safe Staffing Guidance	0	0	0	0	0	0
Quality Standards	36	31	11	3	0	17
Diagnostics Guidance	6	5	4	0	0	1
Highly Specialised Technology Guidance	1	0	0	0	0	0
Total	**175**	**114**	**40**	**12**	**0**	**62***

*The majority of guidelines noted in the above table as “under review” relate to those issued during February and March 2016.

Where non or partial compliance has been identified this is reported to the Trust Clinical Audit and Effectiveness Group and an appropriate action plan agreed.*

Other Clinical Effectiveness news:

- A diabetes patient receiving treatment at RBH has become one of the first in Europe to use a new state-of-the-art insulin pump system. Steve Ingham, 74, said his life has “completely changed” thanks to the Medtronic 640G insulin pump. The device uses sensors to warn him of impending low blood sugar levels and can make the decision to switch off his insulin supply when it detects his blood sugar level is falling too fast, which could save his life.

Emma Jenkins, Diabetes Specialist Dietician and insulin pump trainer at RBH, says: *“It is great that we can offer patients this technology, which not only reduces their risk of ill health but the burden and fear of their condition. Our team has been nationally recognised for the development and innovation of insulin pump therapy for more than 15 years. We aspire to continue to develop our services and work to a high quality standard.”*

- Our Immunology Department has become one of the first in the country to introduce an automated test that can indicate an inflammatory bowel disease such as Crohn's, ulcerative colitis and irritable bowel syndrome (IBS). Faecal calprotectin is a protein that is released into the intestines where there is inflammation. This indicates the movement of neutrophils (white blood cells) highlighting any issues accurately. The test means patients with conditions like IBS will be diagnosed without the need for an endoscopy, and will only have to provide a stool sample. Alexandra Grainey, Cellular Pathology and Immunology Laboratory Manager, says: *"This test has so many benefits. It has a high sensitivity which means we can diagnose patient early and accurately, we can reduce their anxiety because they aren't on a waiting list for invasive investigation."*

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, and Governor audits in Outpatients
- 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

Friends and Family Test (FFT)

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. 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 national directive to implement the Friends and Family Test question has been cascaded throughout the Trust via the use of the patient experience card (PEC).

The results are reviewed through the Healthcare Assurance Committee (HAC) and action taken 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 was extended in 2014/15 to include 40 Out Patient and Day Case areas in addition to inpatient areas.

When compared with the previous year there has been a decrease in the % responses recording unlikely or extremely unlikely to recommend.

FFT April 13 - March 14 (all areas)		FFT April 14 - March 15 (all areas)		**FFT April 15 - March 16 (all areas)**	
Extremely likely responses	16626	Extremely likely responses	25711	**Extremely likely responses**	**34089**
Likely	3466	Likely	5013	**Likely**	**6289**
Neither likely/nor unlikely	437	Neither likely/nor unlikely	569	**Neither likely/nor unlikely**	**569**
Unlikely	208	Unlikely	246	**Unlikely**	**232**
Extremely unlikely	287	Extremely unlikely	380	**Extremely unlikely**	**391**
Total	**21024**	**Total**	**31919**	**Total**	**41570**

FFT April 13 - March 14 (all areas)		FFT April 14 - March 15 (all areas)		**FFT April 15 - March 16 (all areas)**	
Extremely likely responses	79.1%	Extremely likely responses	80.6%	**Extremely likely responses**	**82.0%**
Likely	16.5%	Likely	15.7%	**Likely**	**15.1%**
Neither likely/nor unlikely	2.0%	Neither likely/nor unlikely	1.8%	**Neither likely/nor unlikely**	**1.4%**
Unlikely	1.0%	Unlikely	0.8%	**Unlikely**	**0.6%**
Extremely unlikely	1.4%	Extremely unlikely	1.1%	**Extremely unlikely**	**0.9%**

Year to date a total of 43,327 Patient Experience cards were completed with over 41,000 responses, this is a significant (42%) increase in year. The increase is likely to be due to the implementation of FFT in Out-patients and Day cases based on last year's responses.

Not all respondents to the cards complete all the FFT options. For 2015/16 a total of 22,932 comments were left on the cards by respondents with 96.7% recommending the hospital.

A separate FFT card has been developed to capture the views of younger patients. In 2015/16 the FFT was completed by 445 patients (an increase of 83% on 2014/15) with a 97.3% satisfaction rate.

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 with support from the Clinical Audit Department.

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

One of the main patient feedback 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 5 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 nutrition.

In year a more concise audit has been developed for wider implementation across the Trust. This has meant that outcome results requiring specific focus and action can be highlighted and the more in depth results used to support improvement. The audit questions have been reviewed and refined to respond to common themes across the Trust that have been identified from other patient experience mechanisms.

The table below indicates some of the Care Campaign Audit questions and scores for annual comparison.

Focus Groups and Events

Patient focus groups are run throughout the year.

This year nine events have taken place, including in Physiotherapy, Rheumatology, Occupational Therapy, Endoscopy, Volunteers and Day Hospital.

The focus groups are an excellent way of using the views and recommendations of patients in the development of new or existing services. All focus group results are reported to the sponsoring department with recommendations for improvement.

In addition to focus groups, other patient engagement events have included an annual stakeholder meeting, carers' events, Learning disability forum meetings and a young persons' forum. Other meetings have included:

- Partnership working with the Muslim Sisters' Focus group has resulted in new interfaith gowns being procured and made available to all patients on request. These have been well received by patients and the media.

Care Campaign Question	March 2015 Score	March 2016 Score
Section 1 Communicate with care and compassion (total of all questions) e.g.	90%	91% ↑
Did staff ask you what name you preferred to be known by/called	92%	93% ↑
Do staff use your preferred name when they speak to you	95%	98% ↑
Section 2 Assistance and ensuring dignity (total of all questions)	94%	95% ↑
Section 3 Relieve pain effectively (total of all questions) e.g.	84%	87% ↑
Do staff use other methods to relieve your pain?	83%	79% ↓
Section 4 Ensuing adequate nutrition (total of all questions)	94%	93% ↓
Are the meals provided enough for you?	87%	95% ↑
If you are unable to eat a full meal were you offered regular snacks and drinks?	89%	90% ↑
Are you supported to eat your meals without interruption?	93%	94% ↑
Section 5 - Managing expectations (total of all questions)	91%	94% ↑

- Initial contact has been made with a group who represent Gypsy and Travellers with discussion on joint development of an educational package for staff on any specific needs they may have when in healthcare.
- Lesbian Gay Bisexual and Transgender community focus meetings have taken place resulting in the trust supporting an awareness day. In addition, a vox pop is currently in progress for staff education.
- A Young persons' stakeholder event was held in March 2016 and was co-designed, chaired and facilitated by students from local schools and colleges. The event attracted in excess of 35 attendees and included attendees discussing their feedback on the experience for young patients and how to enhance young persons' volunteering opportunities. The event was in line with the National Association of Voluntary Services Managers (NAVSM) work with Youth Matters - a programme funded by HNS England to explore opportunities for young people to support with volunteering. The Trust was asked to present our successful work at a recent national event.
- A Learning Disability Stakeholder event was held on the 26 February 2016. Representation included Bournemouth People First, Community Support staff, patient representatives and Clinical Commissioning Group leads.

Other Patient Experience news:

- **Linking with Bournemouth University (BU) third year students to make 'twiddle mitts' for patients living with dementia at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH)**.

  'Twiddle mitts' are knitted mittens or hand warmers with beads, buttons and objects sewn on to them. The mitts are becoming popular gifts for those living with dementia, as having something to 'twiddle' helps to calm agitation and restlessness which are common symptoms of the condition. The BU team, which includes adult nurses, midwives, a mental health nurse and an occupational therapist, are working on the 'twiddle mitts' as part of a study project challenging students to make an improvement to a local health service.

  Rachael Davies, RBCH dementia nurse specialist, said: *"At our Trust we see many patients a year who are already living with dementia, but will come in for acute physical health problems. We aim to make their stay as comfortable as possible, especially as an unfamiliar hospital environment can worsen symptoms of anxiety.*

  "We were really excited to hear from BU student group, as it's been shown the twiddle mitts can really reduce stress levels for patients with cognitive difficulties. It's also a fantastic way to support learning, work inter-professionally and pool resources for the benefit of our patients."

  To avoid any risk of infection, each patient receives their own twiddle mitt and can take it home with them after they leave hospital. This means the twiddle mitts are in constant demand, so both BU and RBCH are encouraging natty knitters to pick up their needles to support the cause.

  Although the single use policy is partly owing to infection control policies, it also means our patients get to take twiddle mitts home and receive the benefits from them long after leaving our care. We urge people to get knitting and help us to make this project a sustainable success.

  To get a pattern, please email **communications@rbch.nhs.uk** or visit the RBCH Facebook page at: **www.facebook.com/The-Royal-Bournemouth-and-Christchurch-Hospitals-223693914444115/?ref=hl**.

- **Raising awareness about British Sign Language (BSL) interpreter service.**

  While the Trust has offered the free service for several years, research by staff working in the Trust's Patient Advice and Liaison Service (PALS) identified that it wasn't being used to its full potential. The team subsequently campaigned to raise awareness about how important it is for staff to offer, and for patients to take advantage of, the Trust's BSL Interpreter Service. A set of new resources for staff education were developed, as well as a poster encouraging staff and patients to use the service for all appointments with deaf patients.

  Carolyn Polden, PALS manager, said: *"At our Trust, patient safety is our highest priority, so minimising any potential problems in communication between staff and patients is crucial. "Our patients' comfort and equal access to services is also paramount, so we have been working closely with our team of British Sign Language interpreters to produce comprehensive resources for staff about communicating effectively with deaf patients, as well as producing a new poster to encourage patients to make use of the free service."*

  The Trust only works with fully qualified and registered interpreters who carry a yellow identification badge with their unique registration number and recommends patients to book an interpreter through PALS for any appointments, even if they have access to support from an unqualified interpreter by way of a family member or friend. This ensures all medical terminology is fully explained and accessible.

  To find out more about booking a BSL interpreter for your appointment at RBCH, please call PALS on **01202 704886**, email **pals@rbch.nhs.uk or visit www.rbch.nhs.uk/our_services/support_services/pals**.

  For further information about working with fully qualified BSL interpreters on the National Register, please visit **www.nrcpd.org.uk**.

Working with our volunteers to support patient experience

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

- Royal Voluntary Services
- Chaplains
- League of Friends Christchurch
- League of Friends Bournemouth
- Friends of the Bournemouth Eye Unit
- Hospital Radio Bedside
- British Red Cross
- Headstrong
- Macmillan
- Healthwatch
- Patients Association

Bluecoat volunteer's duties are extensive, including:

- main receptions meet and greet
- ward support offering tea and coffees
- patient companions, who have dementia awareness training
- administration support throughout the Trust
- driving the indoor train to help patients and visitors around the hospital
- surveying patients for real time patient feedback
- meal time companions and meal time assistants

- gardening
- medical photography escort

In year, 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.

Our patient experience plans for 2016/17 includes:

- Contribute to service and strategy development for a framework of discharge support provided by the local Voluntary sector.
- Redesign and re-launch the Dignity pledge
- Perform independent observational dignity audits every 6 months.
- Design and drive a campaign for Protected mealtimes and protected night time
- Design a visible framework for actioning feedback from Diverse groups
- Work with Communications to develop a plan for expanding the patient and public engagement role
- Further develop the Voluntary body in terms of age diversity and roles to perform

Learning from complaints and concerns - Complaints Annual Report 2015-16

Under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, the trust must prepare an annual report each year. This must specify the number of complaints received, the number of complaints which the trust decided were well-founded and to summarise the subject matter of complaints, any matters of general importance arising from those complaints, or the way in which they have been managed and any actions that have been, or are to be taken to improve services as a consequence of those complaints.

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

There were 313 formal complaints received by the Trust for 2015/16, which is a reduction on the previous year by 57 (n=370) complaints and back to similar figures of the 13/14 (n=303).

The focus of the Patient Advice and Liaison Service in resolving concerns informally with front line staff has been constructive but has also been an opportunity for some people to formalise their concerns as complaints. Underlying these changes has been a greater focus within the Trust on addressing complaints of all types and trying to identify how learning or changes in practice can best be integrated as widely as possible. More meetings have been offered to resolve the position and a sustained focus on closing complaints, and ensuring outcome actions and learning has taken place.

The annual focus group with former complainants was held on the 30th March 2015 to obtain feedback on the process and outcome from the experience of complaining to the Trust.

Complaint outcomes

There were 313 formal complaints reported into the Trust with appropriate apologies offered in the letter of response from the Chief Executive. Directorates are required to follow through changes resulting from upheld complaints within their own risk and governance meetings, recording these and reporting them into their governance meetings. A Complaints Performance meeting has also been convened in year to review complaints response times. This has enabled stronger engagement with the directorates. A focus on ensuring outcomes are systematically recorded and learning is disseminated is the focus for the 16/17 year plan.

Subjects of complaints

The main categories of complaint were as follows:

Subject	Formal Complaints 2015/16		Formal Complaints 2014/15	
	Number	Proportion	Number	Proportion
Implementation of care	112	36%	95	32%
Admission, transfer and discharge	61	20%	57	19%
Diagnostic tests (not pathology)	58	19%	55	18%
Communication and consent	55	18%	62	21%
Medication	9	3%	4	1%
Security	3	1%	0	0%
Equipment	2	1%	0	0%
Food Safety and Service	1	0%	1	0%
Visitor incidents/accidents	1	0%	0	0%
Treatment, procedure, care	1	0%	20	7%
Staff incident	1	0%	0	0%
Patient incidents (including falls, other accidents and self-harm)	7	2%	6	2%

A significant proportion of complaint resolution meetings were held with complainants and key staff to assist with resolving complaints and the final response letter. The majority of these were effective in resolving concerns as advised by the complainants.

Feedback from complainant focus groups

A focus group facilitated by the Head of Patient Experience was held on the 30th March 2015. The output of this was reported in the previous year's annual complaints report. In summary the purpose of the focus groups was to define the patients' perspective of those who made official complaints to the Trust. There were a wide range of positive and negative learning points arising from the focus groups that will be integrated into complaints handling practice with directorate complaint leads.

In January 2016, in partnership with Healthwatch, a complaints survey was sent to a list of previous complainants. The results of the survey are pending and will inform our improvement plans for the year.

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 are as follows and have been reported on the Trust website in year.

Problem	We did
Patient lost her clothing and dentures during the admission	A new Property Management Policy was launched in 2015. We encourage patients not to bring items of value into hospital and we have measures to safeguard essential items such as dentures, glasses, hearing aids. In this case ward staff were reminded of patient property processes. Patient property loss is an agenda item on the Complaints Performance Group and lost items will be closely monitored with the aim to track improvements.
Patient suffered a fall whilst on the ward	Training has been carried out in the assessment of patients who may be at risk of falls. Each ward has identified a falls champions and additional training has been provided.
Patient medical history information was incorrect	Staff made aware of the importance of taking an accurate medical history and checking this against forms to ensure they seek the correct information from each patient.
Patient wasn't offered food or drink or welcomed when she was admitted	Staff reminded of the importance of welcoming patients to the ward and orienting the patient fully when they arrive on the ward; including a check of when they last had something to eat and drink.
Why did it take so long to answer my call bell?	Staff were extremely sorry for the delay in responding to the call bell which was due to an emergency situation. Staff awareness has been raised and call bell audits are being conducted regularly to review answering times.
My discharge summary contained incorrect information?	Discharge summary was reviewed by a doctor and amended accordingly.
I attended my outpatient appointment on time, but I had to wait a long time to be seen	Complex patients ahead of this particular patient caused the clinic to overrun. Staff have been reminded to update patients regularly when clinics overrun so that they understand the reason for the delay and receive an apology for this.
My GP didn't know I had been discharged and what my ongoing care needs were	The patient had been discharged without the discharge summary being completed. Checks have been put in place to ensure patients are not discharged without a summary and that it has been faxed to the GP.
I received inappropriate food and wasn't helped with feeding over the weekend	A weekend ward hostess has been appointed to ensure patients receive appropriate meals and assistance.
The instructions I received were confusing and my appointment was affected	Review of instructions and appointment booking system was undertaken.

Problem	We did
I missed my outpatient appointment when I was transferred to another hospital because transport hadn't been booked	Improved procedure for patients who are transferred to another hospital but need to return for an outpatient appointment. Ward staff ensure transport is booked appropriately as well as informing the receiving hospital of the appointment.
The patient was losing weight during admission, but staff didn't notice	MUST champions have been appointed and trained in recording weights of patients. Monthly nutrition meetings are held to identify issues of concern.
My throat was very sore after my operation. No one looked at it and I had to go to A&E after I was discharged because it was so sore	Procedure was changed so that should a patient suffer this rare, but recognised complication of a procedure staff will examine the patient before discharge.
Patient was given incorrect test results	We apologised to the patient. The department has liaised with the Information Technology (IT) Department to design a safeguard so that incorrect test results cannot be given out due to human error.
Patient suffered wound complications after surgery and had to attend the Emergency Department	Emergency Department staff have been told to contact the on-call specialist surgical team for an opinion if a patient attends the Emergency Department with complications of surgery following discharge.
Concerns about inadequate feeding and documenting of food and fluid charts	Nursing staff will ensure relatives are fully informed of particular feeding regimes that are being introduced and possible difficulties that can be encountered in establishing the regime. Guidelines for feeding have been reviewed. Staff advised of the need to maintain accurate, complete charts.
Conflicting information between consultant and information leaflet given to patient	Raised awareness with shoulder surgeons regarding patient information and ensured surgeons give the patients the leaflet personally at the time of adding them to the waiting list.
Patient didn't receive his appointment letters in a timely matter causing problems when he required a blood test prior to his scan	Meeting held with clerical staff to reinforce procedure and avoid this situation again. Reinforcement of procedure through monthly staff bulletin.

Referrals to the Health Service Ombudsman

Complainants who remain dissatisfied with the response to their complaint at local resolution level were able to request an independent review to be undertaken by the Health Service Ombudsman. After receiving a response from the Trust, 12 people chose to refer their concerns to the Parliamentary and Health Service Ombudsman (PHSO) during 15/16 compared to 6 in 2014/15.

The Ombudsman referred one complaint back to the Trust for further local resolution and were satisfied as a Trust we had learnt from the complaint. Two complaints were partly upheld. One complaint is pending a final decision. The remaining 8 are still under investigation by the PHSO.

Performance against national priorities 2015/16

National Priority	2012/13	2013/14	2014/15	2015/16 Target	2015/16 Actual
18 week referral to treatment waiting times - patients on an incomplete pathway	97.1%	96.2%	94.3%	92.0%	**93.7%**
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	97.2%	95.5%	93.3%	95.0%	**93.37%**
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	88.6%	80.3%	84.5%	85%	**85.9%**
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	98.6%	93.4%	93.1%	90%	**90.5%**
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	96.4%	95.7%	95.8%	96%	**95.7%**
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	98.8%	95.1%	92.5%	94%	**94.1%**
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti cancer drug treatment	100%	100%	100%	98%	**100%**
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93.6%	93.8%	87.1%	93%	**96.1%**
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	97.0%	98.0%	91.1%	93%	**99.4%**
Clostridium difficile year on year reduction	31	14	21	14	**17**
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 Hampshire Clinical Commissioning Group
- Health and Social Care Overview and Scrutiny Committee, Borough of Poole
- Bournemouth Borough Council's Health Overview and Scrutiny Committee
- Healthwatch Dorset
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Council of Governors

Comments received were as follows:

Statement from NHS Dorset Clinical Commissioning Group (CCG)

NHS Dorset CCG is pleased to comment on the Quality Accounts for Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. From reviewing the Quality Accounts and monitoring the quality and performance of the Trust throughout the year, the CCG accepts that this is an accurate representation of the performance of the organisation during 2015/16.

Significant improvements continue to be made, a view which was echoed during a Care Quality Commission (CQC) inspection which took place during the year. Whilst it is pleasing to note the progress made in reducing hospital acquired pressure ulcers and Information Governance compliance, the Trust recognises that there are clearly further improvements required.

The CCG were invited to comment on the quality priorities for 2016/17 and is supportive of the areas identified particularly in relation to the continuing focus on safety checklists. The CCG looks forward to working with Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust over the coming year.

Mrs Sally Shead
Director of Quality

Statement from NHS West Hampshire Clinical Commissioning Group (CCG) Re: The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Quality Account 2015/16

West Hampshire Clinical Commissioning Group (CCG) would like to thank The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust (RBCHFT) for the opportunity to review and provide a statement response to their 2015/16 Quality Account.

It is clear from the report that the Trust places a high value on providing quality care throughout all areas and this is evident from the wide range and large number of patient safety initiatives which have taken place over the last 12 months. It is particularly encouraging to note that the CQC inspection report, following their visit in October/November, showed continued improvement from previous visits, and identified a high number of areas that were providing "good" care, and some "outstanding". It is good to see that the actions from your CQC action plan have been integrated into your overall quality improvement plan for the coming year.

The Trust should be congratulated on the efforts made on improving outcomes for patients with the reduction in the number of inpatient falls, and the overall focus on the provision of "Harm Free Care".

It is clear that the Trust has also worked hard to reduce hospital aqcuired infections, and the CCG, following a visit to the Trust, can be assured that the approprite measures are being undertaken to continue with the reduction in cases. However the CCG notes that the Trust breached the NHS England set target of 14 cases of Clostridium Difficile infection (CDI), and have also confirmed with the Trust that there is a requirement to report on Trust apportioned cases for the year (26) and not just "lapse in care" cases (17).

The Trust has also identified that although it has made significant progress with a reduction in avoidable Grade 3 and Grade 4 pressure ulcers the overall number of pressure ulcers is still slightly higher than the national average. The CCG is aware of the number of quality improvement initiatives that the Trust has been involved in that is focusing on this area of patient care and look forward to receiving further progress updates on this ongoing work. The CCG has previously had a number of concerns around the failure to achieve targets related to the management of patients being admitted with a stroke, and which the CQC had also previously identified as an area of concern. The CCG were previously assured that significant improvement would be made during 2015/2016, and the Trust does need to be congratulated on its progress in provision of Stroke services over the last 12 months. Of particular note is the introduction of the Stroke outreach team in April 2015, and a clear improvement seen in the Sentinel Stroke National Audit Programme (SSNAP) rating, from a level of D in 14/15, to a sustained SSNAP level B throughout 2015/16.

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

- The report provides information across the three domains of quality - patient safety, clinical effectiveness and patient experience.
- The mandated elements are incorporated into the report.
- There is evidence within the report that the Trust has used both internal and external assurance mechanisms.
- Commissioners are satisfied, 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's view is 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

Healthwatch Dorset comment for Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Quality Account 2015/16

It has been difficult to comment on some of the patient experience engagement work (e.g. pages 64/65) as the Quality Account provided for our review does not show all the necessary figures and statistics. However, we do note that the Trust will be developing a plan to expand the patient and public engagement role over the coming year and will also be looking to perform independent observational dignity audits every 6 months. We look forward to hearing more about these initiatives.

We do receive comments from patients and relatives concerned about basic care (especially for vulnerable patients who may have communication difficulties) such as access to fluids and long waits for support with toileting. We hope that the dignity audits will help to address some of these issues.

We would like to acknowledge the work being undertaken by the Trust to encourage patient feedback through a variety of methods and would like to see more information in the Quality Account about what has actually changed as a result of patient and public involvement and feedback.

We also acknowledge the work the Trust is doing around complaints and hope that our own survey of people who made a complaint in 2015 (due for publication in May 2016) will help the Trust make improvements to the complaints process.

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.

healthwatch Dorset

Input to RBCH Quality Report in Annual Report and Accounts 2015/16 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Council of Governors

Governors have been involved in a range of activities in helping to deliver the Trust's Quality Objectives. This involvement provides governors with an insight into how the Trust's quality processes are working, hear from staff how they are able to be effective and get an appreciation of what improvements are in hand or needed. The activities include the following:

- involvement in public, patient and carer experience and listening events and work streams covering a range of safety, dignity and quality of care areas;
- receiving and questioning reports from the Director of Nursing and Midwifery on the quality performance and risk management of the Trust at its quarterly Council of Governors meetings (which are held in public);
- supporting executives, clinicians and other staff on ward based audits and walk rounds;
- governor representation at key Trust committees including Healthcare Assurance Committee and Infection Prevention and Control Committee; and
- governor representation on the Trust Workforce Strategy and Development Committee which gives attention to staffing issues. This Committee underpins the quality agenda to ensure that the Trust is supported by skilled and experienced staff now and in the future and that they are supported to help achieve the Trust's focus on safety and quality.

The Trust held its first ever Safety and Quality Conference in September 2015 to which governors were invited. Governors have applauded such moves to underpin the statutory Duty of Candour (being honest with patients when things go wrong) to improve transparency and supports staff who speak out (as does the Board). It is encouraging that this conference is to become an annual event.

In 2015/16, governors selected stroke data (as a key area for the Trust's improvement programme) as its quality indicator for review by the external auditors. We are delighted to have helped support the significant improvements in performance of the Stroke Unit over the course of the year. Furthermore, reducing the levels of pressure ulcers has been a concern for governors. It is encouraging that the levels of hospital acquired pressure ulcers have been reduced in the face of increased incidence in the wider community in 2015/16, although this remains a continuing area of concern and attention. Governors support the continuing efforts of the Trust to work with care homes and others to ensure patients are safeguarded as far as possible. There have also been improvements in the level of Harm Free Care in 2015/16 and this will continue to be a focus of attention for governors in the coming year. For 2016/17, one of the Trust's priorities to control and reduce the number of patient moves is to be supported by the selection of this quality indicator for external audit examination.

The Care Quality Commission carried out an inspection of the Royal Bournemouth and Christchurch Hospitals in Autumn 2015. This recognised significant improvement over the past two years. It graded Christchurch Hospital as "good" and the Royal Bournemouth Hospital as "requires improvement" identifying a number of areas for action. The action plan arising from the inspection will help governors to support and challenge the Trust to improve the consistency in the high quality of care it provides in this extremely challenging financial and workforce environment.

From January 2016, a new governor-led Strategy Committee has been established. This is to provide:

- an even clearer and stronger governor involvement in the preparation of the annual quality accounts;
- the communication of such reports to the public and Foundation Trust members;
- the selection of the quality indicator for audit; and
- consideration of the Trust's quality objectives and priorities going forward.

This will help ensure that the views from the public, patients, public and staff are reflected in the development of the Trust's specific objectives and priorities for 2016/17.

Bournemouth Health and Adult Social Care Panel - Quality Account Statement

Bournemouth Health and Adult Social Care Panel - Quality Account Statement
It is encouraging in the Quality Account to see so many areas of improvement. For example the improvement in the Sepsis 1 hour target, improving from 26% to 67%.some excellent performance. Other areas remain challenging (for example Pressure Ulcers) but the success in other monitored areas such as Serious falls and Catheter acquired UTIs shows that, with actions plans put in place, improvements can be made. We hope the Tissue Viability Staff Nurse can make improvements for the Pressure Ulcer targets.

The overall Care Quality Commission rating is obviously disappointing, though the details reveal many areas of very good performance, including two rated outstanding. Reading the details it shows the very high standards that are expected and it is reassuring the Trust sees these as an opportunity for improvements. The comment from the Medical Director correctly recognises that people make mistakes and it is the systems that have to be improved to better support. This is, and needs to be, a people focused business in both those needing to access the service, and those providing the service.

This Quality Account shows a realistic assessment of where the Trust is and provides assurance of plans to improve future performance.

People (Health and Social Care) Overview and Scrutiny Committee P(HSC)OSC response to Royal Bournemouth and Christchurch Hospital NHS Foundation Trust's Quality Account 2015/16

Members of Borough of Poole's P(HSC)OSC would like to thank the Trust for enabling us to meet with yourselves to discuss quality issues over the last year and also to comment on the Quality Account for 2015/16.

The presentation about the account delivered on 15th April gave a clear outline of how the Trust is endeavouring to deliver high quality care and the activities undertaken during the financial year to improve services. With regard to the priority areas for improvement for 2015/16 we commend the Trust in achieving the majority of what it had planned in relation to:

Improvement in providing harm free care by reducing serious incidents - it is encouraging to note that there has been incremental improvement in this area over the last two years and that improvement has led to a score above the England average.

Reducing the numbers category three and four pressure ulcers- again it is encouraging to note the year on year improvement in this area. Even more is being done in an attempt to reduce incidents further by introducing an electronic risk assessment tool and recruiting more staff into the tissue viability team. We welcome an update on progress in this area during our next mid year visit.

Infection control - We note that the Trust had no MRSA bacteraemia cases but did not achieve its target of no more than 14 Clostridium Difficile cases as set by NHS England. It would be useful to understand what the national average is and how the Trust is performing in comparison to this.

Patient Moves- the committee understand that ensuring patients are cared for in the correct care setting on wards is an issue for acute trusts and are encouraged that the Trust has reduced the number of patient moves that were unjustified within the year. We note that this theme will continue to be a priority moving forward to 16/17 and look forward to receiving updates on this.

Improving management of Sepsis - the committee are very impressed with the level of commitment in regards to improving sepsis awareness and improving response times to delivering antibiotics to patients with sepsis. The Committee would like to continue to be appraised of how this will be improved further over the coming year.

Ensuring uniform use of surgical checklists across the organisation- it is heartening to note that surgical checklists are endorsed as a vital tool across the Trust and that making it real to staff, (the implications of not using a checklist) has reinforced the importance of the checklist tool.

The Committee also notes the draft Quality Priority areas moving into the year ahead and are encouraged that a number are carried forward from 15/16. The committee appreciates that some improvements can take longer than a year to embed and realise the improvements made. The Committee were interested to hear about the findings from the Care Quality Commission Inspection and that the action plan will form one of the quality priority areas for 16/17. It is also clear that since the inspection the Trust has already implemented a number of the key improvement actions.

We were interested to hear how positive the Trust is about seeking improvements in specialist care as a result of the acute hospital Vanguard programme of work. The Committee look forward to future updates on progress made in this exciting venture for the 3 acute Trusts.

Thank you for the opportunity to comment on an interesting Quality Review and Account. We look forward to reading the published version but please take this letter as Borough of Poole’s response to the presentation of the Quality Account on 15th April 2016.

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.

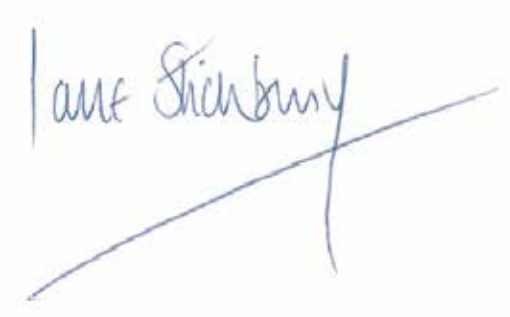
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

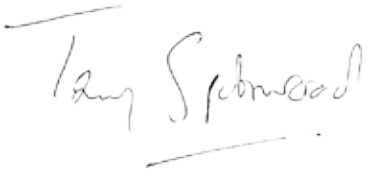
- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including -
    - board minutes and papers for the period April 2015 to May 2016
    - papers relating to quality reported to the Board over the period April 2015 to May 2016
    - feedback from commissioners dated 10 May and 12 May 2016
    - feedback from governors dated 5 May 2016
    - feedback from Local Healthwatch organisations dated 11 May 2016
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2015
    - the latest national in patient survey (awaiting publication)
    - the latest national staff survey dated February 2015
    - the Head of Internal Audit annual opinion over the Trusts control environment dated May 2016
    - Care Quality Commission Inspection Report dated February 2016
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account regulations) (published at **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
Chairperson
25 May 2016



Tony Spotswood
Chief Executive
25 May 2016

Annex C

Independent Auditors' 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 NHS Foundation Trust to perform an independent assurance engagement in respect of The Royal Bournemouth and Christchurch NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicator 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 Guidance.

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 and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;
- feedback from Overview and Scrutiny Committee;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;

- the latest national patient survey;
- the latest national staff survey;
- the 2015/16 Head of Internal Audit's annual opinion over the trust's control environment; and
- the latest CQC Intelligent Monitoring Report.

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.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Royal Bournemouth and Christchurch NHS Foundation Trust as a body, to assist the Council of Governors in reporting the 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 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

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 indicator;
- 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 and supporting guidance to the categories reported in the Quality Report; and
- 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.

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 and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
Bristol
26 May 2016

Glossary of Terms

CA UTI
Catheter Associated Urinary Tract Infections.

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
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.

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.

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 5 pledges and create a 3-5 year plan for safety. To find out more about the Trust's pledge go to: **www.rbch.nhs.uk**

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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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**.