

A meeting of the Board of Directors will be held on Friday 29 September 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		
	Nicola Hartley		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 28 July 2017	Decision	All
8.40-8.45	3. MATTERS ARISING		
	a) Updates to the Actions Log	Information	All
8.45-9.30	4. QUALITY		
	a) Patient Story (verbal)	Information	Paula Shobbrook
	b) Quality Priority: Hospital Flow Update (paper)	Information	Richard Renaut
	c) Safe Staffing Report (paper)	Information	Paula Shobbrook
	d) Update on Governor Activity (verbal)	Information	David Moss
	e) Infection Prevention and Control Annual Report Summary and Statement of Commitment (paper)	Decision	Paula Shobbrook
	f) Annual Protection and Safeguarding Report and Statement of Commitment (paper)	Decision	Paula Shobbrook
	g) Medical Director's Report (paper)	Information	Alyson O'Donnell
9.30-10.20	5. STRATEGY AND RISK		
	a) Clinical Services Review Update (paper)	Information	Tony Spotswood
	b) People Plan (paper)	Discussion	Karen Allman/ Louise Hamilton-Walsh
	c) Progress Update on 2017/18 Corporate Objectives (paper)	Information	Tony Spotswood
	d) Stakeholder Engagement Outcomes (paper)	Information	Tony Spotswood
10.15-10.45	6. PERFORMANCE		
	a) Performance Report (paper)	Information	Richard Renaut
	b) Quality Report (paper)	Information	Paula Shobbrook

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|----|--------------------------|-------------|----------------------|
| c) | Finance Report (paper) | Information | <i>Pete Papworth</i> |
| d) | Workforce Report (paper) | Information | <i>Karen Allman</i> |

10.45-11.05

7. GOVERNANCE

- | | | | |
|----|---|-------------|---------------------------|
| a) | Freedom to Speak Up (paper) | Decision | <i>Helen Martin</i> |
| b) | Emergency Preparedness, Resilience and Response (EPRR) Report (paper) | Information | <i>Richard Renaut</i> |
| c) | Well-led Review Action Plan Update (paper) | Information | <i>David Moss</i> |
| d) | Board of Directors Meeting Dates 2018/19 (paper) | Information | <i>Anneliese Harrison</i> |

8. NEXT MEETING

Friday **24 November 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.

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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



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 28 July 2017** in the Conference Room, Education Centre, Royal Bournemouth Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Tea Colaiani	(TC)	<i>Non-Executive Director</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>
	Pete Papworth	(PP)	<i>Director of Finance</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Cliff Shearman	(CS)	<i>Non-Executive Director</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery/Deputy Chief Executive</i>
In attendance:	Leanne Aggas	(LA)	<i>Cardiac Catheter Laboratory Nurse</i>
	Rachel Bevan	(RB)	<i>Patient Engagement Lead</i>
	Alison Cope	(AC)	<i>Personal Assistant, Chief Executive</i>
	Carla Dimitriu	(CD)	<i>Data Management Assistant</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Trudi Ellis	(TE)	<i>Directorate Matron, Elderly Care</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	Hayley Flavell	(HF)	<i>Consultant Nurse, Anticoagulation</i>
	Louise Hamilton-Welsh	(LHW)	<i>Head of HR Strategy</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Tom Hutley	(TH)	<i>ST7, Anaesthetics</i>
	Louise Johnson	(LJ)	<i>Consultant Therapist for Stroke and Neuro Rehab (shadowing PS)</i>
	Sue Langlois	(SL)	<i>Directorate Matron, Anaesthetics</i>
	Lindsey Legg	(LL)	<i>Personal Assistant, Chief Executive & Chairman</i>
	Dily Ruffer	(DR)	<i>Governor and Membership Manager</i>
	Anthony Young	(AY)	<i>Cardiac Advanced Nurse Practitioner</i>
Public/ Governors:	David Bellamy		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Steve Erskine		<i>Chairman, Poole Hospital NHS Foundation Trust</i>
	Eric Fisher		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Margaret Neville		<i>Member of Public</i>
	Roger Parsons		<i>Public Governor</i>
	Guy Rouquette		<i>Public Governor</i>
	David Triplow		<i>Public Governor</i>
Apologies:	Karen Allman		<i>Director of HR</i>
	Peter Gill		<i>Director of Informatics</i>
	Nicola Hartley		<i>Director of OD and Leadership</i>

53/17 **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 and Steve Erskine, Chairman of Poole Hospital NHS Foundation Trust, was welcomed to the meeting.

54/17 **MINUTES OF PREVIOUS MEETING**

(a) **Minutes of the meeting held on 26 May 2017 (Item 2a)**

The minutes of the meeting held on 26 May 2017 were **approved** as an accurate record of the meeting

55/17 **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.

56/17 **QUALITY**

(a) **Patient Story (Item 4a)**

Leanne Aggas and Anthony Young presented a short film which featured two interviews with patients about their contrasting experiences in the cardiac catheter laboratories. One patient, who had been admitted with symptoms of a heart attack, recalled their experience of the pathway as being faultless, having been kept informed about test results and the next steps and receiving effective treatment. Another patient explained how their experience, having been admitted with similar symptoms, had not been as positive due to unclear communication, particularly regarding the difficulty in diagnosing their condition, which the patient believed would have been improved with specialist intervention at an earlier stage.

In response to feedback obtained from patient focus groups the department had sought to improve the pathway and experience for patients admitted with chest pain by working closely with colleagues in the Emergency Department (**ED**) to identify patients for transfer to Cardiology in order to expedite their treatment. The early identification of patients had contributed to an overall reduction in length of stay of up to 36 hours.

The Board enquired about how the patient experience was affected when the diagnosis was unclear. AY outlined that if a patient was identified as being low risk they could be discharged and referred to the ambulatory heart clinic for follow up which reduced the time they spent in ED.

At present the cardiac advanced nurse practitioner service in ED was available five days a week due to staff numbers however their ambition was to provide a seven day service matching the staffing levels to demand

throughout the day. The cardiac catheter laboratories were already available 24 hours a day, seven days a week.

Board members recognised the important role that the Cardiac Advanced Nurse Practitioner specialist team had in ensuring early intervention and collaborative working, which had contributed to significant improvements in the patient experience.

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

Discussions with Staff Governors had focused on improving channels of communication with staff to raise concerns or queries confidentially and regular staff listening events.

To support more effective management and oversight of feedback on the actions arising from staff governor feedback it was proposed that these were included in the Council of Governors concerns log which was presented at each of its meetings.

DM also noted that voting in the elections to the Council of Governors would begin the following week.

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

Trust Mortality Review Process

The end of year data to 31 March 2017 for Hospital Standardised Mortality Ratio (**HSMR**) performance placed the Trust within the significantly better than expected range. There had been no increase in HSMR over winter as might have been expected with the normal increase in the number of deaths at this time of year. The key to this had been the additional consultant presence and decision-making on admission and the focus on hospital flow as a quality priority.

The report also outlined changes to strengthen the Trust's mortality review processes to reflect the new Care Quality Commission (**CQC**) guidelines which promoted multi-agency and multi-professional reviews of all deaths including regional reviews of deaths of patients with learning difficulties. Families and carers would also be involved in the new process and their questions would be answered as part of the review process.

The new process would ensure the timely review of all deaths which would help identify those deaths requiring a more in-depth review at an earlier stage. It was clarified that although junior doctors would normally complete the death certificate and other documentation, they would be expected to discuss this with the admitting consultant and raise any issues.

A non-executive director lead on mortality assurance would need to be nominated and there would be additional reporting to NHS England on the number of deaths reviewed and avoidable deaths with key themes identified.

Report on Safe Working Hours

An overview was provided of the second quarterly report from the Guardian of Safe Working Hours. Currently only 33 doctors were subject to

the new junior doctors' contract and 67 exception reports had been completed in the past six months relating to working over scheduled hours (62) and educational opportunities/supervision issues (5). No specific patterns had been identified and support for junior doctors had been identified in Surgery which had received the highest number of exception reports.

Some concerns were raised about the level of exception reports when most of the 137 junior doctors starting with the Trust in August would be subject to the new contract as well as the 12 vacancies which the Wessex deanery had not been able to recruit to in 2017/18. While the Trust had been really successful in recruiting to Trust grade post to mitigate the shortfall, the Trust needed to develop, expand and recruit to alternative roles, such as physician associates and nurse practitioners to fill gaps in the rota.

Clinical Audit Plan 2017/18

The Board reviewed the Clinical Audit Plan for 2017/18 which detailed the national, Trust and local audits for the year. Board members agreed that further consideration needed to be given to the outcomes and learning from clinical audits to ensure that data was being used effectively and to increase oversight of the data, particularly data published nationally, at the Board. This had also been considered at the Audit Committee and Healthcare Assurance Committee (**HAC**) and was monitored through the Clinical Audit Effectiveness Group. The effectiveness of internal audit was also being reviewed as part of the internal audit programme which would be reported to the Audit Committee.

(d) CQC Inpatient Survey Results (Item 4d)

There had been minimal variation in the Trust's performance in 2016 compared to 2015 with only two questions showing a significant decrease relating to communication and information around discharge and a notable increase in patients being treated with respect and dignity. The results had been shared with directorates in order to develop improvement plans, the details of which would be reviewed by the HAC.

(e) Well-Led Action Plan (Item 4e)

The Board received the report which detailed progress against the priority themes identified from the independent well-led review of the Board. A more detailed action tracker would be developed to monitor progress on all the recommendations from the well-led report. The results of the review had also been shared with the CQC and this would form part of the evidence base to demonstrate progress against the well-led domain as part of the CQC's next inspection.

57/17 PERFORMANCE

(a) Performance Report (Item 5a)

The performance exceptions were summarised and included:

- the ED 4 hour performance target had been met for the first quarter, despite an increase in attendances in June compared to the

previous year, thereby securing the associated Sustainability and Transformation Fund (STF) payment from NHS Improvement (NHSI) for the quarter;

- Referral to Treatment performance continued to improve and met the national target of 92% of patients seen within 18 weeks, although some deterioration and non-compliant performance continued within Urology and Ophthalmology;
- positive performance for 62 day cancer referrals had been sustained with the Trust benchmarking well nationally;
- the Trust had retained its A rating within the Sentinel Stroke National Audit programme over the winter period; and
- there were ongoing risks against the full national targets for ED 4 hour waits 18 week referral to treatment, cancer 62 day and screening with the 95% performance trajectory for ED in this quarter to receive the STF payment.

Board members were briefed on the work underway to address demand and capacity pressures particularly within ED following an increase in breaches of the 4 hour target. NHSI had confirmed that the Trust would not receive the associated STF payment if the trajectory of 95% was not achieved despite the Trust having submitted a trajectory of 92% within the Annual Plan to take account of the risks around social and community care capacity and workforce shortages.

Ongoing analysis of performance against the 4 hour standard was in progress including daily breach analysis and activity profiling. Key issues related to the Trust's ability to cope with peaks of activity in ED which led to delays in seeing some patients within the department and the number of stranded patients in the hospital, with 190 of the 550 beds in the hospital accommodating patients who were medically ready for discharge. Work to address flow of patients through the hospital, which impacted upon its ability to cope with fluctuations in demand, continued through the Trust's Quality Improvement programme and external partners who were assisting with the development of an urgent care streaming pilot within ED to assess and direct patients to the most appropriate service, including GPs.

Board members expressed their gratitude to staff responding to the continuing pressures. The Board requested a more detailed presentation on the area of stranded patients in order to ensure that those areas within the control of the Trust were being adequately addressed and to identify what further work was required with health and social care partners.

RR

(b) Quality Report (Item 5b)

Two serious incidents had been reported in June and these were subject to review with involvement from family members to promote transparency and to maintain the Trust's duty of candour. Recommendations and learning would be shared with teams following completion of the investigation process.

Friends and Family Test feedback remained positive with increases in the response rate for both ED and Outpatients, which had been placed within the top quartile for the first time. The Trust would be piloting a text option to provide feedback in ED in August, something which was being done in

Poole Hospital.

(c) Financial Performance Report (Item 5c)

Financial performance was better than budgeted, however this had been achieved through the release of contingency to support pressures including the shortfall in the Cost Improvement Plan (**CIP**) and the additional demand above contractual levels.

Staff were recognised for their dedicated work to support the delivery of operational performance but this had diverted their focus away from identifying and further developing schemes to deliver the savings under the CIP. Additional focus would be required going into 2018/19 to deliver the savings required including additional savings due to the number of non-recurrent schemes in the CIP for 2017/18.

(d) Workforce Report (Item 5d)

The key themes from the report were summarised and included:

- staff sickness rates had decreased slightly since May, with a review of the policy and intervention points currently underway;
- gaps within the workforce were being mitigated to support pressures particularly within ED;
- the turnover rate for nursing and midwifery were around 8.8% and the Trust compared well with other organisations for vacancies;
- the Trust continued to support the development of system-wide workforce plans working with Poole Hospital and through the One Acute Network and the Trust's People Strategy would be presented in September; and
- there had been four nurse staffing red flag events over the past two months reflecting the current operational pressures, particularly at night, with the actions taken to secure appropriate staffing outlined to the Board.

58/17 STRATEGY AND RISK

(a) Clinical Service Review (CSR) (Item 6a)

Dorset Clinical Commissioning Group (**Dorset CCG**) had received over 20,000 responses to the consultation and the feedback was being reviewed in detail ensuring that stakeholders' views were recognised and considered in preparing the final recommendations to be considered on 20 September 2017. This included further work modelling ambulance travel times, led by South Western Ambulance Service NHS Foundation Trust, based on the preferred option for acute hospital services. This work demonstrated that the maximum journey time by ambulance would decrease as well as a reduction in the number of transfers between the two hospitals, emphasising the importance of ensuring patients were in the right place. This information would be shared with the public.

The Trust had also received confirmation from the Department of Health that Dorset's Sustainability and Transformation Plan (**STP**) had successfully been awarded over £100 million in capital, which would be required to fund the CSR.

(b) Secretary of State Visit (Item 6b)

The Board viewed a short film documenting the recent successful visit by the Secretary of State for Health on 13 July 2017. This had provided an opportunity for the Trust to promote its work on patient safety and the work done by staff which had contributed to consistent and significant improvements in mortality rates. Jeremy Hunt also gave a talk to staff about his vision for patient safety and answered questions from staff. The visit followed shortly after a visit from Sir Bruce Keogh as part of a tour of Dorset to learn more about the development of an Accountable Care System within Dorset.

(c) Quality Strategy (Item 6c)

The Quality Strategy had been subject to wider consultation within the organisation and set out the plans to address the Trust's key priorities for patient safety, outcomes and experience and a framework to monitor this over the next twelve months. Some minor typographical errors would be amended before publication. The Board **endorsed** the Quality Strategy.

59/17 GOVERNANCE

(a) Trust Constitution (Item 7a)

Minor amendments to the Constitution had been identified and had been considered and approved by both the Constitution Joint Working Group and Council of Governors. The amendments presented were **approved** by the Board.

(b) Non-Executive Director Appointment (Item 7b)

The Board were informed that the recommendation from the Non-Executive Director Nomination and Remuneration Committee of the Council of Governors to appoint Iain Rawlinson as a Non-Executive Director, replacing SP upon the conclusion of his term of office on 30 September 2017, had been approved by the Council of Governors at its meeting on 20 July 2017.

(c) Workforce Strategy and Development Committee Terms of Reference (Item 7c)

The Workforce Strategy and Development Committee terms of reference had been updated to reflect the structure of the People Strategy and other minor drafting amendments. PS requested that the role of the committee in reviewing strategic workforce risks was made more explicit in the terms of reference. Subject to this amendment, the Board **approved** the amendments to the Workforce Strategy and Development Committee terms of reference.

KA

(d) Finance and Performance Committee Terms of Reference (Item 7d)

The Finance and Performance Committee had reviewed the terms of reference and proposed minor changes to ensure that the responsibilities

of both the Finance and Performance and Audit Committees in relation to accounting policies were clearly defined. The Board **approved** the amendments to the Finance and Performance Committee terms of reference.

60/17 NEXT MEETING

The next meeting would take place on Friday 29 September 2017 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

61/17 ANY OTHER BUSINESS

Key Points for Communication:

1. The capital commitment to the STP in Dorset to include consistent and joint messaging about the milestones for the STP and how the One Acute Network Board would be supporting the process to engage staff and public.
2. Improvement in HSMR/mortality rates.
3. The approval of the Quality Strategy.
4. Recognition of the work of staff in light of recent pressures, particularly in ED.

62/17 COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC

1. Further information was provided about the funding for end of life care beds at Fairmile Grange Nursing Home which was a commercial arrangement under which Dorset CCG funded continuing healthcare for end of life care for NHS patients, recognising the shortage of alternatives locally.
2. Challenges around the recruitment of middle grade doctors were noted and concerns were raised about the impact this had on Trust staffing rotas. Although recruitment had increased, posts within some specialities had been difficult to recruit to because of national shortages. Overseas recruitment had also been impacted by the EU referendum and changes to visa criteria. The Trust was also focussing on the development of alternative roles including emergency nurse practitioners. The Board viewed a short film which had been released as part of the Trust's recruitment drive for middle grade doctors.
3. In keeping staff and the public informed about the impact of the proposed changes under the CSR, governors emphasised that it was important to ensure that the rationale for the proposed changes was clearly understood ahead of the announcement of the decision in the autumn.
4. Governors reflected on the positive feedback obtained at a recent public engagement and listening event which praised staff, patient care and services at the Trust. Board members commented that improvements to patient communication and the introduction of humanising care had been beneficial in improving the patient experience in our hospitals.
5. Although the Trust could be satisfied that performance remained consistent in the annual CQC inpatient survey the Trust was asked to state what its aspirations were in terms improving its results and what could be achieved. It was emphasised that the Trust did not aspire to be average and the results had been provided to directorates to promote learning and share positive practice as well as to support the development of improvement plans as noted earlier in the meeting.
6. The appointed governor for Bournemouth Borough Council reflected on a

recent presentation from Healthwatch which promoted a positive relationship with the Trust. DM proposed that Healthwatch were invited to attend a future Board meeting to present on their activities and findings.

PS

63/17 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.

DRAFT

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
28.07.17	57/17	PERFORMANCE			
	(a)	<u>Performance Report</u>			
		The Board requested a more detailed presentation on the area of stranded patients in order to ensure that those areas within the control of the Trust were being adequately addressed and to identify what further work was required with health and social care partners.	RR	Complete	Update on Hospital Flow quality priority included on agenda for September's Board meeting.
	59/17	GOVERNANCE			
		<u>Workforce Strategy and Development Committee Terms of Reference</u>			
		PS requested that the role of the committee in reviewing strategic workforce risks was made more explicit in the terms of reference.	KA	Complete	The proposed wording will be presented at the next Workforce Strategy and Development Committee meeting for approval.
	62/17	COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC			
		DM proposed that Healthwatch were invited to attend a future Board meeting to present on their activities and findings.	PS	In progress	Update to be provided at the meeting.
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	

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th September 2017 Part 1
Subject:	Quality Priority – Hospital Flow Update
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Richard Renaut / Deborah Matthews / Paula Shobbrook
Author(s) of papers:	Nikki Greenall / Richard Renaut
Details of previous discussion and/or dissemination:	TMB
Action required: Approve / Discuss / Information/Note	To review and agree / support
Executive Summary: <p>Good patient flow is central to patient experience, clinical safety and reducing pressure on staff. It is also essential to the delivery of national emergency care access standards. Experts consistently advocate focussing on patient flow as a key factor in providing effective health care. The good practice guide, published by NHSI in July 2017 outlines good practice in ten areas that will improve patient flow. Implementing the good practice in all ten areas is proven to have a positive, cumulative effect on improving hospital flow.</p> <p>Senior clinical and executive leadership is key to ensure we deliver these challenging and complex improvements for patients.</p> <p>The slide set represents a summary of this work.</p>	
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?	Will mitigate risk profile on BAF to ensure delivery of our trust objective: QI hospital flow

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Quality Priority: Hospital Flow
Update to Board of Directors
September 2017

Hospital Flow

Aim:

To improve emergency hospital flow to deliver the right patient, at the right time, in the right place' by March 2018

Outcome measures

- ED performance
- ambulatory care conversion rates
- reduction in occupied bed days
- length of stay reduction
- stranded patients (LOS >7days) reduction


Balancing measures

- re-admissions
- outliers


Process Measures

- re-design of pathways
- delivery of training
- updated policies, processes and procedures i.e. escalation process

Action learning weeks

 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Board rounds - top tips

 I'm Megan, I'm the Discharge Key Worker on Ward 26. My top tip is to invite Social Services to attend, to help us get a defined plan for our patients


Doctors should identify and prioritise at least one patient who will be discharged before 10:00

New patients should be given an Expected Date of Discharge

We're Aleks and Abby. We would like you to make sure your Board Rounds promote real Multi Disciplinary working

I'm Imogen from Ward 2. The leader should ensure everyone has an equal say and that there is collective responsibility

Doctors need to make sure they set the Clinical Criteria for Discharge. This will make it clear to everyone what is needed to get the patient home

 My name is Claire, I'm the Sister on Ward 24. You should know who's coming to the Board Round, and make time for introductions. It should take 30 minutes max

Consider sick and unstable patients first. Is the patient deteriorating? What actions are required?

Ensure you look for delays which need expediting

Improve – Change it!

 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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CERTIFICATE OF APPRECIATION

This certificate is awarded to

Caren Lawlor & Team

IN RECOGNITION OF VALUABLE CONTRIBUTIONS TO

Flow + Board Round Week

13/01/2017
DATE

Associate Medical Director Director of Nursing & Midwifery/Deputy Chief Executive

TITLE TITLE



Four key questions every patient, relative/ carer, should know the answer to



- What is the matter with me? (main diagnosis)
- What is going to happen today? (tests, interventions, etc)
- What is needed to get me out of hospital? (clinical criteria for discharge)
- When am I expected to be leaving hospital? (expected date of discharge)

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A greater sense of 'being in it together'

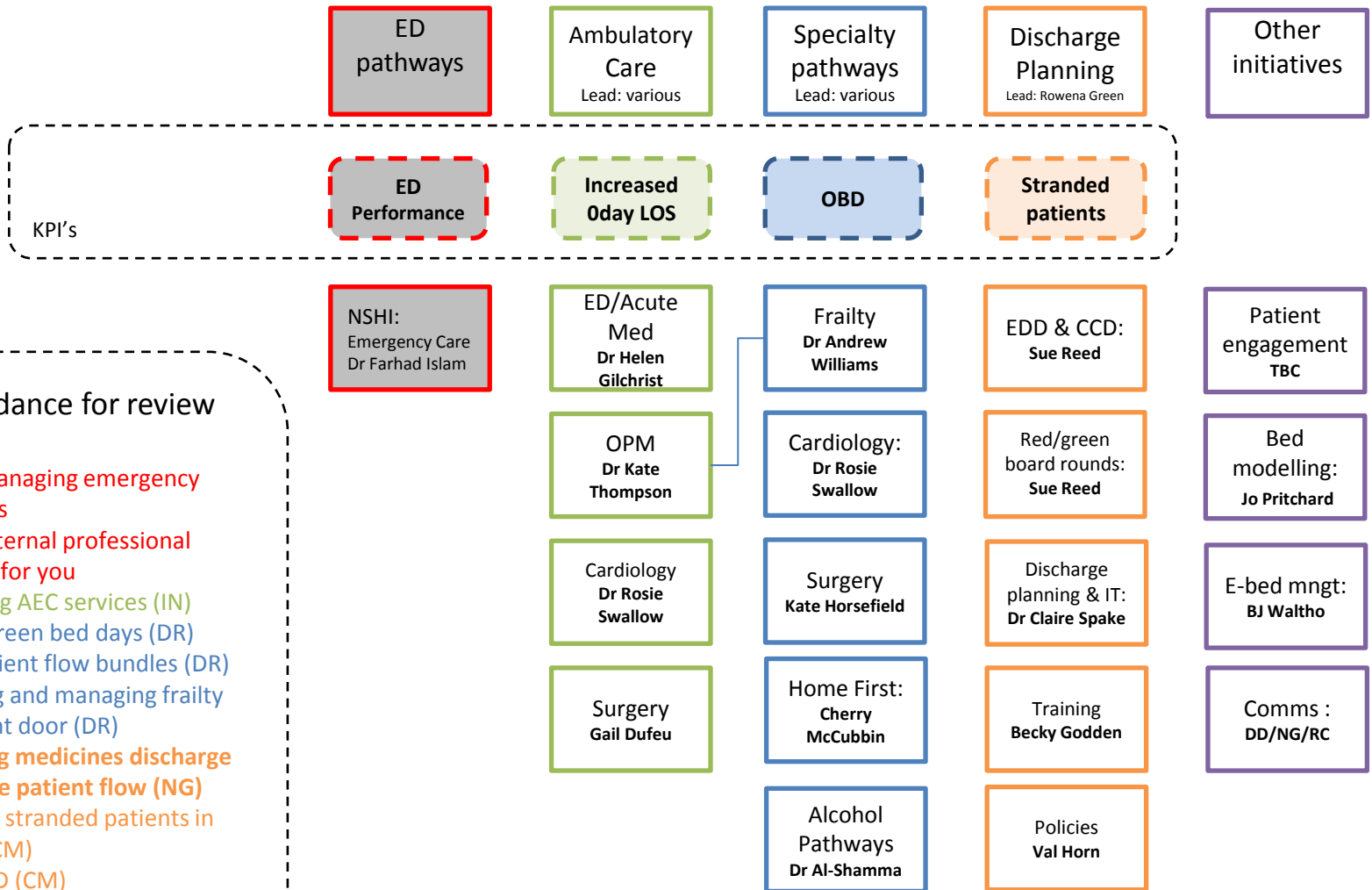


#TeamRBCH
#RBCHQI



Hospital Flow Steering Board –Programme Governance Structure

Exec Sponsor/Chair: Paula Shobbbrook



Bed Modelling

- understand patients flows and bottlenecks
- model for new services and growth
- calculate upcoming year's challenge ('Ask')
 - aim to achieve 90.6% average occupancy across inpatient wards
 - no outliers

The 'Ask' 2017/18

Occupied Bed Day (OBDs) Reduction

Reduction in Average (mean) no. of 14+ day length of stay patients

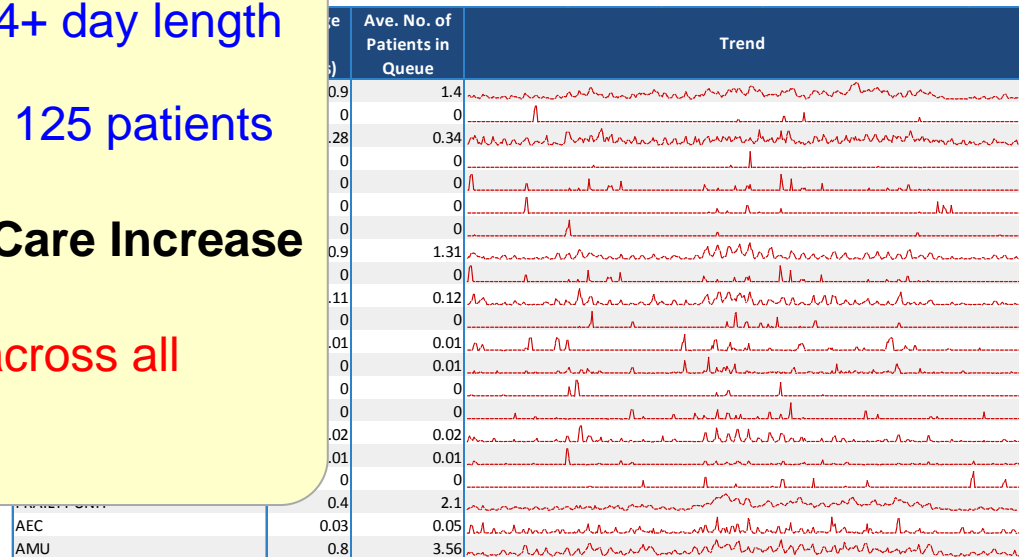
↓ 17 patients from an mean of 142 to 125 patients

Admission Avoidance Ambulatory Care Increase

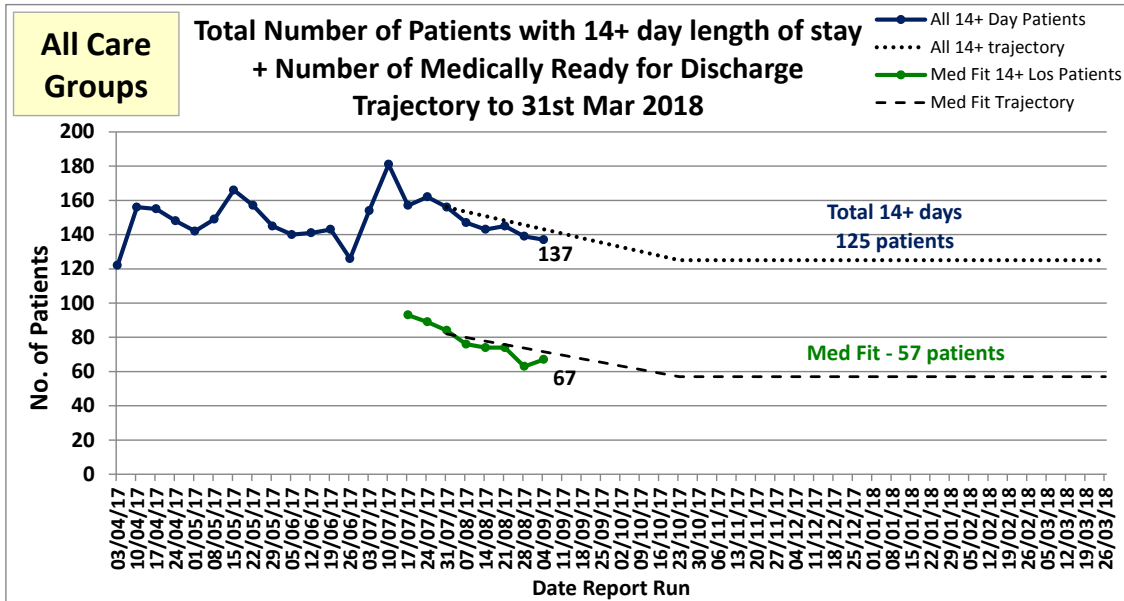
↑ by 7 patients per day

↑ to a mean of 25 patients per day across all services

Set 2017/18 'Ask' to minimise patients 'queuing' in the model by improving hospital flow



Progress so far



Stranded Patients

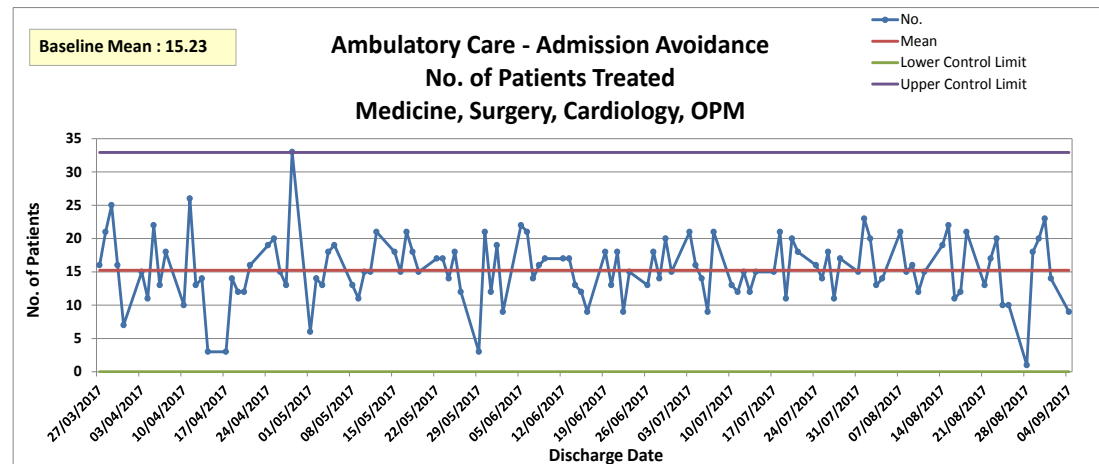
Ahead of trajectory

As we head into winter this will become more challenging

Ambulatory Care (admission avoidance: excludes early supported discharge)

Maintaining baseline level

The Cardiology and OPM bed reconfigurations will deliver sustainable increased activity



Ambulatory Care

Aim: to increase admission avoidance via AEC services to 25 per day (from 18) by March 2018

- standardised metrics / reporting established
- improvement schemes identified across all AEC specialties e.g. later opening for Medical AEC
- significant reconfiguration of both W23 and W26 to support sustainable AEC delivery in Cardiology and Older People services
- learning via membership of the National AEC network
- Exploring more direct access from ED to ambulatory

Specialties

Aim: to reduce the number of beds occupied at midnight

- project groups in place to cohort and standardise care for Frail patients; reduced 7+day patients
- respiratory multi-disciplinary event held, and community pathways strengthened
- cardiology lab data analysed
- new focus on improving care for patients with alcohol problems and reducing LoS
- Surgery working hard to reduce stranded patients

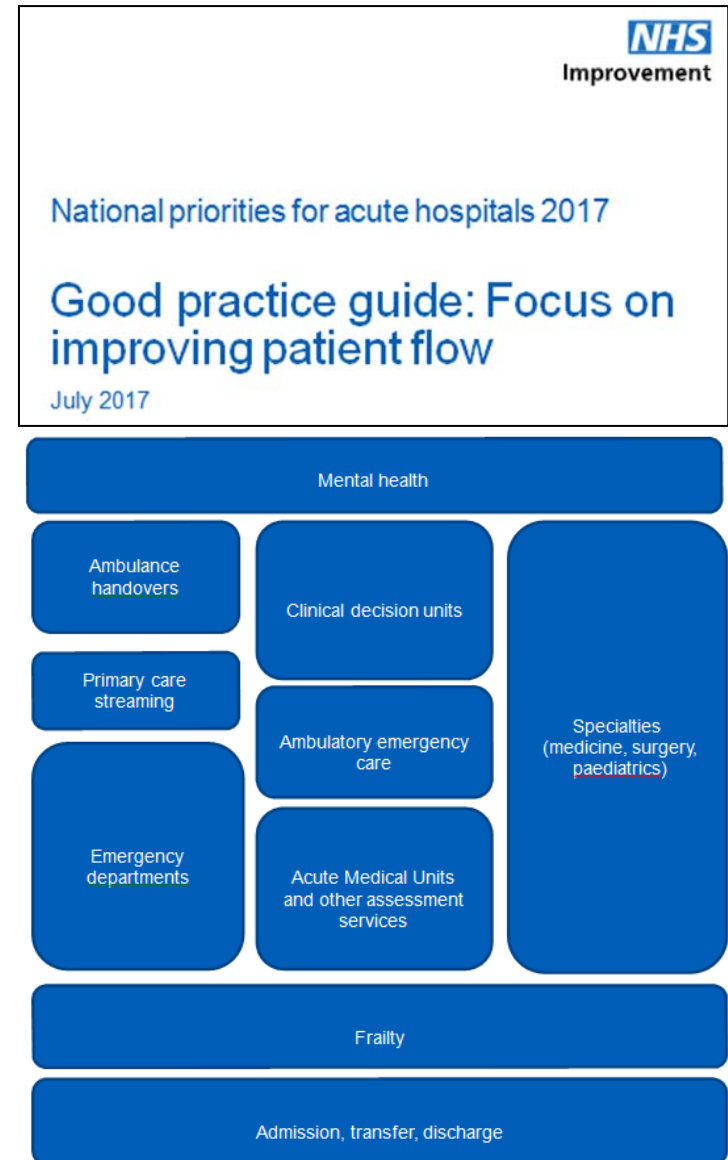
Discharge Planning

Aim: to reduce the number of patients with a LOS >14 days from average of 156 patients to 125 by October 2017

- define and embed consistent use of Estimated Discharge Date (EDD) & Medically Ready for Discharge (MRFD) and develop / embed discharge database
- training and development
- SOPs
- communications plan
- improved reporting
- Multi Agency Discharge Event

NHSI National priorities for acute hospitals 2017

- clinical teams have been asked to review the guidance and RAG rate
- the guidance covers a broad scope with 10 areas of focus
- ambulatory emergency care, specialties, frailty and admission, transfer and discharge are all active QI projects, using national good practice
- there is a dedicated project for primary care streaming
- mental health and alcohol pathway are being developed, with partners
- greater work is needed on escalation actions including “full capacity protocol”. We are experimenting with various operational actions to maintain safe flow and speed up our predict and action cards usage



What is the GAP analysis telling us?

Ambulance handover

- FCP could be adopted to reduce ambulance queues

ED

- delivering EDQIs remains challenging
- direct assessment and referrals to in-taking specialties

Ambulatory Care

- still some improvement work required to deliver sustainable improvements in avoidable admissions
- some issues (i.e. co-location of AEC service to ED) will be resolved in the longer term through CSR
- AEC services are silos
- strategic overview required to provide case for change in line with national best practice

Specialties

- inconsistency across wards possibly contributing to LOS
- fully adoption of national guidance re Red2Green, board round best practice across all

Next steps

Complete analysis with lead clinicians and feed into:

- QI Hospital Flow
- Winter plan
- OPEL escalation actions (care group meetings planned for September / October 2017)

Review November TMB

BOARD OF DIRECTORS

Meeting Date and Part:	29 th September 2017 Part 1
Subject:	Safe Staffing Report (Nurse)
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	Safe staffing report discussed at the Workforce Strategy and Development Committee (WSDC) June 2017
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
Details of previous discussion and/or dissemination:	WSDC
Action required: Approve/Discuss/Information/Note	<p>The Board of Directors is requested to note:</p> <ol style="list-style-type: none"> 1. The Safe Staffing report, produced in line with CQC and NHS England guidance, has been scrutinised by the WSDC 2. The executive summary of the report which is provided for information and assurance.
<p>Executive Summary:</p> <p>The Director of Nursing and Midwifery presented a report at the Workforce Strategy and Development Committee (WSDC) in June 2017, providing assurance that guidance for safe staffing produced by the Care Quality Commission (CQC) and NHS England (2014) is implemented and embedded at RBCH. There are 3 requirements:</p> <ol style="list-style-type: none"> 1. Report and publish a monthly return via Unify indicating 'planned' and 'actual' nurse staffing by ward: Achieved 2. Publish information with the planned and actual nurse staffing for each shift: Achieved. 3. Provide a 6 monthly report on nurse staffing to the Board of Directors: A summary of the report, which is available in the reading room, is provided below. Following scrutiny at the WSDC, there are no additional issues to escalate to the Board. <p>The Safe Staffing report provides an overview of:</p> <ul style="list-style-type: none"> • The RBCH Ward Staffing review process which has been carried out 6 	

monthly since 2012, in line with best practice, and reported to the Board of Directors since October 2013.

- A summary of the outputs of the review for each care group; providing assurance that ward templates were not only reviewed in line with the financial portfolio but they were also reviewed against patient quality metrics for the ward, 'Safe Care' acuity trends and compliance with E-roster metrics.
- The operational management process for managing, mitigating and ensuring safe nursing staffing levels across the trust; in hours and out of hours
- Staffing 'red flags' process launched at RBCH in April 2015 to escalate:
 - Staffing depletion – less than 2 registered nurse on any shift
 - Patient vital signs not recorded/assessed in a timely manner
 - Delay/ omission in care needs
 - Unresolved pain for a significant period of time

There was assurance to the WSDC from the care groups on the reporting process, with oversight of matrons and clinical site team out of hours. Safe staffing 'Red flags' are reported monthly to the board of directors, in line with Department of Health guidance

- Eroster clinics, introduced in 2016 led by the Deputy Director of Nursing, to review individual areas and adherence to the e-roster policy. This has since devolved to the Heads of Nursing as part of the operational oversight, governance and support for safe staffing
- The positive progress with management of temporary nursing staffing in line with Monitor requirements for agency frameworks published in October 2015. This has reduced expenditure with premium agencies whilst focusing on recruitment of substantive staff and the use of our RBCH staff bank.

Relevant CQC domain:

Are they safe?
 Are they effective?
 Are they caring?
 Are they responsive to people's needs?
 Are they well-led?

Safe

Risk Profile:

- i. Impact on existing risk?
- ii. Identification of a new risk?

N/A

BOARD OF DIRECTORS

Meeting Date and Part:	29 September 2017 Part 1
Subject:	IPCC Annual Summary Report and Board Statement of Commitment to Prevention of Healthcare Associated Infection
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Paul Bolton, Lead Infection Prevention Control
Details of previous discussion and/or dissemination:	Infection Prevention and Control Committee Healthcare Assurance Committee
Action required: Discuss/Information	The Board of Directors is asked to note the summary report and approve the statement of commitment with infection prevention and control.
<p>Executive Summary:</p> <p>The Board of Directors is required to sign and publish an annual statement which reaffirms its commitment to infection prevention and control. The statement details the processes which are in place to meet the duties under The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2011). This has been updated to include reference to the CQC essential standards and the Trust's Quality Strategy.</p> <p>The enclosed summary report outlines the Trust's work and progress with the prevention, control and management of infection in 2016-17. This work programme is overseen by the Infection Prevention and Control Committee, which reports to the Healthcare Assurance Committee. Once approved, the IPCC annual report and the statement will be published on the Trust's website to reaffirm to the public the Board's commitment to Infection Prevention and Control.</p>	
Relevant CQC domain:	All
Risk Profile:	No
i. Have any risks been reduced?	No
ii. Have any risks been created?	No

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Board of Directors' Statement of Commitment to the principles of the Code of Practice for the Prevention and Control of Health Care Associated Infections

The successful management, prevention and control of infection is recognised by the Trust as a key factor in the quality and safety of the care of our patients and of those in the local health community, and in the safety and wellbeing of our staff and visitors.

The Board is aware of its duties under the The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2011). The Board has collective responsibility for infection prevention and control including minimising the risks of infection.

The Board receives assurance that the Trust has mechanisms in place for minimising the risks of infection by means of the Infection Control Committee (ICC) and the Director of Infection Prevention and Control (DIPC). Assurance is provided through performance reports, audit reports, root cause analysis reports and verbal updates from the DIPC.

The Infection Control Committee is chaired by the DIPC. It is a sub-committee of the Healthcare Assurance Committee (HAC) and the Board receives the annual IPC summary report and exception reports regarding infection prevention and control. The ICC has terms of reference and produces an annual plan, both of which are approved by the HAC and reported to Board.

The DIPC is appointed by the Board and reports directly to the Chief Executive and the Board. The post holder is a member of the Trust Management Board and Healthcare Assurance Committees, and produces the IPC annual report. The DIPC role is incorporated in the Director of Nursing and Midwifery's portfolio and the post holder is assisted in discharging the relevant responsibilities by the Hospital Infection Control Doctor the Lead Infection Control Nurse and the Infection Control Team.

The Board is committed to the exemplary application of infection control practice within all areas of the Trust. To this end the Board will ensure that all staff are provided with access to infection control advice with a fully resourced infection control and occupational health service, access to personal protective equipment and training and policies that provide up-to-date infection control knowledge and care practices. Individual and corporate responsibility for infection control are stipulated as appropriate in all job descriptions with individual compliance monitored annually through the appraisal systems and personal development plans.

The Quality Strategy, policies in place in the Trust and the arrangements set out above are to encourage, support and foster a culture of trust wide responsibility for the prevention and control of infection in practice, with the aim of continually improving the quality and safety of patient care. This extends to all relevant departments; clinical directorates, clinical support services, estates and ancillary services.

The Trust's policies and practices in respect of infection prevention and control accord with the aims and objectives in national policy and strategy and, in addition, the Trust participates fully in all national mandatory reporting requirements. This is aimed at ensuring the full confidence of the local population in the quality of care the Trust delivers.

Summary of Infection Prevention and Control Annual Report April 2016 to March 2017

Working together to break the chain of infection

The last 12 months have seen continued positive results with progress in infection prevention and control, with no cases of MRSA bacteraemia and low *Clostridium difficile* rates when compared nationally. There have been a range of challenges and a key goal this last year has been to ensure that all the learning from each case is used to reduce the likelihood of further cases. This theme drives the report with a focus on the impact our Infection Control policies have on the patient journey and how this is helping to shape the delivery of care.

The purpose of this summary report is to provide assurance to the Board of Directors and the public on compliance with the Health and Social Care Act 2010: Code of Practice for the NHS on Prevention and Control of Healthcare Associated Infections and related recommendations (the hygiene code) including CQC and NICE guidance.

Infection Prevention Control (IPC) and Information Technology (IT)

Currently the Infection Control team are unable to track and trace patients and their contacts electronically as they move throughout the Trust receiving care in the various departments. The IC team have a good understanding of where a patient is and can use current systems in the Trust to ascertain locations at given points in time but a system does not currently exist that can link this to infectious diseases. In order to truly understand the impact on the Trust of C diff, MRSA or other Multi Antibiotic Resistant Organisms this facility is key.

In order to address the lack of an electronic solution to carry out epidemiological analysis in the hospital and to follow up our patients, the IC team have been reviewing IT developments to help meet NICE guidance. After a failed bid to the Nursing Technology fund for ICNet we are now working closely with the IT department to create our own system within RBCH. This is in the development stage.

Clostridium Difficile Infection (CDI) trajectories

The total number of CDI cases testing positive at RBCH has fallen over the past 6 years, however the number that are coming into the hospital as inpatients has increased. The percentage of cases deemed as late (testing positive after 72 hours in hospital) has fluctuated in that time period but over the last 3 years has remained around 20%.

For 2016/17 the Trust was over the trajectory set by NHS England of 14 by 3 cases. There has been no case caused by spread of CDI in hospital and the rate per 10000 bed days remains low when compared nationally. Practice issues that have may have contributed to these cases, 'lapses in care', have been used to create key learning points for the Trust. In addition to teaching sessions and awareness raising posters the IPC team have worked with wards and departments to help identify any changes that could reduce the likelihood of reoccurrence. A Quality Improvement project looking at reasons behind delays in isolation started this year and remains in progress.

Norovirus

This year 3 wards and 4 bays were closed due to Norovirus. The number of patients reported to have this virus was 39, 12 members of staff reported in unwell with symptoms. In total there were 123 empty bed days (beds unoccupied in closed wards or bays); a reduction on previous years.

At the time of writing this report the Trust had 550 beds and 95 side rooms including 5 wards with an ICEpod (temporary side room) each. Current evidence indicates that on an average day 50% of the side rooms within the Trust are used for patients carrying infectious bacteria. With the rising threat from resistant bacteria and new and emerging infections it is essential that we continue to look at new ways to isolate patients and to decontaminate areas after the patient leaves the hospital. New innovations are coming to market and will be investigated in line with further estates plans so that the Trust can meet the aim to increase the number of side rooms to improve our ability to promptly isolate patients.

Care Quality Commission (CQC)

The CQC inspection carried out in 2015 did not have any compliance actions related to infection prevention and control. However, the inspectors cited examples where staff did not fully comply with the Infection Prevention and Control principles. The summary report stated that staff generally adhered to Infection control procedures, but there were “some lapses in hand hygiene and some practices that did not fully support effective infection control and prevention”.

An action plan has been developed to address these concerns led by the Heads of Nursing and Quality in each Care Group. These actions include but are not limited to:

- An audit of equipment cleaning records to ensure that all equipment is cleaned after each use and that this is documented.
- Hand hygiene awareness which occurs throughout this year with events timed to coincide with World Hand Hygiene Day (May 5th).
- Ensuring that all patients are offered the opportunity to wash their hands before meal times.
- Ensuring that more staff access and complete the mandatory infection control training with a focus on improving uptake of this within the medical professionals.

The Infection Control Team supports these actions, which are monitored through the Infection Prevention and Control Committee, to provide assurance that IPC practice is robust and embedded across the Trust.

*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:	29 September 2017
Subject:	Annual Protection and Safeguarding Report
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:	Fiona Hoskins, Deputy Director of Nursing and Midwifery Jenny House, Senior Nurse Safeguarding Adults Pippa Knight, Named Nurse Safeguarding Children
Details of previous discussion and/or dissemination:	Trust Protection and Safeguarding Committee
Action required: Approve/Discuss/Information/Note	The Board is requested to note the report and approve the statement of commitment
Executive Summary: The enclosed report outlines the Trust's work and progress to Safeguard adults and children in 2016-17 and is provided to the Board for information and assurance. This work programme is overseen by the Trust Protection and Safeguarding Committee, which reports to the Healthcare Assurance Committee. Once approved, the statement of commitment to safeguarding children and adults and the annual report will be published on the Trust's website.	
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

Annual Protection and Safeguarding Report for Vulnerable Adults and Children 2016/ 2017

Adult Protection and Safeguarding Report 2016/ 2017

Executive Trust Lead Nurse for Adult Safeguarding:	Paula Shobbrook
Designated Adult Safeguarding Manager:	Ellen Bull
Named Doctor for Adult Safeguarding:	Sue Hazel
Senior Nurse for Adult Safeguarding:	Jenny House
Facilitator for Adult Safeguarding and Learning Disability:	Vicki West

The Trust's Adult Safeguarding Team is responsible for Adult Safeguarding enquiries, Patients with a Learning Disability, the application of the Mental Capacity Act in practice including Deprivation of Liberty Safeguards.

Adult Safeguarding

1. Introduction

This report details the actions and improvements in 2016/17 in Adult Safeguarding to inform and provide assurance to the Trust Board of Directors. This report is also to inform the Bournemouth and Poole Safeguarding Board and Dorset Safeguarding Adults Board that the Trust is compliant and aligned with their Policies and Procedures.

The Adult Safeguarding Team is compliant with the Internal Auditors recommendations and with our own Action Plan for our responsibilities.

2. Safeguarding Training

Level 1 Adult Safeguarding Training is via e-learning on BEAT VLE. All staff in the Trust must complete this Level along with the face to face training at Level 2. Volunteers within the Trust have face to face training at Level 1.

The target percentage for Adult Safeguarding training for 2016/17 was 95% however the Trust has achieved **96.1% of staff trained to Level 2**. At the beginning of the financial year only 86.2% of staff were trained to this level.

3. Adult Safeguarding Cases

There were **47 Adult Safeguarding Section 42 Enquiries** in 2016/17 which is comparable to other years within the Trust. (*Figure 1*)

This number is not comparable to our neighbouring acute hospitals; however it has been identified by the Designated Adult Safeguarding Lead of the Dorset Clinical Commissioning Group that all three acute Trusts have varying systems for screening and recording which explains the differences in numbers. This part of the process is led by

Social Services and relies on their interpretation of the Adult Safeguarding Policy and the Care Act (2014).

The Adult Safeguarding Team has met with the Poole Hospital Trust Adult Safeguarding Lead to review and align both Trusts processes.

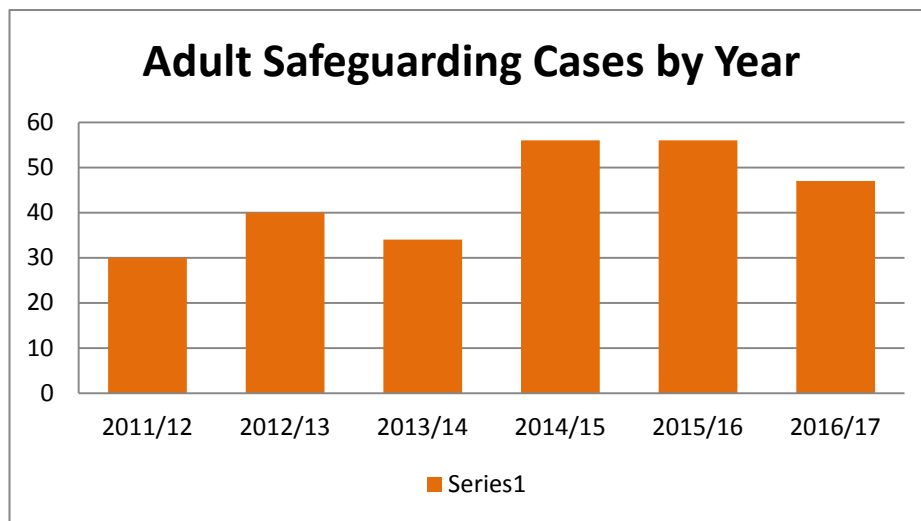


Figure 1: RBCHT ASG

Of the 47 ASG Enquiries 5 were fully substantiated and 12 partially substantiated. (Figure 2)

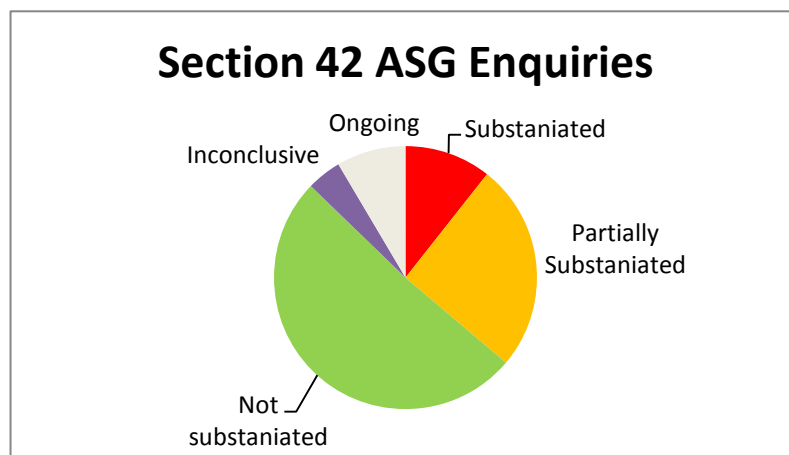


Figure 2: Enquiry Outcomes

Themes:

- Unsafe discharge. e.g. discharge to wrong destination (own home instead of care home)
- Discharged with intravenous (IV) cannula in situ
- Inappropriately dressed for discharge
- Discharged without confirmation of a care package in place.

Measures put in place to prevent reoccurrence:

- Changes to ward discharge lounge booking form. The patients discharge address is now at the top of the form and not the patient's home address as this often differs.
- "IV cannula removed" added to discharge lounge booking form

- Wards are now aware that clothing is available from the discharge lounge and the hospital charity shop.
- Staff instructed to contact Social Service before discharge to ensure correct package of care is in place and funded

4. **Sharing Outcomes**

The ASG team has developed a quarterly Newsletter which is sent to all wards and departments. The newsletter highlights and shares safeguarding themes to prevent re occurrence. The newsletter also provides information on any changes in the ASG process both nationally and locally.

5. **Assurances**

The Adult Safeguarding Team has addressed all the actions highlighted by the Internal Auditors and achieved their team objectives for 2016/2017.

Learning Disability

1. **Introduction**

There were **463 inpatient admissions** of people with a Learning Disability. These figures have not been captured previously. The ASG team now have a live link to the data base to gain access to these figures daily. Outpatient visits are not captured.

The Trust endeavours to enhance the patient with a Learning Disability's journey through out their admission. The Trust pays for specialist carers to support our own nursing staff in caring for those patients with more complex needs .During this financial year the Trust has paid for **11 carers** for the length of the inpatient stay.

2. **Learning Disability Mortality Review**

Deaths of people with a Learning Disability from age 4 years and upward must now have their death reviewed in line with national guidance. This is to ensure the individual was given comparable medical treatments as for a person without a Learning Disability.

The Learning Disability Mortality Review Programme (LeDer) commenced in 2017. This programme allows LD facilitators to be trained to undertake these reviews. The Trust LD Facilitator has completed this training.

3. **Training**

Learning Disabilities training is delivered with Adult Safeguarding therefore the percentage trained is **96.1%**.

4. **Assurances**

The Trust is compliant with Health Care for All the Department of Health 2008.

Deprivation of Liberty Safeguards and Mental Capacity Act

1. Introduction

The Deprivation of Liberty Safeguards (DoLS), were introduced twelve years ago and initially designed to protect peoples Human Rights by working within the framework of the Mental Capacity Act. It also gave Hospitals and Care Homes legal protection and guidance to deprive someone of their liberty to protect them.

The Trust works within the current legal framework for managing DoLS across the organisation

The Law Commission have argued that this is no longer fit for purpose. This is due in part to unanticipated volume of referrals and the 6 tier assessments required by Supervisory Body's Best Interest Assessor and Mental Health Assessor which has led to the increased backlogs of reviews and authorisations.

On 13/03/2017 the Law Commission published suggestions for changing the current system; this will be presented at some point in time to Government for approval.

Some of the proposed changes:

- Future name to be "Liberty Protection Safeguards".
- The minimal age will reduce to 16 years.
- This will no longer be applied only in Hospitals and Care Homes but will cover other areas including a person's own home.
- The application will be for the individual not their location.
- The initial length of time of the Deprivation will be increased.

2. Referrals

The Trust made **317 referrals for Deprivation of Liberty Safeguards** during the last financial year. The Trust figures reflect the national increase in applications since introduction and mandatory reporting. (Figure 3). Of this year's applications 67% were not assessed by the Supervisory Body to be fully authorised. The Trust has agreement with the Local Authority that it will take accountability for patients who continue to be detained even though patient has not been assessed.

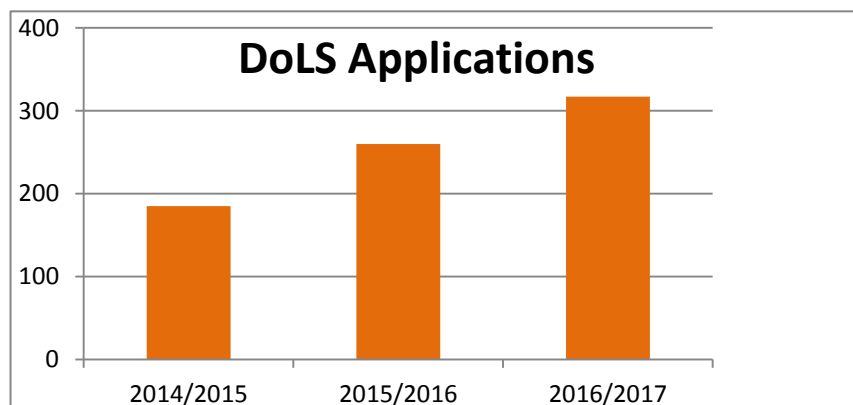


Figure 3: Submitted DoLS applications by year

3. Training

In February 2016 Mental Capacity Act and DoLS Training were incorporated into the Trust Mandatory Training. Compliance is now 84.2% across the Trust.

Workshop to Raise Awareness of PREVENT (WRAP)

1. Introduction

WRAP is a requirement for all NHS Trusts to support the prevention of terrorist related activities and safeguard vulnerable people. This was also incorporated into mandatory training in February 2016. The current Home office training programme is quite generic; a new NHS specific training programme is to be released in the near future.

2. Training

WRAP training is at **84.5%**.

Summary and Actions for 2017-18

1. Improvement in practice:

- Improved Training Compliance from standalone programmes and drop in sessions with other groups.
- A member of the ASG team visit the wards a minimum of twice a week to allow staff to ask questions and receive support.
- Stick on labels for medical notes of patients on a DoLS are now available on all wards. This has been welcomed by the staff as these patients can now be easily identified when being transferred from another ward.

2. Challenges:

- Aligning processes across Dorset to allow easier comparison of information gathered.
- Evidencing that staff consider Mental Capacity in their day to day activity and interaction with patients.
- Implementing the changes from the Law Commission when DoLS is passed through Government.

3. Future Plan:

- Auditing our care provision and facilities from the perspective of patients with a Learning Disability. (All previous audits were for carer / family feedback, not the individual to whom we are providing care).
- Visiting other Trusts to review their procedures for reporting and sharing this with the hospital Social Services team who currently are leads for RBH ASG investigations.

Jenny House
Adult Safeguarding Lead

June 2017

Vicki West
Facilitator for Adult Safeguarding and Learning Disabilities

Annual Safeguarding Children Report 2016/ 2017

Executive Trust Lead Nurse for Safeguarding:	Paula Shobbrook
Designated Officer for Safeguarding Allegations:	Ellen Bull
Named Doctor for Safeguarding Children:	Mr K Hassan
FGM Lead:	Dr E Herieka
Named Nurse for Safeguarding Children (Nominated Lead for CSE and Domestic Abuse):	Pippa Knight
Lead Nurse/Domestic Abuse Lead ED:	Cheryl Chainey/ Ann Brown
Sexual Health Lead Nurse:	Nicky Stewart
Named Midwife for Safeguarding Children:	Carmen Cross

The Trust specifically allocates:
 0.6WTE (Named Nurse)
 0.2WTE (Lead Nurse in ED)
 0.2 WTE (Lead nurse in Sexual Health)
 1PA (Named Doctor) to Safeguarding Children

Safeguarding Children

1. Introduction

This report details activity in respect of Safeguarding Children in the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust during the year 2016/17. It is presented to provide assurance of compliance with Standards from the Care Quality Commission, Working Together (Dept. of Health) and NHS England.

2. Local Arrangements

The Local Safeguarding Children Boards (LSCB) for Bournemouth-Poole (B-P) and Dorset meet four times per year, the Boards share an Independent Chair. RBCH attends the B-P Board; Executive representation is the Deputy Director of Nursing and Midwifery, acting on behalf of the Director of Nursing and Midwifery. The Named Nurse for Safeguarding Children and the Named Midwife deputise at these meetings and represent the Trust at sub-groups as appropriate.

LSCBs are based on the premise that safeguarding and promoting the welfare of children depends on effective joint working between agencies and professionals. The local LSCB PAN Dorset Safeguarding Procedures are revised and updated to reflect current practice and legislation. The LSCBs jointly commission an external agency for the formatting and updating of the Procedures. Our Trust staff access the PAN Dorset procedures via the Trust Intranet Safeguarding Children page <http://rbhintranet/redev/safeguarding/children.php>.

Section 11 of the Children Act 2004 places a duty on all partners to make arrangements to safeguard and promote the welfare of children. The LSCBs have agreed to undertake a Section 11 audit in 17/18. There has been no LSCB Section 11 audit in 16/17.

3. Safeguarding Training

All staff share the responsibility to Safeguard Children and all staff participate in the Trust 3 yearly Essential Core Skills pathway.

Level 1 Safeguarding Training: all staff in the Trust complete this Level as a minimum, including volunteers (e-learning or face to face sessions).

Level 2 Safeguarding Training: is completed by all clinical staff via e-learning on BEAT VLE and a short face to face session.

Level 3 Safeguarding Training: is completed by clinical staff who have regular contact with children, as set out in the Intercollegiate Document. It is delivered via the LSCB, face to face.

[http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20\(3\)_0.pdf](http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20(3)_0.pdf)

Level 4 Safeguarding Training: is completed by the Named Safeguarding staff. It is supported via our Dorset Designated Professionals.

Year-end compliance

Level	Compliance	Barriers	Mitigation
L1	95.8%		
L2	93.8%	Improved by 6.7% in year.	Meets CCG standard but not Trust standard (95%)
L3	78.3%	Improved by 2%. Predominantly reflects ED nursing staff. Barriers have included funding, rota allocation. All ED nurses have now been allocated a place in 2017 and a small funding pot has been secured to cover this training.	L2 training within this cohort is 91% at end of May 2017. All ED nurses will be booked onto L3 courses by end of Q1 and will complete training in 17/18.
L4	33.3%	Difficult to access training. Places secured for Named Doctor and Named Midwife in November 2017.	Lead Nurse in ED has attended and is L4. Lead midwife training secured in July 2017. Places secured for all Named Professionals in November 2017.

The Trust e-learning at Level 2 has been reviewed and updated to reflect National Learning and NHS England Safeguarding Priorities. Level 1 will be reviewed in 17/18.

4. Safeguarding Cases/ Referrals to Social Care

Trust Area	16/17	2015/16	2014/15	2013/14
Emergency Department	*322	566	781	580
Maternity	44	40	58	48
Other corporate	38	50	14	17
Reported FGM cases	2	6	Reporting not in place	Reporting not in place
MARAC Domestic Abuse cases	11	Not collected	Not collected	Not collected
Discussed with LADO cases	3	1	3	Central collection commenced

*Version 2 of the ED Safeguarding Referral form caused a drop in the tracking of referrals for Q1 and 2. This has been corrected and Q3 and 4 account for 254 referrals which is more in line with the previous year.

In Q4 a Corporate Safeguarding Children e-form was launched, in line with the ED version. This has been developed by our in-house IT Project team and is a system that staff and external partners engage well with. The e-form has reduced paper, improved safety for emailing safely since addresses are embedded within the system and all messages are auto encrypted. The system allows for easier quality monitoring and is being enhanced to include attaching outcomes. Our Local partners in Poole and Dorset County Hospitals have requested similar systems to be established within their Trusts.

5. Serious Case Reviews/ Audits

The Trust has engaged with 2 Serious case Reviews for Bournemouth – Poole LSCB. Reports are awaited for both.

The Local LSCBs have published:

- **S18:** This Serious Case Review (SCR) concerns a 15-year-old girl who took her own life in the summer of 2014.
- **C19:** The DSCB completed a Serious Case Audit in 2016 in relation to a baby who was made subject to a child protection plan as an unborn baby.
- **C20:** The DSCB completed a Serious Case Audit in relation to the harm of four children.
- **S23:** The DSCB completed a Serious Case Review in 2016 in relation to the potential serious harm of two Children placed in Foster Care within Dorset.
- Cases 18 and 19 have been incorporated into e-learning at Level 2 (with Baby N and Case 17 2015/16). Cases 20 and 23 are available to staff via the Trust intranet page.

<http://rbhintranet/redev/safeguarding/board.php>

6. Assurances

An audit is planned for Q1 of 17/18, which will be undertaken by the Trust Internal Auditors; BDO.

Department of Sexual Health have undertaken a department level audit of compliance with the internal Under 18s pathway.

Named Nurse completed an audit of referrals to Children's Social Care from the Emergency Department.

Dorset CCG were invited to audit our Maternity services specifically in relation to safeguarding.

The following Trust policies have been reviewed and updated:

- Safeguarding Children
- Supervision for Safeguarding Children
- Child Sexual Exploitation

A new policy has been produced:

- Domestic Abuse

Recruitment and Selection Policy was last updated by Human Resources 2015. In year the Named nurse has conducted an audit of Enhanced DBS check status on all Safeguarding Children Leads. Two were found to have no evidence to support the checks being made and so a DBS has been repeated. It is considered that this was due to the migration of information from one system to another.

7. Key National Safeguarding Children Workstreams

Female Genital Mutilation (FGM)

Systems in place and continue to strengthen awareness and knowledge through training.

Child Sexual Exploitation (CSE)

A change to the Local system – Police have stepped down from co-ordinating multi-agency meetings and each Local Authority has developed a pathway for escalating and reviewing most vulnerable children in a multi-agency meeting. RBCH have engaged with Bournemouth LA but no meetings have been established. The Named Nurse has escalated this to the Designated Nurse, Police and Bournemouth CSC CSE Lead for follow up in 2017-18. As names are not shared, alert flags cannot be added for staff awareness.

Child Sexual Abuse (CSA)

RBCH engaged with local multi-agency partnership meetings for this work stream.

Child Protection Information Sharing (CPiS)

Funding is secured for Symphony to have CPiS embedded at RBCH. Date for 'switch on' to be confirmed by IT. This work stream will gain priority in 2017/18.

Neglect

RBCH engaged with local multi-agency partnership meetings for this work stream. Training reflects a greater focus and awareness on Neglect.

Looked After Children (LAC)

Including Unaccompanied Children Seeking Asylum – Trust has engaged with our Designated LAC Nurse to support the health and well-being of children entering our health economy and continues to participate with the Special Educational Needs and Disability (SEND) agenda.

Pippa Knight

Named Nurse for Safeguarding Children (Lead for CSE and Domestic Abuse)

Maternity Safeguarding

1. Introduction

This report details the actions and improvements in 2016/17 in Maternity Safeguarding to inform and provide assurance to the Trust Board of Directors. This report is also to inform the Bournemouth and Poole Safeguarding Board and Dorset Safeguarding Children's Board that the Trust is compliant and aligned with their Policies and Procedures.

2016/17 saw changes to the Sunshine team following recommendations from an external audit. A new clinical lead was appointed and new team members. New ways of working introduced to ensure all midwives had a caseload which included some of the lower risk safeguarding cases. The Sunshine team moved to caring for the higher risk safeguarding cases plus a caseload of non-safeguarding cases. This move has been received as positive and ensures that all staff are able to support vulnerable women and embed Safeguarding in their practice.

2. Safeguarding Training

Level 2 and 3

Children's Safeguard training specific to maternity is to be undertaken by all midwives and community maternity support workers. The target percentage for child Safeguarding training for 2016/17 was 95%, **maternity has achieved 100% of staff trained to Level 2 and 83% for level 3.** All staff had completed level 3 training and this was for the update sessions.

Level 4

Safeguarding Training should completed by the Named Safeguarding staff. It is supported via our Dorset Designated Professionals. The lead midwife for safeguarding has completed level 4 and the Head of Midwifery will be completing later this year.

Maternity Safeguarding Cases

	2016/ 17	2015/ 16	2014/ 15	2013/ 14
Social Services referral	44	40	58	48
MARAC (Domestic Abuse)	11	Not collected	Not collected	Not collected
Looked after children	1	Not Collected	Not Collected	Not Collected

Caseloads	2016/ 17	2015/ 16
Total	166	Not collected
Drug and Alcohol	1	
Perinatal Mental health	11	
Teenagers	10	
Domestic Abuse	33	
Learning Disability	7	
Homelessness	1	
Trafficked	5	
Mental Health	80	

3. Serious Case Reviews/ Audits

Maternity had one serious case review, relating to Baby Q. The previous midwifery clinical lead for safeguarding completed the report with support from the Head of Midwifery. The current Midwifery clinical lead attended the review of the report together with the midwife involved in care. Currently awaiting the publication.

4. Assurances

An internal audit is planned for Q1 of 17/18 to be undertaken by BDO.

An audit was completed by the CCG in response to a request from the trust specifically for maternity safeguarding. The actions have been overseen by the Trust Protection and Safeguarding Committee

LSCB audit undertaken by maternity clinical lead midwife, initial feedback positive for RBH midwives, awaiting the final report.

Mental Health Policy updated 2015 (uploaded 2016)
Domestic Abuse Maternity Guideline - updated Nov 2016

5. Future Plans

Closer working with Poole Maternity to include safeguarding lead midwife at Poole to attend RBH safeguarding meetings.

Joint working on Safeguarding Policies and SOP's with Poole Maternity.

Audit to include outcomes for families cared for by Sunshine Team 2017/ 18.

Karey Pitkin
Lead Midwife for Safeguarding

Carmen Cross
Head of Midwifery/ Named Midwife for Safeguarding

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BOARD OF DIRECTORS

Meeting Date and Part :	29 September 2017 Part 1
Subject:	Medical Director's Report
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	N/A
Officer with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of papers:	Alyson O'Donnell, Medical Director
Details of previous discussion and/or dissemination:	MSG 14/9/17
Action required:	For information only
Executive Summary:	
To update the board on the Trust's current mortality	
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?	

Medical Director's Report

Board of Directors September 2017

Mortality Update

Overall HSMR for the trust remains in the 'as expected' range at 95.9. The figure for RBH (excluding Christchurch and the Macmillan unit) is 88.4 and in the 'better than expected range'. For the complete financial year 16-17 the Trust's HSMR was rated significantly better than expected for the first time. It is important to note that HSMR has been better than the national average consistently over the last 12 months.

Importantly crude death is stable/falling at 1.09% as are the number of deaths within 36. Reassurance is provided by the continued SHMI position and number of re-admissions which do not suggest that there are inappropriate or late deaths in the community.

We continue to review any alerts in diagnostic groups by undertaking a case note review for any new alerts. For repeat alerts this is done in conjunction with a review of any previous action plans to ensure that all actions have been completed. For example, a recent alert in Peripheral arterial disease and thrombosis has an outstanding action to improve medical (physician) support to vascular patients for which funding has been identified but the post is to be filled.

Learning from Deaths

From this month it is now mandatory for the Trust to centrally report mortality data to include:

Number of deaths

Number of deaths subject to review

Number of deaths where deficiencies in care were identified

Actions arising from any reviews

There is a drive to ensure that processes across Wessex are working in similar ways to allow direct comparisons between Trusts. More importantly this should ensure system learning from deaths rather than for individual organisations. For example, care may have been good but death inevitable by the point of admission but with modifiable features within out of hospital care.

There are between 106-160 deaths per month in the Trust. We achieve up to a 60% review rate of all deaths but there is a significant lag in these being completed ie full cycle of clinician review, mortality lead sign off and presentation at mortality and morbidity

meetings. The rising number of Coroner requested post mortems and the delays in receiving post mortem reports is likely to impact on this further as we have already seen some decline in the timeliness of reviews.

Of 851 deaths reviewed in the last 12 months 68 were graded as Grade 1 where there were some gaps in care but not significantly contributing to death. Only 5 were graded as 2 which indicates a possibly avoidable death. This equates to around 0.6% of deaths reviewed which is lower than the 3.6% reported in two key national studies but in keeping with what has been reported by other organisations piloting the Royal College of Physicians Structured Judgement review. We suspect that 'second look' and wider system consideration being introduced as part of the Medical Examiners Group may increase this number.

Sep-16	106	34	32.1%
Oct-16	132	61	46.2%
Nov-16	125	73	58.4%
Dec-16	135	71	52.6%
Jan-17	169	88	52.1%
Feb-17	158	73	46.2%
Mar-17	132	57	43.2%
Apr-17	129	66	51.2%
May-17	139	57	41.0%
Jun-17	113	16	14.2%
Jul-17	107	10	9.3%
Aug-17	130	0	0.0%

E-mortality review completion -Overall rate 38.5% in the last year

As part of this process any deaths with any 'triggers' reading the quality of care will feed in to a process aligned to our serious incident investigation process. This will allow timely recognition of deaths with avoidable features, ensure that family's voices are heard and questions answered and allow key learning to be shared in a similar format.

SACT data

The national report on Systemic Anti-Cancer Treatment has been awaited for some time. In the previous report the Trust had been identified as an outlier relating to documentation of intention to treat (cure versus symptom control). We have now been notified that the data is likely to be released within the next few weeks. We have received no queries about our data or indications that we are likely to be an outlier but await the formal report

Mortality Report for Board: September 2017

Reviews are deemed completed if either the review or mortality chair review date has been completed, or the review has been marked as complete.

eMortality review data as at 21/09/2017

Month	Jun-17	Jul-17	Aug-17
Deaths in Month	113	107	130
eMortality Reviews Completed in Month	132	117	35
Category of Death by Month Review Completed			
Grade 0	122	108	30
Grade 1	9	8	5
Grade 2	1	1	0
Grade 3	0	0	0
Learning Disability Deaths in Month	0	0	1

eMortality Reviews - Question Breakdown by Month
Data updated 21/09/2017

Number of Deaths in Month

Month of Death	No. of Deaths	No. Completed	% Reviews Completed
Sep-16	106	34	32.1%
Oct-16	132	61	46.2%
Nov-16	125	73	58.4%
Dec-16	135	71	52.6%
Jan-17	169	88	52.1%
Feb-17	158	73	46.2%
Mar-17	132	57	43.2%
Apr-17	129	66	51.2%
May-17	139	57	41.0%
Jun-17	113	16	14.2%
Jul-17	107	10	9.3%
Aug-17	130	0	0.0%
Grand Total	1575	606	38.5%

Number of Reviews Completed in Month

Month Completed	Number of Reviews Completed
Oct-16	40
Nov-16	9
Dec-16	163
Jan-17	52
Feb-17	78
Mar-17	74
Apr-17	71
May-17	60
Jun-17	132
Jul-17	117
Aug-17	35
Sep-17	20
Grand Total	851

Of those reviews deemed as completed...

Complete – Mortality Review Date has been entered or Review is complete and the Form Review Date has been entered

Category of Care Grade

Month Complete	grade0	grade1	grade2	(blank)	Grand Total
Oct-16	40				40
Nov-16	7	1		1	9
Dec-16	153	10			163
Jan-17	43	8	1		52
Feb-17	68	10			78
Mar-17	72	2			74
Apr-17	67	3	1		71
May-17	51	9			60
Jun-17	122	9	1		132
Jul-17	108	8	1		117
Aug-17	30	5			35
Sep-17	16	3	1		20
Grand Total	777	68	5	1	851

Was this hospital the most appropriate place to die?

Month Complete	yes	no	Grand Total
Oct-16	38	2	40
Nov-16	8	1	9
Dec-16	136	27	163
Jan-17	38	14	52
Feb-17	62	16	78
Mar-17	59	15	74
Apr-17	62	9	71
May-17	51	9	60
Jun-17	112	20	132
Jul-17	90	27	117
Aug-17	28	7	35
Sep-17	16	4	20
Grand Total	700	151	851

Were there concerns over manner of death?

Month Complete	yes	no	(blank)	Grand Total
Oct-16		22	18	40
Nov-16		5	4	9
Dec-16	3	114	46	163
Jan-17	2	40	10	52
Feb-17	2	50	26	78
Mar-17	1	49	24	74
Apr-17	1	37	33	71
May-17		47	13	60
Jun-17	1	105	26	132
Jul-17	4	72	41	117
Aug-17	1	20	14	35
Sep-17	1	15	4	20
Grand Total	16	576	259	851

Was there a clear escalation plan documented?

Month Complete	yes	no	(blank)	Grand Total
Oct-16	22	18		40
Nov-16	5	4		9
Dec-16	117	46	163	
Jan-17	42	10	52	
Feb-17	51	26	78	
Mar-17	50	24	74	
Apr-17	38	33	71	
May-17	47	13	60	
Jun-17	104	26	132	
Jul-17	74	42	117	
Aug-17	21	14	35	
Sep-17	16	4	20	
Grand Total	587	4	260	851

Were there any medication errors?

Month Complete	yes	no	Grand Total
Oct-16		40	40
Nov-16		9	9
Dec-16	3	160	163
Jan-17	1	51	52
Feb-17		78	78
Mar-17	2	72	74
Apr-17		71	71
May-17	3	57	60
Jun-17	1	131	132
Jul-17	2	115	117
Aug-17	1	34	35
Sep-17		20	20
Grand Total	13	838	851

Was there evidence of a delay in escalation of treatment?

Month Complete	yes	no	unknown	Grand Total
Oct-16		40		40
Nov-16		9		9
Dec-16		163		163
Jan-17	1	51		52
Feb-17	1	77		78
Mar-17	1	73		74
Apr-17	1	69	1	71
May-17		60		60
Jun-17	2	130		132
Jul-17	4	112	1	117
Aug-17		35		35
Sep-17	1	19		20
Grand Total	11	838	2	851

Did these medication errors contribute to death?

Month Complete	unknown	no	(blank)	Grand Total
Oct-16		4	36	40
Nov-16		9	9	9
Dec-16	1	5	157	163
Jan-17		52	52	52
Feb-17	1	77	78	78
Mar-17		74	74	74
Apr-17	1	70	71	71
May-17		60	60	60
Jun-17		132	132	132
Jul-17		116	117	117
Aug-17		35	35	35
Sep-17		20	20	20
Grand Total	1	12	838	851

Was the patients' care supported by Personalised Care Plan for last days of life?

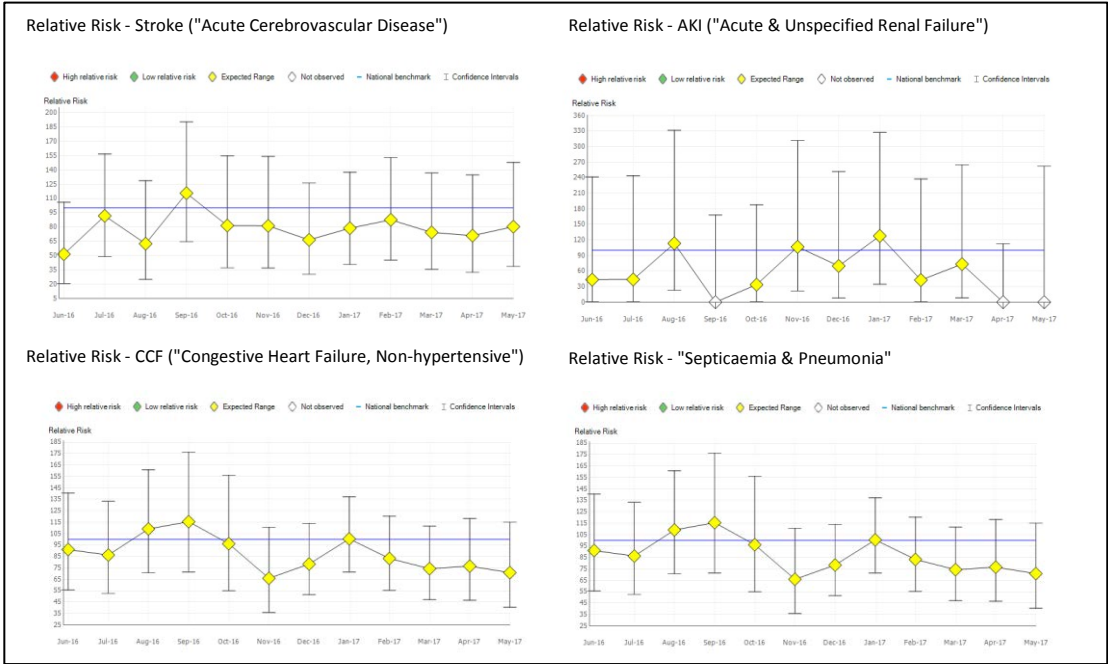
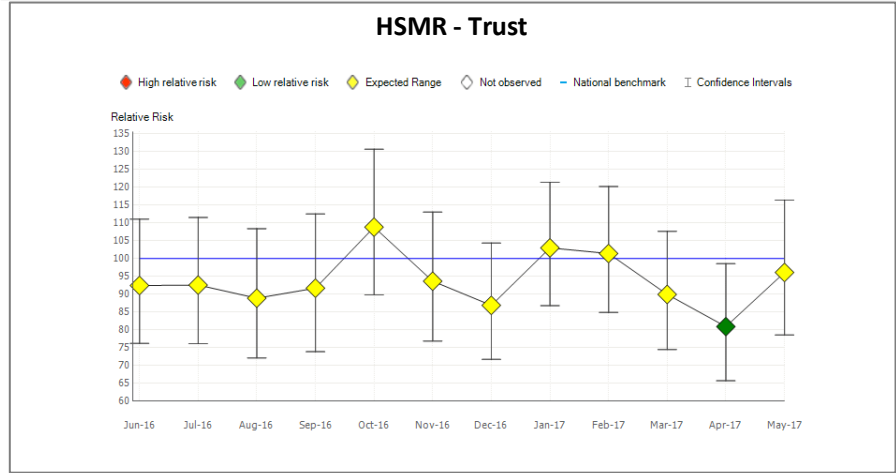
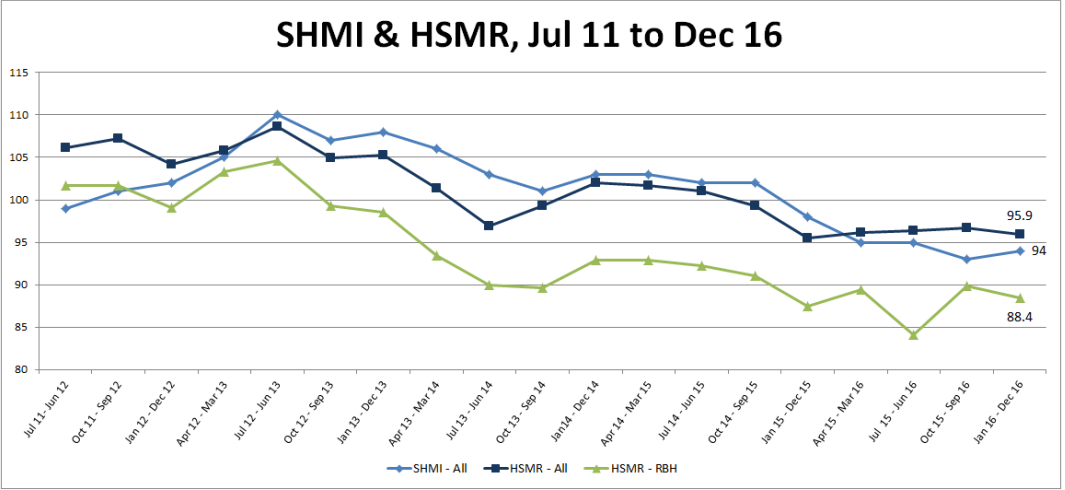
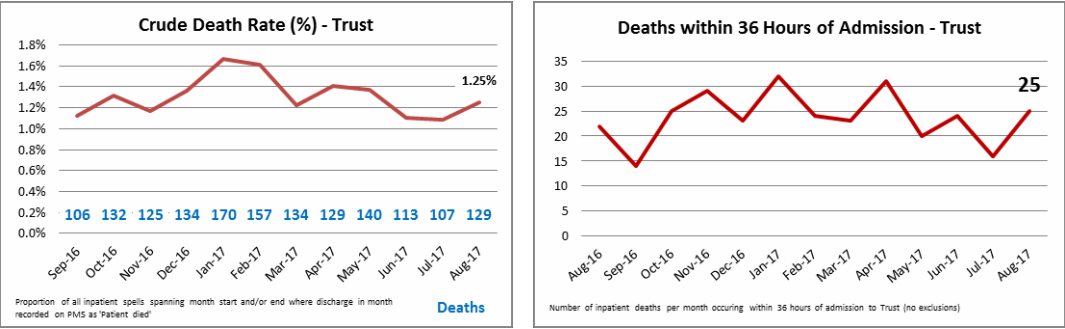
Month Complete	yes	no	Grand Total
Oct-16	22	18	40
Nov-16	6	3	9
Dec-16	117	46	163
Jan-17	42	10	52
Feb-17	52	26	78
Mar-17	49	25	74
Apr-17	38	33	71
May-17	47	13	60
Jun-17	106	26	132
Jul-17	74	43	117
Aug-17	20	15	35
Sep-17	16	4	20
Grand Total	589	262	851

In retrospect could it have been identified earlier that the patient was dying?

Month Complete	definitely	possibly	definitely not	(blank)	Grand Total
Oct-16		4	18	18	40
Nov-16	1	1	3	4	9
Dec-16	1	10	106	46	163
Jan-17	1	13	28	10	52
Feb-17	1	12	39	26	78
Mar-17	5	12	33	24	74
Apr-17		4	34	33	71
May-17	2	10	35	13	60
Jun-17		6	100	26	132
Jul-17	2	6	67	42	117
Aug-17		3	18	14	35
Sep-17		1	15	4	20
Grand Total	13	82	496	260	851

Patients' allow a natural death status documented?

Month Complete	yes	no	Grand Total
Oct-16	35	5	40
Nov-16	9		9
Dec-16	159	4	163
Jan-17	51	1	52
Feb-17	75	3	78
Mar-17	71	3	74
Apr-17	68	3	71
May-17	56	4	60
Jun-17	126	6	132
Jul-17	113	4	117
Aug-17	34	1	35
Sep-17	20		20
Grand Total	817	34	851



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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	29 September 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)	Yes
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	Ongoing discussions at TMB and Board
Action required:	Information
Executive Summary: This paper updates the Board following the recent CCG Governing Body decision	
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

Introduction

The purpose of this paper is to apprise the Board of progress in respect of the key work streams underpinning the implementation of the Clinical Services Review following the CCG's decision on the 20 September to support all of the recommendations contained within the papers detailed in the Reading Pack.

In summary these decisions included:

- Affirming the Royal Bournemouth Hospital as the site for provision of major emergency services
- Utilising Poole Hospital as the major planned site
- Confirming the continuation of both emergency and planned services at Dorset County Hospital and supporting work between Dorset County Hospital and Yeovil Hospital to create an integrated Obstetric and Children's service
- The additional establishment of community beds at both the Poole and Royal Bournemouth Hospital sites
- To support the closure of St Leonards Hospital

With regard to the latter decision we will continue to work closely with both the CCG and colleagues in DHUFT to ensure that inpatient facilities do not close before alternative arrangements are put in place to support patients requiring rehabilitation and ongoing care.

Capital Funding to support the redesign of the two East Dorset hospital sites

I have included within the Reading Pack two letters, one from the Department of Health and the second from NHSI confirming approval of our Strategic Outline Case and the allocation of funding to support the implementation of the Clinical Services Review. The precise level of funding will now be confirmed given that the CCG has made its final decision. It is anticipated that the two Trusts will receive in total £147m.

In order to access and draw down the allotted funds the two Trusts will need to:

- Submit an outline business case and consequent upon the agreement of the OBC submit a full business case in accordance with the Treasury five case model. This will be subject to approval by the DoH, NHSI and the Treasury. This is a standard process for the release of capital funds of this size. The Trusts will, however, require some additional external support to produce this.

- Prepare and submit on behalf of the Dorset Health System a comprehensive estate plan, demonstrating the congruence between this investment and wider plans for the Dorset estate. The funding will only be released once this has been agreed with the DoH.
- Confirm arrangements for post project evaluation to demonstrate the investment represents value for money for the tax payer.

The Implementation of the Planned and Emergency Models at a Speciality level

Very positive discussions have taken place between the two Executive Teams leading to a proposed methodology to take forward the clinical design of services across the two hospital sites. I have included within the Reading Pack a set of slides which summarise these discussions and will form part of a presentation I will deliver at our meeting on 29 September.

In summary it is important that individual specialties and the aggregated Care Groups consider how they aim to provide service at both planned and emergency sites taking account of workforce constraints, the underpinning assumptions that have guided much of our work to date and the need to reflect anticipated changes in service provision including extended use of technology. This work will help shape the subsequent design of facilities on both sites.

To assist this work clarity will initially be provided on the nature of the critical care services provided to both the planned and emergency site. The extent of the medical take on both sites will be determined once a range of specialties have had the opportunity to consider how they propose to support and participate in the medical take. It is anticipated that this phase of the work will run through until the end of March 2018 at which point sufficient information will be available to support the commencement of work for the design of facilities at both hospital sites. Proposals emerging from individual specialty based discussions will be quality assured and tested via a team comprising Medical Directors, Nurse Directors and Senior Clinicians drawn from the two organisations. It is critical that this work involves professional groups across all disciplines and is appropriately supported by the relevant senior teams.

Early Discussions with the CMA

The Board has already had sight of recent correspondence between the two Trusts and the Competition and Markets Authority which follows helpful informal discussions. Post the CCG decision on 20 September and consideration of the paper before the Board today seeking formal agreement to launch the work to lift the undertakings and take forward a potential merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust we will agree advisers to support this work.

Subject to further discussions and clarification it is possible that the CMA will want to undertake a two stage review. The first stage, once initiated, will take 40 days

and the second stage, if activated, could take up to 24 weeks. The key requirement for the Trusts will be the development of the Patient Benefits Case which explains the key benefits for patients through the full implementation of the CSR and why a merger is central to delivering these.

The Benefits Case will be subject to agreement by TMB and HEG prior to being considered by the Boards of the Trusts. Subject to the CMA clearing the proposed merger and lifting the undertakings the two Trusts also require NHSI to agree the merger (which itself requires the submission of a Business Case and approval of the Council of Governors). From a Trust-wide perspective it appears reasonable to plan on a possible merger timeframe of around 12 -15 months.

This paper is provided to the Board for information.

Tony Spotswood
Chief Executive

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th September 2017 – Part 1
Reason for Part 2:	n/a
Subject:	People Plan
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	No
Officer with overall responsibility:	Karen Allman
Author(s) of papers:	Louise Hamilton-Welsh
Details of previous discussion and/or dissemination:	The People Plan has been widely discussed and developed with leaders and in groups including: Management meetings; Partnership Forum; dedicated Workshops, and finally ratified at the August Workforce Committee
Action required: Approve/Discuss/Information/Note	Approve
<p>Executive Summary:</p> <p>Please find attached final versions of the:</p> <ul style="list-style-type: none"> • People Plan logo on a one pager with Priorities for 2017-2020 • Main People Plan document providing detail on all of the areas covered. <p>The People Plan (or Strategy) is designed to enable managers to bring together all people related themes and activities in our Trust within one easily identifiable model, enabling clarity, promoting capability and driving motivation.</p> <p>These versions have been enhanced by Communications in order to support managers to use and apply this model.</p> <p>We will use a soft launch and start to include this graphic and the supporting material where appropriate.</p> <p>It is anticipated that this Plan will be used in RBCH as a dynamic vehicle, to demonstrate our commitment to this agenda at a time of change and to support dialogue and action planning with managers around the themes covered.</p> <p>The Work Plans under the different parts of the People Plan are being collated and will be monitored and reviewed through the Workforce Committee.</p>	

We will be exploring with Staff Groups the best ways to make these messages accessible and meaningful for our people.

We have also involved HR staff from Poole in our planning and workshop and will continue to explore what we can do together in the future.

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 and workforce planning are existing risks on the risk register.

Our People Plan 2017-2020

'Loving what we do'

"Staff engagement is one of the most important influencers of patient outcomes and experiences of being cared for - patients receive better care when staff are engaged, motivated and well led."

Michael West

Why a People Plan?

To represent our shared view of how we need to invest time, effort and money to help our people to be 'loving what we do' now and in future, delivering our Trust vision and strategy and the best possible care for patients. This Plan covers 2017 to the end of 2020 and is supported by a work plan for each year.

We want the employee experience to be outstanding at each stage from start to finish for everyone who works at the Trust in any capacity.

Our Mission is to provide the excellent care we would expect for our own families.

People who are motivated to invest emotionally, 'go the extra mile' and provide excellent patient care are more likely to love what they do, so this is our measure of success.

Our Vision is: To be the most improved hospital in the UK by 2017.

For 2017/18 the Trust Objectives are:

- Valuing Our Staff: Recognising the contribution of our staff and helping them develop and achieve their potential.
- Improving Quality and Reducing Harm: Focusing on continuous improvement and reduction of waste.
- Strengthening Team Working: Developing and strengthening safe and compassionate care for our patients and shaping future health across Dorset.
- Listening to Patients: Ensuring meaningful engagement to improve patient experience.



Our Values give us the day to day behaviours we care about and want to represent. Every single employee of the Trust has an important part to play in the delivery of patient care.

Our Future is about working together across Trust boundaries to realise the patient benefits from the Clinical Services Review including the development of a major emergency care hospital at the Royal Bournemouth Hospital and a major planned care hospital at Poole.

Success hinges on our workforce being skilled, ready for change, adaptable, engaged, healthy and well.

"All staff take responsibility for the success of the organisation in delivering continually improving, high quality and compassionate care."

Developing Collective Leadership for Healthcare'
The King's Fund 2014

How we develop, support and motivate our staff is pivotal to providing outstanding, compassionate care. In the context of major changes to the way in which health services are provided across Dorset it is vital that we plan to ensure we have the capabilities and capacity to meet the needs of our patients. This plan confirms our commitment to nurturing and developing our talent, creating new and expanded roles. and focuses on the importance of valuing and recognising the contribution made by every member of staff. The opportunities that will present for our staff will be significant, it is therefore crucial that we create an environment where all can flourish, fulfil their potential and demonstrate the values which define our ambition.

Tony Spotswood
Chief Executive



In letting people know what is going on and how it affects them we are:

- Sharing updates on strategy e.g. how the Clinical Services Review is changing our services.
- Providing a clear path to access relevant clinical/ non-clinical events and conferences.
- Working with HR and OD to promote people development opportunities.
- Engaging our people before inspections and sharing results.
- Providing updates on policies and promoting access to health and wellbeing advice and services.

Our people engagement and communications objectives are:

- To optimise the effective use of face to face communication including via senior management.
- To develop ways to reach more of our people and gain feedback in a way that suits them.
- To involve more of our people regardless of working patterns, role or location.
- To increase engagement through better fit with specific audiences - targeting more of our messages.
- To make acting on peoples suggestions in a positive way and crediting their contribution part of our DNA.
- To celebrate our people's achievements, enabling them to tell their stories so others can learn and be inspired.

People engagement

In engaging our people, showing we are listening and responding, we are:

- Hearing the voice of our staff e.g. staff survey action discussions, change champion cultural feedback sessions, focus groups, all staff Q and As.
- Recognising and thanking those who go the extra mile. **#Thank you**
- Working together to implement campaigns to help us improve our Trust.



Leadership and management

In driving to ensure our behaviours are reflecting our values we are:

- Helping our people to create an inclusive culture of compassion and continuous improvement.
- Developing our leaders to nurture the culture we want to create.
- Equipping our people with the management skills they need to do their job.
- Actively engaging with our people to ensure better decisions and outcomes for our staff and patients.

In developing current and future leaders we are:

- Ensuring a pipeline of managers and leaders through effective succession planning.
- Helping everyone to be as good as they can be - supporting everyone to achieve their potential.

Our leadership and management objectives are:

- To develop leadership capability in order to deliver transformational change - leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

- To ensure that the leadership, management and governance of our Trust assures the delivery of high quality and person-centred care, supports learning and innovation and promotes an open and fair culture.
- To set out a clear and strategic approach to management and leadership development, recognising, coaching and developing talent in all its forms.
- To use the most effective processes to select, deploy and support our managers.

Recruitment and retention

In attracting the best people to work in our teams, we are:

- Prioritising sustainable options as we face an increasingly challenging recruitment market.
- Being creative to fill 'difficult to recruit' vacancies.
- Successfully running one of the first medical banks in the area.
- Sourcing nearly all temporary cover from our Bank, reducing reliance and spend on agencies.



In striving to retain our people we are:

- Analysing organisation-wide workforce data to gain and act on this.
- Continuously improving our engagement plans, activities and access to feedback.
- Driving to make our e-rostering practice even more attractive for our staff.

Our recruitment and retention objectives are:

- To recruit for values-based behaviours.
- To work with key partners to optimise routes into healthcare education and careers.
- To find joint recruitment-service opportunities across Dorset trusts.
- To provide the best experience we can - responsive, welcoming and attracting the best.
- To monitor and anticipate external impacts, being as creative as possible in attracting others to work with us.
- To join up with Workforce Planning - providing the workforce to anticipate and respond to service need.
- To embrace the opportunities and realise the benefits of new, extended and advanced roles e.g. apprenticeships.

Workforce planning and forecasting

In resourcing our hospitals, we are workforce planning:

- At overall Trust level
- At Service level
- Through identifying pressure points and critical roles.

In transforming our workforce, we are:

- Planning against changing service models for two and six+ years.
- Planning for key professions e.g. doctors and nurses, allied health professionals, scientific and dental.
- Working collaboratively to plan and deliver the Clinical Services Review cross-Dorset.
- Mindful of the broader NHS England agenda.

Our Workforce Planning Programme objectives are:

- To deliver a sustainable workforce to realise the outcomes of the Clinical Services Review.
- To ensure the right roles in the right numbers are commissioned from Education providers.
- To take actions to reduce reliance on international recruitment.
- To coach/upskill our leaders to be more competent in leading workforce planning.
- Using robust data and business plans, to establish a multi-professional workforce scenario planning processes.
- To produce costed plans that can be cross-checked, are simple to update, understand and communicate.
- To record and maintain plans, fit for Trust purposes and for the broader context.

Education and training

In making it easier for all of our people to learn, we are:

- Providing a one stop shop for mandatory training requirements.
- Giving every person unique access to their own online training plan via BEAT.
- Motivating all of our people to get and maintain a 'green brain' to ensure compliance.
- Providing accessible progression pathways (traditional /non-traditional) for all our people.
- Ensuring the appropriate educational governance is in place to maintain standards.

In helping equip our professionals to give an excellent patient experience, we are:

- Enabling access to top quality programmes informed by best practice in patient care and safety.
- Driving forward regular follow-ups, appraisal and personal development planning.
- Partnering with providers to make sure we are 'on the front foot' with changes.
- Communicating opportunities and being persistent in accessing funding streams.
- Regularly evaluating our education and training and its alignment to Trust objectives.

Our education and training objectives are:

- To ensure we have the right skills in the right place at the right time.
- To enable individual passports for each staff member, setting out their training history, needs and resources.
- To improve the overall learning experience with increased emphasis on blended learning approaches.
- To drive creative and effective solutions to upskill new/existing people to help address skill shortages.
- To optimise our education and training proposition as a recruitment and retention tool.

People policies, processes and systems

In making working life easier for our people we are providing:

- Quick and easy ways to update personal information and make requests.
- E-rosters to help plan working time and work life balance.
- Clear standards, consistent and fair processes.

In helping leaders know their people and manage more effectively we are:

- Reducing the time to do routine tasks, freeing up time for patient care.
- Enabling a more robust, professional and often paper free approach.
- Providing better access to management information (often live) and planning tools.
- Providing dedicated HR business partners and relevant professional support.

Our policies and systems objectives are:

- To keep these simple, quick and relevant - enhancing the employee experience.
- Extended functionality and mobile use of self-service, helping people to help themselves including manager's toolkits.
- To improve our interpretation of Management Information to drive behavioural change.
- To ensure our people are well educated and trained to make the best use of systems and policies.
- To make the step into people management easier for new leaders.
- Using employee feedback, to help address any time wasters/frustrations in our processes.
- To make policies far easier to access and use with helpful prompts to promote best practice.



Diversity and inclusion

In showing we value diversity and inclusion in our workforce, we are:

- Ensuring that we reflect the diversity in the population we serve.
- Identifying priorities and setting clear objectives - linked to our business planning.
- Taking appropriate actions e.g. supporting the integration of staff from outside the UK.
- Collecting key data, reporting and tracking effectively.
- Actively promoting regular activities to raise involvement and awareness.
- Demonstrating board level understanding and support
- Giving our people clear and consistent messages about recognising and valuing diversity.

Our diversity and inclusion objectives are:

- To develop our network of champions to support even greater local ownership.
- To review our recruitment practice to ensure there are no hidden barriers and to attract even more widely.
- To ensure that the added value of diversity in teams forms part of our Team Development Programme.
- To ensure that minority groups are listened to and supported.
- To ensure that easily accessible, user-friendly policies are available and consistent standards of practice are set and maintained.
- To ensure that managers are as flexible as possible and equipped to support staff with particular requirements.
- To ensure that hierarchies do not get in the way.

Health and wellbeing

In recognising the behaviours critical to workplace health and wellbeing we are:

- Bringing clarity to the role of leaders in health and wellbeing.
- Identifying good practice and working towards a shared strategic vision.
- Engaging our people in a wide variety of ways.
- Communicating and sharing values, responsibilities and the health and wellbeing proposition

In recognising the actions critical to a robust and effective health and wellbeing offering, we are:

- Working to understand what our data can tell us to support improvements.
- Looking at appropriate actions around prevention.
- Identifying when and how best to intervene.
- Evaluating what we do and informing our next actions.

Our health and wellbeing objectives are:

- To reinforce that happy, healthy staff = safe patients and reduced mortality.
- To go beyond the core objective of reducing sickness absence using a sustainable approach and building resilience.
- To optimise the factors for success - positive team culture, supportive management behaviour, positive contribution, participation and keeping people informed.
- To join with other public sector bodies in Dorset to share good practice and plan appropriate joint interventions.



Our People Plan priorities 2017-2020

Our People Plan brings together all our staff strategies. This alignment will help inspire and support our staff to deliver the best possible care for our patients, attract the best talent to our Trust, recognise the incredible commitment of our people and ensure we offer exciting and stretching opportunities to every member of staff. Our complete People Plan is available on our intranet.



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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	29 September 2017 – Part 1
Reason for Part 2:	n/a
Subject:	Progress Update 2017/18 Corporate Objectives
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:	Sandy Edington
Details of previous discussion and/or dissemination:	N/A
Action required: Approve/Discuss/Information/Note	For Information
Executive Summary:	
Review of Trust Objectives for 2017/18, to end July 17	
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?	

Objective		Lead Exec	RAG Rating			Commentary
			End Jul 17	End Nov 17	End Mar 18	
OBJECTIVE ONE Valuing our staff						
Narrative:	<i>Recognising the contribution of our staff and helping them develop and achieve their potential</i>					
1.1	Publication, by September 2017, of the Trust's People Strategy which will contain clearly defined approaches for:					
	a) Talent management	NH				Detail to be provided within Leadership Strategy being presented to Board in October
	b) Staff Engagement and communication	KA				Engagement plan is part of People Plan at Board in Sept 17.
	c) Leadership Development	NH				Detail to be provided within Leadership Strategy being presented to board in October
	d) Recognition and reward of our staff	NH				#ThankYou day on 12/9 attracted >1100 attendees. Feedback to come. #ThankYou "pot" established.
1.2	The measures we will use to track progress focus on:					
	a) Maintaining our staff survey results and aiming to increase the engagement score from 3.9 to 4 over the next three years, demonstrating an improvement year on year	KA				This is an annual process, survey commences in Oct 17, results at end Feb 18.
	b) Maintaining a Staff Impressions "Mainly Good" overall experience score of over 90%	KA				Staff engagement by change champions to share cultural work and progress organisational development.
	c) Maintaining a turnover rate below 12/%	KA				Below 12% and positive joining rate.
OBJECTIVE TWO Improving Quality and Reducing Harm						
Narrative:	<i>Focusing on continuous improvement and reduction of waste</i>					
2.1	To continue, via the Improvement Academy to build QI capacity and capability to support a culture of continuous improvement by March 2018	DM				QI training now completed by 220 staff, clinical and non-clinical. Further courses scheduled for delivery each month through 2017/18. Alumni established to support QI trained staff taking forward their improvement ideas. QI mentoring and coaching also established as part of the Academy offering.

	a) Fully implement the improvements identified by the CQC for maternity and ED, which will be assessed at the next CQC inspection, with the expectation of a positive review	PS				Good progress in ED and Maternity (Green). Good external visit report of ED from WH CCG. ED presented to CQC at engagement meeting in July 17 with positive feedback from inspectors on improvement initiatives being introduced. Maternity governance in place 2 years and embedded in practice. Further embedding of Gynae governance structure required (Amber)
	b) Demonstrate consistency in safe, effective, responsive and well led services, across the organisation; securing a CQC rating of at least good and aspiring for 'outstanding'	TS				Strong progress to improve care and outcomes evidenced in CQC profile, feedback from commissioners and regulators. Awaiting details of the CQC Inspection date.
2.2	To improve emergency hospital flow to deliver 'the right patient, at the right time, to the right place' by March 2018 we will:					
	a) treat 25% of non-elective patients via our ambulatory care services rather than admitting them to an inpatient ward	RR				Work progressing, cardiac open, further work in OPM & Medicine
	b) improve specialty pathways to avoid unnecessary admissions and reduce patients' length of stay including:	RR				Frailty pathway in place; alcohol pathway task & finish.
	c) To improve discharge planning we will:					
	i.establish the IT systems to support the discharge planning database	RR				Progressing but still some technical issues
	ii.deliver an education programme for the use of estimated date of discharge (EDD) and medically ready for discharge (MRFD)	RR				Discharge & QI team rolling this out.
	iii.adopting best practice board rounds	RR				Work starting. IT support solution being specified.
	d) To improve hospital flow process, to support a reduction in patients with a length of stay >7days	RR				On track for 'Ask'
2.3	To ensure that every deteriorating patient with an early warning score (NEWS) of 9 or above, is escalated for review and then seen by an appropriate clinician within 30 minutes of their initial trigger by the end of July 2017	AOD				
2.4	To treat everyone with Sepsis-related Organ Failure Assessment (SOFA) within one hour and all other sepsis patients within 3 hours of admission / diagnosis of sepsis, by giving a first dose of antibiotics by the end of June 2017	PG				Definition of sepsis remains unclear and therefore metrics are complex. Major project underway with QI team, which will include resolution of metrics.
2.5	Deliver excellent emergency care; minimising the number of patients who wait in the Emergency Department. The metric is that 95% of patients or better are seen and treated/admitted within four hours and that the Trust meets its agreed trajectory set in conjunction with NHSI.	RR				Meeting proposed trajectory but 94.7% is below 95% national standard.

2.6	Deliver excellent planned care, 92% of elective patients being treated within 18 weeks of referral; 99% of patients waiting less than six weeks for their diagnostic tests and as a minimum 85% of patients or better on a 62 day cancer pathway receiving their treatment within that period.	RR				At or about 92% RTT Above 99% diagnostics Meeting 62 days expected in Q1 & Q2.
2.7	We will continue our work to ensure services are provided in a cost effective way and meet our financial plan to deliver a control total of £6,648m deficit or better by the end of March 2018.	PP				As at the end of July, the Trust was operating within its budget and control total. Pressures remain, most notably in relation to achievement of the full cost improvement programme target, however the current forecast indicates that overall the Trust will achieve its full year control total.
OBJECTIVE THREE Strengthening Team Working						
Narrative: <i>Developing and strengthening Team RBCH to deliver safe and compassionate care for our patients and shaping future health care across Dorset</i>						
3.1	Implement the Clinical Service Review, and securing the lifting of the undertakings placed on the Trusts by the Competition and Markets Authority. The Board will monitor and drive progress in accordance with the project plan agreed for this work.	TS				Decision to develop RBH as the major emergency site made on 20 th September. Agreement reached with NHSE and the DH to fund the capital work. Now working to submit an outline business case by the end of January and subsequent submission of a FBC. With respect to merger - ITT issued seeking a partner to help develop the benefits case. Trusts working together to lift the undertakings and enable the full merger. Methodology finalised with Poole colleagues to take forward the clinical design work.
3.2	Strengthen collaborative working and relationships between the Trust and local partners gauged by regular feedback from partners and in so doing progress the implementation of the Dorset Sustainability and Transformation plan.	TS				
3.3	Jointly implement the Dorset Care Record	PG				Dorset Care Record is in the implementation phase: The first release of the service is expected in Nov/Dec 2017. Some of the release timelines are slipping due to the underestimated complexity of the interfacing work but mitigation is in place to recover this.
3.4	Develop team working by embedding the AstonOD Team Coaching approach across the organisation, helping enhance the delivery of care through heightened team effectiveness. Specific measures will focus on: a) Increasing to 30 the number of coaches accredited by March 2018	NH				

	b) Increasing of 40 the number of teams using this approach by March 2018	NH				
OBJECTIVE FOUR Listening to Patients						
Narrative: <i>Ensuring meaningful engagement to improve patient experience</i>						
4.1	Supporting engagement through implementation of patient user groups with a lay chair and three functioning groups by the end of the year	PS				1 Group has been held and fed back to BOD. 1 Further group is in the start up stages with interest from 2 other areas
4.2	Reinstating community focus groups, to formalise external patient experience partnership networks, with each group meeting in 2017-18 with a forward plan of twice-yearly	PS				5 community focus groups have been held so far. This has strengthened our community links in all areas. Groups are scheduled through until Jan 2018.
4.3	Maintain the positive trend of patients recommending the Trust within all areas attaining compliance that reflects better than the national average scores for the Friends and Family Test and increasing the FFT returns to >25% by the end of March 2018	PS				Work has commenced on the triangulation of data for the clinical areas. Regular meetings with the clinical staff will help to improve staff engagement and put patient experience on their agenda.

Table:
G - Delivered, or on track and on time
A - Risk of delay or partial completion
R - Risk of non-delivery or delay
- not yet done

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BOARD OF DIRECTORS

Meeting Date and Part:	29 September 2017 - Part 1
Reason for Part 2:	N/A
Subject:	Stakeholder Engagement Outcomes
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	David Moss, Chairman
Author(s) of papers:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Board/Council of Governors, 10 July 2017
Action required:	Information
<p>Executive Summary:</p> <p>A number of key stakeholder groups and a series of actions were identified at a joint session of the Board and Council of Governors on 10 July 2017. The actions were subsequently developed into a series of outcomes by the executive leads nominated at that meeting. Reports on progress against the outcomes will be provided to the Board quarterly to demonstrate the range of engagement activity being undertaken to develop and enhance these relationships.</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>	All
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	N/A

STAKEHOLDER ENGAGEMENT OUTCOMES

Stakeholder Group	Outcome	Executive Lead(s)
Staff	Ensure that staff receive regular updates aimed at their questions and concerns using existing groups, including the Partnership Forum, Change Champions and Staff Governors, providing an opportunity for staff to respond and then receive feedback	KA, NH and KF
Foundation Trusts in Dorset	Put in place the structures to support Accountable Care System (ACS) working supported by regular contact and organisational development to build relationships and jointly plan and create solutions to deliver better outcomes for patients and benefit taxpayers in Dorset.	TS, RR, Governors
Clinical Leaders (across the system including GPs)	Work jointly with Poole Hospital NHS Foundation Trust to bring clinicians from both organisations together to develop and promote work to improve outcomes for patients and efficient working practices involving colleagues from primary care.	AOD, RW, PS
Dorset CCG	Support activity to develop as a single health system in Dorset through our approach to contracting and risk sharing and coordinating communications and relationships with regulators' regional teams.	PP
Competition and Markets Authority	Work together with Poole Hospital NHS Foundation Trust to develop the patient benefits case for submission to the Competition and Markets Authority.	TS
Patient Groups	Incorporate and involve governors and members in the delivery of the Patient Experience and Public Engagement Plan and participate in governor engagement activity and engagement activity with partner organisations as part of the implementation of the Clinical Services Review (CSR) and the delivery of the Dorset Sustainability and Transformation Plan (STP).	PS

Trust Board Dashboard - August 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 Q4			2017/18 Q1			2017/18 Q2			Trend (where applicable)
			Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	90%	96.48%	93.39%	90.34%	95.73%	92.56%	95.88%	95.95%	95.77%		
	Caring - Inpatient scores from Friends and Family Test % positive	95%	98.10%	98.23%	97.63%	97.20%	98.04%	96.42%	97.85%	96.52%		
	Caring - Maternity scores from Friends and Family Test % positive	95%	96.86%	89.32%	98.06%	98.78%	93.89%	93.33%	96.00%	99.07%		
	Caring - Mixed sex accommodation breaches	0	2	0	0	1	0	0	1	0		
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)			88.37%			89.12%					
	Caring - Formal complaints		14	23	30	22	21	18	19	21		
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	< Prev Yr Month AVG	490	473	552	509	588	480	516	503		
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	< 100	102.4	110.8	103.9	98.8	97.9					
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - MAC	< 100	0.0	0.0	0.0	0.0	0.0					
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - RBH	< 100	97.1	100.3	100.2	90.7	83.9					
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	< 100	103.0	101.4	89.9	80.9	96.1					
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	< 100	262.5	263.0	233.9	348.5	267.6					
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	< 100	96.6	93.8	83.8	73.9	88.3					
	Effective - Summary Hospital Mortality Indicator	< 1										
	ED Attendances		7314	6855	7843	7704	8303	8082	8574	8281		
	Elective Admissions		5750	5549	6282	5397	6098	6342	5684	6226		
	GP OP Referrals		5519	5473	6429	5371	5962	6121	5782	5855		
	Non-elective Admissions		3199	2968	3317	2952	3342	3022	3244	3298		
	Organisational health - Staff sickness in month	< 3%	5.041%	4.718%	3.998%	3.548%	4.050%	4.012%	4.185%	3.992%		
	Organisational health - Staff sickness rolling 12 months	< 3%	4.21%	4.26%	4.24%	4.19%	4.19%	4.20%	4.23%	4.25%		
	Organisational health -Proportion of temporary staff		6.10%	7.57%	7.41%	7.00%	8.09%	6.57%	6.79%	6.74%		
	Organisational health -Staff turnover	< 12%	10.95%	11.17%	11.42%	11.13%	10.94%	10.73%	10.53%	10.56%		
	Safe - Clostridium Difficile - Confirmed lapses in care	<=14 in Yr / 1.2 per Month	1	0	1	1	0	0	1	0		
	Safe - Clostridium Difficile - infection rate	6.9	11.71	0	5.85	12.1	11.71	0	29.27	11.71		
	Safe - MRSA bacteraemias	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		
	Safe - Occurrence of any Never Event	0	0	0	0	0	1	1	1	0		
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)			40.35			36.60					
	Safe - VTE Risk Assessment	95%	95.41%	95.26%	96.41%	95.94%	96.29%	96.83%	96.69%	96.49%		
	Number of Serious Incidents	<= Last Year	3	2	0	0	4	2	3	3		
	Appraisals - Values Based (Non Medical) - Compliance		90.44%	90.50%	90.47%	3.26%	10.78%	21.41%	37.14%	57.24%		
	Appraisals - Doctors and Consultants - Compliance		86.94%	89.74%	83.03%	89.67%	89.82%	88.28%	87.36%	87.86%		
	Essential Core Skills - Compliance		90.02%	90.37%	91.82%	91.62%	92.10%	92.32%	92.55%	92.93%		
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	YTD Plan = 4	3	3	2	4	4	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	2	4	4	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	1	3	3	3	3	3		
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	90.87%	93.54%	94.54%	95.42%	93.70%	92.39%	92.29%	94.57%		
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	100.00%	94.74%	87.50%	92.31%	77.78%	84.62%	92.86%			
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	83.47%	84.24%	89.00%	89.78%	89.16%	89.26%	84.93%			
	Maximum 6-week wait for diagnostic procedures	99%	99.85%	99.79%	99.93%	99.56%	99.77%	99.95%	99.88%	99.66%		
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	91.10%	91.19%	91.73%	91.14%	92.01%	92.17%	92.04%	91.79%		

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)

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BOARD OF DIRECTORS

Meeting Date and Part:	29 September - Part 1
Reason paper is in Part 2:	N/A
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 STF, national targets and our NHSI submitted trajectories to date.
Executive Summary: <p>In summary the Trust performed as follows for August:</p> <ul style="list-style-type: none"> • A&E 4 Hour – below national target and NHSI requirement which has now been confirmed as 95% for Q2 at organisation level. Risk for September and Q2 STF (which requires 4hr target to be met and ED streaming implemented). • RTT 18 Weeks – below national target of 92% though above submitted trajectory. Risk against national target for September and October. • Diagnostics 6 Week Wait – met national target. • Cancer 62 Day from Referral – just below national target in July (last reported month). Some risk to July and Q2. • Cancer 62 Day Screening – met national target in July (last reported month). <p>All other Single Oversight Framework (SOF), NHS Constitution and key contractual targets were met or within expected range for August.</p> <p>A forecast for September, together with key risks 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. The Dorset-wide trajectory is being monitored in relation to system STF.</p>	
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

Operational Performance Report



For the period to end August 2017

Richard Renaut
Chief Operating Officer

1. Introduction

Please refer to the Board dashboard for Single Oversight Framework 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 – July 2017

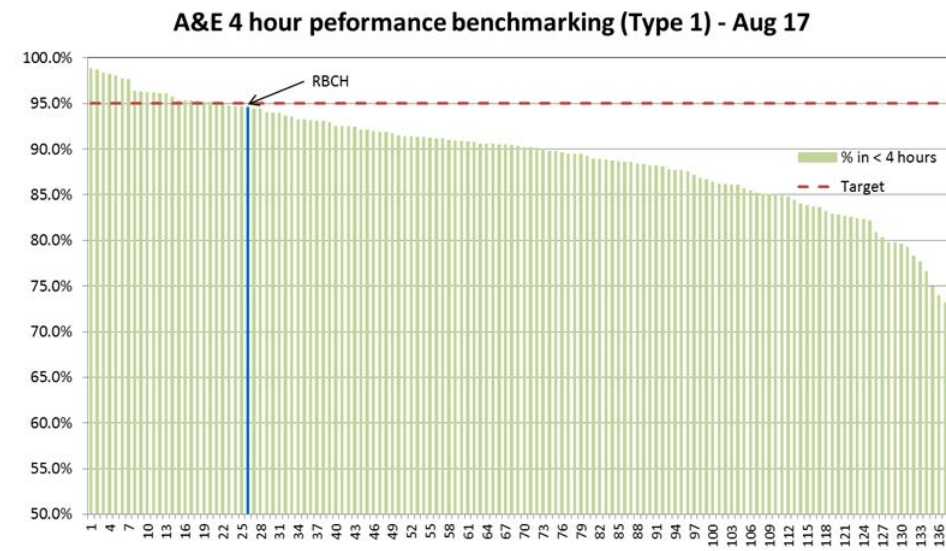
A&E 4 Hour Target and 12 Hour Breaches

Performance improved to 94.57% which meant that we remained within the top 20% nationally. Urgent care admissions were up 3.51% on last August however, ambulatory care approaches and overall discharge levels meant we were able to maintain flow. We are currently on track with our 14+ day stay improvement trajectory.

However, our biggest risk to STF in Q2 remains as a result of our ED performance which currently for the quarter remains below 95% (see section 2.2).

No patients waited longer than the 12 hours standard.

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



RTT Incomplete Pathways (18 week) and 52 Week Breaches

Performance against the RTT Incomplete Pathway indicator for August was 91.79%, just below the national target of 92% but above (better than) our expected trajectory submitted to NHSI.

We saw an increase in our overall 18 week backlog, particularly for those patients on a non-admitted (outpatient) pathway. This was impacted by some reduced outpatient activity during the summer holiday period, as well as some individual speciality pressures. 17% growth in fast track referrals to Dermatology continued to impact on 'routine' appointments and therefore, waits are increasing. Sub speciality (urodynamic) pressures in Gynae also resulted in reduced performance. Whilst still below 92%, some improvement was seen in Urology, partly supported by outsourcing. Orthopaedics has also seen some improvement as non-admitted backlogs began to reduce from May, adding less patients late onto admitted pathways. However, this is a risk speciality going forward. A deteriorated position in ENT is

Operational Performance Report

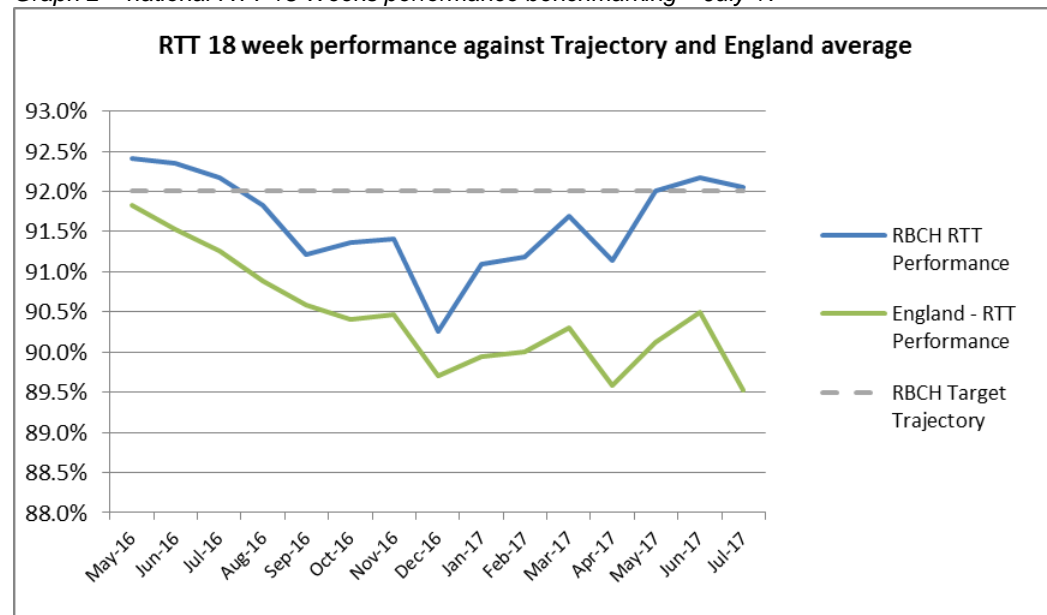
As at 18/09/2017

expected to recover going forward as a full complement of clinics is provided by Poole.

One patient was transferred with an over 52 week wait from Poole Hospital. The patient was treated immediately, within one week of full transfer.

Pressure across the country is evident from the national benchmarking data and whilst RBH saw a slight deterioration in July, we continued to perform well comparatively. However, risk to future months is highlighted in Section 2.2, as we expect to be 90-91% for September and October.

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



62 Day from Referral/Screening for Suspected Cancer to Treatment

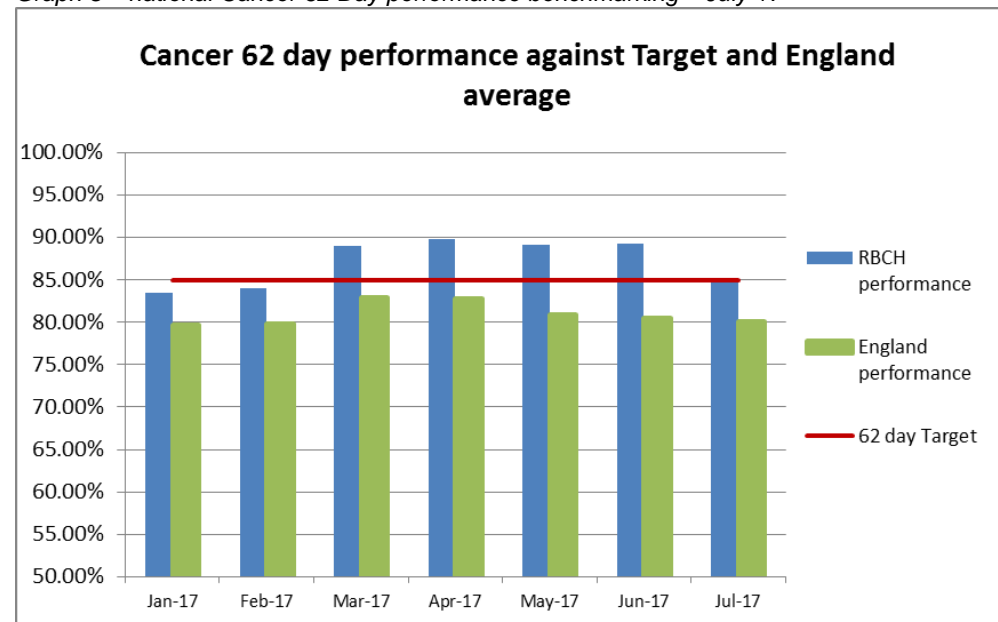
For the month of July (*last formal reported month*) there were 16.5 breaches, with performance at 84.9%. This was just under the national

target of 85%, though we currently expect to be compliant across Quarter 2. Despite this reduced performance, we continued to benchmark well against the national picture (see below graph), though noting some risk to Q2, outlined in Section 2.2.

There were 6.5 breaches across 4 specialities and 10 breaches in Urology. The non-Urology breaches included: 2.5 in Lung, 2 in Breast, 1 in Colorectal, 1 in Gynae. The two main reasons for the breaches were insufficient elective capacity (5), particularly in Urology where we have had medical staff gaps, and Complex diagnostic pathways (4.5).

The Lung breaches were predominantly due to complex diagnostic pathways (including a patient declining diagnostics) with several diagnostics at RBH and/or transfer to another provider for surgical diagnostics. Delay to treatment due to medical reasons also contributed to one patient pathway.

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



Operational Performance Report

As at 18/09/2017

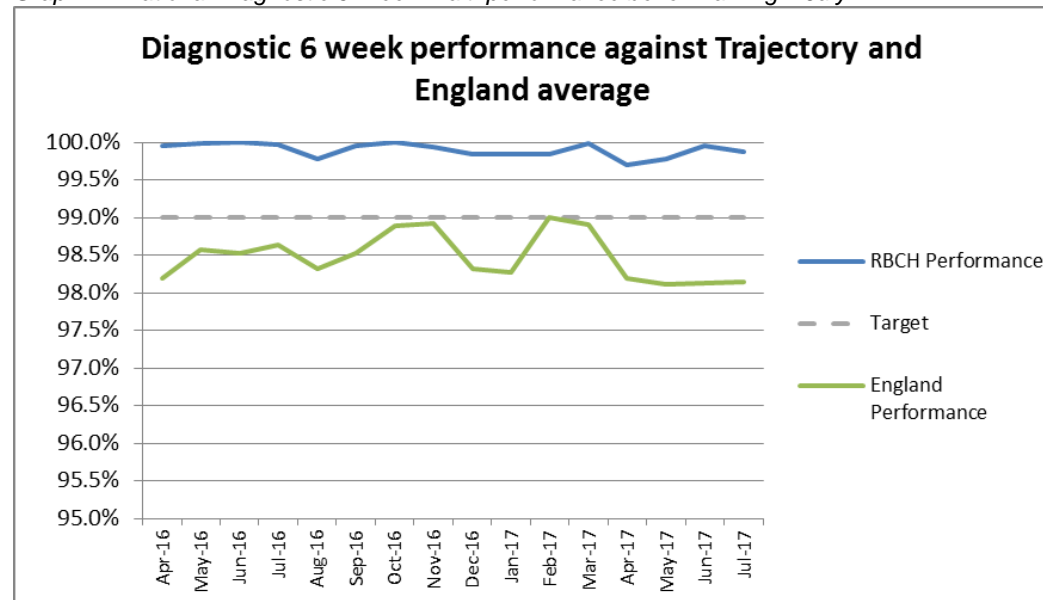
We have 5 patients with over 104 day pathway, which the clinicians responsible assess as causing no harm, but are continuing to manage.

We had 0.5 breaches against the 62 day target from Breast screening to treatment which resulted in performance of 92.9%, a return to above the 90% national target.

Diagnostic 6 Week Wait

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

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



Our positive position continued in August with the final validated performance achieving 99.66%. Performance currently remains on track in the key areas (Endoscopy, Radiology, Cardiology and Urology), however, medical staff gaps in Urology have resulted in

some additional pressures on our cystoscopy capacity. This continues to be closely monitored.

2.2 August and Q2 - 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 & Aug (actual), Sept 2017/18 (Forecast)

Single Oversight Framework Indicator	National Target	NHSI Trajectory	Mth / Qtrly	RAG rated forecast against national targets and NHSI submitted trajectories			
				Qtr 1 act.	Jul 17 act.	Aug 17 act.	Sep-17
A&E 4hr maximum wait time*	95%	91-93%	Mthly	Yellow	Red	Red	Red
RTT 18 week incomplete pathways	92%	91%	Mthly	Yellow	Green	Red	Red
Cancer 62 day wait for first treatment from urgent GP referral**	85%	85 - 85.4%	Mthly	Green	Red	est.	est.
Cancer 62 day wait for first treatment from Screening service**	90%	90%	Mthly	Green	Green	est.	est.
Maximum 6 weeks to diagnostic test	99%	99%	Mthly	Green	Green	Green	Green

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

*STF requirement increases to 95% for Q2 (above locally submitted trajectory)

**Aug cancer final validated upload will be completed early Oct 17

For Q2, we do expect ongoing risk against the full national targets for A&E (95%), RTT (92%), Cancer 62 day (85%) and Cancer Screening (90%). The key impact will be on our achievement of the STF which requires us at organisational level to meet the increased Q2 performance trajectory of 95% for A&E. This is unlikely to be achieved at RBH, though August was 94.57% and September is 94.6% to date. We also have to achieve the GP streaming standard.

The Diagnostics 6 Week Wait is expected to remain compliant. There is some remaining risk to the 62 day and Screening targets for August, September and the Quarter. RTT will dip in October and November, but is expected to recover.

A&E 4 hour, ED Streaming and STF

Whilst our fully rostered Junior Dr rota, breach analysis improvement actions, improved flow and reduced 14+ day stay patients have all contributed to our improved performance in August and into September, this remained just below 95%. Due to the pressures experienced in July, this is likely to mean we will not achieve the 95% required at organisation level for the STF. This continues into Q3 due to staffing fragility, especially at nights, in our Middle Grade rota. A mitigation plan is in place but this is largely reliant on recruitment. Consultant recruitment is also underway.

Latest guidance indicates that both the 95% trajectory and implementation of primary care streaming for ED, are required to achieve the Q2 STF and are now binary, i.e. you must achieve both to access STF. Failure would equate to £384k lost funds to RBH in Q2 (see *separate Finance Report*). The Dorset-wide performance trajectory if 95% is achieved, this could allow/support RBCH's access to STF. However Q2 is expected to be 94%.

The implementation of ED streaming to primary care commences from October. This is facilitated by the continued joint working with and support from SWAST, as well as our GP colleagues to reshape services. Transforming existing and new models and resources, with support from the CCG, will be key to success in providing the right care, at the right time, in the right place to patients. This will also help us to optimise the specialist and acute service provided by our Emergency Department.

Emergency activity has dropped in the Eye Unit (-9%) as demand is managed through alternate pathways, such as phone advice and direction to optometrists where appropriate. This is better for the patients and taxpayers.

There has been a small rise in main ED attenders (2.2%) but the issue of rapid peaks in demand overwhelming the Department remain. Work

on escalation actions is proving successful, when these can be implemented. Standardising and protocols to undertake these are being developed to make these easier to enact.

The improvement work through August and September is continuing and this will be further supported by our ambulatory bay pilots in Cardiology and OPM, as well as the progress on our Christchurch hub and integrated community/interim team. Furthermore, our winter plans are well developed and will see implementation of specific initiatives commencing from October. However the flu experience in the Southern Hemisphere is requiring us to revisit our preparedness for a 'bad' winter.

RTT 18 weeks

In August 91.8% and increasing overall incomplete pathways, together with individual speciality pressures, means September and October are at risk, but we aim to stay above the submitted trajectory.

Whilst overall, GP referral rates are just below last year (YTD to end August), in line with our Collaborative Agreement and Right Referral, Right Care Programme aims, a number of factors are contributing to our overall increased incomplete pathways (non-admitted and admitted 'waiting list') and 18 week backlogs. These factors include:

- Reduced activity due to medical staff gaps and reduced WLIs/premium cost activity in support of our financial Control Total plans
- Priority referrals/pathways (e.g. suspected cancer fast tracks) being prioritised over routine referrals
- 18 week 'lead time' impact of significant increase in referrals in March 17 affecting both outpatient waits and then 'knock on' impact on patients added to the admitted waiting list
- Sub speciality pressures increasing longer waiting patients for some consultants/conditions

- Small increase in late transfers in particular speciality areas like Orthopaedics in recent months (though Trust-wide not significant variation)

Key areas of current concern are: Dermatology, Urology, Orthopaedics, Ophthalmology, Gynaecology, ENT, theatre staffing for additional lists (within appropriate funding terms/envelopes).

Orthopaedics represents a significant risk, due to the high value of the work, dependency on theatre time and beds, and dynamics with multiple providers. Budgeting also has significant demand management assumptions built in for Q3 and Q4.

Actions include:

- Implementation of new Dorset-wide referral pathways for Dermatology which includes tele-dermatology;
- Recruitment of substantive and locum posts in Urology;
- Implementation of Dorset-wide MSK referral triage and CHAIN wellbeing programme for hip patients;
- Release of Ophthalmology capacity through improvements to the cataract follow-up and pre-assessment pathways, supporting a reduction in surgical pre assessment waiting times;
- Recruitment of additional urodynamic related capacity
- Provision of ENT clinic capacity from Poole.

Further actions are also being reviewed and will be overseen by the Trust's Performance Management Group (PMG).

It should however, be noted that there is a 'lead time' for some of the actions, particularly where they are transformational or recruitment dependent, as well as the potential for reduced referrals to lead to a transitional further deterioration in performance as backlog is also cleared. Our trajectory is currently being reviewed, particularly alongside analysis of the expected impact of MSK triage.

Note separate presentation to the Board on risk assessment relating to the Right Referral, Right Care Programme.

Cancer 62 Day

Although we were just below compliance in July, current expectations are that August will return to above the 85% threshold. There remains some risk to September and onwards, predominantly due to the Urology medical staffing gaps and Dermatology pressures – see actions in RTT section above. We are also seeking some rapid implementation opportunities to improve September performance, supported by some additional funding by NHSE and NHSI.

Diagnostic 6 Week Wait

Diagnostic demand in relation to this target, particularly as a result of ongoing inpatient and fast track pathway pressures, will continue to be monitored alongside additional activity supported in 17/18 by commissioners. We also continue to monitor the impact of the Urology medical staff gaps on cystoscopy waits. 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 August have remained compliant or within expected ranges.

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:	29th September 2017 Part 1
Subject:	Quality Report
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:	Fiona Hoskins, Deputy Director of Nursing and Midwifery Jo Sims, Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee 28 th September
Action required: Approve/Discuss/Information/Note	The paper is provided for information and assurance
Executive Summary: The Quality report is a summary of the key quality indicators in Month. <ul style="list-style-type: none"> • 12 serious incidents have been reported since April 17 compared to 11 in the same time period in 2016/17. Three serious incidents were reported in month • Friends and Family Test Performance is sustained for the month. • Complaints response performance above the 75% standard in month and is sustained for the quarter. 	
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 August
2017**

Paula Shobbrook
Director of Nursing and Midwifery

1.0 Introduction

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 Three Serious Incidents were reported in August 2017.

- A complex patient's pressure ulcers deteriorated from an external category 2 to a category 4,
- 2 patient falls sustained as inpatients resulting in neck of femur and wrist fractures,

3.0 CQC Insight Model

3.1 The CQC has published the new "Insight Model" on 5th September, which will be used to monitor potential changes to the quality of care that Trusts provide. CQC Insight brings together in one place the information the CQC holds about Trust services, and analyses it to monitor services at provider, location, or core service level. This will help the CQC to decide what, where and when to inspect and provide analysis to support the evidence in their inspection reports.

The current composite indicator score is similar to other acute trusts that were more likely to be rated as good. For RBCH, the CQC note that 'This trust's composite score is among the highest 25% of acute trusts'

The data sets are being reviewed by the Trust to be confirmed. Of the 17 metrics; 9 rank better or much better, 5

the same and 3 worse when compared nationally.

4.0 Patient Experience Report

4.1 Friends and Family Test: (Benchmarking July data)

Inpatient and day case Friends and Family Test (FFT) national performance in July 2017 ranked RBCH Trust 2nd with 19 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 18.9%.

The Emergency Department FFT performance in July 2017 ranked RBCH Trust 4th with 5 other hospitals out of 141 placing RBCH ED department in the top quartile. The response rate 4.3% against the 15% national standard. A texting service is being piloted aiming to improve the response rate.

Outpatients FFT performance in July 2017 ranked RBCH Trust 4th with 27 other Trusts out of 234 Trusts, placing the departments in the second quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

4.2 Family and Friends Test Trends

	February	March	April	May	June	July
In-Patient Quartile						
Top	98.222%	98.318%		98.553%		98.598%
2			97.938%		97.416%	
3						
Bottom						

	February	March	April	May	June	July
ED Quartile						
Top			95.735%		95.882%	95.946%
2	93.388%	90.341%		92.558%		
3						
Bottom						

	February	March	April	May	June	July
OPD Quartile						
Top				98.421%		
2		97.735%	96.659%		97.926%	97.471%
3	95.963%					
Bottom						

4.3 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.

4.4 Patient Opinion and NHS Choices: August Data

12 patient feedback comments were posted in August, 10 express satisfaction with the staff attitude, care, information, speed of service and treatment they received. 2 negative responses related to poor staff attitude, waiting time and catering. All comments are responded to on line, and shared with clinical teams and relevant staff.

4.5 Complaints Summary report

Formal Complaints

A total of 22 complaints were received in August all of which had a response within the required 3 days. Formal written complaints reduced from this time last year and concerns are showing a slight increase as they are being resolved earlier and not moving to formal written complaints. 2 themes were joint highest in month, Implementation of care and Consent, Communication and Confidentiality.

4.2 Response times

The Percentage of formal responses answered within the Trust standard of 25 working days was achieved in August. The agreed standard is that 75% are responded to within this time frame and a rate of 83% was attained. This is following a slight dip in response rates in June and July.

5.0 Recommendations

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

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would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	29 th September 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:	Chris Hickson, 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 31 st August 2017.
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 31 August 2017

Chris Hickson
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £2.449 million as at 31 August which is £119,000 behind the Trust financial plan.

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 is currently experiencing operational pressures in its ability to achieve the Quarter Two ED access target. Mitigating actions have been identified, however this remains a risk. The Trust has accrued the STF Fund income in full amounting to £1.814 million as at 31 August 2017.

Cost Improvement Programme

Financial savings of £3.145 million have been achieved to date, which is £1.134 million 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 and CIP delivery remains a key area of focus.

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 August 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 31 August £2.345 million of capital expenditure has been committed, which is £712,000 less than planned at this point in the year. The annual plan for capital expenditure is £9.424 million, plus a further investment of £1 million relating to ED streaming supported in year through national funding. The forecast capital plan is fully committed for 2017/18.

Cash

The Trust is currently holding a consolidated cash balance of £31.8 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 31 August 2017.

Finance Report

As at 31 August 2017

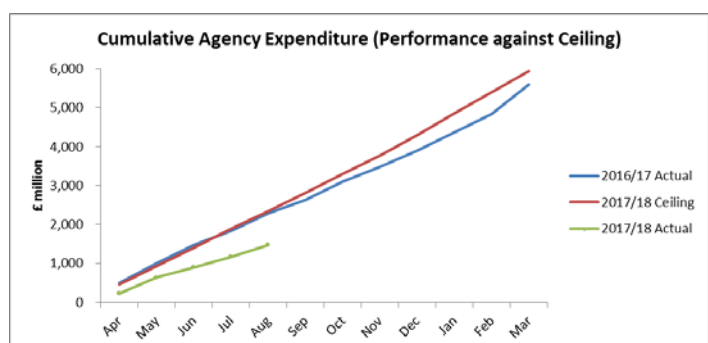
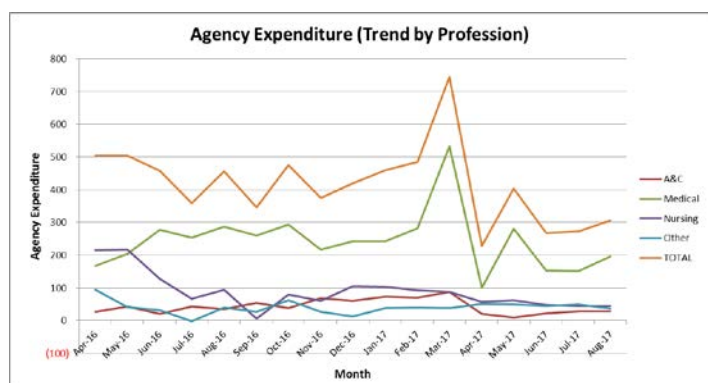
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000
NHS Clinical Income	103,402	104,458	1,056
Non NHS Clinical Income	2,855	2,182	(672)
Non Clinical Income	12,042	12,076	34
TOTAL INCOME	118,299	118,717	417
Employee Expenses	73,923	74,562	(639)
Drugs	13,851	13,187	663
Clinical Supplies	13,415	15,133	(1,718)
Misc. other expenditure	19,441	18,284	1,157
TOTAL EXPENDITURE	120,629	121,165	(536)
SURPLUS/ (DEFICIT)	(2,330)	(2,449)	(119)

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	74,014	74,014	0
NHS England (Wessex LAT)	16,884	17,909	1,025
NHS West Hampshire CCG (and Associates)	10,314	10,318	4
Other NHS Patient Income	2,191	2,217	27
Sustainability and Transformation Fund	1,814	1,814	0
Non NHS Patient Income	2,855	2,182	(672)
Non Patient Related Income	10,228	10,262	34
TOTAL INCOME	118,299	118,717	417

Sustainability and Transformation Fund Income	Budget £'000	Actual £'000	Variance £'000
Financial: Control Total (70%)	1,270	1,270	0
Performance: A&E Trajectory (30%)	544	544	0
TOTAL	1,814	1,814	0

Agency Expenditure

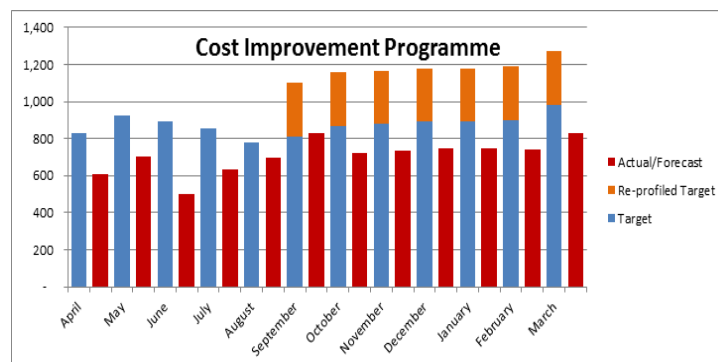


Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	6,033	5,456	(577)
Medical Care Group	4,315	3,128	(1,188)
Specialties Care Group	2,985	2,875	(110)
Corporate Directorates	(14,329)	(14,236)	94
Centrally Managed Budgets	(1,335)	328	1,663
SURPLUS/ (DEFICIT)	(2,330)	(2,449)	(119)

Cost Improvement Programme

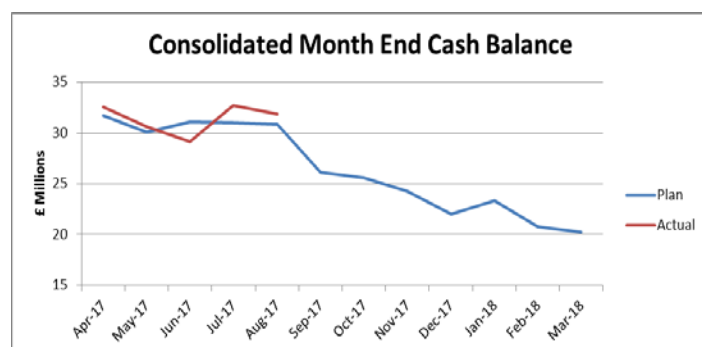
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	848	613	(235)
Medical Care Group	1,439	768	(671)
Specialties Care Group	1,290	1,006	(284)
Corporate Directorates	702	758	56
Total	4,279	3,145	(1,134)



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	1,222	1,158	64
IT Strategy	1,355	701	654
Medical Equipment	450	456	(6)
Centrally Managed	30	30	0
TOTAL	3,057	2,345	712

Cash



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would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	29 th September 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
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.	
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.

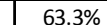
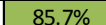

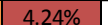
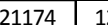



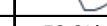





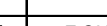









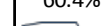
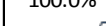
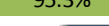





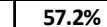



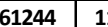
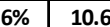




For the period to 31st August 2017

Karen Allman
Director of Human Resources

Workforce Report for Board

As at 31st August 2017

Care Group	Appraisal Compliance		Mandatory	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental	Training Compliance	Absence	FTE Days			
	At 31 August			Rolling 12 months to 31 August				At 31 August
Surgical	48.3% 	86.7% 	91.8% 	4.99% 	16553 	13.5% 	12.0% 	6.4% 
Medical	63.3% 	85.7% 	92.1% 	4.24% 	21174 	12.6% 	10.1% 	9.6% 
Specialities	53.3% 	91.1% 	94.2% 	3.81% 	11640 	12.0% 	10.8% 	7.2% 
Corporate	60.4% 	100.0% 	95.3% 	3.90% 	11877 	7.5% 	9.6% 	4.0% 
Trustwide	57.2% 	87.9% 	92.9% 	4.25% 	61244 	11.6% 	10.6% 	7.2% 

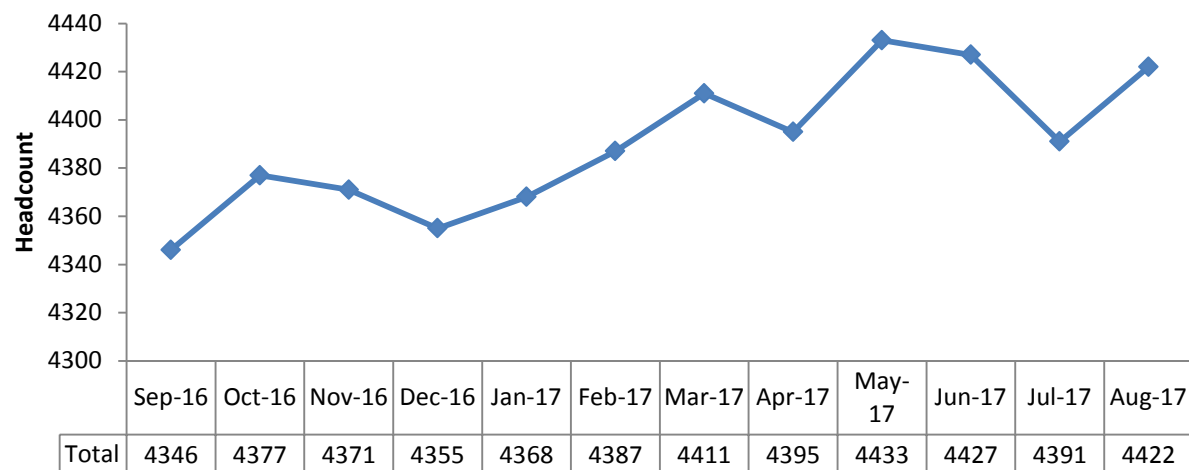
Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 August			Rolling 12 months to 31 August				At 31 August
Add Prof Scientific and Technical	79.4%		94.6%	4.13%	1823	12.6%	14.8%	0.5%
Additional Clinical Services	51.5%		91.9%	6.69%	17272	21.9%	13.8%	8.3%
Administrative and Clerical	61.3%		95.8%	3.74%	11450	9.2%	10.3%	6.3%
Allied Health Professionals	65.5%		93.2%	2.70%	2465	13.8%	11.7%	1.1%
Estates and Ancillary	46.5%		93.6%	5.36%	6642	8.1%	11.7%	8.9%
Healthcare Scientists	74.3%		95.1%	2.03%	701	11.4%	15.2%	11.1%
Medical and Dental		87.9%	88.4%	1.36%	2190	5.4%	5.4%	6.4%
Nursing and Midwifery Registered	55.1%		93.4%	4.44%	18700	8.5%	8.3%	8.7%
Trustwide	57.2%	87.9%	92.9%	4.25%	61244	11.6%	10.6%	7.2%

Workforce Report for Board

As at 31st August 2017

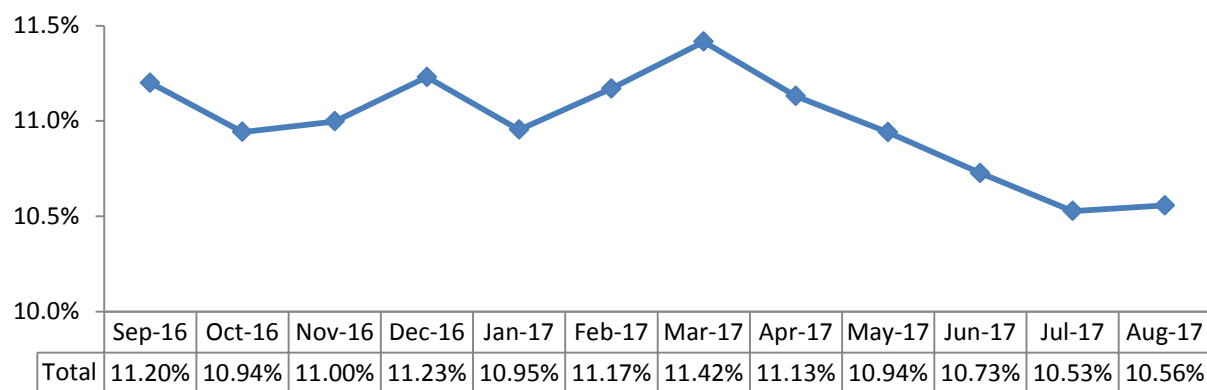
1. Staffing and Recruitment

Substantive Staff (Headcount) Trend



The information demonstrates that the turnover rate remains steady at a comparative low of 10.6% against a joining rate of 11.6% resulting in an increased headcount for the month.

Permanent Staff Turnover Rate (Headcount)

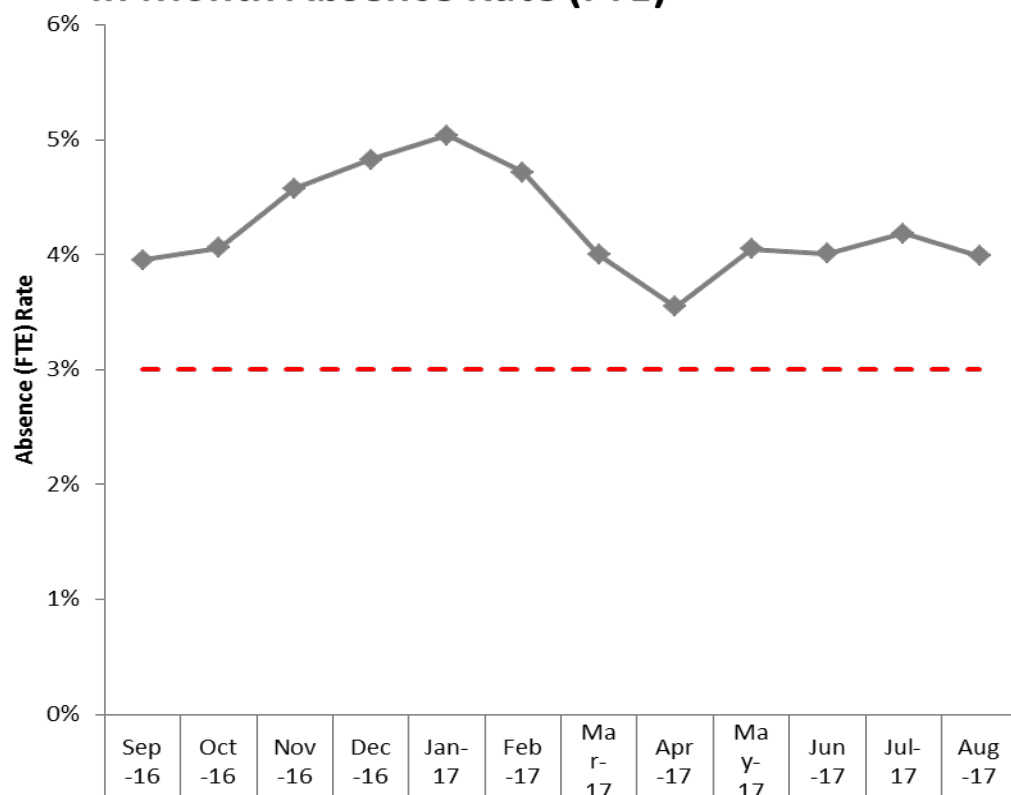


2. Essential Core Skills Compliance

Overall compliance continues its upward trend and currently stands at 92.9% as at 31st August against a target of 95% by December 2017. In addition we are working across Dorset with other NHS organisations to standardise the core skills and ensure that passporting compliance between organisations is effective.

3. Sickness Absence

In Month Absence Rate (FTE)



—◆— In Month Absence Rate	3.96%	4.06%	4.58%	4.83%	5.04%	4.72%	4.00%	3.55%	4.05%	4.01%	4.19%	3.99%
- - - Target	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%

Workforce Report for Board

As at 31st August 2017

	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Surgical	4.79%	5.04%	5.91%	5.62%	5.55%	4.76%	4.48%	4.08%	4.53%	4.81%	5.00%	4.93% ↓
Medical	3.87%	3.58%	4.40%	4.82%	4.99%	4.67%	4.19%	3.42%	4.30%	4.00%	4.32%	3.73% ↓
Specialties	3.66%	4.13%	4.19%	4.88%	5.46%	5.42%	3.50%	3.36%	3.17%	3.32%	3.70%	3.91% ↑
Corporate	3.49%	3.74%	3.82%	4.01%	4.23%	4.12%	3.66%	3.37%	4.01%	3.85%	3.57%	3.49% ↓
Trust	3.96%	4.06%	4.58%	4.83%	5.04%	4.72%	4.00%	3.55%	4.05%	4.01%	4.19%	3.99% ↓

Whilst the 12-month rolling sickness remains at 4.25%, it is pleasing to be able to report that the in-month sickness absence reduced to 3.99% in August, representing an amber rating, reflecting the high degree of focus which is being given to this area. However, this remains an ongoing challenge; the Sickness Absence Focus Group continues to meet and the situation continues to be monitored closely at Workforce Committee where at their meeting on 14th August it was agreed to repeat the “deep dive” exercise into sickness absence for review at their next meeting on 9th October. The findings from this will be reported to Board in due course.

4. People Strategy

Following extensive consultation, a final version of the People Plan was submitted to Workforce Committee for review/approval at their meeting on 14th August, where it was approved for onward submission to Board for agreement in September - *covered under agenda item 5b*.

5. Brexit

We continue to provide reassurance to our EU staff who may be feeling anxious or uncertain around the implications of Brexit. NHS Employers latest bulletin gives the latest advice on the how the outcome will affect staff who already work for us, any action that is advised now and we are developing more information to brief staff and managers as the situation changes.

6. Staff Survey 2017

The staff survey for 2017 will shortly commence. Once again we will be sending the survey to all staff to complete either on line or through hard copy. There will be a communication campaign encouraging staff to participate and we will expect the results towards the end of February 2018.

7. Newly Qualified Staff

We are delighted to welcome a number of newly qualified staff across the Trust who all graduated in July:

- 32 NQ Nurses across the three care groups - 11 in Surgical, 19 Medical, 2 Specialties;
- 5 Physiotherapists,
- 6 Occupational Therapists,
- 3 Cardiac Physiologists,
- 2 Pharmacists,
- 3 Pre-reg Pharmacists, and
- 1 Dietitian.

Work has already started on the recruitment for next year with an open day planned for November masterminded by Sue Davies and Andy Gyngell and supported by BEAT (blended education and training) and HR colleagues.

BOARD OF DIRECTORS	
Meeting Date and Part:	29 September 2017 Part 1
Subject:	Freedom to Speak Up (FTSU)
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	Current position of FTSU
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Helen Martin, RBCH FTSU Guardian (FTSUG)
Details of previous discussion and/or dissemination:	n/a
Action required:	For decision: The Board of Directors is asked to approve the statement of commitment for publication on the website.
<p>Executive Summary: The purpose of this paper is to update the Board on the current position of the speaking up culture at RBCH and outlining the aim and progress of the recently appointed and launched Freedom to Speak Up Guardians (FTSUG). The author of this paper requests that the Board approve the attached statement of commitment and support the development of an open and honest culture, meeting the vision set out by Sir Robert Francis.</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>	Y
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	

THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

Board of Directors' Statement of commitment to the principles of the Freedom to Speak Up Publication set out by Sir Robert Francis.

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication Freedom to Speak Up. The Board of Directors is committed to fostering a culture of safety and learning in which all staff feel safe to raise a concern across the Trust.

Speaking up is essential in any sector where safety is an issue. Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up will persist.

The Board supports the key principles of speaking up and is committed to leading the actions required to implement them. The Board will receive support from the Freedom to Speak up Guardian (FTSUG) who is sponsored by the Chief Executive.

The key principles the Board is committed to include:

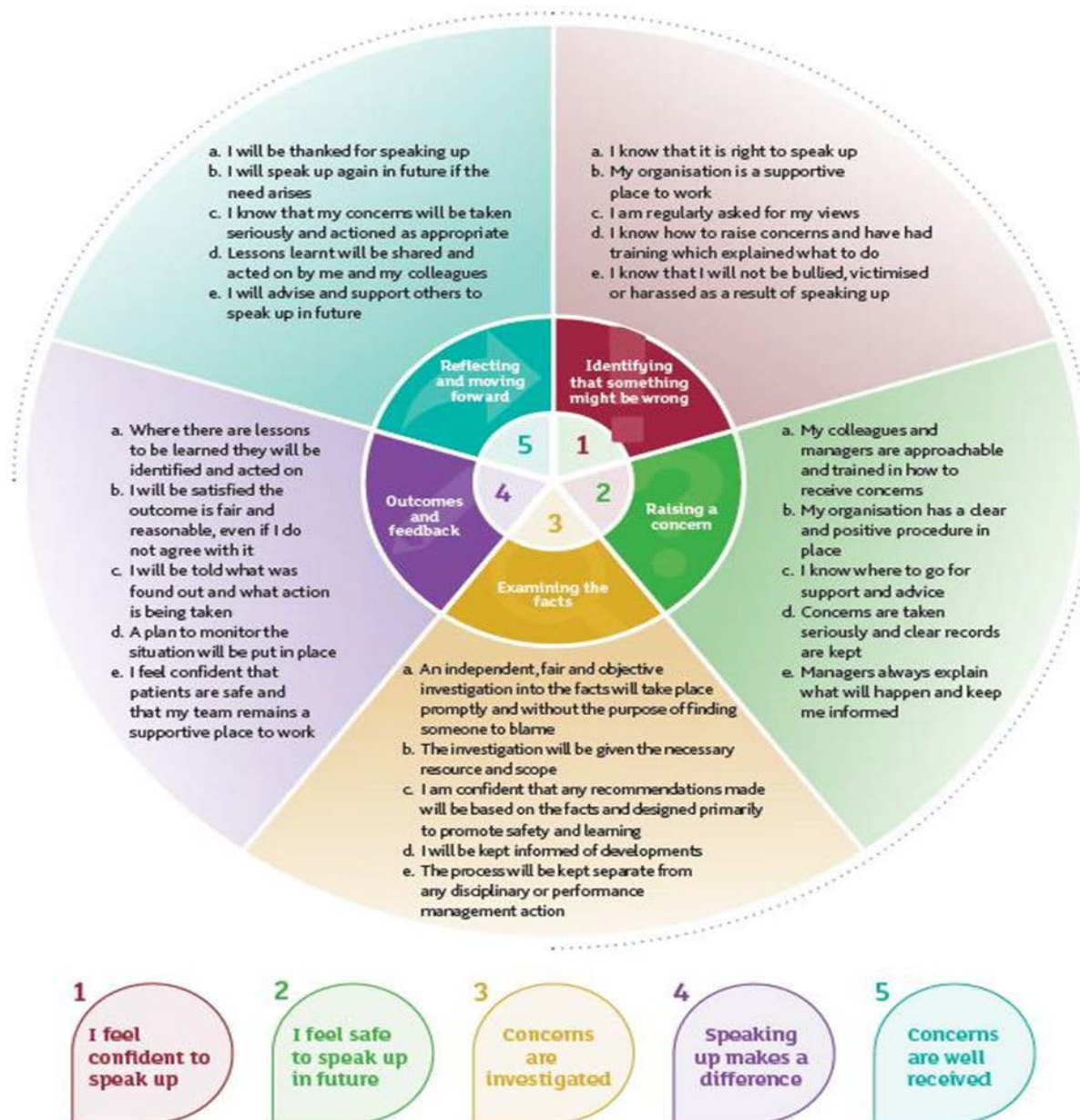
	Principle	Action
1	Culture of safety	Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.
2	Culture of raising concerns	Raising concerns should be part of the normal routine business of any well led NHS organisation.
3	Culture free from bullying	Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
4	Culture of visible leadership	All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.
5	Culture of valuing staff	Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
6	Culture of reflective practice	There should be opportunities for all staff to engage in regular reflection of concerns in their work.
7	Raising and reporting concerns	All NHS organisations should have structures to facilitate

		both informal and formal raising and resolution of concerns.
8	Investigations	When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
9	Mediation and dispute resolution	Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.
10	Training	Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
11	Support	All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality.
12	Support to find alternative employment in the NHS	Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
13	Transparency	All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14	Accountability	Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns.
15	External Review	There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report
16	Coordinated Regulatory Action	There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns
17	Recognition of organisations	CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
18	Students and Trainees	All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
19	Primary Care	All principles in this report should apply with necessary adaptations in primary care.
20	Legal protection	Should be enhanced to those who make protected disclosures.

Freedom to Speak Up (FTSU)

1.0 A Vision for Raising Concerns

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication Freedom to Speak Up. He clearly demonstrated that speaking up protects patients and improves the lives of NHS staff.



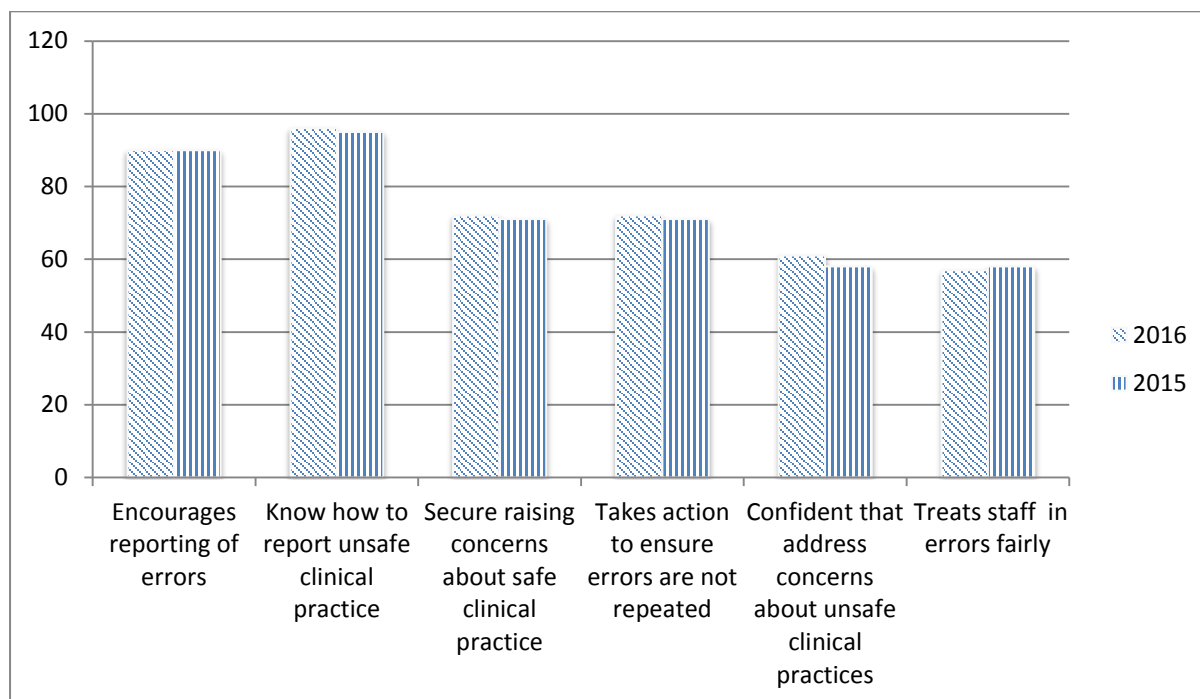
The purpose of this paper is to update the Board on the current position of the speaking up culture at RBCH and outlining the aim and progress of the recently appointed and launched Freedom to Speak Up Guardians (FTSUG). The author of this paper requests that the Board approve the attached statement of commitment

and support the development of an open and honest culture, meeting the vision set out by Sir Robert Francis.

2.0 What does our staff say about our current speaking up culture?

We can get our data from a number of sources. The 2016 annual staff survey is a particularly rich source of information with 44.9% of staff (n=1968) completing it. The graph below looks at those questions within the staff survey relating to FTSU. It clearly show that over 80% of those who completed the survey felt that they were encouraged to report errors and know how to report unsafe clinical practices but areas for improvement in the future could focus more on ensuring that concerns raised are addressed and not repeated. Staff are also saying that we have some way to go to ensuring that we treat staff fairly when raising an error where only 57% felt that this was the case. Trends for 2016 follow that seen from the staff survey in 2015.

GRAPH 1: Staff survey results relating to FTSU questions (% percentage)



Another source of data has come from a recent staff impressions survey which is more of a pulse check of the organisation, completed in quarter 1, 2 and 4. From 8th August to 15th September (Q2) the staff impressions survey not only looked at the mandatory questions of what the organisation is like to work at and be treated at but also asked staff the 5 key questions outlined from the Sir Francis report to assess if RBCH has an open and honest reporting culture.

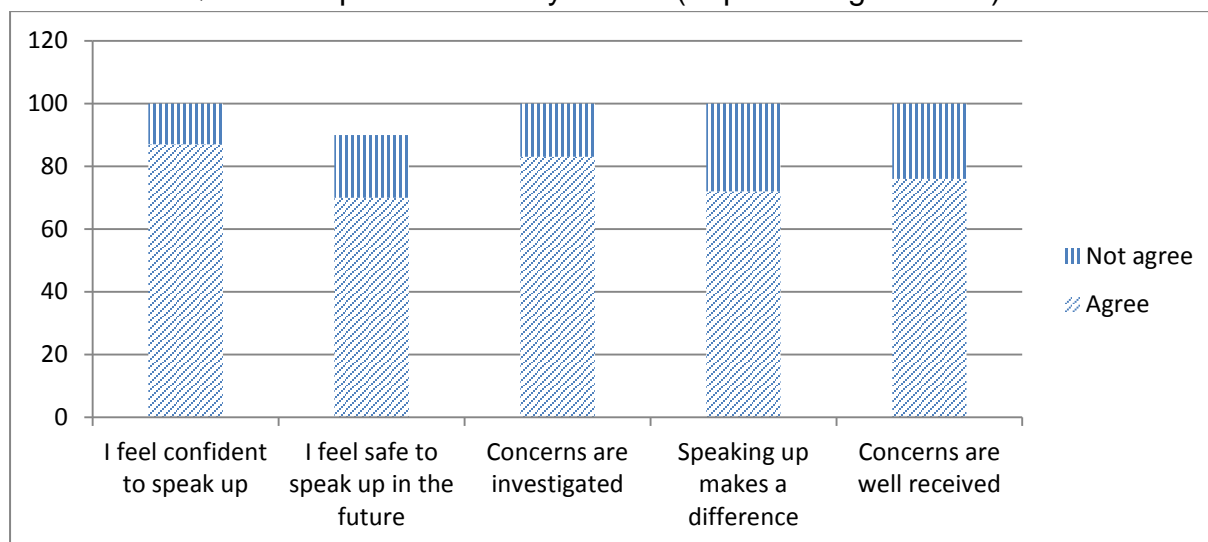
273 of staff completed the survey (6% of the organisation) of which:

- 76% were female,
- 50% had worked at RBCH less than 5 years

- 15% were black and minority ethnic (BME).

Whilst caution needs to be taken when extrapolating this data, information can nonetheless come from this.

GRAPH 2: Q2 Staff impression survey results (% percentage: n=273).



Over 80% of staff told us that they felt confident to speak up, felt safe to speak up in the future and that concerns, once raised, are investigated. In contrast, a quarter of staff felt that speaking up does not make a difference or that they are not well received. This data further concludes that we need to focus more on improving the receiving and dealing with concerns, once raised. Looking at the results from staff from more vulnerable backgrounds, they appear to feel a little more confident and secure when raising concerns but again need more reassurance that any concerns raised will be well received and once raised, are actioned and make a difference. Extreme caution needs to be taken with this particular data set as numbers are small (n <30).

TABLE 1: Staff Impressions survey results (n= 273).

	Total (%)		Black and Minority Ethnic (BME; %)	
	Agree	Not agree	Agree	Not Agree
I feel confident to speak up	87	13	93	7
I feel safe to speak up in the future	70	20	83	17
Concerns are investigated	83	17	90	10
Speaking up makes a difference	72	28	80	20

Concerns are well received	76	24	79	21
----------------------------	----	----	----	----

Alongside this data a number of comments were made and in many ways reflect conversations that were had during the discovery phase of the cultural audit in Spring 2016. A selection of some of the comments is illustrated in the table below. I plan to drill down more into this data over the next few weeks to reveal any particular areas that the FTSUGs should visit in the initial phase.

Positive comments	Negative Comments
Our team wants the best for each-other	Bad news is not well received
My manager is visible, approachable and listens	If you raise an issue, it damages your relationship with your manager
I have raised concerns and it has been listened and acted upon	Larger issues are ignored or given nodding agreement
Improving	Managers only want to hear “happy” comments
My manager makes time to listen to me	Issues continue to be brushed under the carpet
My manager has an open and honest approach	I have spoken up several times and seen no action
My managers operate an open door policy and listen to me	Investigations take too long and not given importance.

3.0 The RBCH Approach

The Trust appointed two Freedom to Speak Up Guardians (FTSUG) who have been in post since 1st April 2017. The post holders are Helen Martin (15hrs/week) and Karole Smith (7.5hrs/week). This report will outline key actions and developments going forward.

3.1 Aim

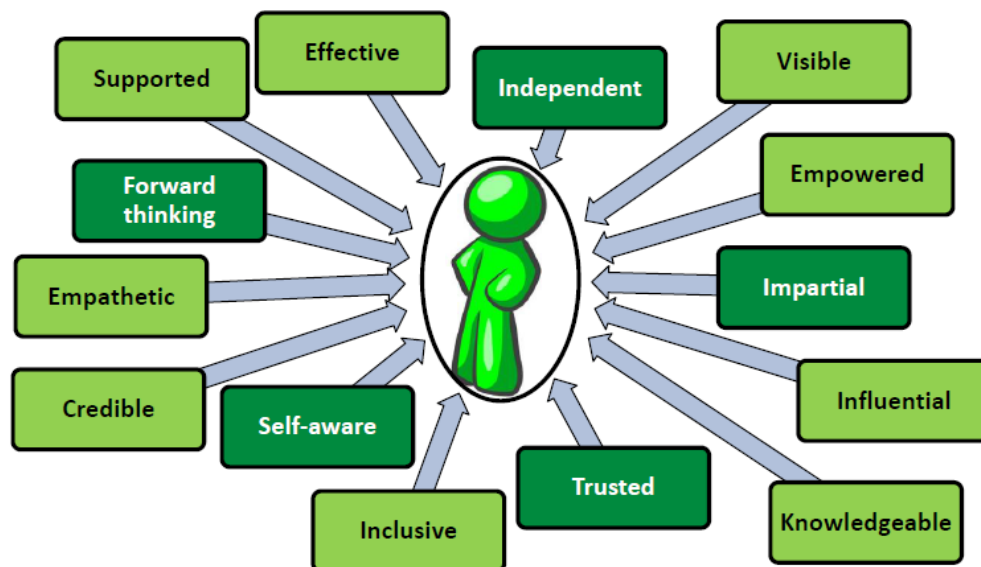
To develop a culture of safety within RBCH so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

The key role of the FTSUGs are to;

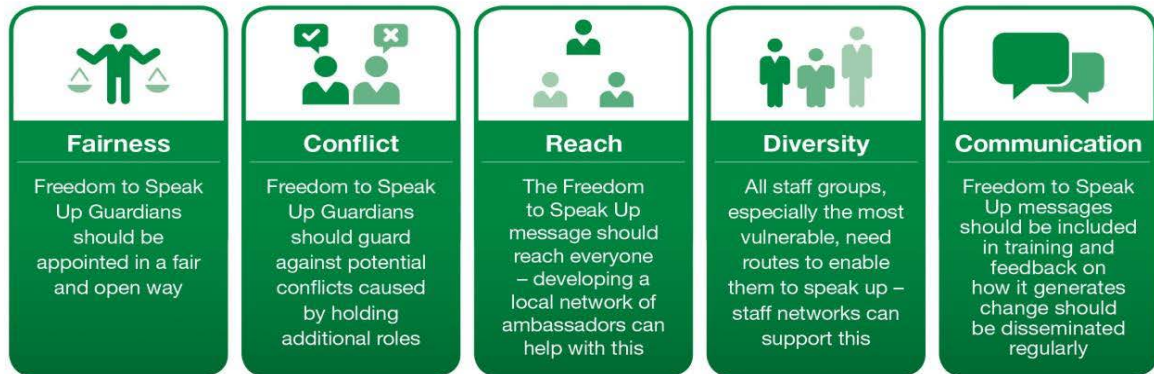
- empower staff to raise concerns within organisations,
- provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled,
- ensure that organisational policies and processes in relation to the raised concern are in place and followed correctly,
- ensure shared learning amongst local/regional/national Networks,
- produce reports to monitor the outcomes and impact of FTSU.

It is not intended that these roles get involved in investigations or complaints.

The National Guardian Office (NGO) outlines the key characteristics of the FTSUG in the diagram below. I am passionate to uphold and bring these qualities to the role and in all developments at RBCH. It requires a high degree of personal integrity, working alongside senior leaders whilst also capturing the confidence of staff throughout the organisation.



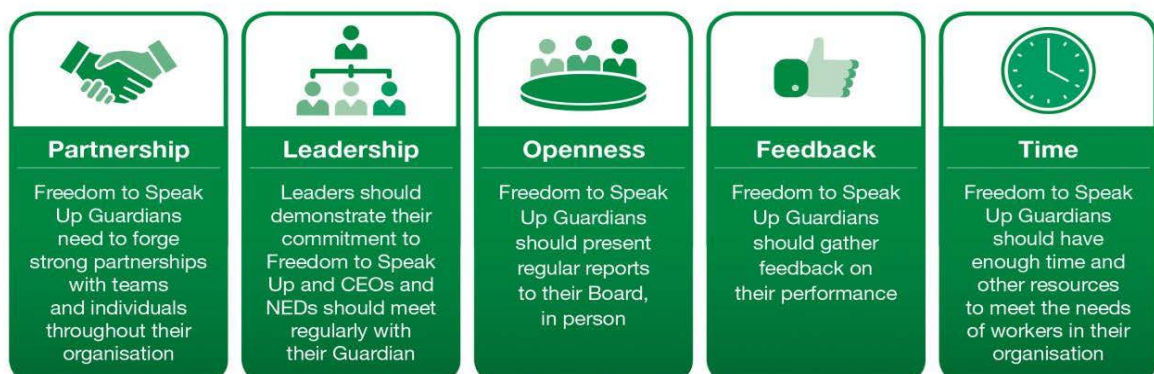
The NGO published on 18th September 2017 results from a recent survey to FTSUG's across the country. The purpose was to provide a systematic understanding of how the role has been implemented, who is being appointed into the role and the support this role is getting from within their trusts. RBCH contributed to this survey. Ten principles for the FTSUG role were drawn up from these survey results and are outlined overleaf.



Freedom to Speak Up Guardian Survey 2017

10 principles for the role.

These principles are derived from the findings of our 2017 Freedom to Speak Up Guardian Survey.



The NGO also recommended that for the role to be successful the following observations needed to occur:

- ring fence time to enable guardians properly to meet the needs of workers,
- all workers, particularly the most vulnerable, should have effective routes to enable them to speak up,
- Boards need to hear regularly from their guardian, in person.

The results of this survey illustrate that the implementation of this role varies greatly across the country. I am confident that with the resources made available to me, the support and commitment from senior leaders and access to the Board will provide

good foundations for this role to being successful, putting patient safety and staff wellbeing at its heart.

3.2 Objectives of FTSU

The Trust set 4 objectives for 2017/18:

1. **Valuing our staff** - Recognising the contribution of our staff and helping them develop and achieve their potential
2. **Improving quality reducing harm** - Focusing on continuous improvement and reduction of waste
3. **Strengthening team working** - Developing and strengthening “Team RBCH” 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

Based on this, the following are key objectives of the FTSUG for the next 12months:

1. **Develop speaking up process, reporting and monitoring system (objective 2)**
2. **Develop a communication and launch strategy (objective 2)**
3. **Develop strong and open working relationship with Trust board (objective 3)**
4. **Develop a training strategy for FTSUG, new, existing and exiting staff (objective 1)**
5. **Develop a network with neighbouring Trusts (objective 3)**
6. **Develop a FTSU advocate team (objective 3)**

3.3 Progress to date

A formal launch of the FTSUG and the speaking up process, occurred on 11th September at the Annual Leadership Summit. Dr Henrietta Hughes, the National Guardian for FTSU was the keynote speaker and presented the latest national position of FTSU. She delivered an excellent overview of speaking up and clearly correlated that organisations whom have a good speaking up culture have a more resilient workforce delivering safer patient care resulting in an improved CQC rating.

Alongside the preparation for the launch other projects have included the;

- development of a clear RBCH speaking up process, working with other departments such as Risk and Governance and Human Resources. This has resulted in the development of a Trust Policy based on the one produced by NHS improvement,
- development of Intranet Webpage,
- development of resources including leaflets, posters, literature, pens etc,
- development of contact details including email and telephone number,

- development of a reporting and monitoring system for national submissions but internally triangulating the data with HR, Risk and Governance,
- participation in Diversity and Inclusion week. The National Guardian office encourage close working partnerships with staff diversity networks so this participation will continue,
- incorporation of speaking up into OD training packages such as customer care,
- presentation to staff meetings within key areas of the organisation,
- discussion regarding FTSU participation within Trust Induction,
- discussions regarding input to exit interviews,
- meeting with medical workforce to look at SAS, junior doctors and medical engagement,
- member and attendance at local FTSUG network,
- submission of FTSU national award for innovative communication,
- Attendance to national conferences, webinars, training,
- meeting with key board members and governors,
- commencement of case referrals.

4.0 Care Quality Commission Inspection and FTSU

The NGO has worked with the CQC to ensure that an assessment of speaking up is at the heart of inspecting the Well Led domain. Listening and responding to people who speak up, and tackling the barriers to speaking up, is a natural ingredient of good leadership, which itself has always been a significant element of the CQC-rating process. Indeed, results from the survey published by the NGO on 18th September described a correlation between CQC-rating and perceptions of the support that respondents felt they received from senior managers and chief executives. This message was also spoken by Dr Henrietta Hughes at our leadership summit on 11th September. She clearly correlated those trusts which have higher CQC-ratings tend to be the ones that support their guardians most and have a stronger speaking up culture at all levels of management and leadership. Both of these have contributed to a higher level of quality of services.

Key guidance on inspections includes:

1. How trusts support the role of FTSU Guardian – including:
 - Evidence that Guardians can regularly access their boards and CEOs
 - Evidence that the role is appropriately communicated and accessible
 - Evidence that the Guardian has the necessary resources, support and independence to effectively undertake the role
2. How trusts respond to the concerns raised by their workers – including:
 - Is there an appropriate speaking up/whistle blowing policy
 - Evidence that trusts appropriately investigate concerns and feedback
3. Evidence of a positive speaking up culture in the trust – including:
 - What steps or initiatives have trusts taken to promote speaking up?
 - What steps has the trust taken to support minority and vulnerable staff groups to have a voice?
 - Are staff who are suspended permitted access to their Guardian?

This guidance has been scrutinised by FTSUG alongside key members of the executive team and CQC project team. A meeting with CQC engagement team is also being

arranged as a means for introduction. It will be crucial that the board are aware of these lines of enquiry in preparation for our next inspection.

5.0 The Role of the Board.

The National Guardian in their letter to all Trusts on 18th September emphasised the need for the Board to be kept abreast of all matters relating to speaking out. This encompasses being sighted on both the issues being raised and apparent barriers to speaking up. It has been suggested that Board reports should include measures of activity and impact and where possible, include “case studies” describing real examples of speaking up that guardians are handling. Many factors play into speaking up activity and no firm conclusions can be drawn by analysing numbers alone. This guidance has only just been released and so these points will be covered by the FTSUG at the next meeting. Further guidance on what and how to present data to the board is intended from the National Guardian Office. It is also the ambition of the FTSUG to triangulate all data concerning the raising of concerns into one document thereby informing the committee of the full speaking out culture of the organisation including data from risk and governance and HR.

Alongside this, the Board need to model speaking up behaviour. Consequently, the author is requesting that the Board approve the enclosed statement of commitment for publication on the website.

6.0 Case Referrals – the headlines

There are a number of routes that the FTSUG can be contacted. To date, seven face to face concerns have been raised to the FTSUG following the attendance of team meetings, OD presentations or walking around the Trust. Of those seven concerns the following themes have been drawn out;

- a bullying culture/senior staff behaviours (3),
- inadequate training (1),
- attitudes and behaviours of staff (1),
- quality and safety of service (2).

The NGO published in September information from the national FTSUGs, of the cases raised in Q1 2017/18. Nationally, over 1100 cases have been raised with 36% of cases having a bullying and harassment nature and 28% included an element of patient safety/quality of care. The themes from the cases raised at RBCH reflect this national picture. Tackling poor behaviours, particularly from senior staff, was also a key theme that came from the cultural audit in 2016 and illustrates that there continues to be more work needed in this area.

Two cases have since been closed and concerns resolved. Feedback from the member of staff who raised the concern has been that they have felt fully supported by the FTSUG and that they have felt that their concern has made a difference. Another 3 concerns have been raised following the formal launch of the role on 11th September.

6.0 What next?

Following the launch on 11th September the FTSUG's main focus will be to increase their visibility with the commencement of guardian walkabouts and visiting team meetings/daily huddles. Working closely with our medical workforce is another key outcome and meetings and training has already been set up. The NGO survey also showed that a number of organisations have set up a network of local advocates and ambassadors roles to increase the reach of FTSU across the Trust. This will be looked into further but the same principles made on pages 5 and 6 will be upheld when and if any appointments are made. Consideration to recruiting and training members of diverse backgrounds will also be key to assure all staff will be supported and able to speak up. Finally I am keen to explore a manager toolkit to support first line managers in handling concerns and better induction and exit interview involvement.

In terms of support from the Board the FTSUG requests the following:

- The approval of the statement of commitment for publication on the website.
- The acknowledgment of Trust Freedom to speak up: raising concerns whistleblowing policy.

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

BOARD OF DIRECTORS

Meeting Date and Part:	29 th September 2017 – Part 1
Subject:	Emergency Preparedness, Resilience and Response (EPRR) Assurance Declaration
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	N/A
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Malcolm Keith / Richard Renaut
Details of previous discussion and/or dissemination:	
Action required: Approve / Discuss / Information/Note	For Information
<p>Executive Summary:</p> <p>The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.</p> <p>NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer (AEO) in each organisation is responsible for making sure these standards are met and is supported by an Emergency Planning Officer (EPO).</p> <p>As part of the national EPRR assurance process for 2017/18, the Royal Bournemouth and Christchurch NHS Foundation Trust have been required to assess itself against these core standards by August 2017.</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>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>
<p>Risk Profile:</p> <p>i) Impact on existing risk?</p> <p>ii) Identification of a new risk?</p>	

Emergency Preparedness, Resilience and Response (EPRR)

1. Summary

The Board is asked to note the Statement of Compliance submitted to Dorset CCG as part of the annual EPRR process.

This results in is a 'partial assurance', with the table below indicating where the outstanding standards where matched.

This level is in line with many Trusts, and our own self-assessment. The year on year need to provide greater assurance levels, and to provide more resilient responses, plus 'deep dives' continues to generate new insight and opportunities for strengthening our preparedness. Therefore areas felt compliant in previous years are now marked in the areas for further improvement, e.g. enhancing the training we provide for our senior management team, updating information and access to the Hospital Control Centre (HCC) and undertaking wider consultation on the governance arrangements with partner agencies.

2. Areas of non-compliance where further work is required (summary) standard

It was confirmed that the overall compliance level for RB&CH is Substantial compliant, given that the following five cores standards remain amber:

- Core standard 3 – EPRR Policy
- Core standard 8 – Incident Response Plan
- Core standard 24 – Using guidance and good practice
- Core standard 48 – LHRP attendance
- Core standard 49 – Work in progress on a needs analysis for training

The full documentation is available via the Trust Intranet or on request.

Quarterly reviews by the CCG EPRR lead will check on progress to give external assurance.

A priority area in EPRR review was to undertake standardisation work across all work streams for policy and procedures in order to enable a more joined up approach to EPRR work, this in light of the Clinical Services Review (CSR).

3. Recommendation

The Board is asked to note the self-assessment, subsequent CCG review and rating as Substantial, and the appropriate action plan to address these.

EPRR statement of compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The accountable emergency officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for 2017/18, The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust have been required to assess itself against these core standards by Friday 11th August 2017. The outcome of this self-assessment shows that against 52 of the core standards, 6 governance standards and 14 Hazmat standards which are applicable to the organisation, The Royal Bournemouth and Christchurch Hospital:

It was confirmed that the overall compliance level for RB&CH is Substantial compliant, given that the following five core standards remain amber:

- Core standard 3 – EPRR Policy
- Core standard 8 – Incident Response Plan
- Core standard 24 – Using guidance and good practice
- Core standard 48 – LHRP attendance
- Core standard 49 – Work in progress on a needs analysis for training

The attached improvement plan sets out actions against all core standards where full compliance has yet to be achieved. The aim is to meet the partially met standards by the end of December 2017. The non-compliant standard (non-executive membership) cannot be officially achieved until the post holder has been in place for a full term.

Richard Renaut



The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

11TH August 2017

*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:	29 September 2017 - Part 1
Reason for Part 2:	N/A
Subject:	Well-Led Review Action Plan Update
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	None
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:	Information
Executive Summary: This report updates on progress against the actions arising from the 12 recommendations in the external well-led review which was received in 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?	N/A

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update
1	The Board should proactively pursue strategic discussions at system level, especially with community, primary care and social care partners.	a Address strategy and strategic risk, using scenario planning. b. Design external engagement strategy.	Autumn 2017 TS/DM	The Chair and Chief Executive are active participants in the Systems Partnership Board which was established earlier this year. It includes the leaders of all NHS and Local Authority organisations in Dorset and oversees the strategic direction of Health and Social Care including progress on the Sustainability and Transformation Plan (STP).
2	The Board should ensure that it continues to make time for strategic discussion.	Design Board development activities to integrate new non-executive directors, create role clarity and identify skills for future.	Apr-17 TS/DM	Conscious efforts are made to include time during Board meetings to discuss emergent strategic issues. In addition separate Board sessions are scheduled for development events and 'Blue Skies' discussions, eg sessions have been held on the cultural change programme and the impact of change champions, and on the quality improvement programme.
3	The Board should prioritise building on its existing engagement with local government, including developing a clear engagement strategy for doing so as the CSR is implemented.	a. Design external engagement strategy. b. Consider role of governors following review timetabled for summer 2017.	Autumn 2017 Various executive leads	See response to Recommendation 1 above. In addition following the Board and CoG workshop in July a detailed action plan 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 in the autumn.
4	The Board should consider how it can increase its engagement with primary and community healthcare organisations, in particular relationships with the local community Trust. This should include direct 'peer to peer' engagement by NEDs as well as working through Trust staff.	a. Design external engagement strategy. b. Consider role of governors following review timetabled for summer 2017.	Autumn 2017 Various executive leads	See response to Recommendation 3 above. In addition, Executive Directors have regular contact with opposite numbers and other keys staff in primary and community organisations. The Chair also has regular meetings with the Chairs of the Dorset and West Hampshire CCGs, and the Chair of the Dorset Healthcare University NHS Foundation Trust.

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update	
5	The Board should keep its governance under review-specifically the cycle of committee meetings in relation to Board meetings, the detail being considered by committee and Board meetings along with the balance of Part 1 and Part 2 agenda items.	Address governance tasks of Board and committee cycle along with delegated decision making and assigning responsibility for operational and strategic risk.	Ongoing	DM/KF	Relevant committee meetings eg Health Assurance Committee (HAC) have been rescheduled to ensure they meet well ahead of the Board meeting and reports can be updated. Committee Chairs have been asked to review committee agendas and reports to ensure they link sensibly with Board agendas and reports and avoid duplication. See also response to Recommendation 7 below.
6	The Board should consider how its strategic direction will influence its information requirements – including those relating to system-wide leadership and management and integrated care.	Address issue of information for Board including review of data/analytics/intelligence required.	Ongoing	DM/TS	See response to Recommendation 1 above. Also the One Acute Network Board has been set up to oversee the implementation of the Acute elements of the CSR across Dorset. This Board will develop metrics to measure progress on reconfiguration and will receive regular reports on progress from the Programme Director.
7	The Board should consider investment in capability around integrated analytics to improve reporting.	Address issue of information for Board including review of data/analytics/intelligence required.	Ongoing	DM/TS	The Board receives standard reports on finance, performance, quality and workforce at each meeting under the performance section of the agenda which allows connections to be made. In addition, the performance section gives an overview of our performance dashboard against the Single Oversight Framework Indicators. The format of all the performance reports has also been reviewed to ensure that they are shorter and more focused on key issues.

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update
8	External risks should be identified and managed systematically, in the same way as strategic or operational risks. Our view is that strategic risk should sit with the Audit Committee rather than the Healthcare Assurance Committee.	Address governance tasks of Board and committee cycle along with delegated decision making and assigning responsibility for operational and strategic risk.	Aug-17 PS/KF/AJ/CH /JL	<p>Following discussion it was agreed to continue to review significant risks at the HAC. Where risks have been received by other committees, such as the Finance and Performance Committee, this will be noted in the report for HAC.</p> <p>The Board Assurance Framework will be reviewed by the Audit Committee at each meeting and by the Board at every other meeting. This will reinforce the overall Board responsibility for strategic risk with the Audit Committee providing oversight as part of its role in assessing the effectiveness of risk management.</p> <p>Both the Board and the Audit Committee will have a role in relation to the strategic risks associated with the CSR, working alongside the One Acute Network Board (see recommendation 6 above).</p>
9	The Board may wish to seek to add expertise (either Executive or Non-Executive) in community or primary care, social care or local government.	Design Board development activities to integrate new non-executive directors, create role clarity and identify skills for future.	Apr-17 DM/TS	This will be actively considered when suitable vacancies arise as it is not considered appropriate to increase the overall size of the Board at the present time. However, arrangements are being considered to engage GP advisors to the Trust.
10	The Board should ensure that it has a clear people strategy in place, as part of its overall strategic planning. This should include consideration of strategic workforce needs across the system (for example new roles), as well as Trust requirements. This can build on the cultural work already in place.	Design people strategy and build leadership capacity as well as change management skills.	Dec-17 Workforce Strategy and Development Committee/ Board/ One Acute Network Board	A people strategy is in course of preparation. It will go to the Workforce and Strategy Development Committee shortly and is due to be considered by the Board in September.
11	As part of its people strategy and its implementation, the Trust should further develop its talent management approach and pipeline. This should include development of Care Group leaders as well as trust-wide clinical and non-clinical leaders, though we note this has already begun with an imminent Leadership Strategy.	Design people strategy and build leadership capacity as well as change management skills.	Dec-17 Workforce Strategy and Development Committee/ Board/ One Acute Network Board	This will be covered in the people strategy described under Recommendation 10 above.

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update
12 The interface between existing Trust governance and the emerging CSR Programme Board should be specified in detail, so that its full implications for the Trust can be discussed and agreed by the Board prior to implementation. This should include clear specification of accountability for both operational and transformation performance at all times, as well as consideration of how the boards can work most effectively together to provide whole-system leadership.	Address strategy and strategic risk, using scenario planning.	Autumn 2017	TS/DM	<p>Terms of Reference were prepared for the purpose, structure and decision-making framework of the One Acute Network Board. Care was taken to ensure that these terms of reference were compatible with the Trust's own Constitution and Standing Orders and the terms of reference were approved by the RBCH Trust Board (as well as the Board of PHFT and DCHFT) prior to adoption by the One Acute Network Board.</p> <p>See also the response to Recommendations 1 and 6 above.</p>

AGENDA DATES – 2017/18/19 RBCH Board and OAN Board

RBCH BOARD OF DIRECTORS		
Date of Meeting	Document submission Deadline (12 noon)	Papers Distributed
2017		
Friday 29 September	20 September	Friday 22 September
Friday 24 November	15 November	Friday 17 November
2018		
Wednesday 31 January	19 January	Wednesday 24 January
Wednesday 28 February (Strat/Dev 8.30-12)		
Wednesday 28 March	16 March	Wednesday 21 March
Wednesday 25 April (Strat/Dev 8.30-12)		
Wednesday 30 May	18 May	Wednesday 23 May
Wednesday 27 June (Strat/Dev 8.30-12)		
Wednesday 25 July **	13 July	Wednesday 18 July
Wednesday 29 August (Strat/Dev 8.30-12)		
Wednesday 26 September **	14 September	Wednesday 19 September
Wednesday 31 October		
Wednesday 28 November	16 November	Wednesday 21 November
Wednesday 12 December (Strat/Dev 8.30-12)		
2019		
Wednesday 30 January	18 January	Wednesday 23 January
Wednesday 27 February (Strat/Dev 8.30-12)		
Wednesday 27 March	15 March	Wednesday 20 March
Part 1 Board (Public) held in the Conference Room, Education Centre at 8.30am Part 2 Board (Confidential) held in the Committee Room, Management offices at 11.00am (NB **July and September Boards will be in the Committee Room from 8.30 or at Christchurch?)		
BoD / TMB in the same week		

ONE ACUTE NETWORK BOARD	
Date of Meeting	Location
2017	
Wednesday 28 June	Poole Hospital
Wednesday 30 August	RBH Conference Room
Wednesday 25 October	Poole Hospital
Wednesday 13 December (early due to Christmas)	RBH (The Village tbc)
2018	
Wednesday 28 February	Poole Hospital
Wednesday 25 April	RBH Conference Room
Wednesday 27 June	Poole Hospital
Wednesday 29 August	RBH Conference Room
Wednesday 31 October	Poole Hospital
Wednesday 12 December (early due to Christmas)	RBH Conference Room
2019	
Wednesday 27 February	Poole Hospital
Wednesday 24 April	RBH
OAN Board / TMB in the same week	

BOARD OF DIRECTORS MEETING – 29 September 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 MEETING		
	a) Minutes of the meeting held on 28 July 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 Report (paper)	Discussion	<i>Paula Shobbrook</i>
	b) Board Assurance Framework (paper)	Decision	<i>Paula Shobbrook</i>
	c) Accountable Care System – Memorandum of Understanding (paper)	Discussion	<i>Tony Spotswood</i>
	d) Capital Plan Update (paper)	Discussion	<i>Richard Renaut</i>
	e) Pathology Outline Business Case (including Future of Pathology Services) (paper)	Discussion	<i>Tony Spotswood</i>
	f) One Acute Network: Competition and Markets Authority Update (paper)	Decision	<i>Tony Spotswood</i>
	g) Recommendation Report – Orthotics and Prosthetics Managed Services (paper)	Decision	<i>Pete Papworth</i>
	h) Recommendation Report - PCI Consumables (Balloons): • Cardiology • Endoscopy (paper)	Decision	<i>Pete Papworth</i>
	i) Recommendation Report – Orthopaedic Hip and Knee (paper)	Decision	<i>Pete Papworth</i> To Follow
13.00	4. GOVERNANCE		
	a) Board Strategy and Development Programme 2017/18 (paper)	Information	<i>David Moss</i>
13.05	5. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff	Discussion	<i>All</i>
	b) Reflective Review	Discussion	<i>All</i>

The meeting will be followed by an extended Blue Skies session on IT Infrastructure, Work Programme and Strategy between **13.30 and 15.30**