

A meeting of the Board of Directors will be held on **Wednesday 31 January 2018** at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital

If you are unable to attend on this occasion, please notify me as soon as possible on 01202 704777 or karen.flaherty@rbch.nhs.uk.

Karen Flaherty
Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8.30-8.35	1. WELCOME, APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
	Tea Colaianne, John Lelliott		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 24 November 2017	Decision	All
8.40-8.45	3. MATTERS ARISING		
	a) Updates to the Actions Log	Information	All
8.45-9.20	4. QUALITY		
	a) Patient Story (verbal)	Information	Paula Shobbrook
	b) Medical Director's Report (paper)	Information	Alyson O'Donnell
	c) Safe Staffing Report (Nurse) (paper)	Information	Paula Shobbrook
9.20-10.15	5. STRATEGY AND RISK		
	a) Clinical Services Review - Implementation Update (paper)	Information	Tony Spotswood
	b) Trust Leadership Strategy (paper)	Decision	Nicola Hartley
	c) Progress Update on 2017/18 Corporate Objectives (paper)	Information	Tony Spotswood
	d) Diversity and Inclusion Update (paper/presentation)	Information	Deb Matthews
10.15-10.45	6. PERFORMANCE		
	a) Performance Report (paper)	Information	Richard Renaut
	b) Quality Report (paper)	Information	Paula Shobbrook
	c) Finance Report (paper)	Information	Pete Papworth
	d) Workforce Report (paper)	Information	Karen Allman
10.45-10.55	7. GOVERNANCE		
	a) Trust Management Board Terms of Reference (paper)	Decision	Tony Spotswood
	b) Healthcare Assurance Committee Terms of	Decision	Paula Shobbrook

Reference (paper)

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|----|---|-------------|-----------------------|
| c) | Workforce Strategy and Development Committee Terms of Reference (paper) | Decision | <i>Karen Allman</i> |
| d) | Charitable Funds Committee Terms of Reference (paper) | Decision | <i>Pete Papworth</i> |
| e) | Well-led Review Action Plan Update (paper) | Information | <i>David Moss</i> |
| f) | Non-Executive Director Appointments to Board Committees (paper) | Decision | <i>Karen Flaherty</i> |

8. NEXT MEETING

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

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.55-11.10

10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

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

11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

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

Part 1 Minutes of a Meeting of the **Board of Directors** (the **Board**) of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the **Trust**) held in public at 08:30 on **Friday 24 November 2017** in the Conference Room, Education Centre, Royal Bournemouth Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Tea Colaiani	(TC)	<i>Non-Executive Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	John Lelliott	(JL)	<i>Non-Executive Director</i>
	Alyson O'Donnell	(AOD)	<i>Medical Director</i>
	Pete Papworth	(PP)	<i>Director of Finance</i>
	Iain Rawlinson	(IR)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Alison Ashmore	(AA)	<i>Associate Director for Cancer Services (for item 4(c))</i>
	Rachel Bevan	(RB)	<i>Head of Patient Engagement (for item 3(a))</i>
	Neil Cowan	(NC)	<i>Director of Operations, Surgical Care Group</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Trudy Ellis	(TE)	<i>Matron, Older Person's Medicine</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	David Flower	(DF)	<i>Chaplain (for item 3(a))</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NHa)	<i>Director of OD and Leadership for item 3(a)</i>
	Lorna Jeffery	(LJ)	
	Marie Miller	(MM)	<i>Matron, Pathology & Cancer Care (for item 3(a))</i>
	Louise Pennington	(LP)	<i>Matron, Palliative Care (for item 3(a))</i>
	James Rowden	(JR)	<i>Patient Engagement and Clinical Liaison</i>
	Dily Ruffer	(DR)	<i>Governor and Membership Manager</i>
	Jacqui Taylor	(JT)	<i>Voluntary Services Co-ordinator</i>
	Heather Trickett	(HT)	<i>for item 3(a)</i>
Public/ Governors:	Richard Allen		<i>Public Governor</i>
	Tracy Broom		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Eric Fisher		<i>Public Governor</i>
	Nick Harrison		<i>Public Governor</i>
	Paul Higgs		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Margaret Neville		<i>Member of Public</i>
	Roger Parsons		<i>Public Governor</i>
	Guy Rouquette		<i>Public Governor</i>
	David Triplow		<i>Public Governor</i>

75/17 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Action

Apologies for absence were **noted**. The Chairperson welcomed those attending the meeting including Iain Rawlinson who was attending his first Board meeting as a director.

76/17 MINUTES OF PREVIOUS MEETING**(a) Minutes of the meeting held on 29 September 2017 (Item 2a)**

The minutes of the meeting held on 29 September 2017 were **approved** as an accurate record of the meeting subject to the following amendments:

- the reference to NHS England in 67/17(e) (Infection Prevention and Control Committee (IPCC) Annual Report Summary and Statement of Commitment) should be changed to Public Health England; and
- in 69/17(b) (Quality Report) to make it clear that the recording of observations of vital signs had been maintained despite the issues with the consistency of nursing assessments recorded on eNA (the electronic nursing assessment application).

77/17 MATTERS ARISING**(a) Updates to the Actions Log (Item 3a)**

The updates to the actions were **noted**. PS confirmed that a meeting had been scheduled with Healthwatch on 19 January 2018 to identify a suitable date for Healthwatch to present on their activities and findings.

78/17 QUALITY**(a) Patient Story (Item 4a)**

Heather Trickett and Lorna Jeffery attended the meeting and shared the moving account of their mother's experiences as a patient at Royal Bournemouth Hospital (**RBH**) and following her discharge. Heather and Lorna's mother, Sally Cook, had sadly died following a recurrence of cancer and had also suffered from Alzheimer's disease.

The main themes identified during the patient story included:

- poor communication about diagnosis, treatment and medications with a patient who had Alzheimer's disease and who required relatives to be present;
- specialist support for patients with Alzheimer's disease when they have other conditions;
- poor communication between teams about arrangements for end of life care;
- lack of clarity and explanation about the roles of the Trust and community palliative care teams leading to confusion;
- a lack of support during the discharge process and once home and no assistance at weekends;

- incorrect drugs being prescribed to take home; and
- poor and patronising experience with a nurse from the community palliative care team.

Lorna and Heather wanted to ensure that experiences like theirs were avoided in the future and that other patients did not suffer at the end of their lives. They had reflected on the care their mother had received and had expressed their desire to be involved in the implementation of the changes that they had identified in collaboration with teams at the Trust. These included:

- to identify patients with dementia or Alzheimer's with a forget-me-not symbol as a subtle indicator;
- the redesign of the discharge service;
- improved co-ordination across departments at RBH;
- specialist care for elderly/dementia patients;
- increased training for staff dealing with patients with dementia;
- more frequent meetings between doctors and family members where patients have dementia;
- more prescribing staff at weekends; and
- the community palliative care nurse involved in their mother's care not to continue having a role in nursing care.

Lorna and Heather were thanked for presenting their story to the Board and for the work they had done with the Trust to improve the care provided to other patients. The teams in the Trust were committed to implementing the improvements identified and would take forward their offer of further help.

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

David Triplow, the Lead Governor, outlined the various activities that governors had been involved in over the past few months as part of their programme of engagement with members, patients and the public within each of their constituencies. These events were important to ensure that any concerns were fed back to the Trust and had been welcomed by the public and governors received an overwhelmingly positive response about the services at the hospitals.

Board members welcomed the update and reinforced the important role that the governors had in representing the views and interests of members and the public.

(c) Cancer Patient Survey (Item 4c)

Alison Ashmore attended the meeting to present the results from the 2016 Cancer Patient Experience Survey in which the Trust had performed well, achieving the highest response rate nationally and with performance within the better than expected range for twelve out of the 52 questions and within the expected range for all other questions.

Areas identified for improvement included ensuring that every patient treated was provided with a care plan and an end of treatment summary, which were now national requirements. The Trust was implementing the following initiatives:

- implementation of the 'electronic Holistic Needs Assessment' (eHNA)

- and care plans;
- introduction of support workers funded by Macmillan Caring Locally and national transformation funding;
- collaborative work with LiveWell Dorset to promote living beyond cancer and the introduction of 'HOPE' and health and well-being sessions for patients to support positive lifestyle choices;
- improvements in the Trust extranet cancer information sites;
- providing end of treatment summaries; and
- 'Patient Triggered Risk Stratified Follow Up'.

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

The mortality themes and trends remained consistent with those reported previously. There had been difficulty identifying patients who had died in the community unless the Trust had been informed by GPs. As a surrogate measure the Trust was monitoring Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) data closely, particularly deaths 30 days after discharge.

The Trust was actively participating in the learning from deaths of patients with learning disabilities and two deaths had been referred to the national LeDeR (Learning Disabilities Mortality Review) programme for review and there had been no notifications of any concerns with the data provided. A small number of grade two and three avoidable deaths had been subject to the Trust's serious incident and root cause analysis process and learning had been disseminated both internally and nationally.

79/17 STRATEGY AND RISK

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

The Board of Directors were due to receive a briefing from Hempsons solicitors during the private session of the meeting on the NHS Improvement (NHSI) transaction approval process for the potential merger with Poole Hospital and the Competition and Markets Authority (CMA) merger review process.

The Outline Business Case for the capital to implement the Clinical Services Review (CSR) was due to be submitted in January 2018. Work to redesign the two sites and either construct or refurbish facilities was dependent upon the completion of the clinical redesign work which was being finalised by clinicians. HM Treasury would require full details the physical design work in the Full Business Case and £9 million of capital funding had been requested from NHS England following approval of the Outline Business Case to enable the trusts to progress to the next stage of the business case process. In addition there had been an early drawdown of funding for an integrated approach to pathology services to support the development of networks in line with the reconfiguration of services.

Residents in the Purbeck area had raised concerns about the impact of the CSR on access to services and this had been referred to the Joint Health Scrutiny Committee with the possibility of referral to the Secretary of State. A series of meetings were underway with clinicians from both the Trust and Poole Hospital to allay concerns raised by residents in Purbeck to mitigate

any potential delays.

In terms of mobilisation of the overall project it was perceived that the Trust was progressing well and this was being driven by the One Acute Network Board.

(b) Ever Safer Care – Winter Plan (Item 5b)

The winter plan had been reviewed and updated to incorporate feedback from Trust departments and the principles of good practice published by the Care Quality Commission (**CQC**) and following a recent focus on escalation planning by NHS England (**NHSE**). Additional funding was being provided to support this work, which should allow the Trust to recover the investment it had already committed to winter planning. However national funding was being prioritised based on need and therefore the Dorset health system may not receive as much of this funding. Ambulance handovers were the priority so that ambulances were not delayed waiting to transfer patients to hospital Emergency Departments, and the Trust was working very positively with South Western Ambulance Service NHS Foundation Trust to address this.

Initiatives already underway in the Trust to improve hospital flow and reduce delays in discharging patients who were medically ready to leave hospital were having a positive impact. However, work to secure community beds and put in place better intermediate care to support patients at home to avoid admissions and return home sooner had not progressed as far as had been hoped ahead of winter in order that the system overall could respond better to the anticipated pressures. Work continued with partners and involving multi-disciplinary teams to address these areas.

The changes to the winter plan would ensure greater visibility and collective ownership of the Emergency Department (**ED**) four hour target, with teams across the Trust working together to support performance. A mandate had been given to consultants in ED to transfer patients from ED to the correct specialty to reduce delays in transferring patients with the admitting specialty taking responsibility for that patient and any further transfers in the small number of cases where patients needed to be cared for by a different specialty. Non-Executive Directors were invited to be involved in the upcoming action learning weeks scheduled in December and January and the programme would be circulated. This would continue the appreciative inquiry approach, working with teams to understand the reasons for delays and what can be done to support patient flow, which had already made a statistically significant difference to the ED and ambulatory pathways and the numbers of stranded patients.

PS/KF

Major incident and business continuity plans had been further developed in recent months to respond to future unplanned IT outages and additional work was planned to segment the network and critical systems so that future cyber-attacks could be isolated, reducing the potential impact on the wider Trust network. The risk relating to unplanned IT outages had been reduced as a result of the work to improve the resilience of the IT infrastructure.

The Board discussed the importance of building capacity to respond to those demands which were predictable during winter and focusing on providing 'Ever safer care', rather than reacting to winter pressures. It was important

that staff had clear information on how to ask for support when they or their areas were under pressure, details of what help was available and how they could help other areas when these were under pressure. This would help reinforce accountability and collective responsibility. Communication plans were in place with action cards and scenario training to practice teams' responses, supported by engagement champions focussed on this area.

80/17 **PERFORMANCE**

(a) Performance Report (Item 6a)

The key performance headlines were summarised and included:

- ED 4 hour performance was just below the national trajectory of 95%, however the Trust's performance continued to benchmark well nationally and the department was focused on implementing a number of actions ahead of the peak winter period to respond to the increase in demand;
- the Trust had received confirmation from NHSI that it had achieved the Sustainability and Transformation Fund (**STF**) payment relating to ED performance for the second quarter as part of the Dorset system, which had achieved 95% trajectory overall;
- January to March 2018 would be challenging for meeting the ED four hour performance trajectory, however the aim was to match the Trust's performance in 2017, with performance in March in particular being linked to an STF payment of around £700,000;
- a decline in 18 week Referral to Treatment (**RTT**) performance was predicted over the next six months as a result of the impact of the new nationally mandated musculoskeletal triage service which would result in a higher proportion of patients being made up of those who had been waiting longer, notwithstanding that patients would not be waiting any longer;
- performance on 18 week RTT would be challenging in January-March 2018 due to continued pressures and demand in certain specialties pressures continued in and the impact of transformational improvement programmes;
- the Trust continued to achieve the national target for Cancer 62 day referral/screening to treatment, benchmarking well against the England average and ensuring patients were treated early to promote better outcomes; and
- demand management remained a key area of focus over the winter period to ensure that capacity was sustained.

The Non-Executive Directors highlighted the importance of clear communication with the Trust's stakeholders around the impact of the musculoskeletal triage service on 18 week RTT performance to avoid any reputational risk. Although nationally mandated, it was highlighted that Dorset were implementing these changes later than other areas, so the speed and scale of implementation meant that the impact was likely to be more pronounced than in other areas.

(b) Quality Report (Item 6b)

The report had been discussed in detail by the Healthcare Assurance Committee (**HAC**) the previous day. The key areas of discussion included:

- the standard set for responding to complaints had not been met in October and a review had shown that the complaints had been complex in nature, however the quality of the responses provided remained high; and
- the new CQC Insight monitoring model, the possible timing of the next CQC inspection and assurance around performance, which included a presentation from ED (rated as 'requires improvement' following the last CQC inspection in 2015) and the self-assessment process in all areas.

(c) Finance Report (Item 6c)

The Trust continued to deliver against its financial plan and had received confirmation from NHSI that the Trust had achieved the full amount of the STF payment for the second quarter. Particular pressures remained in relation to the delivery of the Cost Improvement Plan (CIP), lower than planned private patient income and staffing pressures. Each of the Care Groups had responded with a recovery plan to offset the risks. While there was confidence that the Trust would continue to deliver against the financial element of the control total for the remainder of the year, STF payments relating to ED four hour performance were at risk.

The recent announcement in the Autumn Budget of an additional £1.6 billion for the NHS in 2018/19 was welcomed and would help to offset winter pressures as part of budget-setting for the next financial year. However this fell short of what was required to protect and sustain NHS services.

(d) Workforce Report (Item 6d)

There had been positive performance and progress in a number of areas:

- the vacancy rate remained good with an increased headcount and a reduction in the staff turnover rate, however this needed to be balanced against growing recruitment challenges;
- the Trust was developing Band 4 nursing roles and other alternative roles were being developed in conjunction with other providers across Dorset;
- it was unlikely that the Essential Core Skills training target of 95% by December 2017 would be achieved and achievement of the target may be delayed given the reduction in training courses in January and February as part of the Trust's response to winter pressures;
- the Trust continued to provide work experience opportunities to those who may be interested in a future career in health and social care and encourage them to pursue these ambitions;
- the work with other trusts in Dorset including the development of 'One Acute Bank' service across Dorset;
- the Human Resources department had been awarded the HR Team of the Year by the South West Healthcare People Management Association; and
- the Trust's Change Champions had won the Health Services Journal (HSJ) award for staff engagement.

Following reductions in the sickness absence rate for August and September, sickness absence had increased in October and specific areas were receiving support.

One red flag for staffing had been reported in September and the learning would be shared following a review of this event.

81/17 GOVERNANCE

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

The Board **ratified and approved** the appointment of Iain Rawlinson as a member of the Finance and Performance Committee with effect from 1 October 2017, and **approved** his appointment as a member of the Audit Committee with immediate effect.

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

The update was noted and the Board recognised the importance of progressing the actions that it had committed to following the well-led review.

Board members considered the role of the HAC and the Audit Committee in reviewing the Board Assurance Framework in order to avoid duplication and in light of the recommendation following the well-led review for the responsibility of the review of strategic risk to sit with the Audit Committee. Further clarification would be provided following the meeting and in consultation with the risk management team.

PS/KF

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

The Board **approved** the proposed amendments to the terms of reference of the Healthcare Assurance Committee.

(d) Local Authority Reorganisation (Item 7d)

The Secretary for State for Communities and Local Government had asked interested parties to comment on the proposal to replace the existing nine councils with a single council for the areas of Bournemouth, Poole and Christchurch and another council for the remainder of Dorset.

The Board reiterated its support to create two unitary authorities in Dorset as this would be beneficial for patients in terms of directing resources to social services and promoting greater coordination by reducing the number of separate social services departments. The Board **authorised** the Chief Executive and Chairman to write to the Secretary for State for Communities and Local Government reflecting the views of the Board.

82/17 NEXT MEETING

The next meeting would take place on **Wednesday 31 January 2018** at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

83/17 ANY OTHER BUSINESS

Key Points for Communication:

1. Winter Planning
2. Celebrating the Trusts recent successes and awards

3. Key messages for staff about the CSR and potential merger plans
4. Trust performance in the Cancer Patient Survey.

84/17 COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC

1. A governor commented on the positive feedback he had received about the end of life care provided to patients by the Trust when conducting a survey of relatives and carers for the End of Life Care Steering Group. The Communications team agreed that the positive feedback should be shared with staff.
2. In light of increased waiting times it was suggested that a communication system was installed within the main outpatients area displaying the patient's name when called as it was not always possible to hear this. PS confirmed that the Outpatients team had been focussing on patient engagement and were recently finalists for the UK Digital Experience award. Initiatives implemented as a result of patient feedback included patient zoning by specialty to improve efficiency and privacy which should also help to address this concern.
3. Staff governors had queried how the Board intended to communicate with staff to alleviate their concerns about job security in light of the CSR. Feedback from staff indicated that receiving this information face to face was most effective and Executive Directors and local managers were doing this. This was being supported by Communications to ensure that the information given to staff was consistent.
4. In light of a number of GP practice closures an overview was provided of the different strategies being advanced in Dorset and across Wessex to meet the needs in primary care. GP practices were coming together to make services more robust and sustainable and GPs were working to develop an alternative workforce to free up GPs' time for those patients who needed to see a GP.
5. A governor commented on the current consultation plans to merge the local councils. The Trust's response to the consultation had been based on the best option in terms of patient care.
6. NC highlighted that the Trust's theatre staff had received an NHSE 'Health Heroes' silver award for their work. The department's success in reducing the use of agency staff, having used no agency staff for two and half years, was also highlighted.

JD

85/17 RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
24.11.17	79/17	STRATEGY AND RISK			
	(b)	<u>Ever Safer Care – Winter Plan</u>			
		Non-Executive Directors were invited to be involved in the upcoming action learning weeks scheduled in December and January and the programme would be circulated.	PS/KF	Dec 2017/ Jan 2018	Invitation and programme sent, with Non-Executive Directors attending the action learning weeks.
	81/17	GOVERNANCE			
	(b)	<u>Well-led Review Action Plan Update</u>			
		Board members considered the role of the HAC and the Audit Committee in reviewing the Board Assurance Framework in order to avoid duplication and in light of the recommendation following the well-led review for the responsibility of the review of strategic risk to sit with the Audit Committee. Further clarification would be provided following the meeting and in consultation with the risk management team.	PS/KF	Dec 2017	<p>Email circulated to chairs of relevant committees on 28 December 2017 and subsequently agreed by the Healthcare Assurance Committee (HAC) and Audit Committee chairs.</p> <p>The Board Assurance Framework (BAF) will be reviewed by the Audit Committee at each meeting and then at the following Board meeting. This will reinforce the overall Board responsibility for strategic risk with the Audit Committee providing oversight as part of its role in assessing the effectiveness of risk management. The BAF would continue to be reviewed by the HAC as well as the Audit Committee with the aim of transitioning to this agreed approach in April 2018 when the BAF for 2018 is due to be approved.</p> <p>The Audit Committee will discuss its approach to the quarterly review of the BAF at its meeting in February and feed this into the Board discussion at the following Board meeting. The HAC may continue to have input in relation to the BAF or as part of the approval process given the HAC's ongoing responsibility for operational risk.</p>

	84/17	COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC			
	1.	A governor commented on the positive feedback he had received about the end of life care provided to patients by the Trust when conducting a survey of relatives and carers for the End of Life Care Steering Group. The Communications team agreed that the positive feedback should be shared with staff.	JD		To be included in next edition of the staff magazine, Buzzword.
29.09.17	68/17	STRATEGY AND RISK			
	(b)	<u>People Strategy and Workforce Plan</u>			
		It was suggested that a clearer link to leadership needed to be incorporated in the strategy and plan and this was remitted for the consideration to the WSDC [Workforce Strategy and Development Committee].	KA/TC	Jan 2018	The Leadership Strategy was considered by the Workforce Strategy and Development Committee at its meeting in December and will be presented to the Board at its meeting in January.
28.07.17	62/17	COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC			
		DM proposed that Healthwatch were invited to attend a future Board meeting to present on their activities and findings.	PS	In progress	Healthwatch have been invited to join and present at the Board Strategy and Development session on 28 February 2018.
16.12.16	98/16	QUALITY			
	(d)	<u>Medical Director's Report – Mortality and Sepsis</u>			
		Provide an update on the progress with systemic anti-cancer outcome data performance.	AOD	In progress	The national report on systemic anti-cancer treatment data was expected to be released imminently. There had been no indication that the Trust was likely to be an outlier. See more detailed update in the Medical Director's Report.
Key:	Outstanding	In Progress	Complete	Not yet required	



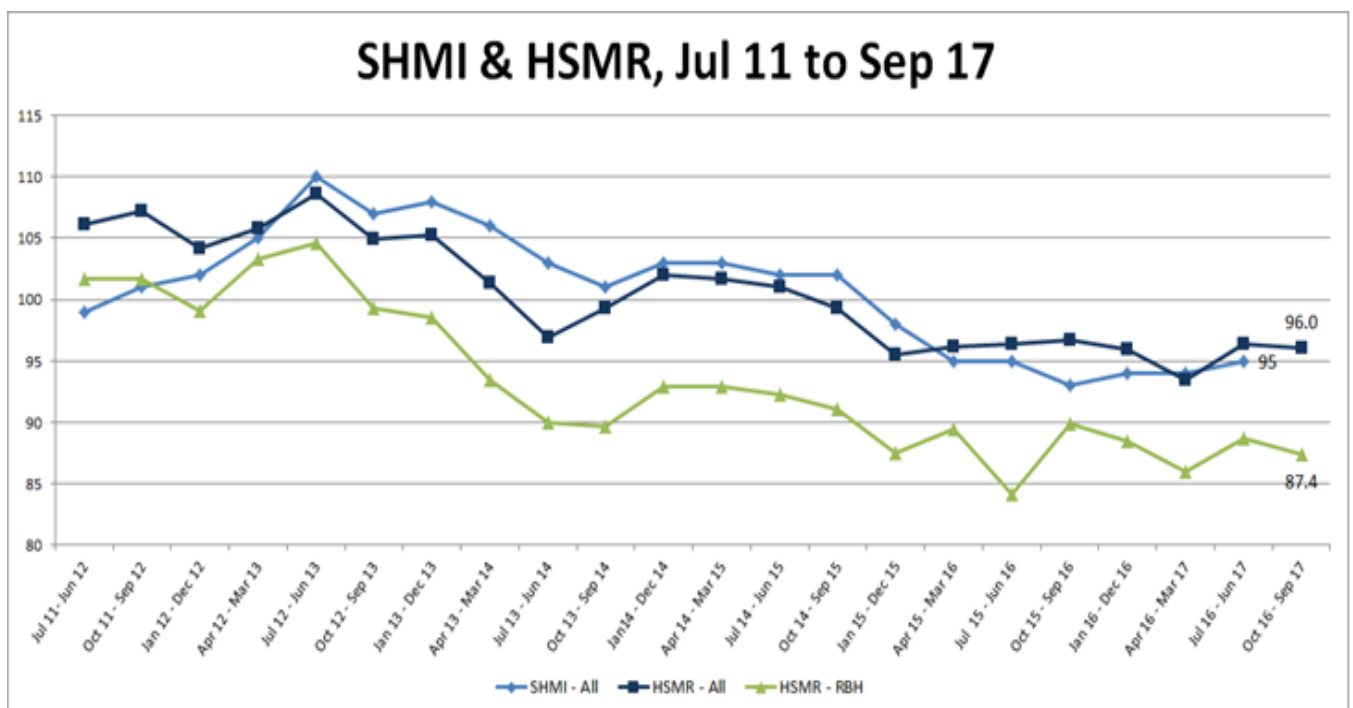
**The Royal Bournemouth
and Christchurch Hospitals**
NHS Foundation Trust

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Medical Director's Report
Section on agenda:	Quality
Supplementary reading:	N/A
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Alyson O'Donnell, Medical Director Divya Tiwari Consultant – Elderly Care
Details of previous discussion and/or dissemination:	N/A
Action required:	Note for information
Summary: To update the Board on the Trust's current mortality and claims data.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/> <input type="checkbox"/>
Are they well-led?	
Impact on risk profile:	N/A

Medical Director's Report Board of Directors January 2018

Mortality Report

Mortality metric reports remain stable. For the most recent period of reporting (Oct 16-Sept 17) HSMR is as expected at 96 and SMR better than expected at 95. The most recent SHMI, which includes deaths up to 30 days post discharge from hospital, also remains significantly better than expected at 94.7.



4 new CUSUM alerts were notified in our most recent Dr Foster report. Three of these are likely to be due to the re-basing of data with update benchmarking that occurs in April and June. The conditions included are aortic or peripheral embolism and thrombosis, hepatitis and non-epithelial cancer of the skin. A separate alert had occurred around the use of residual codes which should be eliminated by our coding practices and will undergo a patient level data review.

There are no active patient safety indicators which are significantly worse than expected with 4 which are significantly better than expected.

Mortality in high risk groups or where there has been an alert were reviewed at MSG. Learning from these and local mortality reviews are included in the attached Mortality Newsletter.

SACT Data

No national report has been published to date. Data continues to be uploaded on a monthly basis with ongoing improvements in data quality being achieved with the data warehouse nearing completion. Regular feedback is received by the lead pharmacist regarding compliance to ensure we meet the requirements of the associated CQUIN. In general compliance is improving. Notably we were previously outliers for the documentation of treatment intent (curative or palliative). We are now performing very well in this area with 99% compliance versus a national average of 92% and our previous performance of 70%.

Consent Working Group

An active consent work group has been established with multi-professional representation across a wide range of specialities. The aim is to improve the quality of consent processes for patients with more of a focus on shared decision making.

Key objectives are:

- To improve documentation and compliance;
- To align with new directives and legal guidance;
- To progress media accessibility.

To achieve these objectives, a series of audits are planned over the next 6 months to inform PDSA cycles to improve our processes. Questions are being finalised for the first snapshot audit of the following specialities:

- Gynaecology and Urogynaecology
- Colorectal and General Surgery
- Breast and Skin Surgery
- Interventional Radiology
- Cardiology
- Ophthalmology
- Endoscopy
- Dermatology
- Vascular Surgery
- Urology
- Orthopaedic Surgery
- Anaesthetics

10 questions are generic with 2 which can be specific for each speciality. Focussed questions have been included to consider compliance with the recommendations from the Montgomery and Thefaut cases.

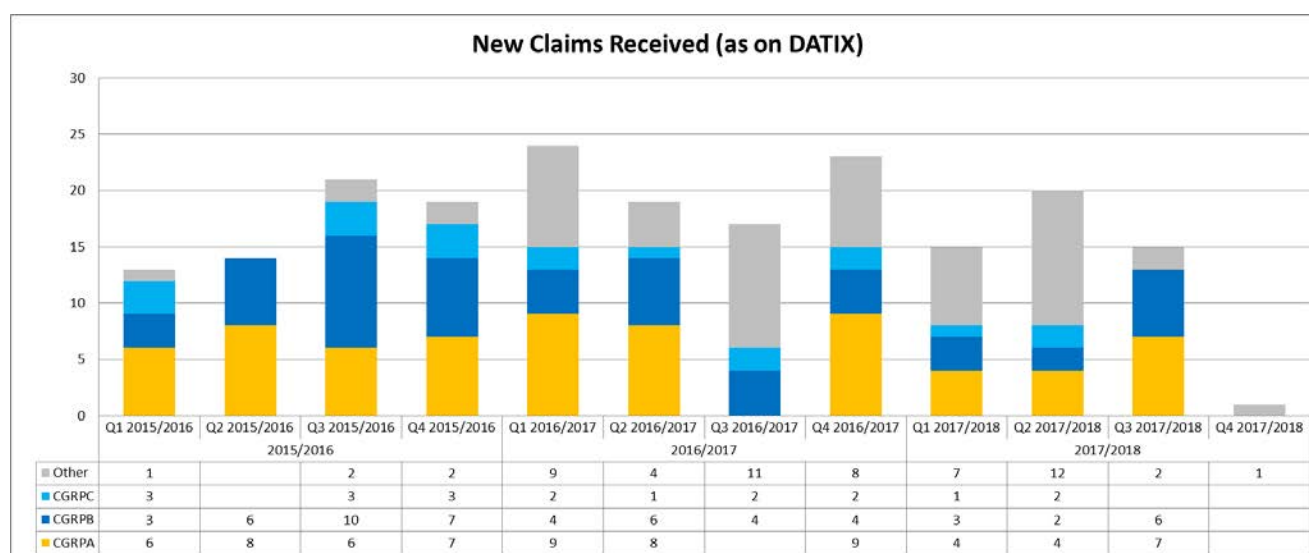
Other key areas of focus will be around consent training, the development of toolkits and checklists and improving the content and provision of patient information. Particular consideration is being given to how we develop shared decision making. It is suggested that

interactive media content to facilitate patients' understanding of risks and benefits of any particular procedure would be helpful as already demonstrated in the tool developed for knee replacement.

Claims Data

Three claims have been settled in the quarter Sep-Dec 17.

Key learning points	Value
Clinical care probably appropriate but case not defended as documentation poor and unable to defend decisions made	Settled out of court £31,000
Missed fracture despite safety net. Human error. Advice that patient's symptoms merited review whether evidence of fracture or not	Settled out of court £25,542
Patient's past medical history not obviously taken in to account in planning treatment with adverse effect	Liability admitted £7,500



Trends in claims by directorate

Reviewing data for the last 5 years approximately 50% of claims will be successful. A significant number of claims do not proceed beyond the disclosure of patient records. The majority of claims (66%) are settled with a value below £10,000 but three high value claims have been settled in this time.

Work continues to improve the triangulation between complaints, adverse events and claims to ensure that claims should not arise in isolation but will have been recognised at an issue by our other processes.

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	N/A
Subject:	Safe Staffing Report (Nurse)
Section on agenda:	Quality
Supplementary reading:	Safe Staffing Report (Nurse) December 2017.
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 Safe Staffing Report (Nurse) for December 2017 was discussed and noted at the Workforce Strategy and Development Committee on 7 December 2017. Following this meeting there are no additional issues to escalate to the Board.
Action required:	Note for information
<p>Summary:</p> <p>The Deputy Director of Nursing and Midwifery presented a Safe Staffing Report at the Workforce Strategy and Development Committee in December 2017 providing assurance that guidance for safe staffing produced by the Care Quality Commission and NHS England is being met within The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. There are three requirements all of which have been met:</p> <ol style="list-style-type: none"> 1. Report and publish a monthly return via unify indicating 'planned' and 'actual' nurse staffing by ward. 2. Publish information with the planned and actual nurse staffing for each shift. 3. Provide a six monthly report on nurse staffing to the Board of Directors. <p>Items of note for the Board within the December 2017 Safe Staffing Report were:</p> <ol style="list-style-type: none"> 1. In 2017 the Royal College of Nursing published two policy reports: <ol style="list-style-type: none"> a. Safe and Effective Staffing: Nursing Against the Odds (May 2017) b. Safe and Effective Staffing: The Real Picture (September 2017) <p>The papers highlighted a number of key concerns around nurse staffing in the United Kingdom including, skill mix dilution and increasing vacancy and retention rates for registered nurses</p>	

A review of the key concerns raised showed that the Royal Bournemouth and Christchurch Hospitals were not experiencing the levels of unsafe staffing cited and that a safe nurse staffing position is being managed and held within the Trust.

2. Since 2012, ward staffing reviews have been performed within the Trust, demonstrating a robust process towards ongoing safe staffing assessment and review. Highlights from the latest reviews are as follows:
 - a. Surgical Care Group: Review of the Surgical Ward templates alongside the Safe Care acuity tool indicated that there is increasing acuity on the Surgical Wards alongside increased activity. Proposals to increase the staffing templates, in particular at night have been submitted via the budget setting process.
 - b. Medical Care Group: A review into the night staffing template is currently being undertaken with a view to increasing it. The benefit of band 4 Assistant Practitioners within the workforce was noted and plans to increase agreed upon.
 - c. Specialties Care Group: Consideration is being given to adjusting the templates to reflect the work of Allied Health Professional roles such as band 4 associate practitioners. The impact of outlied patients on the Eye Unit was also discussed, and a skill mix change and increased night staffing was proposed and is being prepared for budget setting.
3. Ongoing daily review of safe staffing continues within the Care Groups. In early January 2018, in response to the increased operational pressures, a daily safe staffing huddle utilising the Safer Care tool has been implemented. The meeting is chaired by the Deputy Director of Nursing or Head of Nursing and Quality, to assess Trust-wide ward safety in relation to safe staffing for the coming 24 hours. It is envisaged that these half hour meetings will continue outside of winter pressures.
4. Care group e-rostering clinics continue quarterly, chaired by the Head of Nursing and Quality to provide oversight and challenge to rostering practice.
5. In accordance with NICE guidance all red flag shifts, shifts where ward staffing has been compromised were reviewed. In the six months reviewed there were 20 red flag shifts raised of which 19 were mitigated appropriately. The one remaining shift was mitigated with a Health Care Support Worker and therefore remained a red flag. All possible actions for this shift were explored and no harm occurred as a result of the incident.
6. Vacancies continue to be robustly managed within the Trust with a good intake of Newly Qualified Nurses being recruited in the autumn.
7. The Premium Cost Avoidance Transformation Steering Group continues to work effectively at reviewing agency usage and spend across the nursing workforce with a continued reduction in use of high cost off-framework agencies.

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



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

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Clinical Services Review – Implementation Update
Section on agenda:	Strategy and Risk
Supplementary reading:	Draft Outline Business Case
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	RBCH Board of Directors, Trust Management Board, One Acute Network Board
Action required:	Note for information
Summary: This paper briefly summarises the work now required to complete the Outline Business Case and confirms the timeline for the proposed merger of the two Trusts.	
Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	✓ ✓ ✓ ✓ ✓
Impact on risk profile:	None

Clinical Services Review Implementation Update

Introduction

This paper provides the Board with an update on work to advance the Clinical Services Review and the proposed merger of RBCH FT and Poole Hospital FT.

With regard to the Clinical Services Review, the feedback on the draft Outline Business Case from NHSE and NHSI following discussions with the Department of Health is that this submission needs to fully align with The Treasury Five Case Model. Crucially, therefore we will need to provide detailed design drawings within the OBC necessitating the completion of both the Clinical design work scheduled for completion in June 2018 and the physical design including granting of planning permission due to complete in June 2019.

I will update the Board on options and discussions with NHSI to fund the £9.0m required to support the estate (physical) design work. This means that the Full Business Case is unlikely to be submitted to The Treasury before the end of 2019.

Within the Reading Pack I have enclosed a copy of the draft OBC in its current form.

Recent work undertaken across the community with the joint and local health overview and scrutiny committees has been received positively. The conclusion of this work and a series of presentations and discussions is that there will be no referral of the CCG's decision to the Secretary of State. This decision negates any possible involvement of the Independent Reconfiguration Panel

Proposed merger

With regard to the proposed merger with Poole Hospital, I have shared separately the notes of a very helpful informal meeting with NHSI colleagues on 8 January. We are continuing to complete a draft of the Patient Benefits Case for initial discussion with and feedback from NHSI.

Following the recent One Acute Network Board meeting I can confirm the latest timeframe for the merger is as follows:

Revised Merger timeline

A revised timeline has been proposed, a summary of which is below:

November 2017 – January 2018	NHSI Stage 1 strategic review
November 2017 – April 2018	Patient benefits case – finalise for submission to the CMA
December 2017 – Sep 2018	Merger full business case development, Long term financial model, Due diligence, Post transaction implementation plan
January 2018 – April 2018	Heads of Terms agreed
April 2018	Outline LTFM approved by Boards and submitted to NHSI for stage 1 checkpoint
June 2018 – July 2018	Competition and Markets Authority phase 1 review and review of undertaking CMA decision on undertaking and possible referral to phase 2
September 2018	Shadow interim board appointment process undertaken
November 2018 – February 2019	NHS Improvement review of Full Business Case
February 2019 – April 2019	Statutory Orders
1 April 2019	Go live date for new merged Trust (assuming Stage 1 CMA clearance)
1 October 2019	New Board manage new Trust

Tony Spotswood
Chief Executive



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

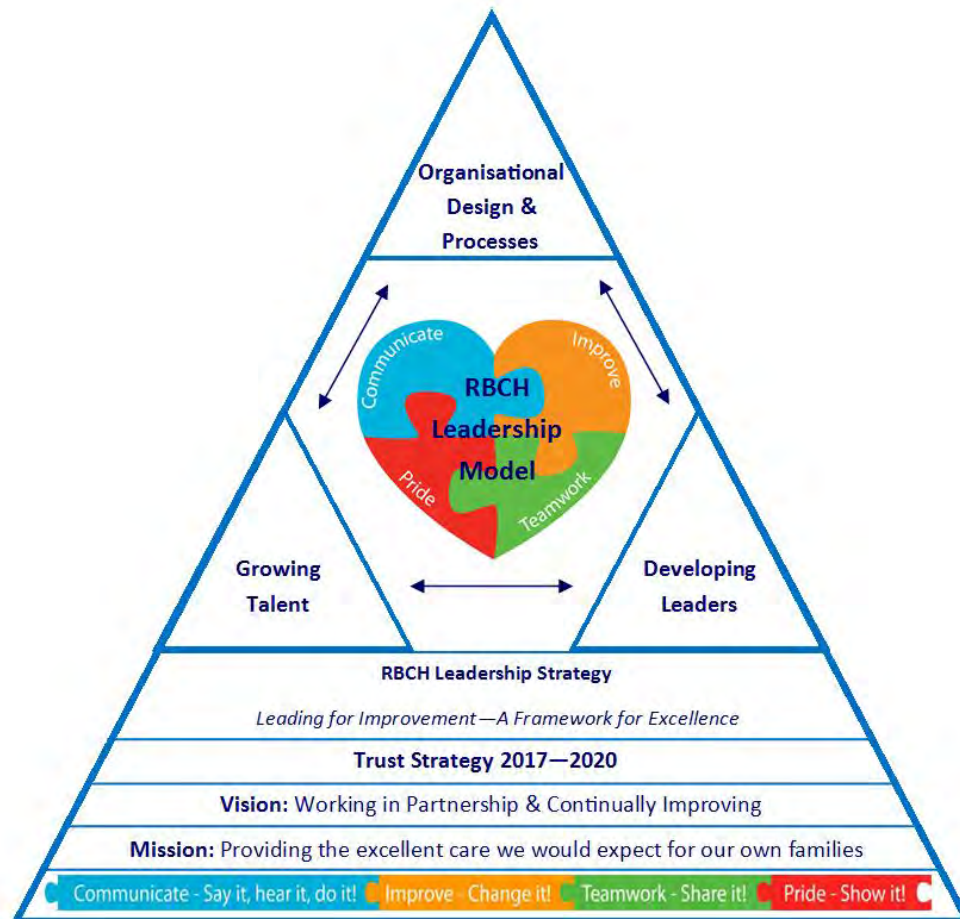
BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	RBCH Trust Leadership Strategy
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Nicola Hartley, Director of OD and Leadership
Author(s) of paper:	Nicola Hartley, Director of OD and Leadership
Details of previous discussion and/or dissemination:	Recommended for approval by the Workforce Strategy and Development Committee at the meeting held on 7 December 2017.
Action required:	Decision
Summary: The RBCH Board has agreed that culture change is best not left to chance and is supporting a strategic approach to Organisational Development and a three year culture change programme. This Leadership Strategy will provide the framework for the Board to oversee the creation of the leadership capabilities and culture we need to achieve our mission and vision.	
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"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Impact on risk profile:	A Leadership Strategy is a requirement within the CQC well-led domain.

providing the excellent care we
would expect for our own families

COLLECTIVE LEADERSHIP STRATEGY

Leading Improvement - A Framework for Excellence

2017-2020



Culture defines any business, but it's one of the hardest things to manage

(Margaret Heffernan)

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

Foreword

On behalf of the Board, I would like to emphasise the importance of the RBCH Collective Leadership Strategy in developing and nurturing leadership capabilities at all levels and across all areas of the Trust. It is vital that we support our staff and compassionate leadership is at the core of outstanding patient care.

This strategy reflects the views of our staff about what is important to help equip them to lead effectively. We recognise the importance of investing in leadership at an individual and team level, as well as working both within and across our health and care system.

Our vision to work in partnership and continually improve means that we will continue to invest in our culture change work, behaviours and quality improvement. Most importantly, we will listen to our staff and patients in shaping and informing our leadership with a focus on continued improvement to provide outstanding care.

Tony Spotswood

Chief Executive

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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A	RBCH Leadership Model and Behaviours
B	Developing People –Improving Care; A national framework
C	Personal Development Plan (PDP) Template
D	Leadership Development Offer sample example



1. THE CULTURE WE WANT TO CREATE

1.1 Why we need a Leadership Strategy

Effective leadership:

- ✓ Is the most powerful factor influencing culture in healthcare organisations because it determines staff engagement and commitment to high quality care
- ✓ Is key to creating cultures that will give NHS staff the freedom and confidence to act in the interests of patients
- ✓ Will lead to sustainable clinical, operational and financial performance

The Royal Bournemouth and Christchurch Hospitals (RBCH) Board has agreed that culture change is best not left to chance and is supporting a strategic approach to Organisational Development (OD) and a three year culture change programme.

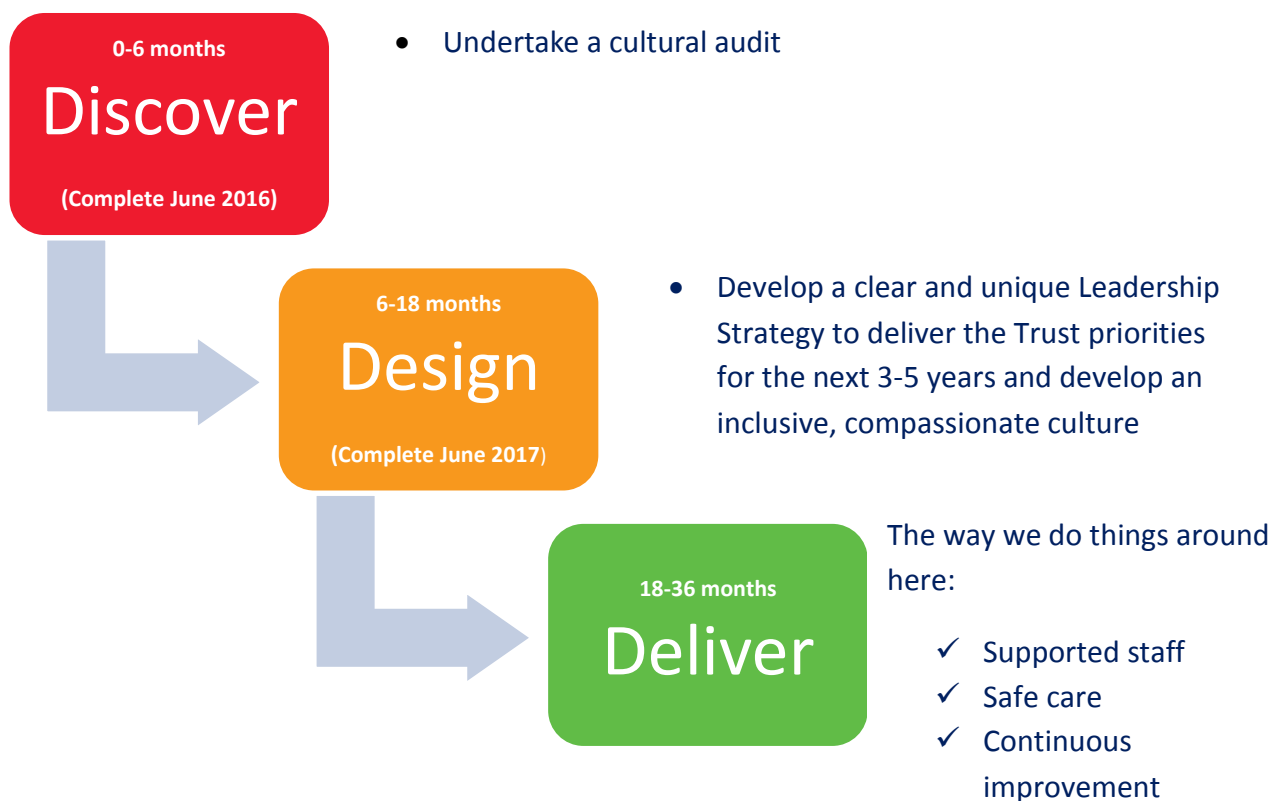
This Leadership Strategy will provide the framework for the Board to oversee the creation of the leadership capabilities and culture we need to achieve our mission and vision.

1.2 Our Culture Change Programme

Diagram 1.1 below describes our three year culture change programme and we are currently at the start of the Deliver Phase:

Diagram 1.1 Developing a Leadership Strategy

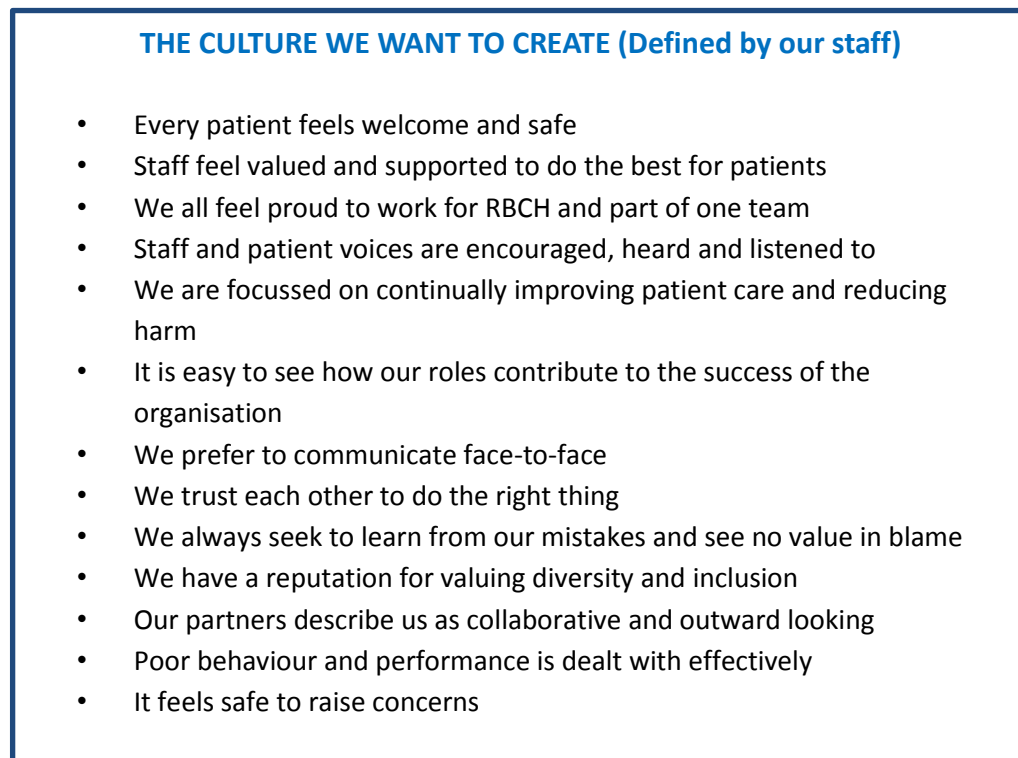
A three year plan



A sustainable programme in place by April 2018 with a culture of collective leadership and continual improvement embedded in the way we do things here.

During the **Discovery Phase** our team of Change Champions undertook a cultural audit and heard the views of over 900 staff about what it is like to work at RBCH. These findings were presented to the Board at a dedicated session held in June 2016. This audit was used to define the culture we want to create and it underpins this Leadership Strategy. This is summarised in diagram 1.2 below:

Diagram 1.2



The culture we want to create sits at the heart of the Leadership Strategy and our approach to leadership development and talent management.

During the **Design Phase** our Change Champions have talked to staff about their findings and tested ideas for improvement. This feedback has been used to shape this Leadership Strategy. This was developed further at the Board Development session in June 2017 with our executive and non-executive directors and wider senior leadership team.



To deliver the desired culture change, we now need to ensure a consistent leadership style, aligned to our organisational vision and goals. We need to develop leaders, who will create the new culture; who are skilled, competent and confident to manage the tensions between delivering quality, financial and performance priorities; and who do this with compassion. This Leadership Strategy provides the framework to achieve this.

Board members are role modelling the change we want to see and have signed up to a team charter – diagram 1.3 - (which they developed with our Change Champions) against which all staff are

invited to hold them to account. They agreed that this Charter will be used at Board meetings as a guide and reference for the way board members work together and make decisions.

Diagram 1.3



2. NATIONAL GUIDANCE AND BEST PRACTICE

Our culture change work and approach to developing this Leadership Strategy is based on evidence and good practice.

The need for a Leadership Strategy is also recognised by regulators and national advisers. In the Lord Carter of Coles report for the Department of Health (February 2016), Recommendation One sets out the requirements on Trusts to develop leadership capability in order to deliver transformational change.

There are two significant national resources we should bear in mind as we develop our leadership capacity and capability:

1. Developing People – Improving Care – a national framework for action on improvement and leadership development in NHS-funded services
2. The Care Quality Commission (CQC) Well Led Domain – new characteristics

2.1 Developing People – Improving Care

In September 2015 a national framework for action on improvement and leadership development in NHS-funded services was published by the National Improvement and Leadership Development Board. It aims to guide team leaders at every level of the NHS to develop a critical set of improvement and leadership capabilities among their staff and themselves, summarised in Diagram 2.1 below:

Diagram 2.1

National Improvement and Leadership Development Board Representation	Capabilities
Department of Health, NHS Improvement, NHS Health Education England, NHS Leadership Academy, NHS England, Public Health England, National Institute for Health Care Excellence, Care Quality Commission, Skills for Care, Local Government Association, NHS Providers, NHS Clinical Commissioners, NHS Confederation.	<ol style="list-style-type: none">1. Systems leadership skills2. Improvement skills3. Compassionate, inclusive leadership skills4. Talent management

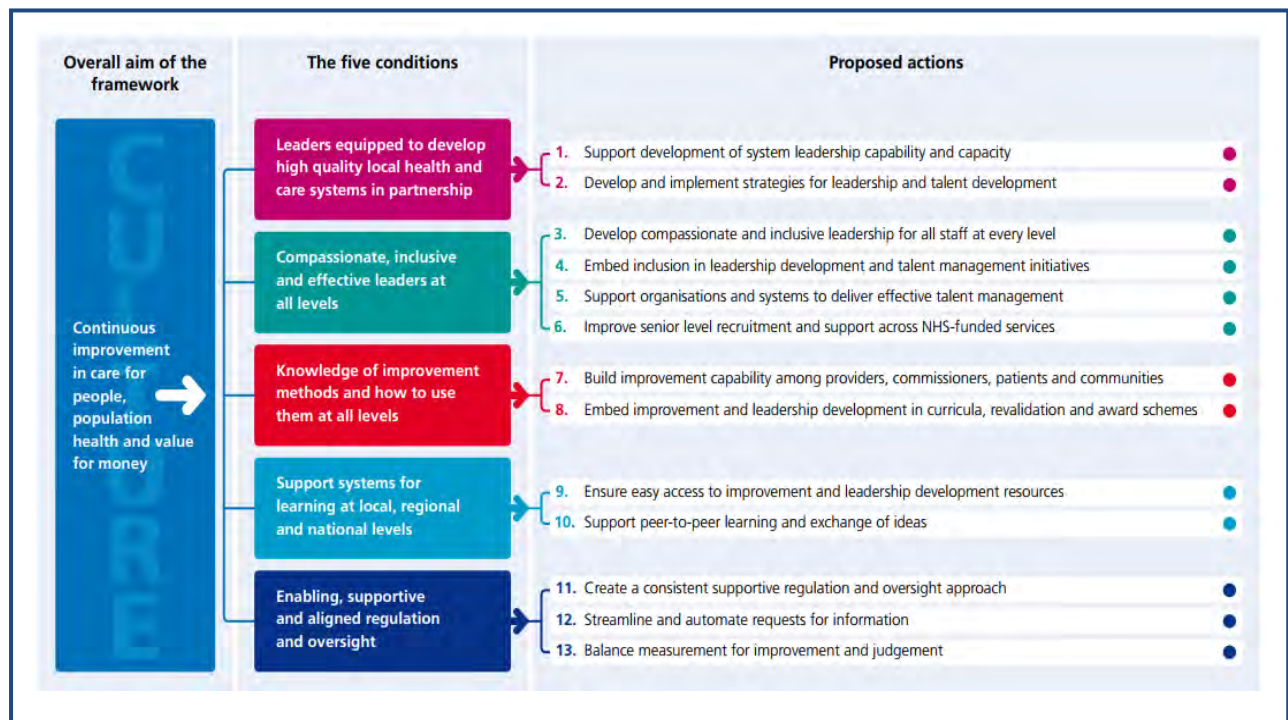
The framework suggests Boards should target:

- **Building improvement skills** among all our staff.
- **Developing current and future leaders** with the compassionate, inclusive leadership qualities, improvement leadership skills and system leadership strengths as well as the specific management skills they need to meet today's challenges.
- **Managing talent** to fill future leadership pipelines with the right numbers of diverse appropriately developed people.

It is a call to leadership teams to prioritise building capacity and capability for organisational development in organisations and systems. Our cultural change programme and the RBCH Leadership Strategy set out to achieve this.

The national framework also identifies five interacting *Conditions* common to high quality systems that produce a culture of continuous learning and improvement, together with 13 *Actions* necessary to create these conditions. These provide a good measure for progress and are discussed in more detail on page 26 in the section, **Measuring our Progress**. The full list is provided in Appendix B and summarised in Diagram 2.2 below:

Diagram 2.2



2.2 The CQC Well Led Domain

In June 2017 the Care Quality Commission (CQC) published a response to its consultation for how it will regulate NHS trusts. Alongside this, the updated provider guidance and assessment frameworks for health care services have been published and the new Well Led Domain now includes eight Key Lines of Enquiry (KLoE) with clear statements regarding the characteristics for a Good and Outstanding assessment rating.

For KLoE W1 and W3, the characteristics for a Good and Outstanding assessment ratings are particularly relevant to our Leadership Strategy. These also provide a good measure for progress and are discussed in more detail on page 26 in the section, **Measuring our Progress**.

The eight KLoE are set out in diagram 2.2:

Diagram 2.2

WELL LED	
Definition: By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture	
Eight Key Lines of Enquiry (KLoE)	
W1	Is there the leadership capacity and capability to deliver high quality, sustainable care?
W2	Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?
W3	Is there a culture of high quality, sustainable care?
W4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?
W5	Are there clear and effective processes for managing risks, issues and performance?
W6	Is appropriate and accurate information being effectively processed, challenged and acted on?
W7	Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?
W8	Are there robust systems and processes for learning, continuous improvement and innovation?

3. OUR LEADERSHIP CONTEXT

3.1 Our environment

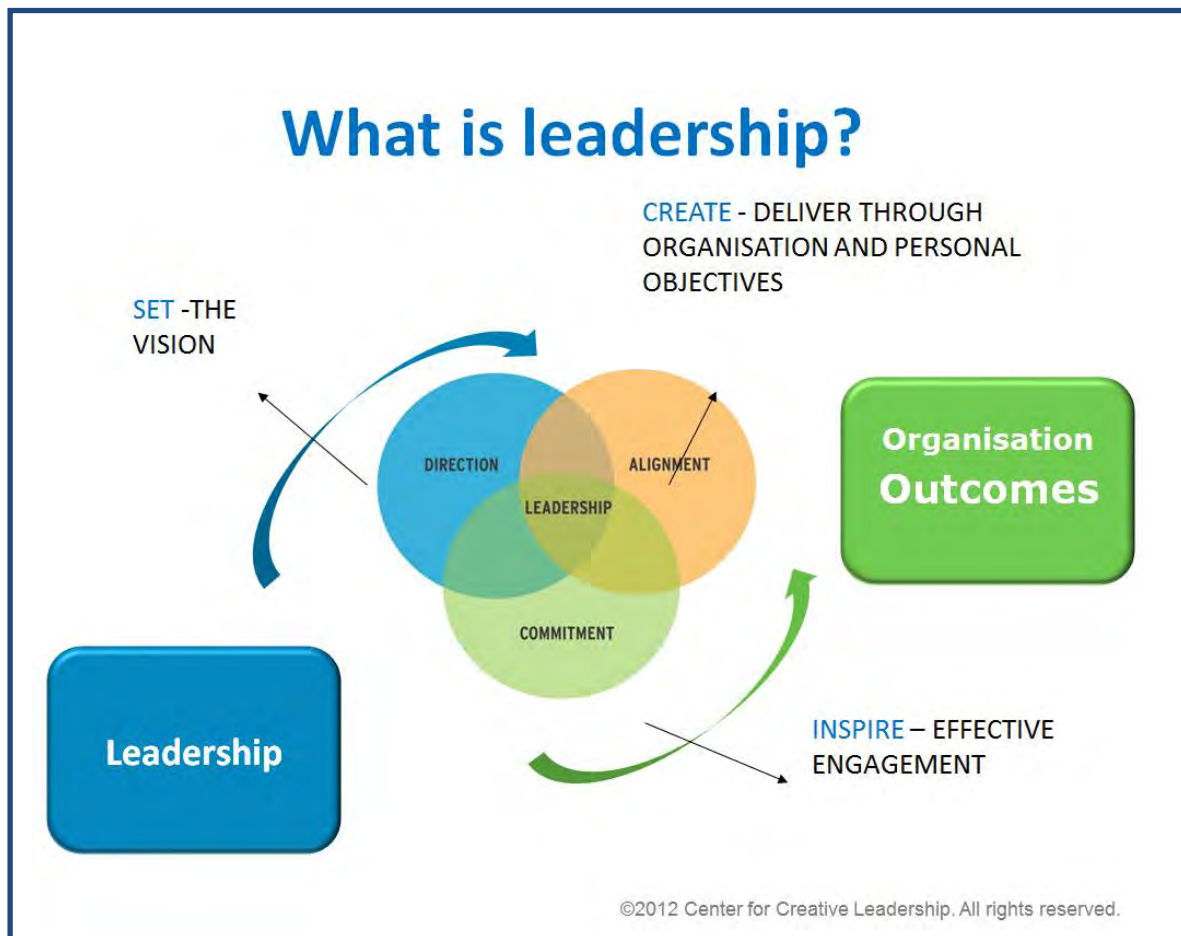
Our external environment is changing fast. We need to build collaborative relationships and work collectively with our partners to drive through change and deliver new service models. Our staff will look to our leaders for direction and support during uncertain and challenging times. Whilst delivering the change we will need to ensure we keep our eye on the daily business of running the hospital and ensuring this remains a great place to work. We want our staff to enjoy coming to work and to feel motivated and involved in supporting an ambition for continuous improvement. Role modelling our values and treating each other with compassion will be vital if we are to succeed in delivering our ambitious vision.

3.2 Our expectations

We have a clear expectation of the role of our leaders, set out in diagram 3.1, which is to:

1. Describe the vision and direction of travel to the people they lead
2. Create the environment to support people to deliver the vision by setting clear expectations through team and personal objectives
3. Inspire and motivate people to work together to engage in delivering the Trust's ambitions

Diagram 3.1



3.3 Ensuring a focus on learning and innovation

For the last three years we have been driving an ethos of continuous quality improvement. This has been reflected in our vision and was the basis of our cultural audit. Don Berwick, in his 2015 report - *A promise to learn, a commitment to act (improving the safety of patients in England)* - identified some essential indicators. These are summarised in diagram 3.2 and provide a helpful focus for our leaders and their teams.

Diagram 3.2

A promise to learn a commitment to Act - Essential Indicators:

- Are staff focused on continually improving patient care?
- Are all staff focused on 'continually and forever reducing harm'?
- Is reflective practice endemic?
- Do all staff intervene to ensure high quality of care?
- Are visits by staff enabled at all levels to learn about best practice?
- Are there effective schemes to promote responsible, safe innovation – Lean, QI?
- Is there recognition and reward for innovations introduced at every level and in every department/team/function?
- Are there high levels of dialogue and discussion end to end and top to bottom – team learning, cross boundary co-operation, trust and openness?

Don Berwick, IHI

4. OUR VISION FOR LEADERSHIP

This Leadership Strategy is designed to underpin and support delivery of our Trust strategy, vision, and mission and to reflect our agreed Trust values. In October 2015 the Board agreed:

- The RBCH **leadership challenge** is to become the **most improved hospital in the UK by 2017** and this will be addressed by being a well led organisation that **delivers safe, high quality patient care that is clinically and financially sustainable**
- The board will oversee the creation of the leadership capabilities and leadership culture the organisation needs to possess in order to achieve its vision through the development of a **leadership strategy**
- The **leadership model** for culture change will be one of **collective leadership which will be clinically led**
- The board will promote the development of an **inclusive leadership and management style**

Research shows that **staff satisfaction and patient experience are closely linked** – patients receive better care when staff are engaged and well led. This highlights the **crucial role of NHS leaders in developing cultures** in which staff are motivated and supported to deliver high-quality, compassionate care to patients. This means **moving from the recent reliance on ‘heroic’ leaders**, where responsibility is concentrated in a small number of individuals at the top of an organisation, to **a more collective approach** in which all staff take responsibility for improving care.

The Kings Fund 2015

4.1 Collective Leadership

The Board has signed up to a model of collective leadership. By this we mean that everyone who works for the Trust takes responsibility for the success of the organisation in delivering continually improving, high quality and compassionate care (Developing Collective Leadership for Healthcare, The Kings Fund 2014). We will do this both within the Trust and working with partners.

For this reason, this Leadership Strategy does not differentiate between the role of supervisors, managers and leaders and it aims to set out a direction of travel that will enable all our staff to embrace the model of collective responsibility.

The key to achieving sustainable business success is to have excellence in leadership at all three levels; strategic, operational and team leaders need to work harmoniously together as the organisation’s leadership team.

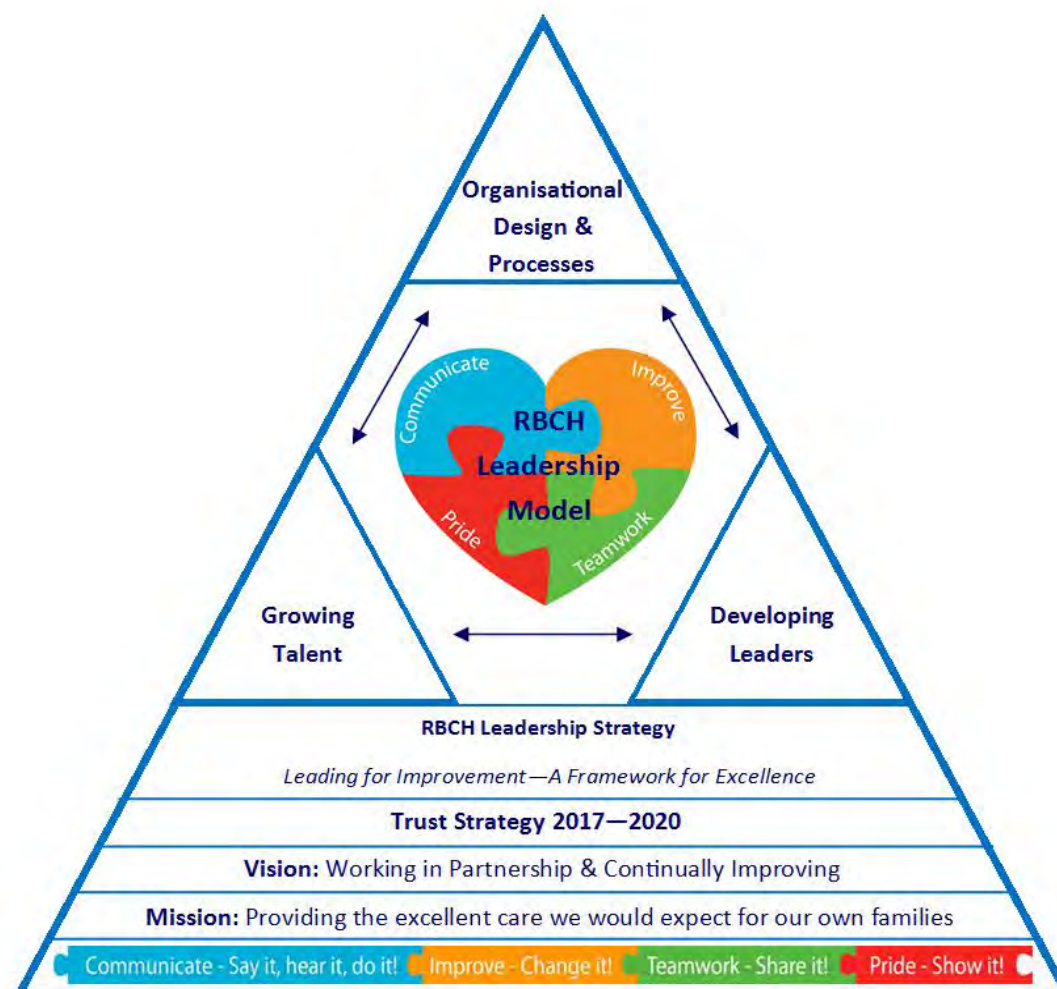
The most common and expensive error that organisations make is to focus leadership development on their more senior managers, so that becomes their entire strategy. In so doing, they completely ignore their team leaders. Yet it is the team leader who is closest to the customer. Make sure that your strategy embraces all three levels.

John Adair

5. MAKING IT HAPPEN

This Leadership Strategy is built on strong foundations and aligns with our Trust People Plan 2017-2020. It is summarised in Diagram 5.1 below:

Diagram 5.1



In 2014, our staff were involved in developing the **Trust Values**. These underpin the behaviour framework used in our values-based appraisal and are now well embedded within the culture of the organisation. They create the basis for our Leadership Strategy.

Similarly, the **Trust Mission** – *providing the excellent care we would expect for our own families* – was developed with our staff and in recent engagement events they have told us how much this matters to them.

In 2017 our Change Champions worked with the senior leadership team to run staff focus groups to develop our new **Trust Vision** for the next 3-5 years. In recognition of the Clinical Services Review decision, we have agreed a new vision – *Working in partnership and continually improving*. This reflects what matters most to staff during a period of significant organisational change. If we merge with Poole hospital, we will need to work together to create a new vision with staff from both organisations.

Our Leadership Strategy comprises four component parts:

1. RBCH Leadership Model
2. Organisational Design and Processes
3. Developing Leaders
4. Growing Talent

The four elements of the Leadership Strategy are described below, together with an action plan for each element:



5.1 Our Leadership Model

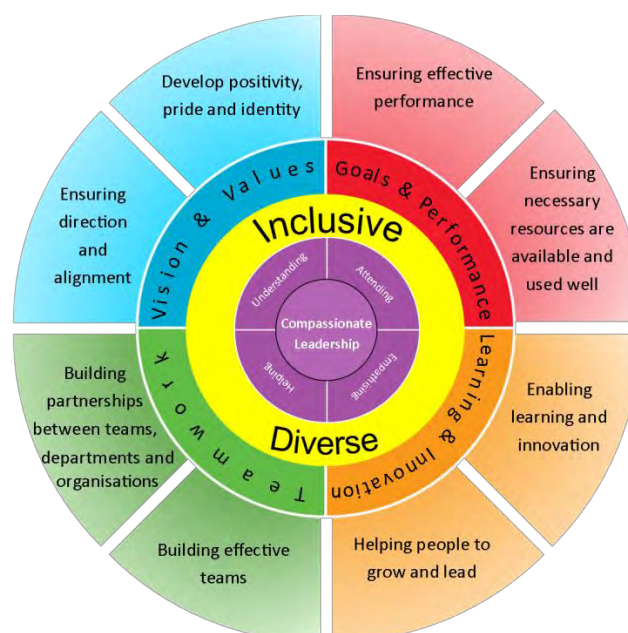
Purpose: To define our standards and expectations for leadership

During 2016/17 we have developed a **Leadership Model** which sets out the behaviours we expect to see in our leaders that we believe will support the creation and sustainability of the culture we want to create. This sits at the heart of our approach and underpins the other three elements.

The model is based on the work of Professor Michael West and NHS Improvement which has been developed to support the publication of the [national culture change toolkit](#) (in which RBCH is included as a case study).

The model places compassionate leadership at the centre and comprises **10 leadership behaviours** linked to the **five cultural elements** that support collective leadership and which formed the basis of our cultural audit. This means that the leadership behaviours we have set out as our standard within this Trust directly link to the findings of the cultural audit and the changes we want to see. Diagram 5.2 below sets out the model:

Diagram 5.2



This model will be used to:

- Set the standards and expectations of our leaders
- Support recruitment to management and leadership roles
- Determine the design and content of all our leadership development work
- Support our talent management programme and processes
- Support personal development planning and appraisals
- Develop 360 feedback tools

There are a range of other leadership models available, for example the NHS Leadership Academy's Healthcare Leadership Model is in part based on the idea of distributed leadership, and as such does have some connection to the approach described here. Both are fundamentally concerned with improving patient care through staff engagement, with leaders playing a pivotal role.

The full details of the model are set out in Appendix A and a summary of the five cultural elements and ten leadership behaviours is described in Diagram 5.3 below:

Diagram 5.3

FIVE CULTURAL ELEMENTS OF COLLECTIVE LEADERSHIP	TEN LEADERSHIP BEHAVIOURS
Vision and Values Constant commitment to quality of care	1. Ensuring direction and alignment
	2. Developing positivity, pride and identity
Goals and Performance Effective, efficient, high quality performance	3. Ensuring effective performance
	4. Ensuring necessary resources are available and used well
Support and Compassion Support, compassion and inclusion for all patients and staff	5. Modelling support and compassion
	6. Valuing diversity and fairness
Learning and Innovation Continuous learning, quality improvement and innovation	7. Enabling learning and innovation
	8. Helping people to grow and lead
Team work Enthusiastic co-operation, team working and support within and across organisations	9. Building effective teams
	10. Building partnerships between teams, departments and organisations

LEADERSHIP MODEL - ACTION PLAN

ACTION/S	BY WHEN
1. We will adopt the Leadership Model across the Trust and use it to: <ul style="list-style-type: none"> • Set the standards and expectations of our leaders • Support recruitment to management and leadership roles • Determine the design and content of all our leadership development work • Support our talent management programme and processes • Support personal development planning and values-based appraisals • Develop 360 feedback tools 	Dec 17



5.2 Organisational Design and Processes

Purpose: To organise ourselves effectively and align our leadership processes

In order to achieve the culture changes we have defined, we need to pay attention to:

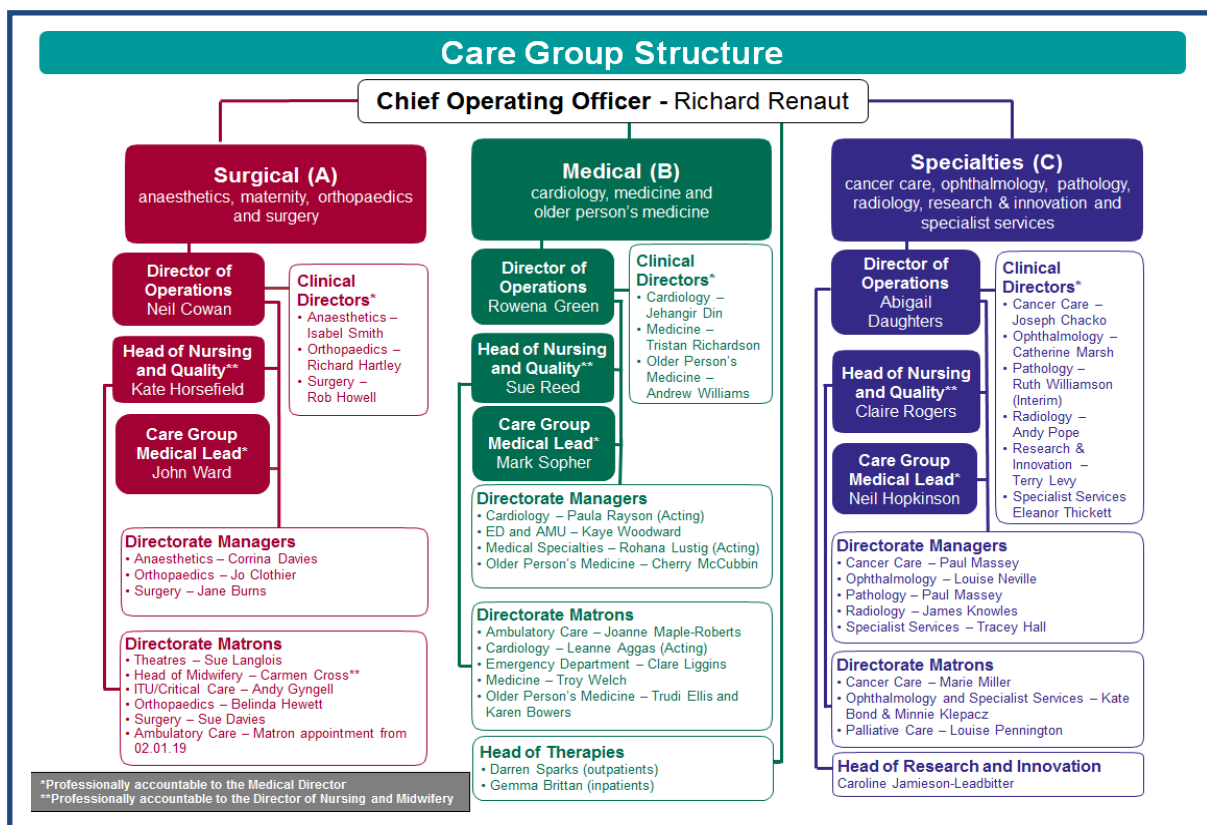
- the way we organise ourselves in terms of management structures
- our leadership capacity
- the processes we put in place to support our leaders

We will need to do this in the context of potential changes to organisational form (merger) and service reconfiguration (Clinical Services Review – CSR).

5.2.1 Management Structures

In 2014 the Trust reorganised and strengthened the management structures in response to a CQC inspection and performance issues. At this time a Care Group model was introduced together with some new roles: Directors of Operations for each care group and Matrons and Directorate Managers at directorate level. In the last year we have reviewed our structures further with a view to strengthening the clinical leadership model and embedding the triumvirate approach through care groups. By triumvirate we mean the three way partnership between the manager, the lead nurse or AHP and the lead doctor. The triumvirate take a collective responsibility for the delivery of services in their area and this is replicated at all leadership levels in the Trust. Diagram 5.5 shows the management structure:

Diagram 5.4



Recent changes have resulted in three new medical leaders being appointed to work alongside the Directors of Operations and the Heads of Nursing and Quality in each of the three care groups.

We will need to continue to review the management structure as new organisational forms are agreed and to ensure effective delivery of the CSR.

5.2.2 Leadership Capacity

We are facing a period of significant change and having the right number of leaders with the right skills, organised in the right way will be vital. Our leadership challenge to maintain a focus on the operational business of the Trust whilst creating future models for both the organisational form and the configuration of services will put our leaders under pressure.

We will need to understand our current leadership capacity in the light of the additional work and the potential for changing roles. We will also need to identify our future leadership requirements ensuring we develop leadership roles fit for the future, taking a fully inclusive approach to this.

5.2.3 Supporting Processes

In order to support our leaders we need to develop relevant processes aligned to our leadership model. Specifically we will focus on the following:

- Values-based recruitment
- Personal development planning
- 360 feedback

Values-based recruitment

For the past three years we have successfully focussed on introducing and embedding values-based appraisals across the Trust. This has involved developing a values-based behaviour framework and supporting staff to have meaningful appraisal conversations that focus on what they are doing and also how they are doing it. This approach is key to developing and sustaining our new culture.

We now need to move towards values-based recruitment. Our Recruiting Manager training is being updated to include values-based scenarios. The Leadership Model and 10 leadership behaviours will also be adopted as part of any leaders' job description.

Personal development planning

The values-based appraisal process provides an opportunity to reflect and feedback on an individual's leadership style and also their development needs. In order to develop our leaders we will now introduce Personal Development Planning alongside the appraisal process. A new Personal Development Plan (PDP) template is being developed and will be used to support leadership development and talent management activities. The draft PDP is attached at Appendix C.

360 degree feedback

We will support leaders to become more self-aware and to understand their personal development needs through a range of activities. Specifically, we will encourage staff to give and receive feedback and we will formalise the use of 360 degree feedback across the Trust.

We have worked in partnership with NHS Improvement (NHSI), The King's Fund and Professor Michael West to develop and pilot a 360 feedback tool based on the leadership behaviours set out in our Leadership Model. We have tested the tool with our executive team and following a positive evaluation we are now working with NHSI to establish a roll out programme with a view to extending the use of the tool to our next tier leadership team. This will then be subject to further evaluation before being made available as part of a national toolkit.

ORGANISATIONAL DESIGN AND PROCESSES – ACTION PLAN

ORGANISATIONAL DESIGN AND PROCESSES ACTION/S		BY WHEN
1.	Management Structures We will develop our new management structures to support transition to the new organisational form and effective delivery of the CSR	April 2018
2.	Leadership Capacity We will develop an outline Leadership Workforce Plan setting out roles, skills and numbers of leadership required for the next 3-5 years	April 2018
3.	Supporting Processes	
3.1	We will introduce values based recruitment for all new leadership roles	April 2018
3.2	We will introduce Personal Development Planning on a roll out basis during 2018 on a cascade basis.	June 2018
3.3	We will formalise the use of 360 feedback to support personal development	July 2018



5.3 Developing Leaders

Purpose: To value our staff and help them develop

Fundamental to this Leadership Strategy is our commitment to value our staff and to help them develop to achieve their potential.

5.3.1 Guiding Principles for our Leadership Development work

We have developed some important principles to guide our leadership development work in this area as set out in Diagram 5.5:

Diagram 5.5

Principles Underpinning our Leadership Development Work

We will:

- Promote leadership development for a purpose – aligned with the Trust’s leadership model, vision and objectives to create our defined culture change.
- Support a culture of proactive self-development and personal responsibility.
- Focus on supporting excellent performance in role, succession planning and talent management.
- Ensure all development activities are fully inclusive, encouraging the development of leaders from a diverse background.
- Retain ownership and control of our leadership development activities, only outsourcing when we believe we do not have the skills in house.
- Develop our in-house capacity and capability.
- Develop programmes that are cost effective and best value.
- Create an appropriate learning environment, prioritising excellent content over external venues

5.3.2 Identifying Strengths and Development Needs

Our Leadership Model provides a framework for identifying strengths and development needs for individuals and teams.

Individuals

During 2018, as part of our Talent Management programme (see Section 5.4), we will encourage individuals to take personal responsibility for their Personal Development Plan, discussing and agreeing their personal development journey with their line manager. We will offer *Effective Development Conversations* training to support line managers to do this well.

We offer our leaders coaching and psychometric assessment feedback and personal development conversations.

During 2018 we will introduce Development Centres, as part of our Talent Management programme (see Section 5.4), as a way of helping individuals understand their leadership strengths and areas for development.

Teams

For teams, we will develop a Team Effectiveness Diagnostic Tool to help teams and team leaders identify their strengths and development needs.

5.3.3 Our Leadership Development Offer

Individuals

For individuals we will run a suite of in-house development programmes and also provide funding and access to the national leadership programmes offered through the NHS Leadership Academy.

Places on the national programmes will be secured through an application process led by the OD Team.

The leadership development route map is shown at Diagram 5.6.

Diagram 5.6

The Leadership Development Route Map			
<i>Target Audience</i>	<i>Internal</i>	<i>TVW Leadership Academy</i>	<i>National Programmes</i>
Aspiring Chief Executives			<i>Aspiring CEO</i>
Experienced Executive Directors			<i>The Director Programme</i>
Aspiring Executive roles			<i>Nye Bevan</i>
Mid- level leadership, Aspiring senior leaders	<ul style="list-style-type: none"> • Matrons Development Programme • Senior Leadership Development Programme (in design) • Medical Leaders Development Programme (in design) • Difficult Conversations • Leadership Summit & Masterclasses 	<ul style="list-style-type: none"> • Access to individual mentoring and coaching • Mentoring Skills and Coaching skills programmes 	<i>Elizabeth Garrett Anderson</i>
New to leadership	<ul style="list-style-type: none"> • Difficult Conversations • Aston Team Journey • Leadership Summit & Masterclasses 	<ul style="list-style-type: none"> • Access to individual mentoring and coaching • Mentoring Skills and Coaching skills programmes 	<i>Mary Seacole</i>
Everyone interested in leadership Open access	<ul style="list-style-type: none"> • Personal resilience • Customer Care • Aston Team Journey 	<ul style="list-style-type: none"> • Access to individual mentoring and coaching 	<i>Edward Jenner</i>
BAME leaders bands 5-7			<i>Stepping Up</i>
BAME senior leaders			<i>Ready Now</i>
Graduate entrants			<i>Graduate Management Trainee Scheme</i>

We will create a *Leadership Development Offer* matrix which will help individuals to identify the most appropriate activity to meet their development needs. This will be included with the PDP

documentation and line managers and the OD team will be available to provide development advice and coaching sessions to help people identify and access the most appropriate support.

Appendix D sets out a sample Leadership Development Offer matrix. This will be developed further to sit alongside the PDP documentation. It will include a Resources section with links to relevant leadership articles and publications. The offer of support will be dependent on the agreed annual investment plan and, therefore, will be reviewed and updated on an annual basis.

Teams

For teams, we will offer a suite of in-house development programmes. Our team interventions will include:

- Team psychometrics, eg MBTI, Belbin, FiroB, TKI Conflict
- Aston Team Coaching
- Bespoke team coaching, development and facilitation
- Arbinger mindset coaching

Management Skills Toolkit

We are working in partnership with colleagues at other trusts who have developed management skills programmes. We are developing a programme of management development support. This will enable all staff to access a menu of management development activities. This is currently one of the work streams being supported by our Change Champion team as part of the Delivery Phase of our OD programme and will report back to the Board on progress in June 2018.

5.3.4 An annual investment plan for leadership development

This is agreed each year as part of the annual budget setting process. The annual plan directly links to the findings of the cultural audit and the needs of individuals being identified through the personal development planning process. The Principles set out in Diagram 5.6 are an important reference point when developing the investment plan.

In addition to existing development activity, three new priority areas for leadership development support are:

- A medical leadership programme
- A Directorate Managers/Heads of Service Development Programme – The Senior Leadership Development Programme (SLDP)
- Coaching – skills and support

All are currently in design and it is hoped that the Senior Leadership Development Programme will commence in spring 2018. We are in discussion with Poole Hospital to explore the potential to offer this programme to participants from both Trusts.

DEVELOPING LEADERS – ACTION PLAN

ACTION/S		BY WHEN
1.	Adopt the Principles underpinning our Leadership Development work across the Trust	April 2018
2.	Develop Passport to Lead process and supporting materials	April 2018
3..	Develop Management process and supporting management development activities with Change Champions with an update to the Board	June 2018
4.	Deliver the annual leadership development investment plan to time and within budget	March 2019
5.	Create and share the Leadership Development Offer matrix via the PDP and Appraisal process	April 2018



5.4 Growing Talent

Purpose: To support our staff to achieve their potential

Early in 2017 we held a workshop with the Trust senior leadership team to develop our ideas and priorities for talent management. We agreed some underpinning principles set out in Diagram 5.7:

Diagram 5.7

Principles underpinning Talent Management at RBCH	
<ul style="list-style-type: none"> • Our philosophy and approach will be: helping everyone to achieve their potential – inclusive not exclusive • We want to make staff feel: <ul style="list-style-type: none"> ○ Valued and recognised ○ Inspired to succeed ○ Encouraged ○ Allowed to grow ○ Motivated and engaged ○ Confident in their role ○ Valued for their diversity • Wherever you come in, wherever you leave, you will have further improved skills • We will support people to be ready for the roles, skills and competencies we will need in future • We want to keep talented people in the system and create a pipeline for Dorset • We will aim to “grow our own” and attract talent from outside • We will build a pipeline through succession planning • We want a process that is: <ul style="list-style-type: none"> ○ Personalised ○ Systematic ○ Aligned to appraisal outputs ○ Fair, open and transparent • We don’t want: <ul style="list-style-type: none"> ○ A scoring system ○ To put people in boxes 	

Talent Management is currently one of the work streams being supported by our Change Champion team as part of the Delivery Phase of our OD programme. They are developing our approach based on these Principles and will report back to the Board on progress in June 2018. They will also take into account the following

5.4.1 The Leadership Pathway

There are many routes into a leadership role within the Trust and our Talent Management process will be available to all, tailored to the individual and their personal career stage.

The Trust has been a host for the National Graduate Trainees Scheme over the last two years. For 2018/19 we have been provisionally accredited to host two Final Year general management placements and we are looking to host more Year 1 and Final Year trainees. This is an important element of our talent management programme.

5.4.2 Identifying Potential and Understanding Personal Aspirations

In 2018 we will launch our Senior Leadership Development Programme targeted at Directorate Managers and Heads of Services. This will include a two day, residential Development Centre. This will be a new approach for the Trust but is a well-evidenced method for helping individuals identify their development needs and providing useful data to support talent management and succession planning. We will work with an external provider to design the Development Centre around our Leadership behaviours. Once designed and evaluated, we will be able to use the Development Centre approach for different cohorts and groups of staff.

As part of this process we will also hold *Achieving your Potential* conversations with each participant. The aim will be to understand personal aspirations and preferences and to map this to our Leadership Workforce Plan in order to create a Talent Map.

5.4.3 A Dorset-wide Approach

We are working with the Dorset Workforce Action Board to develop a Dorset-wide approach. We will ensure that what we do within the Trust aligns with the wider system process.

GROWING TALENT – ACTION PLAN

ACTION/S		BY WHEN
1.	Develop talent management process with Change Champions with an update to the Board	June 2018
2.	Pilot and evaluate the Development Centre approach as part of the SLDP.	March 2018
3.	Work in partnership with partners to develop a Dorset-wide approach to talent management	June 2018

5.5 Building Internal Capacity & Capability

We wish to retain ownership and control of our leadership development activities. We believe an important role of leaders is to support and develop others. We will build our in-house capacity and

capability by extending and strengthening the development skills of our leaders, with a view to being as self-sufficient as we can be.

In 2016-17 we have trained 24 RBCH leaders to become Aston Team Coaches, and have boosted our internal supply of accredited individual coaches. We have increased the number of MBTI and TKI practitioners and have developed the training skills of our leaders through train the trainer programmes, so that they can support the roll out of the Customer Care and Personal Resilience programmes. We also have two accredited practitioners to deliver Arbingers' "Developing an Open Mindset" workshop.

5.6 Widening Access

We also wish to reach as many individuals as possible with our leadership development events. Our Annual Leadership Summit is open to 200 of our leaders and we run three Leadership Masterclasses throughout the year, with inspirational speakers. From Sept 2016 to September 2017, over 900 staff members attended at least one leadership development activities, including Customer Care and Difficult Conversations.

Through our policies and practices we aim to ensure that all staff and patients with protected characteristics are fully included and valued. The cultural audit and our Diversity and Inclusion week in 2017 identified many examples of good practice. However, we also heard that some individuals would like more support and different opportunities for their voices to be heard, with a request for more network support groups. Staff would also like us to take a more interactive approach to diversity and inclusion training.

In December 2017, we appointed a Diversity and Inclusion Lead from the Senior Leadership Team to ensure this agenda is a priority for 2018 and beyond. We also have a nominated Change Champion to support this work stream and a group of staff volunteers who have expressed an interest in getting involved.

Anecdotally, we have heard that some staff with protected characteristics believe they have been overlooked for promotion. We take this concern seriously and this will form part of our Diversity and Inclusion project in 2018.

6. MEASURING OUR PROGRESS

This Leadership Strategy sets out a direction of travel, a vision for outstanding leadership and a plan for delivery. It will be the responsibility of leaders across the Trust to embrace the ethos and ambition and to develop delivery plans with their teams, supported by the central OD Team. Progress will be reviewed through the governance of the Workforce Strategy and Development Committee.

A number of indicators exist against which we should measure our progress in delivering this Leadership Strategy. Each element of the strategy has an action plan and these should be tracked alongside the national guidance and inspection criteria as set out below.

LEADERSHIP MODEL - ACTION PLAN

ACTION/S		BY WHEN
1.	We will adopt the Leadership Model across the Trust and use it to: <ul style="list-style-type: none"> • Set the standards and expectations of our leaders • Support recruitment to management and leadership roles • Determine the design and content of all our leadership development work • Support our talent management programme and processes • Support personal development planning and values-based appraisals • Develop 360 feedback tools 	Dec 17 – June 18

ORGANISATIONAL DESIGN AND PROCESSES - ACTION PLAN

ORGANISATIONAL DESIGN AND PROCESSES ACTION/S		BY WHEN
1.	Management Structures We will develop our new management structures to support transition to the new organisational form and effective delivery of the CSR	April 2018
2.	Leadership Capacity We will develop an outline Leadership Workforce Plan setting out roles, skills and numbers of leadership required for the next 3-5 years	April 2018
3.	Supporting Processes	
a)	We will introduce values based recruitment for all new leadership roles	June 2018
b)	We will introduce Personal Development Planning on a roll out basis: <ul style="list-style-type: none"> • 2nd tier leaders • 3rd tier leaders 	April –Sept 2018
c)	We will formalise the use of 360 feedback to support personal development on a roll out basis: <ul style="list-style-type: none"> • 2nd tier leaders • Evaluation 	July 2018

DEVELOPING LEADERS – ACTION PLAN

ACTION/S		BY WHEN
1.	Adopt the Principles underpinning our Leadership Development work across the Trust	April 2018
2.	Develop Passport to Lead process and supporting materials	April 2018
3..	Develop Passport to Manage process and supporting management development activities with Change Champions with an update to the Board	June 2018
4.	Deliver the annual leadership development investment plan to time and within budget	March 2019
5.	Create and share the Leadership Development Offer matrix via the PDP and Appraisal process	April 2018

GROWING TALENT – ACTION PLAN

ACTION/S		BY WHEN
1.	Develop talent management process with Change Champions with an update to the Board	June 2018
2.	Pilot and evaluate the Development Centre approach as part of the SLDP	Spring 2018
3.	Work in partnership with partners to develop a Dorset-wide approach to talent management	June 2018

Developing People – Improving Care

Of the 15 recommended actions, 7 will be the sole responsibility of national bodies. However, the remaining actions should be owned and delivered locally and it would make sense to assess our progress against these:

CONDITION ONE:		
<i>Leaders equipped to develop high quality local health and care systems in partnership</i>		
Action		By when
2.	Develop and implement strategies for leadership and talent development	April 2018

CONDITION TWO:		
Compassionate, inclusive and effective leaders at all levels		
Action		By when
3.	Develop compassionate and inclusive leadership for all staff at every level	Dec 2018
4.	Embed inclusion in leadership development and talent management initiatives	June 2018
6.	Improve senior level recruitment and support	June 2018

CONDITION 3:		
<i>Knowledge of improvement methods and how to use them at all levels</i>		
Action		By when
7.	Build improvement capability :	

a)	<ul style="list-style-type: none"> All leaders have access to the knowledge and skills they need to lead quality improvement 	March 2019
b)	<ul style="list-style-type: none"> Patients and communities are involved as equal partners in the re-design of processes and systems All senior leaders are embedding an improvement mind-set in their organisations and model this 	April 2018
c)	<ul style="list-style-type: none"> Individuals and teams are strongly incentivised to improve health and care and rewarded for their contributions 	April 2018
CONDITION 4:		
<i>Support systems for learning at local, regional and national levels</i>		
Action		By when
9.	Ensure easy access to improvement and leadership development resources	October 2018
10.	Support peer-to-peer learning and exchange	October 2018

CQC Well Led Domain

Of the 8 Key Lines of Enquiry, two are most relevant to this work and our Leadership Strategy provides the approach we need to take in order to perform well against these indicators for Good and Outstanding. We should self-assess our performance against these criteria on a quarterly basis, identifying specific areas for attention.

Evidence: Good	Progress	Evidence: Outstanding
Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.		There is compassionate, inclusive and effective leadership at all levels.
Leaders at every level are visible and approachable.		Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning.		There is a deeply embedded system of leadership development and succession planning, which aims to ensure that the leadership represents the diversity of the workforce.
The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them		Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.

Evidence: Good	Progress	Evidence: Outstanding
Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported.		Leaders have an inspiring shared purpose, and strive to deliver and motivate staff to succeed.

There are processes to support staff and promote their positive wellbeing.		There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act.
Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity.		There is a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce.
Leaders encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services.		Staff are proud of the organisation as a place to work and speak highly of the culture.
Candour, openness, honesty, transparency and challenges to poor practice are the norm.		Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.
The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued.		There is strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.
Staff actively raise concerns and those who do (including external whistleblowers) are supported.		
Concerns are investigated sensitively and confidentially, and lessons are shared and acted on.		
When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.		
Behaviour and performance inconsistent with the vision and values is identified and dealt with swiftly and effectively, regardless of seniority.		
There is a culture of collective responsibility between teams and services		
There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.		
There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations		
Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these.		
Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably		

7. MEASURING OUR IMPACT

The impact of leadership development is often difficult to quantify but there are a number of measures we will use to assess the impact of this work. The NHS annual Staff Survey and the quarterly Staff Impressions surveys are a valuable source of data and we will also set up bespoke monitoring systems to assess impact in the areas set out below:

IMPACT MEASURES
Recruitment profiles – the behavioural/values profile of the leaders we recruit
Number of 360 survey reports generated
Talent map
Development Centre profiles - the behavioural/values profile of the leaders we develop
PDP analysis – identifying the development needs and activities
Number of appraisals completed
Quality of appraisals completed
Development activities undertaken – by type and number
Staff satisfaction with development opportunities
Progression rates for leaders
Retention rates leaders
Staff engagement scores
Numbers shortlisted for key leadership roles
Breadth of choice for shortlisting panels

Next steps

As we move towards merger and the Clinical Services Review we will need to align this Leadership Strategy with the plans and processes in Poole Hospital. Discussions have now commenced.

There is a real opportunity, given the scale and pace of change facing the two organisations, to explore the potential to achieve greater alignment between the OD and Leadership work and the Quality Improvement programme to create an innovative and agile transformation capability.

The three year OD programme draws to a close in June 2018 and this feels like the right time to rethink how these functions work together more closely in the future.

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would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust

OUR LEADERSHIP MODEL

Ten leadership behaviours to support a culture of collective leadership

Leadership, particularly collective leadership:

- is the most powerful factor influencing culture in healthcare organisations because it determines staff engagement and commitment to high quality care
- is key to creating cultures that will give NHS staff the freedom and confidence to act in the interests of patients
- will lead to sustainable clinical, operational and financial performance

The King's Fund, working with NHS Improvement (NHSI), has identified 10 leadership behaviours linked to the **five cultural elements** that support collective leadership and these are included in the NHSI culture change programme and toolkit. As a Trust, we will adopt this framework as part of our Leadership Strategy to deliver culture change in our organisation and respond to the issues raised by staff in our cultural audit. We will develop our leaders using this model.

FIVE CULTURAL ELEMENTS OF COLLECTIVE LEADERSHIP
Vision and Values Constant commitment to quality of care
Goals and Performance Effective, efficient, high quality performance
Support and Compassion Support, compassion and inclusion for all patients and staff
Learning and Innovation Continuous learning, quality improvement and innovation
Team Work Enthusiastic co-operation, team working and support within and across organisations

There are a range of other leadership models available, for example the NHS Leadership Academy's health care leadership model (soon to be revised and re-launched) is in part based on the idea of distributed leadership, and as such does have some connection to the approach described here. Both are fundamentally concerned with improving patient care through staff engagement, with leaders playing a pivotal role.

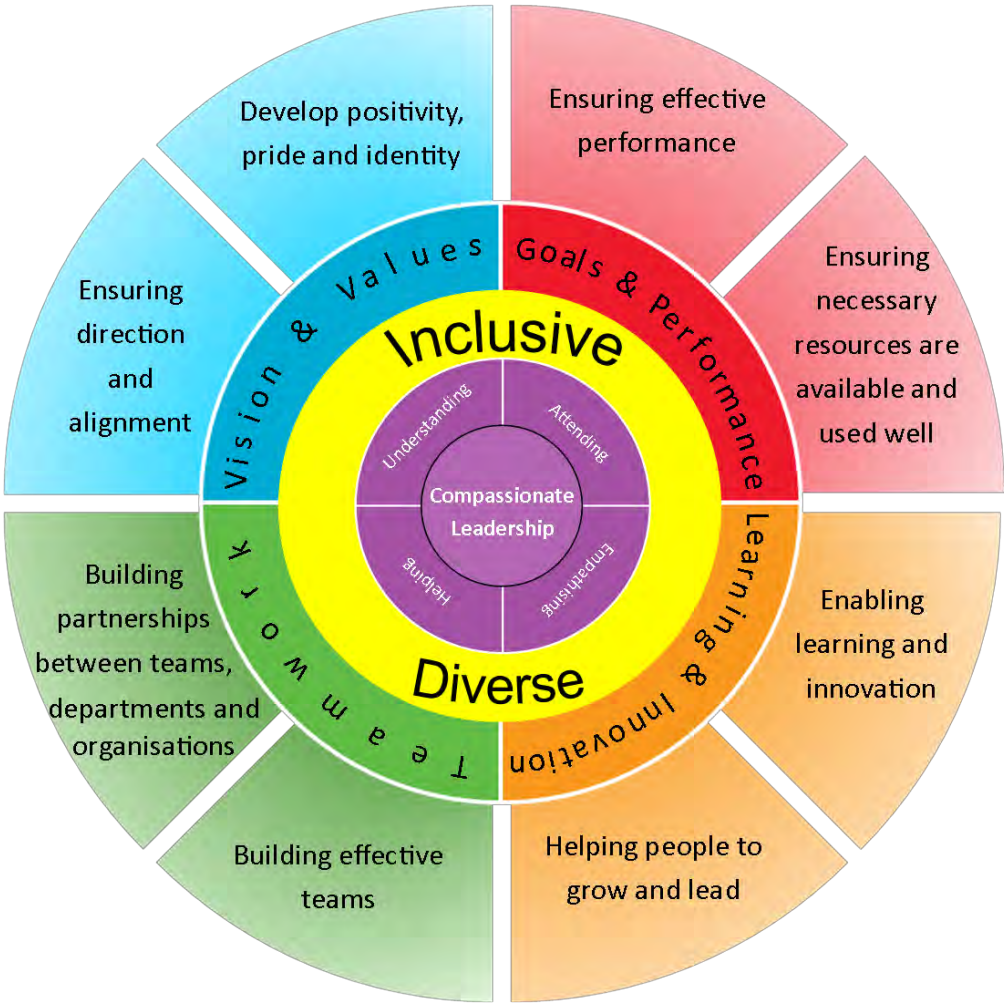
TEN LEADERSHIP BEHAVIOURS		FIVE CULTURAL ELEMENTS
1.	Ensuring direction and alignment	Vision and Values
2.	Developing positivity, pride and identity	
3.	Ensuring effective performance	Goals and Performance
4.	Ensuring necessary resources are available and used well	
5.	Modelling support and compassion	Support and Compassion
6.	Valuing diversity and fairness	
7.	Enabling learning and innovation	Learning and Innovation
8.	Helping people to grow and lead	
9.	Building effective teams	Team Work
10.	Building partnerships between teams, departments and organisations	

More detail about the behaviours:

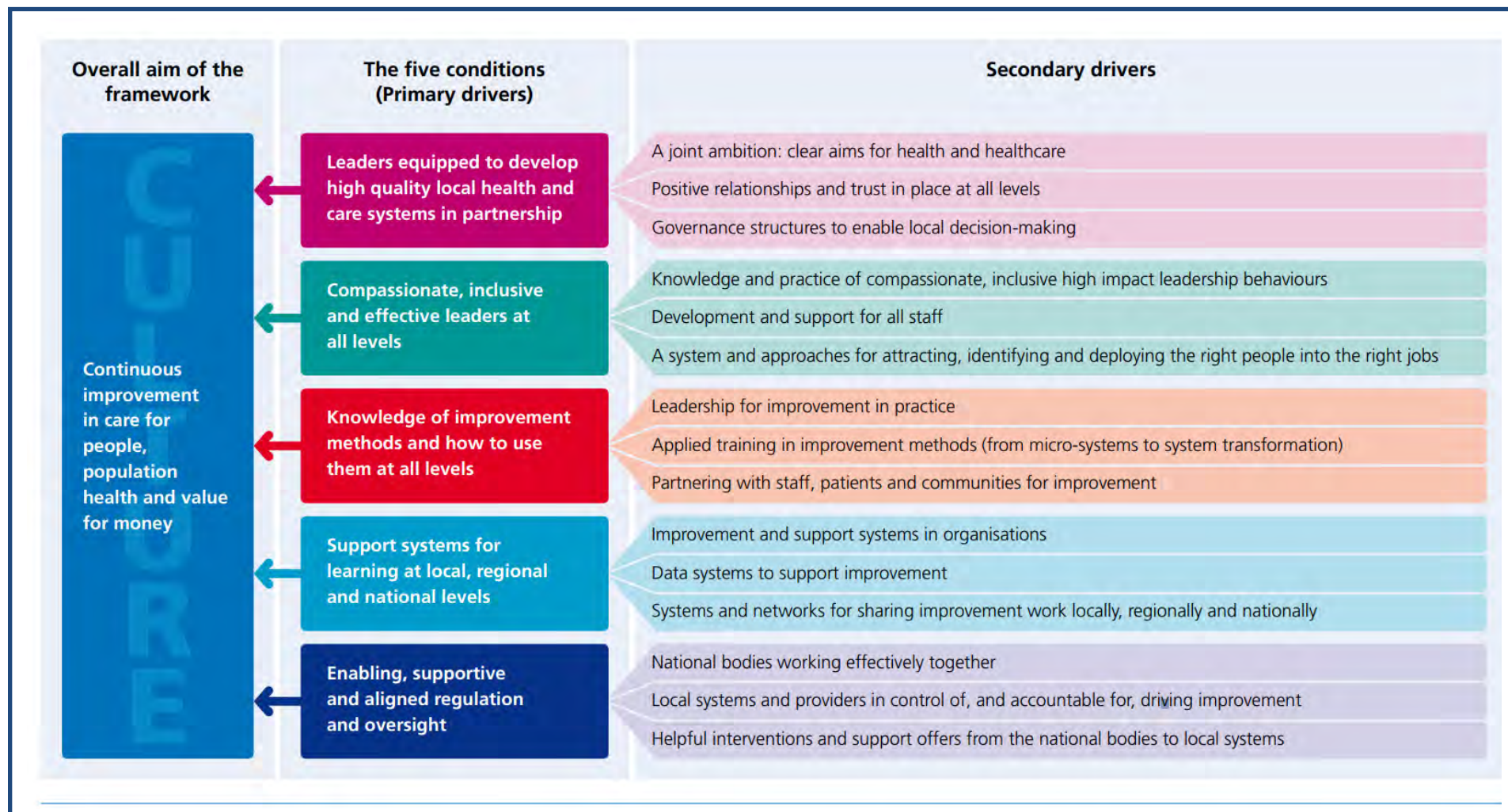
BEHAVIOUR	DESCRIPTION
Ensuring direction and alignment	Includes: <ul style="list-style-type: none"> Seeking shared agreement on direction (the overall purpose and aims of the work) within teams/organisations and across teams Encouraging everyone to work together to ensure all are clear on the direction and strategy of their teams and of the organisation Helping people to make sense of events in the organisation
Developing positivity, pride and identity	Includes: <ul style="list-style-type: none"> Celebrating the successes of the team and organisation Emphasising how the work makes a difference to patients and the community Encouraging others to be positive Expressing optimism, confidence, gratitude and humour Building a sense of positivity about the future
Ensuring effective performance	Includes: <ul style="list-style-type: none"> Ensuring everyone is clear about each other's roles and responsibilities Seeking agreement and shared understanding about key priorities and objectives Organising and co-ordinating work efforts towards agreed goals Dealing with obstacles to the delivery of high quality work such as systems difficulties, challenges and co-ordination problems Giving timely and balanced feedback about progress towards objectives
Ensuring the necessary resources are available and used well	Includes: <ul style="list-style-type: none"> Ensuring staff have the resources and support needed to get the job done, such as money, staff, IT or other specialist support, time Reducing demands on staff when they are overwhelmed Ensuring resources are used efficiently and effectively
Enabling learning and innovation	Includes: <ul style="list-style-type: none"> Sharing learning about errors, near misses, and improved ways of working Improving the quality of their work, including regular reviews of working methods Developing and implementing ideas to improve quality Supporting others in implementing ideas for new and improved ways of working

	<ul style="list-style-type: none"> • Avoid blaming unnecessarily by creating a psychologically safe environment
Helping people to grow and lead	<p>Includes:</p> <ul style="list-style-type: none"> • Promoting continued learning and development for all • Ensuring everyone has the freedom to work autonomously where appropriate rather than being restricted • Ensuring everyone has the chance to take part in challenging projects and other development opportunities, and to lead in their work
Modelling support and compassion	<p>Includes:</p> <ul style="list-style-type: none"> • Being supportive and compassionate to staff and patients who are distressed or under pressure • Understanding the pressures and difficulties staff face • Taking practical action to help those under pressure • Encouraging everyone to support each other
Valuing diversity and fairness	<p>Includes:</p> <ul style="list-style-type: none"> • Ensuring equality and valuing diversity (of race, disability, religion or belief, age, gender, gender reassignment, sexual orientation, professional background, work experience, marital status, pregnancy and maternity) • Encouraging, listening carefully to other's contributions ('listening with fascination') • Ensuring everyone's opinions are valued (staff and patients) and that people feel comfortable to be honest and open • Challenging aggressive or intimidating behaviours, and dealing effectively with bullying, harassment or discrimination, promoting social justice and morality and emphasising fairness and honesty in all dealings • Setting an example of ethical/moral behaviour, especially when it requires the sacrifice of personal interests
Building effective teams	<p>Includes:</p> <ul style="list-style-type: none"> • Ensuring the team has clear objectives and team members have helpful data on team performance • Co-operative working • Shared leadership so everyone contributes their expertise and ideas • Regular time for collective reviews of team functioning and performance
Building partnerships between teams, departments and organisations	<p>Includes:</p> <ul style="list-style-type: none"> • Encouraging everyone to build trust, respect and co-operation – across teams, departments and organisations • Describing and emphasising shared visions • Building long-term continuity and stability in cross-boundary relationships and ensuring frequent contact with these others • Surfacing and resolving cross-boundary conflicts swiftly and creatively • Promoting a 'how can I help you?' orientation of team members towards those in other teams or organisations

The Model Diagram



Developing People – Improving Care; A national framework for action on improvement and leadership development in NHS funded services



(National Improvement and Leadership Development Board)

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THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

PERSONAL DEVELOPMENT PLAN TEMPLATE



Name:

Role:

Date:

EXPERIENCE GAP ANALYSIS

CURRENT ROLE	EXPERIENCE GAINED	EXPERIENCE GAPS

ASPIRATION / FUTURE ROLE	EXPERIENCE REQUIRED	EXPERIENCE GAPS

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

LEADERSHIP STRENGTHS AND AREAS FOR DEVELOPMENT

<div data-bbox="362 438 712 481"></div> <div data-bbox="362 507 712 550"></div> <div data-bbox="362 576 712 798"> <p>WHAT I KNOW ABOUT MYSELF</p> </div>	
<div data-bbox="362 845 712 888"></div> <div data-bbox="362 914 712 1197"> <p>WHAT I HAVE LEARNED THROUGH PSYCHOMETRIC ASSESSMENT, 360 FEEDBACK ETC</p> </div>	

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

10 LEADERSHIP BEHAVIOURS THAT SUPPORT COLLECTIVE LEADERSHIP

COMPETENCY FRAMEWORK	LEADERSHIP STRENGTHS	LEADERSHIP AREAS FOR DEVELOPMENT	RELEVANT NOW	RELEVANT LATER
RBCH Leadership Model				
CULTURAL ELEMENT: Support and compassion—support, compassion and inclusion for all patients and staff				
Modelling support and compassion				
Valuing diversity and fairness				
CULTURAL ELEMENT: Vision and Values—constant commitment to quality of care				
Encouraging pride, positivity and identity in the team				
Facilitating shared agreement about direction and alignment through agreed priorities and objectives				

CULTURAL ELEMENT: Goals and performance—effective, efficient, high quality performance

Managing resources				
Ensuring effective performance				

CULTURAL ELEMENT: Learning and innovation—continuous learning, quality improvement and innovation

Helping people to grow and lead				
Enabling learning and innovation				

CULTURAL ELEMENT: Team work—enthusiastic co-operation, team working and support within and across organisations

Building cohesive and effective team working				
Building partnerships between teams, departments and organisations				

WHAT'S ON OFFER 2017/18

PROGRAMME/COURSE/CONFERENCE	WHO'S IT FOR	WHAT'S IT ABOUT	WHEN
Customer Care	All Staff	Helping us to connect with each other at a human level – developing a compassionate culture	Every two weeks
Personal Resilience	All Staff	Acknowledging the challenging and demanding roles our staff have, an programme to help people develop personal resilience	Dates available on ESR
Difficult conversations	Staff who manage others	Giving staff the tools to help have effective difficult conversations, e.g. <ul style="list-style-type: none"> • Address poor behaviour • Tackle poor sickness rates 	Dates available on ESR
Improvement Skills	All Staff	Getting an understanding of our Trust approach to Quality Improvement with opportunity to practice tools and techniques that can then be applied	Monthly
Aston OD Team Journey	Staff leading teams	The team leader works with a team coach to navigate the AstonOD Team journey with the aim of improving the effectiveness of team working	By application to the OD team
Teams celebrating and working with difference. E.g. MBTI or TKI Conflict Management	All Teams	Using psychometric tools to understand the different preferences that exist within a team and offering tools and ways of working to embrace that different and work effectively as a team	By application to the OD team
Understanding Self – personal feedback sessions. E.g. MBTI or TKI Conflict management	Staff who manage others	Using psychometric tools to understand the different preferences that exist and help individuals to understand the different preferences that exist and to become more self-aware as part of their personal development	By application to the OD team
Annual Leadership Summit	All Staff – on a first come first served basis	An annual leadership development event with key note speakers and taster session workshops	Annually in September
Leadership Masterclass	All Staff – on a first come first served basis	A quarterly leadership development event with a focussed topic and external speaker	Quarterly
Quality and Safety Conference	All Staff	An opportunity to celebrate our successes in quality improvement and also to hear the lessons learned when things go wrong	Annually in September
Diversity and Inclusion	All Staff	An opportunity to learn with colleagues about the issues we need to address and to develop our Trust approach to become a more inclusive and diverse organisation	Register interest to get involved with OD
Schwartz Rounds	All Staff	An opportunity to meet with colleagues from across the Trust to share feelings and experiences related to the topic for each Round.	Monthly

PERSONAL PLAN

Year:

ACTIVITY			DEVELOPMENT NEED TO BE ADDRESSED	ORGANISATIONAL OBJECTIVE THIS WILL SUPPORT	TIMESCALE
WHAT	HOW	COST			
Example: Coaching	External executive coach	£200 per session	<ul style="list-style-type: none"> • Manage a difficult working relationship • Inspiring team members to engage with the vision 	<ul style="list-style-type: none"> • Tackling poor behaviour • Developing effective team working • Supporting delivery of Trust vision 	6 x 2hour sessions in 12 months
Internal development programme					
External development programme					
Secure a mentor					
Shadow a colleague					
Arrange a job swap					
Visit another organisation					

	What I need to work on											
Offer	Self-Awareness	Team work	Communication	Conflict	Negotiating	Listening	Feedback	10 Leadership behaviours	Problem solving	Decision making	Personal impact	Learning & Innovation
Coaching	✓		✓	✓	✓				✓	✓	✓	✓
Mentoring			✓	✓	✓	✓				✓	✓	✓
Improvement skills									✓	✓		✓
MBTI	✓	✓	✓	✓	✓	✓				✓	✓	
TKI	✓	✓	✓	✓	✓	✓					✓	
Leadership Summit & Masterclasses	✓										✓	✓
Quality & Safety Conference	✓											✓
Aston Team Journey		✓	✓				✓		✓	✓		✓
Arbinger Open mindset	✓	✓	✓	✓			✓				✓	
Difficult Conversations	✓	✓	✓	✓			✓					
Personal Resilience	✓			✓							✓	
Team diagnostic		✓							✓			
Team coaching		✓	✓							✓		
Job swap									✓	✓	✓	✓
Shadowing												✓
Matrons Development programme	✓				✓	✓	✓		✓		✓	✓
Senior Leaders Development Programme	✓				✓	✓	✓		✓		✓	✓
Stepping Up*	✓											✓
Ready Now*	✓											✓
Elizabeth Garrett Anderson*	✓						✓					✓
Mary Seacole*	✓						✓					✓
Edward Jenner*	✓											✓
External visits	✓	✓										✓

*National Leadership Academy Programmes



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

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Progress Update 2017/18 Corporate Objectives
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Sandy Edington
Details of previous discussion and/or dissemination:	N/A
Action required:	Note for information
Summary: Review of Trust Objectives for 2017/18, to end November 2017	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	N/A

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

2.1	To continue, via the Improvement Academy to build QI capacity and capability to support a culture of continuous improvement by March 2018	DM			2 day Improvement skills training now completed by 270 staff, clinical and non-clinical. QI junior doctor programme in place and about to commence cohort 3. Additional training modules developed and available to book: Measurement for Improvement and Introduction to project management. QI mentoring and coaching also established as part of the Academy offering. .
	a) Fully implement the improvements identified by the CQC for maternity and ED, which will be assessed at the next CQC inspection, with the expectation of a positive review	PS			Consistent progress in ED and Maternity (Green). ED referenced in new CQC "Sharing examples of best practice from clinical leaders in ED" document (Nov 17). ED, Maternity and Gynae presented to SLT and NEDs on their CQC self-assessment (Nov 17). ED and Maternity rated (self-assessment) as Good for all domains. Gynae rated (self-assessment) as RI for Effective and Good for all other domains. RI rating for Effective recognises that further embedding of Gynae governance structure required although actions are in place.
	b) Demonstrate consistency in safe, effective, responsive and well led services, across the organisation; securing a CQC rating of at least good and aspiring for 'outstanding'	TS			Strong progress to improve care and outcomes evidenced in CQC profile, feedback from commissioners and regulators. CQC inspection imminent
2.2	To improve emergency hospital flow to deliver 'the right patient, at the right time, to the right place' by March 2018 we will:				
	a) treat 25% of non-elective patients via our ambulatory care services rather than admitting them to an inpatient ward	RR			Not achieving the QI "ask" for improvement, but maintaining overall numbers. Work on Frailty a focus.
	b) improve specialty pathways to avoid unnecessary admissions and reduce patients' length of stay including:	RR			Frailty pathway in place; alcohol pathway task & finish, with work through QI and action learning weeks.
	c) To improve discharge planning we will:				
	i. establish the IT systems to support the discharge planning database	RR			System in place. Minor teething issues.
	ii. deliver an education programme for the use of estimated date of discharge (EDD) and medically ready for discharge (MRFD)	RR			Discharge & QI team rolling this out.
	iii. adopting best practice board rounds	RR			Joint project with Poole, moving to implementation over jan-march 18

	d) To improve hospital flow process, to support a reduction in patients with a length of stay >7days	RR				On track for 'Ask' noting half term/Xmas pressures
2.3	To ensure that every deteriorating patient with an early warning score (NEWS) of 9 or above, is escalated for review and then seen by an appropriate clinician within 30 minutes of their initial trigger by the end of July 2017	AOD				The most recent figures are 61% for 30 minutes and 80% for 60 minutes. The majority of late reviews are justified as they are often for individuals on end of life pathways. Performance is prospectively monitored with improving trends.
2.4	To treat everyone with Sepsis-related Organ Failure Assessment (SOFA) within one hour and all other sepsis patients within 3 hours of admission / diagnosis of sepsis, by giving a first dose of antibiotics by the end of June 2017	PG				Improvements continue with the QI focused work to progress towards all appropriate patients having their antibiotics within 1 hr from being triggered
2.5	Deliver excellent emergency care; minimising the number of patients who wait in the Emergency Department. The metric is that 95% of patients or better are seen and treated/admitted within four hours and that the Trust meets its agreed trajectory set in conjunction with NHSI.	RR				Missed Q3 trajectory of 95% national standard (but still significantly better than England average).
2.6	Deliver excellent planned care, 92% of elective patients being treated within 18 weeks of referral; 99% of patients waiting less than six weeks for their diagnostic tests and as a minimum 85% of patients or better on a 62 day cancer pathway receiving their treatment within that period.	RR				Cancer and diagnostics remain strong, but RTT declining below 92% standard (but above Engalnd average) Above 99% diagnostics Meeting 62 days expected in Q1 & Q2.
2.7	We will continue our work to ensure services are provided in a cost effective way and meet our financial plan to deliver a control total of £6,648m deficit or better by the end of March 2018.	PP				As at the end of December, the Trust was operating within its agreed control total. Pressures remain, most notably in relation to achievement of the full cost improvement programme target, however the current forecast indicates that overall the Trust will improve upon its full year control total.
OBJECTIVE THREE Strengthening Team Working						
Narrative:	<i>Developing and strengthening Team RBCH to deliver safe and compassionate care for our patients and shaping future health care across Dorset</i>					
3.1	Implement the Clinical Service Review, and securing the lifting of the undertakings placed on the Trusts by the Competition and Markets Authority. The Board will monitor and drive progress in accordance with the project plan agreed for this work.	TS				Work underway to prepare the benefits case for NHSI and the CMA. Target date for merger April 19. Continuing work with Poole colleagues to take forward the CSR clinical design work.
3.2	Strengthen collaborative working and relationships between the Trust and local partners gauged by regular feedback from partners and in so doing progress the implementation of the Dorset Sustainability and Transformation plan.	TS				Increasing collaboration in all sub-programmes of the Dorset STP including One Acute Network, Integrated Community and Primary Care Services.

3.3	Jointly implement the Dorset Care Record	PG				Dorset Care Record is in the implementation phase: The first release is now mid Jan 2018 (small scale pilot of limited functionality) with a larger release in March 2018
3.4	Develop team working by embedding the AstonOD Team Coaching approach across the organisation, helping enhance the delivery of care through heightened team effectiveness. Specific measures will focus on:					
	a) Increasing to 30 the number of coaches accredited by March 2018	NH				New cohort completing training in February, taking the numbers to 31.
	b) Increasing to 40 the number of teams using this approach by March 2018	NH				43 teams currently going through the Aston team journey.
OBJECTIVE FOUR						
Listening to Patients						
Narrative:						
<i>Ensuring meaningful engagement to improve patient experience</i>						
4.1	Supporting engagement through implementation of patient user groups with a lay chair and three functioning groups by the end of the year	PS				2 Groups has been held 1 fed back to BOD. 1 Further group is in the start up stages with interest from 2 other areas. Endoscopy group will be moving to EBCD in 2018
4.2	Reinstating community focus groups, to formalise external patient experience partnership networks, with each group meeting in 2017-18 with a forward plan of twice-yearly	PS				12 community focus groups have been held this year. This has strengthened our community links in all areas. To increase our community links we will attend a variety of existing community groups while maintaining the links that we have made in 2017
4.3	Maintain the positive trend of patients recommending the Trust within all areas attaining compliance that reflects better than the national average scores for the Friends and Family Test and increasing the FFT returns to >25% by the end of March 2018	PS				Work has commenced on the triangulation of data for the clinical areas. Work in this area has slowed as we are a team member down and the workload from other areas continues to increase. Text messaging for the Emergency Department is shortly to be piloted; following this consideration for this method will be given to wider roll-out across the Trust however this will require costing and working up as a business case.

Table:

G - Delivered, or on track and on time

A - Risk of delay or partial completion

R - Risk of non-delivery or delay

- not yet done

The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Diversity and Inclusion
Section on agenda:	Strategy and Risk
Supplementary reading:	Diversity and Inclusion workbook located in the reading room
Director or manager with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of paper:	Deborah Matthews
Details of previous discussion and/or dissemination:	Workforce Strategy and Development Committee (December 2017)
Action required:	Discussion
<p>Summary:</p> <p>This paper describes the rationale for strengthening our support to diversity and inclusion within RBCH. It highlights some key messages from our 2017/18 Diversity and Inclusion Week and outlines five core elements to our approach:</p> <ul style="list-style-type: none"> • align with our corporate objectives • develop a change model • data driven decision making • leadership commitment and accountability • awareness and education <p>An update on our immediate plan and priorities will be provided at the meeting.</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?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	34T

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

CARE_GROUP	DIRECTORATE
B - MEDICAL	ANAESTHETICS
C - SPECIALITIES	CANCER CARE
CORPORATE	CARDIOLOGY
(blank)	CORPORATE
	ED & AMU
	MATERNITY

Annual Declaration

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

Category	Metric	Trust Target	2017/18 Q1			2017/18 Q2			2017/18 Q3			Trend (where applicable)
			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	90%	95.73%	92.56%	95.88%	95.95%	95.77%	95.65%	95.73%	94.55%	92.16%	
	Caring - Inpatient scores from Friends and Family Test % positive	95%	97.20%	98.04%	96.42%	97.85%	96.52%	97.91%	97.56%	97.53%	98.72%	
	Caring - Maternity scores from Friends and Family Test % positive	95%	98.78%	93.89%	93.33%	96.00%	99.07%	100.00%	97.14%	96.84%	98.33%	
	Caring - Mixed sex accommodation breaches	0	1	0	0	1	0	0	0	0	0	
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)			89.12%			86.08%					
	Caring - Formal complaints		22	21	18	19	23	32	30	36	23	
	Effective - Emergency re-admissions within 30 days following an elective or emergency snail at the provider	< Prev Yr Month AVG	509	588	480	516	503	532	513	508	509	
	Effective - Hospital Standardised Mortality Ratio - Weekend (DF) - All Sites	< 100	105.6	102.4	79.6	91.7	107.0	127.6				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DF) - MAC	< 100	0.0	0.0	0.0	0.0	0.0	0.0				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DF) - RBH	< 100	97.0	87.8	78.8	72.4	91.2	114.0				
	Effective - Hospital Standardised Mortality Ratio (DF) - All Sites	< 100	86.8	104.5	95.1	79.5	91.8	98.3				
	Effective - Hospital Standardised Mortality Ratio (DF) - MAC	< 100	197.4	192.9	183.1	219.5	218.7	199.9				
	Effective - Hospital Standardised Mortality Ratio (DF) - RBH	< 100	79.4	96.8	84.7	65.3	82.8	90.1				
	Effective - Summary Hospital Mortality Indicator	< 1	0.95	0.95	0.95							
	ED Attendances		7704	8303	8082	8574	8281	7977	7998	7726	7742	
	Elective Admissions		5561	8891	6522	5871	6418	5913	8147	7909	5570	
	GP OP Referrals		5375	5969	6181	5860	5951	5628	5695	5704	4604	
	Non-elective Admissions		4995	5903	5381	4176	3311	5674	5315	5450	3144	
	Organisational health - Staff sickness in month	< 3%	3.548%	4.050%	4.012%	4.185%	3.992%	3.839%	4.243%	4.141%	4.348%	
	Organisational health - Staff sickness rolling 12 months	< 3%	4.19%	4.19%	4.20%	4.23%	4.25%	4.23%	4.22%	4.18%	4.16%	
	Organisational health -Proportion of temporary staff		7.00%	8.09%	6.57%	6.79%	6.74%	6.78%	6.90%	6.89%	6.88%	
	Organisational health -Staff turnover	< 12%	11.13%	10.94%	10.73%	10.53%	10.56%	10.37%	10.21%	9.94%	9.74%	
	Safe - Clostridium Difficile - Confirmed lapses in care	<=14 in Yr / 1.2 per Month	1	0	0	1	0	4	1	3	4	
	Safe - Clostridium Difficile - infection rate	6.9	12.1	11.71	0	29.27	11.71	6.05	35.13	12.1	17.56	
	Safe - MRSA bacteraemias	0	0	0	0	0	0	0	0	0	0	
	Safe - NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	
	Safe - Occurrence of any Never Event	0	0	1	1	1	0	0	0	1	2	
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)			41.79			43.69			40.06		
	Safe - VTE Risk Assessment	95%	95.79%	96.02%	96.67%	96.47%	96.28%	96.59%	96.64%	96.93%	96.34%	
	Number of Serious Incidents	<= Last Year	0	4	2	3	3	0	0	4	3	
	Appraisals - Values Based (Non Medical) - Compliance		3.26%	10.78%	21.41%	37.14%	57.24%	84.93%	88.99%	89.94%	89.83%	
	Appraisals - Doctors and Consultants - Compliance		89.67%	89.82%	88.28%	87.36%	87.86%	88.07%	88.19%	86.55%	87.21%	
	Essential Core Skills - Compliance		91.62%	92.10%	92.32%	92.55%	92.93%	92.64%	92.87%	93.31%	93.53%	
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	YTD Plan = 4	4	4	4	4	4	4	4	4	4	
	Sustainability - Liquidity (YTD score)	YTD Plan = 1	1	1	1	1	1	1	1	1	1	
	Efficiency - I&E Margin (YTD score)	YTD Plan = 4	4	4	4	4	4	4	4	4	4	
	Controls - Distance from Financial Plan (YTD score)	N/A	1	1	1	1	1	1	1	1	1	
	Controls - Agency Spend (YTD score)	YTD Plan = 1	1	1	1	1	1	1	1	1	1	
	Overall finance and use of resources YTD score	N/A	3	3	3	3	3	3	3	3	3	
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	95.42%	93.70%	92.39%	92.29%	94.57%	94.47%	93.96%	95.04%	84.71%	
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	92.31%	77.78%	84.62%	92.86%	100.00%	92.86%	100.00%	95.24%		
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	89.78%	89.16%	89.26%	84.93%	89.76%	87.50%	86.50%	90.99%		
	Maximum 6-week wait for diagnostic procedures	99%	99.56%	99.77%	99.95%	99.88%	99.66%	99.80%	99.85%	99.73%	99.59%	
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	91.14%	92.01%	92.17%	92.04%	91.79%	90.67%	90.09%	89.92%	88.71%	

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

BOARD OF DIRECTORS

Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Performance Report
Section on agenda:	Performance
Supplementary reading:	None
Director or manager with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of paper:	Donna Parker, Deputy Chief Operating Officer David Mills, Associate Director of Performance, Information and Contracting
Details of previous discussion and/or dissemination:	PMG, Finance Committee
Action required:	Note for information

Summary:

In summary the Trust performed as follows for November using most recently available data.

- **A&E 4 Hour** – below national target and NHSI organisational level requirement at 84.7% for December and 91.2% for Q3. Appeal submitted for Q3 STF and actions underway, supported by NHSE, to recover performance through Q4.
- **RTT 18 Weeks** – below national target for December at 88.7%. Expected to be similar for January with ongoing risk as MSK triage and other referral improvement workstreams have a transitional impact on performance, plus national requirement to reduce elective activity further to support winter pressures.
- **Diagnostics 6 Week Wait** – above national target at 99.6%.
- **Cancer 62 Day from Referral** – above national target in November (last reported month) at 91%. Currently anticipating the target will be met for the Quarter though there remains some risk to both Q3 and Q4.
- **Cancer 62 Day Screening** – met national target in November at 95.2% compliance (last reported month).

All other Single Oversight Framework (SOF), NHS Constitution and key contractual targets reported were met or within expected range for December except 4 breaches of the C Difficile target (above YTD trajectory. We also had 2 breaches of the 28 day rebook following cancellation target. Both patients were treated at day 30.

A forecast for January, together with key risks and mitigating actions, is included in the report. **Risk to all targets is detailed. Significantly, a key risk to STF due to our Q3 A&E 4 hour performance. This puts at risk 30% of our STF funding. The Dorset-wide trajectory is being monitored in relation to system STF.**

Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	□
Are they caring?	□
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	As already noted in the above summary

Operational Performance Report



For the period to end December 2017

Richard Renaut
Chief Operating Officer

Operational Performance Report

As at 15/01/2018

1. Introduction

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

2. Single Oversight Framework Indicators

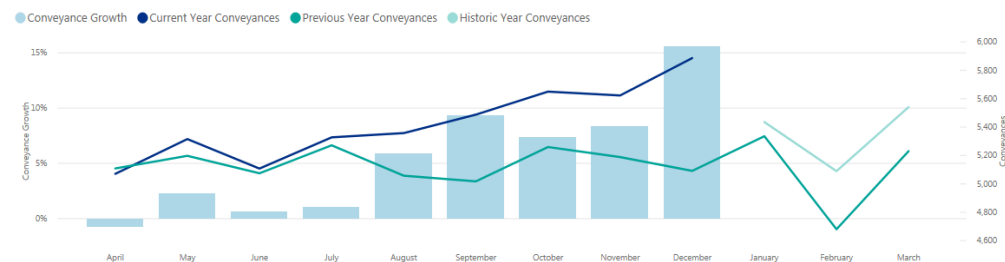
2.1 Current performance – December 2017

A&E 4 Hour Target and 12 Hour Breaches

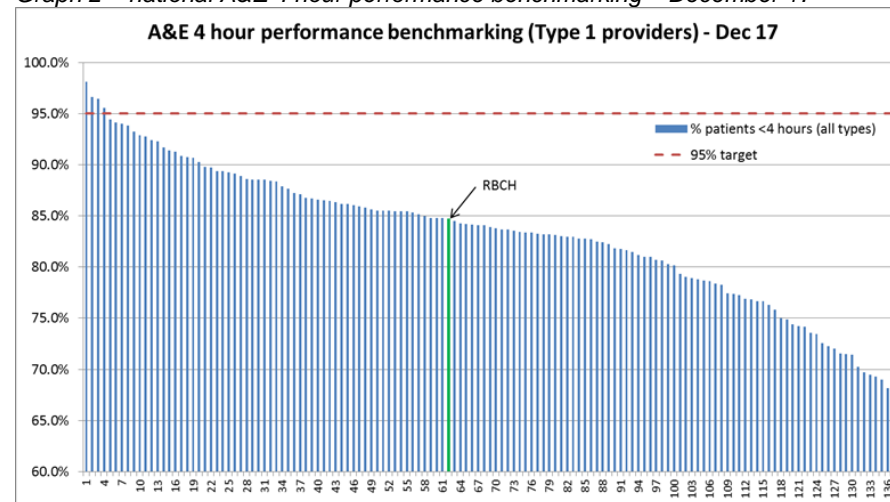
We saw our performance drop in December to 84.71% resulting in 91.2% for Q3. ED attendances were 4.2% higher than last December (6.1% for type 1 attendances) and urgent care admissions 4.1% higher; bucking the trend seen for much of the year to date. SWASFT ambulance conveyances were 15.6% higher than last December. Unfortunately, this meant we did not secure the STF for Q3 as the Dorset-wide system was also below trajectory, however, we are submitting an appeal to NHS England on the basis of our strong benchmarking nationally and YTD.

Graph 1 – Monthly growth in SWASFT Ambulance Conveyances

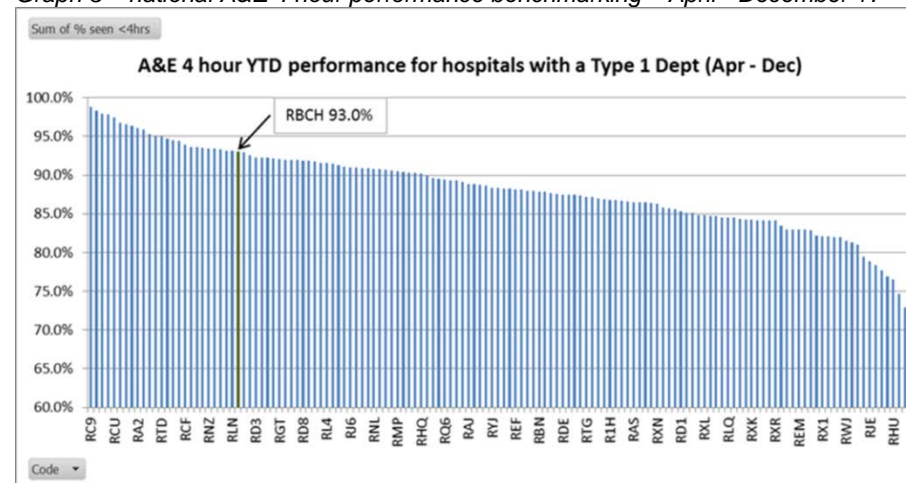
SWASFT Conveyances Annual Comparison (Rolling 24 months)



Graph 2 – national A&E 4 hour performance benchmarking – December 17



Graph 3 – national A&E 4 hour performance benchmarking – April - December 17



The first week in January continued to be particularly challenging. Whilst this reflected the national picture, we saw an unusual and significant reduction in our 4 hour performance resulting in 83.6% for the week. The second week of January has seen a much improved

Operational Performance Report

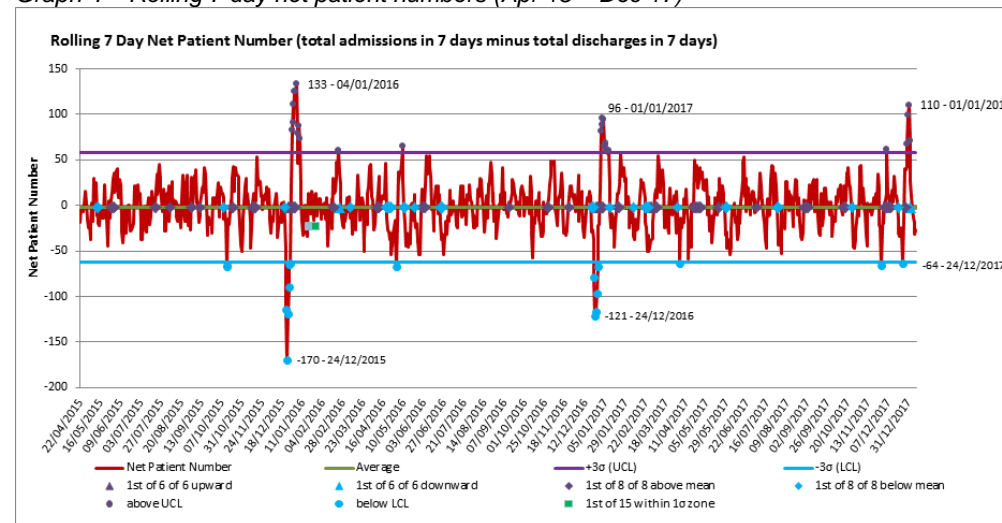
As at 15/01/2018

position at 93.9% with a return to our former strong benchmarked position and month to date at 88.8%. This has been supported by our January winter plan which had planned a number of key interventions including:

- Additional medical and other key clinical staff in a number of areas (e.g. ED, AMU, OPM, GP streaming)
- The release of staff from other areas across the trust (e.g. from clinics, day hospital, mealtime volunteers)
- Oversight from our Exec led, 3 times daily Operational Pressures Escalation meetings
- Additional bed capacity (including the release of elective beds) through a planned reduction in elective activity
- Additional interim community based capacity.

Our analysis has shown that this winter, we did not see the significant surge in discharges on Christmas Eve that we had seen in the previous two years, though experienced the same surge in admissions following. This, along with the high levels of influenza this year, contributed significantly to our challenged position at the end December and beginning of January. This led to implementation of our OPEL 3 escalation actions in line with our escalation policy, including the use of day and elective overnight stay areas for urgent care patients.

Graph 4 – Rolling 7 day net patient numbers (Apr 15 – Dec 17)



Medically Ready for Discharge patients increased significantly (27%) over this period and 14+ day stay patients increased from a 12 week average of 125 at mid-December to 160 (as at 15/1/18).

We have been providing regular reports on our position to NHS England and NHS Improvement, and have hosted their visits during January to outline our work and consider further actions and Dorset-wide support going forward.

Action Learning Weeks were held in both w/c 11/12/17 and w/c 8/1/18. These tested a number of new pathways and interventions and significant learning has been shared with improvement actions already underway.

No patients waited longer than the 12 hours standard in December however, we unfortunately, reported 1 during the first week in January. A full Root Cause Analysis has been undertaken and action taken to avoid a similar incident going forward. At all times, the patient had been under close observation and care.

Operational Performance Report

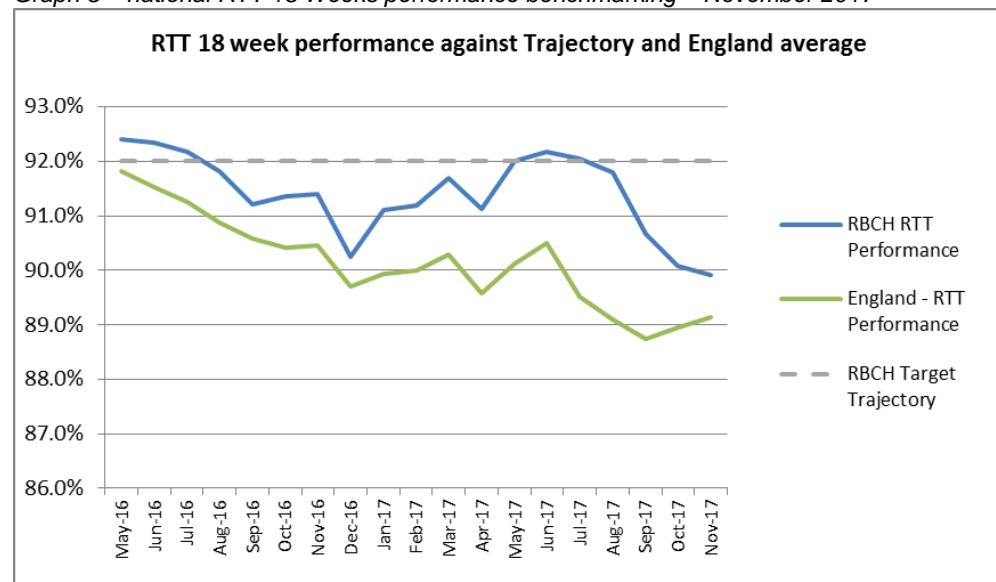
As at 15/01/2018

RTT Incomplete Pathways (18 week) and 52 Week Breaches –

As indicated in last month's report, the Trust predicted to be below the 92% target in December, achieving 88.7%. This predominantly reflected the impact of the MSK Triage Service on referrals into Orthopaedics which reduced the total number of patients on an incomplete pathway. Those waiting more than 18 weeks became a bigger proportion affecting the performance percentage for both Orthopaedics and overall. Dermatology and Ophthalmology continued to be challenged with a slight deterioration in performance, though an improvement was seen in Urology.

Whilst we have seen a deteriorated position, this is also reflected in the national picture and risk to future month's remains – see Section 2.2. December benchmarking is awaited but we understand many Trusts continue to struggle to achieve the target, with a further impact expected from the national requirement to extend the reduction in elective activity programmes further to support winter pressures.

Graph 5 – national RTT 18 Weeks performance benchmarking – November 2017



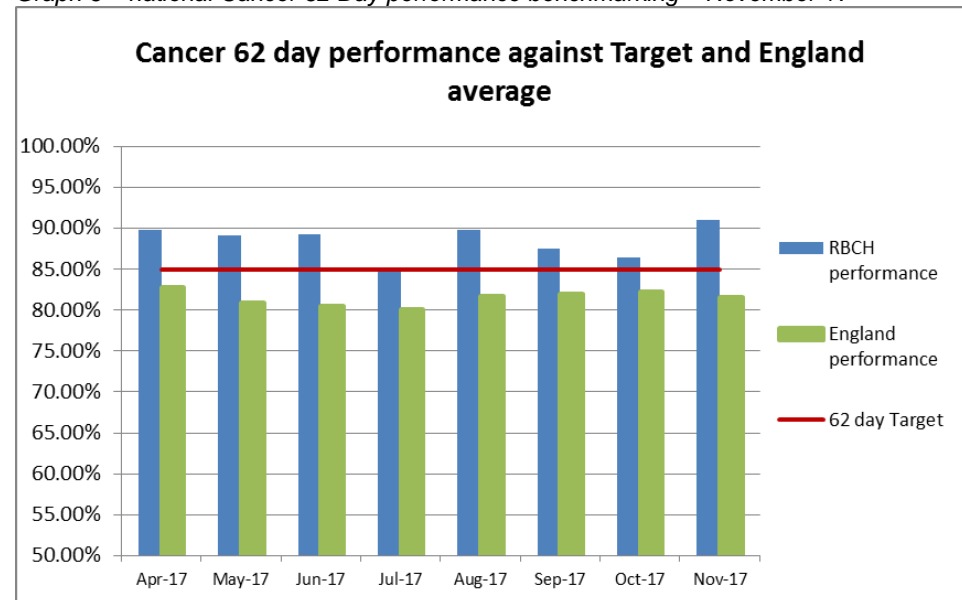
62 Day from Referral/Screening for Suspected Cancer to Treatment

For the month of November (*last formal reported month*) performance was at 91% with 10 breaches. This was well above the national target of 85% and the England average.

There were 10 breaches across 6 specialities with 7 breaches in Urology (*note, 0.5 breach is shared with another provider*). The non-Urology breaches included: 0.5 in Lung, 0.5 in Haematology, 1 in Gynae, 0.5 in Colorectal, and 0.5 in Head and Neck. The most significant reasons for breaches were Complex diagnostic pathway (5 breaches) followed by patient choice (1.5 breaches).

We continue to benchmark well against the England average.

Graph 6 – national Cancer 62 Day performance benchmarking – November 17



We achieved 95.2% for the 62 day screening target.

Operational Performance Report

As at 15/01/2018

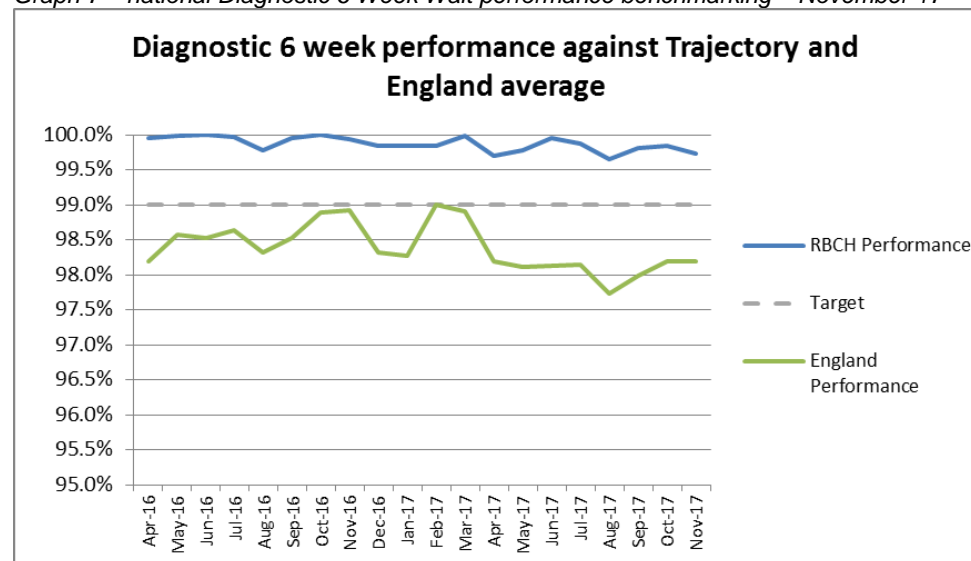
We have 5 patients with a greater than 104 day pathway (3.5 as shared with other sites); clinicians have assessed all patients and confirmed no clinical harm. The most significant reasons for breaches was patient choice and complex diagnostic pathway.

Diagnostic 6 Week Wait

Our positive position continued in December with the final validated performance achieving 99.59%. Performance currently remains on track in the key areas (Endoscopy, Radiology, Cardiology and Urology); though noting some pressures in Cystoscopy over December which have not affected compliance. This continues to be closely monitored.

The below graph shows slightly improved national performance in October. We remained well above the 99% threshold and England average.

Graph 7 – national Diagnostic 6 Week Wait performance benchmarking – November 17



2.2 Q4 - Forecast Performance and Key Risks

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

Table 1 – SoF Key Operational Performance Indicators 2017/18 – actuals and forecast

Single Oversight Framework Indicator	National Target	NHSI Trajectory	Mth / Qtrly	RAG rated forecast against national targets and NHSI submitted trajectories					
				Qtr 1	Q2	Oct-17	Nov-17	Dec-17	Jan 18 est.
A&E 4hr maximum wait time*	95%	91-93%	Mthly	Amber	Amber	Amber	Green	Amber	Amber
RTT 18 week incomplete pathways	92%	91%	Mthly	Amber	Amber	Amber	Amber	Amber	Amber
Cancer 62 day wait for first treatment from urgent GP referral**	85%	85 - 85.4%	Mthly	Green	Green	Green	Green	est.	Amber
Cancer 62 day wait for first treatment from Screening service**	90%	90%	Mthly	Green	Green	Green	Green	est.	Green
Maximum 6 weeks to diagnostic test	99%	99%	Mthly	Green	Green	Green	Green	Green	Green

RAG Key: Red - below national target and organisational trajectory; Amber - above trajectory but below national target or 'at risk'; Green - above national target (and trajectory).
 *STF requirement increased to 95% for Q2 (above locally submitted trajectory). NHSE request to maintain YTD performance at 93% in Q4 and 95% in Mar 18.
 **Dec cancer final validated upload will be completed early Feb 18

For Q4, we do expect ongoing risk against the full national targets for A&E (95%), RTT (92%), Cancer 62 day (85%) and Cancer Screening (90%). In addition, winter monies were awarded with the aim of maintaining YTD A&E performance (93%) through Q4 and achieving the STF requirement of 95% in March.

The Diagnostics 6 Week Wait is expected to remain compliant.

A&E 4 hour, ED Streaming and STF

The detail in Section 2.1 above outlines our position and actions as at January 2018. We continue to work on improving and refining ED medical staff rotas and our winter plan, supported by OPEL escalation actions will continue with robust oversight through the remainder of the Quarter. Progressing the learning and actions from our Action Learning Weeks together with implementation of a stranded /MRFD patient trajectory will be progressed with our Dorset partners. Ongoing regular reporting to NHSE/I will continue.

Primary care streaming will continue to develop with improved cover and daily review of flu incidence is taking place via our 3x daily escalation meetings. The latter is currently being managed through the use of side rooms and timely testing and prophylactic/active treatment.

This has also been supported by the additional national winter funding.

RTT 18 weeks

Continued challenge in relation to our RTT performance is expected. As previously indicated and outlined above, we are now seeing the impact of the MSK Triage Service where patients are reviewed and directed to the most appropriate service for their Orthopaedic or Rheumatology problem. Furthermore, the planned reduction in non-urgent and non-cancer elective activity over the winter has been extended further by NHS England and this is impacting on our and other Trusts' waiting times.

Our actions as outlined in last month's report in: Ophthalmology, ENT and Urology are continuing and we are seeing some improvement in the latter. Ophthalmology are seeing some legacy effect of previously longer outpatient waits, though their overall actions are showing signs of improvement in the key parts of the pathway which will support recovery. However, non urgent Ophthalmology cases are being affected by the winter pressure elective reductions.

Our work in Dermatology also continues, however, further expected capacity reductions due to staff changes are likely to impact. This is being discussed with partners across to develop a system-wide action plan. Referrals will be affected in the immediate future.

Cancer 62 Day

We currently anticipate compliance for Q3 though there remains some risk, particularly given the usual impact of patient choice at this time of year. In line with the national guidance, we are continuing to prioritise cancer treatments despite a reduced elective activity programme to

support winter pressures. The pressures anticipated for Q4 will continue to be closely monitored. Demand and capacity pressures mean Dermatology fast track pathways remain a risk.

Diagnostic 6 Week Wait

Diagnostic demand in relation to this target, particularly as a result of ongoing inpatient and fast track pathway pressures, will continue to be monitored. However, we are currently forecasting a sustained overall positive performance position.

3. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail.

There were 4 reportable breaches (with some evidence of 'lapse in care') against the C Difficile in month target, which puts us above target year to date (14 against 10.5 target). The new Post Infection Review policy is in place but it is too soon to see the impact of this yet. The PII on Ward 17 is ongoing whilst we await ribotype testing, so far 4/6 test results have not demonstrated transmission. Ongoing audit will be carried out on the Ward in line with policy.

We also had 2 operations cancelled on the day not offered a rebooking within 28 days, both Vascular patients cancelled on the same day because of an over running list, 30 days later was the earliest availability for the surgeon. Both patients have now been treated.

4. Recommendation

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

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Quality Report
Section on agenda:	Performance
Supplementary reading:	CQC Insight Report, NHSI Never Events Framework
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Fiona Hoskins, Deputy Director of Nursing and Midwifery Jo Sims, Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee
Action required:	Note for information
Summary: The Quality report is a summary of the key quality indicators in Month. <ul style="list-style-type: none"> • There were 3 serious incidents reported in December 2017 • Friends and Family Test Performance in the top quartile for patient satisfaction with required submission level achieved. • Complaints response performance to formal complaints was 68% in month, an increase on previous month. Of further note for the Board; NHS Improvement issued an updated Never Event policy and list on 17 January 2018. The Board are asked to note the revised framework which will come into effect on 1 February 2018.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	None

Quality Report



For the period to end December
2017

Paula Shobbrook
Director of Nursing and Midwifery

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 2017/18.

2.0 Serious Incidents

2.1 There were 3 Serious Incidents reported in December 2017.

1. Wrong Site Surgery – Never Event.
Patient planned for right eye cataract surgery but was administered a left eye peribulbar block. Immediate actions were taken, investigation is in progress. No harm to patient.
2. Missed diagnosis of subarachnoid haemorrhage.
Investigation completed and panel has taken place. Learning points shared.
3. Wrong Site Surgery – Never Event
Patient attended for a skin biopsy, subsequently the patient contacted the department to say that the biopsy had been taken from the wrong site. Immediate actions were taken, investigation completed and panel has taken place.

2.2 New Never Event Framework – Issued by NHSI 17/1/18

Revisions to the NHSI Never Events policy and framework have been made following consultation with stakeholders at the end of 2016.

In response to the consultation and to further support learning from Never Events, the main changes to the revised policy and

framework are:

- the removal of the option for commissioners to impose financial sanctions on trusts reporting Never Events
- to align the Never Events policy and framework with the Serious Incident framework, to achieve consistency across the two documents (a revised national serious incident framework will be published by NHSI later in 2018)
- revisions to the list of Never Events, including two additional types of Never Event. - Unintentional connection of a patient requiring oxygen to an air flowmeter and, Undetected oesophageal intubation *

*Full details of the amendments to the Never Events list can be found in the reading room.

The revised policy and framework come into effect on 1 February 2018

3.0 CQC Insight Model

3.1 On 22 December 2017 the CQC published their latest Insight Report for this Trust and compared our performance to all other acute NHS Trusts.

Of the 77 trust-wide indicators 1% are categorised as much better, 1% as better, 1% as worse, and 0% as much worse. 38 indicators have been compared to data from 12 months previously of which 6 (16%) have shown an improvement and 2 have shown a decline.

Trust composite of key indicators Sep-16 to Dec-17

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

Outliers, trust wide and core service indicators

- There are currently 0 active outliers for maternity and 0 for mortality. For maternity 0 are with the panel and 0 are with the regional team. For mortality 0 are with the panel and 0 are with the regional team.

Of the 77 trust wide indicators, 1 (1%) are categorised as much better, 1 (1%) as better, 1 (1%) as worse and 0 (0%) as much worse. 38 indicators have been compared to data from 12 months previous, of which 8 (18%) have shown an improvement and 2 (5%) have shown a decline

Much better compared nationally

- Sick days for medical and dental staff- [set target 3.5%] (%)

Much worse compared nationally

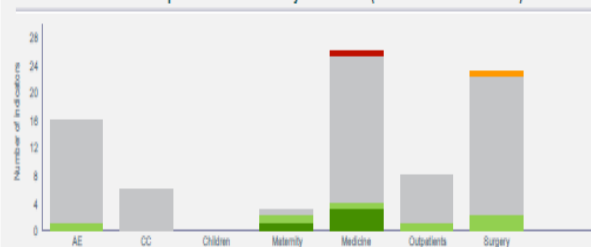
Improved

- Flu vaccination uptake (%)
- Overall experience as an inpatient
- Patient-led assessment of environment for dementia care (%)
- Patient-led assessment of facilities (%)
- Patient-led assessment of privacy, dignity, and well being (%)
- Staff appraised in last 12 months (%)

Declined

- Never Events (total events with rule-based risk assessment)
- Never Events (total events with statistical comparison to bed days)

National comparisons of indicators by core service (much better to much worse)



For each core service, there are different numbers of indicators. When compared nationally, each has been categorised as much better, better, about the same, worse or much worse. The graph shows the number of indicators for each core service and the number within each category:

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

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

INCIDENTS	SAFETY THERMOMETER	MATERNITY & MORTALITY OUTLIERS	MORTALITY	NATIONAL CLINICAL AUDITS	A&E WAITING TIMES	ACCESS AND FLOW	PATIENT SURVEYS	STAFF SURVEYS
National clinical audits are priority information to inform discussions about quality improvement. The table below provides a high-level summary 'at a glance' of the key clinically relevant indicators which best reflect trust performance. Click on the links to see extra site and ward-level audit results to inform monitoring conversations.								
<ul style="list-style-type: none"> Audit results should be followed-up during engagement meetings: <ul style="list-style-type: none"> Better or worse than expected performance should be used to drive quality improvement Where performance is much worse than expected we would expect this to prompt an investigation by the trust National clinical audits are reported here only if the trust participated More audits will be added each quarter and inspectors will soon receive information on audit outliers and audit data quality concerns 								

Core Service	Audit Name	Level	Date last refreshed	Insight indicator national comparison				
				Much Worse	Worse	About the same	Better	Much Better
Critical care	ICNARC	Royal Bournemouth Hospital*	04/17	0	0	5	0	0
Maternity	MBRRACE-UK	Trust	10/17	0	0	0	1	0
Surgery	National Bowel Cancer Audit	Trust	02/17	0	0	1	1	0
Surgery	National Emergency Laparotomy Audit	Royal Bournemouth Hospital	11/17	0	1	3	1	0
Medical care	National Lung Cancer Audit	Trust	06/17	0	0	4	0	0
Surgery	National Oesophago-gastric Cancer Audit	Trust	11/16	0	0	1	0	0
Surgery	National Vascular Registry	Trust	12/17	0	0	2	0	0

*May be an aggregate of more than one ward's results

In relation to National Clinical Audits the Insight report highlights 1 "worse than expected" result for the National Emergency Laparotomy Audit (NELA) question: Crude proportion of cases with pre-operative documentation of risk of death %.

The NELA data for the Trust for the Year 3 Audit period Dec15-Nov 16 was 69.6% compared to a national average of 70.7%. This is therefore historical data.

The Year 4 Audit period finished on 30 November 2017 and the Trust has until the 22nd January to lock all data for those who underwent surgery between 01/12/16-30/11/17. The report will not be published until late spring. The Trust NELA lead has looked at our figures for this time frame which relate to 172 patients. Of these 132 patients had a risk of death documented prior to surgery. This makes 76.7% of patients for Year 4 had risk documented. The Department have also recently changed the anaesthetic chart to include a pre & post op risk score.

4.0 Patient Experience Report

4.1 Friends and Family Test: (Benchmarking November 2017 data)

- Inpatient and day case Friends and Family Test (FFT) national performance in November 2017 ranked RBCH Trust 3rd with 31 other hospitals out of 172 placing RBCH in the top quartile based on patient satisfaction. The response rate was sustained above the 15% national standard at 20.9%.
- The Emergency Department FFT performance in November 2017 ranked RBCH Trust 5th with 11 other hospitals out of 141 placing RBCH ED department in the top quartile. The response rate 5.3% against the 15% national standard.
- Outpatients FFT performance in November 2017 ranked RBCH Trust 4th with 22 other Trusts out of 234 Trusts, placing the departments in the second quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

4.2 Family and Friends Test Trends

	June	July	August	September	October	November
In-Patient Quartile						
Top		98.598%		98.618%	98.355%	98.492%
2	97.416%		97.335%			
3						
Bottom						

	June	July	August	September	October	November
ED Quartile						
Top	95.882%	95.946%	95.765%	95.652%	95.726%	94.545%
2						
3						
Bottom						

	June	July	August	September	October	November
OPD Quartile						
Top						
2	97.926%	97.471%	97.441%	96.932%	97.337%	97.251%
3						
Bottom						

4.3 Care Audit Trend Data

The Care Audit Campaign is changing from the end of the 3rd quarter and will be reported on quarterly as a result of the changes agreed at HAC, with ongoing focused work in the areas that require improvement, such as call bells and noise at night.

4.4 Patient Opinion and NHS Choices: December Data

8 patient feedback comments were posted in December, 6 express satisfaction with the staff attitude, care and treatment. 1 negative response related to poor staff attitude and treatment and 1 mixed comment praising care but highlighting poor communication.

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

4.5 Complaints Summary report

Formal Complaints

A total of 21 complaints were received in December all of which had an acknowledgement within the required 3 days. Formal written complaints increased from this time last year and concerns are showing a slight decrease. Three themes

were highest in month, Care, complication of Treatment, and quality, suitability of care and treatment.

The Percentage of formal responses answered within the Trust standard of 25 working days was not achieved in December. The agreed standard is that 75% are responded to within this time frame and a rate of 68% was attained. This follows a slight dip in response rates in October and November. On investigation this is due to the complexity of the complaints.

The complaints policy is currently being reviewed with a new grading system being introduced, to reflect the complexity of a complaint. Within this system the more complex complaints will have a longer agreed response time with a management plan around communication and regularly updates for the complainant.

5.0 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:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Financial Performance
Section on agenda:	Performance
Supplementary reading:	Yes
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Chris Hickson, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance & Performance Committee
Action required:	Note for information
Summary: The financial reports are detailed in the attached papers.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ✓
Impact on risk profile:	One current financial risk exists on the risk register related to next year's financial planning. The actions are being monitored through the Finance Committee.

The Royal Bournemouth and
Christchurch Hospitals NHS
Foundation Trust

Finance Report



For the period to 31 December 2017

Chris Hickson
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £4.619 million as at 31 December which is £220,000 behind the Trust financial plan. This adverse variance reflects the loss of the Quarter Three Sustainability and Transformation Fund income relating to A&E performance (pending appeal outcome) offset in part by the receipt of national winter pressures funding.

Sustainability and Transformation Fund (STF)

The Trust has achieved its year to date financial control total set by NHS Improvement thereby securing access to the Sustainability and Transformation Fund. As expected and flagged within its submitted trajectory, the Trust experienced significant operational pressures in its ability to achieve the quarter three A&E access target of 95% and delivered 91.24%. December was particularly challenging due to an 8% increase of ED attendances as compared to the prior year, together with a significant increase in the acuity of patients presenting. Overall, the Dorset Health System achieved 93.5% performance against the 95% target. Total STF Fund income to date is £4.160 million and actual achievement of £3.584 million has been reflected in the position as at 31 December 2017. An appeal has been submitted and supported by the regional NHS Improvement team, and the outcome is awaited.

Income & Expenditure

Income is ahead of plan by £1.7 million which is reduced to £0.4 million after adjusting for 'pass through' drugs and devices. This reflects additional income from specialist activity including the new vascular hub arrangements, off-set by lower than anticipated private patient income.

Expenditure reports an over spend of £1.9 million reduced to £0.6 million after adjusting for 'pass through' drugs and devices. This variance is driven by additional staffing costs due to increased activity and the premium cost of continued reliance upon a flexible workforce.

Cost Improvement Programme

Financial savings of £6.162 million have been achieved to date, which is £1.630 million behind the targeted value. This reflects the current gap between the full year target and the value of identified schemes and the challenge in continuing to deliver financial savings. Further schemes continue to be identified to close this gap together with identifying new schemes for 2018/19.

Employee Expenses

The Trust continues to carefully manage its workforce, with a relentless focus on recruitment and retention, to minimise the need for agency staffing. During December the Trust's reported agency expenditure was again lower than both the ceiling value agreed with NHS Improvement and the expenditure reported within the same period last year. It should be noted that whilst agency spend is lower than prior years and the NHS Improvement agreed ceiling, the cumulative cost of bank, agency and overtime is higher than the Trust's vacancy budget.

The aggregate substantive establishment underspend at 31 December is £10.4 million, and is being covered by agency staffing amounting to £2.8 million, bank staffing amounting to £8.7 million and staff overtime of £0.7 million. This represents a total pay over spend of £1.8 million. There is a range within the individual Care Groups from 2.84% underspend to 4.01% overspend reflecting the particular operational challenges. This continues to be an area of focus within Care Group financial recovery plans.

Forecast Outturn

As at 31 December the Trust is forecasting a £659,000 improvement against its agreed deficit control total of £6.648 million. It is anticipated that this will be improved upon further, however there remains a significant level of volatility given the seasonal pressures and continued challenges in achieving financial savings.

Capital Expenditure

As at 31 December £5.436 million of capital expenditure has been committed, which is £1.282 million less than planned at this point in the year. The annual plan for capital expenditure is £9.424 million, plus a further investment of £1 million relating to ED streaming supported in year through national funding. The current underspend reflects the timing of scheme implementation against the initial plan, and is expected to recover in the final quarter of the year.

Cash

The Trust is currently holding a consolidated cash balance of £30.7 million. The forecast planned end of year cash balance is £22.96 million meaning that no Department of Health support is required during the current financial year. As previously reported, the cash position has improved due to the additional 2016/17 STF Incentive and Bonus payments received in July.

Financial Risk Rating

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

Recommendation

Members are asked to note the Trust's financial performance to 31 December 2017.

Finance Report

As at 31 December 2017

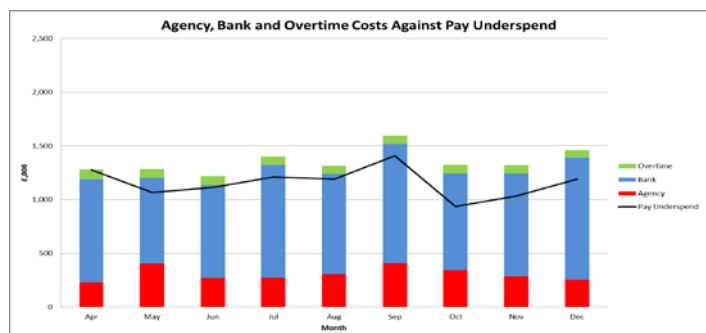
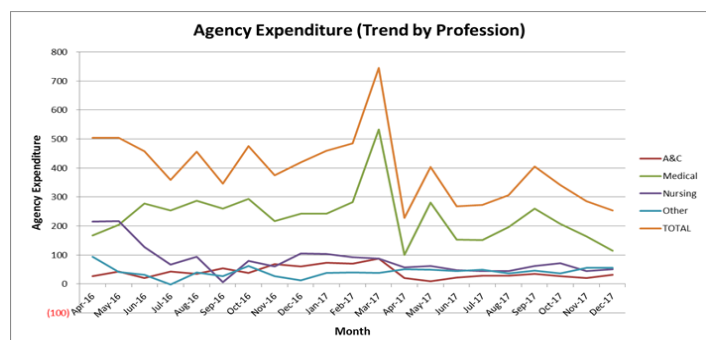
Income and Expenditure

Income and Expenditure Summary as at 31 December 2017	Budget £'000	Actual £'000	Variance £'000	Net "Pass Through" Adjustment £'000	Underlying Variance £'000
NHS Clinical Income	185,940	188,715	2,775	(1,279)	1,495
Non NHS Clinical Income	5,191	4,074	(1,118)	(18)	(1,136)
Non Clinical Income	22,442	22,502	59	0	59
TOTAL INCOME	213,574	215,290	1,716	(1,297)	419
Employee Expenses	133,395	135,167	(1,772)	0	(1,772)
Drugs	25,075	24,167	908	(1,197)	(289)
Clinical Supplies	24,184	26,969	(2,785)	2,494	(291)
Misc. other expenditure	35,320	33,606	1,714	0	1,714
TOTAL EXPENDITURE	217,974	219,909	(1,936)	1,297	(638)
SURPLUS/ (DEFICIT)	(4,400)	(4,619)	(220)	0	(220)

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	132,942	132,942	0
NHS England (Wessex LAT)	30,465	32,997	2,532
NHS West Hampshire CCG (and Associates)	18,632	18,644	11
Other NHS Patient Income	3,901	4,132	231
Sustainability and Transformation Fund	4,160	3,584	(576)
Non NHS Patient Income	5,191	4,074	(1,118)
Non Patient Related Income	18,282	18,918	635
TOTAL INCOME	213,574	215,290	1,716

Sustainability and Transformation Fund Income	Budget £'000	Actual £'000	Variance £'000
Financial: Control Total (70%)	2,912	2,509	(403)
Performance: A&E Trajectory (30%)	1,248	1,075	(173)
TOTAL	4,160	3,584	(576)

Agency Expenditure



Care Group Performance

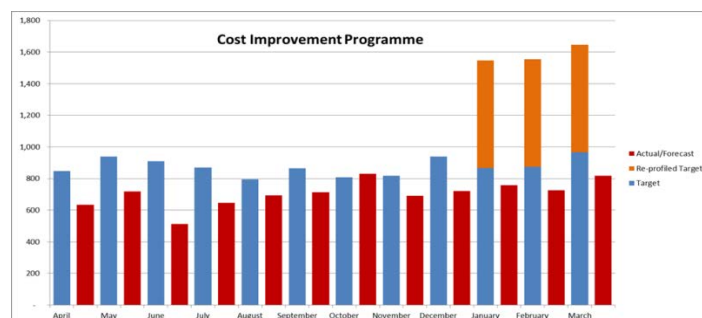
Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	11,033	9,806	(1,229)
Medical Care Group	7,539	5,686	(1,853)
Specialties Care Group	4,851	4,890	39
Corporate Directorates	(26,087)	(25,659)	427
Centrally Managed Budgets	(1,737)	659	2,395
SURPLUS/ (DEFICIT)	(4,400)	(4,619)	(220)

Cost Improvement Programme

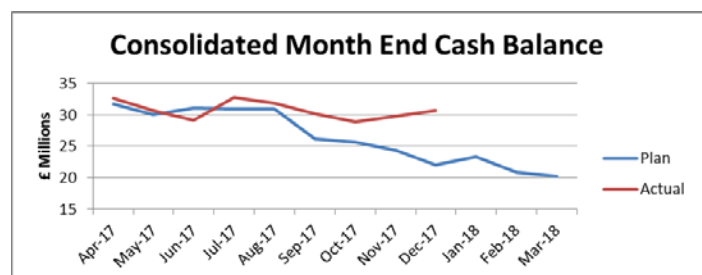
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000	FOT £'000
Surgical Care Group	1,910	1,152	(758)	(1,109)
Medical Care Group	2,609	1,349	(1,260)	(1,694)
Specialties Care Group	2,068	1,825	(243)	(264)
Corporate Directorates	1,205	1,836	631	1,030
SURPLUS/ (DEFICIT)	7,792	6,162	(1,630)	(2,037)

Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	3,100	2,785	315
IT Strategy	2,439	1,142	1,297
Medical Equipment	1,050	1,169	(119)
Centrally Managed	129	340	(211)
SURPLUS/ (DEFICIT)	6,718	5,436	1,282



Cash





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

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

Workforce Report



For the period to 31st December 2017

Karen Allman
Director of Human Resources

Workforce Report for Board

As at 31st December 2017

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 December			Rolling 12 months to 31 December				At 31 December
Surgical	86.2%	88.6%	93.6%	4.60%	15479	13.0%	10.2%	
Medical	89.7%	87.6%	92.4%	3.98%	19948	13.5%	9.8%	
Specialities	92.0%	87.1%	93.9%	3.97%	12287	13.1%	10.7%	
Corporate	91.3%	0.0%	95.7%	4.15%	12751	7.6%	8.1%	
Trustwide	89.8%	87.2%	93.5%	4.16%	60464	12.0%	9.7%	

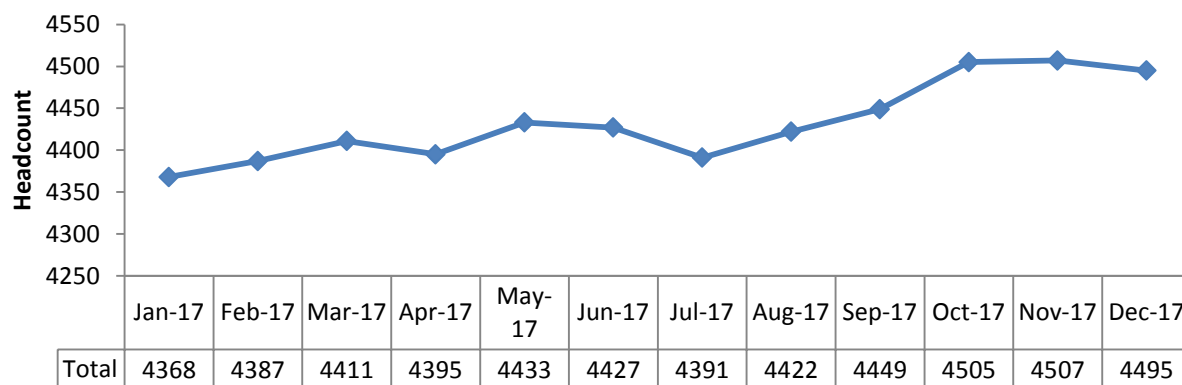
Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 December			Rolling 12 months to 31 December				At 31 December
Add Prof Scientific and Technical	97.9%		95.2%	3.38%	1550	13.8%	8.0%	
Additional Clinical Services	90.8%		93.0%	6.46%	16925	22.6%	15.2%	
Administrative and Clerical	93.1%		96.3%	3.70%	11408	9.6%	8.8%	
Allied Health Professionals	87.8%		93.6%	2.86%	2644	15.3%	12.1%	
Estates and Ancillary	82.9%		93.4%	5.79%	7143	9.1%	10.4%	
Healthcare Scientists	92.8%		95.1%	2.65%	929	9.4%	8.5%	
Medical and Dental		87.2%	88.5%	1.32%	2169	4.5%	3.7%	
Nursing and Midwifery Registered	88.2%		94.2%	4.19%	17696	8.9%	7.8%	
Trustwide	89.8%	87.2%	93.5%	4.16%	60464	12.0%	9.7%	

Workforce Report for Board

As at 31st December 2017

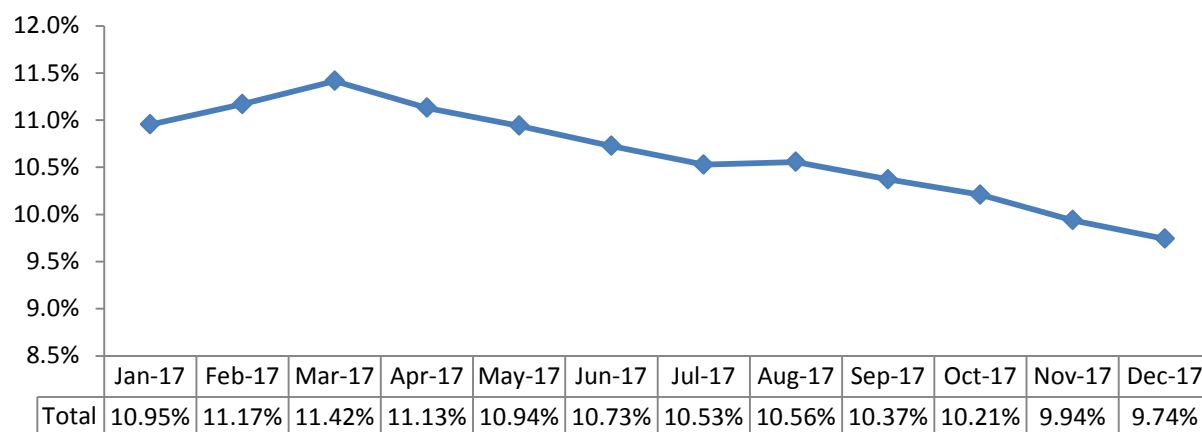
1. Staffing and Recruitment

Substantive Staff (Headcount) Trend



The information demonstrates that the turnover rate continued its downward trend, with a further reduction this month, down to a new low of 9.74% (9.94% last month) which compares favourably with the 11.8% turnover rate at the same point last year.

Permanent Staff Turnover Rate (Headcount)



The joining rate remains at 12%, which shows an improvement over the position at the same point last year: 10.7% as at 31st December 2016.

The vacancy rate at 30th November was 5.7%, figure for December not yet available at time of writing (6.3% as at December 2016).

Workforce Report for Board

As at 31st December 2017

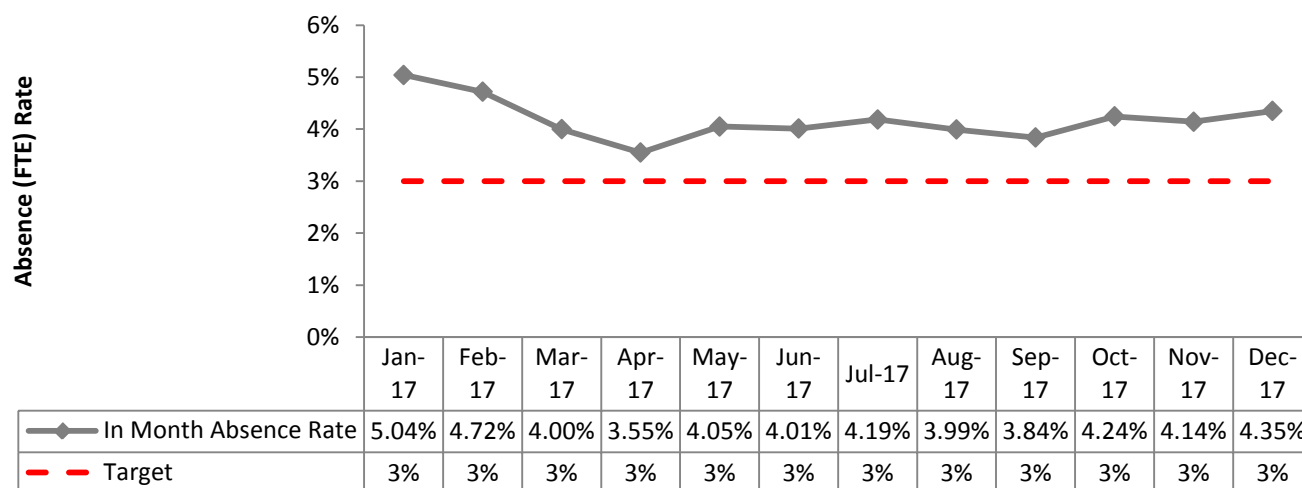
2. Essential Core Skills Compliance

Compliance continues its increasing trend and currently stands at 93.5% as at 31st December (93.3% in November). Despite a concerted push this fell very slightly short of the target of 95% by December 2017; it does, however, represent an increase over the same point last year (90.6%). Compliance for Medical & Dental staff increased by 1% to 88% (84.8% at 31/12/16).

Focus will remain on driving towards our target and we are working with colleagues across the NHS in Dorset to align our training and improve transferability of the skills reducing the need for NHS staff to do the same or similar training more than once. We are also developing some electronic booklets to support the further development of skills and awareness in different subjects.

3. Sickness Absence

In Month Absence Rate (FTE)



	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Surgical	5.55%	4.76%	4.48%	4.08%	4.53%	4.81%	5.00%	4.93%	4.21%	4.21%	4.49%	4.53% ↑
Medical	4.99%	4.67%	4.19%	3.42%	4.30%	4.00%	4.32%	3.73%	3.61%	3.60%	3.34%	4.03% ↑
Specialties	5.46%	5.42%	3.50%	3.36%	3.17%	3.32%	3.70%	3.91%	3.79%	4.21%	4.77%	4.48% ↓
Corporate	4.23%	4.12%	3.66%	3.37%	4.01%	3.85%	3.57%	3.49%	3.86%	5.36%	4.44%	4.53% ↑
Trust	5.04%	4.72%	4.00%	3.55%	4.05%	4.01%	4.19%	3.99%	3.84%	4.24%	4.14%	4.35% ↑

Following last month's slight reduction in the in-month sickness absence rate, it is disappointing to see an increase in December, predominantly in the Medical care group, although this remains the lowest of the care groups for sickness absence. At 4.35% this does, however, represent an improvement on the position at the same point last year (4.83% in December 2016).

Sickness absence continues to be reviewed through care group reports at a variety of meetings including discussion at the Workforce Committee. As a Trust we continue to seek ways of supporting staff with health and wellbeing and once again we are working with colleagues across the NHS in Dorset and wider health and social care to support this important area.

4. Safe Staffing

As part of the Trust's requirement to report on Safe Staffing (CQC – Key Line of Inquiry) the following data summary has been prepared for November 2017.

Registered Nurse (RN)	Actual Day	91.8%	HCA Actual Day	97.6%
Registered Nurse (RN)	Actual Night	97.9%	HCA Actual Night	113.8%

The December staffing return to Unify demonstrates that overall the Trust maintained a safe staffing position. This was achieved by areas either running to full template or implementing effective mitigating actions. There were no red flags for staffing in December 2017. A small percentage of high cost agency was utilised and this continues to be monitored through the Premium Cost Agency meeting. There were some episodes of over filling shifts and the rationale for these is cited below:

Care Group A

- The Intensive Care Unit is experiencing high levels of absence from work five nurses on Maternity leave, 2 taking career breaks and one on long term sickness. Short term sickness was also an issue. Registered nurse shifts unfilled were mitigated where appropriate with allied health care professionals.
- Within the surgical care group, the majority of shifts were mitigated with internal moves.
- Overnight the surgical admissions unit had an increase in staff due to capacity and demand.
- In orthopaedics some additional health care assistant shifts were utilised due to enhanced care and capacity needs.
- The under fill in Day Surgery is due to the area being closed during the Bank Holidays.

Care Group B

- There was an over fill of Health Care Assistants within Older Persons Medicine, due to 1:1 nursing for patients with enhanced care needs.
- The care group also experienced some short term sickness, which affected the fill rates and increased the need to mitigated registered nurse shifts.

Care Group C:

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



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

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Trust Management Board Terms of Reference
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:	Trust Management Board, December 2017
Action required:	Decision
<p>Summary:</p> <p>The main changes proposed to the terms of reference are to include the Care Group Medical Leads in the membership of the Trust Management Board, to provide for joint meetings to be held with the Hospital Executive Group from Poole Hospital NHS Foundation Trust and to update the Trust's strategic objectives, which are referred to in the terms of reference.</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 Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

TRUST MANAGEMENT BOARD

Terms of Reference

~~4.~~ The Trust Management Board (TMB) is a committee established by the Chief Executive ~~and responsible to the Board of Directors~~. It is a forum for strategic development and major operational decision-making at an executive level relating to the Trust's implementation of its vision, goals and values and clinical and corporate governance requirements within the context of NHS policy. It provides clinical, professional and managerial leadership to the Trust.

~~2.1.~~ Membership

~~2.1.1.1.~~ The TMB shall comprise the Executive Directors, the Trust Secretary, ~~t~~The Director of Organisational Development and Leadership, the Director of Improvement, the Directors of Operations, the Care Group Medical Leads, the Clinical Directors, the Associate Medical Directors and the Chairman of the Medical Staff Committee.

~~2.2.1.2.~~ The Chairman of ~~the~~ TMB shall be the Chief Executive. In his/her absence the meeting will be chaired by the Deputy Chief Executive and in the absence of the Deputy Chief Executive the meeting will be chaired by the Medical Director. In the absence of any of the above the remaining members present shall elect one of the Executive Directors to chair the meeting.

~~2.3.1.3.~~ Only members of ~~the~~ TMB or their appointed deputies have the right to attend TMB meetings. If a Clinical Director is absent he/she must nominate a suitable deputy empowered to act in his/her place. Other

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	<u>Draft V6</u> 5	April 2016 <u>December 2017</u>	March 2017 <u>December 2018</u>	Trust Secretary

individuals may be invited to attend for all or part of any meeting, as and when appropriate.

3.2. Secretary

The Trust Secretary or ~~their~~his/her nominee shall act as the Secretary of ~~the~~ TMB.

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Board of Directors	<u>Draft V</u> 6 <u>5</u>	April 2016 <u>December</u> <u>2017</u>	March 2017 <u>December</u> <u>2018</u>	Trust Secretary

4.3. Quorum

The quorum necessary for the transaction of business shall be ten members and should include not less than four Executive Directors and four [members who are either Care Group Medical Leads or Clinical Directors](#).

5.4. Frequency of meetings

~~The~~ TMB shall meet monthly (other than August) and at such other times as the Chairman of ~~the~~ TMB shall require. [These meetings may take place jointly with the Hospital Executive Group or equivalent from Poole Hospital NHS Foundation Trust.](#)

6.5. Notice of meetings

~~6.1.5.1.~~ Meetings of ~~the~~ TMB shall be called by the Secretary of ~~the~~ TMB at the request of the TMB Chairman.

~~6.2.5.2.~~ Only members can submit relevant items for the agenda. Items for inclusion on the agenda must be notified to the Trust Secretary seven working days before the meeting. Exceptionally papers may be submitted less than seven working days before the meeting or tabled at the meeting with the prior agreement of the Chairman. Items of urgent business will be considered at the start of the meeting.

~~6.3.5.3.~~ Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda for the meeting, shall be forwarded to each member of ~~the~~ TMB, 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 TMB members, and to other attendees as appropriate, at the same time.

[5.4.](#) Each agenda item should include a description of the actions requested of TMB.

~~6.4.5.5.~~ [The agenda for TMB meetings shall be set with a view to facilitating considered discussion of key strategic and operational matters affecting the Trust.](#)

7.6. Minutes of meetings

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Draft V65	April 2016 December 2017	March 2017 December 2018	Trust Secretary

~~7.1.~~6.1. The Secretary shall minute the proceedings and resolutions of all TMB meetings, including the names of those present and in attendance.

~~7.2.~~ Minutes of TMB meetings shall be circulated promptly to all members of ~~the~~ TMB unless a conflict of interest exists, in which case suitably redacted minutes of the meeting shall be circulated to those affected.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	<u>Draft V</u> 6 <u>5</u>	April 2016 <u>December 2017</u>	March 2017 <u>December 2018</u>	Trust Secretary

6.2.

8.7. Duties

~~The~~ TMB shall:

8.1.7.1. Strategy

~~8.1.1.7.1.1.~~ Develop, refine and agree the draft strategic plan, capital plan, commercial strategy and transformation programme for approval by the Board of Directors with appropriate recommendations. Clinical Directors have responsibility for development of the directorate strategy in response to the corporate plan in conjunction with the Directors of Operations.

~~8.1.2.7.1.2.~~ Monitor and advise on implementation of the strategic plan, capital plan and transformation programme.

~~8.1.3.7.1.3.~~ Review and agree the Trust's strategy on research and innovation for approval by the Board of Directors with appropriate recommendations.

~~8.1.4.7.1.4.~~ Review and agree the Trust's strategy on developing and maintaining relationships with commissioners and other local partner organisations.

~~8.1.5.7.1.5.~~ Review of the Trust's Vision and Values and Objectives on an annual basis.

Resources

7.2.

~~7.2.1. 7.2.1~~ Refine and agree the annual business plan and budget, including cost improvement plans, ~~for the Board of Directors~~ with appropriate recommendations for optimum patient benefit, for approval by the Board of Directors.

8.2.7.3. Performance Management

~~8.2.1.7.3.1.~~ Receive and review the corporate financial and performance data on a Trust aggregate basis agreeing any mitigating or corrective action as appropriate.

~~8.2.2.7.3.2.~~ Review progress as reported by Care Groups with particular attention to management of specific challenges against the agreed transformation programme and propose action as required to achieve agreed targets.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	<u>Draft V6</u> 5	April 2016 <u>December 2017</u>	March 2017 <u>December 2018</u>	Trust Secretary

~~8.3.7.4.~~ Quality Improvement

~~8.3.1.7.4.1.~~ To agree the QI strategy to support the Improvement Board in implementing the QI Strategy.

~~8.3.2.7.4.2.~~ To consider and agree the allocation of resource to support QI work and to monitor progress against QI milestones and targets.

~~8.4.7.5.~~ Quality

~~8.4.1.7.5.1.~~ Monitor and advise on implementation of the quality strategy and quality objectives across the Trust, consider aggregate quality metric data, agreeing any mitigating actions as appropriate.

~~8.4.2.7.5.2.~~ Review the progress of the appraisal and revalidation of doctors within the Trust and agree and take recommended actions.

~~8.4.3.7.5.3.~~ Review and advise on key policies relating to the patient safety, clinical effectiveness and patient experience.

~~8.4.4.7.5.4.~~ Review Clinical Governance arrangements and performance, including meeting required clinical standards, and recommend appropriate action.

~~8.4.5.7.5.5.~~ Agree the Trust's annual plan for clinical audit prior to final approval by the Board of Directors ~~and NHS Improvement~~.

~~8.4.6.7.5.6.~~ Review the significant risks reported to TMB and work collectively to identify solutions and mitigations for identified risks escalated from directorates and care groups.

~~8.4.7.7.5.7.~~ ~~To a~~ Advise on actions necessary to respond to CQC and other regulatory review of services and to implement agreed actions.

~~8.4.8.7.5.8.~~ ~~To r~~ Review reports from the Quality and ARisk Committee and agree responses which require the input or authority of TMB.

~~8.5.7.6.~~ Advisory

~~8.5.1.7.6.1.~~ ~~The TMB shall a~~ Advise the Board of Directors and take decisions as to:

~~8.5.1.1.7.6.1.1.~~ priorities for the provision and development of clinical services within the Trust's strategic plan;

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Board of Directors	Draft V6 5	April 2016 <u>December 2017</u>	March 2017 <u>December 2018</u>	Trust Secretary

~~8.5.1.2.~~7.6.1.2. the distribution of available resources within the annual business plan, budget and capital plan;

~~8.5.1.3.~~7.6.1.3. performance management of the delivery of clinical services; and

~~8.5.1.4.~~7.6.1.4. the examination and implementation within the Trust of both national and local NHS policy and directives as necessary.

~~9.8.~~ 8. Decision Making

8.1. Issues will always be discussed with a view to reaching a consensus, i.e. broad agreement but not necessarily unanimity. However, in circumstances where this cannot be achieved, the following arrangements will apply:

~~8.1 — Issues will always be discussed with a view to reaching a consensus, i.e. broad agreement but not necessarily unanimity. However, in circumstances where this cannot be achieved, the following arrangements will apply:~~

8.1.1. A decision can be taken by the Chief Executive. He/she should take account of all the views expressed and bears full responsibility and accountability for the decision. Clinical concerns and objections must be fully documented in the minutes.

8.1.2. If there is a significant objection from the Clinical Directors, that issue must be referred to the Board of Directors for review and/or final decision with the objections noted. The relevant Clinical Directors may be invited to attend a meeting of the Board of Directors to speak. A very important or urgent decision could justify an extraordinary meeting of the Board of Directors. In either case, the Chief Executive may take whatever interim actions he/she thinks most appropriate and account for these subsequently to the Board of Directors.

8.1.3. Final decisions of the Board of Directors and TMB will be binding. Members of TMB have a collective responsibility for implementing the decision.

~~**8.1.1 A decision can be taken by the Chief Executive. He/she should take account of all the**~~

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Draft V6 <u>5</u>	April 2016 <u>December 2017</u>	March 2017 <u>December 2018</u>	Trust Secretary

~~views expressed and bears full responsibility and accountability for the decision. Clinical concerns and objections must be fully documented in the minutes.~~

~~8.1.2 If there is a significant objection from the Clinical Directors, that issue must be referred to the Board of Directors for review and/or final decision with the objections noted. The relevant Clinical Directors may be invited to attend a meeting of the Board of Directors to speak. A very important or urgent decision could justify an extraordinary meeting of the Board of Directors. In either case, the Chief Executive may take whatever interim actions he/she thinks most appropriate and account for these subsequently to the Board of Directors.~~

~~8.1.3 Final decisions of the Board of Directors and TMB will be binding. Members of TMB have a collective responsibility for implementing the decision.~~

~~10.~~ Reporting Responsibilities

~~10.1. The minutes of TMB meetings shall be submitted to the Board of Directors after each meeting.~~

~~10.2. The TMB shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.~~

9. Reporting Responsibilities

9.1. TMB reports to the Board of Directors through the Chief Executive and Executive Directors.

9.2. The minutes of TMB meetings shall be submitted to the Board of Directors after each meeting.

9.3. TMB shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

~~11.~~ 10. Other

~~10.1~~ The TMB shall, at least once a year, review its 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.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Draft V6 5	April 2016 <u>December 2017</u>	March 2017 <u>December 2018</u>	Trust Secretary

~~10.2 TMB shall at least once every four months consider single item issues to allow more considered discussion of key matters affecting the Trust.~~

~~12.11.~~ Authority

~~11.1 The~~ TMB is authorised to seek any information it requires from any employee of the Trust in order to perform its duties.

~~13.12.~~ Supported Strategic Goals

~~12.1~~ The key strategic objectives the Trust has set are:

Valuing our Staff - Recognising the contribution of our staff and helping them develop and achieve their potential

Improving Quality and Reducing Harm - Focusing on continuous improvement and reduction of waste

Strengthening Team Working - Developing and strengthening Team RBCH to deliver safe and compassionate care for our patients and shaping future health care across Dorset

Listening to Patients - Ensuring meaningful engagement to improve patient experience

~~12.1.1 To continue to drive improvements in patient experience, outcomes and care across the whole Trust. We will use our QI methodology to support this work.~~

~~12.1.2 To support and develop our staff so that they are able to realise their potential and give of their best within a culture that encourages engagement, welcomes feedback, is open and transparent.~~

~~12.1.3 Developing our services as the main emergency care hospital for Dorset and West Hampshire residents.~~

~~12.1.4 Ensuring patients have rapid access to all of our services focusing on the provision of timely diagnosis and treatment with waiting times exceeding national standards.~~

~~12.1.5 Ensuring our services remain financially sustainable, services are provided within budget and resources are used wisely, cutting waste and thus allowing the maximum funding to flow to front-line patient care.~~

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Draft V6 5	April 2016 <u>December 2017</u>	March 2017 <u>December 2018</u>	Trust Secretary



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

BOARD OF DIRECTORS	
Meeting date:	31 January 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:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee, January 2018
Action required:	Decision
Summary: The attached terms of reference of the Healthcare Assurance Committee (HAC) have been amended to reflect the committees and groups which report to the HAC.	
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 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	September 2017 January 2018	September 2018 April 2018	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	September 2017 January 2018	September 2018 April 2018	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	September 2017 January 2018	September 2018 April 2018	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 when gaps in assurance are identified.
- 7.1.5. To be kept fully apprised 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.

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- 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;

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- 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 ~~and~~ & Control Committee
- Mortality Surveillance Group
- Patient Information Group (reporting by exception and through the Annual Report and Annual Quality Account)
- ~~End of Life Care Group~~ Emergency Preparedness Steering Group

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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"> Assurance Framework (full report) 	Quarterly	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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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 the Trust 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 CQUIN Compliance and Action Plans 	Quarterly	Associate Director of Quality Governance &	PMG

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		Risk / Deputy Director of Nursing	
<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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**The Royal Bournemouth
and Christchurch Hospitals**
NHS Foundation Trust

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Strategy and Development Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Karen Allman, Director of Human Resources
Details of previous discussion and/or dissemination:	Workforce Strategy and Development Committee, December 2017
Action required:	Decision
<p>Summary:</p> <p>Following review and approval at the Workforce Strategy and Development Committee meeting in December 2017, the Board of Directors is asked to approve the attached Workforce Strategy and Development Committee terms of reference.</p> <p>The principal changes proposed clarify the responsibilities of the Committee in relation to risk management and reporting responsibilities, both to and from the Committee.</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

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 ~~and~~ Management ~~Development~~; 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 ~~objective~~ 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 Medical Education, Clinical Skills & Professional Education Manager, Medical Education Manager, Head of HR Strategy, Head of HR Operations, Head of Organisational Development ~~Manager~~, and Director of Operations for Care Groups A, B and C.
- 1.3 Only members of the Committee have the right to attend Committee meetings but if a standing member is unable to attend it is expected that he/she will ensure their nominated deputy is invited and can attend in his/her place, notifying the Chairman.

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

- 1.4 It is expected that members attend a minimum of 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

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

6. Minutes of Meetings

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

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

7. Duties

The duties of the Committee can be categorised as follows:

7.1 People Strategy

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

7.2 Workforce Development 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 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 ~~development~~[delivery](#) of the Leadership Strategy.

7.6 ~~Equality,~~ Diversity and Inclusion

- ~~7.6.1~~ [7.6.1 To provide governance and oversight for the Trust's Diversity and Inclusion strategy.](#)

- [7.6.2](#) The Diversity and Inclusion Committee will report to the Committee and will report on progress against action plans.

8. ~~Reporting Responsibilities~~ Risk Management

~~8.1~~ [Role of the Workforce Strategy and Development Committee](#)

[The Workforce Strategy and Development 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:

<u>Risk Area</u>	<u>Executive Director Lead</u>	<u>Non-Executive Director Lead</u>
<u>HR and workforce</u>	<u>HR Director</u>	<u>Non-Executive Chair of the Workforce Strategy and Development Committee</u>

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.
- ~~89~~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	Staffing <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 <u>and</u> 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
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	of their role.
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~~9.~~ Other

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:

- ~~9~~10.1 have access to sufficient resources in order to carry out its duties;
- ~~9~~10.2 give due consideration to laws and regulations;
- ~~9~~10.3 oversee any investigation of activities which are within its terms of reference;
- ~~9~~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.

~~10~~11. Authority

The Committee is authorised:

- ~~10~~11.1 to seek any information it requires from any employee of the Trust in order to perform its duties;
- ~~10~~11.2 to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference.

~~11~~12. Supported Strategic Goals

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

- ~~11~~12.1 12.1 To strive towards excellence in the services and care we provide;
- ~~11~~12.2 12.2 To listen to, support, motivate and develop staff.;
- ~~12~~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
- Diversity & Inclusion Committee
- ~~19/06~~ Education & Training Strategic Group
- E-rostering Steering Board



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

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Charitable Funds Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Pete Papworth, Director of Finance
Details of previous discussion and/or dissemination:	Charitable Funds Committee, August 2017
Action required:	Decision
<p>Summary:</p> <p>Following review and approval at the Charitable Funds Committee meeting in August 2017, the Board of Directors is asked to approve the attached Charitable Funds Committee terms of reference.</p> <p>Additional paragraphs have been added to incorporate affiliate charity income within the same governance arrangements as the main charities.</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

CHARITABLE FUNDS COMMITTEE

Terms of Reference

The Charitable Funds Committee reports to the Board of Directors whose members are the Trustees of the registered charity (registration number 1057366).

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 2016 <u>2017</u>	August 2017 <u>2018</u>	Stuart Hunter <u>Pete</u> <u>Papworth</u>

3 QUORUM

- 3.1 The quorum necessary for the transaction of business shall be 2 members and should include not less than 2 Non Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the 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 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 2016 <u>2017</u>	August 2017 <u>2018</u>	Stuart Hunter <u>Pete</u> <u>Papworth</u>

- 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.

9.2 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.

9.3 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 2016 <u>2017</u>	August 2017 <u>2018</u>	Stuart Hunter <u>Pete</u> <u>Papworth</u>



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

BOARD OF DIRECTORS	
Meeting date:	31 January 2018
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Well-led Review Action Plan Update
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	David Moss, Chairperson
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Previous Board meetings
Action required:	Note for information
Summary: This report provides the latest updates on progress against the actions arising from the 12 recommendations in the external well-led review which was received in March 2017.	
Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	None

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update
1	The Board should proactively pursue strategic discussions at system level, especially with community, primary care and social care partners.	a Address strategy and strategic risk, using scenario planning. b. Design external engagement strategy.	Autumn 2017	TS/DM The Chair and Chief Executive are active participants in the Systems Partnership Board which was established earlier this year. It includes the leaders of all NHS and Local Authority organisations in Dorset and oversees the strategic direction of Health and Social Care including progress on the Sustainability and Transformation Plan (STP). All partners are working to develop the governance arrangements that will underpin the introduction of a system-wide control total, a key strand of work to create an accountable care system (ACS). Work is also underway to shape the design of the ACS as one of 10 national pathfinders, including governance arrangements. This is referenced within the Trust's revised strategy.
2	The Board should ensure that it continues to make time for strategic discussion.	Design Board development activities to integrate new non-executive directors, create role clarity and identify skills for future.	Apr-17	TS/DM Conscious efforts are made to include time during Board meetings to discuss emergent strategic issues. In addition separate Board sessions are scheduled for development events and 'Blue Skies' discussions as well as joint working sessions with the Council of Governors. The proposed programme for Board Strategy and Development sessions in 2018 is being reviewed by the Board at its meeting in January.
3	The Board should prioritise building on its existing engagement with local government, including developing a clear engagement strategy for doing so as the CSR is implemented.	a. Design external engagement strategy. b. Consider role of governors following review timetabled for summer 2017.	Autumn 2017	Various executive leads See response to Recommendation 1 above. In addition following the Board and Council of Governors workshop in July a detailed action plan for stakeholder engagement was drawn up and presented to the Board of Directors at its meeting in September. Separate work is in hand for the development of a patient engagement strategy and this will be discussed with the Board and the Governors in February 2018.

Recommendation	Action	Timeframe	Responsibility	Progress Update
<p>4 The Board should consider how it can increase its engagement with primary and community healthcare organisations, in particular relationships with the local community Trust. This should include direct 'peer to peer' engagement by NEDs as well as working through Trust staff.</p>	<p>a. Design external engagement strategy. b. Consider role of governors following review timetabled for summer 2017.</p>	Autumn 2017	Various executive leads	<p>See response to Recommendation 3 above. In addition:</p> <ul style="list-style-type: none"> - Executive Directors have regular contact with opposite numbers and other key staff in primary and community organisations. - The Chair has regular meetings with the Chairs of the Dorset and West Hampshire CCGs, and the Chair of the Dorset Healthcare University NHS Foundation Trust (DHC). - Jointly delivered GP extended access bid with local GPs and partner trusts, a product of collaboration to improve services for our local population. - Deputy Clinical Chair of Dorset CCG leading joint Board and Trust Management Board workshop on integrated care in November. - Appointment of joint clinical lead with community trust DHC to develop integration agenda.
<p>5 The Board should keep its governance under review-specifically the cycle of committee meetings in relation to Board meetings, the detail being considered by committee and Board meetings along with the balance of Part 1 and Part 2 agenda items.</p>	<p>Address governance tasks of Board and committee cycle along with delegated decision making and assigning responsibility for operational and strategic risk.</p>	Ongoing	DM/KF	<p>Relevant committee meetings e.g. Health Assurance Committee (HAC) are being rescheduled to ensure they meet well ahead of the Board meeting and reports can be updated. Committee Chairs have been asked to review committee agendas and reports to ensure they link sensibly with Board agendas and reports and avoid duplication. See also response to Recommendation 7 below.</p>
<p>6 The Board should consider how its strategic direction will influence its information requirements – including those relating to system-wide leadership and management and integrated care.</p>	<p>Address issue of information for Board including review of data/analytics/intelligence required.</p>	Ongoing	DM/TS	<p>See response to Recommendation 1 above. Also the One Acute Network Board has been set up to oversee the implementation of the acute elements of the CSR across Dorset. This Board will develop metrics to measure progress on reconfiguration and will receive regular reports on progress from the Programme Director.</p>

Recommendation	Action	Timeframe	Responsibility	Progress Update
7	The Board should consider investment in capability around integrated analytics to improve reporting.	Address issue of information for Board including review of data/analytics/intelligence required.	Ongoing	DM/TS The Board receives standard reports on finance, performance, quality and workforce at each meeting under the performance section of the agenda which allows connections to be made. In addition, the performance section gives an overview of our performance dashboard against the Single Oversight Framework Indicators. The format of all the performance reports has also been reviewed to ensure that they are shorter and more focused on key issues.
8	External risks should be identified and managed systematically, in the same way as strategic or operational risks. Our view is that strategic risk should sit with the Audit Committee rather than the Healthcare Assurance Committee.	Address governance tasks of Board and committee cycle along with delegated decision making and assigning responsibility for operational and strategic risk.	Aug-17	PS/KF/AJ/CH /JL Following discussion it was agreed to continue to review significant risks at the HAC. Where risks have been received by other committees, such as the Finance and Performance Committee, this will be noted in the report for HAC. The Board Assurance Framework will be reviewed by the Audit Committee at each meeting and by the Board at every other meeting. This will reinforce the overall Board responsibility for strategic risk with the Audit Committee providing oversight as part of its role in assessing the effectiveness of risk management. These changes will be reflected in the next revision of the Trust's Risk Management Strategy in April 2018 with a transitional period before the Audit Committee formally assumes this role. Both the Board and the Audit Committee will have a role in relation to the strategic risks associated with the CSR, working alongside the One Acute Network Board (see recommendation 6 above).

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update
9 The Board may wish to seek to add expertise (either Executive or Non-Executive) in community or primary care, social care or local government.	Design Board development activities to integrate new non-executive directors, create role clarity and identify skills for future.	Apr-17	DM/TS	This will be actively considered when suitable vacancies arise as it is not considered appropriate to increase the overall size of the Board at the present time. GP integrator roles appointed across all four foundation trusts in Dorset to progress this work, focussed on cross-cutting themes (urgent care, older people, musculoskeletal and primary care) under leadership of the Deputy Clinical Chair of Dorset CCG.
10 The Board should ensure that it has a clear people strategy in place, as part of its overall strategic planning. This should include consideration of strategic workforce needs across the system (for example new roles), as well as Trust requirements. This can build on the cultural work already in place.	Design people strategy and build leadership capacity as well as change management skills.	Dec-17	Workforce Strategy and Development Committee/ Board/ One Acute Network Board	The People Strategy and Workforce Plan was approved by the Board of Directors at its meeting in September 2017. The Plan is monitored by the Workforce Strategy and Development Committee with periodic reporting to the Board.
11 As part of its people strategy and its implementation, the Trust should further develop its talent management approach and pipeline. This should include development of Care Group leaders as well as trust-wide clinical and non-clinical leaders, though we note this has already begun with an imminent Leadership Strategy.	Design people strategy and build leadership capacity as well as change management skills.	Dec-17	Workforce Strategy and Development Committee/ Board/ One Acute Network Board	The Leadership Strategy is being presented to the Board in January 2018. This reflects the Board's request for a clearer link between leadership and the People Strategy and Workforce Plan.

WELL-LED REVIEW ACTION PLAN

Recommendation	Action	Timeframe	Responsibility	Progress Update
<p>12 The interface between existing Trust governance and the emerging CSR Programme Board should be specified in detail, so that its full implications for the Trust can be discussed and agreed by the Board prior to implementation. This should include clear specification of accountability for both operational and transformation performance at all times, as well as consideration of how the boards can work most effectively together to provide whole-system leadership.</p>	<p>Address strategy and strategic risk, using scenario planning.</p>	<p>Autumn 2017</p>	<p>TS/DM</p>	<p>Terms of reference were prepared for the purpose, structure and decision-making framework of the One Acute Network Board. Care was taken to ensure that these terms of reference were compatible with the Trust's own Constitution and Standing Orders and the terms of reference were approved by the Trust Board (as well as the Board of Poole Hospital and Dorset County Hospital NHS Foundation Trusts) prior to adoption by the One Acute Network Board. The terms of reference for this Board are currently being reviewed as it will be focussing on the reconfiguration of services in East Dorset with Clinical Networks and Business Support Services incorporated within the work of other groups in the Dorset system which include all NHS foundation trusts in Dorset.</p> <p>See also the response to recommendations 1 and 6 above.</p>



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

BOARD OF DIRECTORS	
Meeting date:	31 January 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 notification of Tea Colaianni's resignation as a Non-Executive Director, the Board of Directors is asked to approve:</p> <ul style="list-style-type: none"> the appointment of Cliff Shearman as chairman of the Workforce Strategy and Development Committee; the appointment of Iain Rawlinson as a member of the Workforce Strategy and Development Committee; and the appointment of Iain Rawlinson as a member of the Charitable Funds Committee; <p>each with effect from 1 February 2018.</p> <p>Cliff Shearman would also be the Non-Executive Director lead for Emergency Planning, Resilience and Response.</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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Impact on risk profile:	None

BOARD OF DIRECTORS MEETING – 31 January 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
11.15	1. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 24 November 2017	Decision	<i>All</i>
11.20	2. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Discussion	<i>All</i>
11.25	3. STRATEGY AND RISK		
	a) Draft Trust Strategy (paper)	Discussion	<i>Tony Spotswood To Follow</i>
	b) Interim Board Appointment Process (paper)	Discussion	<i>Tony Spotswood</i>
	c) Significant Risk Report (paper)	Discussion	<i>Paula Shobbrook</i>
	d) Capital Plan 2018/19 (paper)	Discussion	<i>Richard Renaut</i>
	e) Christchurch Fairmile LLP (paper)	Discussion	<i>Richard Renaut</i>
	f) Recommendation: ICD's CRTPs & Loop Recorder	Decision	<i>Pete Papworth</i>
	4. QUALITY		
	a) None		
12.45	5. PERFORMANCE		
	a) Emergency Department Update (verbal)	Information	<i>Tony Spotswood/ Richard Renaut</i>
	b) Staff Survey Update (presentation)	Information	<i>Karen Allman</i>
13.05	6. GOVERNANCE		
	a) Non-Executive Director Replacement (verbal)	Information	<i>David Moss</i>
	b) Board Strategy and Development Programme 2018 (paper)	Discussion	<i>David Moss</i>
13.20	7. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff	Discussion	<i>All</i>
	b) Reflective Review	Discussion	<i>All</i>

The meeting will be followed by a meeting of the Nomination and Remuneration Committee and a Blue Skies session on the Care Quality Commission inspection process