

A meeting of the Board of Directors will be held on Friday 28 July 2017 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital

If you are unable to attend on this occasion, please notify me as soon as possible on 01202 704777.

Karen Flaherty
Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8.30-8.35	1. WELCOME, APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
	Tony Spotswood, Karen Allman, Peter Gill		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 26 May 2017	Decision	All
8.40-8.45	3. MATTERS ARISING		
	a) Updates to the Actions Log	Information	All
8.45-9.35	4. QUALITY		
	a) Patient Story (verbal)	Information	Paula Shobbrook
	b) Feedback from Staff Governors (verbal)	Information	David Moss
	c) Medical Director's Report (paper)		
	a. Update on Trust Mortality Review Process	Information	Alyson O'Donnell
	b. Report on Safe Working Hours		
	c. Clinical Audit Plan 2017/18		
	d) CQC Inpatient Survey Results (paper)	Information	Paula Shobbrook
	e) Update on Well-led review action plan (paper)	Discussion	David Moss
9.35-10.05	5. PERFORMANCE		
	a) Performance Report (paper)	Information	Richard Renaut
	b) Quality Report (paper)	Information	Paula Shobbrook
	c) Financial Performance Report (paper)	Information	Pete Papworth
	d) Workforce Report (paper)	Information	Louise Hamilton-Welsh
10.05-10.50	6. STRATEGY AND RISK		
	a) Clinical Services Review (paper)	Information	Paula Shobbrook
	b) Secretary of State Visit (verbal)	Information	David Moss
	c) Quality Strategy (paper)	Decision	Paula Shobbrook

10.50-11.05

7. GOVERNANCE

- | | | | |
|----|---|-------------|------------------------------|
| a) | Trust Constitution (paper) | Decision | <i>Karen Flaherty</i> |
| b) | Non-Executive Director Appointment (verbal) | Information | <i>David Moss</i> |
| c) | Workforce Strategy and Development Committee Terms of Reference (paper) | Decision | <i>Louise Hamilton-Welsh</i> |
| d) | Finance and Performance Committee Terms of Reference (paper) | Decision | <i>Pete Papworth</i> |

8. NEXT MEETING

Friday **29 September 2017** at 8.30am in the **Conference Room, Education Centre, Royal Bournemouth Hospital**

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

11.05-11.20

10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

Comments and questions from the governors and public on items received or considered by the Board of Directors at the meeting.

11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

To resolve that under the provision of Section 1, Sub-Section 2, of the Public Bodies Admission to Meetings Act 1960, representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded on the grounds that publicity would prove prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

*providing the excellent care we
would expect for our own families*

Part 1 Minutes of a meeting of the **Board of Directors** (the **Board**) of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the **Trust**) held in public at 08:30 on **Friday 26 May 2017** in the Conference Room, Education Centre, Royal Bournemouth Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Tea Colaianni	(TC)	<i>Non-Executive Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	John Lelliott	(JL)	<i>Non-Executive Director</i>
	Alyson O'Donnell	(AOD)	<i>Medical Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Steve Peacock	(SP)	<i>Non-Executive Director</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Clare Atha	(CA)	<i>Cardiac Physiologist (for item 4(a) only)</i>
	Girish Babu	(GB)	<i>Consultant Cardiologist</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Pete Papworth	(PP)	<i>Deputy Director of Finance and Director of Finance Designate</i>
	Simon Quinton	(SQ)	<i>Cardiac Catheter Laboratory Nurse</i>
	James Rowden	(JR)	<i>Patient Engagement Volunteer Coordinator</i>
	Dily Ruffer	(DR)	<i>Governor and Membership Manager</i>
Public/ Governors:	David Brown		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Paul Higgs		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Roger Parsons		<i>Public Governor</i>
	Sue Parsons		<i>Public Governor</i>
	Guy Rouquette		<i>Public Governor</i>
	Maureen Todd		<i>Public Governor</i>
	David Triplow		<i>Public Governor</i>
Apologies:	Cliff Shearman		<i>Non-Executive Director</i>
	Nicola Hartley		<i>Director of OD and Leadership</i>

42/17 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Action

Apologies for absence were **noted**. Members of the public and governors were thanked for attending the meeting.

43/17 MINUTES OF PREVIOUS MEETING

(a) Minutes of the meeting held on 28 April 2017 (Item 2a)

The minutes of the meeting held on 28 April 2017 were **approved** as an accurate record of the meeting subject to amending 34/17(c) to state “*that there was limited capacity within medical rotas to cope with unplanned staff absence*” and at 35/17(d) “*the vacancy rate figures had increased to 7% from 6.4% and a number of healthcare assistants were joining the Trust in May and June*”.

44/17 MATTERS ARISING

(a) Updates to the Actions Log (Item 3a)

The updates to the actions were **noted** and those which had been completed could be closed.

45/17 QUALITY

(a) Patient Story (Item 4a)

The patient story centred on the effective implementation of the World Health Organisation (**WHO**) surgical safety checklist within the cardiac catheter laboratories. The aim of the WHO checklist was to identify the critical steps for healthcare professionals to follow in order to reduce the number of adverse incidents and deaths arising from surgical procedures and promote a higher standard of care for patients.

Claire Atha, a cardiac physiologist, reflected on the journey within Cardiology to embed the use of the checklist to standardise safety procedures within operating rooms and how staff had been motivated through effective leadership to adopt new ideas. Embedding the process it required flexibility to adapt established routines and protocols and commitment from the team to use the checklist consistently. Although it had taken time to implement initially, the use of the checklist had made a profound and positive difference by strengthening teamwork and communication between clinical disciplines and creating a culture that put patient safety as a priority.

Recent feedback received from a patient following their treatment in the catheter laboratories emphasised the impact that checklists had upon patient care, creating an inclusive approach and shared ownership of healthcare and knowledge between the patient and the team. The department aimed to develop the WHO checklist further by working with Informatics to create an electronic form that could be uploaded to the Electronic Nursing Assessment (**ENA**).

The Board praised the team and their commitment to providing a high standard of safe care for patients. Board members considered how this success in embedding the use of the WHO checklist could be replicated elsewhere in the Trust by demonstrating the benefits described in the patient story engage staff and overcome cultural barriers and misconceptions. The non-executive directors wanted to know how progress could be assessed to ensure that the WHO checklist was being

used properly everywhere where invasive procedures were taking place. It was confirmed that ENA will give oversight of how well the WHO checklist was being used and support could then be targeted using teams who had successfully embedded the use of the checklist.

The physiology service was recognised for its work in reducing waiting times for patients and reducing agency costs. CA described how this had been achieved through a flexible approach to working within the multi-disciplinary team with effective leadership, support and communication.

(b) Feedback from Staff Governors (Item 4b)

Staff governors had been unable to meet with the Chairperson and Chief Executive due to work commitments however monthly meetings had been reinstated. There would be three Staff Governor vacancies coming up for election following the expiration of current terms of office with the election process scheduled to start on 28th June.

(c) Feedback from Nursing, Midwifery and Allied Health Professional Conference (Item 4c)

Following on the success of the conference and publication of the Nursing, Midwifery and Allied Health Professional Strategy in 2016, the Board viewed a short video documenting this year's conference which took place on 11 May 2017. Speakers from national, external organisations including the Nursing and Midwifery Council had attended together with Patient Champion Andrea Addis who shared her experience of being a patient at the Trust. The event showcased great examples of teamwork, learning and practices and was a celebration of staff working at the Trust.

The non-executive directors who attended the event commented that it had been a fantastic event and demonstrated the professionalism of staff and the positive culture. It had confirmed that the Trust was at the vanguard for professional development of nursing, midwifery and allied health professionals. This could be developed further by creating a centre of excellence through the Trust's partnership with Bournemouth University, supporting the recruitment and retention of staff. PS and KA reinforced the Trust's commitment to investing in the development of staff, and for PS it was the staff who had brought the strategy to life.

(d) Medical Director's Report (Item 4d)

Positive progress continued around mortality with the Hospital Standardised Mortality Ratio (HSMR) data for February showing performance was within the expected range despite the peak period over winter and year to date performance in the better than expected range.

The Board received an update on the follow-up visits from the Deanery (Health Education England, Wessex) following the 2016 General Medical Council (GMC) junior doctor survey results as well as routine visits.

- Anaesthetics: The feedback from this visit had been positive, particularly in relation to the support and training offered to junior doctors. There was recognition of the work to streamline induction training and rota coordination for staff working across the Royal Bournemouth Hospital and Poole Hospital sites. The service was

now rated green and compliant.

- General Surgery: This was another positive visit with the team on the progress made since the previous visit. The investment in consultant cover had been positively viewed and the strong clinical leadership was recognised. Work was recommended to strengthen team working amongst the SAS medical team and trainee doctors and this was being reviewed. The service was now rated green and compliant.
- Gynaecology: This was a routine visit with positive feedback on leadership, teamwork and training.
- Pathology: Due to consultant vacancies the Trust had suspended training in this area and the Deanery were supportive of this decision. The posts were being advertised as part of the Developing One NHS in Dorset Acute Care Collaboration Vanguard.

There had been two alerts relating to Haematology following the 2017 GMC junior doctor survey. This had been slightly unexpected but the issues were being addressed. The non-executive directors questioned why management at the Trust had not been aware of the issues raised and AOD explained that they were aware that the team had been working hard and the consultants had radically changed the way in which they worked to support junior doctors and were not getting this feedback. The alerts related to practical things like minimising interruptions and improving planning so there was greater foresight going into clinic.

The full results from the latest survey would be provided to the Board once available.

46/17 **PERFORMANCE**

(a) Performance Report (Item 5a)

The performance exceptions were summarised and included:

- the Emergency Department four hour target had been met in April, however in light of current activity levels it was likely that the Trust would miss the target for May by a small margin.;
- additional focus was being placed upon the management of stranded patients to help alleviate the potential related operational risks;
- compliance with the 18 week Referral to Treatment (**RTT**) target was predicted in June as a result of focused work in Ophthalmology and Orthopaedics which focussed on reducing delays and unnecessary referrals; and
- performance remained strong across the 6 week diagnostic and 62 day cancer targets.

The Board were asked to comment on the content and format of the Single Oversight Framework dashboard which had been designed to amalgamate national and internal performance targets within a single report and on a single page. Individual performance reports would continue to provide greater insight on key areas of focus and themes. Board members reflected that the dashboard needed to be more dynamic so that the detail was available ahead of and at meetings where relevant to their discussions.

The usefulness of some metrics such as executive turnover and aggressive cost reduction plans were highlighted for consideration as well as the need to introduce metrics which covered activity levels and demand management. It was highlighted how this could change the way in which the Board operated particularly around setting the Board's risk appetite in some areas.

(b) Quality Report (Item 5b)

Performance against the key patient safety and experience indicators remained consistently positive. Following review by the Healthcare Assurance Committee (**HAC**) additional support was being provided to one ward. The HAC had also developed actions around the management of patient property which had been a theme from complaints and following a recent incident involving the loss of patient property.

Following an end of year review the Trust had achieved 85% (40/47) of the 2016/17 quality objectives and there were actions to address the outstanding objectives in the objectives for 2017/18. The 2017/18 Quality Strategy had been approved by the HAC and would be submitted to the Board in July.

Friends and Family Test (**FFT**) feedback remained positive and the numbers of patients who would not recommend the Trust had gone down. The token approach would be reintroduced in ED to increase the response rate alongside comment cards and renewed engagement from the teams. Further to the review of the Care Campaign Audit, questions had been revised and aligned with the current quality improvements and the national patient survey to reflect the Trust's improvement work around discharge, pain, compassion and noise at night. PS thanked the volunteers who carried out the audits on the wards.

Results from the national Picker inpatient survey for the Care Quality Commission reflected a sustained improvement in those areas identified through the Care Campaign Audit feedback relating to privacy and dignity and food.

Non-executive directors questioned how technology could be used to increase response levels on the FFT. There were a number of different approaches to obtaining this feedback and in some areas of the Trust it was more beneficial to obtain qualitative feedback, such as in Outpatients. Automated systems were being explored to improve efficiency and would be trialled alongside current methods in order to ensure levels of staff engagement were maintained. The impact of the EU General Data Protection Regulation which recognised the 'right to be forgotten' was also likely to influence how the Trust could use data in the future.

(c) Financial Performance Report (Item 5c)

The Trust had delivered the control total for month 1 however this required the release of the contingency to offset the under-delivery of the Cost Improvement Programme (**CIP**) against the target. This re-emphasised the need to drive and monitor the delivery efficiency savings and the level of

challenge facing the Trust. The position is likely to improve by £120,000 as a result of changes to the national tariff payments for activity from specialist commissioners and Dorset Clinical Commissioning Group (**Dorset CCG**).

The Trust's financial risk rating reduced to 3 in line with the budget and annual plan agreed with NHS Improvement (**NHSI**) and was an outcome of the agreed control total. This placed the Trust within the category for potential regulatory support, however discussions with NHSI who recognised this was an unintended consequence of the agreed deficit and control total and had confirmed there were no concerns about the financial position of the Trust.

The release of contingency in month 1 had been debated and approved by the Finance and Performance Committee on the basis that the amount reflected the difference between the savings target and the planned savings delivery. The Finance and Performance Committee would continue to monitor the position against the delivery of the CIP.

(d) Workforce Report (Item 5d)

The report had been restructured to align with the dashboard format of reporting and would be refined further to incorporate additional datasets. The key themes were summarised and included:

- the staffing headcount had remained steady over the year however recruitment remained challenging although the newly qualified nurses event had been encouraging;
- essential core skills training modules continued to be updated and latest performance had increased to 91.8% with the Trust on track to achieve the 95% target set for December; and
- there had been an overall reduction in sickness absence performance in month for the third consecutive month at 3.55%. and the Trust was continuing with the actions and management processes currently in place, which were beginning to have an impact.

Sickness absence would continue to be monitored rigorously by the Workforce Strategy and Development Committee (**WSDC**) with additional focus at executive management level through the premium cost avoidance transformation steering group given the impact on agency costs.

Board visibility of particular areas with recruitment challenges was raised as a concern, given discussions earlier in the meeting around Oncology and Pathology. These needed to be highlighted to the Board more systematically with future projections so that action could be taken. The Trust, both internally and as part of the Dorset Sustainability and Transformation Plan, was working to obtain better oversight of the workforce challenges for the future around the shape of the workforce and the skills and competencies required as well as identifying strategies to address vacancies in areas which had proved difficult to fill historically.

Concerns had been raised at the Finance and Performance Committee about the financial burden arising from the apprenticeship levy and non-executive directors queried how this could be mitigated. Board members

were informed that funding could only be allocated to training costs associated with apprenticeships and not used for salaries or management support. The Trust was working with partners across Dorset and Bournemouth University to develop solutions so the Trust could benefit from the levy and this included developing alternative roles and programmes to address some of the workforce issues discussed.

In response to a question about gender pay information, it was confirmed that this was being addressed through the WSDC and information was due to be published April 2018.

47/17 STRATEGY AND RISK

(a) Clinical Services Review (Item 6a)

Board members received an update on the progress with the Clinical Services Review (**CSR**):

- in advance of Dorset CCG's decision in September members of public who had contributed to the consultation would be invited to attend feedback sessions led by Opinion Research Services (**ORS**) in Dorchester and Poole on 14 June 2017. Briefings for staff and governors would be scheduled in advance of the publication of feedback together with a co-ordinated approach for media enquiries;
- TS and DM had met with their counterparts at Poole Hospital to discuss a range of issues including the agreed approach to the Competition and Markets Authority (**CMA**). A letter had been drafted to the CMA requesting an informal meeting and comments had been requested from NHSI;
- Executives for the Trust and Poole Hospital had met with NHSI to help progress work underpinning the implementation of the CSR ahead of the final decision being made by Dorset CCG in September;
- the Trust was yet to receive feedback following submission of the bid to NHS England for capital funding to advance the CSR and continued to work with McKinsey & Company to develop the business case which would be completed in early summer; and
- Steve Killen, Programme Director for the One Acute Network, had been invited to join the private session of the Board meeting to provide feedback on the proposed changes to the governance structure for the programme following discussions with all three acute trusts in Dorset.

The Board were encouraged by the recent announcement that up to £10 billion could be made available to support capital investment in the NHS by the Conservative party.

(b) Progress Update on 2016/17 Corporate Objectives (Item 6b)

The Board received the update which detailed progress in the final quarter against the agreed metrics for the 2016/17 objectives. Areas which had fared less well than expected included performance against the stretching target for Clostridium difficile cases, embedding Electronic Document Management and Sepsis and work to achieve these objectives would

continue. It was emphasised that the metrics had been challenging and reflected the ambition of the organisation around improvement.

It was considered that IT was an area which required specific support and emphasis was placed on the importance of having adequate resources in IT to drive the clinical change programmes.

(c) Proposed Metrics for 2017/18 Corporate Objectives (Item 6c)

Four clear and concise corporate objectives had been set and these more detailed metrics were proposed to enable the Board to monitor progress against delivery of the objectives, which would be reported on to the Board on a quarterly basis.

The Board **approved** the metrics for the 2017/18 corporate objectives.

(d) Cybersecurity Update (Item 6d)

The Board received a briefing following the recent cyber event which exploited a vulnerability within Microsoft software affecting a number of organisations including the NHS. The vast majority of Trust computers had been protected and further preventative measures had been put in place once the threat was realised. Upon review it was identified that the Trust needed to establish more effective governance processes for the management of applications, out of date operating systems and to ensure that Windows PCs and laptops were consistently being updated. Staff awareness would also be increased through Information Governance training, which would be updated accordingly. The risk register would be updated to reflect the risks.

In response to the recent events in Manchester and the increased threat level NHS England had requested a review of Emergency Preparedness, Planning and Resilience (**EPRR**) arrangements. There had been a strong response from staff and actions identified included strengthening out of hours cover and South Western Ambulance Service NHS Foundation Trust's (**SWASFT**) tactical response provision.

48/17 GOVERNANCE

(a) Changes to Board Meeting Schedule (Item 7a)

The Board **approved** the changes to the Board meeting schedule to allow more time for the work to implement the CSR through the One Acute Network Board.

(b) Non-Executive Director Appointments to Board Committees (Item 7b)

The nominated appointments to Board Committees were **ratified and approved**. TC had agreed to join the Constitution Joint Working Group and her appointment was **approved** by the Board. Non-executive director representation had also been requested for the End of Life Steering Group and a non-executive director to join this group would be identified.

49/17 **NEXT MEETING**

The next meeting would take place on Friday 28 July 2017 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

50/17 **ANY OTHER BUSINESS**

Key Points for Communication:

1. Cyber security/EPRR arrangements
2. Corporate objective delivery measures for 2017/18
3. Nursing, Midwifery and Allied Health Professional Conference
4. Public feedback events for the CSR

51/17 **COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC**

Governors praised the coordinated response from emergency services following the recent terrorist attacks and queried what local plans were in place for such an event. The Trust conducted regular exercises across Dorset and the Wessex region for major incidents but there could always be more practice events. The Trust was well-practised in relation to its own internal incidents and the system response with regular testing out of hours over busy weekends. It was requested that Trust members received an update on the impact on the Trust of the recent cyber-attack.

KF

It was queried what follow-up processes were in place to monitor the effectiveness of recruitment events, to ensure that these were attracting the right calibre of individuals who stayed with the Trust. The Trust had a rigorous recruitment process with experienced students being recruited from both Southampton and Bournemouth Universities. Newly qualified nurses and allied health professionals were part of a preceptorship programme which required regular education sessions and mentoring and supervision. Frequently the Trust also recruited candidates who had previous experience of working at the Trust on work placements.

Trust performance against the *Clostridium difficile* target was highlighted and clarification was provided about the term 'lapses of care' related to delays in identifying samples or the isolation of patients and did not reflect that the virus had spread within the Trust. Performance remained better than the national average and the challenging trajectory had been set in light of strong performance in previous years. The Infection Control team remained focused on addressing any themes and learning identified through quality improvement and peer learning in other trusts was being applied in practice.

52/17 **RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS**

The Board resolved that under the provision of Section 1, Sub-Section 2, of the Public Bodies Admission to Meetings Act 1960, representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded on the grounds that publicity would prove prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
26.05.17	51/17	COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC			
		It was requested that Trust members received an update on the impact on the Trust of the recent cyber-attack.	KF	May	Email to members sent on 30 May.
28.04.17	33/17	QUALITY			
	(b)	<u>Feedback from Staff Governors</u>			
		In addition, further information would be provided on the process to backfill posts for Staff Governors so that they could attend meetings and listening events for staff.	PP	June	This has been raised with potential staff governors and managers as part of the current election process. There are some issues around the ability to backfill certain roles and we will be looking for support to address these.
16.12.16	98/16	QUALITY			
	(d)	<u>Medical Director's Report – Mortality and Sepsis</u>			
		Provide an update on the progress with systemic anti-cancer outcome data performance.	AOD	June	Data not yet available and no firm date has been set nationally for this. Update to be included in the Medical Director's Report once data becomes available.
Key:	Outstanding	In Progress	Complete	Not yet required	

*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017 Part 1
Subject:	Medical Director's Report: Update on Trust Mortality Review Process
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Alyson O'Donnell
Author(s) of papers:	Alyson O'Donnell
Details of previous discussion and/or dissemination:	
Action required: Approve/Discuss/Information/Note	Information
Executive Summary: Update to Board of Directors on Trust Mortality Review Processes	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

Update to Board of Directors on Trust Mortality Review Processes

In February 2017 the CQC released their report – CQC review of investigations into deaths in NHS Trusts. This review had been commissioned following the death of Conor Sparrowhawke and the identified failings in Southern Health.

There are a number of key recommendations with implications for the way that we review and report mortality within the organisation and how this is shared with NHSE/NHSI.

Recommendation 7

Provider organizations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level so that deaths are identified, screened and investigated, when appropriate, and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers.

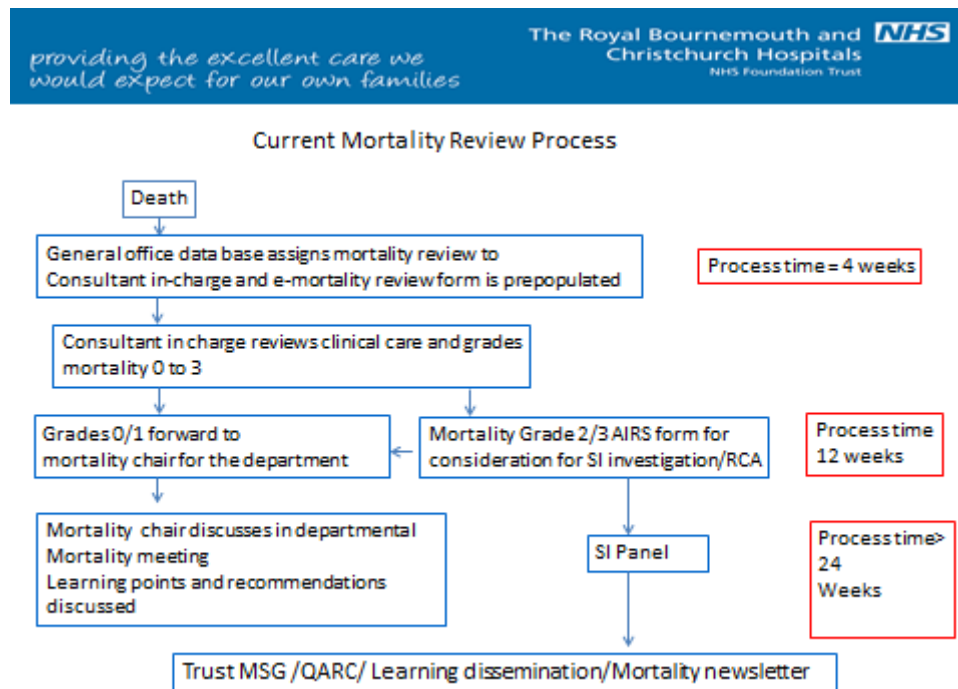
New National Quality Board requirements from April 2017

- All Trusts should ensure their governance arrangements facilitate and give due focus on the review, investigation and reporting of deaths. This includes those deaths not felt to have resulted from problems in care.
- Trusts should also ensure that they share and act upon any learning derived from these processes. 'Learning from all deaths'
- All Trusts should identify a Non executive and executive director with lead responsibility
- All Trusts must have a clear policy for engagement with bereaved families and carers to ensure that mortality reviews include any concerns or questions they may have.
- Each Trust should publish an updated policy by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care.

Current Processes

E-mortality reviews are well established in RBCH. All consultants are notified, monthly and retrospectively, of all patients who have died under their care. A structured electronic review form is completed with deaths graded on a 0-3 scale where 0 is an unavoidable death with no gaps in care to 3 where the death was probably avoidable. Of 717 deaths reviewed in the last 12 months 660 were graded as unavoidable, 53 with evidence of sub-optimal care not affecting outcome and 3 as possibly avoidable. Overall 60% of deaths are reviewed but there is a significant lag in process time. As a result learning from individual deaths or potential incidents

requiring investigation may not come to light for up to 6 months. In addition, the processes for identifying all deaths of patients with learning disability or serious mental health issues is not secure.



Drivers for Change

- There is a need to realign trust mortality reviews to map with the new CQC standards and to improve the completion of reviews within a 60 day timeframe
- To improve the involvement of families and carers in the mortality review process and to ensure that any review addresses their questions. At present family involvement is limited
- To review all deaths of patients with Learning difficulties and serious mental illness
- To review all deaths of patients with acquired harm in our care
- To provide a single IT process and database for death certification and mortality reviews
- To achieve compliance with the new Coroner's requirements

Suggested new process

In order to achieve this it is suggested that a daily review of all deaths is undertaken by a senior clinician, a member of the patient safety team and a member of the general office staff. It is expected that this will support junior doctors to accurately complete death certificates and to inform discussions with the coroner about relevant cases. A series of key questions linked to the Structured Judgement Review supported by the Royal College of Physicians will allow the early identification of

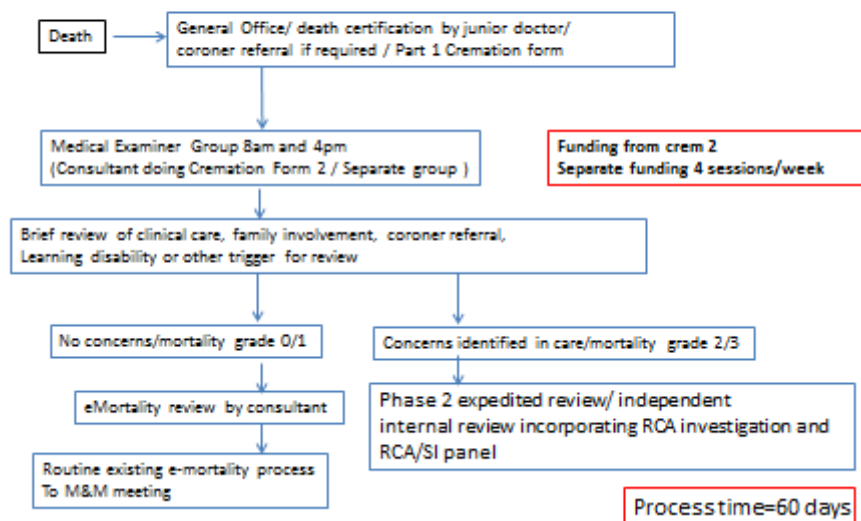
cases requiring a more in depth review and feed these automatically to coronial or SI processes as required.

Currently 2 PDSA cycles have been undertaken to test the process and the key questions. Most cases took less than 10 minutes to accurately respond to the key questions but one review took 30 minutes. Out of 10 cases reviewed 2 were identified as possible serious incidents using the ten questions.

Details of discussion with Medical practitioner who drafted MDDI:			
Details of discussion with Consultant in charge of patient at time of death:			
Details of discussion with nursing staff if applicable:			
Details of any concerns raised by the patient's family as highlighted by any of the above persons, following review of the patient's notes or discussion with patient's family:			
Readmission within 7 days?	Y/N	Delay in diagnostic results	Y/N
Readmission within 30 days for same diagnosis?	Y/N	Unexpected death that has not been discussed with the Coroner?	Y/N
Delay in attendance of specialist advice (more than 1 hour from request for attendance and review)?	Y/N	Evidence of harm as a result of hospital acquired fall, pressure ulcer, UTI or VTE?	Y/N
Delay in recognition of Sepsis or need for Sepsis screen?	Y/N	Evidence of harm as a result of hospital acquired pneumonia?	Y/N
Delay in the provision of antibiotics (within 1 hour of diagnosis or suspicion of sepsis)?	Y/N	Are you concerned there is a lack of evidence in the patient's notes to support the documented cause of death?	Y/N



Proposed New Mortality Review Process



Next Steps

Site visits to Southampton and Dorchester, where similar processes have been developed, are underway. A single electronic proforma is under development which will replace the multiple paper documents currently in use and which often contain much of the same information. This will provide an output for referral to the coroner's office and will also allow the fast tracking of cases requiring more in depth reviews.

It is planned to pilot the process in the next few weeks to establish the likely time commitment required. It was hoped that this would be achieved before the new intake of junior doctors in August but this has not proved possible. It is estimated that this is likely to require around 8-10 hours of Consultant time per week.

In other trusts it has been possible to fund this time by centralising the funding and expertise for completion of the Part 2 cremation form. Currently around 20 individuals complete the vast majority of part 2 forms. When presented to TMB and the Mortality Surveillance Group centralising this funding was not supported. The funding for completion of cremation forms will be changing from 2018/9 as part of the role out of the Medical Examiner system. This individual will provide independent scrutiny and verification of medical certificates of the cause of death. At present it is not clear whether this individual, who is required to be independent of the trust, could feed in to the process.

In other trusts this is included as SPA time for a group of Consultants eg speciality mortality leads and in others is a paid SPA activity for 2-3 Consultants

There is a requirement to provide the first quarterly report to include

- Total number of deaths
- Number of case record reviews undertaken
- Numbers of Sis
- Numbers of deaths where death is likely (>50%) to be due to a problem in care
- Themes and issues identified
- Action plans

Summary

Board is asked to approve the suggested proposals to improve the timeliness and robustness of our mortality review processes.

To consider whether these are likely to provide assurance around the investigation and learning from deaths

To consider whether, if no other funding source is identified, whether a bid for new funding would be supported on an extended pilot basis for 12 months

Alyson O'Donnell
Medical Director

*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017 Part 1
Subject:	Medical Director's Report: Report on Safe Working Hours
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Alyson O'Donnell
Author(s) of papers:	Tanzeem Raza
Details of previous discussion and/or dissemination:	Trust Management Board
Action required: Approve/Discuss/Information/Note	Information
Executive Summary: Quarterly Report on Safe Working Hours July 2017	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

Quarterly Report on Safe Working Hours for Doctors in Training: Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust

Executive summary:

This is the second report since the introduction of the new junior doctors' contract in October 2016. This report summarises work undertaken by the guardian for safe working hours so far. To date we only have 33 trainees on this contract and there have been 67 exception reports completed in accordance with the requirement of the contract.

The new contract necessitates very specific work schedules for each placement. It also needs a very active engagement from educational and clinical supervisors with additional demand on their time.

1. Introduction:

The role of Guardian of Safe Working Hours is an integral part of the 2016 trainee doctor's contract with a fundamental remit to ensure that the doctors working hours remain safe.

The guardian is responsible for:

- Protecting the safeguards outlined in the 2016 contract TCS for doctors in training.
- Ensuring that issues of compliance with safe working hours are addressed.
- Providing assurance to the trust board that doctors' working hours remain safe.

In this hospital 2 O&G ST3 trainees transferred on to the new contract in October 2016 followed by 32 Foundation year 1 trainees in December 2016. This is my second quarterly report to the Trust Board. In August we will have a total of 137 trainee doctors on this new contract with another 23 joining in September/October 2017. There are 11 unfilled deanery posts from August onwards (being filled with Trust grade appointment)

2. Issues:

The initial apprehension with the new contract seems to have settled down to an extent although there continues to be a significant unease for those trainees who might wish to work on less than full time basis.

The new contract has very strict limitations on the working hours and that has potential implications about the flexibilities in any rota affecting rota swaps or ability to cover colleagues etc.

So far we only have a total of 33 trainees on this new contract and although there have been 67 exception reports in the last 6 months it is still too early to see any specific pattern and draw any meaningful conclusions.

3. Exception Reports between 5 October 2016 and 28 June 2017:

Number of doctors / dentists in training (total):	168
Number of doctors / dentists in training on 2016 TCS (total):	33

Amount of time available in job plan for guardian to do the role:	1.5 PAs per week
Admin support provided to the guardian (if any):	0.2 WTE - temporary
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

4.1 Exception reports:

Since the introduction of new contract there have been a total of 67 exception reports – 62 about extra hours and 5 about educational opportunities/supervision issues

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	4	20	8	12
OPM/MFE	9	2	2	0
Cardiology	3	1	1	0
Psychiatry	5	0	0	0
Medicine	3	4	4	0
O & G	0	3	1	2
Educational	3	1	1	1
Total	27	31	17	15

A significant number of exception reports in surgery remain un-resolved at the level of educational/clinical supervisor.

4. Work schedule reviews:

No work schedule reviews were required between March and June 2017. The maximum number of exception reports have been generated by the surgical F1s but there does not appear to be a specific pattern that would require any work review at this stage but the situation will need to be closely monitored in surgery. None of the exception reports so far has identified any specific issues with a particular rota or a part of a pattern that would require a work schedule review. Instead almost all exception reports have resulted from one-off unexpected circumstances like a colleague's absence or a patient getting unwell, which required for the F1 to stay on longer. Most of the exception reports have resulted in compensatory payment to the doctor in question except for 3 instances where time off in lieu was agreed instead. Compensatory payments are made @ £12.6336 per hour.

5. Locum usage:

None of the F1s in medicine on this new contract has done any locum shifts during this time. Only 2 F1s has performed locum work in surgery who had to be remunerated at the agreed locum bank rate with a total cost of £1225 to cover three shifts.

6. Vacancies:

There are 12 gaps which the deanery has not been able to recruit for 2017-18. These gaps are:

7 gaps in junior trainees (SHO) level gaps (1 F2, 3 CMT and 3 in GPVTS). In addition there will 4 gaps in medical registrars (one each in Respiratory, Acute Medicine, Cardiology and OPM) and one registrar gap in Anesthesia.

We are in the process of trying to recruit against these vacancies through Trust level recruitment.

7. Fines

No fines have been levied on any department so far

8. Issues arising

All exception reports have to be acted on by the educational/clinical supervisor within 7 days of those being raised. Unfortunately the engagement by some supervisors has been less than satisfactory and despite several reminders from the Guardian (emails/telephone calls) 12 exceptions reports are still outstanding – some for over 75 days.

9. Questions considered by Trust Management Board

- How to maximize engagement from educational/clinical supervisors for timely completion of exception reports?
- Jacky Hoyle has provided the most valuable support for introduction of the new contract and guardian's work so far but her 'project' is due to come to an end in October. With a large number of trainees on new contract, the number of exception reports is definitely set to rise. Without ongoing admin support it will not be possible for the guardian to protect the safeguards outlined in the 2016 contract TCS for doctors in training.

10. Next Steps:

Most of the remaining trainee doctors including the next batch of F1 doctors (total of 137 trainees) are due to be transferred on to the new contract in August 2017 which will entail a major piece of work by medical HR as well as by the guardian. In addition 8 new trainees will join in September 2017 and 15 in October 2017 and will be employed on the new contract. I am unable to give an estimated cost of these transitional arrangements at this stage.

The next report will be presented in September Trust Board meeting

Dr Tanzeem H Raza

Guardian for Safe Working Hours

28 June 2017

*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017 Part 1
Subject:	Medical Director's Report: Clinical Audit Plan 2017/18
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Alyson O'Donnell
Author(s) of papers:	Julius Cranshaw
Details of previous discussion and/or dissemination:	Audit Committee
Action required: Approve/Discuss/Information/Note	Information
Executive Summary: Clinical Audit Plan 2017/18	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Clinical Audit Plan 2017 - 2018

Title	Care Group	Directorate
Quality Account Audits		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	B	Cardiology
British Association of Urological Surgeons: Cystectomy audit	A	Urology
British Association of Urological Surgeons: Nephrectomy audit	A	Urology
British Association of Urological Surgeons: Percutaneous nephrolithotomy audit	A	Urology
British Association of Urological Surgeons: Radical prostatectomy audit	A	Urology
British Association of Urological Surgeons: Urethroplasty audit	A	Urology
National Bowel Cancer Audit (NBOCAP)	A	Surgical
Cardiac Rhythm Management Audit (CRM)	B	Cardiology
Case Mix Programme (CMP)	A	Anaesthetics
Child Health Clinical Outcome Review Programme - Young Peoples' Mental Health	B	ED
Child Health Clinical Outcome Review Programme - Cancer in Children, Teens and Young Adults	C	Cancer Care and Pathology
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	B	Cardiology
Elective Surgery (PROMs) Hip and Knee replacement	A	Orthopaedics
Elective Surgery (PROMs) Groin Hernia and Varicose Veins	A	Surgery
Falls and Fragility Fractures Audit programme (FFFAP)	B	All
Fractured Neck of Femur (Care in Emergency Departments)	B	ED
Inflammatory Bowel Disease (IBD) programme	B	Gastroenterology
Learning Disability Mortality Review Programme (LeDeR)	B	All
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	A	Maternity
NCEPOD - Acute Heart Failure	B	Cardiology
NCEPOD - Perioperative Diabetes	A	Surgery and Anaesthetics
NCEPOD - New topic to be announced	T.B.C	T.B.C
NCEPOD - New topic to be announced	T.B.C	T.B.C
National Audit of Anxiety and Depression	T.B.C	T.B.C
National Audit of Breast Cancer in Older Patients	A	Surgery
National Audit of Dementia	B	OPM
National Audit of Intermediate Care	B	OPM
National Audit of Psychosis	T.B.C	T.B.C
National Audit of Rheumatoid and Early Inflammatory Arthritis	T.B.C	T.B.C
National Bariatric Surgery Registry	A	Surgery
National Cardiac Arrest Audit (NCAA)	A	Anaesthetics
National Chronic Obstructive Pulmonary Disease Audit programme (COPD) - Pulmonary Rehabilitation	B	Thoracic
National Chronic Obstructive Pulmonary Disease Audit programme (COPD) - Secondary Care	B	Thoracic
National Comparative Audit of Blood Transfusion programme - Red cell and Platelet Transfusion in Adult Haematology Patients	C	Pathology
National Comparative Audit of Blood Transfusion programme - National Comparative Audit of Transfusion Association Associated Circulatory Overload	C	Pathology
National Diabetes Audit - Adults	B	BDEC
National Diabetes Footcare audit	B	BDEC
National Pregnancy in Diabetes Audit	B	BDEC
National Diabetes Transition Audit	B	BDEC
National Diabetes Core Audit	B	BDEC
National Diabetes Pump Audit	B	BDEC
National Emergency Laparotomy Audit	A	Surgery
National End of Life care audit (T.B.C)	C	Cancer Care
National Heart Failure Audit	B	Cardiology
National Joint Registry (NJR) Hip and Knee Replacement	A	Orthopaedics
National Lung Cancer Audit (NLCA) Royal College of Physicians	B	Thoracic
National Maternity and Perinatal Audit	A	Maternity
National Ophthalmology Audit	C	Ophthalmology
National Vascular Registry	A	Surgery
Oesophago-gastric Cancer (NAOGC)	A	Surgery
Pain in Children	B	ED
Procedural Sedation in Adults (care in emergency departments)	B	ED
Prostate Cancer	A	Surgery
Sentinel Stroke National Audit programme (SSNAP)	B	Stroke
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	C	Pathology
UK Parkinson's Audit	B	MFE
Other national audits		
Breast and Cosmetic Implant Registry (BCIR)	A	Surgical
Perioperative Quality Improvement Programme	A	Anaesthetics
National Complicated Diverticulitis Audit	A	Surgical
National Psoriasis audit	C	Dermatology

Society for Acute Medicine's Benchmarking Audit	B	Medicine
National Adult Bronchiectasis audit	B	Medicine
National Adult Bronchoscopy Audit	B	Medicine
Directorate audits		
Medical Directorate		
Patients Waiting in ED for Over 4 Hours Continue to Have a Safe and Positive Experience	B	ED
Coeliac serology	B	GI Medicine
Medical Gases	B	Thoracic
Management of pulmonary nodules	B	Thoracic
Frailty Assessment in the Emergency Department	B	ED
Quality and Risk Directorate		
Transfer checklists - accuracy and completeness	Corporate	Risk
Fluid Balance Chart audit	Corporate	Nursing
Patient Identification bands	Corporate	Risk
Policy audit - compliance with document control standards	Corporate	Risk
Consent	Corporate	Risk
Risk Reporting Processes	Corporate	Risk
Maternity Directorate		
Review of the 36 week clinic	A	Maternity
Management of post natal transfers	A	Maternity
Analgesia/pain management in the Birth Centre	A	Maternity
Home Birth	A	Maternity
GROW	A	Maternity
Cancer Care and Pathology Directorate		
Audit of Thrombophilia screens	C	Haematology
Audit of Discharge Delays in patients know to the Hospital Palliative Care Team	C	Cancer Care
Cancer in Children, Teens and Young Adults (NCEPOD	C	Cancer Care
Audit of neutropenic sepsis	C	Haematology
Audit of PleurX drains	C	Cancr Care
Medicine for the Elderly Directorate		
Dalteparin Prescribing in elderly medicine over 2 week stays (NICE)	B	MFE
Readmissions within 30 days	B	MFE
Mortality within 30 days of discharge	B	MFE
Management of stranded patients	B	MFE
Medical management of pressure sores	B	MFE
Cardiology Directorate		
BCIS PROMS audit Pre and Post Procedural Data Related to Patients' Experience of Percutaneous Coronary Intervention(PCI) Procedures	B	Cardiology
Prescription of correct DOAC dose for AF	B	Cardiology
Intravenous Furosemide Re-audit	B	Cardiology
BCIS PROMS audit Pre and Post Procedural Data Related to Patients' Experience of Chronic Total Occlusion (CTO) Procedures	B	Cardiology
BCIS PROMS audit Pre and Post Procedural Data Related to Patients' Experience Percutaneous Coronary Intervention (PCI) Procedures	B	Cardiology
Ophthalmology Directorate		
Audit of post-injection endophthalmitis	C	Ophthalmology
Audit of post cataract surgery endophthalmitis	C	Ophthalmology
Audit of retinopathy of prematurity screening	C	Ophthalmology
National Ophthalmology Audit	C	Ophthalmology
Audit of outcomes of intravitreal Eylea injections for AMD	C	Ophthalmology
Anaesthetics Directorate		
Comparison of PROM Data Between Patients Who Received a Psychology Intervention Versus Those Who Did Not	A	Anaesthetics; Health Foundation project
Anaesthesia Quality Improvement Audit - a Review of the Length of Stay of the Patients in the PACU	A	Recovery
Service Evaluation of Pain after Joint Arthroplasty; Impact on Mobilisation and Length of Stay	A	Anaesthetics
A survey of the Response to Deteriorating Patients with a High (9 or greater) NEWS Score	A	Anaesthetics
Weekend CEPOD activity	A	Emergency Surgery
Health Records Audit	A	Anaesthetics
Anaesthetic Care Handover Audit	A	Recovery
Radiology Directorate		
Outcomes from fine needle aspiration	C	Radiology
MR imaging in scaphoid injuries	C	Radiology
Ultrasound vs SPECT CT for parathyroid adenomas	C	Nuclear medicine
Radiation doses during EVAR	C	Radiology
Audit of fast-track cancer pathway referrals	C	Radiology
Specialist Services Directorate		
British Association of Dermatologists Psoriasis audit	C	Dermatology
BHIVA Audit	C	DOSH
NICE guidance on back pain and sciatica (NG59)	C	Rheumatology
Audit of Goal Setting in Physiotherapy Amputee Group	C	Dorset Prosthetics Centre
National Audit of Rheumatoid and Early Inflammatory Arthritis	C	DOSH
Surgical Directorate		
PROMS Hernia Surgery	A	Upper GI
CPEX in colorectal cancer patients	A	Colorectal
Mortality After Carotid Endarterectomy	A	Vascular
Mastectomy and Breast Reconstruction Audit TBC / Screening TBC	A	Breast Surgery

Robotic Prostatectomy Audit	A	Urology
Management of Early Pregnancy Complications	A	Gynaecology
Operations and Facilities		
7 day Services	Corporate	Operations
PLACE	Corporate	Operations
Referral to Treatment Time	Corporate	Operations
Communication with GPs	Corporate	Service Development
Response to Red HaN calls	Corporate	Clinical Site
Response to requests for deep cleans	Corporate	Housekeeping
Orthopaedic Directorate		
An Evaluation of Radiographs for Total Shoulder and Reverse Geometry Shoulder Arthroplasty Following Post Operation and at 6 Months Follow-up	A	Orthopaedic
Antibiotic Prophylaxis Protocol for Total Joint Replacements	A	Orthopaedic
Straight to MRI: Can we reduce delay in diagnosis in carpal instability?	A	Orthopaedic
Identifying the Need for an Acute Kidney Injury Assessment Tool in Elective Hip and Knee Orthopaedic Surgery	A	Orthopaedic
Total Knee Replacement Consent Audit	A	Orthopaedic

*providing the excellent care we
would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 July 2017 Part 1
Subject:	CQC Inpatient Survey Results 2016
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery / Deputy Chief Executive
Author(s) of papers:	Paula Shobbrook, Director of Nursing and Midwifery / Deputy Chief Executive/ Jo Sims, Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Healthcare Assurance Group
Action required:	The paper is provided for information and assurance
Executive Summary: In summary, comparison against the Trust's 2015 performance demonstrates minimal variation in results only two questions show a significant decrease related to discharge and one question show a significant increase showing patients are treated with respect and dignity.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All domains
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	N/A

National Care Quality Commission Inpatient Survey results from July 2016

1.0 Introduction

The annual Care Quality Commission (CQC) national inpatient survey is a public determinant of patient experience; a regulatory measure of performance analysed by the CQC and a local performance measure monitored by our local Clinical Commissioning Groups.

The 14th annual CQC in-patient survey includes responses from in excess of 77,850 patients from 149 acute Trusts with a national response rate of 44%. RBCH had an increased response rate of 53% from a sample of 1250 eligible patients who were in the Trust overnight during July 2015. Number of respondents 631.

The data analysis is based on an “expected range” when compared to other Trusts and is standardised by age, gender and method of admission to ensure the results are fair regardless of demographic. The numerical score is 0 (worst) - 10 (best).

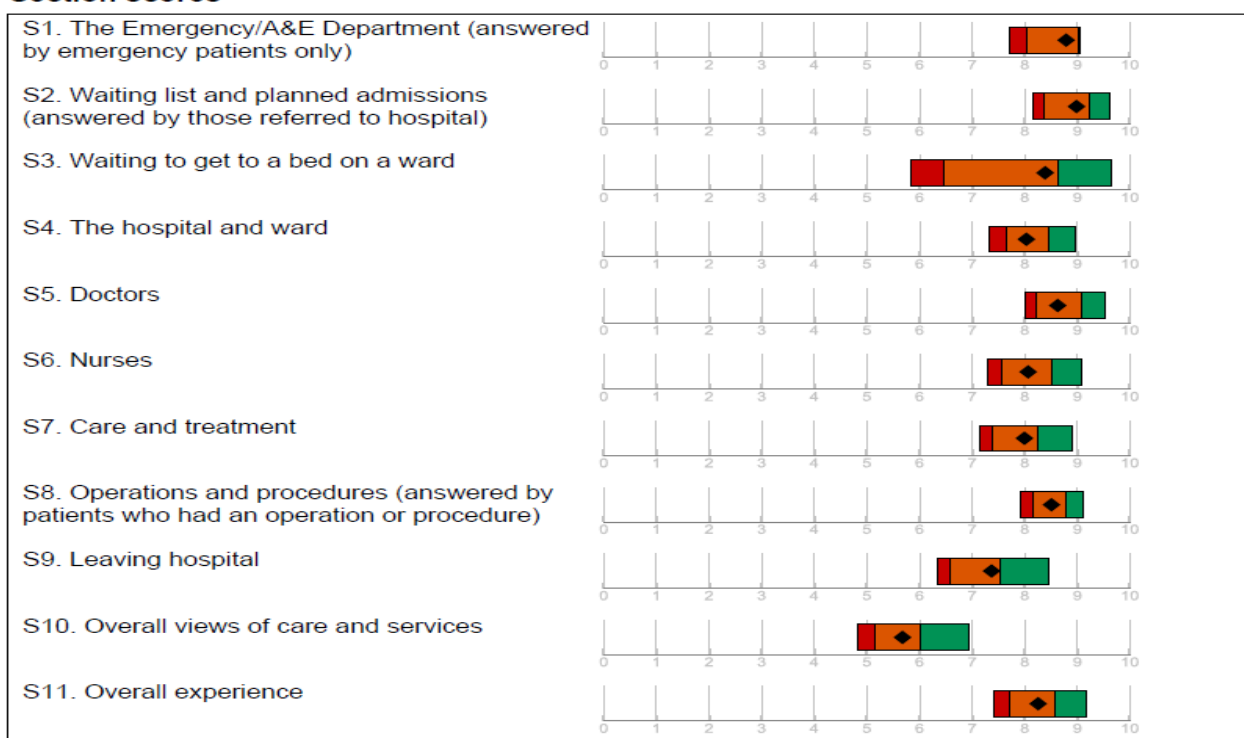
2.0 National comparison of results

Results are displayed when compared with other trusts as:

- **better than most** other trusts (coloured green)
- **about the same** as most other trusts (coloured amber)
- **worse than** most other trusts (coloured red)

There are 66 survey questions, segmented into 11 sections to reflect key aspects of the patient journey or quality of care by professional disciplines. Overall performance results for the 2016 survey by section are displayed in the table below;

Section scores



All questions show RBCH in the 'about the same' section for all questions with the exception of 2 which put the trust in the '**best performing**' section for Questions 66 (danger signals to watch for after discharge) and question 69 (who to contact if you are worried after leaving). The Trust has no results in the 'worse than' category.

Overall, performance when compared to last year is largely sustained with some reduction variations in specific categories: Doctors, Nurses and Operations & procedures.

3.0 Internal comparison of Trust performance

Internal comparison with 2015 performance demonstrates:

- improvement in 20 questions (28 questions in 2015)
- 1 question shows statistical improvement – patients treated with dignity and respect (2 in 2015)
- 2 questions show a statistical decrease; 'were you given enough notice about discharge' and 'were you given any written information about what you should do after discharge' (1 in 2015)

4.0 Next Steps

The results have been requested by directorate so they can be reviewed at specialty level to share positive practice and develop the quality improvement plans from all the feedback. This will be reviewed at the Healthcare Assurance Committee.

5.0 Recommendation

The board is requested to note this paper which is provided for information and assurance

*providing the excellent care we
would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 July 2017 - Part 1
Reason for Part 2:	N/A
Subject:	Update on Well-Led Review Action Plan
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	Minutes of meeting of Board of Directors - 31 March 2017 setting out agreed actions
Officer with overall responsibility:	David Moss, Chairman
Author(s) of papers:	David Moss, Chairman
Details of previous discussion and/or dissemination:	Previous Board meetings
Action required:	Discussion
Executive Summary: A brief update on the Well-Led Review Action Plan post 31 March 2017	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

Well-Led Review Action Plan

1. The Board will recall the workshop that was held on 31 March 2017 to develop an action plan in response to the Well-Led Review (copy of minutes in the Reading Pack).
2. This report gives an update on progress on the priority themes:

a. Share Lessons from the Previous Proposed Merger

The Board held a useful Blue Skies session on this in May led by Tony Spotswood and Steve Peacock. Subsequently a positive informal meeting has been held with the Competition and Markets Authority to sound out the way forward on lifting the undertakings and enabling further cooperation to implement the Clinical Services Review.

b. Agree Vision

Work is currently under way to develop a new vision with widespread engagement within the Trust. Progress on the draft vision was discussed at the Blue Skies event in June involving the Board, the Change Champions and the Trust Management Board. The revised vision will be ready in the autumn for consideration by the Council of Governors and the Board.

c. Identify Key Strategic Issues and Scenarios

The Programme Director for the One Acute Network (OAN) has developed a programme Business Case which addresses these issues and which was agreed at the OAN Board in June. The decision was taken to proceed at risk, prior to the CSR decision on the development of the Business Case, for capital funding to enable the acute reconfiguration in East Dorset to commence.

d. Develop the Implementation Plan

The structure and implementation framework for the One Acute Network was agreed by the OAN Board in June. The go-ahead was also given to key appointments on the project team pending the development of a full case for the capacity to support the transformation work.

e. Stakeholder Map and Engagement Strategy.

The joint Board and Council of Governors meeting in July was dedicated to a workshop on this topic and a detailed action plan on

priorities for Stakeholder engagement was drawn up. Separate work is in hand for the development of a patient engagement strategy and this will be brought to the Board and the Governors for consideration in the autumn.

f. Next Steps

A well-led review tracker document is being developed which will map progress on all the recommendations in the well-led review report and action plan.

David Moss
Chairman

providing the excellent care we
would expect for our own families

BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017 Part 1
Subject:	Operational Performance Report
Section on agenda:	N/A
Supplementary Reading (included in the Reading Pack)	Performance Matrix
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Donna Parker, Deputy Chief Operating Officer David Mills, Associate Director - Information
Details of previous discussion and/or dissemination:	PMG / Finance Committee
Action required: Approve / Discuss / Information/Note	The Board is requested to note the performance exceptions to the Trust's compliance with the 2017/18 SOF and contractual requirements. This includes compliance with national targets and our NHSI submitted trajectories to date.
Executive Summary: Overall the Trust has remained in a good position for Q1 and compared to other trusts on performance. For June: <ul style="list-style-type: none"> • Diagnostics 6 Week Wait – met national target. • A&E 4 Hour – below national target but above NHSI trajectory. • Cancer 62 Day from Referral – expect to achieve national target (<i>met for May – last reported month</i>). • Cancer 62 Day Screening – below national target due to a very small number of patients but expect quarter compliance. • RTT 18 Weeks – met national target of 92% All other Single Oversight Framework (SOF), NHS Constitution and key contractual targets were met or within expected range for June excepting Cancer 31 Days from Decision to Treatment. Though this is expected to be compliant for the quarter. A forecast for July, together with key risks (e.g. demand) and mitigating actions, is included in the report. Risk to all targets is detailed and significantly, a key risk to STF due to our current A&E 4 hour performance level against the now 95% trajectory required by NHSI to achieve the STF.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 Yes Yes

Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	See Risk Register: Urgent Care – Stranded Patient and Flow Domain RAs RTT and Demand Management RAs
Reason paper is in Part 2:	

Trust Board Dashboard - June 2017
based on Single Oversight Framework metrics

CARE_GROUP	DIRECTORATE
A - SURGICAL	ANAESTHETICS
B - MEDICAL	CANCER CARE
C - SPECIALTIES	CARDIOLOGY
CORPORATE	CORPORATE
	ED & AMU
	MATERNITY

Annual Declaration

CQC inpatient/MH and community survey	8.1/10	CQC - Responsive	Requires Improvement
NHS Staff Survey	3.91	CQC - Safe	Requires Improvement
CQC - Caring	Good	CQC - Warning notices	0
CQC - Effective	Requires Improvement	CQC - Well Led	Requires Improvement

Category	Metric	Trust Target	2016/17 Q3			2016/17 Q4			2017/18 Q1			Trend (where applicable)
			Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	90%	94.74%	94.13%	93.03%	96.48%	93.39%	90.34%	95.73%	92.56%	95.88%	
	Caring - Inpatient scores from Friends and Family Test % positive	95%	98.20%	97.64%	97.21%	97.95%	98.16%	97.63%	97.11%	98.09%	96.23%	
	Caring - Maternity scores from Friends and Family Test % positive	95%	97.48%	93.67%	90.00%	96.88%	89.32%	98.06%	98.78%	93.89%	93.33%	
	Caring - Mixed sex accommodation breaches	0	0	4	0	2	0	0	1	0	0	
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)						73.26%					
	Caring - Formal complaints		28	24	17	14	23	30	22	19	19	
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	< Prev Yr Month AVG	465	481	531	488	473	552	509	588	480	
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	< 100	95.1	87.4	100.0	98.3	106.5	102.8				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - MAC	< 100	0.0	0.0	0.0	0.0	0.0	0.0				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - RBH	< 100	86.9	79.9	86.6	93.2	96.4	99.0				
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	< 100	110.2	94.3	86.3	98.6	97.4	86.5				
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	< 100	220.2	166.2	239.3	205.4	216.2	159.4				
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	< 100	98.5	87.7	75.4	92.4	90.1	80.1				
	Effective - Summary Hospital Mortality Indicator	< 1	0.94	0.94	0.94							
	ED Attendances		7952	7568	7389	7314	6855	7843	7704	8303	8082	
	Elective Admissions		5603	6288	5572	5750	5549	6282	5395	6096	6349	
	GP OP Referrals		5891	6275	5216	5517	5472	6420	5336	5882	6081	
	Non-elective Admissions		3142	3085	3102	3199	2968	3317	2953	3339	3022	
	Organisational health - Staff sickness in month	< 3%	4.060%	4.576%	4.831%	5.041%	4.718%	3.998%	3.548%	4.050%	4.012%	
	Organisational health - Staff sickness rolling 12 months	< 3%	4.03%	4.11%	4.18%	4.21%	4.26%	4.24%	4.19%	4.19%	4.20%	
	Organisational health -Proportion of temporary staff		6.06%	6.21%	5.57%	6.10%	7.57%	7.41%	7.00%	8.09%		
	Organisational health -Staff turnover	< 12%	10.94%	11.00%	11.23%	10.95%	11.17%	11.42%	11.13%	10.94%	10.73%	
	Safe - Clostridium Difficile - Confirmed lapses in care	<=14 in Yr / 1.2 per Month	2	3	0	1	0	1	1	0	0	
	Safe - Clostridium Difficile - infection rate	6.9	11.71	12.1	0	11.71	0	5.85	12.1	11.71	0	
	Safe - MRSA bacteraemias	0	0	0	0	0	0	0	0	0	0	
	Safe - NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	
	Safe - Occurrence of any Never Event	0	0	0	0	0	0	0	0	1	1	
	Safe - Potential under-reporting of patient safety incidents (Quarterly)			41.55			40.35			36.60		
	Safe - VTE Risk Assessment	95%	95.62%	95.89%	95.88%	95.41%	95.25%	96.40%	95.92%	96.25%	96.77%	
	Number of Serious Incidents	<= Last Year	1	2	2	3	2	0	0	4	2	
	Appraisals - Values Based (Non Medical) - Compliance		84.34%	87.95%	90.08%	90.44%	90.50%	90.47%	3.26%	10.78%	21.41%	
	Appraisals - Doctors and Consultants - Compliance		86.21%	81.58%	84.81%	86.94%	89.74%	83.03%	89.67%	89.82%	88.28%	
	Essential Core Skills - Compliance		89.59%	90.57%	90.61%	90.02%	90.37%	91.82%	91.62%	92.10%	92.32%	
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	YTD Plan = 4		3	3	3	3	2	4	4	4	
	Sustainability - Liquidity (YTD score)	YTD Plan = 1		1	1	1	1	1	1	1	1	
	Efficiency - I&E Margin (YTD score)	YTD Plan = 4		3	3	3	3	2	4	4	4	
	Controls - Distance from Financial Plan (YTD score)	N/A		1	1	1	1	1	1	1	1	
	Controls - Agency Spend (YTD score)	YTD Plan = 1		1	1	1	1	1	1	1	1	
	Overall finance and use of resources YTD score	N/A		2	2	2	2	1	3	3	3	
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	95.47%	95.86%	94.14%	90.87%	93.54%	94.54%	95.42%	93.70%	92.39%	
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	87.50%	100.00%	100.00%	100.00%	94.74%	87.50%	92.31%	77.78%		
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	86.38%	88.29%	82.13%	83.47%	84.24%	89.00%	89.78%	89.16%		
	Maximum 6-week wait for diagnostic procedures	99%	100.00%	99.94%	99.84%	99.85%	99.79%	99.93%	99.56%	99.77%	99.95%	
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	91.37%	91.41%	90.25%	91.10%	91.19%	91.73%	91.14%	92.01%	92.17%	

NHSI are yet to determine the assessment criteria of the following Single Oversight Framework metrics; Effective boards and governance, Use of data and Contributions to sustainability and transformation plans (STPs)

Operational Performance Report



For the period to end June 2017

Richard Renaut
Chief Operating Officer

1. Introduction

Please refer to the Board dashboard for performance metrics.

This narrative report accompanies the Board dashboard and outlines the Trust's actual and predicted performance against the priority operational performance targets. Exception reporting on other access and performance metrics in the SOF and/or key contractual/local priorities is included and is in the **Performance Indicator Matrix (see Reading Pack)**.

2. Single Oversight Framework Indicators

2.1 Current performance – June 2017

A&E 4 Hour Target and 12 Hour Breaches

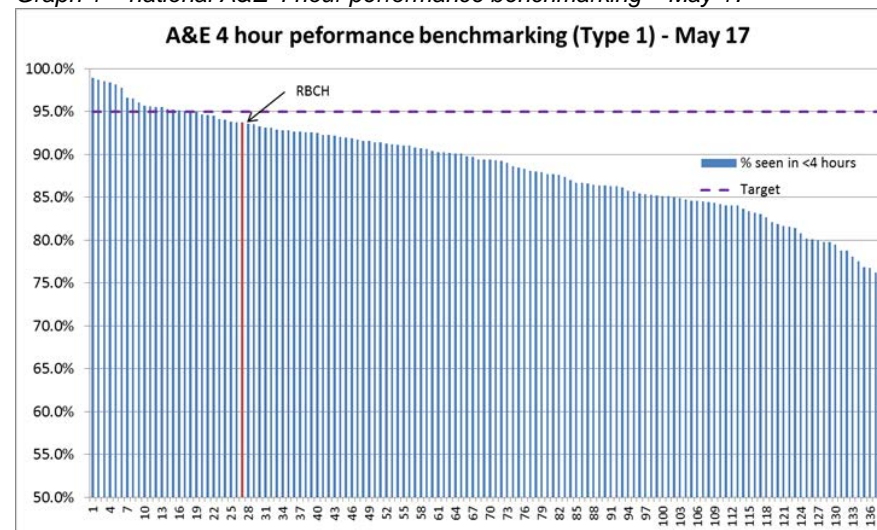
Although ED attendances overall reduced slightly in June compared to May, this level was 2.5% above the same period last year. Type 1 main ED attendances are up 4% in June 17 compared to June 16. A key impact on our reduced performance was a particular activity surge in the middle of June, which is likely to have been related to the heatwave seen at that time. Performance for June was 92.39%, though we did achieve 93.81% for the quarter which was just above our STF trajectory of 93.02% and secured the funds for Q1. Risk to Q2 is however, detailed below (Section 2.2).

Attendances (Type 1 and 2) are up by 1.54% year to date against last year. Urgent care admissions were down 3.16% on last June. No patients waited longer than 12 hours to be admitted.

The graph below shows our overall performance against the 4 hour target in May 2017 compared against the other Trusts with a Type 1 A&E Department. It continues to highlight the significant pressures

faced by all Emergency Departments though we remained within the top quartile.

Graph 1 – national A&E 4 hour performance benchmarking – May 17



RTT Incomplete Pathways (18 week) and 52 Week Breaches

Performance against the RTT Incomplete Pathway indicator for June was 92.2%, a further improvement on previous months and fully achieving the national target of 92%. This was also above our expected trajectory submitted to NHSI. We had no 52 week breaches.

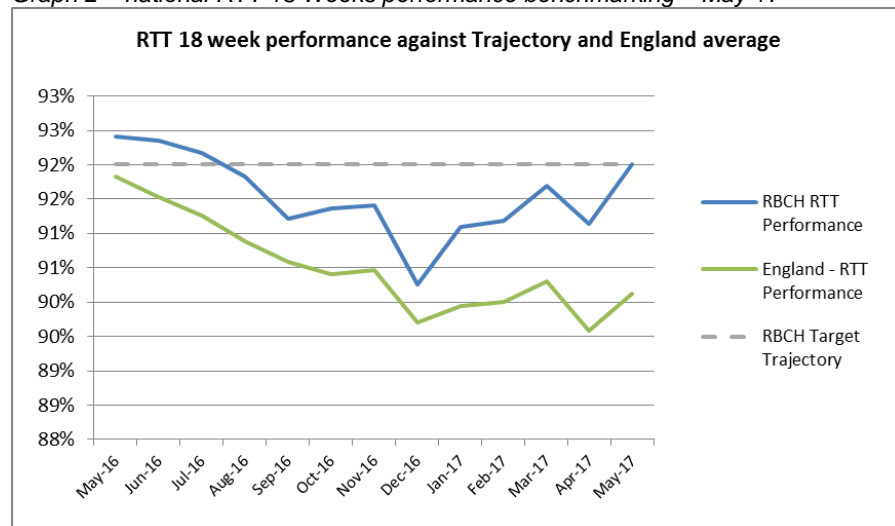
An improved position was seen across the majority of specialities by end June. However, further deterioration and non-compliant performance continued in Urology and Ophthalmology. As highlighted last month, this remains due to capacity pressures in both specialities predominantly due to medical staff gaps or changes. Orthopaedics, whilst remaining below 92%, did see a further improvement in performance.

We have also continued to perform well compared to the England average. However, risk to future months is highlighted in Section 2.2.

Operational Performance Report

As at 19/07/2017

Graph 2 – national RTT 18 Weeks performance benchmarking – May 17



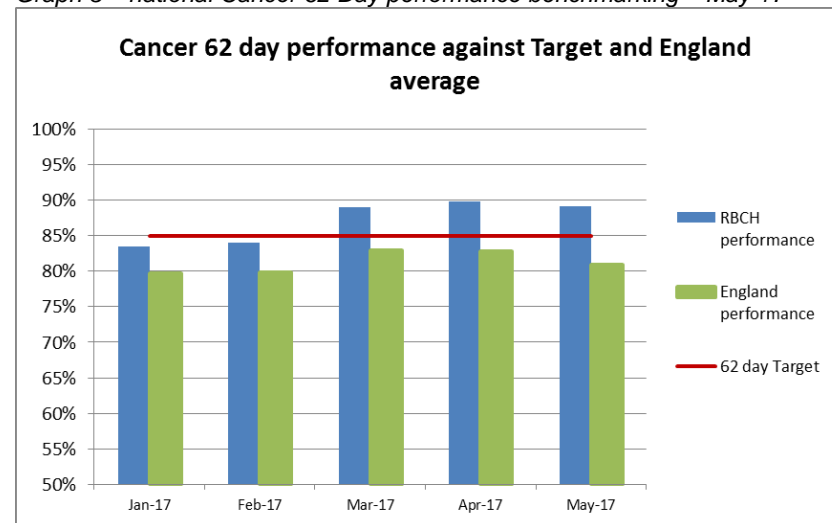
62 Day from Referral/Screening for Suspected Cancer to Treatment

For the month of May (*last formal reported month*) there were 11 breaches, with performance at 89.2%. This maintained the compliant performance seen in March and April and meant that we met the national target of 85% across the Quarter to date. We also continued to benchmark well against the national picture (see below graph) though highlight below some risk to Q2.

There were 5 breaches across 5 specialities and 6 breaches in Urology (a much higher volume tumour site).

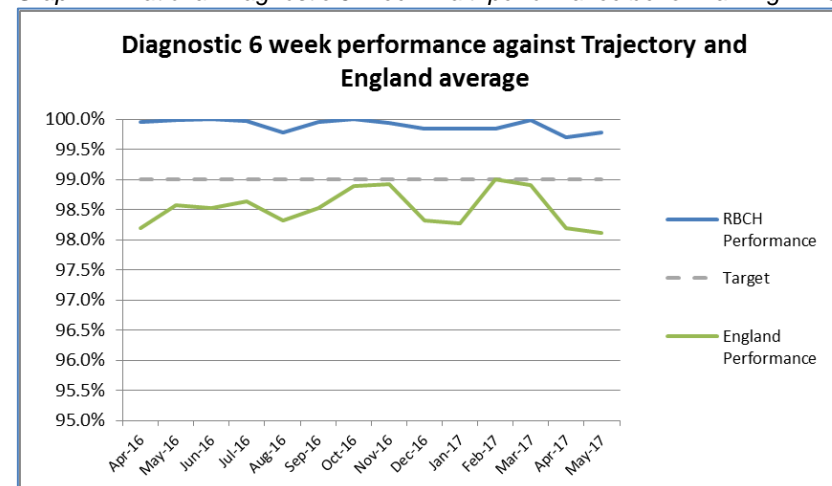
We had two patients breach against the 62 day target from breast screening to treatment, which due to the small number of total screening patients meant we were below target at 77.8%. These breaches were due to a changes in/fitness to proceed with treatment plan. Though we currently expect compliance for the quarter.

Graph 3 – national Cancer 62 Day performance benchmarking – May 17



Diagnostic 6 Week Wait

Graph 4 – national Diagnostic 6 Week Wait performance benchmarking – May 17



Operational Performance Report

As at 19/07/2017

The above graph shows the continued additional pressure across England in May, though noting we remained well above the 99% threshold and England average.

Our positive position continued in June with the final validated performance achieving 99.95%. Performance currently remains on track in the key areas (Endoscopy, Radiology, Cardiology and Urology).

2.2 Q1 and July - Forecast performance and key risks

Below indicates our forecast against the national targets and the expected 17/18 performance trajectories we submitted to NHSI for the key standards:

Table 1 – SoF Key Operational Performance Indicators Q1 & July 2017/18 Forecast

Single Oversight Framework Indicator	National Target	NHSI Trajectory	Mth / Qtrly	RAG rated forecast against national targets and NHSI submitted trajectories				
				Apr-17	May-17	Jun-17	Qtr 1	Jul-17
A&E 4hr maximum wait time*	95%	91-93%	Mthly	95.40%	93.70%	92.39%	93.81%	
RTT 18 week incomplete pathways	92%	91%	Mthly	91.14%	92.01%	92.20%		
Cancer 62 day wait for first treatment from urgent GP referral**	85%	85 - 85.4%	Mthly	89.80%	89.20%			
Cancer 62 day wait for first treatment from Screening service**	90%	90%	Mthly	92.30%	77.80%			
Maximum 6 weeks to diagnostic test	99%	99%	Mthly	99.70%	99.80%	99.95%		

RAG Key: Red - below national target and trajectory; Amber - above trajectory but below national target; Green - above national target (and trajectory)

*STF requirement increases to 95% for Q2

**June cancer final validated upload will be completed early August 17

For Q1 we expect to achieve the STF for the A&E target, being above our trajectory requirement of 93.02%, though below 95%. RTT does not attract STF and though the Quarter overall will be slightly below 92%, we have seen good recovery in May and June. Other targets are expected to remain fully compliant with the quarter target.

Going forward into Q2, we do expect ongoing risk against the full national targets for A&E (95%), RTT (92%), Cancer 62 day (85%) and Screening (90%). The key impact will be on our achievement of the

STF which requires us to meet an increased Q2 performance trajectory of 95%. Currently this remains significantly at risk with July at 92.88% to date. Below indicates the allocation of STF to the requirement to meet the three key trajectories: control total, A&E 4 hour and implementation of ED streaming to primary care.

Table 2 – STF quarterly allocation against 3 key requirements for 17/18

STF	Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000
Control Total	672	896	1,344	1,568	4,480
ED 4 Hour Target	144	192	288	336	960
ED Streaming	144	192	288	336	960
Total	960	1,280	1,920	2,240	6,400

We are currently undertaking full analysis of our performance against the **A&E 4 hour** standard, including detailed work on trends in arrivals and admissions. A new daily and weekly breach analysis process, overseen by our weekly, COO led Performance Management Group, has also been implemented. Work is already underway to map staffing rosters against recent arrival trends to identify potential areas for improvement. Though noting particular gaps in ED medical staffing and Emergency Nurse Practitioner cover is currently resulting in additional challenge to meeting the demand levels. Our work as part of the Flow QI programme continues, including the development of ED streaming to primary care and our focus on patients waiting over 7 days. However, the recent increased 'front door' pressure as well as acuity has resulted in increased outliers which has reduced the efficiency of our medical and specialist capacity and our flow. We also remain concerned about community and care package capacity as we go into the holiday season.

RTT 18 weeks has seen a sustained improvement for a second month. This is largely due to a reduction in both admitted and non admitted 18+ week backlog, though we have also seen an increase in the overall number of patients on our incomplete pathways waiting list.

The latter reflects a significant increase in referrals in March. We are also now seeing some increases in GP referral demand in some specialities in recent weeks. Through our Dorset-wide collaborative Right Referral, Right Care programme, we will need to understand whether this is reflecting a shift from pressures elsewhere across the system or a general increase in demand. We will also need to move our locality based projects on at pace, working on pathways in an identified speciality with primary, community and secondary care. Our work on the rollout of Advice & Guidance will also be key and requires ongoing support from our CCG colleagues to set up referral processes across primary care.

A significant risk is the continued growth in demand in Dermatology, exacerbated by the increase in fast track referrals and cancer surgery, which is pushing already long routine waits out further. Work is underway to rollout teledermatology as well as trialling 'high flow' surgical clinics. An away session will also be taking place across the acute providers, supported by COOs.

These demand pressures together with key medical staff capacity gaps (e.g. Urology, Ophthalmology) also mean that RTT remains at risk for July and Q2.

Despite expected compliance against the **Cancer 62 day** performance in Q1, some risks to Q2 performance are evident. We are currently working with NHSI on our plans to resolve this and have also submitted our work on 104 day 'backstop' breaches which have significantly improved. Although we were below compliance against the Screening target for May, we do currently expect Q1 target to be achieved. However, some risk will always remain, predominantly due to small numbers and patient choice, particularly over holiday periods.

Finally, diagnostic demand in relation to the **Diagnostic 6 week wait** target, particularly as a result of ongoing inpatient and fast track pathway pressures, will continue to be monitored with additional

activity supported in 17/18 by commissioners. However, we are currently forecasting a sustained positive performance position.

3. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail.

All other key targets reported to date for June have remained compliant or within expected ranges, excepting the Cancer 31 Day from Decision to Treat to Treatment. We were just below the 96% target at 94.9% in May (*last reported month*). This was due to 4 breaches under the Skin MDT, 5 Urology and 1 Breast. Reasons for breaches included patient DNAs/cancellation (3), changes to treatment plan/unfitness to proceed (3) and surgeon/surgical capacity (4). We do however, expect to be compliant for the Quarter target, anticipating a reduced number of breaches and improved performance in June.

4. Recommendation

The Board of Directors is requested to note the performance exceptions to the Trust's compliance with the Single Oversight Framework (17/18) and key contractual requirements, as well as the highlighted recovery actions.

BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017, Part 1
Subject:	Quality Report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery / Deputy Chief Executive
Author(s) of papers:	Jo Sims, Associate Director of Quality and Risk Rachel Bevan, Head of Patient Experience, Public Engagement and Volunteer Service
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee
Action required: Approve/Discuss/Information/Note	The paper is provided for information and assurance
Executive Summary: <ul style="list-style-type: none"> • 2 serious incidents were reported in June 2017 (1 of which met the criteria for an NHS Never Event) • The Trust remains in the top quartile for inpatient Family and Friends test scores and ED ranked in the second quartile in month. • The Trust has maintained performance with complaints acknowledgements, with a slight dip in the response times for June. 	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All domains
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	N/A

Quality Report



For the period to end June 2017

Paula Shobbrook
Director of Nursing and Midwifery/Deputy Chief Executive

1.0 Introduction

- 1.1 This report accompanies the Trust Quality Dashboard and outlines the Trust's actual performance against key patient safety and patient experience indicators. In particular it highlights progress against the trajectories for the priority targets set out in the Board objectives for 2017/18.

2.0 Serious Incidents

2.1 2 Serious Incidents were reported in June 17

- A Pressure Ulcer developed in association with an ill-fitting Plaster of Paris cast on lower arm fitted at another hospital. Initial investigation suggests it was not clear who should take responsibility for the management of the Plaster of Paris.
- The wrong femoral artery was punctured during the start of a lower limb angioplasty. This was identified and the correct groin punctured and the correct procedure undertaken. The patient did not come to any clinical harm. This meets the criteria of a Wrong Site Surgery Never Event.

Scoping meetings have been held for both incidents, RCA investigations are in progress and SI panel dates arranged. Recommendations and learning points will be shared following completion of the SI investigation process.

3.0 Patient Experience Report – July 2017 (containing May 2017 data)

3.1 Friends and Family Test

Inpatient and day case Friends and Family Test (FFT) national performance in May 2017 ranked RBCH Trust 2nd with 16 other hospitals out of 172 placing RBCH in the top quartile based on patient satisfaction. The response rate was sustained above the 15% national standard at 16.3%.

The Emergency Department FFT performance in May 2017 ranked RBCH Trust 8th with 10 other hospitals out of 141 placing RBCH ED department in the second quartile. The response rate of 3.2% is a slight increase, against the 15% national standard.

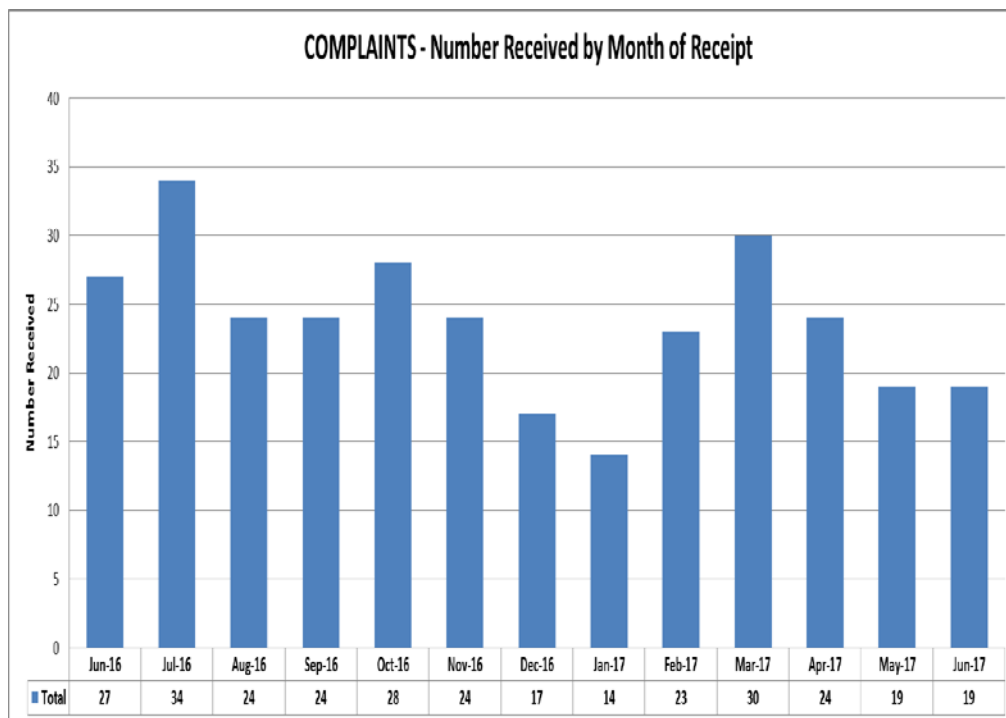
Outpatients FFT performance in May 2017 ranked RBCH Trust 3rd with 26 other Trusts out of 234 Trusts, placing the departments in the Top quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

3.2 Care Audit Trend Data

The Care Audit Campaign continues with close monitoring. Focus groups continue on call bells, noise at night, food and drink, and pain management. New questions are highlighting areas for improvement and work with the QI team around patient flow will help to address these issues. This is reported into the Healthcare Assurance Group and Committee.

3.3 Complaints Summary Report

Formal written complaints are trending down compared with this time last year and concerns via PALs are showing a slight increase. This demonstrates a proactive approach with concerns being resolved at an earlier point and not escalating to formal written complaints. A total of 19 complaints were received in June all of which had a response within the required 3 days.



The percentage of formal responses answered within the Trust standard of 25 days was not achieved in June, for the first time in 9 months This will be reviewed at HAC on 27 July.

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Rolling 12 months	Current Month Jul-17
1st Responses Due in Month	25	32	29	21	30	22	18	12	24	24	28	22	287	21
Number where 1st Response Completed within 25 working days	17	20	21	17	28	21	16	12	20	20	25	16	233	8
Percent with 1st Response within 25 working days	68%	63%	72%	81%	93%	95%	89%	100%	83%	83%	89%	73%	81%	38%

CARE GROUP	COMPLAINTS		
	Number Due	Number on time	% on time
CGRPA	9	9	100%
CGRPB	10	7	70%
CGRPC	2	0	0%
PRIVTE	1	0	0%
GRAND TOTAL	22	16	73%

4.0 Recommendations

The Board of Directors is asked to note the report which is provided for information and assurance.

*providing the excellent care we
would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017 – Part I
Subject:	Financial Performance
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Yes
Officer with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of papers:	Ian Metcalfe, Interim Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required: Approve/Discuss/Information/Note	The Board of Directors is asked to note the financial performance for the month ending 30 th June
Executive Summary:	The financial reports are detailed in the attached papers.
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Well-led
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	Four current financial risks exist on the risk register related to next year's financial planning. The actions are being monitored through the Finance Committee.

**The Royal Bournemouth and
Christchurch Hospitals NHS
Foundation Trust**

Finance Report



For the period to 30 June 2017

Ian Metcalfe
Interim Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £1.999 million as at 30 June, being £13,000 better than budgeted.

Sustainability and Transformation Fund

The Trust has achieved its year to date financial control total set by NHS Improvement thereby securing access to the Sustainability and Transformation Fund. The Trust has also achieved the Accident and Emergency 4 hour trajectory and as a result, the Trust has accrued the associated Fund income in full amounting to £960,000.

Cost Improvement Programme

Financial savings of £1.829 million have been achieved to date, which is £827,000 behind the targeted value. This reflects the current gap between the full year target and the value of identified schemes. Further schemes continue to be identified to close this gap.

Employee Expenses

The Trust continues to carefully manage its workforce, with a relentless focus on recruitment and retention, to minimise the need for agency staffing. During June the Trusts reported agency expenditure was lower than both the ceiling value agreed with NHS Improvement and the expenditure reported within the same period last year. Strong performance continues to be seen in relation to nursing, admin and clerical, and other professional staff groups; with medical agency expenditure remaining high. Whilst this is expected to fluctuate during the year, medical agency expenditure is forecast to reduce overall when compared to the prior year.

Forecast Outturn

The Trust continues to forecast a full year deficit of £6.648 million, consistent with the revenue control total agreed with NHS Improvement.

Capital Expenditure

As at 30 June £1,376,000 of capital expenditure has been committed, which is £405,000 less than planned at this point in the year. The forecast is for total capital expenditure of £9.424 million.

Cash

The Trust is currently holding a consolidated cash balance of £29.1 million. The forecast end of year cash balance is £21.6 million meaning that no Department of Health support is required during the current financial year.

Financial Risk Rating

In line with the agreed financial plan, the Trust has achieved a Use of Resources score of 3 under NHS Improvement's Single Oversight Framework (1 being best and 4 being worst). This is expected to remain consistent for the remainder of the financial year.

Recommendation

Members are asked to note the Trusts financial performance to 30 June 2017.

Finance Report

As at 30 June 2017

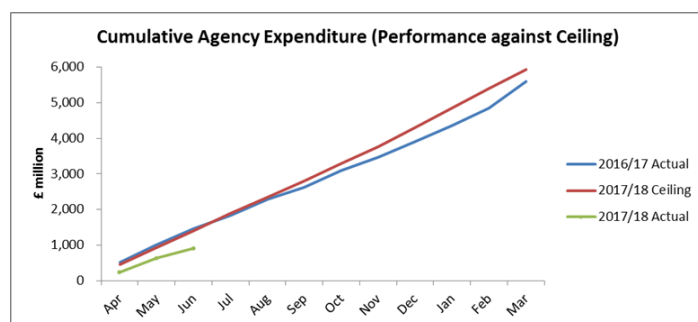
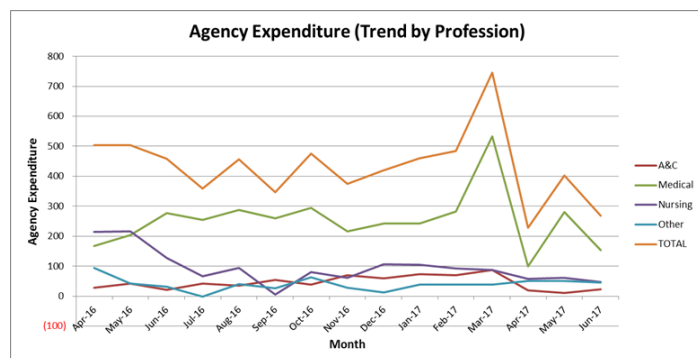
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000
NHS Clinical Income	61,238	61,730	493
Non NHS Clinical Income	1,678	1,268	(409)
Non Clinical Income	7,044	7,051	7
TOTAL INCOME	69,960	70,050	90
Employee Expenses	44,310	44,634	(324)
Drugs	8,120	7,685	436
Clinical Supplies	7,862	8,786	(925)
Misc. other expenditure	11,679	10,943	736
TOTAL EXPENDITURE	71,972	72,049	(77)
SURPLUS/ (DEFICIT)	(2,012)	(1,999)	13

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	43,908	43,908	0
NHS England (Wessex LAT)	9,944	10,464	521
NHS West Hampshire CCG (and Associates)	6,123	6,124	1
Other NHS Patient Income	1,263	1,234	(29)
Sustainability and Transformation Fund	960	960	0
Non NHS Patient Income	1,678	1,268	(409)
Non Patient Related Income	6,084	6,091	7
TOTAL INCOME	69,960	70,050	90

Sustainability and Transformation Fund Income	Budget £'000	Actual £'000	Variance £'000
Financial: Control Total (70%)	672	672	0
Performance: A&E Trajectory (30%)	288	288	0
TOTAL	960	960	0

Agency Expenditure

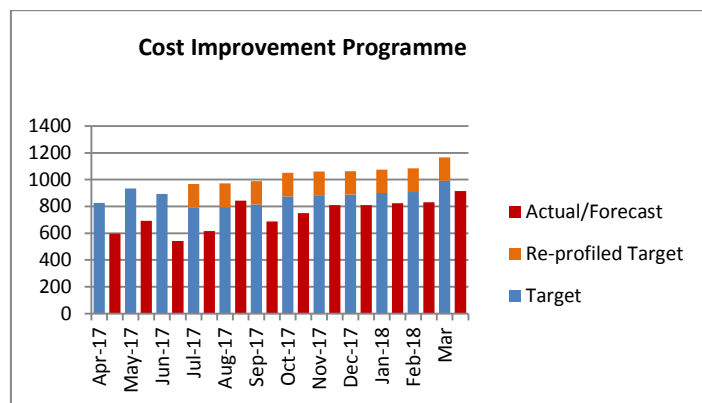


Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	3,394	3,109	(285)
Medical Care Group	2,476	1,758	(718)
Specialties Care Group	1,850	1,708	(141)
Corporate Directorates	(8,599)	(8,550)	49
Centrally Managed Budgets	(1,133)	(24)	1,109
SURPLUS/ (DEFICIT)	(2,012)	(1,999)	13

Cost Improvement Programme

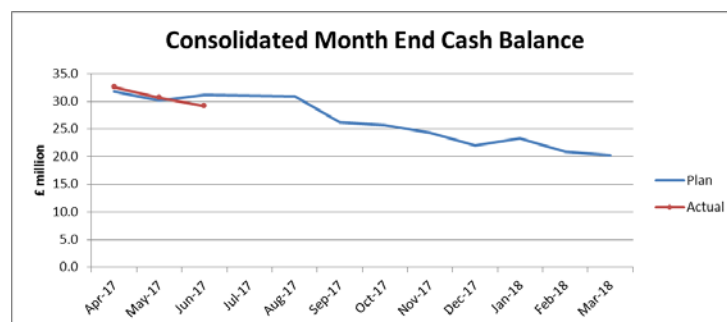
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	482	316	(166)
Medical Care Group	893	457	(436)
Specialties Care Group	829	622	(207)
Corporate Directorates	452	434	(18)
Total	2,656	1,829	(827)



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	813	669	144
IT Strategy	750	661	89
Medical Equipment	200	17	183
Centrally Managed	18	29	(11)
TOTAL	1,781	1,376	405

Cash



Finance Report

As at 30 June 2017

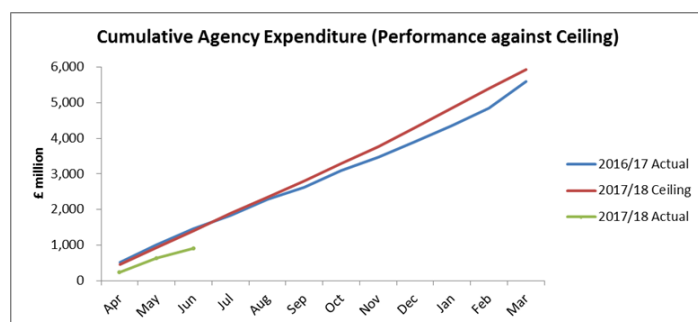
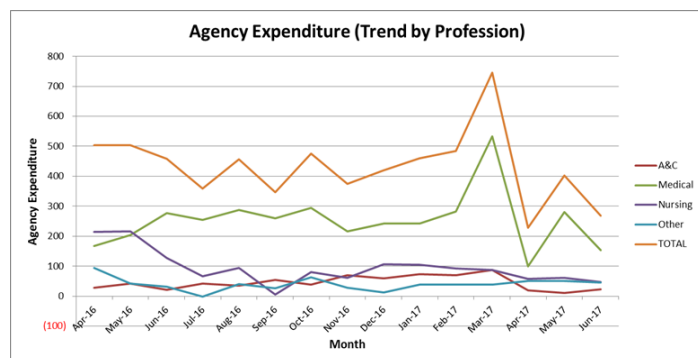
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000
NHS Clinical Income	61,238	61,730	493
Non NHS Clinical Income	1,678	1,268	(409)
Non Clinical Income	7,044	7,051	7
TOTAL INCOME	69,960	70,050	90
Employee Expenses	44,310	44,634	(324)
Drugs	8,120	7,685	436
Clinical Supplies	7,862	8,786	(925)
Misc. other expenditure	11,679	10,943	736
TOTAL EXPENDITURE	71,972	72,049	(77)
SURPLUS/ (DEFICIT)	(2,012)	(1,999)	13

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	43,908	43,908	0
NHS England (Wessex LAT)	9,944	10,464	521
NHS West Hampshire CCG (and Associates)	6,123	6,124	1
Other NHS Patient Income	1,263	1,234	(29)
Sustainability and Transformation Fund	960	960	0
Non NHS Patient Income	1,678	1,268	(409)
Non Patient Related Income	6,084	6,091	7
TOTAL INCOME	69,960	70,050	90

Sustainability and Transformation Fund Income	Budget £'000	Actual £'000	Variance £'000
Financial: Control Total (70%)	672	672	0
Performance: A&E Trajectory (30%)	288	288	0
TOTAL	960	960	0

Agency Expenditure

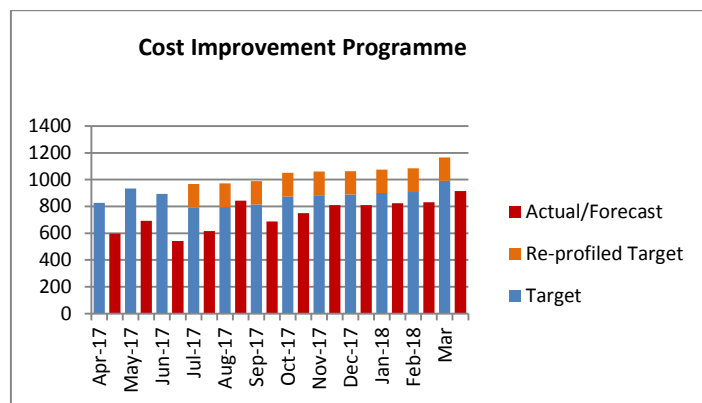


Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	3,394	3,109	(285)
Medical Care Group	2,476	1,758	(718)
Specialties Care Group	1,850	1,708	(141)
Corporate Directorates	(8,599)	(8,550)	49
Centrally Managed Budgets	(1,133)	(24)	1,109
SURPLUS/ (DEFICIT)	(2,012)	(1,999)	13

Cost Improvement Programme

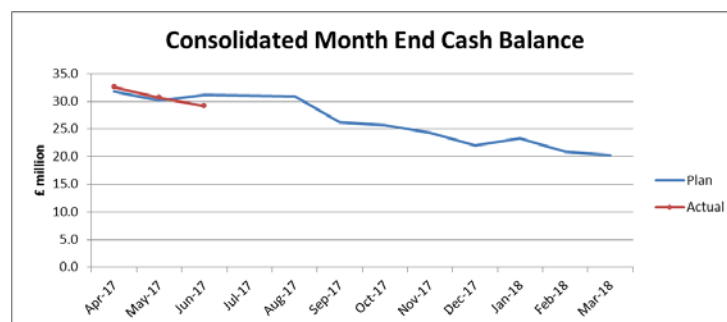
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	482	316	(166)
Medical Care Group	893	457	(436)
Specialties Care Group	829	622	(207)
Corporate Directorates	452	434	(18)
Total	2,656	1,829	(827)



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	813	669	144
IT Strategy	750	661	89
Medical Equipment	200	17	183
Centrally Managed	18	29	(11)
TOTAL	1,781	1,376	405

Cash



*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017 – Part 1
Reason for Part 2:	n/a
Subject:	Workforce Report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Karen Allman
Author(s) of papers:	Karen Allman , Bridie Moore
Details of previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC, Education & Training Committee
Action required: Approve/Discuss/Information/Note	For discussion and noting areas highlighted.
Executive Summary: The paper shows workforce statistics including turnover, vacancy rate and sickness absence, and demonstrates the progress towards achieving the essential core skills target.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Well Led. Providing appropriate staffing to deliver effective and safe care.
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	Recruitment, Appraisal Compliance, Essential Core Skills (mandatory training) compliance, and workforce planning are all existing risks on the risk register.

The Royal Bournemouth and Christchurch
Hospitals NHS Foundation Trust

Workforce Report



For the period to 31st July 2017

Karen Allman
Director of Human Resources

Workforce Report

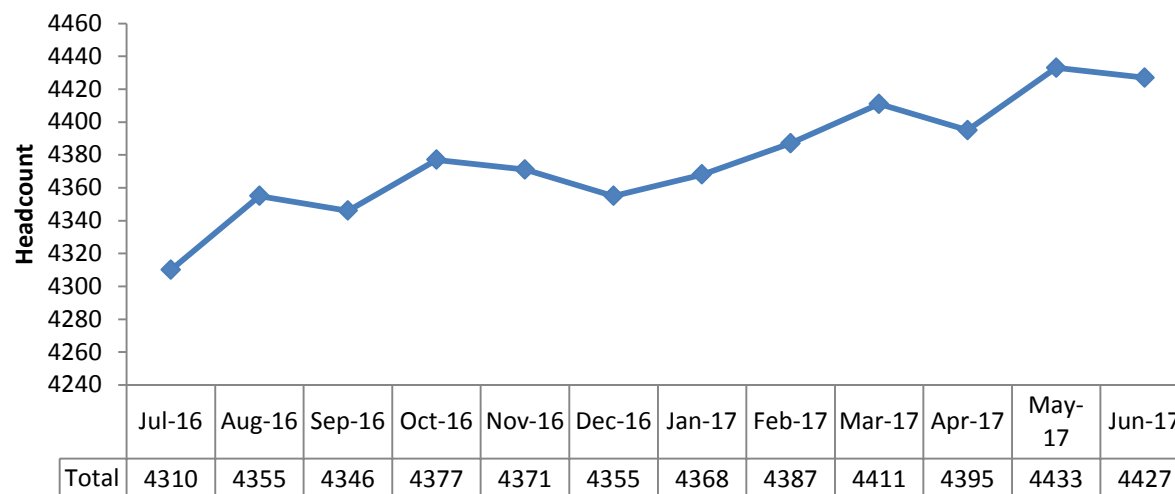
As at 31st July 2017

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 June			Rolling 12 months to 30 June				At 30 June
Surgical	19.4%	88.4%	91.0%	4.87%	16061	14.1%	11.8%	
Medical	21.8%	82.2%	91.4%	4.17%	20835	13.0%	10.4%	
Specialities	18.8%	95.4%	93.5%	3.78%	11487	11.9%	10.7%	
Corporate	25.0%	0.0%	95.5%	3.96%	12036	8.4%	10.0%	
Trustwide	21.4%	88.3%	92.3%	4.20%	60419	12.0%	10.7%	

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 June			Rolling 12 months to 30 June				
Add Prof Scientific and Technical	36.5%		94.4%	3.95%	1733	14.8%	15.5%	
Additional Clinical Services	17.4%		91.0%	6.29%	16115	22.1%	14.1%	
Administrative and Clerical	24.5%		95.5%	3.78%	11532	9.4%	9.9%	
Allied Health Professionals	26.3%		93.7%	2.83%	2569	13.7%	11.9%	
Estates and Ancillary	13.7%		94.1%	5.37%	6673	10.3%	11.6%	
Healthcare Scientists	19.2%		96.3%	1.91%	661	11.7%	16.6%	
Medical and Dental		88.3%	87.0%	1.23%	1963	6.3%	5.0%	
Nursing and Midwifery Registered	21.2%		92.7%	4.54%	19173	8.6%	8.8%	
Trustwide	21.4%	88.3%	92.3%	4.20%	60419	12.0%	10.7%	

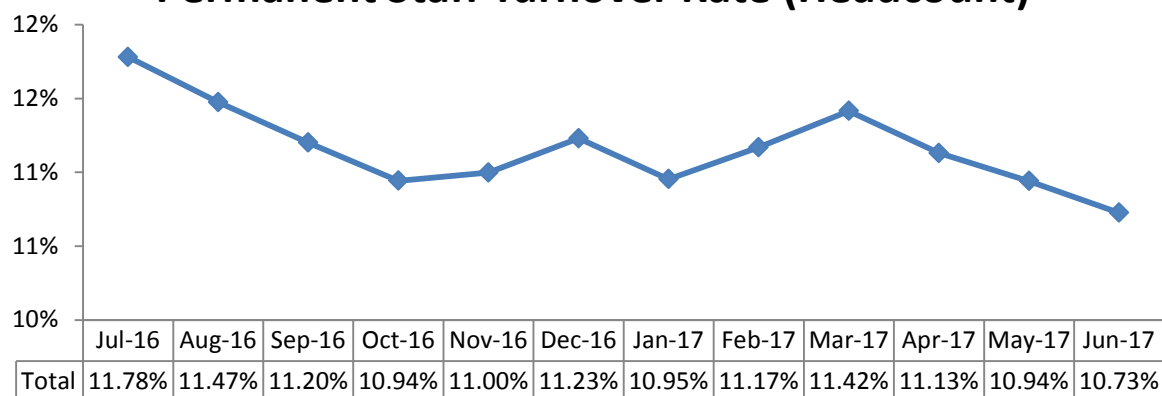
1. Staffing and Recruitment

Substantive Staff (Headcount) Trend



The information demonstrates that the turnover rate has reduced for the third consecutive month and is at its lowest point for the last 12 months, against an increased joining rate, at 12% for June, the highest for the period.

Permanent Staff Turnover Rate (Headcount)

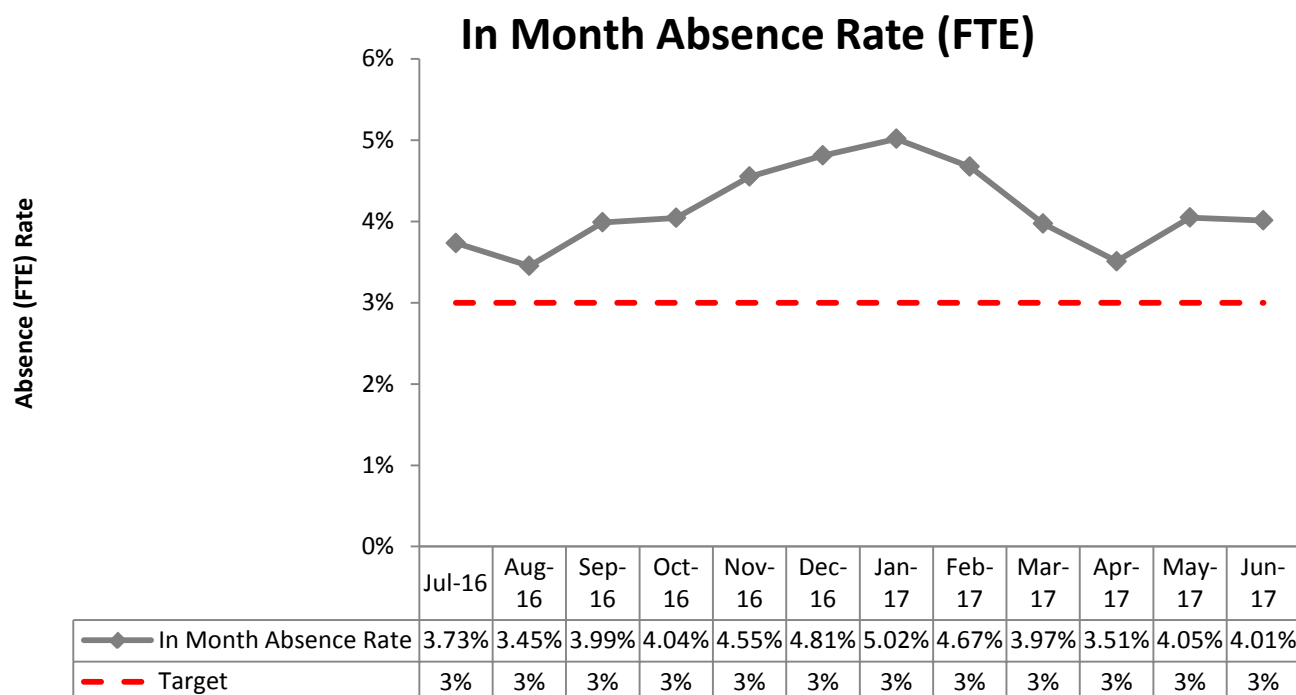


2. Essential Core Skills Compliance

Overall compliance continues above the 90% mark at 92.3%. The target is 95% by December 2017 and we are making slow but steady improvement month on month towards it. As part of the BSS (business support services) work across Dorset, we have a programme to standardise the essential core skills training and frameworks. The subject content is currently mandated by Health Education England as part of the UK core skills framework but the method of delivery and refresher periods are not specified although there is national E'learning content for some subjects.

The BEAT (Blended Education and Training) team were recognised at the national Healthcare People Management awards recently in London. This was for the development and delivery of the virtual learning environment and our “green brain” which was recognised as showing strong staff engagement. Whilst we didn't win the overall prize we were shortlisted and were in the top three.

3. Sickness Absence



Workforce Report

As at 31st July 2017

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Surgical	3.74%	4.01%	4.79%	5.04%	5.91%	5.62%	5.55%	4.76%	4.48%	4.08%	4.53%	4.81%
Medical	3.83%	3.44%	3.87%	3.58%	4.40%	4.82%	4.99%	4.67%	4.19%	3.42%	4.30%	4.00%
Specialties	3.36%	2.67%	3.83%	4.04%	4.09%	4.77%	5.32%	5.17%	3.40%	3.18%	3.17%	3.32%
Corporate	3.93%	3.63%	3.49%	3.74%	3.82%	4.01%	4.23%	4.12%	3.66%	3.37%	4.00%	3.85%
Trust	3.73%	3.45%	3.99%	4.04%	4.55%	4.81%	5.02%	4.67%	3.97%	3.51%	4.05%	4.01%

Sickness absence levels remain challenging and the focus continues on the appropriate management of sickness absence, and in developing the Health and Wellbeing support provided in the organisation. This is another strand of work across Dorset supported as part of the CSR programme as we work together with NHS and other organisations to identify other support for staff. The chart above shows in month sickness levels as distinct from the rolling 12 months and I am pleased to say that the number of reds is decreasing.

4. Friends & Family Test

In June 2017 we carried out our Quarter 1 Staff Impressions survey for 2017. This includes the Friends and Family Test questions and an additional measure of staff engagement. We now have 4 years of data to compare. This quarter we had 579 respondents (13%).

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

There was significant improvement in respondents reporting that they were likely or very likely to recommend the Trust as a place to work. 94% stated that their overall impression of the Trust was mainly good.

Our results for this quarter support the improvements seen in the 2016 National Staff Survey, and also compare favourably with our benchmark Trusts.

However, we must also note there were many free text comments about staff not feeling valued and teams being stretched beyond their capacity. We are currently reviewing these to develop a response.

5. People Strategy

Work continues on the development of the Trust People Strategy. Workshops are taking place throughout the summer to develop and refine our plan and this will be brought back to the Board in September for approval.

*providing the excellent care we
would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 July 2017 Part 1
Reason for Part 2:	N/A
Subject:	Clinical Services Review
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	N/A
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Paula Shobbrook, Director of Nursing and Midwifery/Deputy Chief Executive
Details of previous discussion and/or dissemination:	Ongoing discussions at TMB and Board
Action required:	Information
Executive Summary: A brief update on the Consultation and final decision making process, the bid for capital funding, the process to redesign services and the recent informal meeting with the Competition and Markets Authority.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

Clinical Services Review

This paper has been developed to ensure the Board of Directors is aware of ongoing work to implement the Clinical Services Review (**CSR**). It provides an update on progress with key issues and is for information.

1. CCG Consultation and Final Decision-Making Process

The results of the public consultation have been received by the CCG and careful consideration of this is underway. Broadly, the consultation feedback was supportive of the CCG's plans although some ongoing and significant concerns had been expressed by the residents of both Poole and the Purbeck localities given the proposed relocation of services from Poole Hospital. Equally relevant at this time is the public support for the separation of Paediatric and Maternity services between east and west Dorset and the plans currently being developed between Dorset County Hospital and Yeovil Hospital to create integrated Paediatric and Obstetric services for their local populations.

The CCG is undertaking more detailed work on travel, clinical risk, equality impact and public health to provide a greater understanding of the impact. A number of Clinical Directors and Executives attended a "deep dive" session on acute configuration organised by the CCG, which provided an opportunity to consider at a more detailed level whether there is a need to recalibrate plans at a Specialty level. The CCG Governing Body will consider the consolidated feedback from the deep dive workshops, the confidence of the system to implement the changes, the outcomes and impact of the consultation feedback including the additional work as outlined above. This will inform the final version of the decision-making business case, which will be considered by the CCG in September.

2. Taking forward the design of services to implement the model of planned and emergency sites

The work to define how services both individually and collectively will be provided in the context of the finalised model will be critical to influencing the design of facilities at the two hospital sites in the east of Dorset. There is substantial work required, as one would expect given the degree of change proposed. In particular the provision of Obstetric services, inpatient Oncology, Critical Care services, urgent care and the ED services require further clinical input to work through the detail underpinning the proposed models.

The RBCH Trust Management Board and Poole Hospital Executive Group had a joint meeting on 4th July, recognising the importance of clinical leadership and the process to agree how a number of services will be provided as part of the proposed model. Once this is clear it will help other specialties plan how they wish to use the two sites and to clarify issues relating to clinical dependencies whilst noting that a final decision on the use of sites will not be made until September.

With regard to the latter it is important that any options address issues of patient safety, clinical effectiveness and value and can be delivered within the workforce that will be available.

3. Securing the Capital

The Programme Business Case which represents the first step in the Treasury process to secure capital for the physical rebuilding of the two sites is in development. At this stage the case centres on the need to secure sufficient capital to enable the preferred option. The critical facilitating step within this is the re-design and strengthening of both community and primary care services. Within the Programme Business Case there is a detailed section covering a sensitivity analysis which models possible changes in some of the key assumptions which underpin the planning and request for capital.

At the time of writing, we have been advised that the Dorset capital request features amongst those presently being considered by the Secretary of State and an announcement is expected imminently.

4. Competition and Markets Authority

The Chief Executives from both Poole Hospital and the Royal Bournemouth and Christchurch Hospitals met with the Competition and Markets Authority (**CMA**) on 10 July with representatives from NHS Improvement's transaction team also present. The meeting was arranged in response to a request from both Trusts to get a better understanding of the process the CMA would follow in light of the merger undertakings in place as the Trusts looked to implement the CSR after Dorset CCG's decision in September.

It was a very positive and supportive meeting which began with the Chief Executives providing an overview of the CSR, setting out the scale and extent of the changes to services proposed by the move to a major emergency hospital and one major hospital for planned care in the east of Dorset as well as the development of clinical networks with Dorset County Hospital in the west of Dorset. This included presenting, at a high level, the benefits for patients.

The intention is that we develop our own Benefits Case and finalise this prior to triggering a CMA review in the autumn.

5. One Acute Network Board

Chairs, non-executive directors and a number of the Executive team from Poole Hospital and RBCH met on 28 June for the first one acute network joint programme board. Lead/deputy lead governors also attended the meeting. This was a positive meeting which enabled consideration of the timeline, programme approach and governance to progress our joint work to implement the CSR. Feedback will be formalised for the Board of Directors as the programme board commences the work programme.

Paula Shobbrook
Director of Nursing and Midwifery/Deputy Chief Executive

BOARD OF DIRECTORS

Meeting Date and Part:	28 July 2017 Part 1
Subject:	Quality Strategy 2017/18
Section on agenda:	Strategy and Risk
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery / Deputy Chief Executive
Author(s) of papers:	Jo Sims, Associate Director of Quality and Risk Ellen Bull, Deputy Director of Nursing
Action required: Approve/Discuss/Information/Note	Information and Assurance
Executive Summary: The attached report provides details of the Quality Strategy objectives for 2017/18.	
Relevant CQC domain:	All domains
Risk Profile:	N/A

*providing the excellent care we
would expect for our own families*

Quality Strategy 2017/2018

*Our Strategic Plan
2015/20*



Document Control

Approval Committee	Version	Issue Date	Review Date	Document Author(s)
Board of Directors Healthcare Assurance Committee	1	July 2013	July 2014	Joanne Sims, Associate Director of Quality and Risk Ellen Bull, Deputy Director of Nursing and Midwifery
	2	June 2014	June 2015	
	3	October 2015	March 2016	
	4	April 2016	March 2017	
	5	May 2017	May 2018	

Version Control

Version	Date	Author	Section	Principle Amendment Changes
2	May 2014	JS	2.1 – 2.3 App A&B	Revision of 2014/15 and 15/16
3	October 2015	JS/EB	All	Linked to sign up to safety improvements plan and new Trust strategic objectives/Refreshed strategy objectives
4	April 2016	JS/EB	All	To align with Trust objectives 2016/17
5	May 2017	JS/EB	All	To align with Trust objectives 2017/18

Consultation

<p>Those listed opposite have been consulted and comments/actions incorporated as required.</p> <p>(Author to ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval)</p>	<p>List Groups and/or Individuals Consulted</p> <p>Senior Nurses Board of Directors Healthcare Assurance Committee Clinical Governance and Risk Committee Council of Governors</p>
--	---

Quality Strategy

1.0 What is our current position on quality at the Trust?

We will deliver excellent care for our entire patient population: Patient safety and putting the patient first will always be our foremost responsibility. Patients will be able to tell us that they have received excellent care and that they have been treated with dignity and respect. We will, through our patient surveys, measure, learn and improve from what our patients tell us.

We will achieve excellent quality and outcomes: Patients assume that their hospital is a safe place. It is our duty and responsibility to protect them from unintentional harm. Therefore this value shall be integral to all staff development plans and we will ensure that all staff feel that they can contribute to the quality of care that patients receive, and that every member of staff's priority regardless of position, occupational group or profession is to improve the quality of patient care.

1.1 What is a quality strategy?

A quality strategy details the aims, objectives, time-scales, responsibilities and monitoring processes of how to achieve the Trust strategic goals for patient safety, patient outcome and patient experience.

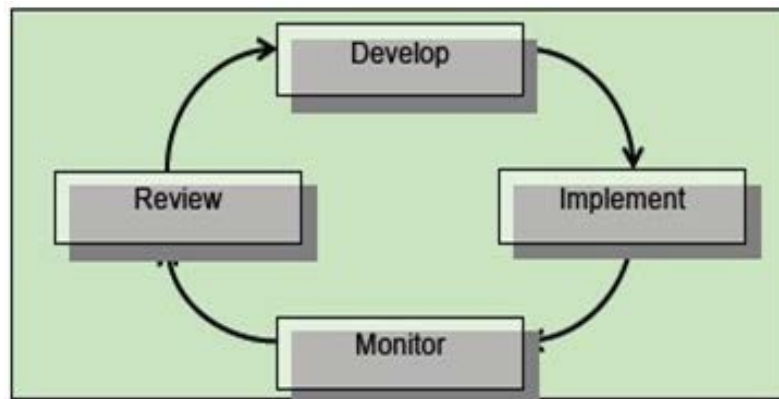
The strategy aligns with the Trust Annual Plan and Annual Quality Report and informs business planning and communication processes. It provides a narrative to stakeholders, patients, the general public and staff about our commitment to high quality.

The strategy is the driver for delivering future healthcare that is safe, clinically effective and a positive experience for all those involved. It reflects corporate activity (in the main body of the document), as well as that identified by individual departments within the Trust.

1.2 Why is a quality strategy important?

In 2008, a national review of quality by Lord Darzi, led to the widespread implementation of his recommendations to achieve 'High Quality Care for All' (2008). This was followed by the Government's commitment to quality through legislation (the Health and Social Care Act, 2008). To ensure organisations operate within this legislation, the Care Quality Commission (CQC) was established as the official regulator of the NHS. The CQC continually reviews NHS performance against the 'essential standards of quality and safety' (CQC 2009). Finally the measures of quality have been explicitly set down in the recent governmental white paper entitled 'Equity and Excellence for All' (Department of Health (DoH) 2010) and its associated document 'The NHS Outcomes Framework' (DoH 2010). The Francis Reports 2010 and 2013 both cite the importance of clear vision and transparent operating partnered with a duty of candour to ensure quality is embedded and appropriately risk assessed in any process within the Trust.

The Trust has an obligation to implement what is set down in these documents and is performance managed against them. It is the content of these documents that will form the quality strategy you are about to read.



2.0 Aims and Objectives

Ensuring high quality care requires organisations to develop a culture where staff are supported to work safely and can utilise the best available evidence to guide and reflect on practice. It is reliant on strong leadership, effective partnership, continuous learning and innovation to deliver safe care. The continuous improvement cycle is integral to this:

This strategy sets out how The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust promotes, coordinates and reviews quality, safety and clinical governance. It outlines the Board of Directors current overarching strategic goals and key quality drivers and defines Executive management and others responsibilities for leading and managing quality and driving forward the agenda.

2.1 Trust Objectives

In 2017/18 our priority is to support continuous improvement for patients. We aim to do this by:

- 1. Valuing our staff**
Recognising the contribution of our staff and helping them develop and achieve their potential.
- 2. Improving quality and reducing harm**
Focusing on continuous improvement and reduction of waste.
- 3. Strengthening team working**
Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset.
- 4. Listening to patients**
Ensuring meaningful engagement to improve patient experience

2.2 Quality Priorities 2017/18

Following review and consultation, the Trust Quality Account for 2016/17 sets out the quality priorities for 2017/18 as follows:

- Managing Sepsis
- Identification and escalation of the deteriorating patient
- Improving hospital (patient) flow

Specific aims and objectives for these priorities and of the patient safety, clinical effectiveness and patient experience measures are set out in the following section of the strategy.

3.0 Specific Quality Objectives for 2017/18

3.2.1 Patient Safety

- Aim to ensure that the number of Never reported in year is zero.
- Reducing the number of repeat fallers and total number of falls with harm.
- Reducing the number of avoidable Hospital Acquired pressure ulcers.
- Encourage incident reporting and be in the top quartile for reporting patient safety incidents by 100 admissions (as measured via the National Reporting and Learning System).
- Ensure the Duty of Candour is met for all serious incidents reported.
- Reduce the number of serious incidents reported in year causing serious patient harm.
- Achieve 0 MRSA bacteraemia cases.
- Reduce the number of lapses in care to below 14.

3.2.2 Clinical Effectiveness

- Ensure all National Audits are implemented in year (Healthcare Quality Improvement Partnership (HQUIP) Audit Plan).
- Ensure at least 95% compliance against the Trust Clinical Audit Plan.
- Reduce hospital mortality as measured by Hospital Standardised Mortality Ratio (HSMR) and SHMI. Enable 75% of all inpatient deaths to be reviewed via the e-mortality case note review process.
- To treat everyone with quick Sepsis related Organ Failure Assessment (qSOFA) positive Sepsis within one hour and all other Sepsis patients within 3 hours of admission or diagnosis of Sepsis.
- To ensure that every patient with an early warning score (NEWS) of 9 or above is escalated for prompt review and then seen by an appropriate clinician within 30 minutes of their initial trigger.
- To improve emergency hospital flow to deliver the right patient at the right time, to the right place. As measured by:
 - 95% of patients admitted, transferred or discharged from the ED within 4 hours.

- All inpatients have a senior review before midday.
- 90% of new patients are given an EDD within 24 hours of admission.
- 33% of patients discharged from inpatient wards are discharged before midday.
- 100% of inpatients with a length of stay in excess of 7 days will be systematically reviewed with clean management plans in place.
- Outliers are reduced.
- Cancelled operations as a result of lack of bed availability are reduced.

3.2.3 Patient Experience

- Sustain the care groups to optimise the foundation of care (food and drink, noise at night, and call bell away).
- To reduce the number of complaints based on 16/17 performance that are investigated by the Parliamentary Health Service Ombudsmen.
- To reduce the number of complaints that lead to a second letter from the original complainant, from the 16/17 performance.
- To be within the top quartile of hospitals nationally for the Friends and Family Test.
- Sustain performance for FFT score on aggregate.
- Achieve 75% of complaint responses within 25 days.
- Develop the public engagement plan.

In addition to the above objectives, specific workforce objectives are incorporated into the Trust valuing our people strategy and strengthening team working. These include improving training and development opportunities for staff, improving mandatory training compliance, improving staff satisfaction, improving recruitment and retention and reducing sickness absence.

4.0 Accountability

4.1 Board level accountability

The overall responsibility for delivery of the quality agenda rests with the Chief Executive. This responsibility is delegated to the Director of Nursing and Midwifery, in conjunction with the Medical Director, who has executive responsibility for ensuring that risk management, patient safety, quality and patient experience is delivered throughout the organisation and remains a Trust priority and an integral part of the Trust policies and procedures.

Information in the Board and Healthcare Assurance Committee reports will routinely include:

- Locally defined priorities and performance against them
- National requirements and performance against them

- High priority outcomes and actions
- Exception reporting and risk based narrative commentary
- Trends – current and future risk, assurance and quality issues
- Internal comparisons and external benchmarks
- Directorate, specialty, ward and consultant level data where appropriate
- Quantitative and qualitative data
- Patient stories
- Statistical interpretation and analysis

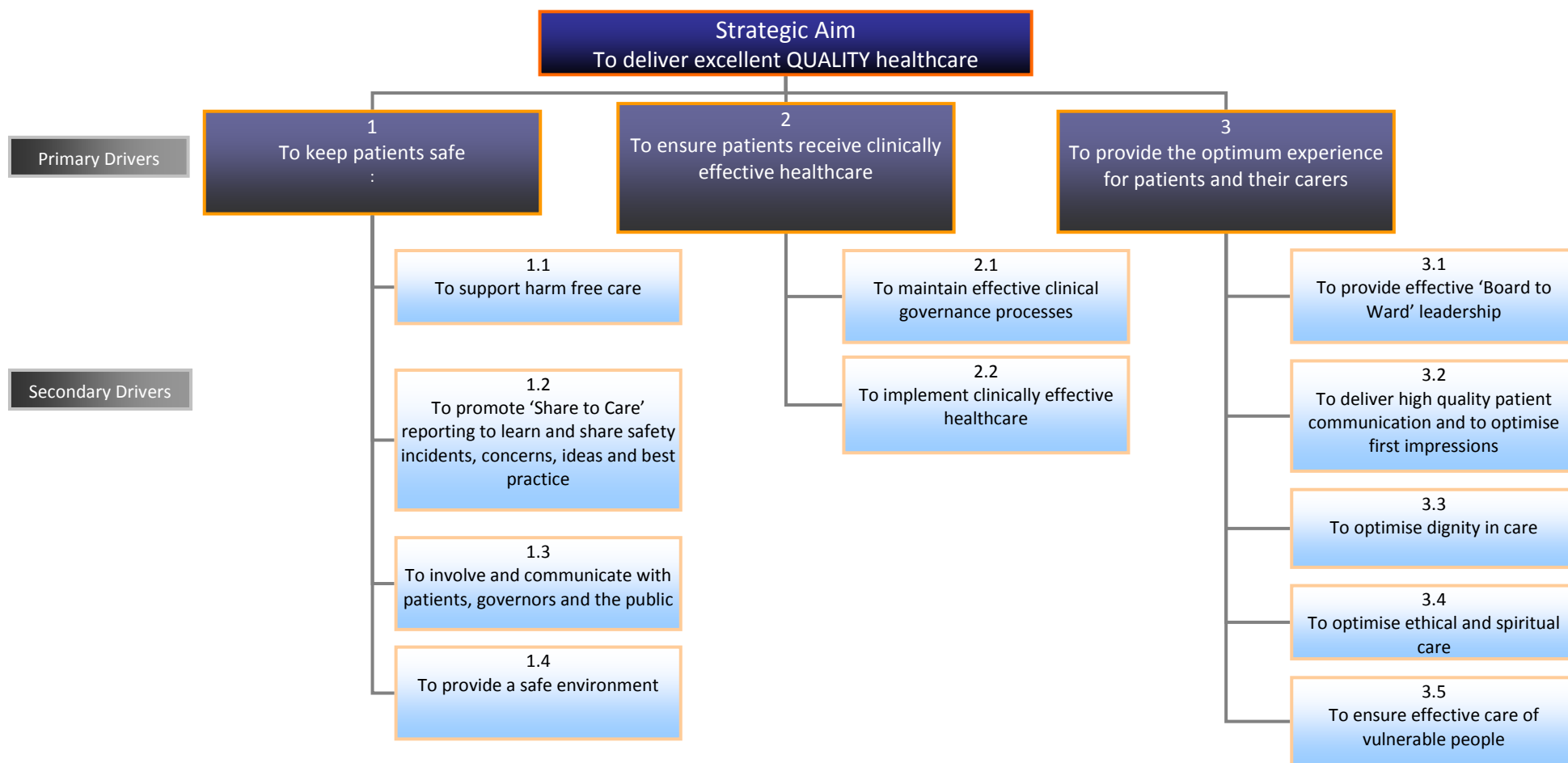
The Trusts quality strategy and performance is reviewed by a number of external organisations and stakeholders:

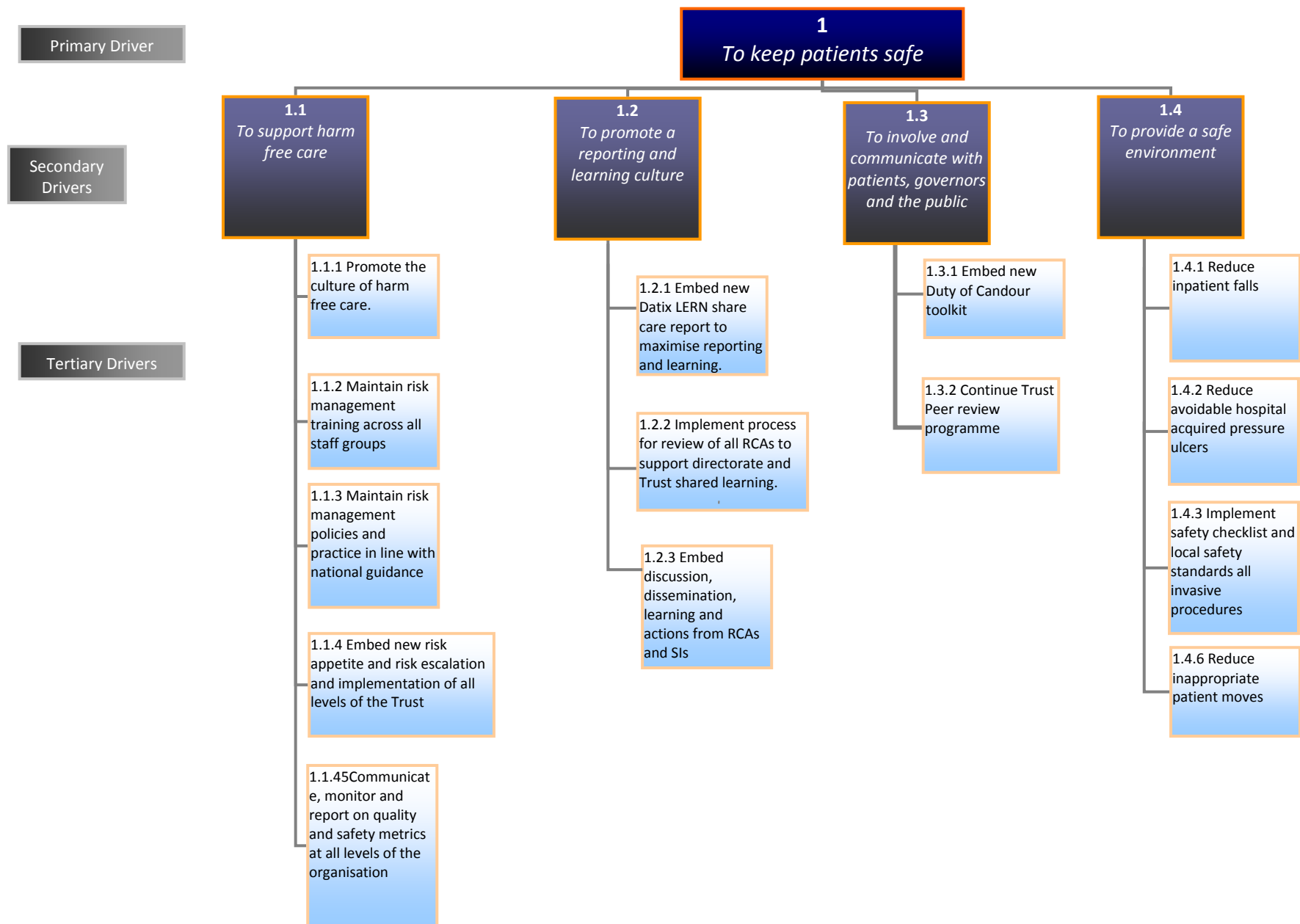
- CQC – review of compliance against the CQC regulatory framework and essential standards via announced and unannounced reviews and inspections.
- Monitor – review of compliance against Monitor Quality Governance Framework
- Clinical Commissioning Groups – review of compliance against National and local CQUIN targets and contractual quality provisions, outcomes and assurance, routine and ad hoc inspections
- Local Healthwatch – review and publically comment on the Trust Annual Quality Report
- Council of Governors – routine monitoring of patient safety, patient experience and patient outcome measures, risks and performance
- Local Health Overview and Scrutiny Committees -review and public comment on the Trust Annual Quality Report
- External Auditors - review and public comment on the Trust Annual Quality Report, completion of annual Internal Audit plan.

5.0 How are we going to deliver our strategy?

To achieve the strategic aim, the Trust has identified ‘drivers’ within each of the domains of the quality framework. ‘Drivers’ are a simple term for interventions needed to achieve the aim. They can be split up into primary, secondary and tertiary drivers depending on their scope and level of detail. Once they have all been identified and mapped out, they provide a visual guide to how quality initiatives interlink. Measures of success can then be identified, attributed and continuously monitored. This will provide the Trust at every level within its operating framework with assurance that the strategy is being monitored on progression to delivery.

The primary (or main) drivers for the strategic aim are the domains of the quality framework.

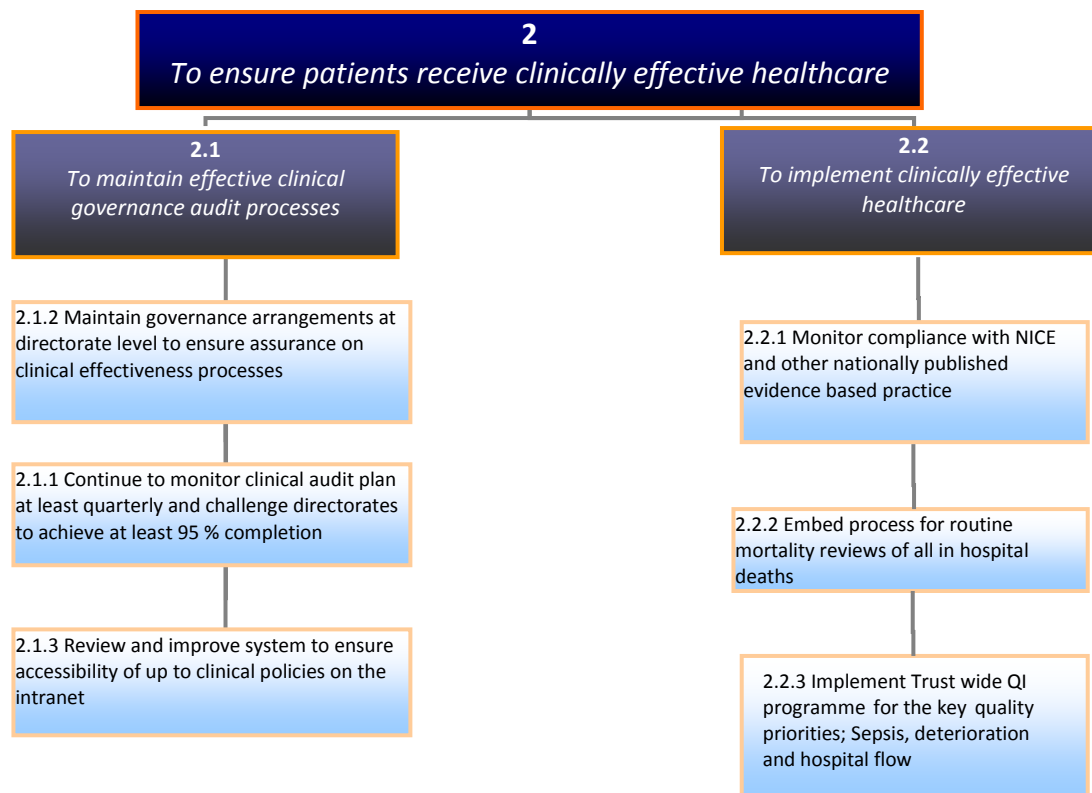


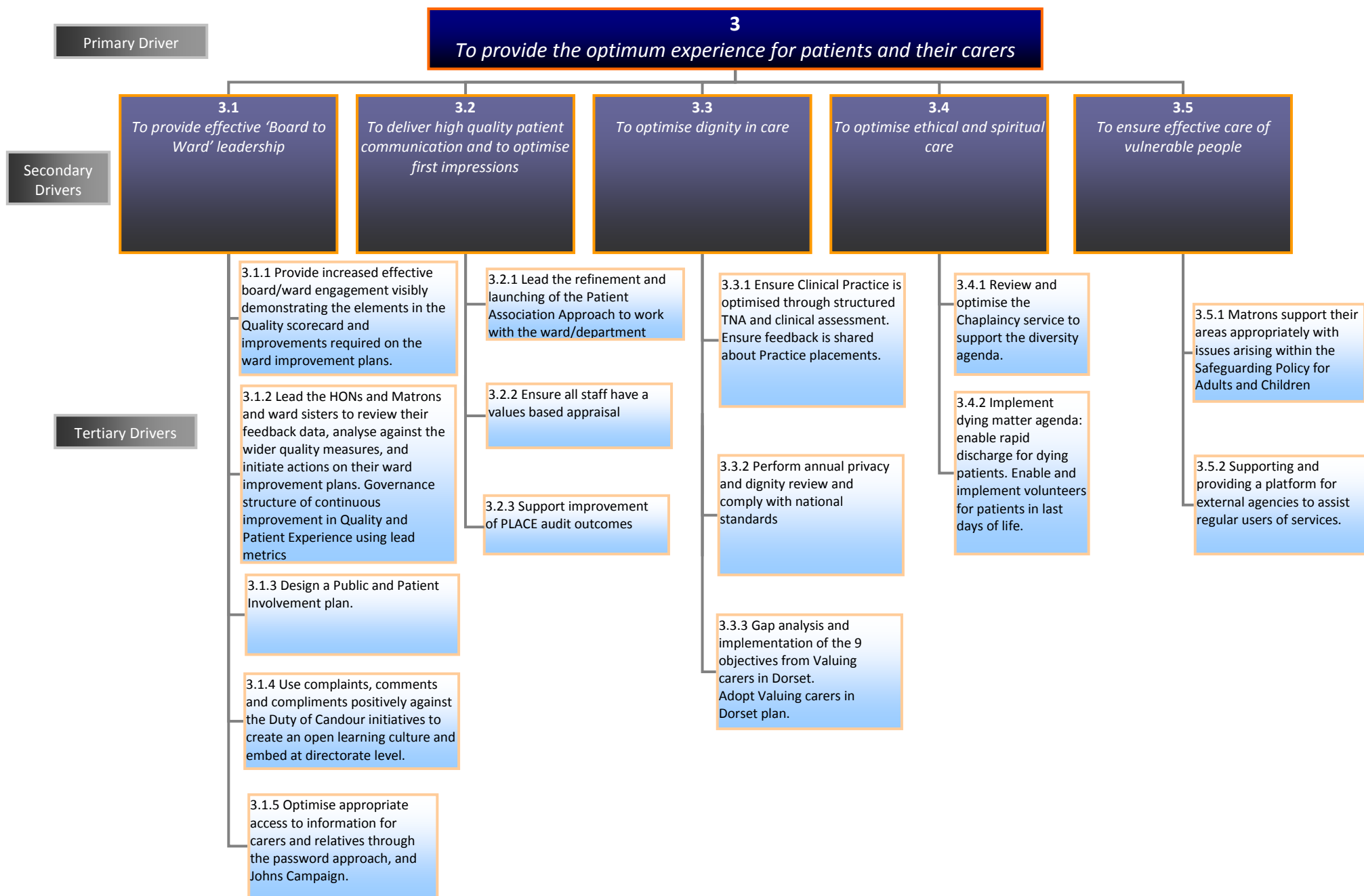


Primary Driver

Secondary Drivers

Tertiary Drivers





1. Outcomes of the Quality Strategy

Primary Driver	Secondary Driver	Tertiary Drivers/Quality Theme	Quality Targets for 2017/18
1. To keep patients and staff safe	1.1 To maintain and improve a positive safety culture	1.1.1 Promote a culture of harm free care	<ul style="list-style-type: none"> Reducing Harm from Inpatient Falls. Reducing the number of Hospital Acquired Pressure Ulcers. MRSA: 0, Clostridium Difficile: less than 14. Improve incident reporting and achieve the middle quartile for reporting patient safety incidents by 100 admissions (NRLS data set). Maintaining a lower than national average for patient safety incidents causing severe harm or death (NRLS data).
		1.1.2 Maintain Risk Management training across all staff groups	<ul style="list-style-type: none"> Provide a risk management training programme to include RCA, risk assessment and doc.
		1.1.3 Maintain Risk Management policies and practice in line with national guidance	<ul style="list-style-type: none"> Annual review of Risk Management strategy. Ensure all risk management policies are reviewed in agreed timescales.
		1.1.4 Embed new risk appetite and risk escalation and implementation of all levels of the Trust	<ul style="list-style-type: none"> Report on risk appetite and risk register.
		1.1.5 Communicate, monitor and report on quality and safety metrics of all levels of the organisation	<ul style="list-style-type: none"> Produce monthly dashboard to QARC, HAC, TMB and BoD.

Primary Driver	Secondary Driver	Tertiary Drivers/Quality Theme	Quality Targets for 2017/18
	1.2 To promote a reporting and learning culture	1.2.1 Embed share to care	<ul style="list-style-type: none"> • Embed use of new LERN forms. • Share and benchmark LERN 'Share to Care' information as part of Trust governance structure and as part of CCG and Wessex AHSN.
		1.3.2 Embed discussion, dissemination, learning and actions from RCAs and SIs	<ul style="list-style-type: none"> • All Serious Incidents to be reported and investigated in accordance with statutory timescales. • Ensure discussion and implementation and learning from RCAs and SIs is a standard agenda item on every Care Group, Directorate and Speciality Quality/Clinical Governance meeting.
		1.2.3 Improve discussion, dissemination, learning and actions from RCAs and SIs	<ul style="list-style-type: none"> • Serious Incident shared learning reports to be presented to BoD, QARC and Directorate Clinical Governance Forums. • Implement quarterly learning bulletins on SIs • Hold annual learning event.
	1.3 To involve and communicate with patients, governors and the public	1.3.1 Implement Duty of Candour	<ul style="list-style-type: none"> • Embed Duty of Candour Policy and processes. • Ensure Duty of Candour is met for all serious incidents.
		1.3.2 Continue Trust Peer review programme	
	1.4 To provide a safe environment	1.4.1 Reduce inpatient falls	

Primary Driver	Secondary Driver	Tertiary Drivers/Quality Theme	Quality Targets for 2017/18
		1.4.2 Reduce avoidable hospital acquired pressure ulcers	
		1.4.3 Implement safety checklist for all invasive procedures	
		1.4.4 Reduce inappropriate patient moves	
2. To ensure patients receive clinically effective healthcare	2.1 To maintain effective clinical governance processes	2.1.1 Monitor compliance against clinical audit plans	<ul style="list-style-type: none"> • National Audit Participation Rate: 100%. • Allocation of Audits: 100%. • Audit Action Plans: 100%.
		2.1.2 Maintain governance arrangements at directorate level to ensure assurance on clinical effectiveness processes	<ul style="list-style-type: none"> • All directorates to identify a Clinical Audit lead. • All directorates to include Clinical Audit, NICE, Clinical Policies on Directorate Clinical Governance Meeting agendas. • Directorate to achieve 95% compliance against annual audit plan. • All Directorate leads to attend at least 50% of CAEG meetings.
		2.1.3 Review and improve system to ensure the accessibility of up to date clinical policies on the intranet	<ul style="list-style-type: none"> • Review and revise Document Control Policy. • Reduce number of out of date policies available on the intranet.

Primary Driver	Secondary Driver	Tertiary Drivers/Quality Theme	Quality Targets for 2017/18
	2.2 To implement clinically effective healthcare evidence	2.2.1 Monitor compliance with NICE and other nationally published evidence and best practice	<ul style="list-style-type: none"> • Implementation of NICE Guidance: 90%. • Implementation of Guidance from National Confidential Enquiries: 90%. • Implementation of all Alerts issued by Central Alert Broadcasting system: 100%.
		2.2.2 Implement process for routine mortality reviews of all in hospital deaths	<ul style="list-style-type: none"> • 75% of in hospital deaths reviewed using eMortality form. • All specialities to use a standard Mortality Review Process and M&M template.
		2.2.3 Implement Trust wide QI programme for 2017/18 quality priorities (as per Quality Account)	<ul style="list-style-type: none"> • See metrics for Sepsis, deteriorating patient and hospital flow.
3. To provide the optimum experience for patients and their carers	3.1 To provide effective 'Board to Ward' leadership	3.1.1 Provide increased board/ward engagement 3.1.2 Review metric and governance structures for review 3.1.3 Design a public and patient involvement plan 3.1.4 Support DoC 3.1.5 Optimise access to information for carers and relatives	<ul style="list-style-type: none"> •

	3.2 Deliver high quality patient communication and to optimise first impressions	<p>3.2.1 Lead the refinement and launching of the Patient Association Approach to work with the ward/dept</p> <p>3.2.2 Ensure all staff have a values based appraisal</p> <p>3.2.3 Support PLACE audit improvement</p>	<ul style="list-style-type: none"> Review and refine and implement Patients Association Complaints Approach. Achieve over 95% compliance Improve results
	3.3 To optimise dignity in care	3.3.1 Clinical Practice is optimised through structured Training needs analysis, and clinical assessment.	<ul style="list-style-type: none"> Training needs analysis structure is implemented. Adopt the Mentorship regional improving Mentorship campaign. Review structure of Mentorship application, funding, support and update training.
		<p>3.3.2 Perform annual privacy and dignity review and comply with national standards</p> <p>3.3.3 Gap analysis and implementation of the 9 objectives from valuing carers in Dorset</p>	<ul style="list-style-type: none"> Annual Privacy and Dignity Audit to be completed. Annual programme of Focus Groups to be completed and feedback into the organisation with shared learning. A programme of patient and carer Focus Groups to ensure feedback on the services we provide are gathered, collated and improved and equality and diversity needs are met.
	3.4 Optimise ethical and spiritual care	3.4.1 Review and optimise the Chaplaincy service to support the diversity agenda	<ul style="list-style-type: none"> Chaplaincy and Bereavement care guidelines and patient information produced. Review of Chaplaincy rosters, service provision. Expand the volunteer Chaplaincy functions.

		3.4.2 Ensure all staff practice in accordance with the Care of Dying patient Policy with appropriate patients and relatives	
	3.5 To Ensure effective care of vulnerable people	3.5.1 Matrons support their areas appropriately with issues arising within the Safeguarding Policy for Adults and Children	<ul style="list-style-type: none"> • Undertake annual audit of compliance against policy. • Achieve 95% compliance against mandatory training requirements for all staff groups. • Ensure Matrons are enabled to support areas with safeguarding arising concerns.
		3.5.2 Supporting and providing a platform for external agencies to assist regular users of services.	

*providing the excellent care we
would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 July 2017 Part 1
Subject:	Trust Constitution
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	Draft Constitution with the changes highlighted
Officer with overall responsibility:	David Moss, Chairperson
Author(s) of papers:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Constitution Joint Working Group – July 2017 Council of Governors – 20 July 2017
Action required:	Decision
Executive Summary: <p>The Board of Directors is asked to approve the amendments described in the attached paper and highlighted in the draft Constitution in the Reading Pack. These amendments are proposed following the annual review by the Constitution Joint Working Group and approval by the Council of Governors.</p>	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Well-led
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	N/A

Trust Constitution July 2017

The Constitution is reviewed annually. The following changes are recommended by the Constitution Joint Working Group for approval by the Board of Directors, having been approved by the Council of Governors. The amendments have been highlighted in the draft of the Constitution included in the Reading Pack.

Tenure of Governors

An amendment is proposed to section 14.1 of the Council of Governors to set out the process for allocating tenure of office to Governors where terms of less than three years are proposed. Three years is the maximum term of office for elected governors permitted by the National Health Service Act 2006.

Terms of less than three years were used when foundation trusts were first established to ensure continuity on the Council of Governors by allowing governors to be appointed for different terms, usually two of three years, so their end of their tenure in office did not coincide. It also meant that elections were not required each year. The means by which different terms have been allocated has been set out as part of the election process.

Terms of less than three years have been used since then to regularise the length of tenure when these have become bunched around a particular point in time. This occurs as a result of resignations by governors or removal from office prior to the end of their term in office. Again the effect of doing this is to ensure a level continuity of membership on the Council of Governors and reduce the number of elections and the associated costs.

Disqualification and Removal of Governors

A new section 15.1.5 has been added to reflect amendments to paragraph 8 of Schedule 7 of the National Health Service Act 2006.

Sealing of Documents

It is proposed to amend the provisions around the sealing of documents in paragraph 9.3 of the Standing Orders of the Board of Directors at Annex 7 of the Constitution to provide greater flexibility, particularly if either the Chief Executive or Chairperson is not available when a document is required to be sealed. It is possible for NHS foundation trusts to execute deeds otherwise than under seal but this is not something which has been widely adopted.

Exclusion of Public from Members' Meetings

It is proposed to amend paragraph 1.3 of Annex 8 of the Constitution to allow the exclusion of the members of the public from Member's Meetings to mirror the provisions for meetings of the Board of Directors and the Council of Governors. This is permitted by Monitor's Code of Governance for foundation trusts.

Miscellaneous Amendments

Other minor changes have been made to ensure consistency in the use of terminology or to correct errors.

*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017 – Part 1
Reason for Part 2:	n/a
Subject:	Workforce Strategy & Development Committee Terms of Reference
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Karen Allman
Author(s) of papers:	Karen Allman
Details of previous discussion and/or dissemination:	Reviewed and agreed at Workforce Committee on 15 th June 2017
Action required: Approve/Discuss/Information/Note	Approve
<p>Executive Summary:</p> <p>The Terms of Reference for the Workforce Strategy & Development Committee were reviewed at their meeting on 15th June. An updated version is tabled for Board approval.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	Well Led.

COMMITTEE FOR WORKFORCE STRATEGY AND DEVELOPMENT

TERMS OF REFERENCE

The Committee for Workforce Strategy and Development (the “Committee”) is a sub-committee of the Board which is responsible for the consideration of matters relating to workforce planning and development, and Human Resources Policy and People Strategy. This includes People Engagement & Communications; OD, Leadership, Talent & Management Development; Workforce Planning & Forecasting; Recruitment & Retention; Education & Training; People Policies, Processes & Systems; Equality, Diversity & Inclusion; People Health & Wellbeing.

The Committee also acts as a means of internal assurance for compliance against the Care Quality Commission’s essential standards of quality and safety: Outcome 12 - Requirements relating to workers; Outcome 13 – Staffing; Outcome 14 - Supporting Workers; and the Trust objective of Valuing our Staff.

1. Membership

- 1.1 The Committee Chairman (the “Chairman”) shall be a Non-Executive Director. In the absence of the Chairman the deputy Chair shall be the Director of Human Resources.
- 1.2 Standing members of the Committee shall include a Non-Executive Director x2, Director of Human Resources, Medical Director, Director of Nursing and Midwifery, Director of OD & Leadership, Director of Medical Education, Clinical Skills & Professional Education Manager, Medical Education Manager, Head of HR Strategy, Head of HR Operations, Organisational Development Manager, and Director of Operations for Care Groups A, B and C.
- 1.3 Only members of the Committee have the right to attend Committee meetings but if a standing member is unable to attend it is expected that he/she will ensure their nominated deputy is invited and can attend in his/her place, notifying the Chairman.

There will be one governor attending each meeting as an observer. Observers are not technically members of the Committee. This governor has been elected to undertake this duty by the Council of Governors by means of a ballot organised by the Trust Secretary in accordance with the process agreed by the Council of Governors.
- 1.4 It is expected that members attend a minimum of 3 meetings per year.
- 1.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.

2. Secretary

The Secretary to the Director Human Resources (the “Secretary”) or their nominee shall act as the secretary of the Committee.

3. Quorum

The quorum necessary for the transaction of business shall be three members, including a NED. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4. Frequency of Meetings

The Committee shall meet every two months.

5. Notice of Meetings

5.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend at least 4 working days prior to the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of Meetings

6.1 The Secretary to the Director of HR shall minute the proceedings and resolutions of all meetings of the Committee, including recording the names of those present and in attendance.

6.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

7. Duties

The duties of the Committee can be categorised as follows:

7.1 People Strategy

7.1.1 To drive the development and monitor the execution of the Trust's People Strategy which will support how the Trust develops, supports and values its workforce.

7.2 Workforce Development & Planning

7.2.1 To ensure that workforce planning and development is considered and appropriate actions are taken to address workforce requirements. The planning process in the NHS is affected by a range of broader political, regulatory and professional policy decisions which are related to workforce modernisation. The Committee aims to pre-empt these changes and anticipate associated workforce requirements.

7.2.2 To review the productivity of the Trust workforce, the Workforce Committee will review plans for the development of new roles and skill mixes to include the utilisation of resources and financial/workforce balance for staff now and in the future.

7.3 Recruitment and Retention

7.3.1 To effect the balance of demand for staff with its supply - to ensure that sufficient numbers of appropriate qualified personnel are available, in the

right place and at the right time, with the right skills, to match the demand for their services.

- 7.3.2 To monitor attrition rates in order to anticipate deficits in numbers of personnel and identify and implement actions to minimize turnover wherever possible.

7.4 Training and Development

- 7.4.1 To anticipate changes in Professional Education and Essential Core Skills training to ensure compliance and the continued provision of high quality care.
- 7.4.2 To monitor the provision of Training and Development and implement solutions which deliver a skilled, flexible and modernised workforce improving productivity, performance and reducing health inequalities.
- 7.4.3 The Essential Core Skills Training Group will report to the Workforce Committee and will report on progress against action plans.

7.5 Organisational Development and Leadership

- 7.5.1 To provide governance and oversight for the Trust-wide culture change programme and development of the Leadership Strategy.

7.6 Equality, Diversity and Inclusion

- 7.6.1 The Diversity and Inclusion Committee will report to the Workforce Committee and will report on progress against action plans.

8. **Reporting Responsibilities**

- 8.1 The Committee shall report bi-monthly on its activities to the Board of Directors by way of Minutes and any report by the Chairman.
- 8.2 The Committee shall provide annual assurance to the Board of Directors that the Care Quality Commission's essential standards for quality and safety (Outcomes 12, 13, 14) are monitored and shall highlight any gaps in compliance, controls or assurance.

Outcome 12	Requirements relating to workers People are kept safe, and their health and welfare needs are met, by staff who are fit for the job and have the right qualifications, skills and experience.
Outcome 13	Staffing People are kept safe, and their health and welfare needs are met, because there are sufficient numbers of the right staff.
Outcome 14	Supporting Workers People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised.

9. **Other**

The Committee shall:

- 9.1 have access to sufficient resources in order to carry out its duties;
- 9.2 give due consideration to laws and regulations;

- 9.3 oversee any investigation of activities which are within its terms of reference;
- 9.4 at least once a year review its own performance and terms of reference to ensure it is operating at maximum effectiveness and discuss any changes it considers necessary.

10. Authority

The Committee is authorised:

- 10.1 to seek any information it requires from any employee of the Trust in order to perform its duties;
- 10.2 to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its Terms of Reference.

11. Supported Strategic Goals

The Committee aims to support the Trust fulfil the following strategic objectives:

- 11.1 To strive towards excellence in the services and care we provide;
- 11.2 To listen to, support, motivate and develop staff.

12. Sub-Committees

The following Committees are established by and responsible to the Workforce Strategy & Development Committee:

Essential Core Skills Training Group

Diversity & Inclusion Committee

*providing the excellent care we
would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 th July 2017 – Part I
Subject:	Finance and Performance Committee Terms of Reference
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	No
Officer with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of papers:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required: Approve/Discuss/Information/Note	The Board of Directors is asked to note the Finance and Performance Committee Terms of Reference
Executive Summary:	The terms of reference have been reviewed by the Finance and Performance Committee and are presented to the Board for approval.
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Well-led
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	Four current financial risks exist on the risk register related to next year's financial planning. The actions are being monitored through the Finance Committee.

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

The Finance and Performance Committee is a committee established by and responsible to the Board of Directors.

1 MEMBERSHIP

- 1.1 The Committee shall comprise the Director of Finance, the Chief Executive, the Chief Operating Officer, and three Non-Executive Directors. All appointments to the Committee shall be made by the Board of Directors. The Chairman of the Trust may attend any meeting and contribute to the quorum. Any other Non-Executive Director may attend and contribute to the quorum.
- 1.2 The Board of Directors shall appoint the Committee Chairman who shall be a Non-Executive Director. In the absence of the Committee Chairman and/or any appointed deputy, the remaining members present shall elect one of the Non-Executive Directors present to chair the meeting.
- 1.3 Only members of the Committee have the right to attend committee meetings. Any other Director may attend by giving prior notification to the Chairman. The Deputy Director of Finance, Deputy Chief Operating Officer, Director of Improvement and Directors of Operations shall normally attend meetings to provide information to the Committee. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.
- 1.4 It is expected that members will attend a minimum of eight meetings per year.

2 SECRETARY

- 2.1 The PA to the Director of Finance shall act as the Secretary of the Committee.

3 QUORUM

- 3.1 The quorum necessary for the transaction of business shall be 3 members and should include not less than 2 Non-Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	June 2017	June 2018	Karen Flaherty

authorities, powers and discretions vested in or exercisable by the Committee.

4 FREQUENCY OF MEETINGS

- 4.1 The Committee shall meet monthly and at such other times as the Chairman of the Committee shall require.

5 NOTICE OF MEETINGS

- 5.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chairman or Director of Finance.
- 5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, other Directors and any other person required to attend, no later than 3 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6 MINUTES OF MEETINGS

- 6.1 The Secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.
- 6.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee unless a conflict of interest exists.

7 DUTIES

The Committee shall:

- 7.1.1 Review in detail, on behalf of the Board of Directors, the financial and operational performance and controls reporting as necessary. This review to include but not be limited to

7.1.1.1 overall financial performance

7.1.1.2 financial performance of each Care Group, with the facility to request attendance from representatives of the relevant Care Group

7.1.1.3 cash flow, debtors and creditors

7.1.1.4 Transformation Programme

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	June 2017	June 2018	Karen Flaherty

- 7.1.1.5 capital spend against plan and resources available
- 7.1.2 Review in detail, on behalf of the Board of Directors, the Trust's compliance against the agreed national and local operational performance targets in line with the NHS Constitution (eg referral to treatments, cancer waits, Emergency Department waits and others as per regulator or commissioner requirements). This review to include but not be limited to
 - 7.1.2.1 NHS Improvement priority targets and progress against agreed trajectories
 - 7.1.2.2 NHS Improvement's Single Oversight Framework
 - 7.1.2.3 priority contractual/local targets
 - 7.1.2.4 directorate level trends, issues and risks in relation to the above area of performance
 - 7.1.2.5 capacity and demand for services.
- 7.1.3 Take decisions on such financial and performance matters that may be remitted to the Committee for decision from time to time by the Board of Directors
- 7.1.4 Keep under review the quality, quantity and timeliness of financial, performance and analytical information provided to the Board of Directors, and recommend any required changes, particularly in response to changes in national requirements on an annual or more frequent basis.
- 7.1.5 Consider the impact of accounting policies for external reporting, taking into account the requirements of Monitor and other appropriate bodies.
- 7.1.6 Keep under review the quality and efficiency of financial and performance analysis, modelling tools and procedures used to ensure the accuracy and relevance of reporting and decision making.
- 7.1.7 Review the Trust's financial statements and indicate agreement therewith to the Audit Committee
- 7.1.8 Review performance information in Quality Account
- 7.1.9 Oversee implementation of recommendations from internal and external performance related audits

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	June 2017	June 2018	Karen Flaherty

- 7.1.10 Review the Trust's annual financial business plan (incorporating long term strategic financial planning, capital planning and scenario planning), and make recommendations to the Board of Directors.
- 7.1.11 Review the Trust's annual Performance Strategy and Framework and make recommendations to the Board of Directors.
- 7.1.12 Consider and make recommendations and approve actions and business cases to support sustainability or recovery of performance.
- 7.1.13 Approve or reject tenders, contracts and business cases for capital and revenue schemes to the value set out in the Schedule of Delegation of the Board of Directors.
- 7.1.14 Consider and make recommendations to the Board of Directors on tenders, contracts and business cases for capital and revenue schemes which exceed the value set out in the Schedule of Delegation of the Board of Directors.
- 7.1.15 Review and approve Treasury Management policies and investments.
- 7.1.16 Review and approve the policies and procedures in place for ensuring economy, efficiency and effectiveness in the use of resources.
- 7.1.17 If applicable, review and comment to the Board on borrowing against Prudential Borrowing Code and other ratios.
- 7.1.18 Monitor banking arrangements, including approving tenders of banking services.
- 7.1.19 Support the Trust in fulfilling the requirements of the NHS Litigation Authority Risk Management Standards by complying with relevant legislation, national policies and recommendations for sound financial management
- 7.1.20 Support the Trust in fulfilling its strategic objective improving quality and reduce harm by focusing on continuous improvement and reduction of waste..
- 7.1.21 Support the Trust in fulfilling the requirements of its license and commissioner contracts in relation to key performance indicators.
- 7.1.22 Review relevant areas of the risk register regularly and report appropriately

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	June 2017	June 2018	Karen Flaherty

8 REPORTING RESPONSIBILITIES

- 8.1 The minutes of the Committee meetings shall be submitted to the Board after each meeting.
- 8.2 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.
- 8.3 The Committee shall compile a report on its activities to be submitted to the Board of Directors annually within two months of the end of the financial year.

9 OTHER

- 9.1 The Committee shall, at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

10 AUTHORITY

- 10.1 The Committee is authorised:-

- 10.1.1 To seek any information it requires from any employee of the Trust in order to perform its duties

- 10.1.2 To obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference

11. SUB GROUPS

- 11.1 The following groups report to the Finance and Performance Committee:-

- Capital Management Group
 - IT Steering Group
 - PBR Group
 - SLR Group
 - Performance Management Group

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	June 2017	June 2018	Karen Flaherty

BOARD OF DIRECTORS MEETING – 28 July 2017

PART 2 AGENDA - **CONFIDENTIAL**

The following will be taken in closed session i.e. not open to the public, press or staff in the
Committee Room in the **Trust Management Offices, Royal Bournemouth Hospital**

The reasons why items are confidential are given on the cover sheet of each report

Timings		Purpose	Presenter
11.30	1. MINUTES OF PREVIOUS MEETINGS		
	a) Minutes of the meetings held on 23 May 2017 and 26 May 2017	Decision	<i>All</i>
11.35	2. MATTERS ARISING		
	a) Updates to the Actions Log	Discussion	<i>All</i>
11.40	3. STRATEGY AND RISK		
	a) Significant Risk and Assurance Framework (paper)	Discussion	<i>Paula Shobbrook</i>
	b) Clinical Services Review (verbal)	Discussion	<i>Paula Shobbrook</i>
	c) Ever Safer Care – Winter Plan (paper)	Discussion	<i>Richard Renaut</i>
	d) Demand Management - Criteria Based Access Procedures (paper)	Information	<i>Richard Renaut</i>
	e) Recommendation Report – Insulin Pumps (paper)	Decision	<i>Pete Papworth</i>
	f) Recommendation Report – PCI Consumables (paper)	Decision	<i>Pete Papworth</i>
	g) Recommendation Report – Catheter Lab Replacement Programme (paper)	Decision	<i>Pete Papworth</i>
12.55	4. GOVERNANCE		
	a) Sealing of Deeds (paper)	Decision	<i>Karen Flaherty</i>
13.00	5. QUALITY		
	a) Appraisal and Revalidation Annual Report 2016/17 (paper)	Decision	<i>Alyson O'Donnell</i>
13.15	6. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff	Discussion	<i>All</i>
	b) Reflective Review	Discussion	<i>All</i>
	- What has gone well?		
	- What do we need more of?		
	- What do we need less of?		

The meeting will be followed by a Blue Skies session on taking Quality Improvement forward within the Trust