NHS

The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

Quality Accounts

2016/17

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 number of improvements in patient safety, outcomes and experience. We have continued to further develop and implement a more open and honest culture to ensure we use information from incident investigations, complaint reviews and patient and staff feedback, to continually learn, innovate and improve. We have encouraged staff to speak out, to raise issues and concerns, to share good practice, to celebrate success stories and share learning and/or quality improvement ideas. A particular success was our second annual Patient Safety and Quality Conference held in September 2016 where over 500 staff shared patient safety and quality improvement stories, projects, case studies and innovations.

This year the overarching objectives agreed by the Board aim to provide a central framework and the basis for individual objective-setting across the whole organisation. It is expected that every member of staff will agree objectives which reflect the key themes of valuing our staff, improving quality and reducing harm, strengthening team working and listening to patients.

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 our quality objectives for 2017/2018 will be on improving patient flow, ensuring appropriate review, treatment and escalation of deteriorating patients and enabling patients with sepsis to receive the right care as early as possible.

The views of our various stakeholders including patients, governors, staff and the wider public have been very important to the development of our specific objectives and priorities for 2017/2018. We have engaged with staff through workshops, Trust and team briefing sessions, clinical governance meetings and Grand Round presentations.

We have listened to patients and carers through our ongoing programme of patient surveys, focus groups, internal reviews and open days. We have also invited clinical teams, patients and relatives to attend our monthly Board of Directors' meeting to present patient stories. 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, Governors and the public on a wide range of patient experience and patient safety initiatives.

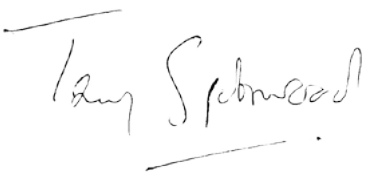
At our last inspection in October 2015 of the Royal Bournemouth Hospital, we were rated by the CQC as "good" for five services: critical care; surgery; outpatient and diagnostic services; end of life care; and children's and young people's services. Three services were rated "requiring improvement": urgent and emergency services; medical care; and maternity and gynaecology. The care of children and young people was rated as "outstanding". We are currently awaiting our next follow up inspection (anticipated late summer 2017) where we hope the improvements that we have made in year will be recognised by the CQC. The CQC recently held a number of focus groups with staff (March 2017) and it was pleasing to hear that the CQC were positive about the progress being made and were impressed with

the commitment, enthusiasm and leadership demonstrated by staff at all levels of the organisation.

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 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
23 May 2017

Part 2

Progress against quality priorities set out in last year's quality account for 2016/2017

In the 2015/16 Quality Account the Trust identified the following key areas for improvement during 2016/2017.

- 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
- 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
- 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 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 Friends and Family Test
- To address all issues highlighted within the CQC Report during 2016/17

Monitoring of progress against each of these priorities has been undertaken by the Board of Directors and specific sub groups, including the Healthcare Assurance Committee, Healthcare Assurance Group, 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.

Reducing Serious Incidents and Never Events

In broad terms, and in accordance with the NHS England Serious Incident Framework (2015), serious incidents are events in healthcare 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 comprehensive investigation and review.

There is no definitive list of events/incidents that constitute a serious incident, however the NHS England framework does set out a number of circumstances in which a serious incident must be declared.

Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that 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;
  - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent he death of the service user or serious harm;
  - Actual or alleged abuse; where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care
- A Never Event. The NHS England has defined a list of specific events that are considered unacceptable and eminently preventable. These are called "Never Events".

In 2016/17 the Trust reported zero Never Events.

- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
  - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
  - Property damage;
  - Security breach/concern;
  - Incidents in population-wide healthcare activities like screening and immunization programmes where the potential for harm may extend to a large population;
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
  - Activation of Major Incident Plans

The Trust has reviewed and updated policies and procedures for the investigation learning from incidents in 2016/17. Improvements have included:

- Implementation of a new Root Cause Analysis (RCA) and Serious Incident (SI) reporting "Toolkit"
- Scoping, mid-point and formal SI/ RCA panel meetings for all serious and potentially serious incidents

- External training for all senior clinicians and Heads of Nursing and Quality on how to chair a formal panel meeting to ensure learning points are identified and agreed
- External training for consultants, senior nurses and managers on Root Cause Analysis investigation procedures
- New templates for RCA investigations, panel meetings and final reports. The templates ensure that vital steps such as involving the patient and their families, documenting Duty of Candour, supporting staff and considering requirements for specialist opinion and/or external review are routinely adopted
- The production and dissemination of twice weekly investigation update summaries
- Circulation of a monthly Top 10 "learning report"

The Trust reported and investigated 25 serious incidents in 2016/17. This compares with 32 in 2015/16, 46 in 2014/15 and 66 in 2013/14.

The reduction in 2016/17 (22%) therefore represents a continued annual trend of improvement in patient safety.

The most significant reductions (over 50%) were seen in the reduction of serious incidents relating to patient falls and hospital acquired pressure ulcers.

Category of Serious Incident Reported	2013/14	2014/15	2015/16	2016/17
Patient Fall	14	15	13	3
Hospital Acquired Pressure Ulcer	30	20	6	3

Promoting a Safety Culture - Share to Care

At the Trust we celebrate what we can achieve when we share the things we have learnt from each other. Sharing our learning can help us make changes for the better - for our staff and our patients. To promote open and honest reporting we launched a new Share to Care initiative in February 2017.

Share to Care launched the implementation of four new ways of reporting a learning event. New Learning Event Report Notification (LERN) forms replaced the previous Adverse Incident Reporting (AIRs) forms. The new forms have a renewed focus on learning from the things that go well, as well as when things do not go according to plan.

The new LERN forms are to:

- report an incident has occurred and someone has, or could have, come to harm
- celebrate something has been done really well
- raise an issue or concern
- suggest an improvement idea

During the launch events we asked staff why they would report a LERN form. Here are just some of the things staff told us:

I **#Sharetocare** *because I have ideas that can improve our service.*

"Here at Christchurch Day Hospital we take ownership of the service we offer so when we spot something that needs improving, we speak up and make the improvement. We've worked together as a team to work through all of our ideas to improve our services and as a result, we feel a huge sense of ownership over our service. I encourage anyone to share their improvements to make their service better for their patients and their colleagues too."

I **#Sharetocare** *to recognise my team and their hard work.*

"Whether they boost team morale, go above and beyond or bring positive innovations, it's important to stop and say 'you're doing a good job - thank you'. Our Emergency Department shares positive feedback with each other via our 'Excellent Event Reporting Form' for a few months now and we're already seeing positive benefits - there's a real sense of camaraderie in the department and a positive team culture."

I **#Sharetocare** *so that mistakes aren't repeated.*

"We have first-hand experience of sharing our learnings from a safety incident. As a result of our reporting, the WHO safety checklist was rolled out across our trust to prevent similar incidents occurring again. We're really proud of the fact that we took ownership of the incident and learnt from it - we acknowledged what happened, talked through the process as a team and empowered ourselves to take action so that we couldn't repeat the same incident. Knowing the WHO checklist has been rolled out shows the value of sharing our learnings as a wider team - #teamRBCH!"

I **#Sharetocare** *to ensure we learn from incidents - as a department and a trust.*

"As the governance lead for my directorate, I see the incidents that are reported and how we learn from them. We can almost always alter our process to significantly reduce the chance of it happening again. Whether an error occurs or we have a near miss, we don't look to point fingers but learn from what went wrong and support our staff to learn from the event. Incidents or problems in one area are rarely isolated - by sharing what went wrong and reviewing it as a team, we improve and develop our practice trust-wide."

I **#Sharetocare** *to help mitigate risk.*

"It's always helpful when staff report concerns as this alerts us to a potential issue and enables us to put in place measures to help us keep our patients and staff safe. I welcome any report that can help us prevent a safety incident. We encourage every member of staff to take the initiative when they see a problem waiting to happen and report it. Any concerns reported will be reviewed and actions taken to try to prevent a safety incident occurring. We sometimes focus on things that have gone wrong, but reporting when things have gone well is a great encouragement and sharing new initiatives enables other departments to develop their systems."

Learning from Mortality reviews

In 2014/15 the Trust introduced a new electronic process (e-Mortality) to ensure all inpatient deaths had a full case note review.

The Trust has a multi-disciplinary Mortality Surveillance Group (MSG), chaired by the Medical Director, to review the Trust's Hospital Standardised Mortality Ratio (HSMR) and internal and external mortality risk reports. 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. e-Mortality reviews are discussed at specialty Mortality and Morbidity meetings and the chairs of these meetings attend the Trust Mortality Surveillance Group. This ensures that the review of all deaths within the hospital are discussed centrally and ensures actions for improvement are identified.

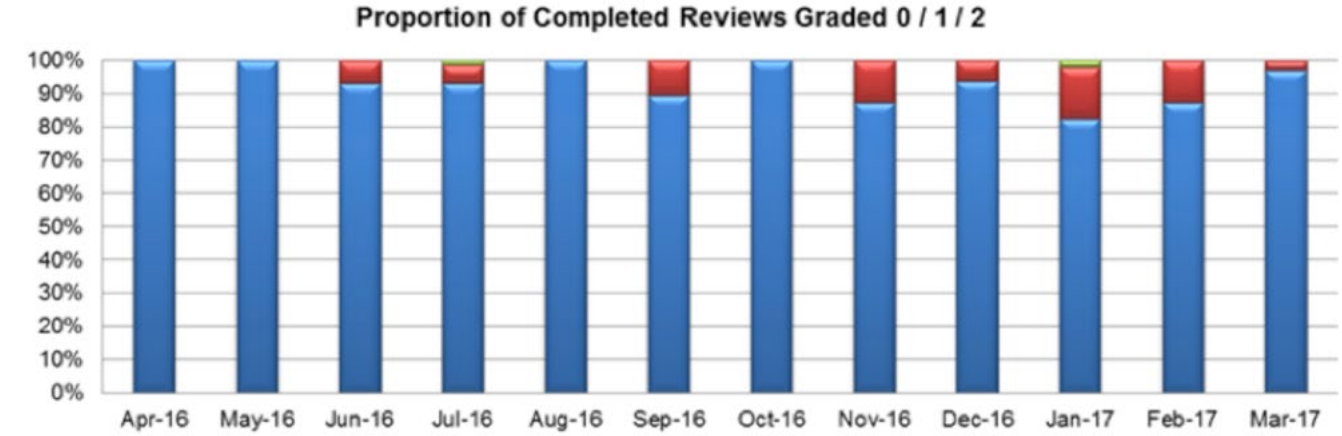
This year the Trust has made significant improvements and changes to the e-Mortality pro forma so that avoidable mortality is constantly categorised. We are now using a new nationaly recognised grading system. The Confidential Enquiry into Stillbirths in Infancy (CESDI) categorises mortality as follows:

- Grade 0-Unavoidable Death, No Suboptimal Care.
- Grade 1-Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2-Possibly Avoidable Death, Suboptimal care, but different care might have affected the outcome.
- Grade 3-Probable Avoidable Death, Suboptimal care, different care would reasonably be expected to have affected the outcome.

Once any death is categorised as grade 2 or 3, an automatic link allows completion of a LERN form, linking with risk governance processes.

The mortality review process has also been updated recently to include the requirements of the National learning disabilities Mortality Review (LDMR) programme

The MSG undertakes a monthly review of all e-Mortality data and any learning points are disseminated through Directorate Mortality and Clinical Governance meetings. The table below shows the proportion of completed reviews and how they were graded using the national grading system. The blue represents the reviews graded as 0, red represents reviews graded as 1 and the green represents those graded as 2.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
grade2				1						1		
grade1			3	4		5		1	10	8	9	2
grade0	5	20	41	67	9	43	40	7	152	42	63	69

A newsletter is produced every two months. The newsletter is an opportunity for wider dissemination of the learning captured through mortality reviews.

Specialties featured in recent newsletters include:

- Acute Kidney Injury (AKI)
- Patients with a learning disability
- Oncology
- Intensive Care medicine
- Respiratory
- Stroke
- Cardiology
- Gastroenterology

Themes for learning include:

- Improving communication opportunities with patients and relatives/carers
- Requirement for accurate and fully completed documentation
- Management of Sepsis
- Timely requesting of appropriate clinical tests

Improving flow of patients and reducing non-clinical patient moves

During 2016/17 the Trust has participated in a West Hampshire Clinical Commissioning Group (CCG) collaborative project to agree a consensus definition for a clinical and non-clinical patient move. At present there is neither a national or local definition. The Trust is working with the CCG and other key stakeholders to agree a standard definition and share models of best practice. This work will continue for 2017/18.

The decision to move a patient is always carefully considered to minimise disruption to patients and ensure patient safety.

The Trust's transfer policy outlines the requirement for safe transfer and ensuring that the accepting ward has the appropriate skills, staff and equipment to meet patient needs.

It is hoped that the current work to improve the discharge process for patients will have a positive impact on patient moves during 2017/2018 as the review of the 2016/2017 data found that the majority of non-clinical moves were for those patients with protracted discharge arrangements.

In addition to support data accuracy, a new electronic bed management system has been introduced which includes a mandatory field for the reason for moving a patient.

Supporting End of Life Care (EoLC)

As part of delivering the Trusts quality objectives a key action has been to ensure provision of outstanding end of life care to all those who come into contact with the Royal Bournemouth and Christchurch hospitals. There is only one chance to get it right. The Trust has an End of Life Care Steering Group. The group is chaired by the Associate Medical Director and is a sub-committee of the Quality and Risk Committee (QARC). It is attended by representation from Chaplaincy, Hospital Palliative Care, Consultants in Palliative Medicine, Senior Nurses and Nurse Practitioners and Governors.

This year the Group has led on the development of a new End of Life Steering strategy. Key goals included within the strategy include:

Recognition - The possibility that a person may die within the coming days and hours is recognised and communicated clearly. Decisions about the person's care are made in accordance with their needs and wishes, and these are reviewed regularly and revised whenever appropriate

Communication - Sensitive communication takes place between staff and the person who is dying and those important to them. The patient and those close to them are listened to, their needs are respected and they are involved in decisions about treatment and care

Compassionate care - Care is tailored to the individual and delivered with compassion - with an individual care plan in place. Staff providing this care are supported and trained to achieve these goals

Specific innovations undertaken within End of Life Care this year to help patients and their families have been:

- Access to Changing facilities for relatives.

  Relatives told us that they would like somewhere to shower, wash and freshen up when they stayed on site overnight to spend time with a loved one at the end of their life. In association with the Village Hotel, the Trust can now issue a special pass to friends and families. This pass will enable the relatives of patients who are on the end of life personalised care plan to use the leisure club facilities. This enables relatives to shower in comfort and to be near their relatives during this difficult time.

- The use of private ambulances to facilitate more timely discharge.

  Private ambulances are now available and being used to move patients at the end of their life. This can help to get a patient home if desired, or to another care provider of the patient's choice

- Collaborative working with Willow Tree Care Agency.

  A pilot has begun with the Royal Bournemouth and Christchurch hospitals to incorporate the care for end of life, palliative patients. A specialist end of life team are available to provide care from 7am to 10pm to allow an alternative opportunity for patients to pass away outside of a hospital or nursing home.

- Post Bereavement questionnaire.

  A new post bereavement questionnaire (based on the Marie Curie Care of the Dying Evaluation Form) has been introduced. The feedback provided from the questionnaire is used by the Trust End of Life Steering Group to inform best practice.

- End of Life Care Companions.

  The Trust has trained 14 volunteers to become EoLC Companions.

Key priorities for improving End of Life Care during 2017/18 include:

- Wprking with partners to discharge patients who are dying to a more appropriate place in keeping with their wishes. This involves working with external agencies to facilitate early, safe discharge home if desired, and also to prevent inappropriate readmission to hospital of patients who are at the end of their lives.
- The input of the palliative medicine consultants to mortality meetings and help in supporting the process to ensure it is standardised and robust.
- Electronic documentation across sites and within primary and secondary care to promote clear communication of EoLC and Advanced Care Planning (ACP) decisions. This builds on the use of Poole Hospital's Electronic Patient Record (EPR) and is now available in Royal Bournemouth and Christchurch hospitals.
- Continuous improvement in the education of staff to understand end of life care issues and support patients and relatives.
- Specialist communication skills training will build on the work already done and the electronic learning programme End of Life Care for All (ELCA) will include essential core skills training. This can encompass opportunities for staff to expand their roles into prescribing and Allow a Natural Death (AAND) decisions and discussions.
- Continued review, revision and improvement of the Personal Care Plan for the last days of life (PCPLDL).

Infection Control

Clostridium Difficile

There were 22 cases of clostridium difficile reported from the Trust in 2016/17. 17 of these cases were attributed to 'lapses in care', against an NHS England target of no more than 14. This represents an increase from last year in terms of the percentage of total late cases (>72 hours from admission to hospital).

A 'lapse in care' is determined through a process of review with the Acute, Community and Clinical Commissioning Group (CCG) infection prevention and control teams. Importantly, this has determined that all cases were community acquired and not caused by being in the hospital.

Lessons learnt from the cases where there were lapses in care 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)

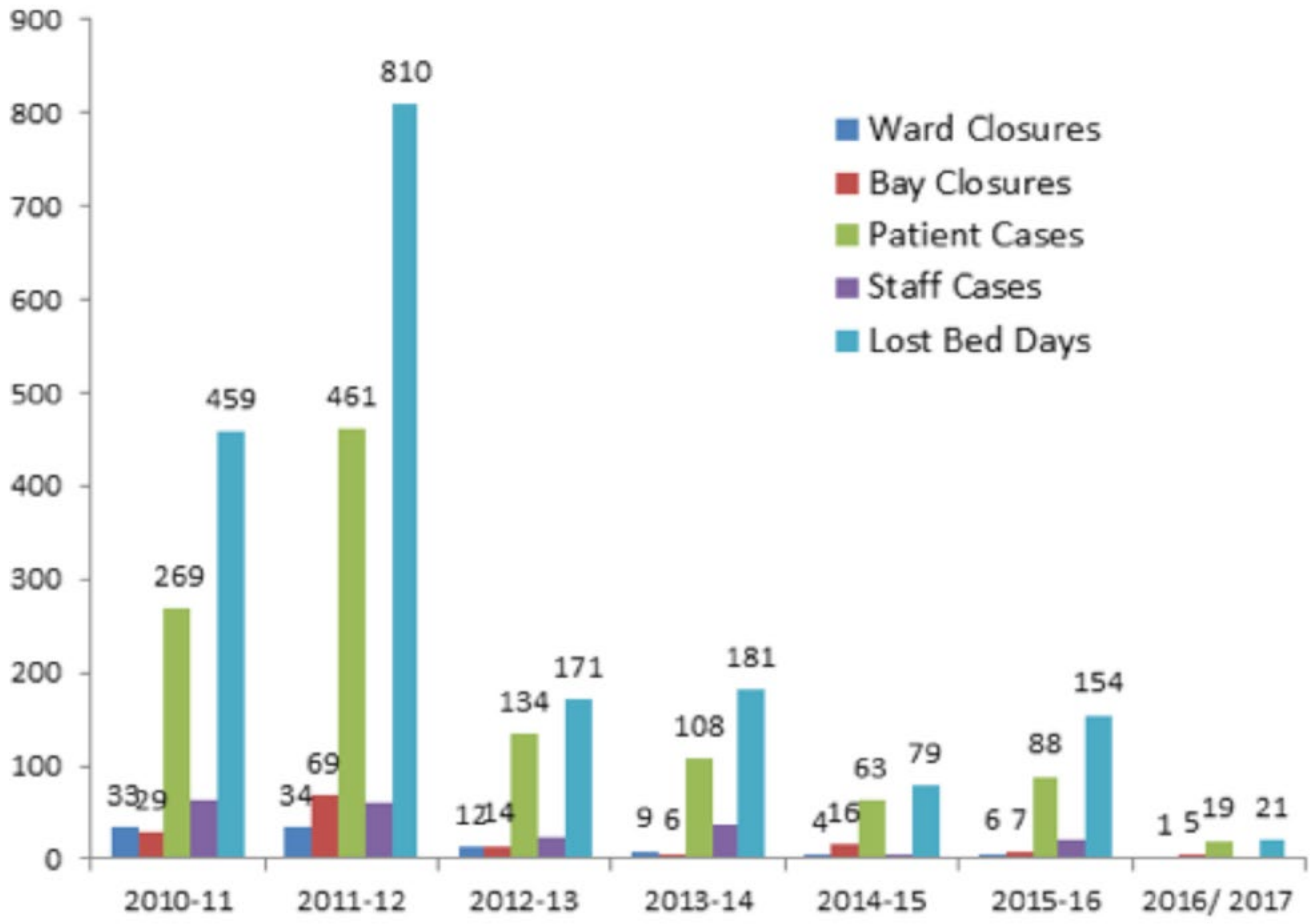
No hospital acquired MRSA bacteraemias were recorded at the Trust during 2016/2017. The Trust supported the investigation of 2 community acquired cases both of which were assigned as third party cases.

Methicillin-Sensitive Staphylococcus Aureus (MSSA)

Reporting of MSSA bacteraemia is in line with other local acute trusts. Each case is assessed by the team and any lapses in care are followed up with a root cause analysis. Findings from these are discussed and learning points shared through Directorate infection control meetings.

Norovirus

Outbreaks of Norovirus were confirmed within the Trust during January 2017. 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.



The number of ward closures and patient cases has remained low in the past 5 years. This matches with the numbers of cases reported at a local and national level. There are many reasons for this drop in numbers since 2012 however the actions carried out by staff in promptly isolating and sampling patients who present with signs of viral gastroenteritis must be praised.

Catheter associated urinary tract infections (CA UTIs)

The mean numbers of new CA UTIs (from NHS Safety Thermometer data) for the Trust in 2016/17 was 0.25% compared to 0.2% in 2015/16. This is slightly lower than the national mean score of 0.3% but represents a slight increase on previous years.

Resistant Organisms

The Infection Control team now has access to a tool that highlights all patients admitted to the Trust with a previous positive test for Clostridium difficile and known resistant organisms. This has enabled us to improve the timeliness of isolation, provision of samples for analysis and to ensure that patients are treated with the correct antibiotics.

Improvement priorities for 2017/18 include:

- Participation in World Hand Hygiene day in May 2017
- Join in the activities held for International Infection Prevention week
- Continue infection control audit programme, including routine hand hygiene audits
- Review of new and novel methods to improve infection control within the Trust.
- Quality Improvement (QI) project for early isolation of patients with loose stools
- QI project for information given to patients placed under isolation precautions.

Our quality priorities for 2017/18

In order to identify priorities for quality improvement in 2017/18, we have used a wide range of information sources to help determine our approach. These include:

- gathering the views of patients, public and carers using real-time feedback and patient surveys
- collating information from claims, complaints and incident reports
- using the results of clinical audits, external reviews and inspections 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 interviews and focus groups.
- Canvassing the views of patients and staff through our internal peer review programme.

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 also considered the 2015-2018 priorities of the Wessex Academic Health Science Network and our continued participation in the Wessex Patient Safety Collaborative.

The Trust has consulted with key stakeholders (general public, staff, patients, governors and commissioners) to help identify quality improvement priorities for 2017/18. Priorities have been discussed with clinical staff through the Trust's Quality and Risk Committee, Improvement Board and Trust Management Board.

We have considered any current action plans in place, for example those forming our Quality strategy (including sign up to safety), 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 Trust's Quality priorities for 2017/18 are:

1) Managing Sepsis

2) Identification and escalation of the Deteriorating Patient

3) Improving Hospital (Patient) Flow

To coordinate implementation, 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 and Improvement Board.

Sepsis

Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs.

Sepsis affects a huge number of people -In December 2015 NHS England publication 'Improving outcomes for patients with sepsis' highlighted that in 2015 over 123,000 people in England suffered from sepsis. The same publication estimates that there are around 37,000 deaths per year associated with sepsis. To put this into context, sepsis now claims more lives than lung cancer, the second biggest cause of death after cardiovascular disease. Failure of healthcare staff to detect or act on the patients who have the signs and symptoms of sepsis can lead to delays in treatment that lead to further patient harm.

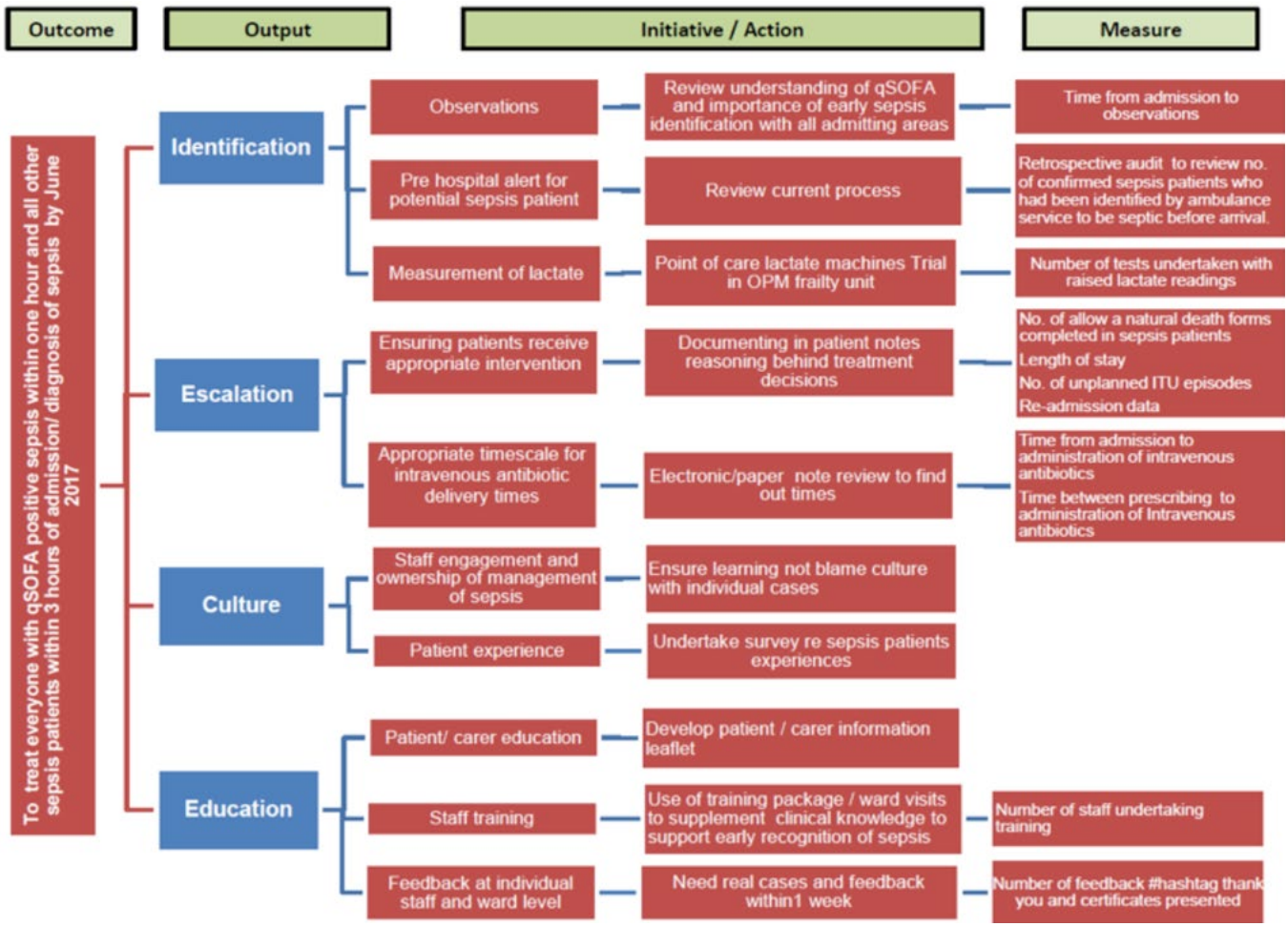
Our Sepsis Quality Priority Aim for 2017/2018 is:

To treat everyone with quick Sepsis-related Organ Failure Assessment (qSOFA) positive sepsis within one hour and all other sepsis patients within 3 hours of admission or diagnosis of sepsis,

We will aim to ensure:

- appropriate observation through a) early identification in all admitting areas b) pre-hospital ambulance alerts and c) measurement of lactate;
- appropriate escalation and intervention through a) the monitoring of intravenous antibiotic delivery times and b) documentation of treatment decisions in patient notes.

The project will look at the management of patients who develop sepsis whilst in our inpatient areas as well continuing to support the work already in place in our emergency admitting areas



Escalation of the Deteriorating Patient

Failure of healthcare staff to detect or act on the deteriorating patient can lead to delays in treatment that lead to further patient harm.

The Hogan study on preventable deaths (2012)1 found 26% of preventable deaths, using a very broad definition, related to failures in clinical monitoring. These included failure to set up systems, failure to respond to deterioration, and failure to act on test results. Together the two data sources suggest failures in monitoring and failure to act on test results are a major source of serious harm and preventable deaths in hospital.

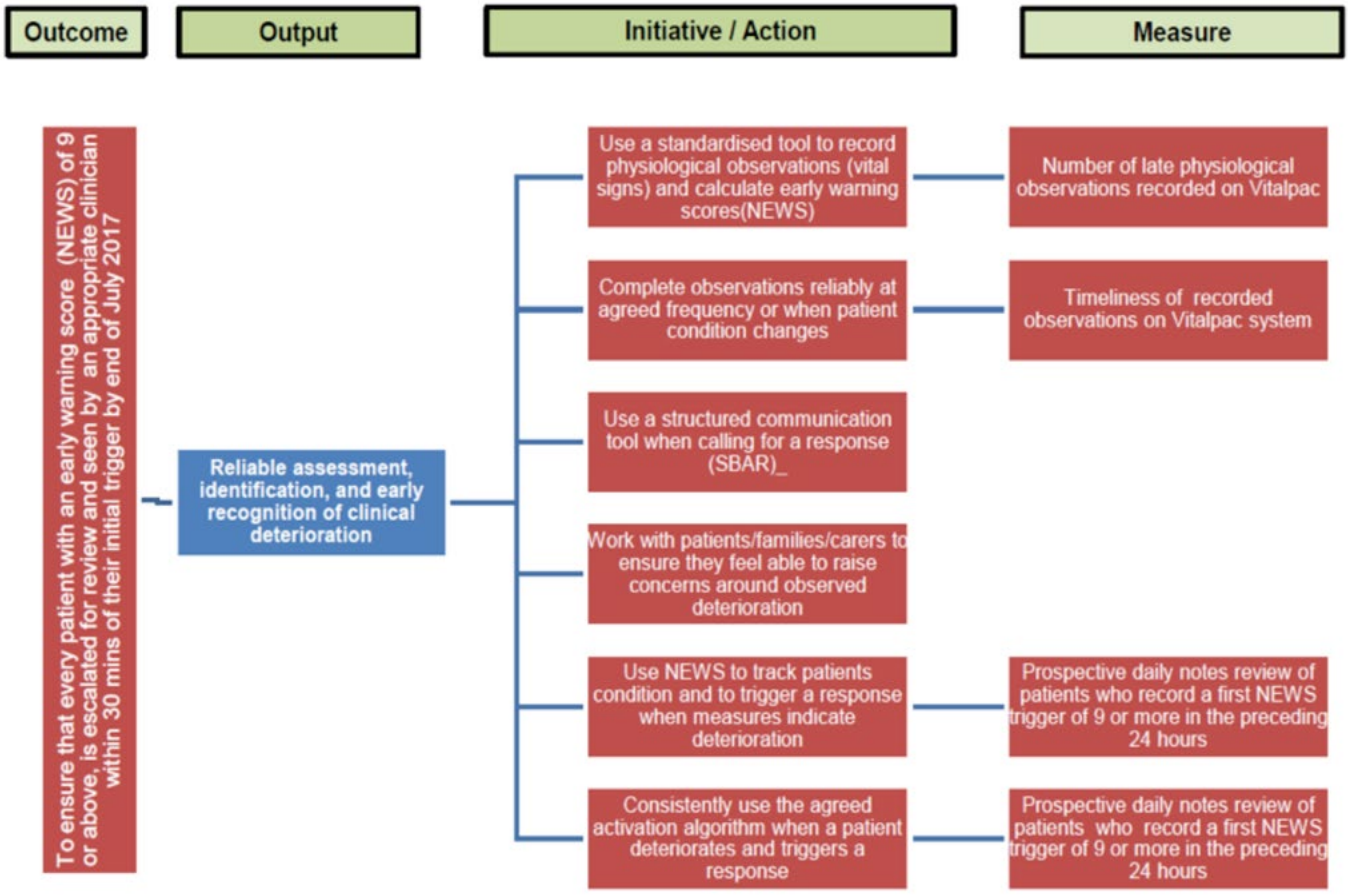
Our escalation of the deteriorating patient quality priority aim for 2017/2018 is:

To ensure that every patient with an early warning score (NEWS) of 9 or above is escalated for prompt review and then seen by an appropriate clinician within 30 minutes of their initial trigger.

We will aim to ensure:

- reliable assessment, identification and early recognition of clinical deterioration;
- reliable therapeutic response and escalation using structured protocols;
- a reliable activation system and tools (including electronic) are in place when calling for a response.

The project will be phased and the first stage focuses on establishing a process to ensure appropriate clinical review within the target 30 minutes. This will apply to all areas where NEWS scores are recorded both in and out of hours. Further stages will cover the delivery of therapy and extend the model to those patients who trigger with NEWS scores less than 9.



1 Hogan H et al. Preventable deaths due to problems in English acute hospitals: a retrospective case record review study. BMJ Qual Saf 2012; 21:737-45

Improving Hospital Flow

The Trust continues to face rising demand on services. Attendances to our emergency department continue to rise - by over 7% in the past year - and emergency admissions have risen by over 9%. ED performance indicators have not been achieved for two quarters in the past year and bed occupancy is higher than required for good flow. This is compounded with significant financial pressures and the ongoing requirement for efficiency savings.

The Trust has an excellent track record of significant improvements in hospital flow, notably with ambulatory care, frailty pathways and reducing length of stay. However, we still need to do more if we are to meet the challenges we currently face and ensure high quality of care for our patients.

Our Hospital Flow Quality Priority Aim for 2017/2018 is:

To improve emergency hospital flow to deliver 'the right patient, at the right time, to the right place'.

Improvement and success will be demonstrated through agreed high level work stream key performance indicators.

We will aim to ensure:

- 95% of patients are admitted, transferred or discharged from the Emergency Department within 4 hours;
- all inpatients have a senior review before midday;
- 90% of new patients will be given an estimated date of discharge (EDD) within 24 hours of admission;
- 33% of patients discharged from our inpatient wards are discharged before midday;
- 100% of inpatients with a length of stay in excess of 7 days will be systematically reviewed with clear management plans in place;
- outliers and cancelled operations are reduced as a result of a lack of bed available.

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 2016/17 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 these eight 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 2016/17 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2016/17.

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, 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. 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 2016/17, there were 33 national clinical audits and 4 national confidential enquiries which covered relevant health services that The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust participated in during 2016/2017 are set out as follows.

The national clinical audits and national confidential enquiries that The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust participated in, and for which

data collection was completed during 2016/2017 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.

National Clinical Audits for Inclusion in Quality Report 2016/17	Eligible to Participate	Participated in 2016/17	% of required cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	100%
Adult Asthma	Y	Y	100%
Adult Cardiac Surgery	N	N/A	-
Asthma (Paediatric and Adult) Care in Emergency Departments	Y	Y	
Bowel cancer (NBOCAP)	Y	Y	121%
Cardiac Rhythm Management	Y	Y	
Case Mix Programme	Y	Y	100%
Child Health Clinical Outcome Review Programme	Y	Y	100%
Chronic Kidney Disease in Primary Care	N	N/A	-
Congenital Heart Disease	N	N/A	-
Coronary Angioplasty / National Audit of Percutaneous Interventions (PCI)	Y	Y	100%
Diabetes (Paediatric) (NPDA)	N	N/A	-
Elective Surgery (National PROMS Programme)	Y	Y	100%
Falls and Fragility Fractures Audit Programme	Y	Y	N/A
Head and Neck Cancer Audit	N	N/A	-
Inflammatory Bowel Disease (IBD) Programme	Y	Y	100%
Learning Disability Mortality Review Programme (LeDeR Programme)	Y	Y	N/A
Major Trauma Audit	N	N/A	-
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Y	Y	100%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Y	Y	100%
Mental Health Outcome Review Programme (NCISH)	N	N/A	-
National Audit of Dementia	Y	Y	100%
National Audit of Pulmonary Hypertension	N	N/A	-
National Cardiac Arrest Audit (NCAA)	Y	Y	100%
National Chronic Obstructive Pulmonary Disease (COPD) audit programme	Y	Y	100%
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	Y	Y	100%

National Diabetes Inpatient Audit	Y	Y	100%
National Pregnancy in Diabetes Audit	Y	Y	69%
National Diabetes Transition Audit	Y	Y	N/A
National Diabetes Core Audit	Y	Y	100%
National Emergency Laparotomy Audit (NELA)	Y	Y	100%
National Heart Failure Audit	Y	Y	
National Joint Registry (NJR)	Y	Y	100%
National Lung Cancer Audit (NLCA)	Y	Y	No number specified - all known cases submitted
National Neurosurgery Audit Programme	N	N/A	-
National Ophthalmology Audit	Y	Y	100%
National Prostate Cancer Audit	Y	Y	100%
National Vascular Registry	Y	Y	Expected to achieve 100%
Neonatal Intensive Care and Special Care (NNAP)	N	N/A	-
Nephrectomy Audit	Y	Y	90%
Oesophago-gastric Cancer (NAOGC)	Y	Y	90%
Paediatric Intensive Care	N	N/A	-
Percutaneous Nephrolithotomy	Y	Y	100%
Prescribing Observatory for Mental Health (POMH-UK)	N	N/A	-
Radical Prostatectomy Audit	Y	Y	100%
Rheumatoid and Early Inflammatory Arthritis	Y	Y	
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	100%
Severe Sepsis and Septic Shock - care in Emergency Departments	Y	Y	
Specialist rehabilitation for patients with complex needs	N	N/A	-
Stress Urinary Incontinence	N	N/A	-
UK Cystic Fibrosis Registry	N	N/A	-

National Confidential Enquiries for Inclusion in Quality Report 2016/17	Eligible to Participate	Participated in 2016/17	% of required cases submitted
Acute Non-Invasive Ventilation	Y	Y	100%
Cancer in Children, Teens and Young Adults	Y	Y	Organisational data only required
Chronic Neurodisability	Y	Y	Organisational data only required
Young People's Mental Health	Y	Y	100%

The reports of 32 national clinical audits were reviewed by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in 2016/17 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- Share nationally (via submission to the British Society of Rheumatology) a description of how we run the Helpline and Education Programme as this was cited as an example of good practice in the national audit.
- The Diabetic foot service in Dorset is under review as part of new Dorset Diabetes Model. Self-referral into the specialist service to be considered as part of this review.
- Appointment of a Heart Failure Data Manager to be responsible for data input to NICOR and other QI projects.
- All Parkinson disease patients to have initial and end of treatment outcome measures documented.
- Incorporate the Acute Abdomen Pathway into the generic admission booklet.
- Local hospital guidelines to state how to manage transfusions in patients at high risk of Transfusion Associated Circulatory Overload (TACO). TACO Risk assessments to be used and the guidelines to state how to manage patients at risk of TACO. Transfusion threshold and reason for transfusion to be clearly recorded in the patient's case notes. Post transfusion increments should be measured for both red cell and platelet transfusions.
- Offer all clinic attendees HIV testing and record why if the test is not done. (Department of Sexual Health)

The reports of 195 local clinical audits (including patient surveys) were reviewed by the Trust in 2016/2017 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- Additional screening installed between Male and Female waiting areas to reduce visibility of opposite sex patients whilst waiting prior to surgery. Further screening planned for Day Surgery.
- Checklist for commencing Mycophenolate developed and included in the Dermatology resource folders used in outpatient clinics. A designated nurse to co-ordinate the monitoring of patients taking Mycophenolate may help to increase adherence with blood test monitoring guidelines.
- Step up and Down approach to be utilised within the Paediatric Clinic for children with Atopic Eczema. Written Management Plans to be given to all children/families. Reduction in long-term facial topical steroids by use of alternative where possible.
- Work with GPs to achieve better use of the referral pro forma and the importance of early referral so that patients suspected with early arthritis are referred within 3 days.
- To continue with stroke awareness promotion activities particularly for GPs and paramedics. To introduce more specific breach analysis in order to understand "what we could have done better" and target improvement.
- Development of a pan-Dorset Urogynaecology referral pathway for initial investigation and management of incontinence.

- Review of availability of consultant on call surgeon to be more available for surgical opinions.
- Stroke team to carry out a patient and carer forum to understand issues around discharge planning and information giving in greater detail.
- Introduction of smoke stop midwife.
- Develop and agree on evidence-based indications for Abdominal x-ray in Emergency Department with Radiologists and Surgeons.
- To set up group sessions for adults with a new diagnosis of coeliac disease. To aim for patients with a probable diagnosis of coeliac disease to be referred to the dietitian at the point of referral to endoscopy to cut down waiting time.
- Signage to Macmillan Unit has been improved.
- All patients to be offered next appointment at the end of every visit to the Dorset Prosthetic Centre. All patients to be recalled within 18 months of last visit if they have chosen not to arrange their next appointment at the end of each visit.
- Standardisation of information given to patients before they undergo Total Knee Replacement. Patient information booklets and consent forms revised to include details of all treatment complications.
- Introduce guidance on which patients are not appropriate for the First Seizure Clinic and recommend where and how they should be referred instead.
- Develop and implement a Nutritional Care Booklet. Agree and implement a Nutritional Care Bundle for Stroke.
- To introduce screening for cognitive and depression/anxiety as a formal assessment.
- Stop midway CT scans on patients treated with first line immune-chemotherapy for lymphoma.
- Develop a thyroid nodule patient information leaflet.
- Making sure that every patient has cholesterol levels checked before discharge from Stroke Unit. Making sure a follow-up plan is mentioned in discharge summary and clinic letter for GPs.
- Use a new mouthwash for chemotherapy patients to reduce the rate and intensity of Oral infections.

3. Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee and NIHR portfolio was 1480 (April 2016 - March 2017). This compares to 1305 for 2015/16 and 1658 in 2014/15.

Research Success Stories during 2016/2017

- The Trust was the first European site to recruit to: The RADIANCE-HTN study; a study of the ReCor Medical Paradise System in Clinical Hypertension which investigates how safe and effective renal denervation is in patients with hypertension (2 patients were recruited on the same day, meaning we recruited the first two European patients) The study is open in Europe and the US.
- The Trust was the first European site to recruit to: The RADIANCE-HTN study; a study of the ReCor Medical Paradise System in Clinical Hypertension which investigates how safe and effective renal denervation is in patients with hypertension (2 patients were recruited on the same day, meaning we recruited the first two European patients) The study is open in Europe and the US.
- The Trust was the first Global site to recruit to: The ELIMINATE-AF study; a study comparing Edoxaban with Vitamin K antagonists (Warfarin) in patients undergoing catheter ablation to investigate how safe and effective anti-coagulant agents are to reduce the risk of thromboembolic complication in patients with non-valvular atrial fibrillation undergoing catheter ablation.

- The Trust is the highest recruiter to the: INCA study; a study for patients with diffuse large B cell lymphoma which compares one group of patients receiving the existing treatment (Gemcitabine plus rituximab and CVP) with another group receiving a potential new treatment (Inotuzumab Ozogamicin plus Rituximab and CVP)
- The Trust is also the highest recruiter for the REDDS study and the first site to recruit a patient in 2017 in addition to the lead recruiting site. REDDS is a study which looks at whether patients with blood disorders (Myelodysplastic syndromes) can have an improved quality of life if their haemoglobin count is maintained at a higher level than current clinical practice can achieve.
- The Trust is the second highest recruiter to the ROSCO study; a study for patients with breast cancer aiming to find out whether two new tests that are performed on cancer tissue will help refine the selection of chemotherapy drugs to treat breast cancers before surgery and to find out if a well-established surgical procedure called sentinel lymph node biopsy is a reliable test to show that chemotherapy given before surgery has eliminated all the cancer cells under the arm.
- Research has expanded into further clinical specialities within the Trust this year including respiratory, an increasing number of studies in the surgical setting, anaesthetics and our first Emergency Department study. Division 6 which covers a number of clinical specialities has recruited more than double its target for the year, recruiting 540 patients with a target of 230.
- Following the closure of another participating site and the confidence in our team having exceeded our original target and providing high quality data, The Trust has just been asked to recruit 10 additional patients to the REACT 2 study; a study for patients with Crohn's disease in which the treating clinician decides whether to combine the drug adalimumab with other drugs to help control Crohn's disease earlier on in the treatment pathway.
- Collaborative working with Bournemouth University saw Research at RBCH becoming a placement for student nurses in its own right. There is now a five week placement in Research available for student nurses. Two students have finished their placements now with another starting in May 2017. Feedback so far has been very positive and both Salisbury and Dorset County Hospitals are now looking to emulate this model.
- The Research Directorate now has a comprehensive and consistent induction package and a competency and training framework is in place for all research staff across the Trust. Training and good practice sharing sessions are being held by experienced research staff identified at appraisal as being keen to present and teach others as part of their ongoing personal development.
- Clinical Research Network (CRN): Wessex held its inaugural awards ceremony this year, celebrating researchers in the Wessex region. Three nominations were shortlisted from the Trust. We were delighted that one of our team won the award for Outstanding Clinical Trials Assistant.
- Research is active on Twitter with 323 followers and publication of the newsletter Clinical Research Today continues. Three issues have been published in the last year.

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

The Trust's income in 2016/17 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 2016/17.

The Trust has not participated in special reviews or investigation by the CQC during 2016/17.

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

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

Since the last inspection, the Trust has been undertaking regular engagement meetings with the CQC in order to continue to develop our relationship and provide opportunities for our teams to present on their ongoing progress. This has included presentations from the teams in Maternity, Gynaecology, Emergency Department, Older Person's Medicine, Stroke Services and the Acute Medical Unit.

These engagement meetings also allow us to make a copy of our Trust action plan available to the CQC, thus enabling us to demonstrate our continued developments and providing assurance.

The Trust is anticipating the next CQC Inspection later in 2017 and, in preparation for this; we have facilitated a number of staff/governor focus groups with some members of the CQC Inspection team. The groups were well attended and feedback was very positive from both staff/governors and the CQC. There will be further focus groups and forums for other staff groups in the near future.

6. Data Quality

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust submitted records during 2016/17 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 99.0% 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 was 100.0% 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 Uses 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 and 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 NHS Digital, with all evidence uploaded by 31 March 2017.

The Trust's Information Governance Assessment Report overall score for 2016/17 was 74% (2015/16 was recorded as 67% with an Improvement Plan) and was graded as "Satisfactory".

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS Trust and submitted to the NHS Digital 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.

During 2016/17, 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 further increase in percentage score for 2016/17 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 across the whole organisation, in the manner required by the IG Toolkit.

In 2017/18, 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; key to this is the engagement and continued co-operation of subject matter experts and Information Asset Owners (IAOs), who provide assurance of their practices across the organisation. The Trust will work to maintain the traction that it has gathered on this work in order to firmly imbed the concepts as "business as usual", and enable the submission of a compliant IG Toolkit for 2017/18.

There has been a sharp increase in reported breaches of Information Governance during 2016/17. During 2015/16, 81 breaches and no Serious Incidents Requiring Investigation (SIRIs) were reported, whereas 2016/17 has seen 134 breaches and six SIRIs reported.

Whilst seemingly a negative point, this is not necessarily indicative of a decline in standards within the Trust, but rather is likely to be as a result of increased levels of incident reporting following the 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 95% at March 2017).

Each of the six SIRIs were reported to the Information Commissioner's Office as required. Of these, one remains under investigation internally and five have been closed. There is no evidence of harm coming to any of those affected by these breaches, or the information involved being disseminated further, and the Information Commissioner's Office confirmed no enforcement action was warranted on any of these.

Work will continue during 2017/18 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 90%, Secondary Diagnosis 93.20%, Primary Procedure 93.02% and Secondary Procedure 88.94%. (*These figures relate to the period January - June 2016)

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

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 2017/18:

- Ensure coders adhere to standards when sequencing codes
- Ensure the standard for Chronic Obstructive Pulmonary Disease/Chronic Obstructive Airways Disease (COPD/COAD) is adhered to
- Revisit FCE (Finished Consultant Episode) when histopathology is available
- Work with Evolve to initiate modifications for efficient access.

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 2015 - September 2016 0.929	1.003	1.164	0.688
		October 2014 - September 2015 1.020	1.00	1.177	0.652
		October 2013 - September 2014 1.009	1.00	1.198	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 specialty 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 specialty level for the Trust	HSCIC	October 2015 - September 2016 46.8%	30.0%	56.3%	0.4%
		October 2014 - September 2015 49.0%	26.6%	53.5%	0.2%
		October 2013 - September 2014 44.0%	24.2%	49.4%	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	April16-Sep16 (provisional, published Feb 2017)	(i) NA (ii) No data (iii) 0.419 (iv) 0.320	(i) 0.089 (ii) 0.099 (iii) 0.449 (iv) 0.337	(i) 0.162 (ii) 0.152 (iii) 0.525 (iv) 0.430	(i) 0.016 (ii) 0.016 (iii) 0.329 (iv) 0.260
	April15-Mar16 (provisional, published Feb 2017)	(i) NA (ii) NA (iii) 0.452 (iv) 0.329	(i) -0.805 (ii) -0.452 (iii) 0.438 (iv) 0.320	(i) 0.157 (ii) 0.145 (iii) 0.510 (iv) 0.398	(i) 0.021 (ii) 0.018 (iii) 0.320 (iv) 0.198
	April14-Mar15 (published Aug 2016)	(i) 0.084 (ii) NA (iii) 0.447 (iv) 0.319	(i) 0.084 (ii) 0.094 (iii) 0.436 (iv) 0.315	(i) 0.154 (ii) 0.154 (iii) 0.524 (iv) 0.418	(i) 0.000 (ii) -0.009 (iii) 0.331 (iv) 0.204
The Trust considers that this data is as described for the following reason. The number of patients eligible to participate in PROMs survey is monitored each month and the number of procedures undertaken by the Trust is cross tabulated with the number of patient questionnaires used.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by reviewing relevant patient pathways and undertaking a detailed quality improvement programme.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
% of patients 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	2016/17 (i) = 0 (ii) = 4456 (11.1%) 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 - NHS Digital	2016/17 - Not available	-	-	-
		2015/16 - 73.4%	69.6%	86.2%	58.9%
		2014/15 - 72.4%	68.9%	86.1%	59.1%
		2013/14 - 69.0%	68.7%	84.2%	54.4%
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 sub-committee of the Board of Directors.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Staff who would recommend the Trust to family or friends	National Staff Survey	2016 - 77.50%	69.85%	84.77%	48.86%
		2015 - 75.49%	69.17%%	88.98%	45.73%
		2014 - 70.79%	67.45%	89.27%	38.17%
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 Strategy and Development Committee (a sub-committee of the Board of Directors) and key actions agreed.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Friends and Family Test - (i) for inpatients and (ii) for patients discharged from Accident and Emergency (types 1 and 2)	(i)				
	Jan 2017	99%	96%	100%	80%
	Dec 2016	98%	96%	100%	76%
	Nov 2016	99%	96%	100%	75%
	(ii)				
	Jan 2017	96%	88%	100%	45%
	Dec 2016	93%	87%	100%	58%
	Nov 2016	94%	88%	100%	49%
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/**					
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 promotion of improvements made from patient feedback.					

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	2016/17 = 95.8% 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	2016/17 8.80/100,000 bed days (17 confirmed cases) 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 NHS Improvement (NHSI).					
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	3945 April16-Sept 16 4133 (Oct15-Mar16) 3832 (April 15-Sept15)	Not available 4818 Not available	Not available 11989 12080	Not Available 1499 1559
Rate of patient safety incidents reported during the reporting period	NRLS	41.11 per 1000 bed days (April - Sept 16) 40.3 per 1000 bed days (Oct15-Mar16) 38.89 per 1000 bed days (April 15-Sept 15)	40.02 per 1000 bed days 39.31 per 1000 bed days 38.25 per 1000 bed days	Not Available 75.91 74.67	Not Available 14.77 18.07
Number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	19 (April - Sept 16) 21 (Oct15-Mar16) 16 (April15 - Sept 15)	Not Available 19 Not available	Not Available 94 89	Not Available 0 1
% of total number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	0.5% (April - Sept 16) 0.5% (Oct15 - Mar16) 0.4% (April15 - Sept 15)	0.4% 0.4% 0.4%	Not Available 2.0% 2.9%	Not Available 0% 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 issued.					
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 new incident reporting system in 2016/17 to increase opportunities for reporting and further improve feedback and learning pathways.					

Part 3
Review of quality performance in 2016/17

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 a sub-committee 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.

The following section provides an overview of the performance in 2016/17 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 2015/16 Quality Report and have also been selected on the basis of data collection, accuracy and clarity.

Patient safety

Reducing adverse events

The Trust has seen a slight decrease in the number of major and severe harm patient safety incidents reported during 2016/2017 and uploaded to the national reporting and learning system.

Table: Patient safety incidents reported during April 2015 to March 2017and uploaded via the national reporting and learning system (NRLS)

	Total number reported 2015-2016	% of incidents reported 2015-2016	Total number reported 2016-2017	% of incidents reported 2016-2017
No Harm	5290	64.70%	5099	63.80%
Minor Harm	2707	33.11%	2684	33.58%
Moderate Harm	136	1.66%	171	2.14%
Major/Severe Harm	43	0.53%	38	0.48%
Total	**8176**		**7992**	

Duty of Candour

The Duty of Candour requires healthcare providers to respond to safety incidents that result in moderate or severe harm or death in line with Statutory Duty of Candour as detailed in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Any patient safety incident meeting the criteria must be notified to the patient or the 'relevant person', as soon as the organisation is aware. Organisations have a duty to:

- apologise
- inform patients that an investigation will be undertaken
- provide the opportunity for them to be involved in that investigation
- provide patients and their families with the opportunity, and support, to receive and discuss the outcomes of the investigation

Duty of Candour is managed within the structure of the Trust's web-based risk management reporting system and is an integral part of the reporting and subsequent incident investigation process. All investigation processes require consideration and undertaking of the Duty of Candour as per national legislation

To support staff with Duty of Candour process.

The Trust has provided external training on Duty of Candour for members of staff across the Trust. We are committed to continuing to provide ongoing training to ensure consistency.

The Risk Management team are currently in the process of developing a toolkit to use as an aid to following the Duty of Candour process correctly.

Harm free care

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).

In 2016/2017, based on a survey of 5418 inpatients over a 12month period April 2016 to March 2017, we achieved an average of 97.45% new harm free care (97.5% in 2015/16 and 97.2%. in 2014/15). This compares to a national average of 97.72%.

Reducing Hospital Acquired Pressure Ulcers

On average less than 1.81% of the hospital inpatients surveyed in 2016/2017 using the National NHS Safety Thermometer tool had a reported hospital acquired pressure ulcer. This compared to 1.73% in 2015/16, 2.00% in 2014/15 and 2.20% in 2013/14.

The result is slightly higher than the national average of 0.91%.

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 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 a Safety Incidents via the Learning Event Report Notification (LERN) system. Each incident is investigated and in cases of significant pressure damage (a category three or four pressure ulcer) a ward review is completed. This identifies the incidents that require a

more formal investigation leading to a case review/panel meeting. 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 further to only 6 cases being reported as Serious Incidents. Our improvement aim this year was to reduce this number by a further 10% to no more than 5 incidents. During 2016/17 we reported a total number of 3 Serious Incidents realising a reduction of 50%.

Quality improvements implemented in 2016/17

- Implemented a competency framework and supporting toolkit for qualified and non-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
- A pressure ulcer session is included in the newly qualified doctors induction programme
- Directorate specific pressure ulcer workshops have been delivered, receiving very positive feedback
- All educational, training and resource material including patient information has been reviewed and refreshed in-line with the most up to date guidance

Improvement priorities for 2017/18

- A Band 5/PhD research post (clinical academic career pathway) in collaboration with Southampton University to examine human factors and barriers experienced when delivering best practice pressure area care has been established
- Continue to focus on increasing the Trust-wide training compliance
- Deliver a study day for hospital staff
- Continue to work closely with our commissioning and community partners.

Reducing harm from Inpatient Falls

All inpatient falls regardless of severity of harm, are recorded via the Trust online reporting system 'Datix'. Falls are investigated locally if classed as minor or no harm, and if classed as moderate or above, then a root cause analysis (RCA) is required. This will enable the investigators to identify good practice or to highlight any gaps to enable the learning to be focussed. This will also help to identify any trends that can be incorporated within the core and mandatory training.

In 2015/16 there were 1,722 reported falls in the Trust, 41 of which were classed as Moderate harm or above in severity. A Quality priority set for 2016/17 was to continue to work to reduce this number. The data show that the total number of falls in 2016/17 was 1600, with 37 classed as Moderate or above in severity. This equates to an overall 7% reduction in total falls from 2015/16 to 2016/17. The percentage of falls classified as Moderate or above remains the same at 2.3% for both years.

On average 0.42% of the hospital inpatients surveyed in 2016/17 using the national NHS Safety Thermometer tool had reported a patient fall resulting in harm. This compared to 0.43% in 2015/16 and a national average of 0.55% in 2016/17.

Our patient demographic includes a very high proportion of elderly frail people who often have multiple complex long-term conditions which may contribute to a higher risk of falls. In view of this, we make falls prevention a priority in the Trust and have developed a Falls Prevention plan to reflect this.

A key element of falls prevention is education. Falls prevention training and education is provided in three main streams:

- Essential core steps training: This is currently provided in a face-to-face manner. This training is mandated every two years for all clinical staff. Bespoke sessions are also provided for specific staff groups including overseas nurses and newly qualified Staff Nurses in their preceptorship

programme. This training focusses particularly around accuracy of mobility and falls risk assessment completion.

- Responsive focussed learning: This is provided face to face in the clinical area/ department as a result of a request from the Ward. Sessions are practical in nature and enable scenario based training.
- Manual Handling and Falls Champions Training. This initiative was reinvigorated in 2016/2017 with an aim to enable the wards and departments to have a person with enhanced knowledge as a local resource for keeping the staff up to date with national guidelines, and changes in practice. Becoming a champion involves the nominated member of staff to attend an initial two day training session and yearly updates. Champions are also encouraged to attend the Falls Steering Group in order to disseminate any feedback to their own areas. We have currently recruited and trained approximately 70 staff as champions.

Falls Steering Group

Another important component of falls prevention is the Falls Steering Group. This is chaired by the Head of Nursing and Quality for the Medical Care Group and attended by representatives from pharmacy, outpatients, wards, physiotherapy and occupational therapy, Christchurch day hospital and the Information Department. The group meets at least every two months and reviews information on NICE guidance, RCA case studies and any trends in Incident reporting.

National Falls Audit

Following the publication of the results from the last National Falls Audit in 2015, there has been a drive across the Trust in the areas that were highlighted for improvement. These were lying and standing blood pressure recordings as part of the falls risk assessment process and provision of walking aids out of hours. There has been a targeted approach to these items in any training delivery and champions are promoting this in their departments. The next audit is due to take place in May 2017 which will provide some assurance and further focus for next year.

Quality priorities for 2017/18

- Developing an e-Learning package for Falls Prevention training as part of our Blended Education and Training (BEAT) software
- Participation in the National Falls Audit
- A small pilot of a quality improvement idea is ongoing on an Older Person's Medicine ward. This involves each bay having a stock of two walking frames to enable easy access out of hours. Feedback is positive so far and formal evaluation will take place later this year.
- Increasing the number of Manual Handling/ Falls Champions in each area

National Staff Survey

The National Staff Survey was undertaken on behalf of the Trust by the Picker Institute. The staff survey questionnaire content is agreed nationally.

All staff employed by the Trust on 1 September 2016 were sent a survey questionnaire Survey letters were 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.

Staff completing the survey questionnaire returned it to the Picker Institute. Non-responders who received a paper questionnaire were sent two reminders, non-responders who were sent an electronic questionnaire received six reminders. Information regarding the survey was distributed in the weekly staff bulletin, on screensavers, on posters sent to each department and in the staff restaurant, by twitter messages and at a Health and Wellbeing event.

This year 44.9% of staff returned their survey questionnaire, a total of 1,968 staff. This is an improvement on the 37% response rate for the 2015 survey.

Full details of the staff survey results are included in the Trust Annual Report 2016/17.

In summary, overall the Trust has achieved a significant improvement on the results of the 2015 survey on 10 questions:

		Higher scores are better	
		2015	**2016**
5b	Satisfied with support from immediate manager	69%	73%
7f	Immediate manager takes a positive interest in my health and wellbeing	66%	70%
8c	Senior managers try to involve staff in important decisions	32%	36%
9e	Not felt pressure from manager to come to work when not feeling well enough	71%	77%
15c	Not experienced harassment, bullying or abuse from other colleagues	80%	83%
15d+	Last experience of harassment/bullying/abuse reported	35%	46%
19+	Had mandatory training in the last 12 months	92%	96%
20a+	Had appraisal/KSF review in last 12 months	79%	95%
21a	Care of patients/service users is organisation's top priority	76%	80%
21b	Organisation acts on concerns raised by patients/service users	74%	77%

The top five ranking scores for the Trust were in relation to:

- Percentage of staff able to contribute towards improvements at work (RBCH score 76%, national average for acute Trusts (70%).
- Effective team working (RBCH score 3.86%, national average for acute trusts 3.75%).
- Percentage of staff appraised in the last 12 months (RBCH score 95%, national average for acute trusts 87%).
- Staff satisfaction with the level of responsibility and involvement (RBCH score 4.01%, national average for acute trusts 3.92%)
- Recognition and value of staff by managers in the organisation (RBCH score 3.57%, national average for acute trusts 3.45%).

The specific results for indicators KF26 and KF21 are as follows:

		RBCH score 2016	National average for acute trusts - 2016
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	23%	25%
KF21	Percentage believing that the Trust provides equal opportunities for career progression or promotion	89%	87%

Staff throughout the Trust were invited to participate in Cultural Feedback sessions to gain a greater depth of understanding of the results and to participate in developing a new Trust Vision. Care Group/Directorate action plans are under development and will be reported at half-yearly reviews and to the Workforce Committee.

The full report, together with Directorate results, has been made available to staff on the intranet and the key findings have been communicated via Core Brief and the Trust's Facebook page.

Workforce Race and Equality Standard

The National Staff Survey report also provides this data split to show separate results for White and Black Minority Ethnic (BME) employees. This split data forms part of the Trust's Workforce Race and Equality Standard (WRES) submission. The WRES is a set of 9 metrics (indicators) selected to identify 'gaps' between the experience that White and BME staff have in the workplace.
The Equality, Diversity and Inclusion Committee has developed an action plan with actions designed to improve experiences for all staff and narrow the gaps between the experience of White and BME staff. We now have 3 sets of data from the Employee Surveys conducted in 2014, 2015 and 2016. This data is presented below and demonstrates the following results on a year on year basis:

Indicator	Employee Survey Results					
	2014		2015		2016	
	White	BME	White	BME	White	BME
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	25	33	26	28	22	27
KF21. Percentage believing that trust provides equal opportunities for career progression or promotion	91	65	90	75	90	77

KF26: Fewer staff are experiencing harassment, bullying or abuse from staff and more staff: For white staff a small increase in 2015, then a significant drop in 2016. For BME staff a significant drop in 2015 followed by a small drop in 2016. However, there still remains a significant gap between the experiences reported by White and BME staff.

KF21: Percentage believing that trust provides equal opportunities for career progression or promotion: For White staff a small decrease in 2015, and the same result for 2016. For BME staff a significant increase in 2015 followed by a small increase in 2016.

While there still remains a gap between the experiences reported by White and BME staff, there is evidence of this becoming significantly narrower.

Improving Staff Health and Wellbeing

The Trust recognises that the health and wellbeing of staff is not only important to individuals but also a key enabler to providing excellent care to patients. The health, safety and wellbeing of staff directly contribute to organisational success and poor workforce health has a potentially high cost.

The Trust's health and wellbeing strategy has been designed to embrace the whole person - physical and mental health both inside and outside of the workplace, acknowledging that a person's wellbeing is greater than simply the absence of ill health and disease, it is a feeling of physical, emotional and psychological wellness.

The Trust has in place a multi-disciplinary Valuing Staff and Wellbeing Group, which includes management, staff, staff side representatives and governor representatives and who work together to promote a range of initiatives for the health and wellbeing of staff. They also receive regular reports on overall sickness absence for the Trust, with specific attention being paid to musculo-skeletal and mental health issues.

In summary, the strategy promotes:

- Physical health and wellbeing - corporate gym membership, in-house exercise programs, such as pilates, zumba, circuits and a running club, an on-site weight management club, smoking cessation promotions, fast track physiotherapy for staff
- Mental and emotional wellbeing - promotion of the Employee Assistance Programme, stress management workshops, managing mental health issues, resilient mind training and mindfulness sessions
- Health promotion - health checks/ assessments, linking to national campaigns (e.g. alcohol and drugs, change for life), vaccines, health and wellbeing staff wellness days
- Advice and signposting - policy advice, employment law, communication e.g. intranet, corporate induction (drawing attention to principles and policies)
- Organisational wellbeing and people management - leadership and management training so that managers are confident in supporting health and wellbeing, for example; in managing change, workplace stressors - recognising that effective leadership is vital to building and sustaining an organisational culture where staff can thrive
- Economic wellbeing - promoting opportunities to have fun and save money; with a staff benefits and offers page on the intranet
- HR intervention - identify trends in sickness and develop appropriate interventions, with managers, as informed by our workforce information and surveys, e.g. fast track services, stress hotspots (stress management workshops)

Schwartz Rounds

In 2016, The Trust introduced Schwartz rounds as an opportunity for staff to get together to discuss the social and emotional issues we face in caring for patients and their families.

Schwartz rounds are used in over 120 trusts in the UK currently, as a forum to share thoughts and feelings on topics drawn from patient and colleague experiences and have been successfully proven to reduce stress in staff who attend them, and also improve our capacity to manage the psychological aspects of patient care.

The Trust's first Schwartz round took place in September 2016 and are now held monthly. Each round includes three or four short presentations from our staff based on a particular theme. There is then a confidential discussion which is open to all present.

The topics of the Schwartz rounds are put forward by our staff and we have found this to positively aid engagement. The premise is that by engaging in Schwartz rounds, we are better able to make personal connections with patients and colleagues when we have greater insight into our own responses and feelings.

Four Schwartz rounds have been held so far since September. Topics have been A Colleague I'll never forget, Why I'm Proud to work at Royal Bournemouth Hospital, A patient I'll never forget and In the Deep Mid-Winter.

174 staff, from a wide range of staff groups, have attended to date. Formal feedback from the sessions has been very positive.

- "Good to talk about emotions not benchmarks"
- "It was a wonderful being part of such a positive experience- thank you"
- "I thought it was well facilitated- I'm leaving feeling very grateful for my colleagues across the hospital"
- "Great to share our experiences this way. Should be a regular part of practice"

Topics and Sessions for 2017/2018 have been developed.

Displaying Quality Data on our Wards

As part of our Qualty Strategy, during 2016/2017 we have improved our quality reporting and provided ward areas with new display boards (HOTBOARDS) to display their quality/safety and peer review information.

It is also an opportunity for the wards to provide welcoming and helpful messages to patients and visitors attending the ward.

Annual Safety and Quality Conference

The Trust held the second annual Safety and Quality Conference on Friday 16 September 2016. This follows the success of the first which was launched to help ensure our patient care is as safe as possible.

Preventable errors can and do happen, and we need to be able to learn from these events, and this is only possible if we are able to talk about them in an open and non-judgemental way. This year there were a range of very frank and honest talks from a range of clinicians on what happened when things did go wrong and what was learnt from these events.

The conference included presentations on what we have learnt from SI and never events, details of our growing number of Quality Improvement (QI) programme and an update on our Cultural Audit by our Change Champions.

Over 350 staff attended and the event was positively evaluated.

"We're really proud to be able to say we acknowledge our mistakes and try to learn and improve from them. It was also an opportunity to look at what we're doing as a Trust to work towards positive change."

"Today was about honesty and it demonstrates that it's not about attributing blame to an individual. There's nothing more powerful than those individual stories that put a name and a person to something and we learn from that sort of thing much better than what a text book says about something."

Clinical effectiveness

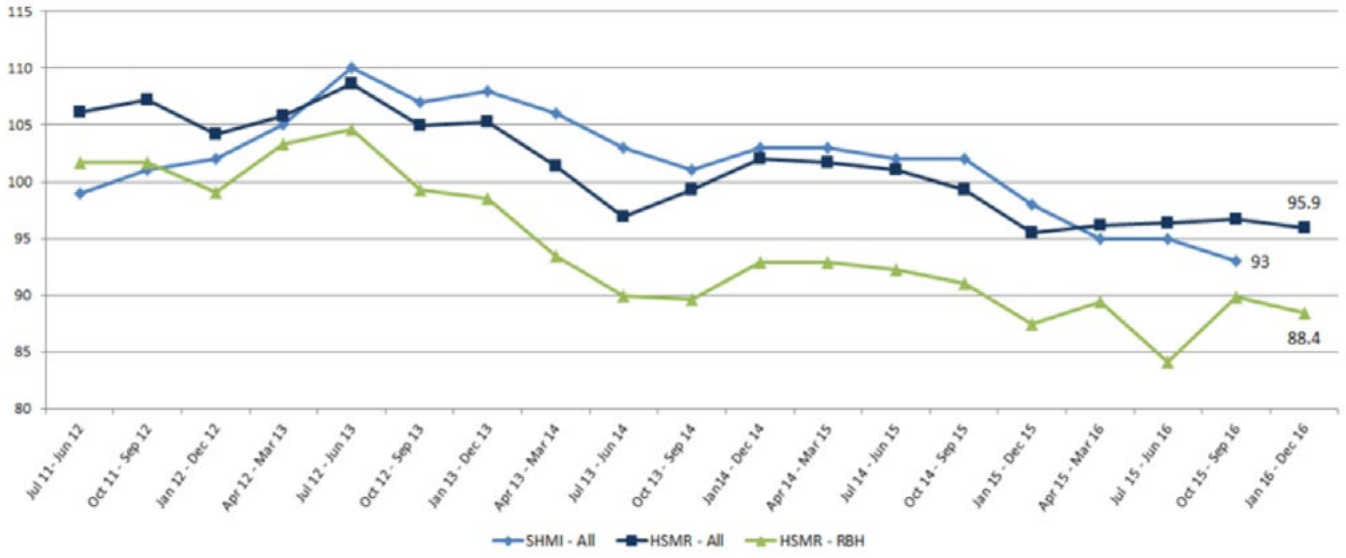
Reducing Mortality

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 NHS Digital, 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 Royal Bournemouth Hospital site alone (which therefore excludes palliative care). The figures lie within the "as expected" range for HSMR and within the "better than expected" range for SHMI.

As previously highlighted, the Trust has a multi-disciplinary Mortality Surveillance 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

SHMI and HSMR, July 2011 to December 2016



Trust HSMR has significantly improved (reduced) over last 3 years compared to the national average (100). The Trust HSMR for the financial year 2015/16 was 96.7 which is a significant achievement as we are also one of only a few Acute Care Trusts to have (and as a result include in our mortality figures) an on-site 'specialist palliative care' unit.

Current HSMR for this financial year (April to December 2016) is 92.6 which is better (lower) than 'national average' and puts our Trust in top 5% nationally.

NHS Digital statistics indicator for SHMI shows a lower reported rate. The improvement is in parallel with HSMR and confirms significant improvement in mortality ratios and our determination to improve quality of care for our patients.

Improving care for Stroke patients

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust 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. The purpose-built 36 bedded stroke unit includes hyper-acute, acute and rehabilitation beds, neurogym, patients dining and activity room and a therapeutic garden. There is a very close working relationship between colleagues in emergency and radiology departments who support the provision of the 24/7 thrombolysis (blood clot-busting treatment) service and initiatives such as the direct door to CT pathway.

In 2015/16 the Trust established a Stroke Outreach service. The service enables patients with suspected stroke to be seen by Stroke Specialist Practitioners in the Emergency Department immediately on their arrival to hospital and ensures that patients consistently receive early stroke specialist assessments, CT scans and timely access to the unit.

During 2016/17 the Stroke team has continued to make further improvements without additional resourcing to streamline patient care. Simple changes to multidisciplinary working practices have been implemented, including the introduction of a single multi-disciplinary team (MDT) assessment for all new admissions, creation of a 6 week MDT Stroke follow up clinic, and re-design of MDT meetings. This has resulted in less duplication for patients and a reduction in the time taken for patients to be seen.

In 2016, the new Ambulatory Care Clinic for patients with milder severity stroke symptoms was established. This weekday clinic ensures daily review of any weekend admissions, stroke mimics and stroke patients requiring early follow up. Working with Radiology colleagues has also improved fast access to specialist assessments and investigations. The Ambulatory Care Clinic has thereby had a significant impact on reducing unnecessarily prolonged hospital stays for many of our patients.

The Trust admits approximately 750 new stroke patients each year, making it one of the busiest stroke services in the Wessex region. As well as the inpatient hyper-acute, acute and rehabilitation provision, there is 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. The tust also provides a seven day rapid access Transient ischemic attack (TIA) service seeing approximately 1000 patients each year. The TIA service is another example of excellent collaborative working as the weekend provision is jointly provided with Poole Hospital and Salisbury Hospital. This service provides consultant-led multi-disciplinary stroke follow-up clinics and has a busy and proactive stroke research team undertaking a wide range of stroke research studies.

Sentinel Stroke National Audit Programme Results

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 triannual 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 two years we have seen our performance improve from a consistent SSNAP Level D prior to Q3 of 2014/15 to a sustained SSNAP Level A from Q4 2015/16 to date The table below provides a summary of our most recent reported SSNAP performance.

Quarter	Oct-Dec 2015	Jan-March 2016	Apr-July 2016	Aug-Nov 2016	National Average
SSNAP level	B	A	A	A	
SSNAP score (team-centred)	80	88	86	86	
Case ascertainment band	A	A	A	A	A
Audit compliance band	A	A	A	A	A
1. Scanning	C	B	C	C	B
2. Stroke unit	C	C	C	C	C
3. Thrombolysis	C	B	C	C	C
4. Specialist Assessments	C	B	B	B	B
5. Occupational therapy	A	A	A	A	A
6. Physiotherapy	B	B	A	A	B
7. Speech and Language therapy	A	A	A	A	C
8. MDT working	B	A	A	A	C
9. Standards by discharge	A	A	A	A	B
10. Discharge processes	A	A	A	A	B

For the last SSNAP report the Trust achieved a score of 86 which is a SSNAP Level A. (A score of 80.1 or more achieves a SSNAP Level A) Nationally for T2 (August -November 2016), only 19% of Trusts achieved a SSNAP Level A (41 Trusts out of 228). From a local and regional perspective, RBCH is the only Trust to have achieved SSNAP A within Dorset, Wessex and the South West of England.

Morwenna Gower, Stroke Services Manager, said: ***"We are extremely proud of our continued SSNAP Level A rating which reflects the commitment of our whole team, and the wider hospital teams, to deliver an excellent standard of care for our patients and their families. The stroke team members work so closely with each other and this is a real joint effort!"***

In 2016/17 there has been sustained performance with the proportion of patients having a CT brain scan within 12 hours of arrival at hospital. This is a result of a new Stroke Outreach Team and Acute CT request for stroke protocol.

Proportion of patients scanned within 12 hours	Q1	Q2	Q3	Q4
2015/16	**88.2%** (N.A. 90.1%)	**91.9%** (N.A. 91%)	**87.8%** (N.A. 91.8%)	**90.8%** (N.A. 92.6%)
	T1	T2	T3	
2016/17	**91.3%** (N.A. 93.2%)	**92%** (N.A. 93.5%)	Not yet complete	

N.A. is national average
T refers to Tertile reporting introduced by SSNAP in April 16 (T1 Apr-July, T2, Aug-Nov, T3 Dec-March)

All people with suspected stroke should be admitted directly to a specialist acute stroke unit. Throughout 2016/17 we have maintained our performance and continue to perform above national average for the proportion of patients directly admitted to a stroke unit within four hours of arrival at hospital (or of stroke if a patient has a stroke whilst an inpatient). The implementation of Quality Improvement initiatives have improved access to the unit.

Proportion of patients directly admitted to the stroke unit within 4 hours	Q1	Q2	Q3	Q4
2015/16	**65.7%** (N.A. 58.7%)	**75.9%** (N.A. 61.8%)	**68.6%** (N.A. 59.8%)	**71.7%** (N.A. - 54%)
	T1	**T2**	**T3**	
2016/17	**72.1%** (N.A. 59.3%)	**68.7%** (N.A. 58.5%)	Not yet complete	

N.A. is national average
T refers to Tertile reporting introduced by SSNAP in April 2016 (T1 Apr-July, T2, Aug-Nov, T3 Dec-March)

Patient feedback:

"You should be proud of who you are and what you do"

"The important thing is I was never left unobserved all the time I was there and felt very safe in the hands of Dr's, nurses and carers"

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. The stroke ESD service continues to support higher number of patients than the national average.

Proportion of patients supported by stroke ESD on discharge from hospital	Q1	Q2	Q3	Q4
2015/16	**49.6%** (N.A. 31.7%)	**41.1%** (N.A. 31.8%)	**46.5%** (N.A. 33.7%)	**36.7%** (N.A. 34.3%)
	T1	**T2**	**T3**	
2016/17	**38.9%** (N.A. 33.7%)	**44.7%** (N.A. 34.5%)	Not yet complete	

N.A. is national average
T refers to Tertile reporting introduced by SSNAP in April 16 (T1 Apr-July, T2, Aug-Nov, T3 Dec-March)

Improving Patient Flow in Urgent care

A large scale quality improvement project has been underway across the Trust this year (2016/2017) to improve the flow through the hospital.

This large scale Quality Improvement project began in 2014/15 and some of the early achievements from the first phase included the expansion of ambulatory care in acute medicine, improved specialty in-reach provision from 'front door' areas and reduced waiting times for clerking new admissions. These delivered improvements in quality of care, performance and financial savings equivalent to around £3 million. The project team were shortlisted for a Health Service Journal award in recognition of their achievements.

However, as with other trusts, we continue to face significant pressures in our unscheduled care pathways due to the rise in demand for acute care.

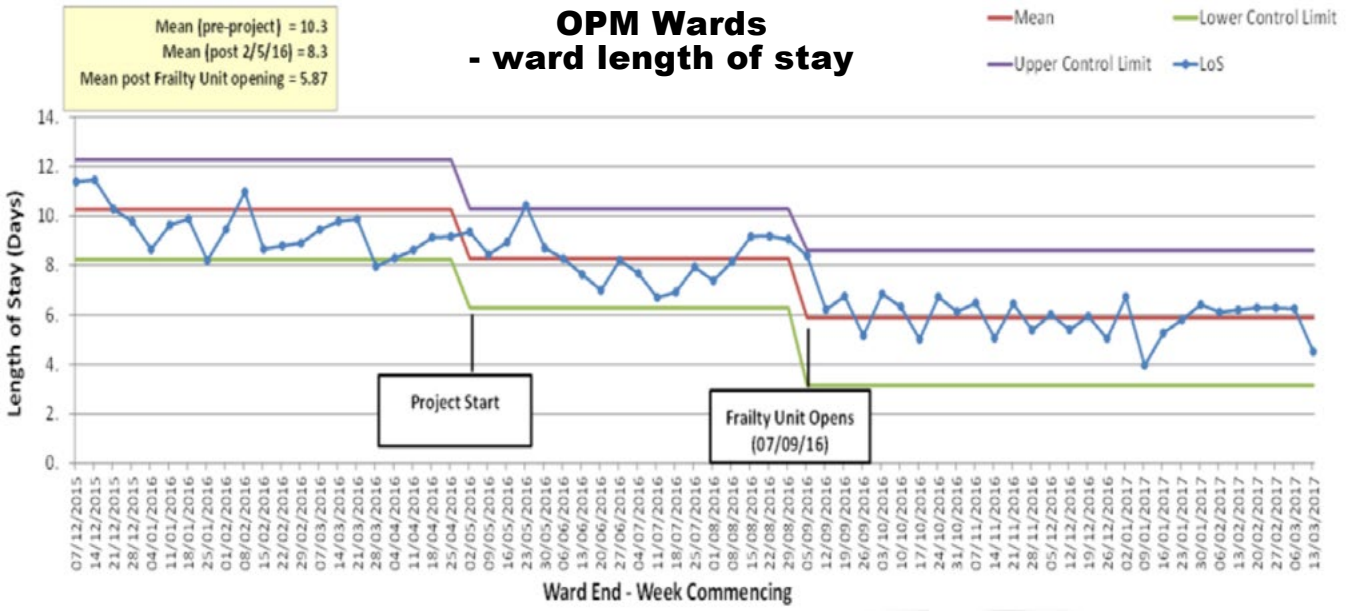
The second phase of the project in 2016/17 aimed to make further improvements in patient pathways to accommodate the growing demand for services and ensure a high quality, responsive service for our patients.

Specific aims included:

- To implement a frailty pathway with direct admissions to Older Person's Medicine
- To provide rapid access Cardiology input for admissions and admission avoidance
- To provide early access to Rapid Access Chest Pain Clinic for chest pain of recent onset
- To ensure early access to investigations
- To develop an integrated Acute Medical admissions unit and ambulatory care service with 7 day specialty in-reach
- Increased Consultant review of inpatients
- Increased ambulatory care access within Treatment Investigation Unit

What did we achieve?

- Implementation of acute frailty unit and frailty pathway in September 2016. The new Unit and pathway enables a streamlined service for Older People to access a Comprehensive Geriatric Assessment within two hours of decision to admit to hospital. Through changing our pathway, the overall length of stay and number of patients who are medical fit and unable to be discharged have reduced and successful discharges have increased.
- There is now a dedicated space for an ambulatory Cardiac Clinic provided on Ward 21. This facilitates early access to specialist assessment.
- Implementation of daily (including weekends) Respiratory Consultant ward rounds for patients that are unwell, and new or potential discharges on Wards 2 and 3.
- Reduction in Length of Stay (LOS) from 10.3 days to 5.87 days for patients within the Older Person's Medicine directorate



Emergency Laparotomy Surgery - Improving patient outcomes through Quality Improvement

The National Emergency Laparotomy Audit (NELA) November 2014 results indicated that the Trust performance for mortality associated with Emergency Laparotomy was ranked as average. The crude mortality rate was 11.9% and high-achieving centres had a much lower rate of around 5%.

As a result a Quality Improvement project was commenced in December 2014 with a clear aim to 'reduce mortality rate from emergency laparotomy surgery from 11.4% to 9% by the end of 2015/2016'.

Following introduction of a new Emergency Laparotomy Pathway the project achieved its initial aim of reducing the mortality rate from 11.9% to below 9% by March 2016.

The project is still going strong and over the past year there have been a number of key achievements:

- Sustained low mortality rates
- Introduction of an acute abdomen pathway
- Now an active member of the Wessex collaborative for emergency laparotomy
- Commencement of joint mortality review meeting with Surgery and Anaesthetics teams
- Introduced new surgical and anaesthetics charts
- Overall increased awareness across the Trust especially within surgery regarding the care of this patient group

Currently the mortality rate for Emergency Laparotomy in the Trust continues to be under the target of 9%.

Quality Improvement 'next steps' for 2017/2018

- continue participation with the Wessex Collaborative
- incorporate acute abdomen pathway into the generic admission booklet

HSJ Award nominations

The Trust was delighted that two of our teams have been shortlisted for the 2017 HSJ Value in Healthcare Awards, due to be presented in May 2017. These prestigious, national awards recognise outstanding practice and cutting-edge innovations in healthcare.

Our Christchurch Day Hospital Team has been recognised in the category 'Improving Value In The Care Of Frail Older Patients.' Recognising the need for change, our Day Hospital Team worked with Bournemouth University to achieve Practice Development Unit Accreditation, identifying ways to improve and taking ownership of their own 'light bulb moments'. The team achieved huge changes, from financial savings, to reducing waiting times from 12 to five weeks.

The team has also worked to involve patients when making improvements and found new ways to liaise with the wider healthcare community, attending virtual ward rounds with local GPs to identify frail older people earlier.

The second shortlisting is for the category 'Improving the Value of Surgical Services'. Working closely with our vascular consultants, Marcus Blake and Tim Randell from our orthopaedic and physiotherapy teams developed a soft cast protector for amputee patients. The new soft cast protector has been designed to be lightweight and comfortable, aiming to reduce the risk of falls related to badly fitting post-operative casts. Their entry outlined that: "for the small cost of fitting a soft cast amputee protector, we are potentially saving hundreds of pounds in reduced length of stay, reliance on pain killers, reliance on carers and thousands of pounds if someone needed revision surgery".

The Nursing, Allied Health Professional (AHP) and Biomedical Science Staff Conference

This conference was held on 11 May 2017 to celebrate the respective international midwives and nurses day with our staff and also to embrace our AHP and biomedical science colleagues. The conference was attended by over 100 members of staff from different staff groups. National keynote speakers included Dame Donna Kinnair, Director of Nursing, Policy and Practice at the RCN, and Shelagh Morris, Deputy Chief Allied Health Professionals Officer, NHS England. The afternoon was a celebration of practice improvement as staff presented the work they were doing in their own areas.

Bournemouth Diabetes and Endocrine Centre (BDEC) celebrate National Standards

BDEC has recently been awarded three national quality standards by the Quality Institute for Self-Management Education and Training (QISMET), an independent body, for its structured education programmes, BERTIE, Pumps and LWD (Living with Diabetes).

Gaining QISMET certification is true marker of excellence and an effective way to demonstrate the management and delivery of programmes is of high quality.

"Once again the Diabetes Team has demonstrated its commitment to provide the highest quality assured education and service to our patients. They are a truly remarkable team of which I am very, very proud. We are delighted to be recognised for this and it is very timely in that the BERTIE education programme is about to be rolled out across Dorset as part of the Dorset Diabetes Service.

Dr Helen Partridge,
Consultant and Clinical Lead Diabetes and Endocrinology

Information Standard Quality Mark

Patients coming to the Royal Bournemouth and Christchurch hospitals can be assured the information they are receiving is of the highest quality thanks to the Information Standard quality mark.

A selection of the Trust's patient information leaflets were assessed by the Royal Society for Public Health before being awarded the mark.

The Information Standard is a certification scheme commissioned by NHS England which assesses whether the information an organisation produces is clear, concise, evidence-based and current. It also aims to ensure that a robust system is in place for the approval and recording of medical information.

The Trust produces a wide range of patient information including advice on preparing for a clinical procedure, details and guidance on specific diets, and advice following surgery. Achieving the accreditation means all of our patient information leaflets can continue to carry the official Information Standard quality mark - a clear indication that it is accurate and reliable.

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

Joanne Sims,
Associate Director of Quality and Risk

The Trust has more than 1,200 patient information leaflets currently in circulation which have gone through a detailed approval process. Information is reviewed on a monthly basis and also includes website content and patient films. In 2016, more than 100 new leaflets for patients were produced.

Improving accessibility for website users

The Trust has installed the reading and translation support tool Browsealoud, to ensure its website content is accessible to all.

The tool, available from any page of the RBCH website, is able to read aloud in 78 languages including English, Afrikaans, Polish, Turkish and many more.

Users simply select the orange headphone logo, highlight the text they'd like read aloud, select their preferred language and press play.

The tool offers a diverse range of reading and translation support. The primary function is turning text into speech, allowing users to click on any text to hear it read aloud while being highlighted for visual guidance. Visual guidance offers magnification of the highlighted text.

The tool also allows users to download and store content as an MP3 file.

The software, which works best on Firefox and Google Chrome, is designed to block screen distractions using a tinted mask, simplify the website and allows users to customise options to suit their individual needs.

All the features are accessed from an easy-to-use, floating toolbar - allowing the user to drag and drop it anywhere on screen. The Trust website also includes additional guidance, including a user friendly video, on how to maximise use the tool.

For more details go to Accessibility page on the Trust website **www.rbch.nhs.uk/about_the_trust/accessibility.php**

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.

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 outpatient departments and 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.

The results are reviewed through the Healthcare Assurance Committee 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.

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)		**FFT April 15 - March 16 (all areas)**	
Extremely likely responses	16626	Extremely likely responses	25711	Extremely likely responses	34089	**Extremely likely responses**	**34065**
Likely	3466	Likely	5013	Likely	6289	**Likely**	**5264**
Neither likely/nor unlikely	437	Neither likely/ nor unlikely	569	Neither likely/ nor unlikely	569	**Neither likely/ nor unlikely**	**498**
Unlikely	208	Unlikely	246	Unlikely	232	**Unlikely**	**215**
Extremely unlikely	287	Extremely unlikely	380	Extremely unlikely	391	**Extremely unlikely**	**358**
Total	**21024**	**Total**	**31919**	**Total**	**41570**	**Total**	**40400**

FFT April 13 - March 14 (all areas)		FFT April 14 - March 15 (all areas)		FFT April 15 - March 16 (all areas)		**FFT April 15 - March 16 (all areas)**	
Extremely likely responses	79.1%	Extremely likely responses	80.6%	Extremely likely responses	82.0%	**Extremely likely responses**	**84.3%**
Likely	16.5%	Likely	15.7%	Likely	15.1%	**Likely**	**13.0%**
Neither likely/nor unlikely	2.0%	Neither likely/ nor unlikely	1.8%	Neither likely/ nor unlikely	1.4%	**Neither likely/ nor unlikely**	**1.2%**
Unlikely	1.0%	Unlikely	0.8%	Unlikely	0.6%	**Unlikely**	**0.5%**
Extremely unlikely	1.4%	Extremely unlikely	1.1%	Extremely unlikely	0.9%	**Extremely unlikely**	**0.9%**

Inpatient returns have remained above the 15% compliance target and the percentage of patient to recommend has remained around 98% and consistently in the higher end of the top quartile for trusts.

Emergency Department returns have been below the 15% compliance target but work is ongoing to try to improve uptake and ensure patient engagement in the FFT return. The good news is that the percentage of patient to recommend is predominantly in the top quartile of trusts in the country with occasional dips into the second quartile. This may be indicative of an increased service demand at these times but the return data is too low to accurately assess this.

While there is no national compliance target for Outpatient Departments, the number of returns when shown against the number of patients eligible to respond each month is around 6%. Patient recommendations remain fairly consistent at around 96% and at the lower end of the second quartile with occasional dips into the third quartile.

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
- Macmillan Caring Locally
- Healthwatch
- The Patients Association
- Bournemouth Leukemia Fund

Bluecoat volunteers duties are extensive, including:

- reception areas meet and greet
- ward support including tea and coffees
- patient companions, who have dementia awareness training
- administration support throughout the Trust
- driving the indoor bus to help patients and visitors around the hospital
- surveying patients for real time patient feedback
- meal time companions and meal time assistants
- pharmacy robot
- medical photography escort
- End of Life Companions
- Pets As Therapy (PAT) dogs

- Stroke unit- Speech and Language therapy (SALT) volunteers assist with conversations
- Physiotherapy volunteers
- One off requests to escort patients
- Patient-Led Assessments of the Care environment (PLACE) visits
- Heart Club volunteers
- Security/CCTV volunteers
- Young volunteers
- Internal Cardiac Defibrillator (ICD) Buddies
- Stoma Buddies
- Breast Care Headstrong volunteers

Our Bluecoat Volunteers

Mealtime Companions

Young Persons event and Student Volunteer Patient Experience Award

We have continued to work with our younger volunteers too. This year we have held as First Aid training course for our young volunteers and future Young Person's Stakeholder events are being planned for 2017/18 to ensure we understand what would attract younger people into volunteering and how we can make it as enjoyable and worthwhile for them as we can.

In year the Trust has started to present celebrate longstanding contributions from our volunteers with Length of Service awards for 5, 10, 15, 20 and 25 years' service to the Trust.

One of our volunteers receiving their 15 year service award

We continue to recruit volunteers who are happy to provide support during the day (especially afternoons) or at evenings or weekends.

The Board of Directors are 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.

To show their appreciation this year the Trust hosted the annual afternoon tea in a marquee by the lake.

Anne Alcock has been volunteering in the Oncology Department at RBH for seven years. She said:

"I've been to a few tea parties now and I always enjoy them. Being together with the other volunteers - whose names I only usually see written in the diary - was a real highlight for me. We share a goal so it was nice to all get together. The atmosphere was great and it meant a lot to be recognised by the senior team."

Jean Cargill volunteers for four shifts each week and has been with us for just over a year. She said:

"I didn't realise how many of us there were until we all got together for the tea party. It was a lovely reception - a real treat."

Quality Improvement plans for Patient Experience 2017/2018

- A series of focus groups are arranged for the coming year including a week-long event focusing around Carers Week and supported by a number of local care support groups and short talks
- Lesbian, gay, bisexual and transgender (LGB&T) work continues to make sure the Trust is accessible to all. The Vox Pop video completed and used on several occasions and well received at Trust Board the Wessex Quality and Improvement Conference
- Work continues with the Informatics department to triangulate the patient experience data, giving the wards automated feedback monthly instead of quarterly.

Care Campaign Audit

One of the main patient feedback audits this year has been the Care Campaign Audit. In partnership with The Patients Association, the Care Campaign Audit has been designed to ensure robust feedback on a daily basis from participating older peoples medicine and medical wards. The audits are facilitated by trained volunteers and review five key objectives:

- Communicating with care and compassion
- Assistance - ensuring dignity
- Relieving pain effectively
- Ensuring adequate nutrition
- Managing expectations

The completed audits forms are returned to the Patient Experience Team and reviewed individually on a daily basis. If issues are identified the ward is contacted immediately and informed of the area of concern and an action plan put in place for improvement. The audits have led to improvement in privacy and dignity, communication, pain control and nutrition.

A review of the questions has been carried out by the senior nurse group. The audit questions have been reviewed and refined to respond to common themes across the Trust with minor alterations made to some questions to drill down to more specific responses.

The table below indicates some of the scores for annual comparison.

Care Campaign Question	March 2015 Score	March 2016 Score	March 2017 Score
Section 1 Communicate with care and compassion (total of all questions) e.g.	90%	91% ↑	93% ↑
Did staff ask you what name you preferred to be known by/ called	92%	91% ↓	93% ↑
Do staff use your preferred name when they speak to you	95%	98% ↑	99% ↑
Section 2 Assistance and ensuring dignity (total of all questions)	94%	95% ↑	95% ↔
Section 3 Relieve pain effectively (total of all questions) e.g.	84%	87% ↑	92% ↑
Do staff use other methods to relieve your pain?	83%	79% ↓	94% ↑
Section 4 Ensuing adequate nutrition (total of all questions)	94%	93% ↓	94% ↑
Are the meals provided enough for you?	87%	95% ↑	95% ↔
If you are unable to eat a full meal were you offered regular snacks and drinks?	89%	90% ↑	95% ↑
Are you supported to eat your meals without interruption?	93%	94% ↑	92% ↓
Section 5 - Managing expectations (total of all questions)	91%	94% ↑	91% ↓

The results of the Care Campaign Audit (CCA) have been used to identify four main themes for action. Working groups led by Matrons have been set up to look at Quality Improvement opportunities for pain management, food and drink, response to call bells and noise at night

Learning from complaints and concerns

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 293 formal complaints received by the Trust for 2016/17, which is a reduction on the previous year (313 complaints received in 2015/16) complaints.

In year the Complaints Team has been reviewed with new work patterns and procedures introduced. A new Complaints Performance meeting has been initiated and this has resulted in high engagement within directorates and improved turnaround in complaint response times.

The focus of the Patient Advice and Liaison Service in resolving concerns informally with front line stuff has been constructive and has supported early discussion and resolution with complainants. The Trust has introduced Customer Care training, which details how to respond to an arising concern and how the PALS team can support staff to manage and resolve concerns. More meetings have been offered to resolve concerns and a sustained focus on closing complaints, and ensuring outcome actions and learning has taken place.

Complaint outcomes

There were 293 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 focus on ensuring outcomes are systematically recorded and learning is disseminated remains the focus for the 2017/18 year plan.

Subjects of complaints

The main categories of complaint were as follows:

Subject	Formal Complaints 2016/17		Formal Complaints 2015/16	
	Number	Proportion	Number	Proportion
Implementation of care	135	46%	112	36%
Admission, transfer and discharge	52	18%	61	20%
Diagnostic tests (not pathology)	25	8%	58	19%
Communication and consent	61	21%	55	18%
Medication	1	0%	9	3%
Security	2	1%	3	1%
Equipment, resources and staffing	5	2%	2	1%
Food Safety and Service	0	0	1	0%
Visitor incidents/accidents	1	0%	1	0%
Treatment, procedure, care	0	0%	1	0%
Staff incident	0	0%	1	0%
Patient incidents (including falls, other accidents and self-harm)	5	2%	7	2%
Environment	3	1%		
Infection Control	2	1%		

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
"My husband was told at 13.30 he could go home but we had to wait until 5pm for his medications and letter".	• Inform our patients' and relatives about how long it will take to obtain medications from pharmacy. • Weekend extended pharmacy services to be continued Summer 2017.
"The waiting area is dark and some of the chairs are worn".	• We have decorated the waiting area and are in the process of raising funds to refurbish the chairs.
"A delay in organising my medication for discharge resulted in me having to wait longer than anticipated on the ward."	• Ward staff have been reminded to use the Pharmacy drug tracking system so that they can monitor the progress of patients' medications. The pharmacy weekend service is currently being reviewed.
"I was not kept informed about delays in clinic"	• Reminded staff of the importance of informing patients of any delays in clinic and also making sure this has been done electronically so patients can see on the screens in the waiting area.
"Someone tried to call me to ask me to come in to hospital later, but it was a withheld number, so I didn't answer"	• We now have a telephone number that comes up when we ring you, so you can identify who is calling enabling you to call us back or answer the next call.
"I am worried that my belongings will get lost in transit if I have to move wards. This happened to one of my neighbours"	• We have organised training for our volunteers to assist in packing up patient belongings to make sure they are appropriately transferred should you have to move wards.
"I live a long way away and I'm worried my mum, who has dementia, has no one to keep her company on the ward when I'm not there"	• Our ward volunteers have comprehensive training as dementia companions, and often play cards; dominos and share memory books. We are starting some art groups and music too.
"The pre-operation patient information wasn't clear."	• Staff are in the process of reviewing all pre-assessment patient information literature.
"It would have been helpful to have a toilet roll holder fixed to the wall in bathroom"	• We have had attached all toilet roll holders to the walls and fixed any that needed repair.
"The tea/ coffee bar shut early so no refreshments available"	• • We do have a cold water dispenser in the department for everyone to use, also there are now two vending machines in the corridor between main outpatients and eye outpatients for use when the coffee bar is closed. • We are looking into extending the tea bar opening hours and have ordered a vending machine for the department.

Problem	We did
"There is a lack of appointment information and waiting time expectation within my letter"	• Reviewed and updated patient appointment letters.
"I think it would be nice to have some background music. The waiting area feels quite awkward"	• A television is now fitted in the waiting room to make the environment more patient friendly.
"Because he suffered from MS and was unable to press the hand held alarm bell he felt a little isolated sometimes"	• Staff have been reminded that chin bells are available and to offer extra attention to patients who are unable to press call bells themselves.

Referrals to the Parliamentary and 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 Parliamentary and Health Service Ombudsman (PHSO).

In 2016/17 11 cases were investigated by the Parliamentary and Health Service Ombudsman (PHSO) compared to 12 in 2015/16. The PHSO fully or partially upheld two cases, three were not upheld and sixcases are still in progress. This is in line with previous years.

Other patient experience news

Flying the Green Flag

In August 2016 the Trust was the first in the UK to ever fly the Green Flag, awarded to our Sustainability Team for maintaining our lakeside and green spaces to the highest possible standard. This allows patients, their families and our staff to use these beautiful grounds year round

Jigsaw 'Orchard Garden'

A patient's environment is a vital element to treatment and can have a really positive impact on their experience at what is a very frightening and difficult time of their lives. Patients often have to wait an hour or more for blood results in order that the correct amount of chemotherapy can be given, so to have a dedicated garden area where they can wait and relax gives a far more relaxing experience.

Research has shown therapeutic gardens could help to lower blood pressure, alleviate stress and reduce depression as well as reduce the requests for pain relief.

The Trust has been fortunate enough to get further support from Charity to develop the outside space in order to improve the experience for patients and visitors.

Over 1000 cancer patients per month access the unit and will benefit from this new facility.

This project will enhance the experience of patients using the Jigsaw building by providing a dedicated garden area accessible to patients before, during and after procedures.

It will additionally provide a much better outlook for our many patients receiving renal dialysis on a regular basis.

Flowers and plants have a well-known link with joyous occasions and new beginnings. Their natural beauty is simple and yet can help lift a person's mood which is why many will consider giving flowers to cheer someone up or help them feel better.

The gardens will benefit the hundreds of patients, relatives, friends and staff who will use the Jigsaw Building each year.

Increasing Dementia Awareness

'Tommy on Tour' March 2017

The Trust was fortunate enough to receive a visit from Tommy Whitelaw, who was a full time carer for his late mum who was living with vascular dementia. Tommy is now travelling around the UK raising awareness of dementia as part of the 'The Dementia Carers Voices Project with the Health and Social Care Alliance'. Tommy's experience highlights the impact on families and carers and he hopes to engage with health and social care professionals by sharing his story. Tommy's session was attended by over 200 Trust staff and was found to be very emotive.

To watch the video of Tommy's trip to our hospital, go to https://www.youtube.com/watch?v=HWR8-2SOX9A&feature=youtu.be and to watch Tommy's moving video, go to **www.youtube.com/watch?v=ag8qwLmW5s4**

Alzheimer's Society Dementia Bus

The Trust received a visit from the Alzheimer's Society Dementia Bus earlier this year as part of its four day national tour of the UK. The bus was staffed by Dementia volunteers including a lady who is living with Dementia and a gentleman who has been a carer for a loved one with Dementia.

This visit gave staff, patients and visitors an opportunity to come and talk about Dementia and get advice and signposting.

The volunteers said there was great engagement by our staff and they were delighted with the numbers of people visiting and getting involved.

Petal Garden

A new The 'Petal Garden' is being designed between Wards 4 and 5. The garden will be a sensory garden for use by patients living with Dementia. Charity donations were secured to fund this garden and it is planned to commence work after Easter with the aim to have this completed by end of the summer.

As this garden will be used by all of the Older Person's Medicine Wards 24, 25, 26, 4 and 5, each ward will have a 'petal' section of their own design to plant and maintain. Each petal will be a flowing and continuous curved feature, so patients can freely wander safely and return to the centre of the petal design. The garden will be a sensory garden with careful planting of scented, colourful and tactile plants aiming to provide calming and comforting influences for patients during their stay.

Other Dementia Friendly improvements

In early 2013, we started thinking about the design of the existing wards and how the environment affects patients with dementia. Following on from the principles learnt from The King's Fund Enhancing the Healing Environment, Ward 26 was the first ward to have some improvements. These included renewing the floor covering, fitting dimmable LED lighting, improving wayfinding by colour coordinating the bays, colour coordinating the WC doors with pictorial signage, introducing nursing pods into the bays, forming a patient seating area, removing the barrier of the nurse station and forming a new reception. Since then other wards have seen these improvements, adjusting the design of the wards as we learn what works well. This year other wards are planned to be improved.

New orientation boards for all wards have been installed.

Performance against national priorities 2016/17

National Priority	2012/13	2013/14	2014/15	2015/16	2016/17 Target	2016/17 Actual
18 week referral to treatment waiting times - admitted	94.5%	90.8%	88.9%	84.5%	90.0%	**81.0%**
18 week referral to treatment waiting times - non admitted	98.9%	98.4%	95.6%	94.4%	95.0%	**89.0%**
18 week referral to treatment waiting times - patients on an incomplete pathway	97.1%	96.2%	94.3%	93.7%	92.0%	**91.5%**
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	97.2%	95.5%	93.3%	93.37%	95.0%	**94.6%**
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	88.6%	80.3%	84.5%	85.9%	85%	**85.7%**
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	98.6%	93.4%	93.1%	76.0%	90%	**96.9%**
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	96.4%	95.7%	95.8%	95.7%	96%	**98.3%**
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	98.8%	95.1%	92.5%	94.1%	94%	**96.3%**
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti cancer drug treatment	100%	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%	96.1%	93%	**96.1%**
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	97.0%	98.0%	91.1%	99.4%	93%	**98.8%**
Clostridium difficile year on year reduction	31	14	21	14	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	Compliance certified

Annex A

Statements from commissioners, local Healthwatch organisations, Scrutiny Committees and Council of Governors

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)

Dorset Clinical Commissioning Group welcomes the opportunity to provide this statement on Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust's Quality Account. We have reviewed the information contained within the Account and can confirm that the information is accurate where available to us as part of existing contract/performance monitoring discussions.

During the year Commissioners have seen progress in a number of areas including a reduction in avoidable pressure ulcers and learning from mortality reviews. An area worthy of particular mention is the excellent progress made in stroke performance reflecting a recognised, valuable service for the patients it serves.

In addition to the above we commend the Trust for its continuing ambition to develop a more open and honest culture supporting staff to deliver safe, high quality care.
The CCG is supportive of the quality priorities for 2017/18. As Commissioners we look forward to the Trust demonstrating the improvements in patient care they will be applying over the coming year and we commend the fact that there is a willingness to work collaboratively to improve the experience for the population it serves.

Statement from People (Health and Social Care) Overview and Scrutiny Committee P(HSC)OSC

Members of Borough of Poole's P(HSC)OSC would like to thank the Trust for enabling representatives from the committee, Cllrs Malcolm Farrell and Russell Trent to meet with yourselves to discuss quality issues over the last year and also to comment on the Quality Account for 2016/17.

The presentation about the account delivered on 23rd March 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. This is commendable especially in a period of unprecedented organisational change through the work of the vanguard programme and the awaited outcome of the Clinical Services Review.

Representatives from the committee were also enthused by the passion and commitment shown by staff during the presentation. It was refreshing to hear about innovations within particular specialist areas such as stroke and

older persons medicine which gave much clarity and insight into the complexities of working in a hospital and working with partner agencies to deliver a quality service to the patient.

With regard to the priority areas for improvement for 2016/17 representatives from the committee would like to 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 performance has been maintained in this area over the last two years and that the Trust has maintained a score that is above the England average.

Reducing the numbers of hospital acquired pressure ulcers - again it is encouraging to note that performance has been maintained in this area over the last two years. What is particularly pleasing is the significant year on year reduction in numbers of grade 3 hospital acquired pressure ulcers since 2013. We welcome an update in this area during our next mid year visit .

Inpatient falls - members note that inpatient falls resulting in harm have reduced slightly compared to 2015/16 and that the Trust is performing above the national average in this area. What is most encouraging to note is that falls resulting in serious harm have reduced significantly since 2015/16.

Ensuring patients are cared for in the most appropriate setting - representatives of the committee note good progress made on reducing the numbers of bed moves during an inpatient stay and that measures have been taken to improve end of life care choices and facilities for patients and their loved ones. 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 was useful to understand that steps are being taken in an attempt to address this issue including education sessions for staff about ensuring sampling is timely and that isolation of the patient is not delayed and that issues regarding labelling samples is also being addressed. We welcome an update on this area during our next mid year visit.

Actions arising from the Care Quality Commission Inspection-members were interested to understand the progress made by the Trust following on from the 2016 inspection. They were pleased to note that 29 of the 30 must do actions from the inspection had been fully completed by the Trust. It will be interesting for the committee to understand the outcome of the further inspection anticipated at the latter part of this summer. The committee also note that the Trust have performed well in regards to patient satisfaction for the Friends and Family Test.

The committee will be interested in understanding progress against the priority improvement areas set for next year which include the management of sepsis, identification and escalation of the deteriorating patient and improving hospital flow. We look forward to receiving these updates and meeting with staff to gain further insights into the work of the hospital over the coming year

Statement from Bournemouth Health Scrutiny Panel

This quality account is encouraging in that in difficult times, with greater pressure on both finances and services, the hospital has managed to maintain clear focus on what they want and to make a difference. The first CQC report gave several areas to address and the hospital has engaged widely and sought to make the changes necessary to improve as the new inspection system beds in.

Their desire for openness and candour is to be applauded as is the falling in the number of serious incidents. It will be interesting to see if the Share to Care initiative can improve these results still further.

It is encouraging to see some innovative initiatives being used to support relatives and patients at the most difficult time with end of life care. As the account says, there is only one chance to get it right.

Fighting infection, particularly brought in from outside, continues to need addressing though with such a busy hospital and so many people coming and going figures are generally about the "norm", whilst the hospital are not complacent and seeking to excel.

I would also add that it was a pleasure to read the report and find the acronyms and abbreviations explained in so many places. This really does make this document so much more accessible to the public.

Statement from Healthwatch Dorset

As the independent voice for patients and the public, Healthwatch Dorset is committed to ensuring local people are involved in the improvement and development of health and social care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts, which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers). In Dorset, this translates to Quality Accounts from five NHS Trusts.

Each document is lengthy and each year we spend many hours reading the draft Accounts and giving suggestions on how they could be improved to make them meaningful for the public. Each year we comment on what each Trust is doing to involve patients and the public and how it might improve the ways in which it engages and listens to all the communities it serves. But continually and continuously through the year we are already, in our day-to-day work, monitoring and commenting on the quality of services of our local NHS providers.

This year we have decided not to spend the hours necessary to read each Quality Account and compose a special commentary on it. Whilst we appreciate that the process of Quality Accounts is imposed on the Trusts, we do not believe it is a process that is accessible to patients or their families, friends or carers, in its current format. We have limited resources and we want to focus them on standing up for and promoting the rights of patients and the public and on supporting and holding Trusts to account for the ways in which they involve patients and the public.

We will continue to provide feedback to the Trust, as appropriate, throughout the year through a variety of channels to improve the quality, experience and safety of its patients, their families and the wider population of Dorset.

Response from the Council of Governors to the Quality Report

Bournemouth Health and Adult Social Care Governors have been actively involved in the quality improvement program of the Trust throughout the year.

Governors have had the opportunity to review and comment on the Quality Report through their Strategy Committee, which was established in January 2016 to ensure that the information in the Quality Report provides wide-ranging, clear and meaningful messages about the quality of care provided to patients.

The Quality Report acknowledges the pressures faced by acute hospitals in terms of increasing demand, staff shortages in some specialities and funding among others but also shows the ongoing continuous improvements happening on the ground in our hospitals in terms of waiting times, the learning and open culture and the standards of care provided to patients.

Each year, the Governors make a tangible contribution to the quality improvement program of the Trust by selecting a quality indicator for external audit. In 2016/17, they were selected the number and types of complaints received by the Trust, whilst recognising the significant improvement the Trust has made in responding to complaints and encouraging patients and their relatives/ carers to raise any concerns at the time so that action can be taken immediately.

The Governors have been encouraged by the progress made in reducing the number of non-clinical patient moves since they selected this indicator as the quality indicator for external audit in the Quality Report for 2015/16.

As well as the reduction in the number of patients affected by moves for non-clinical reasons, there has also been an improvement in developing models of best practice and systems to monitor this.

Governors support the quality priorities that have selected for 2017/18 to improve the quality and safety of care for patients in our hospitals and will continue to be involved in a range of activities to help and support the Trust in delivering these priorities. Through this involvement, Governors get an insight into how the Trust's quality processes are working, opportunities to hear from staff how they are able to be effective and an appreciation of where improvements are being delivered or needed. The activities include the following:

- involvement in public, patient and carer experience and listening events;
- 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;
- visiting different areas of the Trust;
- governor representation at key Trust committees including the Healthcare Assurance Committee, End of Life Care Steering Group, Mortality Group and Workforce Strategy and Development Committee.

Governors have taken part in focus groups with the Care Quality Commission ahead of its next inspection later in 2017 to give their views on the progress against the action plan following the last inspection and on the work of the Trust overall to improve the consistency in the delivery of high quality care and a positive experience for patients.

Statement from NHS West Hampshire Clinical Commissioning Group (CCG)

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 the 2016/17 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 see the focus on developing an open and honest culture, including the reporting and management of incidents. At the same time as doing this the Trust has also demonstrated a significant reduction in the number of serious incidents reported and zero Never Events reported, which is a particularly reassuring achievement. The introduction of the new LERN (Learning Event Report Notification) form also places the focus firmly on learning from things that don't go according to plan as well as things that go well or could be done better.

Although the CCG notes that the Trust breached the NHS England set target of 14 cases of Clostridium Difficile infection (CDI), it is encouraging to know that when compared nationally the Trust still has comparatively low rates, and that the Trust continue to ensure that any learning from identified "lapses in care" is captured and embedded into practice.

The Trust has maintained its focus on the important area of reducing the number of patient falls, and this has been shown by an overall 7% reduction in falls from 2015/16 to 2016/17. Attendance by the CCG quality team at their falls steering group provided a helpful insight into the commitment that all members of the multidisciplinary team have to continue to reduce the number and severity of patient falls in the hospital.

It is right to congratulate the Trust on their continued progress with improving the management of patients being admitted with a stroke, reflected in their ongoing achievement of the Sentinel Stroke National Audit Programme (SSNAP) level A since Q4 2015/16. This is particularly commendable in light of their previous ratings of level D reported during 2014/15. A clinical presentation from the Stroke team followed by a clinical visit by the CCG has demonstrated that the stroke team are not just content to maintain the current level of stroke care but are focusing and targeting their efforts on those elements of stroke care where further improvements can be made to achieve the highest standard possible.

West Hampshire Clinical Commissioning Group colleagues were pleased to attend the Trust's second annual Safety and Quality conference, along with a large number of Trust staff, held in September 2016 and it was encouraging to hear about the comprehensive learning that had taken place following serious incidents as well as a selection of presentations highlighting a number of Quality Improvement initiatives that are being progressed.

The Trust has acknowledged that their income was not dependent on achieving quality improvement and innovation goals through the Commissioning for Quality and Improvement (CQUIN) payment framework. However the CCG has monitored the Trust's progress against the National CQUIN requirements and has identified that they have only partially achieved the targets as set out in the National CQUIN guidance.

- The Trust has shown a significant commitment to improving the health and well-being of their staff and have fully achieved the requirements of this CQUIN
- It is clear that the Trust are committed to "Managing Sepsis" and have identified this as one of their quality objectives for 2017/18. However, due to adopting an alternative method of auditing their progress in improving the identification and treatment of patients with Sepsis mid-year, the CCG are not able to confirm that they have achieved the specific requirements as set out in the CQUIN guidance
- The Trust has made progress with regards to Antimicrobial resistance and stewardship and has demonstrated a significant reduction in usage of antibiotics over recent years. The National guidance measures this achievement against the baseline reported in 2013/14 and the Trust has not achieved the 1% reduction required in all required areas.

The Clinical Commissioning Groups note that during 2016/17 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has been an active participant in the Clinical Commissioning Group led Wessex Patient Moves Pilot. We are pleased that they will continue to be involved during 2017/18 with the aim of reducing patient moves that take place 'out of hours'. This will support the Trust's quality object for 2017/18 which is focused on "Improving Hospital (patient) flow"

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

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.

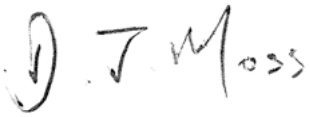
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality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

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

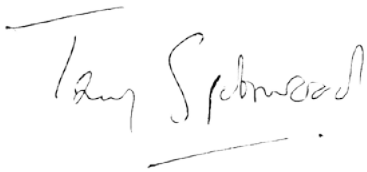
- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to March 2017
  - papers relating to quality reported to the Board over the period April 2016 to March 2017
  - feedback from commissioners dated 10th May 2017 and 16th May 2017
  - feedback from governors dated 15th May 2017
  - feedback from Local Healthwatch organisations dated 28th April 2017
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated May 2017
  - the latest national inpatient survey (awaiting publication)
  - the latest national staff survey dated February 2017
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017
  - 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account regulations) as well as the standards to support data quality for the preparation of the Quality Report

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



David Moss
Chairperson
23 May 2017



Tony Spotswood
Chief Executive
23 May 2017

Annex C

Independent auditor's report to the Council of Governors of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein..

Scope and subject matter

The indicators for the year ended 31 March 2017 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;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

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

Respective responsibilities of the directors and auditors

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

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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2016/17 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.

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 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 10 May 2017;
- feedback from the Council of Governors;
- feedback from Healthwatch Dorset;
- feedback from People (Health and Social Care) Overview and Scrutiny Committee P(HSC)OSC, dated 26 April 2017;
- Feedback from the Bournemouth Health and Adult Social Care Panel, dated 2 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national inpatient survey, dated January 2017;
- the 2016 national staff survey;
- Care Quality Commission Inspection, dated 25 February 2016;
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2017; and

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 Royal Bournemouth and Christchurch Hospitals 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 2017, 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 Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

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 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.

Limitations

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

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

Basis for qualified conclusion

As a result of the procedures performed in relation to the referral to treatment within 18 weeks for patients on incomplete pathways indicator, we have not been able to gain assurance over the six dimensions of data quality as required by NHS Improvements, with issues identified in relation to the operating effectiveness of the control environment.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 Guidance; and
- the remaining indicator in the Quality Report subject to limited assurance (A&E: maximum waiting time of four hours from admission to admission, transfer or discharge) 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

KPMG LLP
Chartered Accountants
68 Queen Square
Bristol
BS1 4BE

25 May 2017

Glossary of Terms

ADD
Actual date of discharge

AEC
Ambulatory Emergency Care

BERTIE
BERTIE Type 1 Diabetes Education Program

CA UTI
Catheter Associated Urinary Tract Infections

CDD
Clinical Criteria for Discharge - This is the minimum physiological, therapeutic and functional status the patient needs to achieve before discharge. It should be agreed with the patient and carers where necessary

Clostridium difficile
also known as C. difficile, or C. diff, is a bacterium which infects humans, and other animals. Symptoms can range from diarrhoea to serious and potentially fatal inflammation of the colon. ... C. difficile is generally treated with antibiotics

COPD/COAD
Chronic Obstructive Pulmonary Disease/ Chronic Obstructive Airways Disease

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

ECIP
Emergency Care Improvement Pathway

EDD
Estimated Date of Discharge

eNA
Electronic nurse assessments

eMortality
Electronic Mortality capture form

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
The name of the Trust patient electronic document management system

EVOLVE
Early supported Discharge

FCE
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.

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 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.

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.

HSJ
Health Service Journal

Lapse in care
A lapse in care would be indicated by evidence that policies and procedures consistent with local guidance, written in line with national guidance and standards, were not followed by the relevant provider.

MRFD
Medically ready for discharge

MRSA
methicillin-resistant staphylococcus aureus. 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
Malnutrition Universal Screening Tool

NEWS
National Early Warning Score - An early warning score (EWS) is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the six cardinal vital signs (Respiratory rate, Oxygen saturations, Temperature, Blood pressure, Heart rate, Alert/Voice/Pain/ Unresponsive scale). This gives a numerical score.

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

NIHR
National Institute for Health Research (NIHR)

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

QELCA
Quality End of Life Care for All. And rnd of life care focussed education programme.

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.

q-SOFA
quick Sepsis-related Organ Failure Assessment

SALT
Speech and Language Therapy

SAS
Staff Grade and Associate Specialist

Serious Incident
In broad terms, serious incidents are events in healthcare 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.

WHO
World Health organisation.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

The Royal Bournemouth Hospital
Castle Lane East, Bournemouth, BH7 7DW

Christchurch Hospital
Fairmile Road, Christchurch, BH23 2JX

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

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