

A meeting of the Board of Directors will be held on **Wednesday 30 May 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		
	Peter Gill, Nicola Hartley, Richard Renaut, Paula Shobbrook		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 28 March 2018	Decision	All
8.40-8.45	3. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Information	All
8.45-9.05	4. QUALITY		
	a) Patient Story (verbal)	Information	Fiona Hoskins
	b) Heart Failure Device Trial (presentation)	Information	James Donald
	c) Medical Director's Report (paper)	Information	Alyson O'Donnell
	d) Quarterly Report on Safe Working Hours (paper)	Information	Alyson O'Donnell
9.05-9.45	5. STRATEGY AND RISK		
	a) Clinical Services Review (paper)	Information	Tony Spotswood
	b) Leading for Equality, Diversity and Inclusion Strategy 2018-2020 (paper)	Decision	Deb Matthews
	c) Bournemouth Hospital Charity (presentation)	Information	Debbie Anderson
	d) Research and Innovation Strategy (paper)	Decision	Abigail Daughters
	e) Progress Update on 2017/18 Corporate Objectives (paper)	Information	Tony Spotswood
9.45-10.25	6. PERFORMANCE		
	a) Trust Board Dashboard (paper)	Information	Donna Parker
	b) Performance Report (paper)	Information	Donna Parker
	c) Quality Report (paper)	Information	Fiona Hoskins
	d) Finance Report (paper)	Information	Pete Papworth

e)	Workforce Report (paper)	Information	<i>Karen Allman</i>
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10.25-10.30

7. GOVERNANCE

a)	Membership Engagement Strategy (paper)	Decision	<i>Karen Flaherty</i>
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b)	Audit Committee Terms of Reference (paper)	Decision	<i>Alex Jablonowski</i>
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8. NEXT MEETING

Wednesday 25 July 2018 at 8.30am in the **Macmillan Seminar Room, Christchurch Hospital**

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.30-10.45

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.

DRAFT

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 8.30am on **Wednesday 28 March 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>
	John Lelliott	(JL)	<i>Non-Executive Director</i>
	Alyson O'Donnell	(AOD)	<i>Medical 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>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery/Deputy Chief Executive</i>
In attendance:	James Donald	(JD)	<i>Head of Communications</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Helen Martin	(HM)	<i>Freedom to Speak Up Guardian</i>
	Deb Matthews	(DM)	<i>Director of Improvement</i>
	Dily Ruffer	(DR)	<i>Governor & Membership Manager</i>
	Louisa Way	(LW)	<i>Lead Tissue Viability Nurse</i>
Public/ Governors:	Richard Allen		<i>Public Governor</i>
	Nigel Beauchamp		<i>ITU Anaesthetist, Portsmouth Hospitals NHS Trust</i>
	Emma Bekefi		<i>Care Quality Commission</i>
	Catherine Bishop		<i>Public Governor</i>
	Tracey Broom		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Paul Higgs		<i>Appointed Governor</i>
	Marjorie Houghton		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Margaret Neville		<i>Friends of the Eye Unit Representative</i>
	Roger Parsons		<i>Public Governor</i>
	Sue Parsons		<i>Public Governor</i>
	Alan Radley		<i>Public Governor</i>
	Guy Rouquette		<i>Public Governor</i>
	Rae Stollard		<i>Appointed Governor</i>
	Anita Tegnah		<i>Care Quality Commission</i>
	David Triplow		<i>Public Governor</i>
	Michele Whitehurst		<i>Public Governor</i>
Apologies:	Cliff Shearman		<i>Non-Executive Director</i>
	Nicola Hartley		<i>Director of OD and Leadership</i>

12/18 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Action

The apologies for absence set out above were **noted**.

13/18 MINUTES OF PREVIOUS MEETING

(a) Minutes of the meeting held on 31 January 2018 (Item 2a)

The minutes of the meeting held on 31 January 2018 were approved as an accurate record of the meeting.

14/18 MATTERS ARISING

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

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

15/18 QUALITY

(a) Patient Story (Item 4a)

Louisa Way, Lead Tissue Viability Nurse, presented the patient story which focused on how a patient-centred approach involving a multi-disciplinary team had improved a patient's quality of life and preserved their independence on discharge from hospital.

Upon admission of the patient to the Stroke Unit, there had been an incidental finding of a category 4 pressure ulcer, which the patient had been living with at home for 18 months. The treatment and care of the patient were adapted to recognise the patient's unique body shape caused by curvature of the spine as well as a cancer diagnosis, nutritional needs and limited mobility.

The patient had also found it difficult to come to terms with the need to adapt their home environment to enable them to continue living independently. Consistent messaging from the multi-disciplinary team had helped the patient reach a decision on having equipment at home, previously refused when offered by the community nurse, alongside appropriate community support.

The role of core nursing risk assessments using the electronic nurse assessment (**eNA**) application on a portable device was highlighted in the patient story. This allowed specialist staff to have remote access to assessments in order to monitor the patient's condition and prioritise specialist input and care. PG commended Louisa Way for her involvement in the development of the 'Waterlow' assessment (which measured the risk of a patient developing a pressure sore) in her role as a subject matter expert for eNA.

PS confirmed that regular feedback was provided to community healthcare colleagues and other healthcare partners including primary care and commissioners to share learning and help reduce the number of patients with community acquired pressure ulcers. The Trust admitted three times the national average of patients with existing pressure ulcers and worked hard to prevent deterioration and improve a patient's comfort during their stay in hospital. There was a range of underlying causes for pressure ulcers as well as very real clinical dangers which needed to be assessed and addressed.

Christine Hallett added, as Chair of the Healthcare Assurance Committee (**HAC**), that safety thermometer and eNA data provided assurance that nurses were assessing patients appropriately and pressure ulcers and further

deterioration were prevented.

(b) Update on Governor Activity (Item 4b)

David Triplow, the Lead Governor, updated the Board on the record number of engagement events planned for the coming year as well as providing feedback on the successful listening event held in Westbourne on 20 March 2018. While more detailed feedback would be circulated to the Board separately, this had been extremely positive about both Royal Bournemouth and Poole Hospitals, particularly the standard of care provided by staff. The most important things to patients were good communication, feeling safe and being treated with dignity. Areas for improvement highlighted were shorter waiting times, more hospital buses and better transport links.

Engagement with members of the public over a number of events had identified a need to improve levels of understanding of the Clinical Services Review (**CSR**) and proposed merger with Poole Hospital NHS Foundation Trust (**PHFT**). A summary document was being developed for use by governors at future events and it would be useful to cover this at all engagement events.

Board members welcomed the update and thanked governors for their work to increase engagement with patients, members and the public.

(c) Safe Staffing Report (Item 4c)

The report incorporated a review of compliance against the four areas of the National Quality Board improvement resource on safe, sustainable and productive staffing to support NHS providers to deliver the right staff, with the right skills, in the right place at the right time. This focused specifically on nurse staffing in adult inpatient wards in acute hospitals and also supported the National Institute for Health and Care Excellence (NICE) guidelines on safe staffing.

The Trust was also benchmarking itself against the ten key recommendations and a detailed action plan would be presented to the Workforce Strategy and Development Committee. Examples of good performance included the Director of Nursing led programme for the annual review of safe staffing prior to budget setting and the transparency of Ward to Board governance processes for monitoring safe staffing.

Areas identified for further development included the development of alternative roles to ensure that appropriately skilled staff were available to deliver care. This aligned with the work currently underway at the Trust to develop alternative roles for both nurses and allied health professionals to provide greater career progression and support recruitment. This also reflected recent guidance from NHS Improvement (**NHSI**) about the positive impact allied health professionals have can have on patient flow and the quality and continuity of care. Board members were encouraged to attend the next Nursing Midwifery and Allied Health Professionals conference taking place on Thursday, 10 May 2018.

There had been no nurse staffing red flags reported in December, which was attributed to support from bank staff and the role of the matrons in

strengthening communication between teams. The reduction in expenditure on agency staff was being maintained and the limited use of high cost agency staff in December was being fed back into the planning for next winter. The strategic development of the staff bank in Dorset was highlighted, beginning with the development of a joint staff bank with PHFT before extending this more widely across Dorset.

(d) Quality Improvement Programme 2018/19 (Item 4d)

An evaluation of the quality improvement (**QI**) programme and progress against the quality priorities for 2017/18 was provided. This included:

- improvements to hospital flow with an increase in the number of patients receiving care in an ambulatory setting, a 15% reduction in outliers, a 14% reduction in length of stay for all patients and a 20% reduction in bed days for stranded patients with the longest stay in the context of a continued rise in Emergency Department (**ED**) attendances and non-elective admissions;
- in relation to the Sepsis quality priority, Summary Hospital Level Mortality Indicator (**SHMI**) and Hospital Standardised Mortality Ratio (**HSMR**) remained below the expected range for the Royal Bournemouth Hospital and delivery of antibiotics to the sickest patients had improved to 72% against a national aggregate of 44%;
- the challenges in achieving the aim to ensure that every patient with an early warning score (NEWS) of 9 or above was escalated for review and seen by a clinician within 30 minutes with progress made around data collection and audit and training and tools for staff to enable earlier identification of deteriorating patients although the Trust had the lowest number of incidences of cardiac arrest for inpatients in the 2017 National Cardiac Arrest Report; and
- the introduction of 'action learning' weeks had been particularly beneficial in promoting joint learning and the identification of practical solutions as reflected in the 2017 Staff Survey results where staff felt able to contribute to changes within the Trust.

The work plan for 2018/19, which would further underpin the Trust's ambition to sustain high quality services, was introduced. The four domains for QI to be prioritised in 2018/19 were:

- Urgent and Emergency Care with a focus on the 'First 24 Hours';
- Surgical Flow;
- Supporting Speciality Pathways including dermatology, ophthalmology, respiratory and bloods on wards to support discharge planning and reduce blood-taking, reflecting the feedback from action learning weeks and patients; and
- Fundamentals of Care, which comprised a range of work driven by serious incident reviews and would sit alongside and support the other QI priorities and would continue QI support around sepsis and the deteriorating patient.

The Chair of the Finance and Performance Committee and Director of Finance acknowledged the impact the QI work had had in delivering improvements in quality of care whilst creating greater staff engagement around identifying efficiencies and the savings required by the Trust. The Board discussed the need to keep staff engaged and enthused in the QI work by setting priorities which encouraged all staff to become involved and

embedding the changes made.

Board members acknowledged the role of the QI programme in the Trust's performance in 2017/18 and ensuring patient safety and quality care in the context of operational and financial pressures. The Board **endorsed** the 2018/19 QI programme.

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

The key themes from the report were:

- the Trust's overall HSMR performance remained consistently within the 'as expected' range, while the Royal Bournemouth Hospital (excluding Christchurch Hospital and the Macmillan Unit) was within the 'better than expected' range;
- there was a peak in the number of deaths within 36 hours during December, which may impact on mortality performance later, although this had declined in February;
- while the peak had been attributed to high levels of respiratory illnesses associated with flu, following a partial case review a more detailed review of a number of patient pathways was being conducted;
- two cases had been identified for review through the Trust's internal serious incident panel process by the Medical Examiners Group; and
- no deaths were reported of patients with learning difficulties between December 2017 and February 2018 although one had occurred within the community.

16/18 STRATEGY AND RISK

(a) Clinical Services Review (Item 5a)

The Board received an update on the recent progress to implement the CSR which covered the following areas:

- the anticipated date for the hearing of the judicial review application in respect of NHS Dorset CCG's consultation process on the CSR;
- the consideration of a referral of the CSR to the Secretary of State for Health and Social Care by Dorset County Council's Health Overview and Scrutiny Committee;
- the impact of the judicial review application and potential referral to the Secretary of State, which could delay the merger and implementation of the CSR by up to nine months;
- the assurance being sought by NHSI on the sufficiency of the £147 million of capital to implement the CSR as part of its assurance on the patient benefits case to the Competition and Markets Authority (**CMA**);
- progress on the patient benefits case which was focussing on the quantification of the patient benefits identified with a further draft due to be available at the end of April; and
- the progress on the clinical design work across the four existing workstreams (critical care, haematology and oncology, women's and children's services and emergency care) and the creation of a fifth workstream for planned care.

Board members reiterated the need for merger in order to implement the CSR and deliver sustainable and good quality care to patients across Dorset and West Hampshire and the risks of delay in realising the benefits.

(b) Trust Strategy and Objectives 2018/19 (Item 5b)

The Board was asked to consider and approve the Trust's objectives for 2018/19, the underpinning metrics and the summary strategy. Board members noted that the corporate objectives had not changed materially, although the underlying metrics had been revised and would enable the Council of Governors to hold the Board to account. The Trust's objectives would form the basis for individual objectives as part of the appraisal process.

The summary strategy had been amended to reflect previous Board discussions around the work with partner organisations to establish Dorset as an Integrated Care System and implementation of the CSR and following consultation with colleagues at PHFT.

Two proposed minor changes to the metrics were highlighted: in relation to peripherally inserted central catheter (PICC) lines in the fundamentals of care objective and to update the title of the diversity and inclusion plan to include a reference to equality. A change to the summary strategy was also proposed to include the full name of the Royal Bournemouth Hospital rather than 'RBH'.

The Board **approved** the Trust's objectives for 2018/19, the underpinning metrics (subject to the changes outlined above) and the summary strategy.

(c) Progress Update on Stakeholder Engagement Outcomes (Item 5c)

The Board received an encouraging report on the progress against the stakeholder engagement outcomes identified following joint work between the Board and the Council of Governors, which highlighted some of the activities that had taken place over the previous few months. The twinning project involving local GPs and 30 consultants was highlighted as key to the successful transformation of services.

The Board discussed moving to joint stakeholder engagement with PHFT given they have stakeholders in common, particularly in relation to Bournemouth University.

17/18 PERFORMANCE

(a) Trust Board Dashboard (Item 6a)

The paper was noted for information.

(b) Performance Report (Item 6b)

The following areas of the report were highlighted:

- the Trust had not achieved the 95% ED four hour wait target for the final quarter despite performing well when compared with other trusts nationally;
- the focus on the 'First 24 Hours' as part of the 2018/19 QI programme would help drive progress to achieve the 95% target, just as the QI work had supported the Trust's performance over winter;
- the pressures during the winter had been intense, however staff had risen to the challenge prioritising safe care and had shown enormous

resilience, returning performance to a stable position following periods of extreme pressure;

- changes to the musculoskeletal pathway to optimise patients for surgery and to provide non-surgical intervention had impacted on 18 week Referral to Treatment (RTT) performance as predicted, with a dip of 2-2.5%;
- cancer referral/screening performance remained strong and above the national target;
- six week diagnostic performance had been maintained above the national target resulting from innovative changes to pathways;
- appointments which had been cancelled due to bad weather had been rebooked within six weeks and again, teams were thanked for striving to maintain performance; and
- the one reportable breach against the clostridium difficile target in February due to delays in isolation and obtaining samples, providing clarification that there were no cases of the infection being spread within the hospital.

Failing to meet the ED 95% four hour target meant that the Trust had not received the Sustainability and Transformation Fund (**STF**) payment of £672,000 for the third quarter and this would also impact of the STF incentive payment to the Trust.

The Board highlighted feedback from patients earlier in the meeting that waiting times were one of the most important things to them. The Board heard about how total waiting times were monitored above and below 18 weeks and the implementation of a 40 week backstop to ensure patients did not breach the 52 week waiting time limit. The Board requested more information on actual waits at future Board meetings.

RR

The Board thanked those who assisted during the bad weather including staff, volunteers and members of the public.

(c) Quality Report (Item 6c)

The report was noted for information and following key areas were summarised:

- two serious incidents had been reported in February, one of which has been categorised as a never event and there would be a further discussion of never events in the private session of the meeting as reports were still being finalised;
- the latest CQC Insight Report performance placed the Trust within the top 25% of acute trusts with only two indicators relating to never events showing a decline in performance;
- work to increase levels of patient feedback in ED was ongoing and feedback from the trial of a text (SMS) based system should improve levels in the current month; and
- 18 complaints had been received in February 2018 and response times had increased; the process for complaints monitoring was due to be revised following consultation to better align this with the internal serious incident processes and prioritise responses for the most serious complaints.

(d) Finance Report (Item 6d)

The report was noted for information. It was anticipated that national winter pressures funding and some non-recurrent financial improvements against budget would offset the loss of the STF in the fourth quarter and that the Trust would deliver its forecast and its financial control total for 2017/18. The amount of the STF bonus for achieving the financial control would not be confirmed until April 2018 but would improve the final outturn position.

The Board discussed the need for clear communication to staff about how the STF bonus would be used to ensure staff understood the financial challenge in 2018/19 and staff engagement in delivering the budget was maintained. Board members suggested using some of the funding received to recognise the role that the Care Groups had played in achieving the end of year position. The Finance and Performance Committee agreed to review this at its meeting in April.

JL/PP

Separately PG advised the Board that the capital expenditure on joint IT infrastructure had been agreed with PHFT and this should assist in the recovery of the overall capital expenditure position in March.

(e) Workforce Report (Item 6e)

The following key themes within the report were noted:

- the Trust's vacancy and staff turnover rates were down to the lowest ever levels;
- the joining rate was 11.2% and nearly 2% higher than the turnover rate reflecting the impact of the Trust's successful recruitment campaigns including social media presence and open days;
- sickness absence performance had improved in February demonstrating the commitment of staff to come into work despite the winter pressures;
- new modules were being introduced for mandatory training in April, including sepsis training, and collaboration with colleagues across Dorset was making it easier for staff to transfer their competencies when they moved to different sites; and
- the Trust's position on gender pay equality did not stand out as unusual but there were actions to address a discrepancy in pay in the top quadrant including the potential impact of Clinical Excellence Awards for consultants.

(f) Staff Survey Results (Item 6f)

Board members were advised that the Trust was in the top 20% of all acute trusts for 24 of the 32 key findings in this year's NHS national staff survey. Listening into Action's analysis had highlighted the Trust as the top performing acute trust in terms of performance and a positive year-on-year trend, having been second highest in 2016/17 and commended the Trust for 'a quite remarkable set of results'.

Further work was being undertaken to understand those areas or groups of staff where performance was not as good and to learn from those areas which were particularly good. Proposed changes to the staff pay would hopefully help address some concerns which had been raised but this

needed to be supported with the work on recognition and development and health and wellbeing.

The Board reaffirmed their commitment to address staff experiences of harassment and bullying within the Trust and expressed disappointment that results remained unchanged despite initiatives put in place.

18/18 **GOVERNANCE**

(a) Directors Register of Interests (Item 7a)

The Board noted the register of interests and no changes were requested.

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

The Board **approved** the proposed minor amendment to the Finance and Performance Committee terms of reference.

(c) Freedom to Speak Up – Update (Item 7c)

This item was considered after item 7(f). Helen Martin, the Trust's Freedom to Speak Up (FTSU) Guardian, presented her six monthly report to the Board.

The results of the 2017 staff survey demonstrated that staff felt encouraged and supported to report any concerns and that the Trust was responding to concerns raised, which was significantly better than in 2016. There were still a number of staff who did not feel this way and it was important for the Trust to address staff concerns fully in order to have an open and transparent culture.

Since the launch of the FTSU Guardian in September 2017, 45 members of staff had raised concerns with the most common themes relating to attitudes and behaviours, which were linked to bullying and harassment and reflected the national themes and the staff survey results. An evaluation of 15 case referrals identified that staff felt listened to and supported and 87% would speak up again. However further work was required to improve case management and reduce the length of investigations as well as raising awareness of FTSU among medical staff.

Other priorities for 2018/19 included supporting the work on equality, diversity and inclusion at the Trust, the appointment of FTSU ambassadors or champions and creating a sustainable model working with PHFT and other providers and commissioners in Dorset.

Helen Martin was recognised for embracing the role of FTSU Guardian and for the professional way in which she dealt with the sensitive issues encountered.

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

The Board noted the updates on progress to the action plan following the external well-led review. Whilst recognising that some of the actions were ongoing and would continue to be a focus for improvement, the Board agreed that the updates provided good assurance and the action plan could now be

closed.

(e) Information Governance Strategy 2018 (Item 7e)

The Board **approved** the Information Governance (IG) Strategy setting out the purpose, resources, policies and management framework for Information Governance responsibilities at the Trust. It was noted that the IG Strategy would be updated to reflect changes in the Data Protection Bill and the General Data Protection Regulation.

(f) Information Governance Annual Report (Item 7f)

The Board noted the Information Governance Annual Report for 2017/18 including continued compliance with the IG toolkit, preparation for the implementation of the General Data Protection Regulation (**GDPR**) and the use of confidentiality to provide assurance through the Information Governance Committee.

19/18 NEXT MEETING

The next meeting will take place on **Wednesday 30 May 2018** at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

20/18 ANY OTHER BUSINESS

Key Points for Communication to Staff:

1. Thank you to all staff during the bad weather and increased pressures
2. Progress on the QI programme and objectives for 2018/19
3. Staff recruitment and retention successes
4. FTSU

21/18 COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC

1. In response to a question about the impact of the GDPR on the Trust, it was recognised that the work to achieve compliance with the IG toolkit had placed the Trust in a strong position in comparison to other sectors. The Trust was currently in the process of updating all privacy notices to inform patients and the public how their information would be used and reviewing all databases to ensure that the Trust has a lawful basis to hold the data. The impact of the removal of the charge to access information was difficult to assess at this stage.
2. The Trust's readiness to adopt the latest version of the National Early Warning Score (**NEWS**) 2 to identify acutely unwell patients following formal endorsement was queried. The Trust had benefitted from one of the ED consultants contributing to this work and was also using eNA to collect information and generate a NEWS score electronically. However, the functionality in eNA was being developed to ensure that it could capture some of the subtleties of NEWS 2 as well as training around levels of consciousness and oxygen saturation.
3. Governors attending the recent listening event in Westbourne highlighted that the public tended to reflect the negative perception of the CSR in the local media. It was important to ensure consistent communication from both the Trust and PHFT; however the timing of communication was also

important given that the changes were unlikely to be implemented for some time. Both trusts would continue to work with NHS Dorset CCG to ensure that the public were well informed about the benefits of CSR.

4. It was confirmed that Staff Governors had been briefed on the results of the latest staff survey and would be engaged to help support improvements in some areas. Increased participation in future staff surveys would be progressed by developing alternative methods for completing the survey more easily.
5. A public governor requested a future patient story on the positive work underway at the Trust to support patients with dementia.

PS/AH

22/18 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
28.03.18	17/18	PERFORMANCE			
	(b)	<u>Performance Report</u>			
		The Board requested more information on actual waits at future Board meetings.	RR	In progress	Going forward the matrix and/or dashboard will include 35 or 40+ week waits (as well as total waiting list monthly). A deep dive will be scheduled for the July Board meeting.
	(d)	<u>Finance Report</u>			
		Board members suggested using some of the funding received to recognise the role that the Care Groups had played in achieving the end of year position. The Finance and Performance Committee agreed to review this at its meeting in April.	JL/PP	Complete	The Finance and Performance Committee agreed to allocate an appropriate amount of the funding to the Care Groups that had delivered within their budget, supporting the Trust to achieve its end of year position.
	21/18	COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC			
		A public governor requested a future patient story on the positive work underway at the Trust to support patients with dementia.	PS/AH	Complete	A request has been submitted for the topic to be included in the schedule for patient stories to the Board.
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	In progress	To be included in the June edition of FT Focus.
Key:	Outstanding	In Progress	Complete	Not yet required	



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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Medical Director's Report
Section on agenda:	Quality
Supplementary reading:	N/A
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:	Regular report
Action required:	Note for information
Summary: Medical Director's regular report to 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?	✓ ✓ ✓ ✓ ✓
Impact on risk profile:	34T

Medical Director's Report

Mortality Update

Overall HSMR (Hospital Standardised Mortality Ratio) for the Trust remains in the 'as expected' range at 100.6 for the last 12 months and 100.6 for the current financial year (April 2017-January 2018). The figure for Royal Bournemouth Hospital (excluding Christchurch Hospital and the Macmillan Unit) is 92.4 and is in the 'better than expected' range. MSG has noted a downward trend in co-morbidity coding (Charleston Index) which is currently 89% of the national index and this may have impacted adjusted mortality ratios for this year.

Crude death rate has steadily declined from 1.97% for December to 1.6% in January, 1.52% in February and 1.45 % in April 2018. These trends for January to April are comparable to January to April 2016/17. The national picture which allows comparison will be clearer in a few months once rebasing is done for the winter months. Deaths within 36 hours surged in December but have declined since then. 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: May 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 09/05/2018

Month	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Deaths in Month	113	107	130	134	155	136	175	168	146	152	141
eMortality Reviews Completed in Month	134	118	35	90	54	24	25	75	107	177	55
Category of Death by Month Review Completed											
Grade 0	124	108	30	79	48	20	23	63	103	173	50
Grade 1	9	9	5	8	4	4	2	10	4	4	5
Grade 2	1	1	0	3	2	0	0	2	0	0	0
Grade 3	0	0	0	0	0	0	0	0	0	0	0
Learning Disability Deaths in Month	0	0	1	2	0	0	0	1	0	0	3
Learning Disability Deaths Reviewed	0	0	1	2	0	0	0	1	0	0	0

There have been 3 deaths reported in individuals with learning difficulties (LD) in April 2018. All three deaths have been forwarded to national LeDER programme for the review. One death occurred under respiratory consultant care and there were two deaths from metastatic cancers in the Macmillan Unit. The consultants responsible for care have been requested to conduct a prompt internal review. The Trust has received no feedback from any LD deaths reported to the LeDER system to date.

As per our mortality review protocol all deaths graded as 2 or 3 are subject to a root cause analysis (RCA) type investigation outside our normal e-mortality process. No deaths were graded as 2/3 following e-mortality review in February/March/April 2018.

Action Plan from the Mortality Surveillance / Reviews

Upward trends in sepsis/ pneumonia mortality

Mortality Surveillance Group (MSG) noted higher mortality from 'Sepsis and Pneumonia' in December 2017 onwards this year. Sepsis lead, Dr David Martin, conducted a fast-track mortality review of 15 random deaths in this group. MSG had noted outcomes from 'deteriorating patient QI project' and agreed the following action plans with the aim of improving outcomes in this group:

- Pneumonia pathway walk
- Review of deaths within 36 hours of admission
- Impact analysis from the deteriorating patient QI project to inform operational measures for the next winter.

Upward trends in stroke mortality/Annual review of high risk conditions

MSG monitors mortality in the nationally mandated high risk conditions. An upward trend was noted for this category although still within the expected range. Dr K Thavanesan, stroke mortality chair, conducted a mortality review to identify obvious contributors to this trend. 30 sets of case notes were reviewed for stroke specific clinical care, communication and end of life care. The review graded 4 deaths as grade 1 and rest as 0. No deaths were avoidable and the palliative care team was appropriately involved in end of life care.

Action plan: MSG is in process of disseminating learning from grade 1 mortalities with the recommendation that this is built in to the QARC (Quality and Risk Committee) top 10 in addition to the mortality newsletter. Issues discussed included:

- Management and investigation of the MRFD (Medically Ready for Discharge) patient
- Adherence to clinical pathways for anti-platelet treatment
- Thrombolysis should not be delayed pending a potential decision for thrombectomy

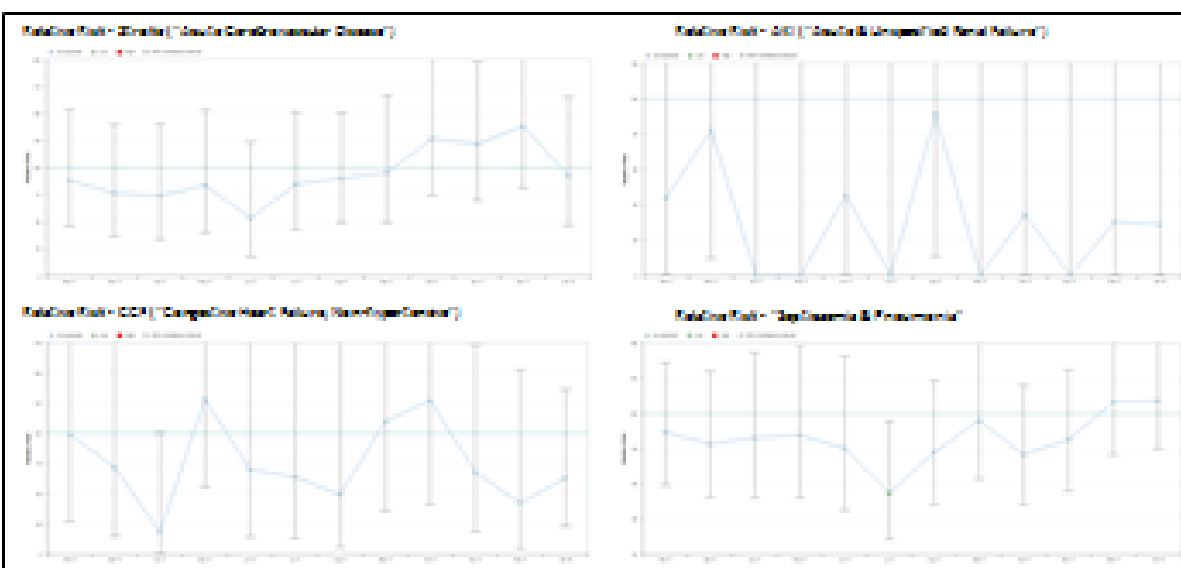
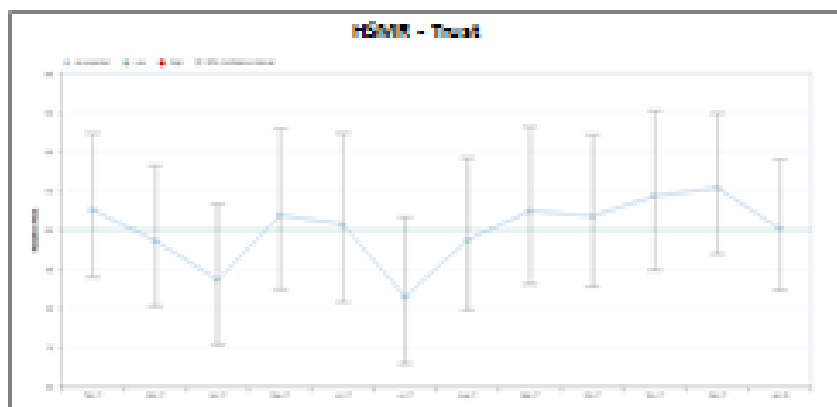
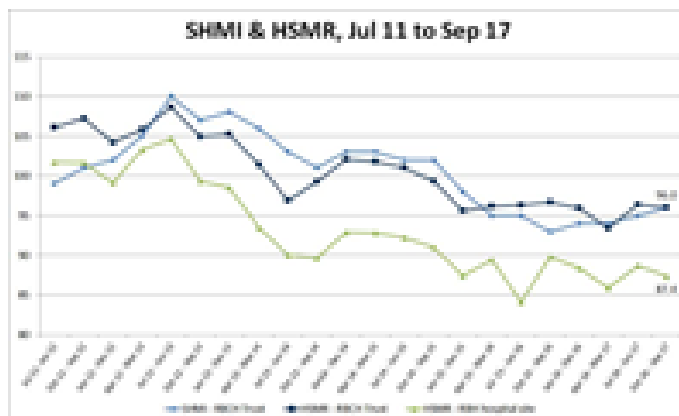
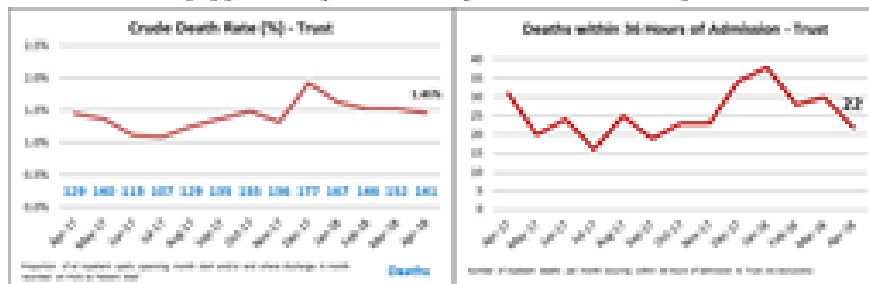
Dr Foster alert: 'Repair of thoracic or unspecified aortic aneurysm'

This is a procedural Cusum alert caused by 3/10 deaths compared to a nationally expected figure of 1/10. Dr John Oakes, vascular surgery mortality chair, conducted a thorough review of clinical care (pre-operative and post-operative), communication, coroner's rulings, where applicable, death certification and coding. All three deaths were coded as grade 0 and no obvious deficiencies in clinical care or delays in pathways were identified.

Action plan: MSG to review coding. Identification of non-matching codes from surgical entries in theatre and final coding from coders.

Annexe A

Data Review (Appendix C) - Mortality Surveillance Group





The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Quarterly Report on Safe Working Hours for Doctors in Training
Section on agenda:	Quality
Supplementary reading:	None
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Dr Tanzeem Raza, Consultant Physician, Guardian for Safe Working for Doctors in Training
Details of previous discussion and/or dissemination:	Trust Management Board
Action required:	Information
Summary: This report summarises work undertaken by the guardian for safe working hours so far. All our trainees are now on this new contract. 202 exception reports have been completed in accordance with the requirement of the contract.	
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?	✓
Impact on risk profile:	N/A

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

Executive Summary:

The new trainee contract is almost fully imbedded now with all trainee doctors in this Trust having been transferred to the new 2016 trainee doctors' contract. There are now 190 trainees on this contract. The new contract necessitates very specific work schedules for each placement. It also needs a very active engagement from educational and clinical supervisors with additional demand on their time.

Since my last report in December 2017 another 124 new exception reports have been submitted. The total reports submitted so far stand at 326 as on 12 April 2018.

Exception reports are a mechanism for trainees to highlight any work that they end up doing which is beyond their contracted hours of work. As the Guardian for Safe Working Hours, I monitor those exception reports, ensure that all exception reports are acted upon in a timely manner and make a judgement where further intervention might be required.

This report provides an overview to the Trust Board about the work done by the Guardian from November 2017 to April 2018

1. Introduction:

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

The guardian is responsible for:

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

We now have a total of 190 trainee doctors on this new contract.

2. Issues:

The 2016 employment contract for trainees seem to have embedded now, however, there continues to be a degree of unease among some trainees, whose earnings have been reduced due to their pattern of work e.g. F2s and CMTs (core medical trainees) working in ITU. Similarly the financial impact of the contract for trainees who wish to work on less than full time basis continues to be a concern for some.

This new contract imposes very strict limitations on the working hours and those limitations have their own implications on the flexibilities in any rota, affecting rota swaps or ability to cover colleagues etc.

Since the introduction of this contract in December 2016 and then rolling it out to all other trainees in August 2017 there have been a total of 326 exception reports; 124 since my last report to TMB in December 2017. Further details of these new exception reports are provided later in this report.

3. Exception Reports between August and November 2017:

Number of doctors in training (total):	195
Number of doctors in training on 2016 TCS (total):	190
Amount of time available in job plan for guardian to do the role:	1.5 PAs per week
Admin support provided to the guardian (if any):	0.2 WTE - temporary
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

4. Exception reports:

Since the introduction of new contract there have been a total of 326 exception report, 124 since my last report to the Board. All exception reports in the last quarter are about extra hours:

Specialty	New exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	61	47	14
Gastroenterology	40	33	7
OPM/MFE	14	8	6
Cardiology	1	0	1
Psychiatry	0	0	0
Medicine	5	2	3
Haematology	3	0	3
Ophthalmology	See comments		
Total	124	90	34

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

5. Work schedule reviews:

The highest number of exception reports has been generated by the Foundation trainees in surgery. Previous attempts on minor tweaks in their rota have failed to address issues. A meeting also took place between Dr. Lynn Poynter (Foundation programme director) and the surgical directorate. I have been given to understand that additional funding has been made available for Trust Grade doctors in surgery. The recruitment process is in the pipeline at the moment. Trust Board will need to monitor the situation after that additional resource becomes available.

A next highest number of exception reports continue to be generated by trainees in Gastroenterology. I met with Dr. Al Shama (trainee lead in Gastro) prior to my last report and it was highlighted that the work load in Gastro is such that the current numbers of trainee doctors are unable to complete all the tasks within contracted hours. There were no easy work schedule/rota review solutions to address this.

A mismatch between the number of trainees and the workload was highlighted. I understand that further meetings took place at the directorate level to explore options to support trainees in Gastroenterology. Unfortunately the situation has only marginally improved. The Board needs to take note of unsustainable work load in Gastroenterology.

OPM and Medicine trainees have also raised 20 exception reports since November 2017. In most cases there were genuine emergencies or colleague sickness etc. when the trainees had to stay back to complete their tasks.

Almost all of the exception reports have resulted in compensatory payment to the doctor in question except for 1 occasion where time off in lieu was agreed instead. Compensatory payments for F1s are made @ £12.6336 per hour.

Although Ophthalmology trainees have not logged any exception reports, it was brought to my attention that there were some major concerns around their work schedules etc. I met with them on 26 March. The main concerns appear to be around loss of training opportunities. It also transpired that they are often having to stay longer than their work schedules would expect them to but they have not been lodging and exception reports - they had some apprehensions around the mechanism which I hope to have addressed. They gave me the impression that the original work schedules that have been issued to them, do not bear any resemblance to their actual work.

There might be some misunderstanding about the whole new contract, work schedules and exception reports and I have offered to go and speak to ophthalmology colleagues in one of their directorate meeting and explain it all if required. Ophthalmology trainees did not seem to know how to use the Allocate system for lodging an exception report - I understand that they have now been given new usernames etc.

6. Locum usage:

A large number of shifts in Medicine/OPM, surgery and Emergency Medicine were filled with locums. From December 2017 to March 2018 a total of 169 shifts/days in Medicine/OPM were filled in by locum SHOs or Registrars costing a total sum of £ 69,710.

In the same period the surgical directorate had to cover 335 Registrar/SHO shifts and 15 F1 shifts during this period with a total cost of £250,317.

Emergency Medicine needed to cover a total of 639 shift and spent £314,120 on locums from December to March.

7. Vacancies:

Currently there are 12 unfilled deanery training posts (including trainees on maternity leave). Some of these posts have been filled with Trust grade appointments but six posts remain unfilled.

The gaps are:

- 5 gaps in junior trainees (SHO) level gaps (1 F2, 3 CMT and 1 in GPVTS). GPVTS gap remains unfilled whereas the rest have been filled with Trust grade appointment.
- Oncology ST3 gaps has also been filled by a LAS appointment. However 2 ST3 gaps in Anaesthesia, 2 in Surgery and one each in GU Medicine and T&O remain unfilled.

8. Trainees committee

With the appointment of a chief registrar who joined in February, the trainee committee meetings have started to be better attended. Last meeting on 9 April 2018 was attended by 16 trainees and various issues were discussed.

It has been agreed by the trainees that they will meet every month. The Guardian for Safe Working hours and the Director of Medical Education regularly attend these meetings. The next meeting is scheduled to be held on 21 May 2018.

9. Fines

No fines have been levied on any department so far.

10. Outstanding Issues

Exception reports must be acted on by the educational/clinical supervisor within 7 days of those being raised. Unfortunately the engagement by some supervisors has been less than satisfactory and despite several reminders from the Guardian (emails/telephone calls) 32 exceptions reports are still outstanding – some for over 60 days.

11. Questions for consideration

- How to maximize engagement from educational/clinical supervisors for timely completion of exception reports?

12. Next Steps:

Almost all our trainees are now on the new contract. Each trainee is given a specific work schedule which specifies their working hours, rota and training opportunities available to them. Most of the exception reports have been generated by Foundation or Core Trainees. More senior trainees have tended not to fill in any exception reports. It is difficult to conclude that the exception reports are accurately capturing all work completed by trainees beyond their contracted hours.

The next report will be presented in the September Trust Board meeting

Dr Tanzeem H Raza
Guardian for Safe Working Hours 12 April 2018



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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Clinical Services Review
Section on agenda:	Strategy and Risk
Supplementary reading:	Yes
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:	Ongoing discussions by the Board
Action required:	Review and comment
Summary: This paper summarises ongoing work to advance the Clinical Services Review (CSR) and proposed merger.	
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:	Remains constant

Advancing the Clinical Services Review

Good progress continues to be made in all five work streams to complete the detailed clinical design of services and so establish a major planned and major emergency site. The planned workstream is now operational and the Clinical Reference Group led by the two trusts' Medical Directors are starting to review proposals emerging from the workstreams prior to a series of configurational recommendations being made to the joint East Dorset Reconfiguration Board.

The Chairman and I together with the CEO and Chairman of Poole Hospital NHS Foundation Trust recently met with colleagues from NHS Improvement (NHSI) to discuss the proposed timeline for a Competition and Markets Authority (CMA) Stage 1 review. I am pleased to confirm that, subject to the agreement of the CMA we agreed to approach the CMA post the judicial review hearing on 17/18 July. Included in the Reading Pack are two timelines for the proposed merger reflecting:

Option 1: being able to begin work with the CMA post the judicial review hearing

Option 2: deferring a review by the CMA until after the submission of the Outline Business Case for capital.

I have placed in the Reading Pack the paper provided to NHSI setting out the rationale and benefits for the timescale with Option 1. I have also enclosed for Board members information the response of the competition team within NHSI to the CMA questions.

We have now received a detailed response from the competition team to the draft patient benefits case. This is very helpful and will inform further iteration of this document. The final case will be available to the competition team to provide their advice on the benefits to the CMA well ahead of the judicial review hearing. The patient benefits case will also inform the submission from the trusts to that hearing.

Finally, I have also added within the Reading Pack an update report prepared by Alan Betts for the Poole Hospital Board on merger.

The Board is invited to consider progress on the Clinical Services Review and proposed merger and to offer comment/questions.

Tony Spotswood
Chief Executive



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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Leading for Equality, Diversity and Inclusion Strategy 2018 – 2020
Section on agenda:	Strategy
Supplementary reading:	None
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Deborah Matthews, Director of Improvement and Inclusion
Details of previous discussion and/or dissemination:	
Action required:	Recommend
<p>Summary:</p> <p>The RBCH Leading for Equality, Diversity and Inclusion Strategy outlines our ambitions to become a truly inclusive employer and service provider for our staff, patients and local health community.</p> <p>It builds upon our positive culture and improvement journey over the last five years and supports our mission <i>to provide the excellent care we would expect for our own families</i>.</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?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	Improving risks relating to delivery of equality, diversity and inclusion agenda



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

Leading for Equality, Diversity and Inclusion

Strategy 2018 – 2020

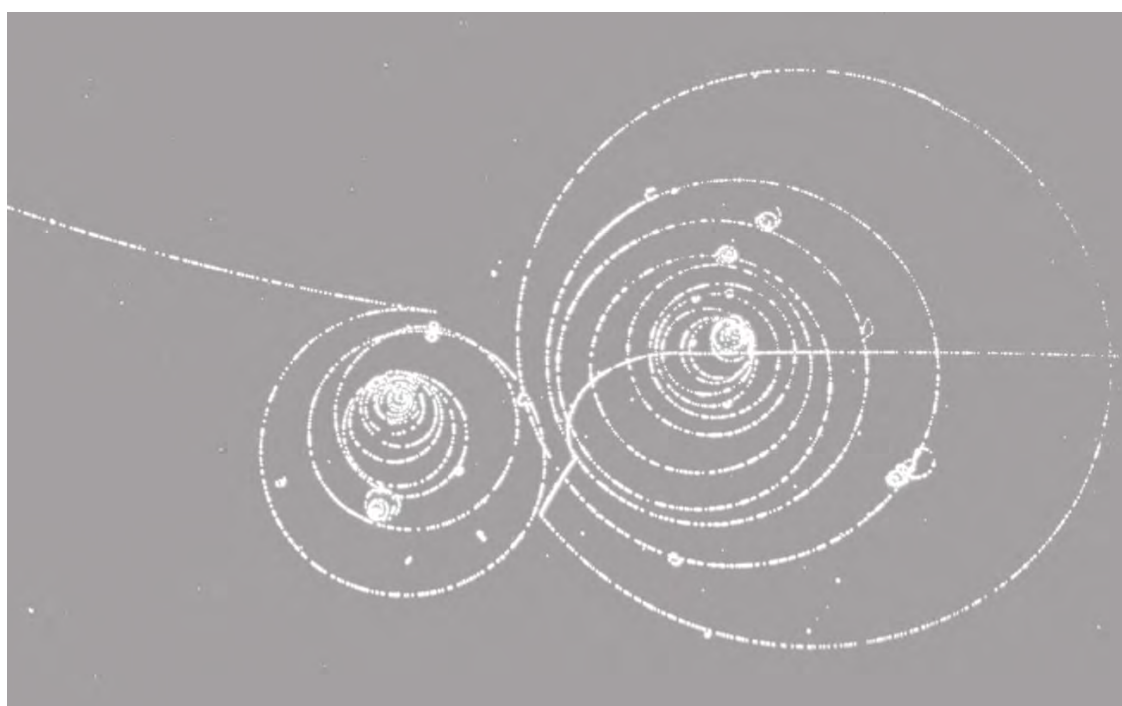


Table of Contents

INTRODUCTION	1
SETTING THE CONTEXT	2
What is equality, diversity and inclusion?	2
Our legal duties	3
The local context	3
OUR STRATEGY	8
Overarching principles and approach	8
Linkages to other strategies and plans	10
OUR WORK PROGRAMME	11
Talent - our staff	11
Patients	12
Improvement and innovation	12
Living our values	13
MEASURING SUCCESS	13
Delivery of <i>Leading Equality, Diversity and Inclusion</i>	14
GOVERNANCE AND ACCOUNTABILITY	16
APPENDICES	18
Appendix 1: Legislation and national standards	18
Appendix 2: Definition of the 9 protected characteristics	21

Introduction

Leading for Equality, Diversity and Inclusion outlines our ambitions to become a truly inclusive employer and service provider for our staff, patients and local health community. It builds upon our positive culture and improvement journey over the last five years and supports our mission *to provide the excellent care we would expect for our own families*.

As a large NHS employer, The Royal Bournemouth Hospitals NHS Foundation Trust (RBCH) recognises we have a corporate responsibility to engage our whole community. Valuing diversity ensures an inclusive environment for potential staff and service users. We also know that celebrating individual difference and bringing diverse teams together with disparate styles and talent will foster innovation and continuous improvement for patients, service users, their families, carers and our staff.

The Royal Bournemouth Hospitals NHS Foundation Trust (RBCH) is hugely privileged to have been selected as one of NHS Employers Equality and Diversity Partners for 2018/19. This will provide an important opportunity for us to work in partnership with other health and social care partners and the voluntary sector to further refine our equality, diversity and inclusion (ED&I) approach.



We are extremely proud of our achievements so far but the evidence from our statutory ED&I reporting and *listening weeks* suggest we need to do more to actively take account of equality, diversity and inclusion in our core business. This strategy outlines our approach and intent – a deliverable plan that will strive to:

- eliminate unlawful discrimination, harassment and victimisation;
- improve year on year the reported patient and staff experience for protected groups;
- reduce health inequalities for protected groups by improving access to all services.

SETTING THE CONTEXT

What is equality, diversity and inclusion?

Equality is about fair treatment - making sure everyone is treated fairly and given the same life opportunities. It is not about treating everyone in the same way, to achieve the same outcomes. Different people have different needs. For example making reasonable adjustments for disabled people (providing correspondence in audio for visually impaired patients removes barriers to equality of opportunity and helps prevent discrimination). Equality recognises that people's needs may need to be met in different ways.

Diversity refers to characteristics relevant to our identity and important for individual authenticity, including gender and gender identity, ethnicity and race, religion and belief, nationality, sexual orientation, disability, age and social class. It is about recognising difference. People differ in all sorts of ways which may not always be obvious or visible. Everyone is an individual with their own background, experiences, styles, perceptions, values and beliefs and we need to understand, value and respect these differences. It is a sense of belonging, of feeling respected and valued for who you are.

Inclusion refers to an environment which values diversity and enables people to be their authentic self in the workplace. It is about positively striving to meet the needs of different people and taking deliberate action to create environments where everyone feels respected and able to achieve their full potential. An inclusive workplace is characterised by openness, equality and non-discrimination. Inclusion is the enabler of diversity in that it provides the environment for our staff to give their best. In an inclusive culture, different perspectives are actively encouraged and people are confident in their ability to progress within the organisation regardless of their particular background or identity. There is a high level of psychological safety within an inclusive organisation.

Diversity and Inclusion is integral to how we attract, retain, develop and engage our staff and the team relationships we have with each other. Inclusive workplaces are crucial for our wellbeing and for minimising risk.

Our legal duties

The Trust is required to provide assurance of delivery against a number of national standards and compliance frameworks for equality, diversity and inclusion (ED&I). These include:

- The Equality Act (2010)
- The NHS Constitution
- The Public Sector Equality Duty (PSED)
- The NHS Equality Delivery System (EDS2)
- The Workforce Race Equality Standard (WRES)
- The Workforce Disability Equality Standard (WDES)

Further details of our legislative framework are described in Appendix 1.

The local context

Leading for Equality, Diversity and Inclusion has been developed in response to our current gaps in compliance against national standards and, more importantly, engagement with staff as part of our *National Equality and Diversity Week* (2017) and a series of *Listening Events* in March – May 2018. During this time we visited many of our wards and departments to encourage conversations about diversity and inclusion. We asked staff:

- what should we do?
- what would make a difference?
- what do you need to know?
- what support would you find helpful?

We also used these events to develop real life stories about diversity and difference amongst our staff and as a result, we will introduce our *Humans of Hospitals* campaign in May 2018.

In the first quarter of 2018 – 19 we also launched our first Lesbian, Gay, Bisexual and Transgender Staff (LGBT) Network and our European Staff Network.

Our next section summarises the feedback and some of the personal comments from staff.

What have we learned?

Our model of staff networks with members and supporters / allies has been very successful.

This has been strengthened by messages of support from our Chief Executive and the Senior Leadership Team and a commitment to support staff through our Equality, Diversity and Inclusion Committee

We don't have a Transgender Equality policy or protocols. Staff report inconsistency across the Trust on how issues are handled in wards and departments.

'I want to do the right thing for my team member who is transgender. I don't want to say the wrong thing'

Visual communication cards used by our speech and language therapy teams.

They would like to share these Trust wide to help ward teams communicate with patients with language and speech barriers.



'I'm a Staff Nurse. The only maternity uniform is available in white. I've lost my role identity. I'm constantly asked if I am agency or Bank'

Christchurch Day Hospital

'we feel empowered and trusted to make small changes and suggestions for improvements'



'Feels like we are an island once you come over that crossing. We appreciate how the wards and departments work but its not reciprocated'



"When I wear my Porter's uniform I feel I wear the Harry Potter invisibility cloak"



What have we learned?

LGBT staff network launched 14 February 2018 in partnership with our colleagues at Poole Hospital. A Committee appointed and monthly meetings underway with 20 Members and 100 Allies



Using the word “just” has an impact – just clerical, just back office.

‘Please call us support staff, because that’s what we do, support patient care’

Training and Development

On our trolley walks we heard stories of staff who wanted to develop their skills but believed the training was not for them ‘only for senior staff’. We were able to check with our training and OD team and bust these myths. PALS staff now aware they can access difficult conversations training and ward staff in our Derwent suite supported with their catheter training.

Quality Improvement

Lots of staff have ideas and feel they have a voice to make suggestions for improvements.

‘Sometimes it’s hard to have the time to commit to improvement projects. Need flexible working to make this happen’

‘I made a suggestion and I got good feedback. It wasn’t taken up but I was pleased someone listened to my idea’

‘I know there is QI training but thought it was only for senior staff’

‘What’s the point of making suggestions, nothing changes’

In our SAU ward staff proudly display their nationalities alongside their photo. They are proud of their multi-national team and celebrate difference.

‘Choose a job you love and you won’t have a single day of your life’



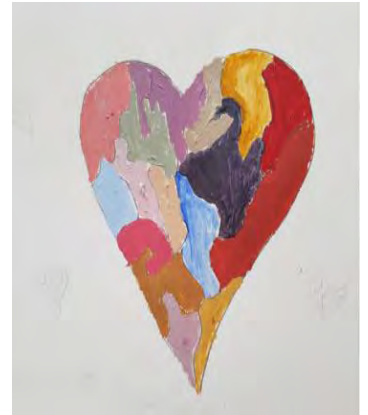
‘Our roles are disappearing as we move towards paperless. We feel unwanted. We are being squeezed into a smaller and smaller place. We asked for a rest area. It’s not very restful’



‘One of our team members has the highest nominations for #thankyou. Not everyone knows that’

What have we learned?

More staff networks are planned.
BAME (Black Asian Minority Ethnic) Mental Health and Carers



Sometimes I don't know what to say, what is politically correct or not as it does change quite often. Information would be really helpful'

'We use our overseas staff to help us translate. It's quicker and easier and puts the patients at ease. Why can't we recognise this huge resource we have in our teams?'



I am a carer for my husband and son. Sometimes it's difficult to balance home and work. Not everyone understands how hard that is, caring at home and work'

European Staff Network launched on 11 May 2018 with 26 members and 160 allies.



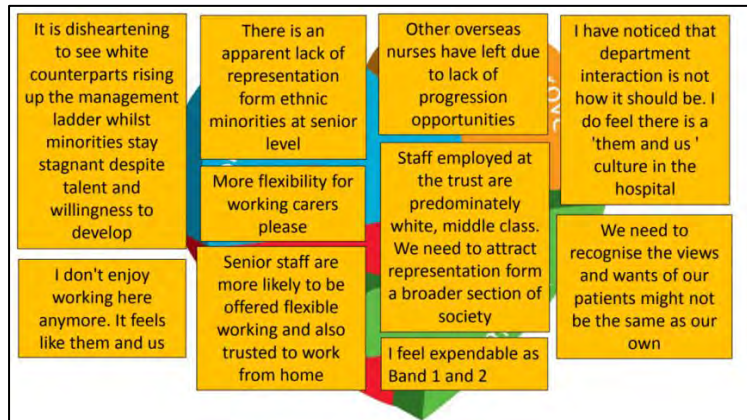
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NHS staff please spread the word to European colleagues:
this is your home, we value your life-saving work, and we want you to stay.

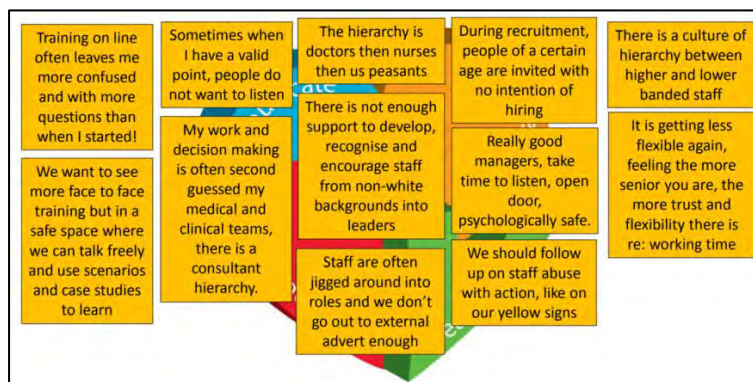
JEREMY HUNT, HEALTH SECRETARY



What have we learned?



'I know of many staff in our hospitals who are working below their professional status, a doctor, a qualified nurse. They qualified overseas and have to work at a lower grade due to registration. That seems a shame we have these hidden talents'



Assistant Practitioners Course

'I'm proud and very grateful for the opportunity. I managed to balance work and home life and felt well supported by the training team. I'm 54 and I didn't have the chance to go to University. Now I have completed a University course and I manage my own bay of patients'



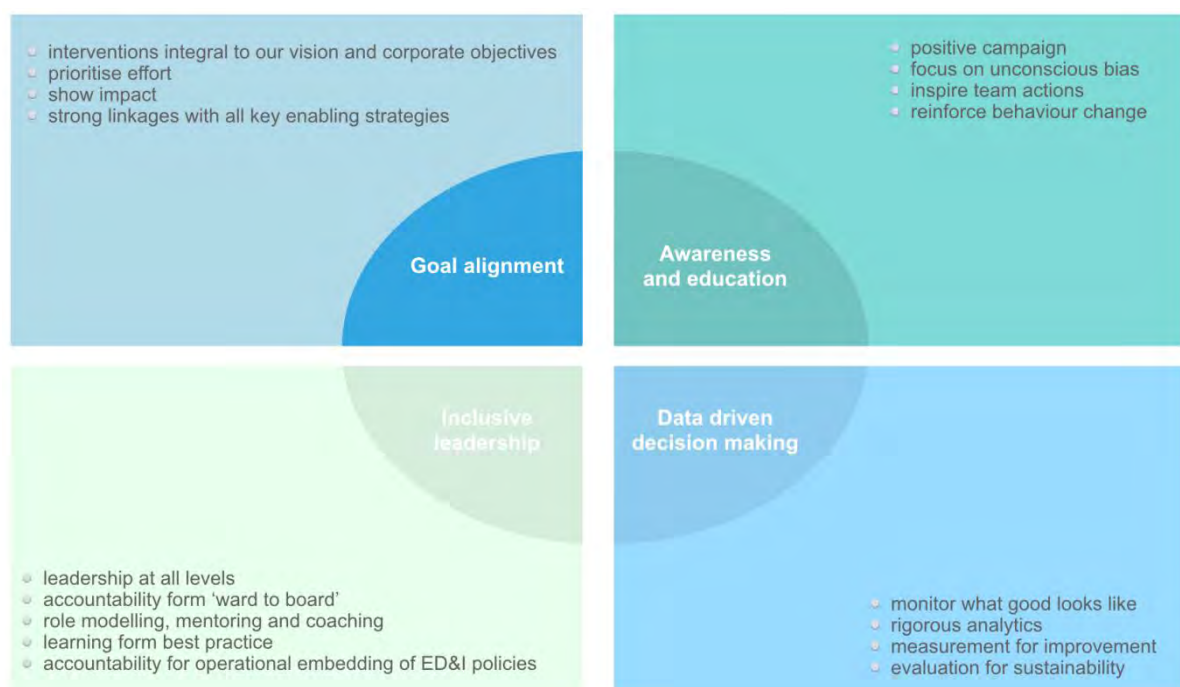
OUR STRATEGY

RBCH is working towards becoming a truly inclusive employer and service provider. We are committed to the elimination of discrimination, reducing health inequalities, promoting equality of opportunity and dignity and respect for all our patients, service users, their families, carers and our staff. We want to create an environment and culture that celebrates diversity and inclusion and in line with our values, nurtures and harnesses difference for the benefit of patients.

The objectives within our *Leading for Equality, Diversity and Inclusion* strategy link closely to those described in the Trust's Quality Account and the Care Quality Commission's (CQC) domains of safe, effective, caring, responsive, and well led. It will be refreshed every twelve months as part of our annual planning round.

Overarching principles and approach

We have agreed a set of core principles that underpin the development and delivery of our ambitions and priority areas. These will help guide our work and re-refresh our approach to equality, diversity and inclusion. We want to achieve deeper cultural change moving beyond compliance and 'tick boxing' to a truly inclusive way of working. These principles will raise our level of aspiration and quicken the pace of change.



Goal Alignment

We need to optimise our efforts by linking our ED&I strategy to our corporate objectives. ED&I will be clearly defined as an integral part of our hospital vision, firmly embedded and fundamental to its success. A standalone or silo approach to ED&I will not be enough to create change or visible progress. We will align all of our interventions directly with the objectives of the organisation and to help us prioritise effort and show impact.

Inclusive Leadership

To make sustained diversity and inclusion progress it is imperative that we have the right level of leadership commitment and accountability at all levels within the organisation. Diversity and inclusion is '*everybody's business*' and everyone in the Trust is therefore expected to take an active part, supported by the work of our specialist teams.

Our Board of Directors will lead by example in relation to inclusive practice and our senior leadership team will focus on operational embedding of ED&I to stimulate action and commitment to behaviour change.

Awareness and Education

To foster a diverse and inclusive workplace we need to create the right levels of ED&I awareness and education, focusing on *unconscious bias*. This will be a central component to engage the hearts and minds of all our staff, inspire team actions and accountability for change.

Data Driven Decision Making

We need to monitor what good looks like to ensure our interventions have an impact and report regularly to the Board of Directors. A data-driven approach will enable us to dispel any myths regarding our baseline (*where are we now?*) and track progress. We will identify a small number of metrics we feel are the most critical to ensure success and use quality improvement (QI) methodology to experiment with new ideas and interventions. An end of stage evaluation framework for sustainability of the benefits will also be available to support our leadership teams and help them undertake meaningful equality analysis.

'I've learned that people will forget what you said, but people will never forget how you made them feel' Maya Angelou

'The main thing is to make the main thing, the main thing' Anon

'Strength lies in differences, not in similarities' Stephen R Covey

'Leaders who are aware of their own biases and preferences, actively seek out and consider different views and perspectives to inform better decision-making. They see diverse talent as a source of competitive advantage and inspire diverse people to drive organisational and individual performance towards a shared vision'

The Employers Network for Equality and Inclusion (ENEI)

To support these core principles, we will adopt a *dialogic*¹ change model to ensure we maintain a balance between planning (*what should be happening*) and space for emergence and dialogue (*what is actually happening*). This requires our diversity and inclusion approach to be deeply collaborative, ensuring the voices of our staff and patients are at the heart of our work, empowered and constantly helping shape the interventions outlined in our plan. We also recognise there is no quick fix solution and that we need to keep our ambitions and long term goals for diversity and inclusion simple and easily understood. This approach will help us consider what critical interventions work and can make a real difference in a complex system so that we aren't defeated by lack of resources and competing pressures. We will actively involve staff in changes to policies, procedures and service improvements that will affect them.

Linkages to other strategies and plans

In addition to our overall aim and corporate objectives, this plan has been developed with clear alignment to other complementary strategies within the Trust including our:

- People Strategy
- Leadership Development Strategy
- 2018 / 19 Improvement Programme

¹ Dialogic Organisational Development (Gervase, Bushe and Marshak 2015); Relational Organisational Gestalt (Chidiac 2018)

OUR WORK PROGRAMME

Our Equality, Diversity and Inclusion Strategy will focus on four key areas.



Talent – our staff

We will:

- (a) embed the concept of inclusive leadership behaviours in all our management and leadership development programmes
- (b) strengthen accountability and visible leadership via ED&I objectives at care group and directorate level
- (c) develop ED&I capability and skills through the introduction of an *unconscious bias* tool kit and learning package
- (d) support the development of a diverse talent pipeline to senior leader roles via sponsorship, mentoring and coaching and promoting positive action programmes e.g. *Ready Now*
- (e) support the next stage in the development of our value based appraisal system, building in greater consideration of talent management approaches
- (f) review progress against our gender pay gap, taking action to support progress
- (g) ensure our recruitment and selection processes are free from bias so we make the fairest and best selection decisions and positively attract and retain diverse individuals within the workforce
- (h) support our health and wellbeing agenda, creating positive working environments for all staff
- (i) support career progression of BAME staff and improve development opportunities, taking positive action to promote equality from initial recruitment and beyond
- (j) support our staff D&I networks by:
 - increased engagement and encourage collaboration across the networks
 - ensuring effective leadership of the networks via Sponsors and Chairs
 - executive championing by our senior leadership team
 - working with our networks to develop their annual plans based on *RBCH Leading for Equality, Diversity and Inclusion*

Patients

We will:

- (a) increase patient collaboration and co-production to ensure their views and perspectives inform our D&I work programme
- (b) further identify and understand our local community and what their specific needs are
- (c) ensure service users, patients, carers and the public have opportunities to share their experience with us and use these shared experiences to inform and improve the design of our services
- (d) close the gap on the personal data we collect on patients to make sure we can accurately identify whether or not there are any trends in patient activity that need to be looked into further
- (e) improve the monitoring of patient data to shape Trust's approach to understanding, achieving and measuring equitable access and outcomes for patients
- (f) develop a community engagement strategy to benefit from the knowledge and expertise of our local community and help create the health services of the future
- (g) work in partnership locally, regionally and nationally to share best practice and develop inclusive initiatives that improve patients outcomes

Improvement and innovation

We will:

- (a) constantly reinforce the link between ED&I and improvement to access diversity of thought and development of innovative ideas and solutions
- (b) use our quality improvement (QI) methodology and experience based design to embed improvements in patient and employee experience
- (c) use data and story-telling to identify outcome focused interventions for ED&I

Living our values

We will:

- (a) be open and transparent in our communications regarding employee experience data for different groups and will work with staff to develop employment practice where employee experience falls short of the standards we are striving for
- (b) focus on effectively addressing bullying and harassment, abuse, violence and

discrimination at work to improve and build psychological safety for black Asian and Minority ethnic (BAME) staff

- (c) actively involve staff in changes to policies, procedures and service improvements that affect them
- (d) champion and recognise inclusive behaviour
- (e) celebrate and share good practice of both individuals and teams at RBCH throughout the year
- (f) improve our presence at ED&I community events, such as local Pride and encourage staff to take the lead in campaigns
- (g) ensure multiple options are available for staff requiring individual support and advice relating to ED&I issues in addition to their managerial team:
 - Freedom to Speak Up Guardian
 - staff networks and ED&I champions

MEASURING SUCCESS

To evidence the impact of our interventions we will:

- ensure our policies, processes and systems are supportive and monitored in line with the ambitions set out in *Leading for Equality, Diversity and Inclusion*
- regularly review our ED&I priorities through feedback and information to ensure they are grounded in reality for patients, public, staff and volunteers;
- measure and publish progress against our priorities every twelve months on our website and intranet;
- share and celebrate examples of good practice and improvement;
- benchmark our ED&I activities in line with national NHS best practice;
- work in partnership and collaboratively with stakeholders, partners and our local community;
- review Equality Impact Assessments (EIA) to support meaningful equality analysis and ensure leaders a) identify where a policy, procedural document, service, service developments or organisational change may have a negative impact on a particular group of people and b) develop action plans to address them;
- ensure ongoing assessment and compliance with the NHS Equality Delivery System (EDS2)
- increase awareness of the NHS Accessible Information Standard to ensure patients with a disability, impairment or sensory loss receive appropriate communication support from all our services;

- measure progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)
- review external best practice accreditations and standards including Stonewall and Mindful Employer
- review patient feedback through national NHS and Staff Impression surveys, Friends and Family Test, PALS and our complaints process;
- metrics including appraisal rates and access to training opportunities;
- feedback from Exit interviews;
- informal observations and conversations as part of our *Action Learning Weeks*.

Delivery of *Leading for Equality, Diversity and Inclusion*

Our *Leading for Equality, Diversity and Inclusion* strategy demonstrates a three-year forward view of inclusion; however, given the pace of change within the NHS over recent years, it is important to identify a number of key outcomes for delivery in 2018 – 19 (Year 1).

These outcomes will be used to provide assurance to the Board of Directors, commissioners, regulators, patients and staff that the improvement goals we set are being achieved. A more detailed action plan will be monitored by the ED&I Working Group and the Equality, Diversity and Inclusion Committee (EDIC).

Outcome	Method	2018 – 19 Target
Improve BAME employee experience	NHS Workforce Race Equality Standard Improvement (WRES)	Significant improvement in % of BAME staff experiencing harassment, bullying or abuse from staff (NHS Staff Survey 2017 = 31%) Significant improvement in % of BAME staff experiencing discrimination from their manager / team leader or other colleagues (NHS Staff Survey 2017 = 18%)
Develop inclusive leadership capability	Core offer for <i>unconscious bias</i> learning and development at all levels within the organisation	Roll out at directorate level Ongoing Board development sessions

	Introduce a mentoring and coaching programme and promote national positive action programmes	<p>Develop and launch ED&I training module for Governors</p> <p>Set targets to improve diversity at Board, VSM and Band 8a and above</p> <p>Input into Leadership Development Programme</p> <p><i>Leading Equality, Diversity and Inclusion</i> Masterclass and Conference</p> <p>Develop national profile as part of the NHS Employers D&I Programme and complete application to become a Stonewall Diversity Champion</p>
Improve communications and engagement	Positive campaign and network leadership	<p>Develop and launch intranet site</p> <p>Regular communication using personal stories – <i>Humans of Hospitals</i></p>
Develop effective staff networks	Sponsorship and support from senior leadership team	Development of BAME, LGBT, European, Mental Health staff networks
Improve use of all ED&I data and compliance against national standards	<p>Equality Impact Assessment (EIA)</p> <p>Public Sector Equality Duty and Equality Delivery System (2)</p> <p>Workforce Equality Standards</p>	<p>Roll out of new Equality Impact Assessment (EIA) process and guideline toolkit and publish on ED&I intranet site</p> <p>Significant improvement across all domains with aspiration to become as a minimum 'Achieving' in all areas (Year 2)</p> <p>Track action plan with targeted interventions against NHS Workforce Race Equality Standard (WRES)</p> <p>Track action plan with targeted interventions against NHS Workforce Disability Equality Standard (WDES)</p>

	Accessible Information Standard	<p>Increase staff awareness of Accessible Information Standard</p> <p>Develop an ED&I dashboard to monitor data quality and compliance</p>
Develop patient co-production and engagement	<p>Friends and Family Test</p> <p>Focus Groups</p>	<p>Pilot Experience Based Design</p> <p>Pilot Quality Improvement (QI) training offer for patients and carers</p> <p>Increase patient and public representation in relevant hospital meetings, committees and groups as part of our continuous improvement plan</p>

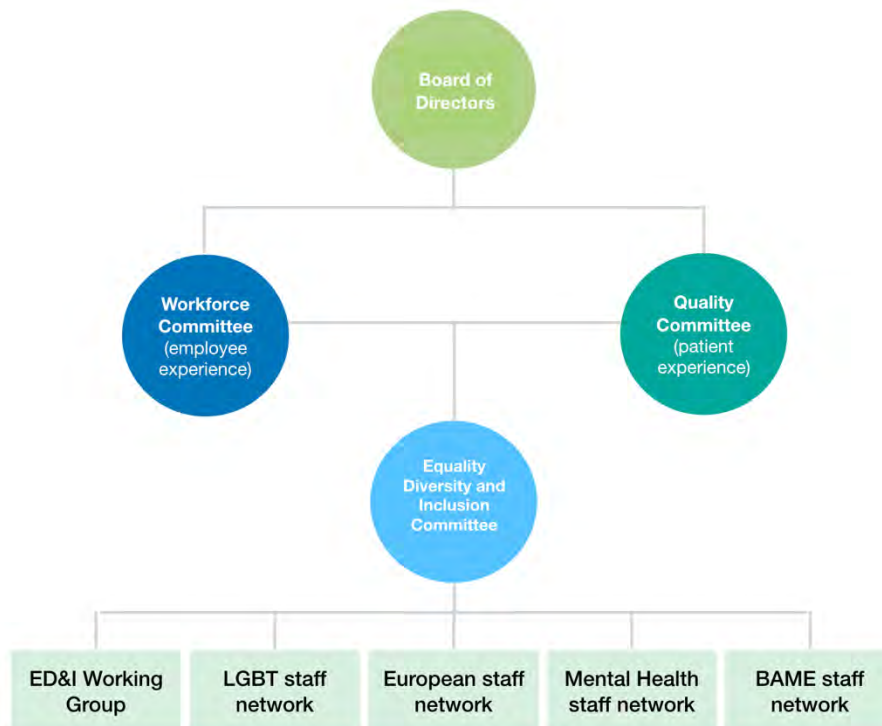
GOVERNANCE AND ACCOUNTABILITY

Governance arrangements for ED&I will ensure the Board of Directors receives regular assurance that the Trust is meeting its Public Sector Equality Duty (PSED) and EDS2 continuous assessment requirements.

The delivery of *Leading for Equality, Diversity and Inclusion* will be overseen by the Equality Diversity and Inclusion Committee (EDIC) and chaired by the Director of Improvement and Inclusion. EDIC is responsible for setting the strategic direction for our ED&I objectives, monitoring their delivery and championing inclusive behaviour within the Trust. EDIC will also ensure that resources are targeted to support key priority areas. Membership includes representatives from each of our inclusion networks, clinical care group and corporate directorate leads. A quarterly update report on progress against our ED&I objectives will be provided to the Board of Directors. EDIC will also contribute to the Trust's Annual Report.

ED&I Working Group

The ED&I Working Group is responsible for designing key interventions within the *Leading for Equality, Diversity and Inclusion* strategy. It will also co-ordinate and reviewing progress in line with key actions and agreed timescales and collect feedback from on-going engagement activities.



Staff Inclusion Networks

Our current and proposed staff networks (BAME, European, Mental Health, and LGBT) are open to all staff, volunteers and students undertaking placements. Each network has an elected chair and secretary and is encouraged to attend EDIC on a monthly basis to provide updates on network activities.

APPENDICES

Appendix 1: Legislation and national standards

There are a number of drivers that inform, regulate and monitor our equality work. These include:

The Human Rights Act 1998

Human rights are the basic rights and freedoms that belong to every person in the world. The Human Rights Act came into force in the UK in October 2000. The Act has two aims: To bring most of the human rights contained in the European Convention on Human Rights into UK law. To bring about a new culture of respect for human rights in the UK – Equality and Human Rights Commission (EHRC) Equality, Diversity and Human Rights is subject to regulation by the Equality and Human Rights Commission which is a public body set up to challenge discrimination, to protect and promote equality and respect for human rights and to encourage good relations between different people of different backgrounds. In addition to our legal duties, we are required to meet the standards set out by the Care Quality Commission (CQC). There are a range of standards determined by the CQC that are linked both directly and indirectly to equality, diversity and human rights. The delivery of our equality strategy will support us in ensuring that we continually meet these standards.

The Equality Act 2010

On 1st October 2010, the Government introduced the Equality Act. This Act brings together, harmonises and extends current equality law. It replaces the existing anti-discrimination laws with a single act. It simplifies the law, removing inconsistencies and making it easier for people to understand and comply with it. The Trust has a legal obligation to ensure consistency and protection for people listed under the Act's 'protected characteristics' (see Appendix 2) and introduced a new general duty on public bodies in carrying out their functions to have due regard to:

- the need to eliminate discrimination, harassment and victimisation;
- the need to advance equality of opportunity between persons who share a relevant protected characteristic and those who do not;
- the need to foster good relations between people who share a relevant protected characteristic and people who do not.

Due Regard (Equality Analysis). The Act also requires the Trust to have 'Due Regard' to the effects of its policies and practices on its service users and workforce in relation to the protected characteristics covered under the Equality Act. The Trust's Due Regard process is robust and has been implemented to gather information and mitigate any adverse impact on vulnerable groups. The Due Regard process helps to make fair, sound and transparent decisions based on a detailed understanding of the needs and rights of the groups and individuals affected by the Trust's policies and practices.

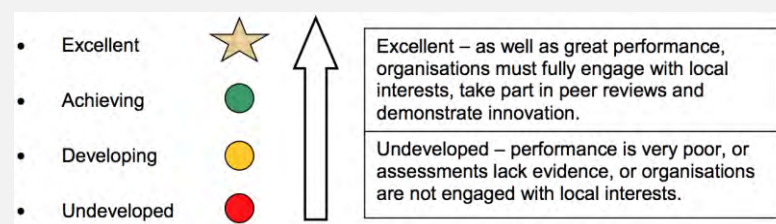
Public Sector Equality Duty (PSED)

The Public Sector Equality Duty came into force on 5th April 2011, a Duty which applies to all public authorities. It brings together previous gender, race and disability duties and extends the protection from discrimination on the basis of the 9 protected characteristics (see Appendix 2). PSED is supported by specific duties set out in regulations which came into force on 10 September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives.

The Equality Delivery System (EDS2)

The Equality Delivery System (EDS) is an NHS Employers initiative that is aimed at improving equality performance of the NHS and embedding equality into mainstream business. The EDS is about real people making real improvements that can be sustained over time. It focuses on the things that matter the most for patients, communities and staff. It emphasises genuine engagement, transparency and the effective use of evidence. By using the EDS NHS organisations will be able to meet the requirements of the Equality Act. There are 18 outcomes, grouped under four goals:

1. Better health outcomes for all
2. Improved patient access and experience
3. Workforce – the NHS as a fair employer
4. Inclusive leadership at all levels.



Based on transparency and evidence, NHS organisations and local interests should agree one of four grades for each outcome. Based on the grading, we will identify how the most immediate priorities are to be tackled, by whom and when. Each year, organisations and local interests will assess progress and carry out a fresh grading exercise. In this way, the EDS will foster continuous improvement.

Workforce Equality Standards

NHS Employers launched the Workforce Race Equality Standards (WRES) in April 2015 giving NHS Trusts a twelve month period to implement the standards and prepare for

publishing 1 April 2016. Similarly the launch of the Workforce Disability Equality Standards (WDES) on 1 April 2017 gives NHS Trusts a twelve month period to implement the standards and prepare for publishing on 1 April 2018. Both schemes assists Trusts to identify areas for improvement in relation to staff from Black Minority or Ethnic (BAME) groups, or who have a disability or long-term health condition by monitoring processes and procedures to ensure equality and limiting discrimination.

Accessible Information Standard

The Accessible Information Standard directs defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. It is of particular relevance to individuals who are blind, deafblind and / or who have a learning disability, although it will support anyone with information or communication needs relating to a disability, impairment or sensory loss (for example people who have aphasia, autism or a mental health condition which affects their ability to communicate). The Standard applies to our services and it specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing. In 2018 we will commence our active monitoring of the Accessible Information Standard. The systems will prompt staff to take appropriate action and / or trigger auto-generation of information in an accessible format / other actions such that those needs can be met.

National Health Service Litigation Authority (NHSLA)

The National Health Service Litigation Authority handles negligence claims and works to improve risk management practices in the NHS. All NHS Organisations are assessed by the NHSLA against a set of core standards, which encompass equality and diversity. Equality Delivery System (EDS) The Equality Delivery System has been designed to improve the equality performance of the NHS and embed equality into mainstream business. By using the EDS all NHS organisations will be able to meet the requirements of the Equality Act and the CQC. RBCH demonstrates its commitment to equality-based national drivers through providing a health service that respects and responds to diversity of the local population.

As described in *Leading for Equality, Diversity and Inclusion*, we oppose all forms of unlawful and unfair discrimination for both service users and our workforce.

Appendix 2: Definition of the 9 protected characteristics

Age – a person belonging to a particular age or age group. An age group includes people of the same age and people of a particular range of ages.

Disability – a person has a disability if the person has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Gender Reassignment – a person has this protected characteristic if they are proposing to undergo, are undergoing or have undergone a process (or part of a process) for the purposes of reassigning their sex, by changing physiological or other attributes of sex.

Marriage and Civil Partnership – people who have or share the common characteristics of being married or of being a civil partner can be described as being in a marriage or civil partnership. A married man and a woman in a civil partnership both share the protected characteristic of marriage and civil partnership. People who are not married or civil partners do not have this characteristic.

Pregnancy and Maternity – relates to women that are pregnant or within their allocated maternity period. Women that are not pregnant nor within their maternity period do not share this characteristic.

Race – for the purpose of the Act, 'race' includes colour, nationality and ethnic or national origins. People who have or share characteristics of colour, nationality or ethnic or national origins can be described as belonging to a particular racial group. A racial group can be made up of two or more different racial groups.

Religion or belief – the protected characteristic of religion or religious or philosophical belief, is also stated to include a lack of religion or belief. It is a broad definition in line with the freedom of thought, conscience and religion guaranteed by Article 9 of the European Convention on Human Rights.

Sex - people having the protected characteristic of sex refers to being a man or a woman, and that men share this characteristic with other men, and women with other women.

Sexual orientation – the protected characteristic of sexual orientation relates to a person's sexual orientation towards people of the same sex as him or her (in other words the person is a gay man or a lesbian); people of the opposite sex from him or her (the person is heterosexual); people of both sexes (the person is bisexual).



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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Research and Innovation Strategy
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Research and Innovation Directorate
Details of previous discussion and/or dissemination:	Trust Management Board, September 2017
Action required:	Decision
Summary: The Research and Innovation Directorate has developed a strategy document setting out the key aims for next 5 years with a particular focus on year one. This has been reviewed and agreed by the Trust Management Board and is recommended for approval 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?	<input type="checkbox"/>
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	34T

Research and Innovation Directorate Strategy 2017-2022

**WE ♥ RESEARCH
@ RBCH**

Our Vision is for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to be a centre of excellence in healthcare research and to lead on collaborative working across Dorset supporting research and innovation.

Our Purpose is to foster a thriving research and innovation culture throughout the Trust ensuring high quality research and respect for our research participants and our researchers.

Our Values

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust strives to provide the excellent care we would expect for our own families. We seek to support and deliver our research strategy by creating an ethos throughout the Directorate underpinned by our four core Trust values:



Communicate – say it, hear it, do it

Improve – change it

Teamwork – share it

Pride – show it

Contents

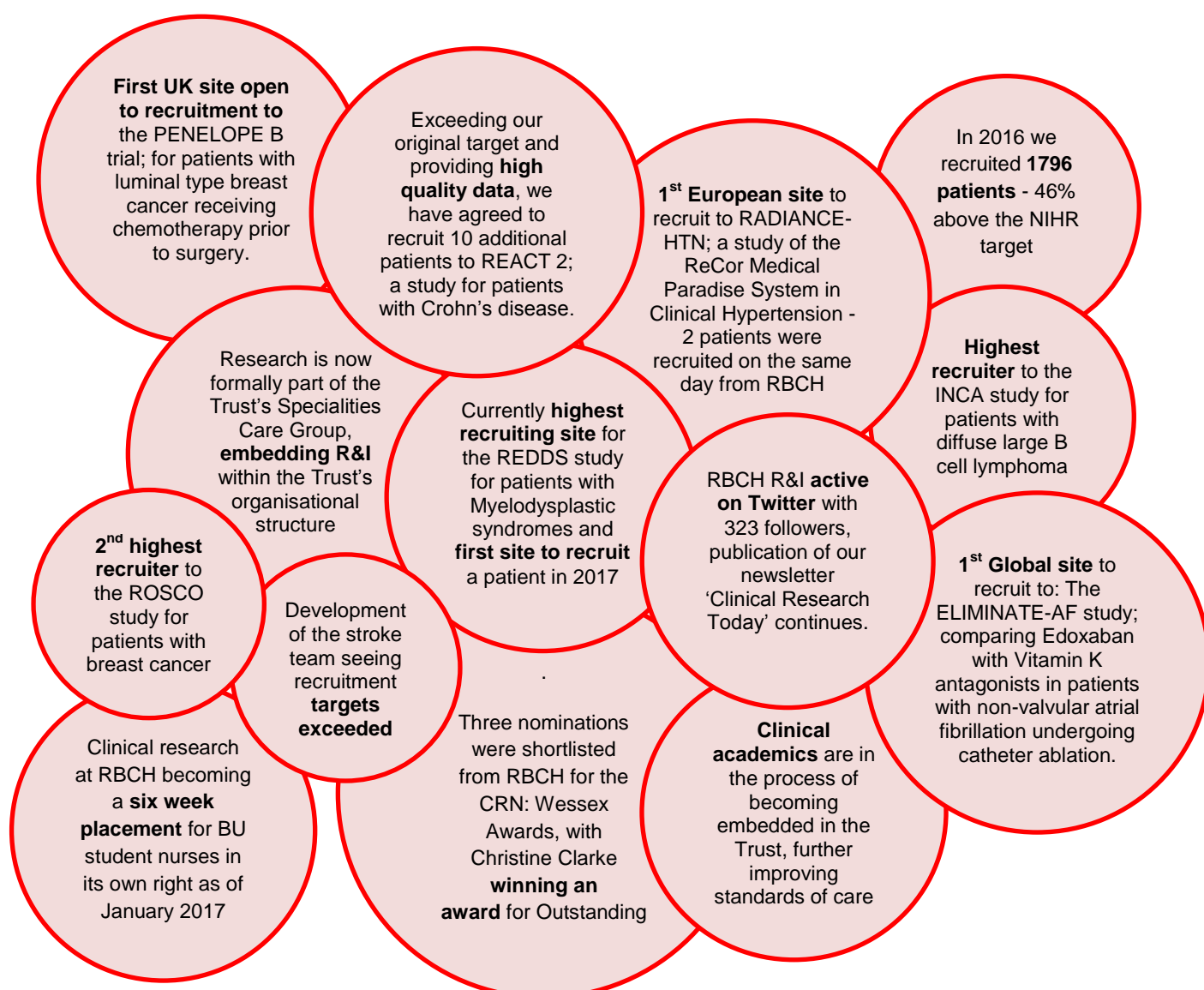
Introduction.....	page 3
Strategic context.....	page 4
Aims.....	page 6
Our team.....	page 9
Leadership & engagement.....	page 9
Governance & quality assurance.....	page 10
Collaborations & partnerships.....	page 11
Finance.....	page 12
IT and Digital Impact.....	page 13
Focus for 2017/2018.....	page 15
R&I Structure.....	page 17

1. Introduction

In the past five years, research within The Royal Bournemouth and Christchurch Hospitals Foundation Trust (RBCH) has undergone major organisational changes, culminating in the development of the Research and Innovation Directorate in 2013 and the formal inclusion of Research and Innovation into the Specialties Care Group from April 2017. This restructuring has **increased accountability and transparency** within research in the Trust. It has provided a platform to enable accurate evaluations of working practices and activity, enabling forward planning and workforce development to streamline the way we work, more cost effectively, to plan for and take advantage of forthcoming developments.

Objective 7 of the Government's mandate to NHS England 2017-2018 is to support research, innovation and growth.

Some of our **successes** over the past year alone are:

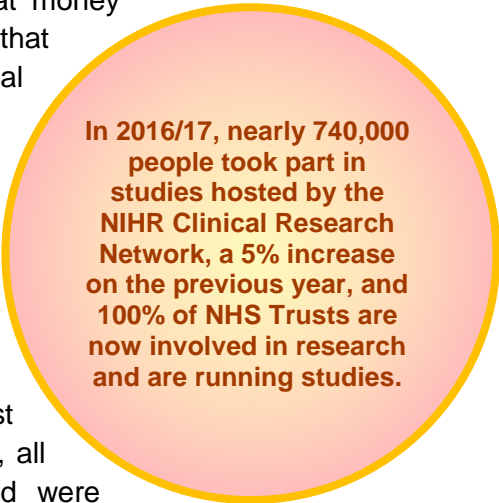


2. Strategic Context

Research is part of the NHS Constitution and all providers are required to promote research. The National Institute of Health Research (NIHR), created in 2006, has a vision of improving the health and wealth of the nation through research¹.

A key strand of the work of the NIHR is ensuring that money intended to support research in the NHS is used for that purpose. Since 2008, investment in the NIHR Clinical Research Networks has led to a trebling in the numbers of patients taking part in clinical research.

This investment has also ensured that research happens more quickly and efficiently, and this has encouraged the Life Sciences industry to invest in clinical trials in the UK. The NIHR has also invested substantially in new research, through a range of funding programmes. The NIHR is now the largest integrated health research system in the world. In 2014, all of the existing clinical research networks in England were merged into 15 Local Clinical Research Networks (LCRNs).



In 2016/17, nearly 740,000 people took part in studies hosted by the NIHR Clinical Research Network, a 5% increase on the previous year, and 100% of NHS Trusts are now involved in research and are running studies.

In 2013, following the recommendations contained in Health, Wealth and Innovation (2011)², NHS England established 15 Academic Health Science Networks (AHSNs), based on the same geographical boundaries as the LCRNs. The purpose of the AHSNs is to bring NHS commissioners and providers together with Higher Education Institutes (HEIs), industry and other stakeholders to accelerate the adoption of innovation in healthcare in order to improve patient outcomes and generate economic benefits for the UK.

Regionally, the Trust is a partner of CRN: Wessex and the Wessex AHSN. The largest share of income received by the Trust to support research delivery comes from the CRN and amounts to approximately £1m in 2017/18. These funds support the delivery of NIHR portfolio studies, RBCH ranks 7th in England of medium-sized acute trusts by complexity weighted recruitment.

Locally the Trust supports the NIHR Research Career Pathways and applications to NIHR Training Programmes for all professional backgrounds.

NHS England has a legal duty to promote research and the use of research evidence in the NHS. This is to allow the NHS to support and harness the best research and innovations to improve patient outcomes, transform services and ensure value for money. Patients benefit from access to clinical trials including cutting edge treatments and the NHS benefits from new medicines, technologies and processes³.

The NHS England research plan is the first step in setting out NHS England's wider strategic approach to research. NHS England focuses its efforts to make the biggest difference for patients and the NHS by driving the direction of research, contributing to creating an environment that fosters research and supporting the use of evidence in decision making and research into practice.

Developing One NHS Research in Dorset

The Dorset Sustainability and Transformation Plan (STP) sets out the strategic direction for Dorset with a key element being the Clinical Services Review (CSR) which will drive significant change across Dorset in the coming years. From a Directorate perspective one outcome of the CSR is the potential to establish a Clinical Research Hub on the emergency site. In addition through the 'Developing One NHS in Dorset' Vanguard programme, work is already underway focused on a Dorset-wide approach for specific services.

This is a model the NIHR have signalled to commissioners that it is keen to consider in terms of a collaborative Dorset-wide approach to Research. In response to this the Directorate with other key partners across Dorset will start these discussions this year. In the longer term the aim for a Dorset wide research function would be further facilitated if an Accountable Care System was in place across Dorset supporting the delivery of integrated services.

3. Aims

Our Strategy is to embed a Research and Innovation ethos across the Trust into daily patient care through the aims below:

Aims	Objectives	Judging our success
PATIENTS		
<p>To improve patient outcomes by offering access to new medicines, technologies and processes</p> <p>To focus on the needs of the patients and the public through patient engagement.</p>	To routinely offer patients in all specialities the opportunity to participate in high quality clinical research studies, with a specific emphasis on interventional studies.	To increase the number of patients who are recruited into NIHR portfolio studies each year.
	We aim to make information about our research studies readily and regularly available to all our patients in a variety of ways, specifically during appointments and consultations, through social media, national campaigns, literature, displays, open days and other outlets.	Every patient to receive the results of the study outcome that they participated in.
	Establish mechanisms and an infrastructure to support the rapid transfer of research knowledge into clinical practice.	Feedback to key forums and the wider clinical staff.
	To engage and involve patients and carers in research in a meaningful and constructive way, including but not solely as research participants.	Implementation of the Research and Innovation Patient Engagement strategy.
TRUST		
Establish the Trust as a centre of Research and Innovation excellence.	Ensure that there are robust and flexible structures in place to: initiate, deliver and manage high quality research and innovation; and that these structures are supported by rigorous governance processes.	To be in the Top 5 of medium-sized acute trusts in England by complexity weighted recruitment.

	Develop a rigorous approach to study feasibility and delivery planning in order to meet Department of Health (70 day Time To Target) and recruitment targets	Increase the number of studies that are setup and recruit to time and target and the number of studies that recruit to target.
	Develop an IP policy to address our approach to protecting and further use of licensing the intellectual property arising from any collaborative innovation work the Trust is involved in.	Implementation of a clear IP policy to support innovative collaborations
To achieve engagement with research and innovation throughout the Trust.	Ensure that research and innovation are strategically and operationally integrated into core Trust business and are fully aligned with Trust vision, values and strategies.	Regular representation of the R&I management team at TMB and being integrated into the Care Group. Inclusion of research during values-based recruitment, job planning and appraisal processes
	<p>To raise awareness about and truly integrate research within the Trust by having a presence at Trust events (e.g. Trust Nursing, Midwifery and AHP conference, Open Day and Patient Panel conferences) and for inclusion of research during the Trust Induction and Grand Rounds.</p> <p>Embedding the BU Student RBCH Clinical Research Placement within the R&I Directorate</p> <p>Ensuring research is embedded within every day care</p>	<p>Increase in the number of events that the Research and Innovation team have a presence at.</p> <p>Having a regular R&I presence at Trust induction.</p> <p>All staff at RBCH aware that we do research.</p>

To achieve digital compliance with all aspects of the Medicines for Human Use SI 2004:1031 (as amended) and with FDA 21 CFR Part 11.	Ensure that the R&I directorate is involved in digital upgrades within the Trust and that these are compliant with the relevant standards.	Positive MHRA and other relevant monitoring/audit inspection feedback.
To participate in the evaluation of a 'Developing One NHS in Dorset' approach to Research and Innovation	Undertake initial scoping work with key partners to understand the opportunities for a Dorset wide approach to Research and Innovation in line with the Dorset STP aspirations and the CSR This should also focus on the inclusion of non-NHS organisations e.g. universities	Options appraisal and recommendation of the way forward
To contribute to the financial balance of the Trust	By growing research studies to generate additional income to support clinical services. To demonstrate how savings are delivered by providing cost effective research and care.	Income generation report. Monitoring uptake of studies Cost savings/cost avoidance as shown via the Clinical Directorate CIP trackers
To attract, develop and maintain a highly skilled work force to deliver and conduct research studies	Continue to strengthen and support strong partnerships with industry partners, the NIHR and others Increase research capability and capacity throughout the Trust, in all clinical service areas among all staff groups and professions Ensuring all staff within the R&I Directorate have access to personal and professional development opportunities identified during appraisal and regular one to ones	Increase in the number of new partnerships that have been developed and the amount of repeat business we have from current partners To increase the number of patients who are recruited into NIHR portfolio studies each year To increase research in areas new to research and those areas that are currently research naïve. Feedback from the NHS staff survey and from meeting objectives during appraisals

4. Our team

Our greatest asset is our staff. Over the past four years a major review of research staffing has resulted in the creation of a Research and Innovation Directorate. This has facilitated a considered approach to workforce planning and development, in particular a revision of the skill mix within research across the Trust. **Continuous review of workforce planning and capability is required** to ensure we have a flexible and adaptable team, with the right staff with the right skills in the right place at the right time. The appointment of a full time Lead Research Nurse in April 2017 is a significant milestone enabling clinical leadership and representation for our research nursing workforce across the Directorate and the wider Trust. An increase in non-clinical support staff has reduced the amount of time nurses spend on administrative work, completion of case report forms and feasibility/capability submissions for new studies.



Our CTA team representing RBCH at the inaugural CRN- Wessex CTA event in March'17

Over the past four years a growing team of Clinical Trials Assistants (CTA's) has been created. Our CTA team support our research nurses and manage their own portfolio of observational studies, requiring minimal specialist nursing support to boost overall recruitment to NIHR portfolio studies.

Our nurses are encouraged to develop specialist skills in order to manage and support their patients being treated within a clinical trial and managing their clinical pathway.

A research capable workforce is critical if we are to achieve our aims.

Numbers of research staff in:

2011  (17 WTE)

2014  (39 WTE)

2017  (51.5 WTE+CD)

5. Leadership and engagement

Principles that guide the NHS, detailed in the NHS Constitution, establish a commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population.



R&I staff discussing the Directorate's revised induction framework

We want to foster engagement with research throughout our Trust. In order to deliver this strategy, robust leadership will be required across the Organisation from the Trust Board and Executives, through the Directorates and into clinical teams.

The Trust R&I governance and management structures were reviewed in 2016, with significant developments in terms of engagement with research across the Trust. The inclusion of the Directorate in a Care Group means there is now Director of Operations input and support and there has also been the appointment of a new Clinical Director at the start of 2017. Both of these posts are members of the Trust Management Board which ensures Research and Innovation is represented at this level. In addition, a full time Lead Research Nurse ensures effective professional nurse leadership within the Directorate. We aim to continue efforts to [create a culture of research and innovation](#) in the Trust, generating greater involvement in research from all our clinicians and service users.

As part of the Specialties Care Group, research is now routinely part of governance and performance metrics. A Research Governance Board with medical and non-medical executive representation, a new chair and terms of reference is required, and membership defined. The senior research management team meet on a regular basis for operational oversight and performance management.



Reviewing performance at a recent RBCH research forum

We will continue to work internally with the Trust Communications team and externally with the CRN: Wessex communications department to [publicise our achievements and events](#), e.g. International Clinical Trials Day.

There is a need to [embed a patient-centred research culture](#) within the Trust with the appointment of Patient Research Ambassadors, to help patients have better informed choices about participating in research at the Trust. The NHS Constitution states patients have the right to expect their NHS health practitioner to tell them about suitable research studies.

6. Governance and quality assurance

In order to achieve and maintain the delivery of [high quality research data](#), robust systems and training programmes are in place to govern and monitor the quality of data being produced. We will ensure governance compliance and patient safety by ensuring that:

- All research staff have completed Good Clinical Practice (GCP) training in the last 2 years and ensure all research is being conducted in accordance with GCP.
- An annual audit is conducted of Trust research governance arrangements, and any gaps are rectified and risks identified.
- Any Corrective and Preventative Actions that have been previously identified are being actioned and implemented in a timely manner.



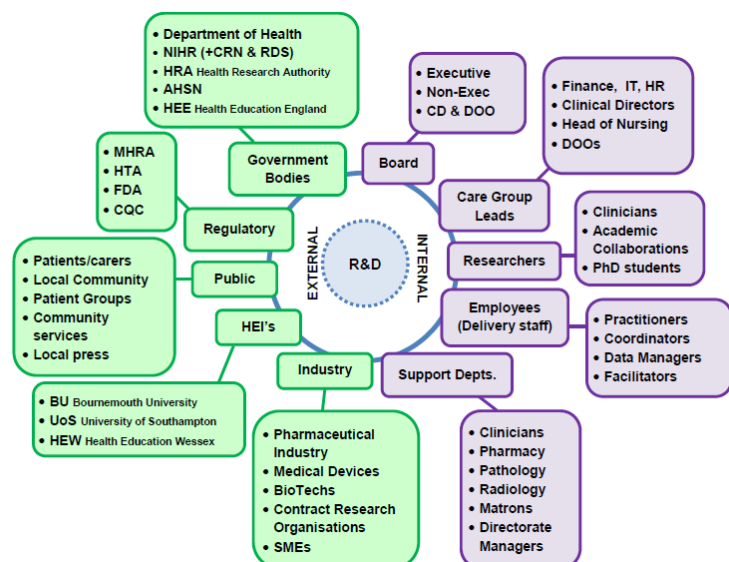
Accurately preparing a participant's clinical trial samples for analysis

- The necessary Research Standards Operating Procedures (SOP's) are in place, being used appropriately, are up-to-date and reviewed at least every 2 years
- Trust performance of recruitment to time and target is monitored internally and externally
- Internal monitoring of governance arrangements on an agreed % of non-commercial research projects are being carried out.
- External monitoring findings are reviewed and areas that require improvement are highlighted and actioned appropriately
- Staff training records are up-to-date and reviewed annually
- A comprehensive in-house training programme is being delivered to all research staff and that this programme is appropriate and being delivered to a consistently high standard.

7. Collaborations and partnerships

Our collaborations with industry and academic partners have brought significant benefits for our patients and the Trust. There is compelling potential for further development in this regard.

Our key partners are the NIHR Clinical Research Network, specifically CRN: Wessex, as well as Industry. We also work closely with the Wessex Academic Health Sciences Network (AHSN), Health Education Wessex (HEW), our local universities (HEIs), particularly Bournemouth, Portsmouth and Southampton, and industry, with RBCH being a preferred partner of Quintiles, a major global Contract Research Organisation.



Currently the R&D team's office is located at Bournemouth University, which provides excellent links, particularly with Bournemouth University Clinical Research Unit, Research Design Service South West (part of NIHR), the Orthopaedic Research Institute, the Aging and Dementia Research Centre as well as the wider university (e.g. Faculty of Health and Social Sciences and Faculty of Science and Technology). This presents opportunities for leading as a Trust on national, non-commercial NIHR supported studies.

Members of the team regularly deliver research related lectures and workshops and provide support, advice and guidance for academics, PhD and Master's students undertaking clinical research project collaborations with the NHS, actively encouraging and fostering collaborations between RBCH and BU.

Currently, RBCH has CRN: Wessex Clinical Research Specialty Group Leads in: Cardiovascular, Dementias and neurodegeneration, Metabolic and Endocrine, and Aging. Our Chief Executive, Tony Spotswood, is the CRN: Wessex Partnership Group Chair.

Further work is required to strengthen and develop the relationships and partnerships which already exist as well as encouraging new partnerships. In order to do this we will:

- Commit to [developing a marketing plan](#) to further promote RBCH to Industry and other external partners as a research capable organisation with a strong national and international reputation for delivering high quality research
- Formalise [high-level strategic partnerships](#) with neighbouring Trusts and HEIs
- Discuss potentials for further and wider collaboration with local community partners e.g. DHUFT, community health services, and utilise opportunities for collaboration within CRN: Wessex
- Develop [an infrastructure for research through Care Group focused workforce planning](#) within Directorates to include a clinical academic pathway for non-medical staff
- Develop and expand [non-medical research](#) with the support of Directorates to better integrate research and enhance the adoption of evidence-based practice to improve patient outcomes
- Develop [non-medical Clinical Academic Career pathways](#) with University of Southampton and Bournemouth University linking closely with the clinical specialties
- Explore the [potential for partnerships](#) with local industry, the pharmaceutical sector and academic units.

8. Finance

Income into the Research and Innovation directorate comes from 2 main funding streams; the NIHR and Commercial Contract Research.

The NIHR supports the delivery of research with approximately £1m of funding per year through the CRN: Wessex Activity-Based Funding Allocations model. This funding is used to support costs incurred during the delivery of NIHR Portfolio studies; additional funding is also awarded in recognition of achievements for delivering research to Time and Target. NIHR funding covers approximately 55% of staff costs.

Income from Commercial Contract Research and reserves are utilised to cover the additional 45% of staff costs and used to support departments to help deliver recruitment to targets. Maintaining and [growing this income stream is a key part of this strategy](#). Commercial Contract Research not only generates income, it also means patients can access new drug treatments and the Trust can benefit from treatments being funded as part of the commercial contracts.



KPMG found that for commercial studies, NHS Trusts receive a pharmaceutical cost saving of £5,250 per patient

2017/18 sees significant investment in staffing and support costs required to sustain the commercial ambitions of the Directorate, costs to deliver research are to increase by over 17%, although return on investment will not be fully appreciated until 2018/19. This is due in

part to the way commercial payments are received up to six months after the work is completed, in the meantime reserves will be utilised to cover these additional costs. There is a challenge to maintain our reputation with commercial partners in delivering research to time and target to attract new and repeat commercial partnerships, development of a marketing plan will complement our commercial ambitions.

	2016/17 Actual		
	NIHR/CRN Income	Commercial and Non Commercial Income	Clinical Specialty Funds Total
	£	£	£
Opening Balances			1,735,449
Income	1,054,000	880,401	
Pay + Support Costs	(1,054,000)	(634,337)	
Non-Pay Costs		(212,619)	
Drug Costs		(20,600)	
Sub Total			
Total Surplus/Deficit	0	12,845	
			1,748,294

	2017/18 Projected		
	NIHR/CRN Income	Commercial and Non Commercial Income	Clinical Specialty Funds Total
	£	£	£
Opening Balance			1,748,294
Income - guaranteed	1,070,265		
Income forecast		900,000	
Pay + Support Cost forecast	(1,070,265)	(915,500)	
Non-Pay Costs forecast		(200,000)	
Total Surplus/Deficit		215,500	

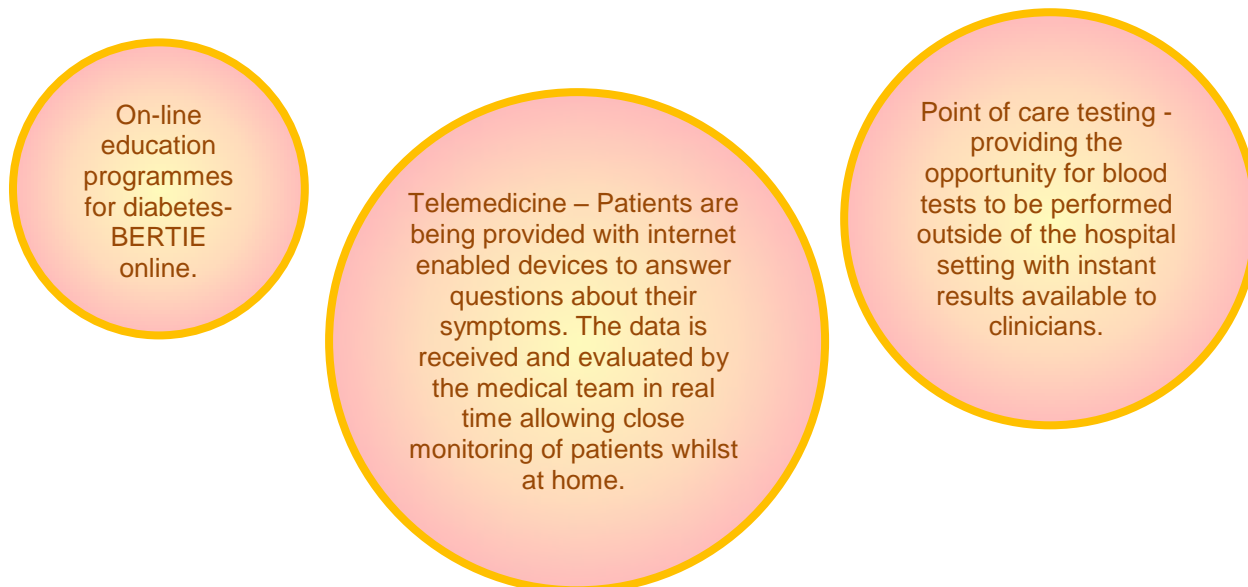
Non-pay costs for example include staff travel and subsistence, PhD fees, procurement, training, courses, archiving, mobiles, furniture and fittings.

9. IT and Digital Impact of Research & Innovation

Digital technologies have the potential to transform healthcare delivery by personalising healthcare and providing service delivery across care pathways and boundaries at scale. There is [huge opportunity to test innovation and identify efficiencies](#) in healthcare through the development of clinical trials and research projects.

We will continue to **actively support and drive forward projects** designed by our clinicians that support innovative healthcare developments and digital platforms, signposting to experts within the Trust, Wessex AHSN and local Universities for support and potential collaboration.

There is a wide range of innovative work being undertaken within the Trust supported by the Research and Innovation Directorate, recent examples include:



Online R&I presence

The Directorate has increased its online presence over the past three years. In addition to the R&I news site (www.dorsetresearch.org) on which details of Trust Sponsored studies can be found, significant work has been undertaken to develop a comprehensive R&I section within the Trust website (http://www.rbch.nhs.uk/our_services/clinical_services/research/). The Research and Innovation Directorate also supports the use of **social media** and **holds a twitter page** for increasing awareness of Research and Innovation within the Trust and engaging with patients and the public as an aid to study recruitment.



The R&I Directorate has been active on Twitter since 2015

We are also working with digital technology (e.g. NIHR Open Data Platform) to streamline our processes and ensure the collation and reporting of up to date, robust business intelligence to monitor Key Performance Indicators and respond quickly to emerging patterns or trends (e.g. recruitment to time and target slippages or areas for improvement following NIHR Performance in Initiating and Delivering Clinical Research ([PID reporting](#))). Work has commenced this year on the utilisation of an electronic Workforce Planning tool.

A detailed digital strategy has been developed and will be updated regularly as work continues across the Directorate and is influenced by the changing national landscape and developing technologies.

The near future

As RBCH and Poole Hospital NHS Foundation Trust (PHFT) build the interconnected Electronic Patient Record the two trusts will be gathering hundreds of thousands of patients' electronic histories in a modern, searchable database. This will include all the medicines prescribed and administered, all the diagnostic test results/reports, coded diagnostic and procedure codes and all the imaging associated with their care. In line with the national NHS Digital strategy "The Target Architecture" this database will enable an acceleration of our ability to participate in research and innovation by (with an appropriate patient consenting process)

- enabling the proactive selection of candidate patients for research,
- providing efficient access to richer datasets about patients (cross referencing all their clinical information using modern analytical tools rather than manual data collection).

In working collaboratively across Dorset we expect, using the Dorset Care Record to expand this database to reach across the entire patient journey including primary, community, mental health and social care aspects to be factored into the research and enable far richer longitudinal studies of patients' outcomes, particularly in the study of Long Term Conditions.

Ultimately, in line with the findings of the Target Architecture, we are likely to find that Dorset as a county is too small to impact significantly on world class level research. Therefore we will explore ways in which the Dorset Care Record can be joined with the Hampshire Health Record and those of our other neighbours to achieve Research at a scale that can fundamentally change the course of major diseases.

Consequently this research strategy will be closely aligned to the RBCH and PHFT Informatics strategy which is one of its key enablers.

9. Focus for 2017/18

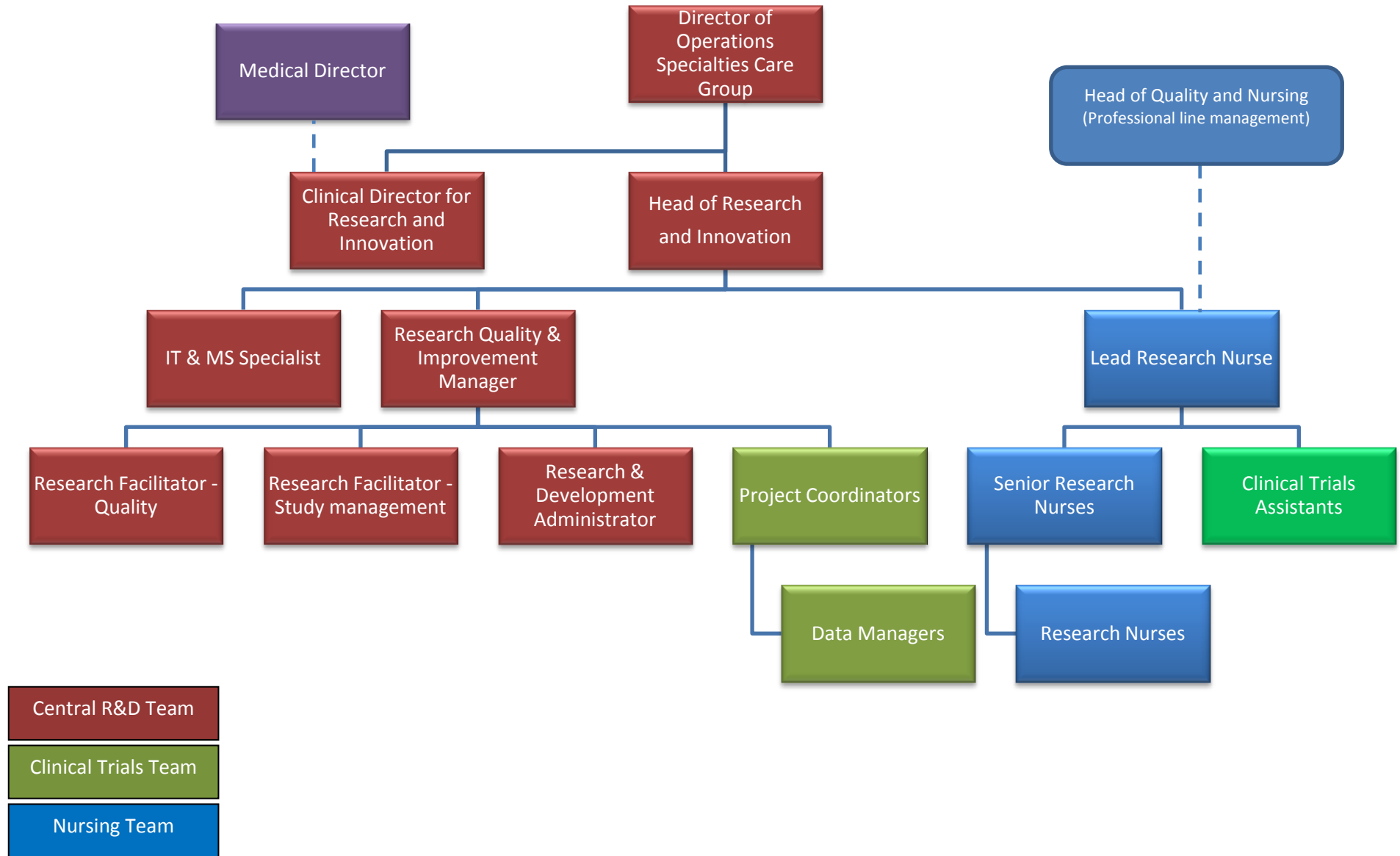
To grow research we will:

- Increase the number of studies and recruitment to Commercial Contract Research
- Develop participation in research in research-naïve specialities.
- Use the profit from Commercial Contract Research to continue the growth in research staff necessary to deliver more research
- Lead on and develop a pan-Dorset collaborative approach in response to the outcome of the CSR including work to support a potential merger with Poole Hospital NHS Foundation Trust.
- Develop a set of internal key indicators to monitor and measure performance and share with key stakeholders to promote the work of the Directorate.
- Continue to form further links with external bodies.
- Further develop the operational capability of the Directorate to support the achievement of the 5 year strategy.
- Ensure this strategy is closely aligned with the Informatics Strategy as a key enabler.

10. References

1. Department of Health. *Best research for Best health: A new national health research strategy*. London 2016.
2. NHS England. *NHS Research Plan*. London 2017.
3. The NHS Constitution *the NHS belongs to us all*. London 2015
4. KPMG NIHR Clinical Research Network: *Impact and Value Assessment*. London 2016
5. Target Architecture link: <http://interopen.org/content/Interoperability%20Summit%20-%20Emerging%20Target%20Architecture%20v1-0.pdf>

Research and Innovation Structure





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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Progress Update on 2017/18 Corporate Objectives
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Sandy Edington
Details of previous discussion and/or dissemination:	Progress update presented quarterly to the Board of Directors
Action required:	Note for information
Summary: Review of Trust objectives for 2017/18 to end of March 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?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	N/A

	Objective	Lead Exec	RAG Rating			Commentary
			End Jul 17	End Nov 17	End Mar 18	
OBJECTIVE ONE	Valuing our staff					
Narrative:	<i>Recognising the contribution of our staff and helping them develop and achieve their potential</i>					
1.1	Publication, by September 2017, of the Trust's People Strategy which will contain clearly defined approaches for:					
	a) Talent management	NH				Talent management addressed within Leadership Strategy being presented to Board in January 2018
	b) Staff Engagement and communication	KA				Staff engagement scores have improved as measured by FFT & staff survey
	c) Leadership Development	NH				Leadership development addressed within Leadership Strategy being presented to Board in January 2018
	d) Recognition and reward of our staff	NH				#ThankYou day on 12/9 attracted >1100 attendees. #ThankYou "pot" established. Evaluation and recommendations part of Delivery Phase of OD programme to be fed back to Board in June 2018.
1.2	The measures we will use to track progress focus on:					
	a) Maintaining our staff survey results and aiming to increase the engagement score from 3.9 to 4 over the next three years, demonstrating an improvement year on year	KA				Outstanding staff survey results for 2017
	b) Maintaining a Staff Impressions "Mainly Good" overall experience score of over 90%	KA				Staff engagement by change champions to share cultural work and progress organisational development.
	c) Maintaining a turnover rate below 12/%	KA				Below 12% and positive joining rate.

	Objective	Lead Exec	RAG Rating			Commentary
			End Jul 17	End Nov 17	End Mar 18	
OBJECTIVE TWO	Improving Quality and Reducing Harm					
Narrative:	<i>Focusing on continuous improvement and reduction of waste</i>					
2.1	To continue, via the Improvement Academy to build QI capacity and capability to support a culture of continuous improvement by March 2018	DM				2 day Improvement skills training now completed by 298 staff, clinical and non-clinical. QI junior doctor programme launched February 2018, with 6 groups each with a consultant mentor. Projects in the planning phase target for delivery September 2018. Additional training modules in project management and measurement for Improvement underway with 42 delegates attended to date. Alumni relaunch planned for 21 May 2018. QI mentoring and coaching continues to be part of the Academy offer. 2018 Patient Safety and Quality Improvement conference in the planning stages and will be held on 12 September 2018.
	a) Fully implement the improvements identified by the CQC for maternity and ED, which will be assessed at the next CQC inspection, with the expectation of a positive review	PS				CQC unannounced inspection 13-14/3/18 included in depth review of ED and Maternity. Initial verbal feedback from CQC inspectors positive, staff commended for their engagement and enthusiasm for improvement and innovation. Trust OPEL 4 at time of inspection and CQC inspectors commented on seeing examples of outstanding leadership in ED and Maternity. CQC Well led inspection 11-12/4/18 – CQC gave verbal feedback that there were no concerns
	b) Demonstrate consistency in safe, effective, responsive and well led services, across the organisation; securing a CQC rating of at least good and aspiring for 'outstanding'	TS				Positive feedback on Inspection and Well Led assessment – draft report available later in May

	Objective	Lead Exec	RAG Rating			Commentary
			End Jul 17	End Nov 17	End Mar 18	
2.2	To improve emergency hospital flow to deliver 'the right patient, at the right time, to the right place' by March 2018 we will:					
	a) treat 25% of non-elective patients via our ambulatory care services rather than admitting them to an inpatient ward	RR				Achieved the stretch target by year end, but not sustainable, partly due to lack of dedicated space and staff for older people's ambulatory. 18/19 QI project: 1st 24hrs for emergency patients seekign to address this.
	b) improve specialty pathways to avoid unnecessary admissions and reduce patients' length of stay including:	RR				Frailty pathway in place; alcohol pathway task & finish, with work through QI and action learning weeks.
	c) To improve discharge planning we will:					
	i.establish the IT systems to support the discharge planning database	RR				System in place.
	ii.deliver an education programme for the use of estimated date of discharge (EDD) and medically ready for discharge (MRFD)	RR				90%+ useof EDD and MFRD
	iii.adopting best practice board rounds	RR				Project started and using e-whiteboards in 2018 to facilitate best practice
	d) To improve hospital flow process, to support a reduction in patients with a length of stay >7days	RR				See QI reporting on flow, and 70+ bed benfit over 2 years
2.3	To ensure that every deteriorating patient with an early warning score (NEWS) of 9 or above, is escalated for review and then seen by an appropriate clinician within 30 minutes of their initial trigger by the end of July 2017	AOD				The most recent figures are 61% for 30 minutes and 80% for 60 minutes. The majority of late reviews are justified as they are often for individuals on end of life pathways. Performance is prospectively monitored with improving trends. The next phase will be to introduce NEWS2 by the dealine of 31st March 19. This lowers the threshold for senior review

	Objective	Lead Exec	RAG Rating			Commentary
			End Jul 17	End Nov 17	End Mar 18	
2.4	To treat everyone with Sepsis-related Organ Failure Assessment (SOFA) within one hour and all other sepsis patients within 3 hours of admission / diagnosis of sepsis, by giving a first dose of antibiotics by the end of June 2017	PG				Improvements continue with the QI focused work to progress towards all appropriate patients having their antibiotics within 1 hr from being triggered. Latest data shows this performance to be around 70% and awareness has significantly improved with the recently launched e-learning tool (1400 staff trained in 3 weeks). Just under 2000 staff have completed the eLearning sepsis and deteriorating patient module (around 50% of staff) within one month, which demonstrates excellent commitment of our clinical staff. The project aim for 2018/19 is currently: To achieve and sustain that 95% of our patients with confirmed high risk sepsis in ED, AMU and SAU receive intravenous antibiotics within one hour by March 2019.
2.5	Deliver excellent emergency care; minimising the number of patients who wait in the Emergency Department. The metric is that 95% of patients or better are seen and treated/admitted within four hours and that the Trust meets its agreed trajectory set in conjunction with NHSI.	RR				Whilst benchmarking well against the rest of the NHS, the 95% level was not achieved.
2.6	Deliver excellent planned care, 92% of elective patients being treated within 18 weeks of referral; 99% of patients waiting less than six weeks for their diagnostic tests and as a minimum 85% of patients or better on a 62 day cancer pathway receiving their treatment within that period.	RR				Cancer and diagnostics remain strong, above target and well above national performance. RTT is below the 92% standard (but above England average).
2.7	We will continue our work to ensure services are provided in a cost effective way and meet our financial plan to deliver a control total of £6,648m deficit or better by the end of March 2018.	PP				The Trust was able to improve upon its full year deficit control total which allowed it to benefit from the incentive and bonus elements of the national Sustainability and Transformation Fund. After accounting for this additional income, the Trust ended the year with an aggregate net deficit of £1.4 million against the initial control total deficit of £6.6m.

	Objective	Lead Exec	RAG Rating			Commentary
			End Jul 17	End Nov 17	End Mar 18	
OBJECTIVE THREE	Strengthening Team Working					
Narrative:	<i>Developing and strengthening Team RBCH to deliver safe and compassionate care for our patients and shaping future health care across Dorset</i>					
3.1	Implement the Clinical Service Review, and securing the lifting of the undertakings placed on the Trusts by the Competition and Markets Authority. The Board will monitor and drive progress in accordance with the project plan agreed for this work.	TS				NHSI have agreed subject to JR being resolved and CMA confirmation the CMA process will start summer of 2018
3.2	Strengthen collaborative working and relationships between the Trust and local partners gauged by regular feedback from partners and in so doing progress the implementation of the Dorset Sustainability and Transformation plan.	TS				ICS status for Dorset one of the first in England ; further work planned with DHC
3.3	Jointly implement the Dorset Care Record	PG				On 28 Feb the DCR went live with its first release. This is a small release of basic "building blocks" of functionality (single Patient Master Index for Dorset) and provides access to GP captured data. This represents about 10% of the data feeds that will ultimately populate the DCR. The timeline to complete all of the data feeds is Sep 2019. There are only a small number of users enrolled at this stage (35 as at 4.5.18).
3.4	Develop team working by embedding the AstonOD Team Coaching approach across the organisation, helping enhance the delivery of care through heightened team effectiveness. Specific measures will focus on:					
	a) Increasing to 30 the number of coaches accredited by March 2018	NH				New cohort completing training in February, taking the numbers to 31.
	b) Increasing to 40 the number of teams using this approach by March 2018	NH				43 teams currently going through the Aston team journey.

	Objective	Lead Exec	RAG Rating			Commentary
			End Jul 17	End Nov 17	End Mar 18	
OBJECTIVE FOUR	Listening to Patients					
Narrative:	<i>Ensuring meaningful engagement to improve patient experience</i>					
4.1	Supporting engagement through implementation of patient user groups with a lay chair and three functioning groups by the end of the year	PS				2 Groups has been held 1 fed back to BOD. 1 Further group is in the start up stages with interest from 2 other areas. Endoscopy group will be moving to EBCD in 2018. There has been a delay in the third group due to the HOPE vacancy. The new HOPE commences on the 20th May 2018.
4.2	Reinstating community focus groups, to formalise external patient experience partnership networks, with each group meeting in 2017-18 with a forward plan of twice-yearly	PS				12 community focus groups have been held this year. This has strengthened our community links in all areas. To increase our community links we will attend a variety of existing community groups while maintaining the links that we have made in 2017. Work is on-going with the established community groups. Throughout 18/19 work will be put in place to support the implementation of more groups.
4.3	Maintain the positive trend of patients recommending the Trust within all areas attaining compliance that reflects better than the national average scores for the Friends and Family Test and increasing the FFT returns to >25% by the end of March 2018	PS				Work has commenced on the triangulation of data for the clinical areas. Work in this area has slowed as we are a team member down and the workload from other areas continues to increase. Text messaging for the Emergency Department is shortly to be piloted; following this consideration for this method will be given to wider roll-out across the Trust however this will require costing and working up as a business case. The ambition to achieve >25% has not been achieved across the Trust; however we remain in the upper quartile (>25%) for our in-patient FFT and 2nd quartile (>50%) for ED and OPD. Work to achieve these targets is on-going and will be a focus for the new HOPE.

	Objective	Lead Exec	RAG Rating			Commentary
			End Jul 17	End Nov 17	End Mar 18	

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

Trust Board Dashboard - April 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 Q3			2017/18 Q4			2018/19 Q1			Trend (where applicable)
			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	90%	95.73%	94.55%	92.16%	92.89%	87.55%	86.08%	87.59%			
	Caring - Inpatient scores from Friends and Family Test % positive	95%	97.56%	97.53%	98.72%	98.19%	98.63%	98.23%	96.94%			
	Caring - Maternity scores from Friends and Family Test % positive	95%	97.14%	96.84%	98.33%	97.24%	95.71%	96.69%	96.89%			
	Caring - Mixed sex accommodation breaches	0	0	0	0	0	0	0	0			
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)											
	Caring - Formal complaints		29	36	23	23	21	45	36			
	Effective - Emergency re-admissions within 30 days following an elective or emergency snell at the provider	< Prev Yr Month AVG	513	508	509	499	434	523	497			
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	< 100	75.1	80.2	125.8	105.4						
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - MAC	< 100	0.0	0.0	0.0	0.0						
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - RBH	< 100	74.7	78.8	120.3	108.3						
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	< 100	94.1	106.4	114.2	100.3						
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	< 100	186.3	216.9	206.7	174.2						
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	< 100	85.4	101.4	107.3	94.4						
	Effective - Summary Hospital Mortality Indicator	< 1										
	ED Attendances		7998	7726	7742	7497	6966	8375				
	Elective Admissions		6626	6646	5586	6603	6124	6274				
	GP OP Referrals		5778	5826	4693	5888	5195	5622	5542			
	Non-elective Admissions		3237	3091	3144	3265	3007	3366				
	Organisational health - Staff sickness in month	< 3%	4.243%	4.141%	4.348%	4.395%	3.750%	3.690%	3.750%			
	Organisational health - Staff sickness rolling 12 months	< 3%	4.22%	4.18%	4.16%	4.08%	4.03%	3.96%	3.98%			
	Organisational health - Proportion of temporary staff		6.90%	6.89%	6.88%	7.20%	7.93%	8.57%				
	Organisational health - Staff turnover	< 12%	10.21%	9.94%	9.74%	9.68%	9.38%	9.20%	9.53%			
	Safe - Clostridium Difficile - Confirmed lapses in care	<=14 in Yr / 1.2 per Month	1	3	4	2	1	3	2			
	Safe - Clostridium Difficile - infection rate	6.9	35.13	12.1	17.56	11.71	6.48	5.85	12.1			
	Safe - MRSA bacteraemias	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			
	Safe - Occurrence of any Never Event	0	0	1	2	0	1	1	1			
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)			40.06								
	Safe - VTE Risk Assessment	95%	96.64%	96.92%	96.43%	96.69%	96.68%	96.14%	96.47%			
	Number of Serious Incidents	<= Last Year	0	4	3	1	2	1	1			
	Appraisals - Values Based (Non Medical) - Compliance		88.99%	89.94%	89.83%	90.37%	90.46%	90.33%	2.08%			
	Appraisals - Doctors and Consultants - Compliance		88.19%	86.55%	87.21%	88.44%	89.04%	90.72%	87.06%			
	Essential Core Skills - Compliance		92.87%	93.31%	93.53%	93.66%	93.51%	93.23%	93.33%			
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	YTD Plan = 4	4	4	4	4	4	3				
	Sustainability - Liquidity (YTD score)	YTD Plan = 1	1	1	1	1	1	1				
	Efficiency - I&E Margin (YTD score)	YTD Plan = 4	4	4	4	4	4	3				
	Controls - Distance from Financial Plan (YTD score)	N/A	1	1	1	1	1	1				
	Controls - Agency Spend (YTD score)	YTD Plan = 1	1	1	1	1	1	1				
	Overall finance and use of resources YTD score	N/A	3	3	3	3	3	2				
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	93.96%	95.04%	84.71%	92.64%	92.67%	90.67%	91.86%			
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	100.00%	95.24%	88.89%	100.00%	84.62%	100.00%				
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	86.50%	90.99%	86.76%	87.25%	87.43%	92.35%				
	Maximum 6-week wait for diagnostic procedures	99%	99.85%	99.73%	99.59%	99.60%	99.47%	99.53%	99.67%			
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	90.09%	89.92%	88.71%	88.03%	88.54%	88.92%	88.81%			

BOARD OF DIRECTORS	
Meeting date:	30 May 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 Chief Operating Officer David Mills, Associate Director Information & Performance
Details of previous discussion and/or dissemination:	PMG / Finance Committee
Action required:	Note for information
<p>The Board of Directors is requested to note the performance exceptions to the Trust's compliance with the 2018/19 SOF, national planning guidance and contractual requirements.</p> <p>The report provides final data for remaining March performance (where not previously reported) and for April 2018. Benchmarking data is also included, as well as expected compliance for May/Q1. Key plans for mitigation of risk to 18/19 performance are also outlined.</p> <p>Executive Summary:</p> <p>In summary the Trust performed as follows for April / March using most recently available data.</p> <ul style="list-style-type: none"> • A&E 4 Hour – 91.86% for April and risk to trajectory and Provider Sustainability Fund (PSF) in Q1. • RTT 18 Weeks – 88.8%, similar level to March, though with increased total waiting list following from residual impact of reduced elective activity to support winter/severe weather pressures. • Diagnostics 6 Week Wait – above national target at 99.7% for April. • Cancer 62 Day from Referral – well above national target in March (last reported month) at 92.3% and Q4 compliance. • Cancer 62 Day Screening – 100%. <p>All other Single Oversight Framework (SOF), national planning guidance, NHS Constitution and key contractual targets reported were met or within expected range where reporting data available.</p> <p>Going forward into 2018/19, whilst the key performance metrics remain, the national priority focus is on the following:</p> <ul style="list-style-type: none"> • ED 4 hour (quarterly improvement on previous year, plus minimum 90% Sept 18 and 95% Mar 19) – 30% of PSF. Headline plan for Q1 programme, ED actions and urgent care pressures is included in the report. • RTT (no patients over 52 weeks; no increase in number of patients on an incomplete pathway) – Headline plan for Right Referral, Right Care Programme, process improvement and activity is included in the report. • Cancer waiting time standards, including 62 day RTT. 	

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:	Performance metrics are key control measures for the following risks on the Trust Risk Register: <ul style="list-style-type: none"> • Flow (463) • RTT (193) • Right Referral, Right Care (604 – <i>being rearticulated for 18/19</i>) • Financial - PSF



Operational Performance Report

For the period to end
April 2018

Richard Renaut
Chief Operating Officer

1. Introduction

This report focuses on April performance where it is available and provides a 'look forward' for Q1 18/19 in light of the national planning guidance. It also finalises the March and end of year 17/18 position for remaining targets where not previously reported. Our planned approach to risk mitigation is also outlined.

It accompanies the Performance Indicator Matrix (see Reading Pack) and Board Dashboard relating to the Single Oversight Framework and national planning guidance.

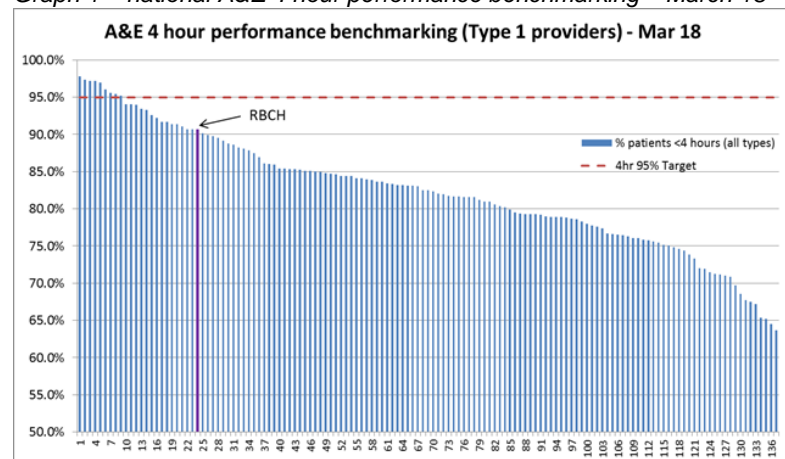
2. Single Oversight Framework and National Indicators

2.1 Current performance – April 2018/19

A&E 4 Hour Target and 12 Hour Breaches

April saw our ED performance rise to 91.86% after the dip last month (90.7%). Despite this, we continued our trend of remaining in the top percentiles (top 20% in March) for Type 1 Emergency Departments.

Graph 1 – national A&E 4 hour performance benchmarking – March 18



Attendances (Type 1) were 2.55% higher than in April 17 and overall urgent care admissions were 3.1% higher. This has maintained the upward trend in demand that we saw in the latter part of 17/18. Of concern, this is continuing, with overall A&E attendances 4.81% (Type 1 - 3.19%) higher YTD and this is challenging performance compliance which currently stands at 92.4% for May (as at 14/5/18).

SWASFT ambulance conveyances have remained significantly above 2017 levels.

Graph 2 – Monthly SWAST handovers



Section 2.2 (and separate presentation to Finance Committee) provides further detail on our ED and urgent care action plans.

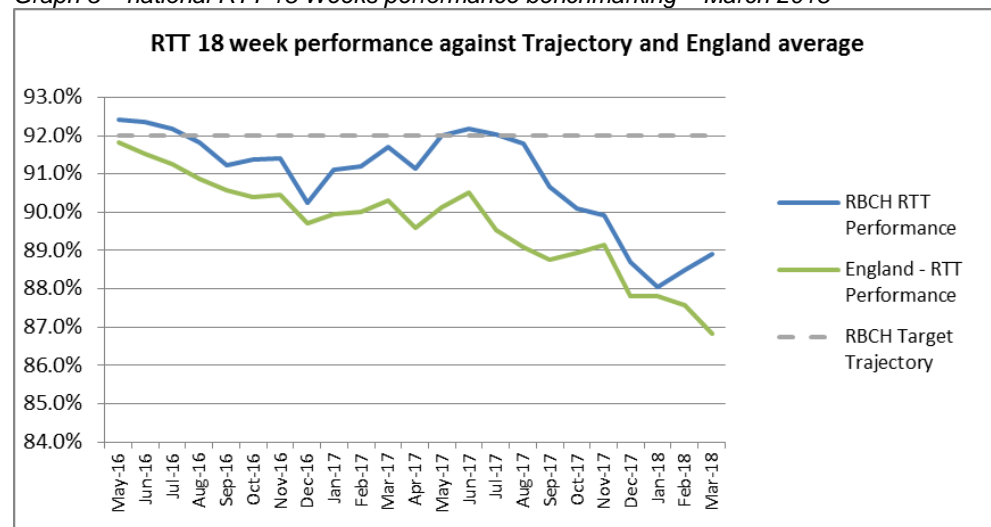
There were no 12 hour Emergency Department breaches in April.

RTT Incomplete Pathways (18 week), Total Incomplete Pathways and 52 Week Breaches

Our validated April RTT performance was 88.81% which was a similar level to our March performance.

As shown in the below graph, our performance remained above the England average in March as it has done all year. The challenge across all Trusts though, is noted.

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



The impact of the winter pressures is still having some residual effect on 18 week backlog pressures. This is born out in the increase in our total waiting list at the end April, though we are seeing some recovery in the admitted backlog, particularly in Orthopaedics, Upper GI and Urology through additional activity.

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. Section 2.2 below outlines our headline plan to achieve the 52 week wait and total waiting list 'must do's', as well as stretch for recovery towards 92% for 18/19.

Monitoring and reducing 40+ week waits forms part of our strategy to avoid 52 week wait breaches. We saw our incomplete pathways waiting over 40 weeks reduce by 15 between March and April. This will continue to be reported to Board.

Table 1- 40+ week incomplete pathways by specialty

Specialty	Mar-18	Apr-18
General Surgery	13	14
Urology	32	30
Trauma & Orthopaedics	8	4
Ear, Nose & Throat (ENT)	1	2
Ophthalmology	3	0
Oral Surgery	1	0
Cardiothoracic Surgery	0	0
General Medicine	2	3
Cardiology	1	1
Dermatology	6	2
Thoracic Medicine	0	0
Neurology	0	0
Rheumatology	0	0
Geriatric Medicine	1	0
Gynaecology	3	4
Other	4	0
Total	75	60

62 Day from Referral/Screening for Suspected Cancer to Treatment

For the month of March (*last formal reported month*) performance was at 92.3% (7.5 breaches). This is significantly better than the national target of 85% and continues the trend seen across the year.

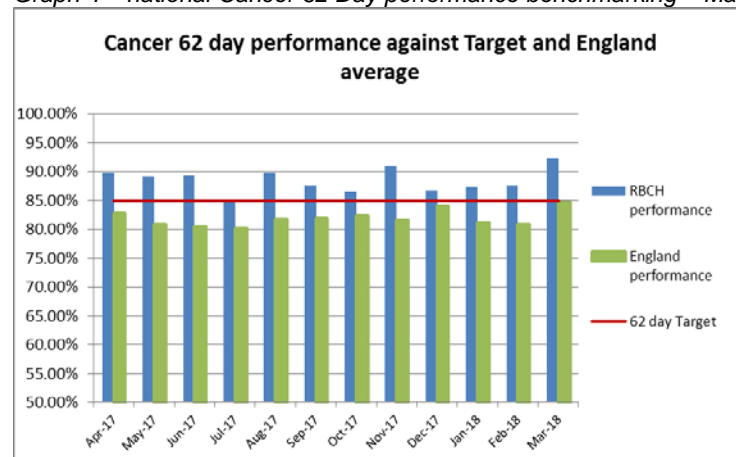
In March, there were 7.5 (62 day) breaches across 5 specialities; with 4 breaches in Urology (*note, 0.5 breach is shared with another provider*). The non-Urology breaches included: 1 in Haematology, 1 in Lung, 1 in Breast, 0.5 in Sarcoma. The most significant reason for breaches was complex pathways (2 breaches). A range of other reasons affected the other breaches with no key trend.

We achieved 100% against the 62 day screening to treatment target in March.

Operational Performance Report

As at 21/05/2018

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



Performance against all of the cancer targets also benchmarks well against the national picture – see below graphs/tables.

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

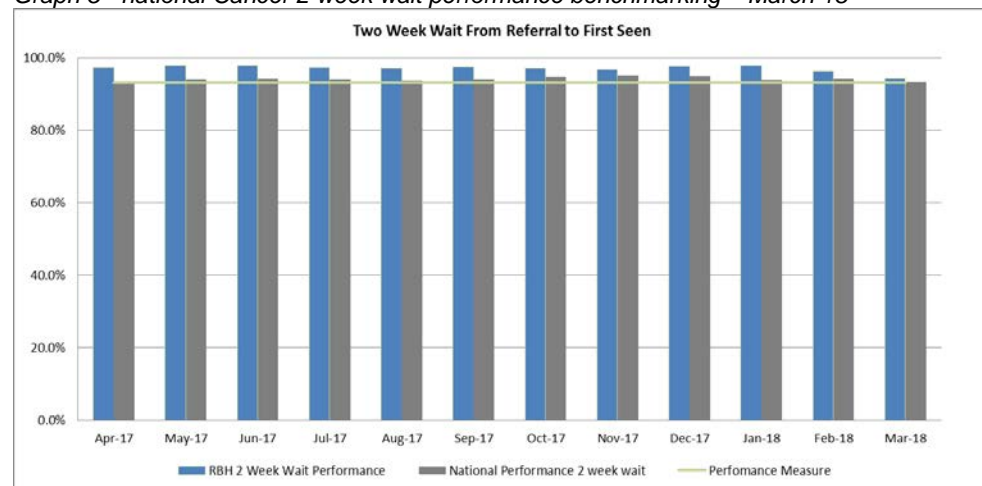


Table 2- National Comparison of 31 Day Tumour Performance 17/18

Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
RBH Performance - 31 Day Tumour	98.3%	94.9%	98.6%	97.2%	97.7%	96.6%	97.1%	98.6%	99.0%	96.5%	98.9%	97.8%
National Performance - 31 Day Tumour	97.4%	97.5%	97.6%	97.7%	97.7%	97.4%	97.8%	97.6%	97.9%	96.5%	97.6%	97.5%

Table 3- National Comparison of key Cancer metrics Quarter 4- 17/18

Area	Indicator	Measure	Target	Quarter 4 2017/18	National Performance - Quarter 4 2017/18
Cancer Waiting Times	2 week wait	From referral to to date first seen - all urgent referrals	93.0%	96.0%	94.1%
	2 week wait	From referral to to date first seen - for symptomatic breast patients	93.0%	100.0%	92.3%
	31 day wait	From decision to treat to first treatment	96.0%	97.7%	97.2%
	31 day wait	For second or subsequent treatment - Surgery	94.0%	95.7%	94.6%
	31 day wait	For second or subsequent treatment - anti cancer drug treatments	98.0%	100.0%	99.3%
	62 day wait	For first treatment from urgent GP referral for suspected cancer	85.0%	89.1%	82.2%
	62 day wait	For first treatment from NHS cancer screening service referral	90.0%	93.3%	88.7%
	62 day wait	Consultant Upgrades	90.0%	88.0%	87.1%

We have 4 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. Capacity in Urology, complex pathway, Histology reporting delay and patient choice contributed to the extended pathways. Learning is being shared.

Diagnostic 6 Week Wait

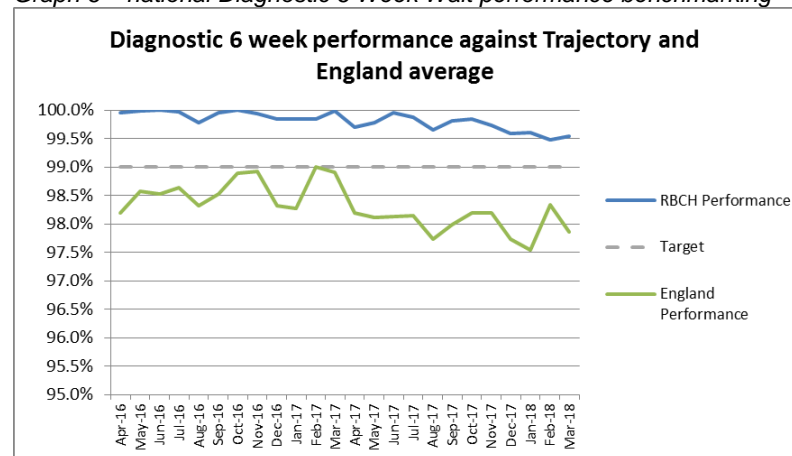
Our positive performance against the 6 week diagnostic standard continued in April with the final validated performance achieving 99.67%. The graph below shows an upturn in the national position though we remained well above this and the 99% threshold.

Performance currently remains on track in the key areas (Endoscopy, Radiology, Cardiology and Urology).

Operational Performance Report

As at 21/05/2018

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



2.2 18/19 Q1 - Forecast Performance and Key Risks

Going forward into 2018/19, whilst the key performance metrics remain, the national priority focus is on the following:

- ED 4 hour (*quarterly improvement on previous year, plus minimum 90% Sept 18 and 95% Mar 19*) – **30% of Provider Sustainability Fund (PSF)**
- RTT (no patients over 52 weeks; no increase in number of patients on an incomplete pathway)
- Cancer waiting time standards, including 62 day RTT.

Whilst we ended 17/18 in a strong benchmarked position, these key metrics continue to be a significant challenge going into 18/19. Below indicates current forecast for next month.

Headline plans for mitigation of our risks to performance are outlined below.

Table4 – Operational Planning and Contracting Guidance - KPIs 2017-19 – actuals/ forecast

Single Oversight Framework Indicator	National Target	NHSI Trajectory 18/19	Mth / Qtrly	RAG rated forecast against national targets and NHSI submitted trajectories		
				Apr 2018 act.	May 2018 est.	Q.1 18/19 est.
A&E 4hr maximum wait time	95%	91-95%	Mthly			
RTT 18 week incomplete pathways	92%	88-89%	Mthly			
RTT - no. of incomplete pathways	≤ March 2018	24,880	Yr End			
RTT - no 52 week waiters	0	0	Mthly			
Cancer 62 day wait for first treatment from urgent GP referral*	85%	85 - 85.4%	Mthly	est.		
Cancer 62 day wait for first treatment from Screening service*	90%	90%	Mthly	est.		
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).

*Apr cancer final validated upload will be completed early June 18

A&E 4 hour and PSF

As highlighted above, the 'step up' in ED attendances, ambulance conveyances and admissions is continuing. A five-pronged approach is being taken to mitigate the significant risk to both performance and securing the PSF:

- QI Programme – 'First 24 Hours'
- ED Action Plan (also informed by regular breach RCAs)
- Urgent care and winter planning, including key schemes throughout the year and for peak periods
- 'Back door' and stranded patients – joint work with partner organisations via the East hub
- Regular monitoring and reporting.

April has seen the launch of the First 24 Hours programme which already commenced detailed pathway mapping and identification of opportunities through ED and ambulatory services.

Furthermore, a detailed ED action plan is in place (*see separate presentation to be made to Finance Committee*) which includes:

- A Nursing template review
- Actions to reduce out of hours breaches
- Actions to reduce Minors breaches
- Direct access from BREATH (rapid assessment hub) to AEC (ambulatory care)
- Actions to reduce time to 'decision to admit'
- Building on Team development work.

The urgent care and winter planning process has also started, which included a workshop session at the April Trust Management Board. Prioritisation of key schemes is being finalised and includes further enhancement of medical cover in ED at night. Additional Physiotherapy, GP and patient tracking support to ED is also being considered.

With regard to 'stranded patients' and discharge flow, we are continuing to work with our East primary, community and secondary care hub partners to reshape rehabilitation and discharge support services to release further capacity for 'hospital to home' approaches. Monitoring of 'stranded patients' by GP locality is also now in place.

Weekly breach analysis overseen by the Chief Operating Officer and Director of Operations and weekly reporting to the Trust's Performance Management Group is in place. Furthermore, progress against the ED action plan is reported to the Care Group Monthly Review meetings with the Executive Team and updates will be provided to the Finance and Performance Committee.

The 4 hour target remains the national and a local priority target with 30% of the PSF attached to this. The increased demand levels and impact of surges continues to present a risk and the approach and actions outlined above will be key to mitigating the risk to the Trust.

RTT 18 weeks

As highlighted last month, nationally, the focus for 18/19 has shifted to ensuring there is no increase in the number of patients on waiting lists (admit/non admit incomplete pathways). Very long waits are also an absolute priority with an expectation that no patients will wait more than 52 weeks for a routine (non clinically urgent) elective procedure.

Our approach to this was presented to our Trust Management Board in April:

- 'Self care to treatment' pathway improvements that ensure the right patients access secondary care at the right time (Right Referral, Right Care Programme)
- Capacity to meet referral and waiting list demand and avoid backlog (18 week) increases that increase risk to 52 week waits
- Capacity and process improvements to meet clinical 'must do's' (e.g. cancer and urgent pathways) and avoid impact on routine RTT patients
- Ability to mitigate the impact of additional or unplanned pressures (e.g. post winter 17/18 recovery, potential 18/19 winter impacts).

A Right Referral, Right Care Programme 'stocktake' workshop took place in early May with partner organisations. This reviewed and shared learning from workstreams and positive progress to date. This has informed further opportunities and plans for 18/19 to sustain and go further on referral/elective pathway improvements. Action plans are now being finalised with the prioritised speciality groups. Workstreams include:

- Detailed work up and rollout of enhanced, consultant-led, Rapid Assessment and Advice & Guidance pathways in identified specialities;
- Further opportunities for supporting IT such as tele-images; and

- Embedding of pathways with enhanced wellbeing and self-care support .

An assessment of the potential impact on RTT and the new national priorities (52ww/total list), against a backdrop of reduced RTT performance across Dorset, is also taking place. This will be presented to the Dorset Operations and Finance Reference Group (OFRG).

Internally, a self-assessment process and dashboard is being developed at speciality level to identify opportunities for further support and improvement to processes and capacity. Alongside this, an assessment of key pressures relating to clinical 'must do's' (e.g. cancer and urgent pathways, 52ww) has been undertaken. This has informed the development of a number of activity schemes and prioritisation of these is being finalised. This has also considered the impact of winter and urgent care pressures. Further work as part of this planning is underway, including reviewing the impact of trauma pathways as well as seasonal scheduling approaches and capacity.

In addition to avoiding 52 week waits and growth in waiting list, encompassed within the above plan is an absolute requirement that RTT performance does not deteriorate (current levels of 88% achieved as a minimum). As a Trust striving to provide outstanding patient care for all of our patients and a strong grounding for future Dorset system services to sustain and improve on, we would aim to move towards a recovery to 92%.

Cancer 62 Day

We currently anticipate our positive performance against the 62 day and other cancer targets to continue. However, key to this, particularly in light of the ongoing significant increase in fast track referrals, will be:

- Activity planning (particularly for outpatient and diagnostic services) that supports timely pathways (whilst not 'carving out' routine capacity)

- System-wide improvements and network working via the Dorset Cancer Alliance
- Improved referral and diagnostic pathways that support early positive/negative diagnosis in the right place
- Ability to mitigate unplanned risks (e.g. medical staff gaps).

Updates on our planning will be provided in future reports.

Diagnostic 6 Week Wait

Following an increase in the overall waiting list for diagnostics in March, this has reduced in April, though noting an increase in the cystoscopy list. Continuation of the Urology locum post will assist in managing this and we do not expect an impact on overall performance going forward. As part of our activity planning as highlighted above, the impact on diagnostic testing has been reviewed and forms part of our plans to mitigate risks to future performance.

3. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail.

2 C Difficile trajectory cases (with evidence of a lapse in care) were confirmed at review in April. Further work on the Antibiotic Policy and Hand Hygiene audits is underway with the areas concerned.

We achieved 77.8% in March (last reported month) against the cancer '62 days from consultant upgrade' standard. This reflected 1 full breach (2 patients, shared breaches at 0.5 each). The key reasons for the breaches were complex pathway and patient choice.

There are currently no other exceptions to report on the other metrics included in the Performance Indicator Matrix. These metrics will continue to be reviewed as part of our 18/19 Board reporting review, reflecting any relevant changes/priorities in national and contractual requirements.

4. 2018/19 National Planning Guidance and Board/Committee Reporting

Recommendations will be made to the Trust Board of Directors next month on any proposed amendments to the Performance Matrix and/or Board Dashboard to reflect national, local and contractual requirements for 18/19 (e.g. total waiting list, over 40 week wait RTT patient numbers).

Recommendation

The Board of Directors is requested to note the April performance, as well as the expected performance, risks and actions relating to 18/19 requirements.



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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
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 Governance and Risk
Details of previous discussion and/or dissemination:	Not Applicable
Action required:	Note for information
<p>Summary:</p> <p>This report accompanies the Trust Quality Dashboard and outlines the Trust's actual performance against key patient safety and patient experience indicators.</p> <p>There were 2 Serious incidents reported in April, one which was reported as a never event</p> <p>The Trust remains upper quartile for inpatient FFT. ED FFT rate has significantly increased due to the texting pilot and the FFT responses now benchmark 3rd quartile</p> <p>A total of 36 complaints were received in April 2018. All were acknowledged within three days. Care Quality remains a theme across all directorates.</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:	34T



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Quality Report

For the period to end

April 2018

Paula Shobbrook
Director of Nursing and Midwifery

Quality Report: April 2018

1.0 Introduction

This report accompanies the Trust Quality Dashboard and outlines the Trust's actual performance against key patient safety and patient experience indicators. In particular it highlights progress against the trajectories for the priority targets set out in the Board objectives for 2018/19.

2.0 Serious Incidents

Two Serious Incident were reported in April 2018

Two patients identified as having hospital acquired invasive Group A streptococcal infections on Ward within 7 days of each other. Further investigations carried out by Public Health England identified that the patients have the same Emm type (3.93) indicating possible transmission occurring on the ward. Reported as external SI following discussion with CCG and PHE. Although we have good infection control principles and hand hygiene regimen in place, a decision was made to report this incident externally due to interest and review by external bodies, and to ensure that we re-evaluate our own systems and practice for further assurance.

Unintentional connection of a patient requiring oxygen to an air flow meter. The patient did not come to harm as a result of this incident. This meets the criteria for and was reported as a Never Event.

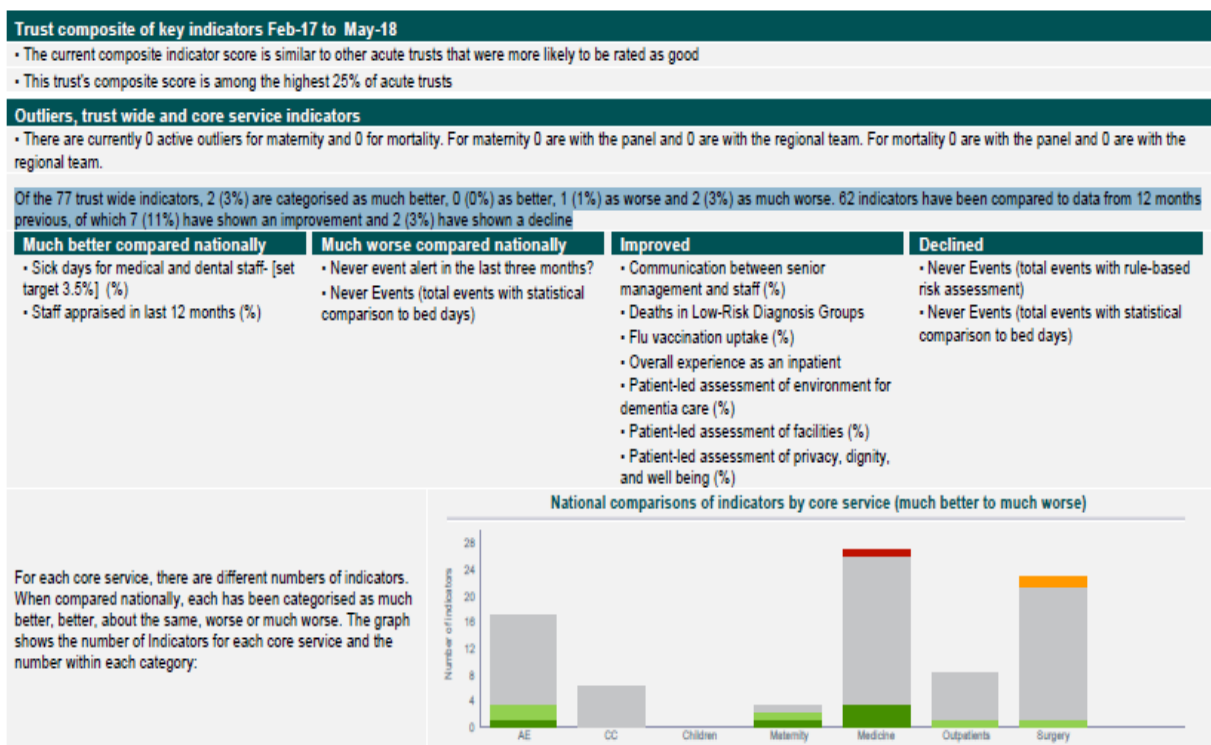
3.0 CQC Insight Model

On 5th May 2018 the CQC published their latest Insight Report for this Trust and compared our performance to all other acute NHS Trusts.

Of the 77 trust wide indicators, 2 (3%) are categorised as much better, 0 (0%) as better, 1 (1%) as worse and 2 (3%) as much worse. 62 indicators have been compared to data from 12 months previous, of which 7 (11%) have shown an improvement and 2 (3%) 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'.



4.0 Patient Experience Report

4.1 Friends and Family Test: March data

National Comparison using NHS England data:

The benchmarking data bullet pointed below is taken from the national data provided by NHS England which is retrospectively available and therefore, represents March 2018 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in March 2018 ranked RBCH Trust 3rd with 31 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 19.1%.
- The Emergency Department FFT performance in March 2018 ranked RBCH Trust 14th with 11 other hospitals out of 140 placing RBCH ED department in the third quartile. The response rate is now 16.3% against the 15% national standard, which has impacted on the FFT rate. A new process utilising text message feedback has begun some minor IT glitches with this system are currently being addressed.
- Outpatients FFT performance in March 2018 ranked RBCH Trust 4th with 27 other Trusts out of 241 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

	October	November	December	January	February	March
In-Patient Quartile						
Top	98.355%	98.492%	98.842%	98.755%	98.665%	98.469%
2						
3						
Bottom						
	October	November	December	January	February	March
ED Quartile						
Top	95.726%	94.545%				
2			92.157%	92.887%	87.545%	
3						86.083%
Bottom						
	October	November	December	January	February	March
OPD Quartile						
Top						
2	97.337%	97.251%	96.436%	97.231%	96.944%	96.880%
3						
Bottom						

4.2 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	72	71	94.4%	0.0%
Main OPD Xch	N/A	30	28	100.0%	0.0%
Oral and Maxillofacial	N/A	9	9	88.9%	11.1%
Outpatients General	N/A	168	166	97.0%	1.2%
Jigsaw OPD	N/A	4	4	75.0%	25.0%
Corporate Total		283	278	96.0%	1.4%

4.3 Care Audit Trend Data

The Care Audit Campaign has now taken on the new format agreed at HAC. It will now be reported on a quarterly basis.

4.4 Patient Opinion and NHS Choices: April Data

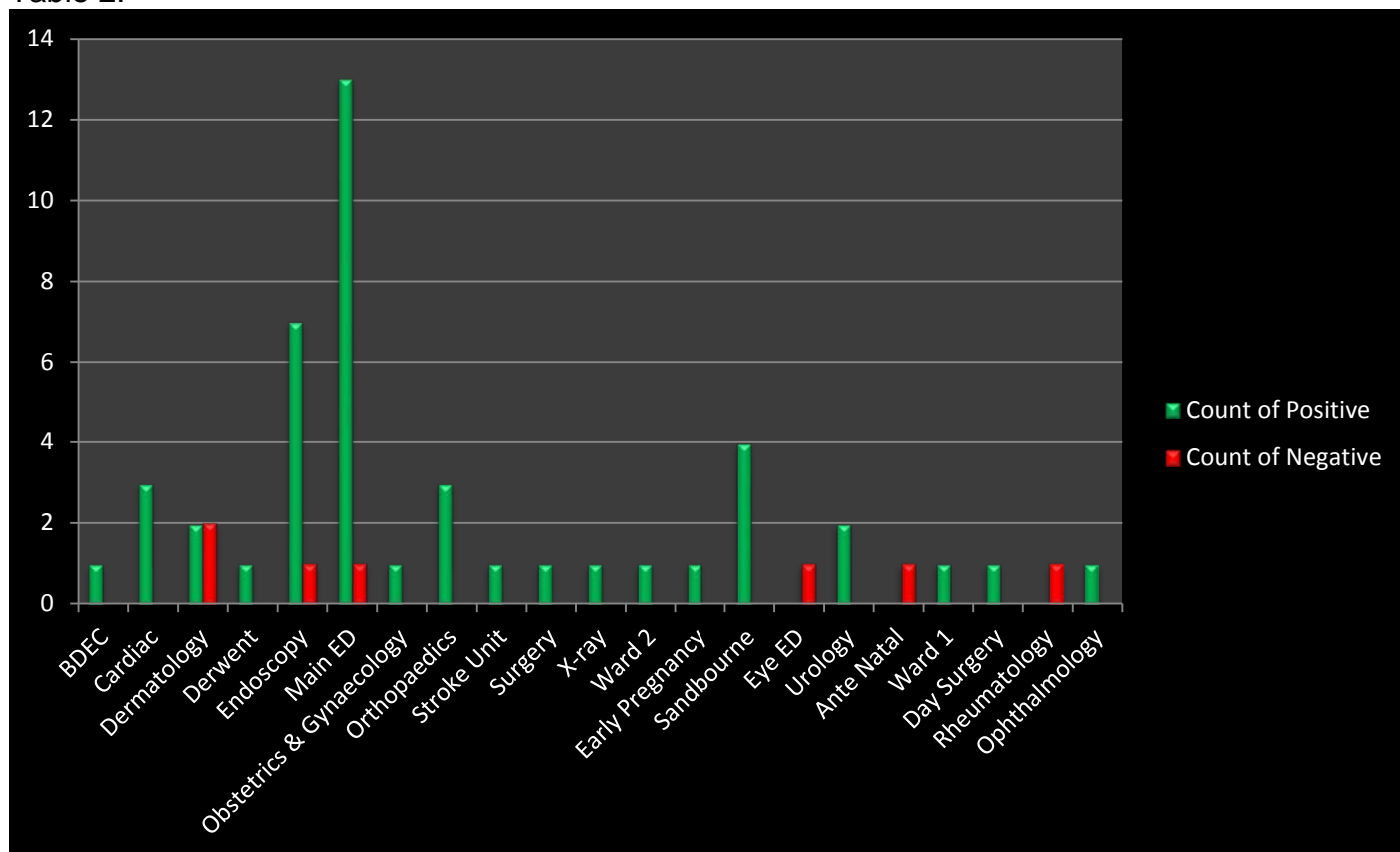
5 patient feedback comments were posted in March, 4 express satisfaction with the staff attitude, treatment and care. 1 negative comment relating to rudeness and staff attitude

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

4.4 Annual accumulation of the online feedback from NHS Choices & Patient Opinion

The below table shows the response breakdown both positive and negative themes by area, based on an accumulation of feedback from January 2018 to May 2018.

Table 2:

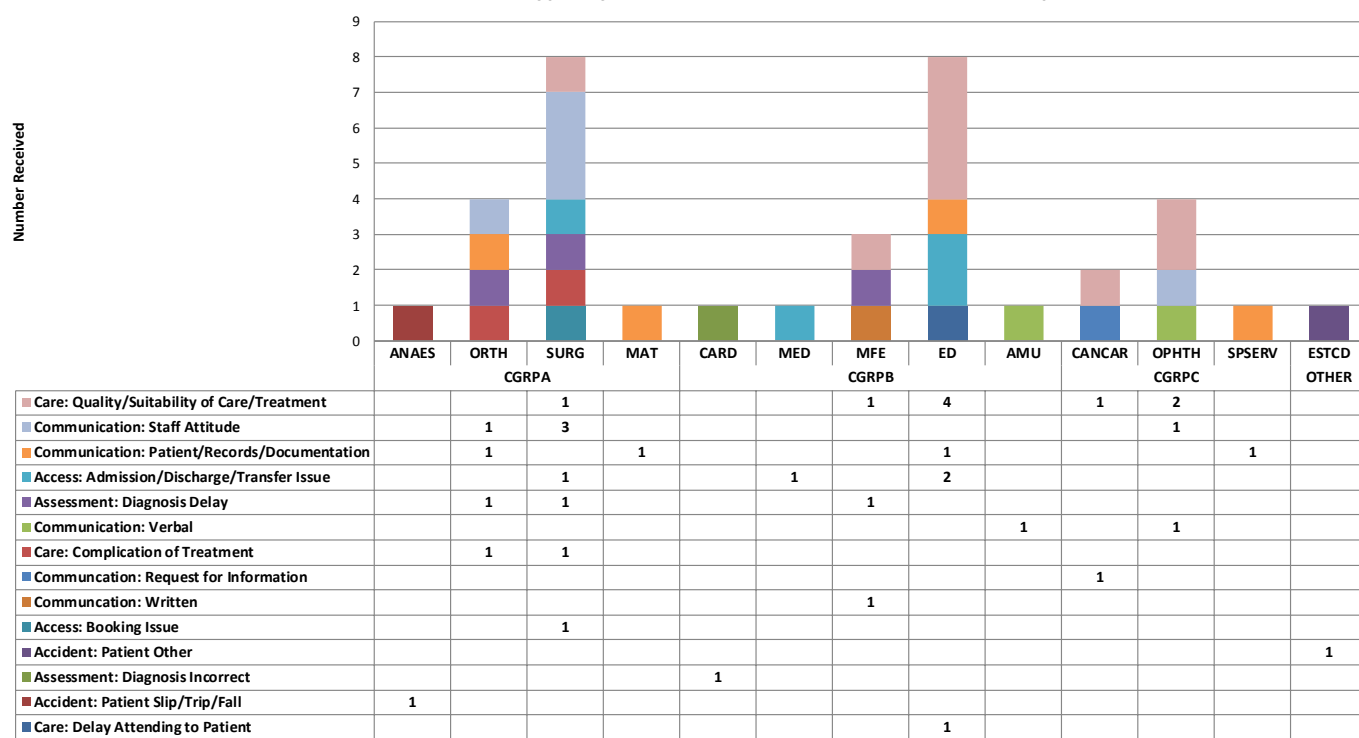


5.0 Complaints

5.1 A total of 36 complaints were received in April all of which were acknowledged within 3 days. This shows a decline in the number of complaints received with the two highest themes being:

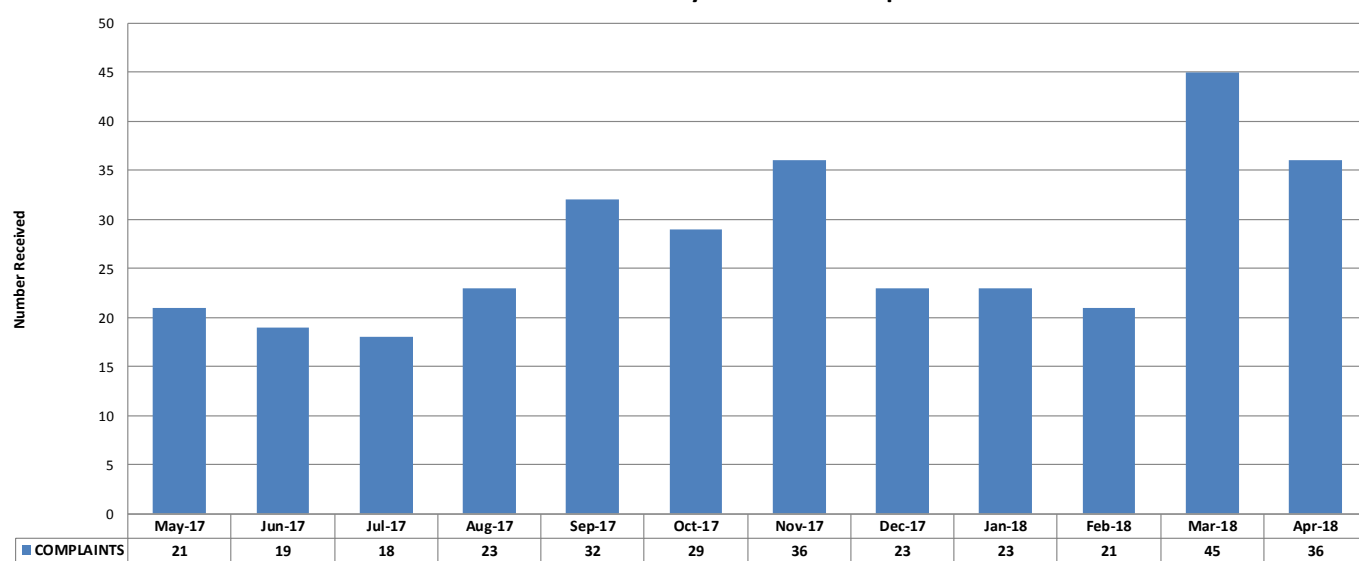
- Consent, communication, confidentiality
 - Staff Attitude
 - Patient / records / documentation
- Implementation of care
 - Quality / Suitability of Care / Treatment

COMPLAINTS - Subtype by Directorate based on Month of Receipt



Total Complaints received from April 2018: 36

Number Received by Month of Receipt









A total of 326 complaints have been received between May 2017 to April 2018

5.2 Complaint response times Year to date:







A gradual decrease in complaint response rates is noted for March and April 2018:

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Rolling 12 months
1st Responses Due in Month	26	23	23	18	17	36	21	37	29	17	26	43	316
Number where 1st Response Completed within 25 working days	23	17	17	15	13	21	13	26	18	13	17	28	221
Percent with 1st Response within 25 working days	88%	74%	74%	83%	76%	58%	62%	70%	62%	76%	65%	65%	70%

5.3 Complaints performance by Care group:

Care Group	Complaints									
	Number Due	Number on time		% on time December	% on time January 2018	% on time February 2018	% on time March 2018	% on time April 2018	Change	Trend
CGRPA	9	8		78	69	50	57	89	▲	
CGRP B	18	10		60	58	83	73	56	▼	
CGRP C	15	9		50	50	50	0	60	▲	
OTHER	1	1		0	50	100	0	100	▲	
PRIVATE	0	0		0	0	0	0	0	=	
GRAND TOTAL	43	28		68	62	78	64	65	▲	

Concerns performance by care group:

Care Group	Concerns including written concerns									
	Number Due	Number on time		% on time December	% on time January 2018	% on time February 2018	% on time March 2018	% on time April 2018	Change	Trend
CGRPA	27	27		100	100	95	93	100	▲	
CGRP B	35	35		88	91	91	85	100	▲	
CGRP C	20	20		63	95	100	47	100	=	
OTHER	25	4		83	100	77	80	100	▲	
PRIVATE	0	0		0	0	0	0	0	=	
GRAND TOTAL	107	107		88	96	91	80	100	▲	

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:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Financial Performance
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 & Performance Committee
Action required:	Note for information
Summary: Whilst overall the Month One financial position is favourable, a number of financial risks are inherent within this. Most notably, there remains a material shortfall between the full year savings requirement and the full year savings forecast. In addition, the Trust is at risk of failing to achieve the Quarter One performance element of the Provider Sustainability Fund. Prompt action is required to mitigate these risks.	
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:	One risk recorded as moderate for 2018/19 on the risk register for monthly review by the Finance & Performance Committee.



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Finance Report

For the period to end

30th April 2018

Pete Papworth
Director of Finance

Executive Summary

As at 30 April the Trust has delivered a cumulative deficit of £1.126 million, being £13,000 better than budget. However, there remains a significant shortfall in the forecast savings as compared to the full year saving requirement, which requires focused attention to ensure the Trust is able to achieve its agreed financial control total. Additionally, there is a risk that the Trust will not secure the quarter one Provider Sustainability Fund payment in full.

Income & Expenditure

At the end of Month One; income is behind plan by £0.175 million which is reduced to £0.114 million after adjusting for 'pass through' drugs and devices. This reflects additional income from specialist activity, off-set by lower than anticipated private patient income.

Expenditure reported an aggregate under spend of £0.188 million reduced to £0.126 million after adjusting for 'pass through' drugs and devices. This variance has been driven by an under achievement against the cost improvement programme, consistent with the identified full year shortfall.

Provider Sustainability Fund (PSF), formally the Sustainability and Transformation Fund (STF)

The Trust has been allocated a total of £9 million through the PSF. Up to £6.3 million is secured if the Trust achieves its Financial Control Total, and up to £2.7 million is achieved if the Trust improves upon its performance against the Accident and Emergency 4 hour access standard.

The PSF income relating to April has been accrued in full, however it should be noted that the Trust is struggling to achieve the required A&E performance and thus a recovery plan has been requested and will be considered by the Finance and Performance Committee in May. The quarter one payment relating to A&E performance amounts to £405,000 and is currently considered to be at risk.

Forecast Outturn

The Trust is forecasting a full year deficit of £2.381 million, consistent with the revenue control total agreed with NHS Improvement.

Cost Improvement Programme

Financial savings of £0.650 million have been achieved during April, which represents a shortfall of £0.375 million against the targeted value of £1.025 million. To date £9.2 million of potential savings have been identified, which is reduced to £8.5 million after accounting for risk. This compares to the full year savings requirement of £12.697 million and equating to 4.5% of operating costs. Further schemes continue to be identified to close this gap; however this remains the most significant financial risk for the Trust.

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. It should be noted however, that whilst agency spend remains comparatively low in April, the cumulative cost of bank, agency and overtime is higher than the Trust's vacancy budget.

Capital Expenditure

Capital expenditure amounting to £1.2 million has been committed during April, being £0.4 million above budget. This reflects the timing of expenditure, particularly in relation to medical equipment, as compared to the initial plan.

Cash

The Trust is currently holding a consolidated cash balance of £31.4 million, which is expected to reduce to £24.1 million by 31 March 2019. This is a strong position, and means that no Department of Health support is required during 2018/19.

Recommendation

Members are asked to note the Trust's financial performance for the period ending 30 April 2018.

Finance Report

As at 30 April 2018

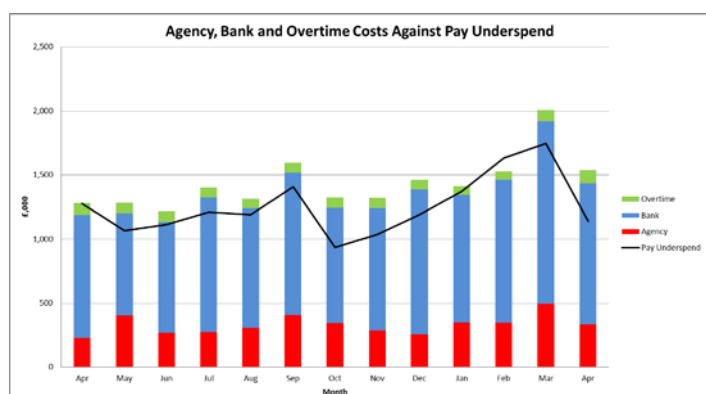
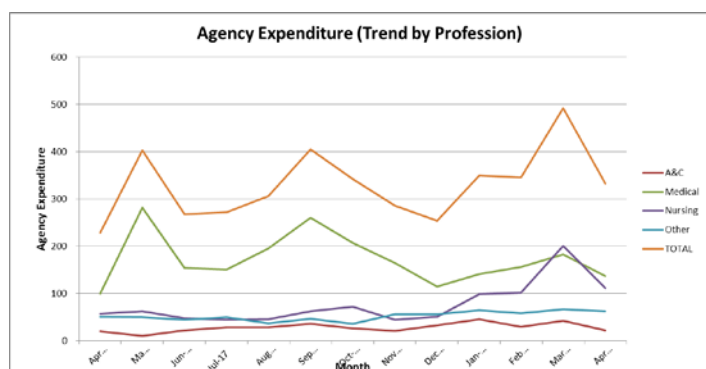
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000	Pass Through £'000	Residual Variance £'000
NHS Clinical Income	20,492	20,428	(64)	62	(2)
Non NHS Clinical Income	480	400	(80)	(1)	(81)
Non Clinical Income	3,274	3,242	(32)	0	(32)
TOTAL INCOME	24,245	24,071	(175)	61	(114)
Employee Expenses	15,178	15,577	(399)	0	(399)
Drugs	2,724	2,645	79	(195)	(116)
Clinical Supplies	2,612	2,803	(191)	134	(57)
Misc. other expenditure	4,871	4,172	699	0	699
TOTAL EXPENDITURE	25,385	25,197	187	(61)	126
SURPLUS/ (DEFICIT)	(1,140)	(1,126)	13	0	13

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	14,718	14,718	0
NHS England (Wessex LAT)	3,297	3,263	(34)
NHS West Hampshire CCG (and Asso	2,044	2,039	(5)
Other NHS Patient Income	434	408	(25)
Provider and Sustainability Fund	450	450	0
Non NHS Patient Income	480	400	(80)
Non Patient Related Income	2,824	2,792	(32)
TOTAL INCOME	24,245	24,071	(175)

Provider and Sustainability Fund Income	Year to Date			Full Year Forecast		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Financial: Control Total (70%)	315	315	0	6,300	6,300	0
Performance: A&E Trajectory (30%)	135	135	0	2,700	2,700	0
Incentive	0	0	0	0	0	0
TOTAL	450	450	0	9,000	9,000	0

Agency Expenditure



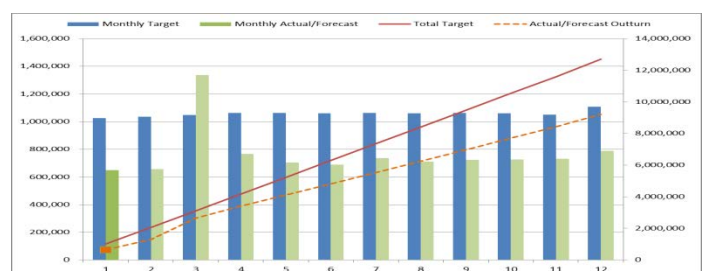
Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	873	597	(276)
Medical Care Group	537	197	(339)
Specialties Care Group	358	301	(57)
Corporate Directorates	(2,987)	(2,966)	21
Centrally Managed Budgets	81	744	664
SURPLUS/ (DEFICIT)	(1,139)	(1,126)	13

Cost Improvement

Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000	Risk Adjusted £'000
Surgical Care Group	182	65	(116)	1,115
Medical Care Group	251	145	(106)	1,223
Specialties Care Group	181	61	(119)	925
Corporate Directorates	412	379	(33)	5,258
SURPLUS/ (DEFICIT)	1,025	650	(375)	8,521

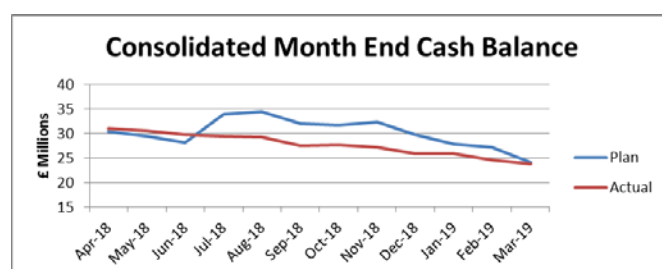
Cost Improvement Programme Graph



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	371	146	225
IT Strategy	269	249	20
Medical Equipment	143	805	(662)
Centrally Managed	8	(1)	9
SURPLUS/ (DEFICIT)	791	1,199	(408)

Cash





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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Report
Section on agenda:	Performance
Supplementary reading:	Minutes of the Workforce Strategy & Development Committee held on 19/4/18.
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Karen Allman, 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.	
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:	Recruitment and workforce planning are existing risks on the risk register.



The Royal Bournemouth
and Christchurch Hospital
NHS Foundation



Workforce Report

For the period to end

April 2018

Karen Allman
Director of Human Resources

Workforce Report for Board

As at 30th April 2018

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 April			Rolling 12 months to 30 April			At 30 April	
Surgical	1.9%	90.9%	93.1%	4.42%	15271	11.5%	9.5%	
Medical	2.4%	79.6%	92.2%	3.73%	19193	13.2%	9.9%	
Specialities	1.8%	91.3%	94.1%	3.82%	12037	11.4%	10.9%	
Corporate	2.1%	50.0%	95.7%	4.05%	12633	6.2%	7.7%	
Trustwide	2.1%	87.1%	93.3%	3.98%	59134	10.9%	9.5%	

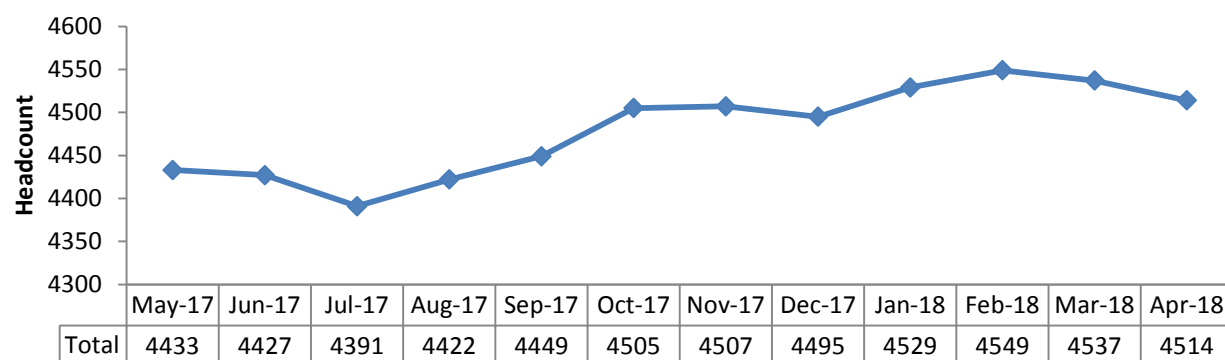
Staff Group	Appraisal Compliance		Mandatory	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental	Training Compliance	Absence	FTE Days			
	At 30 April			Rolling 12 months to 30 April				At 30 April
Add Prof Scientific and Technical	0.7%		94.1%	3.05%	1453	11.3%	9.9%	
Additional Clinical Services	0.5%		92.8%	6.02%	16298	20.0%	14.4%	
Administrative and Clerical	2.6%		95.6%	3.60%	11242	8.5%	9.1%	
Allied Health Professionals	3.2%		92.8%	2.63%	2490	14.7%	12.3%	
Estates and Ancillary	0.0%		95.0%	6.03%	7418	7.8%	7.5%	
Healthcare Scientists	7.3%		97.5%	3.02%	1072	7.7%	8.7%	
Medical and Dental		87.1%	89.0%	1.31%	2301	5.5%	4.8%	
Nursing and Midwifery Registered	2.7%		93.7%	3.95%	16859	8.2%	7.7%	
Trustwide	2.1%	87.1%	93.3%	3.98%	59134	10.9%	9.5%	

Workforce Report for Board

As at 30th April 2018

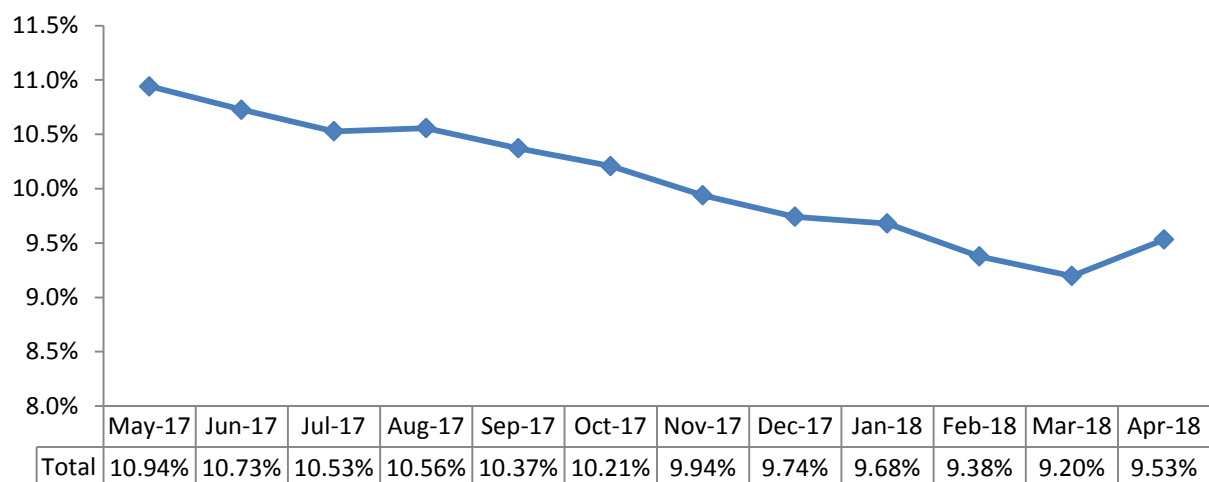
1. Staffing and Recruitment

Substantive Staff (Headcount) Trend



Following many months of continual downward trend, the turnover rate saw a slight increase in April at 9.53% (9.20% the previous month); however this remains a good position and compares favourably with the 11.13% turnover rate at the same point last year.

Permanent Staff Turnover Rate (Headcount)



Joining rate at 10.9%, continues at a higher level than the turnover rate, although overall headcount fell back very slightly (-23 staff)

Vacancy rate not currently available at time of writing.

Workforce Report for Board

As at 30th April 2018

2. Essential Core Skills Compliance

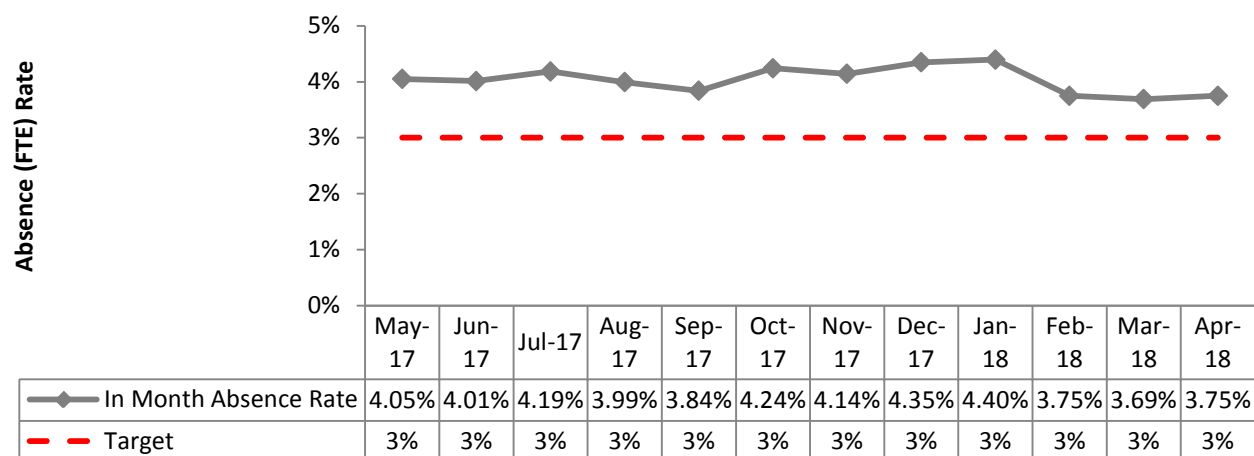
Compliance saw a slight increase for the month and currently stands at 93.3% as at 30th April (93.2% in March), which represents an improvement on the 91.6% seen at the same point last year. Compliance for Medical & Dental staff remains at 89% and continues to be closely monitored by the Medical Director.

Areas highlighted to managers for focus include: Resus L3 (ILS); Conflict Resolution; Fire Training; Blood (eLearning); Moving & Handling Level 2 and Dementia Tier 2.

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)



	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Surgical	4.53%	4.81%	5.00%	4.93%	4.21%	4.21%	4.49%	4.53%	4.70%	3.90%	4.85%	4.21% ↓
Medical	4.30%	4.00%	4.32%	3.73%	3.61%	3.60%	3.34%	4.03%	4.27%	3.70%	2.88%	3.45% ↑
Specialties	3.17%	3.32%	3.70%	3.91%	3.79%	4.21%	4.77%	4.48%	4.32%	3.79%	3.51%	3.77% ↑
Corporate	4.01%	3.85%	3.57%	3.49%	3.86%	5.36%	4.44%	4.53%	4.35%	3.63%	3.94%	3.73% ↓
Trust	4.05%	4.01%	4.19%	3.99%	3.84%	4.24%	4.14%	4.35%	4.40%	3.75%	3.69%	3.75% ↑

The in-month sickness absence figure for April slipped back slightly to 3.75%, continuing its amber rating. Care Group B slipped back following its green-rated 2.88% last month but still remains comparatively low at 3.45%. Care Group A remains red but recorded a 0.64% improvement on the previous month. Overall, this is an encouraging result and focus continues on managing sickness and supporting health and wellbeing within the Trust.

4. Safe Staffing

As part of the Trust's requirement to report on Safe Staffing (CQC – Key Line of Inquiry) the following data summary has been prepared for April 2018.

Registered Nurse (RN)	Actual Day	92.9%	HCA Actual Day	100.4%
Registered Nurse (RN)	Actual Night	98.4%	HCA Actual Night	127.6%

The April staffing return to Unify demonstrates that overall the Trust maintained both a safe and improved staffing position. This was achieved by areas either running to full template or implementing effective mitigating actions. The closure of ward 9 will have supported this improved picture with staff returning to their base wards. There were no red flags for staffing in April 2018. A small percentage of high cost agency was utilised, which continues to be monitored through the Premium Cost Agency meeting; and at year end the overall spend was well below trajectory. There were some episodes of templated shift over and under fill, examples of this are:

Care Group A

- The use of escalation beds on the Surgical Admissions Unit.
- The use of the escalation bay on ward 14.
- Adjusted use of the Derwent ward in support of operational pressures.

Care Group B

- There was an over fill of Health Care Assistants within Older Persons Medicine, due to 1:1 nursing for patients with enhanced care needs.

Care Group C:

- In Ophthalmology there was a shift over fill for Health Care Assistants due to increased eye day surgery and at night increased care needs for the patients due to the escalation bay.

In all three care groups several areas have benefited from an increase in template (shifts) with pipeline recruitment on-going and therefore a greater reliance on bank fill.

5. Workforce Committee

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

- i. Staff Survey follow-up work being undertaken.
- ii. The reduction in agency spend.
- iii. The good work being done by the Equality, Diversity & Inclusion Committee.
- iv. E-rostering initiatives.
- v. Overseas recruitment for nurses – interviews in Dubai.
- vi. The Committee's support for the apprenticeship programme.

6. Recruitment

Two of our matrons - Belinda Hewitt and Troy Welch - recently went to Dubai on a hosted recruitment trip. Offers have been made to a number of experienced nursing staff and we were delighted with the calibre of staff. There will be a delay before these applicants join the Trust as there are a number of processes that we and the applicants must go through before they join us but we hope to have some of these new staff join us early Autumn. Support with orientation, accommodation and education will be provided to these staff and more details will be reported in later board reports.

On Saturday 12 May we held our open day for nurses due to qualify this year. The Board will remember that this is part of our recruitment planning and provides an opportunity for applicants to learn more about our Trust and our values and behaviours as well as education, training and preceptorship programmes. We carry out appropriate tests and interviews on the same day which culminated in 36 offers being made. We are grateful to the staff who helped support the event itself but a particular thank you to Sue Davies and Andy Gyngell, matrons for Surgical Services and Critical Care, who once again managed the process impeccably.



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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Membership Engagement Strategy
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:	Engagement Committee, 1 March 2018 Council of Governors, 18 April 2018
Action required:	Decision
<p>Summary:</p> <p>The Council of Governors approved the Membership Engagement Strategy for 2018-19 at its meeting in April 2018. The Membership Engagement Strategy also requires approval and endorsement by the Board of Directors. The Council of Governors is responsible for the implementation of this Membership Engagement Strategy. The Board of Directors ensures that the necessary support and resources are available for the Membership Engagement Strategy to be successful and to work alongside the Trust's other aims and objectives and strategies to engage with patients and the public.</p>	
Related strategic objective:	Listening to patients. Ensuring meaningful engagement to improve patient experience
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?	✓
Are they well-led?	✓



Membership Engagement Strategy

Approval Committee	Version	Issue Date	Review Date	Document Author(s)
Council of Governors	V4	April 2018	April 2019	Engagement Committee

CONTENTS

1.0	AIMS AND OBJECTIVES	2
2.0	MEMBERSHIP REQUIREMENT	3
3.0	BECOMING A MEMBER	3
4.0	BUILDING AND MAINTAINING THE MEMBERSHIP BASE	4
5.0	MANAGING MEMBERSHIP INFORMATION	6
6.0	MEMBERSHIP COMMUNICATION	6
7.0	DEVELOPING MEMBERSHIP BENEFITS	8
8.0	PLAYING A KEY COMMUNITY ROLE	8
9.0	WORKING WITH OTHER MEMBERSHIP ORGANISATIONS	9
10.0	EVALUATING SUCCESS	9
11.0	MEMBERSHIP RECRUITMENT – EQUALITY AND DIVERSITY	10
12.0	APPROVAL, REVIEW AND REVISION	10
	APPENDIX A	11
	APPENDIX B	12

1.0 AIMS AND OBJECTIVES

- 1.1 A foundation trust is accountable to the local community through its members and the Council of Governors. The Membership Engagement Strategy sets out the way in which The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (**RBCH** or the **Trust**) will recruit and engage with its members. The Membership Engagement Strategy will ensure that the Trust adopts a planned structured and co-ordinated approach to membership and forms part of the Trust's wider engagement activity as set out in the Trust's Patient Experience and Public Engagement Strategy.
- 1.2 Engaging with the membership is a central aspect of a foundation trust. As both a community employer and provider of vital services, there is an obligation continually to listen and react to the needs of staff, local people and stakeholders. Engagement with the membership is a measure of success as a foundation trust, as the more local people are involved and help to inform decisions, particularly on patient-centred services, the better the resulting management decisions. In turn this will inspire the local community to become more involved in a hospital they value and in which they have confidence.
- 1.3 The principal mechanisms for this will be:
 - holding events in the public constituencies to meet members and share information about the Trust;
 - maintaining an active membership and ensuring it is as representative of the local population as possible;
 - engaging with the membership on an ongoing basis and in a timely fashion, and showing how their views are incorporated into decisions; and
 - reporting, using the Annual Report, Annual Members' Meeting and Annual Plan, on the state of membership, how members have been engaged over the previous year and how they will be engaged in the coming year.

2.0 MEMBERSHIP REQUIREMENT

What is the requirement for membership?

- 2.1 The Trust is required by law to have a membership from which a Council of Governors is elected. Members have the right (subject to the Trust's constitution) to stand for election as a governor and to vote for their representative(s) on the Council of Governors. One of the primary purposes of the Council of Governors is to represent the views of the local community to the Board of Directors.

Eligibility for membership and the Constitution

- 2.2 The Trust membership is to be drawn from the communities served by the hospitals and their catchment areas and should reflect as closely as possible the demographic make-up of those communities. The membership should reflect the different age, socio-economic, gender and ethnicity percentages in the communities served.
- 2.3 There are two elected membership groups for RBCH:
- public membership, representing patients, carers and members of the public living in the catchment area; and
 - staff membership, representing employees of the Trust.
- 2.4 Provisions on eligibility to become or remain a member are set out in the Trust's constitution. Any person aged 12 years or over may become a member and membership is open to the constituency areas covering Bournemouth and Poole, New Forest and Rest of England and Christchurch and Dorset County.
- 2.5 There are five classes of staff membership: Medical and Dental, Nursing, Midwifery and Healthcare Assistants, Estates and Ancillary Services, Allied Health Professions, Scientific and Technical and Administrative, Clerical and Management. Provisions on the eligibility for membership of the staff constituency are set out in the Trust's constitution.

3.0 BECOMING A MEMBER

How to apply to become a member

- 3.1 Interested individuals can join the Trust as a member by filling in the membership application form available on the Trust's website or by obtaining a printed membership application form from Governors or the Governor and Membership Manager.
- 3.2 Becoming a member is easy, free of charge and members can get involved as little or as much as they want, in accordance with the Trust's governance and constitutional arrangements.
- 3.3 All new staff who are on permanent contracts or temporary contracts of a duration of twelve months or more will automatically become members of the Trust unless they choose to opt out. The benefits of being a member are explained to staff on induction.

- 3.4 Details of the composition of the membership at the time of the publication of this Membership Engagement Strategy are included in Appendix A of this document.

Benefits of being a member

- 3.5 Joining the Trust gives members a voice so that they can help shape the future of the Trust. Members, where they have indicated that they wish to take part, will:
- be sent a regular newsletter giving information about the Trust;
 - be sent regular email updates on key issues;
 - receive invitations to events;
 - receive invitations to an Annual Members' Meeting;
 - be asked for their views on future developments at the hospitals;
 - be able to vote in elections if 16 years old or over;
 - if eligible, have the opportunity to stand for election to the Council of Governors; and
 - find out more about how to get involved in fundraising or voluntary work.
- 3.6 Members will be supporting their local hospitals and will have access to their local governors.

4.0 BUILDING AND MAINTAINING THE MEMBERSHIP BASE

Building the membership base

- 4.1 The Council of Governors is responsible for the implementation of this Membership Engagement Strategy which is approved and endorsed by both the Council of Governors and the Board of Directors of the Trust. The Board of Directors ensures that the necessary support and resources are available for the Membership Engagement Strategy to be successful and to work alongside the Trust's other aims and objectives and strategies to engage with patients and the public.

Resources

- 4.2 Resources are necessary for the membership recruitment activities to continue and to maintain communications with the Trust's current membership. The Trust has provided a Governor and Membership Manager to act as principal contact for members and governors. The Governor and Membership Manager, alongside the Trust Secretary and the Head of Communications, will also support the activity of the Council of Governors, promote communication with members and work to engage with and develop the membership community.
- 4.3 Resourcing will cover:
- the staffing of the membership function;
 - non-pay costs associated with membership governance such as elections and maintenance of the membership database;
 - provision of newsletters and other communications to members;
 - provision of clinical and medical staff to speak at the Council of Governors' constituency health talks; and
 - support for members' engagement meetings and events.

Maintaining the membership register

- 4.4 This Membership Engagement Strategy focuses the Trust's proactive approach to membership recruitment. The Trust seeks to ensure that the communities it serves are aware of the opportunity to become a member of the foundation trust and what this means for them.
- 4.5 Details of planned events for members are available on request and will be made available on the Trust's website and advertised in member publications.
- 4.6 The Trust will:
- strive for a membership that reflects the diverse communities it serves;
 - provide a simple and accessible process for becoming a member;
 - encourage staff not to opt out and to empower them to take an active role in helping to build the membership base;
 - recognise and use members as a valuable resource who can assist in improving services;
 - maintain an accurate and informative membership database to meet regulatory requirements and to be a tool for developing the membership;
 - identify initiatives for raising the profile of membership with members from all constituencies to encourage them to become active members;
 - consult with patients, the public and other stakeholders so their views and ideas can inform the process of recruitment and retention of members;
 - produce explanatory materials informing the members and public about the Trust, its vision and performance;
 - advertise membership across all sectors of the community;
 - seek out best practice from other member-based organisations and adopt if appropriate; and
 - use appropriate monitoring systems to evaluate whether membership is open and representative.

Constituency boundaries

- 4.7 The constituencies were revised in 2016 and cover:
- Bournemouth and Poole;
 - Christchurch and Dorset County; and
 - New Forest and Rest of England.

Membership target for 2018/19

- 4.8 The Trust aims to attract new members and has set a target of 300 new public members over and above the current number for the financial year 2018/19.
- 4.9 The focus for staff members will be maintaining near 100% membership by focusing on reducing the numbers who opt out of membership by providing more information on membership and the work of Staff Governors at induction and more generally.
- 4.10 An action plan for membership recruitment, management and engagement during the financial year 2018/19 is provided at Appendix B.

5.0 MANAGING MEMBERSHIP INFORMATION

- 5.1 The Trust Secretary's Office is responsible for facilitating and managing the public membership recruitment, engagement and development. A database provides efficient data for the annual reporting to NHS Improvement/Monitor and helps inform the Trust on how to improve its services to members. The public membership database also ensures that the public register of the Trust is accurate and maintained in accordance with the Data Protection Act 1998 and the General Data Protection Regulation. The public membership database is regularly validated by removing the details of deceased members or updating the details of members who have moved, to ensure it is up to date.
- 5.2 The membership application form has recently been updated to reflect the requirements of the General Data Protection Regulation, which comes into effect on 25 May 2018. The membership form now sets out the legal basis for processing personal data that the Trust receives from members. This reflects the Trust's legal obligations under the National Health Service Act 2006 (as amended) to maintain a public register of members and ensure that the membership of the public constituency is representative of those eligible for such membership.
- 5.3 The public membership database allows analysis of membership by constituency, age, ethnicity, gender, disability and socio-economic grouping, which allows the Trust to monitor how representative the members are of the population in the constituencies.
- 5.4 The Human Resources Department database is used to update and maintain the staff membership database together with a register of opted out staff managed and maintained by the Governor and Membership Manager.
- 5.5 The register of members must be available for public inspection and a copy or extract must be provided on request. A reasonable charge will be made if the request for a copy or extract is not from a member. The information made available or provided will be the name of each member and the constituency to which he/she belongs. Members may also request that their information is not made available on the public register.

6.0 MEMBERSHIP COMMUNICATION

- 6.1 The Trust will support all members and their elected governors to contribute as effectively as possible to the development of the organisation and its services. Building on established good practice, clear and reliable methods of communication between the Trust and its members will be maintained.
- 6.2 A range of methods have been identified for this including:
 - Understanding Health talks in public constituencies
 - Governor stands at the Trust's Open Days, Understanding Health talks and Trust charity events
 - Public engagement events
 - Governor stands at community events
 - Governors presenting to local organisations/community groups
 - Governors attending schools careers and other events
 - Surveys of members

- Listening events both within the hospitals and at other venues open to the public
- Public meetings of the Council of Governors and the Board of Directors and the Annual Members' Meeting
- Member newsletter and regular emails to members
- Staff Governors noticeboard and postbox
- Appointed Governor for Volunteers postbox
- Governor awareness events (prior to elections)
- Governor email addresses

All of the above methods will be continued in 2018/19.

- 6.3 More than one governor represents a constituency; therefore governors are encouraged to work together to hold meetings within the constituency, whether they are educational on a service provided by the Trust or to receive feedback and views on Trust service development or the Trust's services more generally. These are important for gathering members' views which can be used to develop the Trust's future strategies and plans for service delivery. They also serve to support governors in their role and help build relationships between governors and their constituency members.
- 6.4 The Trust will arrange and keep members informed of:
- events and meetings;
 - meetings between members and their elected governors;
 - membership opportunities and contacts for queries or further information; and
 - election processes and the outcome of elections.
- 6.5 The Trust will keep members informed of:
- the services and organisation of the Trust; and
 - Trust activities, plans and the processes used in developing those plans, and key performance indicators.
- 6.6 The Trust will seek members' feedback and engagement by:
- encouraging members to vote in governor elections;
 - consultation on future strategies and plans for the Trust;
 - communication opportunities for members to share views amongst themselves, with their elected governors and with the Trust;
 - face-to-face and electronic surveys; and
 - involvement in appropriate consultative and advisory groups, including user groups and focus groups.
- 6.7 In addition to the usual activities listed above, governors are required to have an understanding of the issues, and engage with members and the public to gain their views to include in relation to the proposed merger of the Trust and Poole Hospital NHS Foundation Trust, the implementation of the Dorset Clinical Commissioning Group's Clinical Services Review and revisions to the Sustainability and Transformation Plan for Dorset, including as part of Dorset's evolution to an integrated care system. Members and other stakeholders will be keen to understand the implications for the Trust as their local hospital.
- 6.8 Comments made by members demonstrate that the FT Focus newsletter is valued as an important source of information on developments at the Trust and forthcoming

events. Governors are encouraged to contribute to this publication through articles and suggesting topics or areas that may be of interest to members. However, as well as the FT Focus newsletter sent to all members, the Engagement Committee will email members who have provided email addresses with more current news and also promote the use of the Trust's website to keep up to date on news about the Trust.

- 6.9 Events will be promoted in FT Focus and emails to members and also through the use of posters and flyers in relevant locations in the public constituencies identified by governors and within the hospitals (including the LCD screens), press releases to local media, including community publications, and stakeholder groups, Facebook, Twitter and through notifying local media of events using the facilities provided on their websites. Governors can also provide details of community publications and groups who can be included on the circulation list maintained by the Communications team. In 2018/19 the Trust would like to continue to make progress with regard to ongoing consultation with our members through workshops or user and focus groups and to use information sheets, frequently asked questions and information videos available on the Trust's website to address common issues which are raised by members. The Engagement Committee is currently considering other ways to promote events.
- 6.10 This helps identify the members who wish to have a more active role in the Trust. The Trust is particularly seeking to get email addresses for more members as this makes communication cheaper and easier and will enable opportunities to be offered to more members on a timely basis.
- 6.11 It is the Council of Governors' responsibility to engage with the membership on behalf of the Trust. That includes expanding the membership, communicating with it, ensuring that it is representative and that its voice is heard. Methods by which the Governors and the Trust intend to communicate, recruit and engage with members are set out in Appendix B.

7.0 DEVELOPING MEMBERSHIP BENEFITS

- 7.1 An important aspect of governor work is the development of a benefits package that will make membership more meaningful. Governors are ideally suited to assisting the Trust in its patient feedback and quality assurance effort.
- 7.2 Governors will seek to be involved in focus and user groups looking at patients' and relatives' experiences and patient engagement across the hospital on a periodic basis. This method will also be used to help drive recruitment as well as engagement.
- 7.3 The work of the governors with members and direct feedback will mean that members have direct input into the day-to-day operation of the Trust.
- 7.4 Governors will take responsibility to feed back to the Board a summary of the key issues raised and will communicate the resolution of any issues to the membership.

8.0 PLAYING A KEY COMMUNITY ROLE

- 8.1 NHS organisations are established to serve the needs of their local population. Being an NHS foundation trust highlights the importance of accountability to local communities and of working in partnership with members and colleagues in other organisations to strengthen the community focus and engagement that the Trust

seeks to achieve. Benefits from the activities of the Trust in the local community are already significant. The Trust employs around 4,000 people. Professional and vocational training contributes to the development of skills in the local workforce.

- 8.2 Through the Trust membership and partnerships with local government, Bournemouth University, voluntary organisations and focus, service user, carer and staff groups the Trust will develop its civic partnership role as an active and accessible participant in the life of the community. The Trust seeks to make positive contributions to local initiatives and partnership working that offer greater social inclusion for service users and improve awareness of and access to its services.
- 8.3 The Trust's aim is to develop a strong sense of shared purpose with other like-minded organisations and will work with other NHS foundation trusts to raise the profile of community activity. The Trust will seek to share best practice with partner organisations on membership, co-operation and community relations.

9.0 WORKING WITH OTHER MEMBERSHIP ORGANISATIONS

- 9.1 The Trust is a member of NHS Providers, an organisation offering training and best practice information to help develop governors and the membership function. This includes a governor advisory committee (**GAC**) consisting of eight elected governors and two foundation trust chairs appointed by the board of NHS Providers. The primary role of the GAC is to guide the governor support work programme of NHS Providers. Governors regularly attend training days run by this organisation and will be encouraged to provide reports to the Council of Governors and disseminate information from the training and other events to fellow governors.
- 9.2 In addition, governors are encouraged to network with the governors at local foundation trusts and healthcare providers. Such networking events enable ideas to be exchanged and could lead to the pooling of resources for events of mutual interest.

10.0 EVALUATING SUCCESS

- 10.1 The Council of Governors has a key role in monitoring the effectiveness of this Membership Engagement Strategy and ensuring that it remains a meaningful and relevant document as the membership of the Trust grows and the organisation matures.
- 10.2 The Engagement Committee of the Council of Governors will meet as necessary and not less than six times each year to review progress against this Membership Engagement Strategy. This ensures that governors are fully involved in membership development and engagement given their responsibility for the delivery of this Membership Engagement Strategy. A report will be provided to all members in the Annual Report of the Trust and future plans will be set out in the Trust's Annual Plan.
- 10.3 The success criterion will be that members will become more engaged with activities and consultations in the Trust. This will be supplemented by other measures such as a closer alignment of the membership base with the demographics of the catchment areas (as benchmarked using the Trust's public membership database) and the number of active members, i.e. those attending events organised by the Trust, individual governors and the Council of Governors.

10.4 Using the public membership database, the effectiveness of recruitment processes will be monitored and the profile of the membership recruited will be compared to the demographic characteristics of the local population at regular intervals through the Engagement Committee of the Council of Governors. Consideration will be given to any gaps in the membership profile and what targeted recruitment activities should be introduced to address them. In executing this strategy the Engagement Committee will ensure close liaison and cooperation with the Board of Directors.

11.0 MEMBERSHIP RECRUITMENT – EQUALITY AND DIVERSITY

11.1 All activities connected with membership recruitment will comply with the Trust's Equality, Diversity and Inclusion Policy.

12.0 APPROVAL, REVIEW AND REVISION

12.1 The Membership Engagement Strategy will be approved by the Board of Directors and the Council of Governors.

12.2 The Membership Engagement Strategy will be reviewed annually or earlier if recommended by the Engagement Committee of the Council of Governors.

12.3 Version control will be managed by the Trust Secretary's Office.

APPENDIX A

MEMBERSHIP

i. Eligibility Criteria

Membership is open to individuals who:

- are over 12 years of age
- complete a membership application form

Full details are given in the Trust's constitution.

ii. Constituencies and Statistics

As at 31 March 2018 there are 10,151 public members in the following constituencies:

• Bournemouth and Poole	7357
• Christchurch and Dorset County	1999
• New Forest and Rest of England	795

iii. Council of Governors

Members of the Council of Governors as at 31 March 2018 are set out below.

Public Governors	Staff Governors	Appointed Governors
18*	5	6

*There was vacancy for a Public Governor in the Christchurch and Dorset County constituency as at 31 March 2018.

APPENDIX B

ACTION PLAN

It is the Council of Governors' responsibility to engage with the membership on behalf of the Trust in furtherance of its duty to represent the interests of members and the wider public. That includes expanding the membership, communicating with it, ensuring that it is representative and its voice is heard. This Membership Engagement Strategy has outlined how the Trust and the governors intend to do this with a series of tasks and actions needed to fulfil those objectives:

OBJECTIVE	TASK	TIMING	LEAD OF PROCESS
1. Membership Engagement: Engage with members and within the constituencies	1.1 Establish an annual programme for meetings/events in constituencies and the communications strategy for these. These should include one public engagement event, one listening event and one health talk in each constituency	April 2018	Constituency Governor Representative and constituency event leads
	1.2 Review target for new members 2018/19	April 2018	EC > CoG
	1.3 Work with the Governor and Membership Manager and the Communications Department to ensure Governors' pages on the website are up to date, informative and include events over the next 12 months	Ongoing	All Governors and Trust Secretary's Office and Communications Department
	1.4 Include a section in Trust's Annual Plan on Governors' future plans for membership engagement	March 2018	Trust Secretary's Office > Governor Strategy Committee > Director of Service Development
	1.5 Include section in Annual Report on	March 2018	Trust Secretary's Office > Governor

	Governor membership activities during 2018/19 and message from the Lead Governor		Strategy Committee > Head of Communications
	1.6 Continue to develop strategies to reach identified hard to reach groups, including those groups of the local population which are currently underrepresented geographically or demographically, i.e. working age adults and younger members	Ongoing	EC with all Governors support
	1.7 Send regular email update to members and identify ways of obtaining email addresses for more members	Monthly	Chair of EC/Lead Governor > Trust Secretary's Office

Glossary:

CoG Council of Governors

EC Engagement Committee



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

BOARD OF DIRECTORS	
Meeting date:	30 May 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Audit Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Alex Jablonowski, Non-Executive Director and Audit Committee Chair
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Audit Committee, April 2018
Action required:	Decision
<p>Summary:</p> <p>The Audit Committee is required to review its terms of reference on an annual basis and recommend any changes to the Board of Directors.</p> <p>The Board of Directors is requested to approve the amendments to the Audit Committee's terms of reference highlighted in the attached document. These changes are proposed to update the terms of reference to reflect minor changes to the role and operation of the Committee and to clarify some existing governance requirements.</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:	34T

AUDIT COMMITTEE

Terms of Reference

The Audit Committee (the **Committee**) is a committee established by and responsible to the Board of Directors. The primary aim of the Committee is to monitor and review financial and other risks and associated controls, corporate governance and financial assurance.

1. Membership

1.1. The Committee shall be appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members, at least one of whom shall have recent and relevant financial experience. One member shall be the Chair of the Healthcare Assurance Committee. The Chairman of the Trust shall not be a member of the Committee.

1.2. In addition, the following will attend the Committee to provide advice as required:

1.2.1. the Director of Finance

1.2.2. a representative of the Internal Auditors

1.2.3. a representative of the External Auditors

1.2.4. a representative from the Counter Fraud service

~~1.2.4.1.2.5.~~ the Freedom to Speak Up Guardian

~~1.2.5.1.2.6.~~ the Clinical Director for Clinical Audit

1.2.7. the Director of Nursing and Midwifery (also Deputy Chief Executive)

~~1.2.6.1.2.8.~~ the Medical Director

~~1.2.7.~~ the Chief Operating Officer

~~1.2.8.1.2.9.~~ any other director, as required.

1.3. Only members of the Committee have the right to attend Committee meetings. Any other directors may attend following notification to the Chairman. The chief executive should be invited to attend, at least annually, to discuss with the ~~audit~~-eCommittee the process for assurance that supports the annual governance statement. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.

1.4. There will be one governor attending each meeting as an observer. Observers are not members of the Committee. This governor has been elected to undertake this

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 V5	January 2017 May 2018	January May 2018 2019	Trust Secretary

role by the Council of Governors by means of a ballot organised by the Trust Secretary in accordance with the process agreed by the Council of Governors.

1.4.1.5. Appointments to the Committee shall be for a period of three years, which may be extended for a further three year period.

1.5.1.6. The Board of Directors shall appoint the Committee Chairman (the **Chairman**) who shall be a Non-Executive Director and member of the Committee. In the absence of the Chairman and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.6.1.7. The Committee shall provide an opportunity to meet with the External and Internal Auditors or the representative from the Counter Fraud Service without any Executive Director present.

2. Secretary

2.1 The Trust Secretary (the **Secretary**) or their nominee shall act as the secretary of the Committee.

3. Quorum

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

4. Frequency of Meetings

4.1 The Committee shall meet at least quarterly and otherwise as required.

5. Notice of Meetings

5.1 Meetings of the Committee shall be called by the Secretary at the request of any of the Committee members or at the request of External or Internal Auditors if they consider it necessary.

5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Trust Secretary or their nominee.

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting. Where possible, supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of Meetings

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 V5	January 2017 May 2018	January May 2018 2019	Trust Secretary

- 6.1 The Secretary shall minute the proceedings and resolutions of all Committee meetings, including recording the names of those present and in attendance.
- 6.2 The Secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.
- 6.3 Minutes of Committee meetings shall be agreed by the Committee Chairman prior to being circulated to all members of the Committee unless a conflict of interest exists. The Secretary shall aim to prepare the minutes within one week of the meeting date.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 <u>V5</u>	January 2017 <u>May 2018</u>	January <u>May 2018</u> <u>2019</u>	Trust Secretary

7. Duties

The duties of the Committee are set out below.

7.1 Internal Control, Risk Management and Corporate Governance.

7.1.1 The Committee shall review the implementation and ongoing effectiveness of the system of internal control, risk management and corporate governance, with particular reference to the organisation's assurance framework.

7.1.2 In particular, the Committee will review:

7.1.2.1 The adequacy of all risk and control related disclosure statements, together with any accompanying reports from Internal or External Auditors or other appropriate independent assurance, before making recommendations to the Board of Directors. In reviewing the annual governance statement, the Healthcare Assurance Committee will need to provide assurance on their activities during the year through its Chair.

7.1.2.2 The effectiveness of the foundation trust's internal controls, board assurance framework and risk management systems, including reviewing the board assurance framework for completeness in the context of risks highlighted by external audit, internal audit and counter fraud.

7.1.2.3 The operational effectiveness of relevant policies and procedures including but not limited to:

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as recommended by the appointed Counter Fraud service;
- The policies and procedures in place for ensuring economy, efficiency and effectiveness in the use of resources.

7.1.2.4 The Clinical Audit Programme Plan to ensure that it is robust, reflecting both national and local priorities, comprehensive and embedded across all clinical teams (management arrangements, planning, reporting, communication and learning) with the outcomes used to drive improvement and enhance the overall quality of clinical care.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 <u>V5</u>	January 2017 <u>May 2018</u>	January-May 2018 <u>2019</u>	Trust Secretary

7.2 Internal Audit

The Committee will:

- 7.2.1 Appoint the Internal Auditors, set the audit fee and resolve any questions of resignation and dismissal.
- 7.2.2 Ensure that the Internal Audit function is adequately resourced, has appropriate access to information to perform its function effectively and is free from f management or other restrictions.
- 7.2.3 Review the internal audit programme, consider major findings of internal audit investigations (and management's response), and ensure co-ordination between the Internal and External Auditors.
- 7.2.4 Report non-compliance with, or inadequate response to, Internal Audit Reports to the Board of Directors.
- 7.2.5 Meet with the Internal Auditors at least once a year, without executive management being present.
- 7.2.6 Conduct an annual review of the internal audit function.

7.3 External Audit

The Committee will:

- 7.3.1 Oversee a market testing exercise and consider the appointment of the External Auditor, the audit fee and any questions of resignation and dismissal based on criteria agreed with the Council of Governors. Make a recommendation to the Council of Governors on appointing the External Auditor for a three year period.
- 7.3.2 Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with Internal Audit and the representative from the Counter Fraud service.
- 7.3.3 Assess the External Auditor's work and fees each year and make a recommendation to the Council of Governors with regard to the continuation of the appointment for the remaining period. This assessment should consider a review of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.
- 7.3.4 Review External Audit reports, including the annual audit letter, together with the management response, and monitor progress on implementation of recommendations.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 V5	January 2017 May 2018	January-May 2018 2019	Trust Secretary

- 7.3.5 Report non-compliance with, or inadequate response to External Audit Reports to the Board of Directors.
- 7.3.6 Consider any reports on the provision of non-audit services made to the Committee by the Director of Finance.
- 7.3.7 Meet with the External Auditors at least once a year, without executive management being present.

7.4 Counter Fraud Service

The Committee will

- 7.4.1 Appoint the Counter Fraud service, set the fee and resolve any questions of resignation and dismissal.
- 7.4.2 Ensure that the Counter Fraud function has appropriate standing within the organisation.
- 7.4.3 Review the Counter Fraud programme, consider major findings of investigations (and management's response), and ensure co-ordination between the Internal Auditors and Counter Fraud.
- 7.4.4 Report non-compliance with, or inadequate response to, Counter Fraud reports to the Board of Directors.

7.5 Financial Reporting

The Committee will review the annual report, annual governance statement and annual financial statements before submission to the Board to determine completeness, objectivity, integrity and accuracy. The Committee will focus particularly on:

- 7.5.1 Changes in, and compliance with, accounting policies and practices.
- 7.5.2 Major judgemental areas and explanation of estimates or provisions having material effect.
- 7.5.3 Significant adjustments resulting from the audit and any reservations and disagreements between the External Auditor and management that have not been satisfactorily resolved.
- 7.5.4 The clarity and completeness of disclosure in the foundation trust's financial reports and the context in which statements are made.
- 7.5.5 All material information presented with the financial statements, such as the ~~Annual annual Governance governance Statement statement~~ and forward plan relating to the audit and risk management.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 <u>V5</u>	January 2017 <u>May 2018</u>	January-May 2018 <u>2019</u>	Trust Secretary

7.5.6 The impact of the Trust's Cost Improvement Programme on clinical risk, as assessed through the Quality Impact Assessment process.

7.6 Whistleblowing

7.6.1 The Committee is responsible for approving the Freedom to speak up: raising concerns (whistleblowing) policy.

~~7.6.1~~ The Committee will review arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 <u>V5</u>	January 2017 <u>May 2018</u>	January-May 2018 <u>2019</u>	Trust Secretary

7.6.2

8. Reporting Responsibilities

- 8.1 The minutes of the Committee shall be submitted to the Board of Directors after each meeting.
- 8.2 The Committee shall make whatever recommendation to the Board of Directors 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 included in the Trust's annual report.
- 8.4 The Committee shall compile a report on its activities to be submitted to the Board of Directors annually within three months of the end of the financial year.

9. Other

- 9.1 The Committee shall:
- 9.1.1 have access to sufficient resources in order to carry out its duties, including access to the Trust Secretary's Office for assistance as required;
 - 9.1.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
 - 9.1.3 give due consideration to laws and regulations and the provisions of the NHS Foundation Trust Code of Governance;
 - 9.1.4 be responsible for co-ordination of the Internal and External Auditors and Counter Fraud through the Director of Finance;
 - 9.1.5 oversee any investigation of activities which are within its terms of reference;
 - 9.1.6 at least once a year review its own performance and terms of reference to ensure it is operating at maximum effectiveness, including consultation with the Council of Governors, 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;

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 <u>V5</u>	January 2017 <u>May 2018</u>	January-May 2018 <u>2019</u>	Trust Secretary

10.1.3 to call any employee to be questioned at a meeting of the Committee as and when required.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4 <u>V5</u>	January 2017 <u>May 2018</u>	January 2018 <u>May 2019</u>	Trust Secretary

BOARD OF DIRECTORS MEETING – 30 May 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
11.00	1. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 28 March 2018	Decision	<i>All</i>
11.05	2. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Discussion	<i>All</i>
11.10	3. STRATEGY AND RISK		
	a) Clinical Negligence Scheme for Trusts Maternity Services Self-Certification (paper)	Decision	<i>Mangla Dubey/ Carmen Cross</i>
	b) Confidentiality and Information Barrier Agreement (paper)	Decision	<i>Karen Flaherty</i>
	c) Significant Risk Report (paper)	Discussion	<i>Fiona Hoskins</i>
	d) Future Arrangements for the Leadership and Delivery of Organisational Development (paper)	Decision	<i>Tony Spotswood</i>
12.15	4. QUALITY		
	a) Dermatology Update (paper)	Discussion	<i>Ian Pearson/ Abigail Daughters/ Tracey Hall</i>
	b) Care Quality Commission Inspection (paper)	Information	<i>Tony Spotswood/ Fiona Hoskins</i>
12.35	5. GOVERNANCE		
	a) Local Clinical Excellence Awards Criteria Review (verbal)	Decision	<i>Alyson O'Donnell</i>
	b) National Reference Cost Index (paper)	Decision	<i>Pete Papworth</i>
	c) Recommendation Report: PCI Consumables (paper)	Decision	<i>Pete Papworth</i>
	d) Annual Report from the Finance and Performance Committee (paper)	Information	<i>John Lelliott</i>
	e) Non-Executive Director Composition (verbal)	Discussion	<i>David Moss</i>
12.40	6. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff	Discussion	<i>All</i>
	b) Reflective Review	Discussion	<i>All</i>
	– What has gone well?		
	– What do we need more of?		
	– What do we need less of?		

The meeting will be followed by a meeting of the Nomination and Remuneration Committee between **1-1.30pm** and a Blue Skies session on current plans and future developments in the Cardiology Directorate followed by a tour of the area between **1.30-2.30pm**

Our Charter

As a Board team we will:

- Empower and care for our staff so they can provide compassionate high quality care for our patients
- Trust our staff; encourage & support their innovation and celebrate successes
- Be transparent and consistent in our decision-making and mindful of our impact
- Role model the Trust values
- Be approachable, inquisitive and listen in order to understand and take action
- Provide an inspiring vision and a clear direction for our Trust
- Reflect on the way we work and learn from our mistakes



Communicate - Say it, hear it, do it! Improve - Change it! Teamwork - Share it! Pride - Show it!