

A meeting of the Board of Directors will be held on **Wednesday 28 March 2018** 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 or karen.flaherty@rbch.nhs.uk.

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, Cliff Shearman		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 31 January 2018	Decision	All
8.40-8.45	3. MATTERS ARISING		
	a) Updates to the Actions Log	Information	All
8.45-9.25	4. QUALITY		
	a) Patient Story (verbal)	Information	Paula Shobbrook
	b) Update on Governor Activity (verbal)	Information	David Triplow
	c) Safe Staffing Report (paper)	Information	Paula Shobbrook
	d) Quality Improvement Programme 2018/19 (paper)	Decision	Deb Matthews/ Tony Spotswood
	e) Medical Director's Report (paper)	Information	Alyson O'Donnell
9.25-10.00	5. STRATEGY AND RISK		
	a) Clinical Services Review (paper/verbal)	Information	Tony Spotswood
	b) Trust Strategy and Objectives 2018/19 (paper)	Decision	Tony Spotswood
	c) Progress Update on Stakeholder Engagement Outcomes (paper)	Information	David Moss
10.00-10.40	6. PERFORMANCE		
	a) Trust Board Dashboard (paper)	Information	Richard Renaut
	b) Performance Report (paper)	Information	Richard Renaut
	c) Quality Report (paper)	Information	Paula Shobbrook
	d) Finance Report (paper)	Information	Pete Papworth
	e) Workforce Report (paper)	Information	Karen Allman
	f) Staff Survey Results (paper)	Information	Karen Allman

10.40-11.05

7. GOVERNANCE

- | | | | |
|----|--|-------------|-----------------------|
| a) | Directors' Register of Interests (paper) | Review | <i>Karen Flaherty</i> |
| b) | Finance and Performance Committee Terms of Reference (paper) | Decision | <i>Pete Papworth</i> |
| c) | Freedom to Speak Up – Update (paper/presentation) | Decision | <i>Helen Martin</i> |
| d) | Well-led Review Action Plan Update (paper) | Information | <i>David Moss</i> |
| e) | Information Governance Strategy 2018 (paper) | Decision | <i>Peter Gill</i> |
| f) | Information Governance Annual Report (paper) | Information | <i>Peter Gill</i> |

8. NEXT MEETING

Wednesday 30 May 2018 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.

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 **Wednesday 31 January 2018** in the Conference Room, Education Centre, Royal Bournemouth Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	Pete Papworth	(PP)	<i>Director of Finance</i>
	Iain Rawlinson	(IR)	<i>Non-Executive Director</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:	Rachel Bevan	(RB)	<i>Head of Patient and Public Engagement (for item 4(a))</i>
	Jane Bruccoleri-Aitchison	(JB)	<i>Communications Officer</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	David Flower	(DF)	<i>Chaplain (for item 4(a))</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NH)	<i>Director of OD and Leadership</i>
	Deb Matthews	(DM)	<i>Director of Improvement</i>
	Duncan Ridgeon	(DR)	<i>Chaplain</i>
	James Rowden	(JR)	<i>Patient Engagement and Clinical Liaison</i>
	Maggy Simonot	(MS)	<i>End of Life Companion (for item 4(a))</i>
	Ian Simonot	(IS)	<i>End of Life Companion (for item 4(a))</i>
	Rachel Targett	(RT)	<i>End of Life Care Specialist Nurse (for item 4(a))</i>
Public/ Governors:	Jackie Taylor	(JT)	<i>Voluntary Services Officer (for item 4(a))</i>
	Judith Allebon		<i>Friends of the Eye Unit Representative</i>
	Richard Allen		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Elisabeth Corkell		<i>Friends of the Eye Unit Representative</i>
	Eric Fisher		<i>Public Governor</i>
	Paul Higgs		<i>Appointed Governor for Volunteers</i>
	Marjorie Houghton		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Roger Parsons		<i>Public Governor</i>
	Guy Rouquette		<i>Public Governor</i>
	Rae Stollard		<i>Appointed Governor</i>
	Maureen Todd		<i>Public Governor</i>
	Michele Whitehurst		<i>Public Governor</i>
	Sandy Wilson		<i>Public Governor</i>
	Brian Young		<i>Public Governor</i>
Apologies:	Tea Colaiani		<i>Non-Executive Director</i>
	John Lelliott		<i>Non-Executive Director</i>
	Alyson O'Donnell		<i>Medical Director</i>

01/18 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Action

Apologies for absence were **noted**. The Board recognised and thanked Tea Colaianne for her contribution to the Trust as a non-executive director and as Chair of the Workforce Strategy and Development Committee ahead of her stepping down from her role following the meeting.

02/18 **MINUTES OF PREVIOUS MEETING**

(a) Minutes of the meeting held on 24 November 2017 (Item 2a)

The minutes of the meeting held on 24 November 2017 were **approved** as an accurate record of the meeting.

03/18 **MATTERS ARISING**

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

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

04/18 **QUALITY**

(a) Patient Story (Item 4a)

Members of the Voluntary Services team, Chaplaincy, End of Life Companions and an End of Life Care Specialist Nurse attended the meeting to present on the valuable support provided to patients and their relatives throughout the Trust by the End of Life Companion volunteers.

Since the launch of the End of Life Companion volunteer role in July 2017, 34 companion requests had been received covering 14 different wards and 62 individual visits. Examples were given of how the End of Life Companions had made a difference to patients and their relatives including feedback received from patients' families. The support provided to staff, who may not be able to spend as much time as they would like with patients nearing the end of their life, was also acknowledged. The work carried out by this group of volunteers had been recognised with the Voluntary Services Department receiving regional and national awards from the National Association of Voluntary Services Managers.

A three day training programme had been developed to support End of Life Companions in the role with input from specialist nurses, palliative consultants and Chaplains and covering areas such as communication, safeguarding and reflective practice, recognising that this was a challenging role. The Trust was also sharing its work with other organisations nationally.

Two of the End of Life Companions, Ian and Maggy Simonot, spoke of their experiences as End of Life Companions and how they enjoyed working as part of a team supporting patients, relatives and each other and the privilege of being with people at a very difficult time in their lives.

In response to a request from the Chairperson, a Public Governor, Keith

Mitchell, reflected on his involvement through the Trust's End of Life Steering Committee and the positive feedback he had received from relatives about the quality of end of life care at the Trust in surveys he had carried out, including how the End of Life Companions had contributed to patient and relative experience. CS, as a member of the End of Life Steering Committee, commented on how impressed he had been with the quality of end of life care at the Trust and the ambition and drive to continue to improve patient care and patients' experience.

The Board members thanked the Voluntary Services Department and the End of Life Companions on this outstanding and important service.

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

The report was presented by PS and the following areas were highlighted:

- mortality metric reports remained stable reflecting the positive impact of the Trust's Quality Improvement work;
- four new CUSUM alerts had been received relating to areas representing a small number of cases and were being reviewed by the lead consultant on mortality to identify if there were statistical issues or whether a further investigation was required;
- mortality in high risk groups and where there had been an alert were subject to review by the Mortality Surveillance Group, the learning from which was disseminated;
- an active consent working group had been established with multi-professional representation across a wide range of specialities to improve the quality of the consent process with increased focus on shared decision-making;
- the work to improve the triangulation between complaints, adverse events and claims continued to ensure that issues from claims were recognised through other Trust processes;
- the reduction in the Trust's premium for Clinical Negligence Scheme for Trusts reflected improved claims performance although work to improve record-keeping should further reduce the number of claims; and
- compliance with systemic anti-cancer treatment reporting was improving with regular review by the Chief Pharmacist to ensure that the requirements of the associated CQUIN were met.

(c) Safe Staffing Report (Item 4c)

The Board **considered** the six monthly report, which had been reviewed by the Workforce Strategy and Development Committee, as part of its ongoing responsibility to ensure safe, sustainable and productive staffing and services across the Trust. The report summarised the ward staffing review process including the highlights from the most recent reviews of staff templates and the ongoing daily review of safe staffing and actions taken to mitigate red flags for staffing. The Board discussed the correlation of red flags with how busy the hospitals were and patients being moved to outlying wards, although the winter planning and daily safe staffing huddles had been effective at managing this with no red flags in January.

The use of data from the electronic rostering system as part of the review process for safety incidents was also explained. The reduction in expenditure

on agency staff, which continued to be driven by the substantive appointment of staff, the strengthening of the Trust's staff bank and the expansion of nursing roles creating career development and progression opportunities was also highlighted during the Board's discussion. The impact of this work staff retention and the overall quality of patient care was recognised.

05/18 **STRATEGY AND RISK**

(a) Clinical Services Review – Implementation Update (Item 5a)

The latest update on the progress of the implementation of the Clinical Services Review (CSR) was provided to the Board, which included:

- feedback from NHS England (**NHSE**) and NHS Improvement (**NHSI**) following submission of the draft Outline Business Case (**OBC**) for the capital to implement the CSR indicated that HM Treasury would require both the clinical and physical estate design work included in the OBC;
- the consideration of alternative options to fund the physical estate design work;
- further work to provide assurance to NHSI around the availability of the capital and that the £147 million capital committed to Dorset was sufficient to deliver the reconfiguration of acute services under the CSR;
- the development of the draft patient benefits case for the Competition and Markets Authority, with an overview to be presented to the Council of Governors at its meeting in February 2018;
- the recent meeting between the Trust Management Board and counterparts from Poole Hospital NHS Foundation Trust's Hospital Executive Group to progress the clinical design work across both sites and facilitate further joint working;
- the decision by joint and local health overview and scrutiny committees not to make a referral to the Secretary of State for Health and Social Care in relation to the CSR consultation by NHS Dorset Clinical Commissioning Group (**Dorset CCG**);
- the risk of an application for judicial review of Dorset CCG's decision-making process around the CSR proposals to delay the implementation of the CSR and the delivery of benefits for patients; and
- the joint briefings to staff at both trusts on the implementation of the CSR which would address questions already raised by staff around the timing and impact of the reconfiguration of services, including the proposed merger, as well as any other concerns they may have.

(b) Trust Leadership Strategy (Item 5b)

The Leadership Strategy had been developed in consultation with staff and the Board and provided a framework within a changing external environment and a model for compassionate leadership within the Trust. Following consideration by the Workforce Strategy and Development Committee, the Leadership Strategy was recommended for approval by the Board.

The Board discussed how the action plans set out in the Leadership Strategy would be monitored by the Workforce Strategy and Development Committee, the need to guard against fatigue through the change process and the

proposals for a cultural audit involving staff across both trusts to develop a new strategy aligned with the ambitions for the new merged organisation.

The Board of Directors **approved** the Leadership Strategy.

(c) Progress Update on 2017/18 Corporate Objectives (Item 5c)

The Board **noted** the update which detailed encouraging progress against the agreed metrics for the 2017/18 objectives. It was proposed that the four objectives would be maintained for 2018/19 with refined metrics and priorities in order to build on the progress made this year.

In response to a challenge from one of the Non-Executive Directors around sepsis training for staff not being mandatory, the feedback from staff to use clinical leadership and teamwork to support a multi-faceted education programme rather than making this mandatory was highlighted. This was supported by the Board making sepsis one of the Trust's quality priorities for 2017/18 and using quality improvement to understand how to ensure the timely treatment of these patients.

(d) Diversity and Inclusion Update (Item 5d)

Deb Matthews outlined the proposed approach to diversity and inclusion and in the Trust and plans on how to take this forward following her appointment as the lead for diversity and inclusion to help support the Trust's ambition to improve diversity, equality and inclusion for staff and patients.

A number of initiatives had already begun, led by the Diversity and Inclusion Committee with support from the Change Champions, and had contributed to improvements in the 2017 Staff Survey results around staff experiences of harassment, bullying or abuse and equal opportunities. However, the proposition to the Board was to excel in 2018 and tackle some of the issues facing the Trust.

Work to revise the governance arrangements and carry out a listening exercise and awareness activities in March and April, prior to the Board approving a diversity and inclusion strategy in May.

Non-Executive Directors were encouraged by the plans presented which tied in with the Trust's cultural audit. Board members reflected their dissatisfaction with the current performance and reaffirmed their commitment to help drive and support improvements, particularly highlighting the ability to tackle this immediately through recruitment.

In response to a request from the Chairperson, Eric Fisher, a Public Governor who had been a member of the Diversity and Inclusion Committee also referenced the work to improve patient dignity and the patient experience through diversity, equality and inclusion. DM also indicated her openness to reconsidering the use of the word 'equality' in the approach if there was a feeling that anything had been lost by encompassing this within inclusion.

DM

The Board **supported** the launch of the programme to refresh the Trust's strategy and to role model the leadership required for a culture of inclusion

and high quality care.

06/18 **PERFORMANCE**

(a) Performance Report (Item 6a)

The report was **noted** for information. Board members received an overview of Trust's performance against the Emergency Department (**ED**) target to admit or discharge 95% of patients within four hours as well as overall patient safety during winter to date.

Performance against the ED four hour wait target had fallen in December, ahead of Christmas, as a result of increased ED attendances and urgent care admissions. As a result of a decision to prioritise the sickest patients, who were admitted to hospital, those patients who were discharged had to wait longer than usual waits which affected the Trust's performance against the Ed four hour wait target. One in three patients who needed to be admitted to hospital were admitted within 4 hours.

The number of patients discharged ahead of Christmas was less than in the previous two years so there were between 60-70 more patients than usual. This made it more difficult to cope with the surge in patients needing to be admitted over Christmas and the New Year despite opening additional beds and reducing elective activity as part of winter plans. However, by 5 January the Trust had recovered performance in ED and, as mentioned earlier in the meeting, there were no nurse staffing red flags over this period. The reduction in the number of medical patients on other wards to ten during January was also highlighted, supported by a multi-disciplinary approach and the quality improvement work within the Trust.

The challenge remained to work within the Trust and with health and social care partners to reduce the number of patients in hospital who were medically ready for discharge, including 50 patients with a length of stay over 21 days since they were ready to be discharged. It was also important to maintain morale by having a clear plan, managing performance on a daily basis and thanking staff for their extraordinary efforts. If the Trust could achieve the ED four hour target of 95% in March then it would receive a financial bonus.

Non-Executive Directors queried what areas could be improved in ED in order for the Trust to be able to respond better to surges in activity. The deployment of ED staff and resources to match peaks in demand and provide greater support at evenings and weekends was highlighted as one of the main areas to address with rota changes proposed from the end of March as additional consultants were recruited.

(b) Quality Report (Item 6b)

The key areas within the report were summarised:

- Friends and Family Test performance remained consistent with top quartile performance and positive feedback;
- three serious incidents had been reported in December 2017, two of which had been classified as never events, although with no harm/low impact to each patient;

- revisions to NHSI's never event policy and framework had been made which would take effect from February 2018; and
- the Trust had scored among the highest 25% of acute trusts in the composite indicator score in the Care Quality Commission's latest Insight Report published on 22 December 2017, with an improvement in 16% of the 38 indicators and a decline in 2 relating to the number of never events reported by the Trust.

The Board discussed the review process for never events and the focus on the correct and robust use of theatre safety checklists which had been identified as a common theme. The Trust continued to encourage and nurture a positive reporting culture to drive continuous improvement.

(c) Finance Report (Item 6c)

The key points from the report were summarised:

- the Trust delivered a cumulative deficit of £4.619 million as at December 2017 which was £220,000 behind the Trust's financial plan and reflected the loss of the Sustainability and Transformation Fund (STF) income relating to ED performance for the third quarter offset in part by receipt of national winter pressures funding;
- the appeal against the loss of the STF payment to NHSE had been unsuccessful despite receiving support from NHSI;
- £700,000 was at risk in the fourth quarter which was linked to ED performance;
- there was a forecast improvement of £659,000 against the agreed deficit control total of £6.648 million; and
- details of the allocation of the £1.6 billion national settlement and planning guidance were awaited in order to finalise the budget for 2018/19.

(d) Workforce Report (Item 6d)

The key areas covered by the report were summarised:

- the downward trend in the staff turnover rate continued with a further reduction in month and the joining rate had improved upon the position at the same point last year;
- Essential Core Skills training compliance continued to increase with the Trust achieving 93.5% as at the end of December 2017;
- there had been an increase in sickness absence in December following recent reduction although this was an improvement upon the position at the same point last year; and
- the staffing return to Unify for December demonstrated that the Trust maintained a safe staffing position and no red flags for staffing were reported in December 2017.

07/18 GOVERNANCE

(a) Trust Management Board Terms of Reference (Item 7a)

The amendments to the terms of reference for the Trust Management Board were outlined and **approved** by the Board.

(b) Healthcare Assurance Committee Terms of Reference (Item 7b)

The terms of reference had been amended to reflect the current governance structure. The Board **approved** the amendments to the terms of reference for the Healthcare Assurance Committee.

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

The amendments had been reviewed by the Workforce Strategy and Development Committee and were recommended for approval by the Board. The Board **approved** the amendments to the terms of reference for the Workforce Strategy and Development Committee.

(d) Charitable Funds Committee Terms of Reference (Item 7d)

The amendments had been reviewed by the Charitable Funds Committee and were recommended for approval by the Board. The Board **approved** the amendments to the terms of reference of the Charitable Funds Committee.

(e) Well-led Review Action Plan Update (Item 7e)

The Board of Directors **noted** the updates to the action plan.

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

The Board **approved**:

- the appointment of Cliff Shearman as chairman of the Workforce Strategy and Development Committee;
 - the appointment of Iain Rawlinson as a member of the Workforce Strategy and Development Committee; and
 - the appointment of Iain Rawlinson as a member of the Charitable Funds Committee,
- each with effect from 1 February 2018.

Cliff Shearman's assumption of the role of the Non-Executive Director lead for Emergency Planning, Resilience and Response was also **noted**.

08/18 **NEXT MEETING**

The next meeting will take place on **Wednesday 28 March 2018** at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

09/18 **ANY OTHER BUSINESS**

Key Points for Communication:

1. Clinical Services Review
2. Leadership Strategy
3. The new approach to Diversity and Inclusion and the Board's commitment to improve.
4. To recognise and thank staff for working as a team to support the Trust during winter pressures.

10/18 COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC

1. A Public Governor queried whether a cultural audit had been conducted at Poole Hospital NHS Foundation Trust which would help the organisations to better understand the cultural fit ahead of the merger. While Poole Hospital had not completed the same work as this Trust there was a strong culture with the well-established 'Poole Approach'. It was important to build on the mutual respect and existing positive cultures at both the organisations and in jointly developing the culture within the new merged organisation.
2. In response to a comment about the need for another ward for elderly patients it was emphasised that the Trust had appropriate capacity for the patients needing a hospital bed, however, more focus needed to be placed on providing appropriate care to allow patients who were medically ready for discharge to return home. This would also be more beneficial for patients longer term as it would avoid the decompensating effect of a prolonged stay in hospital. This could only be achieved through greater partnership working and increased support from community care and social services.
3. A concern was raised by a Public Governor about the functionality and ability to look up test results within ED. This concern had been highlighted to the Trust Secretary's office previously and further information would be provided outside the meeting.
4. The care provided by staff to address the management of sepsis was praised by a Public Governor, who also asked how the Leadership Strategy would impact patient care. The underpinning ethos of the strategy was to have supported and engaged staff and to develop them as leaders. It was leadership for a purpose however which linked to the delivery of all the strategic objectives and quality priorities, resulting in better outcomes for patients and improved patient care.

KF

11/18 RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
31.01.18	05/10	STRATEGY AND RISK			
	(d)	<u>Diversity and Inclusion Update</u>			
		DM also indicated her openness to reconsidering the use of the word 'equality' in the approach if there was a feeling that anything had been lost by encompassing this within inclusion.	DM		The term had been reintroduced with revised the terms of reference and membership of Equality, Diversity and Inclusion Committee.
	10/18	COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC			
	3.	A concern was raised by a Public Governor about the functionality and ability to look up test results within ED. This concern had been highlighted to the Trust Secretary's office previously and further information would be provided outside the meeting.	KF		Information now shared with Peter Gill.
24.11.17	84/17	COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC			
	1.	A governor commented on the positive feedback he had received about the end of life care provided to patients by the Trust when conducting a survey of relatives and carers for the End of Life Care Steering Group. The Communications team agreed that the positive feedback should be shared with staff.	JD		To be included in the June edition of FT Focus.
Key: Outstanding In Progress Complete Not yet required					

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Safe Staffing Report (Nurse)
Section on agenda:	Quality
Supplementary reading:	Workforce Strategy and Development Committee paper February 2018 and associated appendices
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Fiona Hoskins, Deputy Director of Nursing and Midwifery
Details of previous discussion and/or dissemination:	<p>The National Quality Board; Edition 1, January 2018 Safe, sustainable and productive staffing paper with associated appendices:</p> <ol style="list-style-type: none"> 1. NQB Action plan 2. January 2018 Safe Staffing Report <p>was discussed and noted at the Workforce Strategy and Development Committee on 19th February 2018. Following this meeting there are no additional issues to escalate to the Board.</p>
Action required:	Note for information
<p>Summary:</p> <p>Main paper:</p> <p>The focus of the February 2018 Safe Staffing Report was the National Quality Board (NQB), improvement resource; Safe, sustainable and productive staffing. This paper was published in January 2018 as part of a suite of speciality resources designed to underpin the NQB publication supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing (2016).</p> <p>The resource is focused specifically on nurse staffing in adult inpatient wards in acute hospitals and supports the National Institute for Health and Care Excellence (NICE) guidelines on safe staffing.</p> <p>The resource follows the 2016 Safe, sustainable and productive staffing principles of</p>	

Right Staff, Right Skills, Right Place, Right Time. The paper addresses each of the four areas, in turn; highlighting areas where the Trust is compliant with the recommendations and areas for improvement. Examples of good Trust performance include:

- Director of Nursing led programme of annual review for safe staffing prior to budget setting.
- Transparent Ward to Board governance process for safe staffing monitoring

Areas which are being further developed within the Trust include:

- Taking a wider view of access to expertise and the consideration of specialist, advanced and consultant nurses roles in the delivery of care.
- The development of new roles both nursing and Allied Healthcare (AHP) to ensure that appropriately skilled staff are available to deliver care.
- Capturing the impact of AHP roles within the workforce and how they positively impact on patient flow and the continuity of care.

The NQB paper sets out 10 key recommendations for Trusts to benchmark against, Work has already begun in reviewing the recommendations in preparation for a more detailed action plan, which will be presented at the Workforce Strategy and Development Committee.

Further detail is available in the supplementary reading pack:

Appendix one: Sets out the high level benchmarking action plan for completion by Care Groups in respect of the National Quality Board: Safe sustainable and productive staffing; an improvement resource for adult inpatient wards in acute hospitals.

Appendix two: A precis of the monthly return to Unify indicating 'planned' and 'actual' nurse staffing by ward in line with the Care Quality Commission and NHS England requirements for safe staffing. Of note for the Board within the Safe Staffing report:

- The January staffing return to Unify demonstrates that overall the Trust maintained a safe staffing position with no red flags during December
- A small percentage of high cost agency was utilised in December 2017 and this continues to be monitored through the Premium Cost Avoidance group.

There are two further requirements for reporting and assurance, which are well embedded into our practice.

- a) Requirement to publish information with the planned and actual nurse staffing for each shift; this is available and updated daily outside of each clinical area either electronically or in paper format.
- b) Requirement to provide a six monthly report on nurse staffing to the Board of Directors. Last published January 2018.

Related strategic objective:

Improving quality and reducing harm. Focusing

	on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	<input type="checkbox"/>
Impact on risk profile:	N/A



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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Quality Improvement Programme 2018/19
Section on agenda:	Quality
Supplementary reading:	None
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Deborah Matthews
Details of previous discussion and/or dissemination:	Board of Director meetings
Action required:	Review and comment
Summary: The RBCH Improvement Programme workbook summarises and evaluates the Improvement Programme objectives for 2017/18 and outlines our work plan for 2018/19.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	<input type="checkbox"/> ✓ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Impact on risk profile:	Improving risks relating to patient flow, 18 week RTT and urgent care



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

Improvement Programme

2018/19



Contents

	Page		Page
Overview	3 - 7	Programme Management	49 - 51
• Improvement programme blueprint	5	• governance	50
• CIP track record	7	• process for managing risks	51
Key Actions and Evaluation of 2017/18	8 - 21	Appendices	52 - 57
• the improvements we have made	9	1. RBCH QI model	53
QI Priorities	21-35	2. Risks	54
• Urgent and Emergency Care 'First 24 Hours'	24	CIP Reporting arrangements	55
• Surgical Flow	26	4. CIP Tracker extract	56
• Specialty Pathways	28	5. CIP QIA form	56
• Fundamentals of Care	32	6. Programme team structure	57
Productivity and Efficiency	36 - 44		
• 2018/19 high level CIP programme	37		
• Model Hospital	32		
• Quality Impact Assessment	37		
Building Capacity and supporting a Culture of Improvement	45 - 48		
• Improvement Academy	46		

Improvement Programme

Part A – Overview and Context


Part B – QI Priorities

Part C – Productivity and Efficiency

Part D – Building Capacity and supporting a Culture of Improvement

Part E – Programme Management

Appendices



Improvement programme blueprint
CIP track record
2017/18 delivery against target

Improvement Programme

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) Improvement Programme was launched in May 2014.

The programme objectives are designed to support the organisation's vision to *'To work in partnership and continually improve our services.'*

We will do this by:

- delivering transformational change and quality improvement projects, resulting in a safer and more caring hospital for patients
- revolutionising our culture towards continuous quality improvement
- creating an environment where all staff have a sense of shared ownership and responsibility and feel enabled to help make our hospital one of the best
- capitalising on the energy and enthusiasm of staff by taking the best ideas for improving the quality and safety of patient care – and encouraging uptake throughout the hospital
- achieving top decile performance in a number of key performance and quality measures
- engaging and empowering staff to deliver and sustain the required change in their workplace
- harnessing individual and collective talent and supporting clinical leaders at every level within the hospital
- providing improvement and change expertise - to give skill and enable learning - for as many staff as possible through direct involvement in projects and sharing of best practice
- achieving a consistent message that improving quality eliminates waste, reduces variation and improves efficiency. **All are of equal importance.**

More specifically, the blueprint emphasises the need to ensure the way money and quality are put together is essentially the same agenda. This will ensure we do not let debates run that crystallise as 'keep control of money OR improve quality'

RBCH Improvement Programme : Blueprint

Vision

To work in partnership and continually improve our services

1. Delivering transformational change and quality improvement projects, resulting in a safer and more caring hospital for patients
2. Revolutionising our culture towards continuous quality improvement
3. Creating an environment where all staff have a sense of shared ownership and responsibility and feel enabled to help make our hospital one of the best
4. Capitalising on the energy and enthusiasm of staff by taking the best ideas for improving the quality and safety of patient care – and encouraging uptake throughout the hospital
5. Engaging and empowering staff to deliver and sustain the required change in their workplace
6. Harnessing individual and collective talent and creating clinical leaders at every level within the hospital
7. Providing improvement and change expertise - to give skill and enable learning - for as many staff as possible through direct involvement in projects and sharing of best practice
8. Achieving a consistent message that improving quality eliminates waste, reduces variation and improves efficiency. **All are of equal importance.**

Outputs

Addresses the gap between the 'as is' organisation and the 'to be' organisation

Programme Office

Review of resources and governance arrangements to ensure it is fit for purpose. Governance and programme plan and monitoring progress against patient quality measures through programme board. Continuously check we are 'adding value' through lessons learnt. Strong communication strategy through the development of intranet site

Building Capacity and Capability

Support skills and expertise within the organisation. Develop and strengthen academy for continuous quality improvement and rolling programme of learning and development for staff, including junior doctors. Spot high potential and encourage mentoring and coaching to 'grow our own' leadership capability.

Delivering quality improvements for patients

Urgent and Emergency Care – First 24 hours
Surgical Flow
Supporting our Specialty Pathways
Fundamentals of Care

Supporting the required change in culture

Create a mind set for innovative change. Encouraging a climate of high expectations with staff looking for ways for service delivery to be even better. Ensure improvement projects set clear standards and hold others to account to reduce variations in the quality of care. Identify the right metrics and measure progress. Ensure real time patient feedback for experiential design of new pathways. Co-produce with patients and carers. Develop external relationships in primary / community care to signal change. Identify opportunities to reward high standards and celebrate success. Active member of Wessex PSC and support Wessex Deanery QI Fellows. Support annual Quality Conference

Productivity and efficiency

Implement tracking and reporting arrangements to secure delivery of 2018/19 CIP. Support early work up of 2018/19 initiatives to ensure implementation of savings start promptly. Use analytics/metrics to encourage further efficiency and productivity gains including Lord Carter programme. Support budget setting through development of capacity and demand/bed modelling tools. Develop and monitor implementation of improvement and CIP strategy to support delivery of financial plan

Outcomes

Better patient experience and feedback
Patients feel confident about our services. Patients feel more involved and know what is happening to them.

Better working environment for staff
Staff are less stressed and not under constant pressure. They are working within more ordered processes and protocols, with care based around internal professional standards and evidence based best practice. Staff feel central to everything we are going – empowered, with the right skills and competencies to do their job effectively. Staff are clear about their accountabilities and responsibilities and feel valued for the contributions they are making to the organisation.

Performance and outcome metrics are moving in the right direction. We are inquisitive and interested in what we can do better and are achieving upper quartile performance and benchmark well across a range of outcome measures. We are viewed as an acute hospital capable of delivering significant improvements.

Delivering a cost effective and value for money service. We are delivering the 2017/18 and 2018/19 efficiency and productivity plan. We are investing our resources wisely and in the most effective way.

Our health system is more integrated. We will be seen as a catalyst for change and act as a fully engaged participant in making the CSR, merger and Vanguard a success.

Staged Plan

The Dorset healthcare economy is in the process of being reshaped – with significant impacts on how our organisations will operate. We need to ensure that maintain focus on quality and safety for patients whilst delivering our productivity and efficiency agenda throughout this period of change.

2017/18 onwards

CSR, the proposed merger with Poole and One Acute Network will change the efficiency and improvement agenda across Dorset as we will fundamentally transform our models of care.

Whilst quality benefits and savings are likely to be substantial, these will be delivered in the longer term. Therefore we need to continue to identify opportunities for the short and medium term that provide quality and efficiency benefits and support these potential strategic changes in the future.

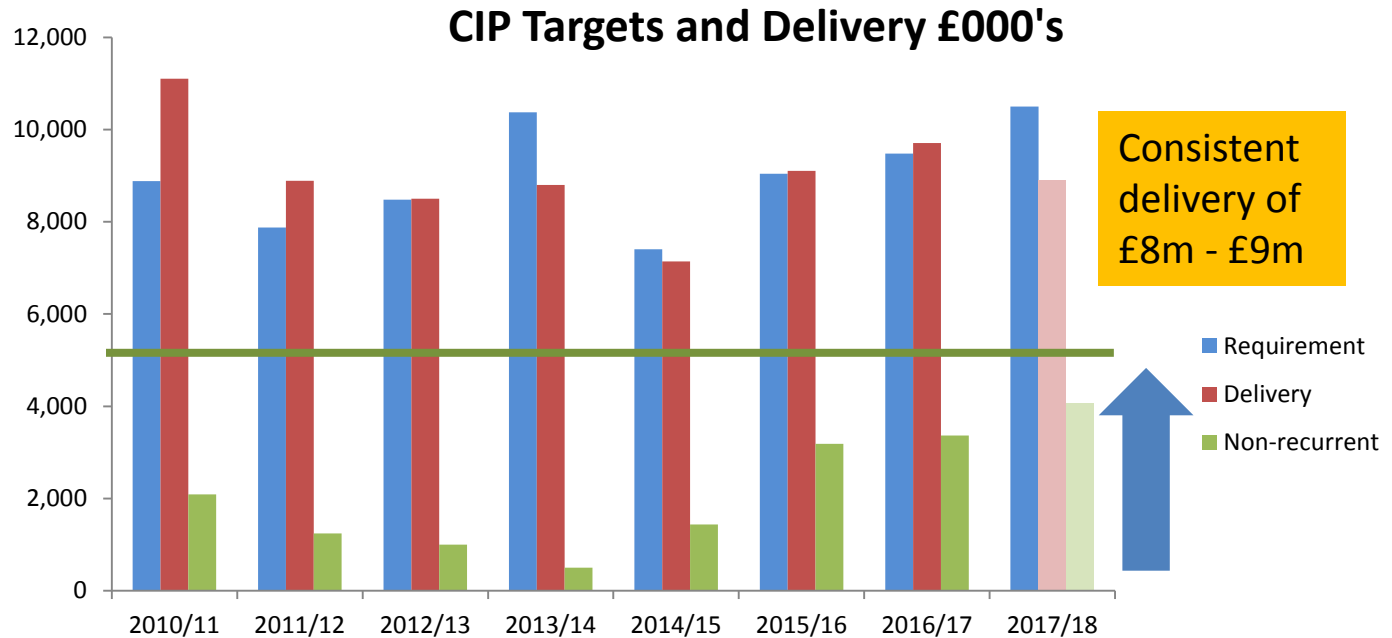


Process	Technology
New ways of working Required performance levels (dashboards and metrics) Patient pathways and protocols Operational costs	Equipment Accommodation IT systems and tools
Organisation	Information
Structure Roles Culture Staffing levels Skills requirements Training	Reports Data for future operation Performance measurement Analysis

In the last six years the Trust has consistently delivered savings in excess of £8m (with the exception of 2014/15 where the Trust focused on the delivery of efficiency savings to support increasing activity).

In 2017/18 we are currently forecasting a £1.6m deficit however we are still forecasting that we will better our control total.

Work has been on-going to maintain and support the efficiency of the hospital through the QI programme (see page X for further details). This has focused on length of stay reduction and admission avoidance through the expansion of our AEC provision.



Cost Improvement Plan 2017/18	FOT (as at Month 10)		
	Target	Actual	Variance
Surgical	(2,624)	1,511	(1,123)
Medical	(3,557)	1,943	(1,614)
Specialties	(2,673)	2,407	(222)
Corporate	(1,695)	3,000	1,353
	(10,548)	8,589	(1,605)

Improvement Programme

Part A – Overview

Part B – Key Actions and 2017/18 Evaluation

Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building Capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices



The improvements we have made

What are the improvements we have made?

The revised governance and controls for CIP have been in place for 30 months and were audited in 2015 with follow up in 2016 to review compliance. We have maintained a focused effort to ensure all staff within the organisation are fully engaged and understand the consequences of poor cost control and failure to deliver financial sustainability. Full details of 2017/18 QI programme deliverables and end of stage reports are available [here](#)

Risk	Description	Achieved	Further Action Required
Silo Planning	CIP should not be considered separately to cost pressures, income, expenditure and activity	Move to flat cash contract has meant capacity and demand work is now focused on developing future operational plans and options for identifying savings	QI projects to be developed with understanding of opportunities for improving efficiency
Inconsistent Communication	Message to staff must legislate against <i>'regardless of the financial pressures created, focus on quality and safety'</i>	Development of Finance and Performance Committee to ensure quality and finance considered jointly.	Development of intranet materials setting out CIP and QI links. Integration of QIA into main CIP document.
Lack of Accountability for actions not taken	Clarity of Executive accountability of CIP programme	Expanded reporting at Finance Committee and Improvement Board reviewing opportunities for change.	Development of additional reporting on procurement, model hospital etc. to identify opportunities not taken.
Poor time commitment	Time should be prioritised for escalation meetings to progress actions and unblock barriers for delivery	Reduction in focus as year has progressed and financial position stabilised.	Refresh of CIP delivery group governance and terms of reference
Programme not owned or understood across the organisation	Reporting of progress should be transparent throughout the organisation	Satisfactory and maintained as we approach potential for single merged organisation with PHT	Refresh of #NHSpound campaign

2017/18 Programme Evaluation

What are the improvements we have made?

Sustainability Score: 70.0

Full details of 2017/18 QI programme deliverables and end of stage reports are available [here](#)

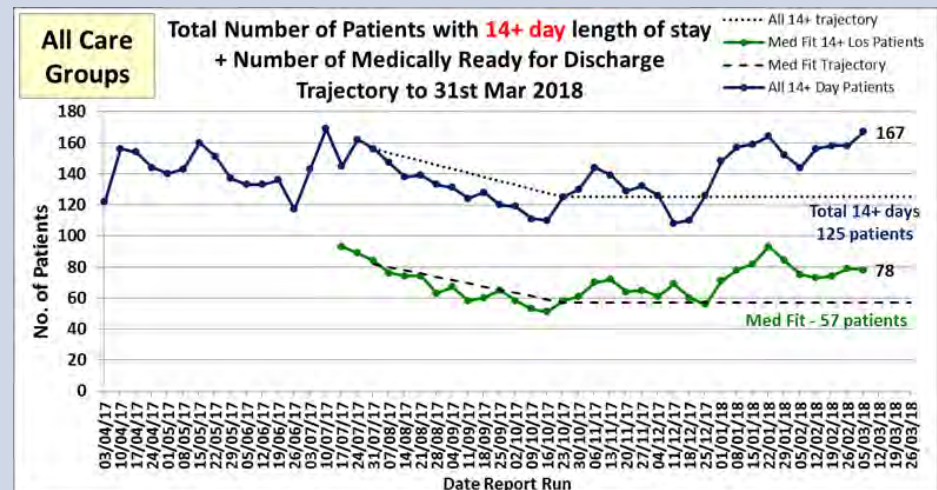
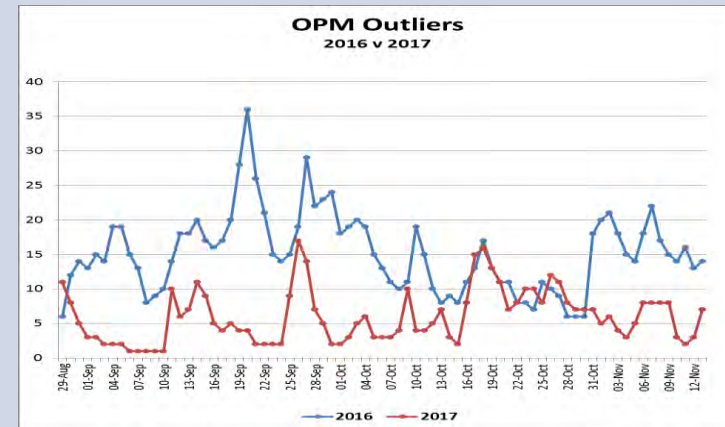
Workstream	Key Deliverables
<p>Hospital Flow</p> <p>Aim</p> <p>To improve hospital flow to deliver 'right patient, right time, right place' by March 2018 by:</p> <ul style="list-style-type: none"> reducing the average number of 14+ day length of stay patients to an average (mean) of 125 increasing the number of admission avoidance ambulatory care patients seen daily to a mean of 25 (Mon-Fri) <p>Context</p> <p>It's been a tough year BUT we have delivered further improvements for patients this year despite a continued rise in Emergency Department (ED) attendances (>3.5%) and non-elective admissions (>2.4%)</p> <p>Without this sustained level of improvement from 2015 we would have required an additional circa 70 beds</p>	<p>Total Weekly Ambulatory Care Activity Admission Avoidance</p> <p>Activity has grown from 119 in Jan-16 to 474 in Jan-18 An increase of 298%</p> <p>Feb-18 outturn predicted based on 282 admissions avoided by 19th Feb with addition of new OPM ED service</p> <p>All AEC Services Medicine, Surgery, Cardiology & OPM</p> <p>Baseline Mean = 14.9 Latest Mean = 27</p>

What are the improvements we have made?

Sustainability Score: 70.0

Full details of 2017/18 QI programme deliverables and end of stage reports are available [here](#)

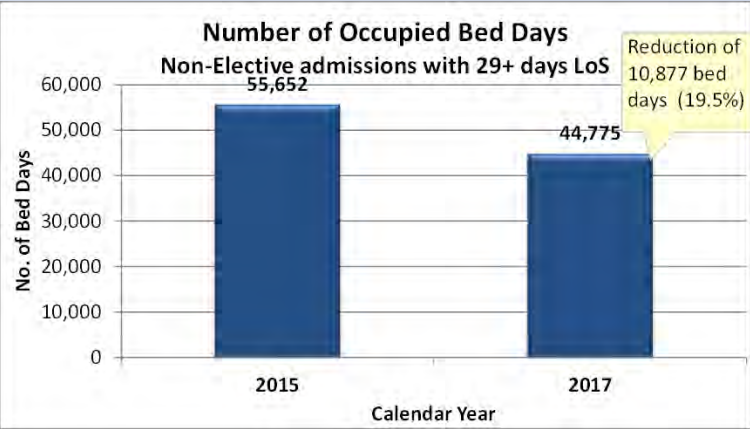
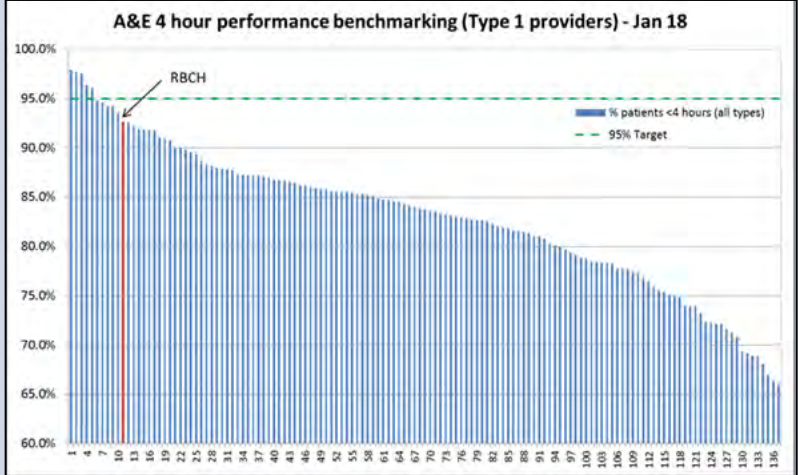
Workstream	Key Deliverables
Hospital Flow	<p>What have we achieved?</p> <ul style="list-style-type: none"> ambulatory care patients baseline mean has improved from 14.9 to 27 patients per day 15% reduction in outliers, with frailty pathway significantly reducing OPM outliers and occupied bed days for 14+ stranded patients a 14% reduction in length of stay for all patients (2015 – 2017) bed days for super stranded patients has fallen by 20% transparency of discharge status through improved IT and process (stranded patient review meetings, communication and training, eNA functionality to review MRFD / EDD) resulting in 95% of patients having an EDD



What are the improvements we have made?

Sustainability Score: 70.0

Full details of 2017/18 QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables															
Hospital Flow	<div>What have we achieved?</div> <ul style="list-style-type: none">new alcohol pathway (teaching for MDT and ward champions)effective hospital escalation procedures to minimise delays to ED patientsED waits consistently in top quartileour cumulative spend on agency (all staff) has reduced since last year and remains on track to be within the NHSI ceiling of £5.94M set for 2017/186 action learning weeks and MADE event to promote awareness of EDD / MRFD and support delivery of above	<div><div><div>Number of Occupied Bed Days</div><div>Non-Elective admissions with 29+ days LoS</div><table border="1"><thead><tr><th>Calendar Year</th><th>No. of Bed Days</th></tr></thead><tbody><tr><td>2015</td><td>55,652</td></tr><tr><td>2017</td><td>44,775</td></tr></tbody></table></div><div><div>A&E 4 hour performance benchmarking (Type 1 providers) - Jan 18</div><table border="1"><thead><tr><th>Provider Rank</th><th>% patients <4 hours (all types)</th></tr></thead><tbody><tr><td>1</td><td>~98.0%</td></tr><tr><td>10</td><td>~93.0% (RBCH)</td></tr><tr><td>136</td><td>~65.0%</td></tr></tbody></table></div></div>	Calendar Year	No. of Bed Days	2015	55,652	2017	44,775	Provider Rank	% patients <4 hours (all types)	1	~98.0%	10	~93.0% (RBCH)	136	~65.0%
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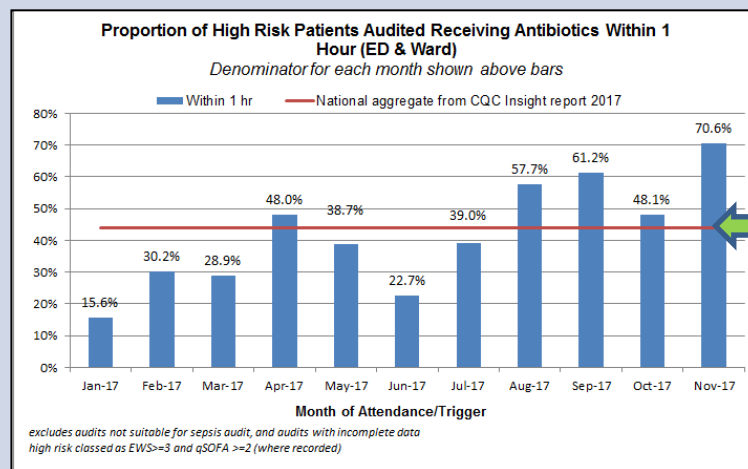
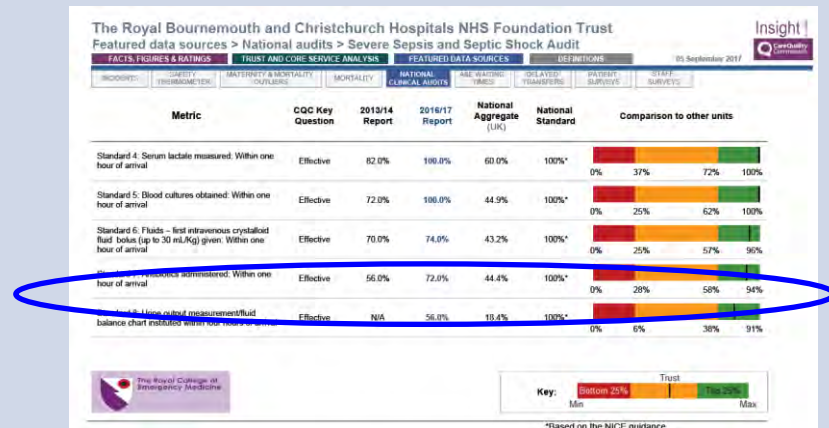
2017/18 Programme Evaluation

What are the improvements we have made?

Sustainability Score: 70.7

Full details of 2017/18 QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables
Sepsis	<p>Aim</p> <p>To treat all patients with a high risk of sepsis with a first dose of antibiotics within 1 hour of admission/diagnosis of sepsis and all other suspected septic patients within 3 hours by March 2018</p> <p>Context</p> <ul style="list-style-type: none"> we set ourselves an aspirational goal to tackle some 'wicked problems' the landscape is moving with no agreed definition for sepsis <p>What have we achieved?</p> <ul style="list-style-type: none"> SHIMI and HSMR continue to show our mortality rate is below expected how we respond to our sickest patients puts us in the top quartile nationally (CQC Insight Report Sepsis Audit : The Royal College of Emergency Medicine) our delivery of antibiotics to our sickest patients has improved to 72% against a national aggregate of 44%



National aggregate from CQC Insight 2017 report is 44%

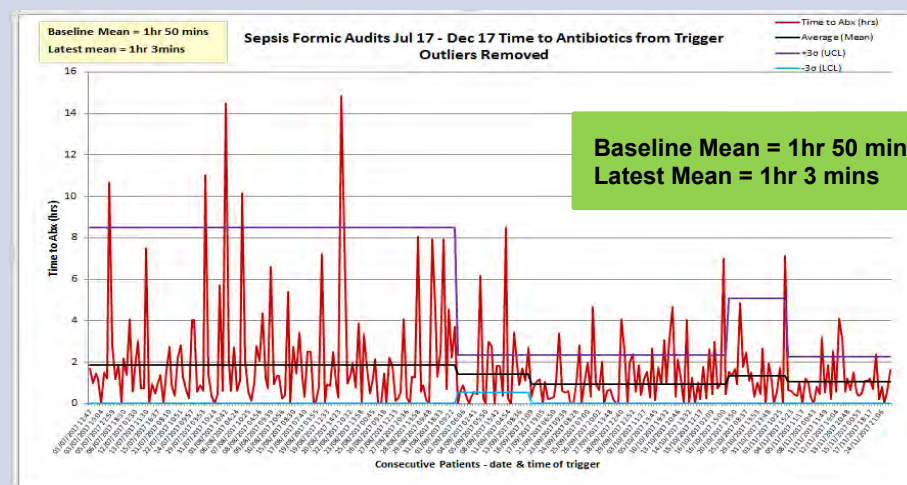
2017/18 Programme Evaluation

What are the improvements we have made?

Sustainability Score: 70.7

Full details of 2017/18 QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables
Sepsis	<p>What have we achieved?</p> <ul style="list-style-type: none"> an online and face to face education package for all frontline staff to aid recognition and treatment of patients with sepsis has been developed. This will be mandatory from 2018 /19 we have developed an eNA sepsis APP to support recognition and treatment



2017/18 Programme Evaluation

What are the improvements we have made?

Sustainability Score: 70.7

Full details of 2017/18 QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables																												
Patient Deterioration	<p>Aim</p> <p>To ensure that every 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</p> <p>Context</p> <ul style="list-style-type: none"> we set ourselves an aspirational goal to tackle some 'wicked problems' <p>What have we achieved?</p> <ul style="list-style-type: none"> our data collection is exemplar and has resulted in 1800 patients audited overall (380 patients by CCOT) encouraging measurement as part of routine work One of the first Trusts to audit deteriorating patients against their escalation policy 	<p>% of patients reviewed within 30 minutes for an EWS ≥ 9 against the number of EWS ≥ 9 calls</p> <table border="1"> <thead> <tr> <th>Month</th> <th>% Reviewed within 30 mins</th> <th>No. of EWS ≥ 9 calls</th> </tr> </thead> <tbody> <tr> <td>Jun-17</td> <td>50%</td> <td>~120</td> </tr> <tr> <td>Jul-17</td> <td>62%</td> <td>~110</td> </tr> <tr> <td>Aug-17</td> <td>59%</td> <td>~140</td> </tr> <tr> <td>Sep-17</td> <td>65%</td> <td>~150</td> </tr> <tr> <td>Oct-17</td> <td>57%</td> <td>~140</td> </tr> <tr> <td>Nov-17</td> <td>54%</td> <td>~150</td> </tr> <tr> <td>Dec-17</td> <td>42%</td> <td>~210</td> </tr> <tr> <td>Jan-18</td> <td>31%</td> <td>~180</td> </tr> </tbody> </table> <ul style="list-style-type: none"> The reasons for not achieving our aim of a 30 minute review is multifactorial. One reason is that many patient reviews are written retrospectively therefore the time recorded in the medical notes does always reflect the actual time of review. It was therefore decided to look at the number of patients reviewed within 60 minutes (shown on next graph). Summer months Jul-Aug show improvement in the percentage of patients reviewed but with increased acuity over the winter months the percentage decreases. This reflects a seasonal trend. <p>No change from baseline with an average of 53% of patients reviewed within 30 mins</p>	Month	% Reviewed within 30 mins	No. of EWS ≥ 9 calls	Jun-17	50%	~120	Jul-17	62%	~110	Aug-17	59%	~140	Sep-17	65%	~150	Oct-17	57%	~140	Nov-17	54%	~150	Dec-17	42%	~210	Jan-18	31%	~180
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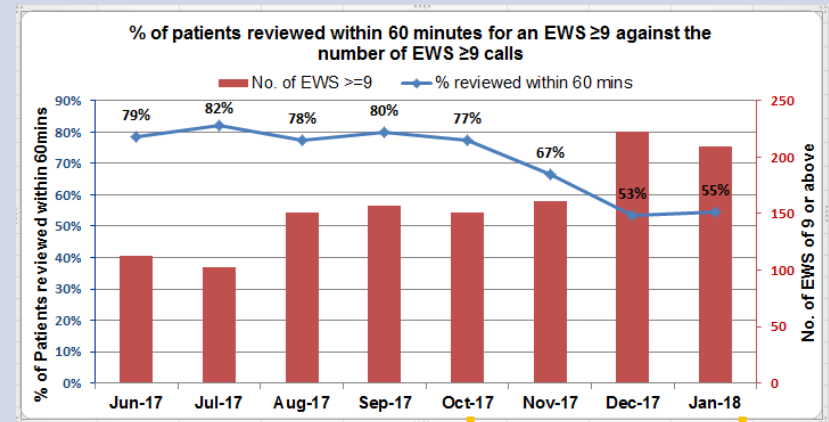
What are the improvements we have made?

Full details of 2017/18 QI programme deliverables and end of stage reports are available [here](#)

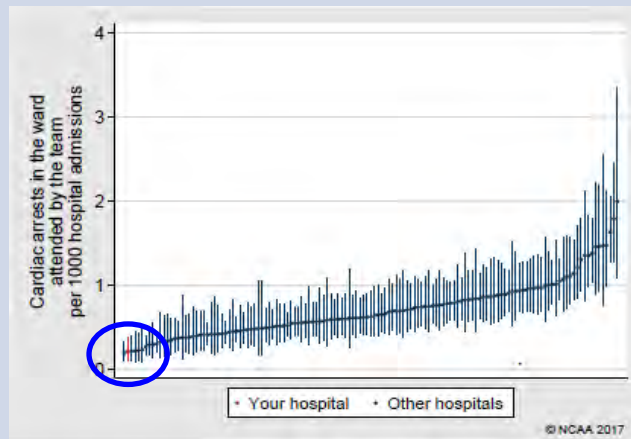
Sustainability Score: 70.7

Workstream	Key Deliverables
Patient Deterioration	<p>What have we achieved?</p> <ul style="list-style-type: none"> developed a Critical Notification Dashboard (CND) to be trialled March 2018. this will support quicker identification via EWS trends at a glance on wards development of education and training package for all staff – mandatory from 2018 delivered teaching to junior doctors and ward staff In the 2017 National Cardiac Arrest report RBCH has lowest number of incidences of cardiac arrest for our in-patients development of EWS trigger tools to help identify septic and deteriorating patients, plus easy to use audit forms Active member of Wessex Collaborative

68.3% of patients reviewed within 60 minutes



Seasonal trend in elevated number of high EWS calls



National Cardiac Arrest audit report for 2017 places the Trust with one of the lowest incidences of inpatient cardiac arrest calls

What are the improvements we have made?

Workflow	Key Deliverables																																																																																																												
<div>Developing a continuous improvement culture</div> <ul style="list-style-type: none">Improvement Academy: 300 staff trained on QI methodology – course popular and continues to received very positive feedbackadditional modules in <i>Measurement for Improvement</i> and <i>Introduction to Project Management</i>local improvement projects now supported via central QI coaching and support2nd Junior Doctor QI programme3 successful QI and safety conferences - 2017/18 here (50 posters submitted)Wessex Fellowships for QI (Team Based)HSJ Award Shortlist – Surgical Productivity and BMJ Awards – Acute Pain Team	<div><p>Attendees Modules held in 2017 8 being highest/ good knowledge (mode)</p><table><thead><tr><th rowspan="2">Skill, Mix, Tool/Technique</th><th colspan="8">Self assessed knowledge</th></tr><tr><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th></tr></thead><tbody><tr><td>Systems including complexity and types of systems</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Profound Knowledge</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Quality Improvement</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>RBCH Quality Improvement model</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Tools and techniques for Quality Improvement</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Measurement for Improvement</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>PDSA cycle</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Sustain and spread</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Psychology of improvement</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Variation</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table><div><div>key</div><div>before training</div><div>after training</div></div></div> <div>Significant improvement in self assessed knowledge and awareness scores post training</div>	Skill, Mix, Tool/Technique	Self assessed knowledge								1	2	3	4	5	6	7	8	Systems including complexity and types of systems									Profound Knowledge									Quality Improvement									RBCH Quality Improvement model									Tools and techniques for Quality Improvement									Measurement for Improvement									PDSA cycle									Sustain and spread									Psychology of improvement									Variation									<div><p>Very inspirational and thought provoking overall, particularly the tools for improvement! Consultant</p><p>An excellent 2 days Ward Sister</p><p>I really like the interactive sessions enabling learning in practice Nurse Specialist</p><p>It was a really good way to learn about QI, I really enjoyed it Clinical Audit</p><p>Excellent refresh on theory and engaging practical tasks Directorate Manager</p><p>This course helped me demystify a difficult hypothetical area! Staff Nurse</p><p>Pitched perfectly, good mix of theory and practical interactive sessions to embed learning Nurse Specialist</p><p>Really good pace and lots of really relevant examples Speciality Manager</p></div>
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2017/18 Programme Evaluation

What are the improvements we have made?

Workstream	Key Deliverables																																																																		
Cost Improvement Programme	<ul style="list-style-type: none">• QI supporting delivery of cost savings programme• forecast savings £8.8m (as at Month 11)• shortfall against target £1.65m• non-recurrent £4.0m leading to pressure into next year• interrogation and analysis of model hospital to identify potential areas for change• PCI sustainability project initiated focusing on consultant cost variation; initial indications of a reduction in cost are positive although a longer period of time is required to confirm that this is an embedded change in behaviour	<table><caption>Estimated Data from Chart</caption><thead><tr><th>Month</th><th>In Month Target (Left Axis)</th><th>In Month Actual (Left Axis)</th><th>Yearly Target (Right Axis)</th><th>Actual YTD (Right Axis)</th></tr></thead><tbody><tr><td>April</td><td>850</td><td>620</td><td>1,000</td><td>1,000</td></tr><tr><td>May</td><td>950</td><td>720</td><td>1,100</td><td>1,500</td></tr><tr><td>June</td><td>920</td><td>520</td><td>1,200</td><td>2,000</td></tr><tr><td>July</td><td>880</td><td>650</td><td>1,300</td><td>2,500</td></tr><tr><td>August</td><td>800</td><td>700</td><td>1,400</td><td>3,000</td></tr><tr><td>September</td><td>850</td><td>750</td><td>1,500</td><td>3,500</td></tr><tr><td>October</td><td>800</td><td>850</td><td>1,600</td><td>4,000</td></tr><tr><td>November</td><td>820</td><td>700</td><td>1,700</td><td>4,500</td></tr><tr><td>December</td><td>880</td><td>720</td><td>1,800</td><td>5,000</td></tr><tr><td>January</td><td>880</td><td>480</td><td>1,900</td><td>5,500</td></tr><tr><td>February</td><td>900</td><td>620</td><td>2,000</td><td>6,000</td></tr><tr><td>March</td><td>1,000</td><td>900</td><td>2,100</td><td>6,500</td></tr></tbody></table>	Month	In Month Target (Left Axis)	In Month Actual (Left Axis)	Yearly Target (Right Axis)	Actual YTD (Right Axis)	April	850	620	1,000	1,000	May	950	720	1,100	1,500	June	920	520	1,200	2,000	July	880	650	1,300	2,500	August	800	700	1,400	3,000	September	850	750	1,500	3,500	October	800	850	1,600	4,000	November	820	700	1,700	4,500	December	880	720	1,800	5,000	January	880	480	1,900	5,500	February	900	620	2,000	6,000	March	1,000	900	2,100	6,500
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August	800	700	1,400	3,000																																																															
September	850	750	1,500	3,500																																																															
October	800	850	1,600	4,000																																																															
November	820	700	1,700	4,500																																																															
December	880	720	1,800	5,000																																																															
January	880	480	1,900	5,500																																																															
February	900	620	2,000	6,000																																																															
March	1,000	900	2,100	6,500																																																															

Key Actions and 2017/18 Evaluation

Evolution of the programme: Lessons Learnt?

Learning Point	Description	Next Steps / Action Required
Methodology and Approach	Risk of being pulled into solutions rather than applying the method of improvement science.	Focused area for 2018/19 workbooks and ongoing practice within teams.
	Identifying aspirational goals can be motivating but sometimes unachievable.	Focus more on how we set our aims.
Information and Data	Data collection remains challenging.	Ensure sufficient baseline data at the outset of the project. Develop a coherent 'measurement for improvement' plan with our Information Team and ensure consistency.
Support for Change	Change is difficult! Ongoing communication in teams is vital to ensure staff are appropriately supported. There are sometimes unreasonable expectations for rapid improvement.	Team health checks to be included as part of QI projects. Additional learning modules (psychology of improvement) also planned to support change. Work with OD and Aston Team Coaching. Managing expectations of what can be achieved. use of prioritisation matrix – ease / benefit within projects
Sustainability	Further embedding of improvements into 'business as usual' still required despite use of NHS Sustainability Model. Embedding new processes takes longer than one might expect.	Plan for ensuring reportable measures are included within standard work and performance management within directorates.
	Some evidence of sustainability gaps e.g. clinical leadership and support to ensure ownership remains. Staff can find it difficult to release time to get involved in QI projects.	Review clinical engagement approach for QI, specifically PA time allocation as part of job planning process. Appropriate escalation if membership / attendance is problematic. More focus on roles and responsibilities when QI team is formed
	Training of staff in new processes / SOP is also key to ensure change is successful. This often lagged behind implementation.	Bespoke and mandatory training packages should be developed as part of the scope of improvement work.
Patient Engagement	Further work still required to ensure more active use of patient stories, focus groups, and patient surveys to encourage patient voice in improvement ideas.	Develop a standard approach for patient co-production in QI projects with patient engagement team. Skill up IPT in experience based design.

Key Actions and 2017/18 Evaluation

Evolution of the programme: Lessons Learnt?

Learning Point	Description	Next Steps / Action Required
Integration	To maximise impact and delivery of national strategy <i>'Developing People – Improving Care'</i> .	Continued work to embed leadership for improvement. Closer working with clinical audit to maximise impact of roles / responsibilities.
Communication	Developing our internal and external profile to support and encourage generation of ideas and external profile. Feedback from 2017/18 QI conference suggests still gaps in inclusion for some staff groups keen to get involved in QI	Simple messaging remains a focused area for 2018/19. More effective use of social media RBCHQI and re-launch of intranet site  More systematic approaches to ensure QI communication is effective across the Trust. Experimentation with QI Newsletter. Stronger links with D&I work programme.
Building Capacity and Capability	Training and development effective but staff need to practice to maintain skills and embed. Increase in training cancellations due to operational pressures.	Encourage as part of talent management approach and appraisal. Experimentation – lunchtime masterclasses and webcasts.
IT	Some delays within IT due to competing priorities.	More focus on pipeline and ongoing assessment during 5Ps and ideas generation stage in order to support IT Development Team planning.
Action Learning Weeks	An active ingredient to support continuous improvement culture during 2017/18.	Consider evolution into rapid improvement events (RIE) for local improvement hubs.
Governance	A slight tendency to lean towards more central governance and control in 2018/19 due to 3 priority approach.	Ensure right balance between governance and assurance v agility and maintaining strong challenge within 2018/19 programme.

Improvement Programme

Part A – Overview

Part B – Key Actions and 2017/18 Evaluation


Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices



Urgent and Emergency Care: 1st 24 Hours
Surgical Flow
Supporting our Specialty Pathways
Fundamentals of Care

Overview

The Trust has confirmed four domains for quality improvement (QI) to be prioritised in 2018/19. The resulting workstreams will cover a range of projects facilitated directly and indirectly by the Improvement Programme Team (IPT):

- **Urgent and Emergency Care : ‘First 24 Hours’**
- **Surgical Flow**
- **Supporting our Specialty Pathways**
- **Fundamentals of Care**

Following wide ranging organisational support, and to support our front line teams and embedding of existing improvements the IPT will continue with a series of Action Learning Weeks (ALW) across the organisation.

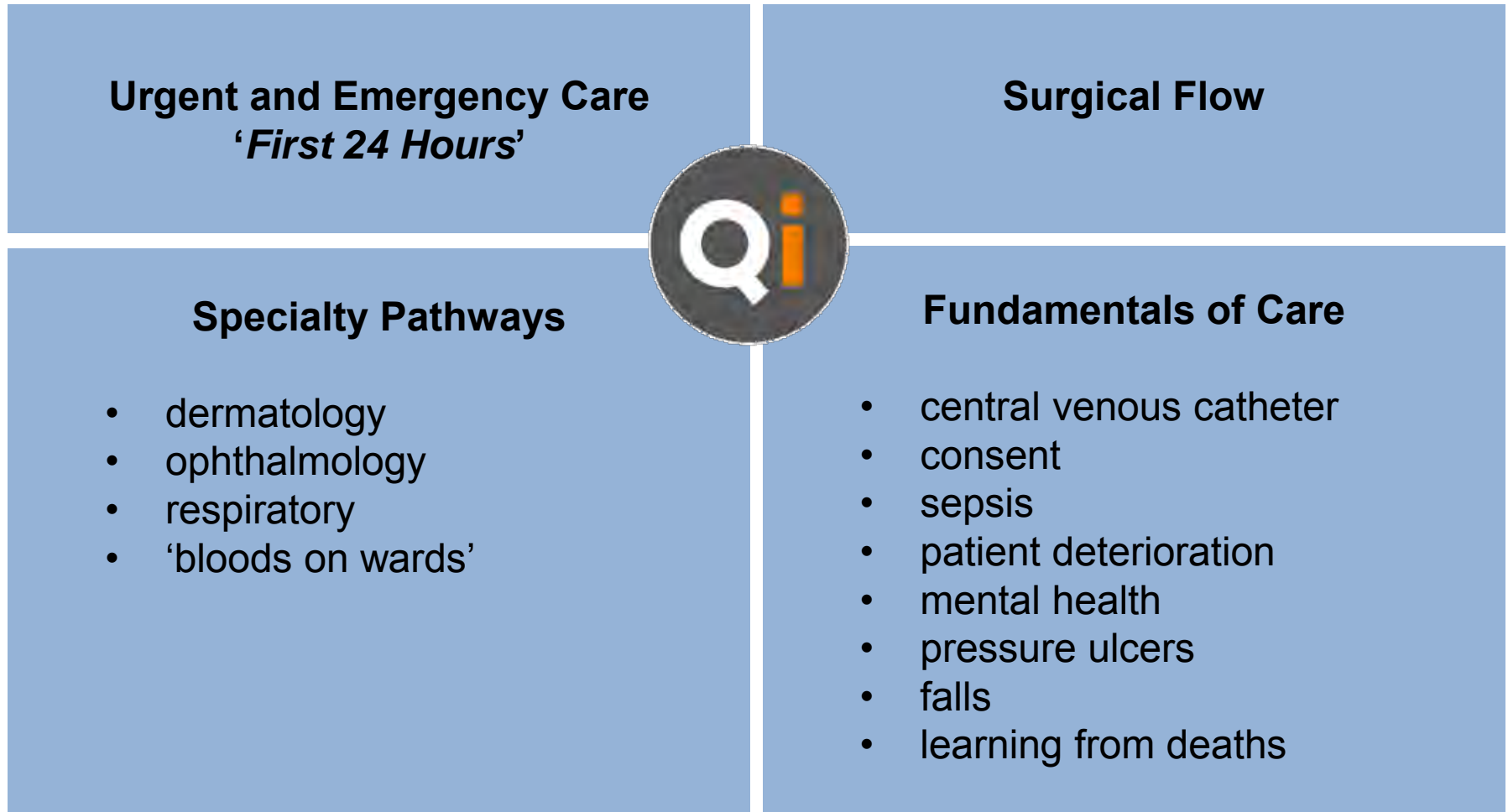
All projects follow the agreed Trust Improvement methodology (see Appendix 1) by setting clear aims and objectives for the project and using measurement for improvement tools to identify the impact of changes made.

All projects will require clear clinical and operational leadership to ensure that improvements are sustainable. The NHS Sustainability Model together with clear benefits realisation will be key tools during 2018/19.

As new and / or local projects are identified they will be scoped to determine their scale and resource requirements before being added into the work programme. These will be agreed directly with speciality and departmental leads

The Improvement Programme team (IPT) will provide QI coaching and rapid improvement events (30-60-90 days) to ensure support remains agile and adds value to our clinical micro-systems and improvement hubs .

Staff are encouraged to contact the team to explore how best to implement their improvement ideas.



Our programme of work this year will be split into four key workstreams. Each area will consist of a range of QI projects managed and supported according to their size, complexity and operational capacity. This will support a culture of continuous improvement and help **spread and sustain improvement capability as part of standard work in our wards and departments**

Urgent and Emergency Care 'First 24 Hours'

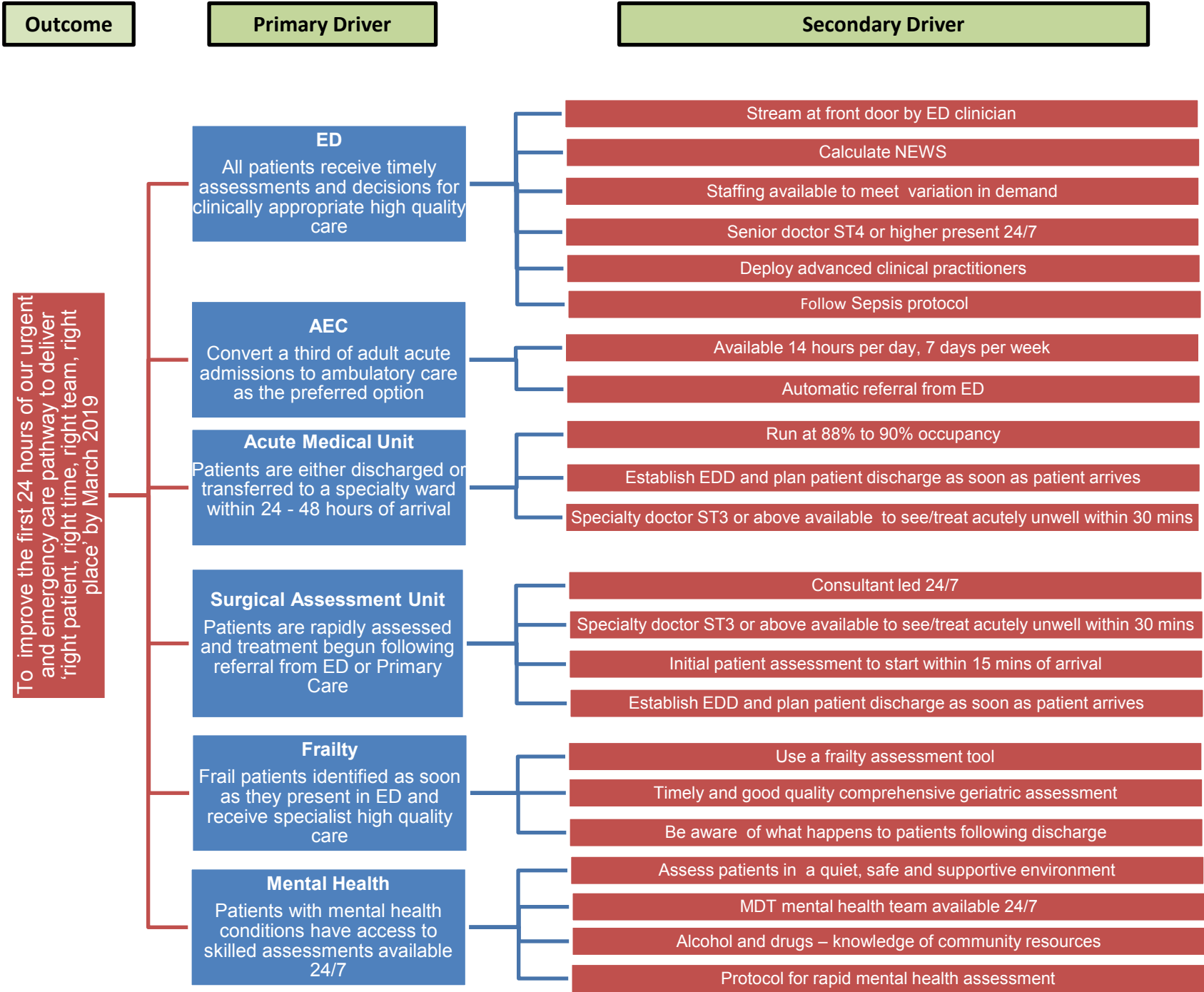
Aim: To improve the first 24 hours of our urgent and emergency care pathway to deliver 'right patient, right time, right team, right place' by March 2019

We will do this by ensuring:

- all patients receive timely assessments and decisions for clinically appropriate high quality care
- we convert a third of adult acute admissions to ambulatory care as the preferred option by March 2019
- patients are either discharged or transferred to a specialty ward within 24 - 48 hours of arrival by January 2019
- we improve our 7 day standards including for admitted patients having a consultant review in no more than 14 hours
- patients are rapidly assessed and treatment begun following referral from ED or primary care by March 2019
- frail patients are identified as soon as possible as they present in ED and receive specialist high quality care by June 2019
- patients with mental health conditions have access to skilled assessments available 24/7 by June 2019
- we deliver the 4 hour performance trajectory and 95% ED standard by March 2019

This project is the continuation of the successful programme of work within Hospital Flow over recent years and our work further downstream to support EDD, MRFD to facilitate patient discharges, reduce stranded patients and increase ambulatory emergency care (AEC).

Exec Sponsor: Alyson O'Donnell (Medical Director)



Improvement Programme

Surgical Flow

Aim: To improve flow through our operating theatres and intensive care beds, to achieve 85% utilisation (with a stretch target of 90%) for theatres. To also reduce time delays out of ITU by 20% by March 2019.

In line with Model Hospital metrics, our own strategy, and to complement the First 24 hours project. We want to ensure that our theatres and intensive care unit are used efficiently whilst caring for staff and that emergency surgery in particular meets the full spirit of WHO safety and quality standards.

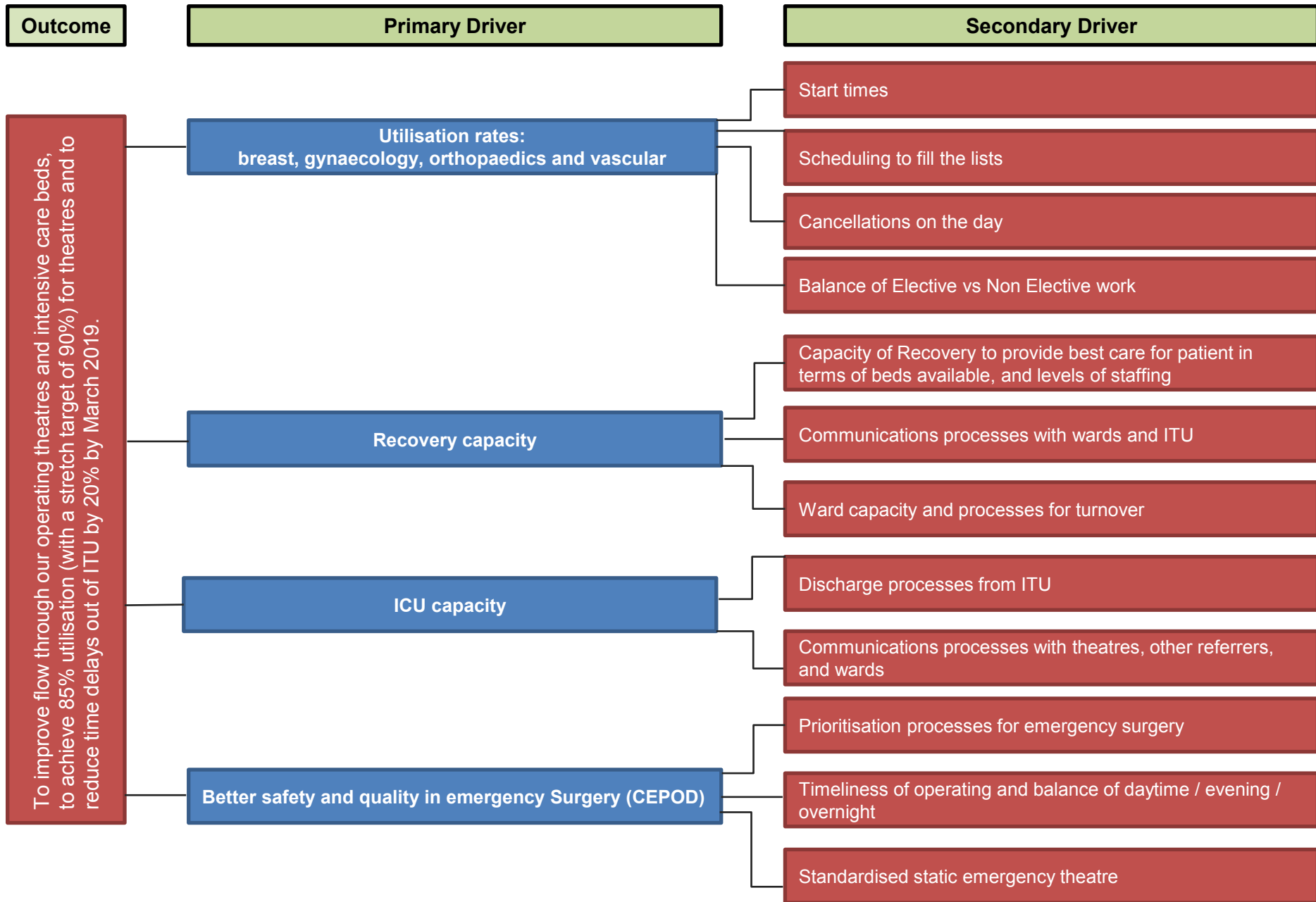
Projects to address theatres, ITU and recovery will be overseen by a Surgical Flow QI Team chaired by the Head of Nursing and reporting into the Improvement Programme Board.

We will do this by:

- improving theatre scheduling and start times in breast, gynaecology, vascular and orthopaedics
- reducing on the day cancellations
- redesigning ward processes to increase capacity in recovery areas and ensure it is right for flow through recovery enabling patients to move on in a timely manner
- redesigning ward processes to improve ITU capacity and discharge arrangements so that ITU is best used for the sickest patients and patients move off ITU quicker
- redesigning our daily prioritisation and planning processes in emergency surgery to further improving the quality and safety of the WHO checklist

This project is a continuation and expansion of work which has been ongoing for several years around theatres and which has attracted national recognition, including a Silver Award for Workforce Planning at the *Our Health Heroes Awards 2017*, and being shortlisted for the *2018 HSJ Value Awards* in the workforce efficiency category and the *BMJ Awards 2018* in the Managing complex surgical pain category.

Exec Sponsors: Deborah Matthews (Director of Improvement and Inclusion) and Neil Cowan (Director of Operations)



Improvement Programme

Supporting our Specialty Pathways Ophthalmology

Aim: To improve patient safety and experience by reducing RTT waiting times in ophthalmology to a maximum of 18 weeks and follow up rates, including improving efficiency in eye theatres by March 2019

To ensure that patients can access eye care in a timely way whether this is elective or non-elective in order to meet national waiting time targets. This will involve eye theatres and outpatient clinics, with particular focus on the Acute Referral Clinic (ARC).

We will ensure:

- staff are aligned to the new standard day and to the theatre template
- procedures are scheduled and cancellations minimised to reduce variation between sessions
- processes are streamlined and standardised for ARC referral and follow up
- staff are developed and rotated in ARC and outpatient clinics
- capacity is adapted to match demand in the most economical and safe manner

This continues some scoping work around eye theatres which was conducted in 2017-18, and rolling forward the clinically-led project working on ARC processes. It also involves new improvement work for this year.

See Appendix X for detailed work-stream governance structure.

Exec Sponsor: Cath Marsh (Medical Lead)

Supporting our Specialty Pathways Dermatology

Aim: To ensure implementation of recommendations outlined in the external cultural review and British Association of Dermatology review in accordance with agreed timelines by March 2019

This will include:

- redesign of booking process
- improved staff training
- improved patient information
- introduction of electronic systems
- all surgical forms in dermatology are completed accurately by August 2018 and zero avoidable hospital reason cancellations by October 2018

Exec Sponsor: Alyson O'Donnell (Medical Director)

Outcome

Primary Driver

Secondary Driver

All surgical forms completed accurately by August 2018 and zero avoidable hospital reason cancellations by October 2018

Adopt electronic systems

Improve patient information

Provide staff training

Improve booking process

- Electronic diary to support surgical bookings – get rid of paper diary
- Review IT systems - potentially use HICCs
- Use e-Roster
- Improve patient forms
- Improve patient information post procedure – continuity in community
- Update appointment letters to include medication lists
- Outpatient department to include INR message I appointment letter
- Update patient letters and information with correct telephone numbers
- Create patient information page on Internet
- Guidelines for anti-coag surgery
- Improve consistency of booking ABPI for leg surgery
- Record information to patients on telephone helpline
- Create training video for WHO checklist
- Improve use of surgical booking forms
- Update competencies matrix
- Update surgical timings
- Provide timely access to all necessary patient information e.g. medications list
- Extend lead times for off-duty rosters
- Review staff capacity for surgery clinics
- Reduce number of steps in booking process

Supporting our Specialty Pathways

Tests on Wards

Aim: To ensure that there are no unnecessary diagnostics and / or nursing observations for patients who are medically ready for discharge by March 2019

Problem Statement

- blood results frequently arrive too late in the day to support discharge before lunchtime
- some evidence to suggest patients might be bled too often (i.e. routine bloods on MRFD patients) leading to inefficiencies and poor patient experience
- phlebotomists feel 'invisible' and undervalued on the wards, therefore are not empowered to make improvements

In Scope

- ward based phlebotomy services

Out of Scope

- outpatient and community phlebotomy

Exec Sponsor: To be confirmed

Fundamentals of Care

PICC Lines

Aim: To improve the coordination of Peripherally Inserted Central Catheter (PICC) lines, confirming status of every patient with a PICC line inserted by RBCH and ensuring compliance with the CVAD care bundle by March 2019

In line with risks identified at QARC and national best practice from Royal Marsden; to ensure we are meeting our own specified practice as set out in our SOPs; and to improve patient experience. We plan to reinstate the line working group which will report jointly to QARC and Improvement Board.

Currently identified projects:

- referral process, looking at the insertion process and reducing the number of inappropriate referrals
- education and training, looking at improving the compliance with our SOPs
- cross-site working and community, looking at patients who come from other hospitals or are discharged back into the community, and ensuring these patients have good continuity of care

Exec Sponsor: Paula Shobbrook (Director of Nursing and Midwifery / Deputy CEO)

Purpose

Primary Driver

Secondary Driver

To improve the coordination of Peripherally Inserted Central Catheter (PICC) lines, confirming status of every patient with a PICC line inserted by RBCH and ensuring compliance with the CVAD care bundle by March 2019

Referral Process

Reducing the numbers of inappropriate referrals for PICC lines by improving doctor education

Reducing the number of incomplete referrals by developing electronic form for PICC insertion with compulsory fields

Improving data capture on database to include patient location, duration of line, date of removal and reason for removal

Education and Training

Number of nursing staff who have current competencies within the Trust

Updating CVADs SOPs and policies on intranet

Repeat audit on CVADs care bundle for nursing interventions on the ward with focus on PICC lines

Cross site working and community

Develop and implement a referral process for both cross site working and community discharged

To monitor the number of PICC line infections developed within the community setting

All patients discharged with CVADs to be given appropriate booklet

Improvement Programme

Fundamentals of Care Patient Escalation

Aim: To continually improve the safety and timeliness of treatment and reduce avoidable patient deterioration on our wards

We will do this by:

- ensuring that every 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 March 2019

This workstream will remain a cross hospital QI priority in 2018/19 focussing on:

- embedding reportable measures for avoidable patient deterioration and timeliness of treatment within standard work
- support to QI Urgent and Emergency Care 'First 24 Hours'
- monitoring the impact of our new mandatory training and education package on patient outcomes
- notekeeping and documentation
- accurate recording of 'time of arrival' for senior review
- consider seasonal job plans

Exec Sponsor: Peter Gill (Informatics Director)

Improvement Programme

Fundamentals of Care Sepsis

Aim: To further improve the identification and management of sepsis in our emergency and admitting areas by March 2019

We will do this by:

- treating all patients with a high risk of sepsis with a first dose of antibiotics within 1 hour of admission/diagnosis of sepsis and all other suspected septic patients within 3 hours by March 2019

This workstream will remain a cross hospital QI priority in 2018/19 focussing on:

- embedding reportable measures for sepsis identification and management within standard work
- support to QI Urgent and Emergency Care 'First 24 Hours'
- monitoring the impact of our new mandatory training and education package on patient outcomes
- notekeeping and documentation
- review timings to ensure we are accurately reflecting time of arrival and ABX administered (not when clinician writes up the notes)
- consider seasonal job plans

Exec Sponsor: Peter Gill (Informatics Director)

Improvement Programme

Part A – Overview

Part B – Key Actions and 2016/17 Evaluation


Part C – QI Priorities

Part D – Productivity and Efficiency

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Part F – Programme Management

Appendices



- 2018/19 high level CIP programme
- Model Hospital
- CIP risk assessment
- Key milestones
- Quality Impact Assessment

2018/19 High Level Programme

The IPT has been supporting the development of a 2018/19 CIP programme. As at end February 2018 CIP plans for 2018/19 are well developed with c £9.8m being identified however additional savings are required to meet our expected target of c. £11.4m. To ensure there is a clear line of sight from the Board down through the organisation for accountability, each of the care groups and corporate directorates hold the responsibility for their contribution to financial control and are held accountable for achieving the plan.

	Total	Forecast	Variance	Downside forecast	Difference down-side to expected
Surgical Care Group	(2,829,460)	2,398,860	(430,600)	2,110,539	(288,321)
Medical Care Group	(2,861,516)	1,971,698	(889,818)	1,953,698	(18,000)
Specialties Care Group	(2,070,550)	542,600	(1,527,950)	471,600	(71,000)
Corporate	(1,068,340)	778,160	(290,180)	507,160	(271,000)
Total	(8,829,866)	5,691,318	(3,138,548)	5,042,997	(648,321)
Organisation-wide	(2,600,000)	4,122,000	(1,078,000)	4,122,000	-
Total	(11,429,866)	9,813,318	(1,616,548)	9,164,997	(2,264,869)

Risk rating our schemes provides a downside forecast of £9.1m. We therefore remain short of our target, however the plans we have in place are robust

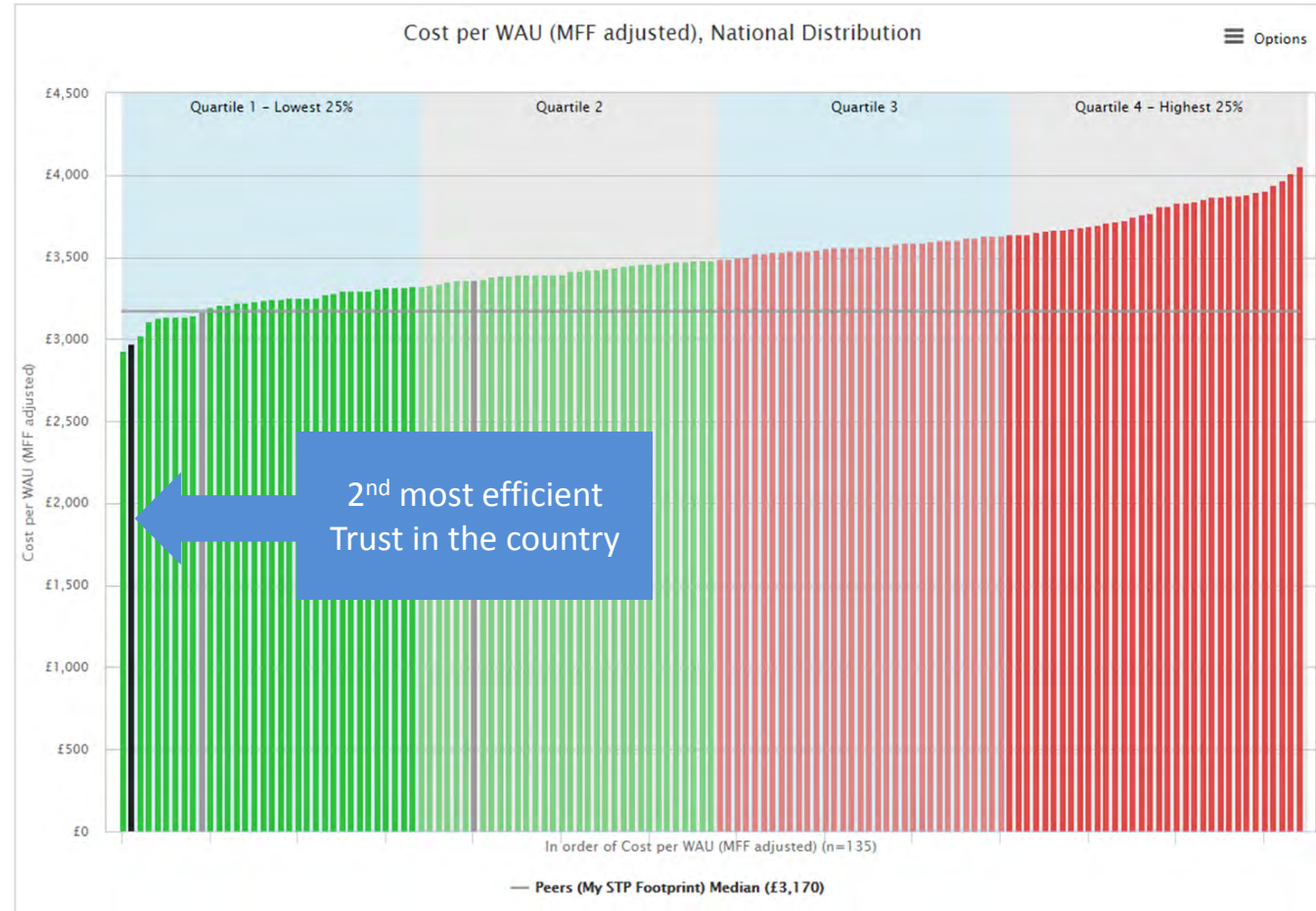
Productivity and Efficiency: Model Hospital

The model hospital provides us with a significant range of performance and contextual metrics setting out how our productivity and quality of care compares to other organisations.

Notwithstanding our excellent performance in 2016/17 (showcased left), we believe that this tool will help us identify opportunities to improve.

We will review updates as they are published and report (by exception) on areas of good/poor performance to both senior and operational leaders as relevant.

Reports are regularly timetabled at TSGs where opportunities can be identified (e.g. Premium Cost Avoidance).



Productivity and Efficiency

Case Example: PCI Sustainability

As part of the work on the PCI tender process data analysing consultant consumable usage and spend it has been identified that the consultant body has a considerable variation within individual practice and spend despite consistent clinical outcomes. So far we have developed:

- a detailed data review and dashboard to support Directorate understanding of the analysis
- Consultant review of pathways
- identification of smaller projects to support cost reduction
- increased consultant engagement and understanding of cost per case leading to changed behaviours (awaiting confirmation that this is sustained)

In 2018/19 we will:

- ensure regular operational reviews of spend to confirm changes are being implemented
- Carry out an executive 'confirm and challenge' session to review revised spend profile
- expand process and learning for EP

Clinical Specialty	2016/17	2015/16	Trend
Emergency Medicine	£2,701	£3,118	←→
Orthopaedic Surgery	£3,282	£3,226	→
General Surgery	£3,222	£3,360	←→
Urology	£3,285	£3,067	→
Obstetrics and Gynaecology	£4,061	£3,824	→
Breast	£3,274	£3,242	←→
Vascular	£2,527	£3,183	←
Ophthalmology	£3,072	£3,013	←→
Plastic Surgery and Burns	£3,968	£3,361	→
General Medicine	£3,066	£3,141	←
Cardiology	£3,384	£3,982	←
Geriatric Medicine	£3,574	£3,978	←
Respiratory	£3,886	£4,782	←→
Dermatology	£3,264	£3,186	←→
Rheumatology	£2,748	£2,745	←→
Gastroenterology	£2,858	£3,186	←
Diabetes and Endocrinology	£2,904	£2,638	←→
Medical and Clinical Oncology	£1,693	£2,200	←→

We will be working with individual specialties to identify whether the performance differentials identified within the model hospital represent opportunities for improvement or reflect differences in the type of service we provide.

Work has commenced with respiratory reviewing their data in detail.

Delivering 'real CIP' - NHSI definition

Cost reduction means providing a service at the same or better quality for a lower unit cost, through new ways of working that eliminate excess costs. The costs that are reduced could be on-going or future pay or non-pay expenditure. A simple example is the use of a different orthopaedic prosthesis offering the same or improved clinical quality for a lower unit cost. Cost reduction savings are typically savings that are cash-releasing. Cash can be released on a recurrent, on-going basis (if, for instance, staff costs are reduced) or a one-off, non-recurrent basis. They differ from non-cash releasing savings, which result in more activity or services for the same cost or for an additional contribution.

Cost avoidance is a type of cost reduction but refers specifically to eliminating or preventing future costs arising. Cost avoidance measures may involve some expenditure but at a lower level than the expected future costs to be avoided. They may typically not formally be part of the CIP programme but instead avoid future cost pressures. Examples are the avoidance of using locum doctors by making substantive appointments, reducing (non-budgeted) premium pay spend, or increased use in the future of nursing bank staff to avoid higher cost agency premium pay.

Income generation This applies to non-NHS contract funding schemes that provide a contribution to an NHS body that can be used for improving health services. Examples include charging for certain patient services or facilities such as a private room and television or telephone. NHS bodies can also enter into commercial ventures with private companies to generate income from specific services. The Department of Health provides further details. Income generation schemes are typically cash generating schemes as opposed to cash releasing cost reduction schemes.

Service productivity improvements These schemes aim to improve patient care by changing the way services are delivered so that productivity is increased and financial benefits can be delivered. Service productivity improvements often involve joint working between clinical, operational and finance staff, sometimes across different organisations, to develop new ways of working. Improving service quality and safety are the main priority with the intention of identifying on-going, recurrent efficiency savings and productivity gains through delivering services in the best way. These schemes can make cost savings or can generate an additional contribution.

Transformation Steering Groups

The overall governance structure including escalation arrangements is outlined in Part F: Programme Management.

The Trust has adopted a process of Transformation Steering Groups acting as the key to delivering suitable governance over efficiency and productivity developments. Through 2017/18 some individual Groups have been stood down and merged into existing Directorate meetings to ensure that the level of meetings within the Trust is appropriate. A review of the processes in place to govern CIP will be conducted in the first quarter of 2018/19

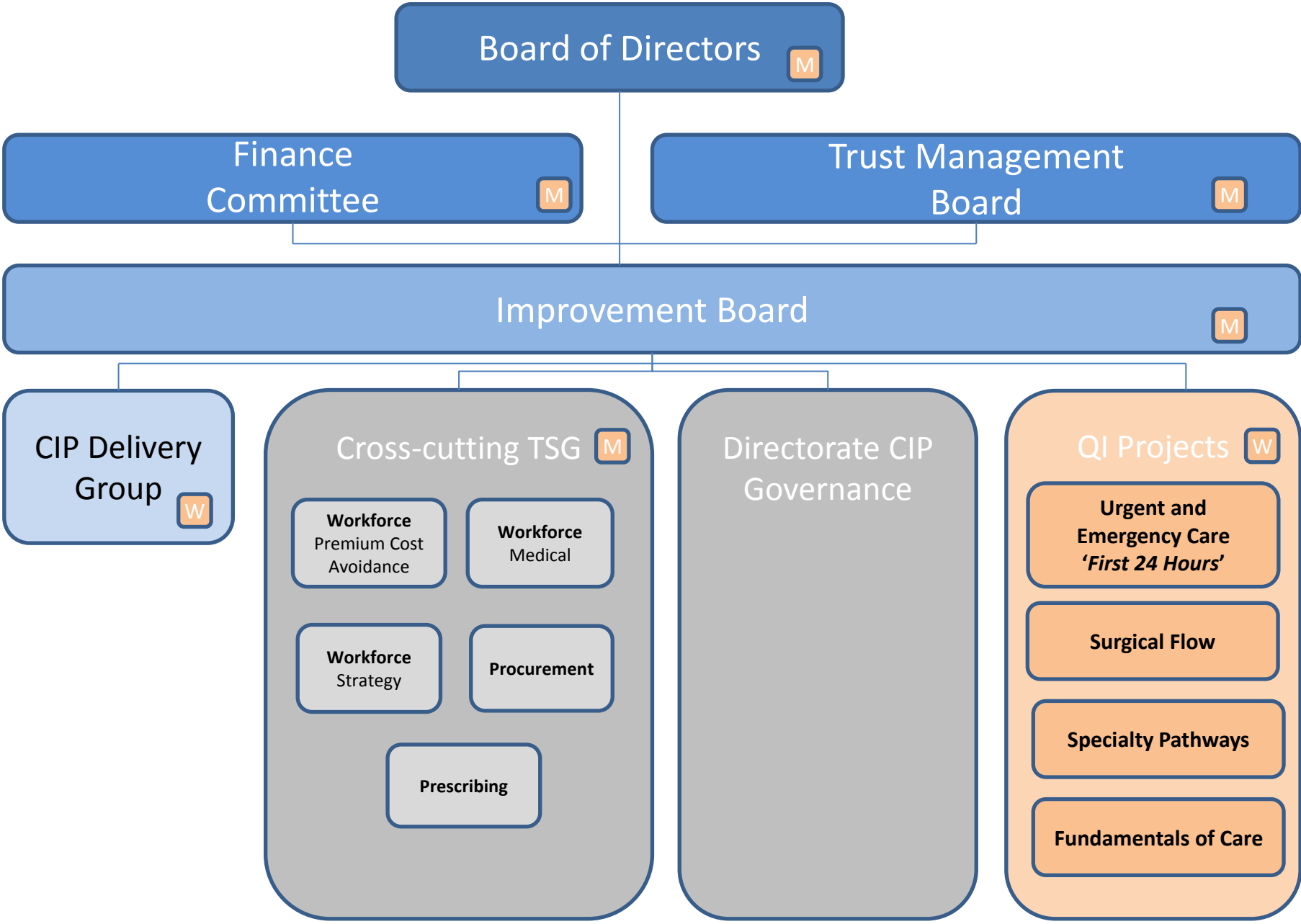
The Terms of Reference for each TSG is to:

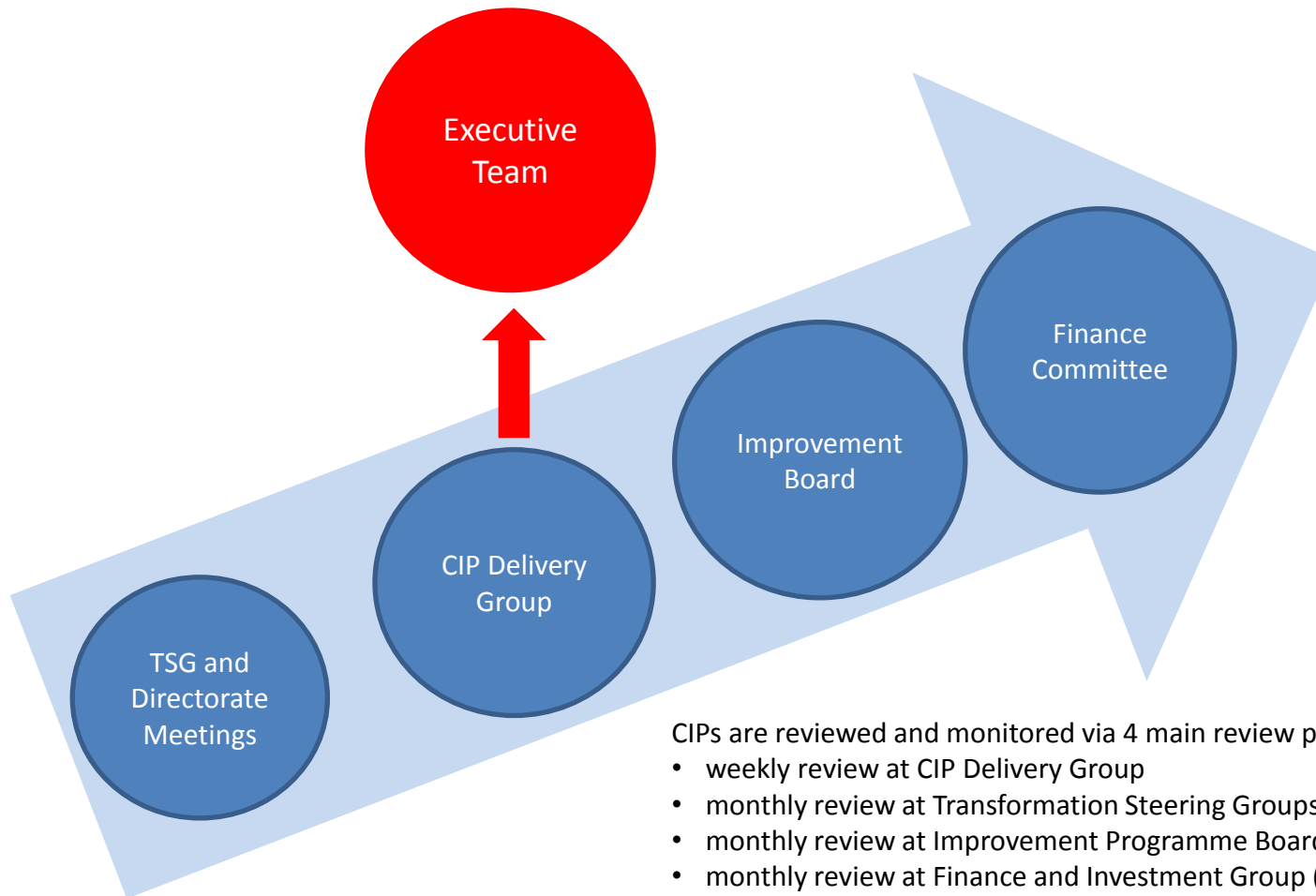
- compile and be accountable for the delivery of a range of schemes and ensure that these are translated into genuine delivery;
- consider the full spectrum of opportunity from basic local ideas to radical change for the steering groups to evaluate and convert;
- ensure all schemes are fully risk assessed according to the QIA criteria and appropriate actions taken to minimise any identified risks;
- encourage the proactive involvement of all staff identified to fully explore associated service transformation opportunities and be responsible for achieving the required goal;
- maintain a clear financial overview of individual schemes and make necessary adjustments to ensure delivery of the same;
- provide a forum for discussion on local and national guidance and recommendations to support service redesign, delivery and quality assurance;
- engage the support of others external to this work in the scoping and development of future project plans;
- maintain an iterative approach to continuous ideas development;
- ensure that sub groups or individuals produce a rolling action plan and the sub-group or individual delivers the products and provides regular progress reports to the TSG, and in turn to the Improvement Board.

The CIP Delivery Group meets weekly to:

- ensure continued grip over the delivery of the current year CIP programme (including metrics and milestones);
- unblock issues and develop mitigations where TSG leads have flagged concerns;
- oversee forward planning of future annual CIP programmes in line with our budget setting process;
- confirm benchmarking and / or best practice material to support implementation and ideas generation.

Membership includes all TSG SROs (Executive Leads) and their delegated authority. Any immediate action required based on the outputs of the meeting is escalated to the Executive Team within 24 hours.





CIPs are reviewed and monitored via 4 main review processes:

- weekly review at CIP Delivery Group
- monthly review at Transformation Steering Groups (TSG) meetings
- monthly review at Improvement Programme Board
- monthly review at Finance and Investment Group (FIC) – sub committee of the Board of Directors

A fast track escalation process is in place for issues that cannot adequately be resolved by the CIP Delivery Group. These are escalated immediately to the weekly executive team for review and decision.

To ensure that we do not deliver cost savings at the expense of quality for our patients we have implemented a quality impact assessment process. All CIP schemes with a full year impact of £20k or higher require assessing to confirm whether they require a QIA completing.

Documentation is submitted as part of the CIP tracker process, including information on how the Directorate has assured itself that it has sufficiently mitigated against quality risks. All information is reviewed by the Medical Director and Director of Nursing and signed off. Any areas of concern are 'called in' to enable more detailed scrutiny.

- does the scheme have an impact upon the quality of patient care?
 - patient safety
 - clinical outcome / effectiveness
 - patient experience
- does the scheme have an impact upon the Trust's workforce?

The Trust recognises that in the current highly challenging financial situation that difficult decisions may be required. For complex or sensitive decisions the Board may be consulted to determine the course of action to take.

Improvement Programme

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Appendices



Improvement Academy

Improvement Academy

Key priorities for 2018/19:

- further develop QI Alumni - a social network for RBCH improvers
- expanding the provision of QI coaching support and training and development programmes to frontline teams
- deepening the involvement of patients and carers in our QI work
- embedding local ownership and performance management of improvement projects to sustain front line staff engagement in QI
- experimenting with lunchtime QI masterclasses and webcasts
- further embed a culture for quality improvement in line with *NHS/ Developing People – Improving Care Framework*. This will include input into the RBCH Leadership training modules
- Lead role within 'Valuing You Week'

2 Day Quality Improvement Training

We have now trained circa **300** staff with further coaching support to help them deliver front line improvements for patients



Interested in Quality Improvement?

The RBCH Improvement Academy is continuing to offer a two day practical improvement skills training course in 2019.

The course is designed to introduce the basics of quality improvement through a mixture of presentation, video and practical exercises.

It will support your improvement work, help you do what is best for patients and continuously improve compassionate care at every level.

Some of the concepts covered on the course will include:

- Systems thinking
- The model for improvement
- Planning, improvement and generating change ideas - PDSA cycles and process mapping
- Measurement for improvement - understanding variation, time series data and run charts
- The psychology of improvement

For more information, please contact the Improvement Academy. Email: QualityImprovement@rbch.nhs.uk Telephone: 01202 784229 or visit our website at: www.improvementacademy.nhs.uk

Improve - Change It!

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Measurement for Improvement

The RBCH Improvement Academy is offering a new measurement for improvement 2 day course.

The module is designed to build on the knowledge you will have gained from attendance at the two day improvement skills course. The course is a mixture of presentation and practical activities.

It will support you to select the best measures, collect and measure the right data and generate a plan. It is a key step in change to achieve an improvement. You must have completed the 2 day improvement skills training course to book this module.

Some of the concepts covered in the course include:

- A set of measures and targets (what to measure)
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For more information, please contact the Improvement Academy. Email: QualityImprovement@rbch.nhs.uk Telephone: 01202 784229 or visit our website at: www.improvementacademy.nhs.uk

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

RBCH Quality Improvement Model





A standard methodology and training method for staff to use at all levels



Junior Doctors QI Programme



A culture of continuous improvement



A culture of continuous improvement: Action Learning Weeks

Our introduction of action learning weeks has been a significant active ingredient in 2017/18.

They have helped us create a culture of 'improving and learning together' whereby we focus on open dialogue, creating shared meaning regardless of role or hierarchy.

This fosters improved communication and trust - an atmosphere where everyone feels safe to share ideas:


- asking rather than telling – a problem solving approach to support staff thinking and taking responsibility; never diagnosing or prescribing as this takes away ownership
- a helping approach to build relationships that move things forward

During our action learning weeks, together we ask:


- how would we describe what is happening vs. what should be happening?
- why is it happening?
- what would happen if?
- what's the problem we are trying to solve?
- what have we looked at already?
- what have we thought of trying?

Action Learning Weeks

A different way of working
Inquiry – seeking to understand view of multidisciplinary ward teams



Year	Focus
Jan 2017	Definition of EDD
Feb 2017	Process and policy to support EDD
April 2017	Matron led focus on embedding EDD and MRFD
Nov 2017	Multi agency discharge event (MADE)
Dec 2017	Focus on admission avoidance and ambulatory pathways
Jan 2018	A Perfect Week



What caused the pressure?
How is it experienced by staff?
What can we do next time to alleviate it?

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



What is the matter with me?
(What I am diagnosed)

What is going to happen today?
(Tests, interventions, etc)

What is needed to get me out of hospital?
(Discharge criteria for discharge)

When am I expected to be leaving hospital?
(Expected date of discharge)

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust



We also gave staff permission to try ideas to improve processes, with support from our quality improvement team. We use the plan-do-study-act (PDSA) cycle approach, which is a scientific method of testing improvement ideas.

Paula Shobbrook DIRECTOR OF NURSING AND MIDWIFERY AND DEPUTY CHIEF EXECUTIVE, THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST



Improvement Programme

Part A – Overview

Part B – Key Actions and 2016/17 Evaluation

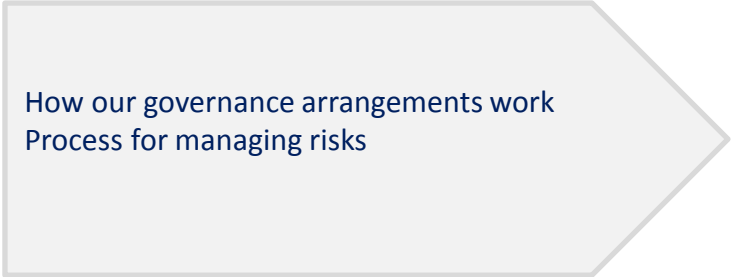
Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building Capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices



How our governance arrangements work
Process for managing risks

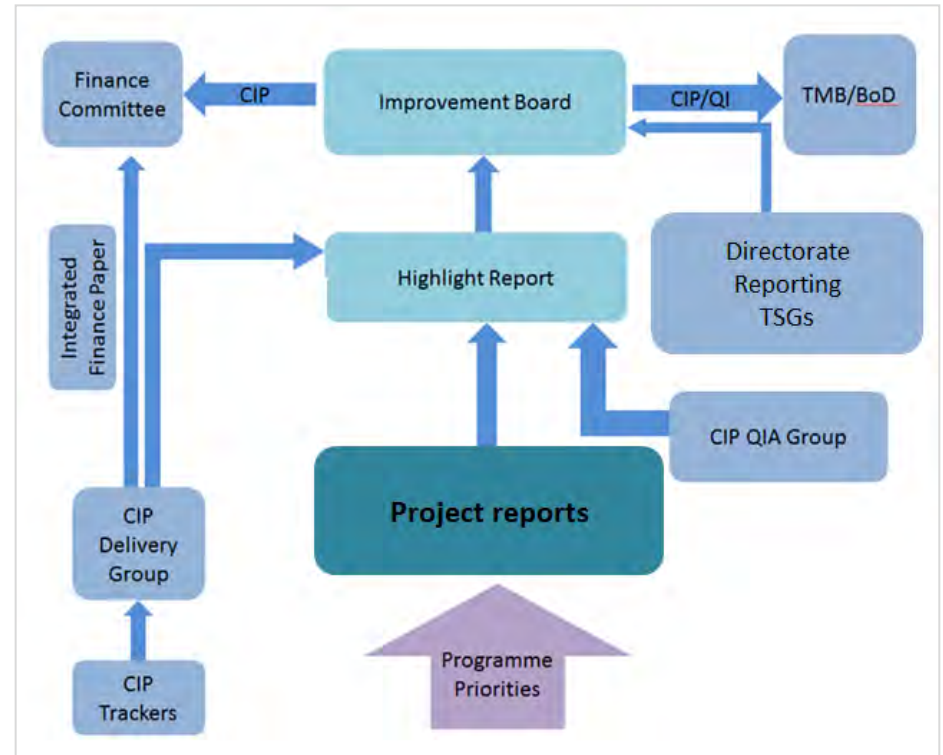
The Improvement Programme Team (IPT) is responsible for supporting and facilitating the implementation of the Improvement Blueprint. The IPT provides assurance on the delivery of progress against the programme objectives and plays a key role in providing project management and improvement expertise to operational and organisational projects.

This assurance is provided to the Improvement Board (a sub-committee to the Trust Board) via a monthly meeting.

A highlight report and set of project reports summarise progress against key deliverables for:

- QI projects
- productivity / efficiency workstreams
- delivery against the cost improvement programme
- delivery on recommendations and actions from within Lord Carter action plan

Further details of the programme governance structure, including CIP reporting arrangements and extracts from the CIP tracker are included in Appendix 3 - 6



Managing material risks

The Board of Directors manage material risks through the use of the Board Assurance framework (BAF). This focuses attention on high risks where there are gaps in control and / or gaps in assurance, risks which are currently running at a level which is higher than the BoD's risk appetite and to prompt action in those areas.

BAF and associated risks in corporate risk register (CRR) triangulated with IPT programme and risk log to ensure comprehensive record of controls and assurances reported on a monthly basis.

Material risks relevant to this document are detailed in Appendix 2.

These are aligned to our five strategic objectives and the Board Assurance Framework:

- Quality of care that is safe, compassionate and effective
- Quality Improvement
- Support and Develop Staff
- Strategy and Performance
- Value for money

Improvement Programme

Part A – Overview

Part B – Key Actions and 2017/18 Evaluation

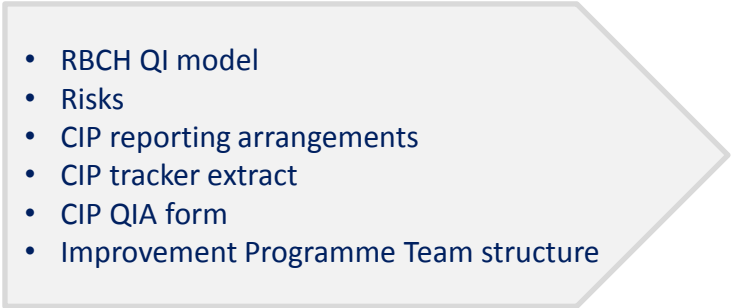
Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building Capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices

- 
- RBCH QI model
 - Risks
 - CIP reporting arrangements
 - CIP tracker extract
 - CIP QIA form
 - Improvement Programme Team structure

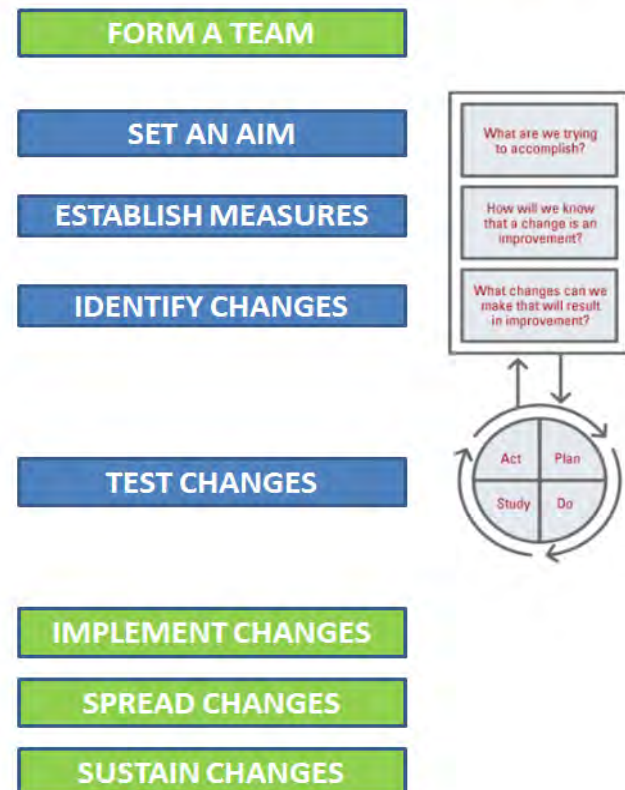
Appendix 1: RBCH Model for Improvement

You must have the **will** to improve









You must have **ideas** about alternatives to the status quo.

Then, you must make it real — **execution**

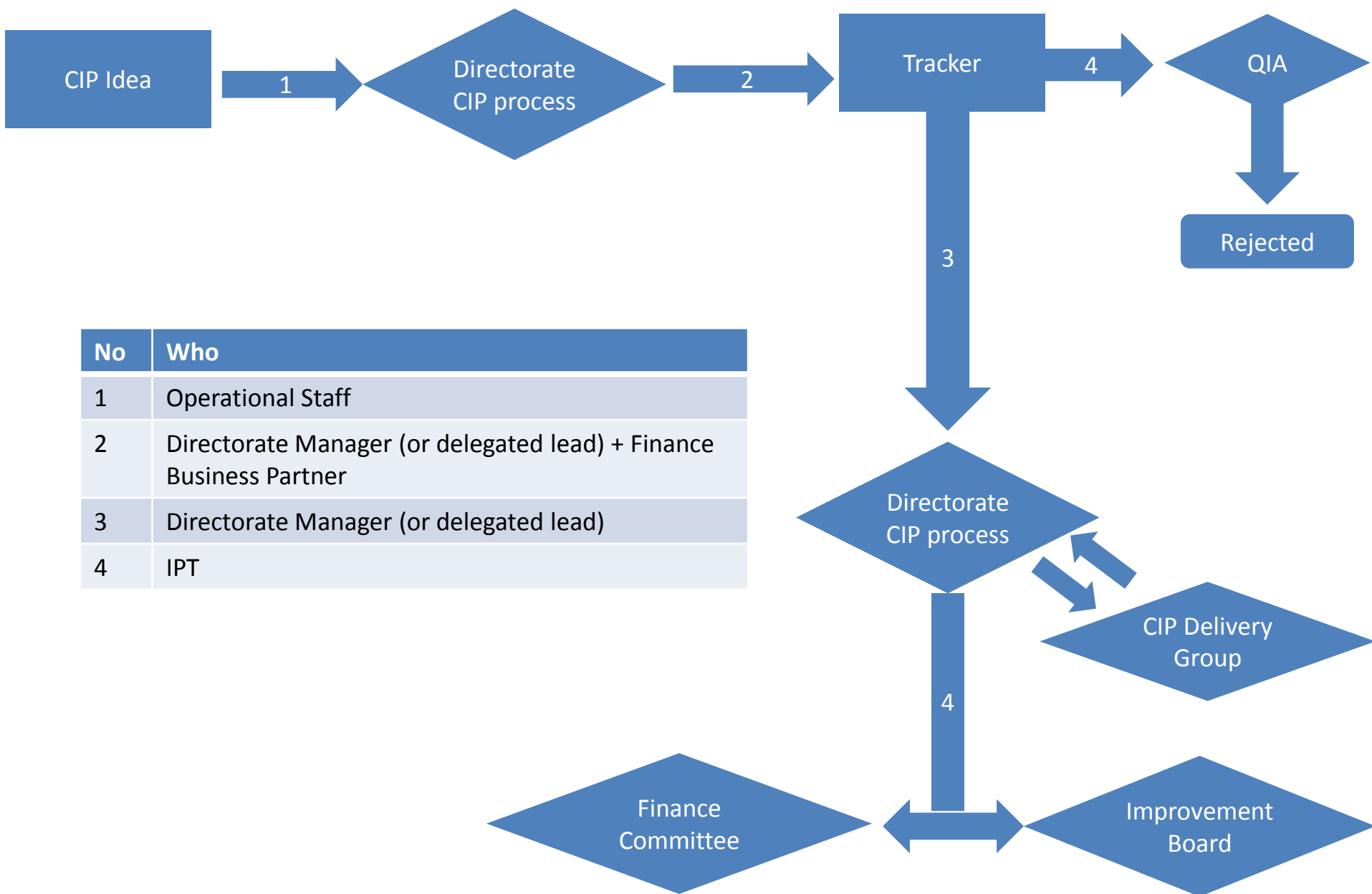
RBCH Quality Improvement Model



Appendix 2: Risks

Principle Risk Description of Risk	Current Risk	Risk Description	Control Measures	Target Risk
Non compliance with 18 week RTT 92% target; risk of escalation by NHSI and clinical impact of delays to patient treatment (ID193)		Delayed treatment pathways, non compliance with the 92% target (and potential loss of STF funds) due to: <ul style="list-style-type: none"> • demand and/or capacity pressure with increasing 18wk backlogs in specialities particularly: Orthopaedics (though some improvement), Ophthalmology, Urology, Dermatology, Colorectal, Vascular • reduced WLIs/rates limiting capacity to respond to pressures. • unplanned Dr absence and/or lead in time for substantive doctor appointments • referral demand reduction is not delivered 	QI priorities in Ophthalmology and Dermatology for 2018/19.	
Stranded Patients (ID452)		If the number of stranded patients in the hospital (patients in hospital for 7+ days) remains at the current levels, then there will be potentially avoidable harm to those patients.	Seasonal Action Learning Weeks . Rapid Improvement Events (RIE) . Daily monitoring of urgent care key measures available via Stranded Patient Trajectory Report and Hospital Flow Metrics Report .	
Urgent Care – Front Door and Flow (ID463)		If patient flow is compromised within the Trust, then there will be avoidable harm to those patients entering any front door to the hospital	QI priority in Urgent and Emergency Care (1st 24 Hours) will support downstream flow. Seasonal Action Learning Weeks .	
Risks to performance, patient delay and financial balance if elective care demand management initiatives are not supported or fail to materialise (ID604)		There is a risk that demand management initiatives will not be fully supported and/or implemented effectively out of hospital which could impact on the elective services at RBCH; resulting in capacity issues and therefore, delays to patient pathways, waiting list performance failure and financial imbalance.	QI priority in Surgical Flow. Seasonal Action Learning Weeks.	

Appendix 3: CIP Reporting Arrangements

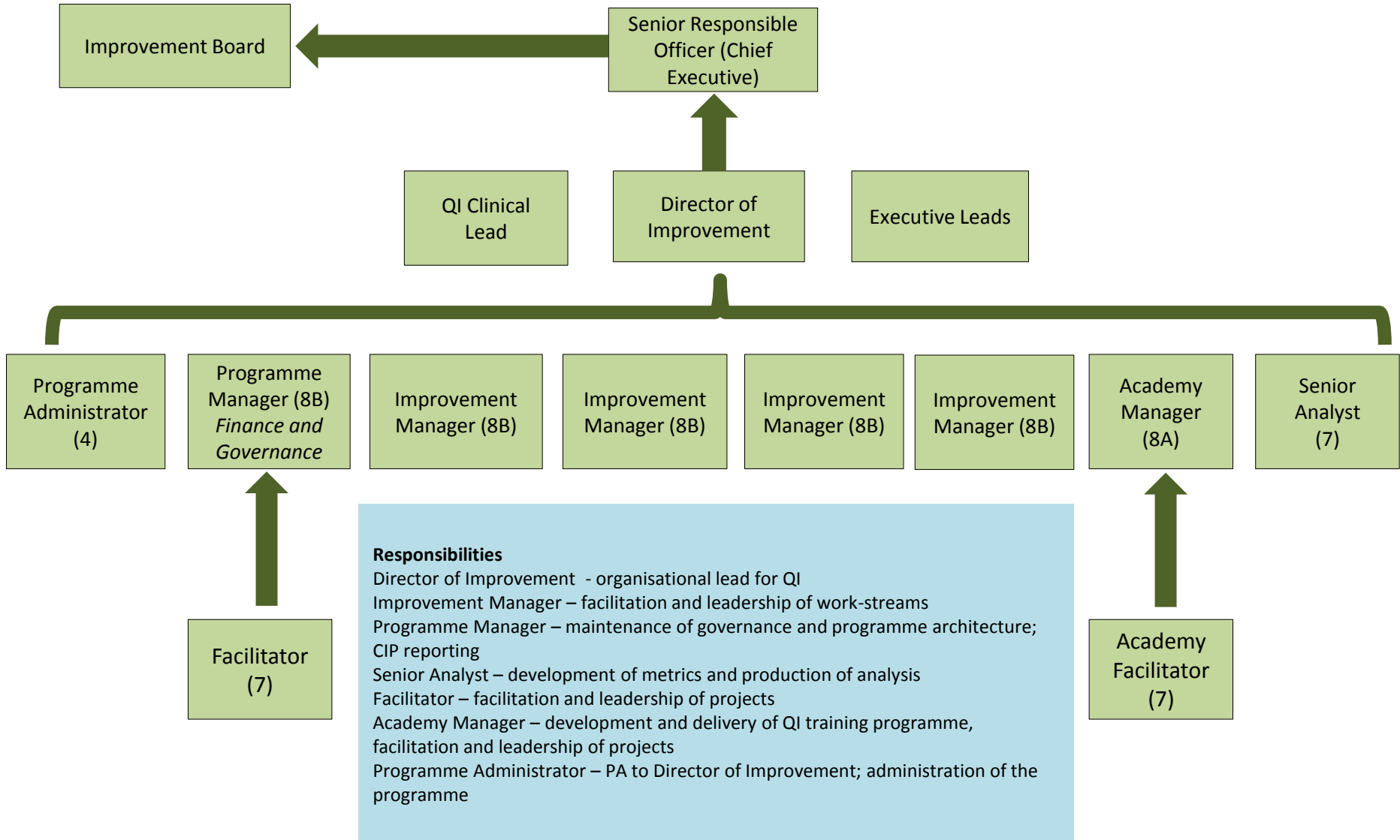


Appendix 4 and 5: Tracker Extract and QIA Form

	SUMMARY					SCHEME DETAILS								
Reference	Scheme	NHSI Plan Amount £	Forecast Amount £	FYE?	Recurrence (R / NR)	Brief Description	Lead	Directorate	Spend Category	NHSI Submission category	Project Risk	Risk %	Risk adjusted Forecast £	Project Status
	B/FWD TARGET	683,960	683,960											
	18/19 TARGET	216,667	216,667											
	TOTAL TARGET	900,627	900,627											
	ALLOCATED	167,827	167,827											
	UNALLOCATED	732,799	732,799											
A11819	WLI Reduction	50,000	50,000	New	R	Demand capacity work enabling reduction in extra payments	Corrina Davies	Anaesthetics	Pay (Skill Mix)	Workforce: Medical	Low	100%	50,000	Started - has minor delays
A21819	SSD Tender - Pay	28,125	28,125	New	R	Tender to provide SSD service via an alternative method	Commercial Services	Anaesthetics	Pay (WTE)	Workforce: Other	High	0%	0	Not yet due to start
A31819	SSD Tender - Non-Pay	28,125	28,125	New	R	Tender to provide SSD service via an alternative method	Commercial Services	Anaesthetics	Non-Pay	Other Savings	High	0%	0	Not yet due to start
A41819	SPP theatre caps deal	818	818	FYE	R	SPP Deal	Commercial Services	Anaesthetics	Non-Pay	Procurement	Completed	100%	818	Completed
A51819	Heel Lifts Save	760	760	FYE	R	Change in Spec to move product	Commercial Services	Anaesthetics	Non-Pay	Procurement	Completed	100%	760	Completed
A61819	Medical Agency reduction	60,000	60,000	New	R	Reduce spend on medical agency	Neil Cowan	Anaesthetics	Pay (Skill Mix)	Workforce: Medical	Low	100%	60,000	Started - has minor delays

	SUMMARY					QIA										
Reference	Scheme	NHSI Plan	Forecast	FYE?	Recurrence (R / NR)	Potential to					Quality Review Process used	Additional information	Risks identified	KPI's	KPI Review	Call-in
		Amount	Amount			Greater than £20k (FYE)	Impact quality (directly or indirectly)?	Impact on workforce?	QIA required?							
		£	£													
	B/FWD TARGET	683,960	683,960													
	18/19 TARGET	216,667	216,667													
	TOTAL TARGET	900,627	900,627													
	ALLOCATED	167,827	167,827													
	UNALLOCATED	732,799	732,799													
A11819	WLI Reduction	50,000	50,000	New	R	Y	N	Y	Y							
A21819	SSD Tender - Pay	28,125	28,125	New	R	Y	Y	Y	Y							
A31819	SSD Tender - Non-Pay	28,125	28,125	New	R	Y	Y	Y	Y							
A41819	SPP theatre caps deal	818	818	FYE	R	N			N							
A51819	Heel Lifts Save	760	760	FYE	R	N			N							

Appendix 6: Improvement Programme Team Structure





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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Medical Director's Report
Section on agenda:	Quality
Supplementary reading:	None
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Alyson O'Donnell and Divya Tiwari
Details of previous discussion and/or dissemination:	N/A
Action required:	Note for information
Summary: Medical Directors Monthly Report	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Impact on risk profile:	None

Medical Director's Report

Board of Directors March 2018

Mortality Update

Overall HSMR for the Trust remains in the 'as expected' range at 96.8 for the last 12 months and 95.7 for the current financial year (April 2017-November 2017). The figure for RBH (excluding Christchurch and the Macmillan unit) is 87.1 and is in the 'better than expected range'. MSG has noted high a HSMR (106) for November. This figure is possibly compromised by a data submission flaw and will be under review pending further data submission.

Crude death rate has steadily declined from 1.97% for December to 1.6% in January and 1.52% in February. These trends for January and February are comparable to January and February 15/16. The National picture which allows comparison will be clearer in a few months. Deaths within 36 hours surged in December but have declined in February. As the peak in deaths appear to be related to respiratory illness associated with flu this may reflect that the high acuity associated with flu admissions has declined (Annex A).

Learning from Deaths

Mortality Report for Board: March 2018

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

Data as at 09/03/2018

Month	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Deaths in Month	113	107	130	134	155	136	177	178	179
eMortality Reviews Completed in Month	134	118	35	90	50	22	24	69	107
Category of Death by Month Review Completed									
Grade 0	124	108	30	78	44	19	22	57	103
Grade 1	9	9	5	9	4	3	2	10	4
Grade 2	1	1	0	3	2	0	0	2	0
Grade 3	0	0	0	0	0	0	0	0	0
Learning Disability Deaths in Month	0	0	1	2	0	0	0	1	

There have been no deaths reported in individuals with learning difficulties in December, January or February. The case recorded in January relates to the LeDER review of a death from November with no care concerns identified. All LD deaths are reported to the LeDER system as required but there are substantial delays in reviews at the current time.

As per our mortality review protocol all deaths graded as 2 or 3 are subject to an RCA type investigation outside our normal e-mortality process. The two cases in January were both urology cases and have been subject to SI panel review.

Key learning points from reviews

- 1: Suprapubic catheter insertion outside a theatre environment is a high risk procedure. SOP developed for failed urethral catheterisation including escalation and location of care.
- 2: Development of standardised consent form to include patient information
- 3: Communication and handover of complex patients during periods of leave
- 4: Escalation and hand off of tasks with identification of responsible individual
- 5: To consider ECG and troponin in the investigation and management of non-specific chest pain in high risk individuals

Action Plan from the Mortality Surveillance / Reviews

(1) Non-Hodgkin's Lymphoma:

Mortality Chair, Helen McCarthy, discussed the findings of this review. MSG is tasked to create workflow solutions for all deaths from Non-Hodgkin's lymphoma which will be forwarded to Haematology department to facilitate timely mortality reviews. Department will review three cases where patients have died within 30 days of Chemotherapy to define appropriateness.

(2) Aortic and peripheral arterial embolism:

This is an ongoing alert in a diagnostic group in Vascular surgery. Action plan from the mortality review for the alert in 'Femoral bypass' Surgical group has been implemented. There is now medical input from a speciality doctor in Geriatric Medicine five days a week. This is likely to improve procedural and non-procedural outcomes from vascular problems in frail older adults. MSG will continue to monitor and commission further a review if required.

Sepsis Alert

MSG noted higher mortality from 'Sepsis and Pneumonia' in December 2017. Sepsis lead, Dr David Martin, conducted a fast-track mortality review of 15 random deaths in this group. MSG noted no significant concerns in clinical care specifically 'antibiotics delivery time' all but one death was classified as unavoidable. Possible avoidable mortality is currently under review by the Vascular department.

Dr Foster alert 'Residual Codes'

MSG in January noted a new alert in use of 'residual codes'. This is an important data quality issue; 1500 discharge spells from our Trust have been submitted as 'residual codes' (i.e. 'R' code in the primary position) of which 42 patients have died. Majority of these 'spells' come from August and September 2017.

Action plan: MSG has now completed the process map and changed the process to avoid this in the future. We have also submitted corrections for the retrospective data and the March up-load will now be a true representation of Trust HSMR.

New Dr Foster alert: 'Repair of thoracic or unspecified aortic aneurysm'

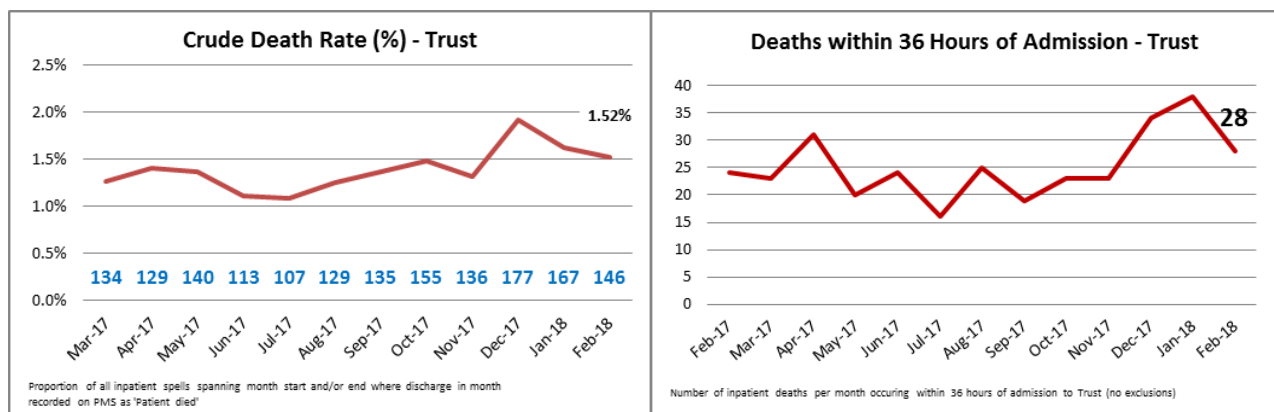
This is a procedural Cusum alert mounted by 3/10 deaths in this category compared to 1/10 expected nationally. MSG has shared this alert with the lead and Mortality Chair for the Vascular department and commissioned a thorough review of pre-operative/post-operative clinical care, communication, death certification and codings. The findings will be discussed in the next MSG meeting.

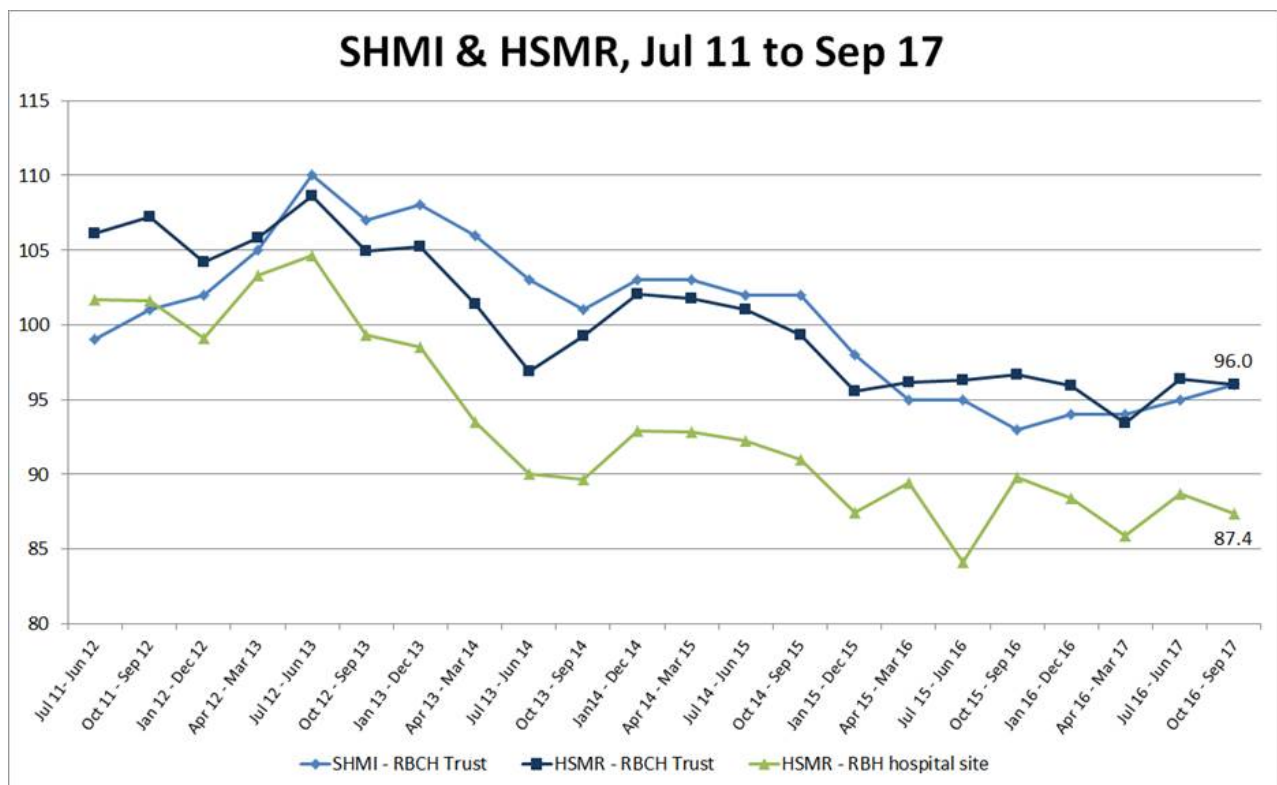
MSG will also conduct an audit into accuracy of procedural coding and Urology will pilot this to start with.

Mortality outcomes from National COPD Audit 2014

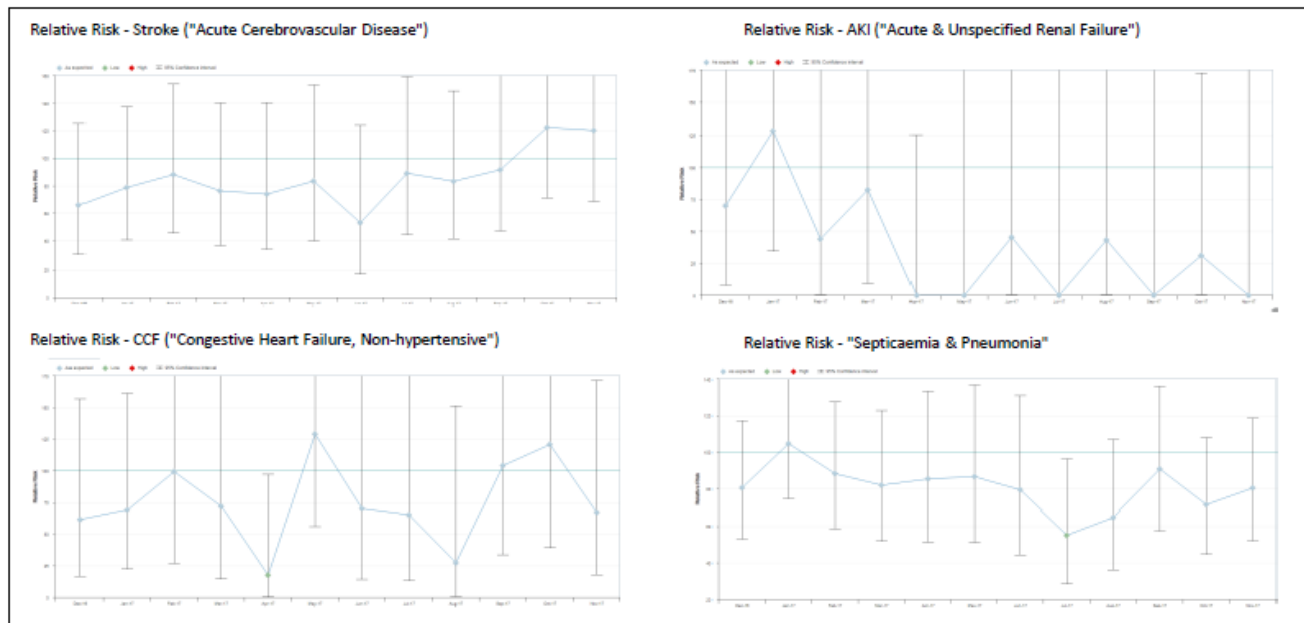
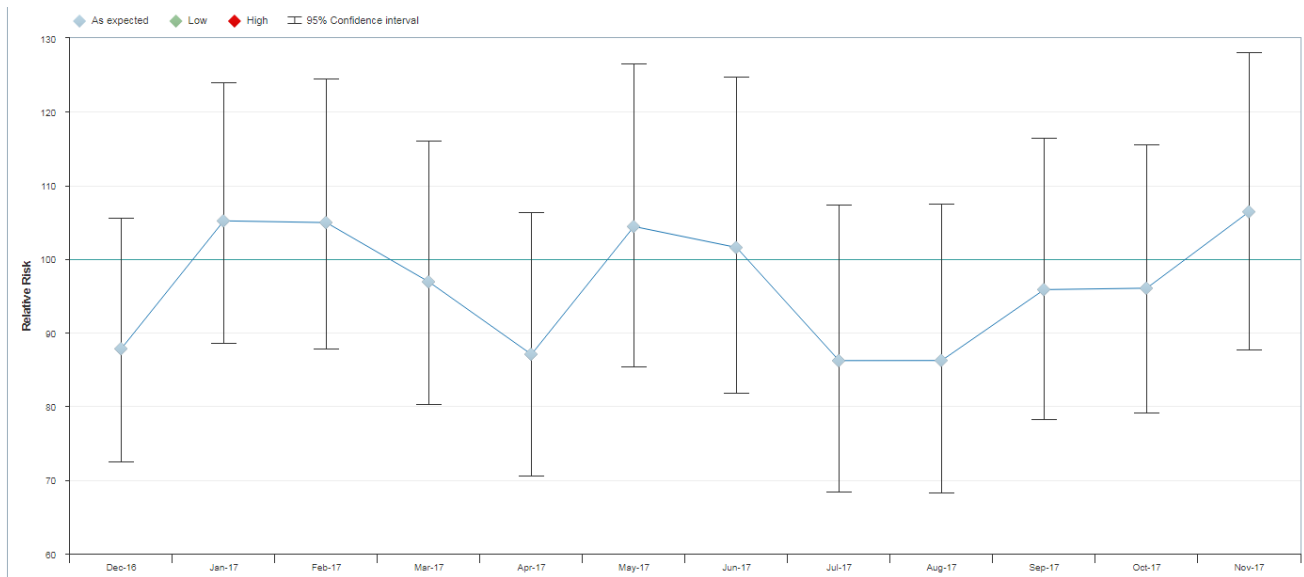
MSG noted mortality outcomes for COPD in this audit; in-hospital mortality for this group has significantly improved over last 3 years, however, 90 day mortality outcomes are not measured. Dr Laws and Dr Edwards reviewed clinical care, end of life care and coding for the COPD discharges where a death is recorded within 90 days of admission. MSG is reassured that there were no deficiencies in the clinical/end of life care and all re-admissions following index admission were unavoidable. One patient received resuscitation inappropriately; this will be discussed with IT.

Annex A





Trust HSMR





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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Clinical Services Review
Section on agenda:	Strategy and Risk
Supplementary reading:	Merger update and draft patient benefits case
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	RBCH Board of Directors, Trust Management Board, One Acute Network East Reconfiguration Board
Action required:	Note for information
Summary: This paper summarises the key issues to be covered in a verbal briefing to the Board.	
Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	✓ ✓ ✓ ✓ ✓
Impact on risk profile:	This is central to the realisation of the benefits of the Clinical Services Review

Clinical Services Review Update

Introduction

I will brief the Board on the latest position with regard to:

- The judicial review challenge to Dorset CCG and the implications it has for ongoing work associated with the Clinical Services Review (CSR).
- The potential for the Dorset Health Overview and Scrutiny Committee to refer the CSR proposal to the Secretary of State.
- Ongoing discussions with NHS Improvement regarding the timing and requirements for engaging with the Competition and Markets Authority.
- Proposals that could see a truncation in the time taken to produce the Outline Business Case.
- An update on the outcome of the Board to Board meeting with Poole Hospital NHS Foundation Trust taking place on the 27 March.
- Progress with regard to the completion of the Patient Benefits Case.
- An update on the clinical design phase of the CSR.

A more general update on the merger is provided within the Reading Pack.

Tony Spotswood
Chief Executive



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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Trust Strategy and Objectives 2018/19
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	The Board has previously reviewed the draft strategy
Action required:	Decision
Summary: The Board is asked to consider and approve the Trust Objectives for 2018/19, the underpinning metrics and summary strategy	
Related strategic objective:	All Valuing our staff Improving Quality and reducing harm Strengthening Team Working Listening to Patients
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	✓ ✓ ✓ ✓ ✓
Impact on risk profile:	This work is central to the on-going operational performance of the Trust

Trust Strategy and Objectives 2018/19

I am pleased to enclose for Board consideration and agreement a paper providing details of the metrics and milestones underpinning the delivery of the Trust's four objectives for 2018/19. In particular the paper includes a range of detailed actions underpinning the key Quality Improvement priorities for 2018/19.

A short summary of the Trust's Strategy Refresh is also appended for consultation and agreement, reflecting the work we are engaged in with partner organisations to establish Dorset as an Integrated Care System and implement the Clinical Services Review.

The Board is asked to consider and, subject to any final comments, approve the Trust Objectives for 2018/19, the underpinning metrics and the summary strategy.

Tony Spotswood
Chief Executive

Metrics for the 2018/19 Corporate Objectives

The Board has agreed the following four objectives for 2018/19, designed in conjunction with our Change Champions.



It is proposed that we monitor progress against these objectives using the following metrics and key milestones:

OBJECTIVE ONE		Valuing our staff
Narrative:		<i>Recognising the contribution of our staff and helping them develop and achieve their potential</i>
Measures:	1.1	Delivery of the Trust's People Strategy with a focus on: <ul style="list-style-type: none"> a) Developing fit for purpose workforce plans by December 2018 b) Further enhancing health and wellbeing support for staff in place by December 2018 c) Recruiting, retaining and developing staff in line with the strategy d) Delivering on key priorities in our diversity and inclusion plan in accordance with the timescales set out in the plan
	1.2	Delivery of the Leadership Strategy Implementation Plan with a focus on: <ul style="list-style-type: none"> a) Talent management b) Leadership development c) Management Toolkit d) Recognition and Reward – these will be implemented throughout 2018/19 in accordance with the timescales set out within our strategy
		The measures we will use to track progress focus on: <ul style="list-style-type: none"> a) Action plans to address issues raised by staff, with the aim of maintaining our staff survey results and aiming to increase the engagement score from 3.9 to 4 over the next two years, demonstrating an improvement year on year b) Improving the Staff Impressions "Mainly Good" overall experience score to exceed 92%

		c) Maintaining a turnover rate below 12/%
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OBJECTIVE TWO		Improving Quality and Reducing Harm
Narrative:		<i>Focusing on continuous improvement and reduction of waste</i>
Measures:	2.1	<p>Urgent and Emergency Care 'First 24 Hours' <i>Aim: To improve the first 24 hours of our urgent and emergency care pathway to deliver 'right patient, right time, right team, right place' by March 2019</i></p> <p>We will do this by ensuring:</p> <ul style="list-style-type: none"> • all patients receive timely assessments and decisions for clinically appropriate high quality care • we convert a third of adult acute admissions to ambulatory care as the preferred option by March 2019 • patients are either discharged or transferred to a specialty ward within 24-48 hours of arrival by January 2019 • to improve on our 7 day standards, including for admitted patients having a consultant review in no more than 14 hours. • patients are rapidly assessed and treatment begun following referral from ED or primary care by September 2019 • frail patients are identified as soon as possible as they present in ED and receive specialist high quality care by June 2019 • patients with mental health conditions have access to skilled assessments available 24/7 by June 2019 • to deliver the 4 hour performance trajectory and the 95% ED standard by March 2019
	2.2	<p>Surgical Flow <i>Aim: To improve flow through specialty theatres and intensive care beds, to achieve 85% utilisation (with a stretch target to 90%) for theatres. To also reduce time delays out of ITU by 20% by March 2019.</i></p> <p>We will do this by:</p> <ul style="list-style-type: none"> • improving theatre scheduling and start times • reducing on the day cancellations • redesigning ward processes to increase capacity in recovery areas • redesigning ward processes to improve ITU capacity and discharge arrangements • redesigning our prioritisation and planning processes to further improving the quality and safety of the WHO checklist in emergency surgery
	2.3	<p>Supporting our Specialty Pathways <i>Aim: To ensure implementation of recommendations outlined in the external cultural review and British Association of Dermatology review in accordance with agreed timelines</i></p> <p>This will include:</p> <ul style="list-style-type: none"> • redesign of booking process • improved staff training • improved patient information • Introduction of electronic systems • all surgical forms in dermatology are completed accurately by August 2018 and zero avoidable hospital reason cancellations by October 2018
	2.4	<p><i>Aim: To improve patient safety and experience by reducing RTT waiting times in ophthalmology to a maximum of 18 weeks and outpatient follow up</i></p>

		<i>waits. The focus of this work will extend to improving efficiency in eye theatres by March 2019</i>
	2.5	<i>Aim: To ensure that there are no unnecessary diagnostics and/or nursing observations for patients who are medically ready for discharge by March 2019</i>
	2.6	<p>Fundamentals of Care <i>Aim: To improve the coordination of Peripherally Inserted Central Catheter (PICC) lines, confirming status of every patient with a PICC line inserted by RBCH and ensuring compliance with the CVAD care bundle by March 2019</i></p> <p><i>Aim: To continually improve the safety and timeliness of treatment and reduce avoidable patient deterioration on our wards</i></p> <p>We will do this by:</p> <ul style="list-style-type: none"> ensuring that every 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 March 2019. <p><i>Aim: To further improve the identification and management of sepsis in our emergency and admitting areas by March 2019</i></p> <p>We will do this by:</p> <ul style="list-style-type: none"> treating all patients with a high risk of sepsis with a first dose of antibiotics within 1 hour of admission/diagnosis of sepsis and all other suspected septic patients within 3 hours by March 2019. <p><i>Aim: To reduce the number of Never Events and promote an open learning culture</i></p> <p>We will do this by:</p> <ul style="list-style-type: none"> embedding the learning from Never Events and Serious Incidents and implement agreed actions arising from the human factor work led by the Medical Director, it is ongoing through 2018/19
	2.7	<p>Building QI Capacity and Capability To continue to develop our infrastructure for quality improvement at all levels within the organisation by March 2019. We will do this by:</p> <ul style="list-style-type: none"> expanding the provision of QI coaching support and training and development programmes to frontline teams deepening the involvement of patients and carers in our QI work embedding local ownership and performance management of improvement projects to sustain front line staff engagement in QI
	2.8	<p>Efficiency and Productivity We will continue to ensure services are provided in a cost effective manner and that we achieve our financial plan to deliver a deficit of no more than £2.381 million by the end of March 2019.</p>
	2.9	<p>To continue to improve the responsiveness of services for patients and achieve the national standards of:</p> <p>Cancer waits (62 days) Elective referral to treatment waits (18 weeks RTT) Diagnostic waits (maximum 6 weeks)</p>

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>
Measures:	3.1	Progressing implementation of the Clinical Services Review by completing the clinical design of the planned and emergency sites by July 2018 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.
	3.2	Strengthen collaborative working and relationships between the Trust and local partners gauged by regular feedback, via a structured qualitative assessment, from partners and in so doing progress the implementation of the Dorset Sustainability and Transformation Plan. To be completed by March 2019.
	3.3	Jointly implement the Dorset Care Record (DCR) Phases 1a-2, 1b and 2 in accordance with the timescales in the DCR programme plan.
	3.4	Develop team working by embedding the Aston OD Team Coaching approach across the organisation, helping enhance the delivery of care through heightened team effectiveness. Specific measures will focus on: <ul style="list-style-type: none"> a) At least 50 teams being engaged with the Aston OD Team Journey by March 2019 b) Achieving an average Trust score of 4 in the NHS Staff Survey key finding for Effective Team Working
	3.5	To work with partners to submit a successful bid to reshape urgent care services in Dorset. This includes preparing for a “go live” in April 2019. Key aspects are developing the Urgent Treatment Centre (UTC) at RBH, work with GPs on Improving Access especially out of hours, as well as the wider 111 and 111 on line offer to patients, to provide alternatives to A&E attendance.

OBJECTIVE FOUR		Listening to Patients
Narrative:		<i>Ensuring meaningful engagement to improve patient experience</i>
Measures:	4.1	Maintain progress in meeting our improvement trajectory for the National Patient Experience benchmarks by March 2019, by: <ul style="list-style-type: none"> • Maintaining internal focus on patient experience agendas • Engaging, listening and responding to patient feedback
	4.2	Maintain and strengthen community links by March 2019 through: <ul style="list-style-type: none"> • Running in partnership with our Governors a series of listening events • Establishing community focus groups to provide feedback on current services and future proposals for service delivery
	4.3	Actively engage in transitional work with the One Acute Network, ensuring that our patients and population are involved in service redesign from the outset using: <p style="text-align: center;">Experience based co-design</p>

	4.4	<p>Working in partnership with our patients and health care partners to ensure right referral and right care, by March 2019, especially focused on four specialities (Dermatology, Cardiology, Orthopaedics and Ophthalmology), by:</p> <ul style="list-style-type: none">• Informing and helping educate our population to access resources appropriate to their need• Improve self-care education with a particular focus on chronic diseases
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Trust Strategy Summary for 2018

To Work in Partnership and Continually Improve

Our strategy is intended to ensure we support our staff to provide outstanding patient care. The key highlights are:

- Valuing and developing our staff and our organisation to deliver a service that is fit for the 2020s and beyond
- Continue to improve our clinical services, both as an existing trust and as part of a merged organisation
- Rearrangement of health services across Dorset, in particular acute services, as part of the Clinical Services Review, incorporating a £150m capital build over five years
- Strengthening team working including likely merger with Poole Hospital in 2019, assuming regulatory approval

Our Trust Board has agreed this interim strategy following the Clinical Services Review consultation process and pending merger.



Clinical Services Review (CSR)

The RBH site has been chosen to be the major emergency hospital for Dorset. This entails a substantial capital development programme with a review and design process for those services affected. As a result, in the latter part of 2017, work commenced specialty by specialty, to determine how each service will be provided on the planned and emergency sites. Diagnostic and outpatient services will remain on both sites. We will be designing pathways of care to reflect how services will be in 2025-2030, not for 2018. This will inform the physical (estate) design of the two main sites and provides more information about the new facilities and in particular when they will be built. Christchurch Hospital will continue to act as a community hub with a new inpatient palliative care unit and an enhanced range of outpatient services. Equally important is the timescale for the relocation of existing services from any of the acute sites. The scale of the changes is huge and will take five years to implement:

- £147m investment in new hospital services
- Beds at RBH will increase from 630 to 1,050-1,100
- Number of staff working on RBH site increasing from 4,000 to approx 6,000
- New ED (A&E Department) and Urgent Care Centre
- New women's and children's services
- New trauma unit
- Transfer of some elective and day case services to Poole as the major planned care hospital
- New community hospital beds at RBH and relocation of some services to Christchurch and community localities

<p>Poole: major planned hospital</p>	<p>Dorchester: planned and emergency hospital</p>	<p>Bournemouth: major emergency hospital</p>

We are now working very closely with Poole to take forward the CSR and have collectively developed four workstreams to consider which aspects of a range of services are to be provided at the two sites. The workstreams focus on: i) women and children's services; ii) cancer services; iii) the future provision of critical care services, including how we best support elective work at the planned site; iv) how we organise the emergency medical and surgical take at the emergency site; how ED will work with specialities, drawing patients directly through to specialist wards and; what level of emergency work will be retained on the planned site. It will also consider how the Urgent Treatment Centres (UTC) will operate. The results of this will allow detailed work to then start on the physical estate redesign of the two hospitals. This will take approximately 10 months to complete, taking us to May 2019.

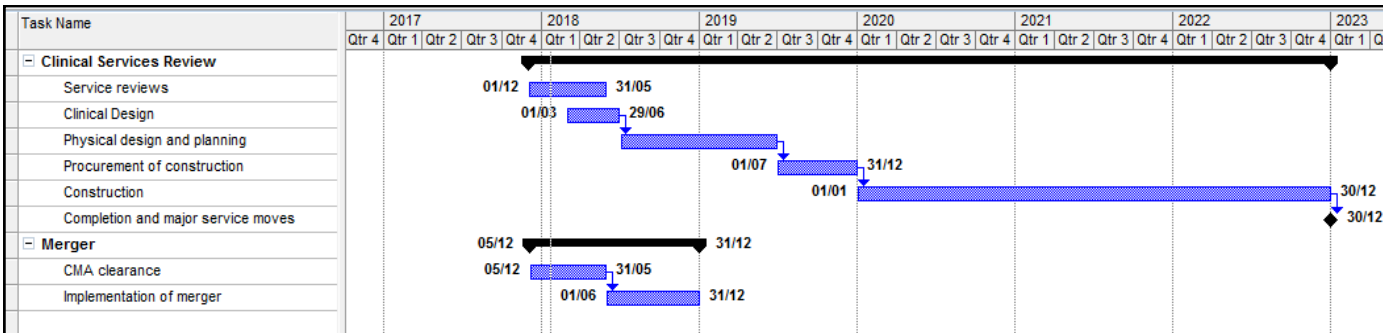
During the estate design phase we will also undertake two other important pieces of work. Firstly, we will consider with each of the relevant teams and staff groups the options for the relocation of orthodontics, sexual health services, the Dorset Prosthetic Centre and some outpatient physiotherapy. No decisions have yet been made about the future location of these services. Following the review of options, decisions will be made to enable each of these services to relocate, thereby freeing space for refurbishment as we start work in earnest to create the emergency and planned hospital sites. Secondly, we will also begin work to plan facilities for the establishment of community hospital beds at both RBH and the Poole Hospital sites. The major building work will not be completed until early 2023 and due to the nature of the clinical inter-dependencies, it is anticipated the major changes in service location will mainly occur at this time.

Services that are not directly affected are likely to develop a network approach across Dorset to ensure their future sustainability, including with colleagues at Dorchester.

Merger with Poole Hospital

Work is underway to enable the merger of our Trust with Poole Hospital. The purpose of merging is to allow us to come together as a single organisation so we can implement more effectively and quickly the establishment of emergency (RBH) and planned (Poole) care sites. In developing our plans jointly, we will be better placed to tackle our collective financial and workforce challenges, and to establish more resilient services. The ambition is to have the best of both, so we can better serve our combined local population

The two trusts have now determined a timetable for merger subject to the agreement of the Competition and Markets Authority (CMA) and NHS Improvement. The target date for merger is **1 April 2019**. To achieve this we aim to present to the CMA a detailed Patient Benefits Case in April 2018 - setting out the benefits of implementing the Clinical Service Review and merger. The CMA is anticipated to undertake its assessment of the impact of the two trusts merging during June and July 2018. Subject to being cleared by the CMA, in September and October we will appoint a shadow Board to oversee the work of preparing for merger. We will also start to work through how the new organisation will operate. NHS Improvement will receive a case setting out plans for the new Trust in November 2018 and conduct its own assessment prior to agreeing the merger. The overall programme for merger and the Clinical Services Review looks like this:



Improving our clinical services

We have had a Quality Improvement Programme for several years and introduced a wide range of quality improvement initiatives. This has had a significant impact on the developing culture of our organisation, with measurable benefits for patients and staff. Examples of successes include our

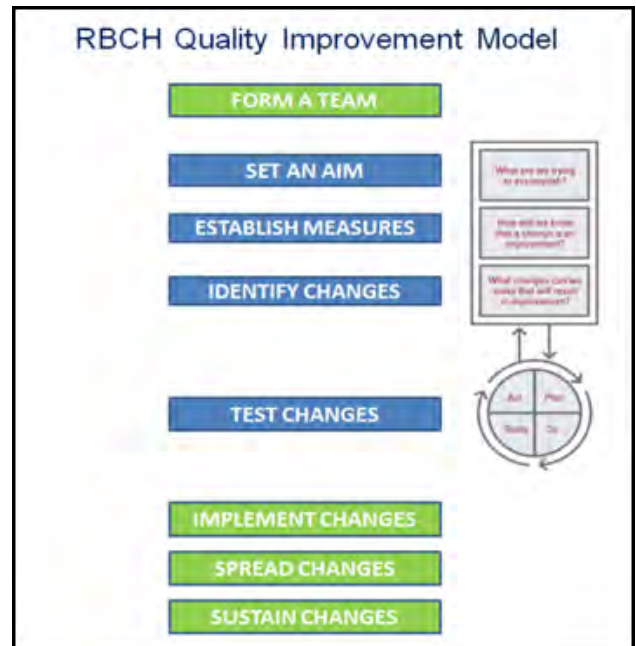
stroke service being classified as Band A in the national audit, the reduction in mortality as measured by HSMR and the best cancer patients survey results of any service in Wessex.

We will continue to improve quality by:

- delivering transformational change and quality improvement projects, resulting in a safer and more caring hospitals for patients
- establishing a culture of continuous quality improvement
- creating an environment where all staff have a sense of shared ownership and responsibility and feel enabled to help make our hospital one of the best
- capitalising on the energy and enthusiasm of staff by taking the best ideas for improving the quality and safety of patient care – and encouraging uptake throughout the hospital
- engaging and empowering staff to deliver and sustain the required change in their workplace
- harnessing individual and collective talent and creating clinical leaders at every level within the hospital
- providing improvement and change expertise - to give skill and enable learning - for as many staff as possible through direct involvement in projects and sharing of best practice
- achieving a consistent message that improving quality eliminates waste, reduces variation and improves efficiency

Our quality priorities include the optimising of patient safety, clinical effectiveness and patient experience and each of these has an annualised set of metrics against which our improvements can be measured, including for example mortality rates, Friends and Family Test and others.

In addition to this there are a key number of themes and philosophies that support the development of the quality of the care we deliver, such as leadership, team development and patient engagement and these feature across all aspects of our strategy.



Developing our people and culture

We recognise that culture change is best not left to chance and is supporting a strategic approach to organisational development and the development of our workforce.

We need to build collaborative relationships and work collectively with our partners to drive through change and deliver new service models. Our staff will look to our leaders for direction and support during uncertain and challenging times.

While delivering complex change we will need to ensure we keep our eye on the daily business of running the hospitals and ensuring this remains a great place to work. We want our staff to enjoy coming to work and to feel motivated and involved in supporting an ambition for continuous improvement. Key areas for further development include

leadership and teamwork, and an example of the work we are doing would be the Aston OD coaching programme we are using to support the development of our team leaders.

Progress with informatics

How we can exploit IT and harness the opportunity it offers to improve the patient pathway will be critical in supporting our clinical teams, improving care, reducing transaction costs and to make best use of new techniques such as Artificial Intelligence (AI). Some of the key programmes are:

Workstream	Projects and programmes
Clinical applications	Strategic Electronic Patient Record (EPR) for RBCH (creating a single EPR between trusts) Agree the strategic future for electronic National Early Warning Score (eNEWS) and eNurse assessments Order Communications/Results Reporting (OCS/RR) Electronic Prescribing and Medication Administration (EPMA) Dorset Care Record Clinical Handover, patient flow, electronic whiteboard
Infrastructure development	Network replacement, WiFi network, internet telephony Migrating our network connections to the “Health and Social Care Network” (HSCN) migration
Effective support	Developing a Dorset shared Informatics service Information governance— achieve the nationally mandated IT security, confidentiality and data quality standards
Merger support	Once the merger has been approved, we will be developing a programme to support this
Digital consumer	Digitising access to health services - managed under the framework of the Dorset Care Record - Dorset patients will have a consistent and single point of access for all their health and social care record transactions.

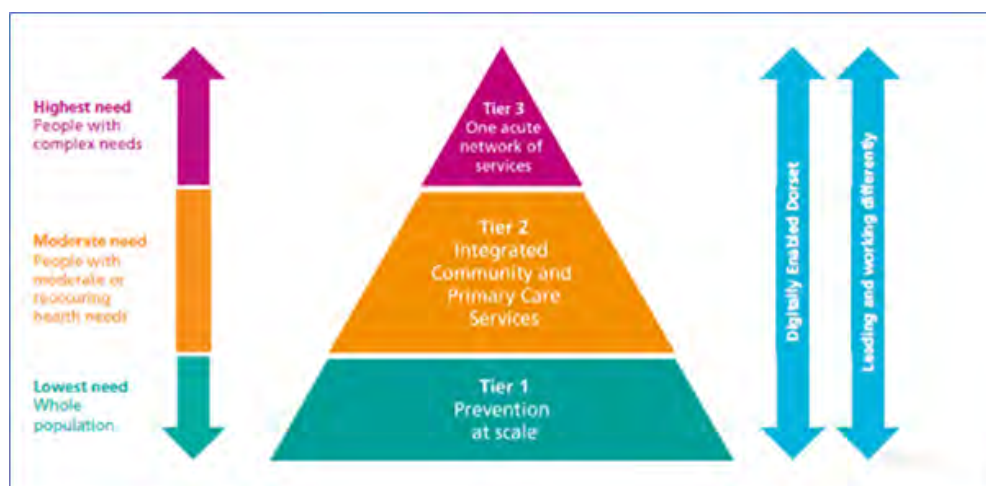
Developing as a integrated care system within Dorset

The Dorset Sustainability and Transformation Plan (STP) is the blueprint for the development of the Dorset health system. One of the key components was the strand entitled ‘Integrated Community and Primary Care Services’.

The successful delivery of the community services is vital to the operations of our hospitals and by working more closely with our colleagues in primary care we will be able to improve the use of our shared resources. The “primary” component recognises the significant difficulties that have developed in primary care with increasing workload and recruitment problems. This has led to a substantial level of “vulnerable” GP practices in Dorset and an increasing emphasis in working together across the health system to help mitigate this.

Another area of focus is the Right Care programme - there are wide variations in resources used and outcomes delivered (e.g. GP referral rates, or levels of procedures), within services and across Dorset even when adjusted for age, deprivation etc. Benchmarking using national and local Right Care and Atlas of Variation data provide a starting point for opportunities for greater consistency.

Dorset CCG has established a ‘Right Care’ Programme Board and this will provide a driving force and support removal of some of the barriers and enabling factors such as GP engagement, analytical support, and sharing of good practice.





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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Progress Update on Stakeholder Engagement Outcomes
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	David Moss, Chairperson
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Board of Directors, September 2017 Board and Council of Governors Joint Working Event, July 2017
Action required:	Note for information
Summary: This report provides the latest updates on progress against the stakeholder engagement outcomes identified by the Board of Directors and Council of Governors and subsequently developed into a series of outcomes approved by the Board of Directors.	
Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	None

Progress Update Stakeholder Engagement Outcomes

March 2018

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

February and March
21 Change Champion Focus Groups

January 2018
Interim Patient Experience and Public
Engagement Strategy

Shadow Integrated Care System - design, co-
create and operation support from the King's
Fund

Dorset Health System 2018/19 Financial
Framework

Patient representatives on East Dorset
reconfiguration clinical design workstreams

Joint Board and TMB seminar on Primary Care and
Vertical Integration with CCG/GP Lead

Dorset Health System Collaborative
Agreement

6 March
Dorset NHS NED, Lay Member and
Lead Governor Event

From March 2018
Future RBCH Joint Staff Briefings

Patient Benefits Case 70% complete and
ready end April

Staff Governors input on Governor
Concerns Log

28 February
Joint Board and Governor Development
patient and public engagement session

OAN clinical design workstreams

Two patient user groups

Joint Hospital Executive Group and Trust
Management Board meetings

Staff Governors at team meetings

Twelve patient focus groups



Trust Board Dashboard - February 2018
based on Single Oversight Framework metrics

CARE_GROUP	DIRECTORATE
B - MEDICAL	ANAESTHETICS
C - SPECIALTIES	CANCER CARE
CORPORATE	CARDIOLOGY
(blank)	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	2017/18 Q2			2017/18 Q3			2017/18 Q4			Trend (where applicable)
			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	90%	95.95%	95.77%	95.65%	95.73%	94.55%	92.16%	92.89%	87.55%		
	Caring - Inpatient scores from Friends and Family Test % positive	95%	97.85%	96.52%	97.91%	97.56%	97.53%	98.72%	98.19%	98.63%		
	Caring - Maternity scores from Friends and Family Test % positive	95%	96.00%	99.07%	100.00%	97.14%	96.84%	98.33%	97.24%	95.71%		
	Caring - Mixed sex accommodation breaches	0	1	0	0	0	0	0	0	0		
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)			86.08%								
	Caring - Formal complaints		18	23	32	29	36	23	23	21		
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	< Prev Yr Month AVG	516	503	532	513	508	509	499	434		
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	< 100	92.8	96.7	127.6	75.1	80.2					
	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	73.3	85.9	114.0	74.7	78.8					
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	< 100	81.9	80.5	98.3	94.1	106.4					
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	< 100	221.9	211.2	199.9	186.3	216.9					
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	< 100	67.6	73.3	90.1	85.4	101.4					
	Effective - Summary Hospital Mortality Indicator	< 1										
	ED Attendances		8574	8281	7977	7998	7726	7741	7496	6968		
	Elective Admissions		5871	6418	5913	6626	6646	5570	6582	6115		
	GP OP Referrals		5860	5977	5640	5731	5753	4636	5811	5125		
	Non-elective Admissions		3249	3311	3234	3237	3091	3144	3264	3006		
	Organisational health - Staff sickness in month	< 3%	4.185%	3.992%	3.839%	4.243%	4.141%	4.348%	4.395%	3.750%		
	Organisational health - Staff sickness rolling 12 months	< 3%	4.23%	4.25%	4.23%	4.22%	4.18%	4.16%	4.08%	4.03%		
	Organisational health -Proportion of temporary staff		6.79%	6.74%	6.78%	6.90%	6.89%	6.88%	7.20%	7.93%		
	Organisational health -Staff turnover	< 12%	10.53%	10.56%	10.37%	10.21%	9.94%	9.74%	9.68%	9.38%		
	Safe - Clostridium Difficile - Confirmed lapses in care	<=14 in Yr / 1.2 per Month	1	0	4	1	3	4	2	1		
	Safe - Clostridium Difficile - infection rate	6.9	29.27	11.71	6.05	35.13	12.1	17.56	11.71	6.48		
	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	1	0	0	0	1	2	0	1		
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)			43.69			40.06					
	Safe - VTE Risk Assessment	95%	96.47%	96.28%	96.59%	96.64%	96.92%	96.43%	96.70%	96.66%		
	Number of Serious Incidents	<= Last Year	3	3	0	0	4	3	1	2		
	Appraisals - Values Based (Non Medical) - Compliance		37.14%	57.24%	84.93%	88.99%	89.94%	89.83%	90.37%	90.46%		
	Appraisals - Doctors and Consultants - Compliance		87.36%	87.86%	88.07%	88.19%	86.55%	87.21%	88.44%	89.04%		
	Essential Core Skills - Compliance		92.55%	92.93%	92.64%	92.87%	93.31%	93.53%	93.66%	93.51%		
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	YTD Plan = 4	4	4	4	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	4	4	4	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	3	3	3	3	3	3	3	3		
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	92.29%	94.57%	94.47%	93.96%	95.04%	84.71%	92.64%	92.67%		
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	92.86%	100.00%	92.86%	100.00%	95.24%	88.89%	100.00%			
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	84.93%	89.76%	87.50%	86.50%	90.99%	86.76%	87.25%			
	Maximum 6-week wait for diagnostic procedures	99%	99.88%	99.66%	99.80%	99.85%	99.73%	99.59%	99.60%	99.47%		
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	92.04%	91.79%	90.67%	90.09%	89.92%	88.71%	88.03%	88.54%		

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)

BOARD OF DIRECTORS

Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Performance Report
Section on agenda:	Performance
Supplementary reading:	None
Director or manager with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of paper:	Donna Parker, Deputy COO David Mills, Assoc Director of Information & Performance
Details of previous discussion and/or dissemination:	PMG, Finance Committee
Action required:	Note for information

Summary:

In summary the Trust performed as follows for February / January using most recently available data.

- **A&E 4 Hour** – improved to 92.67% for February but below national target. Pressures in March, including the impact of the severe weather conditions mean March remains at significant risk.
- **RTT 18 Weeks** – improved to 88.54% though below national target for February. Key risks are impact of MSK triage on denominator and reduced elective activity to support winter and severe weather pressures.
- **Diagnostics 6 Week Wait** – above national target at 99.5% for February.
- **Cancer 62 Day from Referral** – above national target in January (last reported month) at 87.3%. There currently remains some risk to Q4.
- **Cancer 62 Day Screening** – the national target was fully met in January at 100%.

All other Single Oversight Framework (SOF), NHS Constitution and key contractual targets reported were met or within expected range for February except 1 breach of the C Difficile target (remaining above YTD trajectory) and 1 breach of the 28 day rebook following cancellation target.

Whilst we continue to benchmark well against national comparators, the forecast and associated risks and mitigating actions for March are included in the report. A key risk to the Q4 STF is our A&E 4 hour performance in March 18 which to secure the STF funding (30%) needs to be above 95%. The Dorset-wide trajectory is also being monitored in relation to system wide delivery of the STF.

Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓



Operational Performance Report

For the period to end
February 2018

Richard Renaut
Chief Operating Officer

1. Introduction

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)**. Please also refer to the Board dashboard for all **Single Oversight Framework** performance metrics.

2. Single Oversight Framework Indicators

2.1 Current performance – February 2018

A&E 4 Hour Target and 12 Hour Breaches

We saw our performance slightly improve in February to 92.67%. Emergency Department attendances were 1.27% higher than in February 17 with urgent care admissions 4.4% higher. SWASFT ambulance conveyances in February 18 are 15.3% higher than February last year and 5.8% up year on year.

Graph 1 – Monthly growth in SWASFT Ambulance Conveyances

SWASFT Conveyances Annual Comparison (Rolling 24 months)



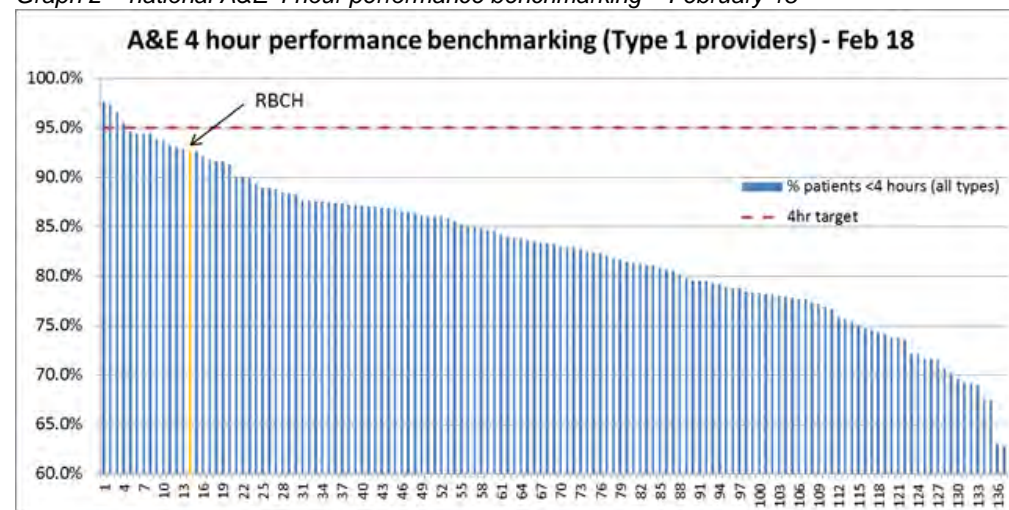
February had a good start to the month, continuing the improvement in performance seen at the end January. The increased level of attendances and admissions pushed up bed occupancy through the month. This has then affected ED flow, and performance reduced. This still gives us a comparatively high performance (see graph).

The ongoing team commitment to our Flow QI work, our early planning for winter, plus escalation actions (in OPEL Escalation Guide) have all underpinned safe emergency flows.

There were no 12 hour Emergency Department breaches in February.

Despite challenges in the latter half of the month, we were in the top 10% of Type 1 provider Trusts in February 18, maintaining our strong benchmarked position. However, we continue to strive to achieve the 95% target with a refreshed current ED action plan and Front Door Flow QI Programme for 18/19. Though noting heightened risk in March as a result of the severe weather conditions (see section 2.2).

Graph 2 – national A&E 4 hour performance benchmarking – February 18

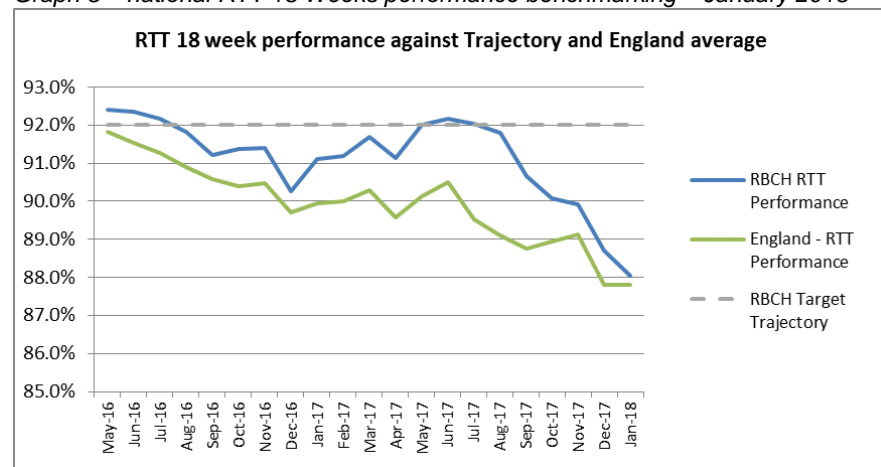


RTT Incomplete Pathways (18 week) and 52 Week Breaches

The validated RTT performance for February is 88.54% which is a slight improvement on January's performance.

Current performance is reflective of the reduced elective activity programme as well as additional cancellations that were required to support urgent care pressures over winter, in line with the national guidance. The impact of the MSK Triage Service on referrals is also continuing to impact on RTT performance. We continue to monitor this and work jointly with our partners under the oversight of a joint Performance and Governance Group, to ensure quality of care for patients.

Graph 3 – national RTT 18 Weeks performance benchmarking – January 2018



As shown in the above graph, January benchmarking reflects the continued challenge across all Trusts.

Whilst we have seen a deteriorated position, we have continued to be above the national average. Risk to future months does remain, though in line with the NHS planning guidance, we will continue to focus on at least stabilising our overall waiting list and avoiding very long waits – see Section 2.2. To support our spot clinical audit and

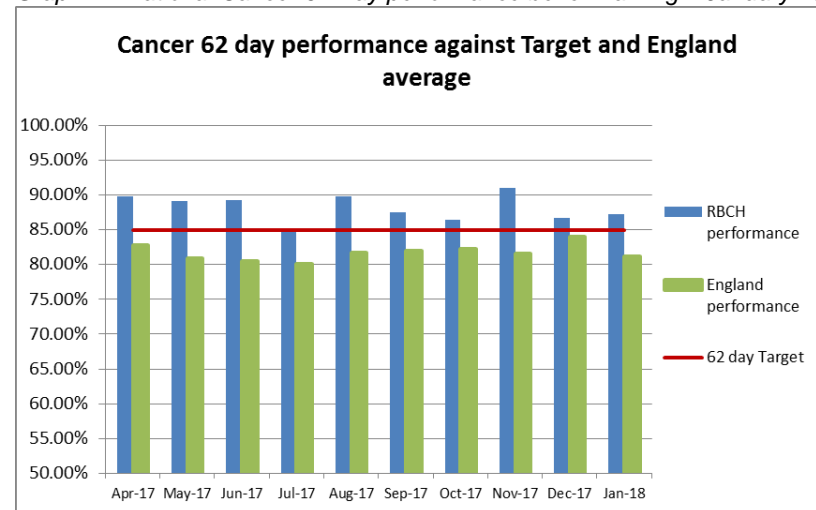
proactive approach to avoiding clinical harm in relation to long waiting patients, we are planning to implement a similar RCA and monitoring process to the cancer 104 day 'backstops'.

62 Day from Referral/Screening for Suspected Cancer to Treatment

For the month of January (*last formal reported month*) performance was at 87.3% with 13 breaches. This is better than the national target of 85%.

There were 13 breaches across 6 specialities with 9.5 breaches in Urology (note, 0.5 breach is shared with another provider). The non-Urology breaches included: 1 in Breast, 1 in Sarcoma, 0.5 in Skin, 0.5 in UGI, 0.5 in Head and Neck. The most significant reason for breaches was complex pathways (5 breaches). Other reasons included cancellation due to last minute staff shortage, elective capacity and 2 late referral breaches from other trusts.

Graph 4 – national Cancer 62 Day performance benchmarking – January 18



Operational Performance Report

As at 20/03/2018

We continue to benchmark above the England average for the 62 day target as well as for all of the cancer metrics.

Graph 5 - national Cancer 2 week wait performance benchmarking – January 18

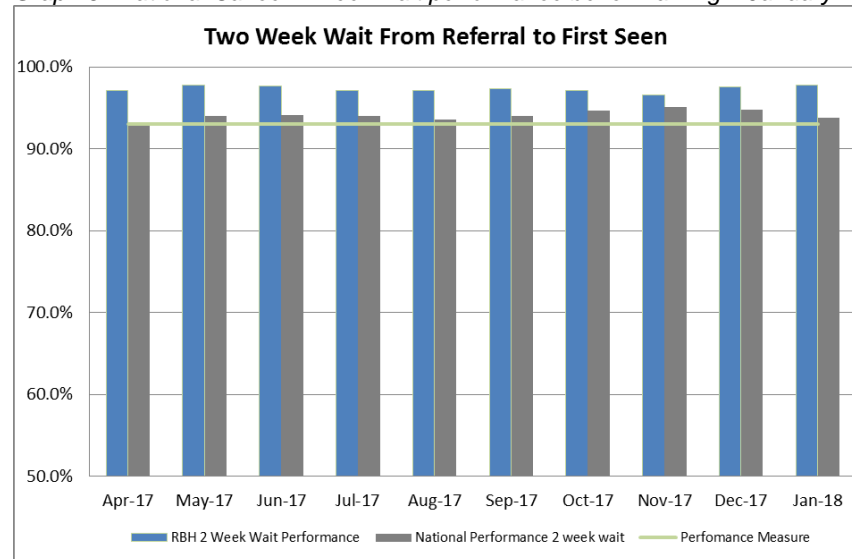


Table 1- National Comparison of key Cancer metrics January-18

Area	Indicator	Measure	Target	Jan-18	National Performance - Jan 18
Cancer Waiting Times	2 week wait	From referral to to date first seen - all urgent referrals	93.0%	97.8%	93.8%
	2 week wait	From referral to to date first seen - for symptomatic breast patients	93.0%	100.0%	91.9%
	31 day wait	From decision to treat to first treatment	96.0%	96.5%	96.5%
	31 day wait	For second or subsequent treatment - Surgery	94.0%	94.4%	93.6%
	31 day wait	For second or subsequent treatment - anti cancer drug treatments	98.0%	100.0%	99.0%
	62 day wait	For first treatment from urgent GP referral for suspected cancer	85.0%	87.3%	81.0%
	62 day wait	For first treatment from NHS cancer screening service referral	90.0%	100.0%	87.7%
	62 day wait	Consultant Upgrades	90.0%	100.0%	87.0%

We were compliant with our performance for the 62 day screening target with our performance at 100% in January.

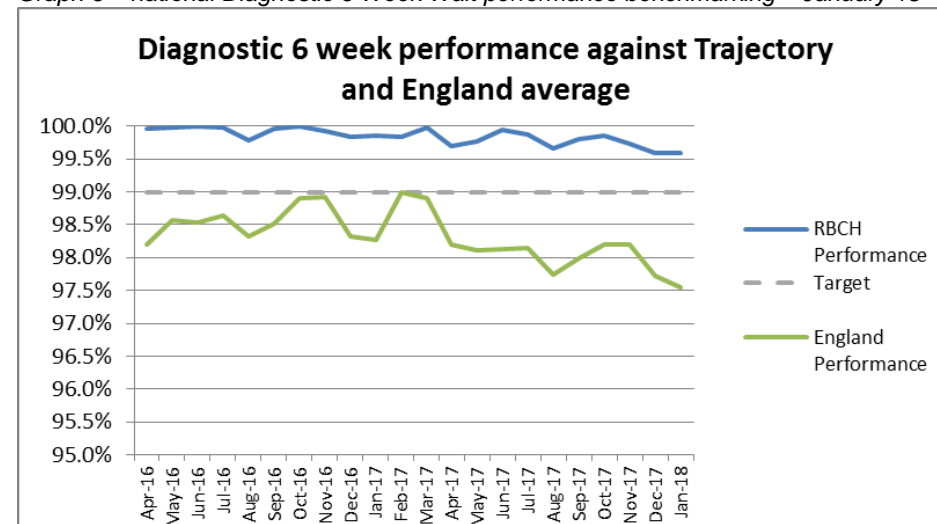
We have 3 patients with a greater than 104 day pathway (2.5 as shared with other sites); clinicians have assessed all patients and confirmed no clinical harm. The most significant reason for breaches was complex pathway.

Diagnostic 6 Week Wait

Our positive performance against the 6 week diagnostic standard continued in February with the final validated performance achieving 99.5%. Performance currently remains on track in the key areas (Endoscopy, Radiology, Cardiology and Urology).

The graph below shows deterioration in the national position. We remained well above the 99% threshold and England average and anticipate maintaining this, noting additional diagnostics required to support the ongoing increase in suspected cancer fast track referrals.

Graph 6 – national Diagnostic 6 Week Wait performance benchmarking – January 18



2.2 Q4 - Forecast Performance and Key Risks

The table below indicates our forecast against the national targets and the expected 17/18 performance trajectories we submitted to NHSI for the key standards.

For Q4, 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 Diagnostics 6 Week Wait is expected to remain compliant.

Table 2 – SoF Key Operational Performance Indicators 2017/18 – actuals and forecast

Single Oversight Framework Indicator	National Target	NHSI Trajectory	Mth / Qtrly	RAG rated forecast against national targets and NHSI submitted trajectories					
				Qtr 1	Q2	Q3	Jan-18	Feb-18	Mar 18 est.
A&E 4hr maximum wait time*	95%	91-93%	Mthly						
RTT 18 week incomplete pathways	92%	91%	Mthly						
Cancer 62 day wait for first treatment from urgent GP referral**	85%	85 - 85.4%	Mthly						
Cancer 62 day wait for first treatment from Screening service**	90%	90%	Mthly						
Maximum 6 weeks to diagnostic test	99%	99%	Mthly						

RAG Key: Red - below national target and organisational trajectory; Amber - above trajectory but below national target or 'at risk'; Green - above national target (and trajectory).
 *STF trajectory requirement for 95% in Mar 18
 **Feb cancer final validated upload will be completed early Apr 18

A&E 4 hour, ED Streaming and STF

The extreme weather conditions led to a challenging start to March with reduced performance seen both at RBH and across the country. Early indications suggest the Trust and Dorset system benchmarked well comparatively and likely to remain in the top 20%. We implemented our full internal significant incident process during this time and the efforts and dedication of staff were exemplary. Community support meant staff and patients were supported by 4 wheel drive transport on a voluntary basis. The Trust wishes to formally acknowledge and thank all of those staff and volunteers who supported us in maintaining patient care at this time.

We have continued to enact our full OPEL escalation process to also support the recovery and ongoing challenges we are still seeing with unprecedented ED attendances and admissions. Unfortunately, our and the Dorset position to date, is however, unlikely to meet the 95% target requirement associated with the Q4 STF.

A mid term 'winter debrief' has already commenced in order to learn from challenges and actions so far. A Dorset-wide debrief, including the severe weather response, will also be carried out. This will inform our continued work.

ED Streaming is continuing with an increased number of patients receiving timely and appropriate care from primary care clinicians.

RTT 18 weeks

Continued challenge in relation to our RTT performance is expected. As previously indicated and outlined above, we are now seeing the impact of the MSK Triage Service where patients are reviewed and directed to the most appropriate service for their Orthopaedic or Rheumatology problem. Furthermore, the planned reduction in non-urgent and non-cancer elective activity over the winter together with additional cancellations, including during and in the recovery phase of the severe weather, has impacted on waiting times and our 18 week backlog.

Currently, in addition to cancer pathways, maintaining backlogs at their current level and a focus on longer waiters will be our key priority in line with the NHS planning guidance. We will also continue to monitor the impact of the MSK Triage service. Reduction in backlog is currently unlikely unless additional national funds become available to support premium cost or outsourced activity. We will however, be reviewing our activity plans for 18/19 in line with the trajectory required for improvement. Phase 2 of our Right Referral, Right Care Programme has commenced and the Programme will be continuing into 18/19. We have also been linking with the NHSE/I South

initiatives, utilising the recently developed speciality handbooks as part of our programme progress reviews.

Our work in Dermatology also continues jointly with our partners to support our current capacity challenges. Dorset CCG are supporting the procurement of an app to as part of our further development of teledermatology.

Cancer 62 Day

Compliance has been maintained from Q3 into January and is also expected for February. There is currently some risk in relation to anticipated March breaches where some delays over the winter and peak holiday periods impact, but we continue to work on pulling patient appointments and treatments forward.

In line with the national guidance, we are continuing to prioritise cancer treatments. Demand and capacity pressures mean Dermatology fast track pathways remain a risk.

Diagnostic 6 Week Wait

A slight increase in the overall waiting list for diagnostics has been seen. The shorter month, together with winter pressures, sees reduced activity levels in February. However, we do not expect an impact on performance going forward. We will continue to monitor demand, particularly as a result of ongoing inpatient and fast track pathway pressures. However, we are currently forecasting a sustained overall positive performance position.

3. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail.

There was 1 reportable breach (with some evidence of 'lapse in care') against the C Difficile in month target, which puts us above target year

to date (17 against a target of 12.8). Actions being taken in relation to C Difficile include:

- A trigger added so that if a patient with stool types 5, 6 and 7 prompts staff to take a sample
- Targeted plans related to antibiotic usage
- Improvements in cleanliness and decluttering.

It should be noted that we are seeing a reduction in C.difficile cases over time (since 2008/09) following better use of antibiotic therapy.

We had 1 patient not treated within 28 days after being cancelled on the day; this patient was a Dermatology patient who was treated after 30 days. Unfortunately, the surgeon was unwell when they were originally scheduled and were unable to find a slot within 28 days as slots were filled with fast track Cancer activity.

4. 2018/19 National Planning Guidance

As highlighted last month, following publication in September 2016 of the NHS operational planning and contracting guidance 2017/18 - 2018/19, NHSI and NHSE have recently published supplementary guidance for 2018/19 planning round. We are currently reviewing our activity plans against the key performance deliverables, with a focus on:

- ED 4 hour (90% Sept 18; 95% Mar 19; quarterly improvement on previous year) – 30% of STF
- RTT (no patients over 52 weeks; no increase in number of patients on an incomplete pathway)
- Cancer waiting time standards, including 62 day referral to treatment.

The NHSI Single Oversight Framework continues to focus on four key operational performance metrics; the 4 hour A&E standard, RTT 18-week incomplete pathways standard, the 62-day cancer standard and 6 week diagnostic standard.

All of the above are included within the integrated dashboard and performance matrix submitted monthly to the Trust Finance Committee, Trust Management Board and Board of Directors.

5. 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 and requirements for 18/19.

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	N/A
Subject:	Quality Report
Section on agenda:	Performance
Supplementary reading:	None
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Fiona Hoskins: Deputy Director of Nursing and Midwifery Jo Sims: Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Not Applicable
Action required:	Note for information
<p>Summary: This report accompanies the Trust Quality Dashboard and outlines the Trust's actual performance against key patient safety and patient experience indicators.</p> <p>Serious Incidents: There have been 2 serious incidents reported in February 2018</p> <p>Complaints: A total of 18 complaints were received in February 2018. All were acknowledged within three days. Care Quality remains a theme across all directorates.</p> <p>Friends and Family Test: The Trust has been ranked 2nd out of 172 Trusts for friends and family test placing us in the upper quartile for inpatients. FFT feedback for ED is the second quartile.</p>	
Related strategic objective:	
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	N/A



Quality Report

For the period to end
February 2018

Paula Shobbrook
Director of Nursing and Midwifery

1. 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. Serious Incidents

Two Serious Incidents were reported in February 2018

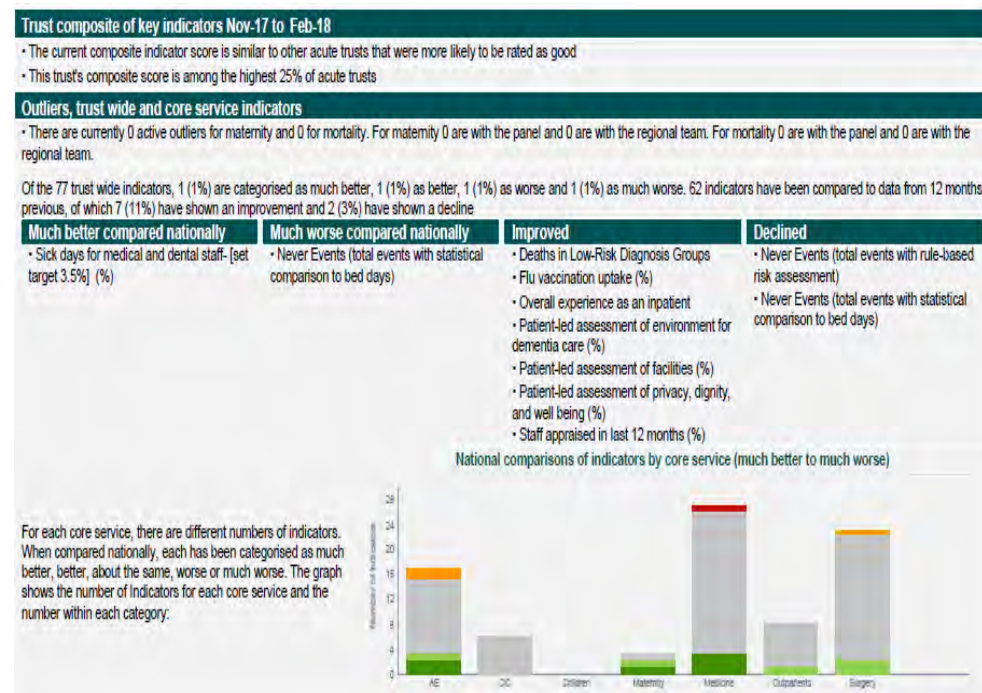
- Error in relation to the preparation of a Chemotherapy medication that resulted in an administration of an incorrect dose. SI process has been undertaken. This incident has also been subject to an MHRA investigation.
- During a Cardiology procedure a second stent was positioned, instead of a balloon dilatation, which was planned. There was no harm to the patient, however, this meets the definition of a Never Event and an investigation is in progress.
- A further Never Event involving wrong site laser surgery has been reported. The incident was agreed at a scoping meeting on the 9/3/18 and an initial 72 hour report shared with the CCG, CQC and NHSI. An investigation is in progress.

The Board has been advised of the seven Never Events which have been reported this year. Whilst it is of note that the majority of these did not result in harm and demonstrate a positive reporting culture, there is further investigation and support to focus on lessons learnt. This includes external clinical reviews and commissioning a human factors expert for advice. The Medical Director has also written to the CQC and NHS Improvement expressing our willingness to be one of the Trusts partaking in the national review of Never Events.

3. CQC Insight Model

On 20 February 2018 the CQC published the latest Insight Report for this Trust and compared our performance to all other acute NHS Trusts.

Of the 77 trust-wide indicators 1 is categorised as much better, 1 as better, 1 as worse, and 1 as much worse. 62 indicators have been compared to data from 12 months previously of which 7 (11%) have shown an improvement and 2 have shown a decline.



The 2 indicators showing a decline relate to the number of Never Events reported by the Trust.

Overall the current composite indicator score for RBCH is similar to

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

4. Patient Experience

4.1 Friends and Family Test

National Comparison using NHS England data:

The national performance benchmarking data bullet pointed below and shown in table 1 is taken from the national data provided by NHS England which is retrospectively available and therefore, represents January 2018 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in January 2018 ranked RBCH Trust 2nd with 16 other hospitals out of 172 placing RBCH in the top quartile based on patient satisfaction. The response rate was sustained above the 15% national standard at 18.4%.
- The Emergency Department FFT performance in January 2018 ranked RBCH Trust 8th with 7 other hospitals out of 138 placing RBCH ED department in the second quartile. The response rate 3.9% against the 15% national standard. A texting service is being tested in ED to gain more responses.
- Outpatients FFT performance in January 2018 ranked RBCH Trust 4th with 27 other Trusts out of 243 Trusts, placing the departments in the second quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

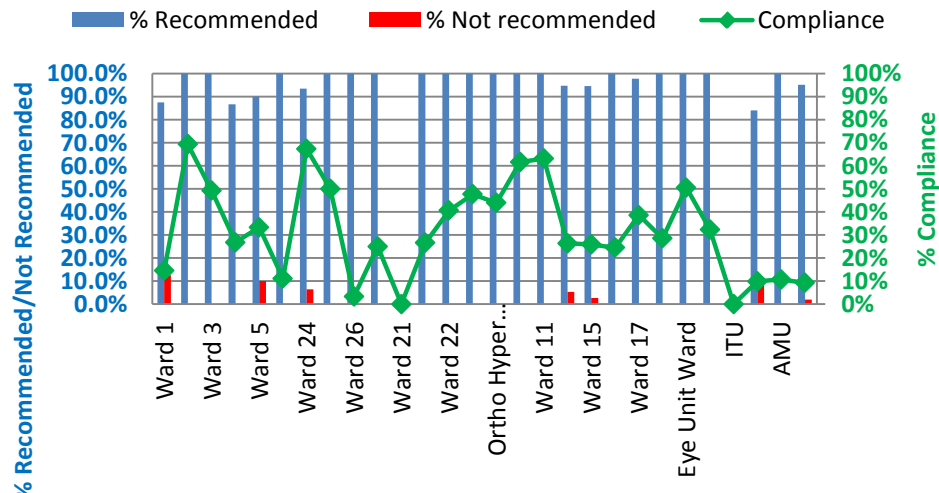
Table 1: National Performance Benchmarking data

	August	September	October	November	December	January
In-Patient Quartile						
Top		98.618%	98.355%	98.492%	98.842%	98.755%
2	97.335%					
3						
Bottom						
	August	September	October	November	December	January
ED Quartile						
Top	95.765%	95.652%	95.726%	94.545%		
2					92.157%	92.887%
3						
Bottom						
	August	September	October	November	December	January
OPD Quartile						
Top						
2	97.441%	96.932%	97.337%	97.251%	96.436%	97.231%
3						
Bottom						

4.2. Trust wide data

The following data is taken from internal data sources. Table 2 below represents Trust ward and department performance for FFT percentage to recommend, percentage to not recommend and the response compliance rate (February 2018)

% Recommended v Compliance Feb 2018 Overall Trust



4.3. Family and Friends Test: Corporate Outpatient areas

Corporate	Total eligible to respond	No. PEC's completed	No. of FFT Responses	% Recommended	% Not Recommended
Derwent OPD	N/A	34	34	100.0%	0.0%
Main OPD Xch	N/A	56	54	98.1%	1.9%
Oral and Maxillofacial	N/A	7	7	100.0%	0.0%
Outpatients General	N/A	231	223	96.9%	1.3%
Jigsaw OPD	N/A	7	5	80.0%	20.0%
Corporate Total		335	323	97.2%	1.5%

4.4. Care Audit Trend Data

The Care Audit Campaign has changed and data will now be reported on a quarterly basis.

4.5. Patient Opinion and NHS Choices: February Data

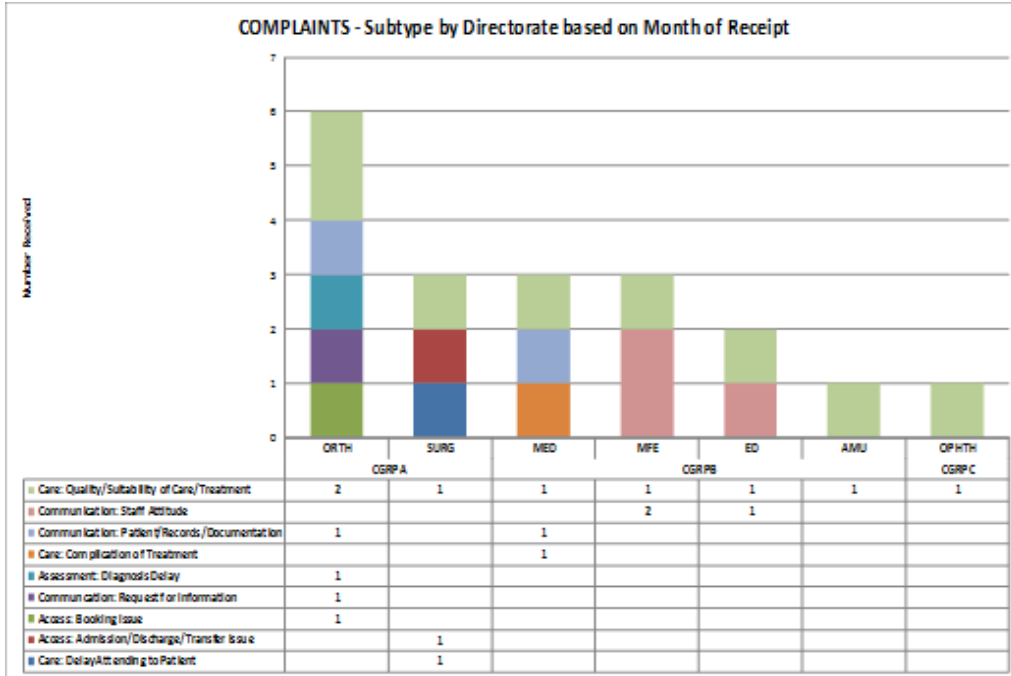
11 patient feedback comments were posted in February, 10 express satisfaction with the staff attitude, care and professionalism. 1 negative response related to waiting time and support.

All information is shared with clinical teams and relevant staff, with Senior Nurses responses included in replies following concerns.

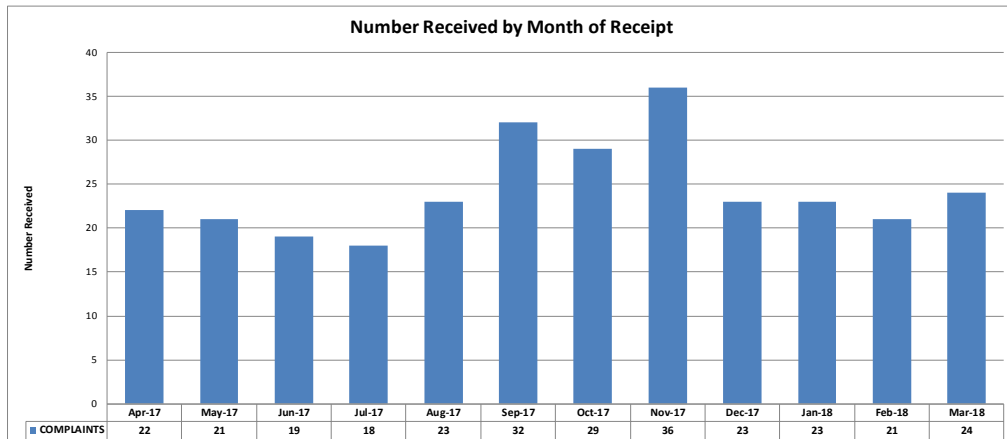
5.0. Complaints







A total of 18 complaints were received in February all of which were acknowledged within 3 days. Of note, formal written complaints have trended down in February with the highest theme being:

- Implementation of care
 - Quality / suitability of care / treatment
- Communication
 - Staff attitude



There have been a total of 291 complaints received from 1st April 2017.



Care Group	Complaints										
	Number Due in February 2018	Number on time in February 2018		% on time September	% on time October	% on time November	% on time December	% on time January 2018	% on time February 2018	Change	Trend
CGRPA	2	1		75	22	80	78	69	50	▼	
CGRPB	12	10		86	60	50	60	58	83	▲	
CGRPC	2	1		100	100	50	50	50	50	=	
OTHER	2	2		100	75	0	0	50	100	▲	
PRIVATE	0	0		0	0	0	0	0	0	=	
GRAND TOTAL	18	14		78	56	59	68	62	78	▲	

There has been an increase in the percentage of complaints responded to within the Trust's internal timescales in February. Some more complex complaints take longer to investigate in order to provide a thorough response and the complainant is informed of the anticipated timeframe.

A more detailed Trust wide report for Complaints in January and February 2018 will be provided for HAC in March and will be noted at the next board.

6.0 Recommendations

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



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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Finance Report
Section on agenda:	Performance
Supplementary reading:	Yes
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Chris Hickson, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required:	Note for information
Summary: The financial reports are detailed in the attached papers.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ✓
Impact on risk profile:	One current financial risk exists on the risk register related to next year's financial planning. The actions are being monitored through the Finance and Performance Committee.



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Finance Report

For the period to end

February 2018

Pete Papworth
Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £5.123 million as at 28 February which is £166,000 behind plan. This adverse variance largely reflects the loss of the Sustainability and Transformation Fund income relating to A&E performance. This has been offset in part by the receipt of national winter pressures funding together with a small number of non-recurrent financial improvements against budget.

Sustainability and Transformation Fund (STF)

The Trust has continued to deliver within its year to date financial control total set by NHS Improvement thereby securing access to the Sustainability and Transformation Fund. As reported previously, the Trust failed to achieve the quarter three A&E access target of 95%, due to exceptional operational pressures and has therefore failed to secure the associated £576,000. Due to the continuation of these pressures into March, exacerbated by the adverse weather, the Trust is also now forecasting the loss of the quarter four performance element amounting to £672,000.

As such, STF income to date totals £4.630 million reflecting an adverse variance of £1.024 million. This represents the loss of the quarter three and two months of the quarter four performance payments.

Income & Expenditure

Income is ahead of plan by £3.348 million which is reduced to £1.261 million after adjusting for 'pass through' drugs and devices. This reflects additional income from specialist activity including the new vascular hub arrangements, off-set by lower than anticipated private patient income.

Expenditure reports an over spend of £3.514 million reduced to £1.428 million after adjusting for 'pass through' drugs and devices. This £1.428 million variance is driven by additional staffing costs due to increased activity and the premium cost of continued reliance upon a flexible workforce.

Cost Improvement Programme

Financial savings of £7.241 million have been achieved to date and total savings for the year are forecast to be £1.659 million behind the targeted value. This reflects the challenge in continuing to deliver year on year recurrent financial savings particularly given the relative efficiency of the Trust when benchmarked nationally. Further schemes continue to be identified to close this gap in addition to identifying new schemes for 2018/19.

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 February the Trust's reported agency expenditure was lower than both the ceiling value agreed with NHS Improvement and the expenditure reported within the same period last year. It should be noted that whilst agency spend remains comparatively low, the cumulative cost of bank, agency and overtime is higher than the Trust's vacancy budget.

The aggregate underspend against the Trust's staffing establishment at 28 February is £13.423 million and is being covered by agency staffing amounting to £3.459million, bank staffing amounting to £10.817 million and employee overtime of £0.857 million. This represents a total pay over spend of £1.710 million. There is a range within the individual Care Groups from 2.84% underspend to 3.66% overspend reflecting the particular operational challenges faced including over the winter period. This continues to be an area of focus within Care Group financial recovery plans.

Forecast Outturn

Due to a number of non-recurrent financial improvements, the Trust is confident in its ability to achieve its agreed control total. In addition to the receipt of national funding amounting to £659,000, the Trust is expecting to improve its position by £546,000. This aggregate improvement of £1.205 million will be matched with a further £1.205 million of STF incentive funding. After accounting for the loss of the Quarter three and four STF performance payments of £576,000 and £672,000 respectively, the Trust is forecasting a net favourable variance of £1.162 million against its original NHS Improvement agreed control total.

This favourable position will result in the Trust receiving an STF bonus payment. The value of this will not be confirmed until April and will be a benefit to the current forecast outturn position.

Capital Expenditure

As at 28 February £6.817 million of capital expenditure has been committed, which is £1.755 million less than planned at this point in the year. The annual plan for capital expenditure is £9.424 million, plus a further investment of £0.998 million relating to ED streaming supported in year through national funding. The current underspend reflects the timing of scheme implementation against the initial plan and whilst some recovery will be made during March, will result in an under spend against the full year programme. This under spend, currently forecast to be £1.067 million, will be carried forward and added to the 2018/19 capital programme.

Cash

The Trust is currently holding a consolidated cash balance of £30.84 million. The forecast end of year cash balance is £25.16 million meaning that no Department of Health support is required during the current financial year. During March material cash payments will be made in relation to Public Dividend Capital dividends to the Department of Health together with the capital and interest repayments in relation to the Trusts ITFF loan.

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 Trust's financial performance to 28 February 2018.

Finance Report

As at 28 February 2018

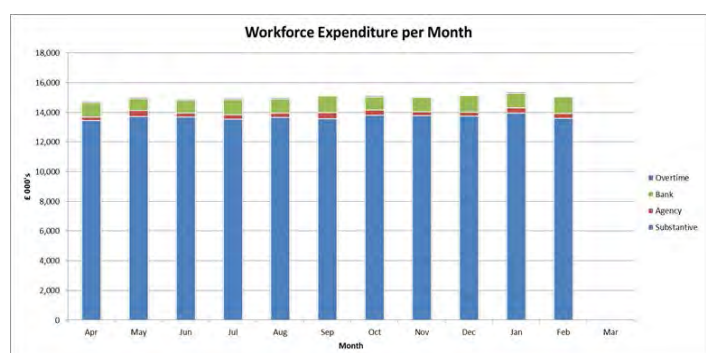
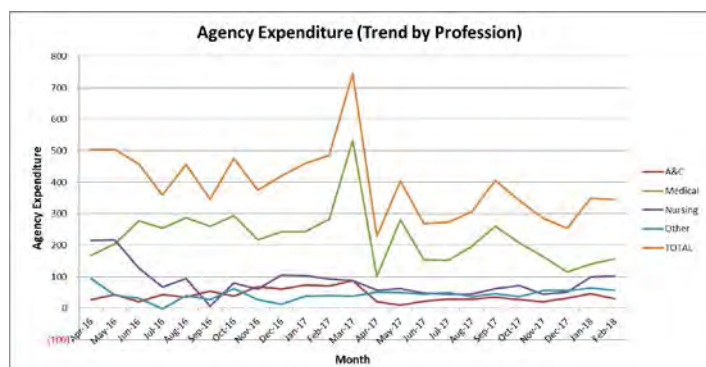
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000	Pass Through £'000	Residual Variance £'000
NHS Clinical Income	226,922	231,832	4,910	(2,052)	2,858
Non NHS Clinical Income	6,200	4,812	(1,388)	(35)	(1,423)
Non Clinical Income	27,939	27,766	(174)	0	(174)
TOTAL INCOME	261,061	264,409	3,348	(2,087)	1,261
Employee Expenses	163,936	165,646	(1,710)	0	(1,710)
Drugs	30,582	30,237	345	(956)	(611)
Clinical Supplies	29,866	32,787	(2,921)	3,043	121
Misc. other expenditure	41,634	40,862	772	0	772
TOTAL EXPENDITURE	266,018	269,533	(3,514)	2,087	(1,428)
SURPLUS/ (DEFICIT)	(4,957)	(5,123)	(166)	0	(166)

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	161,956	161,956	0
NHS England (Wessex LAT)	37,292	42,179	4,887
NHS West Hampshire CCG (and Associates)	22,765	22,787	23
Other NHS Patient Income	4,909	4,909	(0)
Sustainability and Transformation Fund	5,654	4,630	(1,024)
Non NHS Patient Income	6,200	4,812	(1,388)
Non Patient Related Income	22,285	23,136	850
TOTAL INCOME	261,061	264,409	3,348

Sustainability and Transformation Fund Income	Year to Date			Full Year Forecast		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Financial: Control Total (70%)	3,958	3,958	0	4,480	4,480	0
Performance: A&E Trajectory (30%)	1,696	672	(1,024)	1,920	672	(1,248)
Incentive	0	0	0	0	1,205	1,205
TOTAL	5,654	4,630	(1,024)	6,400	6,357	(43)

Agency Expenditure



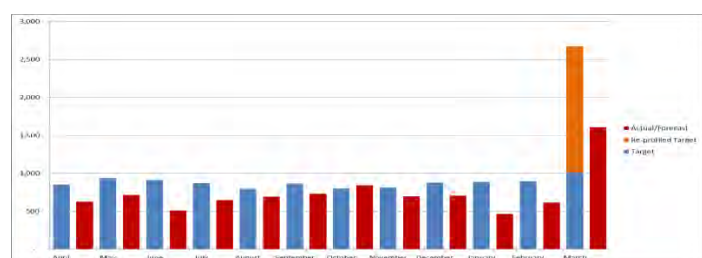
Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	13,509	11,957	(1,554)
Medical Care Group	8,508	6,490	(2,018)
Specialties Care Group	5,691	5,678	(12)
Corporate Directorates	(31,946)	(31,523)	422
Centrally Managed Budgets	(719)	2,276	2,995
SURPLUS/ (DEFICIT)	(4,957)	(5,122)	(166)

Cost Improvement Programme

Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000	FOT £'000
Surgical Care Group	2,361	1,381	(980)	(1,123)
Medical Care Group	3,241	1,757	(1,484)	(1,614)
Specialties Care Group	2,419	2,201	(218)	(215)
Corporate Directorates	1,482	1,902	420	1,293
SURPLUS/ (DEFICIT)	9,503	7,241	(2,262)	(1,659)

Cost Improvement Programme Graph



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	4,050	3,712	338
IT Strategy	2,981	1,589	1,392
Medical Equipment	1,350	1,267	83
Centrally Managed	191	249	(58)
SURPLUS/ (DEFICIT)	8,572	6,817	1,755

Cash





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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Report
Section on agenda:	Performance
Supplementary reading:	Minutes from the Workforce Strategy & Development Committee held 19/2/18
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Karen Allman, Louise Hamilton-Welsh, Fiona Hoskins
Details of previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC, Education & Training Committee
Action required:	Note for information
Summary: The paper shows workforce statistics including turnover, vacancy rate and sickness absence, together with Safe Staffing information for the month. Also included this month is the Trust's Gender Pay Gap data as per national requirements for reporting by 31/3/18.	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on risk profile:	Recruitment and workforce planning are existing risks on the risk register.



Workforce Report

For the period to end

February 2018

Karen Allman
Director of Human Resources

Workforce Report for Board

As at 28th February 2018

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate
	Values Based	Medical & Dental		Absence	FTE Days			(from ESR)
	At 28 February			Rolling 12 months to 28 February				At 28 February
Surgical	91.3%	88.5%	93.3%	4.47%	15120	12.5%	9.4%	3.6%
Medical	89.2%	86.0%	92.4%	3.88%	19503	13.2%	9.4%	9.0%
Specialities	91.6%	93.5%	94.3%	3.76%	11722	11.9%	11.1%	3.8%
Corporate	90.3%	50.0%	95.6%	4.06%	12540	6.3%	7.5%	3.2%
Trustwide	90.5%	89.0%	93.5%	4.03%	58886	11.2%	9.4%	5.5%

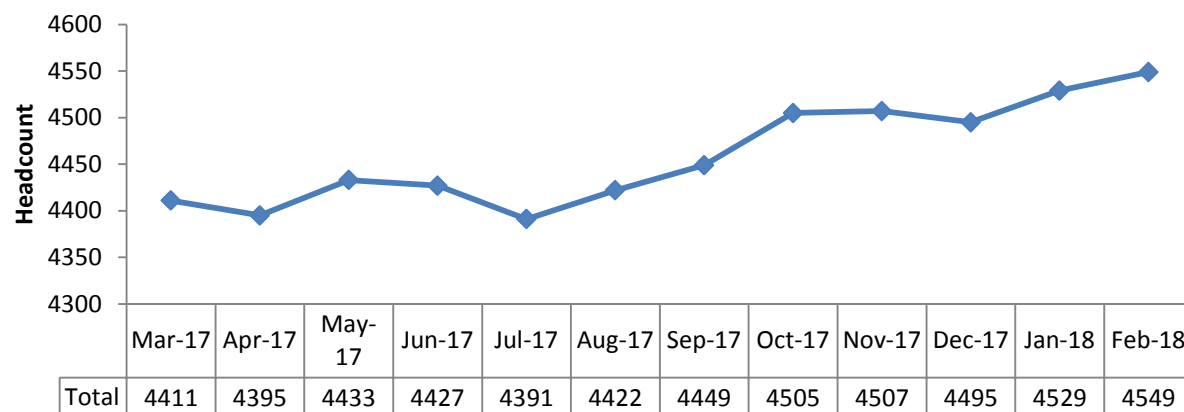
Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 28 February			Rolling 12 months to 28 February				At 28 February
Add Prof Scientific and Technical	97.9%		94.4%	2.94%	1378	12.8%	10.0%	-3.9%
Additional Clinical Services	89.9%		92.8%	6.27%	16563	22.1%	14.9%	6.0%
Administrative and Clerical	92.0%		95.9%	3.58%	11105	8.1%	9.0%	5.1%
Allied Health Professionals	86.8%		93.3%	2.66%	2475	14.2%	11.3%	1.9%
Estates and Ancillary	86.9%		93.8%	5.79%	7142	8.0%	8.5%	10.1%
Healthcare Scientists	92.2%		96.9%	2.85%	1008	8.5%	6.6%	6.3%
Medical and Dental		89.0%	88.9%	1.32%	2188	4.0%	4.0%	3.4%
Nursing and Midwifery Registered	90.5%		94.2%	4.02%	17026	8.5%	7.2%	6.6%
Trustwide	90.5%	89.0%	93.5%	4.03%	58886	11.2%	9.4%	5.5%

Workforce Report for Board

As at 28th February 2018

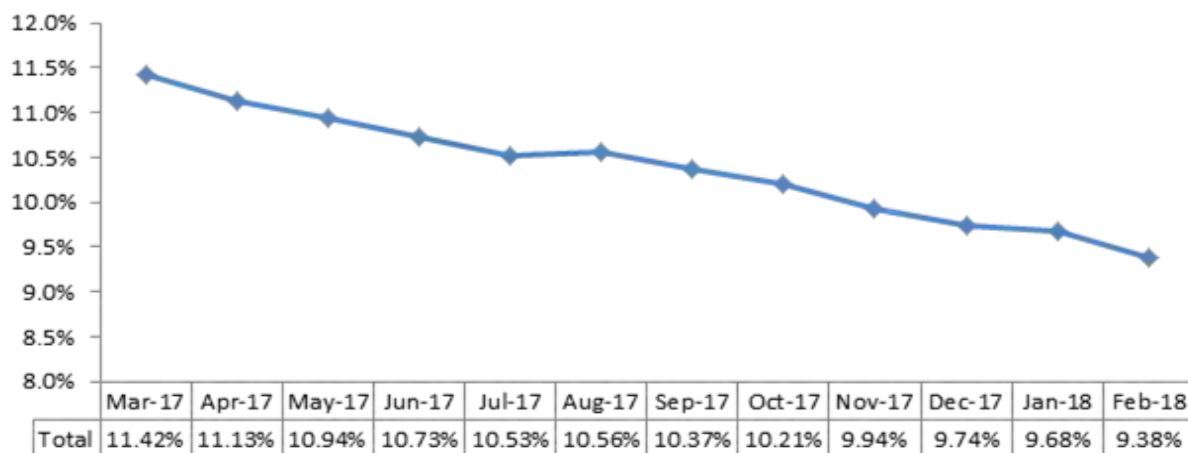
1. Staffing and Recruitment

Substantive Staff (Headcount) Trend



The information demonstrates that the turnover rate continued its downward trend, with a further reduction this month, down to a new all-time low of 9.38% (9.68% last month) which compares favourably with the 11.17% turnover rate at the same point last year.

Permanent Staff Turnover Rate (Headcount)



Joining rate 11.2%, nearly 2% higher than the turnover rate, resulting in an increased headcount.

Vacancy rate down to a new low of 5.5%.

Workforce Report for Board

As at 28th February 2018

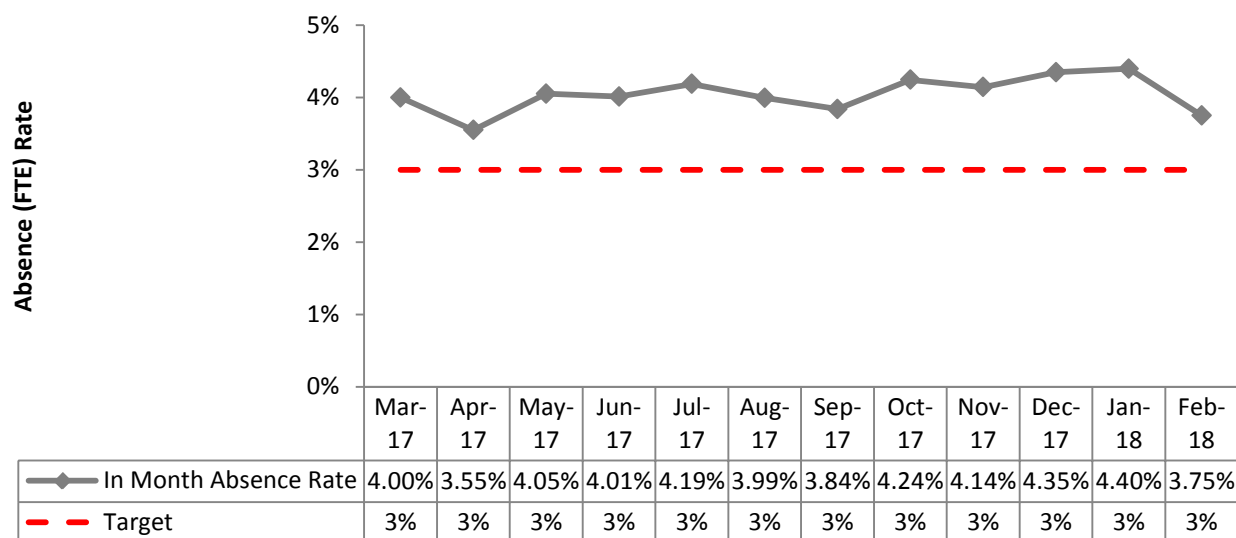
2. Essential Core Skills Compliance

Compliance fell back very slightly and currently stands at 93.5% as at 28th February (93.7% in January). This is disappointing but not unexpected due to winter pressures, but still represents an improvement on the 90.4% at the same point last year. Compliance for Medical & Dental staff remains at 89% and is being closely monitored by the Medical Director.

Focus continues on driving towards our target and working with colleagues across the NHS in Dorset to align training and improve the transferability of skills, thus reducing the need for NHS staff to do the same or similar training more than once.

3. Sickness Absence

In Month Absence Rate (FTE)



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Surgical	4.48%	4.08%	4.53%	4.81%	5.00%	4.93%	4.21%	4.21%	4.49%	4.53%	4.70%	3.90% ↓
Medical	4.19%	3.42%	4.30%	4.00%	4.32%	3.73%	3.61%	3.60%	3.34%	4.03%	4.27%	3.70% ↓
Specialties	3.50%	3.36%	3.17%	3.32%	3.70%	3.91%	3.79%	4.21%	4.77%	4.48%	4.32%	3.79% ↓
Corporate	3.66%	3.37%	4.01%	3.85%	3.57%	3.49%	3.86%	5.36%	4.44%	4.53%	4.35%	3.63% ↓
Trust	4.00%	3.55%	4.05%	4.01%	4.19%	3.99%	3.84%	4.24%	4.14%	4.35%	4.40%	3.75% ↓

It is very pleasing to be able to report a huge improvement in sickness absence with the in-month figure for February reducing from a red rating of 4.4% down to 3.75%, with reductions seen across all care groups. This is the lowest figure since April of last year and represents a significant improvement on the 4.72% at the same point last year. This is an excellent result at this time of winter pressures and it is important that focus continues in managing sickness in order to maintain, or indeed further improve, this position.

4. Safe Staffing

As part of the Trust's requirement to report on Safe Staffing (CQC – Key Line of Inquiry) the following data summary was prepared and submitted to Unify for **January 2018**:

Registered Nurse (RN)	Actual Day	94.1%	HCA Actual Day	97.5%
Registered Nurse (RN)	Actual Night	98.2%	HCA Actual Night	116.2%

The February staffing return demonstrates that overall the Trust maintained a safe staffing position during January 2018. This was achieved by areas either running to full template or implementing effective mitigating actions. There were no red flags for staffing in January 2018. A small percentage of high cost agency was utilised and this continues to be monitored through the Premium Cost Agency meeting. For registered nurse night fill rates, the Trust improvement noted in December 2017 has been maintained. There were some episodes of over-filling shifts and the rationale for these is cited below.

As part of the Trust's requirement to report on Safe Staffing the following data summary was prepared and submitted to Unify for **February 2018**:

Registered Nurse (RN)	Actual Day	92.7%	HCA Actual Day	98.3%
Registered Nurse (RN)	Actual Night	97.9%	HCA Actual Night	115.2%

The March staffing return demonstrates that overall the Trust maintained a safe staffing position during February 2018. There was one red flag for staffing raised in February 2018, however on investigation the staffing had been appropriately mitigated and no harm occurred.

The Trust experienced some challenges around staffing during the February half-term holidays, however safe staffing was maintained through the implementation of effective mitigating actions, co-ordinated through the daily staffing review meetings. Examples actions taken to ensure safe staffing throughout the month includes:

Care Group A: Surgery / ITU / Orthopaedics / Anaesthetics

- ~ Daily staffing reviews with mitigating actions undertaken with regards to trained and health care assistant under fill. Directorate staff used to support these actions.
- ~ Where appropriate skill mix swaps undertaken at night to ensure safe staffing.
- ~ Increased trained and untrained staffing to support patient acuity and capacity fluctuations.
- ~ Use of the surgical night rotational HCA to support safe staffing and provision of 1:1 nursing.

Care Group B: medicine / Emergency Department / Older Persons Medicine

- ~ Daily staffing reviews with mitigating actions undertaken with regards to trained and health care assistant under fill. Directorate staff used to support these actions.
- ~ Older Persons Medicine, health care assistant, overfill due to one to one nursing for confused patients.
- ~ Ward 26 registered nurse night under fill is due to acuity reviews and identifying whether the fourth nurse is required on a day-to-day basis.
- ~ Increased trained and untrained staffing to support patient acuity and capacity fluctuations.
- ~ Utilisation of non-ward based (research nurses and Allied Health Professionals) staff to support patient personal hygiene and nutrition.

Care Group C: Eye Unit /Cancer Care / MacMillan Unit

- ~ Daily staffing reviews with mitigating actions undertaken with regards to trained and health care assistant under fill. Directorate staff used to support these actions particular on the MacMillan Unit where the matron and specialist nurses provide clinical support and care.
- ~ Appropriate increase resource sourced for escalation areas and increased acuity.
- ~ The Ophthalmology shift overfill for Health Care Assistants during the day is due to increased activity and at night due to increased care needs for the patient group being cared for.
- ~ In Oncology the Registered Nurse gaps during the day were supported by appropriately trained, non-ward based staffing (clinical nurse specialists).
- ~ There was an increase in Health Care Assistants due to acuity on the ward and providing one to one care.

5. Gender Pay Equality

RBCH welcomes the introduction of gender pay gap reporting across public and private sector organisations. We fully support equality of opportunity and recognise the further work we need to do to achieve this. Females are represented in many senior positions (our Medical Director, Director of Nursing & Midwifery and Human Resources Director are female) but we acknowledge there are still significant gaps e.g. in senior clinical roles which drive the greatest variances in our results.

Reporting on our overarching Trust position is helpful and meets our legal requirements, however, we want to go further in exploring any existing or potential inequalities for all protected groups. Specific actions will form part of the wider Trust's Diversity and Inclusion plan. Progress against these actions will be monitored by the Trust's Equality, Diversity and Inclusion Committee and reported to the Workforce Committee and Trust Board annually as part of the agreed Equality and Diversity Strategy reporting system. In addition, from now on, we will publish our previous year's data on the Government website and our own website.

The reported data is based upon an NHS-wide gender pay reporting dashboard, developed using the Electronic Staff Record system. Gender pay gap reporting is different from equal pay which looks at pay differences between men and women who do similar jobs or work of equal value. It is therefore possible to have genuine pay equality but still have a significant gender pay gap.

Factors impacting Gender Pay Gaps in the NHS Workforce:

The current NHS medical workforce has a far greater proportion of men, although, more balanced numbers of Junior Doctors should even this up over time. There are also social and cultural reasons why, historically, fewer men have been attracted to the lower paid roles in health. The national NHS terms and conditions 'Agenda for Change' was introduced in 2004 and is designed to avoid pay inequalities. Agenda for Change covers more than 1 million people and harmonises their pay scales and career progression arrangements across traditionally separate pay groups. Staff move up the pay bands irrespective of gender. Medical and Dental staff have different sets of Terms and Conditions, depending on their seniority. However, these too are set across a number of pay scales for basic pay, which have varying thresholds within them.

Some senior Medical and Dental staff hold management positions such as Clinical Directors and are in receipt of responsibility payments in addition to their basic pay. In addition some senior Medical and Dental staff receive Clinical Excellence Awards which are consolidated into basic pay.

Not all roles within the Trust attract enhancements and this has had some impact in distorting the mean hourly rate. In addition, flexible working opportunities are available for all staff to apply for, and some staff whose role would normally attract enhanced pay in addition to their basic pay may choose to work set shifts, which do not attract the enhancements that colleagues would receive and this again will have had an impact on the mean hourly rate.

Workforce Report for Board

As at 28th February 2018

RBCH Gender Pay Gap Statistics 2017:

As at 31 March 2017, RBCH had 4,411 substantive staff (headcount), of which 1,060 were male (24%) and 3,342 female (76%).

This gender split is broadly consistent with most NHS Acute Trusts in England and Wales.

The table below shows RBCH figures against the national measures as at 31/03/2017.

	Mean	Median	Quartile			Bonus Pay received by %;		Bonus Pay Women's Rate lower %	
	Women's rate lower%		Range	Male	Female	Male	Female	Mean	Median
Royal Bournemouth Hospitals NHS Foundation Trust	23.17%	4.18%	Top	31.98%	68.02%	6.00%	0.61%	40.82%	58.39%
			Upper	16.48%	83.52%				
			Lower Mid	21.70%	78.30%				
			Lower	23.77%	76.23%				

Please see Appendix A for a visual representation of these results.

Please see www.gov.uk/government/news/gender-pay-gap-reporting for detail on how these results are calculated.

Action Planning:

In order to act to address the Gender Pay Gap, initial plans include:

- Further analysis of the detail to understand exactly what the statistics are telling us.

- Identification of specific actions we can take to influence and enable more women to move to the highest paid roles. These may include targeted management of the talent pipeline, targeted links with universities and educational establishments, more emphasis on family friendly policies and flexible working.
- Identification of any hidden barriers preventing women taking the next step up in their roles and career paths and acting to address these. At RBCH we are pleased to see a positive skew in females in the upper quadrant (84%) suggesting that women are progressing, however this does not translate to the Top quadrant (68%), so we need to understand why. This could resolve itself over time or there may be obstacles to be addressed.
- At the stage RBCH is at in our Cultural Change programme, we are placing an even greater emphasis on ensuring that our values and behaviours translate into an environment where all protected groups can thrive and achieve their career aspirations.
- Review of governance and assurance for the Workforce/Remuneration Committees and Board regarding:
 - ~ Ensuring that starting salary exceptions can be objectively justified.
 - ~ Ensuring equity of access to premium payments.
 - ~ Ensuring clear accountability for continuous measurement, analysis and reporting of data, actions and outcomes.

6. Workforce Committee

The Workforce Strategy & Development Committee met on 19th February and the minutes are included in the reading pack. Items to highlight to Board are:

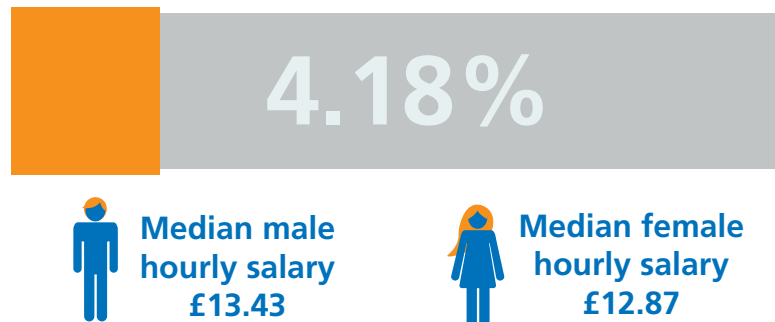
- i. Gender Pay Gap: reporting to be published by 31/3/18. See above.
- ii. Safe Staffing for the Trust: a very impressive position with no red flags since November, despite winter pressures.
- iii. Progress made with ED middle grade vacancies and the risk has been downgraded from significant. There is a middle grade starting in April in an associated specialist post which will make a big difference to the middle grade team in ED who have had a tough time over the winter period.
- iv. Workforce Committee are committed to supporting Diversity & Inclusion in the Trust; Deb Matthews will keep Committee informed on progress and initiatives via regular updates.

Summary of the Gender Pay Gap ...

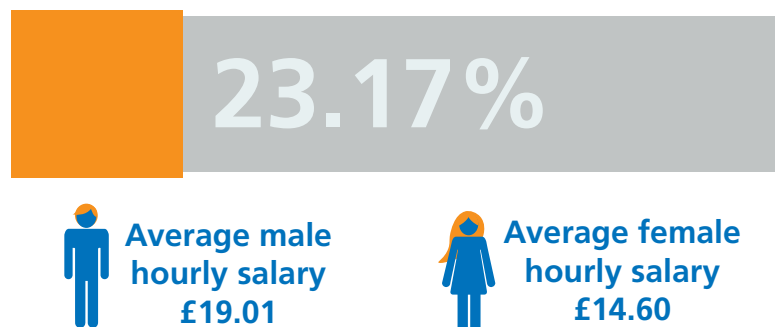
RBCH fully supports equality of opportunity and recognises the further work we need to do to achieve this. Females are represented in many senior positions but we acknowledge there are still significant gaps e.g. in senior clinical roles which drive the greatest variances in our results.



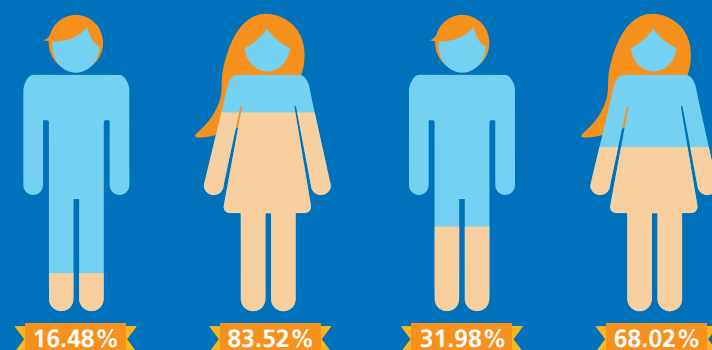
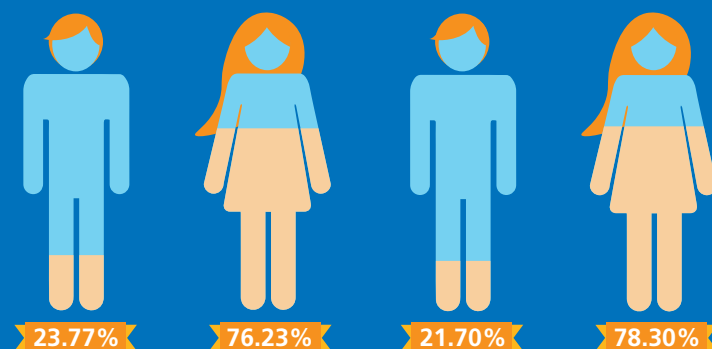
Median gender pay gap (in hourly pay)



Mean gender pay gap (in hourly pay)



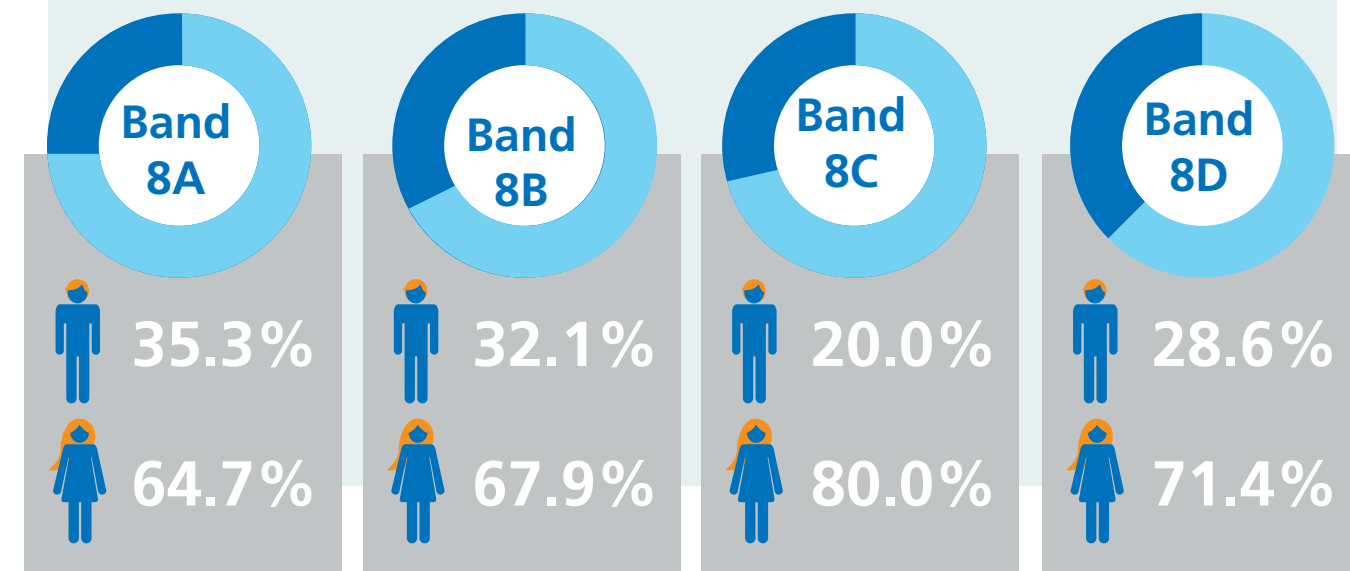
Proportion of males and females in each pay quartile



A positive skew for females in the Upper-middle quarter suggests women are progressing but we need to understand why this does not translate to the Upper quarter. We also want to attract more males to the less senior roles.

The senior Agenda for Change grades

In RBCH around ¾ of employees are female and the proportion in Bands 8C and 8D is pretty much in line. Bands 8A and 8B show a disproportionately higher level of men.




Our
Gender
Pay Gap is

4.2%

Moving Forward

To address the gap, initial plans will include:
 More analysis - to be clear exactly what the statistics are telling us.
 More action to influence and enable women to achieve the highest paid roles.
 Exploring and addressing any barriers.
 Further work on translating our values and behaviours to support all protected groups.
 Review of governance and assurance around Gender Pay Gap actions and reporting.

Figures taken as of 31/03/2017

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Staff Survey Results
Section on agenda:	6. Performance
Supplementary reading:	Additional reports and analysis can be obtained via the following links: 
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Louise Hamilton-Welsh, Head of HR Strategy
Details of previous discussion and/or dissemination:	
Action required:	Note for information
Summary: The purpose of this paper is to update the Board on the exceptional results of the 2017 staff survey, to provide insights and analysis on the feedback and to clarify how action planning will be taken forward in 2018.	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	✓ ✓ <input type="checkbox"/> <input type="checkbox"/> ✓
Impact on risk profile:	

National Staff Survey 2017

Results in context:

'Take a bow The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, for a quite remarkable set of results from staff in the current national context. They might only have gone up one place from their league position last year, but the results are a trend-bucker'.

Listening into Action Trust Analysis, March 2018

Contents:

Part	Content	Page
1.	Response rate and Eligibility	
2.	Reporting and Benchmarking the results	
3.	Key Results: <ul style="list-style-type: none"> • RBCH question results against 2016 • RBCH Key Findings against other Acute Trusts • Listening into Action (LiA) Trust Analysis • Additional Benchmarking against the 49 Picker Acute Trusts: • Free text comments – random sample 	
4	Engagement	
5	Areas for focus	
6	Making use of the survey data	
7	Next Steps in Developing Action Plans:	

1. Response Rate & Eligibility:

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

The average response rate for Acute Trusts was 45.5%.

The RBCH response rate in 2016 was 44.9% and in 2015 it was 37%.

1.1 Eligible staff included:

- All full time and part-time staff who were directly employed by the organisation on 1 September 2017;
- Employees on all types of contract;
- Permanent, fixed period, locum, or temporary staff;
- Staff on secondment to a different organisation for less than a year if still on RBCH payroll;
- Hosted staff if on RBCH payroll;
- Any staff member meeting the above criteria who was on parental leave.

1.2 The list excluded:

- Staff who started working for the organisation after 1 September 2017;
- Staff who were on long-term sick leave² on 1 September 2017;
- Staff on unpaid career breaks;
- Suspended staff;
- All staff employed by sub-contracted organisations or outside contractors;
- Bank staff (unless they also had substantive organisation contracts);
- Seconded staff who were not being paid by the participating organisation;
- Student nurses;
- Non-executive directors.

2. Reporting and Benchmarking the Results:

2.1 Picker administer the RBCH survey and provide this service for 49 Acute Trusts in total, so it is indicated where reports relate to the Picker 49 and where comparisons are against the total 93 Acute Trusts.

2.2 Results are reported and benchmarked against the same 88 questions used in both 2016 and 2017.

2.3 Results are also reported and benchmarked against 32 'Key Findings' which this year are groups of questions under nine themes i.e. Appraisals & support for development; Equality & diversity; Errors & incidents; Health & wellbeing; Job satisfaction; Managers; Patient care & experience; Violence, harassment & bullying and Working patterns.

For each of the 32 Key Findings, Trusts were placed in order from 1 (the top or 'best' ranking score among organisations of a similar type) to X (the bottom or 'worst' ranking score among organisations of a similar type).

For Acute trusts five benchmarking groups (lowest 20%, below average, average, above average, and highest 20%) are then created on the basis of these rankings.

Depending on the question, as in previous years, there are two types of Key Finding: **percentage scores** out of 100 and **scale summary scores** out of 5.

2017 Key Findings are directly comparable to those from the 2016 iteration of the survey.

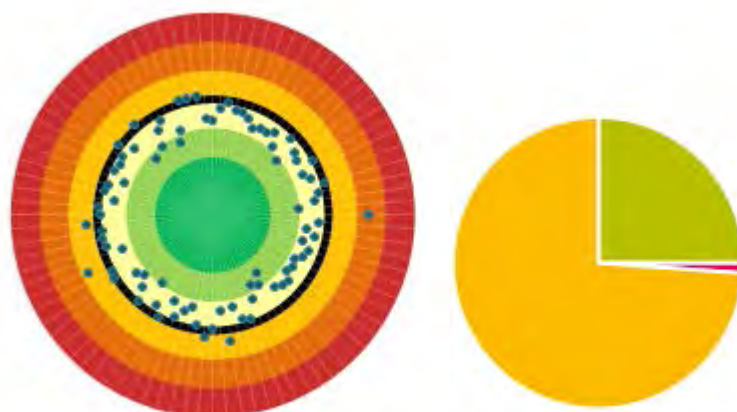
3. Key Results:

3.1. RBCH question scores against 2016:

A total of 88 questions were used in both the 2016 and 2017 survey and the following table shows that RBCH scored significantly better on 22 questions, worse on 1 question and showed no significant difference in 65 questions. The individual question results for 2017 are shown as dots and the improvement is shown by the distribution inside the black circle which represents the 2016 results.

The only question scoring lower than 2016 relates to pay.

Table 1: Dartboard showing distribution of scores against 2016 results.



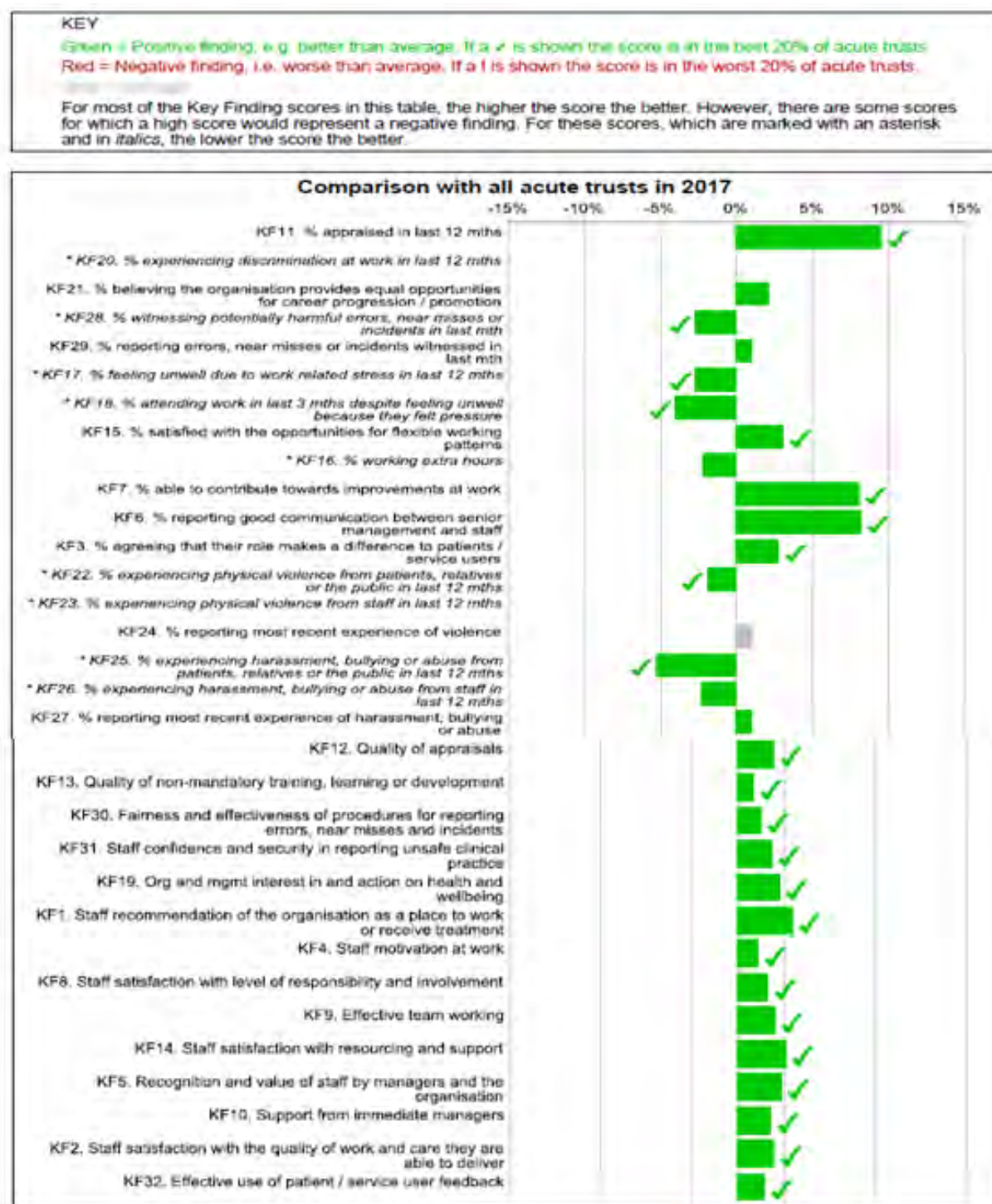
3.2. RBCH Key Findings compared to all 93 Acute Trusts:

The following table shows better than average Key Finding results in green.

The green ticks show a score in the top 20% of all Acutes in 24 of the 32 Key Findings.

RBCH ranked first in 3 Key Findings and equal first in 2 Key Findings across all 93 Trusts.

Table 2: RBCH Key Finding Results vs all 93 Acute Trusts:



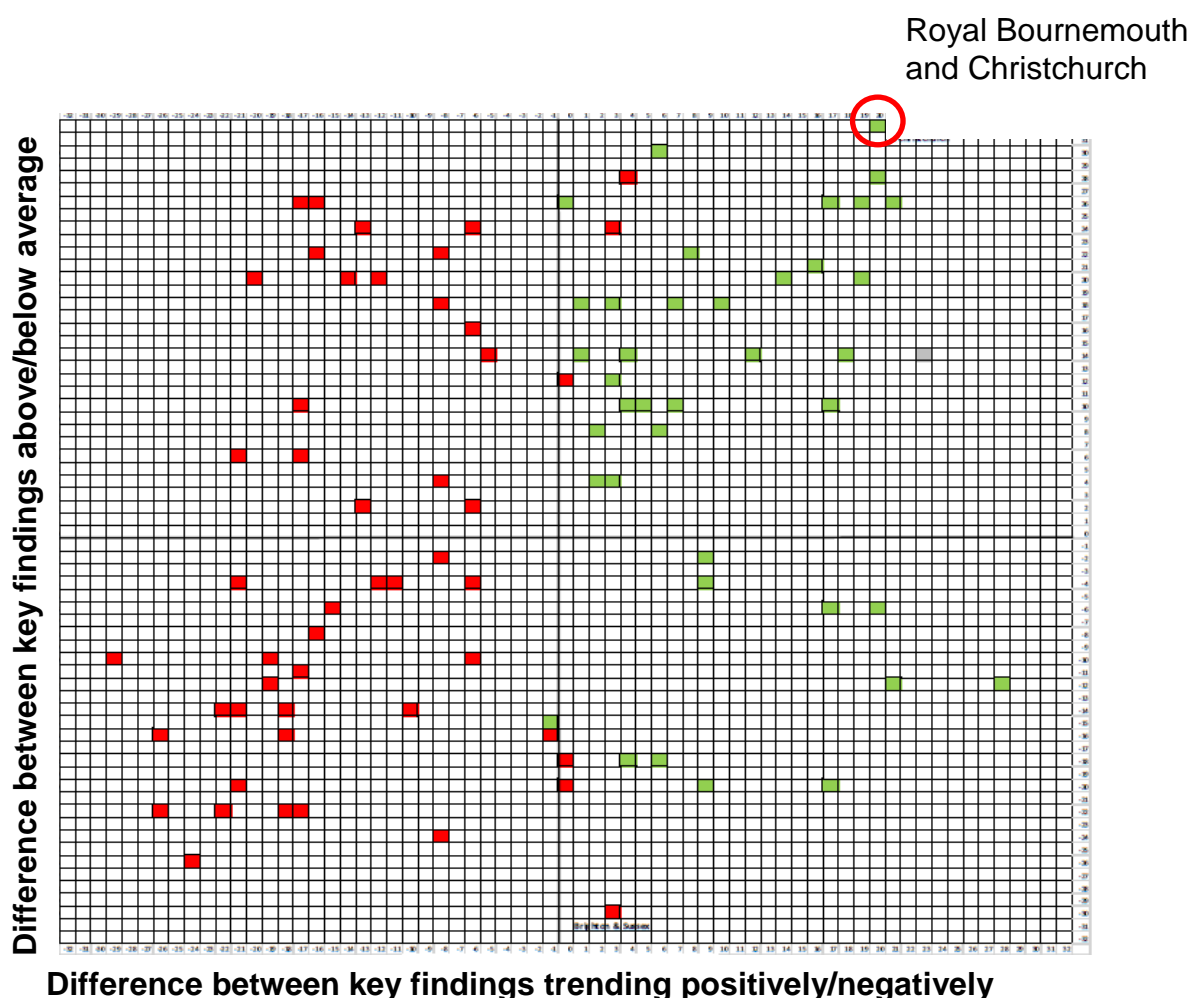
3.3 Listening into Action (LiA) Trust Analysis:

The following table was published by Listening in Action (8.3.17) and shows an analysis of the 32 Key Findings. Each Trusts' results are reflected at a grid reference on a 32 by 32 'Scatter Map' that shows how staff have rated the Trust's leadership and culture over the past year.

- The higher up the Trust is, the better the performance against peers in the eyes of staff
- The further to the right, the more positive the Trust trend, year-on-year.

The best quadrant for the Trust to be in is 'top right' which shows an above average performance and a positive trend. RBCH was highlighted on the Scatter Map in the top right with 'a quite remarkable set of results'.

Table 3: LiA Scatter Map showing distribution of Acute Trust NHS National Staff Survey Key Findings 2017/2018



3.4 Additional Benchmarking against the 49 Picker Acute Trusts:

Picker provide additional external benchmarking across their 49 Acute Trusts.

The following tables show extracts from question clusters relating to 'your job', 'your managers' and 'your health, wellbeing and safety at work'.

Each blue bar shows the range of performance on a question. The yellow triangle is the RBCH score and the black line is the average for these 49 Trusts.

Table 4: 'Your job' question cluster:

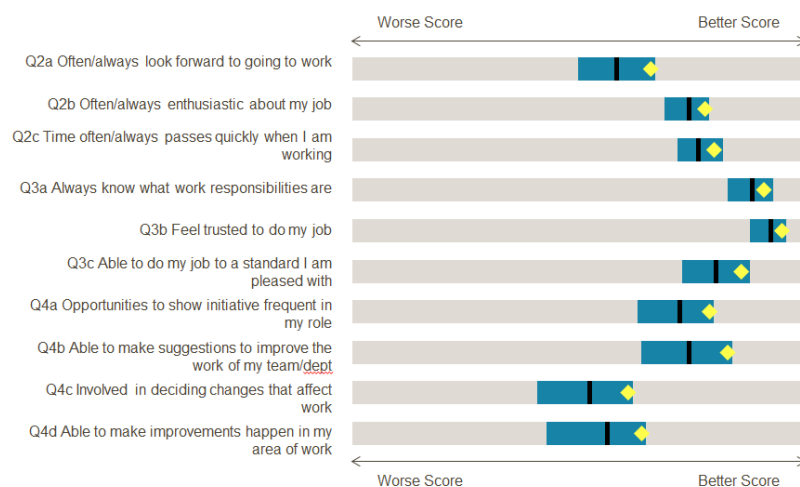


Table 5: 'Your Manager' question cluster:

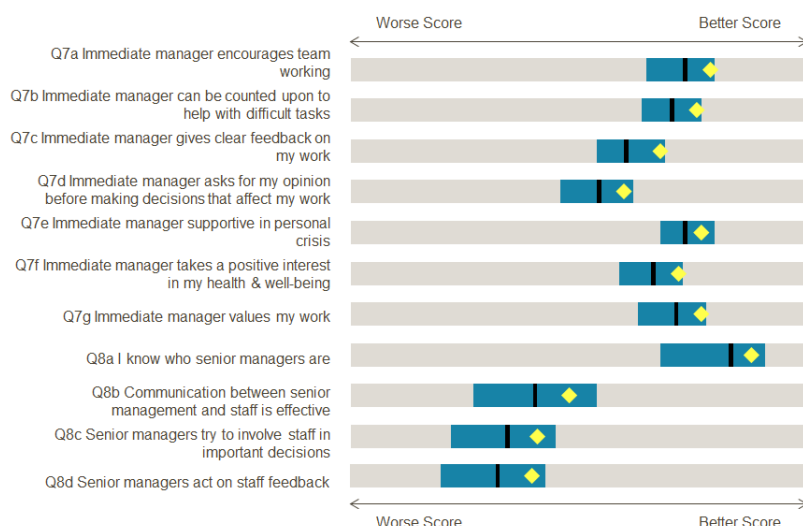
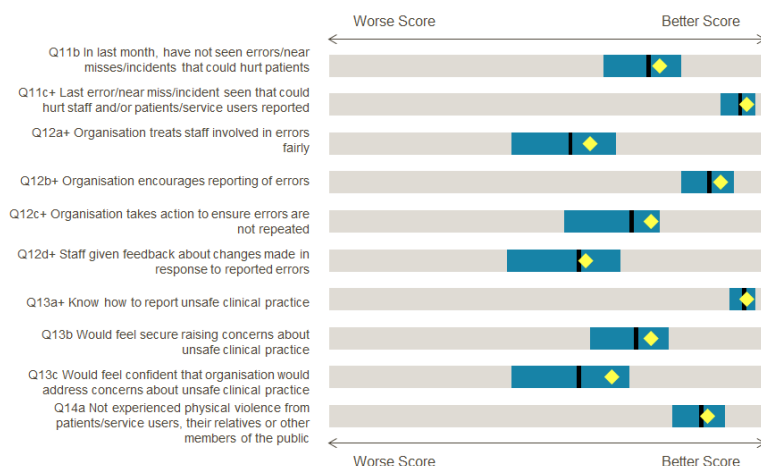
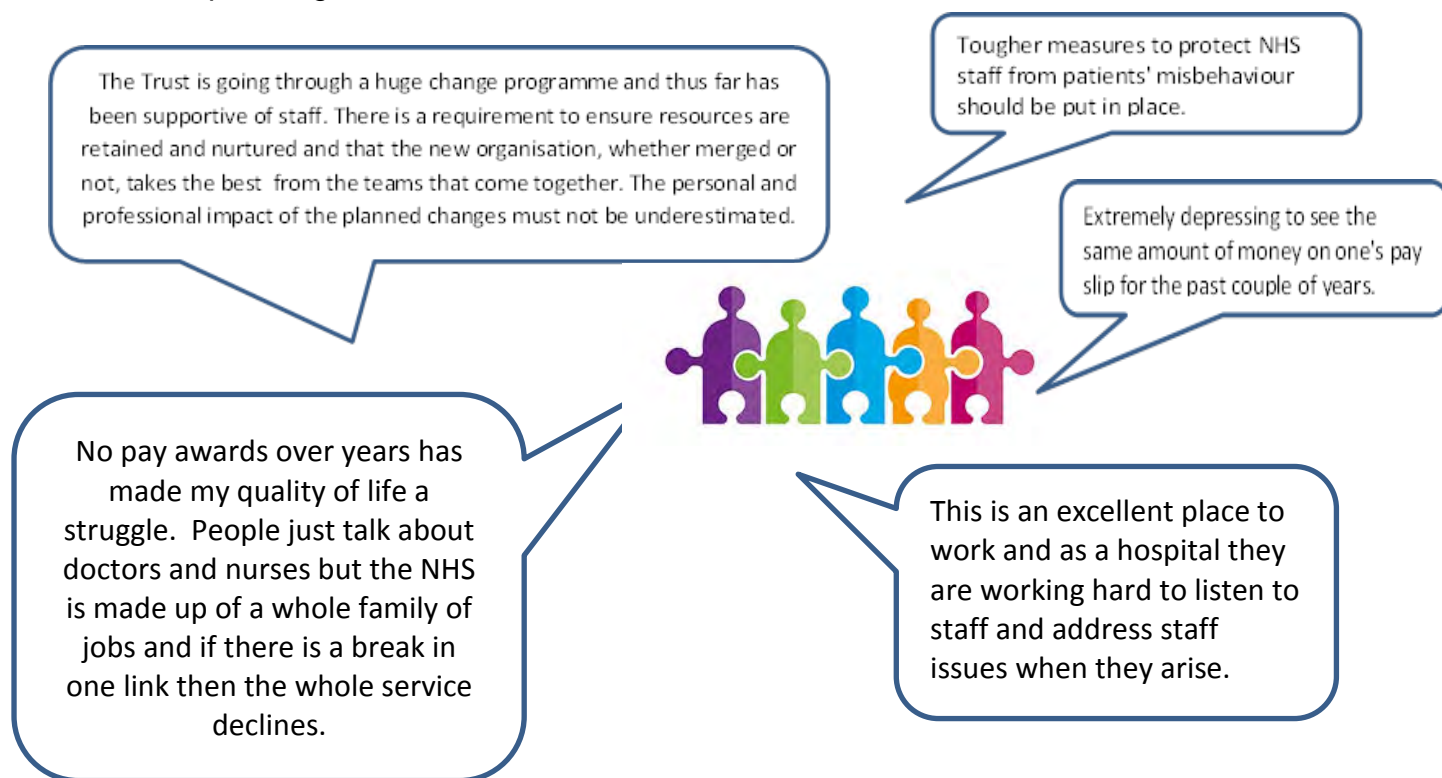


Table 6: 'Your health, wellbeing and safety at work question cluster:



3.5 Free-text comments – random sample:

RBCH collected 204 free text comments covering a wide range of issues. These will be used at Trust and Directorate level to provide additional insights and to inform action planning.



4. Engagement:

The Engagement score is calculated using the responses to the following nine individual questions which make up three Key Findings related to staff engagement, shown under the headings Advocacy, Involvement and Motivation:

Key Factor 1: Staff recommendation of the organisation as a place to work or receive treatment

- Care of patients / service users is my organisation's top priority.
- I would recommend my organisation as a place to work.
- If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.

Key Factor 4: Staff motivation at work

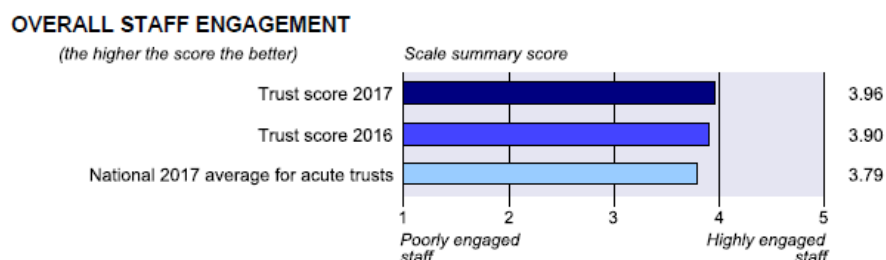
- I look forward to going to work.
- I am enthusiastic when I am working.
- Time passes quickly when I am working.

Key Factor 7: Staff ability to contribute towards improvement at work

- I am able to make suggestions to improve the work of my team / department.
- There are frequent opportunities for me to show initiative in my role.
- I am able to make improvements happen in my area of work.

The following table shows the improvement in the RBCH Engagement Score against 2016 and the strong position against all Acute Trusts this year. RBCH ranked joint first of all Acute Trusts (with Surrey and Sussex) with an overall Engagement Score of 3.96 out of 5.

Table 7: Overall Staff Engagement:



5. Areas for Focus:

5.1 Lowest scoring questions:

The following table shows the lowest scoring questions. The scores are compared with the all Acute average and with the RBCH results from 2016.

Table 8: Lowest Scoring Questions with Comparators:

Question number	RBCH Lowest scoring questions:	RBCH 2017	average score all Acute 2017	RBCH 2017 vs Acute average	RBCH 2016	RBCH 2017 vs RBCH 2016
5g	Satisfied with level of pay	30	30	=	36	-6
20d	Appraisal/performance review: definitely left feeling work is valued	36	30	+6	34	+2
20c	Clear work objectives definitely agreed during appraisal	38	34	+4	38	=
9a	Organisation definitely takes positive action on health and well-being	39	32	+7	36	+3
8d	Senior managers act on staff feedback	40	32	+8	35	+5
4g	Enough staff at organisation to do my job properly	41	31	+10	37	+4
8c	Senior managers try to involve staff in important decisions	41	34	+7	36	+5
15d+	Last experience of harassment/bullying/abuse reported	46	45	+1	46	=
20e	Appraisal/performance review: organisational values definitely discussed	46	33	+13	41	+5
8b	Communication between senior management and staff is effective	48	40	+8	42	+6

5.2 Lowest scoring Key Findings:

The following table shows the lowest scoring Key Findings. Compared with the average for all Acute Trusts in 2017 the scores are at average or better in all cases.

Table 9:



6. Making use of the survey data:

The national Survey Coordination Centre has published full and summary reports of core survey responses appropriately benchmarked against national data for all Trusts in England. <http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2017/>

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

- Care Quality Commission for ongoing monitoring of registration compliance.
- Department of Health for the development of NHS workforce policies.
- The Pay Review Body uses the results as part of evidence for their recommendations.
- The Social Partnership Forum, where Unions, NHS Employers and the Department of Health, meet regularly to consider the results and influence national workforce policy.
- Organisations at all levels use the results as a basis for partnership working with unions/staff sides.
- The survey provides valuable information about staff working conditions and practices, which are linked to the quality of patient care.

At RBCH we are analysing our data at team, subject and Trust Level in order to understand:

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

Action Plans will be discussed, agreed and implemented at Trust, Care Group and Team Level to act to make RBCH an even better place to work in 2018.

7. Next Steps in Developing Action Plans:

We are mindful of the balance between celebrating our results and acknowledging that not all teams are in a good place.

Our objectives are:

To identify quickly where we can focus our energy to help improve the experience for our staff, starting with:

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

To empower Managers in the areas concerned and support them to action plan with access to resources, including:

- Task Team – made up of a member of QI, their HR Business Partner and a member of OD – with their management teams (Directorate Mgr, Matron, CD and others as appropriate) – to have a supportive workshop to ask “how can we help?”
- Full Diagnostic - cross referencing all we know about these areas – such as changing service models, green brains, number of ER cases, #ThankYous, use of Thank you pot, Staff Impressions survey results, use of Aston Team journey, improvement skills training attendance and number of QI projects running.
- Team Tools e.g. Aston OD methodology to help identify how we can connect.
- Action Planning - Joining up with the People Plan, to develop, agree and implement Trust Level actions to ensure that significant themes are addressed appropriately.

To reinforce Leader Accountability for improvements and monitor progress via the Workforce Committee.



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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Directors' Register of Interests
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	David Moss, Chairperson
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Interests declared as these arise
Action required:	Review and comment
<p>Summary:</p> <p>The Trust is required to maintain a register of interests for its directors. This facilitates the identification and management of potential conflicts of interests by the Board of Directors. The register is reviewed annually by the Board to ensure that it is up to date as the information will be used in determining any related parties disclosure in the Annual Report and Accounts.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	✓
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on risk profile:	None

REGISTER OF DIRECTORS AND DIRECTORS INTERESTS 2017/18

Director	Appointed/ Reappointed	Resigned/ Removed	Interests Declared	Acquired	Declared	Ceased
Karen Allman Director of HR	01/06/2007		Governor. Queen Elizabeth's School, Wimborne Minster	February 2017	April 2017	
Tea Colaiani Non-Executive Director	I. 01/11/2016	31/01/2018	Non-Executive Director for Mothercare Plc. Non-Executive Director for SD Worx	October 2016 January 2017	November 2016 January 2017	
Peter Gill Director of Informatics	01/06/2016		No relevant or material interests.			
Interim Director of Informatics	01/02/2015	31/05/2016				
Christine Hallett Non-Executive Director	I. 29/06/2015		No relevant or material interests.			
Alex Jablonowski Non-Executive Director	I. 20/06/2016		Director of Datalyx Ltd Director of High Performance Leadership Ltd Non-Executive Director for Maritime Coastguard Agency Non-Executive Director for Office for National Statistics Programme Board Chair of City Fencing Club Chair of Defence Electronics and Components Agency Member of London Veterans Advisory and Pensions Committee Member Advisory Board Westminster University Business School		June 2016	
John Lelliott Non-Executive Director	I. 01/06/2016		Wife is a Physiotherapist at Wessex Nuffield Hospital Vice-Chairman of Asthma UK Chairman of Natural Capital Coalition Management Board member of the Christchurch Fairmile Village LLP Non-Executive Director, Covent Garden Markets Authority Non-executive Board member of the Environment Agency	June 2016 July 2016 June 2016 January 2018	December 2016 May 2016 July 2016 June 2016 March 2018	
David Moss Chairperson	I. 13/03/2017		No relevant or material interests.			
Alyson O'Donnell Medical Director	07/11/2016		No relevant or material interests.			
Pete Papworth Director of Finance	29/05/2017		Wife is a HR Business Partner at Dorset Healthcare University NHS Foundation Trust	May 2017	July 2017	

REGISTER OF DIRECTORS AND DIRECTORS INTERESTS 2017/18

Director	Appointed/ Reappointed	Resigned/ Removed	Interests Declared	Acquired	Declared	Ceased
			Director of The Bournemouth Private Clinic Limited Director and member of The Bournemouth Healthcare Trust Management Board member of the Christchurch Fairmile Village LLP	July 2017 July 2017 August 2017	July 2017 July 2017 May 2017	
Iain Rawlinson Non-Executive Director	I. 01/10/2017		Director of the following companies: <ul style="list-style-type: none"> • Crowdcaster Limited • Sibbick Yachts Limited • Charles Sibbick Limited • C. Sibbick & Co. Limited • Online Digital Broadcasting Limited • Online Radio Broadcasting Limited • Studyvox UK Limited • The Parkmead Group PLC • The Online Radio Broadcasting Foundation Limited • Rawlinson Partners Limited • Vico Partners Limited • Walhampton School Trust Ltd • IBTC Portsmouth 	October 2015 June 2012 June 2012 June 2012 April 2011 April 2011 April 2011 December 2010 October 2009 May 2009 October 2017 March 2017 December 2016	March 2018	
Richard Renaut Chief Operating Officer	12/09/2014		Married to Christine Renaut – an employee of the Trust (Pharmacist)	April 2009	April 2009	
Director of Service Development	29/10/2001	11/09/2014	Director of The Bournemouth Private Clinic Limited Management Board member of the Christchurch Fairmile Village LLP	January 2016 September 2014	July 2016 July 2014	
Cliff Shearman Non-Executive Director	I. 01/04/2017		Company Secretary of Wessex Medical Reporting Limited Member, Council of the Royal College of Surgeons Chairman of the Grants Award Committee, Pelican Cancer Foundation Member of Programme Organising Board, Charing Cross International Vascular and Endovascular Symposium	July 2015 2015	April 2017 April 2017 April 2017	
Paula Shobbrook Director of Nursing and Midwifery/ Deputy CEO	05/09/2011		Husband is director of various group companies of Albany Farm Care Homes, Hampshire.	February 2014	February 2014	
Tony Spotswood Chief Executive	04/01/2000		Trustee Board Member of NHS Providers (formerly the Foundation Trust Network) Chair of Clinical Research Network, Wessex	April 2010 February 2015	April 2010 February 2015	May 2016

REGISTER OF DIRECTORS AND DIRECTORS INTERESTS 2017/18

Director	Appointed/ Reappointed	Resigned/ Removed	Interests Declared	Acquired	Declared	Ceased
			National Institute for Health Research - member of the Board and Chair of the remuneration committee Board member, Wessex Academic Health Science Network Director of The Bournemouth Private Clinic Limited Director and member of The Bournemouth Healthcare Trust	July 2016 May 2015 January 2016 January 2016	July 2016 March 2014	January 2017



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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Finance and Performance Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Finance and Performance Committee, March 2018
Action required:	Decision
<p>Summary:</p> <p>The attached terms of reference of the Finance and Performance Committee have been amended to reflect the committees and groups which report to the Committee. The Informatics Steering Board now reports to the Trust Management Board on a quarterly basis.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	None

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

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

1 MEMBERSHIP

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

2 SECRETARY

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

3 QUORUM

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

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final <u>Draft</u>	June 2017 <u>March 2018</u>	June 2018	Karen Flaherty

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

4 FREQUENCY OF MEETINGS

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

5 NOTICE OF MEETINGS

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

6 MINUTES OF MEETINGS

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

7 DUTIES

The Committee shall:

- 7.1.1 Review in detail, on behalf of the Board of Directors, the financial and operational performance and controls reporting as necessary. This review to include but not be limited to
- 7.1.1.1 overall financial performance
- 7.1.1.2 financial performance of each Care Group, with the facility to request attendance from representatives of the relevant Care Group
- 7.1.1.3 cash flow, debtors and creditors

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final <u>Draft</u>	June 2017 <u>March 2018</u>	June 2018	Karen Flaherty

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

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

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

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final <u>Draft</u>	June 2017 <u>March 2018</u>	June 2018	Karen Flaherty

7.1.22 Review relevant areas of the risk register regularly and report appropriately

8 REPORTING RESPONSIBILITIES

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

9 OTHER

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

10 AUTHORITY

- 10.1 The Committee is authorised:-

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

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

11. SUB GROUPS

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

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

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



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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Freedom to Speak Up (FTSU)
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Helen Martin, RBCH FTSU Guardian
Details of previous discussion and/or dissemination:	N/A
Action required:	Decision
<p>Summary:</p> <p>This paper is an annual report following the formal launch of the FTSU in September 2017. The paper looks at the objectives since FTSU Guardian came into post in April 2017, the key themes being raised by staff and the challenges for 2018. The presentation will discuss the themes in more detail and the plans to address these. The Board is asked to support the plans for 2018 plans and addressing the challenges highlighted.</p>	
Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	None

Freedom to Speak Up (FTSU)

Annual Report 2017/18

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”. The Trust Board at RBCH publicly committed to these principles in September 2017. The purpose of this paper is to outline the progress of the Freedom to Speak up Guardian (FTSUG) and determine the way forward for 2018.



2.0 The RBCH Approach

In April 2017, the Trust appointed a Freedom to Speak up Guardian (FTSUG) – Helen Martin (15 hrs/week). An additional support role was also created and Karole Smith was appointed (7.5 hrs/week) which completed end of January 2018.

2.1 Aim

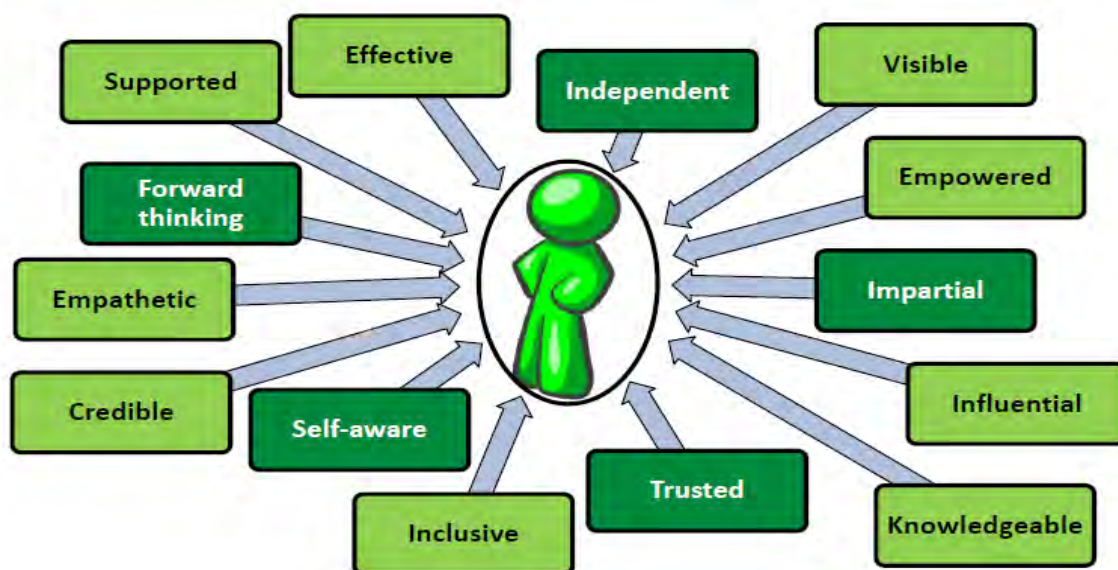
To develop a culture of safety within RBCH so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

The key roles of the FTSUG 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, Dr Henrietta Hughes, had a clear vision in 2016 at the National Guardian Office (NGO) conference when she announced that the **local FTSU guardian role needs to be a highly professional individual, someone whom is trusted and effective and is able to interface with staff and the executive team.** The NGO outline the key characteristics of the FTSUG in the diagram below.



3.0 Review of objectives for 2017

The Trust set 4 objectives for 2017:

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 first year:

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

Table 1: Key Objectives for 2017

	Action lead	Timescale Completed/update
1. Develop speaking up process, reporting and monitoring process		
Appoint Trust FTSUG	Trust Executive Board	Completed and post-holders in post 1 st April 17
Review and agree Trust “speaking up” policy in line with national policy, outlining clear process of reporting concerns.	FTSUG	Completed Board approval and statement of commitment (Sept 17). Approval Audit committee (Oct 17)
Self-assessment of current speaking up culture <ul style="list-style-type: none"> Completion of national self-assessment tool of current culture. Review of staff survey, Trust grievance data, HR workforce, PALs feedback 	FTSUG FTSUG	Internally completed to act as a benchmark Completed staff survey, staff impressions and ongoing.
Develop a “speaking up” process: <ul style="list-style-type: none"> Intranet site development Telephone contact Email contact Development of resources Reporting forms and paperwork 	FTSUG	Completed Completed Completed Completed Completed.
Commence case referrals	FTSUG	Commenced and on going
Submission of data to NGO	Quarterly	Completed Qtr 2. Qtr 3 submission Jan 18.

	Action lead	Timescale Completed/update
Approval of: <ul style="list-style-type: none"> governance structure 	FTSUG and Exec lead	Completed
Development of reports to monitor outcomes and impact of FTSU. Development of key lessons	FTSUG	Bi annual (October 17/April 18). Working with Risk and Governance/HR. Completed Board and Audit committee. Workforce committee 7 th Dec 17
Development of “taking the pulse” staff survey to measure the culture of the organisation	FTSUG	Completed 15 th September 17. To repeat Summer 2018.
Develop relationship with CQC engagement team	FTSUG	Completed. 18 th October 17. Complete CQC documentation for impending visit
2. Development a communication and launch strategy		
Leadership summit <ul style="list-style-type: none"> National FTSUG key note speaker with breakout practical workshops with PCaW Full Launch of local FTSUG with policy, process and referral launch Search for local guardians/advocates 	FTSUG ALL FTSUG	Completion 11 th Sept 17 Completed Tba. Discussions re: D+I, dignity at work or system approach guardians.
Communication strategy <ul style="list-style-type: none"> Guardian walkabouts- to increase visibility Presentations/road shows to key areas Diversity and inclusion work-stream Meeting with key players Screen savers Payroll literature Pull ups Apps Development of video 	FTSUG	Commenced alongside flu campaign. Looking at medical walkabouts. Commenced. Completed May 17. Runner up at NGO conference Commenced and ongoing Completed Autumn 17 – delay to Jan 18 Winter 17 Spring 2018. Approved by CAB Script approved. Awaiting filming
3. Develop strong and open working relationship with Trust board		
<ul style="list-style-type: none"> Set up regular meetings with <ul style="list-style-type: none"> CEO Director of OD and leadership Chair of Audit committee Director of Nursing 		Completed and meeting monthly Completed and meeting regularly Completed and meeting regularly Completed and meeting regularly
<ul style="list-style-type: none"> Integration to Organisation Team 	FTSUG/OD	Completed
4. Develop a training strategy for new, existing and exiting staff		
<ul style="list-style-type: none"> Development of training and support programme for first line managers in conjunction with OD leadership programme Incorporate “speaking up” into OD training 	FTSUG/OD	Work in progress. Intranet site completed Completed

	Action lead	Timescale Completed/update
packages: customer care • Incorporate induction programmes • Exit questionnaire working group		Completed. Working with medical induction Commenced with HR. Anticipated to complete Spring 18
Training of FTSUG • National training • National Conference • Ad hoc training (CQC inspections, case reviews, training for managers)	FTSUG	Completed 28 th February 2017 Completed 8 th March 17, 19 th October 17 and 6 th March 2018 Completed and on going
5. Develop a network with neighbouring Trusts (Work to include potential merger)		
Integral member of local FTSUG network	FTSUG	Commenced and attended 4 th July/ 7 th Dec.
One System approach guardian model	FTSUG	Commenced
Poole Hospital integrated model development	FTSUG	Meeting with PHT lead FTSUG on 8 th March 18
6. Develop a FTSU advocate team.		
Development of Trust guardians/advocates to review cases		Been in discussion Re: JD/JS and process with local network. Plan for late Spring/Summer 2018

4.0 Staff survey results – What do our staff say about our current speaking up culture?

The annual staff survey is a particularly rich source of data informing us on how staff feel about our speaking up culture. Table 2 shows the initial findings of the survey carried out in 2017 and received from Picker only in the last couple of weeks. A total of 2050 staff completed this survey, giving a response rate of 46.2% compared to the national average of 45.5%. The report summarise those scores which have changed significantly over the last year and how this compared to similar acute Trusts.

Table 2: Staff survey results of questions relating to FTSU

*Significant result as compared to 2016

** Significant as compared to similar organisations

	2017	2016	2015
Encourages reporting of errors **	89.5	90	90
Know how to report unsafe clinical practice **	96.2	96	95
Secure raising concerns about safe clinical practice **	73.8	72	71
Takes action to ensure errors are not repeated **	73.6	72	71
Confident that concerns about unsafe clinical practices are addressed *	64.7	61	58
Treats staff in errors fairly **	59.7	57	58

Initial results demonstrate significant improvements since 2016 with staff reporting that they feel significantly more confident that RBCH would address concerns about unsafe clinical practice. This area has been targeted by the FTSUG with initiatives of workshops skilling staff with the skills on how to address and receive concerns along with key documents.

All other questions within the survey relating to speaking up reported significantly better to that as compared to other similar organisations. This data illustrates that as an organisation we are above the curve in creating a culture which promotes and nurtures those who raise concerns and in all but one which remained the same, have seen improvements since 2016.

5.0 Case Referrals – the headlines

A range of data is collected by the FTSUG which helps conclusions to be drawn on where work needs to be focussed and support offered. This report will look at this data including the key themes of concerns raised, where concerns have been raised and by whom. Throughout this section key work for 2018 has been identified. Referrals are received via a number of routes. One key link has been with the risk and governance tool LERN – raise an issue form which has resulted in referrals but also healthy discussions of hot spots at our monthly meetings. Alternatively, referrals have come directly from presentations, the organisation department, word of mouth and by recommendation.

5.1 Key Themes of concerns

Table 3 illustrates the number of cases heard through the FTSUG office at RBCH. It is this data that forms part of what is submitted quarterly to the National Guardian Office (NGO).

Table 3: Themes raised through the FTSUG office

Themes	Qtr 1 (April – June)	Qtr 2 (July – Sept)	Qtr 3 (Oct – Dec)	Qtr 4 (Jan – Mar) As of 9.3.18	Number of concerns raised
Attitudes & Behaviours	7	9	9	5	30
Other		2	1		3
Performance Capability		1		3	4
Policies			4		4
Quality & Safety		1		1	2
Staffing Levels	1	1			2
Total	8	14	14	9	45

Table 3 shows up to 67% of cases raised at RBCH have an element of behaviours and attitudes followed by 9% associated with policies and procedures. The NGO recognises bullying and harassment as a key theme seen in both quarter 1 and 2 national submissions and consequently plans to look at providing support and training for FTSUG and Trusts in these areas in 2018.

The need to tackle poor behaviours has previously been raised at RBCH within both the cultural audit published in spring 2016 and then again in the 2016 staff survey. Moreover, the 2016 staff survey results showed that staff who felt they had experienced harassment, bullying or abuse, 46% of them said that they did not report this. Such a result, suggests that the Trust has some work to do in encouraging staff to report experiences of bullying, abuse or harassment. Initial results from the 2017 survey show this position remains the same as 2016 but, comparatively to other organisations, we are in significantly better position. Linking in with HR will be key to moving this forward in a joint and coordinated approach. Discussions have already commenced with HR and the FTSUG plan to work together with HR to ensure staff experience dignity at work. The full analysis of the staff results from the 2017 survey will be essential to review this theme further.

As part of the Delivery Phase of the Trust Culture Change Programme, the Change Champions are looking at tackling poor behaviours. Key actions from this work stream will attempt to look at how messages and behaviours can be interpreted by parties through the use of staff stories. We have also reached out to Frimley and other Trusts in an attempt to share learning. Working with Poole Hospital (PHT) in view of the merger, will also be integral for 2018.

Another piece of work is looking at policies and procedures, alongside HR. The length of investigations, support and focused case management are key elements being raised. Initial discussions with the director of HR have occurred and senior HR team. This is another key area for development in 2018.

5.2 Where are concerns being raised?

Table 4 shows the areas from where concerns have been raised to date, and shows that staff from both CCG A and C have raised the largest number of concerns. This may be explained by the work completed by the FTSUG as illustrated in table 5, which shows more of its communications

coincidentally been focused within these clinical care groups. A key objective moving forward will be to extend its reach into Clinical Care Group B and links within Older Persons Medicine and Emergency Medicine have since already occurred.

Table 4: The number of concerns raised in Clinical Care Groups

Clinical Care Group	Qtr 1 (April – June)	Qtr 2 (July – Sept)	Qtr 3 (Oct – Dec)	Qtr 4 (Jan – Mar) As of 9.3.18	TOTAL
Clinical Care Group A	5	3	3	2	13
Clinical Care Group B	2	2	1	2	7
Clinical Care Group C	1	7	6	5	19
Corporate/operational	0	2	4		6
Total	8	14	14	9	45

Table 5: Communications completed by FTSUG

Type of Communication	Where this communication has occurred (and number of staff attended)
Presentations	SAS training (30), Governors (30), Leadership Summit (150), Senior Briefing (150 + 60), Board meeting (40), Audit committee (20), Junior Doctor meeting (15), Grand Round (100), Specialist services symposium (60), theatres (66)
Table top open sessions	Diversity week, Christchurch open day, staff wellbeing, patient safety conference, flu rounds (x)9
Team meetings	Maternity (10 +11), Ophthalmology (30), Pharmacy (60), theatres (30), OPAL (30), Dietetics (15), Housekeeping (30), Christchurch day unit (25), orthopaedic (10), Dermatology (15), matrons (13), rheumatology (12), IT (15), AMU (16), DoSH (30), partnership forum (10), charity office (14), Interim team (22), OPM meeting, sisters meeting, post room, housekeeping, therapy services, palliative care (30).

Since April, the guardians have visited a number of areas in the form of attending team meetings, as table top presentations at conferences or a keynote speaker. To date over 1000 staff will have heard the message directly from the guardians in one form or another. Other routes have also been used to reach other staff such as through the development of intranet site, banner, screen savers and core brief articles. Communications is key to its success and will be integral for 2018.

5.3 Who are raising concerns?

Table 6 shows that Allied Health Professionals (AHPs) are the largest group of professionals who have raised a concern to the FTSUG followed by nursing. A key area for 2018 is the need to engage further with the medical workforce. Some work has already commenced and meetings with key people in the medical workforce including the Medical Director, Guardian of working times and lead Medical Educator have occurred. Attendance at a junior doctor committee meeting and a grand round presentation has also taken place. It will be important to link this work with the Change

Champion work stream, alongside developing open space sessions in the doctor mess and medical walkabouts. Scrutiny of the GMC annual questionnaire has helped to focus this work and contact with cardiology has already been made with the view of attending their local induction training.

Table 6: Who are raising concerns in RBCH

	Qtr 1 (April – June)	Qtr 2 (July – Sept)	Qtr 3 (Oct – Dec)	Qtr 4 (Jan – Mar) As of 9.3.18	
Dr		2		2	4
Nurse	1	3	3	3	10
HCA	3		3		6
Midwives	1				1
Dentists					
AHPs		7	3	3	13
Admin/Clerical			1		1
Cleaning/catering/ maintenance/ancillary	2				2
Board Members					
Corporate service			4		4
Other		1		1	2
Anon	1	1	0		2
Total	8	14	14	9	45

Another area of the workforce that needs further development is that within minority groups of the organisation. The Francis Freedom to Speak Up review highlighted that minority staff, including black and minority ethnic (BME) workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in the review also showed that minority staff groups are more likely to suffer detriment for having spoken up. The NGO first case review at Southport and Ormskirk Hospital NHS Trust highlighted the importance for every Trust and FTSUG to ensure that work reaches this group of staff and that their voice is also being heard.

The Staff impression survey carried out in September gave a small insight into what staff from a minority background feel about speaking up. Looking at the data in table 7, staff from Black and minority ethnic (BME) backgrounds 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). A key piece of work will be to scrutinise the data from the 2017 staff survey which will help benchmark how staff feel we are as an organisation in speaking up.

Working alongside the newly appointed Director of Diversity and Inclusion particularly exploring joint champions is already happening to ensure that every voice matters will be a key objective for 2018. A network approach is already being planned with the launch of the first LGBT network on the 14th February. This work has been done in conjunction with PHT and it is envisaged that the BME network occurs in Spring. The FTSUG is a key member in this group and is keen that we work in conjunction and even brand this work to give a simple message to our staff which is we are here to listen to your voice from whoever that may come from.

TABLE 7: 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	80	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

6.0 Objectives for 2018 and moving forward.

A number of key objectives have already been identified for 2018 and outlined throughout section 5. Table 8 illustrates these alongside those that have commenced in 2017 which need to continue to develop.

Table 8: Objectives for 2018

Objectives	Description
Key themes actions	Tackling poor behaviour <ul style="list-style-type: none"> • working with HR/dignity at work. • change champion work-stream Investigations <ul style="list-style-type: none"> • work with HR focusing on case management and time taken to complete investigations
Development of FTSU team	<ul style="list-style-type: none"> • Development of Trust guardians/advocates to review cases +/- diversity team
Target work	<ul style="list-style-type: none"> • CCGB linking in with OPM and ED • Medical engagement working alongside change champion work-stream • Junior doctors walkabouts/open space sessions • Minority groups working with diversity lead and exploring joint champions/ambassadors
Board/System work/CSR	<ul style="list-style-type: none"> • Board work and updates • Continued key meetings with key staff. • Explore One system approach across Dorset • Merger with PHT
NGO	<ul style="list-style-type: none"> • Pull themes from national case reviews • Conference and submission to awards • Training • Continue quarterly submissions
Data	<ul style="list-style-type: none"> • Staff survey

	<ul style="list-style-type: none"> • Triangulate with risk governance, HR, counter fraud. Links to complaints
Communications	<ul style="list-style-type: none"> • Banners • Explore innovative methodology
Training staff	<ul style="list-style-type: none"> • Management toolkit linking with change champion • Exit interviews/induction improvements

7.0 Proposal to deliver 2018 Objectives

The NGO published in September 2017 ten principles for those who are within the FTSUG role and are illustrated below.



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.



Within this report the NGO echoed the clear vision outlined in 2016 by Dr Henrietta Hughes that the **local FSTU guardian role needs to be a highly professional individual, someone whom is trusted and effective and is able to interface with staff and the executive team.** Alongside this other observations were deemed as paramount to the success of a local FTSUG including:

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

Taking this guidance and drawing on the work completed within 2017 a process commenced in March to support the delivery of the key objectives identified in table 8. An expression of

interest was advertised and interviews occurred in March. The 20hr post was another secondment opportunity in view of the CSR/merger until end of March 2019 at which time a substantive role would be jointly developed across both sites.

8.0 Summary

The purpose of creating a speaking up culture at RBCH is so that our patients remain safe and at the heart of everything we do. The FTSUG has been successful in setting this role up within the organisation and has already started to hear concerns. This will continue in 2018 alongside the anticipated challenges of merger and delivery of the clinical services review. Alongside this will be the ever growing interest in delivering one system cross Dorset and this model needs to evolve with this in mind.



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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Well-led Review Action Plan Update
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	David Moss, Chairperson
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Previous Board meetings
Action required:	Note for information
Summary: This report provides the latest updates on progress against the actions arising from the 12 recommendations in the external well-led review which was received in March 2017.	
Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 ✓ ✓ ✓ ✓ ✓
Impact on risk profile:	None

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). All partners are working to develop the governance arrangements that will underpin the introduction of a system-wide control total, a key strand of work to create an integrated care system (ICS). Work is also underway to shape the design of the ICS as one of 10 national pathfinders and a shadow ICS, including governance arrangements. This is referenced within the Trust's revised strategy.
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 as well as joint working sessions with the Council of Governors. The proposed programme for Board Strategy and Development sessions in 2018 was reviewed by the Board at its meeting in January and arrangements are now being finalised.
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 Council of Governors workshop in July a detailed action plan for stakeholder engagement was drawn up and presented to the Board of Directors at its meeting in September. An interim patient experience and public engagement strategy was presented to the Board and Governors in February 2018.

Recommendation	Action	Timeframe	Responsibility	Progress Update
<p>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.</p>	<p>a. Design external engagement strategy. b. Consider role of governors following review timetabled for summer 2017.</p>	Autumn 2017	Various executive leads	<p>See response to Recommendation 3 above. In addition:</p> <ul style="list-style-type: none"> - Executive Directors have regular contact with opposite numbers and other key staff in primary and community organisations. - The Chair has regular meetings with the Chairs of the Dorset and West Hampshire CCGs, and the Chair of the Dorset Healthcare University NHS Foundation Trust (DHC). - Jointly delivered GP extended access bid with local GPs and partner trusts, a product of collaboration to improve services for our local population. - Deputy Clinical Chair of Dorset CCG led joint Board and Trust Management Board workshop on integrated care in November 2017. - Appointment of joint clinical lead with community trust DHC to develop integration agenda.
<p>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.</p>	<p>Address governance tasks of Board and committee cycle along with delegated decision making and assigning responsibility for operational and strategic risk.</p>	Ongoing	DM/KF	<p>Relevant committee meetings e.g. Healthcare Assurance Committee (HAC) are being 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.</p>
<p>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.</p>	<p>Address issue of information for Board including review of data/analytics/intelligence required.</p>	Ongoing	DM/TS	<p>See response to Recommendation 1 above. Also the One Acute Network East Reconfiguration 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 and worksteam leads.</p>

WELL-LED REVIEW ACTION PLAN

Recommendation		Action	Timeframe	Responsibility	Progress Update
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.
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>These changes will be reflected in the next revision of the Trust's Risk Management Strategy in April 2018 with a transitional period before the Audit Committee formally assumes this role.</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 East Reconfiguration Board (see recommendation 6 above).</p>

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update
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. GP integrator roles appointed across all four foundation trusts in Dorset to progress this work, focussed on cross-cutting themes (urgent care, older people, musculoskeletal and primary care) under leadership of the Deputy Clinical Chair of Dorset CCG.
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	The People Strategy and Workforce Plan was approved by the Board of Directors at its meeting in September 2017. The Plan is monitored by the Workforce Strategy and Development Committee with periodic reporting to the Board.
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	The Leadership Strategy was presented to the Board in January 2018. This reflected the Board's request for a clearer link between leadership and the People Strategy and Workforce Plan.

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update
<p>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.</p>	<p>Address strategy and strategic risk, using scenario planning.</p>	<p>Autumn 2017</p>	<p>TS/DM</p>	<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 Trust Board (as well as the Board of Poole Hospital and Dorset County Hospital NHS Foundation Trusts) prior to adoption by the One Acute Network Board. The terms of reference for this Board are currently being reviewed as it will be focussing on the reconfiguration of services in East Dorset with Clinical Networks and Business Support Services incorporated within the work of other groups in the Dorset system which include all NHS foundation trusts in Dorset.</p> <p>See also the response to recommendations 1 and 6 above.</p>

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Information Governance (IG) Strategy 2018
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Peter Gill, Director of Informatics
Author(s) of paper:	Camilla Axtell, IG Manager
Details of previous discussion and/or dissemination:	Approved by IG Committee, February 2018
Action required:	Recommend
Summary: The IG Strategy sets out the purpose, resources, policies and management framework for the IG work at the Trust. It is a stipulation of the national IG Toolkit that this strategy is approved by the Board of Directors.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Impact on risk profile:	None



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

Information Governance Strategy

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	5	March 2018	March 2019	Information Governance Manager

Table of Contents

1. Introduction.....	3
2. Purpose and Scope	3
3. Senior Roles	4
4. Key Policies	4
5. Governance Framework	5
6. Resources	5
7. Training and Guidance	7
8. Incident Management	7

1. Introduction

Information Governance provides a framework to bring together all the legal rules, guidance and best practice that apply to the handling of information, supporting:

- high quality care;
- compliance with the law;
- implementation of central advice and guidance, and;
- year on year improvement.

Information Governance provides a consistent way for the Trust and its employees to deal with the many different standards and legal rules that apply to information handling, including:

- data protection and confidentiality
- information sharing for care and for non-care purposes
- information security and information risk management
- information quality
- records management for both clinical and corporate information

The Trust believes that accurate, timely and relevant information, protected as required and appropriate, is essential as a component of the highest quality healthcare. As such, it is the responsibility of all clinicians and managers to promote the quality and care of information used in decision-making processes throughout the Trust.

2. Purpose and Scope

The purpose of this document is to set out the internal management structures and responsibilities and provide an overview of the policies and procedures to ensure the safe handling of all information in the Trust in accordance with the law, regulation, best practice and national guidance and minimising information risk within the Trust. Information Governance is the responsibility of every member of staff. The Information Governance Strategy is designed to set out the responsibilities of key staff, and provide all staff with information regarding the structures that are in place to achieve compliance.

The document should not be considered in isolation as it forms part of the Trust's Integrated Governance approach to the management and monitoring of corporate and clinical governance, risk management and clinical effectiveness.

The scope of Information Governance is wide ranging and includes electronic and paper records relating to patients and service users and employees as well as corporate information. The goal is to embed best practice in the Trust so that sensitive and safe handling of all information is considered as part of normal business.

3. Senior Roles

The lead for Information Governance within the Trust is the Director of Informatics, who is also the Senior Information Risk Owner (**SIRO**) and the Named Data Protection Officer.

The SIRO is responsible for coordinating the development and maintenance of information risk management policies, procedures and standards for the Trust in the context of the Trust's overall risk management framework, and updating the Board regularly on information risk issues. The Director of Informatics has line management responsibility for the Information Governance Manager.

The Trust's Caldicott Guardian is the Medical Director. The Caldicott Guardian is the most senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

4. Key Policies

The Trust has the following Information Governance-related policies:

- Data Protection Policy
- Freedom of Information Policy
- Confidentiality and Disclosure Policy
- Safe Haven Policy
- Information Risk Management Policy & Procedures
- Corporate Records Management and Information Lifecycle Policy
- Health Records Strategy
- Health Records Retention and Disposal Policy
- IT Security Policy
- Risk Management Strategy & Risk Assessment Toolkit
- Policy for Reporting & Investigation of Learning Event Report Notifications (LERNs) Including Serious Incidents
- Essential Core Skills Training Policy

Copies of the policies are available on the Trust's intranet and separate guidance on confidentiality and data protection is provided to all staff, governors and volunteers through Essential Core Skills training.

Policies are ratified by the appropriate committees and groups as detailed on the front page of each document, a full list of which is included in the Trust's Document Control Policy.

Policies relating to health records management and subject access requests will be ratified by the Electronic Document Management User Group and reviewed by the Information Governance Committee. IT related security policies will be ratified by the Informatics Steering Board and reviewed by the Information Governance Committee.

The Healthcare Assurance Committee is responsible for reviewing and approving the Risk Management Strategy & Risk Assessment Toolkit which is ratified by the Board of Directors.

The Quality and Risk Committee is responsible for reviewing and approving the Serious Incident Policy and the Policy for Reporting & Investigation of Learning Event Report Notifications (LERNs) Including Serious Incidents.

The Essential Core Skills Training Group is responsible for reviewing the Essential Core Skills Training Policy which is ratified by the Workforce Strategy Group.

The Information Governance Committee is responsible for reviewing and approving the other policies which are ratified by the Board of Directors or the Healthcare Assurance Committee as required.

5. Governance Framework

The Information Governance Committee is the key governance body with overall responsibility for delivering the Information Governance agenda across the Trust. The Information Governance Committee reports to the Healthcare Assurance Committee, which in turn is a sub-committee of the Board of Directors.

The Trust is audited on the basis of compliance with the laws and standards specified in Appendix A. Compliance is monitored internally through clinical audit, the results of which are reported through the Quality and Risk Committee and Healthcare Assurance Committee, and internal audit which is reported through the Audit Committee. In addition the Information Governance Toolkit is completed each year and the results are forwarded to the local Clinical Commissioning Groups, NHS Improvement and the Care Quality Commission, all of which have powers to intervene in the running of the Trust in the event of failings in its healthcare standards.

Compliance with the Information Governance Toolkit is used as one of the measures reported in the Quality Report and Annual Governance Statement in the Annual Report and Accounts. This assures compliance with the Care Quality Commission's standards relating to Information Governance.

6. Resources

The Information Governance Manager is responsible for:

- ensuring compliance with legislation and standards for Information Governance and reporting performance to the Information Governance Committee;
- keeping new legislation and standards under review and ensuring appropriate amendments to policies and procedures are introduced;
- developing and reviewing the Information Governance action plan and reporting progress, risks and outcomes to the Information Governance Committee;
- reporting issues and risks relating to confidentiality to the Information Governance Committee;
- developing and maintaining relevant policies, standards, procedures and guidance;
- reviewing operational Information Governance issues that arise;

- providing a co-ordinating role for Information Governance within the Trust;
- communicating and raising awareness of Information Governance across the Trust.

The **SIRO** is also supported by **Information Asset Owners (IAOs)** who have been appointed by their respective departments/directorates, and who shall ensure that information risk assessments are performed at least once each year on all information assets (IT systems which contain personal data) where they have been assigned 'ownership', following guidance from the SIRO on assessment method, format and content. This process should reflect the policy and procedures for risk assessment adopted by the Trust more generally. IAOs shall submit the risk assessment results and associated mitigation plans to the SIRO for review at meetings of the Information Governance Committee.

IAOs are also responsible for:

- ensuring that commercial contracts with third parties relating to their assets contain the relevant Information Governance clauses;
- ensuring that their assets support appropriate access controls;
- putting in place business continuity arrangements as required to support the continuation of services in the event of the asset being unavailable;
- providing the Information Governance Manager with details of any transfers of personal data into and outside of the Trust from within their work areas, including those that are overseas;
- understanding the legal basis under which data within their department is processed, and keeping this up to date on the Information Asset Register, and;
- disseminating best Information Governance practice throughout their department/work areas.

A full role profile for IAOs is available within the Information Risk Management Policy.

The lead for **Information Security** (including policy development) is the Assistant Director of IT Operations.

The lead for **Data Quality** (including policy development) is the Head of Information.

The lead for **Health Records** management and subject access policy development is the Health Records Manager.

The lead for the Trust's **Registration Authority (RA)** function is the Director of Informatics. Responsibilities for the management and implementation of the RA function including documenting a local RA policy have been allocated to the Assistant Director of IT Operations, who acts as the RA Manager.

The Trust has also nominated a **Clinical Safety Officer** who is responsible for the control of clinical risk associated with a new IT system roll out or change to an IT system to support compliance with ISB 0160.

All staff contracts contain clauses relating to data protection and confidentiality. These clauses alert staff to how their data will be used and their data protection

rights and the consequences of breaching confidentiality in terms of disciplinary action and professional registration. Breaches of confidentiality are specifically referred to in the Trust's Disciplinary Policy and Procedure as an example of gross misconduct.

There is also a Code of Conduct for Staff which acts as a guide to all members on the required behaviours, responsibilities and actions expected of employees of the Trust. This has been produced in line with guidance issued by the Department of Health.

7. Training and Guidance

All staff, volunteers and governors receive Information Governance training as part of initial induction and annually thereafter. The Information Governance training programme covers staff at all levels, both clinical and non-clinical, and is detailed in full in the Information Governance Training Plan, which is reviewed annually for its effectiveness.

In addition, IAOs are given specific training by the Information Governance Manager, SIRO and other subject matter experts (e.g. the Director of Commercial Services) to ensure that they understand their duties and can complete their IAO tasks effectively.

8. Incident Management

Information Governance incidents should be reported and managed in accordance with the Trust's Policy for Reporting & Investigation of Learning Event Report Notifications (LERNs) Including Serious Incidents. The Quality and Risk Department will inform the Information Governance Manager of all LERNs which relate to Information Governance so that the Information Governance Manager can provide input and support to staff dealing with these incidents and monitor these as required. The reporting process for incidents which are suspected to be serious incidents is set out in Appendix D. Serious incidents are assessed using the NHS Digital Information Governance Serious Incident Requiring Investigation (SIRI) Reporting Tool and reported in accordance with the relevant policies supported by additional guidance used by the Information Governance Manager.

APPENDIX A

Legislative and Regulatory Framework

The Information Governance Strategy brings together all the requirements, standards and best practice that apply to handling information. The areas that are covered are to be kept under review as changes are made to legislation and guidance.

Legislation and common law

This includes:

- Access to Health Records Act 1990
- Access to Medical Reports Act 1988
- Common law duty of confidentiality
- Computer Misuse Act 1990
- Data Protection Act 1998 (until 25 May 2018)
- General Data Protection Regulation (GDPR) 2016 (from 25 May 2018)
- Environmental Information Regulations (EIR) 2004
- Freedom of Information (FOI) Act 2000
- Health and Social Care Act 2012
- Human Rights Act 1998 (Article 8)
- National Health Service Act 2006
- Privacy and Electronic Communications (EC Directive) Regulations 2003
- Protection of Freedoms Act 2012
- Re-use of Public Sector Information Regulations 2005

Standards and Guidance

The standards are defined by a number of national bodies and include:

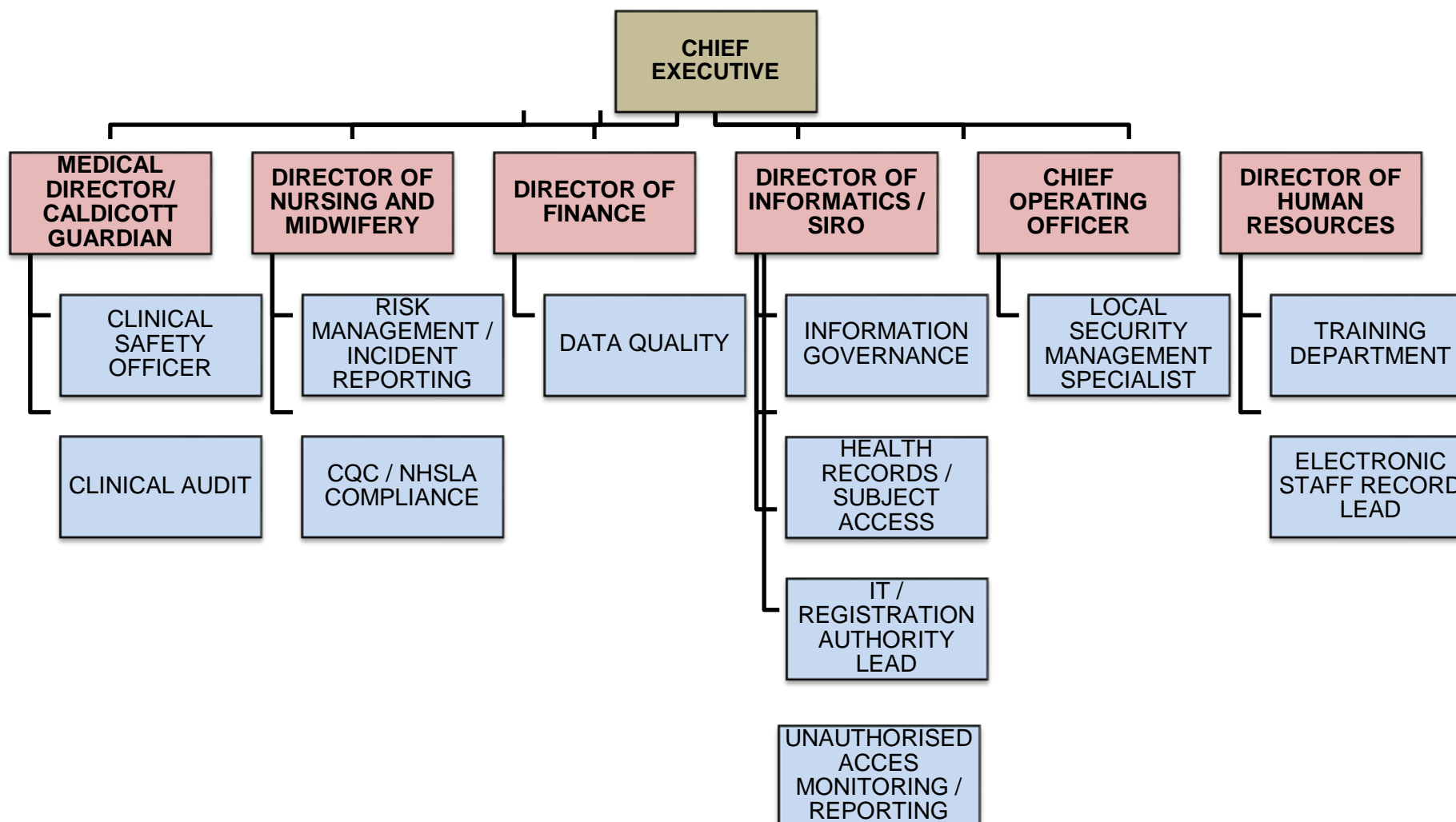
- Health Service Circular: HSC 1999/012 (requirement for NHS organisations to have a Caldicott Guardian)
- The Caldicott Principles
- The Caldicott Guardian Manual 2010
- Care Quality Commission Fundamental Standards Regulation 17: Good Governance
- NHS Information Governance Toolkit
- NHSLA standards for Acute Trusts
- BS ISO/IEC 17799:2005; BS ISO/IEC 27001:2005; BS7799-2:2005 – Management Information Security compliance
- Information Security Management: NHS Code of Practice (April 2007)
- Confidentiality: NHS Code of Practice (November 2003)
- Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems (ISB 0160 2013)
- HSCIC: A guide to confidentiality in health and social care (September 2013)
- Information Governance Alliance Records Management Code of Practice for Health and Social Care (July 2016)
- Information: To Share or not to Share – The Information Governance Review (“Caldicott 2”) (March 2013)
- National Data Guardian for Health and Care Review of Data Security, Consent and Opt-Outs (“Caldicott 3”) (June 2016)

Professional Codes and Rules

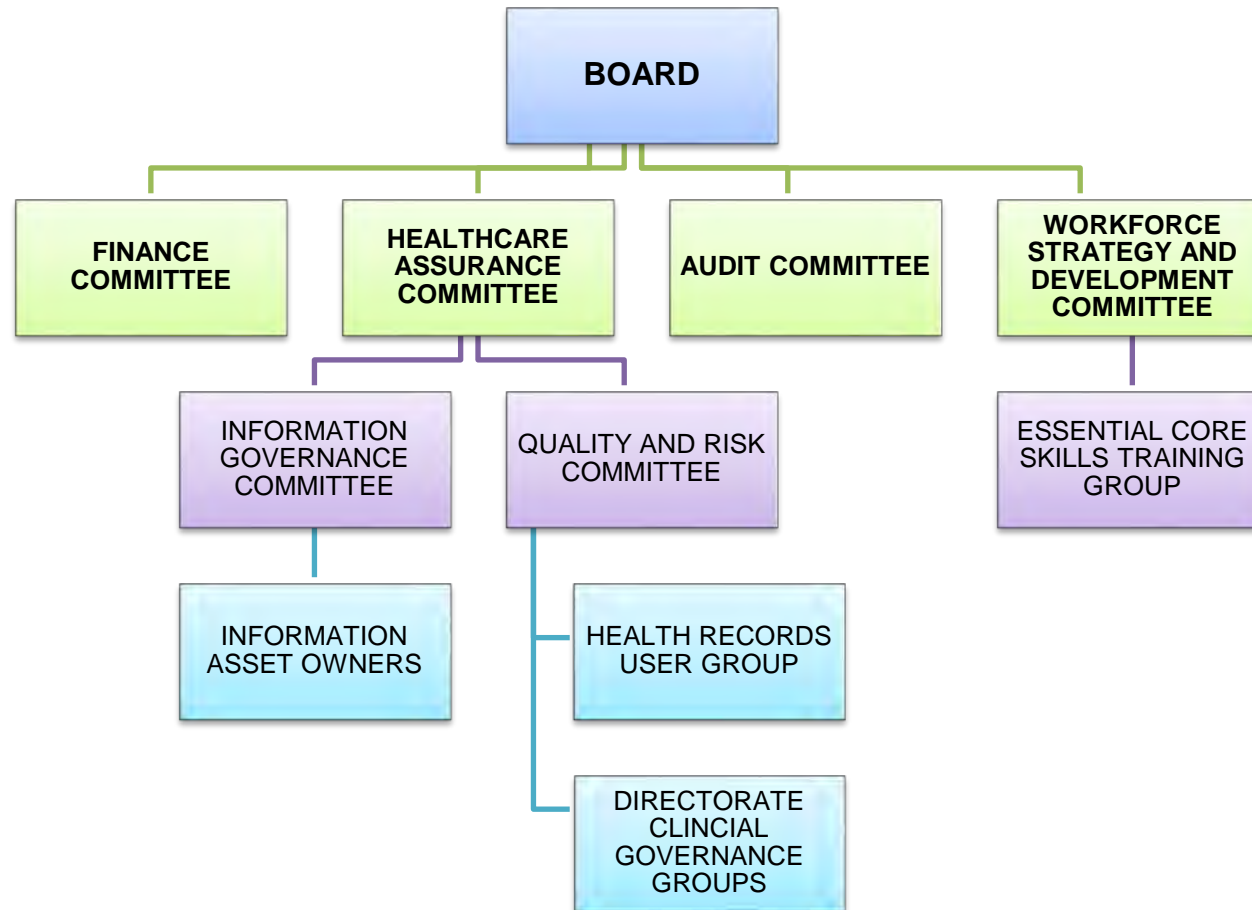
Professional bodies have also set out standards for relevant professionals and associated guidance which includes:

- General Medical Council, Good Medical Practice (2013)
- General Medical Council, Confidentiality for Doctors (2017)
- Nursing & Midwifery Council, The code: Standards of conduct, performance and ethics for nurses and midwives produced by the– paragraphs 42-47 (May 2008)
- Nursing & Midwifery Council, Record keeping: Guidance for nurses and midwives (July 2009)
- General Pharmaceutical Council, Standards of conduct, ethics and performance – principle 3 (July 2012)
- Health & Care Professions Council, Standards of conduct, performance and ethics – principle 2 (2012)
- Chartered Society of Physiotherapy Rules of Professional Conduct (2nd edition) – Rule 3 (January 2002)
- British Medical Association, Confidentiality and Disclosure of Health Information Toolkit
- Royal College of Physicians, Generic Medical Records Keeping Standards (June 2015)

APPENDIX B
Overarching Information Governance Structure

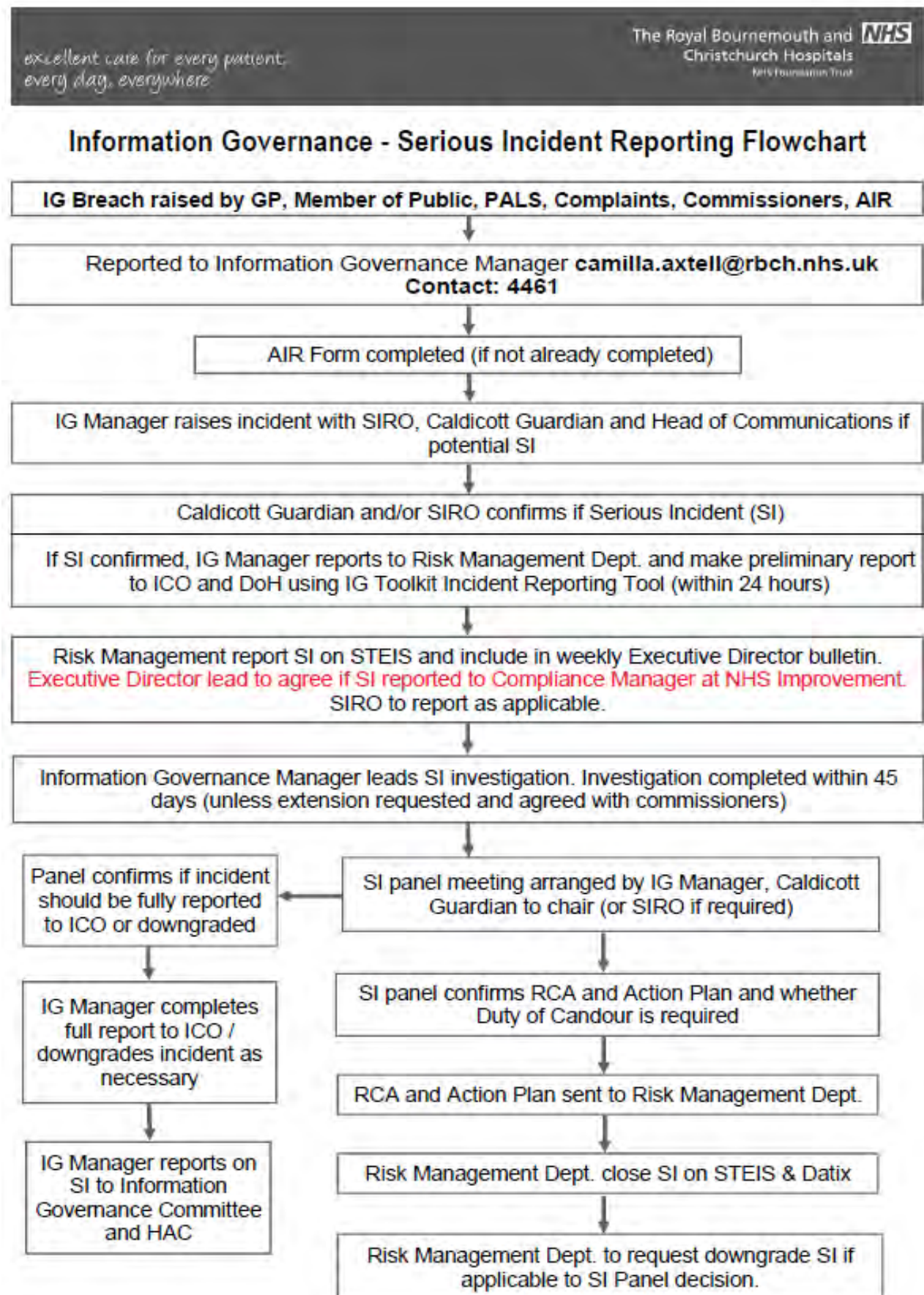


APPENDIX C
Committee Structure



APPENDIX D

Information Governance Serious Incident Reporting Flowchart





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

BOARD OF DIRECTORS	
Meeting date:	28 March 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Information Governance Annual Report
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Peter Gill, Director of Informatics
Author(s) of paper:	Camilla Axtell, Information Governance Manager
Details of previous discussion and/or dissemination:	Information Governance Committee
Action required:	Note for information
Summary: Annual Information Governance summary report for 2017/18.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on risk profile:	None

INFORMATION GOVERNANCE ANNUAL REPORT 2017/18

Introduction

Much of this year has been devoted to preparing for a number of significant forthcoming changes affecting Information Governance provision. The extensive improvement work undertaken around the Trust's Information Governance Toolkit submission in the last few years has proven to be extremely difficult to sustain; it has not been possible to devote the required staffing and time to advance this momentum and as such 2017/18 has been a year of maintenance rather than of great improvement. However the aim of imbedding good IG practice throughout the Trust and providing assurance to patients and to the Board that information is managed in a legally compliant fashion remains a priority.

Summary

Below is a high-level summary detailing significant Information Governance statistics from 2016/17 and 2017/18, and the relative percentage differences. These figures are elaborated on within the main report.

	2016/17	2017/18	Projected	+ / -
Information Governance Toolkit compliance	74%	71%	-	-3%
Data Protection and Confidentiality Incidents – breaches	124	85*	93**	-25%
Data Protection and Confidentiality Incidents – SIRIs	6	4*	-	-33%
Freedom of Information Requests	681	595*	649**	-5%
Information Governance Training (highest % reached)	97.1%	95.1%*	-	-2%

(*as at 28 February 2018)

(** projection for 31/03/18 based on average by month)

Information Governance Toolkit

The Information Governance Toolkit is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital on 31st March each year. The purpose of the IG Toolkit is to assure an organisation's IG practices through the provision of evidence around 45 individual requirements. This is the most significant single piece of work regularly undertaken by the Information Governance department.

It is widely recognised that good IG can be built around the tenets of this audit, and this can only be achieved through rigid adherence to the audit requirements. As such, the Trust's focus is placed on attaining a robust level of compliance by providing better quality evidence for each of these requirements which will in turn give a greater level of assurance of the Trust's IG practices.

Much of this audit is underpinned by work associated with information risk assurance. This involves the identification of the Trust's key information systems (information assets), the designation of a senior person who is responsible for each system (known as an Information Asset Owner), and ensuring that each of these systems has in place such measures as appropriate contract clauses, adequate access controls, regular risk assessments and suitable business continuity plans, and to ensure that any information which is transferred into or out of the Trust through this system is risk assessed and appropriately protected. This work is essential to ensure the continuous provision of effective care and to ensure that any risks to the integrity and availability of critical information are mitigated as far as is possible.

A twofold approach is taken to the completion of the IG Toolkit – requirements are divided into those requiring input from IAOs and those requiring completion by subject matter experts. The IAOs co-operation is critical to the completion of this work, as they take responsibility for providing the required assurance within each separate area of the Trust, meaning that the level of assurance provided within the IG Toolkit submission covers the whole organisation rather than selected areas. These members of staff are directed by the Information Governance Manager under the jurisdiction of the Director of Informatics, and compliance amongst IAOs is routinely monitored through IG Committee and PMG meetings.

A considerable amount of work has been undertaken during the last three years to ensure that the tasks required to be completed by IAOs are started and seen through to completion or maintained year on year, and also to provide more accurate assurance to all other IG Toolkit requirements through the designated requirement owners. This has enabled the Trust to maintain its compliance from 2016/17. The Trust must continue to maintain the traction that it has gathered on this work in order to firmly imbed the concepts as “business as usual” – this must be seen as an ongoing assurance project in order to be successful.

The nature of the IG Toolkit's scoring system is that if one of the requirements is deemed non-compliant then the whole audit is scored as “Not Satisfactory”. Please see Appendix 1 for a breakdown of the requirements and predicted scores (between 0 and 3) associated with each of these.

Moving into 2018/19, the IG Toolkit is being replaced by NHS Digital with the new Data Security and Protection (DSP) Toolkit. This will set the standard for cyber and data security for healthcare organisations, and will place a much greater focus on assuring against modern threats. Based around the National Data Guardian's 10 Data Security Standards, the DSP Toolkit will be divided into three categories of leadership obligations: People, Process and Technology. Organisations will still be required to self-assess their compliance against a range of Assertions and make an annual submission to the Department of Health, NHS Digital, CQC, etc.

Data Protection and Confidentiality Incidents

There has been a decrease in reported breaches of Information Governance during the year, as illustrated in the table above.

Some of the types of incidents reported are recurrent – the most common types being inappropriate disclosures of sensitive information. These vary in nature, however around 25% of incidents reported related to patients receiving information about another patient, and 23% relate to confidential paperwork being lost or found. However these tend to be one-off incidents rather than incidents that reoccur within one department, and can therefore generally be attributed to human error rather than lack of appropriate training or processes not being in place. In addition to routine training, further staff awareness campaigns relating to the correct handling of confidential data are planned for 2018/19. In addition, work around the management of confidential waste will continue to ensure that clear processes are in place for handling paperwork throughout its lifecycle.

During 2017/18, the Trust has reported four Serious Incidents Requiring Investigation (SIRI) to the Information Commissioner's Office (ICO). These are incidents which are categorised as serious in accordance with the guidance provided by NHS Digital and the ICO using criteria such as sensitivity of information involved, number of individuals affected, etc.

Two of the SIRIs reported related to patient information being lost or disposed of inappropriately. In one case a number of ward handover sheets that had been inadvertently taken home by a doctor were disposed of in household waste in error. The second was reported recently and remains under investigation at time of writing; a contact book containing details of surgical site infections held within the Derwent went missing. It is so far assumed that this was also disposed of within household waste in error.

The remaining SIRIs reported relate to sensitive patient data being shared inappropriately with internal auditors, and a letter being sent to the incorrect patient. The latter of these was considered to be more severe than other similar incidents as the letter contained particularly sensitive information about the patient, and the recipient made a formal complaint regarding the breach.

There is no evidence of harm coming to any of those affected by these breaches, or the information involved being disseminated further, and with the exception of the recent incident which remains under investigation, the ICO has confirmed no enforcement action was warranted on any of these.

Further awareness-raising will be delivered through appropriate channels during 2018/19 to ensure that all staff are aware of what may constitute an IG breach and therefore what they should be reporting as such. Anecdotal evidence has established previously that some members of staff do not consider such things as accessing medical records inappropriately to be an IG breach which requires formally reporting, and therefore clarity for all staff is required on this.

In May 2018 the Data Protection Act 1998 will be repealed and replaced with new legislation, bringing the EU's General Data Protection Regulation (GDPR) into UK law. Amongst the changes that this brings includes the statutory obligations to report the most serious breaches within 72 hours and to inform data subjects affected by breaches, and significantly increased financial penalties for a wider range of breaches of the legislation. Successful completion of and compliance with the IG

Toolkit enables the Trust to comply with many of the requirements of the updated legislation; however it remains important to ensure that work streams which are key to attaining GDPR compliance such as data flow mapping and privacy impact assessments are supported to be considered as a “business as usual” processes.

Freedom of Information

During 2017/18 the Trust has seen a slight decrease in the number of Freedom of Information (FOI) requests received from the previous year; 609 as at 9 March 2018, an average of 54 requests per month from April - February. This is down from 627 at the same point last year. A full time IG Officer was recruited during 2016, and to date the vast majority of this role has been dedicated to responding to FOI requests to the detriment of other duties.

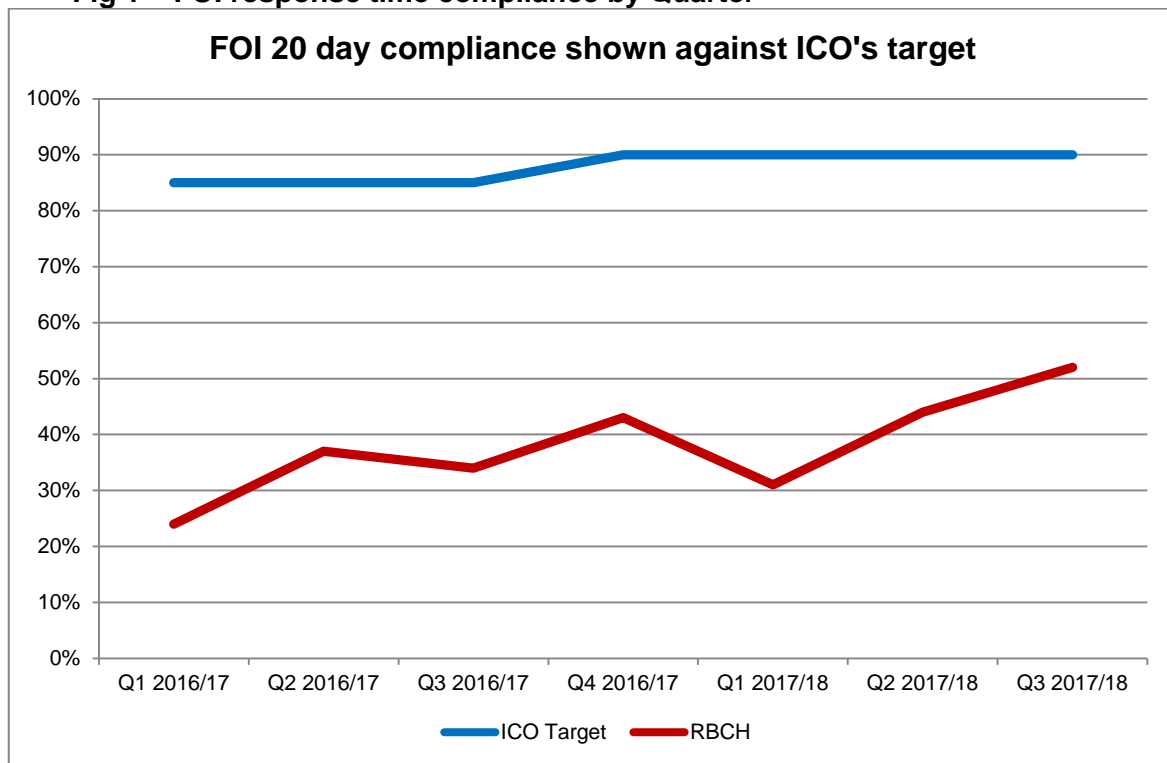
Compliance with the statutory time limit imposed by the FOIA remains poor overall, although a steady increase in compliance can be observed in the chart below. The number of breaches seen generally remains indicative of the large number of requests received, and the increased complexity of these requests which can require a significant amount of work to locate the information requested. Additionally, this can also be attributed to the difficulty of obtaining full and timely responses from staff who are managing competing priorities, and the Trust's position that critical reporting that is key to patient care and managing the financial affairs of the Trust should take priority over handling FOI requests.

The Trust Board is actively monitoring FOI compliance and is seeking ways to improve this. Routine compliance updates are being provided to the Healthcare Assurance Committee and Trust Board, and solutions to improve compliance rates are being formulated. This will continue to be monitored throughout 2018/19.

The ICO will monitor selected organisations to review their performance in adhering to the Freedom of Information Act, targeting those authorities which repeatedly fail to respond to at least 90% of FOI requests received within the appropriate timescales. Monitoring may be a precursor to further action if an authority is unable to demonstrate an improvement. Further action could include the Trust having to sign an undertaking to improve its practices, an enforcement notice, reports to Parliament, or prosecution.

The Trust has recorded the response times for FOI requests over the last 23 full quarters, broken down by month. During this period there has been no month where the required quantity of requests have been responded to within 20 days. During 2017/18, the Trust has received an average of 54 requests per month, and a response was provided on average within 24 days. During this period 57% of requests overall have been responded to within the statutory time limit, with compliance rates fluctuating between 20% and 59% for each individual month throughout the year.

Fig 1 – FOI response time compliance by Quarter



Information Governance Training

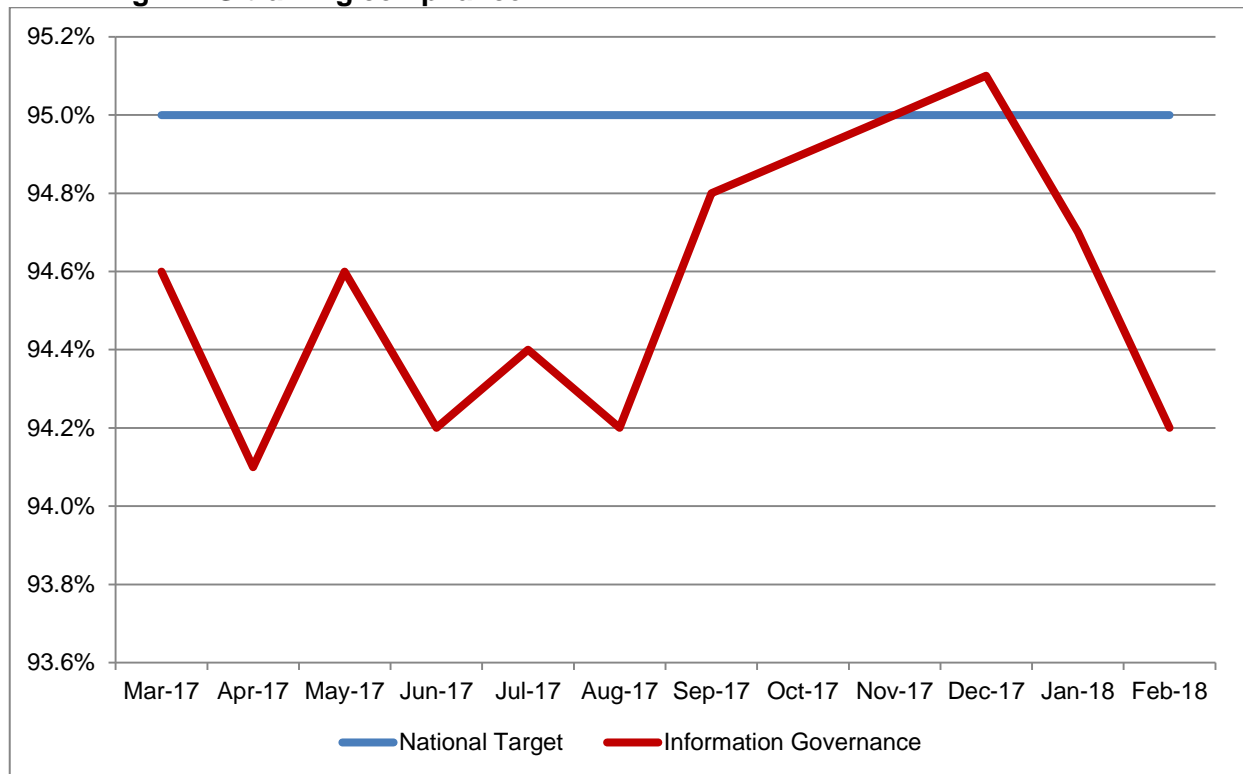
Information Governance training compliance has remained relatively high during the year and at the end of February 2018 sits at 94%. Between November and January, compliance rates exceeded the 95% national target.

The concerted campaign of chasing individual non-compliant members of staff and their line managers, led by the Director of Informatics, has continued throughout 2017/18. An automated e-mail reminder is issued weekly to staff who are not compliant with their IG training.

One of the major challenges in attaining compliance is the fact that IG training is an annual competency unlike many other subjects which only require renewing every two or three years, and so requires staff to go out of their way to obtain this competency in the “off years”.

For 2018/19, IG training is being replaced by NHS Digital to incorporate changes in data protection legislation, and increased training on cyber security. During March 2018 the Trust will be ceasing use of its in-house produced content and moving to the programme produced by NHS Digital, which will be made available to staff through the usual BEAT VLE platform.

Fig 2 – IG training compliance



Conclusion

Improvements made have been limited during 2017/18, owing in part to the additional pressures associated with forthcoming changes such as the GDPR, the new Data Security and Protection Toolkit and Data Security Awareness Training. It must be recognised that the assurance work undertaken under the auspices of the current IG Toolkit is ongoing and requires continual update and maintenance to ensure that compliance with the relevant legislation and national standards can be sustained. While the initial drive to begin to imbed this initiative is perhaps the most difficult, it is essential that this momentum is sustained to avoid a retrograde slump, negating the achievements now realised.

During 2018/19, the priority will be to continue to work towards attaining compliance with the GDPR, particularly through successful completion of the new DSP Toolkit, as well as continuing work to imbed information risk assurance and improve FOI compliance.

Appendix 1 – IG Toolkit scores

Standard	Description		Predicted Level
101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Information Governance Manager	3
105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Information Governance Manager	3
110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Associate Director Commercial Services	2
111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	HR Manager	3
112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Information Governance Manager	2
200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Information Governance Manager	2
201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	Information Governance Manager	2
202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	Information Governance Manager	2
203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	Information Governance Manager	2
205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Health Records Manager	2
206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	Information Governance Manager	2
207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Information Governance Manager	2
209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Information Governance Manager	2
210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Assistant Director IT Development	2

300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Assistant Director IT Operations	3
301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Information Governance Manager	2
302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Information Governance Manager	3
303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Assistant Director IT Operations	2
304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Assistant Director IT Operations	2
305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Assistant Director IT Operations	2
307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Information Governance Manager	3
308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Information Governance Manager	2
309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Information Governance Manager	2
310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Assistant Director IT Operations	2
311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Assistant Director IT Operations	2
313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Assistant Director IT Operations	2
314	Policy and procedures ensure that mobile computing and teleworking are secure	Assistant Director IT Operations	2
323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Assistant Director IT Operations	2
324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Information Manager	2
400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Information Governance Manager	2

401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Assistant Director IT Development	2
402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Assistant Director IT Development	2
404	A multi-professional audit of clinical records across all specialties has been undertaken	Clinical Effectiveness Manager	2
406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Health Records Manager	2
501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Assistant Director IT Operations	2
502	External data quality reports are used for monitoring and improving data quality	Information Manager	2
504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Information Manager	2
505	An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	Clinical Coding Manager	2
506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Information Manager	2
507	The Completeness and Validity check for data has been completed and passed	Information Manager	2
508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Clinical Coding Manager	2
510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	Clinical Coding Manager	2
601	Documented and implemented procedures are in place for the effective management of corporate records	Information Governance Manager	2
603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Information Governance Manager	3
604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Information Governance Manager	2
			71%

BOARD OF DIRECTORS MEETING – 28 March 2018

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 31 January 2018	Decision	<i>All</i>
11.35	2. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Discussion	<i>All</i>
11.40	3. STRATEGY AND RISK		
	a) Significant Risk Report (paper)	Discussion	<i>Paula Shobbrook</i>
	b) Capital Plan 2018/19 (paper)	Decision	<i>Richard Renaut</i>
	c) Commercial Development Strategy (paper)	Discussion	<i>Richard Renaut TO FOLLOW</i>
	d) Draft Dorset Integrated Care System Operational Plan 2018/19 (paper)	Discussion	<i>Tony Spotswood</i>
	e) Budget 2018/19 (paper)	Decision	<i>Pete Papworth</i>
	f) The South 6 Pathology Network (paper)	Information	<i>Tony Spotswood</i>
	g) Integrated Urgent Care Service for Dorset (paper)	Decision	<i>Richard Renaut TO FOLLOW</i>
	h) Recommendation Report: Orthopaedic Hip and Knee Implants (paper)	Decision	<i>Pete Papworth</i>
	i) Recommendation Report: PCI Consumables Lot 5 and 6 (paper)	Decision	<i>Pete Papworth</i>
13.00	4. QUALITY		
	a) Never Event Update (paper)	Discussion	<i>Alyson O'Donnell</i>
13.15	5. GOVERNANCE		
	a) Local Clinical Excellence Awards – 2016 Awards (paper)	Decision	<i>Alyson O'Donnell</i>
	b) Standing Financial Instructions (paper)	Decision	<i>Pete Papworth</i>
	c) Medical Appraisal and Revalidation Update (paper)	Information	<i>Alyson O'Donnell</i>
13.30	6. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff	Discussion	<i>All</i>

b) Reflective Review

Discussion

All

- What has gone well?
- What do we need more of?
- What do we need less of?

The meeting will be followed by a Blue Skies session between 1.45-2.45pm