Royal Berkshire NHS
NHS Foundation Trust

ROYAL BERKSHIRE NHS FOUNDATION TRUST'S QUALITY ACCOUNTS

1 Background

1.1 The Quality accounts are a statutory report about the quality of services provided by an NHS healthcare service. The report is published annually by each NHS healthcare provider and is available to the public.

1.2 The Quality Accounts have to conform with the National Health Service (Quality Accounts) Regulations 2010 statutory instrument No 279 and for Foundation Trust's with Monitor's "NHS Foundation Trust Annual Reporting Manual".

1.3 Quality accounts aim to enhance the accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

1.4 The Royal Berkshire NHS Foundation Trust published their first statutory quality accounts in June 2010 covering activity for 2009-10. Quality accounts are published on the NHS choices website and a copy is sent to the Secretary of State.

1.5 The Royal Berkshire NHS Foundation Trust invites comments from the local commissioning PCT (Primary care trust), LINKs (Local Involvement Networks) and OSC (Overview and Scrutiny Committee) and includes these verbatim within the published Quality Accounts.

2 Required content

2.1 Quality accounts should include:

- A statement from the chief executive
- Priorities for quality improvement and why they have been chosen
- A review of the quality of services, using selected quality indicators chosen by the provider but aiming to be representative of quality across all the services provided
- A standardised set of statements on data quality, participation in clinical audits and confidential enquiries, participation in research, commissioning for quality and innovation (CQUIN) schemes and care quality commission assessments
- A description of who has been involved and engaged to determine the content and priorities
- External comments provided by the local PCT, LINKs, and OSC, if they choose to provide it, to ensure that there is some external assurance and scrutiny of the content.

3 Royal Berkshire NHS Foundation Trust Process/Scheduling

3.1 The Trust board has agreed the quality priorities and indicators that will feature in this year's Quality Accounts.

3.2 The draft Quality Accounts will be approved by the Trust Board on 27 March, pending the addition of end of year data.

3.3 End of year data may not become available until 16 April 2012.

3.4 The draft Quality Accounts will be sent to the local PCT, LINKs, OSCs on 28 March inviting comments to be returned by 30 April 2012. Further updates of the draft Quality Accounts will be made available to the PCT, LINKs and OSC as year end data are added.

3.5 The unaudited Quality Accounts will be submitted to Monitor on 23 April 2012.
3.6. Verbatim comments from the PCT, LINKs and OSC will be included in the final Quality Accounts.
3.7 The Royal Berkshire NHS Foundation Trust Board will sign off the Quality Accounts as part of the Trust's Annual Report on 29 May 2012.
3.8 The Trust's approved and audited Annual Report and Accounts will be submitted to Monitor on 31 May 2012.

4 Written statements by other bodies

4.1 The National Health Service (Quality Accounts) Regulations 2010 statutory instrument No 279, requires the Royal Berkshire NHS Foundation Trust to publish in their Quality Accounts with comments from other bodies as part of the external review process.
4.2 In relation to Overview and Scrutiny Committees, the Regulations state: *a copy of any written statement relating to the content of the Quality Accounts, which is no more than 500 words in length, provided prior to publication in response to the draft received (within 30 days beginning with 1st April following the end of the reporting period) by the appropriate Overview and Scrutiny Committee.*
4.3 The 2010/11 Quality Accounts did not include a statement from Wokingham HOSC, but did include the following:

Reading Overview and Scrutiny Committee
Reading OSC did not consider the Royal Berkshire foundation trust draft quality accounts

Wokingham Involvement Network (Link)
On behalf of Wokingham Involvement Network (Link) I have read the Royal Berkshire NHS Foundation Trust Draft Quality Accounts for 2010/2011 and find them well written and clear to understand.
In particular it is good to see that the discharge processes are being closely monitored as this is an area which in the past has led to many complaints and some confusion. More information, verbal and written, for patients and carers is definitely needed including who/where to contact after the patient has left the hospital.
It is also good to see that the patient experience programme, aiming for better understanding between staff and patients, for both in-patients and out-patients, is being successful and this includes the personal touch of senior staff making phone calls to anyone entering a formal complaint (people like to know their complaint has genuinely been noted).
In general the reports seems well balanced and covers a wide range of monitoring for hospital improvement which, with the accumulation of more data, should enable The Trust to reach its aims.
Again this year Wokingham Link were pleased to be invited to give their views on the Hospital's areas of priority for the coming year

Royal Berkshire NHS
NHS Foundation Trust

Quality Accounts 2010/11

Part 1: Statement on quality

Our Quality Accounts form part of our continual progress to improve our organisational accountability to the public and demonstrate the engagement of the Board and our Governors in the Trust's quality improvement agenda. We have taken this opportunity to review our services with our patient and public stakeholders, identifying where we are doing well and also where improvement is required. The Royal Berkshire NHS Foundation Trust views the NHS services that it provided during 2010/11 as high quality, substantiated by feedback from patient and staff surveys, external monitoring by organisations such as the Care Quality Commission and internal reports to the Board.

We will outline the quality improvements that we plan to make over the next year (2011/12) and provide a retrospective check on how we did during 2010/11.

We are therefore very pleased to have the opportunity to publish these Quality Accounts and to confirm our personal commitment to them.

To the best of our knowledge the information in this document is accurate

Colin Maclean
Chair

Edward Donald
Chief Executive

Jonathan Fielden
Chief Medical Officer

Nigel Davies
Chief Nurse and Director of Public and Patient Affairs

About the Trust

The Royal Berkshire NHS Foundation Trust provides acute medical and surgical services to Reading, Wokingham and West Berkshire and specialist services to a wider population across Berkshire and its borders. Our vision is to deliver the best healthcare in the UK for our patients in our community.

Best patient experience, best healthcare, best value and best place to work, train and learn are principles that run through all our activities, which have quality and safety at their heart. Over the last year we have been implementing the Trust's strategic objectives:

- Developing more services, closer to home: building provision for cancer and renal service delivery in the new Bracknell Clinic
- Investing in success: providing the most efficient cardiology 24/7 service for heart attack patients in the whole of England and Wales
- Sharing and listening: identifying areas for improvement such as timely antibiotics for neutropenic sepsis and disseminating our care bundles to other Trusts to help their patients
- Working together: using the Think Glucose project to ensure patients with diabetes have a smooth journey across the different healthcare organisations
- Exceeding expectations: providing a dedicated triage phone line for mothers who have antenatal queries or who are in labour

Part 2a: Priorities for improvement

Five stakeholder events were held in 2011 providing feedback from 42 people including representatives from trust staff, PCT, LINks, Trust patient panels, Council of governors, Learning Disability Partnership boards and unitary authorities.

The stakeholders ranked the previous years' priorities (2009 and 2010) in the following order:

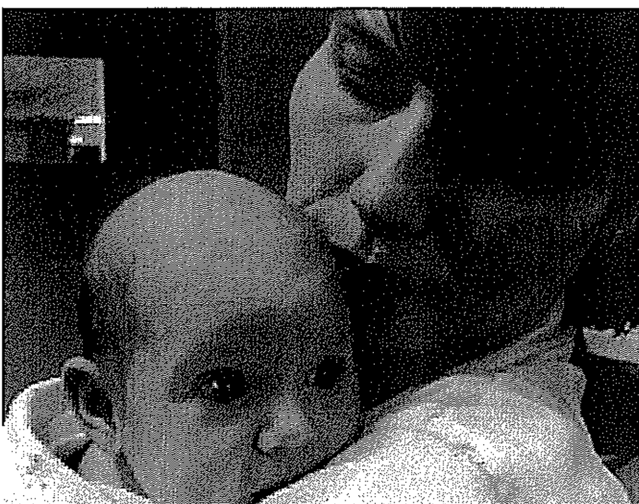
The stakeholders ranked the previous years' priorities (2009 and 2010) in the following order:

Ranked (1st to last)	Priority Description
1	2009/10 Providing a positive patient experience by improving staff attitude and communication
2	2008/09 To reduce healthcare associated infection (HCAI) by exceeding national targets
3	2009/10 Introducing care bundles to reduce mortality
4	2009/10 Preventing Venous Thromboembolism (VTE)
5	2008/09 To increase the quality of care for stroke patients
6	2009/10 Reducing harm from patient falls
Last	2008/09 To increase the number of patients treated by primary angioplasty (PPCI)

In addition the stakeholders were keen that dementia care and a more holistic patient approach featured in the priorities for the coming year.

The following stakeholders were involved as described below:

- Trust's stakeholders, including: Patient Panels, Council of Governors, LINKs, OSCs, LSCBs, LDPBs have suggested priority areas
- Trust patients, public and partner organisations have submitted feedback via a number of mechanisms including the Annual Members Meeting, Pulse magazine, Talk to Us, patient surveys and the NHS Choices website (www.nhs.uk).
- Trust staff and clinical teams have identified quality improvement projects and participated in stakeholder events
- Trust Clinical Governance Board and Patient Safety Council members have identified priority areas and have reviewed the Quality Accounts
- Our Local Involvement Networks (LINks) and Overview and Scrutiny Committee (OSC) have reviewed the Quality Accounts and provided commentary which has been included verbatim



- NHS Berkshire West (our commissioners) have identified quality improvement and innovation goals (CQUINs) within our Quality contract and have reviewed the Quality Accounts and provided commentary which has been included verbatim

A list of seven priorities were reviewed by the Board in February 2011 and were considered against a review of areas identified as needing improvement from the following sources:

- Board Minutes and Integrated Board Report (April 2010-January 2011)
- CQC Quality and Risk Profile (published December 2010)
- National NHS Maternity Survey (2010)
- Inpatient Survey (2010)
- Children and Young People's Inpatient Survey (2010)
- Children and Young People's Outpatient Survey (2010)
- National staff survey (2009)

The Board recommended four priorities, and the final priorities were agreed by our Chief Executive Edward Donald, Chief Medical Officer Jonathan Fielden and Chief Nurse and Director of Public and Patient Affairs Nigel Davies and approved by the Board on 31 May 2011.

Quality Priorities for 2011/2012

1. Providing a positive patient experience by improving communication to inpatients, outpatients, and where appropriate to family and carers, particularly during the discharge process
2. Further reducing the numbers of patients who develop *Clostridium difficile* infection while in hospital
3. Improving care for patients with dementia
4. Reducing harm and mortality from VTE, falls and sepsis

Priority 1: Providing a positive patient experience by improving communication to inpatients, outpatients and where appropriate to family and carers, particularly during the discharge process

Why has this been chosen?

Providing the best possible patient experience is one of the Trust's aims, this was also the main area of focus in all the 2011 Quality Accounts stakeholder events. This priority was identified last year and it is felt that there are still further opportunities for progress, while maintaining the focus on communication it should be expanded to include inpatients, outpatients and the discharge process. Our rolling inpatient survey and those undertaken nationally this year (Inpatient, Maternity, and Paediatrics) show that there is still room for improvement in this area. No one wants to be a patient, so it is really important to us that when you are a patient we can assure you of the best possible service and experience while you are visiting us.

Debbie visited Royal Berkshire Hospital in September 2010 and commented on NHS Choices:

What I liked: "I visited A&E with a very painful torn ligament the doctor was patient helpful and very informative at all times"

What could have been improved: "a smile from other clinicians in the unit would have been nice"

Any other comments: "it was rather dusty didn't help my asthma but this was due to building work, an apology for this would have helped"

The CQC's Quality and Risk Profile records the Trust as Much worse than expected for the "Proportion of Outpatients stating doctors did not listen to what they had to say". The 2010 Children and Young People's Outpatient Survey showed we were significantly worse for the categories: Patient not told that they would have to wait and Parent did not fully know before appointment what was going to happen to their child. The Trust has over 500,000 outpatient clinic appointments each year, so these communications impact on a significant number of patient experiences.

Anonymous visited Royal Berkshire Hospital in Feb 2010 and commented on NHS Choices:

What I liked – "Nothing. Outpatients was crowded and disorganised. Despite a notice saying the appointment schedule was on time I was kept waiting an extra half hour. I was then kept waiting two hours for pre-operation screening. The doctor was unfriendly, unsympathetic and clearly disinterested in myself as a patient despite the fact that they were delivering the news that I had been diagnosed with cancer."

What could have been improved – "Better systems for processing patients. Should not be kept waiting for two hours."

Any other comments – "Better training for doctors so that they treat patients with more respect."

Transferring patients from hospital to a more appropriate setting as soon as they are well enough is in the best interest of the patient. In order to do this we need to work as part of a system and at present pressure remains on nursing and residential home placement with some shortage of domiciliary care in West Berkshire and Oxfordshire.

This means we are not meeting the national performance indicator for delayed transfers of care. We have also received complaints from patients about delays in our discharge processes.

During 2010, we worked with NHS Berkshire West to release some additional funding for care outside of the hospital setting, but despite the success of this project, we have needed to impose a fine on some local authorities for not enabling patients to move out of the Trust on time.

During the Council of Governors Quality Accounts Stakeholder event issues were raised concerning delays in patient transport away from the hospital which have led to patients waiting to go home.

In the 2010 Inpatient Survey, our results showed that we had significantly improved in 9 areas which included providing patients with copies of the discharge letter sent to their GP. However, despite this positive progress, there are some areas identified in the survey where we still need to make improvements in the information given by us to our patients during the discharge process. The survey showed that we were significantly worse in the following areas: Did not feel involved in decisions about discharge from hospital; Family not given enough information to help; Not fully told of danger signals to look for; and patients were delayed. We need to improve our discharge so that patients can return home more quickly, with the right medication and better information.

What indicators will help us to measure this?

To allow us to measure patient experience, we will be reviewing the responses to those questions in our rolling inpatient survey that reflect "responsiveness to personal needs of patients".

Five of these questions form part of our PCT's potential CQUIN (Commissioning for Quality and Innovation) payment for 2011/12.

- Involved as much as desired in decisions about care and treatment
- Satisfaction that they had member of staff to talk to about worries and fears Satisfaction that they had enough privacy when discussing condition/ treatment
- Informed about medication side effects (this relates to discharge)
- Informed who to contact if worried about condition after leaving hospital (this relates to discharge)

We will measure outpatient did not attend (DNA) rate, outpatient cancellation rate, and waiting times via the development of our newly introduced rolling outpatient survey. We will continue to measure National performance indicator for delayed transfers of care.

What improvements are we going to make?

Patient Experience

We are continuing to develop our patient experience programme, rolling out a number of strategies to help staff engage with and better understand the needs of our patients. Part of this approach has involved the presentation of patient stories to the Board each month and the expansion of the weekly Executive Team Walkarounds, so that the focus now alternates between patient safety and patient experience. Leadership of measures to improve patient experience will be enhanced

through the engagement of all directors and senior managers by personal telephone calls to anyone making a formal complaint, manning the PALS telephone line and Matron's ward rounds. The information generated is fed back into the Patient Experience Steering Group and to the wards and outpatient areas on the new "Experience Boards" that will be going up across the Trust.

We will continue to survey patients throughout the year asking key questions about their experience of the care we have provided. In 2011, we will increase the ways in which we do this with separate surveys conducted for inpatients, outpatients, people attending the emergency department and women using our maternity services. We will also use different ways to obtain this information including volunteers asking patients, feedback kiosks located in prominent areas of our hospitals, through the internet and telephone surveys.

We continue to provide the best possible information for patients in a variety of formats and media. Our patient information is developed in collaboration with clinicians and our patients who are part of our reader register.

Patient Safety

The Patient Safety Team is using patient stories in training DVDs to help staff better understand the patient's experience and the longer term effects that can result from issues such as pressure ulcers.

Pharmacy will be improving timeliness of the provision of medications for patients to take home (TTOs) when they are discharged. In part, this will be driven by the discharge team who identify patients for discharge 24-hours ahead of discharge where possible, this then enables the wards to arrange for TTOs to be prescribed by the doctors so that Pharmacy can dispense them promptly.

Clinical Effectiveness

The Trust has recognised that we have challenges with providing a good Outpatient experience and has set up an improving patient experience within outpatient areas group to review the issues and implement changes. Their work focuses particularly on outpatients 1 & 2, orthopaedic and facture clinics and the data from the Quality Account indicators will help to measure the improvement process. Areas for focus in 2011/12 include:

- Working to display electronic notice boards, which will ensure a standard approach to the information displayed.
- Redesign options are being considered for South Block including the fracture clinic with a project plan being developed for redecoration and building work for new reception and waiting areas.
- Patient transport services are contracted via the Berkshire Shared Services to South Central Ambulance Service. We are in discussion as to the most appropriate way forward to ensure timely transport away from hospital for our patients.

How will we show change?

Our aim is to: Increase the inpatient experience (measured in the rolling inpatient survey) in each of the following five areas by meeting the 2011/12 CQUIN indicator by March 2012. The indicator will be a composite, calculated from these 5 survey questions on the National inpatient survey.

Survey Question	% RBFT inpatients Data from Rolling inpatient Survey 2010/11	% RBFT inpatients Data from National 2010 Inpatient survey	% Picker Average Data from National 2010 Inpatient survey
Involved as much as desired in decisions about care and treatment	84	50	54
Satisfaction that they had member of staff to talk to about worries and fears (discuss concerns with)	82	42	43
Satisfaction that they had enough privacy when discussing condition/treatment	88	70	72
Informed about medication side effects (this relates to discharge)	68	53	54
Informed who to contact if worried about condition after leaving hospital (this relates to discharge)	42	76	79

The information will be obtained from the Patient Relations Department from the rolling inpatient survey and from the National inpatient survey undertaken by Picker. Monitoring of the information will be reported via the monthly Integrated Board Report (IBR 2.4).

Our aim is to: Reduce the number of outpatient appointments cancelled as DNA (Did not attend) by the patient (currently 6.90%), or the Trust (currently 31.80%) by 2% by March 2012. The information will be obtained from the Commercial Department from the Trust information systems. Monitoring of the information will be reported via the monthly Integrated Board Report (IBR 1.2).

Our aim is to: Measure the waiting time in outpatient clinics by March 2012. The information will be obtained from the Patient Relations Department from the rolling outpatient survey. Monitoring of the information will be reported via the monthly Integrated Board Report.

Priority 2: Further reducing the numbers of patients who develop *Clostridium difficile* infection while in hospital

Why has this been chosen?

The 2011 Quality Accounts stakeholders identified infection prevention and control as an area of great concern to patients, their families and carers. *Clostridium difficile (C. diff)* was a particular focus of the LINKs and patient panels during the stakeholder events. *C. diff* has been identified in Board papers and by the Care Quality Commission in their Quality and Risk Profile of the Trust.

The Trust has developed a zero tolerance approach to infection prevention and control which has meant for the past year that there have been no cases of hospital acquired MRSA. We would now like to achieve similar success with managing C. *diff.*

C. *diff* can cause diarrhoea, ranging from a mild disturbance to a very severe illness which can sometimes be fatal. Generally, C. *diff* is a risk when the normal, healthy intestinal bacteria have been killed off by antibiotics. Most of those affected are elderly patients with serious underlying illnesses who have needed treatment with antibiotics. The spread of these infections can usually be prevented by practising good hygiene, such as washing hands regularly and cleaning surfaces.

The Trust introduced a new "gold standard" testing algorithm for *Clostridium difficile* in 2009. This has resulted in increased numbers of cases being detected compared to other trusts who do not report against new testing methods.

Essentially the new testing method identifies a proportion of cases based on C. *diff* toxin being present (this is the same as the 'old' test) but also identifies additional cases through culture of the specimen. The table below breaks down the cases for the baseline period of October 2009 – September 2010. This shows that if we had continued to use the "old" test only then we would have reduced to 53 cases. Compared to other trusts this would have placed us in the best performing 25% of large acute trusts in the country.

Cases of C. *diff* (48 hrs post admission) Oct 2009 – Sept 2010

	Actual number of cases	Rate per 10,000 bed days	Position/ Rank compared to other Large Acute Trusts
Identified through presence of toxin (CDT)	53	2.48	10 out of 40
Identified through additional culture of specimen	69	-	-
Total cases (with new test)	122	5.62	38 out of 40

Despite this, we have still met the 2010/11 reduction target agreed with our PCT commissioners. However, we fully recognise that any *C. diff* infection has a significant impact on the lives of our patients and so we are taking a very robust approach to its management within the Trust.

Anonymous visited Royal Berkshire Hospital Maternity services in October 2010 and commented on NHS Choices:

What I liked: "I was referred for consultant care by my GP following complications in a previous pregnancy. The consultant I saw was very knowledgeable and able to put my concerns at ease. I had a number of detailed ultrasound scans and the staff in that area were extremely professional and skilled. I have since attended for an anti-d injection and the clinic was run very efficiently with no delays. Everything was clean and staff paid particular attention to handwashing which I was impressed by."

What indicators will help us to measure this?

We will be measuring the responses in our rolling patient survey to the question: Rating of cleanliness of hospital area, room or ward. We will be monitoring the incidence of infection during a hospital stay (classified as an infection that occurs 48 hours post-admission) for *C. diff.*

What improvements are we going to make?

Patient Experience

Information is provided to patients and visitors on good hand hygiene, our visiting policy along with explanations of how we manage cases such as *C. diff.* We are looking into developing further training resources that will include using a patient story to further engage staff with the debilitating effects from *C. diff* that can continue for the patient after discharge from hospital.

Patient Safety

Annual staff training in infection prevention and control is mandatory for all, whether clinical or non-clinical and the incidence data from 2010/11 will be fed into this training to further emphasise the importance of hand washing.

Clinical Effectiveness

We reduced our incidence of *C. diff* in September 2010 following our targeted deep cleaning programme for those wards where we had had outbreaks. We will continue to add in these targeted deep cleans during 2011/12, as well as providing an extra deep clean of all wards over the summer.

How will we show change?

Our aim is to: Monitor the patient experience in rating of cleanliness of hospital area, room or ward. Currently 93% of patients surveyed during their stay (via the rolling inpatient survey) stated that their room or ward is clean, the data from national 2010 Inpatient survey, show that 97% of Trust inpatients rated their room or ward clean (which is better than the 96% national average).

The information will be obtained from the Patient Relations Department from the rolling inpatient survey and from the national inpatient survey undertaken by Picker. Monitoring of the information will be reported via the monthly Integrated Board Report (IBR 2.4).

Our aim is by March 2012 to: Reduce by 20% the number of patients who develop *Clostridium difficile* infection (classified as an infection that occurs 48 hours post-admission). This 20% reduction is equivalent to reducing to 96 cases. There were 121 cases in 2010/11. The Trust will still report nationally against a Department of Health objective of 77 cases, equivalent to a 36% reduction. An upper threshold of 96 cases has been agreed locally to take into account the increased sensitivity of the multi-step (toxin and culture) *C. diff* testing regime.

The information will be obtained from the Infection Prevention and Control Team who review and record all infections. Monitoring of the information will be reported via the monthly Integrated Board Report.

Priority 3: Improving care for patients with dementia

Why has this been chosen?

Dementia is a common condition affecting 570,000 people in England and this number is expected to double over the next 30 years. Dementia is one of the conditions that affects our patients usually in addition to other health issues. The Department of Health publication in November 2010: 'Nothing Ventured, Nothing Gained': Risk Guidance for people with dementia has helped to clarify how we can assist patients in the most relevant ways. This places a challenge on us to provide a holistic patient approach and a smooth healthcare pathway that ensures our patients receive the right care, from the right professionals at the right time.

The 2011 Quality Accounts stakeholders, in particular members of the patient panels were keen that Dementia care and the holistic patient journey were reflected in the Quality Accounts. This priority has also been championed by the Trust's Dementia Steering Group which is a multi-disciplinary, multi-organisational team. Improving care for patients with dementia was also suggested by staff as one of this year's priorities and fits well with some of the development work we are implementing.

What indicators will help us to measure this?

We will measure the number of patients clinically coded as having dementia, the number of patients referred to OPMHLT (Older People's Mental Health Team), the number of staff trained in Dementia awareness and the number of reported adverse incidents that happen to patients with dementia.

What improvements are we going to make?

Patient Experience

As part of Dementia treatment strategies we are implementing "Dementia Resource Tables" in a number of Elderly Care wards that can help stimulate people, so that they are able to cope better with their symptoms and so improve their quality of life.

Patient Safety

Patients with dementia may have problems controlling their emotions or may behave inappropriately. This can present a challenge to staff and other patients, as well as having a direct effect on the safety of the patient with dementia. The implementation of the Behavioural & Psychological Symptoms in Dementia (BPSD) care bundle for relevant patients will be rolled out throughout Elderly Care to ensure that patients are carefully reviewed against standard criteria to minimise their symptoms by providing the most appropriate treatment. A care bundle is a checklist for a specific condition of five to ten key treatment steps, ensuring that each patient gets the right treatment at the right time.

Clinical Effectiveness

Training of staff in Dementia awareness will result in a better understanding of the condition and a more holistic approach to the patient. This programme is being driven by the Dementia Steering Group, which has very active participation from patients, their families and carers. This will be developed further by the OPMHLT (Older People's Mental Health Team) as they are able to undertake neuropsychological and other relevant assessments.

How will we show change?

Our aims by March 2012 are to:

- Increase the number of staff trained in Dementia awareness by 25%
- Measure the number of patients clinically coded as having dementia
- Measure the number of reported adverse incidents that happen to patients with dementia
- Measure the number of patients with dementia who are referred to OPMHLT (Older People's Mental Health Team)

The clinical coding data will be collated by the Commercial Department, and the adverse event data will be collated by the Patient Safety Team. The number of patients seen by the OPMHLT and number of staff trained will be collated by the OPMHLT and all data reported to the Dementia Steering Group. Monitoring of the information will be reported via the monthly Integrated Board Report.

Priority 4: Reducing harm and mortality from VTE, falls and sepsis

Why has this been chosen?

The risk of developing a blood clot in hospital is 1000 times greater than air travel. In the UK it is estimated that 25,000 people die each year from hospital-acquired blood clots known as Venous Thromboembolism (VTE). VTE is a serious problem which the 2011 Quality Accounts stakeholders felt should not be withdrawn from the priorities, but should be one of the indicators in the priority to reduce harm and mortality. Maintenance of VTE risk assessment in at least 90% of patients also forms part of our PCT's potential CQUIN payment for 2011/12.

Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year. While falls reduction was also a priority in last year's Quality Accounts and great progress has been made at the Trust, we have still not significantly reduced the number of falls. So once again falls will be part of the Quality Accounts, particularly in relation to addressing ways to prevent falls resulting in serious injury and death, which is in line with the recent National Patient Safety Agency (NPSA/2011/RRR001) alert on essential care after an inpatient fall.

Sepsis is one of the world's oldest and most virulent killers, with an estimated worldwide mortality of 1,400 people every day. Sepsis is a syndrome characterised by the body's response to infection, which can rapidly lead to organ failure and, ultimately, death. Sepsis is a medical emergency just like a heart attack or a stroke because there is an interruption of oxygen and nutrients to the tissues including the vital organs such as the brain, intestines, liver, kidneys and lungs. Sepsis needs to be recognised quickly by staff in the Emergency Department and the Clinical Decision Unit (CDU) and responded to promptly by treatment with antibiotics. Sepsis has been prioritised by the Trust's Prevent Harm from Deterioration Group.

What indicators will help us to measure this?

We will be measuring the percentage of patients who have a VTE risk assessment, the percentage of appropriately prescribed and administered prophylaxis and the number of patients who develop VTE in hospital. We will measure the percentage of completed falls care bundles, the number of falls per 100,000 bed days and the number of serious falls. For sepsis, we will measure the elements of completed sepsis care bundles in CDU and the percentage of patients in CDU who receive timely antibiotics within one hour of recognition.

What improvements are we going to make?

Patient Experience

Reducing the risk of developing VTE for our patients will mean that we can reduce the likelihood of future health-related issues such as the development of leg ulcers. If we can reduce the number of patients who fall, we will reduce some of the fear of falls which will enable our patients to mobilise and so have more fulfilling lives. This will also mean patients are discharged as planned and not delayed and so avoiding increased lengths of stay.

Patient Safety

The falls policy will be amended to include recommendations in the Essential care after an inpatient fall NPSA's guidance. This will require further staff training, but is expected to facilitate a reduction in patient harm. Recognising and reacting quickly to sepsis is a crucial element of the emergency pathway. The Trust is part of the Surviving Sepsis Campaign but has identified that we need to re-focus on the recognition of sepsis, especially in light of the recent HSJ Patient Safety award for the administration of timely antibiotics to patients with neutropenic sepsis (a complication of chemotherapy). We are introducing a sepsis care bundle and have added sepsis recognition to our staff training.

Clinical Effectiveness

The updated VTE risk assessment has already been introduced. Further review of appropriately prescribed and administered prophylaxis and feedback to staff of the audit data will help to improve risk reduction. An easily accessible online training package will be developed to include assessments for nurses and junior doctors.

How will we show change?

Our aim by March 2012 is to:

- Reduce the number of patients who develop VTE in hospital by 25%
- Maintain VTE risk assessments for at least 90% of our patients
- Measure the % of patients (via point prevalence audits) who have appropriately prescribed and administered prophylaxis.

The data on risk assessments and incidence will be obtained from the Commercial Department from the Trust information systems. The point prevalence audit data will be determined by healthcare records review by the Clinical Audit Team. Monitoring of the information will be reported via the monthly Integrated Board Report.

Our aim by March 2012 is to:

- Reduce the number of serious falls by 5%
- Maintain 80% completion of the falls care bundles (measured via point prevalence audits)
- Measure and report on falls per 1,000 bed days

The information will be obtained from the matrons ward audits, collated by the head of nursing standards. Monitoring of the information will be reported via the monthly Integrated Board Report.

Our aim by March 2012 is to:

- Increase the completion of the sepsis care bundles to 80% for those patients identified as having sepsis (measured via point prevalence audits in CDU)
- Measure the % of patients who receive antibiotics within one hour of recognition of sepsis (measured via point prevalence audits in CDU)

The information will be obtained from the Surviving Sepsis Group audits, collated by the head of nursing standards. Monitoring of the information will be reported via the monthly Integrated Board Report.

Part 2b: Board Quality Assurance Statements

Quality Assurance Statements on specified areas are provided as part of the Quality Accounts to ensure that the accounts are comparable between organisations. These also provide assurance that the board has reviewed and engaged in initiatives that link strongly to quality improvement. These statements are available in Appendix 1.

Part 3: Review of Quality Performance 2010/11

Quality priorities and their associated indicators identified in previous years will continue to be monitored and reported in the annual Quality Accounts. Three of the quality priorities from 2010/11 have been incorporated into the priorities for 2011/12 to ensure that the initial momentum is not lost and that further improvement is achieved. The care bundles specified in priority 4 will not contribute directly to the 2011/12 priorities as it was felt more pertinent to monitor the prevention of VTE, falls and sepsis as mechanisms for reducing harm and mortality. Where data sources for the indicators are governed by standard national definitions this is shown by reference to the relevant external source which is marked *.

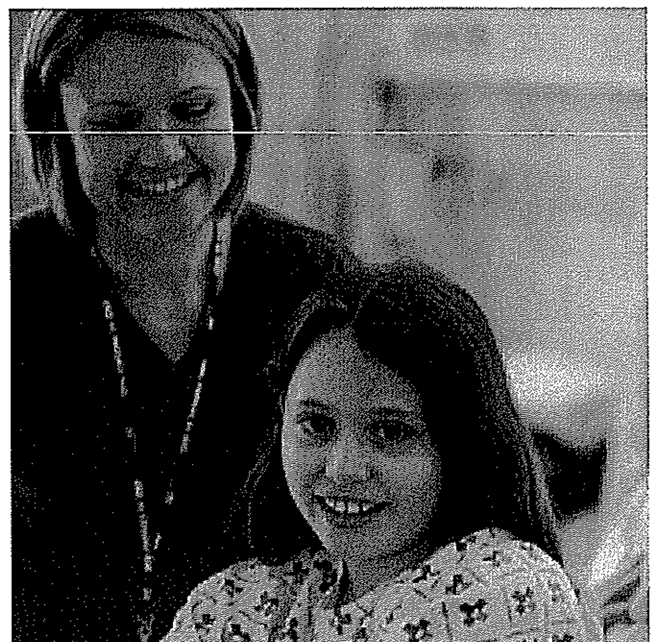
Review of Quality Priorities from 2010/11

Priority 1: Providing a positive patient experience by improving staff attitude and communication

We have developed our patient experience programme over the year, which has included very active complaints management at ward level to review issues and plan improvements. Together with the implementation of the rolling inpatient survey, in which over 3,500 patients have participated during 2010, these data are fed back to the wards by the patient experience team.

The views of patients, their families and carers who use our services are extremely important to us. During 2010, we have developed our virtual surveys so that patients, their families and carers can tell us their views by completing an online survey - either via touch screens in the Information Zone and near Maternity Reception or by visiting the Trust website www.royalberkshire.nhs.uk/surveys.

Our priority for last year was to reduce the numbers and percentage of complaints relating to attitude, communication and behaviour by 25% comparing the figures for January – March 2010 to the same period next year. We aimed to increase the percentage of patients who rated staff as understanding and compassionate from 87% to 90% in the Patient Survey. The data are presented on the next page.



Priority 1 Indicators	Data 2009/10	Target 2010/11	Data 2010/11
Number of formal complaints relating to attitude, communication and behaviour	51 (Jan-Mar)	38 (Jan-Mar)	22
% of formal complaints relating to attitude, communication and behaviour	35% (Jan-Mar)	26% (Jan-Mar)	24% (22/90)
% of patients who rated staff as understanding and compassionate (Source rolling inpatient survey)	87%	90% (Apr 10 – Jan11)	89%

Priority 2: Preventing Venous Thromboembolism (VTE)

In June 2010, we started using the Department of Health's updated VTE risk assessment. Alongside this we developed mechanisms to log risk assessment completion electronically, to enable us to record VTE risk assessments for all our inpatients and day case patients. This included recording and submitting the data to Unify* (Department of Health) to provide evidence for the CQUIN.

In addition, the development of electronic data collection has meant that we also have a mechanism to feed the results directly to the clinicians on the wards and this is what has helped us to increase the numbers of patients who have received a VTE risk assessment.

Our priority for last year was to increase use of VTE risk assessments from 65% to 90% and reduce the numbers of patients who develop VTE in hospital by 25%. The data are presented below.

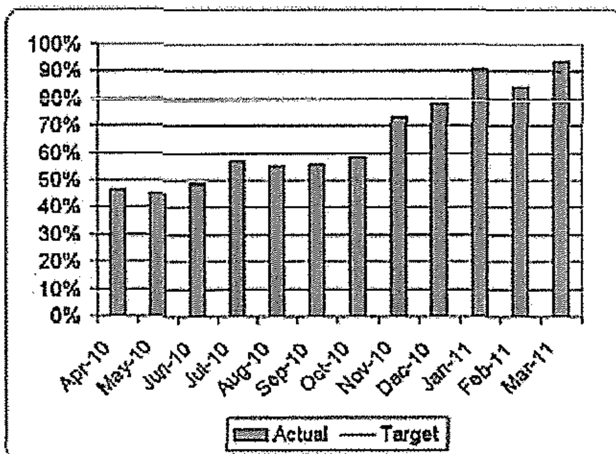


Figure showing Percentage of inpatients and daycase patients with completed VTE Risk Assessments per month

As can be seen we have progressed from electronically risk assessing just over 40% of our patients, to achieving just over 90% VTE risk assessment, which also means we have met the national target.

We have also amended the drug chart to include a pre-printed section for prescribing the drug Tinzaparin, which helps to prevent VTE. The increased awareness of VTE, through the introduction of the newer risk assessment in June, has had a significant effect on the numbers of patients who have developed VTE in hospital and has enabled us to reach the target of over 25% reduction from 138 to 99.

Priority 2 Indicators	Data 2009/10	Target 2010/11	Data 2010/11
% of patients (inpatients and daycases) with a completed VTE risk assessment	65%	90% (Jan-Mar 11)	90.05% (16629/18466)
Number of patients who developed VTE in hospital (Source clinical coding data post admission)	138	104 (25% reduction)	99

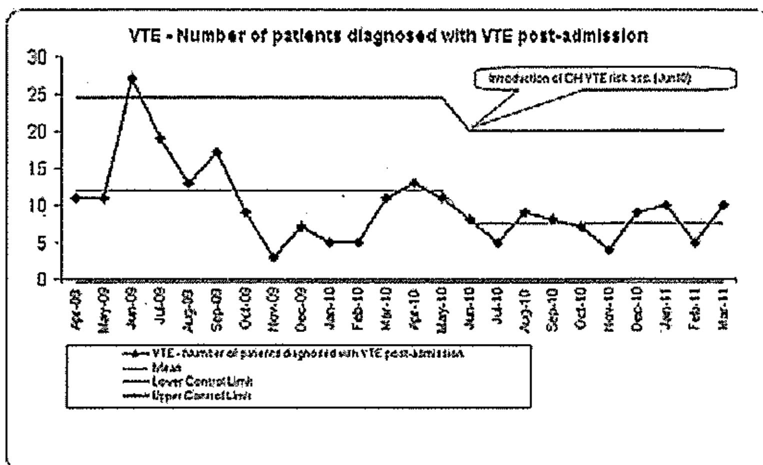


Figure showing number of patients diagnosed with VTE after admission to hospital, as recorded by clinical coding

Priority 3: Reducing harm from patient falls

In April 2010, we introduced the Falls Care Bundle across the Trust. It has been challenging to ensure completion of this care bundle, due to its multi-disciplinary nature. However, the Falls Steering Group and Matrons have monitored the bundle each month and encouraged staff to fully complete the bundle.

Our priority for last year was to successfully introduce the Falls Care Bundle. Therefore, we were measuring compliance with completion of each of the 10 key areas in the bundle. We were aiming for 80% of these care bundles to be fully completed by March 2011. We promised to continue to measure the number and seriousness of falls that occur, benchmark our progress against other NHS trusts and report this in this year's Quality Accounts. The data are presented below and in the Performance table. Whilst the number of serious falls (defined by the NPSA* as falls resulting in severe harm or death) has reduced there has been an increase in the number of falls, this is thought to be due to increased awareness, better reporting and interventions reducing the severity of falls.

Priority 3 Indicators	Data 2009/10	Target 2010/11	Data 2010/11
% completed falls care bundles	none	80% (Mar-11)	92%
Number of falls	1454	Provide data	1547
Number of serious falls	25	Provide data	20

However, we still need to reduce the number of falls and during 2011/12, so we will continue to monitor the use of these care bundles and have a Patient Safety Hot Topic on Falls (to include awareness raising and practical falls prevention) at the end of August and beginning of September 2011.

Priority 4: Introducing care bundles to reduce mortality

We have now introduced a total of 16 care bundles across a number of different areas in the Trust.

Our priority for last year was to introduce four specific care bundles for: acute myocardial infarction, heart failure, naso-gastric tube placement and central venous catheter insertion. Following this, we measured compliance with completion of the key treatment steps in the bundles. We aimed to treat all relevant patients using the care bundles and have a minimum of 60% of relevant patients with fully completed care bundles by March 2011. We also committed to reporting on the Trust's HSMR (Hospital Standardised Mortality Ratio*) and our progress towards our target of 75. The data is presented on the next page.

Priority 4 Indicators	Data 2009/10	Target 2010/11	Data 2010/11
Acute myocardial infarction % completed care bundles	Zero	60% (Jan-Mar-11)	96.6% (Jan-Feb11)
Heart failure % completed care bundles	Zero	60% (Jan-Mar-11)	51.1% (Jan-Feb11)
Naso-gastric tube placement % completed care bundles	Zero	60% (Jan-Mar-11)	50% (10 patients audited)
Central venous catheter insertion % completed care bundles	Zero	60% (Mar-11)	64% (29/45)
Hospital Standardised Mortality Ratio (HSMR) rolling 12 months	102.4	75	92.3

Acute myocardial infarction (AMI)

At the start of last year the data collection mechanism for the key steps in AMI treatment was reviewed and it was decided to use an electronic care bundle to capture the data. This is tied into the National MINAP audit and has worked well, as can be seen we achieved 96.6% completion of the care bundle. This care bundle is also linked to one of our CQUIN targets.

Heart failure (HF)

This care bundle has proved the most challenging to implement, most frustratingly because the paper copy of the bundle is only placed into the patient's healthcare record for about a third of the relevant patients. We have found that the key elements in the bundle are being completed more frequently. Following this audit, and in order to improve our quality of care for our heart failure patients in 2011 we will be providing a heart failure nurse to ensure the appropriate level of care and will be monitoring the key steps by developing an electronic version of the care bundle.

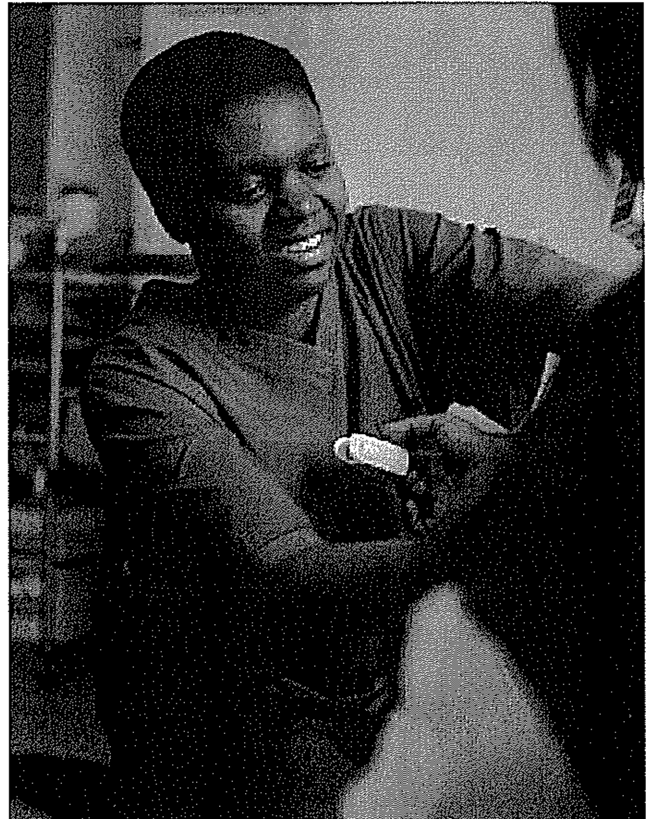
Naso-gastric tube placement (NG)

These care bundles were tested and then piloted on the Stroke unit during 2010/11. NG tube risk assessments were completed for 10 patients on the Stroke unit during Jan-Mar 2011, resulting in a decision to feed by NG which was documented in notes. For all 10 patients care bundles were started and 50% were fully completed. The area of incompletion was around daily review by nursing and medical staff. It is felt that it is not practical to record a daily review on a once-only use care bundle, so the format is under review for this year.

Central venous catheter insertion (CVC)

These care bundles were piloted in the following areas: Emergency department, Victoria Whitely, Theatres 12 and 2. Data were reviewed from 45 sets of patient healthcare records. It was apparent that there were some issues with the interpretation of the key steps in the care bundle and that in particular step 8 is not applicable to all CVC insertions and has thus been excluded from the analysis of care bundle completion. With this exclusion, a care bundle completion rate of 64% (29/45) was obtained.

The Hospital Standardised Mortality Ratio (HSMR) is used as the national measure of mortality, which is one way of reviewing the quality and safety of hospital services. We are aiming to reduce our HSMR to 75 over the next five years. We have reduced our HSMR this year to 92.3, though this will change with the annual re-benchmarking undertaken nationally in October 2011.



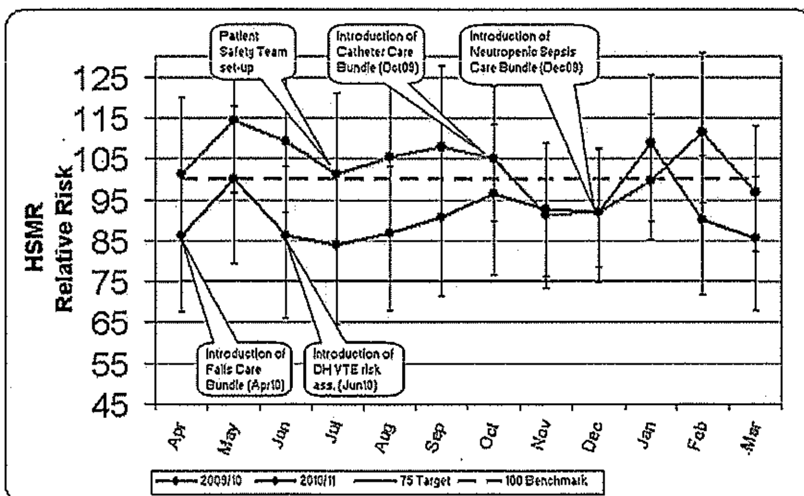


Figure showing HSMR relative risk per month over the last two years

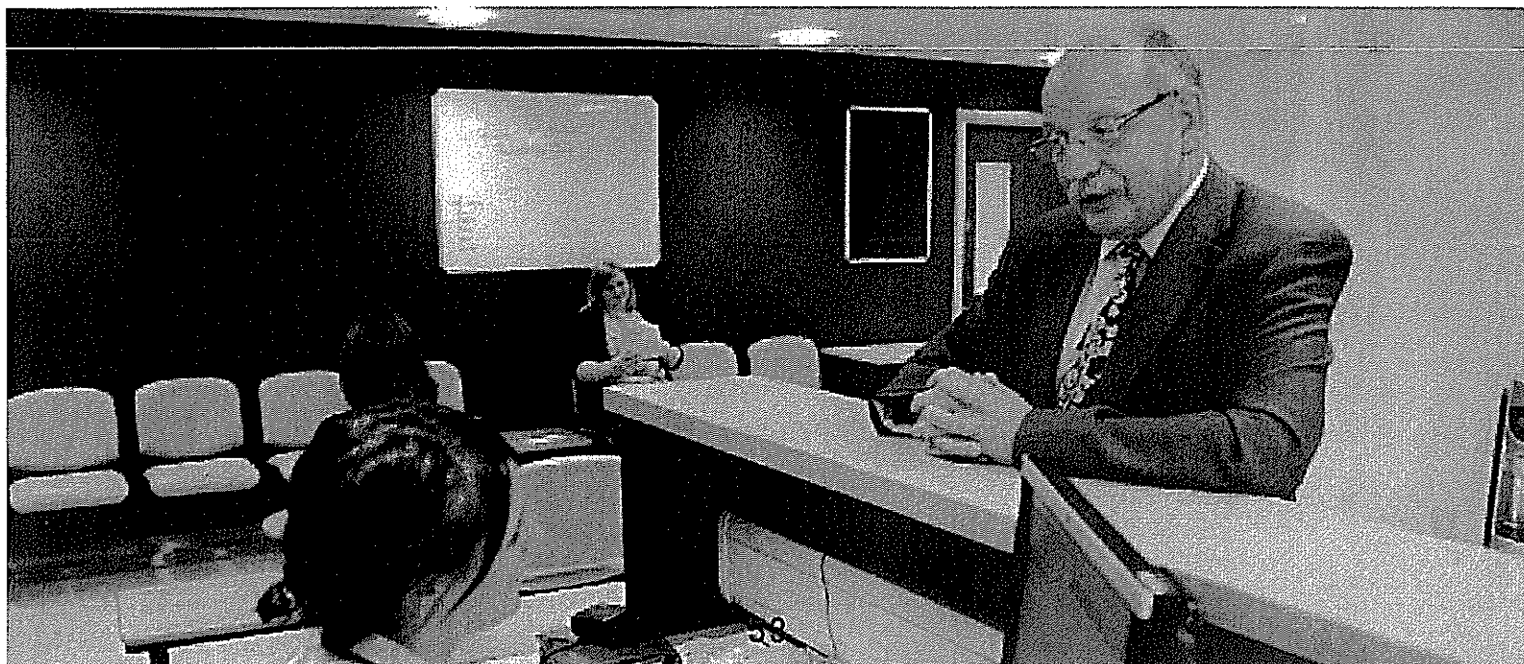
Performance against selected Trust indicators during 2010/11

We have maintained the same reporting as last year in order to track our progress, and have added further indicators published in previous year's Quality Accounts.

Indicator	Data Source/ Rationale	2010/11	2009/10	2008/09	National Average
Patient Safety					
1. Mortality – Hospital Standardized Mortality Ratio (HSMR)	Dr Foster Intelligence* (IBR 1.1)	92.3	102.4	108.4	100
2. Incident reporting rate (incidents reported per 100 admissions)	National Patient Safety Agency* (NPSA)	5.82	5.2	4.56	5.25
3. Staff who said that they had seen at least one error, near miss or incident that could have hurt staff or patients in the last month	National Staff survey *	35%	38%	33%	37%
4. MRSA bacteraemia (numbers)	Trust data submitted to HPA* (IBR 1.1) 2009/10 Priority	0	8	8	Data not yet available
5. *Clostridium difficile* (numbers)	Trust data submitted to HPA* (IBR 1.1) 2009/10 Priority	121	107	70	Data not yet available
6. VTE risk assessments %	Trust data submitted to Unify* (IBR App1) 2010/11 Priority	90.05%	65% (audit data)	No data	unknown
7. Patients who develop VTE in hospital (based on clinical coding)	Trust data 2010/11 Priority	99	138	150	unknown
8. Falls Care Bundle completion %	Trust data 2010/11 Priority	92%	No data	No data	Not relevant
9. Falls per 1,000 bed days	Trust data* (IBR 1.1) 2010/11 Priority	7.10	7.01	No data	5.6
10. Serious falls (according to NPSA definition: severe harm and death)	Trust data* (IBR 1.1) 2010/11 Priority	20	25	No data	unknown
11. Serious incidents (according to NPSA definition: severe harm and death) %	Trust data submitted to NPSA* Requested by Stakeholders 2011	0.51%	0.29%	No data	0.75%

Indicator	Data Source/ Rationale	2010/11	2009/10	2008/09	National Average
Clinical Effectiveness					
12. Patients treated for more than 50% of their stay in the Stroke Unit	National Audit Sentinel	Indicator retired	Data not collected	85%	54%
13. Stroke patients who spend more than 90% of their time on the stroke unit	Trust data* 2009/10 Priority	79%	60%	No data	unknown
14. Patients who have a high risk TIA (mini stroke) who are seen and treated within 24 hours	Trust coded data* (CPI35) / Vital Signs	88.6% (Jan- Mar11 average)	68%	67%	25%
15. Breastfeeding initiation	Trust data* submitted to CQC	78.60%	79.11%	77.78%	71.00%
16. Patients treated by primary angioplasty (PPCI)	Trust data* submitted to MINAP 2009/10 Priority	98.8%	98.7%	No data	unknown
17. Call-to-Balloon target of less than 120 minutes	Trust data* submitted to MINAP 2009/10 Priority	93.9%	94.9%	No data	unknown
18. Door-to-Balloon target of less than 60 minutes	Trust data* submitted to MINAP 2009/10 Priority	90.4%	91.2%	No data	unknown
19. Patients presenting with a stroke or query stroke who are scanned within 24 hours of admission %	Trust data* 2009/10 Priority	93%	68%	No data	unknown
20. Patients diagnosed with stroke receive early multidisciplinary assessment – to include swallow screening (within 24 hours) and identification of cognitive and perceptive problems (within 4 working days).	Trust data* 2009/10 Priority	100%	95% 85%	No data	unknown

Indicator	Data Source/ Rationale	2010/11	2009/10	2008/09	National Average
Clinical Effectiveness Cont...					
21. Patients who receive 45 minutes daily of therapy as clinically appropriate (physiotherapy, speech and language therapy and occupational therapy) %	Trust data* 2009/10 Priority	86.2%	71%	No data	unknown
22. Acute myocardial infarction care bundle completion %	Trust data 2010/11 Priority	96.6% (Jan-Feb11)	No data	No data	Not relevant
23. Heart failure care bundle completion %	Trust data 2010/11 Priority	51.1% (Jan-Feb11)	No data	No data	Not relevant
24. Naso-gastric tube placement care bundle completion %	Trust data 2010/11 Priority	50% (10 patients audited)	No data	No data	Not relevant
25. Central venous catheter insertion care bundle completion %	Trust data 2010/11 Priority	64% (29/45)	No data	No data	Not relevant
26. Normal birth rate %	Trust data* (IBR 2.9) Requested by Stakeholders 2011	60% (Mar-11)	54% (Mar-10)	Data not available	Data not available
27. Caesarean section rate %	Trust data* (IBR 2.9) Requested by Stakeholders 2011	27% (Mar-11)	30% (Mar-10)	Data not available	Data not available



Indicator	Data Source/ Rationale	2010/11	2009/10	2008/09	National Average
Patient Experience					
28. Patients who would recommend this hospital to their family and friends	National inpatients survey*	94%	93%	94%	94%
29. Patients who reported they were treated with respect and dignity	National inpatients survey*	80%	79%	82%	80%
30. Patients who felt that the hospital (room or ward) was clean	National inpatients survey*	97%	96%	97%	96%
31. Patients who reported that they were able to find a convenient place to park	National emergency patients survey	Indicator retired	Data not collected in survey	83%	74%
32. Complaints relating to attitude, communication and behaviour %	Trust data 2010/11 Priority (IBR 2.5)	24%	35%	No data	unknown
33. Diversions to other Maternity units (number)	Trust data Requested by Stakeholders 2011	38	17	No data	unknown
34. Ambulance handover in ED, compliance with 15 minute target for Emergency Calls	SCAS data Requested by Stakeholders 2011	55.58% (Mar-11)	No data	No data	unknown
35. Medical outliers in surgical beds	Trust data (BedMan) Requested by Stakeholders 2011	111 (Mar-11)	No data	No data	unknown

Performance against National Priorities and Core Standards*

National Standards/Priorities/Commitments	2010/11	2009/10	2008/09	2010/11 Target
Compliance with Core Standards as declared to the Care Quality Commission	Indicator removed As now registered without conditions	24/24	24/24	Indicator removed
18 week referral to treatment waiting times % of patients who were admitted who waited 18 weeks or less	Q1:94.46% Q2:93.50% Q3:93.54% Q4 93.5%	Q1:94.79% Q2:94.13% Q3:91.69% Q4:92.6%	92.30% 99.80%	Not yet published Data completeness 80-120%
% of non admitted patients with completed pathways, plus the total number of direct access audiology patients with completed pathways who were admitted who waited 18 weeks or less	Q1:99.50% Q2:99.08% Q3:99.206 Q4 98.89%			
A&E waiting times	97.93%	98.85%	99.62%	>=95%
Access to genito-urinary medicine (GUM) clinics	100%	100%	100%	>=98%
Access to healthcare for people with a learning disability	Indicator removed	4/4 scored for 3 indicators 3/4 scored for 2 indicators 2/4 scored for 1 indicator	New target	Indicator removed
Cancelled operations % Operations cancelled on day of operation or after admission, cancelled by hospital for non-clinical reasons	0.43%	0.89%	0.19%	<=0.8% cancelled
% Patients not treated within 28 days of cancelled operation	3.11%	10.78%	4.76%	<=5% breaches

National Standards/Priorities/Commitments	2010/11	2009/10	2008/09	2010/11 Target
Cancer diagnosis to treatment waiting times (31 days)				
% Patients receiving their first definitive treatment within 31 days of a decision to treat	98.12%	97.00%	99.45%	Not yet published
% Patients receiving subsequent treatment (surgery) within 31 days	95.58%	97.80%		
% Patients receiving subsequent treatment (drugs) within 31 days	99.17%	98.9%		
Cancer urgent referral to first outpatient appointment waiting times (2 weeks)				
All cancers 2 week wait	95.25%	93.20%	98.88%	Not yet published
All referrals with breast symptoms, regardless of whether cancer is suspected to be seen in 2 weeks	95.74%	96.08%		
Cancer urgent referral to treatment waiting times (62 days)				
% Patients receiving their first definitive treatment for cancer within 62 days of GP or dentist urgent referral	90.22%	85.40%	97.79%	Not yet published
% Patients receiving their first definitive treatment for cancer within 62 days of urgent referral from the national screening service	95.38%	87.00%		
% Patients receiving their first definitive treatment for cancer within 62 days of urgent referral from a Consultant (consultant upgrade)	89.34%	95.90%		
Clostridium difficile infections	121	107	70	121
Delayed transfers of care	4.99%	3.38%	5.10%	<5%
Engagement in clinical audits	Indicator removed	6/6	6/6	Indicator removed
Ethnic coding data quality	89.2%	88.19%	91.43%	>=85%
Inpatients waiting longer than the 26 week standard	1.16%	0.021%	0%	<=0.03%

National Standards/Priorities/Commitments	2010/11	2009/10	2008/09	2010/11 Target
Maternity data quality	0.87%	3.82%	Data not returned	<=15%
MRSA Bacteraemias	0	8	8	2
Outpatients waiting longer than the 13 week standard	0.015%	0.006%	0.001%	<=0.03%
Participation in heart disease audits	Not relevant	100%	100%	Not relevant
Patient experience	CQC Data not yet available	7.9/10 - the A&E department 6.2/10 - waiting lists and planned admissions 8.3/10 - waiting to get to a bed on a ward 8.1/10 - the hospital and ward 8.6/10 - doctors 8.5/10 - nurses 7.5/10 - care and treatment 8.3/10 - operations and procedures 6.9/10 - leaving hospital 6.8/10 - overall views and experiences	83.21 86.34 75.83 77.07	Statistically banded
Quality of stroke care	79%	73%	79.55% 81.30%	Not yet published
Rapid access chest pain clinic waiting times	100%	99.91%	99.91%	>=98%

National Standards/Priorities/Commitments	2010/11	2009/10	2008/09	2010/11 Target
Reperfusion waiting times	100%	98.25%	78.38%	Not yet published
Revascularisation waiting times	0%	0%	0%	<=0.1%
Smoking during pregnancy and breastfeeding initiation rates	6.65% 78.6%	7.43% 79.11%	7.45% 77.78%	Not yet published
Staff satisfaction	Data no longer available in this format	Data not reported by CQC	3.42	Statistically banded

An explanation of who the Royal Berkshire NHS Foundation Trust involved in consultation on these Quality Accounts is provided in part 2a.

External Review Statements

The regulations require us to send copies of our Quality Account to our relevant Local Involvement Network (LINk), Overview and Scrutiny Committee (OSC) and lead commissioning primary care trust (PCT) for comment prior to publication. This review and feedback process was extremely useful to us last year. In particular comments from the LINks identified changes that were needed to the wording of confusing statements and clarification of acronyms. Following this year's review, we have again reviewed the wording and included verbatim comments in the section below.

Statements from Local Involvement networks, Overview and Scrutiny Committees and Primary Care Trusts

NHS Berkshire West

NHS Berkshire West has reviewed the Royal Berkshire NHS Foundation Trust's Quality Account. The Quality Account provides information across the three domains of quality: patient safety, patient experience and clinical effectiveness. There is evidence that the Trust has relied on both internal and external assurance mechanisms.

The Primary Care Trust (PCT) is satisfied as to the accuracy of the data contained in the Account.

Royal Berkshire NHS Foundation Trust (RBFT) is well recognised for their desire to deliver high quality services for their patients as well as their commitment for continued improvement. RBFT clearly demonstrate that they value partnership working across organisations and NHS Berkshire West is pleased to work with them in support of this.

Within the report the Trust clearly identifies their achievements to date, but also areas within their service delivery requiring improvement. The PCT welcomes the openness of this approach and is committed to supporting the Trust in achieving improvement in the areas identified within the Quality Account through existing contract mechanisms and collaborative working.

The PCT is particularly pleased to note that in 2010/11 RBFT's performance in stroke has improved significantly due in no small part to the professional and enthusiastic work by the staff in the stroke team. The stroke care delivered at the trust is among the best in South Central and the PCT looks forward to further collaborative working in this area.

Progress on the joint PCT/Trust Maternity Review has been steady, with an implementation group overseeing the Trust's normal births project, training on team development and leadership, and the Trust's plan to set-up a new midwifery-led unit.
The PCT remains concerned about the slow progress in reducing rates of caesarean section and looks forward to further improvement in this area in 2011/12.

The Trust is pleased to note that the Trust have had no cases of MRSA during 2010/11. The PCT acknowledges the heightened sensitivity of the *Clostridium Difficile* testing methods used at the Trust which underpins the higher numbers of infections indentified. The PCT supports the Trust's commitment to continue to reduce the number of patients who develop the *C. Diff.* infection. The Trust's national target equates to a reduction of 36% from the 121 cases in 2010/11 and the PCT endorses this challenging target as beneficial to patients and the healthcare economy as a whole.

The PCT notes that the management of serious untoward incidents has resulted in good reporting and sharing of learning.

The PCT is pleased that the Trust has focussed work on achieving same sex accommodation and that there have been no reported breaches in the second half of 2010/11.

Areas of non-achievement of CQUINS are disappointing particularly in relation to patient experience, maternity care (normal birth rates and caesarean section rates) and smoking cessation. The PCT continues to view these areas as priorities for the trust and will offer further incentives next year to contribute to the quality improvement agenda.

The 2011/12 Quality Account priorities are consistent with priorities agreed with NHS Berkshire West in improving the experience of patients accessing these services. Areas to be covered in the 2011/12 CQUIN scheme are: VTE, patient experience, diabetes, maternity, smoking cessation, urgent care, end of life, cardiovascular care, neonatal BCG vaccination, and patients receiving the right care at the right time.

This Quality Account provides an excellent overview of the quality of care within the trust and the PCT looks forward to continuing to work alongside the trust in meeting the quality aspirations of local users, carers, partners and staff. NHS Berkshire West will continue to work with the Trust to achieve their delivery of the initiatives outlined in the Quality Account.

West Berkshire Local Involvement Network

We have reviewed the Quality Accounts Draft 3 v2 and have the following comments.

If one accepts that there is merit in prioritisation and specifically the process used in developing these quality accounts then the priority targets set out as priorities 1 to 5 broadly encompass our views as expressed in earlier consultation meetings, though we might take issue with the order.

Priority 1 - Patient experience

We would add that in outpatient areas, there should be a screen available which indicates for each individual when his / her appointment is likely to occur.

We would also add that it should be a medium to long term objective of the RBH to reduce the level of noise in wards at night to ensure, so far as is possible that patients get a good nights sleep. Interventions and observations made at night should be minimised and ear plugs / eye masks should be made available for purchase.

Finally, there is evidence that patients do not fully understand why they are receiving a particular course of treatment especially when things are changing rapidly. Consideration needs to be given to how patients and their close relatives can be better kept informed about the reasons for providing particular treatments and for changing those treatments.

Priority 2 – C Diff

We particularly welcome this and would ask that somehow or other you put out the message that hand washing and not hand gels will reduce the risk of spreading C Diff infections. Perhaps the occasional use of the UV light box might help augment the message.

We reiterate our recommendation made last year that measures be taken in ward and public toilets to keep personal possessions off the floor when using toilets. We still believe that hooks are the simplest solution even if they are placed relatively low down on doors.

We would also urge an innovative and methodical science based study of the spread of the infection insofar as this has not already been done elsewhere.

Priority 3 – Dementia

We would ask that the number of patients with delirium is measured and recorded separately from the dementia statistics. The elderly persons mental health liaison team is due to commence operations in April 2011 and we would expect that the differentiation of delirium from dementia would be another measure of their effectiveness.

Priority 4 VTE falls and sepsis

No additional comments

Other points

1) Staff attitudes.

We note the comments on this issue (Priority 1 in 2010/11) but would point out that the CQC staff survey 2010 is not very complimentary about the RBH and would make the very obvious point that a happy, valued and well managed workforce is much more likely to display good attitudes towards patients

2) Asbestos

We believe that many of the ceiling tiles in South Block are (or were) made of white asbestos. We realise that there is no risk to health if these are left undisturbed but would like assurance that your maintenance staff and contractors are fully aware of the fact and that any intensive C Diff related cleaning regimes are unlikely to generate an unexpected problem related to asbestos dust.

3) Prioritisation

There is a view amongst our Steering Group that the very act of prioritisation is, in itself, a risk factor for patients and as we have seen in recent times, the standards of care in some specialities has been below acceptable standards. We would specifically mention ophthalmology and orthopaedics where waiting times have been and may still be unacceptable.

Many of the main neurological conditions are also barely mentioned (MS, ME, Parkinson's, epilepsy, PPS, Fibromyalgia etc) and we would recommend that the Board should in addition receive some routine assurance from all clinical departments that the basic standards of patient care are being maintained and hopefully improved upon.

4) Anonymous surveys

There is little doubt in our minds that if patients are asked to comment on the care that they have received either as out patients or in patients then they will be reluctant to be critical if they think their responses will be traceable. For this reason we would urge that random sampling of attendees at out patients and of discharged in patients (or their carers) be done on a regular and standardised basis by post or by a web based questionnaire (via e-mail invitation). The subsequent analysis could be done by patient panel members or other qualified volunteers provided the responses were genuinely anonymous.