NHS

The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

Quality Report

2018/19

Contents

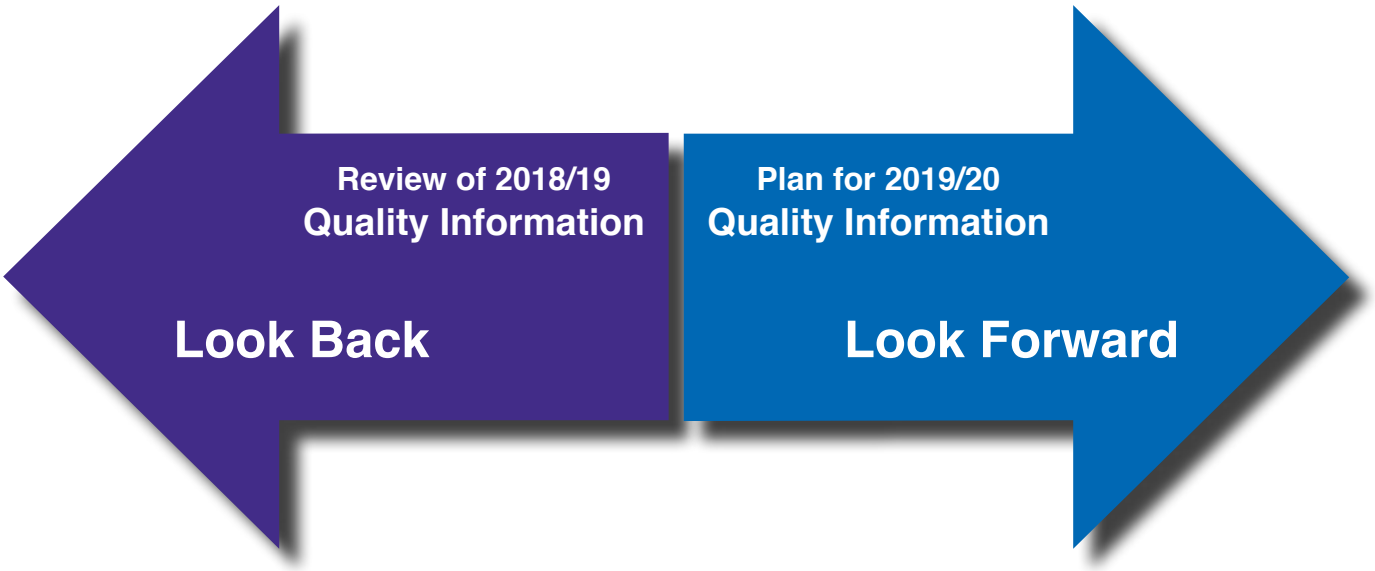
What is a quality account?

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 2018/19; and
2. set out our quality priorities and objectives for 2019/20.



To begin with, we will give details of how we performed in 2018/2019 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 2019/2020, 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 2018/19 quality priorities
	Quality priorities for 2019/20
	Statements of assurance from the Board
	Reporting against core indicators
Part 3	Other information

Part 1

Statement on quality from the Chief Executive

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

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

This year we have been able to report on the progress of quality improvement work on front door and surgical flow, speciality pathways such as Dermatology and Ophthalmology and important aspects of the "Fundamentals of Care". All of the quality and safety objectives set out are designed to support our vision to 'work in partnership and continually improve our services'.

We were delighted that the Care Quality Commission rated the Trust as Good overall following their inspection in March and April 2018 and we were particularly pleased to achieve an "Outstanding" rating for Well led. These results reflected how hard everyone had worked to make improvements to benefit our patients. Building on our last set of CQC results has been a true team effort, with everyone bringing ideas to the table and embracing new ways to improve patient care.

I am also very proud that our Trust was Highly Commended in the Health Service Journal Award 2018 Trust of the Year category. The award is designed to recognise those trusts which are offering excellent patient centric care built on strong engagement between clinicians within and beyond the organisation. This result was a fantastic achievement and truly represents the commitment of all our staff to providing the best care for our patients, with a strong focus on safety and quality.

As we move forward with implementing the results of the Dorset Clinical Services Review it is vital that we ensure co-production with patients and the public is at the forefront of all our changes. We are working closely with colleagues across all the trusts in Dorset, with our Clinical Commissioning Group colleagues and with the One Acute Network to consider ways to better develop and improve services across Dorset. Further details of this work are included in the Annual Report.

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 2019/2020. 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.

Debbie Fleming,
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 2018/2019

In the 2017/ 2018 Quality Account the Trust identified the following key areas for improvement during 2018/2019.

Quality Improvement Priorities 2018/19

Urgent and Emergency Care
'First 24 Hours'

Surgical Flow

Supporting our Specialty Pathways

- dermatology
- ophthalmology
- respiratory
- 'bloods on wards'

Fundamentals of Care

- central venous catheter
- consent
- sepsis
- patient deterioration
- mental health
- pressure ulcers
- falls
- learning from deaths

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, 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.

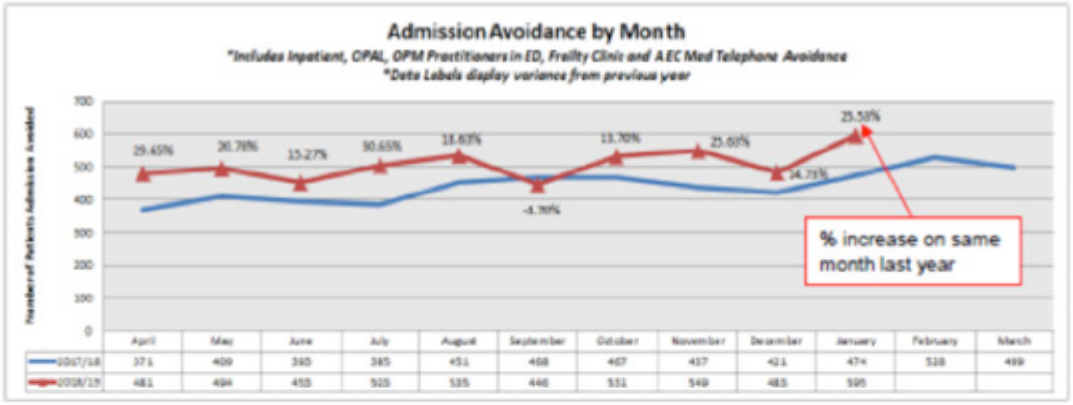
Urgent and Emergency Care

1. First 24 Hours (F24H) Programme - Ambulatory Care

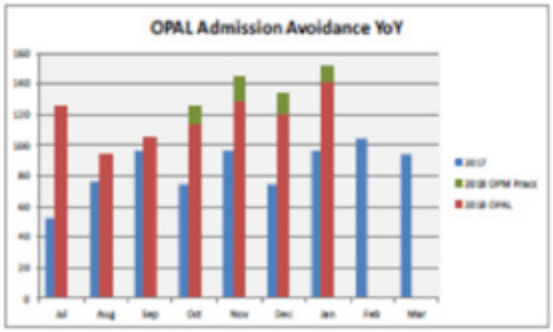
Reducing avoidable emergency admissions improves the quality of life for people with long term and acute conditions and their families, as well as reducing pressures upon the resources of local hospitals. The trust has undertaken a number of quality improvement projects in 2018/2019 with the aim of improving patient pathways and implementing new ways of working that support patient care and avoid unnecessary hospital admissions.

Aim	To increase by 50% the 2017/18 admission avoidance performance by 31 March 2019.
Measure	Length of Stay (LoS)
Outcome	An average increase of 19% avoided admissions per month has been achieved based on a comparison with 2017/2018 data

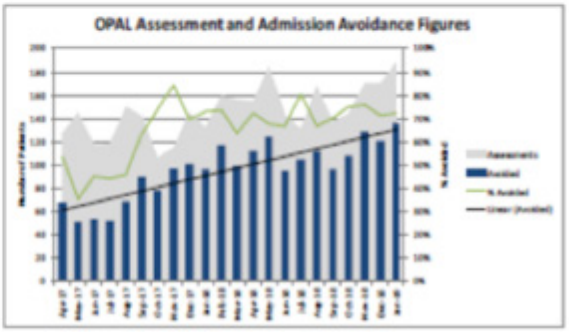
Admission avoidance



An average increase of **+19%** per month avoided admissions (all specialties) has been achieved year-to-date based on direct comparison with corresponding months 2017/18



A key driver in the increase in avoided admissions has been the scale of improvement delivered by the work of the OPAL & Frailty ANP teams in ED



How has the project been achieved?

Since October 2018, the Older Peoples Medicine (OPM) Advanced Nurse Practitioners (ANPs) have worked as part of the initial clerking and assessing team within the Emergency Department (ED). They have identified those patients that met the frailty pathway criteria on arrival, enabling their assessment, examination, diagnostic requirements, and treatment plan in accordance with best practice guidelines.

Earlier intervention by older peoples assessment (OPAL) and Frailty ANPs, working collaboratively with community colleagues in ED, has directly enabled the avoidance of significant numbers of unnecessary admissions.

What improvements has the project seen?

In addition to the quantitative achievements a number of qualitative benefits have arisen from the work of the F24H Ambulatory Care Quality Improvement project:

- Improved working relationships between Trust clinicians and GPs
- 'SystmOne' rollout/training to nominated clinicians has enabled them to access the patient database currently used across GP practices, enabling more informed discussion/collaboration between primary and secondary care clinicians.
- Collaboration and shared learning/experience between clinical teams
- Consultant engagement with new ways of working - exemplified by the increasing level of participation with the 'Consultant Connect' system. Consultant Connect is a new IT application enabling GPs to contact Consultants to support appropriate referrals. The app was launched in December 2018 across a few pilot areas.

Overall Summary

- Very successful - 19% increase in overall admission avoidance represents an excellent achievement.
- Seeking new working relationships with primary care and ambulance services has identified a significant area for growth, bolstered by proactive support of the local CCGs.

Next Steps

- The work of the sub group will continue. Areas for potential improvement include the further expansion of the range of Trust services available to GPs for rapid telephone advice and guidance and, the further development of the Trust funded taxi conveyance (both into and out of hospital) to support admission avoidance and reduced length of stay.
- To continue working on collaborative improvement opportunities with primary care/ambulance services.

2. First 24 Hours (F24H) Programme - Combined Clerking

Aim	To reduce the overlap between Emergency Department (ED) and Acute Admission Unit (AMU) and Surgical Assessment Unit (SAU) clerking by 50% by March 2019 Outcome measures
Measure	Time to clerking after referral to specialty How long before the patient has their post take review following an acute admission to hospital
Outcome	49% reduction in the time from ED arrival to a patient being fully clerked

How has the project been achieved?

A multidisciplinary team was established to review existing paperwork and what needed to be amended to streamline documentation and avoid duplication when obtaining a patient's history and examining the patient.

The new proforma was implemented at the end of October 2018 and has remained in place since this time, with further iterative improvements

What improvements has the project seen?

- The time from ED arrival to being fully clerked has dropped from 5 hours and 10 minutes to 2 hours and 28 minutes. This is a 49% reduction (against the target of 50%). There has also been much less variation in clerking times.

- The time from ED arrival to post take ward round dropped from 11 hours and 2 minutes to 7 hours and 17 minutes (a reduction of 3 hours and 45 minutes improvement). There has also been less variation in this metric.
- The improvement is greatest in the evening, for example four hours less to post take ward round on average for patients arriving between 4pm and midnight.

Overall Summary

- Very successful. The combined clerking project has met its main aim to reduce duplication of clerking by 50%
- There are important but unmeasurable safety benefits beyond the speed of clerking. We now know that the emergency departments clerking is more visible and readable. The proforma itself discourages unnecessary repetition.

Next Steps

- A scoping meeting has been arranged to consider a potential Digital Clerking project as part of the quality improvement (QI) suite of projects for 2019-2020.

Surgical Flow

Achieving good hospital flow remains fundamental to our success as a Trust. Surgical flow is complex and involves elective and emergency cases through our theatres, as well as availability of beds on wards or in ITU which sometimes delays theatres or blocks flow at the front door. The Model Hospital says we are fourth quartile for utilisation of theatres, and third quartile for available unused capacity. We know that we have room for improvement.

We also know that our ITU is at capacity and we will need to improve flow so it can continue to manage the growing demand for high acuity care. In addition, we need to optimise our clinical pathways as part of the Dorset Clinical Services Review.

Aim	To improve flow through our operating theatres and intensive care beds, so that we utilise these expensive resources more efficiently. We aim to achieve 85% utilisation for theatres and to reduce time delays out of ITU by 20%
Measure	Utilisation rates for theatres Compliance with safety and quality standards for emergency surgery Delays per month for patients awaiting a ward bed, for Intensive Care Unit
Outcome	Partially achieved

What improvements has the project seen?

- We achieved 81.4% utilisation in theatres against a target of 85% - a rise of nearly 4% from three years ago. There is also now less variation which signifies the more stable processes and workforce.
- Achieved a 10% reduction (on average 40 minutes) in time delays out of ITU for patients against a target of 20%.
- Established a Surgical Frailty Service, based on a previous QI project which showed how Geriatric specialist input reduced the length of stay for over 85 year olds undergoing an emergency laparotomy. This has reduced Length of Stay by three days for older surgical patients on ward 14.
- Commissioned human factor observation and training from two senior airline pilots, bringing techniques from the aviation industry into healthcare on the Surgical Admissions Unit (SAU).

Next Steps

- Rationalisation of the Orthopaedic extended day to the standard theatre day, bringing efficiencies and better resilience through cross-cover.
- Continue with the successful surgical flow meetings held by Head of Nursing and Quality to generate and test further quality improvement ideas.
- Based on evidenced current delivery, the Surgical Care Group proposes to release beds through proposed expansion of the Surgical Frailty team and the Urology Consultant of the Week and increased day cases.

Supporting our Speciality Pathways

1. Dermatology

Aim	All surgical forms completed accurately by August 2018 and zero avoidable hospital reason cancellations by October 2018
Measure	Documentation standards
Outcome	Improved accuracy of form filling, e-form version now being developed

What improvements has the project seen?

- Introduced an electronic system for booking appointments to replace the paper diary
- Created a surgical timings model to assist with slot time calculation when booking appointments. This model also provides a means of recording competencies for consultant, doctor and nurse surgeons.
- Introduced a nurse assessment clinic. This new service involves meeting with a nurse immediately following an outpatient appointment before patient leaves the department to:
  - ensure all elements of surgical form have been completed
  - further clarify the procedure with the patient, providing additional time to ask questions
  - arrange an appointment date for surgery
- Established a process for collating clinicians annual leave and ensuring clinics are scheduled to take into account all planned absence.
- Started work on the e-form to replace the paper surgical booking form.

Next Steps

- Review the outstanding tasks from the project and set up teams or assign tasks as required.
- Update the department internet page.
- Carry out Experience Based Design questionnaires in outpatients.
- Continue to develop surgical e-form.
- Further review the surgical bookings administration process.

2. Ophthalmology

Aim	To improve patient safety and experience by reducing Referral to Treatment Time (RTT) waiting times in Ophthalmology to a maximum of 18 weeks and improving efficiency in eye theatres by March 2019
Measure	To improve patient safety and experience by reducing Referral to Treatment Time (RTT) waiting times in Ophthalmology to a maximum of 18 weeks and improving efficiency in eye theatres by March 2019
Outcome	Partially achieved

How has the project been achieved?

A multi-disciplinary team was formed for the quality improvement project in autumn 2018. The team included consultants, technicians, the Matron, nurses, healthcare assistants (HCAs), the directorate manager and administration staff.

What improvements has the project seen?

Eye Outpatients

- Positive changes to nurse clinics were made. Patients are now allocated to a named nurse. This means it is more equitable and patients are given longer appointments. This arrangement also provides better lunch cover and avoids peaks and troughs of work and activity.
- New morning and afternoon daily huddles introduced.
- Clinic templates have been changed for consistency of appointment slots and start/end times.

Eye Theatres

- Produced a scheduling tool showing a percentage for scheduling by surgeon by procedure to help the team book into lists.
- Conducted observations of theatre practice including staff and equipment movements.
- Set out the theatre opening times and displayed these outside each theatre.
- Set up time for the whole theatres team to receive quality improvement training and consider projects for 2018/19 and 2019/20.
- Established the INSIGHT theatre tool to identify and monitor opportunities for optimal use.

Next Steps

- Ophthalmology has been relisted to continue as a project for 2019-20 to build upon the work started in 2018/19.

Reducing Unnecessary Interventions on Wards
(initial project title 'Bloods on Wards)

Aim	To reduce unnecessary diagnostics and/or nursing observations for patients who are medically ready for discharge by March 2019
Measure	Number of interventions out of hours
Outcome	Baseline assessment completed

How has the project been achieved?

The overall project was extensive and consisted of a number of separate work streams and quality improvement ideas. All staff were asked to send in their ideas for improvements around three main themes:

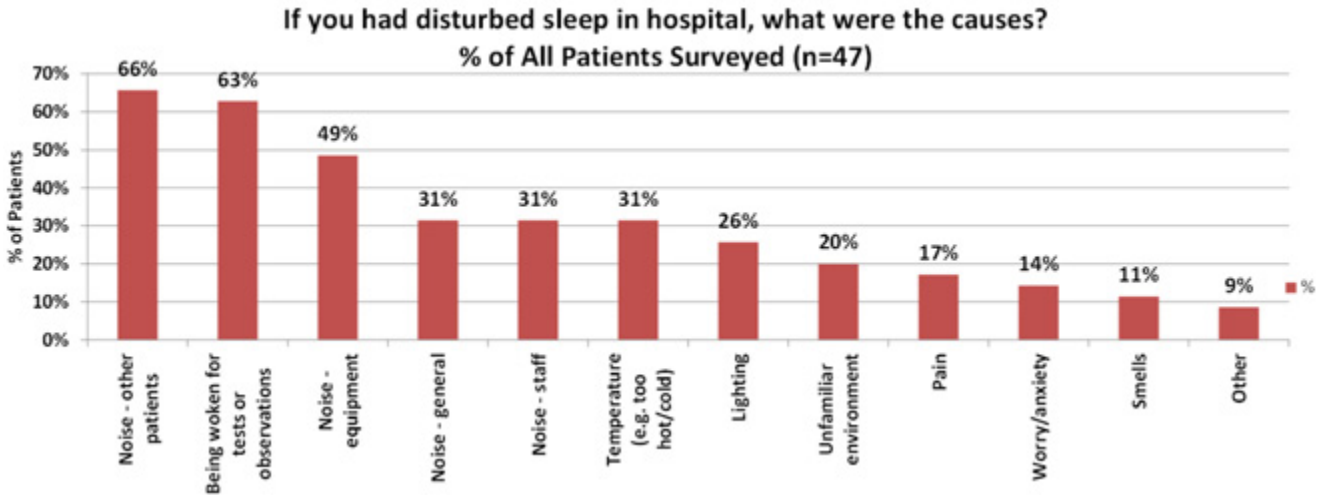
- How to reduce unnecessary tests for patients
- How to improve pain control for patients
- How to ensure patients get more sleep.

Multidisciplinary teams were then set up to consider and work through all of the ideas submitted. The specific aims of the Sleep Well project included:

- To draft a set of hospital standards promoting adequate rest and sleep for patients based on national best practice, staff and patient engagement.
- To reduce the number of overnight nursing observations for patients who are medically ready for discharge.
- To undertake awareness and education for nurses promoting the importance of using professional judgement when undertaking nursing observations.

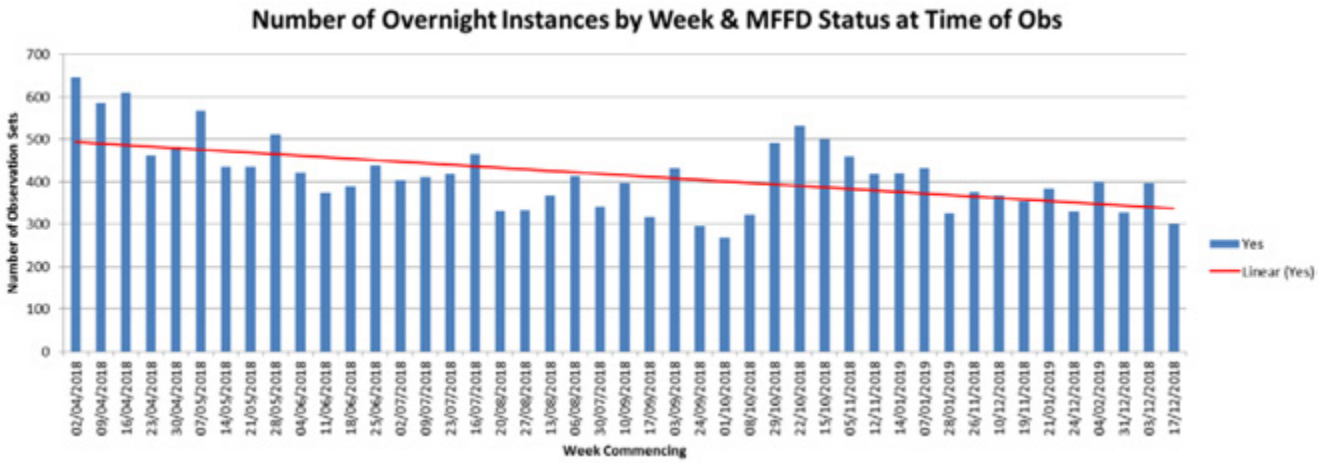
What improvements has the project seen?

- We conducted a number of audits to understand what was causing sleep disturbance in hospital. The two main reasons were noise and being woken for tests and observations. Between April and October 2018 around 3500 observations were taken each week on patients who were medically ready for discharge.



- The project team drafted hospital standards promoting adequate rest and sleep for patients based on national best practice. These are aimed at improving the environment for sleep and reducing the number of routine observations for patients who are medically ready for discharge The guidelines were formally launched with an action learning week in early 2019/20.

- The work to increase awareness has already shown some improvements (see table below)



Next Steps

- Sleep well guidance for wards to be launched during an action learning week in the near future.

Fundamentals of Care

Patient Deterioration

The focus of the QI project for 2018/19 was on three key principles of physical deterioration for patients with an Early Warning Score (EWS) of ≥9:

- **Recognition** - identification, monitoring and assessment
- **Response** - reliable and timely activation and communication, looking at Hospital at Night (H@N) data
- **Escalation** - clinical interventions. Are patients with a EWS ≥9 reviewed within our escalation parameter of 30 minutes?

Aim	For 65% of appropriate patients with an EWS ≥9 to have a documented review by a competent practitioner within 30 minutes, and 100% within 60 minutes, by March 2019
Measure	Time
Outcome	38 % of patients (February 2019 data) seen within 30 minutes who have an EWS ≥ 9 (against an aim of 65%) 57% of patients (February 2019 data) seen within 60 minutes who have an EWS ≥ 9 (against an aim of 100%)

Note:* We have identified that the time written in the patient's records usually relates to the time of writing after the clinical assessment/review. Therefore it has been difficult to capture the actual time of review.

How has the project been achieved?

A Deteriorating Patient QI team was established. Team meetings were arranged every two weeks. Initial meetings focused on designing a report that could show metrics easily and could eventually be understood and owned by wards/departments.

The group focused on developing four winter pressures quality improvement projects to support winter acuity pressures. These were:

- Development of the predictive high acuity reports.
- Streamlining communication between Clinical Site Team (CST) and senior medical staff out of hours specifically in relation to deteriorating patients.
- Additional shifts for senior doctor (ST3 and above) and either a CST or Critical Care Outreach Team (CCOT) member to work weekends. The purpose of these shifts is to focus on our sickest patients and support junior staff.
- Improving attendance of medical staff at the13:30 weekend meeting in the CST office. The purpose is to bring medical/nursing teams to discuss issues/concerns around our sickest patients.

What improvements has the project seen?

- Over 900 patients who had a EWS ≥ 9 have been audited by the Critical Care Outreach Team since April 2018.
- Successfully rolled out the Critical Notification Dashboard (CND) to most of our acute wards, the Acute Admissions Unit, the Surgical Assessment Unit, the Acute Stroke Units and wards 14, 15, 16, 17, 2 and 3.
- Development of ward-friendly metrics report which includes Hospital at Night (H@N) data. This report can be used by the wards to monitor their own escalation performance.
- 96.4% of our frontline staff (approximately 4000 staff) have completed the sepsis and deteriorating patient e learning module.
- The Trust has become an active member of the Wessex Academic Health Science Network (AHSN) Patient Safety Collaborative.

Next Steps

- The Critical Care Outreach team has agreed to continue audit data collection after March 2019.
- Launching eNA Observations and implementing National Early Warning Score (NEWS)2 in all wards and departments across the Trust in line with national requirements.
- Continue involvement in the Wessex AHSN Patient Safety Collaborative.
- Finish rolling out the Critical Notification Dashboard to all wards that request it.
- Ensure patient engagement on future projects and education programmes regarding physical deterioration.
- Ensure the escalation quality improvement project includes human factors surrounding difficult conversations.
- Improving the quality of clinical documentation (separate project for 2019/20).

Central Venous Access Device (CVAD)

Aim	To improve the co-ordination of all Central Venous Access Devices (CVADs), so that we know the status of every patient with a CVAD line inserted by the Royal Bournemouth Hospital by March 2019
Measure	Documentation
Outcome	Partially achieved

What improvements has the project seen?

- Established a group with a high level of engagement.
- Rewritten the Standard Operating Procedures so staff have clear clinical guidelines.
- In January 2019 the Education Team launched the Central Venous Access Devices (CVAD) training as part of essential core skills training.
- Produced an outline design for a new electronic platform to record CVAD use.

Next Steps

- The project has been extended until September 2019 with the support of its executive sponsor.
- Work with Interventional Radiology to develop a new electronic referral form.
- Implement a new line checklist including a CVAD checklist to go onto the electronic platform eNA.
- Work with the procurement team to have a single product for needle-free bungs.
- Introduce additional medical training regarding access and care of CVADs.

Sepsis

Aim	To achieve and sustain that 95% of our patients with confirmed high risk sepsis in ED, AMU and SAU receive intravenous antibiotics within one hour by March 2019
Measure	Time to antibiotic administration
Outcome	Partially achieved

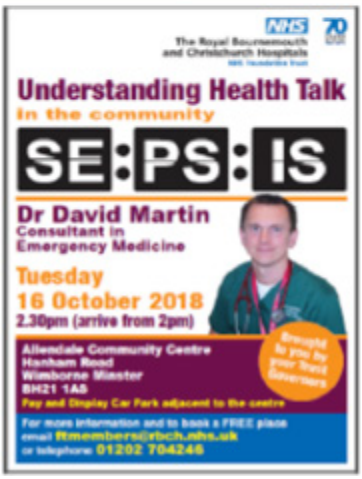
What improvements has the project seen?

- 96.4% of frontline staff have completed the sepsis and deteriorating patient e-learning module launched on 27 March 2018.
- The project team submitted a paper to the Health Services Journal (HSJ) Patient Safety Education and Training Award in February 2019.
- Approximately 270 nurses and healthcare assistants have received bespoke ward based sepsis training designed and delivered by the Education team.
- In house monthly mortality review for sepsis by the Mortality Surveillance Group compared data between 2017 (42 deaths) and 2018 (19 deaths) and concluded that overall there was an improvement with the Trust now in line with the national average (15-20).
- A repeat of the 2015 pneumonia audit in September 2018 showed improvement in the delivery of first dose antibiotics within one hour from 33.3% to 61.8%.
- Improvement in daily consultant reviews from 27.8% to 76.5%.
- Completion of escalation documentation improved from 65% to 75%.
- Prototype development of an eNA sepsis application.
- 120 people attended a community health talk arranged by the Trust governors and presented by Dr David Martin in October 2018 in Wimborne.

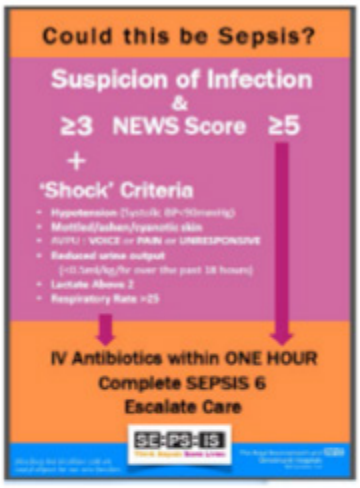
96.4% of our staff have completed their sepsis & deteriorating patient e-learning module within 10 months

Achievements

"The training got me thinking, highlights how critical time is, to save lives, be aware and look for the early warning signs."



Poster 2018/19



Over 120 members of the public attended the Health Talk in October 2018

Next Steps

- Patient engagement. There has been interest from patients to be involved in future projects.
- Consider resource for continued data collection or an alternative approach. A Suspicion of Sepsis (SOS) Insights Dashboard has been developed through the AHSN.
- Ensure the sepsis e-learning module is kept relevant and up to date.
- Support the implementation of a "new" gentamicin calculator being developed by pharmacy.
- Continue to improve on the delivery of intravenous antibiotics especially for our high risk sepsis patient groups.
- Implementation of the sepsis eNA application.

Falls Prevention

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

Falls are particularly common among older patients (aged 65 and above), with estimates suggesting this group accounts for approximately 80% of all falls in hospital. Falls in hospital can have a detrimental impact 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 attending our Trust with multiple, complex long-term conditions and 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.

Falls prevention has been a top "fundamentals of care" quality priority for the trust for a number of years and in previous quality accounts we have reported on how we have reduced the number of falls that that resulted in significant harm to patients. We are pleased to report that this has continued for 2018/19 with only three serious incidents reported in year (see section 3 for further details).

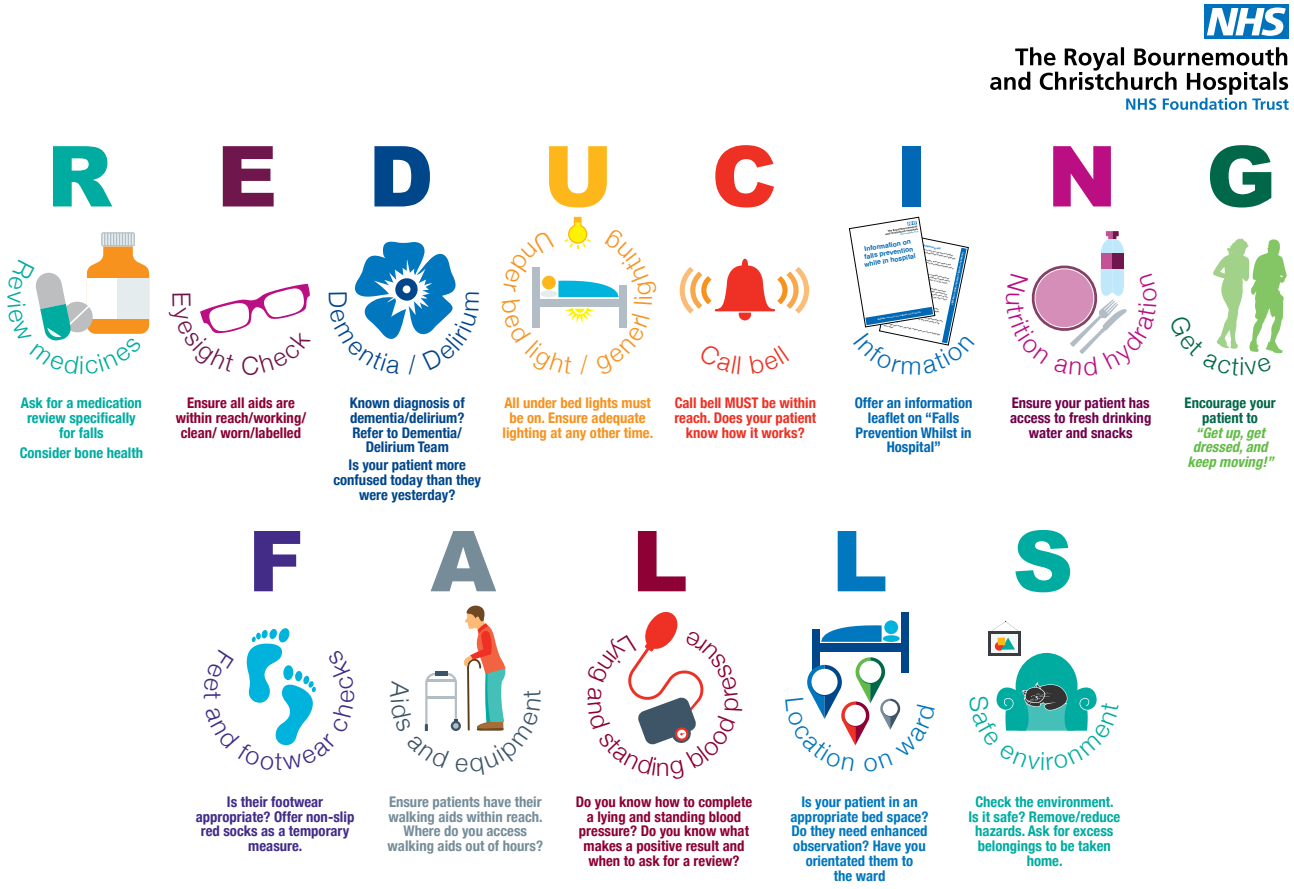
As part of our continuous improvement programme a specific aim for 2018/2019 was to look at ensuring all patients have their falls risk assessment identified and documented daily.

The project was started on one pilot ward in November 2018 following a review of comments, ideas, and issues raised during falls awareness week in October 2018. An aim was agreed and baseline data collection initiated.

What improvements has the project seen?

The project is still ongoing but actions achieved to date include:

- Falls awareness stand and simulation training held as part of the Patient Safety and Quality Improvement Conference in 2018
- Falls awareness week held during the week commencing 29 October 2018. To raise staff awareness, this included a daily visit to all wards and a public stand in the atrium at the Royal Bournemouth Hospital to raise public awareness about falls prevention.
- Falls eLearning updated to highlight importance of lying and standing blood pressure
- New lanyard cards on lying and standing blood pressure developed
- New falls prevention posters developed and implemented



Pressure Ulcer Prevention

The patient profile of the trust means that we have a high proportion of very elderly frail inpatients with often complex and long-term health issues. Our patients are often admitted with existing pressure damage (community acquired cases are much higher than the national average) or at a high risk of early skin deterioration. We therefore have a detailed proactive pressure ulcer prevention strategy. This involves ensuring that all patients are placed immediately on a pressure relieving mattress on admission and also have a risk assessment (Waterlow) completed at regular points during their admission.

Our quality priority for 2018/19 aimed at looking at completing and documenting a full SKINS assessment (see below) of a patient within six hours of admission to hospital.

What improvements has the project seen?

- No serious incidents involving hospital acquired pressure ulcers reported in 2018/2019
- Workshops held with all Acute Medical Unit staff and baseline assessment data collected in September 2018. Improvement plan identified.
- New pressure ulcer categorisation posters and lanyard cards produced for all areas.
- International STOP Pressure Ulcer Day celebrated across the Trust in November 2018.
- Trust wide wound care study day held on 14 February 2019.

Next Steps

- Review progress of improvement plan.
- Develop new e-learning module for pressure ulcer prevention. The Trust has been asked to lead on development of a national e-learning module by NHS Improvement.

Our quality priorities for 2019/20

In order to identify priorities for quality improvement in 2019/20, 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
- using the Getting it Right First Time (GIRFT) and Model Hospital analyses
- listening to staff feedback during Action Learning weeks
- 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 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 2019/20. 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.

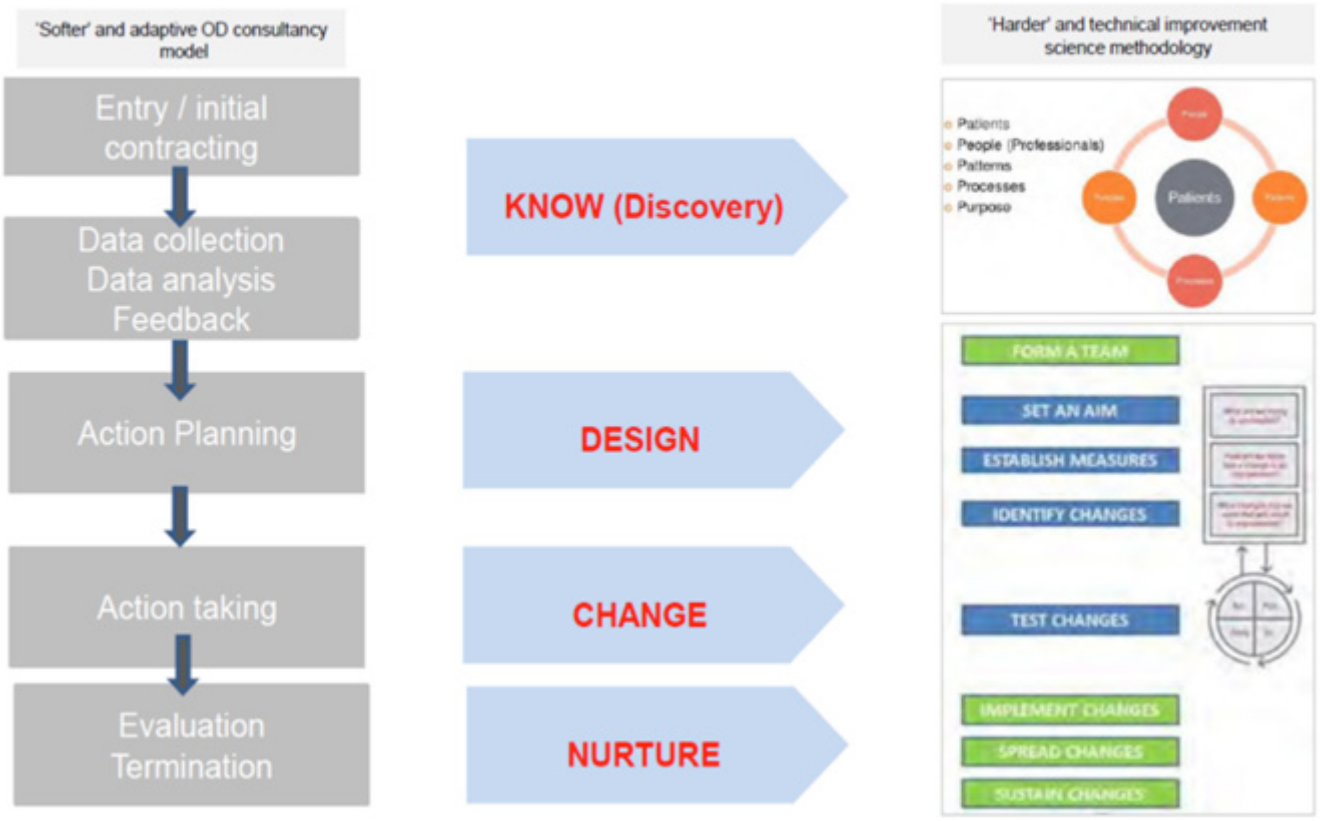
To coordinate implementation, the Trust has developed a comprehensive quality strategy improvement plan. Progress against the plan will be monitored by the Board of Directors, Improvement Board, Senior Leadership Team and the Council of Governors.

Following consultation the Trust's quality priorities for 2019/2020 are:

- **Urgent and Emergency Care** - to improve the first 24 hours of our urgent and emergency care pathway to deliver 'right patient, right time, right team right place' and adopting NHS Improvement Emergency Care Intensive Support Team (ECIST) recommendations.

- **Improving hospital flow** - to optimise in-patient hospital flow reducing the number of stranded patients and ensuring patients have appropriate lengths of stay.
- **Ophthalmology** - to optimise the use of theatre resources in Ophthalmology and achieve Eye Theatre efficiency of 80% by March 2020.
- **Gastroenterology** - to analyse capacity and demand in Gastroenterology and improve throughput.
- **Orthopaedics** - to review the patient pathway in Orthopaedics, identify opportunities, improve the patient pathway and optimise the use of the specialty's theatre resource.
- **Outpatients** - to ensure there is effective use of outpatient services across all specialties centred on the needs of the patient. To redesign outpatient services to reduce the number of unnecessary visits for our patients, improve efficiency and free up time for our health care professionals.
- **Documentation** - to improve inter and intra team working including how patient notes are recorded and shared. To introduce new fundamental standards of record keeping within the Trust. To manage how health records are filed and to improve the consistency and accuracy of what is recorded in the health records. To improve communication between teams though digital innovation.
- **Medical Rotas** - to review and improve the medical rota processes reducing variation where appropriate. To optimise the use of medical manpower through the introduction of a consistent process for managing medical rosters, using the most effective digital solutions, and enabling a clear oversight of sickness absence, annual leave and study leave.

In 2019/20 the Improvement Programme Team (IPT) will also support the transformation and early integration of services as part of our East Dorset clinical reconfiguration programme. Working with our 'four early services', we will apply QI methodology to redesign patient pathways and develop new models of care to create a sustainable future – co-produced with staff, patients and service users and based on national best practice.



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 2018/19 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 services
- 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 2018/19 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2018/19.

2. Participation in clinical audit

During 2018/19, there were 45 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 2018/2019, 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	Eligible	Participated in 2018/19	% of cases submitted	Purpose of audit
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	100%	To examine the quality of the management of heart attacks in hospital
Adult Cardiac Surgery	N	N		
British Association of Urological Surgeons (BAUS) Audit: Cystectomy	Y	Y	100%	To publish surgeon patient outcomes data to improve standards of surgery and help patients make informed decision about their care
BAUS Audit: Nephrectomy	Y	Y	100%	As above
BAUS Audit: Percutaneous nephrolithotomy	Y	Y	100%	As above
BAUS Audit: Radical prostatectomy	Y	Y	100%	As above
BAUS Urology Audits: Female stress urinary incontinence	N	N		
Bowel Cancer (NBOCAP)	Y	Y	100%	Measures the quality of care and survival rates of patients with bowel cancer in England and Wales
Cardiac Rhythm Management (CRM)	Y	Y	100%	Examines the implant rates and outcomes of all patients who have a pacemaker, defibrillators or cardiac resynchronisation therapy implanted in the UK

National Clinical Audits	Eligible	Participated in 2018/19	% of cases submitted	Purpose of audit
Case Mix Programme (CMP) - Intensive Care National Audit	Y	Y	100%	The CMP is an audit of patient outcomes from adult general critical care units
Child Health Clinical Outcome Review Programme	N	N		
Congenital Heart Disease (CHD)	N	N		
Diabetes (Paediatric) (NPDA)	N	N		
Elective Surgery (National PROMs Programme)	Y	Y	Partial submission	Patient reported outcome measures (PROMs) survey patients before and after surgery for the following planned procedures; 1) Groin hernia repair 2) Hip replacement 3) Knee replacement 4) Varicose veins
Falls and Fragility Fractures Audit programme (FFFAP)	Y	Y	100%	Inpatient falls: Evaluates compliance against best practice standards in reducing the risk of falls within hospitals
Feverish Children (care in the Emergency Department)	Y	Y	100%	A tool to support the quality of urgent and emergency care services for patients
Inflammatory Bowel Disease (IBD) programme	Y	Y	Submitted 100% of patients who consented (1000+)	A tool to support the quality of urgent and emergency care services for patients
Learning Disability Mortality Review Programme (LeDeR)	Y	Y	Full submission	Aims to make improvements to the lives of people with learning disabilities by undertaking case reviews of patients who died
Major Trauma Audit -The Trauma Audit & Research Network (TARN)	Y	Y	Incomplete submissions due to data capture issues.	Analyses data of trauma care to improve emergency care management and systems
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Y	Y	Full submission	Collection is mandated by NHS-Improvement (previously by the Department of Health)
Maternal, Newborn and Infant Clinical Outcome Review Programme - MBRRACE-UK	Y	Y	Full compliance	Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies
National Asthma and COPD Audit Programme	Y	Y	100%	To drive improvements in the quality of care and services provided for COPD patients.

National Clinical Audits	Eligible	Participated in 2018/19	% of cases submitted	Purpose of audit
National Audit of Anxiety and Depression	N	N		
National Audit of Breast Cancer in Older Patients (NABCOP)	Y	Y	Not submitted by RBCH data pulled via RCS Cancer Registry	Improves the quality of hospital care for older patients with breast cancer by looking at the care received by patients with breast cancer and their outcomes
National Audit of Cardiac Rehabilitation	Y	Y	100% of NACR data collected.	Aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live
National Audit of Care at End of Life	Y	Y	100%	Focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals
National Audit of Dementia	Y	Y	100% case submission	Measures criteria relating to care delivery which are known to impact on people with dementia admitted to hospital
National Audit of Intermediate Care (NAIC)	Y	Y	100%	The purpose of the audit is to improve intermediate care services for older people by providing benchmarked information on service models, spend, activity, workforce and, importantly, outcomes
National Audit of Percutaneous Coronary Interventions (PCI)	Y	Y	100%	The aim of the audit is to describe the quality and process of care and compare patient outcomes
National Audit of Pulmonary Hypertension	N	N		
National Audit of Seizures and Epilepsies in Children and Young People	N	N		
National Audit of Psychosis	N	N		
National Comparative Audit of Blood Transfusion Programme	Y	Y	100%	Measures compliance with standards related to the recommended use of blood components
National Diabetes Audit - Adults	Y	Y	100% except for 2018/19 insulin pump audit data due to system error	Measures the effectiveness of diabetes care compared to NICE guidance

National Clinical Audits	Eligible	Participated in 2018/19	% of cases submitted	Purpose of audit
National Emergency Laparotomy Audit (NELA)	Y	Y	100% for Year 5 submission -1/12/2017-30/11/2018	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales
National Heart Failure Audit	Y	Y	100%	Focuses on the clinical practice and patient outcomes of patients discharged following an emergency admission with a primary diagnosis of heart failure
National Joint Registry (NJR)	Y	Y	100%	Data analysis of joint replacement surgery in order to provide an early warning of issues relating to patient safety
National Lung Cancer Audit (NLCA)	Y	Y	100%	Measure lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best
National Maternity and Perinatal Audit (NMPA)	Y	Y	100%	Evaluates a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services
National Neonatal Audit Programme (NNAP)	N	N		
National Oesophago-gastric Cancer (NAOGC)	Y	Y	100%	Investigates whether the care received by patients with oesophago-gastric cancer is consistent with national standards
National Ophthalmology Audit	Y	Y	Partial submission	Assesses key indicators of cataract surgical quality
National Prostate Cancer Audit	Y	Y	100%	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and their outcomes
National Vascular Registry (NVR)	Y	Y	Awaiting data from NVR	Established in 2013 to measure the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals
Neurosurgical National Audit Programme	N	N		

National Clinical Audits	National Clinical Audits	National Clinical Audits	National Clinical Audits	National Clinical Audits
Non-Invasive Ventilation - Adults	Y	Y	Data collection phase still open	British Thoracic Society audit programme is to drive improvements in the quality of care and services for patients with respiratory conditions across the UK
Paediatric Intensive Care (PICANet)	N	N		
Prescribing Observatory for Mental Health (POMH-UK)	N	N		
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Y	Y	Full submission	Public Health England data collection
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	Full submission	See Part 3
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y	Y	Full submission	Analyses information on adverse events and reactions in blood transfusion with recommendations to improve patient safety
Seven Day Hospital Services	Y	Y	Full submission	See Part 2
Surgical Site Infection Surveillance Service	Y	Y	Partial submission	Public Health England data collection
UK Cystic Fibrosis Registry	N	N		
Vital Signs in Adults (care in the Emergency Department)	Y	Y	100%	A learning tool to support the quality of urgent and emergency care services for patients
VTE risk in lower limb immobilisation (care in the emergency departments)	Y	Y	100%	A Royal College of Emergency Medicine National Quality Improvement Project

National Confidential Enquiries	Eligible to Participate	Participated in 2018/19	% of required cases submitted
Perioperative Diabetes	Y	Y	100%
Pulmonary Embolism	Y	Y	100%
Acute Bowel Obstruction	Y	Y	Study is still open
Long Term Ventilation	Y	Y	No eligible cases to submit, organisational questionnaire to be completed when received

The reports of 42 national clinical audits were reviewed by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in 2018/19 and, as examples, the Trust intends to take the following actions to improve the quality of healthcare provided as a result:

- A business case has been developed for another heart failure consultant and specialist nurse
- Following the National Diabetes Foot Care Audit a review of the service will be undertaken, to include the option of self-referral.
- Following the Falls and Fragility Fractures Audit programme - re-introduction of the Continence Trigger Tool into the 7 day Care Plan. To implement an identifiable sticker to be added to the front of the patients prescription chart. This will be signed and dated following medication discussions on the ward round.
- Following the Audit of Patient Blood Management in Scheduled Surgery - use data to encourage better use of Tranexamic Acid, maintain/increase use of Intra-op cell salvage and consider transfusion triggers peri-op and post transfusion targets when deciding when and how much to transfuse.
- Additional Parkinson's clinic set up to enable patients to be seen in a timely manner.
- Commencement of rolling Cardiac Rehabilitation programme to facilitate more flexibility on dates and times of classes offered to patients.
- Following the Sentinel Stroke National Audit Programme, an internal review was undertaken to ensure there is consistency in decision making regarding eligibility for thrombolysis.
- Amend the Transfusion Care Chart to add Yes/No box against questions in Transfusion Associated Circulatory Overload (TACO) checklist. TACO assessment added to Haematology Dr training.
- Following the National Adult Bronchiectasis Audit, inpatients and will be identified daily by the Dorset Adult Integrated Respiratory Service (DAIRS) Team. The DAIRS team will review and place sticker in notes and the DAIRS physiotherapist will see and teach chest clearance. The outpatient check list is to be updated to include DAIRS referral.

The reports of 186 local clinical audits (including patient surveys) were reviewed by the Trust in 2018/19 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, so that palliative patients admitted to hospital can be reviewed earlier during their admission.
- A Nurse-led Telephone Assessment Clinic (TAC) position will be funded for 6 months, to further demonstrate the value of a TAC for Fast Track Colorectal Referrals. A new GI cancer referral pathway will be introduced.
- New authorised controlled drugs (CD) signatory lists prepared by each clinical area, which will be reviewed by the clinical area sister / charge nurse at least monthly as well as during 4 monthly CD audit.
- New Pain Team guideline to be developed to improve the basics of pain assessment and management.
- Update written information on care of breast prosthesis. Update guidelines on replacement of prosthesis and making follow-up requests to be seen if there is a problem with the product.
- 'BERTIE' (Type 1 Diabetes Education Programme) has been revamped as an on-line educational resource.
- Task and finish group set up to resolve any issues arising regarding the use and storage of medical gases.
- Specialist Palliative Care Community Team to set up an automated telephone answering system to enable patients and carers to contact the most appropriate person in a timely manner. Business case submitted to MacMillan Caring Locally to fund iPhones for the community team, to enable further routes of contact.

- A protocol has been produced to ensure the appropriate monitoring of patients on Cyclosporin. This has been distributed to all Dermatology Outpatient Clinics. Every patient will be asked to book their next follow-up appointments at the end of their review.
- A Pathology patient satisfaction project led to the development of a community phlebotomy hub offering booked appointments, plus the introduction of booked appointments as well as open access at Royal Bournemouth Hospital.
- Re-design the preoperative anaemia care pathway for elective hip and knee arthroplasty to include all patients with a plasma haemoglobin concentration <130gL.
- A new consultant ward round sheet introduced on the rehabilitation side of the stroke ward. This prompts consideration of dalteparin at day 14 post ischaemic stroke.
- Dedicated psoriatic arthritis clinic set up following audit of NICE guidance
- Changes made to the Nursing Daily Assessment sheet to facilitate completion of all essential questions, following a re-audit of the completion of the Personalised Care Plan for the Last Days of Life.
- A documented birth plan to include third stage management is to be completed at the 36 week appointment, following an audit of post-partum haemorrhage management.

3. Participation in clinical research:

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee and National Institute for Health Research (NIHR) portfolio was 1986 (April 2018 - March 2019).This compares with 2,157 for 2017/18, 1,480 for 2016/17 and 1,305 for 2015/16.

Our vision is for the Trust to be a centre of excellence in healthcare research and to lead on collaborative working across Dorset supporting research and innovation. Our purpose is to foster a thriving research and innovation culture throughout the Trust ensuring high quality research, respect for our research participants and respect for researchers.

The Trust underwent a triggered Medicines and Healthcare products regulatory agency (MHRA) good clinical practice (GCP) inspection in February 2018. A corrective and preventative action (CAPA) plan was put into place which was accepted by the MHRA and the inspection officially closed in August 2018.

Following the triggered inspection, and the reporting of two protocol breaches to the MHRA, a further MHRA GCP inspection of Trust sponsored research projects took place in July 2018. Seven trials were selected as part of this inspection. The report from this inspection was received in January 2019, a CAPA plan was put into place which was accepted by the MHRA in April 2019 with the inspection closed. Quarterly reporting to the MHRA was required following this inspection and the first quarterly report from this inspection is due for submission by 3rd June 2019.

A further MHRA GCP inspection took place in January 2019 to review progress made with the actions implemented so far and the MHRA chose 10 further trials for inspection. The MHRA inspectors were very pleased with the progress made with improvements to processes and quality management since the first visit in February 2018. A further CAPA plan was put in place which was accepted by the MHRA in April 2019

The team continue to be complimented by the organisations we work with for high quality research data and timely responses to requests. To achieve this over the next year, the Research and Innovation directorate will continue to increase patient access to National Institute for Health Research (NIHR) badged research studies and to grow our commercial research portfolio, balancing continued growth with a focus on the delivery of high quality clinical research. Monthly governance meetings established during 18/19 and regular review of action plans ensure a continued focus on robust quality systems with appropriate quality assurance. We are further developing the operational capability of the Directorate this year to support the delivery of the five year research and innovation strategy; this includes a commitment to provide staff with advice, support and signposting to develop their ideas into deliverable research projects or new innovations (e.g. new products and services) that will benefit our patients, the Trust and the wider NHS.

The research patient experience survey conducted in 2018 by the NIHR was overwhelmingly positive for the Trust. 50 patients who had taken part in research studies this year were asked to complete a questionnaire. 93% of patients strongly agreed that they had a good experience of taking part in research, with the remaining 7% agreeing. We will continue to develop a patient charter and ensure that we enable patients to take part in research, reviewing and redeveloping our patient travel expenses process this year. We welcome Care Quality Commission indicators for research under the 'well-led' domain and are committed to raising the profile of research within the Trust to contribute to achieving excellence in this indicator.

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

The Trust's income in 2018/19 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 the 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 2018/19.

The Trust has not participated in special reviews or investigation by the CQC during 2018/19.

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. The report was published in June 2018.

The CQC last inspected the Trust in March 2018 and published their report in June 2018. The inspection covered urgent and emergency care, medical care, maternity, and surgery which had previously been rated as requiring improvement at the last inspection in 2015. The CQC also looked specifically at leadership and how the Trust used its resources.

The inspection also looked at safety, and whether services are effective, caring, responsive and well-led. It was leadership, culture and governance at the Trust that gained a rating of Outstanding. The Trust was rated as Good for being safe, effective, caring and responsive to people's needs. The Trust made significant improvements in all areas inspected.

CQC Rating Table: June 2018

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Bournemouth Hospital	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑↑ Mar 2018
Christchurch Hospital	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Overall trust	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑ Mar 2018

Commenting on the report, the Chief Inspector of Hospitals, Professor Ted Baker, said:
"The board and staff must also be congratulated for setting out an aim to be the most improved trust by 2017 and working towards that, and for its achievement in working collaboratively with local stakeholders to help transform local health service throughout Dorset. Since we last inspected, Royal Bournemouth and Christchurch Hospital NHS Foundation Trust has taken significant strides to improve in all areas. I am satisfied that the trust has worked to ensure every stage of improvement has been embedded before moving on. Senior managers have taken a thorough approach to improve services across the trust by developing team coaching, change champions and quality improvement training. By actively promoting staff empowerment to raise concerns and drive improvement, the trust has helped embed quality improvement in the everyday workings of the trust."

"Inspectors visited the Trust during a particularly busy time and made a number of observations, including:

- *we observed a deeply positive and embedded culture of caring*
- *the Trust had planned and provided services in a way that met the needs of local people, such as investing time and money to support people living with dementia*
- *patients with complex needs were taken into account when delivering and organising services*
- *patients and those close to them felt fully involved in all aspects of care with staff providing compassionate and consistent support*
- *the Trust has an exemplary reporting system for sharing learning, improvements and best practice*

The inspection identified "that Trust leadership had taken a cultural approach to improving services, ensuring that quality improvement and continuous improvement were integral to the everyday workings of the Trust".

6. Data Quality

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust submitted records during 2018/19 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 98.0% for accident and emergency care. The percentage of records in the published data which included the valid General Medical Practice code was 100% for admitted patient care: 100% for outpatient care; and 99.6%

for accident and emergency care. (Taken from the National April-December 2018 SUS data quality report)

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 Data Security and Protection Toolkit. This replaced the Information Governance Toolkit from April 2018 onwards. The self-assessment must be submitted to NHS Digital, with all evidence provided by 31 March 2019.

The Data Security and Protection Toolkit required the Trust to confirm compliance with all mandatory requirements across the organisation. The Trust's Information Governance Assessment Report overall score for 2018/19 was 92% and was graded as "Standards not fully met". However an improvement plan has been submitted to NHS Digital, outlining how the Trust intends to achieve the remaining eight requirements in the coming months. Once this is approved by NHS Digital it is expected that the Trust's assessment will be re-graded as "Standards not fully met (Plan Agreed)".

The Data Security and Protection Toolkit (DSP Toolkit) replaced the Information Governance Toolkit during 2018. This remains a self-assessment audit completed by every NHS trust annually and submitted to NHS Digital; the purpose being to assure an organisation's information governance practices through the provision of evidence around 40 mandatory individual assertions. The DSP Toolkit sets the standard for cyber and data security for healthcare organisations, and places a much greater focus on assuring against modern threats. Based around the National Data Guardian's ten data security standards, a significant portion of this audit is underpinned by work associated with information risk assurance.

During 2018/19, the Trusts aim was to achieve compliance with all the mandatory assertions. However, the DSP Toolkit required the Trust to provide different assurances to those which were previously required, and as such it was not possible to provide substantial evidence for all these within the first year of this assessment. The Trust has complied with 92% of these by 31 March 2019, and is implementing an improvement plan to achieve compliance with the remainder in the coming months.

In 2019/20, work will continue to establish and firmly embed the principles of information risk management and information governance 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 remains increasingly important during 2019/20 given the recent 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 an increase in reported breaches of information governance during 2018/19. During 2017/18, 93 breaches and four Serious Incidents Requiring Investigation (SIRIs) were reported, whereas 2018/19 has seen 188 breaches and one SIRI reported (on which the Information Commissioner's Office decided to take no further action).

Information governance breaches tend to be one-off incidents rather than incidents that recur within one department, and can therefore generally be attributed to human error rather than an endemic issue. Some of the types of incidents reported are recurrent in nature; for example, around 31% of incidents reported related to personal data being stored in the wrong person's record, and around 28% related to inappropriate access to or use of personal data (including instances where patients have received correspondence relating to others).

While reasons for the increased numbers are difficult to quantify, this is likely to be indicative of greater awareness affecting levels of incident reporting; the Trust's information governance training compliance has been above 93% for each of the last 12 months. Work will continue during 2019/20 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 91%, Secondary Diagnosis 82%, Primary Procedure 90% and Secondary Procedure 83%. (These figures relate to the period 1 April 2018 - 31 March 2019)

The results should not be extrapolated further than the actual sample audited; the services that were reviewed within the sample were as follows: Cardiology, Geriatric Medicine, Vascular 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 that there was an error.

9. Learning from deaths

During period 1 April 2018 to 31 March 2019 1535 patients died in the Royal Bournemouth Hospital and Christchurch Hospital (which includes the Macmillan Unit).

On the 31 March 2019, 546 case record reviews and/or investigations have been carried out in year in relation to 1535 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 Reviewed	% Reviews Completed
Apr 18 - Jun 18			
Apr-18	141	77	54.6%
May-18	121	66	54.5%
Jun-18	141	59	41.8%
Jul 18 - Sep 18			
Jul-18	128	65	50.8%
Aug-18	103	41	39.8%
Sep-18	116	45	38.8%
Oct 18 - Dec 18			
Oct-18	118	49	41.5%
Nov-18	121	51	42.1%
Dec-18	118	44	37.3%
Jan 19 - Mar 19			
Jan-19	164	37	22.6%
Feb-19	132	8	6.1%
Mar-19	132	4	3.0%
Grand Total	**1535**	**546**	**35.6%**

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's Mortality Surveillance Group. This ensures that the reviews of all deaths within the hospital are discussed centrally and ensures actions for improvement are identified.

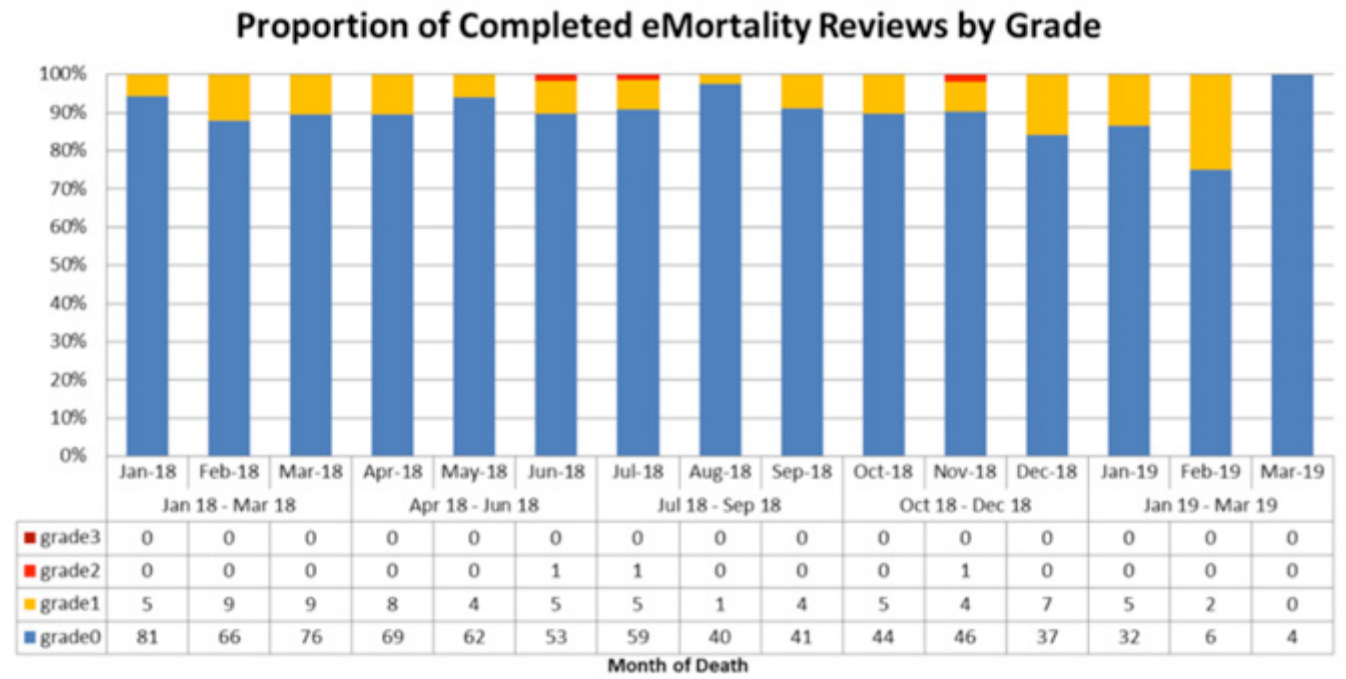
The e-Mortality pro forma also includes a nationally recognised grading system to ensure that avoidable mortality is clearly categorised. The tool used codes the reviews into one of the following categories:-

- 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 Learning Event Report Notification (LERN) form and a full serious incident root cause analysis process is undertaken.

The following table provides details of the number of case note reviews that were graded as 0, 1, 2 or 3 for the period 1 April 2018 - 31 March 2019. Grade 2 and 3 cases are those where it has been 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 3
Apr 18 - Jun 18						
Apr-18	69	8	0	0	77	0.0%
May-18	62	4	0	0	66	0.0%
Jun-18	53	5	1	0	59	1.7%
Jul 18 - Sept 18						
Jul-18	59	5	1	0	65	1.5%
Aug-18	40	1	0	0	41	0.0%
Sep-18	41	4	0	0	45	0.0%
Oct 18 - Dec 18						
Oct-18	44	5	0	0	49	0.0%
Nov-18	46	4	1	0	51	2.0%
Dec-18	37	7	0	0	44	0.0%
Jan 19 - Mar 19						
Jan-19	32	5	0	0	37	0.0%
Feb-19	6	2	0	0	8	0.0%
Mar-19	4	0	0	0	4	0.0%
Grand Total	**473**	**45**	**3**	**0**	**521**	**0.5%**



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	Jan 18 - Mar 18			Apr 18 - Jun 18			Jul 18 - Sep 18			Oct 18 - Dec 18			Jan 19 - Mar 19		
grade3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
grade2	0	0	0	0	0	1	1	0	0	0	1	0	0	0	0
grade1	5	9	9	8	4	5	5	1	4	5	4	7	5	2	0
grade0	81	66	76	69	62	53	59	40	41	44	46	37	32	6	4

Although the above figures relate to completion of a full case note review in October 2018 the Trust introduced a new Medical Examiner process. Part of the Medical Examiner process includes completion of an initial case note screen by a senior clinician. The aim of the screening process is to highlight any cases that require an urgent, full, case note review. All inpatient deaths from the 22 October 2018 have been screened.

In addition to the above figures, 392 case record reviews were completed after 31 March 2018 which related to deaths which took place before the start of the reporting period. From these additional reviews a revised estimate of the number of deaths during the previous reporting period judged to be more likely than not to have been due to problems in the care provided to the patient has been undertaken. Four representing 0.4% of the patient deaths during 1st April 2017 - 31st March 2018 are judged to be more likely than not to have been due to problems in the care provided to the patient

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

- Elderly Care
- Stroke
- Acute Medicine
- Emergency Medicine

- Intensive care
- Cardiology
- Urology
- General Surgery
- Vascular Surgery

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

- For patients with a learning difficulties and cerebral event think about escalation plans and collateral history early in the admission to help with future management.
- Request a mid-stream urine (MSU) sample before starting antibiotics for a urinary tract infection (UTI) and fill the forms correctly so that this is processed. Treatment with empirical antibiotics in absence of MSU results may not be optimal.
- If a patient receives a long term catheter during the admission clearly mention this on the e-discharge summary so that this is not removed in community. Re-catheterization can cause significant trauma and readmission.
- Once a decision is made to palliate patients a personalised care plan for end of life care should be started. Involve specialists for appropriate symptom control even if patients are in the Emergency Department, Acute Medical Unit or Surgical Admission Unit.
- Always check renal function following angiography and or angioplasty as contrast nephropathy can be reversed in early stages and can cause significant damage to kidneys.

CQC report on Learning from Deaths

In March 2019 the CQC published a report that looked at the progress made by NHS trusts in implementing new guidance on how they should investigate and learn from deaths in their care. The report highlighted the Trust as an area of good practice.

"Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust was rated as good overall and outstanding for well-led in June 2018. Since its last inspection in 2015, the trust had improved the culture of the organisation. Inspectors found that the trust had a learning culture, which acted as an enabler to developing their mortality processes and was indicative of their outstanding rating."

"Staff in all areas felt empowered and had access to the right tools to drive improvements and innovate, resulting in a firmly established culture of continuous improvement. The trust had developed an innovative reporting system that enabled staff to report incidents, share improvement ideas, raise a concern or highlight good practice. When incidents did occur, investigations were timely, thorough, person-centred and led to improvements in patient safety and experience."

"The trust produced a quarterly mortality newsletter for all staff, which captured key learning from across the directorates. Clinical staff interviewed across the trust were aware of the mortality newsletter and could give examples of learning from death reviews"

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 seven 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 Medicine, Older People's Medicine, Gastroenterology and Emergency Medicine. Further initiatives have also supported seven 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 2018 on the four 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.

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- 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.

The latest review of 7 day services for the Trust indicates the following:

	Weekday	Weekend	Overall	
Clinical Standard 2: Time to first consultant review				Weekday 90%; Weekend 87.2% compliance. Overall 90%
Clinical Standard 5: Diagnostics				Green across all areas including Microbiology, Radiology and Endoscopy
Clinical Standard 6: Intervention / key services				Green across Critical care, Interventional Radiology, Endoscopy and Cardiology
Clinical Standard 8: On-going review Once daily				Once daily weekly review achieved overall compliance 93% weekdays 98% weekends 78%. Twice daily weekly compliance was lower at 57%. The second evening ward round for critical care on-call was identified as a gap and this has now been addressed through job plans.
Clinical Standard 8: On-going review Twice Daily				

There has been a steady improvement in our delivery of seven day services and the rigor with which they have been audited over the last several years. In 2016 the percentage of patients meeting standard 2 was as follows:

2016 compliance was 70.4% on weekdays, 39% on Saturdays and 59% on Sundays. This compares to 2018 scores of 90% on weekdays, 78% on Saturdays and 96% on Sundays Progress has been achieved by improvements in data collection and with increasing clinical engagement. For the last two surveys, gap analysis allowed a targeted approach to be made with regard to job planning and investment in services. These have included additional evening shifts for consultants in the Acute Medical Unit alongside job planning and investment in surgical specialties to provide twice daily ward rounds for emergency admissions.

Medical rota gaps are monitored via the Medical Staffing Transformation Group. The trust has a good track record of filling training rotation vacancies with trust grade doctors. In hard to recruit to areas teams are encouraged to consider alternative staffing models. Examples include plans for a resident on call model in Obstetrics to mitigate middle grade gaps and the enrolment of our first

cohort of Physician's Associate students. Other successful strategies include increased partnership working of Older People's Medicine Consultants between Poole and Bournemouth and Dorset wide network recruitment in Histopathology. The Trust actively supports doctors who have not pursued standard training to achieve entry to the specialist register via the Certificate of Eligibility for Specialist Registration (CESR) route.

A significant challenge remains with the delay between referral and attendance of admissions from primary care. Trials of innovative transport solutions have been undertaken as well as investment into ambulatory care and admission avoidance.

Documentation of the ongoing need for clinical review remains a challenge although in the last couple of months a trial of a dedicated form for medically ready/ optimised patients has been undertaken, formally delegating ongoing daily review and documenting escalation protocols.

The national process for ongoing audits has not yet been defined as we are looking to work in partnership with other organisations within our healthcare system to collect meaningful data in the same way to allow better comparisons and sharing of best practice. Opportunities still remain for improving medical record keeping to better capture the clinical need for consultant or delegated ongoing daily or twice daily review.

11. 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.

In September 2017 the Trust 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. Staff who raise concerns do so in a nurturing and confidential environment with support and regular feedback from the FTSUG to ensure that their voice is being heard and no detriment experienced.

In addition to the FTSUG, during our "Speak to me" campaign in October 2018, the Trust launched an additional team of six Freedom to Speak Up (FTSU) Ambassadors. The role of the FTSU Ambassador is to contribute to creating a culture of speaking up where staff feel safe and confident to raise concerns. The FTSU Ambassadors work alongside the FTSU Guardian promoting, listening, supporting and providing an impartial view to staff when speaking up

The FTSU Team can be contacted via the **freedomtospeakup@rbch.nhs.uk** email, by telephone leaving a message on 01202 704220, via the LERN - raise an issue forms or by stopping them in the corridor.

The FTSU team attend team meetings, presentations, conferences and carry out regular walkabouts of the Trust. The aim this year is to try to reach those staff who are harder to reach.

Since April 2018, 40 members of staff have raised a concern; 68% were related to behaviours and attitudes which is reflective of what has been seen nationally. A work stream has been set up to look at this specific issue with members of the organisational development, FTSU, human resources, medical staffing and quality improvement teams. Its aim is to help provide the tools for staff to role model behaviours which underpin our values, to provide feedback when this does not happen and provide a safe and nurturing environment in which they feel empowered to tackle poor behaviours if it arises.

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 and Social Care 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 2017 - September 2018 0.9981	1.00	1.268	0.692
		October 2016 - September 2017 0.955	1.00	1.247	0.727
		October 2015 - September 2016 0.929	1.00	1.164	0.688
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission to HSCIC. The data has been extracted from available Department of Health and Social Care 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 2017 - September 2018 48.0%	333.6%	59.5%	14.3%
		October 2016 - September 2017 48.2%	31.5%	59.8%	11.5%
		October 2015 - September 2016 46.8%	30.0%	56.3%	0.4%
The Trust considers that this data is as described for the following reason. The data has been extracted from available Department of Health and Social Care 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	April 2017 - March 2018 (published February 2019)	(i) N/A (ii) N/A (iii) 0.505 (iv) 0.326	(i) N/A (ii) N/A (iii) 0.467 (iv) 0.338	N/A N/A 0.566 0.417	N/A N/A 0.376 0.234
	April 2016-March 2017 (published February 2018)	(i) N/A (ii) N/A (iii) 0.436 (iv) 0.323	(i) N/A (ii) N/A (iii) 0.445 (iv) 0.324	(i) N/A (ii) N/A (iii) 0.536 (iv) 0.404	(i) N/A (ii) N/A (iii) 0.310 (iv) 0.242
	April 2015-March 2016 (published August 2017)	(i) N/A (ii) N/A (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
The Trust considers that this data is as described for the following reason. The number of patients eligible to participate in the 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	2018/19 (i) 1 (25%) (ii) 5246 (12.7%) 2017/18 (i) = 0 (ii) = 4677 (11.7%) 2016/17 (i) = 0 (ii) = 4456 (11.1%)	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	2018 - not yet available 2017 - 72.2% 2016 - 73.4%	 68.1% 69.6%	 885.2% 86.2%	 60.0% 58.9%
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	2018 - 83.51% 2017 - 81.01% 2016 - 77.50%	69.95% 69.87% 69.85%	86.84% 85.71% 84.77%	41.08% 46.84% 48.86%
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 2019 December 2018 November 2018 (ii) January 2019 December 2018 November 2018	 99% 98% 99% 89% 92% 91%	 96% 96% 96% 87% 87% 88%	 100% 100% 100% 100% 100% 100%	 76% 81% 80% 60% 43% 63%
The Trust considers that this data is as described for the following reason. Data is derived from validated monthly reports collated in accordance with **www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/**					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by the promotion of improvements made from patient feedback.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
% of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)	HSCIC	2018/19 = 96.2% 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 and Social Care 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	2018/19 - Not yet available	Not available	Not available	Not available
		2017/18 - 10.38/100,000 bed days (20 confirmed cases)	Not available	"	Not available
		2016/17 8.80/100,000 bed days (17 confirmed cases)	13.2/100,000 bed days	"	
The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission. All cases of Clostridium difficile infection at the Trust are reported and investigated by the Infection Control Team and reported monthly to the Board of Directors. Reporting is in line with the requirements of the Health Protection Agency (HPA) and NHS Improvement.					
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	3637 (April 18-Sept 18) 4060 (April 17 -Sept 17) 3945 (April 16-Sept 16)	Not available Not available Not available	- 15,228 -	- 1133 -
Rate of patient safety incidents reported during the reporting period	NRLS	39.36 per 1,000 bed days (April 18 - Sept 18) 42.85 per 1,000 bed days (April 17 - Sept 17)	Not available 40.02 per 1,000 bed days	- 111.69	- 23.47
Number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	Not available	Not available	Not available	Not available
Percentage of total number of patient safety incidents reported during the reporting period that resulted in severe harm or death	NRLS	0.27% (April-Sept 18) 0.47% (April-Sept 17) 0.5% (April - Sept 16)	Not available 0.4% -	- - -	- - -
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.					
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken action to improve this indicator, and so the quality of its services, supporting an open culture for incident reporting and investigation and has embedded learning event notification (LERN) processes and investigation 'Toolkits' in 2018/2019 to further enhance learning and improvement.					

Part 3

Review of quality performance in 2018/19

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 against which it will be monitored. 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 2018/19 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 2018/2019 and uploaded to the National Reporting and Learning System.

	Total number reported 2016-2017	% of incidents reported 2016-2017	Total number reported 2017-2018	% of incidents reported 2017-2018	Total number reported 2018-2019	% of incidents reported 2018-2019
No Harm	5,099	63.80%	5,180	65.93%	4,664	65.68%
Minor Harm	2,684	33.58%	2,543	32.37%	2,300	32.39%
Moderate Harm	171	2.14%	105	1.34%	122	1.70%
Major/Severe Harm	38	0.48%	29	0.37%	16	0.23%
Total	**7992**		**7857**		**7102**	

Table: Patient safety incidents reported during April 2016 to March 2019 and uploaded via the national reporting and learning system (NRLS)

In 2018/19 the Trust reported 19 serious incidents including four never events. The Trust reported and investigated 23 serious incidents in 2017/18 and 25 in 2016/17. This compares with 32 in 2015/16, 46 in 2014/15 and 66 in 2013/14. The figure for 2018/2019 therefore equates to an 18% reduction from 2017/18 and continues the trend of year on year improvement in patient safety

Category of Serious Incident Reported	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Patient Fall	14	15	13	3	4	4
Hospital Acquired Pressure Ulcer	30	20	6	3	2	0
Other	22	11	13	19	17	15
Total	66	46	32	25	23	19

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. The full list of never events is available on the NHS England website

In the last 12 months (1 April 2018 - 31 March 2019) we have reported four never events. None of these have caused any serious harm to the patients involved but do show some common themes. We encourage an open reporting and learning culture. It is really important all areas understand the issues highlighted from incident reviews 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:

- Ensure a whole team approach to the application of the Surgical Safety Checklist and procedural STOP moments.
- Always re-visit/repeat the Safety Checklist if there is a change in circumstance e.g. the position of patient, a change in theatre team members, a change in the procedure plan.
- Site marking is vital for the consistent identification of site and, particularly, laterality
- Team training is important when implementing new equipment/devices/procedures.
- Consider the potential impact of human factors particularly confirmation bias, situational awareness and authority gradients
- National guidance is not infallible

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.

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: **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?
- The areas and issues for particular attention.

The Trust chose to survey all staff (rather than a random sample), with 2402 staff returning a completed 2018 survey, giving a response rate of 53% compared to a 2017 rate of 46.2%. The average response rate for acute trusts in 2018 was 46.6%.

The results from this year's survey are presented in a slightly different way to previous years. This year the scores are represented under ten themes so that a high level overview of the results for an organisation can be viewed more easily. One of those themes is Safety Culture.

The table below presents the overview of the Trust's safety culture as compared to previous years and in the context of the best, average and worst results for similar organisations. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score.

Table 1: Safety Culture of the Trust in context of the best, average and worst results for similar organisations

Safety Culture (0-10 scale, where a higher score is more positive than a lower score)	2018	2017	2016	2015
Best	7.2	7.0	7.1	7.2
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	7.2*	6.9	6.8	6.7
Average	6.6	6.6	6.6	6.5
Worst	6.0	5.9	6.0	5.9
No of responses	2298	1996	1903	1516

Table 1 illustrates that the Trust scores have improved year on year in terms of how staff view the safety of the organisation. This year they are distinctly higher than the benchmarking group 'Average' score and the Trust is the best or leader organisation for this theme.

The specific survey questions that form the overall score are presented in the following table:

TABLE 2: Questions driving the Safety Culture Theme Score

	Safety Culture questions (%)	2018	2017	2016	2015
17a	My organisation treats staff who are involved in an error, near miss or incident fairly #	69.5	60.3	57.1	58.4
17c	When errors, near misses or incidents are repoerted, my organisation takes action to ensure they do not happen again #	81.2	74.1	72.6	72
17d	We are given feedback about changes made in response to reported errors, near misses and incidents #	69.7	60.2	55.7	54.1
18b	I would feel secure raising concerns about unsafe clinical practice	76.7	74.6	72.4	72.3
18c	I am confident that my organisation would address my concerns about unsafe clinical *	69.1	65.2	61.5	58.9
21b	My organisation acts on concerns raised by patients/ service users	82.6	78.9	77.6	74

most improved since last year's survey

Positively the question relating to the addressing of concerns was seen as one of the top five scores for the Trust this year. Three of the six questions (annotated with # on table 2) were also seen as questions which were the most improved since 2017 staff survey.

In addition to the above questions, the Trust achieved the highest scores reported nationally against similar trusts in the following questions:

- 79% feel their manager values their work (average response 71%)
- 79% feel supported by their manager in a personal crisis (average response 74%)
- 77% say their manager encourages them at work (average response 68%)
- 74% feel their manager takes a positive interest in their health and wellbeing (average response 67%)

This year 77% of staff said they would recommend the Trust as a place to work against an acute trust average of 63%. Staff also gave a vote of confidence to standards of care at the Trust, with 84% recommending it as a place to receive treatment against an acute trust average of 71%.

The largest local change indicates improvements in communication between management and their teams. Over the last few years, we've done a great deal of work around our culture with the help of the Change Champions. Part of this work has focused on empowering everyone to be effective leaders.

We've also all worked on learning from incidents and near misses so that we're better able to support each other to change processes and make improvements so that our patients receive the best possible care. This ethos is at the centre of our culture of continuous improvement.

Alyson O'Donnell, Medical Director at the Trust said about the results: *"We've done a lot of work around our safety culture, in particular how we process and learn from errors and near misses. We know that the more open we are when things don't go to plan, the more we can learn and build on our practices. The fact that so many of you feel able to raise concerns and make improvements happen shows this hard work is paying off."*

Infection Control

Clostridium Difficile

There were 12 hospital associated cases of clostridium difficile reported from the Trust in 2018-19. Six of these cases were attributed to 'lapses in care', against an NHS England trajectory of 13. This represents a marked decrease from last year thanks to the continued hard work and attention to detail by Trust staff. 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.

Next year the trajectory and targets will change to include cases that have had previous care at the Trust.

For 2019/2020 NHS Improvement have adjusted the parameters against which cases of clostridium difficile will be added to the Trusts trajectory. Cases previously identified as late cases will now be classified as Hospital Onset Hospital Associated (HOHA) and will be allocated to the trajectory if identified on or after day 2 of admission (previously this was day 3). An additional group of patients to be added to the trajectory will be those who test positive for CDI in the community within 4 weeks of discharge from the Trust. These will be Community Onset Healthcare Associated cases (COHA). Our trajectory will therefore increase to reflect this change from 13 to 30 cases. The same rigorous methods for investigation of each cases will be followed.

Methicillin-Resistant Staphylococcus Aureus (MRSA)

One hospital acquired MRSA bacteraemia was recorded at the Trust during 2018/ 2019.
This case was investigated as a serious incident by leads from within the Medical Care Group. Significant findings from the review included;

- Guidelines, policies and procedures - staff did not follow infection control and documentation guidelines, which resulted in lapses of care.
- Written communication- it was difficult to establish when and where cannulas were inserted, including dates. Poor written communication in the patients notes impacted on the correct care being delivered

The Head of Nursing and Quality for the Medical Care Group held a debrief with all nursing staff involved and provided 1:1 support where required. An overarching ward action plan is in place for concerns raised within the review and to address learning identified from additional serious incidents. Actions that remain open are under regular review.

The Trust also supported the investigation of two community acquired cases which were assigned as third party cases.

Methicillin-Sensitive Staphylococcus Aureus (MSSA)

The rate of healthcare associated MSSA bacteraemia's reported within the Trust is above the UK average rate. Each health care associated case is assessed by the infection prevention and control team and any lapses in care are followed up with a root cause analysis using the post infection review toolkit. Findings from these are discussed and learning points shared through directorate infection control meetings.

Current common findings associated with MSSA bacteraemia's are missing or delayed inspections of cannula. An electronic version of the paper form for assessing and recording these inspections is due to be launched next year, this will automatically flag patient with outstanding cannula inspections.

Gram negative blood stream infections (GNBSIs)

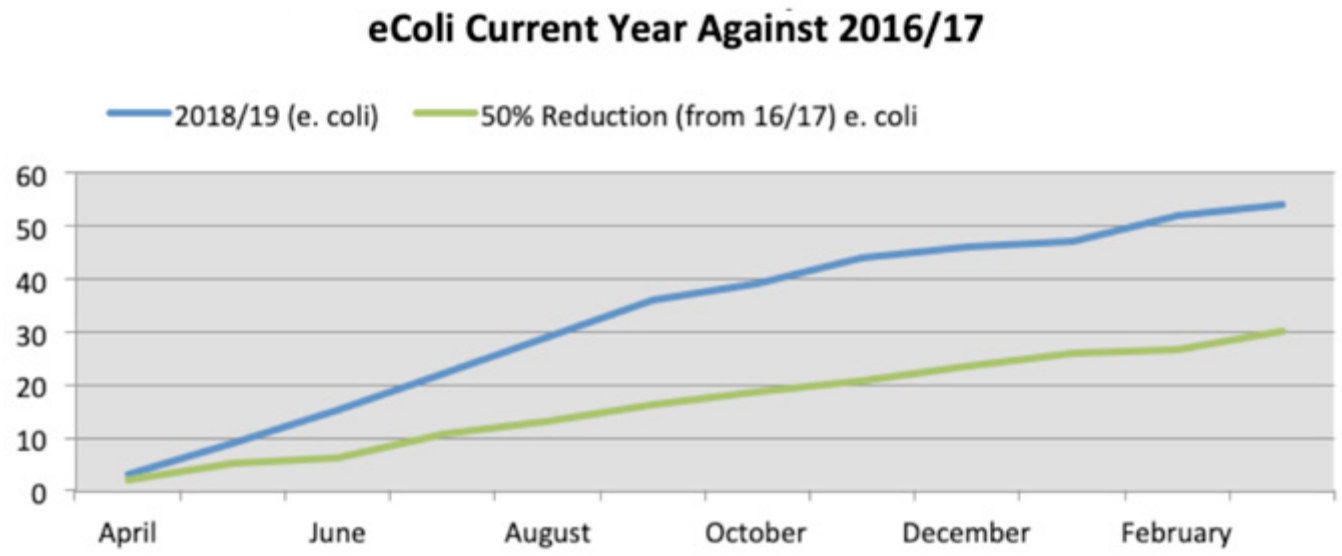
In England, Gram-negative bloodstream infections (GNBSIs) are increasing despite the decreases seen in Meticillin-Resistant Staphylococcus aureus (MRSA) bloodstream infection and Clostridium difficile infections (CDI). Gram negative bacteraemia's include e. coli, pseudomonas aeruginosa and klebsiella pneumonia. The Government has therefore set an ambition to reduce healthcare associated GNBSI by 50% by 2020/21.

Dorset has a high number of GNBSIs, which is indicative of the population demographic. The Trust is an outlier for the number of e. coli bacteraemia's, with the latest data indicating that we have a higher number of hospital associated cases. However, when this is correlated against the number of blood tests taken in the hospital the rate is within the national average. The Trust is committed to the nationally led ambition by NHS Improvement to reduce these infections and we are working with staff from community settings and the other hospitals on a Dorset wide improvement plan. This work is led by the infection prevention and control leads for the Dorset integrated care system.

It is widely accepted that the older persons age group are at greater risk than other populations. We are working towards the reduction of these infections in line with strategies set out in the Dorset wide action plan. There is a general consensus that the strategies we have had in place so far across Dorset has not reduced the incidence of these cases. A south west wide meeting to review this plan and set new strategies took place in February 2019 with colleagues from community and acute healthcare provision led by the clinical commission group.

Period	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust					Non-teaching trust	England
		Count	Value	Lower CI	Upper CI		
2012/13		58	28.4	-	-	20.4*	21.9
2013/14		46	22.7	-	-	19.8*	22.0
2014/15		53	26.4	-	-	19.5*	21.2
2015/16		36	17.9	-	-	20.6*	22.3
2016/17		68	35.2	-	-	20.5*	22.5
2017/18		51	26.5	-	-	20.2*	22.2*

Source: HCAI Mandatory Surveillance Data



The infection prevention and control team will continue to focus our education based on findings from clinical visits and audit results to shape education delivered at ward level and wider opportunities to reduce the number of cases. In addition to this targeted work a study day is planned for April 2019 to raise awareness of the wider impacts of choosing the correct continence products, improving oral hydration and nurse led trials without catheter.

Norovirus

Outbreaks of Norovirus were confirmed within the Trust during April and December. Cases and number of staff affected were at similar levels to previous years. Media messages and communications are currently our best defence against outbreaks.

Catheter related urinary tract infections (CA UTIs)

The percentage of patients with a urinary catheter inserted within the Trust is higher than the UK average. However the percentage of patients with a CAUTI (from NHS Safety Thermometer data) is in line with national reporting.

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 2019/2020

- Participation in World Hand Hygiene day in May 2019
- Participation in glove awareness week (April/ May 2019) with an overall aim of reducing unnecessary glove use
- Continue infection control audit programme, including routine hand hygiene audits in line with annual plan
- Review of new and novel methods to improve infection control within the Trust
- Integration of ICNet into the Trust
- Closer working with Poole Hospital's infection prevention and 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 faced 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 improve our capacity to manage the psychological aspects of patient care.

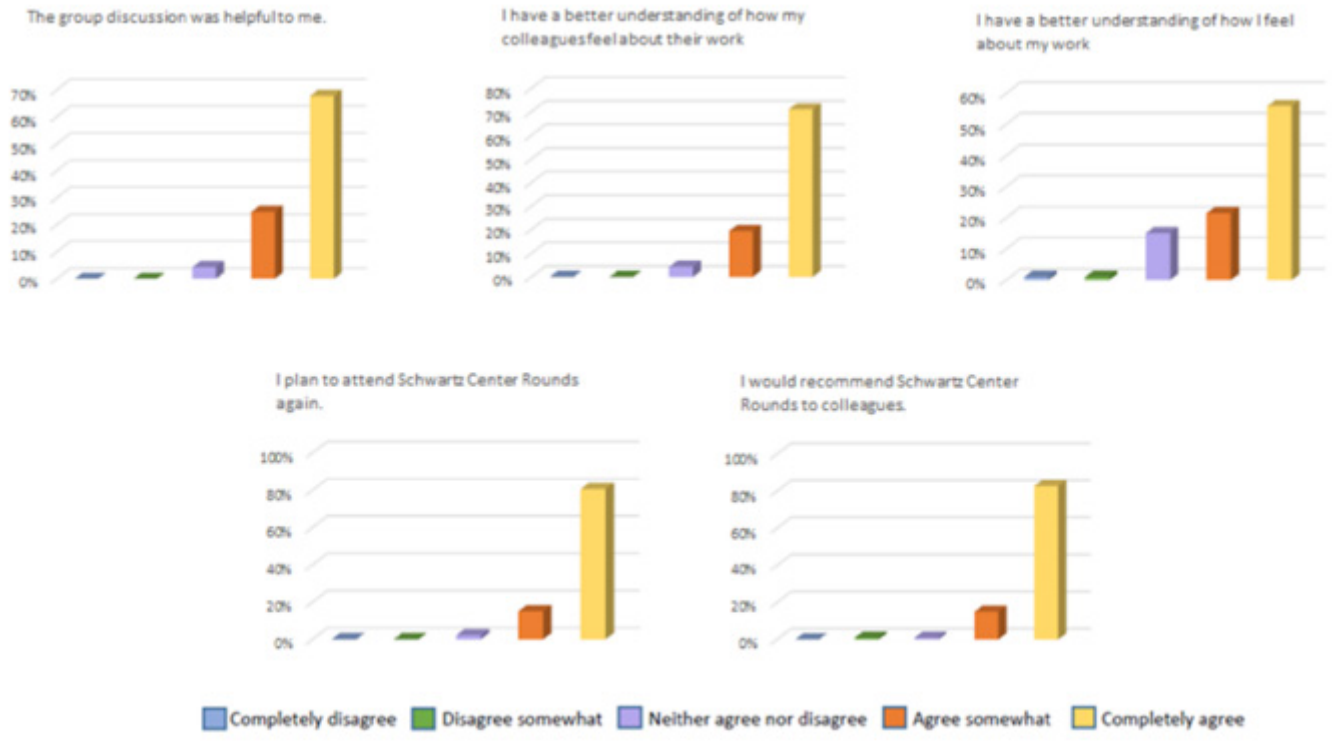
Each session includes three or four short presentations from our staff based on a particular theme. There is then a confidential discussion which is open to all present.

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 2018/19 include

- The impact of suicide
- What do you see when you see me?
- How do we make our values real?
- First days
- Complications
- A patient I will never forget
- Why I volunteer?

Attendance remains high with approximately 275 staff each attending a session between April 2018 and March 2019. It is pleasing to see there is representation from nearly all disciplines. Feedback from staff suggests that attendees continue to value this forum.

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



Quotes from staff feedback forms include:

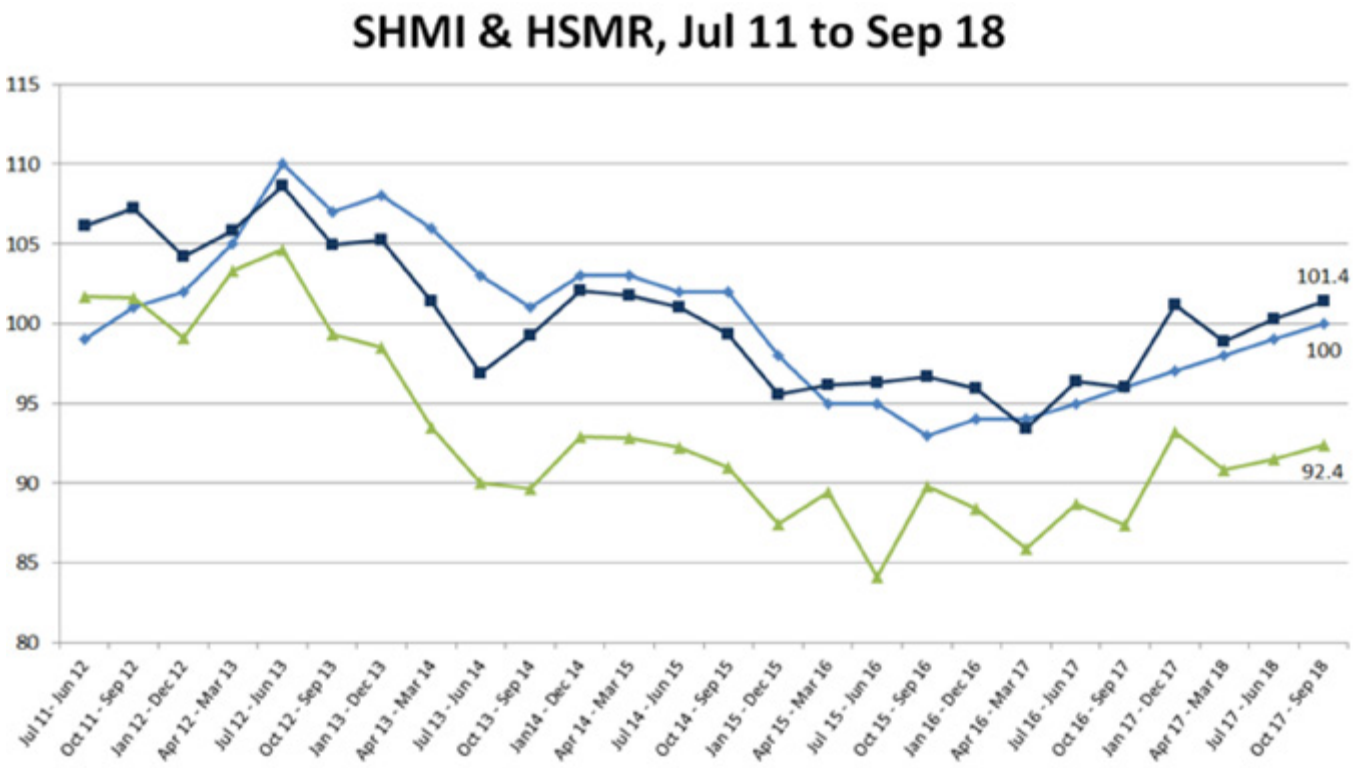
- It helped me open up feelings I thought I had buried
- Very grateful to everyone who was able to openly talk about such an emotional and difficult topic
- Excellent Schwartz Round. Really difficult subject and panel and facilitators were exceptional. Thank you all.
- Excellent stories because they are told be experienced consultants
- As a junior doctor I often go home and agonise over things. It was so refreshing to hear our bosses have the same stresses. I feel less alone
- I am proud to work at RBH which has a culture of openness and supporting each other
- Thanks to panel members for sharing it has helped to relate with feelings I had when things went wrong

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, with HSMR shown 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.

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.



Overall HSMR for the Trust for the last 12 months (December 2017 - November 2018) is 97.6, which is in the 'as expected' category when compared with the national average of 100. Our overall mortality ratio is consistently showing improvement.

The SHMI (Summary Hospital Mortality Indicator, which includes deaths within 30 days of discharge) is in the 'as expected' category.

Reducing Mortality

The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme based in the School of Population Health and Environmental Studies at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland.

SSNAP measures both the processes of care (clinical audit) provided to stroke patients and the structure of stroke services (organisational audit) against evidence based standards, including the 2016 National Clinical Guideline for Stroke. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients.

The clinical audit collects a minimum dataset for stroke patients in England, Wales and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of six month assessment. SSNAP is a prospective, continuous audit. This means that data collection is ongoing until at least 31 March 2021 when the current contract for running the national stroke audit ends. SSNAP has been voted the most effective national clinical audit in the UK for nine consecutive years by healthcare professionals involved in audit.

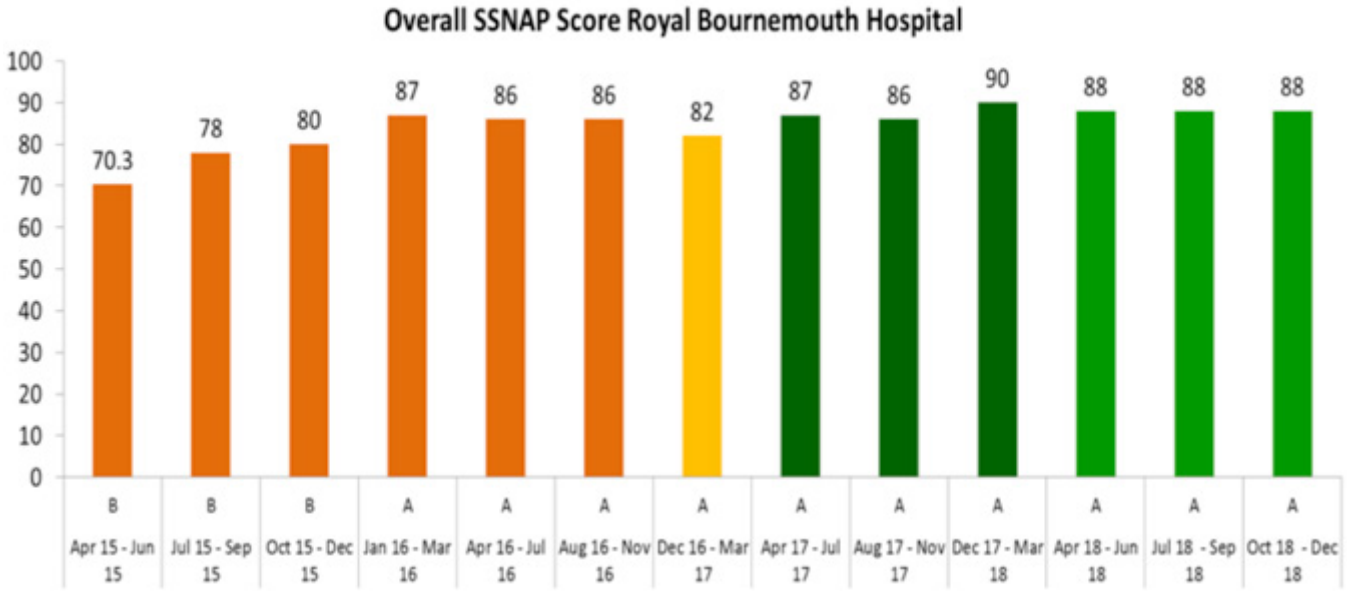
Included in SSNAP's reporting suite are colour coded performance tables which give a high level summary of hospitals' performance across ten key aspects of stroke care, an overall SSNAP score is also given. The best score is a grade A.

The audit scores for the Trust for the last three years are shown below.

SSNAP (Team-centred)	2016/17 T1	2016/17 T2	2016/17 T3	2017/18 T1	2017/18 T2	2017/18 T3	2018/19 Q1	2018/19 Q2	2018/19 Q3
	Apr 16 - Jul 16	Aug 16 - Nov 16	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18
Domain 1 - Scanning	C	C	C	B	B	B	B	B	A
Domain 2 - Stroke Unit	C	C	C	C	C	C	C	C	C
Domain 3 - Thrombolysis	C	C	C	B	C	B	B	C	D
Domain 4 - Specialist Assessments	B	B	B	B	B	B	B	B	B
Domain 5 - Occupational Therapy	A	A	A	A	A	A	A	A	A
Domain 6 - Physiotherapy	A	A	B	A	A	A	A	A	A
Domain 7 - Speech and Language Therapy	A	A	A	A	A	A	A	A	A
Domain 8 - MDT Working	A	A	A	A	A	A	A	A	A
Domain 9 - Standards by Discharge	A	A	B	B	B	A	B	A	A
Domain 10 - Discharge Processes	A	A	A	A	A	A	A	A	A
Combined Total Key Indicator Score	86	86	82	88	86	90	88	88	88
Combined Total Key Indicator Level	A	A	A	A	A	A	A	A	A
Overall (after adjustments) Score	86	86	82	88	86	90	88	88	88
Overall (after adjustments) Level	A	A	A	A	A	A	A	A	A

We are proud to maintain an overall rating of A.

SSNAP Reporting Period	Apr 15 - Jun 15	Jul 15 - Sep 15	Oct 15 - Dec 15	Jan 16 - Mar 16	Apr 16 - Jul 16	Aug 16 - Nov 16	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18
SSNAP level	B	B	B	A	A	A	A	A	A	A	A	A	A
SSNAP score	70.3	78	80	87	86	86	82	87	86	90	88	88	88
Case ascertainment band	A	A	A	A	A	A	A	A	A	A	A	A	A
Audit compliance band	B	A	A	A	A	A	A	A	A	A	A	A	A
Quarter	Apr 15 - Jun 15	Jul 15 - Sep 15	Oct 15 - Dec 15	Jan 16 - Mar 16	Apr 16 - Jul 16	Aug 16 - Nov 16	Dec 16 - Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18	Apr 18 - Jun 18	Jul 18 - Sep 18	Oct 18 - Dec 18
Combined Total Key Indicator level	B	B	B	A	A	A	A	A	A	A	A	A	A
Combined Total Key Indicator score	74	78	80	87	86	86	82	87	86	90	88	88	88



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 an increase in the percentage of responses recording extremely likely to recommend.

FFT April 2015 - March 2016 (all areas)		FFT April 2016 - March 2017 (all areas)		FFT April 2017 - March 2018 (all areas)		FFT April 2018 - March 2019 (all areas)	
Extremely likely responses	34089	Extremely likely responses	34065	Extremely likely responses	35120	**Extremely likely responses**	**38304**
Likely	6289	Likely	5264	Likely	5278	**Likely**	**4802**
Neither likely/nor unlikely	569	Neither likely/ nor unlikely	498	Neither likely/ nor unlikely	496	**Neither likely/ nor unlikely**	**555**
Unlikely	232	Unlikely	215	Unlikely	188	**Unlikely**	**289**
Extremely unlikely	391	Extremely unlikely	358	Extremely unlikely	382	**Extremely unlikely**	**639**
Total	**41570**	**Total**	**40400**	**Total**	**41464**	**Total**	**44589**

FFT April 2015 - March 2016 (all areas)		FFT April 2016 - March 2017 (all areas)		FFT April 2017 - March 2018 (all areas)		FFT April 2018 - March 2019 (all areas)	
Extremely likely responses	82.0%	Extremely likely responses	84.3%	Extremely likely responses	84.7%	**Extremely likely responses**	**85.9%**
Likely	15.1%	Likely	13.0%	Likely	12.7%	**Likely**	**10.8%**
Neither likely/nor unlikely	1.4%	Neither likely/ nor unlikely	1.2%	Neither likely/ nor unlikely	1.2%	**Neither likely/ nor unlikely**	**1.2%**
Unlikely	0.6%	Unlikely	0.5%	Unlikely	0.5%	**Unlikely**	**0.6%**
Extremely unlikely	0.9%	Extremely unlikely	0.9%	Extremely unlikely	0.9%	**Extremely unlikely**	**1.4%**

Our patient experience plans for 2019/20 include:

- Train Patient Engagement Champions across the Trust and Poole Hospital NHS Foundation Trust to be experts in co-design facilitation, ensuring inclusion in project design.
- With partners in Dorset ensure there is a joint agreement for the level of patient participation that is required at differing levels of engagement, identifying the need for co-designing service redesign.
- Working with the One Acute Network (OAN) in Dorset to centralise and coordinate patient engagement activities ensuring the correct methodology is used.
- Embed ‘Care Conversations’, recorded patient led feedback with our survey volunteers edited into ‘snippets’ to highlight good practice and to get in-depth feedback on four key areas.
- Develop the Patient Experience and Engagement Steering group to triangulate feedback and identify work streams.
- Create a joint Patient Engagement and Experience Strategy with Poole Hospital NHS Foundation Trust.
- Increase numbers of ‘patient voice volunteers’ to sit on committees, interviews and to be involved in quality improvement projects.
- Work with the Communications team to look at ‘First Impressions’- how the patient experience is influenced from first contact with the Trust.
- Increase the workforce in Voluntary Services to provide dedicated members of staff to engage with the younger members of our community.

Volunteers

A dedicated Macmillan Caring Locally volunteer has received the Volunteer of the Year award at the Unsung Hero Awards, the only national award for non-medical NHS staff and volunteers who go above and beyond the call of duty.

Mandy Preece, a volunteer at the Macmillan Unit based at Christchurch Hospital, collected her award at The Hilton, Deansgate in Manchester, where she was praised for her services in supporting palliative care patients and creating a unique training programme for volunteers.

Mandy has volunteered for the Macmillan Unit since 2011, starting as a companion volunteer in the Day Centre. Mandy then volunteered alongside staff within the Macmillan Unit, carrying out roles which directly enhanced patient care such as providing end of life companionship and offering support to patients' families.

Mandy created a successful volunteer communication training programme since 2013 which helps to recruit, train and retain volunteers for the Macmillan Unit, and has since been asked to sit on a national Directors' of Nursing Panel to give her input into volunteering within an NHS Trust.

Speaking after the awards ceremony Mandy said:
"It was very humbling to receive the award, especially when you hear of all the tremendous work of other volunteers in the NHS. It is a huge privilege to be part of the NHS volunteer and staff family, and I am very grateful to Macmillan Caring Locally for their immense support in allowing me and other volunteers to shine. For me, the gift of volunteering is to be alongside somebody authentically, and to provide a sense of normality when the day-to-day can often be very upsetting and difficult to cope with. What myself and my fellows nominees are representing is that volunteers can make a big impact, and that's something to be so proud of."

Anita Rigler, Volunteer Project Co-Ordinator at the Macmillan Unit, and who nominated Mandy for the award said:
"To have Mandy's contribution to volunteering within the NHS acknowledged nationally is hugely important to me. She changes lives, challenges perceptions, and has transformed the unit and the approach to the way we train and retain our volunteers. It would be wonderful if Mandy's efforts inspire others to consider volunteering so that more families can be comforted when they lose a loved one. Mandy is an inspiration to so many and I am delighted for her."

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 426 formal complaints received by the Trust in 2018/19 against a background of 114,236 admissions and 467,804 ED, outpatient and day case attendances. The number of complaints has shown an increase over 2018/2019 compared to previous years (310 complaints received in 2017/18, 292 complaints received in 2016/17, 313 complaints received in 2015/16). This increase can be attributed to the change in Trust policy which simplified the recording of the complaints and removed the categorisation of written concerns.

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 426 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.

Subjects of complaints

The main categories of complaint were as follows:

Subject	Formal Complaints 2018/19		Formal Complaints 2017/18		Formal Complaints 2016/17	
	Number	Proportion	Number	Proportion	Number	Proportion
Implementation of care - including quality, delays and/or complications of treatment	173	41%	122	39%	135	46%
Clinical Assessment	25	6%	22	7%	-	-
Admission, transfer and discharge	67	18%	46	15%	52	18%
Diagnostic tests (not pathology)	0	0%	0	0%	25	8%
Communication and consent	131	31%	105	34%	61	21%
Medication	13	3%	7	2%	1	0%
Security	8	2%	1	0%	2	1%
Equipment	0	0%	1	0%	5	2%
Food Safety and Service	1	0%	0	0%	0	0
Visitor incidents/accidents	0	0%	0	0%	1	0%
Treatment, procedure, care	0	0%	0	0%	0	0%
Staff incident	0	0%	0	0%	0	0%
Patient incidents (including falls, other accidents and self-harm)	5	1%	2	1%	5	2%
Environment	0	0%	0	0%	3	1%
Infection Control	2	0%	4	1%	2	1%

A 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's Healthcare Assurance Committee. 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's website during the year.

You said
"My father was sent home in hospital pyjamas that had blood stains on"

We implemented a new discharge checklist on the ward and sent a newsletter to all staff working on the ward to remind them about the Trust's dignity pledge"

You said
"I hold power of attorney for my relative and I was not given updates about their discharge, the nursing home were contacted in place of me"

A new policy has been written regarding power of attorney and has been disseminated to all Trust staff.

You said
"I had a reaction to the medication that was put into my eyes, because I was vomiting so much the team had to take me to ED instead of giving me medication in the department to stop the vomiting"

We ensured that anti-sickness medication is available in the eye department for patients

You said
"My father was discharged from hospital and turned up at home in clothes that were not his, it was a shock"

On discharge it was noted that the patient only had his pyjamas at the hospital, in line with our dignity pledge the nursing team purchased some clothes enable the patient to be discharged in clothing and not his pyjamas. We reminded staff of the importance communicating with relatives.

You said
"I had to wait weeks for any information about a biopsy that had been done"

The Clinical Nurse Specialists will now dictate a letter to the patient on the day of the biopsy advising of the next steps in the process.

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, 7 people chose to refer their concerns to the Parliamentary and Health Service Ombudsman (PHSO) during 2018/19 compared to 3 in 2017/18, 11 in 2016/17 and 12 in 2015/16.

The PHSO referred 2 complaints back to the Trust for further local resolution. During 2018/19 the total number of complaints investigated by the Ombudsman was 16, ranging between the years 2014 and 2018, 0 complaints were upheld, 3 were partly upheld, 8 were not upheld and 1 was rejected. 4 complaints remain under investigation by the PHSO.

Performance against national priorities 2017/18

National Priority	2014/15	2015/16	2016/17	2017/18	2018/19 Target	2018/19 Actual
18 week referral to treatment waiting times - admitted	88.9%	84.5%	81%	80.5%	90.0%	74.6%
18 week referral to treatment waiting times - non admitted	95.6%	94.4%	89.0%	88.7%	95.0%	84.3%
18 week referral to treatment waiting times - patients on an incomplete pathway	94.3%	93.7%	91.6%	90.3%	92.0%	84.6%
Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge	93.3%	93.37%	94.6%	92.7%	95.0%	92.6%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	84.5%	85.9%	85.7%	88.5%	85%	85.9%
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	93.1%	76.0%	96.9%	92.8%	90%	88.3%
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	95.8%	95.7%	98.3%	97.6%	96%	97.8%
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	92.5%	94.1%	96.3%	97.0%	94%	95.6%

Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti-cancer drug treatment	100%	100%	100.0%	100%	98%	100%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	87.1%	96.1%	96.1%	97.0%	93%	93.4%
Two week wait for Breast Symptoms (where cancer was not initially suspected)	91.1%	99.4%	98.8%	100%	93%	96.4%
Clostridium difficile year on year reduction	21	14	17	20	13	6
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%	99.72%	>99%	96.3%

** 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 provided 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

The Council would like to thank Royal Bournemouth Hospital NHS Foundation Trust for their professional and open approach to meeting with representatives of Borough of Poole's, Health and Social Care Overview and Scrutiny committee throughout the year. Some very enlightening discussions have been held around the progress made in key quality improvement areas. We would like to thank the hospital for allowing the Council an opportunity to comment on this account regarding the achievements and areas for improvement detailed in the Quality Report for 2018/19.

The presentation about the account delivered on 14th March 2019 gave a clear outline of how the Trust is endeavouring to deliver high quality care and the activities undertaken during the financial year to improve services. With regard to the priority areas for improvement for 2018/19 we would like to commend the Trust in achieving the majority of what it had planned in relation to:

Urgent and emergency care 'First 24 hours'- It was pleasing to hear from the Trust about improvements in approaches to care within the first 24 hours in particular how admission avoidance performance has improved through good triaging in same day emergency care. It was heartening to hear about the project to reduce duplication in the clerking process from entrance into the emergency department through to a patient seeing a speciality

consultant and that it is having a real positive impact on reducing timescales by up to four hours and reducing duplication of effort by 50%.

Surgical Flow- It was encouraging to hear about progress made in reducing delays in ITU beds although the reduction was only 10% or 40 minutes it is still movement in the right direction.

Speciality pathways- Improvements in the speciality pathways sounded varied but very worthwhile pieces of work, the introduction of e-forms in response to learning in dermatology and improving the morale of staff in ophthalmology had led to significant improvements in both services.

We were also heartened to hear about the project to reduce the number of unnecessary interventions especially at night when a patient is sleeping including blood tests, observations and blood glucose and also resolving issues earlier in the day.

Fundamentals of care- the deteriorating patient- we understand that this national initiative and roll out of the new early warning system is a paramount piece of work in all the Trusts visited. It is pleasing to note that the recognition and early detection of sepsis is well embedded within the trust with a significantly high level of staff having undertaken the mandatory training. It would be encouraging to hear that this reaches 100% compliance in the not too distant future.

Thank you for the opportunity to comment on an interesting Quality Review. We look forward to reading the published version but please take this letter as Borough of Poole's response to the Quality Account.

Phil Hornsby
Head of Commissioning and Improvement, People Services
Borough of Poole
I28 March 2019

healthwatch Dorset

Healthwatch Dorset welcomes the opportunity to comment on The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust's quality account for 2018/19.

Healthwatch Dorset exists to promote the voice of patients and the wider public with respect to health and social care services.

As of April 1st 2019 Healthwatch Dorset came under new management and therefore we are unable to comment on the previous year's activity as it relates to work carried out under the previous Healthwatch Dorset contract. However, we welcome the Trusts patient experience plans for 2019/20 and look forward to developing relationships over the coming year and working with them to ensure the experiences of patients, their families and unpaid carers are heard and taken seriously.

Louise Bate
Healthwatch Dorset Manager
9/5/19

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 would like to begin by recognising the achievement of the Trust on the outcome of their CQC inspection which was published in June 2018 and rated the Trust as 'Good' overall and 'Outstanding' in the well-led domain. This represents significant progress and the acknowledgement of the support that staff receive from senior managers was highlighted and is worthy of mention.

The CCG has reviewed the progress that the Trust has made with the quality priorities set for 2018/19, and it is evident that the Trust has fully or partially achieved a number of the priorities. It is particularly encouraging to see the significant training around sepsis and the deteriorating patient, including the 96.4% of frontline staff who have completed the relevant e-learning module. However, with reference to the aim of administering intravenous antibiotics to 95% of eligible patients within 1 hour of diagnosis of sepsis the Trust has not achieved their aim. They have achieved an average of 65% over the last 12 months within inpatient areas and an average of 42% within the Emergency Department. The Trust has acknowledged the need to improve their practice in this area and potentially consider a different approach to data collection, and the CCG looks forward to seeing how the Trust can improve both their data collection and their performance in this area over the coming 12 months to ensure that patients are protected and receive timely treatment.

The Trust's priorities for 2019/20 have been reviewed and it is encouraging to see the wide variety of information sources and consultation that has been used to determine the priorities going forward. Those identified are wide-ranging and show a focus on improving how services are provided with the focus on the needs of the patient.

The CCG acknowledges the Trust's progress with the reduction of Never Events reported from eight in 2017/8 to four in 2018/19. Although the target is zero for each hospital trust the reduction that the Hospital has reported is encouraging, and it is reassuring to hear that none of the never events reported resulted in any serious harm to the patients involved. It is also evident that the Trust has an open and transparent reporting culture for Never Events and their willingness to enlist the help of external organisations to visit key clinical areas provides an additional level of assurance.

The continued year on year reduction in reported serious incidents, along with a slight decrease in patient safety incidents resulting in major or severe harm indicates the Trust's commitment to improving the safety of the patients in their care. This is supported by the positive results from the National Staff Survey, which demonstrates the positive improvement over the last four years across a number of staff reported questions reflecting the safety culture of the Trust. In particular the result indicating that 94% of staff "feel encouraged to report errors, near misses or incidents" is acknowledged as the highest score reported nationally against similar Trusts.

The Quality Account also includes the new requirements for 2018/19 regarding details of ways in which staff can speak up and how the trust will ensure staff who do speak up do not suffer detriment as well as progress in implementing the priority clinical standards for seven day hospital services. However, within the report we could not see the new requirement to include a consolidated annual report on rota gaps or the plan for improvement to reduce these gaps within the Trust's Quality Account. *

Although the Royal Bournemouth and Christchurch Hospitals NHS Trust have continued to find it a challenge to meet the constitutional standard regarding patients waiting longer in the Emergency Department, they have consistently remained in the top quartile of Trusts. The CCG looks forward to see how their quality priorities, focusing on urgent and emergency care and improving hospital flow will continue to have a positive impact on their performance in this constitutional standard.

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

Heather Hauschild (Mrs)
Chief Officer
NHS West Hampshire Clinical Commissioning Group
7 May 2019

[1] The CCG were provided with a draft copy of the Quality report which did not have this section completed at that stage, the final version includes this requirement.

NHS
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

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 and the Council of Governors to ensure that the information in the Quality Report provides comprehensive, clear and meaningful messages about the quality of care provided to patients.

We recognise the tremendous amount of work that goes into producing the overview provided in the Quality Report in order to ensure that this reflects the pressures and challenges faced by acute hospitals and other health and social care partners and the ongoing learning and continuous improvement happening in our hospitals. The complexity of the data and the limitations on the way that some of this data can be presented in the Quality Report has been managed well through the use of additional information, which helps to ensure that the data is more readily understandable. This is particular relevant in the case of clinical audit where important changes to clinical practice and patient safety based on the learning from both national and local clinical audit cannot always be set out in full as these do not fit readily into the format or timescales for the production of the Quality Report. For governors it is important that we focus on the outcomes for patients and the impact on the patient experience so that we can reflect on the human side of healthcare as part of presenting the data around the quality of care and services.

The Quality Report demonstrates the extensive quality improvement programme within the hospitals and the benefits being delivered through this. This reflects the inclusive, learning and open culture developed in the Trust over a number of years and the continued focus on providing high standards of care to patients in a sustainable way.

Governors support the focus on improvement and the way in which the Trust continues to prioritise the quality and safety of care for patients in our hospitals through the quality priorities that have been selected for 2019/20. 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. This has already included participation in the 'Sleep Well' action learning week early in 2019/20.

The Quality Report also includes the ways in which governors are involved in this work through their membership and participation in a number of groups across the Trust including the Mortality Surveillance Group, Audit Committee, End of Life Care Steering Group, Healthcare Assurance Committee, Equality, Diversity and Inclusion Committee, Infection Prevention and Control Committee, and Workforce Strategy and Development Committee, Nutrition Steering Group, Patient Information Group and Valuing Staff and Wellbeing Group.

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 2018/19, the

Governors have selected the Summary Hospital-level Mortality Indicator, based on a recommendation from NHS Improvement. The Council of Governors are hopeful that the selection of this indicator at the Trust and other trusts will bring with it the ability to benchmark the Trust against other trusts through the external auditors and NHS Improvement and to share learning from this.

Governors will continue their involvement in a range of activities to deepen their insight in the areas covered by the Quality Report including:

- proactive involvement in public, patient and carer experience and listening events;
- receiving and questioning reports from executive directors on performance against objectives and key performance indicators 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; and
- participation in focus groups with the Care Quality Commission.

17 May 2019

NHS
Dorset
Clinical Commissioning Group

Dorset Clinical Commissioning Group welcomes the opportunity to provide this statement on Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust's Quality Account. The information contained within the Account for the year 2018/19 is consistent with information shared with commissioners throughout the year. The CCG would also like to commend the Trust on its achievement of a Good overall rating from CQC in June 2018 and in particular the achievement of the outstanding rating for the Well-led domain.

During the year Commissioners have noted success and progress in a number of the priorities through the use of Quality Improvement methodology and a project management approach. The staff survey results also support the recognition of an engaged workforce in the implementation of these improvements. The progress made in the Urgent and Emergency Care priorities has been supported by a collaborative approach and it is anticipated that the new priority in this area as well as hospital flow will further develop this work with partner agencies such as Primary Care and the CCG to achieve positive outcomes.

The CCG are supportive of the quality priorities for 2019/20 which have been identified through review of review and audit of Trust information, feedback from staff, patients and the public and look forward to working with the Trust as part of the Integrated Care System to improve the health and well-being of the local population.

Vanessa Read
Director of Nursing & Quality
NHS Dorset Clinical Commissioning Group
09 May 2018

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 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19
- 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 2018 to 23 May 2019
  - papers relating to quality reported to the Board over the period April 2018 to 23 May 2019
  - feedback from commissioners dated 7 May 2019 and 9 May 2019
  - feedback from governors dated May 2019
  - feedback from local Healthwatch organisations dated 9/05/2019
  - feedback from the Overview and Scrutiny Committees dated 28/03/2019
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated May 2019
  - the latest national inpatient survey dated 2017
  - the latest national staff survey dated February 2019
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019
  - Care Quality Commission inspection report dated June 2018
- 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
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality account regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the Board

David Moss
Chairperson
23 May 2019

Debbie Fleming
Chief Executive
23 May 2019

Annex C

2018/2019 limited assurance report on the content of the quality reports and mandated performance indicators

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

We have been engaged by the Council of Governors of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent

GP referral to first treatment for all cancers; We refer to these national priority indicators collectively as the 'indicators'..

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by 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 2018/19 ('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 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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 15 May 2019;

- feedback from governors, dated 13 May 2019;
- feedback from local Healthwatch organisations, dated 25 April 2019;
- feedback from Overview and Scrutiny Committee, dated 28 March 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated 13 June 2018;
- the latest national staff survey, dated 2018;
- Care Quality Commission Inspection, dated 18 June 2018;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 23 May 2019; and
- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods

used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the 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
66 Queens Square,
Bristol, BS1 4BE
23 May 2019

Annex D

Glossary of Terms

Admission Avoidance
Unplanned admissions to hospital are can be distressing and disruptive for patients, carers and families. Many unplanned admissions are for patients who are elderly, infirm or have complex physical or mental health and care needs which put them at high risk of unplanned admission or re-admission to hospital. Admission avoidance looks at providing alternative care pathways that support individual patients needs and avoids the patient being admitted to a hospital bed

AMU
Acute Medical unit

BAUS
The British Association of Urological Surgeons

BEAT
Blended Education and Training team

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 2018/2019

ECG
Echocardiogram

ED
Emergency Department

eNA
Electronic nurse assessments

eMortality
Electronic Mortality capture form

FY1/2
Foundation Year doctors

Good clinical practice (CGP)
Good clinical practice (GCP) is a set of internationally-recognised ethical and scientific quality requirements that must be followed when designing, conducting, recording and reporting clinical trials that involve people

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**

ITU
Intensive Care Unit

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

MHRA
The Medicines and Healthcare products Regulatory Agency (MHRA) regulates medicines, medical devices and blood components for transfusion in the UK

Model Hospital
The Model Hospital supports the NHS to provide the best patient care in the most efficient way. This free digital tool from NHS Improvement enables trusts to compare their productivity and identify opportunities to improve. It is currently available to all NHS provider trusts

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

NRLS
National Reporting and Learning System

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)

OPM
Older Persons Medicine directorate

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

Patient Reported Outcome Measure
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, CCG and NHS treatment centre data. Private hospital data is omitted.

EQ-VAS is a 0-100 scale measuring patients' pain, with scores closest to 0 representing the 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 are 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
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

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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

Christchurch Hospital
Fairmile Road, Christchurch, BH23 2JX

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

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