

A meeting of the Board of Directors will be held on Wednesday 26 September 2018 at 8.30am in the **Vision Suite, The Village Hotel, Deansleigh Road, Bournemouth BH7 7DZ**

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		
	John Lelliott		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 25 July 2018 (paper)	Decision	All
8.40-8.45	3. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Information	All
8.45-9.35	4. QUALITY		
	a) Patient Story (verbal)	Information	Paula Shobbrook
	b) Medical Director's Report (paper) including:	Information	Alyson O'Donnell
	i. Quarterly Report on Safe Working Hours for Doctors in Training		
	ii. Annual Report from the Director of Medical Education		
	c) Infection Prevention and Control Annual Report Summary and Statement of Commitment (paper)	Decision	Paula Shobbrook
	d) Safe Staffing Annual Report (paper)	Information	Paula Shobbrook
	e) Winter Plan Update (paper)	Discussion	Richard Renaut
	f) Feedback from Valuing You Week (presentation)	Information	Deb Matthews
9.35-10.00	5. STRATEGY AND RISK		
	a) Implementing the Clinical Services Review (paper)	Information	Tony Spotswood
	b) Progress Update on 2018/19 Corporate Objectives (paper)	Information	Tony Spotswood
	c) Communications Strategy Update (presentation)	Information	Jamie Donald
10.00-10.40	6. PERFORMANCE		
	a) Trust Board Dashboard (paper)	Information	Richard Renaut
	b) Performance Report (paper)	Information	Richard Renaut
	c) Quality Report (paper)	Information	Paula Shobbrook

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

10.40-10.45

7. GOVERNANCE

- | | | | |
|----|---|-------------|---------------------------|
| a) | Clinical Audit Plan 2018/19 (paper) | Information | <i>Alyson O'Donnell</i> |
| b) | Workforce Strategy and Development Committee Terms of Reference (paper) | Decision | <i>Karen Allman</i> |
| c) | Healthcare Assurance Committee Terms of Reference (paper) | Decision | <i>Paula Shobbrook</i> |
| d) | Charitable Funds Committee Terms of Reference (paper) | Decision | <i>Pete Papworth</i> |
| e) | Freedom to Speak Up Update (paper/presentation) | Information | <i>Helen Martin</i> |
| f) | Non-Executive Director Appointments to Board Committees (paper) | Decision | <i>David Moss</i> |
| g) | Meeting Dates for 2019/20 (paper) | Information | <i>Anneliese Harrison</i> |

8. NEXT MEETING

Wednesday 28 November 2018 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.45-11.00

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.

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 25 July 2018** in the Macmillan Seminar Room, Christchurch 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>
	Cliff Shearman	(CS)	<i>Non-Executive Director</i>
In attendance:	Karen Bowers	(KB)	<i>Matron, Older People's Medicine (for item 4(b))</i>
	Lauren Daughtrey	(LD)	<i>Dementia Nurse Specialist (for item 4(b))</i>
	Pankaj Davé	(PD)	<i>Non-Executive Director designate</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Kate Horsefield	(KH)	<i>Head of Nursing & Quality, Surgical Care Group (for item 4(a))</i>
	Fiona Hoskins	(FH)	<i>Deputy Director of Nursing and Midwifery</i>
	Rebecca Jones	(RJ)	<i>Communications Officer</i>
	Dily Ruffer	(DR)	<i>Governor and Membership Manager</i>
	Jonathan Rust	(JR)	<i>Specialty Registrar, Obstetrics and Gynaecology</i>
	David Sell	(DS)	<i>Specialty Doctor, Older Persons' Medicine (for item 4(a))</i>
	Sean Weaver	(SW)	<i>Associate Medical Director (for item 4(a))</i>
Public/ Governors:	Marjorie Houghton		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Tom Murphy		<i>Member of Public (for item 4(b))</i>
	Mavis Murphy		<i>Member of Public (for item 4(b))</i>
	Roger Parsons		<i>Appointed Governor</i>
	Maureen Todd		<i>Staff Governor</i>
	David Triplow		<i>Public Governor</i>
	Sandy Wilson		<i>Public Governor</i>
	John Wilson		<i>Member of the Public</i>
	Josh Wright		<i>Member of the Public/Bournemouth Daily Echo</i>
Apologies:	Deb Matthews		<i>Director of Quality Improvement and Organisational Development</i>
	Paula Shobbrook		<i>Director of Nursing and Midwifery</i>

34/18 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Action

Pankaj Davé was welcomed as Non-Executive Director designate who would be commencing in post by 1 September 2018.

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

35/18 **MINUTES OF PREVIOUS MEETING**

(a) Minutes of the meeting held on 30 May 2018 (Item 2(a))

The minutes of the meeting held on 30 May 2018 were **approved** as an accurate record of the meeting.

36/18 **MATTERS ARISING**

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

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

37/18 **QUALITY**

(a) Feedback from Schwartz Rounds (Item 4(a))

Sean Weaver, Kate Horsefield and David Sell joined the meeting to give an overview of Schwartz rounds and their impact, having been adopted by the Trust two years ago. Schwartz rounds involved both clinical and non-clinical staff discussing the emotional and social aspects of delivering healthcare. Over 350 members of staff had taken part in the Schwartz rounds and feedback demonstrated how these were valued by staff and provided a safe space to talk about difficult subjects and share experiences. There had been a real willingness to be involved despite the challenging topics addressed and, for many; the experience enhanced their ability to care for patients by engaging with patients and their families in a different way.

Peter Gill provided his experience as a panellist at a Schwartz round speaking from a non-clinical perspective and Non-Executive Directors who had attended these sessions emphasised that Schwartz rounds added a different dimension to subjects that may be raised at Board and other meetings.

The Board confirmed its continued support for Schwartz rounds and their sense that the process helped bring staff at the Trust together and created greater resilience among staff. Board members recognised that the style of Schwartz rounds would not appeal to everyone but encouraged all staff who wanted to attend to do so.

(b) Patient Story (Item 4(b))

This item was presented after item 4(d). Lauren Daughtrey introduced Tom and Mavis Murphy who had been invited to attend the meeting for Tom to give his perspective as Mavis's carer, following her recent admission to

hospital after a fall at home.

Tom had nothing for praise for the staff, including ambulance staff and staff in the Emergency Department (**ED**), and their ability to manage with patients who were sometimes aggressive and to take the time to explain what was happening despite interruptions. However, he reflected on the importance of creating a quiet environment for Mavis, who was living with dementia, to avoid distress and a better understanding of the needs of carers. He relayed a story about the loss of Mavis's handbag containing a number of sentimental items while in hospital and how it was located and safely returned to her after she had returned home.

Lauren explained how the Trust's Older Persons' Assessment and Liaison (OPAL) team had supported Tom by arranging for carers to assist Mavis with each morning following her discharge from hospital. The Trust also ran a six week carers information programme designed for people caring for those living with dementia, which Tom had attended.

Board members thanked Tom and Mavis for attending the meeting and providing such honest feedback about their experiences at the Trust.

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

David Triplow, the Lead Governor, updated the Board on the recent engagement and other activities that governors had been involved in, which included:

- a stand at the Mudeford Arts Festival over a weekend to recruit members and engage with the public;
- a listening event held at Christchurch Hospital that specifically sought feedback from patients about signage;
- the development of the Governors' Charter, which reflected how they worked as a team to represent the views of members and members of the public while supporting the Trust; and
- setting up joint working groups with Poole Hospital NHS Foundation Trust to prepare the Council of Governors for their role in the merger approval process.

Governors had been pleased to see the positive report from the Care Quality Commission (**CQC**) in June, which rated Trust services as 'good' overall and 'outstanding' for well led and had recognised the positive relationship between the Board and the Council of Governors.

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

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

The report was **noted** for information and the following areas were highlighted:

- the overall Hospital Standardised Mortality Ratio (HSMR) for 2017/18 was 92.2 placing the Trust in the 'as expected' range and the Royal Bournemouth Hospital in the 'better than expected' range at 91.2;
- the number of deaths within 36 hours of admission had returned to

normal levels following an increase in December, which was due to respiratory illness associated with flu and the high acuity associated with these patients, with the Mortality Surveillance Group having reviewing a random sample of cases within this group of patients;

- there were three deaths reported in individuals with learning difficulties in May which were forwarded national Learning Disabilities Mortality Review (LeDeR) programme for review as well as being reviewed internally; and
- the development of the medical examiner role at the Trust was being progressed and would be launched in September.

Board members questioned the downward trend in co-morbidity coding and were updated on the additional support being provided and the resubmission of data following review and revalidation. The importance of the work of the Mortality Steering Group in getting behind the data and identifying any learning or where the Trust could do things differently was emphasised.

(e) CQC National Inpatient Survey 2017 (Item 4(e))

There had been minimal change in the Trust's performance in 2017 compared to 2016 with the Trust ranked as average across all themes. There had been a small improvement in the theme of 'leaving hospital' and only two themes showing a small decline, 'noise at night' and 'knowing which nurse is in charge of patients' care'. The Trust also scored lower on patients 'offered a choice of food'. The work to address some of the feedback was highlighted including the Healthy Sleep campaign the following week, better understanding the reasons for the feedback on the choice of food as this did not align with the results from the PLACE (Patient-Led Assessment of the Care Environment) and the possible impact of bay-based nursing on the patients being able to identify the nurse in charge given the Trust's previous improvement in this area.

CH as Chair of the Healthcare Assurance Committee (**HAC**) reiterated the importance of addressing recurrent themes such as noise at night which was consistently highlighted through the Trust's own Care Campaign Audit. Board members were not satisfied with this position and encouraged visits to other trusts who were performing better to see what they were doing in order address the recurrent themes.

38/18 STRATEGY AND RISK

(a) Clinical Services Review and Merger (Item 5(a))

The paper providing an update on the development of clinical networks across Dorset was noted for information. An update was provided on progress to implement the Clinical Services Review (**CSR**) including:

- the anticipated publication of the judgment following the judicial review hearing of NHS Dorset Clinical Commissioning Group's (**Dorset CCG**) consultation on the CSR in September;
- the progress on the patient benefits case to be submitted to NHS Improvement (**NHSI**) to provide its feedback ahead of submission to the Competition and Markets Authority (**CMA**);
- the commencement of the physical design work across the two sites which was expected to draw more staff into the process;

- confirmation from the CMA that they will require the outline business case (**OBC**) for capital to be approved by NHSI, and possibly the Department of Health and Social Care and HM Treasury in order to review the merger to provide assurance around the delivery of the patient benefits that were dependent on the receipt of the capital;
- the likelihood that the CMA merger review process may incorporate both phases, which, when combined with the OBC approval process, could potentially delay the merger until April 2021;
- informal discussions with the CMA about the potential for a fast track review in advance of the approval of the OBC by NHSI, to bring forward the timeline for merger to April 2020; and
- discussions with NHSI about a proposal to appoint a single chairperson and chief executive across both trusts ahead of the merger in light of the potential delays to help advance the joint work around the reconfiguration of services and business case for capital.

The Board **highlighted** the need to consider the impact of the work on the reconfiguration of services in east Dorset on the clinical networks across Dorset.

(b) Commitment to address Local Challenges in Dorset Sustainability and Transformation Plan (Item 5(b))

The Board **reaffirmed** its commitment to addressing the three major challenges identified within the Dorset Sustainability and Transformation Plan (**STP**): the health and wellbeing gap, the care and quality gap and the finance and efficiency gap.

The Board considered if there were other ways in which the Trust could contribute to addressing the gaps, outside of its work on the CSR and merger, particularly the health and wellbeing gap. While the work on the reconfiguration of acute services would help to address the variation in health outcomes for patients in some areas of Dorset, there was wider work required to tackle the root causes around housing, poverty and employment. The Board welcomed the involvement of local authorities in this work as partners in the STP. The Board also discussed what else the Trust could do building on existing work around smoking cessation for pregnant women and working with primary care around issues such as coronary heart disease and cancer prevention.

(c) Improved Car Parking and Comparability of Pricing for Site Visitors (Item 5(c))

Board members were asked to consider proposed changes to improve visitor car parking and maintain comparable pricing. These changes were designed to contribute to the wider traffic congestion reduction efforts around the Trust although these would be more fully addressed in a separate travel plan.

Board members agreed that the proposed changes were reasonable and it was important that any increase in charges delivered a benefit for patients and visitors and welcomed the work to develop the wider travel plan.

The Board **approved** the recommendation set out in the paper:

- to move to comparable parking costs of nearby acute hospitals with

the two to six hour parking rates, matching Dorchester and Southampton Hospitals but remaining lower cost than Bournemouth Council;

- to make slight changes to long stay (6.30pm–7.00am) parking charges;
- to have a 20 minute free drop off time in car parks combined with an increase in drop off/pick up zones near hospital entry points;
- to install a modern car park management system using Automatic Number Plate Recognition; and
- to introduce the changes from 1 September 2018 so as to allow for improvements which incur costs to be started in this financial year and to allow as early as possible benefits for travelling to and from the Royal Bournemouth Hospital.

39/18 **PERFORMANCE**

(a) Trust Board Dashboard (Item 6(a))

The paper was **noted** for information.

(b) Performance Report (Item 6(b))

The following areas from the report were summarised:

- the Trust achieved the ED four hour performance target for June despite increased levels of ambulance conveyances, attendances and admissions;
- there was a risk to achieving both the two week and 62 day wait cancer standards in future quarters following an increase in fast track referrals as a result of recent national campaigns; and
- referral to treatment time performance remained stable and above trajectory with no patients waiting longer than 52 weeks.

The Board discussed the increase in referrals to Urology, which was above the levels experienced elsewhere in the country, and the continuation of work with GPs to identify patients who needed a fast track referral. However, given the lower cancer survival rates in England compared to the rest of Europe and the proposed introduction of a new 28 day standard for cancer diagnostic, work continued to improve efficiency and increase capacity.

(c) Quality Report (Item 6(c))

The key themes highlighted from the report were:

- three serious incidents were reported in June including one never event resulting in no harm to the patient and one isolated case of Methicillin-resistant *Staphylococcus aureus* (MRSA), the first in over five years;
- the CQC had rated Trust services as 'good' overall and 'outstanding' for well-led demonstrating the significant improvements made since the previous inspection in October 2015;
- the Trust's composite score for the CQC Insight report was among the highest 25% of acute trusts;
- national performance benchmarking data for the Friends and Family Test (FFT) remained strong, with an improvement in the response rate in ED;

- consultations with the volunteers who conducted the Care Campaign Audit survey, including governors, were taking place to structure a new approach to gathering feedback from patients through the Care Campaign Audit; and
- 31 complaints were received in June, all of which were acknowledged within three days and the top three themes were implementation of care, access and care.

(d) Finance Report (Item 6(d))

The key themes from the report were:

- the Trust was in a comparatively strong position as it continued to deliver against its agreed financial control total and the ED four hour performance standard and had secured the quarter one Provider Sustainability Fund (**PSF**) monies in full as a result;
- the forecast shortfall against the cost improvement programme (CIP) was receiving attention through targeted workshops and the Finance and Performance Committee to ensure the Trust continued to deliver against its agreed regulatory control total; and
- while spending on agency staff remained comparatively low at 2% of the pay budget, the cumulative cost of bank, agency and overtime was higher than the Trust's vacancy budget.

The Board discussed the funding of the latest pay awards for staff, not all of which had been funded nationally. The Trust was providing details of the resulting cost pressure to Dorset CCG and NHS Providers and NHSI had also requested details of the impact on the Trust. It was important for the Trust to continue to deliver its financial control total and the ED performance target in order to receive the PSF payments.

(e) Workforce Report (Item 6(e))

The key points highlighted were:

- essential core skills compliance remained consistent at 93.4%;
- sickness absence had increased slightly to 3.82% for June, however this was an improvement on the position in 2017;
- the vacancy rate had increased to 5.9% from 5.6% and the relentless focus on recruitment and retention and the development of alternative roles to support workforce resilience continued; and
- the June safe staffing return to Unify demonstrated that overall the Trust maintained a safe and stable staffing position for May 2018.

40/18 GOVERNANCE

(a) Complaints Policy Briefing (Item 7(a))

The Board noted that the changes made to the process for resolving concerns and complaints and the increase in the time to respond to the most complex complaints set out in the revised Complaints Policy approved by the HAC. The Board supported the decision to report on the grading and response times for complaints under the previous and new methods set out in the policy for the remainder of 2018 in order to provide assurance to the Board, commissioners and regulators.

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

The Board welcomed Pankaj Davé's appointment as a non-executive director by the Council of Governors earlier that month. He had been appointed on an interim basis ahead of the proposed merger with Poole Hospital NHS Foundation Trust following Tea Colaianni's resignation as a non-executive director in January 2018.

41/18 NEXT MEETING

The next meeting will take place on **Wednesday 26 September 2018** at 8.30am in the Village Hotel, Deansleigh Road, Bournemouth.

42/18 ANY OTHER BUSINESS

There was no further business.

Key Points for Communication to Staff:

1. Schwartz Rounds
2. Clinical Services Review
3. Dorset STP
4. Car parking changes and work on the wider travel plan with Bournemouth Borough Council
5. Pankaj Davé's appointment.

43/18 COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC

1. David Triplow commented on the recent training that governors had received about the initiatives underway to support public health, which they had been keen to support.
2. Governors thanked Sean Weaver for his presentation which had reinforced the importance of Schwartz rounds for staff. Keith Mitchell, who had attended Schwarz rounds as a governor, remarked on how it had been humbling for him to hear about the work that staff did and the issues that they coped with.

44/18 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.

The meeting adjourned at 10.50am

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
25.07.18		<i>There were no actions arising from the Part 1 Board of Directors meeting.</i>			
Key:	Outstanding	In Progress	Complete	Not yet required	



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Medical Director's Report
Section on agenda:	Quality
Supplementary reading:	None
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Alyson O'Donnell Dr Divya Tiwari
Details of previous discussion and/or dissemination:	Mortality indices and reviews discussed at Mortality Steering Group
Action required:	Note for information
Summary: Monthly Medical Director's Report.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	N/A

Medical Director's Report to the Board

Mortality Update

Overall, HSMR for the Trust for the last 12 months (June 2017 – May 2018) is 100.8%; this is rebased for February 2018 and is in the 'as expected' range. The figure for RBH (excluding Christchurch and the Macmillan unit) is 91.9% and is in the 'better than expected range'. Latest SHMI (Standardised Hospital Mortality Indicator April 2017-March 2018) is 0.98%, which is within the expected range. The Mortality Steering Group (**MSG**) has noted a downward trend in co-morbidity coding (Charleston Index) which is currently 89% of the national index this may have influenced adjusted mortality ratios for this year. MSG has conducted a detail analysis with Dr Foster to understand the reasons behind this downward trend. Early indications from data analysis suggest that this trend is driven by declining rates in co-morbidity coding for 'cancer' and 'dementia'. Moving 'medical oncology' services to Poole in 15/16 is likely to have contributed to decreases in proportion of patients with this condition being admitted to the oncology unit/for other emergency problems to the RBH and therefore a proportionate decline. The statistical model will readjust the changes in rates for the 'cancer' due to changes in service provision, however, decreased rates for 'Dementia' coding are multifactorial and need an action plan which is being discussed with the coding team.

Crude death rate has steadily declined from 1.97% for December 2017 to 1.02% in August 2018. Deaths within 36 hours surged in December but have declined since then. (Annex A).

Learning from Deaths

Mortality Report for Board: September 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 11/09/2018

Month	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Deaths in Month	113	107	130	134	155	136	175	168	146	152	141	121	141	128	Not yet available
eMortality Reviews Completed in Month	134	118	35	90	54	24	25	75	107	177	55	26	20	34	4
Category of Death by Month Review Completed															
Grade 0	124	108	30	79	48	20	23	63	103	173	50	23	19	32	2
Grade 1	9	9	5	8	4	4	2	10	4	4	5	3	1	2	2
Grade 2	1	1	0	3	2	0	0	2	0	1	0	0	0	0	0
Grade 3	0	0	0	0	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	0	2	0	0
Learning Disability Deaths Reviewed	0	0	1	2	0	0	0	1	0	0	0	0	0	0	0

LeDeR

There were no deaths reported in individuals with learning disability in July and August 2018. All five deaths in May and June have been forwarded to national LeDeR programme for review. Four deaths have been reviewed internally using a structured case note review process. One death occurred under stroke/ITU having been reviewed by the ITU team and discussed in the August MSG. This awaits comments from the stroke review. The National LeDeR team has requested to share the findings of this internal review for this mortality in learning disability.

As per our mortality review protocol, all deaths graded as 2 or 3 are subject to an RCA type investigation outside our normal e-mortality process. One grade 2 mortality in March went

through the internal SI panel, this was not avoidable. It was acknowledged that the pathway as a direct admission to Ward 26 may have contributed to a delay in infection triggers being identified, as the patient would have gone into Resus after review in ED and received a Consultant review. Gaps were identified in terms of documentation, communication and handover of his ceiling of care, which led to additional interventions being carried out which would be considered inappropriate for a patient on an end of life pathway. Name stamps have been issued to new doctors for clearer identification and standard operating procedures for ward 26 have been reviewed as a result of this investigation.

Action Plan from the Mortality Surveillance / Reviews

Upward trends in sepsis/ pneumonia mortality

There is a new Dr Foster alert in this diagnostic group for UTI, we are currently monitoring the trend and implementing an action plan from December 2017 sepsis alert. We will assess its impact in the August/ September upload and if the alert persists, we will be conducting a detail review of clinical care. Dr Foster analysis team attended the August Trust MSG meeting where the sepsis trends were discussed in detail. MSG agreed the following action plan:

- Pneumonia pathway walk: Emma Willet will lead alongside respiratory and ITU physicians. Pathway walk is proposed for 25th September and following this, MSG will analyse the results and conclude an action plan.
- Dr Foster alert in UTI: Clinical lead will conduct a themed retrospective mortality review for 20 random deaths focussing on clinical care, communication, end of life care and coding.

New Dr Foster Alert in Multiple Myeloma

MSG noted a new mortality alert in the diagnostic group of haematological malignancy 'multiple myeloma' for the period of March 2017-February 2018. There were 13 deaths observed where 6 were expected. This was discussed in detail with the mortality lead, Dr Helen McCarthy. Dr Rachel Hall kindly conducted a thorough retrospective case note review and discussed the findings in the Trust MSG. Most of the deaths were due to end stage Myeloma and not avoidable. The two infection associated deaths occurred in the setting of active high risk Myeloma with significantly immunosuppressed patients so were not avoidable. 1/13 case was graded as 1 and this was due to an outpatient angiogram performed electively 4 days prior to final admission. No further action is required; MSG would suggest that all co-morbidities are coded alongside myeloma to represent the actual case mix. It should be noted that RBH is a clinical trial centre for Myeloma and accepts patients from all over the region.

New Dr Foster Alert: Higher mortality for other respiratory procedures

MSG noted an alert in this category; this is a procedural alert where procedure is defined as 'invasive ventilation'. This is an association and does not implicate causation; patients were intubated and ventilated in ITU. MSG has requested a themed review to understand indication for ventilation (therapeutic/organ donation) and grading of these mortalities to understand how avoidability. Mortality governance lead, Dr Jules Cranshaw, kindly conducted this overview review. Early indicators for this association were discussed in the September MSG e.g. higher proportion of Out of Hospital cardiac arrests being diverted to

RBH due to being the cardiology centre. MSG noted an upward trend in ITU mortality in RBH by two Standard Deviations over the last year. To investigate this upward trend further MSG has requested following information:

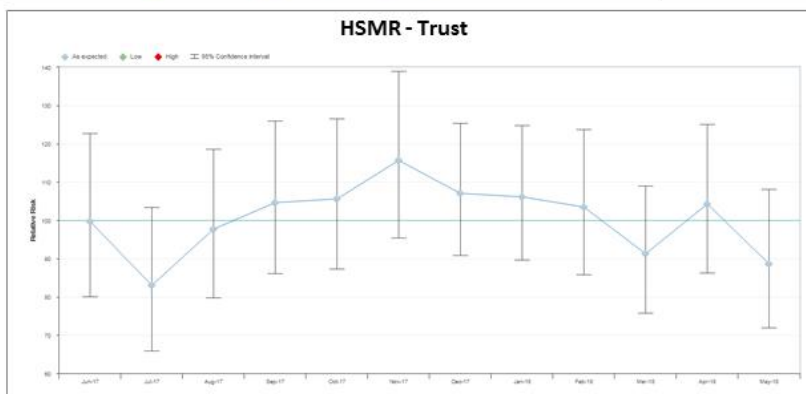
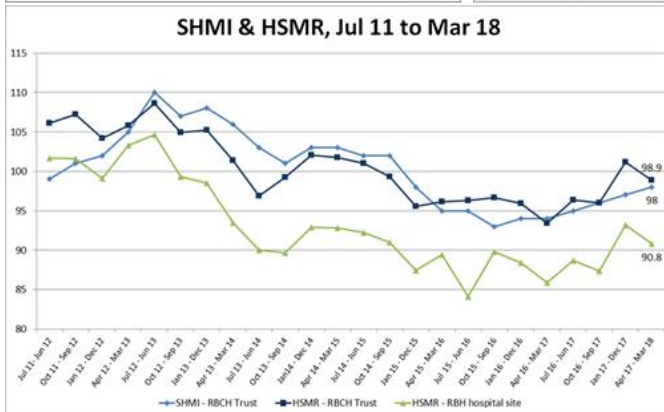
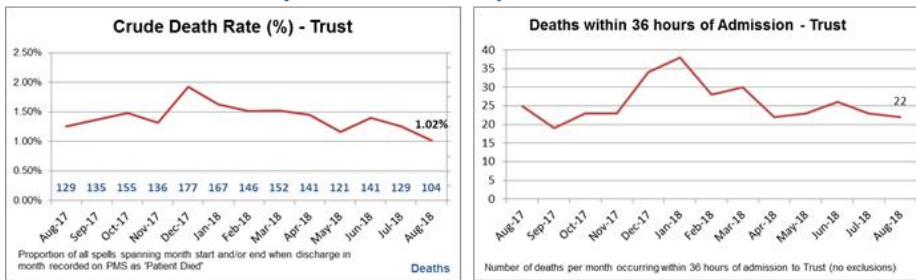
- Trends for predicted mortality;
- ITU admissions following OOH cardiac arrest for last three years;
- Mortality associated with in-hour and out of hour admissions to ITU.

Mortality associated with long-line sepsis (Long term intravenous access for chemotherapy or prolong antibiotics)

MSG in discussions with the haematology department has commissioned a review of Long-line associated mortality (non-causative i.e. death may or may not have been caused by line associated sepsis) to understand process and management of long lines, protocols and policies. We hope to understand pathways and improve outcomes in this specific group of patients. ITU consultant Dr Rob Charnook is leading on this review with the mortality lead for the Trust. This review has now been completed, learning and an action plan will be discussed in the October MSG.

Annexe A

Data Review - Mortality Surveillance Group



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

Executive summary:

All trainee doctors in this Trust are now on the (new) 2016 trainee doctors' contract. The number of trainees on this contract is 193. 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 April 2018 another 119 new exception reports have been submitted until 12 September. The total reports submitted so far stand at 445 as on 12 September 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 by the Guardian for safe working hours from 12 April to 12 September 2018.

1. Introduction:

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

The guardian is responsible for:

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

We now have a total of 193 trainee doctors on this new contract.

2. Issues:

The 2016 employment contract for trainees is well embedded now. Trainees seem to accept that there may be variation in their earnings according to the individual trainee's work schedule within the same grade e.g. F2s and CMTs working in ITU earn less than their counterparts in other placements. Financial impact of the contract for trainees who wish to work on less than full time basis however, 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 445 exception reports; 119 since my last report to TMB in April 2018. Further details of these new exception reports are provided later in this report.

3. Exception Reports between April and September 2018:

Number of doctors in training (total):	193
Number of doctors in training on 2016 TCS (total):	193
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): temporary	0.2 WTE
Amount of job-planned time for educational supervisors: trainee	0.25 PAs per

4. Exception reports:

Since the introduction of the new contract there have been a total of 445 exception reports – 119 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	48	42	6
Medicine (including MFE)	37	43	14
Gastro	20	0	0
Haematology	11	7	4
Ophthalmology	3	0	3
Total	119	92	27

Unresolved exception reports need to be resolved by the named educational/clinical supervisor.

5. Work schedule reviews:

The highest number of exception reports, once again, have been generated by the Foundation trainees in Surgery. Previous attempts on minor tweaks in their rota have failed to address issues. After previous meetings with the surgical directorate, additional funding has been made available for Trust Grade doctors in surgery.

However the recruitment process has had limited success. I understand that another advertisement is in progress and I will continue to monitor the situation along with the surgical directorate.

Gastroenterology continues to be another area where a large number of exception reports have been generated. As I mentioned in my last report, 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 is highlighted again.

OPM and Medicine trainees have also raised 37 exception reports since April 2018. In most cases there were genuine emergencies or colleague sickness etc. when the trainees had to stay back to complete their tasks.

Most of the exception reports have resulted in compensatory payment to the doctor in question except 6 exception reports, where time off in lieu was agreed instead. Compensatory payments for F1s are made @ £12.6336 per hour.

Ophthalmology directorate accepted my offer and I gave a presentation at one of their meetings to explain the new contract, role of exception reports and my role as the Guardian for Safe Working Hours. As reported above there have been only 3 exception reports from ophthalmology trainees since then. Unfortunately all three reports remain unresolved so far.

6. Locum usage:

A large number of shifts in Medicine/OPM, surgery and Emergency Medicine were filled with locums. From April to August 2018 a total of 249 shifts/days in Medicine/OPM were filled in by locum SHOs or Registrars costing a total sum of £166,075.

In the same period the surgical directorate spent a total of £124,252 during this period to cover locum shifts for trainee doctors.

Emergency Medicine needed to cover a total of 488 shift and spent £219,600 on locums from April to August 2018.

None of the above spend includes any locum expenditure on covering shifts for the doctors who are not in training and are not on the 2016 contract.

This brings total spend in these three areas to £509,927.00

7. Vacancies:

Currently there are 14 unfilled deanery training posts. In addition there are 18 trainee doctors who are currently on maternity leave. Some of these posts have been filled with Trust grade appointments but six posts remain unfilled.

8. Trainees committee

As mentioned in my last report, the appointment of Dr. Dominic Reynish as the chief registrar has revitalized trainee committee meetings with much better attendance. Last meeting on 20 August 2018 was attended by over 20 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 25 September 2018.

9. Fines

No fines have been levied on any department so far

10. Ongoing 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) 30 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:

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 January 2019 Trust Board meeting

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

Annual Report from the Director of Medical Education

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

Executive summary:

This report summarises the state of medical education at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. It highlights issues arising after the introduction of the Junior Doctor contract, the GMC survey 2018 and other developments over the year.

1. Introduction

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust employs 168 Trainee doctors and a variable number of Trust doctors. The new contract necessitates very specific work schedules for each placement. It also needs very active engagement from educational and clinical supervisors with additional demand on their time. Exception reports are a mechanism for trainees to highlight any work that they end up doing which is beyond their contracted hours of work and helps identify a loss of educational opportunities. The Guardian for Safe Working Hours monitors exceptions in relation to excess hours worked beyond what is contracted and the Director of Medical Education monitors those exception reports in relation to loss of educational opportunities. Both ensure that all exception reports are acted upon in a timely manner and make a judgement where further intervention might be required.

2. Issues:

A. Rota Gaps and Vacancies:

Currently there are 14 unfilled deanery training posts. In addition there are 18 trainee doctors who are currently on maternity leave. Some of these posts have been filled with Trust grade appointments but six posts remain unfilled. A large number of shifts in Medicine/OPM, Surgery and Emergency Medicine were filled with locums. From April to August 2018 a total of 249 shifts/days in Medicine/OPM were filled in by locum SHOs or Registrars costing a total sum of £166,075. In the same period the surgical directorate spent a total of £124,252 to cover locum shifts for trainee doctors. None of the above spend includes any locum expenditure on covering shifts for the doctors who are not in training and are not on the 2016 contract. This brings the total spend in these three areas to £509,927.

Medicine: Due to the offset of 7 additional posts above template Medicine are running on full establishment overall. The over-recruitment was designed to buffer and offset the challenges of a changing workforce. In Medicine since the start of the new junior doctors in August 2018 there were 3 WTE not being backfilled for the reason above. 7.6 WTE are filled or to be filled from September 2018.

Surgery: Concerns have been raised during 2018 about the inadequate level of junior doctor ward cover particularly at Foundation level. These concerns have been highlighted to the Surgery Clinical Director and Trust's Freedom to Speak Up Guardian, via the GMC junior doctor survey and Datix submissions, concerning

cover particularly at weekends for General Surgery/Urology patients. These concerns are also reflected in the higher volume of exception reports from Surgery and the GMC survey 2018. There are examples where junior doctors have been asked to work more than 12.5 hours to cover weekend shifts for General Surgery. Registrars are also often in theatres rather than ward-based, meaning junior doctors are unable to rely on senior decision-making and support on the wards. The directorate has updated these risks on the risk register. Several actions are being taken to mitigate these risks.

Ophthalmology: The Deanery was able to allocate only five trainees to Bournemouth for this academic year but as the funding was in place for a sixth the department went out to advert for a trust grade doctor. They managed to appoint a trainee from overseas who has an excellent grasp of English and is helping out in outpatients and in A&E. There may be a future gap and the department is monitoring this with a view of filling in a gap from February 2019.

Haematology: Currently have one gap due to maternity leave of a trainee starting from September. This has been filled by a locum Core Medical Trainee who has experience of haematology already.

Emergency Department: Emergency Medicine needed to cover a total of 488 shifts and spent £219,600 on locums from April to August 2018. Currently ED has one junior vacancy. The department have appointed to this vacancy from overseas and currently there are visa issues that are being solved. In the meantime the shifts are internally absorbed and some covered by locums on our locum bank. None are covered by agency. ED have recently changed the Junior rota to include 4 Juniors on overnight however this has left a gap of 2 x late Juniors at the weekends, these gaps are covered by Juniors on the medical bank. ED has a 3.2 vacancies of specialty doctors. The majority of the day shifts are uncovered or covered by a junior locum on the medical bank. Core shifts, lates, weekends are covered by our current Specialty doctors doing extra shifts or moving out of a day shift into an evening or weekend shift. Nights are more difficult to cover, some shifts are covered by our own doctors doing extra shifts or by Consultants acting down. ED is constantly out to advert for Specialty Doctors. They also go out to agency for locums however there are very few Middle Grades with an agency that want to do night shifts.

Intensive care has one vacancy in the trainee rota. The gaps are being filled using current and previous trainee grades (ST 3-7) to cover for locum payment. All trainees are encouraged to join the Medical Bank in order to expedite remuneration. On occasion they have also had to use staff grade doctors and agency consultants.

B. Exception reports

There have been a total of 449 exception reports by 18 September 2018. Of these 14 were education exceptions where trainees reported loss of education opportunities due to work pressures. In the big majority of cases these were isolated episodes.

i. Hours Exceptions

Specialty	New exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery (inc Obs and Gynae)	182	171	11
Medicine (including MFE)	213	205	8
Gastro	25	25	0
Haematology	12	12	0
Ophthalmology	3	0	3
Total	435	413	22

ii. Education Exceptions

Specialty	New exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	3	3	0
Medicine (including MFE)	7	7	0
Obs and Gynae	4	3	1
Total	14	13	1

3. 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 ongoing issues highlighted above. Gastroenterology continues to be another area where a large number of exception reports have been generated. 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 is highlighted again. OPM and Medicine trainees have also raised 37 exception reports since April 2018. In most cases there were genuine emergencies or colleague sickness etc. when the trainees had to stay back to complete their tasks.

Most of the exception reports have resulted in compensatory payment to the doctor in question except 6 exception reports, where time off in lieu was agreed instead. Compensatory payments for F1s are made @ £12.6336 per hour. As reported above there have been 3 exception reports from ophthalmology trainees since then. Unfortunately all three reports remain unresolved so far. Dr Raza as Guardian for

Safe Working Hours is proactively investigating these. To date no fines have been imposed. Engagement by a minority of educational supervisors however remains a challenge.

4. GMC Survey 2018

The issues highlighted in surgery have been reflected in the GMC 2018 report. Attachment 1 relates to post specialty by trust. One can see that the red areas are in Surgery and surgical specialties of urology, vascular, ophthalmology. Anesthesia also highlights in red particularly in relation to induction and rota design. This was investigated last year by the deanery and the issues arise from the fact that there needs to be an induction at Bournemouth and one in Poole and cross site working. Most of the issues do not arise from the Royal Bournemouth as recognised in last year's deanery report. Attachment 2 details programme group in the Trust. An area of red is due to workload in ED. This is not something we have control over and is unlikely to change for the better but we are working with ED consultants to explore whether changes to the rota can improve perceptions. Karen McCarthy (Education Centre Manager) and myself have a detailed breakdown of the trainee responses and are working with the various sites to address issues.

Having said that however one must also recognise that as a Trust we are among the better trusts in the region. Attachment 3 shows overall satisfaction at RBCH compared to other trusts for various specialties. We also had 8 green outliers for the CMT programme in Bournemouth.

5. Other developments

i: Trainee Committee

After a slow start the committee is now functioning well with excellent engagement from trainees. The last two meetings were very well attended. This is mostly due to the leadership of Dr Dominic Reynish who was appointed as chief registrar. 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. Dr Reynish will finish early next year and the Trust is urged to consider appointing a replacement.

ii: SAS doctor lead

This year Karen Mounce retired and Dr Dave Sell was appointed as her successor. Dr Mounce has been a very strong champion of SAS doctors and has made a significant contribution to supporting their development. She leaves an excellent legacy for the future.

iii: Foundation Programme

Dr Lynn Poynter has left the Trust and has been replaced by Dr Mihye Lee as Foundation Training Programme Director.

6. Next Steps:

As a Trust we are committed to work towards achieving the goals set out in the Health Education England (HEE) document, Enhancing Junior Doctors working lives. All 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. We continue to encourage trainees to fill in exception reports when appropriate and also continue monitoring to ensure that Trainees are not put off exception reporting by consultants.

Trust doctors remain an important part of the medical workforce. They fall outside the framework of training programmes and therefore the onus is on the Trust to support their development and welfare. The Trust is investing in the appointment of a director for this group of doctors. We hope that over the coming months we can appoint to this role. In the meantime we have conducted our own survey to explore how best we can support them in their work. Offering a good experience to them will certainly be of benefit to the Trust in supporting recruitment and retention.

Finally we need to continue addressing issues arising from the GMC survey with a view of improving red areas as well as maintaining the standard in areas where we are performing well.

Prof Michael Vassallo

Director of Medical Education

19th September 2018

GMC Trainee Survey 2018 - post specialty by Trust

[illegible]

GMC Trainee Survey 2018 - programme group by Trust

[illegible]

and

Report By is equal to / is in Post Specialty by Site by Trust/Board

and

and

Indicator is equal to Overall Satisfaction

Post Specialty is equal to Acute Internal Medicine , Cardiology , Endocrinology and diabetes mellitus , Gastroenterology , General (internal) medicine , General surgery , Geriatric medicine , Obstetrics and gynaecology , Ophthalmology , Respiratory Medicine , Urology , Vascular surgery

GEO LETB/deanery is equal to Health Education Wessex

Post Specialty	Trust / Board	Site	Indicator	2012	2013	2014	2015	2016	2017	2018
Acute Internal Medicine	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction						65.83	85.83
Acute Internal Medicine	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction		59.33	68.80	74.86	73.00	73.20	
Acute Internal Medicine	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	62.67	76.00	68.00	72.36	73.33	67.00	76.00
Acute Internal Medicine	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction		70.00	68.00	70.00	72.00	62.50	51.50
Acute Internal Medicine	Jersey	Jersey General Hospital - U142677	Overall Satisfaction							
Acute Internal Medicine	Poole Hospital NHS Foundation Trust	Poole General Hospital - RD300	Overall Satisfaction			56.00		68.67	68.40	77.67
Acute Internal Medicine	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction			89.00	85.00			
Acute Internal Medicine	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		74.77	72.00	78.24	70.97	66.74	72.69
Acute Internal Medicine	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction		74.00	73.78	76.00	77.33	73.50	90.25
Acute Internal Medicine	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction			82.67		85.33	93.75	79.75
Acute Internal Medicine	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		77.50	70.40	75.27	77.23	76.56	64.63
Cardiology	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		64.67	83.20	78.67	62.00	73.80	79.60
Cardiology	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction	83.00				86.40	59.17	85.60
Cardiology	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	74.67	69.33	60.00	74.00	89.00	62.40	
Cardiology	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction			88.00	62.67	78.00		59.67
Cardiology	Jersey	Jersey General Hospital - U142677	Overall Satisfaction							
Cardiology	Poole Hospital NHS Foundation Trust	Poole General Hospital - RD300	Overall Satisfaction					72.00	69.86	48.50
Cardiology	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction		70.67	77.00	76.00			
Cardiology	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		74.00	80.36	88.00	82.46	67.11	86.36
Cardiology	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction		84.00	73.33			77.50	71.33
Cardiology	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction		74.80	79.71	79.33	66.15	69.36	81.18
Cardiology	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		74.29	73.88	85.00	73.87	70.50	68.27
Endocrinology and diabetes mellitus	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		80.00	66.00	65.33	70.67		
Endocrinology and diabetes mellitus	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction					69.00		
Endocrinology and diabetes mellitus	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	74.67	86.40	76.80		77.60	83.00	
Endocrinology and diabetes mellitus	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction		60.00	68.00				
Endocrinology and diabetes mellitus	Jersey	Jersey General Hospital - U142677	Overall Satisfaction							
Endocrinology and diabetes mellitus	Poole Hospital NHS Foundation Trust	Poole General Hospital - RD300	Overall Satisfaction					78.40	86.60	75.00
Endocrinology and diabetes mellitus	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction		82.29	78.67	85.71			
Endocrinology and diabetes mellitus	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		92.00	82.00	76.00	88.80	88.20	61.60
Endocrinology and diabetes mellitus	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction					81.00		78.50
Endocrinology and diabetes mellitus	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction		85.00	92.00	69.00	80.00	85.50	86.75
Endocrinology and diabetes mellitus	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		74.67	82.67	62.00	78.67		82.75
Gastroenterology	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		78.67	80.00	89.33	79.00	60.33	
Gastroenterology	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction					86.00	90.50	62.00
Gastroenterology	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	81.60	68.00	66.40	88.00	71.20	82.40	79.50
Gastroenterology	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction		46.67		68.00	72.00		76.00
Gastroenterology	Jersey	Jersey General Hospital - U142677	Overall Satisfaction							
Gastroenterology	Poole Hospital NHS Foundation Trust	Poole General Hospital - RD300	Overall Satisfaction					80.00	81.75	71.00
Gastroenterology	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction		78.67	80.80	88.00			
Gastroenterology	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		65.67	73.67	62.40	66.40	68.50	59.43
Gastroenterology	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction		72.00	68.00	89.33	68.00	70.00	63.40
Gastroenterology	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction		73.14	78.67	84.50	82.22	85.56	88.00
Gastroenterology	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		91.11	93.33	69.78	78.91	76.00	81.80
General (internal) medicine	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		74.67					
General (internal) medicine	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction	70.96	68.60	72.00	70.50	76.00		
General (internal) medicine	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	68.40	69.60	79.43	67.00	74.29	67.71	63.56
General (internal) medicine	Isle of Wight NHS Trust	St Mary's Hospital - 5QT01	Overall Satisfaction							
General (internal) medicine	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction		74.22	72.57	62.29		76.00	79.50
General (internal) medicine	Jersey	Jersey General Hospital - U142677	Overall Satisfaction							
General (internal) medicine	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction							

General (internal) medicine	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		68.00	74.67	66.86		53.33	74.33
General (internal) medicine	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction		83.11	79.20				
General (internal) medicine	Southern Health NHS Foundation Trust	Lyminster New Forest Hospital - RW1YM	Overall Satisfaction		68.00	78.22	61.00	76.80	78.71	85.27
General (internal) medicine	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction		81.60	70.00	73.33		84.00	82.33
General (internal) medicine	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth and Christchurch NHS Trust - RD200	Overall Satisfaction							
General (internal) medicine	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		70.67	74.14	75.52	84.00	70.00	79.17
General surgery	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		80.62	78.00	77.54	79.73	73.09	77.11
General surgery	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction	67.69	66.57	73.85	70.46	65.85	72.69	64.23
General surgery	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	74.29	76.36	84.33	76.31	76.92	76.75	67.83
General surgery	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction		71.60	70.00	74.22	76.67	85.50	57.67
General surgery	Jersey	Jersey General Hospital - U142677	Overall Satisfaction	66.00	74.67	79.00	79.00	77.33	82.00	82.00
General surgery	Poole Hospital NHS Foundation Trust	Poole General Hospital - RD300	Overall Satisfaction					82.67	80.31	78.90
General surgery	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction		77.23	81.00	81.23			
General surgery	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		68.22	80.00	73.90	70.36	76.00	76.10
General surgery	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction		84.00	80.31	84.73	88.36	86.62	83.67
General surgery	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction		74.12	76.73	74.15	74.86	74.00	65.00
General surgery	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		76.00	68.36	82.79	78.63	69.83	66.48
Geriatric medicine	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		79.64	67.56	84.89	83.56	72.89	74.50
Geriatric medicine	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction	82.67				78.67	71.17	76.83
Geriatric medicine	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	71.20	81.00	74.00	86.00	82.86	67.14	74.00
Geriatric medicine	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction							
Geriatric medicine	Jersey	Jersey General Hospital - U142677	Overall Satisfaction							
Geriatric medicine	Poole Hospital NHS Foundation Trust	Poole General Hospital - RD300	Overall Satisfaction			84.80	67.00	74.20	70.52	79.60
Geriatric medicine	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction		86.12	79.20	73.60			
Geriatric medicine	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		75.38	76.27	82.29	80.00	75.74	76.90
Geriatric medicine	Portsmouth Hospitals NHS Trust	St Mary's Hospital - RHU02	Overall Satisfaction							
Geriatric medicine	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction		95.00		90.67	80.00	56.00	71.20
Geriatric medicine	Solent NHS Trust	The Royal South Hants Hospital - R1C34	Overall Satisfaction							
Geriatric medicine	Southern Health NHS Foundation Trust	Lyminster New Forest Hospital - RW1YM	Overall Satisfaction							
Geriatric medicine	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Christchurch Hospital - RD205	Overall Satisfaction							
Geriatric medicine	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction		79.16	76.00	77.26	80.00	76.67	75.44
Geriatric medicine	University Hospital Southampton NHS Foundation Trust	Royal South Hants Hospital - RHM02	Overall Satisfaction							
Geriatric medicine	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		80.24	72.53	79.33	86.31	81.18	78.96
Obstetrics and gynaecology	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		85.50	69.71	67.43	64.00	69.57	70.00
Obstetrics and gynaecology	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction	79.43	65.00	75.56	75.50	80.00	71.86	75.50
Obstetrics and gynaecology	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	86.18	82.55	88.00	85.00	82.00	76.13	86.91
Obstetrics and gynaecology	Isle of Wight NHS Trust	St Mary's Hospital - 5QT01	Overall Satisfaction		94.67					
Obstetrics and gynaecology	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction		69.33					
Obstetrics and gynaecology	Jersey	Jersey General Hospital - U142677	Overall Satisfaction	65.00	69.33	68.00	70.67	77.00	73.00	
Obstetrics and gynaecology	Poole Hospital NHS Foundation Trust	Poole General Hospital - RD300	Overall Satisfaction			84.00		79.67	81.43	82.62
Obstetrics and gynaecology	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction		82.91	91.64	86.18			
Obstetrics and gynaecology	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		76.91	84.17	85.71	87.11	81.05	77.46
Obstetrics and gynaecology	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction	57.33	76.44	70.29	67.00	76.00	77.43	77.40
Obstetrics and gynaecology	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction		84.57	92.00	81.00	85.33	71.88	88.00
Obstetrics and gynaecology	University Hospital Southampton NHS Foundation Trust	Princess Anne Hospital - RHM12	Overall Satisfaction		84.42	83.62	87.60	76.44	74.35	86.71
Obstetrics and gynaecology	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		84.80	81.60	87.20	85.60	70.20	66.00
Ophthalmology	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction							
Ophthalmology	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction							
Ophthalmology	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction							
Ophthalmology	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction							
Ophthalmology	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		91.50	88.00	83.11	87.00	86.25	65.63
Ophthalmology	Salisbury NHS Foundation Trust	Salisbury District Hospital - RN202	Overall Satisfaction		68.00	80.00	78.67			
Ophthalmology	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RD220	Overall Satisfaction		90.67	89.33	91.33	93.60	80.14	84.80
Ophthalmology	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		77.33	87.43	85.00	85.82	80.75	75.88
Respiratory Medicine	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		86.00	72.00	75.20	66.67	80.83	75.80
Respiratory Medicine	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction	78.67		84.00	76.00	76.00	73.50	77.80
Respiratory Medicine	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	68.00	76.00	85.33	89.00	76.00	82.80	83.83

Respiratory Medicine	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction							28.25	58.00
Respiratory Medicine	Jersey	Jersey General Hospital - U142677	Overall Satisfaction								
Respiratory Medicine	Poole Hospital NHS Foundation Trust	Poole General Hospital - RD300	Overall Satisfaction						82.67	75.83	66.25
Respiratory Medicine	Poole Hospital NHS Foundation Trust	Poole General Hospital NHS Trust HQ - RD304	Overall Satisfaction		80.00	94.00	89.14				
Respiratory Medicine	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		74.00	80.00	77.18	76.75	85.31	79.47	
Respiratory Medicine	Salisbury NHS Foundation Trust	Salisbury District Hospital - RNZ02	Overall Satisfaction		77.60	86.67	85.33	82.40	57.00	72.40	
Respiratory Medicine	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RDZ20	Overall Satisfaction		79.56	87.60	92.44	88.80	80.00	81.25	
Respiratory Medicine	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		82.00	81.75	83.76	83.20	77.67	77.79	
Urology	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital - RBD01	Overall Satisfaction		86.00	74.00	69.00	66.00	63.00	63.33	
Urology	Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire Hospital - RN506	Overall Satisfaction								
Urology	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital - RN541	Overall Satisfaction	86.67	81.33	81.33	69.33	66.67	88.67	74.33	
Urology	Isle of Wight NHS Trust	St Mary's Hospital - R1F01	Overall Satisfaction		74.67			73.33	63.75		
Urology	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction		76.50	66.67	82.00	92.00	90.14	86.20	
Urology	Salisbury NHS Foundation Trust	Salisbury District Hospital - RNZ02	Overall Satisfaction			77.33	72.00	83.00	86.75	86.50	
Urology	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RDZ20	Overall Satisfaction		86.67	76.80	72.00	84.00	79.33	56.33	
Urology	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction		84.00	89.00	89.00	83.33	70.00	62.50	
Vascular surgery	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital - RHU03	Overall Satisfaction			77.00	56.00				
Vascular surgery	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Royal Bournemouth General Hospital - RDZ20	Overall Satisfaction							77.67	
Vascular surgery	University Hospital Southampton NHS Foundation Trust	Southampton General Hospital - RHM01	Overall Satisfaction						85.50		

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	N/A
Subject:	IPCC Annual Summary Report and Board Statement of Commitment to Prevention of Healthcare Associated Infection
Section on agenda:	Quality
Supplementary reading:	The full IPCC Annual Report is available in the reading room
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Alsaffar Layth, Consultant Microbiologist Trish Turton, Infection Prevention and Control Nurse Paula Shobbrook, DIPC
Details of previous discussion and/or dissemination:	The Infection Prevention Annual Report has been reviewed and approved at the IPCC and the Healthcare Assurance Committee.
Action required:	Decision
<p>Executive Summary:</p> <p>The Board of Directors is required to sign and publish an annual statement which reaffirms its commitment to infection prevention and control. The statement details the processes which are in place to meet the duties under The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2011).</p> <p>The enclosed summary report outlines the Trust's work and progress with the prevention, control and management of infection in 2017-18. This work programme is overseen by the Infection Prevention and Control Committee, which reports to the Healthcare Assurance Committee. Once approved, the IPCC annual report and the statement will be published on the Trust's website to reaffirm to the public the Board's commitment to Infection Prevention and Control.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe?	✓

Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	37T

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

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

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

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

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

The DIPC is appointed by the Board and reports directly to the Chief Executive and the Board. The DIPC role is incorporated in the Director of Nursing and Midwifery's portfolio and the post holder is assisted in discharging the relevant responsibilities by the Hospital Infection Control Doctor the Lead Infection Control Nurse and the Infection Control Team.

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

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

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

Summary of IPCC Annual Report April 2017 to March 2018

Working together to break the chain of infection

The annual report summarises our progress against the 10 criteria, set out by the Health and Social Care Act 2010: Code of Practice for the NHS on Prevention and Control of Healthcare Associated Infections and related recommendations (the hygiene code) including NICE guidance.

As a Trust we are complying with the requirements of the Health and Social Care Act - Good Infection Prevention and Control (IPC). Compliance with this legislation is an essential element to delivering safe and effective care to the people who use the Trust services. Our aim as an Infection Control Team is to ensure that IPC is embedded in all parts of everyday practice and is applied consistently by everyone. This was observed by the Care Quality Commission during the unannounced inspection in March 2018.

This has been another busy year for the trust infection control team some of the highlights from the IPC annual report are given below:

Biofire

The Microbiology laboratory has commissioned a new rapid molecular testing platform funded by money released from internal cost savings within the laboratory. This platform, known as Biofire allows us to test for nineteen respiratory viruses including MERS on respiratory samples and fourteen viral/bacterial causes of meningitis or encephalitis on Cerebrospinal fluid. These tests have significant implications for bed flow and antimicrobial/antiviral stewardship, since patient samples would have previously been sent to a reference laboratory with a turn round time of days we can now deliver the result on site in just over an hour.

Carbapenamase Producing Enterobacteriaceae (CPE)

Resistant gram negative organisms remain a growing threat to global public health with increased incidence of CPE infections in the UK being reported. To prevent the spread of these organisms in this trust we have used a combination of surveillance/screening and isolation of CPE carriers it is important that we continue this approach in line with national policy. In the past year we have identified positive patients with and without known risk factors.

Candida Auris

Since 2016 three UK hospitals have reported outbreaks associated with *Candida Auris* a yeast resistant to multiple antifungal medications. Once established in a healthcare environment it is very difficult to dislodge this organism which evades infection control measures including enhanced cleaning and disinfection with Hydrogen Peroxide Vapour.

PHE guidance recommends enhanced screening of all *Candida albicans* species isolated from patients within augmented care settings. No positive samples for this yeast have been identified at the Trust.

Clostridium Difficile (CDI)

The Trust reported 27 cases of *Clostridium difficile*, deemed as late (testing positive after 72 hours in hospital). 7 of these cases were agreed as not associated with 'lapses in

care' when reviewed by the Dorset Post Infection Review group, Whilst this is 6 cases above a trajectory of 14 set by NHSI, it is of note that no cases have been caused by spread in the hospital. The lapses in care relate to learning points related to delays in screening and isolation.

The number of trajectory cases for 2018/ 19 has further reduced to 13. Achieving this target will be present a challenge, in light of the significant reductions in the past 5 years

Norovirus

Outbreaks of this viral illness have been identified at the Trust during this year in line with seasonal reporting. Individual cases have also been reported in small numbers.

Influenza

The 2017/18 season started with Influenza B virus circulating between Christmas until February. Unfortunately the Yamagata Influenza B strain circulating was not covered by the Trivalent vaccine used. In the later part of the flu season Influenza A virus was the dominant strain and it has continued to give rise to sporadic cases in the April and May. Identification and isolation of influenza cases has been a considerably challenge for the IPC team with this busy and prolonged flu season.

Flu testing was restricted and clinicians outside ITU and Haematology had to obtain approval for flu tests with the expert advice from either the Infection Control Team or and the Consultant Medical Microbiologist on call. In RBH a total of 421 flu tests were approved with a positivity rate of 52% at a cost of around £ 12 600. This compares to a neighbouring comparable trust which operated an on demand approach to flu testing and carried out over 2500 tests in the same period. If we had adopted an on demand approach it is estimated that we would have incurred an additional cost of approximately £85 000 as well as substantial disruption to the laboratory manpower with scientists being called in to carry out the testing at night and out of hours.

ICNET

As a Trust we lack an electronic tool for contact tracing of infectious patients that would allow a more rapid response to potential control threats. Work is progressing to look for a countywide solution which may involve ICNET a computer application that other Trusts in the region already use under licence to great effect. Procurement of a system such as ICNET would substantially improve the effectiveness of the Infection Control Team reducing the need for laborious manual tracking of patient admissions.

Conclusion

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



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Safe Staffing Annual Report (Nurse)
Section on agenda:	Quality
Supplementary reading:	Workforce Strategy and Development Committee paper September 2018
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Fiona Hoskins, Deputy Director of Nursing and Midwifery
Details of previous discussion and/or dissemination:	The Annual Safe Staffing Report was presented to the Workforce Strategy and Development Committee on the 6 th September 2018
Action required:	Note for information
<p>Summary:</p> <p>The annual safe staffing paper was prepared for and presented by the Director of Nursing at the September Workforce Strategy and Development Committee.</p> <p>The purpose of this annual paper is to provide assurance to the committee and the Board of Directors around all issues pertaining to safe nurse staffing levels within the Trust, in line with NHS England and CQC safe staffing requirements. Aside from this annual report a six monthly interim report is also published in February.</p> <p>Since the last publication of this report a bi-monthly Director of Nursing report is also published and presented to the Workforce Strategy and Development Committee. This provides more detailed assurance around safe staffing, workforce initiatives and key activities around nurse staffing recruitment and retention.</p> <p>Precis of key points from the Safe Staffing Annual Report 2018:</p> <p><u>Ward Staffing Reviews</u></p> <p>The latest update from the six monthly ward reviews was presented by Care Group:</p> <ul style="list-style-type: none"> • Within the medical care group investment has been made on uplifting the night staffing to include band 4 practitioners on wards 4, 5, 24, 25 and the stroke unit. • Within the surgical care group, wards 14,15, 16 and 17 had an increase of Health Care Assistants on the night shift. An increase of one registered nurse per shift was also made to the surgical admissions unit template. 	

- Within the specialities care group changes were made the eye ward template ensure that two registered nurses are on shift each night.

SafeCare

In terms of implementation of SafeCare, the Trust is one of the highest performers nationally, with a weekly attainment of compliance with set data entries of greater than 90%. The tool is reviewed daily at the safe staffing meeting where it is used to support staffing decisions on the basis of acuity.

Unify Data

Unify data is the reported metrics of staff who actually worked and staff who were planned to work on each of the inpatient areas. Our monthly return has remained relatively stable for 2018 with the Trust achieving around 90% for registered nurses on day shifts; a higher HCA percentage is noted at night with relative consistency, due to managing specials and patient acuity. This has been addressed through the ward staffing reviews

Red Flags

A red flag staffing incident is a shift where the staffing levels are deemed to be unsafe as set out by the NICE safe staffing recommendations and our local agreed criteria. There have been no red flag staffing incidents reported externally to the Trust in 2018.

Care Hours per Patient Day

Care Hours per Patient Day (CHPPD) is a way of representing staffing data that puts the nursing hours in the context of the patient activity, in an easy to understand figure. New national recommendations state that CHPPD should be reported regularly at board level and will now be included with the Unify Data reports.

CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight). Using CHPPD has a number of advantages over other methods of representing this data:

- It gives a single figure that represents both staffing levels and patient requirements, unlike actual hours alone, and
- It allows for comparisons between wards/units. As CHPPD has been divided by the number of patients, the value doesn't increase due to the size of the unit – allowing comparisons between different units of different sizes.

Our current CHPPD data as shown in the table below shows the Trust as 7.5 (the black circle) as just below the national median (7.9). This means that we are cost effective and given our current performance against our quality metrics running an efficient nursing workforce.

Care Hours per Patient Day - Total Nursing & Midwifery Staff	Apr 2018	7.5	-	7.9			
Care Hours per Patient Day - Registered Nurses & Midwives	Apr 2018	4.4	-	4.7			
Care Hours per Patient Day - Healthcare Support Workers	Apr 2018	3.2	-	3.2			

Since August 2018 the Trust is required to report to Board monthly our CHPPD figures. This will be included in the monthly safe staffing data provided via the Director of Nursing Report to the Workforce Strategy and Develop Committee or in the Workforce paper for Board.

In July the overall Trust CHPPD reported via Unify was 8.2, however where this sits in the context of the national picture will not be known until the model hospital quarter two data is published.

Exception Report for Vacancies

The medical care group continues to carry a higher number of vacancies. To support addressing this challenge a six month post holder has been recruited to concentrate on staff retention and advanced nursing practice. Success has already been noted in the Emergency Department with a number of vacancies recruited to.

Recruitment Update

A number of nurse recruitment initiatives are being explored in partnership with the HR department and a nurse recruitment strategy is being developed. Key initiatives being explored includes:

- Non-traditional unregistered healthcare roles such as associate practitioners
- Recruitment into nursing associate training programmes
- Recruitment into the registered nurse degree apprenticeship scheme
- Further exploration of overseas recruitment.

Agency Provision

Alongside the reduction in high cost agency that the Trust has achieved and increase in the use of the in-house bank has been noted. This was expected as part of the overall move away from high cost agency. Work is on-going to reduce all temporary staffing requirements and increase our permanent staff head count. The overall trajectory for temporary staff usage continues to be downward.

Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe?	✓



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

Are they effective?	<input type="checkbox"/>
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	<input type="checkbox"/>
Impact on risk profile:	N/A

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Winter Plan Update
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of paper:	Donna Parker, Deputy Chief Operating Officer
Details of previous discussion and/or dissemination:	PMG, SLT, TMB, BoD
Action required:	Review and comment
<p>Summary:</p> <p>The Trust commenced its planning for 2018/19 expected winter and peak pressures in April 2018. This followed a review of the learning from the previous winter, including a requirement to start planning early. It also included working discussions at the Trust's Management Board and in other forums through the Spring to inform the plans.</p> <p>This document outlines the 'all year round' improvements as well as schemes to mitigate the expected specific winter related challenges. These plans have also been reviewed against the updated national guidance; <i>letter from NHS England and NHS Improvement: Supporting the delivery of elective and emergency care, 7 September 2018; and the NHS Review of Winter 2017/18, September 2018.</i></p> <p>The document forms the final draft and any further key comments and feedback from TMB are welcomed prior to final sign off at the Trust Board of Directors in September. The plan itself remains iterative and further updates will be provided by exception to both committees over the remainder of 2018/19.</p> <p>A separate presentation at Board will highlight key messages and areas for ongoing work. In particular, the actions contributing so far and ongoing focus required, to maintain services within the planned winter bed complement.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>
Impact on risk profile:	Aims to mitigate risk to patient flow, safety, performance and finance.

Winter Plan 2018-19

1. Introduction

The Trust commenced its planning for 2018/19 expected winter and peak pressures in April 2018. This followed a review of the learning from the previous winter, including a requirement to start planning early. It also included working discussions at the Trust's Management Board and in other forums through the Spring to inform the plans.

This document outlines the 'all year round' improvements as well as schemes to mitigate the expected specific winter related challenges. These plans have also been reviewed against the updated national guidance; *letter from NHS England and NHS Improvement: **Supporting the delivery of elective and emergency care**, 7 September 2018; and the NHS Review of Winter 2017/18, September 2018*. See Appendix E.

Longer term (i.e. all year round improvements) key updates are:-

- Two Quality Improvement (QI) priorities:
 - First 24 hour emergency admissions
 - Intensive Therapy Unit (ITU) flow
- Emergency Department (ED) improvement plan
- Transfer of rehabilitation ward (Fayrewood)
- Integrated community & primary care services (ICPS) investment in community/primary care
- E-whiteboards for Health of the Ward at a glance
- Partners key initiatives

Winter specific challenges are:-

- Annual leave booking and rota/service commitments
- Bed base for winter
- Elective activity reductions for January and February
- Social admissions
- 'Normal' step up actions
- Operational Pressures Escalation Levels (OPEL) and major incidents

Care Group and Directorate level specific plans are also included.

2. All Year Round Improvements

There remains very large scope to improve our everyday emergency care services, and to have as much progress in place before winter. This is, quite rightly, about getting the basics consistently right.

2.1 QI

The first 24 hour project is the priority QI work seeking to get patients the right care in a timely way, and reduce the 'multiple front doors' which creates duplication, hand offs and delays. Mapping our existing offers and resources, designing ideal pathways and learning from elsewhere have all been underway this year. This fits very well with the Clinical Services Review (CSR) / merger work in redesign care. It is a bridge between now and five years hence.

The priority projects and developments so far this year have been:-

- Single clerking from ED
 - Draft 'hybrid' model and document developed and being tested in September and October for implementation prior to winter.
- Single point of ambulation
 - Joint work with SWAST and GPs to reduce time to arrival and increase potential for ambulation
 - Developing swifter specialist admission 'advice and guidance' for GPs
 - Exploring potential for access to SystmOne to optimize the AEC interface with primary care
 - Developing governance arrangements to support AHP/ANP roles to support sooner intervention in ED
- Mapping pathways and workforce
 - Detailed mapping supported by Action Learning Weekend (ALWe) in ED – informed ED action plan (see below) and PDSAs for a second ALWe.
- Surgical Flow
 - ITU PDSA2 in place – with a near one hour delay reduction April-August year on year
 - ITU redesigned nurse and medical rotas in place from August/September, which also support the RCOA #fightfatigue campaign
 - CEPOD PDSA testing scrub leadership model
 - Reviewing theatre cancellations and identifying areas for improvement (e.g. kit readiness)
 - Human factors and interpersonal behavior project (learning from the aviation industry), commencing in SAU in September
 - Reduced length of stay through OPM input in Surgery.

2.2 ED Improvement Plan

Achieving a decision to admit (DTA) or not, within 2 hours is a crucial element of success for the system to meet the national standard of actually admitting or discharging in 2 hours.

This year a greater focus on what admitting specialties need to do to after the 2 hour DTA is required. Too many patients wait whilst we as a hospital debate next steps. Getting a service where the right decision is achieved and enacted within the 4 hours, will be the single greatest measure of our clinical processes. This importance is reinforced by the government attaching £2.7m of funding to RBCH achieving at least as well as last year in terms of emergency care waits, within 4 hours.

ED's internal plan consists of:

- Strengthening ED minors (and linked work with the GP Improving Access Service (GPIAS) in the GP Out of Hours (OOH) and local practices)
- Improving the 2 hour DTA (including some point of care testing, and review of slow, low value add activities, such as IT and clerking)
- Better access to ambulatory care services, in hours, and for high volume pathways, i.e. headaches
- Better overnight cover in ED (despite greater numbers of middle grade vacancies), via extended consultant hours later at night due to 1-2 new appointments; from August an additional junior at night; continued recruitment, especially now visa restrictions are being relaxed
- Strengthening the shift nursing leadership role
- Increasing the hours of BREATH

This is in the context of work that has focused on team building and creating a positive learning culture. The excellent Care Quality Commission (CQC) report is a huge encouragement but the team recognises significant opportunity to further improve for our patients, remains.

2.3 Transfer of Rehabilitation Unit (Fayrewood)

Dorset Healthcare (DHC) and RBCH have agreed to transfer this ward from St Leonards. Phased opening will commence on 3 October and the facility will be based on Ward 9, with a day room.

The reasons for the move are:-

- Care closer to home as most patients live in Bournemouth or Christchurch
- Removes an ambulance transfer and discontinuity in care from transfer
- Allows more daily input from services at RBH (i.e. medical specialties, diagnostics, therapy and social care)
- Creates a smoother patient pathway, including straight from the Acute Frailty Unit (AFU), and on to the Interim Care team.

The 22 beds have a current length of stay (LoS) of 40 days. The national expectation is to challenge all hospital stays over 21 days. Our ambitious goal is to complete the overall inpatient stay including rehabilitation, within 20 days, and to measurably improve the long term functional levels of patients and return them to their own homes earlier. If achieved, this doubles the effective capacity to the system for bed based care. Careful case management will be crucial.

2.4 Integrated Community & Primary Care Services (ICPS) Investment Plans

Dorset Clinical Commissioning Group (CCG) has committed £6.5m of growth monies to improving ICPS. This is the main stay of the CSR out of hospital improvements. The intent is to have recruited and started by this autumn to have a half year cost, and full impact for winter.

The objectives upon which Key Performance Indicators (KPI's) are being developed at practice and locality level to enable tracking are:-

- a) Reduced emergency admissions
- b) Reduction in long stay, medically ready for discharge (MRFD) patients and overall reduction in occupied bed days (OBD)
- c) Support for care homes, and especially emergency admissions reduction
- d) Targeted work for asthma/chronic obstructive pulmonary disease (COPD) and diabetes
- e) Genuine net increase in workforce, (to mitigate against the loss of staff from other services locally, which is a risk)
- f) Cultural improvements including greater integrated working (so a-e can be delivered by the whole system).

Typical plans include strengthening frailty teams already in existence to provide a more rapid response, proactive care and support for care homes. These teams having improved access to secondary care expertise and diagnostics, is a common theme.

Workforce is the greatest challenge to delivery and so secondments, rotations, etc. can be helpful. Pharmacy is a leading exemplar, with rotations to GP localities.

2.5 Health of the Ward

The aim of the Health of the Ward project is to implement an Electronic Patient Flow Management System to improve patient flow and enhance SAFER Board rounds for both Trusts, RBCH & PHFT. It will improve our ability to get the right patient in the right ward and reduce outliers.

The project will provide an 'at a glance' e-whiteboard for patient status, including NEW's and critical safety information (i.e. falls risk). It also includes discharge information helpful for the Multi-Disciplinary Team (MDT), such as estimated discharge date (EDD) and tasks required and completed, which informs the red/green day status.

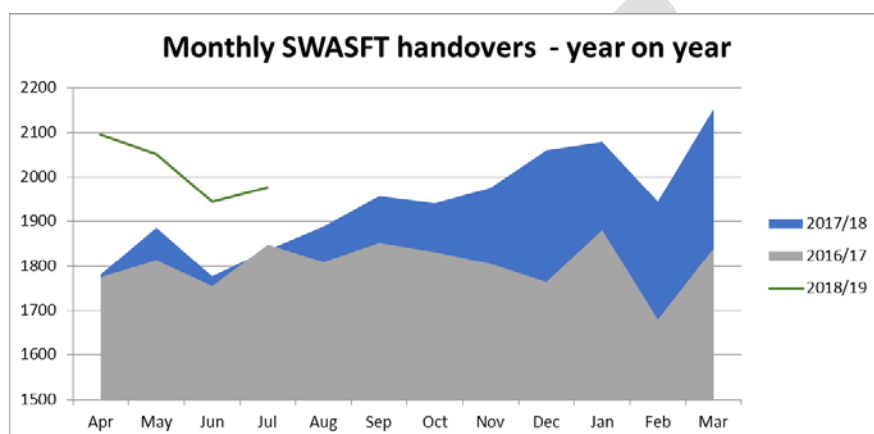
The beta testing and roll out to wards is planned to start in the Autumn and will replace the pen and whiteboard. This will require support from all senior leaders, as it will be a major change in practice. The project is joint with Poole who will also be rolling out shortly.

This should make daily tasks easier and improve communications and MDT working. Greater consistency and transparency will potentially create some cultural issues which we will support as an organisation.

2.6 Partner Key Initiatives

Our partners are of course developing their plans and regular sharing and coordinating is occurring.

South West Ambulance Service Trust (SWAST). The rise of 11% in ambulance conveyances and 24.9% (April-July) from care homes to RBH, is being investigated.



Rapid phone advice to crews from GP's working extended hours and from ED teams, may help support crews to return to their 'normal' levels of conveyances.

Mental Health. The opening of the 'retreat' in May for self-referral and support, especially to avoid a crisis, will be evaluated but should be positive given evidence from other UK examples. Work on 'stranded' mental health patients should also help flow and access to acute beds.

The mental health steering group, chaired by Dr James Stallard, will provide a better coordinating role and help achieve parity of esteem for treating mental health for all patients at RBCH.

DHC Community Services. Work continues and the ICPS investments will benefit this. The establishment of two community geriatricians will provide the leadership for the local teams. A management reorganisation, once complete, also offers new ways of approaching perennial issues.

Social Care. The effective single management of Bournemouth & Poole Adult Social Care is now well established. Christchurch locality (as part of the new Council) will need to merge up to April 2019. Work on a possible single manager for the discharge bureau (similar to Poole), is being explored including the issue of their remit and responsibilities. RBCH's joint work with domiciliary agencies (i.e. Agincare) and the step down from interim which has been so successful in winter 2017/18, is something we are seeking to maintain.

GP's and third sector work is focussed via the ICPS. In addition, the 111 / GP OOH service transformation is progressing. This has 3 parts:-

The first part is the GPIAS. This is based at the RBH GP OOH service adding workforce in evenings and weekends. With the 111/OOH service moving to SystmOne the flow of information and ability to message and book follow ups with the regular GP practice could start to provide much greater continuity of care. The Christchurch locality will also extend its weekend GP service from 9am – 6pm, and be available for advice to SWAST (especially for frail elderly and patients with long term conditions (LTC). These services are very workforce dependent and have taken some time to establish. However they will allow greater streaming from ED minors but hopefully also become more the first port of call than ED walk in, therefore reducing demand.

The second part is the Integrated Urgent Care Service (IUCS) tender. The alliance of all Dorset FT's and SWAST has bid, with a decision likely late July. This is for a mobilisation for April 2019. However, given all parties are 'incumbent' the mobilisation could happen more quickly. The new model of care includes more integration and the start of patients interaction (with quicker signposting to mental health, maternity and third sector resources), increased direction to 111 online and with SystmOne access, back to core primary care or the GPIAS (RBH OOH and Christchurch locality).

The third area has greatest potential change. This would be for the GP OOH physical bases (on each of the acute sites), combining with the GPIAS. This could come under the RBCH contract and operational responsibility but with a primary care led Board (as the Bournemouth and Christchurch cluster GPIAS does now). Ensuring a smooth mobilisation and robust service over winter is very important and the IUCS/GPIAS Boards are overseeing this. More work is needed to fully assess this, but the focus now is on the tender process and July decision.

Poole hospital is also developing its plans. Improvement in trauma services responsiveness is crucial for patient safety, and to allow patients at RBCH to transfer in a timely way.

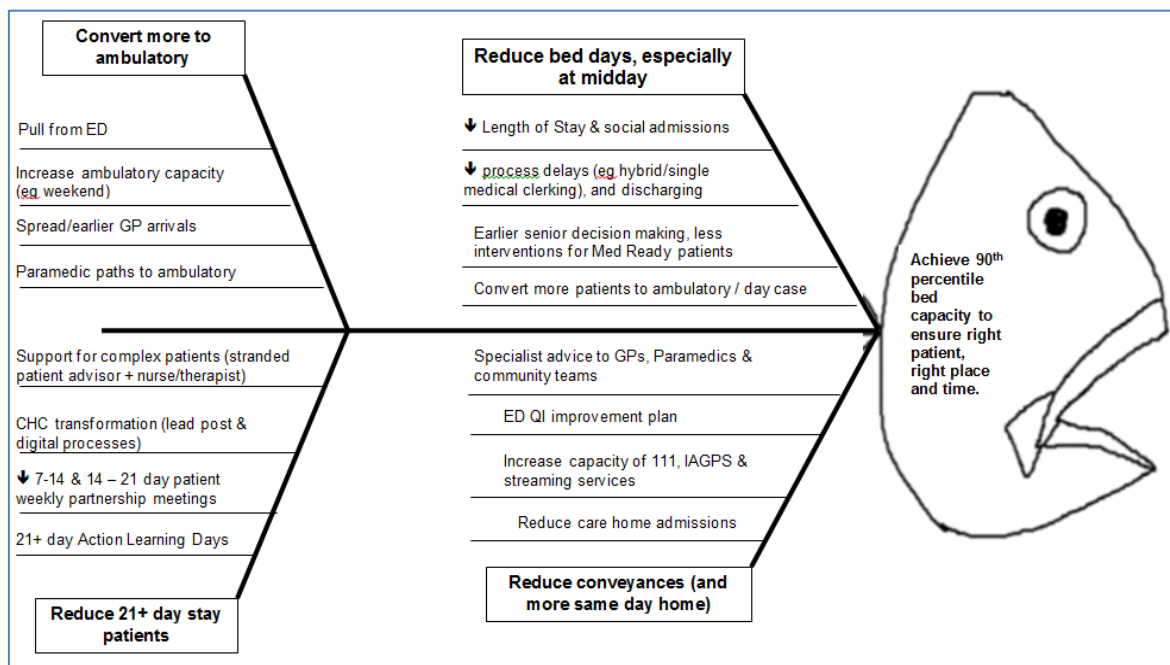
3. Winter Specific Challenges

Below indicates our specific Trust actions in support of the winter period. These will be shared at Dorset-wide winter workshop event in September. Partners plans will also be presented and the detail will be available locally and shared with appropriate staff.

3.1 Activity and Bed Modelling

The Trust has refreshed its activity and bed modelling in light of activity increases YTD: non elective admissions 3-4%, ED attendances 6-7%. This has informed the Trust's plans for increased bed capacity within the winter financial funding envelope available. This does currently show a shortfall and a resulting high level of occupancy. To meet a 4% non-elective demand increase, means a non-elective average length of stay reduction of 0.3 of a day on average is required and/or a

reduction in activity to 17/18 levels or below to meet a 4% demand increase. Worst case week last year (post 'snow' in March) would require a 0.5 day reduction and worst week in January, a 0.4 day reduction. The work outlined above and below, will be key and will be closely monitored in advance of and during the winter period. Key drivers that will influence this position and remain a focus for continued work in the lead up to and over winter are:



3.2 Christmas

Section 2 above reflects the core work on making services more effective 365 days. However December – Easter (late April) remains a time of increased demand, with 21st December to 15th January the predictable peaks

The way Christmas falls is a major risk compared to previous winters. Christmas Eve on a Monday creates a 'five day weekend' effect. Then two working days and then a four day weekend to 2nd January.

Over the summer every directorate and specialty was asked to set out:-

- The December / January rota with names and roles.
- How 'normal' cover weekend/bank holidays will be strengthened for higher emergency demand (assume 'double or treble ups' required)
- How the working days, Friday 21st Monday 24th Thursday 27th Friday 28th Monday 31st December and Wednesday 2nd January and strengthened, to cope with wider system pressures expected.

Submissions are being reviewed in September and plans adjusted as required.

Initially a minimal annual leave approach this Christmas/New Year and 'fair sharing' out of leave taken to spread this. Staff need to take leave but this may need to be spread over the year, rather than leave patient services short at a critical time.

Starting now to handle this appropriately is advised. By way of context SWAST has stopped all leave over this period at all levels.

It may be demand is not especially high and discharges flow, in which case, staff will have a pleasant and festive time. If demand is up, then to share the workload over the whole team and the fortnight is better for teams and our patients.

Specifically all non-essential activities should be stopped to focus on urgent care. This includes not booking elective care (unless there is no benefit from stopping). Specialty team knowledge and management of this is expected.

3.3 Elective activity reductions January – March

As with winter 2017/18 our early planning worked on the expectation that services will get ahead in the autumn so as to sustain a reduction in clinics and treatments in January and February. On the whole, this has previously worked well with services having the autonomy to make these decisions and the trade-off between elective and emergency demands. However, the elective waiting list trend overall has deteriorated through 18/19 due to a number of additional/unexpected pressures (e.g. 14% increase in fast track referrals 'carving out' routine activity, unplanned medical and theatre staff gaps). This does mean there is a risk to further planned reduction January-March. On balance, the Trust considers that this remains a key part of the winter plan in some areas in order to meet the emergency and urgent care demand. However, this will remain under close review alongside an internal and system-wide review of potential further actions to mitigate the risks to elective care waiting lists. Noting cancer and 52 week waits will remain the elective clinical priorities.

The Derwent will not operate elective work January and February (8 weeks, not 6 as last year).

Where there is little gain from 'swapping' staff to emergency care, then ring-fencing elective work is best achieved by maximising day case or clinic work for January. This may mean amending normal booking patterns and waiting times. However to ensure maximum use of capacity means patients overall will benefit. For example, if day cases scheduled for November/December were swapped with inpatients due January. Once again specialty teams are making these decisions and planning activity accordingly.

The Day Hospital will once again close and transfer over the peak period.

3.4 Social admissions

One of the challenges from last winter was the number of patients requiring a social admission, even when there was significant bed pressures. This could be ten patients a week who would be expected to go home post-procedure but for whom living on their own, or other factors, led to a decision to book a hospital bed. Patient safety is paramount. However the time and effort, and on the day stress, to patients and staff is entirely avoidable. A task and finish group has been looking at this issue, with a proposal potentially based on a risk stratification approach and considering the potential for hotel, monitoring and/or support schemes. A proposal, to cover

medical (Cardiology, Endoscopy) and surgical patients will be developed by October 2018.

3.5 21+ day stay patients

By now hopefully, it is well evidenced that it is not the number of beds, but how you use them, that is crucial to emergency flow. To illustrate this if we had approached winter 2017 using our bed base as we did in winter 2015, we would have required 70 more beds for the same level of flow. This is not just unaffordable, and difficult to staff, but wrong for patients. Medically ready patients are at a heightened risk of harm, long-term deconditioning and loss of independence.

Currently there are 43 patients with over 21 day stays who are medically ready. There are over 105 individuals medically ready (out of 550 beds). The ICPS investment and joint work is to create whole system visibility, at a level of individuals, so we take specific action to get patients home. The Health of the Ward work is to ensure our internal processes are transparent and coordinated as we know often our internal processes cause the delays.

Nationally the focus is to cut by 25% the number of over 21 day stay patients, which fits well with our local MDT assessments that over half of this patient group are medically fit. The advice is not to focus on 21+ day stays, but avoid patients ever getting to that length of stay unless there is an acute medical reason.

System-wide and RBH action plans have been developed, supported by national transformation monies. Our plans include:

- Work in partnership to redesign the CHC process and reduce length of stay for those patients – pilot Transformation Lead post
- Development of electronic processes (e.g. CHC referral)
- Pilot focused on 21+ day stay patients with complex care needs, supported by a 'Stranded' Patient Advisor and Nurse/Therapist
- Focused weekly partnership meetings targeting plans for 7-14, 14-21 and 21+ day stay patients
- Trusted Assessor social worker supporting ED and OPAL teams
- 21+ day stay Action Learning days.

3.6 Bed Base - same numbers as last year, but better flow

In looking at the bed base the aim has been to have the same number of beds, but achieve better flow, and thus better respond to peaks in demand.

Appendix A outlines the Trust's additional bed capacity plan.

In summary the bed base changes/'step up' from October are as follows:

- Fayrewood ward moves to Ward 9, 19 beds (aim: to reduce length of stay) – October, phasing up to 25.

- Rather than open 'Fayrewood Ward' and a winter ward, the 23 beds 'step up' in winter capacity from last year are achieved by:

- Open both back bays on Ward 9	+12 (net +9)
- 7 beds on TIU (ACM patients)	+7
- Open Derwent empty side room January / February	+9
- Expand interim care, to the equivalent of	+6-12

Total 25+ Interim

3.7 The 'usual' winter step up

Many of last year's winter pressure activities will be repeated, as they worked. These include:

- +5 beds on Ward 14, November 2018 to March 2019; + further 6 (date tbc)
- +2 beds on Macmillan unit
- +3 Paeds Bay on Eye Unit
- Flex areas: SAU and Ward 23
- Clinical Site Team (CST), Housekeeping, Portering and Transport step up;
- Additional weekend sessions ('double up') for front door;
- Consultant teams (Acute Medical Unit (AMU), Older Person's Medicine (OPM), Physicians rota), beyond rostered and released sessions

Work is also underway with ED to complete a 'zero based budget' exercise, to ensure the budget available best aligns to patient demand and workforce availability. This will decide on the various Plan Do Study Act (PDSA) initiatives and if they can be made recurrent, and/or for the winter period (e.g. queue nurse, Bournemouth Rapid Evaluation, Assessment and Treatment Hub (BREATH), opening hours, Extended Nurse Practitioners (ENP) and physiotherapists in minors etc.)

3.8 Workforce

Appendix B outlines our current 'safe staffing' work and governance processes.

The 'step up' model outlined above and below means that securing the appropriate workforce is a lower risk as staff/shifts are added to existing, embedded ward areas. There does remain a risk, particularly given the potential for heightened levels of sickness and demand pressure, as well as the availability of non agency staff. However, this approach will ensure continuity of high quality care and leadership. Safe staffing will be maintained through use of existing ward workforce and specialist staff with the use of bank and agency where necessary. Clinical nursing support and advice for patients receiving care off their base ward will be accessed through the matron workforce.

A number of staff will transfer from Fayrewood Ward supporting the relocation of the service. This is supported by an experienced clinical leader and further recruitment – interviews planned for early September. Any vacancies remaining at the time of opening will be covered with agency and the Trust is confident that this is achievable. This however, will remain under close review as the unit transfers and phases up bed numbers.

With regard to medical cover, schemes outlined in this plan demonstrate areas of additional cover for peak periods as well as additional non-medical/MDT support. Areas of risk remain ED and OPM with ongoing work to resolve recruitment challenges, secure backfill/additional sessions, secure locums and/or other 'insourced' support.

Last winter, volunteers (both external and internal corporate staff) formed an increased part of our response to operational pressure escalation. A Task and Finish Group are working on enhancing this further through a more planned approach and increased training in advance of winter.

3.9 Patient acuity

A new risk was identified in winter 2017/18 for which a response is being developed. We can now measure patient acuity across the Trust, through the aggregated National Early Warning Score (NEWS). This is both absolute levels of patient acuity and also when this is increasing. Currently the static levels of workforce respond as best they can, but this means other important tasks (such as discharge planning, and more proactive care) necessarily takes a lower priority. This can lead to a vicious cycle of sicker patients and more outliers, increasing workload.

For 2018/19 the plan is to track NEWS, and for it to be a formal OPEL trigger and have actions. This is being developed via the Deteriorating Patient (DP) group. £46k has been budgeted for the group to allocate. This could be an additional Band 7 in Critical Care Outreach or Clinical Site so the team can better cover. Alternatively it could be adhoc shifts, of doctors or nurses, when a peak is identified as approaching. Or the group may have other ideas to meet this need. This will be finalised by December 2018.

In hours the OPEL actions should identify how to better target sufficient staffing to 'get on top of' any spike in acuity. Once again the trigger and actions should be advised by the Medical Director and DP group.

3.10 Operational Pressures Escalation Levels (OPEL) - trigger and actions

OPEL is a nationally mandated system, further developed internally last winter, which sets out a formal and transparent approach to the state of departments and the Trust. This improves consistency and speed of response. There continues to be opportunity to refine our approach internally and linking into the system pressures and escalation.

Over September and October 2018 the OPEL triggers and actions will be reviewed and further tested at an internal multidisciplinary winter preparedness event.

Feedback from other departments will be undertaken to see where improvements can be made. Specific themes include:

- Anticipating OPEL escalation and taking mitigating actions
- Planning 24-48 hours in advance
- Actions being sufficient to address the issues
- Consistency in reviewing and using the pre agreed actions
- Trust-wide actions which facilitate a 2 hour DTA in ED, especially out of hours.

The Trust's Escalation Policy and OPEL Action Guide are accessible via the Trust's intranet. In hours, the process and protocols are supported by the Trust's corporate and Care Group structure, including the triumvirate of executive/senior doctor, manager and nurse. The Trust's on-call arrangements consist of an on-call manager and on-call executive. There will normally be on site presence out of hours for key escalation meetings/actions by the manager from OPEL 2 with a deteriorating position and OPEL 3 for the executive.

3.11 Flu vaccination programme

The Trust is in receipt of the NHS England letter dated 7 September 2018: **Health care worker flu vaccination**. In 2017/18 the Trust 70.01% uptake in staff vaccination (above the national average of 68.7%).

The Trust will be reviewing practice against the mandated checklist, with a view to full compliance. The letter recommends a number of key expectations and actions, including:

- Board commitment to ambition to achieve 100% staff vaccination
- The quadrivalent (QIV) flu vaccine will be ordered and provided for healthcare workers
- Anonymous collection of data on reasons for staff who decides against uptake
- 'Flu team' established
- Full comms plan in place
- Drop in clinics, 24 hour mobile vaccination schedule and flexible OHD 'bleep' service

As requested by the guidance, we will also be looking at appropriate to achieve higher take up in higher clinical risk areas.

Progress will be regularly reported to the Trust Board.

3.12 Infection control

The impact on ILI, especially Flu B, was considerable in terms of bed capacity in 2017/18. In particular, isolation rooms and time resources for the CMM, IPCT and microbiology lab staff. Furthermore, the Trust saw associated cost implications of screening and additional out of hours working. 25% of side rooms were allocated to ILI. Cohorting, whilst considered in line with our Trust policies, was not an option in bays due to the mix of Flu A+B. The areas that felt considerable pressures were

AMU, Haematology and Respiratory wards.

A review of lessons learned last year have informed the following actions through 2018/19:

- Increase education and awareness for ILI, PCR screening and PPE.
- Tailored education provided to portering services
- Continue with successful triage approach to PCR screening
- Ongoing liaison with Pharmacy to ensure timely/sufficient ordering of Osetamivir stocks
- Improving consistency of prophylaxis for staff via OHD
- Health of the Ward system will improve side room management
- Improved stock control systems in relation to PPE
- Relatives information leaflet updated
- Continue weekly and quarterly updates to staff including doctors on case numbers/relevant infection control information and protocols.

Norovirus will be managed using the Trust Norovirus policy and Outbreak policy
Testing for influenza will continue to be managed through the microbiology lab. Point of care testing in ED is not being considered at this present time.

3.13 KPIs

Measurement of progress is using our existing KPIs and balancing metrics. These include:

- 4 hour ED performance
 - Decision to admit / discharge at two hours
 - Over 7, 21 day LoS
 - Medically ready patients (and those over 21 days)
 - Ambulatory care
 - ED attendances and ambulance conveyances
 - Activity and occupancy levels against predictor
 - NEWS
 - Readmissions at 48 hours and 28 days
 - Cancelled on the day admissions
 - Outliers outside of the medical care group
 - Days at OPEL 3 and 4
- } balancing measures

4. Care Group and Directorate Plans

The particular schemes and plans developed by Directorates and Care Groups which support the overarching plans outlined above are attached in Appendices C

and D. Specialities and departments may also have their own further detailed plans within their Directorates.

5. Next steps

5.1 Engagement

Circulation of this report, to staff groups and partners will be undertaken. This will also be supported by Care Group clinical workshops in September/October which will test plans and OPEL responses. Furthermore, key aspects of the plan will be shared at the Dorset-wide winter planning workshop in September.

5.2 Emergency Preparedness, Resilience and Response (EPRR)

Whilst not part of winter per se, the EPRR work continues, so as to anticipate major incidents and plan for business continuity. Major concerns remain (flu, IT failures and attacks, terrorism, disruptions such as utilities and weather and so on). Likewise planning if another neighbouring hospital was compromised (e.g. Salisbury poisoning, trauma backlogs etc.) is also part of our work. Following external assessment of our EPRR work, based on the Core Standards Self-Assessment, the Trust has submitted an overall compliance rating of Substantially Compliant against the core stands.

It should be noted that in line with the recent national letter: *Government's Preparations for a March 2019 'No Deal' Scenario*, the Trust will also be required to update our business continuity plans in advance of a 'no deal' Brexit in March 2019.

5.3 Further updates

This paper will be submitted to the Trust Management Board and Board of Directors in September 2018. It remains an iterative plan and further updates will be provided by exception to both committees over the remainder of 2018/19.

APPENDIX A

WINTER BED CAPACITY PLAN

WINTER BED CAPACITY & PHASING (v7 14/9/18)																																										
	indicates school holidays and Bank Holidays																																									
	September				October				November				December				January				February				March				April				May									
Week Commencing:	3	10	17	24	1	8	15	22	29	5	12	19	26	3	10	17	24	31	7	14	21	28	4	11	18	25	4	11	18	25	1	8	15	22	29	6	13	20	27			
Ward 9 - 'Fayrewood'					1																																					
Ward 9 - Extra (6 + 6)																	2	3																								
Ward 14 (Bay x5 + further 6 phasing tbc)									4																																	
Derwent 'Swing' (No/reduced elective activity) x20																	5																									
Derwent Extra (x9)																			6																							
Eye Unit (x3)																	7																									
Mac (x2)																	8																									
TIU (x7)																	9																									
Interim To be confirmed														10																												

***Legend**

1 - Ward 9 opens 19 beds (3 October)

2 - Ward 9 increases from 19 to 25 beds (2 January - phasing tbc subject to staffing)

3 - Ward 9 increases from 25 to 31 beds (7 January)

4 - Ward 14 increases from 17 to 22 beds (29 October). Plus further 6 (closed bay) - phasing tbc

5 - Derwent stops Orthopaedic activity [last day of activity 21 December] (22 December to 1 March 2019)

6 - Derwent increases from 21 to 29 beds (14 January)

7 - Eye ward increases from 13 to 16 beds (27 December). Paeds surgery reinstated from start of Feb half term onwards

8 - MAC Unit increases from 16 to 18 beds (27 December)

9 - TIU converts 7 beds to inpatient beds (27 December)

10 - Interim increase capacity (3 December)

APPENDIX B

Safe Staffing

Recruitment:

The Trust has robust plans for the monitoring and management of staffing vacancies, through its existing governance process.

Current recruitment initiatives being undertaken include:

- Regular advertisements on NHS Jobs.
- Cohort of 35 newly qualified nurses expected in the autumn.
- Return to practice nurses approximately 8 in a year.
- Return to acute care programme.

The Trust is also exploring further overseas opportunities and the recruitment of Nursing Associates and Associate Practitioners at Band 4 following qualification.

Operational Management:

A midday safe staffing meeting is held Monday - Friday to enable effective staffing resource management through identifying hotspots and focusing on key areas of concern. Each meeting reviews the next 24 hour period. At the weekends the operational Matron undertakes this role. This has proved effective at preventing staffing red flag incidents. The Trust has not reported any red flag staffing incidents in 2018. The Trust Unify data also demonstrates that a safe staffing position has been maintained throughout the past year including when extra capacity has been in operation.

The Trust has utilised a small amount of premium cost agency (PCA) over the past year and whilst the aim is to continue to reduce this, the Trust will utilise PCA in order to maintain safe staffing and patient safety.

APPENDIX C

Care Group Plans

ACTION	National A&E Improvement Requirement		
	<i>Front Door including streaming & ambulatory</i>	<i>Improved Flow & SAFER bundle</i>	<i>Improved Discharge & Discharge to Assess</i>
CARE GROUP A – SURGERY			
Surgery			
<p>Surgical AEC 5-day service - single point of access for Surgical emergencies. Calls streamed via central bleep. Consultant of the day named, Surgical Registrar relieved of general duties to focus on emergency surgical care. All day CEPOD list in place. Vascular calls taken by Vascular Consultant in hours. Gynae and Vascular hot clinics in place.</p> <p><u>Winter 2018</u>: It is proposed to re-open AEC at weekends during the winter period ie 1st Jan – 31st March 2019 from 0800-1600</p>	✓		
<p>Vascular: RBH is the vascular hub. Ward 14 – LoS improvements have enabled bed reduction to 15.</p> <p><u>Winter 2018</u>: It is proposed to open 1 additional Ward 14 bay of 5 beds to support Medicine on 1st Nov 2018 giving a cohort of 22 beds on WD14, plus return to 28 bed cohort for winter period (Jan-Mar – tbc) to support overall Trust pressures.</p>		✓	
General Surgery: 7 Day a week Consultant rota (1:9) in place		✓	
Ward 14 increased to 22 beds from 01/11/18 to support flow, further increase to 28 beds once staffing permits (7 WTE vacancies as at September 2018)		✓	
DiSCO and ' bag packer' in place in Surgery 5/7. Annual leave support in place to ensure consistency of provision			✓
Additional FY1/2 support from new rota of 1/17 and not 1/14 from August 2018 and ongoing		✓	
Additional 1 x Nurse Practitioner cover 0800-1600 at weekends will be starting 1 st October 2018		✓	

Orthopaedics			
Streaming from ED for Trauma care is via the Orthopaedic Registrar at PHT with updated and improved SOP in place by November 2018 to include all relevant patients and conditions	✓		
Ring-fenced Derwent beds to maintain major elective work and RTT compliance until late December and then re-opening to NHS Orthopaedics March 2019		✓	
Derwent beds moving from 20 to 29 from January 14 th to support additional medical patients, plan to cohort rehabilitation patients there with additional therapy support (as in 2018)		✓	
Psychology input in place and funded to support LOS reduction evidenced at 2 days average, alongside MSK hub and CHAIN development holding Derwent Ortho bed stock at 20			✓
Ongoing support of the treatment of Upper Limb patients from Poole at Bournemouth (daily liaison between Poole TAC and RBH Admissions to facilitate) to support Poole Trauma capacity over winter period	✓		
Consider post trauma transfers from PHT to facilitate ED to Trauma moves assisting ED flow and 4hr	✓		
Effective use of Derwent theatres with patients operated there in January and February flowing to BPC to protect Derwent beds for medicine		✓	
Additional palliative care and OPM input into Derwent beds during January and February 2019		✓	
Anaesthetics			
ITU transfer prioritisation PDSA to support transfers out of ITU and timely support for ED Resus and other appropriate patients (QI programme work)	✓		
New ITU Consultant rota from September 10 th to reduce risk of fatigue and increase Monday cover	✓		
Optimise use of Ward 12 Short Stay Unit and day case by using Derwent for onward flow. Book NO social ONS admissions unless clinically urgent (supported by Trust project)		✓	

New ITU Nursing rota from August 28 th , allowing for additional bed capacity on Tuesday and Fridays nights for elective and non elective surges	✓		
Waking night in place to ensure 24/7 cover for CEPOD cases to protect daytime EL activity Daily review of CEPOD and cancellation of EL activity to support second CEPOD if required		✓	
Hourly review of live theatre dashboard, review of dashboard at CST & ELF meetings as required		✓	
Sterile services to run flexibly to support demand.		✓	
Maternity			
Use of escalation SOP to SWAST as required for emergency transfers if either birthing unit full or patients needing NEL transfer Daily review by Head of Midwifery of operational position in East Dorset to ensure consistency of provision of birthing resources.		✓	
CARE GROUP B – MEDICINE	<i>Front Door including streaming & ambulatory</i>	<i>Improved Flow & SAFER bundle</i>	<i>Improved Discharge & Discharge to Assess</i>
Medicine and ED			
GP streaming - weekly timetable to review capacity	✓		
AEC during peak times Dates and times to be confirmed as part of detailed planning.	✓		
24/7 Crisis support to ED for mental health patients.	✓		
Escalation process in place to facilitate timely transfer from ED of mental health patients to appropriate facility.	✓		
Additional GP in minors in the evening at weekends through January – availability to be confirmed as part of detailed planning	✓		
BREATH open 24 hours at peak times through January.	✓		
Fit to Sit in place to maintain trolley capacity in majors.	✓		
Tested escalation process in place to maintain flow out of ED.	✓		

Model of speciality consultant of the day in place in hours for all medical specialities – available to GPs and ED Consultants. Out of hours, any calls will be to the on-call consultant (Medicine, Cardiology, Gastro – GI bleed).	✓		
Continued high acuity bay model in AMU to facilitate streaming and care for very unwell patients.	✓		
Additional Acute Medical Ward round at weekends during peak periods and 2 nd AMU Consultant on twilight shift during the week to reach into ED and triage patients on AMU.		✓	
Alcohol Nurse/support worker working across ED and AMU to avoid admission and direct patients to alternative service.	✓		
SHINE in place to ensure early patient assessment and handover if ambulance queueing. Queue nurse part of bottom up rota planning	✓		
Three times a day ED Board Round to facilitate ED flow and maintain safety.	✓		
Cardiology			
Acute Cardiac Clinic opened and works alongside the Cardiac ANPs in-reaching into ED and AMU. The ambulatory service is currently open 5 days a week taking referrals from ED and AMU, moving towards direct referral from GPs. This will compliment some of the urgent access clinics already in place (rapid access AF, Heart function clinic and the rapid access chest pain clinic). Change to bed base to accommodate two trolley spaces for Cardiac ANPs to bring patients from ED to CIU for further assessment rather than remain in ED or go to AMU	✓		
Joint working with other local acute providers to develop timely advice and guidance for GPs to roll out Autumn/winter as part of one Dorset Network	✓		
Cardiac LoS improvements also supported by 'step up'/'step down' area allowing reduced time to lab and day case approaches. Working with Poole Hospital on one combined rota to allow routine weekend inpatient lab procedures		✓	
Admission avoidance and discharge of patients facilitated through planned clinics which support the ongoing pathway whilst allowing patients to remain at home.			✓

Weekend NSTEMI lists to be established to support improved flow for this group of patients requiring diagnostics +/- intervention		✓	
PGH daily transport pilot for patients requiring lab procedures- eZec have put in place a planned daily transfer to reduce delays to procedures due to transport issues for interventional cardiology pathways		✓	
ANP cover on Saturdays and bank holidays to support timely discharge for post procedures patients who do not qualify for same discharge avoiding need to wait for the medical ward rounds			✓
Older Persons' Medicine (incl Discharge Team)			
Increased bed capacity through anticipated pathway redesign work for patients who require in patient rehabilitation through transfer of Fayrewood Ward from St Leonards Hospital.		✓	✓
Older Person Ambulatory Care Clinic (OPAC) runs Monday – Friday supported by Geriatricians and Nurse Practitioners. Function of avoiding admission or supporting early discharge from the frailty unit.	✓		✓
Additional OPM weekend and evening ward rounds (MDT support) with focus on additional discharges		✓	
<p>Increased focus on stranded patients (7-21 days LOS) to deliver additional bed capacity through implementation of:</p> <ul style="list-style-type: none"> • CHC Clinical Transformation Lead • Stranded Patient Clinical Advisor • Enhanced Fast Track Domiciliary Care Service (Agincare) to expedite rapid discharge for end of life patients on fast track CHC pathway • Additional stranded patient meetings supported by the Discharge Services Manager <p>Senior leadership and support from the Dorset system to expedite discharge for super stranded patients over 21 days</p>			✓
OPM Clinical Nurse Specialist roles developed to support frailty pathways.	✓	✓	✓
Increased capacity of the Interim Care service including the Agincare Domiciliary Service to bridge delays for patients awaiting social services packages of care at home as an alternative to being stranded at RBCH.	✓		

Older Persons Admission Unit (Frailty Unit) which includes Ambulatory Care and short stay beds for up to 5 days LOS. Comprehensive Geriatric Assessment (CGA) commences within 2 hours of admission to support triage of patients identified with frailty to access the appropriate acute or community service from ED. This will include either transfer to: OPAU (Older Persons Frailty Unit) OPAC (Older Persons Ambulatory Care) Discharge to Locality Community Hub Services (Intermediate care, Day Hospital, Step down beds or reablement).	✓	✓	✓
Increased capacity of the CHS (Care Home Select) service to expedite discharge for patients identified with complex care needs who will be self-funding care on discharge from RBCH.-			✓
MDT Outlier reviews			✓
'Funding out of hospital' in place			✓
Trusted Assessor social worker as part of 21+ day action plan			✓
Discharge to Assess Service currently in development with Bournemouth & Dorset Local Authorities and Dorset Healthcare Community Services. Includes the following services / initiatives: Trusted Assessors (as above) Interim Care Service providing two functions: <ul style="list-style-type: none"> • Transfer to an interim care home for a further period of social care assessment • Transfer home with an interim package of care whilst awaiting long term domiciliary or Reablement services to commence. 			✓
Response from Dorset Healthcare (Bmth & Dorset) Intermediate Care service within 2 hours of referrals to avoid admission. Potential enhanced in-reach offer this winter to pull patients from front door	✓	✓	✓
Care Group Wide			
Silver command rota in place to ensure named senior care group manager to oversee flow and expedite discharges.		✓	
CARE GROUP C – SPECIALITIES			
Specialist Services			
Developing proposal for senior pharmacist presence on AMU consultant ward rounds.		✓	

Dedicated pharmacy support provided to AMU, AFU and Cardiology to support timely review of and provision of discharge medications, supported by a pharmacy hub approach.			✓
Reviewing potential for a fixed term pharmacist to provide a winter service to additional winter bed capacity in the mornings and AMU in the afternoons to support discharges and flow.			✓
Pathology			
Ongoing review and flexible management of phlebotomy provision across the trust to support wards. Appointments process being established for outpatient phlebotomy to optimise capacity for inpatient and outpatient provision.		✓	
Cancer Care			
Macmillan Unit flex capacity is to be provided, linked to an escalation process agreed with the Macmillan team. This will include a trigger for fast track CHC patients. De-escalation process also to be identified and agreed to maintain patient safety.		✓	
Consider Ward 11 flexing capacity to support haematology outliers.		✓	
Focus on admitting and discharging from the day unit and ambulating patients where appropriate.		✓	
Radiology			
Maximise MR capacity to enable improved 7 day access for inpatient/ambulatory cases (as per phased business case).		✓	
Consider cancellation/reduction of elective 'cold' outpatient (and ultrasound) work during the Christmas and New Year period to release capacity for urgent/inpatient and fast track slots.		✓	
Additional RDA cover now routinely rostered for all bank holidays.		✓	
Review provision of ultrasound lists on Christmas day – will be dependent on level of vacancies. Confirmation tbc as part of detailed planning up to peak period.		✓	
Ophthalmology			
QI review of ARC to maximise efficiency and capacity to support demand.		✓	

Ophthalmology ward to continue to provide flex capacity to support outliers and maintain flow. This will be supported with strict criteria to select appropriate patients for transfer.		✓	
Cease elective non urgent paediatric surgery from Christmas to mid-February Reinstate from half term.		✓	
Cease undertaking non urgent GA's over the Christmas and New Year period.		✓	
Maintenance of RTT through winter - plans to include: <ul style="list-style-type: none"> • continuation of demand management and referral process review • additional activity (to include spread into weekends) • focus on outpatient waits to reduce late 'additions to list' requiring surgical capacity • additional locum/substantive posts • outsourcing 		✓	
TRUST-WIDE/CORPORATE			
"Late Matron Shift" (shared between all Care Groups) Monday – Friday from 12pm – 8pm – to also help support hospital when at OPEL 3. Plus weekend Duty Matron.		✓	
Escalation Policy and OPEL action guide continues. Workshops in Sept/Oct to review any further refinement/operational implementation	✓	✓	✓

APPENDIX D

List of 18/19 Winter Schemes

SCHEME
Front Door' (ED/AMU)
Plan to achieve double up consultant capacity weekends and evenings
ED Tracker - Additional Band 2, 12 hours per day, 7 days per week
Band 7 Additional Physio in minors, 8 hours per day, 7 days per week
Additional Streaming Capacity Fri-Mon, 6 hours per day
ED - Additional Ambulance Queue Nurse (5pm-2am) Band 5, 7 days per week for 12 weeks
AMU - Additional Nurse Practitioner to support Outlier Management, 1.00 WTE Band 6
AMU Consultant Additional Ward Rounds (7 Day / Extended Hours)
Inpatients and OPM
Additional SHO's / Extended hours support (3.00 WTE)
SHO Additional On Call / Extended Hours
OPM Consultant Additional Ward Rounds (7 Day / Extended Hours)
OPM Additional Therapy Input - Extended Hours
Flow and Acuity
Responding to Acuity Metrics - Outreach/CST Response Role; 'Screen' in CST; Drs Annualised Additional Hours / Sessions
Extended Clinical Site (B6 1.00 WTE) Dec-Mar
OPAL - 7 Day / Extended Hours
Out of Hours Additional Transport Pressures
Portering ALW review outputs
Additional Terminal Clean Capacity
Bed capacity
Winter Wards - Extended Beds - Derwent
Winter Wards - Extended medical bed base
Winter Wards - Pharmacy Input to extended bed base
Ward 14 +5 beds (Nov-Mar 18/19)
Macmillan Unit - Flex bed capacity (x2)
Equipment / Bed Lockers

APPENDIX E

National Guidance - Self Assessment (Acutes) – RBCH as at Sept 18

Ref: letter from NHS England and NHS Improvement: **Supporting the delivery of elective and emergency care**, 7 September 2018; **and the NHS Review of Winter 2017/18**, September 2018.

RAG key: Green – compliant &/or complete; Amber – in progress &/or some risk; Red – delayed &/or non compliant; A/G tending towards green; A/R tending towards Red

	Requirement	Comment	RAG
1.	ED 4 hour target in line with PSF trajectory (incl 95% in March).	Q2 on target but some risk. Q.3/4 at risk as 95% required and ambulance conveyances still high.	A/R
2.	Incomplete elective pathway (total waiting list) will be no higher in Mar 19	Remain c1,500 patient pathways above target. System-wide action plan being developed but noting have declared unlikely to meet “no growth” target.	R
3.	Flexible clinical workforce, e.g. annualised job plans, e-rostering, leave planning.	Some annualised job plans in place. Xmas/New Year rota and leave planning underway. eRoster for key groups. OPM rota high risk –internal and work with Poole to mitigate this.	A
4.	Long stay (21+ days) patients reduced by 25%	Action plan in place, with some funding but currently remain significantly off target. Partners engaged eg CHC and DHC.	A
5.	Primary care streaming for attendance/admission avoidance	In place but remaining workforce gaps. Increased workforce expected from Sept 18.	A
6.	Treat and discharge 99% of non admitted patients within 4 hours (e.g. ED Minors)	Minors breaches small proportion of total but do continue.	A
7.	Manage up to 50% of acute medical referrals with non admitted approach (e.g. ambulatory)	Ambulatory Care is key project in our ‘First 24 Hours’ QI Programme. Current phase working with primary care on specialist guidance/process/routes to ambulatory services and arrival times.	A/R
8.	Review A&E pathways	Process mapping undertaken and supported by ALWe. Pathways for Poole (Trauma and Paeds) remain a clinical and wait times risk).	A
9.	Reducing/managing corridor care, including safety checklist (e.g. SHINE)	Queue nurse in ED rota plan – await confirmation. Currently provided as required. SHINE in place	G

10.	Healthcare worker flu vaccination	See HR/OH plan. 70.01% uptake last year above national average. Work underway on actions to increase high risk area uptake	A/G
11.	Continued OPEL policy	In place and review workshops in Oct 18	G
12.	Credible capacity plans with realistic assumptions and 'gaps' driving operational change e.g. LoS reductions	Activity and bed model under review. LoS target reduction identified. Attendance, admission and 21+ day patients remain a risk	A
13.	Recommends below 92% bed occupancy	Activity and bed model under review. LoS target reduction identified. Attendance, admission and 21+ day patients remain a risk	R
14.	Recommends visible leadership	Executive dept visits OPEL process requires on site leadership Cultural/OD work. Well led CQC rating.	G
	<i>Primary Care – extended access</i>	<i>IAGPS in place</i>	
	<i>Mental Health – 24/7 psych liaison; crisis, acute and community capacity</i>	<i>24/7 psych liaison but shared with Poole. Mental Health bed delays increasing, adding to ED/AMU delays. Additional retreat capacity this year</i>	

Note: links provided to the following materials – Directorates to review

<https://analytics.improvement.nhs.uk/#/workbooks/250/views>

<https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays>

https://improvement.nhs.uk/documents/2982/AEC_Managing_increased_demand_winter_illness_June2018.pdf



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Implementing the Clinical Services Review
Section on agenda:	Strategy and Risk
Supplementary reading:	Final Proposal to CMA One Dorset Pathology Briefing Paper
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:	Previous Board of Directors meetings
Action required:	Note for information
Summary: This paper provides an update on the work to implement the Clinical Services Review	
Related strategic objective:	Strengthening team working. Providing safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	✓ ✓ ✓ ✓ ✓
Impact on risk profile:	None

Implementing the Clinical Services Review

This paper provides a brief update on key streams of work to implement the Clinical Services Review (CSR) proposals.

Judicial Review

The summary findings from the High Court in rejecting the proposal to halt the CCG's proposals for a major service reconfiguration are available at:

<https://www.dorsetsvision.nhs.uk/#news>

The finding on all points of challenge were in favour of the CCG. The findings provide welcome clarity and mean that the work to design the major planned and emergency sites can now proceed.

There still remains the possibility that the Dorset Health Overview and Scrutiny Committee could refer the proposal to the Secretary of State for further review. Hitherto the CCG has worked hard to ensure this has not occurred. Should such a referral be made – it is likely that the Secretary of State will conclude that there is no basis to halt the proposals particularly in the context of the High Court decision.

Advancing the Proposals for the Configuration of Services across the Planned and Emergency sites

Building on the work of the 5 work streams we now have greater clarity on which element of each service will be delivered on each site. Whilst there remains further work to do, including retrieval arrangements and out of hours medical cover for the planned site, there is sufficient detail emerging to enable the broad quantification of facilities, beds, theatres etc. across the two sites. This information is being refined and this work will continue with clinical teams.

We propose to use 11 and 12 October to evaluate the emerging quantification of facilities across the two sites and establish how we can best deliver the agreed benefits and model of care with the £147m allocated.

It is anticipated that this will require some iteration of plans: given the level of building inflation since the original decision to allocate funds to the Trusts. We will seek to create as much scope as possible to support the necessary building work. Some flexibility will be created from:

- The majority of design costs which it was originally proposed were funded in the £147m are being funded from other sources.
- seeking to identify an alternative source of funds to establish the main Pathology hub proposed for the emergency site
- use of the newly merged Trust's capital funding financed through depreciation.

It is also the case that some elements of the original plans had too high a cost attributed to them. However, conversely other elements are likely to cost more.

In addition, the Trust will also need to fund the decanting of some services, (Sexual Health, Orthodontics, and Patient Physiotherapy and the Prosthetic service) and the construction of a new community hospital on the emergency site.

The event on 11 and 12 of October will therefore be critical in seeking to agree affordable plans to deliver the key service changes and benefits.

Submission of Benefits Case

The Patient Benefits Case is now almost complete. The two Trusts are shortly to agree with the CMA a process and timeline to enable their consideration of the merger. The Trusts have been advised that the CMA are likely to initiate a full Stage 2 review and are minded not to commence their work until the Outline Business Case has been agreed by NHSI. It is still to be determined whether they will defer this work until after the Treasury has agreed the OBC. The Trusts, in conjunction with NHSI, are therefore seeking to explore the potential to undertake fast track Stage 2 review. If successful, the CMA are likely to begin their work towards the end of this calendar year, but defer a decision on whether or not to approve the merger until the OBC has been approved. This is anticipated to happen over the summer of 2019.

Once the CMA have completed their assessment and if they agree the proposed merger then NHSI will also undertake their own detailed review. This means that the earliest the two Trusts will merge is April 2020. If the CMA insist on waiting until the OBC is agreed before they commence their review and then undertake a detailed Stage 1 and Stage 2 review, the merger is unlikely to take place before April 2021.

Early appointment of a joint Chair and CEO

As a consequence of this time frame and a clear need to ensure as much cohesion and agreement as possible in taking forward our plans to establish a major emergency and major planned site, both Trust Boards have proposed the early appointment of a joint Chair and CEO. This rationale has recently been added to by NHSI who have expressed their support for the proposal, but also emphasised its importance in helping stabilise the increasing fragility of some of Poole Hospital's services.

I have included in the Reading Pack a copy of the proposal sent to the CMA. Specifically, NHSI have asked the Trusts to establish single management arrangements alongside a single interim CEO and Chair for 4 services:

- Trauma and orthopaedics
- ED (which will include AMU)
- Theatres

- Older Peoples Medicine (where we are seeking to establish a joint medical workforce)

If the CMA agree to the proposal to establish a joint CEO and Chairman then it is envisaged that this could be in place by the end of the calendar year. Once established it will enable some reshaping of executive responsibilities in both Trusts and the subsequent creation of single management arrangements for these services. The appointment process for an interim Chair and CEO will be subject of discussion and agreement by both Boards.

This paper is provided for information.

Tony Spotswood
Chief Executive



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Progress Update 2018/19 Corporate Objectives
Section on agenda:	Strategy & Risk
Supplementary reading:	N/A
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	N/A
Action required:	Note for information
Summary: Review of Trust Objectives for 2018/19, to end Q1, June 2018	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 ✓ ✓ ✓ ✓ ✓
Impact on risk profile:	34T

			Lead Exec	RAG Rating				Commentary		
				Q1	Q2	Q3	Q4			
OBJECTIVE ONE	Valuing our staff									
Narrative:	Recognising the contribution of our staff and helping them develop and achieve their potential									
Measures:	1.1	Delivery of the Trust's People Strategy with a focus on: a) Developing fit for purpose workforce plans by December 2018 b) Further enhancing health and wellbeing support for staff in place by December 2018 c) Recruiting, retaining and developing staff in line with the strategy d) Delivering on key priorities in our diversity and inclusion plan in accordance with the timescales set out in the plan	KA KA KA DM	<div><div></div><div></div><div></div><div></div></div>				Work continuing across trust and STP Continued focus on supporting health and wellbeing - lower sickness absence and positive staff feedback Vacancy rates remain good overall at 6% but there are challenges in key areas Good progress with staff networks and delivery to plan Board/SLT heard feedback, and Valuing You Week Sep 18 2017 action plans developed and monitored - 2018 survey will go out in Sept Exceeded at 94% for Q1 Turnover rate 9.5% and is consistently lower than joining rate		
		Delivery of the Leadership Strategy Implementation Plan with a focus on: a) Talent management b) Leadership development c) Management Toolkit d) Recognition and Reward – these will be implemented throughout 2018/19 in accordance with the timescales set out within our strategy	DM DM DM KA/DM	<div><div></div><div></div><div></div><div></div></div>						
		The measures we will use to track progress focus on: a) Action plans to address issues raised by staff, with the aim of maintaining our staff survey results and aiming to increase the engagement score from 3.9 to 4 over the next two years, demonstrating an improvement year on year b) Improving the Staff Impressions “Mainly Good” overall experience score to exceed 92% c) Maintaining a turnover rate below 12%	DM DM KA	<div><div></div><div></div><div></div></div>						
OBJECTIVE TWO	#									
Narrative:	Focusing on continuous improvement and reduction of waste									
Measures:	2.1	Urgent and Emergency Care ‘First 24 Hours’ Aim: To improve the first 24 hours of our urgent and emergency care pathway to deliver ‘right patient, right time, right team, right place’ by March 2019 We will do this by ensuring: <ul style="list-style-type: none">all patients receive timely assessments and decisions for clinically appropriate high quality carewe convert a third of adult acute admissions to ambulatory care as the preferred option by March 2019patients are either discharged or transferred to a specialty ward within 24-48 hours of arrival by January 2019to improve on our 7 day standards, including for admitted patients having a consultant review in no more than 14 hours.patients are rapidly assessed and treatment begun following referral from ED or primary care by September 2019frail patients are identified as soon as possible as they present in ED and receive specialist high quality care by June 2019patients with mental health conditions have access to skilled assessments available 24/7 by June 2019to deliver the 4 hour performance trajectory and the 95% ED standard by March 2019	RR RR RR RR RR RR RR	<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>				Optimising front door pathways continues to be a priority Recommendations being worked up to increase AEC activity Compliance with national audit Clerking and referral processes continue to be reviewed Soonest Frailty intervention in ED in place - pts identified on arrival Mental health pathway mapping planned Optimised admission avoidance and AEC will support achievement Dedicated workstream within Q1 - to date has seen a 1.4% increase in utilisation across elective theatre time Review of escalation processes to reduce time spent in ITU New nursing template approved and 'golden patient' PDSA cycles Planned changes to 1st scrub leadership to be trialled September/October Complete 2* clinical staff training weeks in Q1 New internet page for patient information in design phase New booking form in place On track to deliver with regular progress monitoring		
		2.2	Surgical Flow Aim: To improve flow through specialty theatres and intensive care beds, to achieve 85% utilisation (with a stretch target to 90%) for theatres. To also reduce time delays out of ITU by 20% by March 2019. We will do this by: <ul style="list-style-type: none">improving theatre scheduling and start timesreducing on the day cancellationsredesigning ward processes to increase capacity in recovery areasredesigning ward processes to improve ITU capacity and discharge arrangementsredesigning our prioritisation and planning processes to further improving the quality and safety of the WHO checklist in emergency surgery	RR RR DM DM DM	<div><div></div><div></div><div></div><div></div><div></div></div>					
			2.3	Supporting our Specialty Pathways Aim: To ensure implementation of recommendations outlined in the external cultural review and British Association of Dermatology review in accordance with agreed timelines This will include: <ul style="list-style-type: none">redesign of booking processimproved staff trainingimproved patient informationIntroduction of electronic systemsall surgical forms in dermatology are completed accurately by August 2018 and zero avoidable hospital reason cancellations by October 2018	DM DM DM DM DM	<div><div></div><div></div><div></div><div></div><div></div></div>				

			Lead Exec	RAG Rating				
	2.4	Aim: To improve patient safety and experience by reducing RTT waiting times in ophthalmology to a maximum of 18 weeks and outpatient follow up waits. The focus of this work will extend to improving efficiency in eye theatres by March 2019	RR					Improved follow-ups, but deteriorated RTT / total waiting list position
	2.5	Aim: To ensure that there are no unnecessary diagnostics and/or nursing observations for patients who are medically ready for discharge by March 2019	RR					
		Fundamentals of Care	PS					
		Aim: "To improve the coordination of Peripherally Inserted Central Catheter (PICC) lines, confirming status of every patient with a PICC line inserted by RBCH and ensuring compliance with the CVAD care bundle by March 2019"						The CVAD QI subgroup meet regularly. The aim of the workstream has been further defined and updated for Trust objective. The SOP is being written and the line checklist will be reviewed by October 2018. This will then be developed into an IT solution. Scoping is underway for a Trust wide needle free device to standardise practice.
		Aim: To continually improve the safety and timeliness of treatment and reduce avoidable patient deterioration on our wards						
		We will do this by:						
		• ensuring that every patient with an early warning score (NEWS) of 9 or above, is escalated for review and then seen by an appropriate clinician within 30 minutes of their initial trigger by the end of March 2019.	AOD					Project on track. Ward level metric developed.
	2.6	Aim: To further improve the identification and management of sepsis in our emergency and admitting areas by March 2019						
		We will do this by:						
		• treating all patients with a high risk of sepsis with a first dose of antibiotics within 1 hour of admission/diagnosis of sepsis and all other suspected septic patients within 3 hours by March 2019.	AOD					Aim being reviewed for attainability. 95% eLearning completed by clinical staff.
		Aim: To reduce the number of Never Events and promote an open learning culture						
		We will do this by:	PS					Human factors work at beginning stages and will be progressed during the year. Learning from Never Events discussed and disseminated through QARC and Care Group Governance. Posters and presentations planned for September QI and Patient Safety Conference.
		• embedding the learning from Never Events and Serious Incidents and implement agreed actions arising from the human factor work led by the Medical Director, it is ongoing through 2018/19						
		Building QI Capacity and Capability						
		To continue to develop our infrastructure for quality improvement at all levels within the organisation by March 2019. We will do this by:						
	2.7	• expanding the provision of QI coaching support and training and development programmes to frontline teams						Continued implementation of Improvement Skills Training (more than 300 staff now trained); development of coaching offer for individual teams e.g. ED Patient involvement in Specialty Pathways projects and reviewing how to include in other areas
		• deepening the involvement of patients and carers in our QI work	DM					Sustainability planning within projects to ensure continuous improvement after close. Additional work to embed within performance management framework on-going.
		• embedding local ownership and performance management of improvement projects to sustain front line staff engagement in QI	DM					
		Efficiency and Productivity						
	2.8	We will continue to ensure services are provided in a cost effective manner and that we achieve our financial plan to deliver a deficit of no more than £2.381 million by the end of March 2019.	PP					The Trust achieved its financial control total for Q1, with a small favourable variance. However considerable risk remains as savings schemes have not yet been identified to meet the cost improvement target in full. Financial recovery plans are currently being developed to mitigate this risk and ensure the full year control total is achieved'
		To continue to improve the responsiveness of services for patients and achieve the national standards of:						
	2.9	Cancer waits (62 days)	RR					
		Elective referral to treatment waits (18 weeks RTT)	RR					
		Diagnostic waits (maximum 6 weeks)	RR					
OBJECTIVE THREE		Strengthening Team Working						
Narrative:		Developing and strengthening Team RBCH to deliver safe and compassionate care for our patients and shaping future health care across Dorset						
Measures:		Progressing implementation of the Clinical Services Review by completing the clinical design of the planned and emergency sites by July 2018 and securing the lifting of the undertakings placed on the Trusts by the Competition and Markets Authority. The Board will monitor and drive progress in accordance with the project plan agreed for this work.						
	3.1		TS					We are awaiting confirmation from the CMA of the timeline for consideration of our proposed merger. We anticipate giving clarity on this by November 2018. Detailed site planning is now underway to enable completion of the OBC by March 2019.

		Lead Exec	RAG Rating				
	3.2	Strengthen collaborative working and relationships between the Trust and local partners gauged by regular feedback, via a structured qualitative assessment, from partners and in so doing progress the implementation of the Dorset Sustainability and Transformation Plan. To be completed by March 2019.	TS				The Trust is part of the Dorset ICS. Regular joint Board meetings are held with Poole Hospital FT and the Trust inputs fully to the Dorset Partnership Board. The Trust has been successful as part of a joint bid to run urgent primary care services.
	3.3	Jointly implement the Dorset Care Record (DCR) Phases 1a-2, 1b and 2 in accordance with the timescales in the DCR programme plan.	PG				The Dorset Care Record continues to release iterations of the service (second iteration included encounter information from DCH) and has progressed approximately 15% of the required interfaces.
	3.4	Develop team working by embedding the Aston OD Team Coaching approach across the organisation, helping enhance the delivery of care through heightened team effectiveness. Specific measures will focus on: a) At least 50 teams being engaged with the Aston OD Team Journey by March 2019 b) Achieving an average Trust score of 4 in the NHS Staff Survey key finding for Effective Team Working	DM				Currently 24 teams underway Inc from 3.9 to 3.99; in top 20%
	3.5	To work with partners to submit a successful bid to reshape urgent care services in Dorset. This includes preparing for a "go live" in April 2019. Key aspects are developing the Urgent Treatment Centre (UTC) at RBH, work with GPs on Improving Access especially out of hours, as well as the wider 111 and 111 on line offer to patients, to provide alternatives to A&E attendance.	RR				Bid successful. Work on mobilisation now developing.
OBJECTIVE FOUR		Listening to Patients					
Narrative:		<i>Ensuring meaningful engagement to improve patient experience</i>					
Measures:		Maintain progress in meeting our improvement trajectory for the National Patient Experience benchmarks by March 2019, by:	PS				Our first 'Patient Voice Volunteers' have been recruited to work with the QI team, ensuring that patients are informing and steering projects. We are holding a recruitment event in October to get more patients safely enrolled
4.1		<ul style="list-style-type: none"> Maintaining internal focus on patient experience agendas Engaging, listening and responding to patient feedback 	PS				
		Maintain and strengthen community links by March 2019 through:	TS				Regular listening events run by the Trust governors are supported, with excellent public feedback. More work is needed in order to establish community groups to input to proposals for future service delivery.
4.2		<ul style="list-style-type: none"> Running in partnership with our Governors a series of listening events Establishing community focus groups to provide feedback on current services and future proposals for service delivery 	TS				
		Actively engage in transitional work with the One Acute Network, ensuring that our patients and population are involved in service redesign from the outset using: Experience based co-design	DM				Work progressing. Referrals continue to be lower than last year overall.
4.3			DM				
		Working in partnership with our patients and health care partners to ensure right referral and right care, by March 2019, especially focused on four specialities (Dermatology, Cardiology, Orthopaedics and Ophthalmology), by:	RR				
4.4		<ul style="list-style-type: none"> Informing and helping educate our population to access resources appropriate to their need Improve self-care education with a particular focus on chronic diseases 	RR				

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

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

Annual Declaration

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

Category	Metric	Trust Target	2017/18 Q3			2017/18 Q4			2018/19 Q1			Trend (where applicable)
			Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	90%	92.89%	87.55%	86.08%	87.59%	89.61%	89.43%	89.59%	92.60%		
	Caring - Inpatient scores from Friends and Family Test % positive	95%	98.19%	96.63%	98.23%	96.94%	97.85%	97.87%	97.47%	98.15%		
	Caring - Maternity scores from Friends and Family Test % positive	95%	97.24%	95.71%	96.69%	96.89%	97.32%	96.17%	96.45%	97.79%		
	Caring - Mixed sex accommodation breaches	0	0	0	0	0	0	0	3	0		
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)			90.93%			89.44%					
	Caring - Formal complaints		23	21	45	35	41	30	33	43		
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	< Prev Yr Month AVG	499	434	523	497	513	489	550	574		
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	< 100	104.9	101.6	96.8	95.5	91.1					
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - MAC	< 100	0.0	0.0	0.0	0.0	0.0					
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - RBH	< 100	107.8	94.7	89.3	82.4	82.1					
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	< 100	99.6	97.2	89.1	104.2	88.6					
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	< 100	181.1	176.8	193.9	229.9	185.9					
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	< 100	93.1	90.9	80.4	91.8	79.7					
	Effective - Summary Hospital Mortality Indicator	< 1										
	ED Attendances		7497	6966	8375	8031	8707	8531	8884	8610		
	Elective Admissions		6603	6124	6274	5749	6262	6104	6115	6051		
	GP OP Referrals		5935	5284	5732	5666	6275	5787	5976	5427		
	Non-elective Admissions		3265	3007	3366	3208	3297	3173	3323	3332		
	Organisational health - Staff sickness in month	< 3%	4.395%	3.750%	3.690%	3.750%	3.401%	3.822%	4.119%	4.286%		
	Organisational health - Staff sickness rolling 12 months	< 3%	4.08%	4.03%	3.96%	3.98%	3.94%	3.94%	3.94%	3.99%		
	Organisational health -Proportion of temporary staff		7.20%	7.93%	8.57%	7.07%	6.44%	7.10%	7.26%	7.63%		
	Organisational health -Staff turnover	< 12%	9.68%	9.38%	9.20%	9.53%	9.39%	9.53%	9.36%	9.23%		
	Safe - Clostridium Difficile - Confirmed lapses in care	<= 14 in Yr / 1.2 per Month	2	1	3	2	0	0	0	2		
	Safe - Clostridium Difficile - Infection rate	6.9	11.71	6.48	5.85	12.1	0	6.05	17.56	17.56		
	Safe - MRSA bacteraemias	0	0	0	0	0	0	1	0	0		
	Safe - NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0		
	Safe - Occurrence of any Never Event	0	0	1	1	1	0	1	0	0		
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)			40.83			32.86					
	Safe - VTE Risk Assessment	95%	96.69%	96.69%	96.15%	96.51%	96.93%	96.41%	96.34%	96.26%		
	Number of Serious Incidents	<= Last Year	1	2	1	1	2	3	4	1		
	Appraisals - Values Based (Non Medical) - Compliance		90.37%	90.46%	90.33%	2.08%	10.94%	22.41%	39.16%	59.84%		
	Appraisals - Doctors and Consultants - Compliance		88.44%	89.04%	90.72%	87.06%	88.93%	88.81%	88.85%	89.25%		
	Essential Core Skills - Compliance		93.66%	93.51%	93.23%	93.33%	93.35%	93.43%	93.68%	94.07%		
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	YTD Plan = 4	4	4	3	4	4	4	4	3		
	Sustainability - Liquidity (YTD score)	YTD Plan = 1	1	1	1	1	1	1	1	1		
	Efficiency - I&E Margin (YTD score)	YTD Plan = 4	4	4	3	4	4	4	4	4		
	Controls - Distance from Financial Plan (YTD score)	N/A	1	1	1	1	1	1	1	1		
	Controls - Agency Spend (YTD score)	YTD Plan = 1	1	1	1	1	1	1	1	1		
	Overall finance and use of resources YTD score	N/A	3	3	2	3	3	3	3	3		
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	92.64%	92.67%	90.67%	91.85%	93.52%	96.37%	95.97%	94.05%		
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	100.00%	84.62%	100.00%	100.00%	87.50%	96.00%	73.68%			
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	87.25%	87.43%	92.35%	88.56%	90.19%	84.56%	86.13%			
	Maximum 6-week wait for diagnostic procedures	99%	99.60%	99.47%	99.53%	99.67%	99.38%	99.49%	94.43%	93.94%		
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	88.03%	88.54%	88.92%	88.81%	89.98%	89.79%	88.75%	87.59%		

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	
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 and Finance Committee
Action required:	<p>The Trust Finance Committee 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><i>Note, the narrative report should be read in conjunction with:</i></p> <ul style="list-style-type: none"> • Trust Board Dashboard • Performance Indicator Matrix
<p>Summary:</p> <p>This report focuses on August performance where it is available and provides a 'look forward' in light of current/projected trends and actions being taken.</p> <p>Key Highlights & Exceptions:</p> <ul style="list-style-type: none"> • ED performance remains above the PSF trajectory for Q.2 with only 0.29% clearance - significant risk remains. • Ambulance conveyances, ED attendances and admissions continue at increased levels. • Clocks Still Running (CSR / RTT total waiting list) remains off target – Dorset system-wide assessment currently indicates risk for March 2019 target • Cancer fast track referrals reduced August – now 9% above last year YTD, though noting 14% increase to end July. • Urology fast track referrals 34% above last year YTD. • Continued risk to 2 week wait and 62 day cancer standards, as well as knock on impact on routine RTT pathways. • Diagnostic 6 Week Wait remains below threshold. Endoscopy recovery plan underway. 	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓



Operational Performance Report

For the period to end
August 2018

Richard Renaut
Chief Operating Officer

Operational Performance Report

As at 17/09/2018

1. Executive summary

Key highlights and exceptions:

- ED performance remains above the PSF trajectory for Q.2 with only 0.29% clearance - significant risk remains.
- Ambulance conveyances, ED attendances and admissions continue at increased levels.
- Clocks Still Running (CSR / RTT total waiting list) remains off target – Dorset system-wide assessment currently indicates risk for March 2019 target.
- Cancer fast track referrals reduced August – now 9% above last year YTD, though noting 14% increase to end July.
- Urology fast track referrals 34% above last year YTD.
- Continued risk to 2 week wait and 62 day cancer standards, as well as knock on impact on routine RTT pathways.
- Diagnostic 6 Week Wait remains below threshold. Endoscopy recovery plan underway.

This report accompanies the Board Dashboard and Performance Indicator Matrix which should be referred to for further detail.

2. PSF, Single Oversight Framework and National Indicators

2.1 Current performance – August 2018/19

In August, we achieved 94.05%, below the national ED 4 Hour target, but on track for the Q.2 PSF target of 93.86%. We also avoided any breaches of the 12 hour from decision to admit (DTA) target.

RTT performance reduced to 87.6% though was above trajectory and we had no 52 week wait breaches. Positively, we did see a reduction (of 534) in the total waiting list (Clocks Still Running - CSR), though remained above the March 2019 target level by 896. However, impact

of cancer fast track referrals, resource gaps, inability to fund premium activity to offset (due to control total/CIPs) and impending winter pressures mean these targets are at significant risk at RBCH and across the system. The detail of our and the system position in response to NHSI's concern nationally is included in Section 3.2

July performance (*last reported month*) improved for the 62 day cancer target, achieving 86.1% (above national target). However, performance against the 62 day Screening target slipped to 73.7%. 2 Week Wait performance returned to compliance at 95.2%; securing timely capacity for outpatients and pathways remains a pressure.

Table 1 – Operational Planning and Contracting Guidance - KPIs 2017-19 – actuals & forecast

Single Oversight Framework Indicator	National Target	NHSI Trajectory 18/19	Mth / Qtrly	RAG rated performance against national targets and NHSI submitted trajectories		
				Jul-18	Aug 18 projection	Sep 18 projection
A&E 4hr maximum wait time	95%	92.40-94.67%	Mthly & Qtrly	95.97%	94.05%	
RTT 18 week incomplete pathways	92%	86.49-86.84%	Mthly	88.7%	87.60%	
RTT - no. of incomplete pathways	≤ March 2018	24,880	Yr End	26,310*	25,776*	
RTT - no 52 week waiters	0	0	Mthly	0	0	
Cancer 62 day wait for first treatment from urgent GP referral*	85%	84.1-85.7%	Mthly & Qtrly	86.10%	est.	
Cancer 62 day wait for first treatment from Screening service*	90%	90%	Mthly & Qtrly	73.70%	est.	
Maximum 6 weeks to diagnostic test	99%	99%	Mthly	94.4%	93.9%	

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).
 *Improvement on previous month
 **Final validated Aug performance upload will be completed early Oct 18

As highlighted last month, our unexpected additional pressures in Endoscopy (e.g. sickness, paternity leave, increase in colorectal fast track referrals) require an ongoing recovery plan. As expected, performance has reduced further in August to 93.9% due to the backlog. Our aim remains to achieve recovery in November but this remains subject to ongoing sickness levels and our ability to secure additional internal sessions as well as insourcing, within our financial envelope.

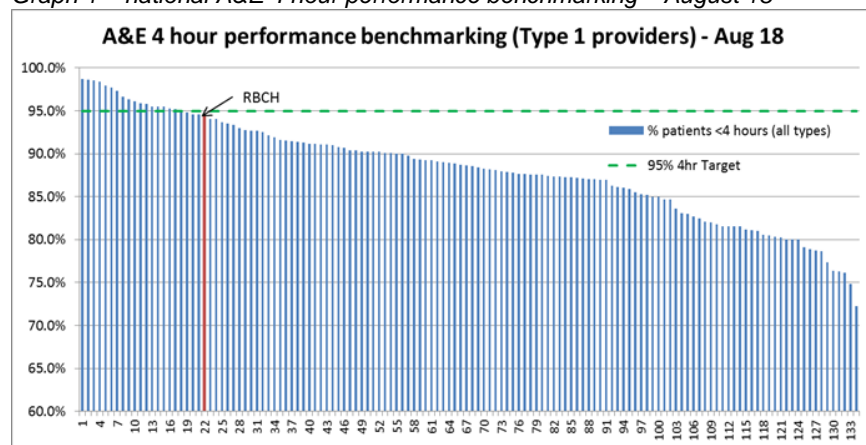
Operational Performance Report

As at 17/09/2018

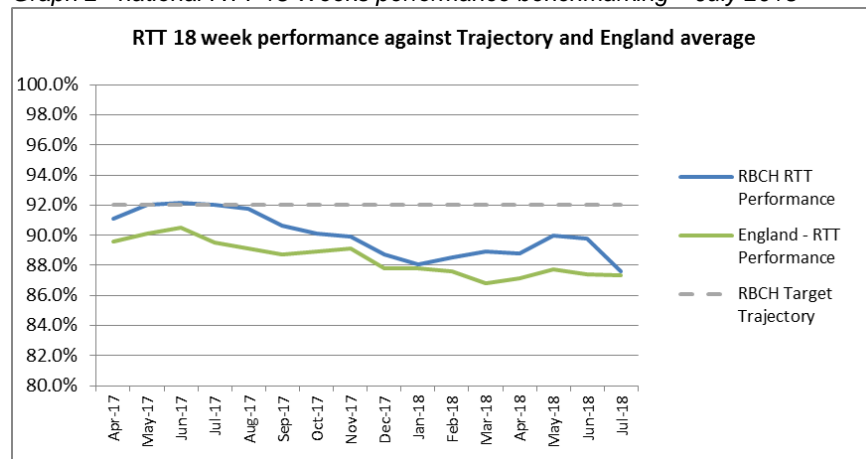
2.2 National Benchmarking – August 2018/19

July/August has seen, for the first time in a number of months, our challenges in RTT and Diagnostics bring us closer to or below the national averages. We do continue to maintain our more positive position for the A&E 4 Hour and Cancer 62 Day targets, noting the deteriorated position in the latter locally and across the country.

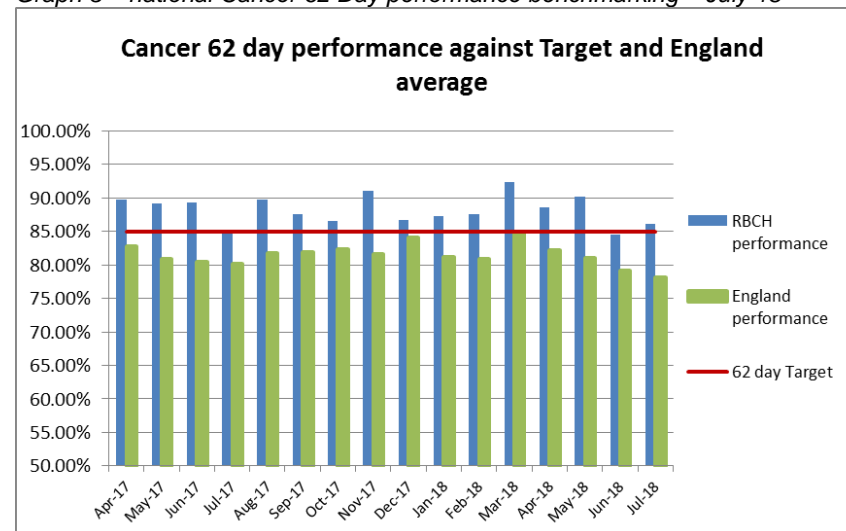
Graph 1 – national A&E 4 hour performance benchmarking – August 18



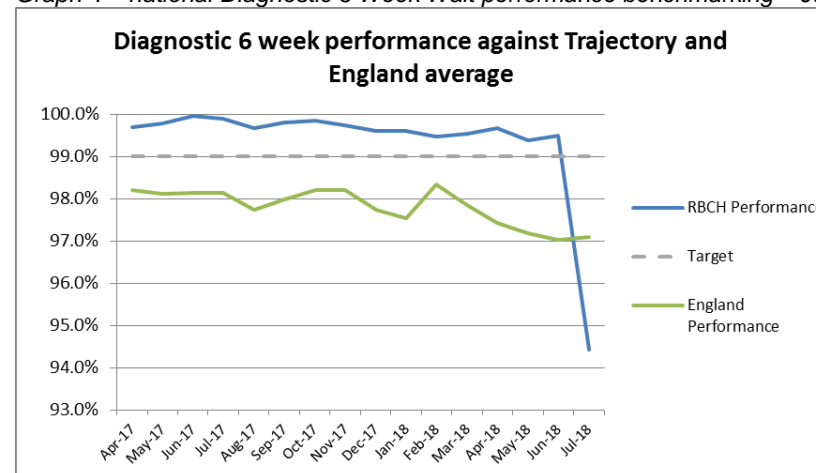
Graph 2 – national RTT 18 Weeks performance benchmarking – July 2018



Graph 3 – national Cancer 62 Day performance benchmarking – July 18



Graph 4 – national Diagnostic 6 Week Wait performance benchmarking – July 18

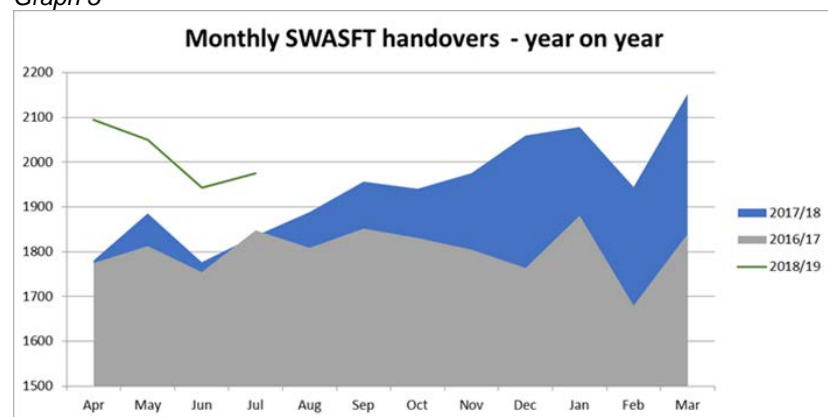


3. Forecast Performance, Key Risks and Action

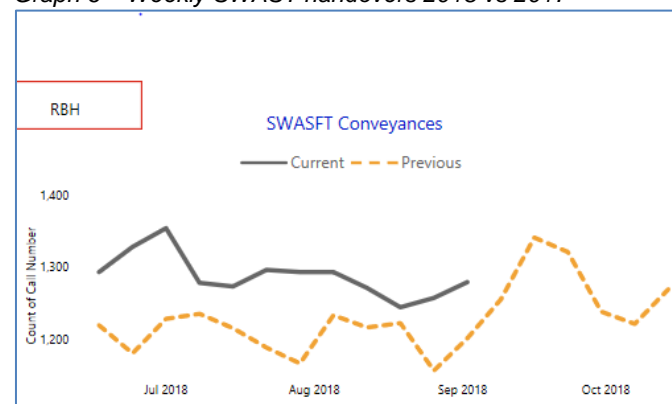
3.1 A&E Targets, PSF and Stranded Patients

One of our biggest current challenges remains the sustained higher level of ambulance conveyances which are consistently well above last year's levels, together with the hourly 'surge' patterns.

Graph 5 –



Graph 6 – Weekly SWAST handovers 2018 vs 2017



Overall ED attendances (Type 1) in August were 1.2% higher than in August 2017 and overall urgent care admissions were up by 3.51%.

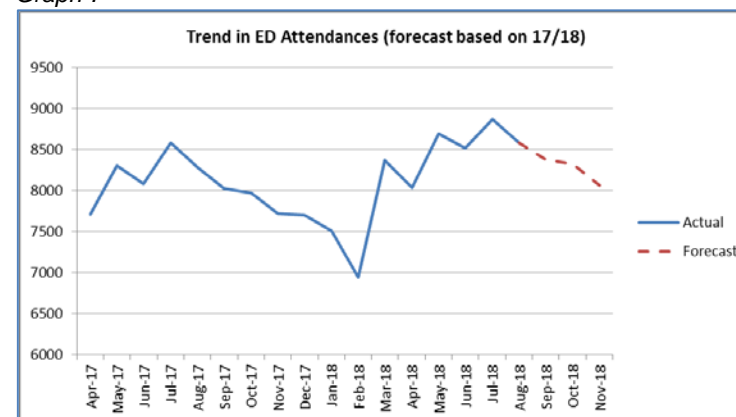
We are currently working with the Dorset-wide 'Ambulance Pillar Group' to review specific patterns and potential interventions to reduce this and the related 'surge' pressure. Ongoing audits will continue to inform this which includes:

- Understanding alternative pathways/interventions for those conveyed patients who are discharged quickly from ED
- Working with GPs and paramedics to improve our 'Bed Bureau' service, providing greater specialist advice and alternative pathways to ambulatory/acute medical care
- Support for care homes to avoid unnecessary/inappropriate conveyances.

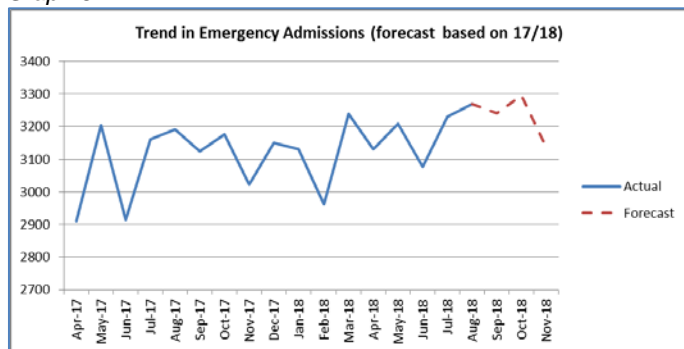
A meeting is being held at Executive level to review further action required.

Going forward, as we move away from the summer months we do still expect to see attendances reducing, however, recent trends suggest a recovery to previous levels will not be achieved. Furthermore, acuity tends to increase resulting in longer lengths of stay and increased bed pressures.

Graph 7 –



Graph 8 –



Our Q.2 ED 4 Hour performance to date (as at 17.09.18) is 94.15%. This means we are now unable to meet the national 95% target but do have a small tolerance remaining which would allow us to secure our PSF trajectory which is 93.86%. However, the pressures outlined above, together with staff sickness mean this remains an extremely challenging target for the rest of September.

Progress against the ED Action Plan and learning from our Action Learning Weekend continues (*further detail is available in our action plan progress tracker*). Our zero based rota exercise is nearing completion with the proposal paper being submitted to key committees early September.

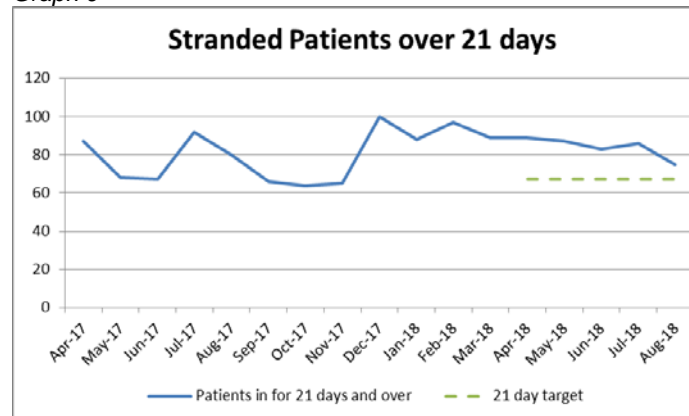
Working with Partners and 21+ Day Stay ('Stranded') Patients

We continue to see patients streamed to the RBH based, Urgent Treatment Centre. This is expected to improve further as capacity increases from the autumn.

The other key area of work remains around the 21+ day stay patients. To date we have remained above the end October target (see graph 9) however, the national transformation funds have now been confirmed and the priority projects for the East RBH 'hub' include:

- CHC pathway transformation supported by a transformation lead and working towards digital processes
- Support for complex discharge patients from 'Stranded patient' advisor and nurse/therapist roles
- Multidisciplinary/multi-organisational weekly meetings focusing on 7-14, 14-21 and 21+ day patients
- Action learning days.

Graph 9 –



Winter Planning Update

Finally for this month's report, our winter plan is being presented to our Trust Management Board, Board of Directors and Dorset system winter preparedness workshop in September. Our planning is also being supported by an internal winter preparedness event which will facilitate further testing of our escalation protocols and actions. Clearly, the winter period remains a significant risk to our ongoing ED 4 Hour performance and PSF. Modelling to date suggests ongoing work is required in advance of and over winter to reduce conveyances and length of stay/stranded patients, as well as convert more pathways to ambulatory care and reduce process and decision making delays in hospital.

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

Elective pathways and deterioration against waiting lists across England is now causing national concern. A number of Trusts, including ourselves, received a letter from Ian Dalton, Chief Executive – NHSI, outlining the requirement to meet the total waiting list target at the end March 2019 as well as avoid 52 week waits. This required that issues were scrutinised at Board level.

In July, both the Finance Committee and Board of Directors received a detailed 'deep dive' presentation outlining the significant work and processes aimed at managing and improving RTT waiting lists, as well as outline forward plans. This work continues, however, a number of particular pressures have meant that our total waiting list trajectory currently remains a challenge. The reasons are several-fold and include cancer 'carve out' pressures (where fast track demand has been well above plan), unplanned medical staff gaps, recruitment challenges and unexpected deterioration in theatre staffing vacancies. We have a number of plans developed at the outset of the year (or during the year in response to unexpected demand or capacity pressures) that come on line for the second half of the year. These include:

- Substantive replacement, locum or additional medical posts (e.g. Ophthalmology, Colorectal, Dermatology, Urology)
- Activity priority plans that included activity to offset increased cancer fast tracks, though note these were based on 8% growth overall
- Job planned weekend sessions in small number of specialities from September
- Appointment of nurse practitioners/specialist nurses to support pathways (e.g. Colorectal)
- Theatre staffing recruitment and reduced sickness absence expected from September 2018

- Endoscopy recovery programme, including additional and insourced sessions
- Other in/outsourcing as per plan – Dermatology, Urology.
- Continued transformational work through the Right Referral, Right Care Programme (e.g. tele-dermatology app rollout from 17/9).

However, review both internally and across the Dorset integrated system suggests that the total waiting list targets may not be met, particularly based on current 'run rate' and upcoming winter risks given the increased levels of attendance, conveyance and admission. This is at least, without additional financial support. The Dorset Operations and Finance Reference Group have requested a review across the system of the potential impact of planned transformation activity and actions (e.g. RBH Q.2/3 existing plans) on this position. This is being presented within the month and further update will be brought to the Finance Committee and Board of Directors.

On a more positive note, whilst our RTT 18 Week performance reduced in August, as highlighted above our overall waiting list did see a slight improvement. This was partly due to our tracking team (now at full complement and able to 'pull' patients through the system) as well as some areas of increased activity (e.g. Orthopaedic follow ups) that assisted with reducing delays in our RTT pathways.

Further elements of our elective 'must do' activity and productivity plan are expected to come on line over the coming months (e.g. Ophthalmology cataract capacity, Oral Surgery clinics). However, the significant impact of 'carve out' for the increase in cancer fast track referrals continues presenting continued risk to our RTT and waiting list targets overall. Furthermore, capacity pressures in Dermatology and Endoscopy (see 3.4 below) increase performance risk further.

Projecting our trend forward **if** our waiting list followed a similar pattern to last year (rather than 'run rate' as mentioned above) also points to a

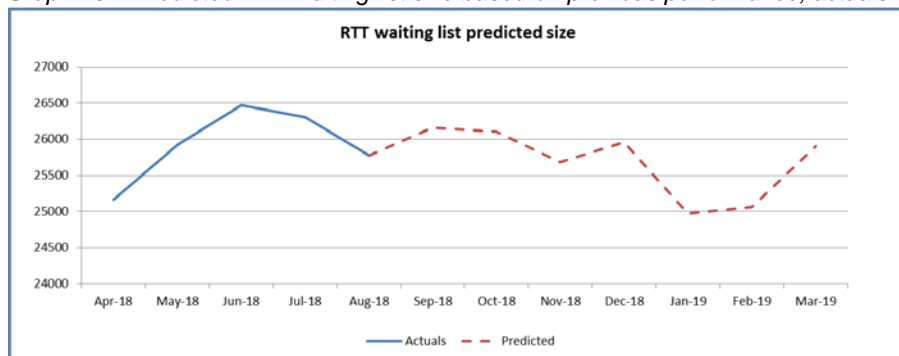
Operational Performance Report

As at 17/09/2018

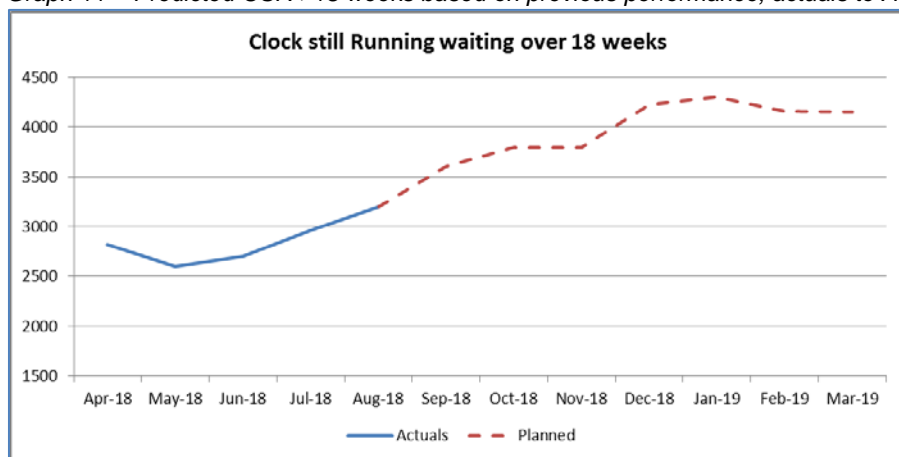
high risk of non-compliance with the national total waiting list requirement in March 2019. Over 18 week waiters would also follow an increasing pattern.

Whilst the locally based Independent Sector capacity may provide a potential solution to some capacity issues, currently our financial envelope restricts this to only a few targeted cases/specialities already in our planning.

Graph 10 – Predicted RTT waiting list size based on previous performance, actuals to Aug-18



Graph 11 – Predicted CSR >18 weeks based on previous performance, actuals to August-18



It should be noted that the additional pressures on our overall waiting list do mean that sustained reduction in the number of 40+ week wait patients remains challenging, though is closely monitored with escalated actions.

Table 2- 40+ week incomplete pathways by specialty

Specialty	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
General Surgery	13	14	13	14	13	18
Urology	32	30	35	20	18	16
Trauma & Orthopaedics	8	4	12	11	5	3
Ear, Nose & Throat (ENT)	1	2	2	5	4	3
Ophthalmology	3	0	0	1	5	1
Oral Surgery	1	0	0	1	2	3
Cardiothoracic Surgery	0	0	0	0	0	0
General Medicine	2	3	3	1	1	5
Cardiology	1	1	0	4	5	0
Dermatology	6	2	4	5	3	10
Thoracic Medicine	0	0	0	0	0	0
Neurology	0	0	0	0	0	0
Rheumatology	0	0	0	0	0	0
Geriatric Medicine	1	0	0	0	0	0
Gynaecology	3	4	3	2	4	8
Other	4	0	1	2	2	5
Total	75	60	73	66	62	72

3.3 62 Day from Referral/Screening for Suspected Cancer to Treatment

Our performance in July recovered to above the national 85% target with our performance at 86.1%. There were 16.5 breaches in July where as usual, there was a majority in Urology with 10, we also saw breaches in Lung (2.5), UGI (1.5), Breast (1), Haematology (1) and Head and neck (0.5). The most common reason for breaches was complex diagnostic pathway, with patient choice and limited elective capacity the other main reasons. Due particularly to the impact of increased Urology and Colorectal fast track referrals YTD; we are currently predicting non-compliance for August.

The Dorset Cancer Partnership are fully sighted on the additional fast track pressures across the tumour sites and particularly in Urology,

Colorectal, Skin and others. The partnership is currently reviewing existing cancer pathway related resource and how this may be utilised differently to support pathways most affected. Further detail will be provided as finalised. Current projections indicate further non-compliance in August for 2 week wait referrals, particularly due to demand and capacity challenges in Dermatology.

The number of 104+ day (backstop) patients has reduced to 19, 5 of which may not have cancer confirmed. 15 are in Urology where the additional demand pressure has been seen, but noting patient choice (e.g. holidays), complexity of pathways and transfers from other providers have also contributed to extended pathways. The clinical review process remains in place. Of the 14 with a confirmed decision to treat, all have a treatment date planned in September or October.

3.4 Diagnostic 6 Week Wait

Our performance against the 6 week diagnostic standard remained below the 99% target with our performance at 93.9% for August as expected. Most of the breaches continue in Endoscopy where the waiting list size has remained at a similar level to July at 218. Additional internal sessions as well as insourcing are being implemented as part of the recovery plan. Current indications are recovery will be achieved in November 2018, though risk remains if fast track referrals as well as staff sickness remain at higher levels.

Urology cystoscopies remain a risk with the overall pressures on Urology. Locum capacity and plans as part of the Dorset Cancer Partnership work are expected to assist in mitigation.

4. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail.

Two C Difficile trajectory cases (evidence of lapse in care) were confirmed in August, though we remain within YTD trajectory.

Overall cancer fast track demand challenges together with small numbers of cases, meant symptomatic breast and consultant upgrade targets were below threshold.

Positively, the Trust has continued to maintain Sentinel Stroke National Audit Programme level A with a score of 90 in the last published results (Dec-Mar 18). Our score puts us within the top 3% in the country. Internal ongoing monitoring indicates our quality performance continues to be maintained.

Recommendation

The Board of Directors is requested to note the August performance and the Performance Matrix. It should also note the expected performance, risks and actions relating to 18/19 requirements.

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	N/A
Subject:	Quality Report
Section on agenda:	Performance
Supplementary reading:	None
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Fiona Hoskins: Deputy Director of Nursing and Midwifery Laura Northeast: Head of Patient Experience Jo Sims: Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Not Applicable
Action required:	Note for information
Summary: The Quality report is a summary of the key quality indicators in Month. There was 1 Serious incident reported in August and 1 incident which meets the criteria of a never event reported in September The Trust was back into the top quartile for inpatient FFT for July. ED and OPD FFT responses remained in second quartile. A total of 43 complaints were received in August 2018. All were acknowledged within three days.	
Related strategic objective:	
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	N/A



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Quality Report

For the period to end

August 2018

Paula Shobbrook
Director of Nursing and Midwifery

Quality Report: August 2018

1.0 Introduction

This report accompanies the Trust Quality Dashboard and outlines the Trust's 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

One serious incident was reported in August 18.

A patient died following diagnosis and treatment which required debridement surgery. This was investigated and reviewed by a panel which identified with some gaps in care. This case has been submitted and confirmed closed by CCG

One serious incident has been reported in September which meets the definition of a Wrong Prosthesis Never Event. A scoping meeting has been undertaken. Immediate actions carried out and an investigation is in progress.

The outcomes will be reviewed by the Healthcare Assurance Committee

3.0 CQC Insight Model

The CQC have not updated the Insight report for the Trust this month.

4.0 Patient Experience Report

4.1 Friends and Family Test: August report

Benchmarking information is provided by NHS England which is retrospectively available and therefore, represents July 2018 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in July 2018 ranked RBCH Trust 3rd with 26 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 20.3%.
- The Emergency Department FFT performance in July 2018 ranked RBCH Trust 11th with 9 other hospitals out of 140 placing RBCH ED department in the second quartile. The response rate 11.1% against the 15% national standard.
- Outpatients FFT performance in July 2018 ranked RBCH Trust 4th with 34 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 2018

	February	March	April	May	June	July
In-Patient Quartile						
Top	98.665%	98.469%		98.374%		98.213%
2			97.741%		97.939%	
3						
Bottom						
	February	March	April	May	June	July
ED Quartile						
Top						
2	87.545%			89.607%	89.427%	89.591%
3		86.083%	87.588%			
Bottom						
	February	March	April	May	June	July
OPD Quartile						
Top						
2	96.944%	96.880%	97.536%	97.643%	97.164%	97.037%
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	43	40	95.0%	0.0%
Main OPD Xch	N/A	36	35	100.0%	0.0%
Oral and Maxillofacial	N/A	2	1	100.0%	0.0%
Outpatients General	N/A	238	232	98.7%	0.0%
Jigsaw OPD	N/A	7	7	85.7%	14.3%
Corporate Total		326	315	98.1%	0.3%

4.3 Care Campaign Audit Data

Following consultation, the CCA is in the early stages of redesign with trials of the new format being commenced in the end of September. The CCA will take on the format of qualitative methodology with survey volunteers having 'Care Conversations' with patients asking them to describe the positive and negative experiences they have had in relation to four themed areas.

5.0 Complaints

5.1 A total of 43 complaints were received in August all of which were acknowledged within 3 days. Of note complaints have begun to show a downward trend with the highest themes being:

- Implementation of care
 - Quality / Suitability of Care / Treatment
- Access
 - Admission / Discharge / Transfer issue
- Implementation of care
 - Complication of Treatment

Total Complaints received Year to date: 183

5.2 Complaint response times year to date are outlined in table 3. There has been an improvement in the complaint response rates from May 2018 and a focus on addressing complaints and concerns proactively.

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Rolling 12 months
1st Responses Due in Month	17	36	21	37	29	17	26	43	33	36	40	31	366
Number Where 1st Response Completed On Time	13	21	13	26	18	13	17	27	23	26	30	21	248
Percent With 1st Response On Time	76%	58%	62%	70%	62%	76%	65%	63%	70%	72%	75%	68%	68%

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:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Finance Report
Section on agenda:	Performance
Supplementary reading:	Yes
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Chris Hickson, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required:	Note for information
Summary: <p>The Trust continues to deliver against its agreed financial control total; however there remains a material forecast shortfall against the cost improvement programme. Detailed financial recovery plans have been prepared which has mitigated the risk substantially; however some slippage has been reported during August resulting in the overall forecast outturn deteriorating. A continued focus is required to ensure the Trust achieves its agreed regulatory control total.</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?	 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Impact on risk profile:	Two financial and performance risks recorded 2018/19 on the risk register for monthly review by Committee



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Finance Report

For the period to end

31 August 2018

Pete Papworth
Director of Finance

Executive Summary

As at 31 August the Trust has delivered a cumulative deficit of £1.523 million, being £51,000 better than budget. However, this has been achieved by a number of non-recurrent benefits which are masking a substantial underlying financial challenge. Most notably, there remains a material shortfall of £2.4 million against the full year cost improvement programme.

As a result of this, during August all directorates continued to refine their financial recovery plans following significant scrutiny and challenge and these now provide adequate assurance that the Trust will continue to meet its agreed financial control total.

Income & Expenditure

As at 31 August income is behind plan by £2.701 million due to pass through drugs and devices. After adjusting for this; income is behind plan by £373,000 which is mainly being driven by Non NHS Clinical Income which is £385,000 behind planned levels. NHS Clinical Income is planned to increase in the latter part of the year following the resolution of some key workforce challenges, and this will need to be carefully monitored as it represents significant risk if not achieved.

Expenditure reported an aggregate underspend of £2.752 million, mainly due to pass through drugs and devices. After adjusting for this; expenditure is £0.424 million underspent comprising a £0.831 million overspend against the Trusts pay budget, together with a pressure of £0.700 million in relation to general drugs expenditure. These are currently being off-set by savings against non-pay budgets.

Provider Sustainability Fund (PSF)

As reported previously, the Trust has been allocated a total of £9 million through the PSF for 2018/19. The Trust is part of the Dorset Integrated Care System (ICS) which has accepted a system control total approach. As such, up to £6.3 million is secured for the Trust if the Dorset ICS achieves its cumulative financial control total. The remaining £2.7 million is realised if the Trust achieves its trajectory in relation to the Accident and Emergency 4 hour access standard.

The PSF income relating to quarter one was achieved in full, with the system financial control total met and the Trusts A&E performance being 0.04% above the agreed trajectory. The ICS expects to achieve the quarter two financial control total and at present the Trust is well placed to achieve the Accident and Emergency performance element with current performance standing at 94.05% against the trajectory of 93.86%.

Forecast Outturn

The Trust is currently forecasting a full year deficit of £2.381 million, consistent with the revenue control total agreed with NHS Improvement. However, there remains considerable risk within this forecast given the shortfall against the Cost Improvement Plan requirement. As such, a continued focus must remain on delivering the agreed financial recovery actions to ensure the control total is achieved.

Cost Improvement Programme

As at 31 August financial savings of £4.444 million have been achieved. This represents a shortfall of £0.788 million against the year to date planned value of £5.232 million.

The risk adjusted base forecast for 2018/19 delivers a total forecast saving of £10.311 million. This compares to the full year savings requirement of £12.697 million which equates to 4.5% of operating costs. The current forecast ranges from £10.054 million to £11.639 million, and further schemes continue to be identified to close this gap.

Employee Expenses

The Trust continues to carefully manage its workforce, with a relentless focus on recruitment and retention to minimise the need for agency staffing. However, whilst agency expenditure remains comparatively low, the cumulative cost of bank, agency and overtime is higher than the Trust's vacancy budget by £0.831 million.

Agency expenditure as a percentage of pay budgets increased from 1.93% in July to 2.04% during August. This upward trend is shown graphically overleaf and reflects the particular challenges within the Medical Care Group with recruitment challenges across both the medical and nursing staffing templates together with the continued investment in the delivery of the A&E access standard.

Capital Expenditure

Capital expenditure amounting to £2.486 million has been committed, which is £1.239 million behind budget. This reflects the timing of expenditure, particularly in relation the phasing of the Catheterisation Laboratory and Radiology refurbishment schemes and the implementation of the Informatics data storage programme. The full year forecast for capital expenditure remains at planned levels.

Cash

The Trust is currently holding a consolidated cash balance of £34.6 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.

Financial Risk Rating

In line with the agreed financial plan, the Trust has achieved a Use of Resources rating of 3 under NHS Improvement's Single Oversight Framework (1 being best and 4 being worst). This is expected to improve to a rating of 2 from October.

Recommendation

Members are asked to note the Trust's financial performance for the period ending 31 August 2018.

Finance Report

As at 31 August 2018

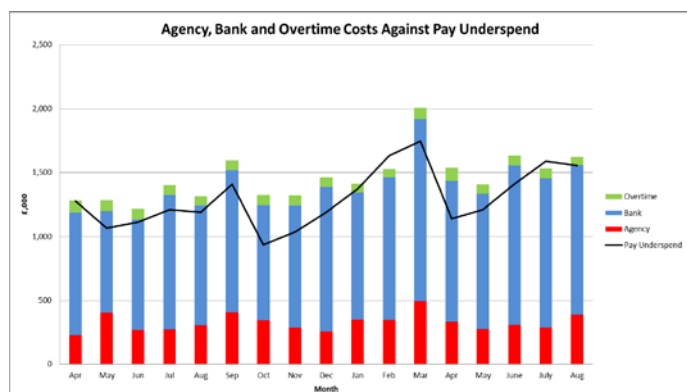
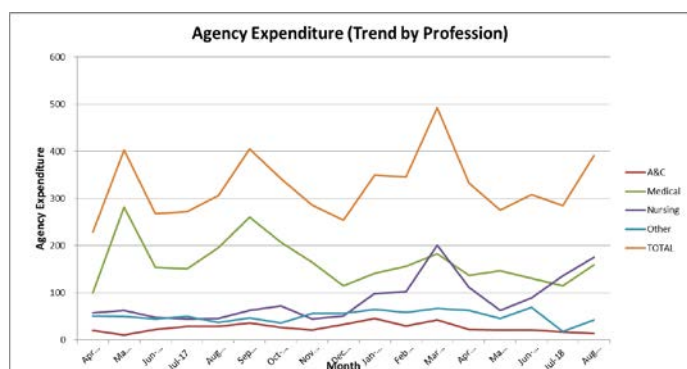
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000	Pass Through £'000	Residual Variance £'000
NHS Clinical Income	109,620	107,442	(2,178)	2,328	150
Non NHS Clinical Income	2,621	2,236	(385)	0	(385)
Non Clinical Income	16,532	16,393	(138)	0	(138)
TOTAL INCOME	128,772	126,071	(2,701)	2,328	(373)
Employee Expenses	78,177	79,008	(831)	0	(831)
Drugs	14,971	13,644	1,327	(2,027)	(700)
Clinical Supplies	15,126	14,601	526	(301)	225
Misc. other expenditure	22,071	20,341	1,730	0	1,730
TOTAL EXPENDITURE	130,346	127,594	2,752	(2,328)	424
SURPLUS/ (DEFICIT)	(1,574)	(1,523)	51	0	51

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	76,302	76,302	0
NHS England (Wessex LAT)	20,403	18,307	(2,097)
NHS West Hampshire CCG (and Associates)	10,608	10,587	(21)
Other NHS Patient Income	2,307	2,246	(61)
Provider Sustainability Fund	2,550	2,550	0
Non NHS Patient Income	2,621	2,236	(385)
Non Patient Related Income	13,982	13,843	(138)
TOTAL INCOME	128,772	126,071	(2,701)

Provider Sustainability Fund Income	Year to Date			Full Year Forecast		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Financial: System Control Total (70%)	1,785	1,785	0	6,300	6,300	0
Performance: A&E Trajectory (30%)	765	765	0	2,700	2,700	0
Incentive	0	0	0	0	0	0
TOTAL	2,550	2,550	0	9,000	9,000	0

Agency Expenditure

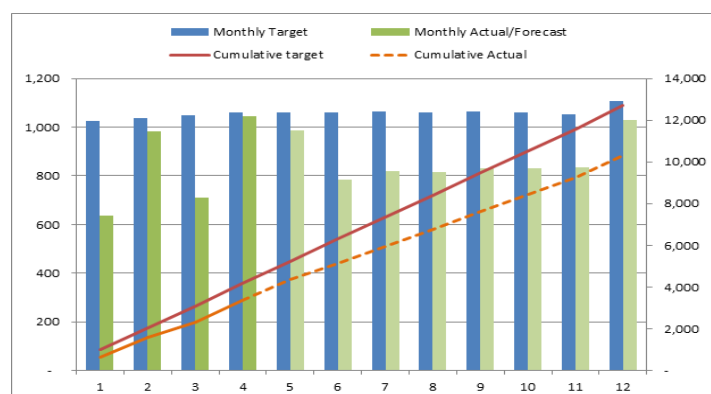


Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	5,268	4,463	(805)
Medical Care Group	3,422	2,373	(1,049)
Specialties Care Group	2,497	2,187	(310)
Corporate Directorates	(14,946)	(14,852)	94
Centrally Managed Budgets	2,185	4,305	2,120
SURPLUS/ (DEFICIT)	(1,574)	(1,523)	51

Cost Improvement Programme

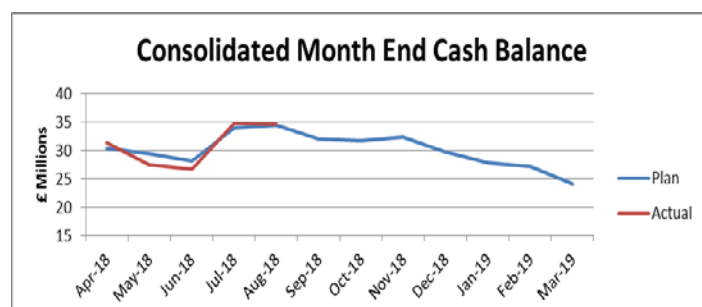
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000	Base Forecast £'000
Surgical Care Group	909	554	(355)	1,427
Medical Care Group	1,254	857	(397)	1,899
Specialties Care Group	903	489	(414)	1,372
Corporate Directorates	2,166	2,544	378	5,613
SURPLUS/ (DEFICIT)	5,232	4,444	(788)	10,311



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	1,940	1,259	681
IT Strategy	1,270	833	437
Medical Equipment	380	392	(12)
Centrally Managed	135	2	133
SURPLUS/ (DEFICIT)	3,725	2,486	1,239

Cash





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

BOARD OF DIRECTORS	
Meeting date:	26 September 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 6/9/18.
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Karen Allman
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 items to highlight to the Board from Workforce Committee.	
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 Bournemo
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Workforce Report

For the period to end































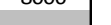




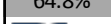

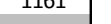


























August 2018

Karen Allman
Director of Human Resources

Workforce Report for August Board pack

As at 31st August 2018

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 August			Rolling 12 months to 31 August				At 31 August
Surgical	53.0%	91.8%	93.8%	4.21%	14588	11.2%	9.2%	
Medical	63.5%	86.4%	93.0%	3.48%	18034	12.4%	9.3%	
Specialities	61.5%	89.1%	95.5%	4.14%	13158	9.7%	10.6%	
Corporate	59.6%	100.0%	95.4%	4.41%	13864	5.9%	7.7%	
Trustwide	59.8%	89.2%	94.1%	3.99%	59644	10.1%	9.2%	

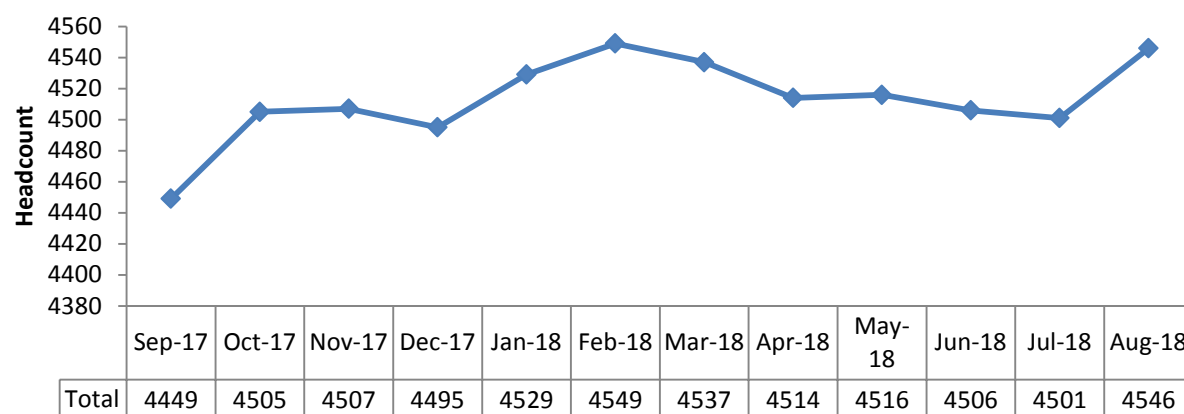
Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 August			Rolling 12 months to 31 August				At 31 August
Add Prof Scientific and Technical	68.4% 		95.9% 	3.67% 	1790 	9.9% 	9.2% 	
Additional Clinical Services	58.0% 		93.3% 	5.78% 	15732 	17.8% 	12.9% 	
Administrative and Clerical	62.2% 		96.1% 	3.82% 	12045 	8.2% 	9.9% 	
Allied Health Professionals	60.8% 		93.9% 	2.71% 	2583 	12.8% 	11.4% 	
Estates and Ancillary	47.2% 		92.9% 	6.56% 	8006 	8.1% 	7.3% 	
Healthcare Scientists	64.8% 		98.1% 	3.23% 	1161 	6.6% 	6.6% 	
Medical and Dental		89.2% 	90.9% 	1.10% 	1990 	4.3% 	3.9% 	
Nursing and Midwifery Registered	61.4% 		94.5% 	3.83% 	16337 	8.1% 	7.7% 	
Trustwide	59.8% 	89.2% 	94.07% 	3.99% 	59644 	10.1% 	9.2% 	

Workforce Report for August Board pack

As at 31st August 2018

1. Staffing and Recruitment

Substantive Staff (Headcount) Trend

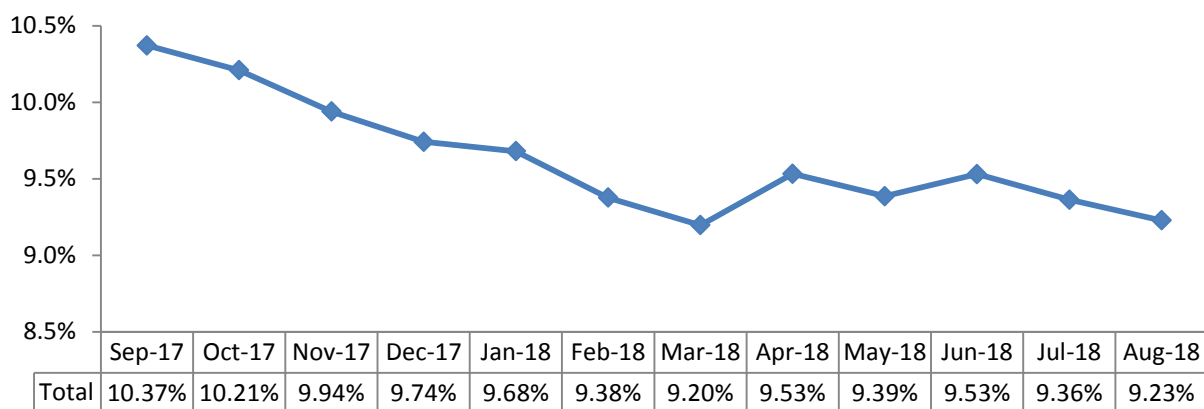


Turnover rate down to **9.23%** from 9.36% the previous month, and this represents a 1.33% reduction on the 10.56% seen at the same point last year.

Joining rate 10.1% and continues at a higher level than the turnover rate.

Vacancy rate unavailable at the time of writing (6.1% at 31st July).

Permanent Staff Turnover Rate (Headcount)



Workforce Report for August Board pack

As at 31st August 2018

2. Essential Core Skills Compliance

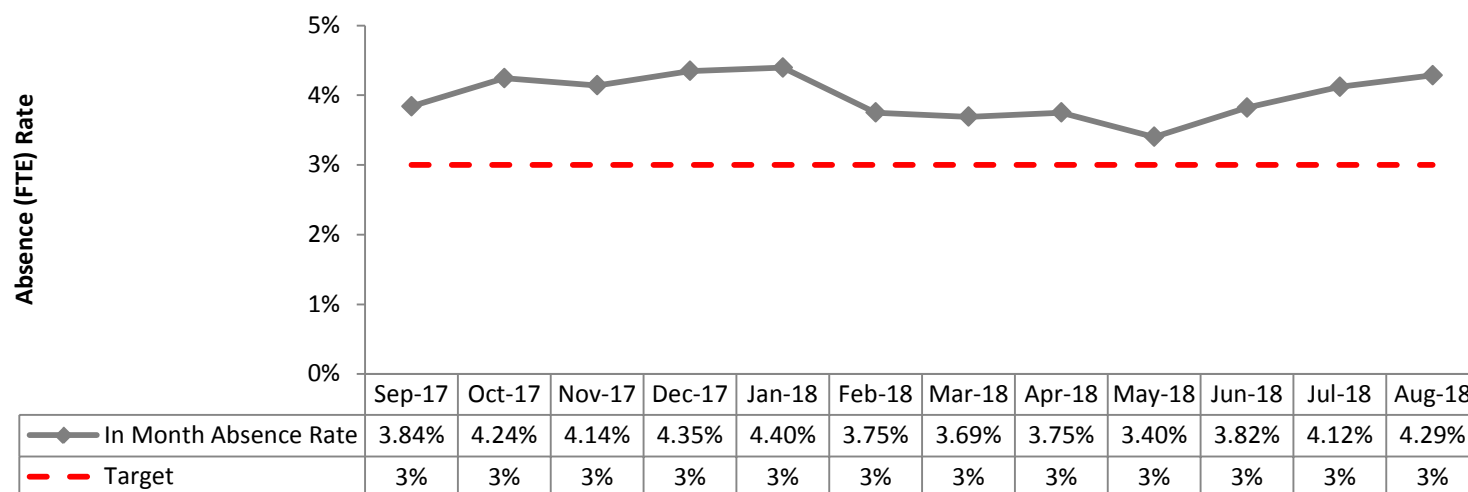
Compliance for the month improved 0.4% to 94.1% as at 31st August, passing the 94% mark for the first time, with Specialties care group at 95.5% and Corporate areas 95.4%, both above the 95% target. Compliance for Medical & Dental staff showed a 2% improvement to 91% from 89%; this continues to be closely monitored by the Medical Director.

Fire remains a prime area for focus and it has been agreed that this will now move to two-yearly (aligned across Dorset) and will be via an e-learning module which is currently in development, plus ward evacuation training for appropriate roles. This new approach will relieve the time pressures involved in attending face-to-face training which should help to increase compliance.

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)



Workforce Report for August Board pack

As at 31st August 2018

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Surgical	4.21%	4.21%	4.49%	4.53%	4.70%	3.90%	4.85%	4.21%	3.70%	4.24%	4.38%	4.12% ↓
Medical	3.61%	3.60%	3.34%	4.03%	4.27%	3.70%	2.88%	3.45%	2.43%	2.77%	3.58%	3.75% ↑
Specialties	3.79%	4.21%	4.77%	4.48%	4.32%	3.79%	3.51%	3.77%	3.66%	3.82%	4.31%	5.08% ↑
Corporate	3.86%	5.36%	4.44%	4.53%	4.35%	3.63%	3.94%	3.73%	4.41%	5.08%	4.53%	4.55% ↑
Trust	3.84%	4.24%	4.14%	4.35%	4.40%	3.75%	3.69%	3.75%	3.40%	3.82%	4.12%	4.29% ↑

Sickness absence has increased slightly for August at 4.29% overall, up from 4.12% last month. A 0.26% improvement was seen for the Surgical care group although this remains red. Despite an increase for the Medical care group they retain an amber rating at 3.75%. The largest increase was for the Specialties care group, up 0.77% to 5.08%. This result is disappointing in view of the continued focus being given to managing sickness and the health and wellbeing initiatives being promoted within the Trust, and it is hoped to see a reversal of this trend soon. The rolling 12 month for the same point last year was 4.25% so this year's 3.99% still represents a significant reduction year on year.

4. Workforce Committee

The Workforce Strategy & Development Committee met on 6th September and the minutes are included in the reading pack. Items to highlight to the Board as noted therein are:

- The Safe Staffing Assurance report was reviewed and accepted by the Committee as providing the appropriate assurances. A summary paper will be submitted to the Board in September.
- Health & Wellbeing - Flu update: The vaccines have arrived early; our campaign was due to start at the beginning of October but we are endeavouring to bring this forward, subject to staffing resource. This year we will use the quadruple vaccine which protects against 4 different strains, rather than the triple version used previously.
- Health & Wellbeing - Staff Physiotherapy service : Since the service transferred to Occupational Health improvements have been made into the reduction in sickness absence and the service model has supported a 9% reduction in musculoskeletal issues. The Staff Physiotherapists are also carrying out more case conferences on complex health issues and extending their skills in other areas including mental health.
- AHPST – The Committee received an update on the work being undertaken to formulate a strategy with regard to Allied Health Professionals, Scientific and Technical Staff. Priority areas and deliverables were outlined, aligning with our own People Plan and recruitment strategies, and also across Dorset and nationally. Work continues, with a plan to bring back to Committee in December before then bringing to Board for approval.

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Clinical Audit Plan 2018/2019
Section on agenda:	Governance
Supplementary reading:	Clinical Audit Plan
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Jo Sims, Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Clinical Audit and Effectiveness Group 26 th July 2018, Audit Committee 9 th August 2018
Action required:	Recommend
<p>Summary:</p> <p>The Trust Clinical Audit plan for 2018/19 encompasses the statutory and mandatory requirements for clinical audit and includes clinical services local plans for audits, service evaluations and patient feedback surveys.</p> <p>The plan includes:</p> <ul style="list-style-type: none"> • Relevant National Audits (HQIP) and Quality Account Listed audits • Quality priorities audit requirements (e.g. Medicines Management, Infection Control, Patient Safety, Information Governance and Safeguarding) • Contractual audits / CQUIN audits <p>In addition, each Directorate has identified a minimum of 5 clinical audits linked to relevant NICE guidance, risk issues and/or quality priorities for their services.</p> <p>The plan has been reviewed by the Clinical Audit and Effectiveness Group (CAEG) and shared with the Audit Committee prior to being approved by the Trust Management Board (TMB) and Board of Directors.</p> <p>Completion of the plan will be monitored as follows:</p> <ul style="list-style-type: none"> • The Clinical Audit Department will provide a monthly report to directorates audit leads showing all uncompleted projects, and their current status • The Clinical Audit and Effectiveness Group (CAEG) will receive and 	



The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

review a monthly report of new projects registered and all audit reports received, including relevant action plans. CAEG will also review reports of incomplete projects, projects not yet registered and any archived projects. CAEG will, as appropriate, request additional details of quality improvement actions required to mitigate risk and/or will share learning across the Trust.

- CAEG will receive presentations on National Audit reports as appropriate and escalate any issues to the Healthcare Assurance Committee and Board of Directors as required.
- The Associate Director of Quality and Risk will produce a quarterly report of progress against all statutory, mandatory and contractual audits. The report will be presented to the Audit Committee for information and to the Clinical Commissioning Group for assurance.

Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	✓ ✓ ✓ ✓ ✓
Impact on risk profile:	None

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Clinical Audit Plan 2018 - 2019

Title	Care Group	Directorate
Quality Account Audits (Audits featuring on the NHS England Quality Accounts List 2018/19)		
Adult Community Acquired Pneumonia	B	Medical
BAUS Urology Audit - Cystectomy	A	Surgical
BAUS Urology Audit - Nephrectomy	A	Surgical
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	A	Surgical
BAUS Urology Audit – Radical Prostatectomy	A	Surgical
Cardiac Rhythm Management (CRM)	B	Cardiology
Case Mix Programme (CMP)	A	Anaesthetics
Elective Surgery (National PROMs Programme) - Hip and Knee replacement	A	Orthopaedics
Falls and Fragility Fractures Audit Programme (FFFAP) - Inpatient Falls	B	OPM
Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database	B	OPM
Feverish Children (care in emergency departments)	B	Medical
Inflammatory Bowel Disease programme / IBD Registry	B	Medical
Learning Disability Mortality Review Programme (LeDeR)	C	Corporate
Major Trauma Audit	B	Medical
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	C	Pathology
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	A	Maternity
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality and Morbidity confidential enquiries (collecting data but not publishing a report this year)	A	Maternity
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality surveillance and mortality confidential enquiries	A	Maternity
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries	A	Maternity
Medical and Surgical Clinical Outcome Review Programme x2 new workstreams TBC		
Medical and Surgical Clinical Outcome Review Programme - Pulmonary Embolism	B	Medical

Medical and Surgical Clinical Outcome Review Programme - Acute Bowel Obstruction	A	Surgical
Myocardial Ischaemia National Audit Project (MINAP)	B	Cardiology
National Asthma and COPD Audit Programme - Pulmonary Rehabilitation	B	Medical
National Asthma and COPD Audit Programme - COPD secondary care	B	Medical
National Asthma and COPD Audit Programme - Adult Asthma secondary care	B	Medical
National Audit of Breast Cancer in Older People	A	Surgical
National Audit of Cardiac Rehabilitation	B	Cardiology
National Audit of Care at the End of Life (NACEL)	C	Cancer Care
National Audit of Dementia	B	MFE
National Audit of Intermediate Care	B	
National Audit of Percutaneous Coronary Interventions (PCI)	B	Cardiology
National Bariatric Surgery Registry (NBSR)	A	Surgical
National Bowel Cancer Audit (NBOCA)	A	Surgical
National Cardiac Arrest Audit (NCAA)	A	Anaesthetics
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	C	Specialist Services
National Comparative Audit of Blood Transfusion programme - Management of massive haemorrhage	C	Pathology
National Diabetes Audit – Adults - National Diabetes Foot Care Audit	B	Medical
National Diabetes Audit – Adults - National Diabetes Inpatient Audit (NaDia) -reporting data on services in England and Wales	B	Medical
National Diabetes Audit – Adults - National Core Diabetes Audit	B	Medical
National Diabetes Audit – Adults - National Diabetes Transition	B	Medical
National Diabetes Audit – Adults - National Pregnancy in Diabetes Audit	B	Medical
National Emergency Laparotomy Audit (NELA)	A	Anaesthetics
National Heart Failure Audit	B	Cardiology
National Joint Registry (NJR)	A	Orthopaedics
National Lung Cancer Audit (NLCA)	B	Medical
National Maternity and Perinatal Audit (NMPA)	A	Maternity
National Mortality Case Record Review Programme	Trustwide	Trustwide
National Oesophago-gastric Cancer (NAOGC)	A	Surgical
National Ophthalmology Audit	C	Ophthalmology
National Prostate Cancer Audit	A	Surgical
National Vascular Registry	A	Surgical
Non-Invasive Ventilation - Adults	B	Medical

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption	C	Pathology
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship	C	Pathology
Sentinel Stroke National Audit programme (SSNAP)	B	MFE
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	C	Pathology
Seven Day Hospital Services	C	Corporate
Surgical Site Infection Surveillance Service	A	Surgical
UK Cystic Fibrosis Registry	B	Medical
Vital Signs in Adults (care in emergency departments)	A	Medical
VTE risk in lower limb immobilisation (care in emergency departments)	A	Medical
Other national audits		
Breast and Cosmetic Implant Registry (BCIR)	A	Surgical
BAUS Urology Audit – Urethroplasty Audit	A	Surgical
Endocrine and Thyroid National Audit	A	Surgical
Head and Neck Cancer Audit	A	
Investigation and Detection of urological Neoplasia in patients referred with suspected Urinary Tract Cancer (IDENTIFY)	A	Surgical
Mimic: A multi centre cohort study evaluating the role of inflammatory markers in patients presenting with acute ureteric colic (Mimic)	A	Surgical
National Acute Kidney Injury Programme	A	Medical
National Audit of Small Bowel Obstruction	A	Surgical
Perinatal Mortality Review Tool (TBC)	A	Maternity
Society for Acute Medicine's Benchmarking Audit (SAMBA)	B	Medical
Safety Thermometer	Corporate	Quality and Risk
PLACE	Corporate	Quality and Risk

Directorate audits		
Anaesthetics Directorate		
PACU Bottlenecks	A	Anaesthetics

WHO Checklist	A	Anaesthetics
Pain in PACU	A	Anaesthetics
PONV in PACU	A	Anaesthetics
Temperature in PACU	A	Anaesthetics
Orthopaedic Directorate		
Delayed discharge of THR and TKR patients on the Derwent due to wound ooze.	A	Orthopaedic
Audit of adherence to new STOP moment for implant checking in theatre	A	Orthopaedic
Theatre cancellations due to CSSD issues – re-audit	A	Orthopaedic
Genesis and Nexgen outcomes for TKR patients	A	Orthopaedic
Use of Diabetic Foot Emergency Admission Proforma	A	Orthopaedic
Surgical Directorate		
Do We Meet The NICE Recommendations for Women Offered Botulinum Toxin A (Botox)	A	Urogynaecology
Intravesical Instillation of Chemotherapy in Patients Undergoing Surgery for Upper Urinary Tract Urothelial Carcinoma	A	Urology
Breast Photography Audit	A	Breast
Are We Using the Guidelines When We Use the CRP to Detect Early Colorectal Leak?	A	Colorectal
Audit on Pregnancy of Unknown Location	A	Gynaecology
Maternity Directorate		
TAMBA	A	Maternity
PPH (reaudit following change to Syntometrine)	A	Maternity
Management of Antenatal/Postnatal Transfers	A	Maternity
Continuity of Antenatal Care in the Community	A	Maternity
BBA audit	A	Maternity
Medical Directorate		
Hyperkalemia	B	Medicine
Care process for type 1 diabetes	B	Medicine
Acute Kidney Injury audit	B	Medicine
Alcoholic liver disease - use of alcohol history and audit tool	B	Medicine
Referral of people with suspected celiac disease	B	Medicine
Older Person's Medicine Directorate		
Timeliness of CGA in Frailty Pathway	B	OPM
Dalteparin Prescription Duration in Elderly Care	B	OPM
Escalation Planning in Elderly Medicine	B	OPM
Outliers Audit	B	OPM
Fast Track CHC referral Audit	B	OPM

Stroke Services		
AF detection in TIA	B	OPM
Psychology provision re-audit	B	OPM
VTE prevention in stroke	B	OPM
Adherence to MUST scoring and onward referral to dietician	B	OPM
Cardiology Directorate		
Re-audit of NICE QS heart failure discharge plans	B	Cardiology
Re-audit of rapid access heart failure clinic waiting times	B	Cardiology
usefulness of telemetry in patients admitted with collapse	B	Cardiology
improvement in ejection fraction post STEMI	B	Cardiology
Atrial Fibrillation Ablation Complications and Outcomes Audit	B	Cardiology
Ophthalmology Directorate		
Audit of endophthalmitis after cataract surgery	C	Ophthalmology
Audit of endophthalmitis after anti-VEGF intravitreal injections	C	Ophthalmology
Audit of effectiveness of reception age vision screening	C	Ophthalmology
Comparison of visual acuity at referral, initial visit and discharge	C	Ophthalmology
Audit of macular hole repair outcomes	C	Ophthalmology
Audit of retinal detachment outcomes	C	Ophthalmology
Audit of corneal transplant outcomes	C	Ophthalmology
Radiology Directorate		
Current Orthopaedic clinical practice – do agreed ‘Clinician reported’ Radiographs fulfil 383/17?	C	Radiology
Cervical spine imaging in trauma.	C	Radiology
Re-audit of in-patient abdominal ultrasound requests.	C	Radiology
NICE pancreatic cancer guidelines.	C	Radiology
RFA outcomes.	C	Radiology
Specialist Services Directorate		
Audit of HSV PCR Tests Undertaken in the Department of Sexual Health Between April 2016 and March 2017	C	Dept of Sexual Health
Are We Following NICE Guidance in Our Use of Secukinumab in Psoriatic Arthropathy (TA445) and in Ankylosing Spondylitis (TA407)?	C	Rheumatology
Re-Audit of Advice Given to Patients About Symptoms of Cauda Equina Syndrome	C	Rheumatology
Audit of the Assessment of Rheumatology Patients on Glucocorticoids for Fracture Risk	C	Rheumatology

An Audit to Assess the Number of Fixed Appliance Breakages Within the Orthodontic Department in 2018	C	Orthodontics
Pathology Directorate		
Audit of D-dimers in deep vein thrombosis and pulmonary embolism	C	Haematology
Audit of appropriateness of Thrombophilia screen requests	C	Haematology
Audit of High Grade Dysplasia in Bowel Cancer Screening Polyps	C	Pathology
Audit the use of Transfusion Care Chart	C	Haematology
Functionality of Blood Track safe transfusion	C	Haematology
Cancer Care Directorate		
Audit to look at the number of patients in RBH known to Specialist Palliative Care who are outliers for the team who is responsible for them	C	Cancer Care
Audit of completion of Personalised Care Plan for the Last Days of Life	C	Cancer Care
Audit of Adherence with Checklists for Haematological Interventions: Bone Marrow Aspirate/Biopsy	C	Cancer Care
Audit of Adherence with Checklists for Haematological Interventions: Administration of Intrathecal Chemotherapy	C	Cancer Care
Audit of DPD	C	Cancer Care
Network audit of imaging in new diagnosis Myeloma patients and compliance to NICE guideline.	C	Cancer Care
Nursing, Quality and Risk Directorate		
Hand Hygiene Audit	Corporate	Infection Control
Saving Lives - Infection Control Audit	Corporate	Infection Control
Pillow Audit	Corporate	Nursing
MCA Audit	Corporate	Nursing
Products of Conception; The Robustness of the Policy – analysing time from Clinical Procedure to Sensitive Disposal	Corporate	Chaplains
Monitoring Mortuary Capacity	Corporate	Chaplains
Chaplaincy Referrals – analysing type of Chaplaincy Encounter.	Corporate	Chaplains
LERN Policy compliance	Corporate	Quality and Risk
Consent (reaudit)	Corporate	Quality and Risk
Tissue Viability - Patient evaluation of Service	Corporate	Quality and Risk
Waterlow Assessment Audit (Compliance v Accuracy)	Corporate	Quality and Risk
Wound care plan audit (CQUIN compliance)	Corporate	Quality and Risk
Review of the effectiveness of the Healthcare Assurance Committee and the Healthcare Assurance Group	Corporate	Quality and Risk
Patient Handover (Re-Audit)	Corporate	Quality and Risk
Medical Gas Outlet Audit	Corporate	Quality and Risk

Patient Identification/ Patient Wristband Audit	Corporate	Quality and Risk
Operations Directorate		
Facilities staff survey (three workstreams - catering, housekeeping, portering)	Corporate	Facilities
Patient Food Waste	Corporate	Facilities
Response to Red HAN calls (re-audit)	Corporate	Operations
RTT (Referral To Treatment) Delays	Corporate	Operations
Use of Urgent Treatment Centre	Corporate	Operations
Plated Waste Audit	Corporate	Facilities
Non Emergency Patient Transport - Patient Satisfaction and Staff Survey	Corporate	Facilities



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Strategy & Development Committee – Terms of Reference
Section on agenda:	Governance – 7(c)
Supplementary reading:	Minutes of the Workforce Committee meeting held on 6 th September are included in the reading pack.
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Karen Allman
Details of previous discussion and/or dissemination:	Reviewed at Workforce Committee on 11 th June and 6 th September
Action required:	Decision
Summary: The Terms of Reference for the Workforce Strategy & Development Committee were reviewed at their meeting on 11 th June; a further review was required post June month end to reflect updated committee membership; tabled and agreed at the meeting on 6 th September. The updated version is now tabled for Board approval.	
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:	

WORKFORCE STRATEGY AND DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

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

The Committee also acts as a means of internal assurance for compliance against the Care Quality Commission's fundamental standards of quality and safety and the safe, caring, effective and well-led domains; and the Trust objectives of Valuing our Staff and Strengthening Team Working

1. Membership

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

There will be one governor attending each meeting as an observer. Observers are not technically members of the Committee. This governor has been elected to undertake this duty by the Council of Governors by means of a ballot organised by the Trust Secretary in accordance with the process agreed by the Council of Governors.

- 1.4 It is expected that members attend a minimum of three meetings per year.
- 1.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.

2. Secretary

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

3. Quorum

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

4. Frequency of Meetings

The Committee shall meet every two months.

5. Notice of Meetings

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

6. Minutes of Meetings

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

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

7. Duties

The duties of the Committee can be categorised as follows:

7.1 People Strategy

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

7.2 Workforce Development and Planning

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

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

7.3 Recruitment and Retention

- 7.3.1 To effect the balance of demand for staff with its supply - to ensure that sufficient numbers of appropriate qualified personnel are available, in the right place and at the right time, with the right skills, to match the demand for their services.
- 7.3.2 To monitor attrition rates in order to anticipate deficits in numbers of personnel and identify and implement actions to minimize turnover wherever possible.

7.4 Training and Development

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

7.5 Organisational Development and Leadership

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

7.6 Equality, Diversity and Inclusion

- 7.6.1 To provide governance and oversight for the Trust's [Equality, Diversity and Inclusion](#) strategy.
- 7.6.2 The [Equality, Diversity and Inclusion](#) Committee will report to the Committee and will report on progress against action plans.

8. **Risk Management**

8.1 Role of the Workforce Development and Strategy Committee

The Workforce Development and Strategy Committee receives workforce reports from Care Groups and sub-committees, considers the mitigations and controls in place; highlighting any significant issues to the Healthcare Assurance Committee (HAC) and Trust Management Board.

A standard report template is used for sub-committee reports. The role of the template is for the sub-committees to highlight any significant risk issues to the WDSC for information, discussion or escalation.

The Committee will review the Trust's significant risks report and receive updates on directorate workforce risk issues, action plans or unresolved matters/concerns for escalation. The Committee will consider strategic workforce risk themes for escalation to HAC/Trust Management Board or Board of Directors.

Executive Directors sponsoring significant risks (as the Risk Owner) on the risk register will be responsible for ensuring that a monthly update on risk status is detailed within the risk record in order to update HAC/Board via the relevant 'Risk Register report'. Executive Directors leading on any corporate or Board

Assurance Framework risks on the Trust Risk Register will be asked to complete a separate quarterly report on compliance to the HAC.

8.2 Role of Directors

The Director of Human Resources has delegated responsibility for all aspects of human resource risk management, workforce, health & safety and for the co-ordination and implementation of the Trust's strategy for Occupational Health services.

Executive and Non-Executive involvement for specific areas of risk management, including the Board Assurance Framework risks, are identified as follows:

Risk Area	Executive Director Lead	Non-Executive Director Lead
HR and workforce	HR Director	Non-Executive Chair of the Workforce Strategy & Development Committee

9. Reporting Responsibilities

- 9.1 The Committee shall report bi-monthly on its activities to the Board of Directors by way of Minutes and any report by the Chairman.
- 9.2 The Committee shall provide annual assurance to the Board of Directors that the Care Quality Commission's relevant fundamental standards for quality and safety (Regulation 18) are monitored and shall highlight any risks, gaps in compliance, controls or assurance.

Regulation 18	<p>Staffing</p> <ol style="list-style-type: none"> 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 2. Persons employed by the service provider in the provision of a regulated activity must - <ol style="list-style-type: none"> a. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, b. be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and c. where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.
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- 9.3 The Committee will have a framework in place for monitoring the Key Lines of Enquiry for the CQC and provide annual assurance to the Board of Directors.

10. Other

The Committee shall:

- 10.1 have access to sufficient resources in order to carry out its duties;
- 10.2 give due consideration to laws and regulations;
- 10.3 oversee any investigation of activities which are within its terms of reference;
- 10.4 at least once a year review its own performance and terms of reference to ensure it is operating at maximum effectiveness and discuss any changes it considers necessary.

11. Authority

The Committee is authorised:

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

12. Supported Strategic Goals

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

- 12.1 To strive towards excellence in the services and care we provide;
- 12.2 To listen to, support, motivate and develop staff;
- 12.3 To support the Trust's corporate objectives and vision.

13. Sub-Committees

The following committees are established by and responsible to the Committee:

- Essential Core Skills Training Group
- [Equality, Diversity & Inclusion Committee](#)
- Education & Training Strategic Group
- [E-rostering Steering Board](#)
- [Workforce Planning Strategic Steering Group](#)

[10/07/18]



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Healthcare Assurance Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Christine Hallett, Senior Independent Director and Healthcare Assurance Committee Chair
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Board of Directors, Healthcare Assurance Committee and Audit Committee
Action required:	Decision
<p>Summary:</p> <p>The Board of Directors is requested to approve the amendments to the Healthcare Assurance 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 the Audit Committee in relation to the Board Assurance Framework.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	None – the proposed amendments reflect changes in the Board Committee responsible for review of the principal risks to achieving the Trust's strategic objectives as set out in the Board Assurance Framework

**THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS
NHS FOUNDATION TRUST**

HEALTHCARE ASSURANCE COMMITTEE

TERMS OF REFERENCE

The Healthcare Assurance Committee (the “Committee”) is a committee established by and responsible to the Board of Directors.

The Committee serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely, cost-effective, manner across the following areas of business; Quality, Patient Experience, Patient Safety, Risk Management, Information Governance, Emergency Preparedness, Health & Safety, Safeguarding (Children and Vulnerable Adults), Infection Prevention & Control and Medicines Management.

The Committee also acts as a means of internal assurance for compliance against the Care Quality Commission regulating and inspection compliance framework.

1. Membership

- 1.1 The Board shall appoint the Committee Chairman (the “Chairman”) who should be a Non-Executive Director. In the absence of the Committee Chairman a Non-Executive Director shall act as appointed deputy. In the case of a tied vote the Chairman will have a casting vote.
- 1.2 The Committee shall be appointed by the Board of Directors and shall consist of:
- Three Non-Executive Directors, one of whom will be a member of the Audit Committee
 - Chief Executive
 - Medical Director
 - Director of Nursing & Midwifery
 - Chief Operating Officer
 - Director of Human Resources
 - Director of Finance
 - Director of Informatics
 - Director of Infection Prevention & Control

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final <u>Draft</u>	January <u>September</u> 2018	April <u>April</u> 2018 <u>2019</u>	Director of Nursing Associate Director of Quality, Governance and Risk

- Chair of Information Governance Committee
- 1.3 In addition, the following will attend the Committee to provide information and advice as required:
- Associate Director of Quality Governance and Risk
 - Deputy Director of Nursing & Midwifery
 - Heads of Nursing and Quality
 - Deputy Director of Nursing & Midwifery
 - Associate Medical Director – Clinical Governance
 - Chief Pharmacist.
- 1.4 The above membership shall ensure representation from all Board committees and the Committee's sub-committees. Membership shall also ensure representation from the three clinical care groups. Representatives are responsible for bringing any risk or governance matters raised at the sub-groups to the attention of the Committee to ensure full integrated governance.
- 1.5 Only members of the Committee have the right to attend Committee meetings. If a member is unable to attend it is expected that he/she will ensure their nominated deputy is invited and can attend in his/her place, notifying the Chairman. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate. Any Non-Executive Director not appointed to the Committee may attend with the prior consent of the Chairman.
- 1.6 It is expected that members attend a minimum of four meetings per year.
- 1.7 There will be one staff and one public governor attending each meeting as observers. Observers are not technically members of the Committee. These governors have been elected to undertake this duty by the Council of Governors by means of a ballot organised by the Trust Secretary in accordance with the process agreed by the Council of Governors.

2. Secretary

- 2.1 The PA to the Director of Nursing & Midwifery (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 six members, at least one of which must be a Non-Executive Director and one must be the Medical Director

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final Draft	January September 2018	April April 2018 2019	Director of Nursing Associate Director of Quality, Governance and Risk

or Director of Nursing & Midwifery (or their nominated Deputy). 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 bi-monthly.

5. Notice of Meetings

- 5.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chairman.
- 5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Secretary.
- 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. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of Meetings

- 6.1 The Secretary shall minute the proceedings and resolutions of all meetings of all Committee meetings, including recording the names of those present and in attendance.
- 6.2 Minutes of Committee meetings shall be agreed by the Committee Chairman prior to being circulated promptly to all members of the Committee.

7. Duties

The duties of the Committee (and as such the standing agenda headings of the Committee) can be categorised as follows:

7.1 Quality Assurance

- 7.1.1 To ensure that the Trust has effective systems and processes in place for ensuring high standards for quality of care.

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Board of Directors	Final <u>Draft</u>	January <u>September</u> 2018	April <u>April</u> 2018 <u>2019</u>	Director of Nursing Associate Director of Quality, Governance and Risk

- 7.1.2 To ensure the Trust has an effective framework to support assurance regarding Trust systems relating to patient safety, patient outcome and patient experience.
- 7.1.3 To provide assurance to the Board that the Care Quality Commission's fundamental standards for quality and safety are monitored and shall highlight any gaps in compliance, controls or assurance.
- 7.1.4 To review the Board Assurance Framework ~~delegating actions to, and requesting ad-hoc or regular reports from, risk leads and sub-committees~~ ensuring that significant clinical and non-clinical risks are appropriately reflected and ~~when any~~ gaps in assurance are identified reported to the Audit Committee and the Board of Directors.
- 7.1.5. To be kept fully appraised of all new significant risks, clinical and non-clinical, identified on the Risk Register across the organisation and progress of action plans identified to mitigate those risks.
- 7.1.6 To ensure the Board of Directors is kept fully informed of specific clinical and non-clinical matters on the Risk Register where advice on controls has been sought and implemented, illustrating risk mitigation progress over time.
- 7.1.7 To ensure the Trust maintains compliance with Monitor's quality governance framework and Annual Governance Statement.
- 7.1.8 To ensure that the Trust regularly reviews and updates, as appropriate, corporate policies relating to the core business of the Committee.
- 7.2 Patient Experience
- 7.2.1 Identify key themes from complaints, PALS and patient engagement, good practice and learning identified from Care Group reports and provide oversight on behalf of the Board.
- 7.2.2 Identify key themes from patient experience quality indicators and provide oversight of action plans to attain assurance.
- 7.2.3 Receive by exception, reports relating to patient experience following review at relevant sub-committee.
- 7.3 External Validation and Assessment
- 7.3.1 Patient Safety:
- To review reports on serious incident, significant events, claims, inquests, Incidents, to receive assurance that appropriate thematic review, investigation and learning to prevent reoccurrence.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final <u>Draft</u>	January <u>Septemberr</u> 2018	April <u>April</u> 2018 <u>2019</u>	Director of Nursing Associate Director of Quality, Governance and Risk

- 7.3.2 Ensure a proactive response has been taken to issues identified through internal and external audit and/or inspection reports relating to patient safety, patient experience, quality and risk standards.
- 7.4 External Reporting
- 7.4.1 To receive an update on quality reports, provide to external organisations, including assurance to Clinical Commissioning Groups regarding CQUIN performance.
- 7.4.2 To oversee, approve and recommend to the Board of Directors the Trust's Annual Quality Account including the external assurance process.
- 7.4.3 To receive and monitor the CQC in-patient Survey reports and associated action plans.
- 7.4.4 To receive and submit to the Board any external peer reviews or reports relating to patient experience, clinical effectiveness or patient safety.
- 7.5 National Guidance and Policy
- 7.5.1 To ensure that all relevant National standards and guidance in relation to quality governance are met to comply with Monitor's requirements.
- 7.5.2 To ensure the Trust complies with legislation, national policies and recommendations for safer practice relevant to Trust activity, by receiving exception reports from the relevant sub-committee where implementation is non-compliant or resource issues have been identified that prevent adequate assurance being achieved in a timely manner.

8. Reporting Responsibilities

- 8.1 The minutes of the Committee meetings shall be submitted to the Board of Directors after each meeting.
- 8.2 The Committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed, via the Chairperson's report.

9. Other

The Committee shall:

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

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final Draft	January Septemberr 2018	April April 2018 2019	Director of Nursing Associate Director of Quality, Governance and Risk

- 9.3 be mindful of the need to ensure economy, efficiency and effectiveness in the use and management of the Trust's resources;
- 9.4 oversee any investigation of activities which are within its terms of reference;
- 9.5 at least once a year review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

10. Authority

The Committee is authorised:

- 10.1 to seek any information it requires from any employee of the Trust in order to perform its duties;
- 10.2 to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its Terms of Reference;
- 10.3 to call any employee to be questioned at a meeting of the Committee as and when required.

11. Sub-Committees

- 11.1 The following committees are responsible to the Healthcare Assurance Committee:
 - Healthcare Assurance Group
 - Information Governance Committee
 - Quality & Risk Committee (including Clinical Audit & Effectiveness Group)
 - Health & Safety Committee
 - Safeguarding (Children & Vulnerable Adults)
 - Medicines Governance Committee
 - Infection Prevention & Control Committee
 - Mortality Surveillance Group
 - Patient Information Group (reporting by exception and through the Annual Report and Annual Quality Account)
 - Emergency Preparedness Steering Group

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final Draft	January September 2018	April April 2018 2019	Director of Nursing Associate Director of Quality, Governance and Risk

Appendix 1: HEALTHCARE ASSURANCE COMMITTEE ASSURANCE MEASURES

<i>Regular Reports Received by HAC</i>			
Performance Indicators	Frequency of Report	Received from:	Previously discussed by:
<ul style="list-style-type: none"> CCG Quality Governance & Risk Report 	Quarterly	Associate Director of Quality Governance & Risk	QARC CCG contract meeting
<ul style="list-style-type: none"> Board Assurance Framework (full report) 	Quarterly Annually	Associate Director of Quality Governance & Risk and Exec Director Leads	Healthcare Assurance Group
<ul style="list-style-type: none"> Serious Incidents 	Each meeting	Associate Director of Quality Governance & Risk	QARC Healthcare Assurance Group
<ul style="list-style-type: none"> Risk Register Report – New significant Risks 	Each meeting	Associate Director of Quality Governance & Risk	QARC Healthcare Assurance Group
<ul style="list-style-type: none"> Mortality Surveillance Group Report 	Each meeting	Medical Director	Mortality Surveillance Group
<ul style="list-style-type: none"> Policies & Procedures where HAC approval 	Ad hoc	HAC Sub Group Chairs	Relevant Consultation Committees

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Board of Directors	Final Draft	January September 2018	April April 2018 2019	Director of Nursing Associate Director of Quality, Governance and Risk

required as per Trust Document Control Policy			
<ul style="list-style-type: none"> Sub Committee reports on quality indicators and any gaps in controls or assurance relevant to risks to the Trust's Strategic Objectives 	Quarterly	Sub Committee Chairs	HAC Sub Committees
<ul style="list-style-type: none"> Patient Safety, Patient experience and Quality Dashboard 	Each meeting – exception reporting. Key areas and trends as per forward programme	Associate Director of Quality Governance & Risk / Deputy Director of Nursing	Healthcare Assurance Group QARC
<ul style="list-style-type: none"> Quality and Risk Committee report 	Each meeting	Associate Medical Director	QARC
<ul style="list-style-type: none"> Care Group Quality Performance Report 	Each meeting	HONQs	Healthcare Assurance Group
<ul style="list-style-type: none"> Healthcare Assurance Committee Chair report from Board of Directors 	Verbal each meeting	Healthcare Assurance Committee Chair	Board of Directors
<ul style="list-style-type: none"> National & Local Quality 	Quarterly	Associate Director of	

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Board of Directors	Final Draft	January September 2018	April April 2019	Director of Nursing Associate Director of Quality, Governance and Risk

CQUIN Compliance and Action Plans		Quality Governance & Risk / Deputy Director of Nursing	PMG
<ul style="list-style-type: none"> CQC reports 	Each meeting	Associate Director of Quality Governance and Risk Heads of Nursing and HAC Sub Committee Chairs	Healthcare Assurance Group HAC Sub Committees

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Board of Directors	Final <u>Draft</u>	January <u>September</u> 2018	April <u>April</u> 2018 <u>2019</u>	Director of Nursing Associate Director of Quality, Governance and Risk



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Charitable Funds Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	No
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Pete Papworth, Director of Finance
Details of previous discussion and/or dissemination:	Charitable Funds Committee
Action required:	Decision
Summary: The terms of reference have been reviewed by the Charitable Funds Committee and are presented to the Board for approval.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	<input checked="" type="checkbox"/>
Impact on risk profile:	

CHARITABLE FUNDS COMMITTEE

Terms of Reference

The Charitable Funds Committee reports to the Board of Directors ~~whose~~ which ~~is members are~~ the Trustees of the registered charity, The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Charitable Fund (registration number 1057366), known as the Bournemouth Hospital Charity.

1 MEMBERSHIP

- 1.1 The Committee shall comprise the Director of Finance, Director of Human Resources, Director of Nursing and three Non-Executive Directors. ~~All~~ appointments to the Committee shall be made by the Board.
- 1.2 The Board shall appoint the Committee Chairman who should be a Non-~~Executive~~ Director. ~~In~~ the absence of the Committee Chairman and/or any appointed deputy, the remaining members present shall elect one of the Non-~~Executive~~ Directors present to chair the meeting. ~~In~~ the case of a tied vote the Chairman will have a casting vote.
- 1.3 Only members of the Committee have the right to attend committee meetings. ~~However~~ the Deputy Director of Finance, a Consultant and the Head of Fundraising shall normally attend meetings to provide information to the Committee. ~~Other~~ individuals may be invited to attend for all or part of any meeting, as and when appropriate. ~~Any~~ Non-~~Executive~~ Director not appointed to the Committee may attend with the prior consent of the Chairman.
- 1.4 There will be one governor attending each meeting as an observer. ~~Observers are not~~ ~~technically~~ members of the Committee. ~~This~~ governor has been elected to undertake this duty by the Council of Governors by means of a ballot organised by the Trust Secretary in accordance with the process agreed by the Council of Governors.

2 SECRETARY

- 2.1 The Secretary of the Committee will be supplied by the Director of Finance.

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Board of Directors	Final	August 2017 <u>September 2018</u>	August 2018 <u>September 2019</u>	Pete Papworth

3 QUORUM

- 3.1 The quorum necessary for the transaction of business shall be ~~2~~ two members and should include not less than ~~2~~ two Non-Executive Directors. -A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4 FREQUENCY OF MEETINGS

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

5 NOTICE OF MEETINGS

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

6 MINUTES OF MEETINGS

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

7 DUTIES

- 7.1 The Committee shall:

7.1.1 endeavour to make an adequate return on prudent investments;

7.1.2 consider and agree any changes to investment policy,

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- 7.1.3 regularly review the performance of current investments in terms of income and capital appreciation;
- 7.1.4 appoint independent advisors on investment policy as the Committee sees fit;
- 7.1.5 approve charitable fund bids in accordance with the relevant procedures;
- 7.1.6 review annually the fund-raising projects and recommend schemes to the Board for approval;
- 7.1.7 ensure that expenditure is controlled and utilised on suitable projects;
- 7.1.8 receive all necessary information from authorised fund signatories;
- 7.1.9 determine the format of the information required to effectively manage the charitable funds;
- 7.1.10 safeguard donated money;
- 7.1.11 ensure legacies are realised in a timely and complete manner;
- 7.1.12 review and approve the charitable funds annual accounts and annual report;
- 7.1.13 review and approve annually the overall fundraising strategy for the Charity department;
- 7.1.14 review and approve annually medium term strategy and annual operating plan for the annual objectives;
- 7.1.15 fully account to the Charity Commission and the public.

8 REPORTING RESPONSIBILITIES

- 8.1 The minutes of the Committee meetings shall be submitted to the Board after each meeting.
- 8.2 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

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Board of Directors	Final	August 2017 September 2018	August 2018 September 2019	Pete Papworth

- 8.3 The Committee shall provide a report on its activities to be included in the Trust's annual report.

9 OTHER

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

~~9.1~~
9.2 All affiliate charity income should be routed through the charity to ensure all spend is subject to the same application process as funds direct to the charity this includes VAT implications.

~~9.2~~
9.3 All approaches to the affiliate charities should be coordinated through the charity office to ensure process is followed and spend meets the charity's objectives.

10 AUTHORITY

10.1 The Committee is authorised:

10.1.1 To oversee and authorise expenditure from charitable funds (subject to all process being in accordance with the Trust's Standing Orders and Standing Financial Instructions).

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

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

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Board of Directors	Final	August 2017 <u>September 2018</u>	August 2018 <u>September 2019</u>	Pete Papworth



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Freedom to Speak Up (FTSU) Update
Section on agenda:	Governance
Supplementary reading:	Bi-annual report of FTSU
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Helen Martin, RBCH FTSU Guardian (FTSUG)
Details of previous discussion and/or dissemination:	N/A
Action required:	Note for information
<p>Summary:</p> <p>The purpose of this paper is to update the Board, outline the progress of speaking up and present the key themes being raised by staff.</p> <p>The presentation will discuss the themes in more detail and the plans to address these.</p>	
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:	None



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Non-Executive Director Appointments to Board Committees
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:	Discussions between the Chairperson and individual Non-Executive Directors
Action required:	Decision
<p>Summary:</p> <p>Following Pankaj Davé's appointment as a Non-Executive Director, and the subsequent review of Committee membership, the Board of Directors is asked to approve the following:</p> <ul style="list-style-type: none">• the appointment of Pankaj Davé as a member of the Finance and Performance Committee;• the appointment of Pankaj Davé as a member of the Workforce Strategy and Development Committee;• the appointment of Pankaj Davé as a member of the Healthcare Assurance Committee;• the appointment of Alex Jablonowski as the lead for Emergency Planning, Resilience and Response; and• the appointment of Christine Hallett as a member of the Constitution Joint Working Group in her role as Senior Independent Director, <p>each to take effect from the date of this meeting.</p> <p>In addition the Board of Directors is asked to approve the alterations to the relevant Committee terms of reference to reflect the changes to the number of non-executive directors in the membership of each Committee.</p> <p>The Board of Directors is also asked to ratify and approve John Lelliott's appointment as one of three Trust representatives to act on its behalf on the Management Board of Christchurch Fairmile Village LLP, effective from his appointment as a Non-Executive Director in June 2016.</p>	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential



The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on risk profile:	None



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

BOARD OF DIRECTORS	
Meeting date:	26 September 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Meeting Dates for 2019/20
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Not applicable
Action required:	Note for information
<p>Summary:</p> <p>Attached are the dates for next year's Board of Directors and One Acute Network Board meetings. The Board of Directors meetings will continue to take place on the last Wednesday of every other month allowing the One Acute Network Board to meet on the last Wednesday during the alternate months. Once the dates are confirmed electronic invitations will be circulated.</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:	Not applicable

RBCH BOARD AND ONE ACUTE NETWORK BOARD AGENDA DATES 2019

BOARD OF DIRECTORS		
Date of Meeting	Document submission Deadline (12 noon)	Papers Distributed
2018		
Wed 28 November	16 November	Friday 21 November
2019		
Wed 30 January	18 January	Wed 23 January
Wed 27 March **	15 March	Wed 20 March
Wed 29 May	17 May	Wed 22 May
Wed 31 July	19 July	Wed 24 July
Wed 25 September	13 September	Wed 18 September
Wed 27 November	15 November	Wed 20 November
2020		
Wed 29 January	17 January	Wed 22 January
Wed 25 March	13 March	Wed 18 March

ONE ACUTE NETWORK BOARD	
Date of Meeting	Location
2018	
Wednesday 31 October	Poole Hospital
Wednesday 12 December <i>(early due to Christmas)</i>	RBH Conference Room
2019	
Wednesday 27 February	Poole Hospital
Wednesday 24 April **	RBH <i>(The Village Hotel)</i>
Wednesday 26 June	Poole Hospital
Wednesday 29 August	RBH Conference Room
Wednesday 30 October	Poole Hospital
Wednesday 18 December	RBH Conference Room
2020	
Wednesday 26 February	Poole Hospital

Part 1 Board (Public) held in the Conference Room, Education Centre at 8.30am

Part 2 Board (Confidential) held in the Committee Room, Management offices at 11.00am

(March Board venue to be confirmed)**

BOARD OF DIRECTORS MEETING – 26 SEPTEMBER 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 25 July 2018 (paper)	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) Competition and Markets Authority Update (verbal)	Discussion	<i>Tony Spotswood</i>
	b) Board Assurance Framework (paper)	Discussion	<i>Paula Shobbrook</i>
	c) Significant Risk Report (paper)	Discussion	<i>Paula Shobbrook</i>
	d) Commercial Strategy Update (paper)	Information	<i>Richard Renaut</i>
	e) Annual Plan Resubmission (presentation)	Decision	<i>Pete Papworth</i>
12.15	4. QUALITY		
	a) Trust Response to Gosport Independent Panel Report (paper)	Discussion	<i>Paula Shobbrook/ Alyson O'Donnell</i>
	b) Managing Non-Elective Demand (paper)	Discussion	<i>Richard Renaut</i>
	c) Vascular Service Review (paper)	Discussion	<i>Alyson O'Donnell/ Tony Spotswood</i>
	d) Integrated Urgent Care Service (verbal)	Discussion	<i>Richard Renaut</i>
	e) Elective Care Expectations (paper)	Information	<i>Richard Renaut</i>
12.45	5. GOVERNANCE		
	a) Bournemouth Hospital Charity Annual Report and Accounts (paper)	Decision	<i>Pete Papworth</i>
	b) Scheme of Delegation and Reservation of Powers of the Board of Directors (paper)	Decision	<i>Anneliese Harrison</i>
	c) Standing Financial Instructions (paper)	Decision	<i>Pete Papworth</i>
	d) Award of Principal Supply Chain Partner for Clinical Services Review (paper)	Decision	<i>Richard Renaut TO FOLLOW</i>

6. ANY OTHER BUSINESS

- | | | |
|--|------------|-----|
| a) Key Points for Communication to Staff | Discussion | All |
| | | |
| b) Reflective Review | Discussion | All |
| – What has gone well? | | |
| – What do we need more of? | | |
| – What do we need less of? | | |

The meeting will be followed by a Blue Skies session on current plans and future developments in the Bournemouth Diabetes and Endocrine Centre 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!