Quality Report
2017/18

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Part 1

What is a quality account?

All NHS hospitals or trusts have to publish their annual financial accounts. Since 2009, as part of the drive across the NHS to be open and honest about the quality of services provided to the public, all NHS hospitals have had to publish a quality account.

You can also find information on the quality of services across NHS organisations by viewing the quality accounts on the NHS Choices website at www.nhs.uk.

The purpose of this quality account is to:

1. summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2017/18; and
2. set out our quality priorities and objectives for 2018/19.

To begin with, we will give details of how we performed in 2017/18 against the quality priorities and objectives we set ourselves under the categories of:

Patient Safety

Clinical Effectiveness

Patient Experience

Where we have not met the priorities and objectives we set ourselves, we will explain why, and set out the plans we have to make sure improvements are made in the future.

Secondly, we will set out our quality priorities and objectives for 2018/19, under these same categories. We will explain how we decided upon these priorities and objectives, and how we will aim to achieve these and measure performance.

Quality accounts are useful for our board, who are responsible for the quality of our services, as they can use them in their role of assessing and leading the trust. We encourage frontline staff to use quality accounts both to compare their performance with other trusts and also to help improve their own service.

For patients, carers and the public, the quality account should highlight how we are concentrating on improvements we can make to patient care, safety and experience.

It is important to remember that some aspects of this quality account are compulsory. They are about significant areas, and are usually presented as numbers in a table. If there are any areas of the quality account that are difficult to read or understand, or you have any questions, please contact Joanne Sims, Associate Director of Quality and Risk at **Joanne.Sims@rbch.nhs.uk**

This Quality Account is divided into three sections.

Part 1	Introduction to the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and a statement on quality from the Chief Executive
Part 2	Performance against 2017/18 quality priorities and our quality priorities for 2018/19
	Reviewing progress of the quality improvements in 2017/18 and choosing the new priorities for 2018/19
	Statements of assurance from the Board
	Reporting against core indicators
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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 on the progress of Quality Improvement work on improving patient flow and patient safety across the Trust.

We launched our Quality Improvement Programme and QI Academy in 2014 and during this time have achieved a great deal to be proud of, implementation improvements and innovations that have made a big difference to the safety of staff, patients and visitors.

Our programme objectives are designed to support our vision to 'work in partnership and continually improve our services'.

We are particularly proud that our change champion and cultural audit work was recognised by the Health Service Journal Awards for "Staff Engagement" and that the Trust was rated as the top performing Acute Trust in the National Staff Survey. The passion and commitment of our staff to go the extra mile was seen in full over the winter and during the unexpected arrival of Storm Emma.

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 2018/2019. We have engaged with staff through our cultural change programme, quality improvement workshops, focus groups, briefing sessions, Trust and directorate governance meetings.

We have talked 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 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.

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

Part 2

Priorities for improvement and statements of assurance from the board

Progress against quality priorities set out in last year's quality account for 2017/2018

In the 2016/ 2017 Quality Account the Trust identified the following key areas for improvement during 2017/2018.

- **Sepsis**
  - 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.
- **Escalation of the Deteriorating Patient**
  - 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.
- **Improving Hospital (Patient) Flow**
  - To improve emergency hospital flow to deliver 'the right patient, at the right time, to the right place'.

The Managing Sepsis and Deteriorating Patient projects were merged into one Quality Improvement project as the work to support these was cohesively aligned.

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 Improvement Programme Board. 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.

Improving the management of Sepsis and the escalation of the Deteriorating Patient

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 the 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 for 2017/2018 was:

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.

There was a specific focus 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 time and b) documentation of treatment decisions in patient notes.

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

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

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.

There was a specific focus to ensure:

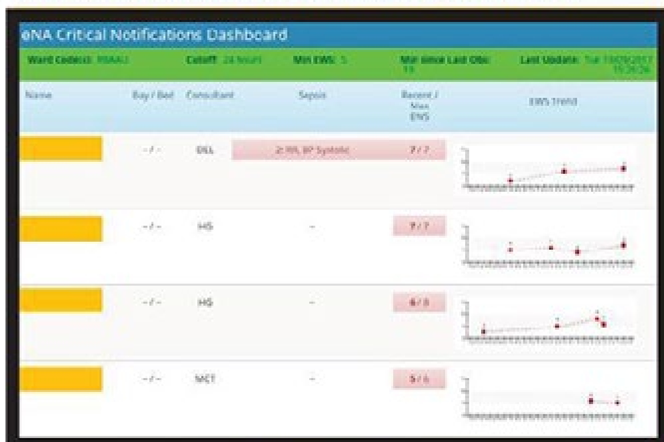
- reliable assessment, identification and early recognition of clinical deterioration;
- reliable therapeutic response and escalation using structured protocols;
- a reliable activation system and tools (including electronic) are in place when calling for a response.

What did we achieve?

We:

- Developed trigger tools to help identify septic and deteriorating patients.
- Designed and adapted audit forms to routinely capture important patient safety information
- Completed over 1,800 audits of patient care and compliance with sepsis and deterioration patient standards.

- Introduced sepsis and deteriorating patient stickers for patient notes to act as a prompt for staff and to improve documentation standards.
- Developed a Critical Notification Dashboard (CND) - which was to be rolled out April 2018



NHS
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Making sure we are there when you need us

We are now displaying the vital observations of patients on our wards. This is to make sure that if you need help urgently, we are informed as quickly as possible. The screens look like this:

If you have questions or wish to discuss what is being displayed, please speak to the nurse in charge on your ward

Patient CND poster

- Undertook a successful "Action Learning Week" in June 2017

Action Learning Week June 2017

Staff on the team
33 clinical
11 non-clinical

- Developed eNA Sepsis application to support recognition and treatment
- Delivered teaching to junior doctors and ward staff
- Developed an education and training package for all staff as a result of staff feedback from the Action Learning Week. Training was made mandatory for all clinical staff from 1 April 2018.

Junior Doctor sepsis teaching
for all new FY1s in
July and August 2017

BEAT team at the sepsis and

- Developed a process for the Critical Care Outreach Team (CCOT) to collect deteriorating patient data daily and feedback results to ward teams for immediate learning.
- Worked as an active member of the Wessex Academic Health Science Network (AHSN) Collaborative for sepsis and deteriorating patient sharing tools, and ideas across partner organisations.
- Purchased new equipment to speed up diagnosis of critical illnesses.

Two new machines which enable clinical teams to assess the severity of a patient's illness are now in use at the Royal Bournemouth Hospital (RBH).

The blood analyser 'Gem 4000' machines measure lactate in a patient's blood which, alongside clinical assessment, gives clinicians vital information on the physiological stress a patient is under.

They are located in RBH's Acute Medial Unit and Surgical Admissions Unit - both key areas of the hospital where patients are admitted - and will be used alongside machines already in place in the Emergency Department, Intensive Care Unit and Respiratory Department.

The new machines mean staff do not have to travel to other departments to access the vital equipment and blood can be analysed in just minutes. The results can then be used to help identify critical illnesses including sepsis, a serious complication of an infection.

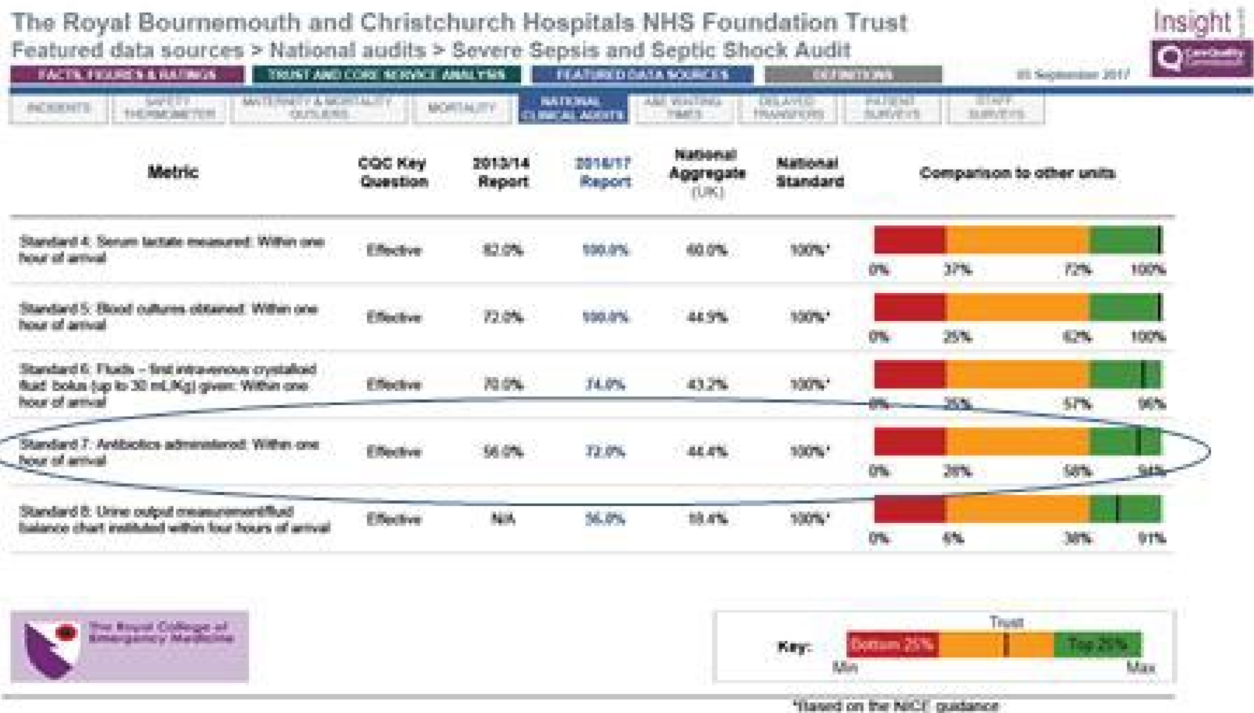
Dr David Martin, Consultant in Emergency Medicine and Clinical Lead for Sepsis at RBH, said: "Sometimes clinical assessment underestimates how unwell a patient is, and in these scenarios, lactate may be the only indicator that something is seriously wrong."

Identifying and treating sepsis is one of the top three priorities for RBH. Measuring lactate is one of six key measures that make up the 'sepsis six' - a series of tests and treatments which should be initiated by the medical team within an hour of diagnosis.

Dr Martin added: “Early checking of blood lactate in patients who we suspect may be unwell can only be a good thing. The machines also allow blood gas analysis and electrolyte results to be available quickly. This type of information is essential when managing complex problems such as pneumonia, asthma or worsening of chronic airways disease. “This is really good news for our patients and staff as we continue our fight to speed up the diagnosis and treatment of such critical illnesses.”

- Performed well in the Royal College of Emergency Medicine national audit

CQC Insight for Acute NHS Trusts September 2017 showing improvement in antibiotic delivery



The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Featured data sources > National audits > Severe Sepsis and Septic Shock Audit

Metric	CQC Key Question	2013/14 Report	2016/17 Report	National Aggregate (UK)	National Standard	Comparison to other units
Standard 4: Serum lactate measured: Within one hour of arrival	Effective	82.0%	100.0%	60.0%	100%*	0% 37% 72% 100%
Standard 5: Blood cultures obtained: Within one hour of arrival	Effective	72.0%	100.0%	44.5%	100%*	0% 25% 62% 100%
Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival	Effective	70.0%	74.0%	43.2%	100%*	0% 25% 57% 96%
Standard 7: Antibiotics administered: Within one hour of arrival	Effective	56.0%	72.0%	44.4%	100%*	0% 28% 58% 94%
Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival	Effective	N/A	56.0%	10.4%	100%*	0% 6% 38% 91%

The Royal College of Emergency Medicine

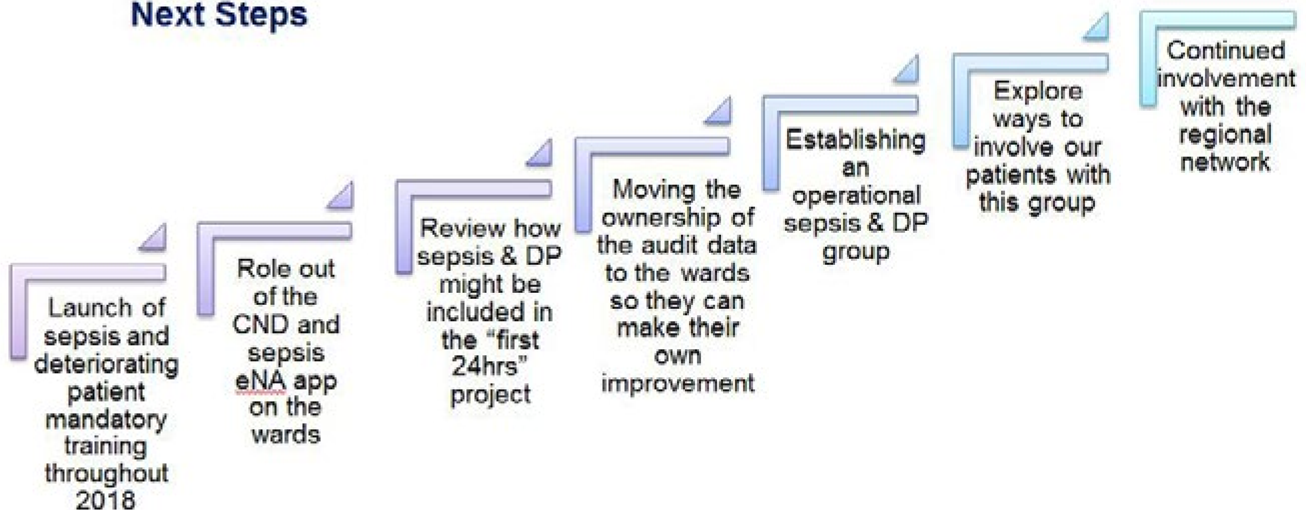
Key: Bottom 25% | Trust | Top 25% (Min – Max)

*Based on the NICE guidance

Overall summary

"The deteriorating patient project has achieved many things with a much greater knowledge base and data awareness of current positions both now and moving forward. It has I am confident resulted in much better care for this group of patients as shown by data such as our very low Cardiac Arrest levels and us still maintaining a lower than anticipated mortality rate. Unfortunately we did not achieve our aim although have improved review times and most importantly the actual escalation of these sick patients more reliably. The key in our next steps will be to continue to improve our times and technology may help us here as new IT systems work closer together automating some aspects of the pathway but also how this work spreads to all unwell patients in our trust."

Mike Wheble: AMU Consultant, Deteriorating Patient Lead



"The challenge is not starting, but continuing after the initial enthusiasm has gone'

2010 NHS Institute for innovation & improvement

The quality improvement work and progress achieved in 2017/18 forms the foundation for next years continuing focus.

Improving Hospital Flow

At the beginning of 2017/2018 the Trust continued to face rising demand on services. Attendances to our Emergency Department (ED) continued to rise by over 7% and emergency admissions had risen by over 9%. ED performance indicators had not been achieved for two successive quarters and bed occupancy was higher than required for good flow. This was compounded with significant financial pressures and the ongoing requirement for efficiency savings.

We had to do more to meet these challenges and ensure a high quality of care for our patients.

Our Hospital Flow Quality Priority Aim for 2017/2018 was to improve emergency hospital flow to deliver ‘the right patient, at the right time, to the right place’.

A steering group was formed and ideas generated to inform the structure of the programme.

An aim was set to improve patient flow by March 2018 as demonstrated through agreed high level work stream Key Performance Indicators:

- To reduce the average number of 14+ day length of stay patients to an average (mean) of 125
- To increase the number of admission avoidance ambulatory care patients seen daily to a mean of 25 (Monday-Friday)

Specialty pathways – what did we do?

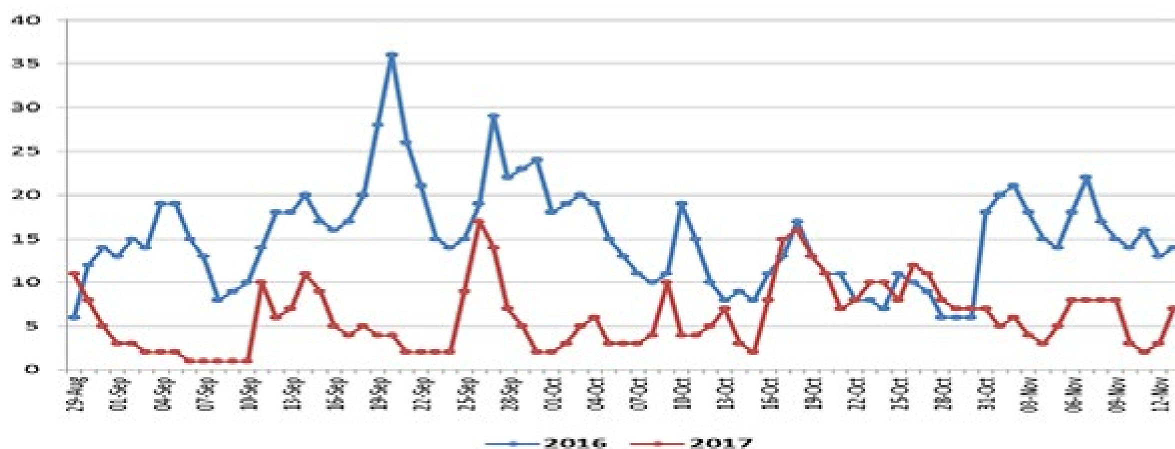
Frailty

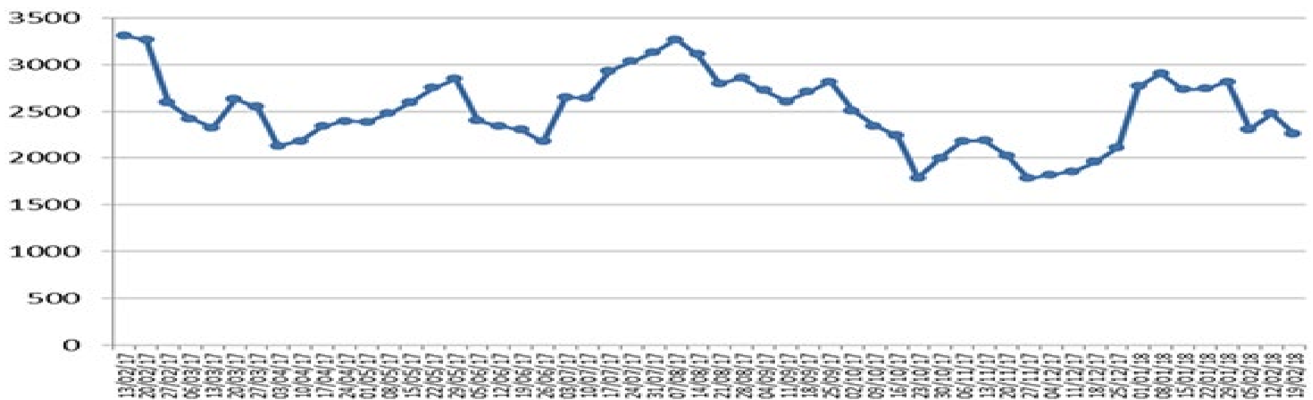
- Specialisation of short and long stay wards
- Standard Operating Procedure produced for Frailty pathway
- Process of starting assessment in Emergency Dept reviewed and enhanced, halving the time to assessment
- Frailty metrics established and now monitored each week (see picture)
- Bi monthly Ward reviews established.

Surgical flow

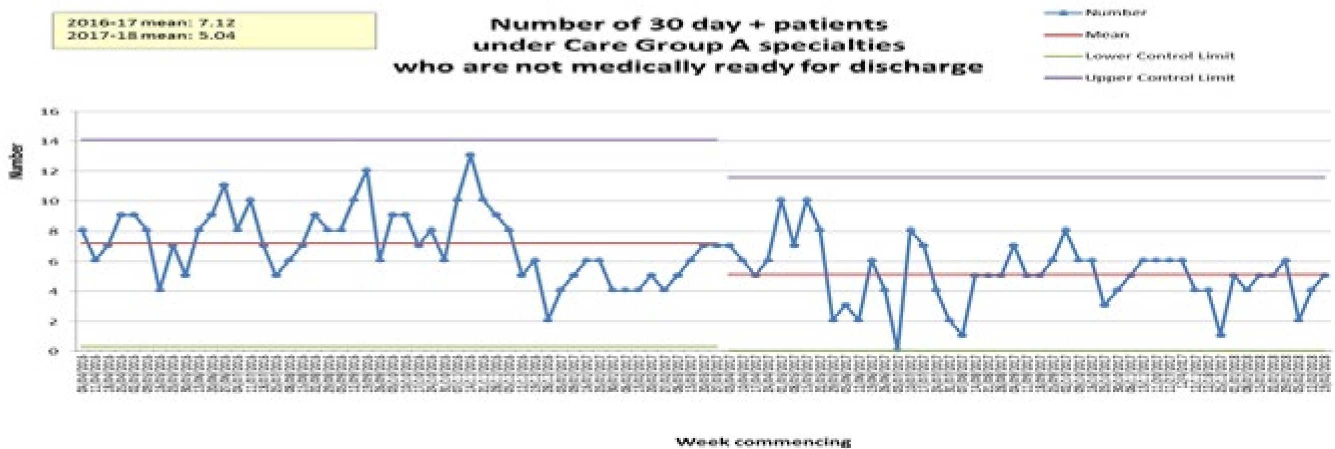
- Nurse Practitioner for Older People in Surgery appointed
- Ambulatory Matron established
- Work done with Gynaecology clinics in Jigsaw and Antenatal clinics, to ensure better efficiency
- Nurse led discharge criteria revised
- New venous blood gas machine for Surgical Assessment Unit purchased
- Weekend emergency surgery audit carried out
- Started and embedded stranded patient review process

The success of the Frailty pathway can be seen in reduced outliers, and in less occupied bed days used by 14+ day stranded patients





The improvement work has also led to fewer long stay surgical patients who are not medically ready for discharge.



Specialty pathways – what did we do?

Alcohol pathways

- Additional nurse appointed on basis of invest-to-save business case
- We have run two pilots of alcohol intervention in Emergency Dept / Acute Medical Unit
- Teaching slots provided for Allied Health Professionals, Nurses, and Doctors
- We have had a GP with Special Interest advice on homelessness pathways
- Ward champions have been identified & training held for them
- We have established processes to screen for alcohol related conditions and improve detoxification regimes

Our quality priorities for 2018/19

In order to identify priorities for quality improvement in 2018/19, 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, including never events
- 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.
- listening to what governors have told us following engagement with the public, patients and members
- canvassing the views of patients and staff through our internal peer review programme.

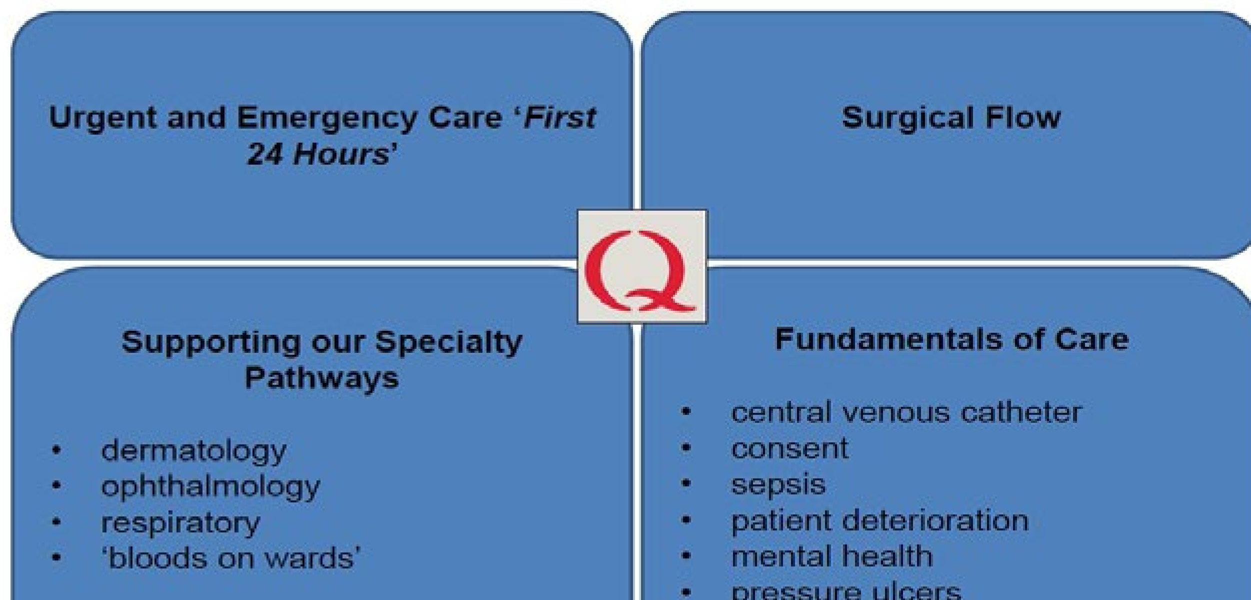
We have also considered the results of the national staff survey to help us decide where we need to focus our quality improvement efforts and actions. We have also taken on board the national picture for patient safety and collaborated with Clinical Commissioning Groups (CCG) as part of wider strategy work and clinical service reviews. We have also considered the 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 2018/19. Priorities have been discussed with clinical staff through the Trust's Quality and Risk Committee, Improvement Programme 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 2018/19 are:



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 and the Council of Governors through monitoring of the Trusts objectives.

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 gives a local context to the information provided in the statutory statements.

1. Review of services

During 2017/18 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 2017/18 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2017/18.

2. Participation in clinical audit

During 2017/18, there were 46 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, and for which data collection was completed during 2017/2018, 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 2017/18	Eligible to Participate	Participated in 2017/18	% of required cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100%
Adult Cardiac Surgery	No	N/A	
BAUS Urology Audits: Cystectomy	Yes	Yes	100%
BAUS Urology Audits: Nephrectomy	Yes	Yes	100%
BAUS Urology Audits: Percutaneous nephrolithotomy	Yes	Yes	100%
BAUS Urology Audits: Radical prostatectomy	Yes	Yes	100%
BAUS Urology Audits: Urethroplasty	No	N/A	
BAUS Urology Audits: Female stress urinary incontinence	No	N/A	
Bowel Cancer (NBOCAP)	Yes	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	Yes	-
Case Mix Programme (CMP)	Yes	Yes	100%
Child Health Clinical Outcome Review Programme	Yes	Yes	-
Congenital Heart Disease (CHD)	No	N/A	
Diabetes (Paediatric) (NPDA)	No	N/A	
Elective Surgery (National PROMs Programme)	Yes	Yes	-
Endocrine and Thyroid National Audit	TBC	TBC	-
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	Yes	100%
Fractured Neck of Femur	Yes	Yes	100%
Head and Neck Cancer Audit (HANA)	No	N/A	
Inflammatory Bowel Disease (IBD) programme	Yes	Yes	100%
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100%

National Clinical Audits for Inclusion in Quality Report 2017/18	Eligible to Participate	Participated in 2017/18	% of required cases submitted
Major Trauma Audit	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Yes	100%
National Audit of Anxiety and Depression	No	N/A	
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	100%
National Audit of Dementia	Yes	Yes	100%
National Audit of Intermediate Care (NAIC)	Yes	Yes	100%
National Audit of Psychosis	No	N/A	
National Audit of Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	No data submission required in 2017
National Audit of Seizures and Epilepsies in Children and Young People	No	N/A	
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary Rehabilitation	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Secondary Care	Yes	Yes	100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	N/A	
National Comparative Audit of Blood Transfusion Programme	Yes	Yes	100%
National Diabetes Audit - Adults - Foot Care Audit	Yes	Yes	-
National Diabetes Audit - Adults - Inpatients Audit	Yes	Yes	100%
National Diabetes Audit - Adults - Core Audit	Yes	Yes	100%
National Diabetes Audit - Adults - Transition	Yes	Yes	100%
National Diabetes Audit - Adults - Pregnancy in Diabetes	Yes	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
National End of Life Care Audit	Yes	Yes	100%
National Heart Failure Audit	Yes	Yes	National Audit deferred to 18/19
National Joint Registry (NJR)	Yes	Yes	-
National Lung Cancer Audit (NLCA)	Yes	Yes	100%
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	No	N/A	

National Clinical Audits for Inclusion in Quality Report 2017/18	Eligible to Participate	Participated in 2017/18	% of required cases submitted
National Ophthalmology Audit	Yes	Yes	-
National Vascular Registry	Yes	Yes	-
Neurosurgical National Audit Programme	No	N/A	-
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	100%
Paediatric Intensive Care (PICANet)	No	N/A	
Pain in Children	Yes	Yes	100%
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	-
Procedural Sedation in Adults (care in emergency departments)	Yes	Yes	100%
Prostate Cancer	Yes	Yes	-
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	100%
UK Parkinson's Audit	Yes	Yes	100%

National Confidential Enquiries for Inclusion in Quality Report 2017/18	Eligible to Participate	Participated in 2017/18	% of required cases submitted
Chronic Neurodisability	Yes	Yes	No cases required to be submitted in 2017/18
Young People's Mental Health	Yes	Yes	100%
Acute Heart Failure	Yes	Yes	100%
Perioperative Diabetes	Yes	Yes	100%

The reports of 33 national clinical audits were reviewed by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in 2017/18 and, as examples, the Trust intends to take the following actions to improve the quality of healthcare provided as a result:

- Update the DAIRS (Dorset Adult Integrated Respiratory Service) asthma checklist to ensure quality of inhaler technique is documented. Document peak flow results on ward round entries. (National COPD Audit)
- Review possible changes to patient pathways (e.g. early CT requests and a RAPID CT pathway, introduction of in house molecular testing) in order to improve numbers fit for treatment by time of diagnosis and outcomes. (National Lung Cancer Audit)
- Introduce and document compulsory foot checks for patients. Launch new drug chart - designed to reduce medication and prescribing errors. (National Diabetes Inpatient Audit)
- Regular auditing and promotion of the use of 'This is me' (a tool for people with dementia that lets health and social care professionals know about their needs, interests and preferences) on all wards. Ensure clearer documentation of Mental Capacity Act Assessments and best interest meetings for patients with dementia. Train staff to ensure access to dementia support and advice 24/7. (National Dementia Audit)

The reports of 186 local clinical audits (including patient surveys) were reviewed by the Trust in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- The hospital palliative care team has been expanded and now covers weekends such that palliative patients admitted to hospital can be reviewed earlier during their admission.
- Specialist Palliative Care Community Team to set up an automated answering system to enable patients and carers to contact the most appropriate person for their enquiry in a timelier manner.
- Malnutrition Universal Screening Tool (MUST) E-Learning module introduced.
- Provide Group education sessions for the low FODMAP diet for people with Irritable bowel syndrome
- Trial the use of negative pressure dressings post-operatively for specific knee and hip replacement patients.
- Update written patient information on care of (breast) prosthesis and guidelines on replacement of prosthesis, making follow up clinic requests for patients to be seen if there is a problem with the product.
- A protocol has been produced for monitoring patients on Cyclosporin and distributed to all Dermatology outpatient clinics.
- Amendments to be made to the patient cataract booklet - to include detailed advice about drops, driving, glasses etc. as well as some FAQs.
- Development of a community phlebotomy hub offering booked appointments.

Introduction of booked phlebotomy appointments, as well as open access, at the Royal Bournemouth Hospital. Introduced booked appointments for warfarin patients.

- Continue to encourage the use of a laminated prompt sheet for the WHO safer surgery checklist to ensure any specific list issues are discussed prior to starting, using the slogan - 'You haven't done the checklist unless you've checked the list'.
- Design and implement an individualised patient care plan/diary to be issued to inpatients receiving stoma care.
- Set up 'meet the midwife' sessions so women who would like to find out more about home birth can meet midwives and other women.
- New guidelines have been issued for booking transport for palliative patients. When booking transfers to the Macmillan Unit from the Royal Bournemouth Hospital the bookings are labelled 'time critical' and 'last days of life'. This identifies that the patients are frail, often unwell and need timely transfers.
- New Recovery (Post-anaesthesia Care Unit) pain management program to be implemented

3. Participation in clinical research:

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee and NIHR portfolio was 2,157 (April 2017 - March 2018).This compares to 1,480 for 2016/17 and 1,305 for 2015/16.

Research Success Stories during 2017/2018

- The Trust was first UK site to recruit to: MERU; a Randomized, Double-Blind, Placebo-Controlled Phase 3 Study of Rovalpituzumab Tesirine as Maintenance Therapy Following First-Line Platinum-Based Chemotherapy in Subjects with Extensive Stage Small Cell Lung Cancer.
- The Trust was the second highest UK recruiter to: TWILIGHT Study; a multi-centre, global research study comparing the use of ticagrelor and aspirin as Dual Antiplatelet Therapy (DAPT) to ticagrelor alone (antiplatelet monotherapy) to treat high-risk patients that have received percutaneous coronary intervention (PCI) with at least one drug-eluting stent (DES).

- The Trust is the third highest recruiter for Division 1 (Cancer) in the Wessex region, closely behind Portsmouth Hospitals NHS Trust.
- Dr Helen McCarthy, Consultant Haematologist, was the winner of the Inspirational Woman in Science and Technology 2017 Dorset Venus awards. Dr Helen McCarthy was awarded for her dedication to science. She leads a team of scientific and clinical researchers committed to innovative research, with the aim of improving survival rates and the quality of life of patients with blood cancers.

Dr. McCarthy said: "I am delighted to win this award and it is wonderful to receive recognition for the work I have been involved with. I'd also like to acknowledge and impart my thanks to the research team that I work alongside. We are very passionate about bringing state-of-the-art cancer treatment to Dorset patients through innovative laboratory and clinical research.

"I'm also especially thankful for local support from the Bournemouth Leukaemia Fund (BLF), whose fundraising has enabled us to maintain our molecular haematology research as we continually try to improve the outlook for our patients with cancer."

Laura Purandare, Research and Quality Improvement Manager at RBH, added: "Helen is fiercely committed to this work, seeking studies using novel treatments to ensure our patients have treatment options. This award was richly deserved."

- Clinical Research Network (CRN) Wessex held its second awards ceremony this year, celebrating researchers in the Wessex region. Congratulations to the Cardiac Research Team for winning the Excellence in the delivery of commercial research award and joint winner of best video.
- Dr Sally Killick, Consultant Haematologist, has been appointed Chair of the Myelodysplastic syndrome (MDS) clinical study group for the National Cancer Research Institute (NCRI).

MDS are cancers in which immature blood cells in the bone marrow don't mature to become healthy blood cells. They are seen more commonly in older people and more frequently in our region as it has a higher national average age.

The NCRI's clinical study groups are a central cog in the wheel of cancer research in the UK. They are key route through which new clinical trials are developed.

Dr Killick will be leading a team of clinical researchers with the aim of improving treatment for patients with MDS in the UK.

Dr Killick said: "It's a great privilege to chair the MDS subgroup. I have a strong interest in MDS and our hospital is an accredited MDS Centre of Excellence. Our national team of clinical researchers will be working to make developments that will progress the treatment of MDS cancers."

Nicola Keat, Head of NCRI's Clinical Research Groups said: "We're delighted to welcome Dr Killick as Chair of the MDS subgroup. Through collaboration amongst a diverse group of experts, NCRI's Clinical Studies Groups make a huge impact on driving up the quality of clinical research. They are central to the UK's clinical cancer research structure."

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

The Trust's income in 2017/18 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 2017/18.

The Trust has not participated in special reviews or investigation by the CQC during 2017/18.

The CQC inspected the Royal Bournemouth Hospital and Christchurch Hospital on 11 and 12 March 2018 and undertook an additional Well-led inspection on the 11 and 12 April 2018. A report is expected in early June 2018.

In December 2017 the Royal Bournemouth Hospital's (RBH) Emergency Department was one of 17 across the country to be included in the Care Quality Commission's (CQC) best practice guide for all NHS hospital trusts.

The publication "Meeting the quality challenge; sharing best practice from clinical leaders in emergency departments", provides examples of positive action trusts are taking to help manage capacity and demand. It was developed following a workshop involving 36 senior clinicians and managers from trusts across the country which were identified by the CQC as having good practice in their emergency departments.

Some of the positive actions taken by the Royal Bournemouth Hospital Emergency Department cited in the report, include:

- Introduction of a weekly, combined, online rota so staff can easily see who is on duty instead of having multiple rotas for junior doctors, consultants, advance nurse practitioners and minor injury nurses.
- Electronic staff feedback forms, encompassing safety concerns, near misses, good ideas and positive event reporting as well as allowing staff to say #Thank you to any colleague.
- Implementation of the 'Happy App' which measures the live 'mood' of the department, giving all staff a voice and allowing senior team members to be responsive to concerns, praise and good ideas.
- The team host a 'Staff Vision and Innovation Day' where all members can discuss their ideas and innovations and priorities for the next year.
- Project management software is used to keep doctors, nurses and managers up-to-date with risks, new policies, education and safety alerts in the department.
- An electronic child safeguarding process, which identifies all children and ensures that a safeguarding assessment is completed, has been introduced.

RBH Emergency Medicine Consultant, Dr Aidan Siggers, said: “We’ve been visiting a number of different trusts around the country observing examples of outstanding practice and are incorporating a lot of the ideas they are using here. There really is some fantastic work being done in quite difficult circumstances. This is all about teamwork so we’ve been working closely with colleagues in the hospital here as well, looking at better ways of working to make our patient’s experience better.”

Professor Ted Baker, the CQC’s Chief Inspector of Hospitals, said: “Despite the challenges, our inspections have shown that many hospitals are providing good and outstanding urgent and emergency care and have demonstrated their ability to plan for and cope with increased attendances.”

The guide can be found on the CQC’s website.

6. Data Quality

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data which included the patients’ valid NHS number was 99.7% for admitted patient care; 99.9% for outpatient care; and 98.1% 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 2018.

The Trust’s Information Governance Assessment Report overall score for 2017/18 was 73% (2016/17 was recorded as 74%) 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 2017/18, the Trusts aim was to maintain compliance levels comparable with previous IG Toolkit assessments without compromising on the quality of assurance provided. This year marked the final year of the IG Toolkit in its current format, with the new Data Security and Protection Toolkit being launched in April 2018 to replace this. As such it was not felt to be a good use of time or resource to strive to improve all requirements to Level 3 (maximum compliance) for the purposes of increasing the overall IG Toolkit percentage score when the whole assessment would soon be changing.

In 2018/19, work will continue to establish and firmly embed the principles of information risk management and IG throughout the organisation, in order to ensure that the Trust is complying with its legal obligations. Key to this is the engagement and continued co-operation of subject matter experts and Information Asset Owners (IAOs), who provide assurance of practices within their respective departments across the organisation. This will be increasingly important during 2018/19 with the forthcoming significant changes in data protection legislation meaning that the Trust must provide a greater level of assurance to individuals and regulators around its data processing activities.

There has been a decrease in reported breaches of Information Governance during 2017/18. During 2016/17, 134 breaches and six Serious Incidents Requiring Investigation (SIRIs) were reported, whereas 2017/18 has seen 93 breaches and four SIRIs reported.

While reasons for this are difficult to quantify, this may be indicative of an improvement in standards within the Trust or of decreased levels of incident reporting. However indications are that the former is likely to be the case given the levels of incident reporting elsewhere in the Trust, as well as the continued high compliance levels in IG training uptake (in excess of 94% for the full 2017/18 year).

Each of the SIRIs was reported to the Information Commissioner's Office as required. Of these, one remains under investigation internally and three 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 2018/19 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 and the error* rates reported in the latest published audit for that period of diagnosis and treatment coding (clinical coding) were Primary Diagnosis 96%, Secondary Diagnosis 93.92%, Primary Procedure 93.21% and Secondary Procedure 88.59%. (These figures relate to the period January - August 2017)

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 Gynaecology.

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 2018/19:

- The Trust will continue to work with service providers to enable duplication recording of OPCS codes
- Reiterate to coders the need to access all electronic data to optimise coding

- Reaffirm new coding standards
- Promote clinical validation in gynaecology
- Review the process of histopathology coding for timeliness and accuracy

9. Learning from deaths

During period 1 April 2017 to 31 March 2018 1684 patients died in the Royal Bournemouth and Christchurch Hospital NHS Foundation Trust. On the 31 March 2018, 518 case record reviews and investigations have been carried out in year in relation to 1684 deaths reported.
In all cases a death was subjected to both a case record review and, where required an additional investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out is shown in the Table below;

Month of Death	Number. of Deaths	Number with case note reviews completed by the 31 March 18	% Reviews Completed by the 31 March 18
Apr 17 - Jun 17	**381**	**208**	**54.6%**
Apr-17	129	76	58.9%
May-17	139	80	57.6%
Jun-17	113	52	46.0%
Jul 17 - Sept 17	**371**	**135**	**36.4%**
Jul-17	107	40	37.4%
Aug-17	130	49	37.7%
Sep-17	134	46	34.3%
Oct 17 - Dec 17	**466**	**146**	**31.3%**
Oct-17	155	50	32.3%
Nov-17	136	51	37.5%
Dec-17	175	45	25.7%
Jan 18 - Mar 18	**466**	**29**	**6.2%**
Jan-18	168	25	14.9%
Feb-18	146	4	2.7%
Mar-18	152	0	0.0%
Grand Total	**1684**	**518**	**30.8%**

e-Mortality process

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.

All deaths receive a consultant review against a specific questionnaire. Reviews are discussed at specialty Mortality and Morbidity meetings and the chairs of these meetings attend the Trust Mortality Surveillance Group. This ensures that the reviews of all deaths within the hospital are discussed centrally and ensures actions for improvement are identified.

The e-Mortality pro forma also includes a nationally recognised grading system to ensure that avoidable mortality is clearly categorised. The tool used is the Confidential Enquiry into Stillbirths in Infancy (CESDI) coding which categorises 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 and a full serious incident root cause analysis process is undertaken.

The Mortality Surveillance Group undertakes a monthly review of all e-mortality data and any learning points are disseminated through Directorate Mortality and Clinical Governance meetings.

With reference the Trust e-Mortality process and grading structure, the following table provides details of the number of case note reviews that were graded as 0, 1, 2 or 3.

Grade 2 and 3 cases are those were we have identified that there may have been problems in the care provided to the patient.

Month of Death	Grade 0	Grade 1	Grade 2	Grade3	Grand Total	Proportion graded 2 or more
Apr 17 - Jun 17	**189**	**18**	**1**		**208**	**0.5%**
Apr-17	69	6	1		76	1.3%
May-17	72	8			80	0.0%
Jun-17	48	4			52	0.0%
Jul 17 - Sept 17	**126**	**8**	**1**		**135**	**0.7%**
Jul-17	37	2	1		40	2.5%
Aug-17	47	2			49	0.0%
Sep-17	42	4			46	0.0%
Oct 17 - Dec 17	**131**	**13**	**2**		**146**	**1.4%**
Oct-17	44	4	2		50	4.0%
Nov-17	44	7			51	0.0%
Dec-17	43	2			45	0.0%
Jan 18 - Mar 18	**28**	**1**			**29**	**0.0%**
Jan-18	24	1			25	0.0%
Feb-18	4				4	0.0%
Grand Total	**474**	**40**	**4**	**0**	**518**	**0.8%**

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
grade3	0	0	0	0	0	0	0	0	0	0	0
grade2	1	0	0	1	0	0	2	0	0	0	0
grade1	6	8	4	2	2	4	4	7	2	1	0
grade0	69	72	48	37	47	42	44	44	43	24	4

Month of Death

A regular newsletter following discussions at the Mortality Surveillance Group is produced. The newsletter is an opportunity for wider dissemination of the learning captured through mortality reviews.

Specialties featured in recent newsletters include:

Intensive Care Unit	General Medicine/ Endocrine
Cardiology	Geriatric Medicine
Respiratory	Gastroenterology
Surgery	Emergency Medicine

Themes for action and learning from mortality case note reviews and investigations include:

- Patients undergoing interventional radiological procedures for source control of sepsis (e.g. nephrostomy tube insertion or control of internal haemorrhage) can rapidly become hypotensive and peri-arrest. Patients should have reliable secure large bore IV access before such procedures.
- Ensuring patients presenting with chest pain have an ECG within 15 minutes of arrival irrespective of their age.
- Unwell patients in ED resuscitation must have specialist review and should be transferred from ED when haemodynamically stable.
- Consider early x-ray of the abdomen to rule out bowel obstruction if in doubt.
- Consider Nasogastric (NG) tube insertion in confirmed bowel obstruction early on to avoid aspiration pneumonia, which can be fatal.
- All direct transfer to wards from regional hospitals should be clerked within four hours of arrival if they are haemodynamically stable or within an hour if unwell and haemodynamically unstable.
- Consider atrial flutter/tachyarrhythmia if there is a step-change in heart rate during admission and no obvious cause to suggest sinus tachycardia.
- Older patients with conducting system disease on resting ECG are a higher risk for Brady-arrhythmic complications from drugs which block the AV node. Consider starting with small doses of shorter acting agents.
- Nasal high flow should be considered equivalent to Continuous Positive Airway Pressure (CPAP) and instigated only after discussion with the consultant in charge at the time.

10. Delivering Seven Day Services

The Trust is committed to providing high quality consistent care, whatever day patients enter the hospital. Job planning and consultant recruitment has ensured formal provision for most inpatient specialties 7 days per week. Consultant appointments since 2013 have allowed a greater amount of weekend and evening coverage in key services such as General Surgery, Acute Internal Medicine, Older People's Medicine, Gastroenterology and Emergency Medicine. Further initiatives have also supported 7 day services including:

- Consultant of the day models
- Weekend Radiology extended to urgent care patients
- Weekend multi-disciplinary team (including medical, nursing and therapy) assessment and support, especially for frail, elderly patients
- Out of hours nurse and therapy practitioner cover
- 24/7 dedicated CEPOD (emergency surgery) theatre lists.

We have participated in the national (twice yearly) Seven Day Services Audit since its inception under the Executive leadership of the Medical Director. The Trust benchmarked well against other acute trusts in the last published audits in March and September 2017 on the 4 priority clinical standards:

- Standard 2 - Time to first consultant review
- Standard 5 - Access to diagnostic tests
- Standard 6 - Access to consultant-directed interventions
- Standard 8 - Ongoing review by consultant twice daily if high dependency patients, daily for others.

We continue to strive to consistently achieve 90% of patients with a documented consultant review within 14 hours. Overall performance averaged 80% (range 74-92%) though no pattern of variation or adverse clinical outcomes are evidenced. Overall there is a slight decline compared with previous audits but changes in methodology and more robust data validation mean that these may not be directly comparable.

The trust has now consistently provided access to the key diagnostic tests and consultant directed interventions 7 days a week. 85% (ave) of patients received the determined ongoing consultant review.

Audit results are routinely presented to the Trust (clinical) Management Board and ‘breach’ analysis has identified themes which have informed our planning for improvement. Our action plan should also be seen in the context of the wider Dorset Clinical Services Review which sets out a blueprint for creating a major emergency hospital at RBH, with 7 day specialist service provision at the heart of this.

The Trust will be participating in the next audit, being undertaken in April-May 2018.

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 2016 - September 2017 0.955	1.00	1.247	0.727
		October 2015 - September 2016 0.929	1.00	1.164	0.688
		October 2014 - September 2015 1.020	1.00	1.177	0.652
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 HSCICS. The data has been extracted from available Department of Health information sources. The SHMI data is taken from **https://beta.digital.nhs.uk/data-and-information/publications/clinical- indicators/shmi**					
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 Surveillance 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 2016 - September 2017 48.2%	31.5%	59.8%	11.5%
		October 2015 - September 2016 46.8%	30.0%	56.3%	0.4%
		October 2014 - September 2015 49.0%	26.6%	53.5%	0.2%
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://beta.digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi** 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-March 17 (published February 2018)	(i) NA (ii) NA (iii) 0.436 (iv) 0.323	(i) NA (ii) NA (iii) 0.445 (iv) 0.324	(i) NA (ii) NA (iii) 0.536 (iv) 0.404	(i) NA (ii) NA (iii) 0.310 (iv) 0.242
	April15-March16 (published August 2017)	(i) NA (ii) NA (iii) 0.452 (iv) 0.330	(i) 0.088 (ii) 0.096 (iii) 0.440 (iv) 0.320	(i) 0.157 (ii) 0.150 (iii) 0.512 (iv) 0.398	(i) 0.021 (ii) 0.018 (iii) 0.320 (iv) 0.198
	April14-March15 (published August 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	2017/18 (i) = 0 (ii) = 4677 (11.7%) 2016/17 (i) = 0 (ii) = 4456 (11.1%) 2015/16 (i) = 0 (ii) = 3973 (10.9%)	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	2017/18 - not yet available 2016/17 - 72.2% 2015/16 - 73.4% 2014/15 - 72.4%	 68.1% 69.6% 68.9%	 85.2% 86.2% 86.1%	 60.0% 58.9% 59.1%
The Trust considers that this data is as described for the following reason. The data source is produced by the Care Quality Commission.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services. An action plan that addresses the issues raised in the report will be overseen by the Healthcare Assurance Committee, which is a 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	2017 - 81.01% 2016 - 77.50% 2015 - 75.49%	69.87% 69.85% 69.17%	85.71% 84.77% 88.98%	46.84% 48.86% 45.73%
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.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust intend to take the following action to improve this percentage, and so the qualities 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 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) January 2018 December 2017 November 2017 (ii) January 2018 December 2017 November 2017	 99% 99% 98% 93% 92% 95%	 96% 96% 96% 88% 87% 88%	 100% 100% 100% 100% 100% 100%	 75% 64% 73% 66% 57% 66%
The Trust considers that this data is as described for the following reason. Data is derived from validated monthly reports collated in accordance with https://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	2017/18 = 96.4% 2016/17 = 95.8% 2015/16 = 96.13% 2014/15 = 95.2%	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	2017/18 - 10.38/100,000 bed days (20 confirmed cases)	Not available	Not available	Not available
		2016/17 8.80/100,000 bed days (17 confirmed cases)	13.2/100,000 bed days		
		2015/16 12.89/100,000 bed days (26 confirmed cases)			

The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission. All cases of Clostridium difficile infection at the Trust are reported and investigated by the Infection Control Team and reported monthly to the Board of Directors. Reporting is in line with the requirements of the Health Protection Agency (HPA) and Monitor

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by ensuring high standards of infection prevention and control are implemented, monitored and maintained.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value (non-specialist acute trusts)	Highest value	Lowest value
Number of patient safety incidents reported during the reporting period	NRLS	4060 (April 2017 - September 2017)	Not available	15,228	1133
		3945 (April 2016-September 2016)	-	-	-
		4133 (October 2015 - March 2016)	4818	11989	1499
Rate of patient safety incidents reported during the reporting period	NRLS	42.85 per 1,000 bed days (April 17 - Sept 17)		111.69	23.47
		41.11 per 1000 bed days (April - Sept 16)	40.02 per 1,000 bed days	-	-
		40.3 per 1,000 bed days (October 2015 - March 2016)	39.31 per 1,000 bed days	75.91	14.77

<table>
<tr><td>Number of patient safety incidents reported during the reporting period that resulted in severe harm or death</td><td>NRLS</td><td>19
(April - Sept 16)

21
(October 2015 -March 2016)

19
(April 17 - September 17)</td><td>-

19

Not available</td><td>-

94

121</td><td>-

0

0</td></tr>
<tr><td>% of total number of patient safety incidents reported during the reporting period that resulted in severe harm or death</td><td>NRLS</td><td>0.5%
(April - September 2016)

0.5%
(October 2015 - March 2016)

0.4%
(April 2017 - September 2017)</td><td>0.4%

0.4%

Not available</td><td>-

2.0%

2.0%</td><td>-

0%

0%</td></tr>
<tr><td colspan="6">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 (NRLS). 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.</td></tr>
<tr><td colspan="6">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 learning event notification (LERN) processes and investigation ‘Toolkits’ in 2017/2018 to further enhance learning and improvement.</td></tr>
</table>

Part 3

Review of quality performance in 2017/18

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.

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 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's Board Assurance Framework.

The following section provides an overview of the performance in 2017/18 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 2017/18 Quality Report and have also been selected on the basis of data collection, accuracy and clarity.

Patient safety

Reducing harm from adverse events

The Trust has seen a slight decrease in the number of major and severe harm patient safety incidents reported during 2017/2018 and uploaded to the national reporting and learning system.

	Total number reported 2015-2016	% of incidents reported 2015-2016	Total number reported 2016-2017	% of incidents reported 2016-2017	Total number reported 2017-2018	% of incidents reported 2017-2018
No Harm	5290	64.70%	5099	63.80%	5180	65.93%
Minor Harm	2707	33.11%	2684	33.58%	2543	32.37%
Moderate Harm	136	1.66%	171	2.14%	105	1.34%
Major/Severe Harm	43	0.53%	38	0.48%	29	0.37%
Total	**8176**		**7992**		**7857**	

Table: Patient safety incidents reported during April 2015 to March 2018and uploaded via the national reporting and learning system (NRLS)

- In 2017/18 the Trust reported 23 serious incidents including eight never events
- 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.
- This equates to a 8% reduction from 2016/17 therefore continues the trend of year on year improvement in patient safety

Category of Serious Incident Reported	2013/14	2014/15	2015/16	2016/17	2017/2018
Patient Fall	14	15	13	3	4
Hospital Acquired Pressure Ulcer	30	20	6	3	2

Never Events

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

When a never event occurs we have a duty to report it nationally and to ensure we learn lessons from it. In the last 12 months (1 April 2017 - 31 March 2018) we have reported eight never events. Many of these have not caused any significant harm to the patients involved but do show some common themes. We know this is an indication of the open reporting culture we have and which we encourage and support. However, it is really important all areas understand the issues and learn from them.

As a Trust, to help us to support our learning from these events, we have asked a number of external organisations (including the new national Healthcare Safety Investigation Branch) to review the human factors involved, the culture within departments and also how services run. We have also asked to be visited as part of the new CQC review programme for trusts reporting never events and are keen to learn from others.

Key messages from our never event investigations have been shared across the Trust and these are summarised as follows:

- Make sure you are trained and competent in the insertion of nasogastric tubes (NGT) and you use the Trust NGT safety checklist care bundle.
- Make sure you have LOCSSIPs (local safety standards for invasive procedures) in place if you undertake invasive procedures in your area.
- You are more likely to make a mistake if procedures are lateralised (i.e. left or right) or potentially in multiple sites. It is important to accurately identify and mark sites pre procedure.
- Remember the potential for confusion between left and right when facing the patient.
- Safety checklists are there to support but need to be more than a tick box exercise.
- Anyone can call a 'STOP'.
- It takes two to check.
- You are more likely to make a mistake if you are disturbed or interrupted.
- Be clear and specific about what you want when asking for equipment.

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 management process. All investigation processes require consideration and undertaking of the Duty of Candour in accordance with national legislation. A Duty of Candour "Toolkit" is available to support staff.

Freedom to Speak Up

Speaking up is essential in any sector where safety is an issue and should be something that everyone does and is encouraged to do. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up will persist. Sir Robert Francis in 2015 set out a vision for creating an open and honest reporting culture in the NHS following his independent review into the failings at Mid Staffordshire NHS Foundation Trust.

The Board of Directors at the Trust agreed to support the key principles of speaking up at the September 2017 board meeting and is committed to leading the actions required to implement them.

The Trust has appointed a Freedom to Speak up Guardian (FTSUG), Helen Martin, to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation. Helen has spoken to date to over 1000 members of staff by attending team meetings or presentations.

This role has been given special responsibility and training in dealing with whistleblowing concerns. Freedom to Speak Up Guardians will:

- empower staff to raise concerns within organisations
- provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled.
- ensure that organisational policies and processes in relation to the raised concern are in place and followed correctly
- not investigate but support staff in their journey of raising a concern

Since introducing the FTSUG role in April 2017, 45 members of staff have raised a concern. Over 70% were related to behaviours and attitudes which is reflective of what has been seen nationally. Addressing this will be a key objective for 2018/19 along with working closely with Poole Hospital NHS Foundation Trust.

National and Local Staff Survey

National level

The **NHS Staff Survey** is the largest survey of staff opinion in the UK where staff are given the opportunity to share their views of experiences at work. It gathers views on staff experience at work around key areas, and including appraisal, health and wellbeing, staff engagement and raising concerns.

The national survey centre publishes full and summary reports of core survey responses appropriately benchmarked against national data for all trusts in England: http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2017/

The survey data is used in a variety of ways including:

- Care Quality Commission for ongoing monitoring of registration compliance.
- Department of Health for the development of NHS workforce policies.
- The Social Partnership Forum, where Unions, NHS Employers and the Department of Health, meet regularly to consider the results and influence national workforce policy.
- The survey provides valuable information about staff working conditions and practices, which are linked to the quality of patient care.

Within the Trust we analyse our data at team, subject and Trust level in order to understand:

- How we can celebrate and share good practice.
- How we can communicate results in a meaningful way and in the context of change to come.
- How we can channel resources to best support our teams.
- Areas and issues for particular attention.

The Trust chose to survey all 4441eligible staff (rather than a random sample), with 2050 staff returning a completed survey, giving a response rate of 46.2%. The average response rate for acute trusts was 45.5%.

A total of 88 questions were used in both the 2016 and 2017 survey and results show that RBCH scored significantly better on 22 questions, worse on 1 question and showed no significant difference in 65 questions. The only question scoring lower than 2016 relates to pay.

Of the 93 acute trusts, our results were in the top 20% in 24 of the 32 Key Findings. We ranked first in three key findings and equal first in two key findings across all 93 trusts.

In terms of overall Engagement Score the Trust ranked joint first of all acute trusts (with Surrey and Sussex Healthcare NHS Trust) with an overall Engagement Score of 3.96 out of 5. We are now working to identify where we can focus our energy to help improve the experience for all of our staff, starting with:

- Areas of lowest question and engagement scores.
- Areas with outstanding results where we can engage others to share best practice.
- Analysis of data for themes, trends, issues, concerns, subjects for more attention

Local level

In addition to the National Staff Survey the Trust also undertakes an internal staff survey every 6 months. Key indicators from the survey show year on year improvement as shown below:

Staff Impressions Survey June 2017

Q1	2014	2015	2016	2017
Recommend as place to work	60%	68%	67%	**77%**
Recommend as place for treatment	73%	84%	83%	**89%**
Overall Impression - Mainly Good	86%	92%	88%	**94%**

Flu Fighters

The Trust has worked in partnership with NHS Employers and Public Health England, supported by the Department of Health, to deliver the national seasonal flu campaign for NHS staff.

We are proud to have achieved the National target to vaccinate over 70% of front line staff in the Trust.

Financial Year	Vaccinated	Total Frontline Staff	Vaccination Rate
2016/17	3075	4386	70.1%
2017/18	2503	3532	70.9%

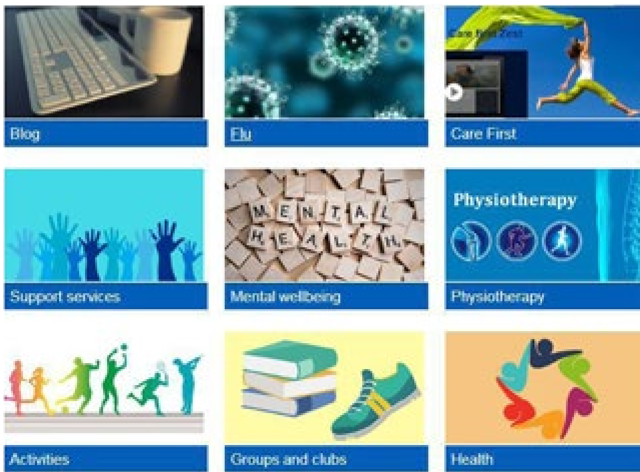
Staff wellbeing

The Trust has developed a multi-disciplinary Valuing Staff and Wellbeing Group, which includes management, staff, staff side representatives and governor representatives who work together to promote a range of initiatives for the health and wellbeing of staff.

Some examples of wellbeing services available to our staff at #TeamRBCH include:

Library services

- Offering a quiet place to sit at lunch
- Good selection of self-help books and fiction as well as computers and medical books and journals.



Clubs

- Lunch Club monthly meet ups in the library meeting room with guest speakers and are non-work related.
- Book Club discovering different genres and having interesting discussions on a bi-monthly basis.

Clinics

- Weight management clinic
- Alcohol support and advice
- Smoking cessation and support

Working with Nature

- Establishing links with a local nature reserve to enable staff on time off to take part in projects with nature to help de-stress and unwind and promote good mental wellbeing.

Self-Help Groups

- Pause for Thought - menopause support

Education to help wellbeing

- Mindfulness courses
- Personal resilience course

Infection Control

Clostridium Difficile

There were 27 cases of clostridium difficile reported from the Trust in 2017-18. 20 of these cases were attributed to ‘lapses in care’, against an NHS England target of 14. This represents an increase from last year in terms of the percentage of total late cases identified. Thorough analysis and ribotyping of clostridium difficile cases is undertaken and it is reassuring that there has not been any patient to patient transmission of clostridium difficile in 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 2017/2018. The Trust supported the investigation of community acquired cases which were assigned as third party cases.

Methicillin-Sensitive Staphylococcus Aureus (MSSA)

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

Norovirus

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

Catheter related urinary tract infections (CA UTIs)

The mean numbers of new CA UTIs (from NHS Safety Thermometer data) for the Trust in 2017/18 was 0.21% compared to 0.25% in 2016/17. This is slightly lower than the national mean score of 0.3% and represents a slight decrease on the previous year.

Alert 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 C. 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 2018/2019

- Participation in World Hand Hygiene day in May 2018
- 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
- Development of in house infection control surveillance tool
- Closer working with Poole Hospital's infection control team

Clinical effectiveness

Schwartz Rounds

Schwartz rounds continue to be a very well-attended forum for staff across the Trust. They were first introduced in the Trust in 2016 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.

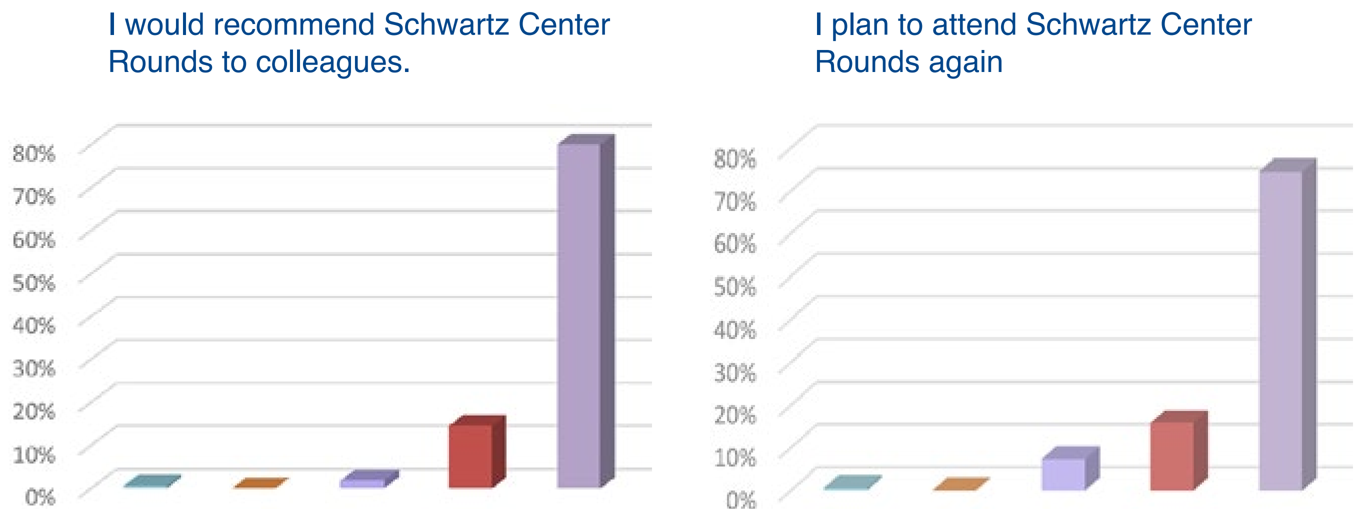
Each session includes three or four short presentations from our staff based on a particular theme. There is then a confidential discussion which is open to all present.

The topics for the Schwartz rounds are put forward by our own staff and we have found this to positively aid engagement. Examples of rounds from 17/18 include

- Loyalty
- Dealing with aggressive patients
- Working in a team within a team
- In the Dead of the Night
- Why 2017 Was A Good Year for Me at RBCH
- Lessons Learnt

Attendance remains high with approximately 300 staff each attending a session between April 2017 and March 2018. It is pleasing to see there is representation from nearly all disciplines. Evidence shows that staff really value this forum.

Table: Percentage of staff attending a Swartz round between 1 April 2017 - 31 March 2018 who would recommend attending to a colleague and who would attend future sessions.



Some quotes from staff feedback forms:

- ***very good to listen to other peoples' experiences in the hospital***
- ***Excellent opportunity, very easy to talk***
- ***Extremely helpful as a student to get an insight into what I might face. Was quite emotional and has definitely given me a lot to think about.***
- ***Very powerful***
- ***really interesting and thought provoking. First time at a Schwartz Round - will definitely come to another one again.***
- ***excellent session as usual***

Falls prevention

Falls in hospital are the most commonly reported safety incident in acute trusts (RCP 2015). Based on data submitted to the National Reporting and Learning Systems (NRLS), around 250,000 falls were reported in 2015/16 across acute, mental health and community hospital settings.

They are particularly common among older patients (aged 65 and above), with estimates suggesting this group account for approximately 80% of all falls in hospital. This represents significant costs to trusts. The total cost to the NHS from falls among older people alone is estimated at approximately £2billion. (NHS Improvement 2017).

There is not only a financial cost associated with falls, but they can also have detrimental impacts on confidence as well as health and can significantly increase risks of isolation, reduced independence and the need for residential care (Age UK).

In Bournemouth and Christchurch the patient demographic has a very high proportion of people aged 65 years and older. These people are attending our Trust with multiple, complex long-term conditions and are already at a very high risk of falling on admission. Our primary focus has been recognising these high risk patients and their falls risk factors directly on admission; and even in some areas, prior to admission; and then developing an individualised plan to mitigate any risks. Patient safety measures we implemented in 2017/18 included:

- Developing an eLearning package for falls prevention training. The package was developed for all clinical staff. The aim was for the learning to be engaging and interactive. It follows a patient journey and looks at how we can risk assess our patients, mitigate risks; but also ensure staff know how to deal with a patient fall safely, should it arise. The package was completed and went live in October 2017. Feedback

from staff has been positive with an average overall rating of 4.3/5

Aim for 2018/19 - For the Falls lead to work with the training department to look at implementing bespoke eLearning for areas that felt the current training was not appropriate for them e.g. Theatres

- The Falls Steering Group continues to meet every two months with an aim for 2018/2019 to carry out falls specific peer reviews on the months between the meetings. This is still in the early developmental stages. The Falls Steering Group continues to look at and discuss all reported incidents, trends and learning from serious incident panels.

  Aim for 2018/19 - To plan and implement the falls specific peer review

- Training has remained the main focus for 2017/18. Face- to- face scenario based falls prevention training continues to be delivered to all new Health care Support Workers (HCSW), HCSW updates, Return to Acute Nursing, Overseas Nurses and the newly qualified Preceptors. The scenario based training is carried out in the training department and encourages staff to always be aware of falls risks, not only for the patients but for their colleagues and themselves.

  Aim for 2018/19 - To continue with scenario based training for the above groups of staff

- The Trust took part in the National Falls Audit 2017. As part of the audit, 30 patient case notes were reviewed and audited against compliance with the essential elements of a falls risk assessment. The results below showed there was a small improvement and we are above the national average in most areas.

Risk factors assessed	2015	2017	National Average
Delirium	29.2%	36%	40%
Continence CP	66.7%	69%	67%
Lying and Standing Blood Pressure	21.7%	36%	19%
Medication	81%	70%	48%
Vision	62.1%	43%	46%
Mobility Aid	60%	75%	72%
Call Bell	89.7%	93%	81%

  Aim for 2018/19 - To continue with the above improvements and to include them in the falls specific peer review to evidence increased compliance.

- We have continued to increase the number of Manual Handling and Falls Champions in each area. Champions have been encouraged to become more involved with investigating LERN forms to enable them to identify local themes and learning.

  Aim for 2018/19 - Falls Champions to be invited and attend serious incident meetings for their areas.

- A Falls Incident Toolkit has been implemented and is available for all ward areas to use. Ward managers have been encouraged to complete a Falls Improvement Plan. This can be used for investigating LERN forms, and is also a way of evidencing improvements.

  Aim for 2018/19 - For the Quality and Risk team to assist ward managers with completing and implementing their Falls Improvement Plan.

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.

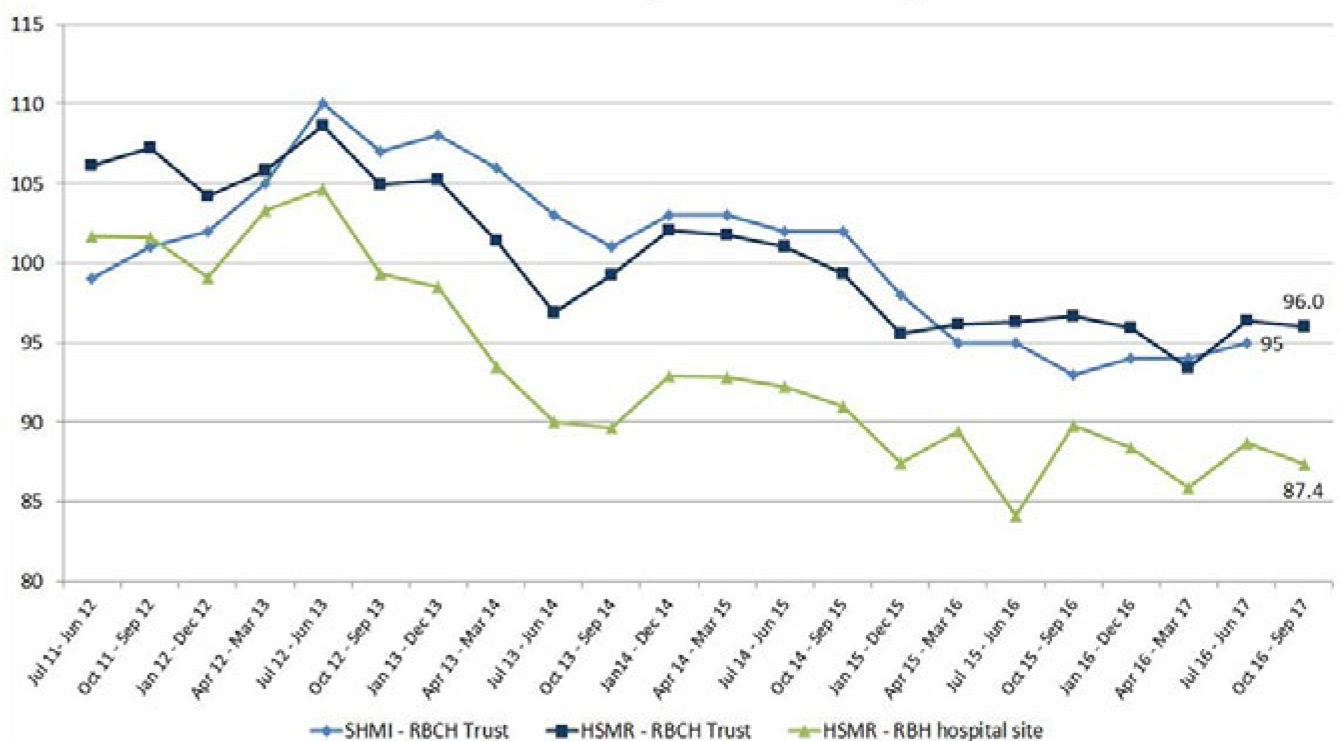
As previously highlighted, the Trust has a multi-disciplinary Mortality Surveillance Group, chaired by the Medical Director, to review the Trust's HSMR and Dr Foster Intelligence Unit mortality risk reports on a monthly basis.

The Trust's HSMR has significantly improved (reduced) over last 3 years compared to the national average (100). Current HSMR for the period October 2016 to September 2017 is 96.0 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.

Achieving high standards in Anaesthetics

Anaesthesia Clinical Services Accreditation (ACSA) is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review. The scheme has been developed by the Royal College of Anaesthetists (RCoA) Quality Management of Service Group and the Clinical Quality Directorate.



Engagement with the scheme entails a period of detailed self-assessment against the ACSA standards and gap analysis. Assistance and support in improving those areas is then offered. This includes access to the good practice library; a collection of good practice documents and guidance gathered from organisations that are engaged with the scheme. When the organisation achieves 100% compliance with the ACSA standards and this has been confirmed during an on site review, they become accredited.

The Anaesthetic department achieved RCoA accreditation in January 2018. The department is one of only 18 nationally to have received the award and the first Vascular Anaesthesia department to have done so.

Pathology Department achieves success in accreditation

Each individual Pathology laboratory has recently undergone a period of inspection by the new accrediting body UKAS (United Kingdom Accreditation Service). This was the first inspection against the ISO15189 standard which is currently being rolled out across the UK. The inspections was an extremely detailed and rigorous process to assure the highest level of quality in all aspects of laboratory medicine and quality management. Feedback from assessors was overwhelmingly complementary in all areas.

Accreditation has already been awarded to Cellular Pathology, Immunology, and Microbiology. The last queries are being resolved in Blood Sciences from the most recent assessment, therefore we anticipate that Molecular Pathology, Haematology, Transfusion and Phlebotomy will be awarded very soon.

The result is testament to all our pathology staff who have adopted a culture of continual quality improvement, ensuring the provision of a high quality service to support excellent patient care.

Maintaining High standards in Maternity

Royal College of Midwifes (RCM) - Caring for you Charter

In early 2017 the Trust's maternity services signed the RCM's Caring for You Charter, which aims to improve the health, safety and wellbeing of maternity staff. This supports and enables them to continue providing the highest levels of maternity care for women and their families.

Julia Chandler, the Royal College of Midwives Regional Officer, said: "I am delighted that the Trust has signed the Charter. They have a committed team of midwives and maternity support workers at the Trust, led by an enthusiastic head of midwifery committed to the welfare of her staff. This is a very positive move by the Trust and I welcome their commitment to staff and the people they care for."

When signing the charter, organisations are committing to five key principles:

- Work in partnership with the RCM Health and Safety Representative to develop and implement an action plan about health, safety and wellbeing issues that are important to the maternity workforce and maternity service users.

- Ensure that midwives and maternity support workers have access to a variety of shift patterns and flexible working and promote a positive workplace culture around working time including taking breaks.
- Foster a positive working environment for all by signing up to the RCM/RCOG statement of commitment calling for zero tolerance policy on undermining and bullying behaviours.
- Enable midwives and maternity support workers to access occupational health and other organisational policies for their mental and physical health, safety and wellbeing.
- Nurture a compassionate and supportive workplace that cares for midwives and maternity support workers so that they can care for women and their families.

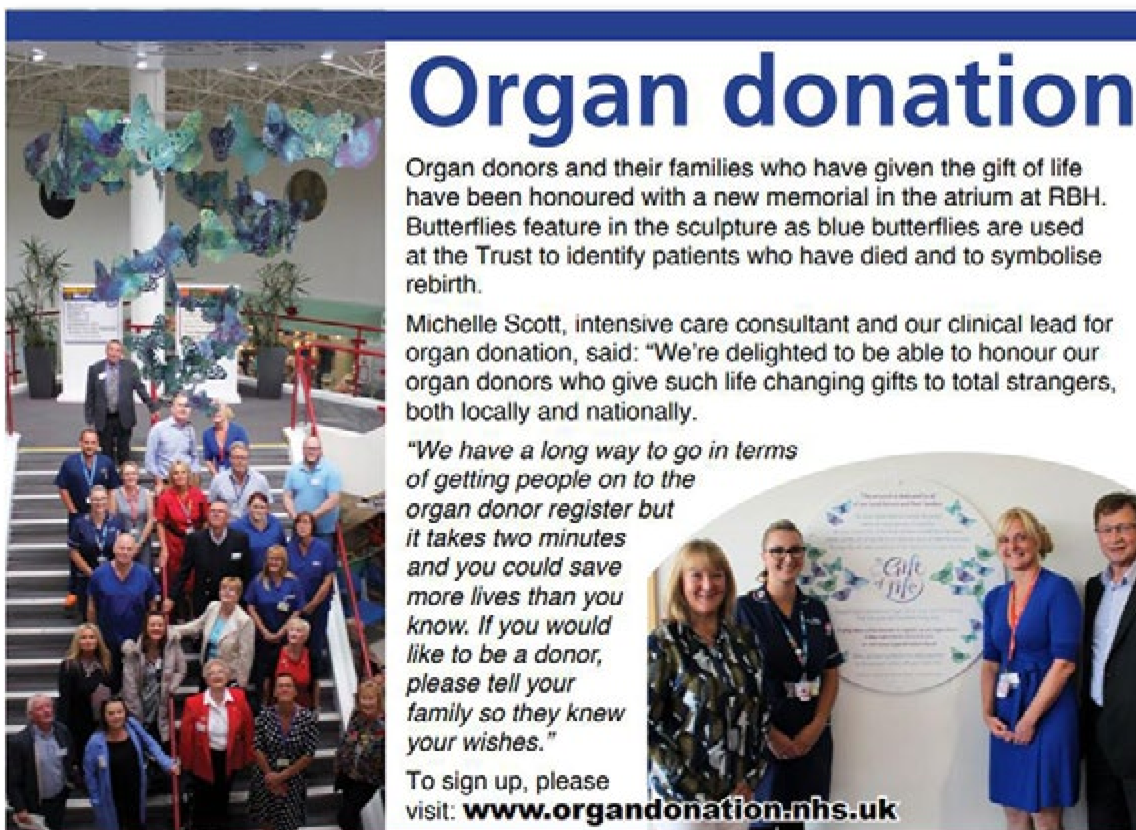
Following implementation, the Midwifery Team were shortlisted for a Royal College of Midwives (RCM) Caring for You Award in March 2018. The prestigious accolade recognises those who have signed the RCM Caring for You Charter, demonstrating their commitment to improve the health, safety and wellbeing at work of midwives, student midwives and maternity support workers so they are able to give even better care for women and their families.

RBCH Head of Midwifery, Carmen Cross, and Maternity Audit Facilitator, Audrey Wareham led on the Charter work and set up Caring for You drop-in clinics, a Caring for You team party to coincide with the International Day of the Midwife, a staff motivational committee and team fundraising events.

Carmen said: "We're so delighted to be shortlisted. This is not just the senior team being nominated for this award but the whole of maternity - without the staff engagement we would not be able to have achieved what we have. I'm so proud of the team and to work for RBCH."

The Community Midwife team are also celebrating after having been chosen as the 'Early Years Sector Award Winners 2017' for their collaborative work with Bournemouth Children's Centres.

Press Cuttings:



Organ donation

Organ donors and their families who have given the gift of life have been honoured with a new memorial in the atrium at RBH. Butterflies feature in the sculpture as blue butterflies are used at the Trust to identify patients who have died and to symbolise rebirth.

Michelle Scott, intensive care consultant and our clinical lead for organ donation, said: "We're delighted to be able to honour our organ donors who give such life changing gifts to total strangers, both locally and nationally.

"We have a long way to go in terms of getting people on to the organ donor register but it takes two minutes and you could save more lives than you know. If you would like to be a donor, please tell your family so they knew your wishes."

To sign up, please visit: **www.organdonation.nhs.uk**

Transplant Unit teams achieve accreditation

Thanks to teams in our fantastic Haematology Department, our Transplant Unit has been accredited for another four years under JACIE – The Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT). This is excellent news for our patients as it offers reassurance that our unit works in line with international standards and has been rigorously inspected.

JACIE establishes minimum requirements for facilities, education and training, quality management, donor and patient management and care, and good cell collection and laboratory practice. Having a robust quality management system in place is key to achieving accreditation. This means all the teams involved must work together and develop effective methods of communication, common working practices and ways of rapidly identifying errors or accidents and resolving them so they are unlikely to be repeated.

It is thanks to the commitment and vigilance of the Transplant Team and the teams on the Jigsaw Day Unit and Ward 11 that the criteria for this Europe-wide seal of approval was met. Huge thanks and congratulations to all involved!

BERTIE online ends 2017 with national award win

The Diabetes Team at the Royal Bournemouth Hospital (RBH) is celebrating a fantastic end to the year with another national award win for BERTIE online, a diabetes education forum for patients with type 1 diabetes.

The diabetes education forum designed and relaunched last year by the Diabetes Team at the Royal Bournemouth Hospital (RBH) was successful in winning the “Best Learning Technologies Project -UK public and non-profit sector” award at the 2017 Learning Technologies Awards in London. The win is the latest accolade for the team which also scooped a highly commended award at the Quality in Care (QiC) Diabetes 2017 Awards for the same online education forum in the autumn.

The portal offers vital education via an innovative and unique platform and also provides a forum for people to share their experiences and build a support network - ideal for those who have recently been diagnosed and may be feeling alone and overwhelmed.

Helen Partridge, RBH diabetes consultant, said: “I was absolutely astounded to have won this award among competition from some multinational, world-famous companies. It reaffirmed how vital it is to look at innovative ways of offering accurate, safe advice to people who perhaps don’t have access to the sort of education we can offer to people in Bournemouth with type 1 diabetes.”

Endoscopy Team recognised for high quality care

The Endoscopy Team at the Royal Bournemouth Hospital has been awarded Joint Advisory Group (JAG) on Gastrointestinal Endoscopy Accreditation for the second year running.

Gaining the accreditation for 2018 demonstrates the department meets a stringent set of standards relating to high quality patient care - the kind we would expect for our own families.

The JAG scheme is regarded as one of the most innovative and effective in the healthcare sector and the accreditation can assure patients that the department is committed to high quality standards in their clinical practice.

To achieve the accredited standard, the Endoscopy Team had to provide evidence of clinical quality, quality of patient experience, workforce and training.

The service sees around 15,000 patients each year and consistently receives positive feedback in the Friends and Family Test - on average, 99% of our patients would recommend the service.

Samantha Hornby-Wykes, Sister for Endoscopy, said: “We’re really pleased to have received the accreditation again. It’s great for us to be able to show our patients that we’re accredited and the Joint Advisory Group endorses us.

“The Endoscopy Team here at Bournemouth takes great pride in excellent patient care and this accreditation goes to show that all their hard work pays off. I’m so proud of the team and everything they’ve achieved, including this accreditation.”

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 real time patient feedback, patient surveys and focus groups
- Monitoring for any emerging issues via 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 percentage of responses recording unlikely or extremely unlikely to recommend.

FFT April 2014 - March 2015 (all areas)		FFT April 2015 - March 2016 (all areas)		FFT April 2016 - March 2017 (all areas)		**FFT April 2017 - March 2018 (all areas)**	
Extremely likely responses	25711	Extremely likely responses	34089	Extremely likely responses	34065	**Extremely likely responses**	**35120**
Likely	5013	Likely	6289	Likely	5264	**Likely**	**5278**
Neither likely/nor unlikely	569	Neither likely/ nor unlikely	569	Neither likely/ nor unlikely	498	**Neither likely/ nor unlikely**	**496**
Unlikely	246	Unlikely	232	Unlikely	215	**Unlikely**	**188**
Extremely unlikely	380	Extremely unlikely	391	Extremely unlikely	358	**Extremely unlikely**	**382**
Total	**31919**	**Total**	**41570**	**Total**	**40400**	**Total**	**41464**

FFT April 2014 - March 2015 (all areas)		FFT April 2015 - March 2016 (all areas)		FFT April 2016 - March 2017 (all areas)		**FFT April 2017 - March 2018 (all areas)**	
Extremely likely responses	80.6%	Extremely likely responses	82.0%	Extremely likely responses	84.3%	**Extremely likely responses**	**84.7%**
Likely	15.7%	Likely	15.1%	Likely	13.0%	**Likely**	**12.7%**
Neither likely/nor unlikely	1.8%	Neither likely/ nor unlikely	1.4%	Neither likely/ nor unlikely	1.2%	**Neither likely/ nor unlikely**	**1.2%**
Unlikely	0.8%	Unlikely	0.6%	Unlikely	0.5%	**Unlikely**	**0.5%**
Extremely unlikely	1.1%	Extremely unlikely	0.9%	Extremely unlikely	0.9%	**Extremely unlikely**	**0.9%**

Patient Focus Groups

Through May to October 2017, the Trust held a number of focus groups across Trust to provide patients and former patients to feedback on the care they have received.

The groups focussed on different topics, appealing to patients from various parts of the local community, including Lesbian, Gay, Bisexual and Transgender, different faith groups, patients / carers of patients living with dementia and patients with learning disabilities and physical disabilities.

All attendees were asked: ‘What did it feel like to receive care at RBCH?’ and ‘What small change would you make to have a big difference to the care you received?’

The sessions were open to patients and former patients who have come to the hospital as inpatients and outpatients, as well as the carers and families of those who have received care.

Rachel Bevan, Head of Patient Experience and Public Engagement, said: “We’re immensely proud of the care we provide at RBCH. It’s really important we take our patients’ views and experiences on board. By listening to our community we can learn about the care they receive and look to make changes that are relevant to the people who use our services.

National Cancer Patient Experience Survey

RBH has performed exceptionally well in the sixth annual National Cancer Patient Experience Survey. From a total of 50 questions, we scored higher than the expected range in 12 questions (up from six in 2015), with the remainder all scoring within the expected range. We had no questions which scored negatively. Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of nine to RBH, compared to the national average of 8.7.

Alison Ashmore, Associate Director for Cancer Services, said: *“This survey has been designed to monitor our progress on cancer care and to provide us with information to help with quality improvements. It is very pleasing to see how we have improved on the previous results and also how well we have done compared to other trusts around the country. We have a number of current initiatives to help us continue improving, but in the meantime I would like to thank all staff involved in helping us do so well as demonstrated by these results.”*

The full results are available here: **www.ncpes.co.uk**

Working with our volunteers to support patient experience

End of Life Care Voluntary Services Team scoops national award

The Royal Bournemouth and Christchurch Hospitals' Voluntary Services Team won a national award in 2017/18 for its innovative End of Life Companion initiative.

The team won the National Association of Voluntary Service Manager's' Excellence in Volunteer Management Award for the way it has set up and managed the new End of Life Companion (EOLC) voluntary role. EOLCs are volunteers who spend time supporting patients nearing and at the very end of their lives, along with their family and friends. The new role ensures no one need die alone and they have companionship when they need it most.

Those coming to the end of life while in hospital often find it helpful to talk through their fears and wishes and their friends and relatives often require support to come to terms with their loss.

Making sure EOLCs are on hand and available, often at short notice, meant developing clear processes, making sure staff were aware of how to access the volunteers, and ensuring the EOLCs were well prepared for the range of situations they may face.

Rachel Bevan, Head of Patient Experience and Public Engagement, said: "Our End of Life Companions are doing a very important job - helping us make sure we are looking after the emotional wellbeing of our patients and their loved ones, as well as their physical needs. "There was a significant amount of work involved in organising the recruitment and training of the volunteers, as well as setting up a robust system to ensure the volunteers are alerted when they are needed, and supported afterwards. I could not be more proud of my team for making the project such a success. It was an honour to win the award and have our hard work, and the work of our volunteers, recognised on a national scale."

Macmillan Unit volunteers team receive royal award

Christchurch Hospital's Macmillan Unit is one of just 40 organisations to be awarded the HRH Princess Royal's Training Award. The award for training excellence was given to the specialist palliative care unit for its innovative approach to training its volunteers. The programme, headed up by Volunteer Coordinator Anita Rigler, has seen the Unit recruit volunteers based on a number of values, allows experienced volunteers to train new volunteers and support each other via peer support and supervision.

The new training follows a 40% increase in referrals to the Macmillan Unit and since it was introduced, more than 300 people have volunteered their time. Not only has the training benefited the Macmillan Unit, other charities in the area are also adopting the same techniques, with volunteers going to Christchurch Angels, Lewis-Manning Hospice and the Motor Neurone Disease Association, as well as local care agencies to deliver training on the innovative programme.

Anita Rigler, along with her husband and volunteer, Mandy Preece, attended a presentation by HRH The Princess Royal at St James's Palace to accept the award. They were joined by representatives from 39 other organisations, including RBS, Barclays and Waitrose.

Anita said: "It's an absolute honour to have our hard work acknowledged by a Princess Royal Training Award. Our service simply wouldn't be the same without our wonderful volunteers so it's important we attract the right people to volunteer with us and support and train them as best we can for the important work they do - this award is for them."

(l-r) Macmillan Unit volunteer Mandy Preece and Volunteer Coordinator Anita Rigler outside St James's Palace.

Outstanding' hospital Orchard Garden wins Gold at South and South East in Bloom Awards

The therapeutic Orchard Garden at the Royal Bournemouth Hospital was heralded as 'outstanding' by judges after it received a Gold award at the South and South East in Bloom 2017 awards ceremony.

The Orchard Garden - funded by donations to Bournemouth Hospital Charity - was awarded the highest honour of a Gold award at the annual ceremony in Gatwick after it had been nominated for the awards by the Bournemouth in Bloom organisation.

South and South East in Bloom judge Ruth Growney, who visited the Royal Bournemouth Hospital to evaluate the Orchard Garden in July 17, said "The Orchard Garden is an outstanding example that is made even more extraordinary as it is a first time entry. It's incredibly rare for this to happen, but so well deserved."

Haematology Consultant Dr Helen McCarthy, who originally envisioned the concept of the Orchard Garden project, said: "I strongly believe in the healing power of gardens and I'm grateful to those who supported my vision of creating this small oasis in the grounds of a hospital. "I would like to thank all of our patients, their families and our staff for their passion in fundraising to make this possible. Much emotion has been invested in this lovely garden for cancer patients to enjoy."

The Orchard Garden has transformed the previously unused and unattractive courtyard in between the hospital's Jigsaw Building and Pathology Department into a tranquil area of relaxation and beauty for patients, visitors and staff to enjoy. The area now features a therapeutic courtyard garden linked by a sensory orchard walkway to the hospital lake, where a fully accessible wooden deck offers an area of peaceful retreat overlooking the water.

The Orchard Garden was significantly supported by Dorset Cancer Care Foundation - which administered a legacy from the late Betty Hyams - as well as the Tesco 'Bags of Help' programme that contributed £12,000 after local Tesco shoppers voted to back the project at the checkouts.

Learning from complaints and concerns

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

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

There were 310 formal complaints received by the Trust for 2017/18, which is an increase on the previous year by 17 complaints (293 complaints received in 2016/17, 313 complaints received in 2015/16).

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

Complaint outcomes

There were 310 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.

Ensuring outcomes are systematically recorded and learning is disseminated remains the focus for the 2018 /19 year plan.

Subjects of complaints

The main categories of complaint were as follows:

Subject	Formal Complaints 2017/18		Formal Complaints 2016/17		Formal Complaints 2015/16	
	Number	Proportion	Number	Proportion	Number	Proportion
Implementation of care - including quality, delays and/or complications of treatment	122	39%	135	46%	112	36%
Clinical Assessment	22	7%	-	-	-	-
Admission, transfer and discharge	46	15%	52	18%	61	20%
Diagnostic tests (not pathology)	0	0%	25	8%	58	19%
Communication and consent	105	34%	61	21%	55	18%
Medication	7	2%	1	0%	9	3%
Security	1	0%	2	1%	3	1%
Equipment	1	0%	5	2%	2	1%
Food Safety and Service	0	0%	0	0	1	0%
Visitor incidents/accidents	0	0%	1	0%	1	0%
Treatment, procedure, care	0	0%	0	0%	1	0%
Staff incident	0	0%	0	0%	1	0%
Patient incidents (including falls, other accidents and self-harm)	2	1%	5	2%	7	2%
Environment	0	0%	3	1%		
Infection Control	4	1%	2	1%		

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

The PALS and Complaints team monitor emerging themes from complaints on a daily basis and discuss as a team ensuring escalation to the directorate or appropriate manager.

Any trends or themes identified are reported to the Deputy Director of Nursing. A full report on the themes from complaints is reported into the Trust Healthcare Assurance Committee meeting. Themes are then reviewed and triangulated with appropriate action taken

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
I came for an appointment and had bloods done on the same day. I was not given my test results at this appointment so presumed they were all clear.	The department have implemented two prompts on the computer system to check results, all positive results are sent weekly to clinical leader, patients are now also encouraged to have blood tests done 2 weeks prior to appointment to enable the results to be ready at the appointment
I came to the hospital as I had hurt my knee, I was called 5 days later and told it may be broken and I would be referred on for this. I heard nothing and had to chase this up on several occasions	Spoke with the reception staff regarding referrals and reminded them of the need for timeliness, we are also looking into streamlining the referral process
I had an ECG and was shocked and surprised that the technician had to physically touch me, I was not aware that this would happen	A local chaperone policy has been created for the department and the appointment letters will be reviewed to include more relevant information in regards to what the test involves.
My surgery was cancelled and I was told that this was due to contaminated equipment	The surgery equipment packing process has been reviewed and the trays are wrapped as they are put together to reduce the length of time the tray is exposed to the atmosphere, the managers have also increased the number of visual quality assurance checks
GP service called to arrange for a patient to be admitted, the requested ambulance did not arrive to collect the patient	We brought in a new procedure for ensuring ambulances are booked when requested and reminded all staff to be vigilant.
My mum needed a cannula inserted for her to have fluids but there was no-one trained on the ward to insert this	We reviewed the staff skill mix to ensure that there is always at least one member of staff on shift that can perform this task.
There was conflicting information given regarding the Power of Attorney that I hold for my relative	Arranged training for staff on the ward for them to have a better understanding of the Power of Attorney rights and documents
Incorrect information is on my electronic records	Removed the information and reminded staff to be vigilant with ensuring the patient's records are correct
I was calling a ward to get information on my relative and the phone was not answered for over 2 minutes	Ward staff reminded of the importance of answering the telephone. Telecoms will monitor and review the timeliness of calls being answered

Problem	We did
I had a procedure which involved me turning my arm round and holding it for 90 minutes, this put pressure on my shoulder and exacerbated an injury	Included in the pre-clerking documentation a "previous shoulder injury" section so that the staff are aware prior to the procedure starting.
The transport staff use the discharge lounge as a break room and they are loud and sometimes offensive	We contacted the ambulance teams that come to the hospital and asked for all staff to be mindful of conversations if using the area for a break.
The triage Nurse did not recognise the patient's learning difficulties when they attended	We implemented a training programme "Disability Matters - Confidence Matters" for all nursing staff in ED
The curb outside Christchurch hospital is not flush to the road making this difficult for wheelchair users	The Estates Manager contacted the architect and engineer and looked into this to ensure compliance
I've not been able to order a Kosher meal whilst on the ward	The Catering Manager investigated and identified that there had been a delay in these meals being delivered. An alternate supplier was found to avoid any future issues
I had to wait a long time for my medication to be issued	Provided education to everyone in Pharmacy regarding paperwork and keeping patients informed for Clinical trials

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.

After receiving a response from the Trust, 3 people chose to refer their concerns to the Parliamentary and Health Service Ombudsman (PHSO) during 2017/18 compared to 11 in 2016/17 and 12 in 2015/16. The PHSO referred 0 complaints back to the Trust for further local resolution. During 2017/18 the total number of complaints investigated by the Ombudsman was 18, ranging between the years 2014 and 2017, 1 complaint was upheld, 6 were partly upheld, 6 were not upheld and 1 was withdrawn. 6 complaints remain under investigation by the PHSO.

Performance against national priorities 2017/18

National Priority	2013/14	2014/15	2015/16	2016/17	2017/18 Target	2017/18 Actual
18 week referral to treatment waiting times - admitted	90.8%	88.9%	84.5%	81%	90.0%	**80.5%**
18 week referral to treatment waiting times - non admitted	98.4%	95.6%	94.4%	89.0%	95.0%	**88.7%**
18 week referral to treatment waiting times - patients on an incomplete pathway	98.4%	95.6%	94.4%	89.0%	95.0%	**88.7%**
	96.2%	94.3%	93.7%	91.6%	92.0%	**90.3%**
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	95.5%	93.3%	93.37%	94.6%	95.0%	**92.7%**
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	80.3%	84.5%	85.9%	85.7%	85%	**88.5%**
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	93.4%	93.1%	76.0%	96.9%	90%	**92.8%**
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	95.7%	95.8%	95.7%	98.3%	96%	**97.6%**
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	95.1%	92.5%	94.1%	96.3%	94%	**97.0%**
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti cancer drug treatment	100%	100%	100%	100.0%	98%	**100%**
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93.8%	87.1%	96.1%	96.1%	93%	**97.0%**
Two Week Wait for Breast Symptoms (where cancer was not initially suspected)	98.0%	91.1%	99.4%	98.8%	93%	100%

Clostridium difficile year on year reduction	14	21	14	17	14	20
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
Maximum 6 week wait for diagnostic procedures **	-	-	-	99.3%	>99%	99.72%
Maximum 6 week wait for diagnostic procedures **	-	-	-	99.3%	>99%	99.72%

** please note this year is the first time this information has been required as part of this report.

Annex A

Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees and the 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 West 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:

NHS Dorset Clinical Commissioning Group

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

During the year Commissioners have continued to see progress in a number of areas including the identification and management of sepsis and the deteriorating patient. We also commend the Trust for its continuing ambition to develop a more open and honest culture supporting staff to deliver safe, high quality care. This has been further supported by the introduction of a Positive Reporting Form, which replaces the previous Adverse Incident Reporting (AIRs) form, thus further reinforcing a positive message of promoting a safety culture.

The Trust has also had a recent CQC inspection and we await the final outcome of that inspection.

The CCG are supportive of the quality priorities for 2018/19 and commend the engagement of patients, carers and the public in identifying these priorities. At a time of significant change across the Dorset economy, we look forward to continuing our collaborative work with the Trust over the coming year.

NHS West Hampshire Clinical Commissioning Group

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 2018/19 Quality Account.

We are satisfied with the overall content of the Quality Account and believe that it meets the required mandated elements.

The CCG has reviewed the progress that the Trust has made with the quality priorities set for 2017/18. The CCG recognises the initiatives and efforts of staff in relation to the management of sepsis and the deteriorating patient whilst also acknowledging that some of the key aims were not achieved. We are pleased to see that these quality priorities have been carried over to 2018/19, and we look forward seeing the progress that will be made over the coming 12 months.

The CCG notes and supports the quality priorities identified by the Trust for 2018/19 that have been signed off by the Board but await further detail around the specific improvement work stream objectives and measures as these are developed by the respective Trust quality improvement teams.

It is evident from the report that the Trust places a high value on providing quality care throughout all areas and this is demonstrated by the wide range and large number of patient safety initiatives which have taken place over the last 12 months.

It is encouraging to see ongoing work towards ensuring an open and honest culture, including the reporting and management of incidents. Although the Trust has again demonstrated a reduction in the number of serious incidents reported there has been a high number of Never Events declared making the Trust an outlier for this event.

Although the majority of these have not resulted in significant harm to patients this is still of concern. The CCG has been encouraged to hear of the Trust's response to the Never Events and will continue to work as a priority with the Trust to gain assurance that all learning from these incidents is being captured and embedded in all applicable clinical settings.

The Quality account recognises the inclusion of the Hospital's Emergency Department by the Care Quality Commission in their best practice guide. It is clear the department continues to demonstrate a forward-thinking approach, which the CCG were able to see at first hand during a visit to the department by members of the commissioning and quality teams during July 2017.

It is right to congratulate the Trust again on their continued work with 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 quarter four 2015/16. The CCG appreciated the department's involvement in the CCG's Stroke Pathway review during November, where we had the option to see a number of the key services providing care to those patients admitted to the hospital with a suspected stroke. The team's commitment to the continued improvement of all aspects of the care they provide was particularly evident. 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.

Health and Social Care Overview and Scrutiny Committee, Borough of Poole

The presentation about the account delivered on 18th April gave a clear outline of how the Trust is endeavouring to deliver high quality care and the activities undertaken during the financial year to improve services. This is commendable especially in a period of unprecedented organisational change including the outcome of the Clinical Services Review and the move to the prospective "one acute network programme".

With regard to the priority areas for improvement for 2017/18 we would like to commend the Trust in achieving the majority of what it had planned in relation to:

Managing Sepsis-It was encouraging to note that much has been achieved including action learning weeks relating to sepsis and that an e-learning program has been developed that is interactive and hits home the key messages about early sepsis identification. It is reassuring to note that the Trust is much improved in regards to antibiotic administration rate from 1 hour of detection for patients with quick sepsis related organ failure and that this journey of learning and improvement will continue through an ongoing programme.

Identification and escalation of the Deteriorating Patient-It is encouraging to note that the early warning signs trigger of deteriorating patient being escalated and treated within 30 minutes is being monitored and audited closely to feedback to ward teams to inform immediate learning. The Trust has acknowledged that there is more to do in this

area to improve performance and that new ICT systems may enhance some areas of the patient pathway.

Improving Hospital (Patient) Flow-the committee are fully aware of the complex and multifactorial issues that lead to hospital admissions and can hinder discharge. It is also understood that this has been a particularly difficult winter in regards to rates of admissions to hospital. It is encouraging to note that as a Trust you have taken steps and been successful in reducing the average number of 14+ days length of stay patients and that you have managed to increase the use of ambulatory care, from 14.7io to 27io of patients now being assessed that way rather than being admitted to hospital.

The committee will be interested in understanding progress against the priority improvement areas set for next year which include urgent and emergency care, surgical flow, fundamentals of care and supporting speciality pathways.

Bournemouth Borough Council's Health Overview and Scrutiny Committee

It is encouraging to see the Sepsis rate improving and avoid unnecessary harm to patients. The work done on Sepsis and the deteriorating patient show good result, though as the text acknowledges, having achieved these high standard it is important to maintain them.

The last year has obviously been a difficult time with increased patient numbers, very tight budgets and still the need to try and improve patient flow. However, despite these challenges the result show an encouraging improvement in the flow, reducing costs to the trust, freeing up assets for others to use and improving the outcomes for patients who are in the right place at the right time and home as soon as is safe.

The quality improvement priorities for 2018/19 look interesting and address some important issues. We look forward to seeing how these areas of focus improve over the year.

Healthwatch Dorset

Thank you for the opportunity to comment on your annual Quality Account. This is to let you know that we will not be offering a commentary this year.

As you know, all through the year local people share with us their feedback on their local health and social care services. As part of our core work, we use that feedback to, in turn, feedback to local providers on people's experiences and views on the quality of their services whenever is appropriate. We also do that regularly in the form of particular investigations into particular services, sharing our findings and recommendations with the relevant providers.

The current prescriptive framework for Quality Accounts that is set down nationally for providers does not, we believe, allow you the freedom to produce reports that are as publicly accessible as they might and, we believe, should be. This is something that Healthwatch (nationally) wants to influence in the future as we believe that the language, focus and layout of Quality Accounts should be simpler to enable greater accessibility for the public.

Healthwatch England has been involved in discussions with the Department of Health for a number of years now in an attempt to make Quality Accounts more accessible but has not been successful. Locally in Dorset, we have had some discussion with some of our providers and with NHS Dorset CCG about the possibility of providers producing alongside the "official" Quality Account a more accessible, public-facing resource which not only reflect's the organisation's own self-assessment of the quality of its services but also reflects the assessments made by patients, service users and families.

With the backing of Dorset CCG, we propose to invite representatives of local providers to meet with us to discuss this suggestion and how it might work in practice.

Please be assured that we understand that there are prescriptive requirements laid on organisations sometimes which limit your ability to change things in the particular context.

That's why we think the answer lies elsewhere and why we propose to invite representatives of provider organisations to engage with us later in the year to explore possibilities. Our decision to not take up the (voluntary) opportunity to provide a commentary to go with your Quality Account is no reflection on the Trust or on the quality of services.

We very much value the working relationship we have with you and other organisations and look forward to continuing to work with you in the best interests of patients and the public.

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

Governors have had the opportunity to review and comment on the Quality Report through the Governor Strategy Committee to ensure that the information in the Quality Report provides comprehensive, clear and meaningful messages about the quality of care provided to patients.

The Quality Report recognises the pressures faced by acute hospitals and other health and social care partners in terms of increasing demand, staff shortages in some areas and funding. However, it also shows the ongoing continuous improvements happening in our hospitals in terms of waiting times, the inclusive, learning and open culture and the focus on providing high standards of care to patients in a sustainable way. The focus on recognition for staff in the report demonstrates the excellent and innovative care provided in many areas and reinforces the culture of continuous improvement.

Each year, the Governors make a tangible contribution to the quality improvement programme of the Trust by selecting a quality indicator for external audit. In 2017/18, the Governors have selected Clostridium difficile as this indicator as the number of cases of Clostridium difficile was above the, albeit challenging target, set by NHS England. The Governors wanted to provide some additional focus on this area and ensure 'lapses in care' were reported appropriately. The selection of the number and categorisation of complaints as the indicator in 2016/17 provided additional assurance around the significant improvement the Trust had made in responding to complaints.

Governors support the quality priorities that have been selected for 2018/19 to improve the quality and safety of care for patients in our hospitals and support the work to reduce waiting times, which our own engagement activities have highlighted as being one of the most important things for patients. Governors will continue to be involved in a range of activities to help and support the Trust in delivering these priorities as well as monitoring progress against these as part of the Trust's objectives. Governors will continue their involvement in a range of activities to deepen their insight in these areas including:

- involvement in public, patient and carer experience and listening events;
- receiving and questioning reports from directors on quality, performance and workforce at its quarterly Council of Governors meetings;
- supporting staff on ward based audits including the Patient Led Assessments of the Care Environment and unannounced infection control walkabouts supported by clinicians and estates and housekeeping staff;
- visiting different areas of the Trust;
- governor representation at key Trust committees including the Healthcare Assurance Committee, End of Life Care Steering Committee, Mortality Surveillance Group, Equality, Diversity and Inclusion Committee, Infection Prevention and Control Committee, Valuing Staff and Wellbeing Group and Workforce Strategy and Development Committee.

Governors appreciated the opportunity to meet with the Care Quality Commission as part of its well-led inspection in early 2018 and to give their views on the progress against the action plan following the last inspection and on the work of the board of directors and the Trust overall to deliver high quality care and a positive experience for patients.

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.

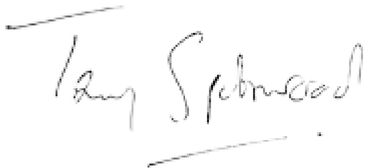
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 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 2017 to May 2018
  - papers relating to quality reported to the Board over the period April 2017 to May 2018
  - feedback from commissioners dated 11 May and 16 May 2018
  - feedback from governors dated 11 May 2018
  - feedback from local Healthwatch organisations dated 23 April 2018
  - feedback from the Overview and Scrutiny Committees dated 23 April 2018 and 3 May 2018 respectively
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated April 2016
  - the latest national inpatient survey 31 May 2017
  - the latest national staff survey dated February 2018
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2018
  - Care Quality Commission Inspection Report dated February 2016
- the Quality Report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with 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
24 May 2018



Tony Spotswood
Chief Executive
24 May 2018

Annex C

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

We have been engaged by the Council of Governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (the 18 week RTT indicator);
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge (the four hour A&E indicator);

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 2017/18 ('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 2017/18 ('the Guidance').

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 11 May 2018;

- feedback from governors, dated 11 May 2018;
- feedback from local Healthwatch organisations, dated 23 April 2018;
- feedback from Overview and Scrutiny Committee, dated 23 April 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey, dated 31 May 2017;
- the latest national staff survey, dated January 2018;
- Care Quality Commission Inspection, dated 25 February 2016; and
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of The Royal Bournemouth and Christchurch 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 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Royal Bournemouth and Christchurch 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 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Basis for qualified conclusion on the 18 week RTT indicator

Our sample testing for the 18 week RTT indicator identified three issues from a sample of 20 pathways. Two of the three cases with issues identified related to incorrect clock start dates. The remaining issue related to a new pathway being started in error. However, of these three instances, the errors identified would not have resulted in a breach.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the 18 week RTT inicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual 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 2018

Annex D
Glossary of Terms

AMU
Acute Medical unit

AV node
Atrioventricular node which controls the heart rate, is one of the major elements in the cardiac conduction system.

BAUS
The British Association of Urological Surgeons

BEAT
Blended Education and Training team

BERTIE
BERTIE Type 1 Diabetes Education Program

CA UTI
Catheter Associated Urinary Tract Infections

CEPOD
Confidential Enquiry into Perioperative Deaths

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

CT
Computed tomography scan
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

DP
Deteriorating Patient, one of our key quality priorities for 2017/2018

ECG
Echocardiogram

ED
Emergency Department

eNA
Electronic nurse assessments

eMortality
Electronic Mortality capture form

FODMAP
stands for Fermentable Oligosaccharides, Disaccharides, Monosaccharides, and Polyols, which are short chain carbohydrates and sugar alcohols that are poorly absorbed by the body, resulting in abdominal pain and bloating. occur in some foods naturally or as additives

FY1/2
Foundation Year doctors

GP
General Practitioner

Grand Round
is a medical educational meeting open to doctors and doctors in training from all specialties on topics of generic clinical interest

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/

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.

LERN
Learning Event Report Notification system

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)

NG (T)
Naso-gastric (tube)

OPM
Older Persons Medicine directorate

OPS coding
OPCS Classification of Interventions and Procedures is a World Health Organization measurement for all patient procedures.

Outlier
a patient who is admitted to a ward which is not their speciality ward, for example a medical patient placed on a surgical ward due to lack of medical beds available at that time.

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

National data (HSCIC) 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.

RCOG
Royal College of Gynaecologists

RCP
Royal College of Physicians

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 three year objective to reduce avoidable harm by 50% and save 6000 lives. Healthcare organisations have been encouraged to sign up to five pledges and create a 3-5 year plan for safety. To find out more about the Trust's pledge go to: **www.rbch.nhs.uk**

UKAS
United Kingdom Accreditation Service UKAS is the UK's National Accreditation Body, responsible for determining, in the public interest, the technical competence and integrity of organisations such as those offering testing, calibration and certification services.

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