

A meeting of the Board of Directors will be held on Wednesday 31 July 2019 at 2.15pm in the Board Rooms, Poole 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
2.15-2.16	1. WELCOME, APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
	Debbie Fleming, Iain Rawlinson		
2.16-2.19	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 29 May 2019 (paper)	Decision	All
2.19-2.20	3. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Information	All
2.20-3.30	4. QUALITY AND PERFORMANCE		
	a) Patient Story (verbal)	Information	Paula Shobbrook
	b) Update on Governor Activity (verbal)	Information	David Triplow
	c) Medical Director's Report (paper)	Information	Alyson O'Donnell
	d) Infection Prevention and Control Annual Report Summary and Statement of Commitment (paper)	Decision	Paula Shobbrook/ Layth Alsaffar
	e) Trust Board Dashboard (paper)	Information	Richard Renaut
	f) Performance Report (paper)	Information	Richard Renaut
	g) Quality Report (paper)	Information	Paula Shobbrook
	h) Finance Report (paper)	Information	Pete Papworth
	i) Workforce Report (paper)	Information	Karen Allman
	j) Safe Staffing Report (paper)	Information	Paula Shobbrook
	k) CQC National Inpatient Survey 2018 (paper)	Information	Paula Shobbrook
3.30-3.50	5. STRATEGY AND RISK		
	a) Chief Executive's Report (paper)	Information	Paula Shobbrook
	b) Organisational Development Update (paper)	Information	Deb Matthews
	c) Progress Update on 2019/20 Corporate Objectives (paper)	Information	Paula Shobbrook

3.50-4.00

6. GOVERNANCE

- | | | | |
|----|---|-------------|-------------------------|
| a) | Clinical Audit Plan 2019/20 (paper) | Information | <i>Alyson O'Donnell</i> |
| b) | Workforce Strategy and Development Committee Terms of Reference (paper) | Decision | <i>Karen Allman</i> |

7. NEXT MEETING

Wednesday 25 September 2019 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

8. ANY OTHER BUSINESS

Key Messages for Communication to Staff

4.00-4.15

9. 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.

10. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

This meeting will be recorded in order for minutes of the meeting to be produced. The recording will be deleted once the minutes of the meeting have been approved.

Minutes of a Meeting of the **Board of Directors** (the **Board**) of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the **Trust**) held in public at 8.30am on **Wednesday 29 May 2019** in the Conference Room, Education Centre, Royal Bournemouth Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Debbie Fleming	(DF)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Pankaj Davé	(PD)	<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>
	Cliff Shearman	(CS)	<i>Non-Executive Director</i>
In attendance:	James Donald	(JD)	<i>Head of Communications</i>
	Suranga Dharmisiri	(SD)	<i>Registrar, Gastroenterology</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	David Flower	(DF)	<i>Chaplain (for item 5(a))</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Fiona Hoskins	(FH)	<i>Deputy Director of Nursing and Midwifery</i>
	Deborah Matthews	(DMA)	<i>Director of Improvement and Organisational Development</i>
	Naomi Wee	(NW)	<i>Registrar, Anaesthetics</i>
	Donna Parker	(DP)	<i>Deputy Chief Operating Officer</i>
	Louise Pennington	(LP)	<i>Palliative Care Matron (for item 5(a))</i>
	Duncan Ridgeon	(DR)	<i>Assistant Chaplain (for item 5(a))</i>
	Helen Rushforth	(HR)	<i>Improvement Manager (for items 5(h) and (i))</i>
	Dily Ruffer	(DR)	<i>Governor and Membership Manager</i>
	Douglas Tunney	(DT)	<i>Registrar, Anaesthetics</i>
Public/	Derek Chaffey		<i>Public Governor</i>
Governors:	Paul Higgs		<i>Appointed Governor</i>
	Marjorie Houghton		<i>Public Governor</i>
	Andrew Kerby		<i>Appointed Governor (from item 5(e))</i>
	Keith Mitchell		<i>Public Governor</i>
	Margaret Neville		<i>Member of Public</i>
	Donald Park		<i>Member of Public (for item 5(a))</i>
	Roger Parsons		<i>Public Governor</i>
	Maureen Todd		<i>Public Governor</i>
	David Triplow		<i>Public Governor</i>
	Michele Whitehurst		<i>Public Governor</i>
	Jessica Wiggins		<i>Registrar, University Hospital Southampton NHS Foundation Trust</i>
Apologies:	Brian Young		<i>Public Governor</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>

23/19 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Action

The Chairperson welcomed those attending the meeting, including the newly appointed governor from Dorset Council, Andrew Kerby, when he joined the meeting. The apologies for absence set out above were noted.

24/19 **MINUTES OF PREVIOUS MEETING**

(a) Minutes of the meeting held on 27 March 2019 (Item 2(a))

The minutes of the meeting held on 27 March 2019 were **approved** as an accurate record of the meeting.

25/19 **MATTERS ARISING**

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

The update was **noted** and those which had been completed could be closed.

26/19 **Chief Executive's Report (Item 4)**

The Board **noted** the report from the Chief Executive and in particular:

- the appointment of the four interim Clinical Transformation Leads working to bring teams together and develop joined up workforce plans across the two organisations in advance of merger in emergency medicine, trauma and orthopaedics, theatres and anaesthesia and older people's medicine;
- the work with NHS Improvement (**NHSI**) on the review the outline business case for capital and the timetable for the merger;
- recent engagement events held on both the Royal Bournemouth and Poole Hospital sites informing members of the public, patients and stakeholders about the plans for the development of both sites;
- the recent article in the Bournemouth Echo, noting that the rationale for the Clinical Services Review (**CSR**) was to ensure that all of the acute hospitals in Dorset were sustainable for the future;
- that Poole Hospital NHS Foundation Trust (**PHFT**) had been identified as a pilot site for the proposed new urgent and emergency care standards;
- the continuing development of relationships with members of the new local authorities in Dorset following the recent elections on 2 May 2019;
- the opening of the new front entrance at Poole Hospital and the completion of refurbishment of the cardiac catheter laboratories at the Royal Bournemouth Hospital (**RBH**); and
- the positive feedback received from the National Institute for Health and Care Excellence (**NICE**) on both trusts' compliance with NICE guidance which recently held its board meeting at PHFT.

In response to a question from one the Non-Executive Directors, DP confirmed that there had been no further updates on preparations for the UK's exit from the European Union (**EU**) in response to recent developments and the announcement that the Cabinet office had suspended planning for a 'no deal' exit from the EU.

(a) Patient Story (Item 5(a))

This item was considered at item before item 4.

Donald Park attended the meeting to express his gratitude to the staff on Ward 2, in particular Sister Mel Ivory and Dr Morgan, who had cared for his daughter at the hospital before she sadly passed away in November 2018, aged 41. Following his daughter's diagnosis he explained that she had been admitted to the hospital on several occasions with breathing problems and that all staff had been so caring, attentive and friendly. Staff had gone above and beyond anything he had expected by arranging a wedding for his daughter and her partner and the marriage had meant so much to her in the final days of her life. The care extended into her final hours when she died without any pain or discomfort.

The Board thanked Donald Park for sharing his story recognising that this must have been difficult. Board members reflected on the story and the care and compassion shown by staff, which reflected the Trust's aim to provide the care they would expect for their own families, particularly the personalised care provided at the end of life.

(b) Medical Director's Report (Item 5(b))

The key themes from the report were summarised and included:

- the rebased figures for the Hospital Standardised Mortality Ratio (HSMR) were within the 'better than expected' range;
- Summary Hospital-level Mortality Indicator (**SHIMI**) figures indicated that performance was within the 'expected' range;
- the results of a review of the previous upward trend in SHIMI data that identified that this pattern was driven by a higher proportion of inpatient deaths i.e. fewer patients dying in the community in the 30 days after discharge and the more recent downward trend in SHIMI;
- continued positive progress with the medical examiner process ensuring that every death in the Trust since October had been screened and a third of all death certificates were now issued within 24 hours with further recruitment planned to provide improved cover; and
- an action plan had been put in place following a mortality review of aspiration pneumonia prompted by a Dr Foster alert supported by the Speech and Language Therapy (SALT) team to support better communication on 'feeding at risk' plans between primary and secondary care and on readmission and additional mouth care training.

The positive impact of the medical examiner role was recognised in identifying any deficiencies in clinical care and embedding any learning in order to improve patient care.

(c) Trust Board Dashboard (item 5(c))

This item was noted for information.

(d) Performance Report (Item 5(d))

An update was provided on the recent changes to Phlebotomy service at RBH as part of the transfer of phlebotomy services closer to patients' homes by providing these in GP practices and community locations. Feedback from patients had highlighted that they were not sufficiently informed about the changes and they were experiencing delays in accessing the phlebotomy services.

The changes had been planned since October and were implemented from April 2019. Unfortunately a number of vacancies had arisen in the Phlebotomy service provided at RBH and there had also delays in recruiting staff to provide the service in primary care. As a result the transition had not been as smooth as the Trust would have wanted and this has impacted on the level of service provided to patients. Joint communications had been prepared with NHS Dorset CCG to make the public aware of where they can get blood tests in the period leading up to the primary care service being fully operational on 1 July 2019. The Board requested that further updates were provided to the Board and Council of **DP** Governors in July.

The Board noted the performance exceptions to the Trust's compliance with the 2018/19 Single Oversight Framework, national planning guidance and contractual requirements. The following areas were highlighted:

- performance against the Emergency Department (**ED**) four hour standard dropped to 91.1% following increases in attendances and a peak in patient acuity;
- the quality improvement (**QI**) work to help improve patient flow and pathways with experienced coordinators being introduced to provide support in ED;
- performance against the 18 week Referral to Treatment (**RTT**) standard dropped slightly to 83.9% overall and remained below with one 52 week wait breach in Dermatology reflecting the current pressures on this service across Dorset due to demand and staffing;
- a new Associate Director for elective care had been appointed who would be focusing on patients with the longest waits and demand and capacity management tools;
- all three cancer 31 day standards had been achieved in March and the final quarter of 2018/19;
- six week diagnostic standard performance was just below the target achieving 98.3% in April and additional capacity had been secured in Endoscopy; and
- ten mixed sex accommodation breaches in April as a result of delays in moving patients who no longer required higher acuity care to other wards due to increased operational pressure in the hospital.

In response to a question from one of the Non-Executive Directors as to whether the actions to reduce waits were working, there was work to address issues in particular specialties such as Urology and Ophthalmology and work to improve processes and pathways more generally. In addition, there were system-wide initiatives to understand and manage demand and capacity as well as to provide support around workforce challenges. Patients who were waiting longer were being kept up to date by the Trust and through their GPs and some may be having

other interventions while waiting.

Another Non-Executive Director wanted to understand if there was a link between the pressures in ED and the feedback and the drop in the number of responses to the Friends and Family Test (**FFT**). The Board was informed about the QI work which would incorporate outcome measures as well as internal process measures and patient co-production to help understand some of the underlying issues.

(e) Quality Report (Item 5(e))

The key updates from the quality report were:

- three serious incidents had been reported in April, including one never event, and there had been no evidence of patient harm in two of these;
- positive performance in the FFT with the Trust in the top quartile for inpatients and the second quartile for outpatients;
- the benefits of staff listening to recordings of feedback from Care Conversations with patients to help improve the quality of care and patient experience;
- the areas of improvement identified following the recent 'Sleep Well' QI campaign, which had been well supported by the governors and volunteers; and
- the slight decline in the number of complaints responded to within 25 days although the number of patients not satisfied with their response had also reduced.

(f) Finance Report (Item 5(f))

The Trust would shortly be publishing its Annual Report and Financial Accounts for 2018/19 reflecting the strong performance over past year delivering a surplus of over £29 million, which would be an important contribution to capital to support the implementation of the CSR.

The Trust had set a breakeven budget for 2019/20 and the Trust was marginally behind plan by £66,000 mainly due to a shortfall in the cost improvement programme (**CIP**) and rising nurse agency costs. Medical locum spend was a risk given the tax changes affecting NHS pensions.

The Board thanked staff for their work in achieving such a strong financial performance in 2018/19.

(g) Workforce Report (Item 5(g))

The following areas from the report were highlighted:

- the increase in the substantive staff headcount by 187 as compared to the previous year;
- the continued focus on recruitment initiatives, working closely with colleagues at PHFT and the Dorset system, ;
- the increase in essential core skills training compliance which was just below 94%;
- the increase in staff sickness rates with ongoing support to managers to manage absence and the development of health and wellbeing initiatives to support staff given the operational pressures;

- the Trust maintained a safe staffing position with a small percentage of high cost agency utilised alongside bank staff; and
- increased joint working with PHFT to align reporting and share initiatives to develop the future workforce.

The Board recognised the workforce challenges within the NHS, with a new NHS Chief People Officer recently appointed. It was important to remain innovative and flexible in recruiting and retaining staff. Exit interviews continued to be used to identify the reasons why staff might be leaving the Trust and there was a need to work more coordinated system approach to retain staff.

(h) Quality Impact Assessment Process (Item 5(h))

Board members were updated on the changes made to the Quality Impact Assessment (**QIA**) process following an internal audit review of the Trust's CIP. The changes ensured that there was greater oversight of the cumulative effect of smaller schemes within the CIP as well as the individual impact of the larger schemes.

The Board **approved** the changes outlined to the Quality Impact Assessment Policy.

(i) Getting It Right First Time (GIRFT) Update (Item 5(i))

The Board received an update on the clinically-led national programme launched by Professor Tim Briggs in 2012 that sought to improve care by reducing unwarranted variation while also generating savings for the NHS. The GIRFT programme had been introduced in 37 clinical specialties helping clinicians to identify changes and develop local action plans to would improve care and outcomes for patients and deliver efficiencies.

There had been visits from the national teams in 14 specialties at the Trust since March 2014 and a further three visits were currently planned. A regional team helped to support the implementation of the identified action plans and a GIRFT steering group was also now in place to ensure good oversight of progress and to support the work on themes across multiple specialties. Feedback from clinicians to date had been positive as these were clinically-led conversations that addressed real practice, although the timescales and expectations were often challenging. The strategy to support the action plans was to try to fit the GIRFT recommendations into existing work on the CSR and joint work on services with PHFT going forward.

28/19 STRATEGY AND RISK

(a) Progress Update on 2018/19 Corporate Objectives (Item 6(a))

The Board noted the progress against the 2018/19 corporate objectives for the final quarter highlighting where aims that had not been achieved had been incorporated into the objectives for 2019/20.

(b) Trust Objectives 2019/20 (Item 6(b))

The Board noted the Trust Objectives for 2019/20 and the priorities and measures identified to allow the Board to monitor progress. These had been approved at the meeting in March 2019.

29/19 **GOVERNANCE**

(a) Membership Engagement Strategy (Item 7(a))

The Board of Directors received the strategy, which had been approved by the Council of Governors at its meeting on 2 May 2019. The key change to the action plan for the year included the joint work with PHFT on future engagement events. The membership target would remain the same and governors would continue to build on the information and engagement with patients and the public.

The Board thanked the Council of Governors for their support to increase engagement and **endorsed** and **approved** the Membership Engagement Strategy.

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

The Board **approved** the amendments to the terms of reference of the Trust Management Board.

(c) Council of Governors Determination on Non-NHS Activity (Item 7(c))

The Board was advised that the Council of Governors had received an update on the Trust's private patient activity at its last meeting on 2 May 2019 and had been satisfied that the carrying on of non-NHS activity would not to any significant extent interfere with the fulfilment by the Trust of its principal purpose (the provision of goods and services for the purposes of the health service in England) or the performance of its other functions.

30/19 **NEXT MEETING**

The next meeting will take place on **Wednesday 31 July 2019** at 2.00pm in the Board Room, Poole Hospital.

31/19 **ANY OTHER BUSINESS**

There was no other business.

Key Messages for Communication to Staff:

1. Chief Executive Report
2. Phlebotomy
3. QIA Policy
4. GIRFT
5. Patient story

32/19 **COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC**

DM noted that the procedure for questions from the governors and public at Board meetings had been updated to ensure that personal confidential information about individuals was not disclosed in questions or comments and to ensure questions could come from a range of those present in the time available.

DT updated the Board on the recent Understanding Health talk arranged by the governors in Brockenhurst from by Dr Chris Critoph about heart failure.

The governors present had appreciated the update on the phlebotomy service and the information provided by the Trust for those using the service as concerns had been raised with governors and it was important to clearly set out the alternative options available for patients.

33/19 **RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS**

The Board resolved that, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

The meeting adjourned at 10.25am.

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
29.05.19	27/19	QUALITY AND PERFORMANCE			
	(d)	Performance Report			
		The Board requested that further updates [on phlebotomy services] were provided to the Board and Council of Governors in July.	DP	July 2019	Update provided to Council of Governors at its meeting on 18 July. Further update to be provided at Board meeting on 31 July.
Key:	Outstanding	In Progress	Complete	Not yet required	



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

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Medical Directors Report
Section on agenda:	Quality and Performance
Supplementary reading:	Medical Appraisal and Revalidation Annual Report 2018-19 in Reading Pack National Audit of Care at the End of Life (February 2019) Claims and Inquests Report (April-June 2019)
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Alyson O'Donnell, with input from Dr Divya Tiwari
Details of previous discussion and/or dissemination:	Mortality indices and reviews discussed at Mortality Surveillance Group
Action required:	Review and comment
<p>Summary:</p> <p>Monthly Medical Director's Report. To update the Board on the Trust's mortality performance. This report includes an update on Claims Report and in a separate paper the Medical Appraisal and Revalidation Annual Report 2018-19.</p> <p>The Board will need to confirm that it has reviewed the content of Medical Appraisal and Revalidation Annual Report 2018-19 and that the Trust is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and authorise the statement of compliance to be signed by the Chairperson or Chief Executive on behalf of the Trust.</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?	✓



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

Impact on significant risks:	N/A
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Medical Director's Report to the Board

Mortality Update

Overall Hospital Standardised Mortality Ratio (HSMR) for the Trust for the last financial year (April 2018 –March 2019) is 95.6; this is rebased for December 2018 and is within the expected range. Standardised Mortality Ratio (SMR - includes all inpatient deaths) is 94.6, this is in the 'better than expected' range. The figure for RBH (excluding Christchurch Hospital and the Macmillan Unit) is 85.2 and is in the 'better than expected' range. The latest SHMI (Summary-level Hospital Mortality Indicator February 2018-January 2019) is 94.94 is again within the expected range. The SHMI figure for RBH is 86.76 and this is in the 'better than expected' range. Predictably the figure for Macmillan Unit (specialist palliative care unit) is 290.74; this is in the 'higher than expected' category. The coding department has an ongoing piece of work to improve data quality for vascular procedures and also the depth of coding for 'elective' versus 'non-elective' activity. This work is progressing more slowly than expected however an escalation plan is in place if required. Over all position is satisfactory for mortality outcomes.

The Trust has observed improvements in crude mortality rates for the financial year 2018/19 compared to financial year 2017/18, especially over the winter months (December/January/February). Recent upload (May 2018-June 2019) shows stable trends in crude mortality ratios (Annexe A).

Learning from Deaths

Mortality Report for Board

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

Data as at 17/07/2019

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Deaths in Month	141	128	103	116	118	121	118	164	132	132	120	117	109
eMortality Reviews Completed in Month	69	76	8	38	84	18	18	210	71	121	12	62	13
Category of Death by Month Review Completed													
Grade 0	64	71	6	29	77	18	17	190	63	110	11	49	8
Grade 1	5	5	2	8	6	0	1	19	8	11	1	11	4
Grade 2	0	0	0	1	1	0	0	1	0	0	0	2	1
Grade 3	0	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disability Deaths in Month	2	0	0	0	1	0	0	0	0	0	0	0	0
Learning Disability Deaths Reviewed	2	0	0	0	0	0	0	0	0	0	0	0	0

LeDeR Mortality

There were no deaths reported in patients with a learning disability in March, April, May and June 2019. The Trust has been forwarding the details of any deaths in patients with a learning disability to the national mortality review in learning disability programme(LeDeR) since 2017. The LeDeR annual report has been discussed in the Mortality Surveillance Group (MSG) meeting. Much of the focus of the report, as this is where most of the reviewed deaths fall, is patients under the age of 17. However, learning points applicable to our Trust were noted and disseminated through speciality mortality chairs. These are:

- Learning disability should never be described as the underlying or only cause of death in part one of the Medical Certificate Cause of Death (Death Certificate);

- Learning disability should never be an acceptable rationale for a DNACPR (Do Not Attempt CPR) order;
- The Care Quality Commission will identify and review DNACPR decisions and Treatment Escalation Personal Plans relating to people with learning disability during their inspection visits;
- Sepsis should be promptly diagnosed and managed to improve premature mortality rates;
- ME (Medical Examiners) should raise and discuss with clinicians any 'unconscious bias' they or family identify related to learning disability during the ME screening process.

Medical Examiner's Report

Since November 2018 all deaths have been screened to identify any gaps in clinical care or hospital induced harm using a standardised screening pro forma. Relatives are contacted to provide an opportunity for them to raise any concerns and to discuss the contents of the medical certificate of the cause of death.

Lead Medical Examiner (ME) Dr Cranshaw produced his first report detailing findings/ learning themes identified by Medical Examiners. This was discussed at the July MSG for dissemination of the learning. The report highlights two main emerging themes to explore related to end of life care and clinical care.

End of Life Care

- Rationale for transition to end of life care is sometimes poorly documented. When the question was asked close to the time of death some relatives/next of kin reported that they did not always feel involved in decisions or know what to expect next, leaving them feeling unprepared for the duration of the dying process;
- The ME was concerned that the AMBER care bundle is not used or implemented appropriately in a consistent way. Documentation of the rationale for decisions or expectations is not always clear;
- Documentation of the rationale to increase doses of sedatives or opioids in symptomatic patients on end of life care is not always clear and could be improved.

It should be noted that this does not triangulate with the information we receive from the relative feedback questionnaire, which is sent to all bereaved relatives three months after their loved one's death. This may simply be a reflection of timing as the ME's office is asking the question within 48 hours of the patient's death when things are still very fresh and emotional.

It should be noted that regular audits on the use of Personalised Care Plans in the last days of life enable Allow a Natural Death documentation to be undertaken. The most recent audits were presented to the End of Life Care Steering Group and are consistent with the provision of good end of life care.

There have been recent changes to the National Audit of Care at the End of Life. This is split in to three sections.

1. Organisational survey of service provision.
2. Detailed notes review of clinical care.
3. Relative feedback.

The relative feedback section process involves a central request to relatives to complete an online feedback form. The response rate to this was extremely low with a 7% return rate nationally. Locally, our response rate was slightly better at 16% (18/82), but this is still substantially below the 35% response rate achieved with our current paper return. Not only is the response rate higher, but the number of returns are significantly higher (227 in 6 months) as it is sent to all relatives.

A recommendation has been made by the Senior Leadership Team that we will only participate in the first two elements of the audit in the coming year. This will not affect our overall performance in the audit but will result in a null score for this element. The End of Life Care team have been asked to align the questions to include emerging themes e.g. access to side rooms and to allow comparison with the national results. This will also mean that we can continue to provide feedback to individual Ward areas on their performance and areas for development, which is not possible with the national audit.

Clinical Care

- Intravenous fluid prescription in relation to illness including content, rate, volume and administration time is often difficult to ascertain. Rationale behind these decisions may not be always documented by clinicians. This can have a potential harmful effect on outcomes.
- Hyperkalaemia is not managed according to Trust/National Guideline and some junior doctors are unaware of these guidelines.

Action Plan

- Disseminate learning through speciality chairs and End of Life Steering Group to improve documentation around end of life care;
- Conduct an audit of use of AMBER care bundle in the Trust;
- NICE approved IV fluid management guidelines are no longer available. A recommendation has been made that a small group is tasked to develop a new e-Learning module of IV fluid management and to work with the education and training department about how this is rolled out.

Mortality Surveillance/Reviews

There are no new Dr Foster analytical alerts in any diagnostic or procedural categories. All existing alerts have been investigated and action plans are in place.

Annual Review of High Risk Conditions: Stroke

Mortality chair for Stroke Medicine, Dr Thavanesan, presented an annual report from mortality reviews. This review focussed on learning and action plans from grade one and grade two mortalities.

Learning

Anticoagulation reversal in patients presenting with life-threatening cerebral bleed should be done in Emergency Department (ED) (Grade 2).

Patients requiring thrombectomy for life threatening stroke should be transferred to the Wessex Neurological Centre irrespective of Intensive Care Unit bed availability (Grade 1).

Venous Thromboembolism (VTE) guidelines related to stroke patients should be followed to avoid life threatening thromboembolic events (Grade 2).

Action

- Guidelines and reversal agents for patients presenting with bleed on anticoagulation are now easily accessible to ED staff;
- Policy for transfer to Wessex Neurological Centre for thrombectomy is now agreed with critical care staff to avoid delay in transfer;
- VTE guidelines and surveillance discussed and agreed at Wessex Stroke Clinical Forum.

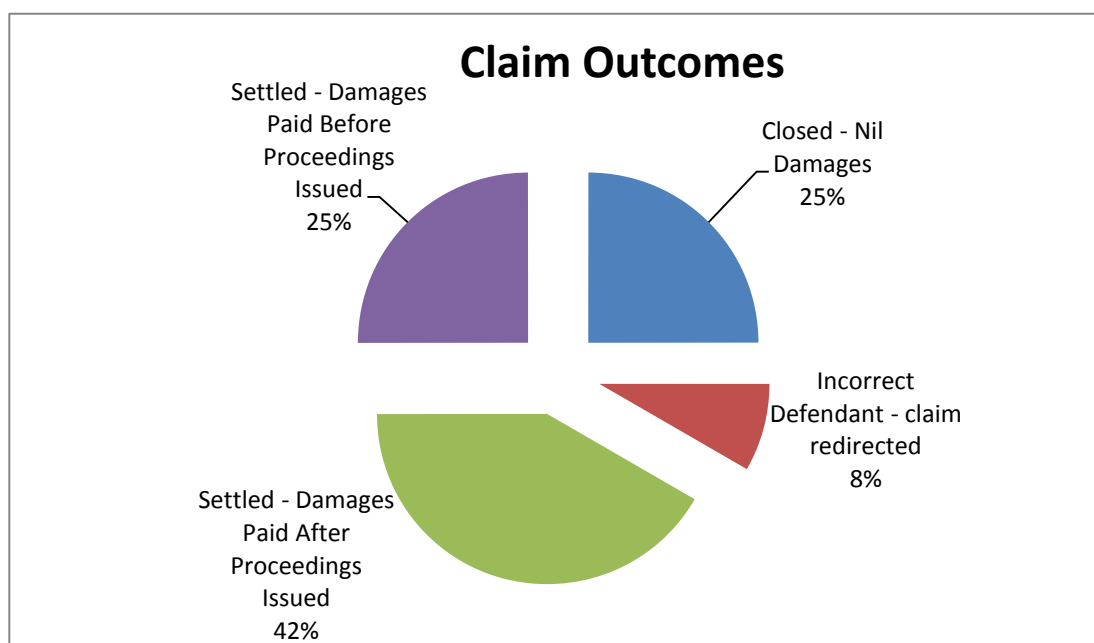
Update on Clinical Claims

Over the last quarter the Trust has received 19 requests for disclosure of records indicating that a claim is being considered. In this time four new claims have been opened and 5 have been closed. In total there are 73 active claims at this present time. It should be noted that some of these date back several years due to the length of time it takes for the process to complete.

General Themes Emerging:

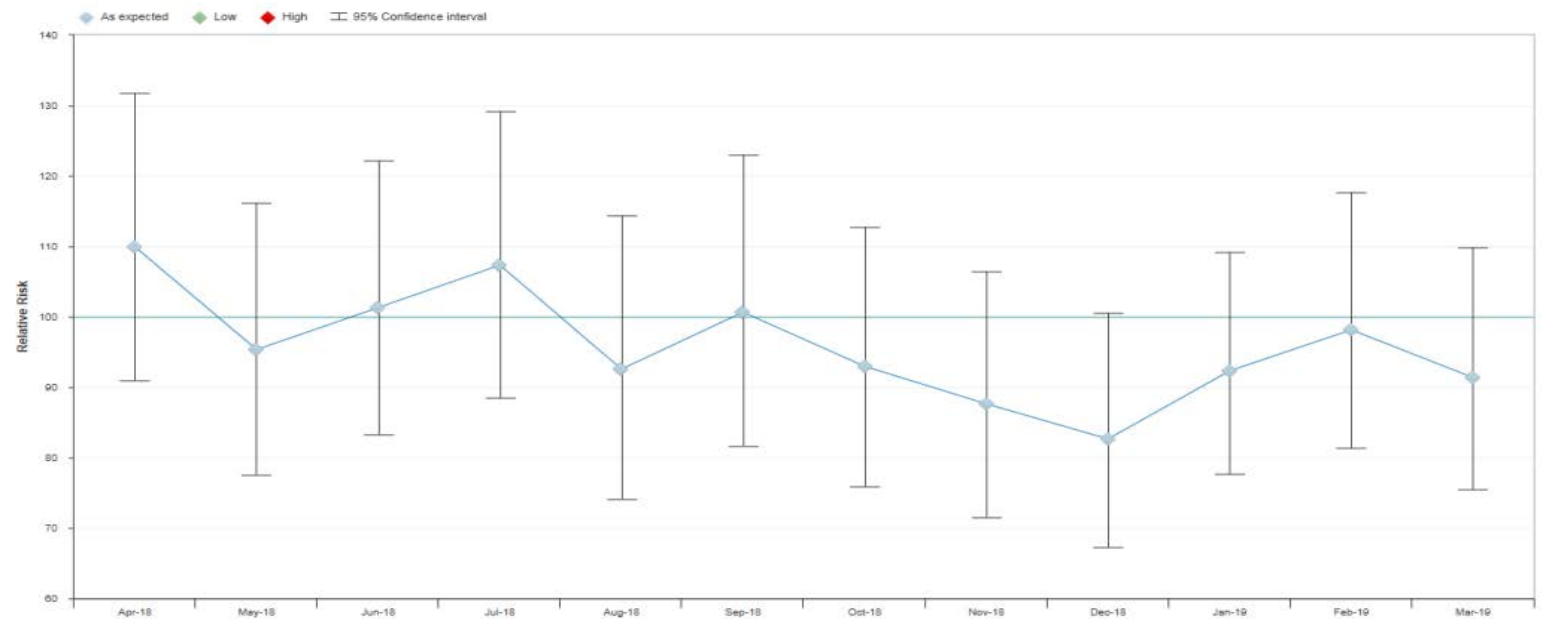
- The number of claims in Orthopaedics, which has historically been the highest area for claims, continues to fall. It is thought that this is a reflection of improved consent and shared decision making processes;
- The Emergency Department is now the area attracting the largest number of claims for the first time;
- Orthopaedics and ED constitute 40% of all claims in the Trust;
- Failure of delay in diagnosis is the highest category of claim making up 25% of the total;
- Where the claim relates to perceived harm this relates to unanticipated pain and additional or unnecessary procedures or operations;
- Failure to warn/consent makes up about 10% of claims which is relatively static.

Themes from closed claims:



Themes from recently closed claims are consistent with the general themes above ie failure or delay in diagnosis, missed fracture, chronic pain associated with plastering and a medication error.

Annexe A





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

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Infection Prevention and Control Annual Report and Statement of Commitment
Section on agenda:	Quality and Performance
Supplementary reading:	Infection Prevention and Control Committee Annual Report (attached)
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Paul Bolton, IPC Lead Nurse
Details of previous discussion and/or dissemination:	Infection Prevention and Control Committee held on 24 June 2019
Action required:	Decision
<p>Summary:</p> <p>The Board of Directors is required to sign and publish an annual statement which reaffirms its commitment to infection prevention and control. The statement details the processes which are in place to meet the duties under The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2011). This has been updated to include reference to the CQC essential standards and the Trust's Quality Strategy.</p> <p>The attached report outlines the Trust's work and progress with the prevention, control and management of infection in 2018-19. This work programme is overseen by the Infection Prevention and Control Committee (IPCC), which reports to the Healthcare Assurance Committee.</p> <p>Once approved, the IPCC annual report and the statement will be published on the Trust's website to reaffirm to the public the Board's commitment to Infection Prevention and Control.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
	<input type="checkbox"/>

Are they well-led?	
Impact on high risks:	

Board of Directors' Statement of Commitment to the principles of the Code of Practice for the Prevention and Control of Health Care Associated Infections: July 2019.

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

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

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

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

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

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

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

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



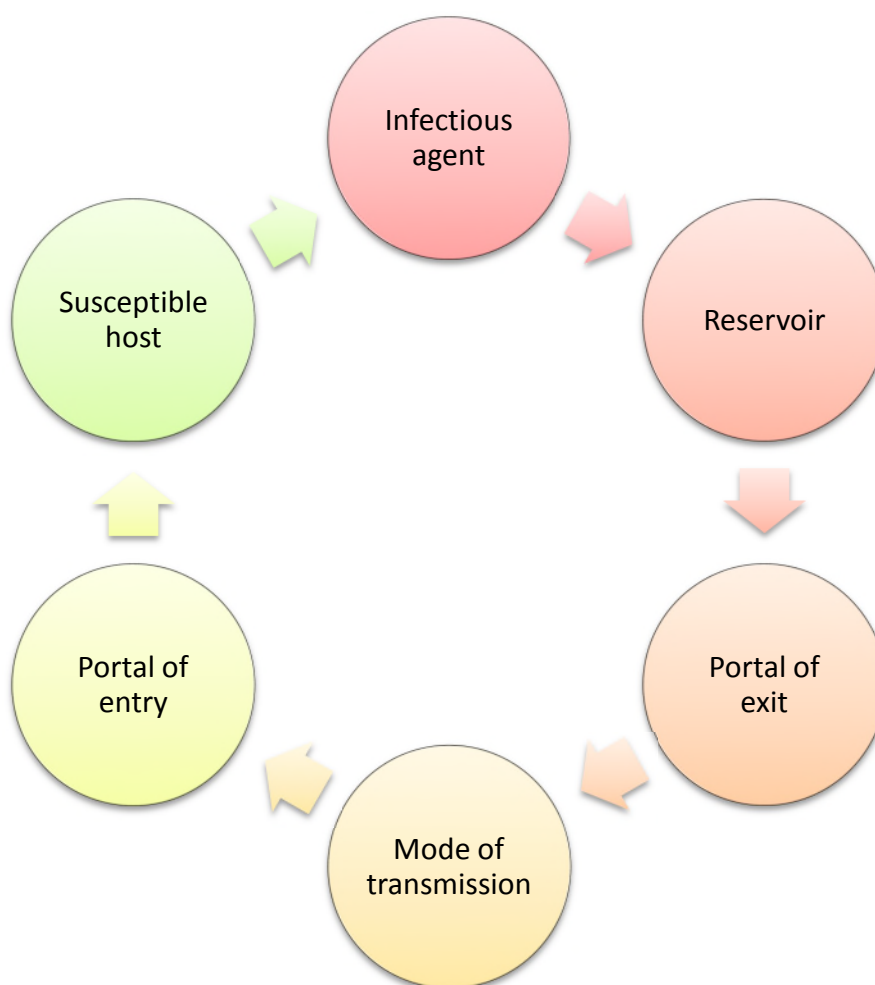
**The Royal Bournemouth
and Christchurch Hospitals**
NHS Foundation Trust

Infection Prevention Control Committee

Annual Report

April 2018 to March 2019

Working together to break the chain of infection



1. Executive Summary

Effective Infection Prevention and Control (IPC) is a priority at The Royal Bournemouth and Christchurch Hospitals and the Trust continues to ensure it has the processes, systems and expertise to support patients, staff and the public.

This year has seen a continued increase in gram negative bacteraemia cases in line with findings in other Trusts and national data. Next year we are planning a review by NHS Improvement IPC leads as well as a focus upon making improvements to basic patient care such as hydration, catheter hygiene and mouth care.

This year's influenza season saw similar case numbers to previous years. Influenza A was the predominant circulating strain which was included in this season's vaccine.

Cases of *Clostridium difficile* were reduced by 50% this year. This reduction reflects excellent work by staff across the hospital. Specific actions which have brought about this improvement include: the Infection Prevention and Control (IPC) team continually raising awareness of this condition, ward staff for the prompt isolation and identification of patients at risk and antibiotic leads within the Trust ensuring the very low percentage of use of high risk antibiotics.

This year has continued to present a challenge with water management in new and old parts of the Trust. Action plans from the Water Safety Group have been effective in protecting staff and patients but further work is needed to address the sources.

Projects to look out for in 2019/ 20 include improved cleaning of medical devices, glove awareness and safer more cost effective management of waste.

2. Purpose of the report

To provide assurance to the Board of Directors, our patients, staff and the public on compliance with the Health and Social Care Act 2010: Code of Practice for the NHS on Prevention and Control of Healthcare Associated Infections and related recommendations (the hygiene code) including NICE guidance.

Good Infection Prevention and Control practices (IPC) are essential to ensure that people who use the Trust services receive safe and effective care. Our aim is to ensure that IPC is embedded in all parts of everyday practice and is applied consistently by everyone.

The publication of this report is a requirement to demonstrate good governance and public accountability. It should provide assurance about our systems and processes in relation to IPC.

There are 10 criteria set out by the Health and Social Care Act which are used to judge how we comply with its requirements for cleanliness and infection control. This is reflected in the Care Quality Commission fundamental standards outcome 8 detailed in the annual work plan which is monitored by the Trust's Infection Prevention and Control Committee (IPCC).

This report summarises our progress against the 10 criteria, our business plan and any related National Institute for Health and Care Excellence (NICE) guidance.

Paul Bolton Lead Infection Control Nurse

Paula Shobbrook Director of Nursing and Midwifery/ Director of Infection Prevention and Control/Deputy Chief Executive

Layth Alsaffar Infection Control Doctor/ Consultant Medical Microbiologist

Criterion 1

Systems to manage and monitor the prevention and control of infection.

Governance Arrangements.

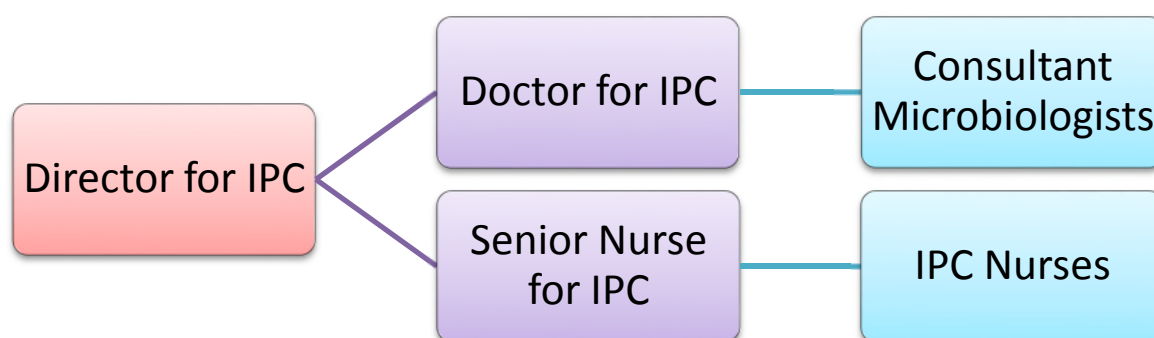
The Board of Directors has a collective responsibility for keeping the risk of infection to a minimum. The Board discharges this responsibility in the following ways:

The Director of Nursing and Midwifery/Deputy Chief Executive is the designated Director with responsibility for Infection Prevention and Control (DIPC).

The Board of Directors statement of commitment and IPCC Terms of Reference are on the infection control intranet and Trust internet sites.

Infection Prevention and Control Team (IPC)

Structure



The Director for Infection Prevention and Control at this Hospital is also the Director of Nursing and Midwifery/Deputy Chief Executive, Paula Shobbrook. The Trust has a Doctor for Infection Prevention and Control, Layth Alsaffar, supported by two microbiologists (CMM) as well as a Senior Infection Prevention and Control Nurse supported by three IPC Nurses. Two members of administrative staff support the whole IPC team and the Microbiology laboratory. The Trust enjoys strong external links with Local Authority Public Health teams, Public Health England South West, NHS Improvement, the local Trusts, Dorset CCG and West Hampshire CCG and meets regularly with them to discuss IPC targets, lapses in care and resultant learning.

Within the Trust the IPC Team rely heavily on the skills and knowledge of IPC resource staff. These staff members include nurses and varied allied health professionals ensuring that all areas are able to share and cascade learning to the staff in their area in a way that is tailored to their needs. They are responsible for carrying out various audits including the monthly Hand Hygiene and IPS 'Saving Lives' audit and supporting the Ward Sisters in delivering action plans based on their findings. The IPC team support the IPC resource staff to deliver messages around new guidance and current communicable disease epidemiology to their wards.

Out of hours IPC advice and guidance implementation on the wards and departments is delivered by the Clinical Site Team (CST) with the Senior Nurse for Infection Control providing remote advice over the telephone/ through email when required. There is always a CMM on call who will also provide advice based upon received samples and results. There is currently no official on call rota in place for IPC, as a trust we train our CST and the resource staff to help ensure that IPC guidance and support is available 24/7.

IPC roles.

The skill mix for the IPC team is: 2.0 WTE Band 6, 1.0 WTE Band 7 and 1.0 Band 8 plus a 1.0 WTE data administrator. One member of staff is the clinical bleep holder each day, this allows for project work and additional surge capacity when outbreaks are reported.

For a 6 month period in 2018 the Senior IPC Nurse took a secondment to Cardiology. This post was acted into by the current Band 7 and a fixed term 6 month band 6 post created to back fill. At the same time the admin member of the team left and we spent a considerable amount of time relying on bank staff to help deliver the teams functions. The team coped admirably with these changes and were well supported by other areas.

There is no guidance set down by the NHS or Government on what a team should consist of or how many should be in a team per NHS bed. Focus should instead be on quality of service, multimodal working with other disciplines and good links into all departments.

The Doctor for Infection Control and the Clinical Microbiologists covers a clinical rota so are available at all times to support the team. Ward rounds are carried out to review complex cases with the IPC team. The IPC Team work closely with the Trust antibiotic pharmacist in order to review patients on specific antibiotics and to carry out audits ensuring that the Trust antibiotic policy is followed.

IPC and Information Technology

In order to address current gaps in our ability to carry out epidemiological analysis of our patients we have been looking at IT solutions to help address requirements set out under NICE guidance.

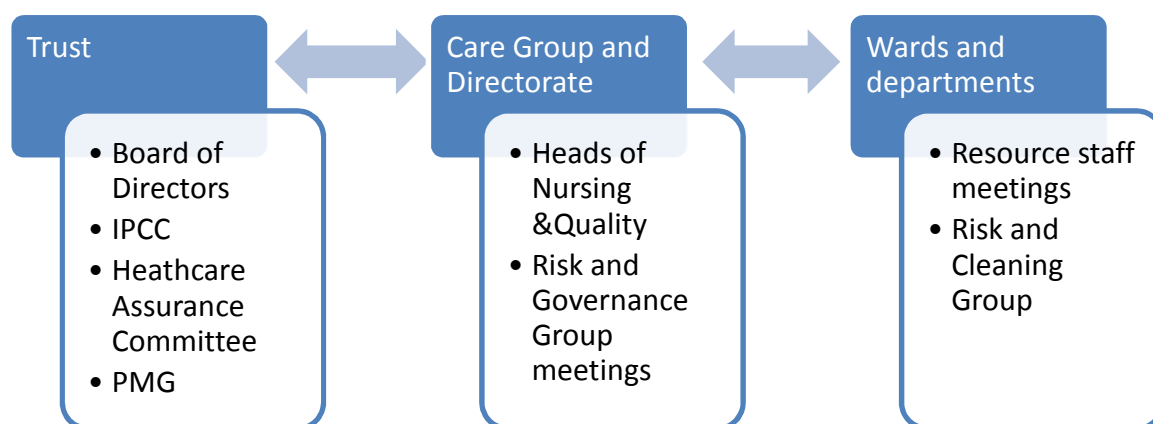
This year a joint IT and IPC led project reviewed the possibilities of purchasing a Dorset wide ICNet system. With the future One Dorset Pathology review, Clinical Services Review and the planned merger this will be of great benefit to patients and each Trust involved. Currently the plans to implement this system are still under review but it is likely that this system will be in place during 2019.

Currently we are unable to track and trace patients and their contacts as they move throughout the Trust receiving care in various departments. We have a good understanding of where a patient is and can use current systems in the Trust to ascertain locations at given points in time but a system does not currently exist that can link this to infectious diseases. Therefore we cannot always truly understand and minimise the risk of *C. difficile*, Methicillin Resistant *Staphylococcal Aureas* (MRSA) or other multi antibiotic resistant organism transmission in the trust.

To date we have developed a system that flags all the patients on eCamis and the Bed Management System with an IPC critical patient information flag. All ward electronic boards indicate if a patient on the ward has a CPI flag. We are currently using a spread sheet that automatically reports all new and current admissions to the Trust with this flag. We are using this to ensure that the isolation policy is followed and appropriate screens are carried out as and when necessary. Through the use of this tool we have been able to identify that approximately 50% of the Trusts side rooms are being used for IPC reasons, this is outside of any outbreak or rise in communicable disease numbers within the community.

Infection Prevention and Control Committee (IPCC)

The IPCC meets quarterly following a standard agenda. Each care group is represented and the IPCC is aiming to increase the representation from the medical professions. The following structure is in place to support information flow:



In addition to these structures of reporting and information sharing, weekly emails are sent out to all Senior Nurses and General Managers indicating current status against targets for alert organisms such as *MRSA* and *C. Difficile*. This information is also sent to the Performance Management Group (PMG) with key learning obtained from investigation into any associated IPC adverse incidents included to add context to the data.

Patient-led Assessments of the Care Environment - PLACE

This was carried out in October 2018. In total 29 environments and 6 food assessments were carried out across both sites. The Bournemouth site exceeded the national average in 5 out of the 8 domains, the Christchurch site exceeded them in 7.

PLACE DOMAINS	Scores 2017		Scores 2018		
	RBH	Christchurch	RBH	Christchurch	National Average
Cleaning	98.95	99.08	↓97.65	↑99.65	98.47

This year the Bournemouth site scored lower than last year and was below the national average. Findings from the inspection were addressed. The below bullet points detail these actions.

- Cleaning faults rectified after the assessments. A comprehensive, routine monitoring system is in place. Cleaning schedules all visible.
- Vending machine in ED – contractors asked to be more vigilant spot cleaning machines when they are topped up. Staff will report any cleaning issues to the catering department for resolution. External and internal ventilation grilles have been cleaned where identified.
- Sticky labels on gel dispensers have been renewed.
- Incorrect bags in waste bins have been rectified

There is a direct link between the cleanliness of a Hospital and maintaining low numbers of Healthcare Associated infections (HAI's). Whilst many other factors contribute to low HAI's, environmental cleaning and the ability of staff to effectively clean an area are key in our ability to provide clean and appealing area for patients to be looked after in.

Policies and Procedures

IPC policies are reviewed on a regular basis in line with the action plan and submitted to IPCC for review and sign off, if there are suggested changes to current clinical practice then these go to the Practice Development Group for review and implementation support.

Benchmarking

At the time of writing this report the data is not currently available for this financial year. Data based on the latest rolling reports have been used instead.

Clostridium difficile

Clostridium difficile rates are down this year and as a Trust we report just under the England national rate. We have reported 12 cases against a trajectory of 13, 6 of which were classified as late cases. Common themes from the lapses in care were delays in isolation and sampling. However, to have 50% less cases identified is an excellent improvement over last year. A project is underway to better understand the reasons for this to ensure we can replicate them.

Methicillin Sensitive *staphylococcus aureus*

The rates for this infection are in line with previous reporting months but we remain higher than the England national rate.

E. coli

The rates for this infection are higher than previous reporting months but we remain higher than the England national rate. Further comments are made upon this later in the report.

Klebsiella

The rates for this infection are in line with previous reporting months but we remain lower than the England national rate

Pseudomonas aeruginosa

The rates for this infection are in line with previous reporting months but we remain lower than the England national rate

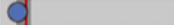


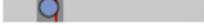

* a note is attached to the value, hover over to see more details

Quintiles: Low ● ● ● ● ● High ○ Not applicable

Recent trends: Could not be calculated Increasing / Getting worse Increasing / Getting better Decreasing / Getting worse Decreasing / Getting better No significant change Increasing Decreasing

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Export table as CSV file

			Worst/Lowest	25th Percentile	75th Percentile	Best/Highest		
Indicator	Period	The Royal Bournemouth and Christchurch Hospitals			England			
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	Best/ Highest
C. difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month	Jan 2019	⬇️	1	9.9	14.6	0.0		97.1
MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month	Jan 2019	➡️	3	10.9	9.4	0.0		24.6
E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month	Jan 2019	⬆️	32	175.0	123.1	0.0		220.7
Klebsiella spp. hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month	Jan 2019	➡️	0	7.8	9.0	0.0		34.7
P. aeruginosa hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month	Jan 2019	⬇️	2	3.1	4.5	0.0		46.8

CDI trajectories.

The trajectory objectives have been calculated by NHS Improvement on the basis of requiring continuous improvement from all trusts and CCGs, but also reflect a need for organisations with higher rates of infections to do more than those organisations with lower rates.

How does this impact upon the patient?

Cases of inpatient CDI at this hospital are routinely investigated by the IPC team. Cases occurring within 3 days of admission to the Trust are categorised as community acquired, those occurring after this time period are subjected to further follow up. Twelve cases occurring after 3 days of admission to the Trust were found to have been caused by inappropriate medication or 'lapses in care'.

However a number of cases followed up did identify 'lapses in care' that could contribute to further cases; delays in isolation for example. The cases identified as occurring after 3 days of admission associated with a lapse in care, are presented to the Clinical Commissioning Group and form part of the Trust trajectory cases.

Weekly meetings are held with the Director of Nursing or her deputy to review late cases. A tool for reviewing these has been created using the serious incident process as a framework. Learning from cases is discussed at these meetings as well as action place to prevent further cases occurring.

It is reassuring that thorough analysis and ribotyping of our cases this year has not been able to identify any patient to patient transmission of CDI. It is estimated that 3% of the population are colonised with CDI, these patients are at greater risk of developing a severe infection with CDI, particularly if given antibiotics. Within the

Trust and community antibiotic use is audited on a continuing basis. Current findings indicate that 92.6% of inpatients on antibiotics are either compliant with national guidelines or have been approved by a microbiologist, in 4% of cases there was no guidance to follow.

Going forwards a new form has been agreed across the Dorset Healthcare system to assist us in capturing more information when following up late cases of *C. difficile*.

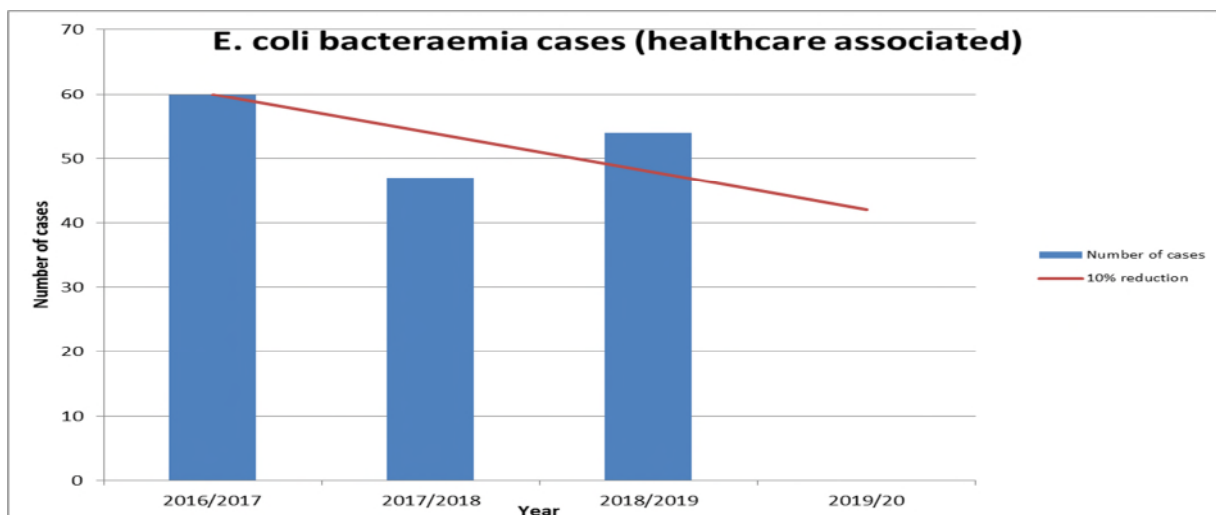
Gram negative bacteraemia

The Secretary of State for health has launched a national ambition to reduce gram – negative blood stream infection by 50% by 2021. Gram negative bacteraemia's are steadily increasing numbers despite the work carried out by IPC. These bacteria are particularly good at surviving in wet environments and picking up antibiotic resistance, it is therefore key that we try to reduce these as much as possible.

Currently the Trust is working within the Dorset IPC Integrated Care System to implement a Dorset wide action plan. As 80% of these cases are identified from patients in the community it is key we work closely together to reduce their incidence. As a Trust we have carried out in depth reviews of cases but not found common contributing factors, however in line with local and national findings frailty, dehydration and recent treatment in the community for a urinary tract infections were found.

Currently RBCH figures demonstrate an increasing number; however this may well be due to the fact that we are a high performer across the UK for taking blood cultures when looking for patients with sepsis. The high percentage of gram negative blood stream infections is due to *E. coli*; these are the focus for reduction strategies. Other gram negative bacteria are identified in the Trust but in much smaller numbers.

Projects for the year 2019/2020 are aimed at improving care for patients, reduction in urinary catheter use and reducing length of insertion time as well as focussing more on prevention by looking at hydration and mouth care.



***Klebsiella* outbreak.**

During this year Poole Hospital reported an outbreak of *Klebsiella pneumoniae* (KP), a gram negative bacteria. All patients admitted to this Trust who had been an inpatient at Poole in the previous 3 months were isolated on admission and screening samples obtained to ensure avoidance of carriage.

Overall 782 patients were screened for this organism and 31 patients were identified as being positive (4%). The teams based on both sites worked closely to ensure results for patients traveling between the sites were rapidly communicated. The Clinical Site Team at RBCH was extremely supportive of this action. The largest impact was seen in Cardiology who transfer patients in between the Trusts. A specific side room was set aside in one of the wards to ensure that patients waiting at Poole did not experience a delay in their procedure due to a side room not being available.

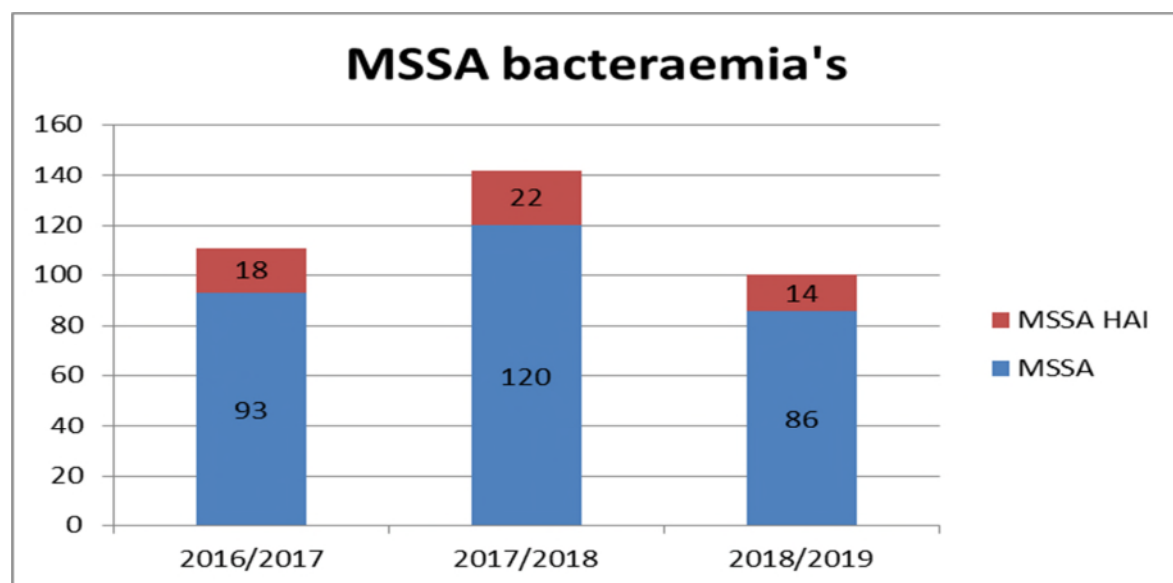
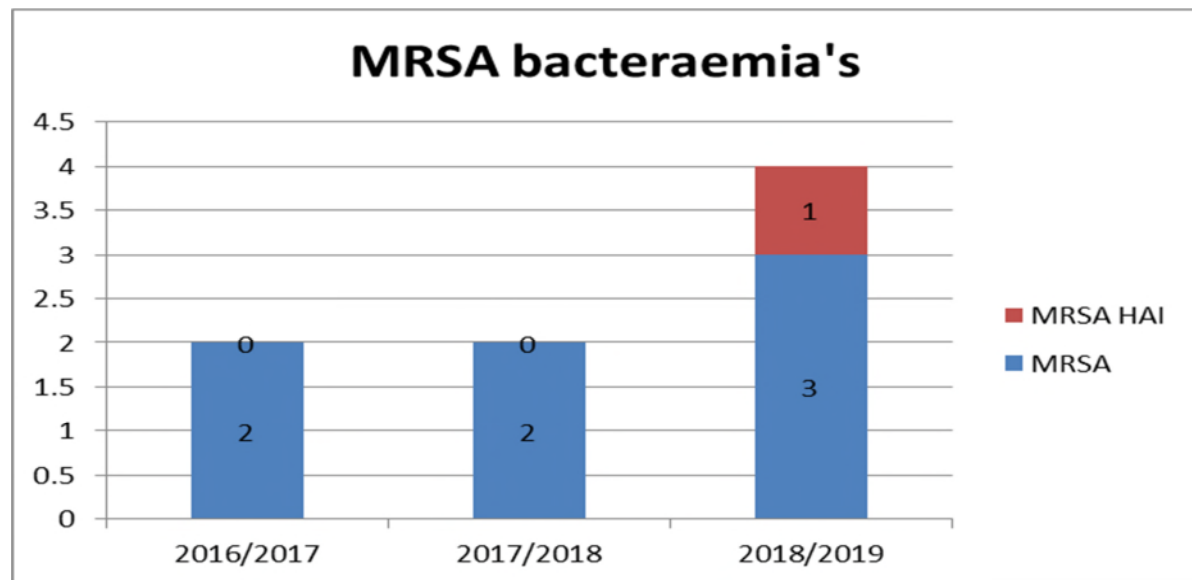
At the time of writing the report is not available but when it is ready it will be used to ensure we can learn from the outcomes.

Methicillin sensitive *Staphylococcus aureus*.

The total number of health care associated blood stream infections caused by methicillin sensitive *Staphylococcus aureus* dropped this year. Each bacteraemia case was followed up by the IPC team using a root cause analysis approach. Common findings from each case identified an association with peripheral venous cannula. Care of these devices is on the risk register and an electronic monitoring and assessment tool is under development and expected to be delivered early in 2019/ 20.

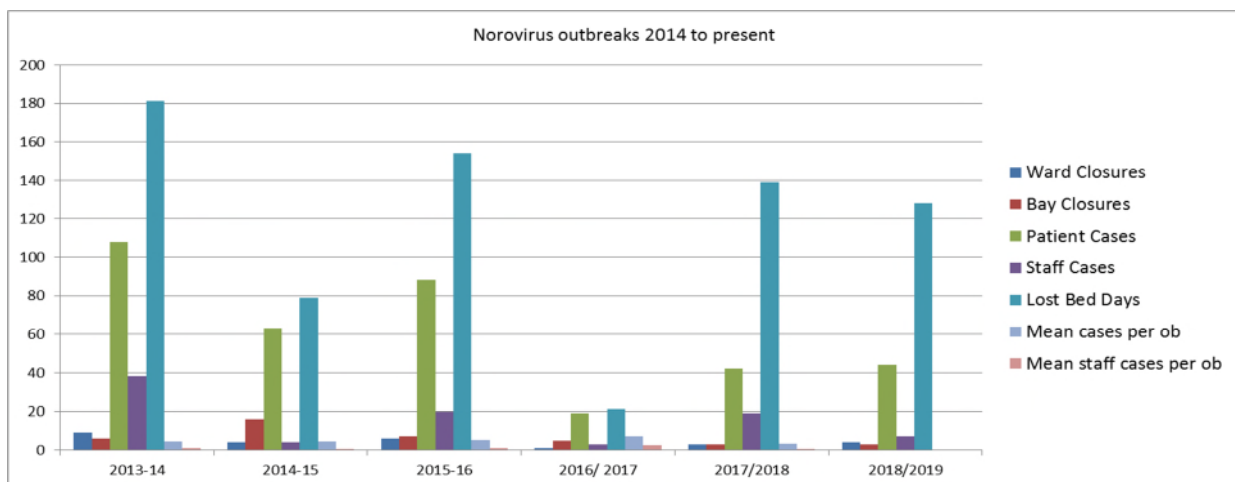
A case of healthcare associated MRSA bacteraemia was identified who had received care on Wards 1 and 3 this year. A number of learning and action points were identified as a result of an RCA and a plan of action put in place which was supported and overseen by the Matron and Head of Nursing and Quality. As part of this,

ongoing education and awareness sessions for infection prevention and control are being delivered on the ward by the IPC team. The following tables show the total number of cases identified and the number of healthcare associated infections (HAI: allocated to RBCH)



Norovirus

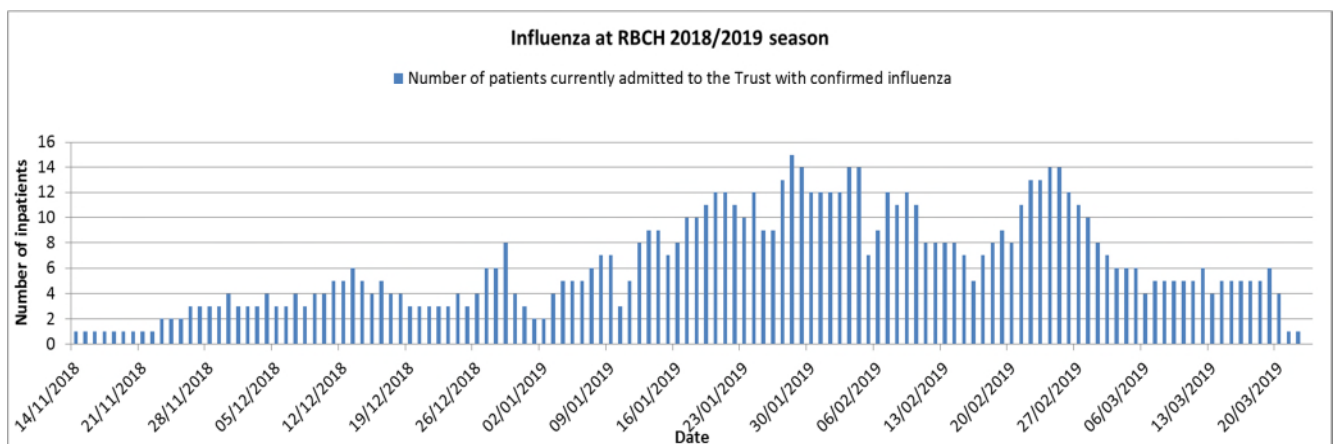
The number of ward closures and patient cases have remained low over the past 6 years. This matches with the numbers of cases reported at a local and national level. There are many reasons for the reducing impact upon the Trust, however the actions carried out by staff in promptly isolating and sampling patients who present with signs of viral gastroenteritis must be praised.



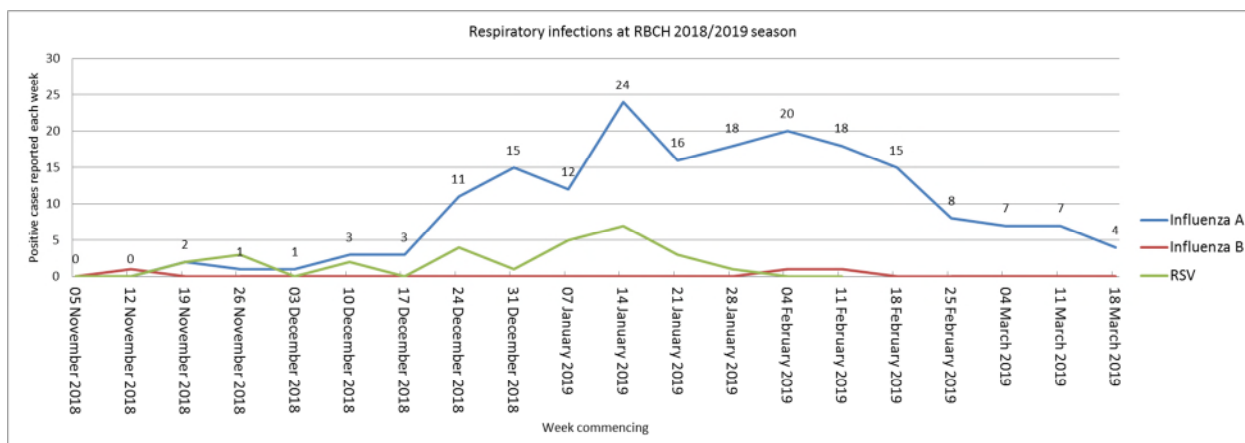
Influenza

The influenza season for 2018 – 19 started in earnest in November 2018 for this Trust with cases being reported in larger numbers. Testing protocols remained the same with a request to a Consultant Medical Microbiologist being the only way to obtain an influenza test. Influenza testing was carried out by staff from the pathology department during normal working hours. With several potential outbreaks to support both within and external to the Trust, the team from the laboratory went above and beyond on several occasions to support the infection control team.

Patient admissions for influenza peaked during January/ February.



This matched the peak in cases being identified within the Trust.



In total 219 patients were identified as being +ve for influenza, out of 492 clinically suspected samples that were submitted. 9 patients were identified as having influenza on or after their 5th day of admission, with an incubation period of up to 4 day this would class those cases as health care associated. It is not possible, given the amount of influenza circulating at this time in the community to tell if these cases were acquired as a result of exposure from other patients.

12 patients were admitted from care homes into the Trust, each of these were reported to Public Health England to follow up the contacts.

A Trust wide communications campaign on influenza was jointly led by occupational health and infection control. The “Rumour has it” videos, posters and educational material were all well received. However, gaining support from frontline facing staff required a great deal of effort and as a Trust we did not meet the targets for percentage of staff immunised we wanted to achieve.

There were a number of factors that led to this. These have been reviewed within the influenza wash up group; the outcomes from this group will be fed into future IPCC meetings.

Invasive Group A *Streptococcus* (iGAS).

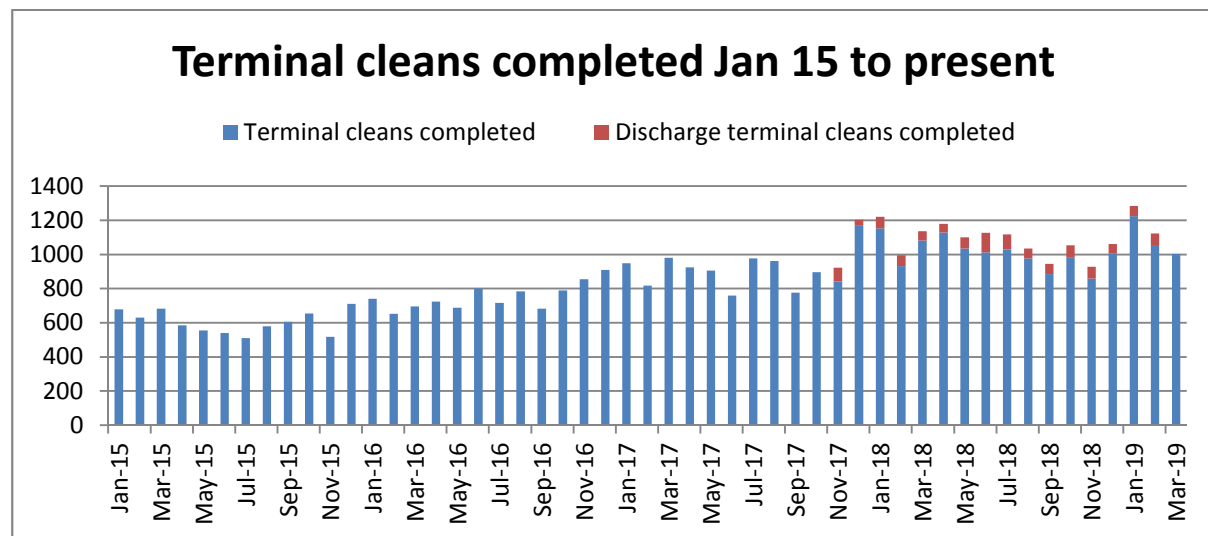
This year iGAS infections within the Trust were reported in line with seasonal trends. The majority of these came from wound swabs and blood cultures. No transmission at ward level was identified.

Terminal cleans

The IPC team work closely with staff from housekeeping and rely heavily on their skills and support to deliver our role. With the number of resistant organisms continuing to rise, as well as patients being admitted with communicable diseases, the pressure on the team to ensure terminal cleans take place is high.

With better identification of patients with loose stools and those admitted or transferred within the organisation carrying a resistant organism, the IPC team have

been able to ensure appropriate terminal cleans take place. The impact of this has meant however that the number of terminal cleans carried out by the housekeeping teams in January 2019 was double that of January 2015.



Antibiotic usage

Antibiotic stewardship remains very well managed at RBCH. Data submitted to the PHE Fingertips website continues to show that we remain in the best performing quartile for total antibiotic and for Carbapenem and Tazocin usage in English hospitals measured in defined daily doses for 1000 admissions. We also easily succeeded in meeting the WHO AWARE antibiotic category CQUIN this year.

Within the Trust we now audit between 100 and 125 patients per month on antibiotics, across a whole range of clinical specialties to assess appropriate use. Performance is very good utilising a series of standard questions. This information will soon be available to all staff as part of the Trust's Quality Dashboard. This information can also be used to highlight if any areas performance dips over time so that we can monitor this and take action if needed.

Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Decontamination of medical devices

The Trust policy is to ensure that all devices are cleaned, decontaminated and labelled as such after each patient use. Audits are carried out on a monthly basis to ensure this takes place and each ward has a list of all the medical devices in their area. This list is used to drive the weekly cleaning for nursing staff ensuring that low use equipment is clean and ready for use.

This evidence can reassure patients that all equipment used is clean and free from potentially harmful pathogens.

Supply and provision of linen and laundry

Clean comfortable linen plays an integral part in patient care. The current supplier has a state of the art system to ensure clean, good quality linen. Throughout this year regular meetings have held with stakeholders and linen suppliers, minimal issues have been reported with the supply, cleaning and removal of linen to the Trust.

Following environmental audits the IPC team identified that another provider was being used for small use items, within the Trusts private patient care sector. This has been audited and the findings indicate that this is not in line with current guidance and will therefore the recipients were advised to seek a different supplier of clean linen.

Policies on the environment

The Trust has a number of policies in place in relation to cleaning services, building and refurbishment, waste management, infected linen, planned preventative maintenance, pest control, drinkable and non-drinkable water and legionella.

IPC staff regularly attend Estates meetings in particular those related to water services, planning of new buildings and modification of current structures.

The Trust is constantly looking at ways to reduce its impact upon the environment whilst continuing to provide excellent healthcare. This year the IPC team have worked closely with the Estates team looking at new builds and redevelopment of current structures to meet the demands of the clinical service review.

At the time of writing many of the 1:50 plans have been reviewed and approved.

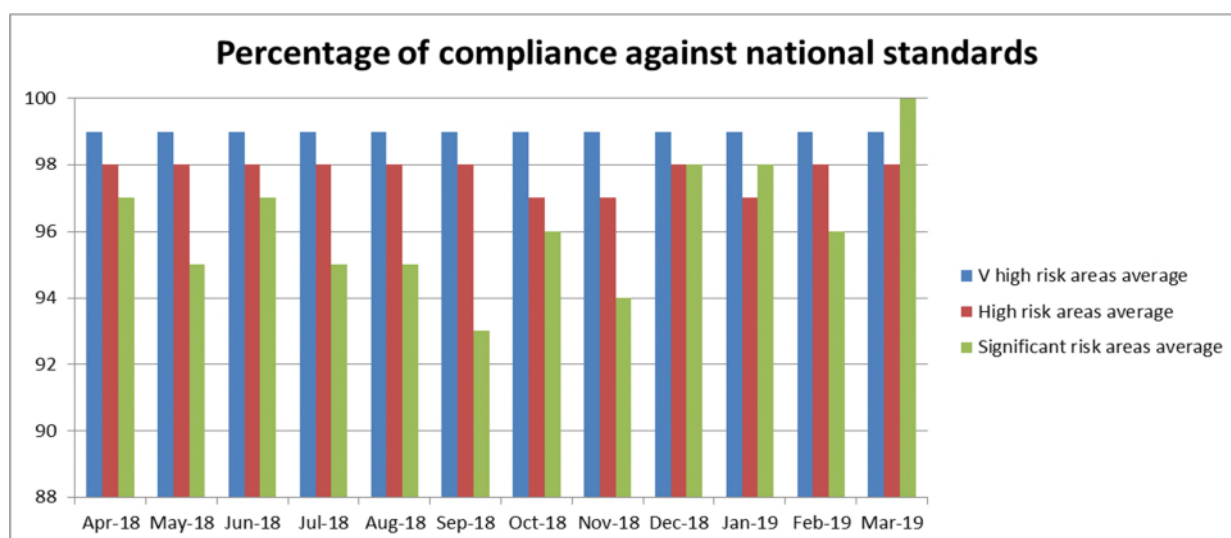
Water Group report

There are ongoing Legionella issues with the cold water system in the Jigsaw building and Dermatology, with levels ranging from high to low from diverse outlets. There has been no documented transmission of the organism to either patients or staff. Legionella has been present in the cold water system since the building was handed over and it is likely that a poor system design led to the cold water system initially being seeded with the organism and we have been unable to eradicate despite numerous interventions.

The main contributing factor to the ongoing problems is the fact that the building is not used over the weekends which allows the temperature of the cold water distribution system to rise above 20°C. The interventions which we have tried to eradicate the organism from the cold water system have included: by passing the storage tanks, removal of little used outlets, and continuous chemical sanitisation of the system, installation of point of use filters and automated flushing. We are continuing to take regular samples and respond to the positive results when they occur and we are working closely with Estates to find a permanent solution to this issue.

Cleaning service

Housekeeping audits are carried out on a routine and regular basis across the Trust. Internal audit results on average have been above 97% across the Trust.



External audits are in line with these findings. Action plans are created by the Housekeeping team and reviewed at monthly intervals with the IPC team.

Cleanliness of wards and departments is key to preventing occurrence of HCAI's. Audit results demonstrate the high standards we are striving to achieve at RBCH. IPC staff have excellent links with the Housekeeping team and work closely to reduce the various challenges presented to the teams.

Audit scores

Regular fortnightly walkabout audits are carried out in all wards and departments within the Trust as well as services commissioned by the Trust. These are led by IPC staff in conjunction with representation from senior nursing staff, the board of governors, housekeeping and estates. In addition to these Matrons and ward leaders have been given an IPC environmental checklist to review their areas.

Governor involvement in these walkabout reviews brings the patient perspective to our inspections and adds a level of insight the team benefit from.

The overall score for the walkabout audit for this calendar year is 88%. Key issues that have arisen during these audits are storage and cleaning of equipment, low level dust and care of intravenous cannula. These issues have been discussed at key meetings to raise awareness. Actions plans have been created and are in place at ward level to address these.

Care Quality Commission (CQC)

The latest CQC inspection reported that the Trust “controlled infection risk well. That staff kept themselves, equipment and the premises clean. Control measures were in place to prevent the spread of infection.” However some areas were identified where patients were not always offered hand washing before meals and cleaning standards were not always consistent. These actions are being addressed and monitored by the matrons and housekeeping teams.

Criterion 3

Provide suitable accurate information on infections to service users and their visitors.

The Trust makes information available on the RBCH internet site relating to MRSA screening, *C. Difficile* and other infectious diseases as well as outbreaks as they arise. IPC audit results and other markers of good infection control are displayed on every ward and form part of the Ward quality matrix.

The IPC team work closely with the communications team to ensure consistent and far reaching communications. We are aware that many of our patients may not have access to IT and many prefer fact to face communications. So we spend a great deal of our time offering direct advice to patients and their relatives on various factors related to their diagnosis. A quality improvement project is currently reviewing patient information in relation to isolation and multi drug resistant organisms.

All ward closure information is displayed on the Trust's website, the intranet and on display boards at the entrances to the main hospital and the Emergency Department. Social media updates on these issues are led by the communication team. Key reports and documents are also held on the Trust internet webpage for all patients to see.

The use of social media has been actively taken up this year with poster, videos and key messages shared by the communications team on behalf of the IPC Team.

Criterion 4

Provide suitable accurate information on infections to any person concerned with providing further information support nursing/ medical care in a timely information.

The IPC team are available 07:00 to 17:00 Monday to Friday. Reports of infectious pathogens are reported to the IPC team if they are presumptive or as soon as they are confirmed by the microbiology laboratory. The team visit each ward in person to ensure that staff and the patient are aware of the result and its implications. Written information is given to the patient and follow up visits arranged as necessary. Clear instructions are left within the patients notes on any requirements to isolate, wear protective equipment and whether or not treatment and further sampling is required.

Out of Hours (OOH) arrangements

OOH Infection Control advice is addressed firstly by the Clinical Site team. Any issues related to infection control that are urgent and cannot be addressed by the team or the on call microbiologist are passed on to the Lead Infection control nurse. This is supported over the weekend by the on call Matron and Manager.

Issues related to microbiology results, sampling and interpretation of results are addressed by the on call microbiologist.

Criterion 5

Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

Cases of infectious disease are reported to the IPC team on a daily basis either as they are identified by the microbiology laboratory or by clinical suspicion on admission/ transfer. Advice related to IPC is given over the telephone to patients on actions to take following results and information leaflets with letters are sent out. We also ensure regular communications with GP's, other hospitals and colleagues in the community to ensure that all those involved in the healthcare of the patient are made aware of any new or existing diagnoses.

The IPC team have worked closely with the informatics department to create a live spread sheet that identifies all patients admitted with a potentially contagious infection/ colonisation. This tool reports on all admitted patients and alerts the IPC team if the patient is moved from one ward to the next. This has enabled the IPC team to ensure isolation, prompt and regular screening takes place and that the patient and their medical team are aware of the diagnosis.

The information that this tool creates has meant that patients with resistant organisms or highly transmissible infections are being identified more promptly than was previously possible. The impact of this has meant that terminal cleans, required following a discharge or transfer of a patient with a resistant organism or potentially infectious pathogen have increased by over 30%.

IPC staff visit wards to discuss results and give practical or technical advice to the multidisciplinary team. Audits are carried out to ensure that the appropriate steps have been taken following diagnosis of an infectious disease. The Consultant Microbiologists carry out regular ward rounds visiting patients and providing advice on managing clinical symptoms and medical treatment. Joint visits by the IPC team and the Consultant staff often take place in particular when dealing managing complex cases.

Alert organisms, such as MRSA and *C. Difficile*, are reported on a monthly basis via email to all departments. Each case identified as being healthcare associated is investigated by the team looking after the patient in conjunction with the infection control team following the Post Infection Review process. Findings from these investigations are reviewed on a monthly basis with the team looking after the patient, the infection control team and the Director of Nursing or deputy.

Currently we are partially non-compliant with NICE Infection Control Guidance as there are no electronic epidemiological tools within the Trust. This means we are unable to assure the Board that all cases of infectious disease are monitored at a

Trust wide level in a robust manner and that there is no ward to ward transmission of resistant strains of bacteria. This is mitigated by good communication within the infection control team, microbiology staff and lab staff to ensure that we keep an overall awareness of trends in results and observational findings. Excel files and access databases are used for all patient results but these depend upon human interaction to identify and report trends. These are old systems and the Trust will very much welcome the introduction of ICNet when this occurs.

Outbreaks and occurrence of unusual infections are reported to Public Health England (PHE) and local healthcare providers/ commissioners on a routine basis. Current epidemiology is discussed on a monthly basis with Infection Control leads from Acute and Community providers alongside representative from the CCG and PHE.

Surgical site infection surveillance (SSIS)

A surgical site is the incision or cut in the skin made by a surgeon to carry out a surgical procedure and the tissue handled or manipulated during the procedure. A surgical site infection occurs when micro-organisms get into the part of the body that has been operated on and multiply in the tissues.

RBCH complies with continues mandatory SSIS audit for hip replacements and knee replacement. In addition to this we complete voluntary surveillance on vascular surgery, limb amputation, gastric surgery, large bowel surgery and small bowel surgery. Data for each 3 month audit period is gathered on a day to day basis and analysed by Public Health England. Reports are generally returned to the Trust 3 months after the final submission, the audit results within this report will be from July to September 2018 to allow timely completion of the report.

Orthopaedic SSIS (Hips)

Table 1: No. of operations and completed post-discharge questionnaires with rates of SSI by selected period (Jul-Sep 2018) and the last 4 periods for which data are available (Jul-Sep 2018, Apr-Jun 2018, Jan-Mar 2018, Oct-Dec 2017) at your hospital.

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	190	773
	No. with PQ given	187	764
	% PQ completed	88.8%	84.3%
Surgical Site Infection	No. inpatient/readmission	1	3
	% infected	0.5%	0.4%
	No. post-discharge confirmed	0	0
	% infected	0.0%	0.0%
	No. patient reported	2	9
	% infected	1.1%	1.2%
	All SSI	3	12
	% infected	1.6%	1.6%

Orthopaedic SSIS (Knee's)

Table 1: No. of operations and completed post-discharge questionnaires with rates of SSI by selected period (Jul-Sep 2018) and the last 4 periods for which data are available (Jul-Sep 2018, Apr-Jun 2018, Jan-Mar 2018, Oct-Dec 2017) at your hospital.

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	216	862
	No. with PQ given	213	843
	% PQ completed	86.4%	80.9%
Surgical Site Infection	No. inpatient/readmission	0	3
	% infected	0.0%	0.3%
	No. post-discharge confirmed	0	0
	% infected	0.0%	0.0%
	No. patient reported	7	32
	% infected	3.2%	3.7%
	All SSI	7	35
	% infected	3.2%	4.1%

The last 4 periods of Knee replacement SSIS indicate that 1.6% of patients reported an infection or had an infection identified. This compares us as slightly above the national 5 year percentage of 1.0%. Follow up of individual cases has occurred with no concerns raised related to individual cases. The orthopaedic team have worked extremely hard to complete post discharge questionnaires (PDQ's) and have a percentage PDQ completion of 85% compared to the national 5 year percentage of 76.5%.

The last 4 periods of Hip replacement SSIS indicates that 4.1% of patients reported an infection or had one confirmed during their admission. RBCH has identified a higher percentage of post-operative infections for hip operations during this period than the national 5 year average of 1.3%. Follow up investigations by the IPC and orthopaedic team have not identified any trends for this. Confirmed infections were 0 for the past 12 months.

The Trust has completed post discharge questionnaires 86.4% of patients who had a knee replacement, this is 11% higher than the national all hospital figure.

For the year 2019/ 20 the Getting It Right First Time (GIRFT) will include a focus on Orthopaedic operations.

General surgery SSIS (Small bowel)

Table 1: No. of operations and completed post-discharge questionnaires with rates of SSI by selected period (Jul-Sep 2018) and the last 4 periods for which data are available (Jul-Sep 2018, Jul-Sep 2017, Jul-Sep 2016, Oct-Dec 2015) at your hospital.

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	12	65
	No. with PQ given	0	1
	% PQ completed	0.0%	100.0%
Surgical Site Infection	No. inpatient/readmission	0	3
	% infected	0.0%	4.6%
	No. post-discharge confirmed	0	0
	% infected	0.0%	0.0%
	No. patient reported	0	0
	% infected	0.0%	0.0%
	All SSI	0	3
	% infected	0.0%	4.6%

General surgery SSIS (Large bowel)

Table 1: No. of operations and completed post-discharge questionnaires with rates of SSI by selected period (Jul-Sep 2018) and the last 4 periods for which data are available (Jul-Sep 2018, Jul-Sep 2017, Jul-Sep 2016, Oct-Dec 2015) at your hospital.

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	54	218
	No. with PQ given	1	2
	% PQ completed	0.0%	50.0%
Surgical Site Infection	No. inpatient/readmission	1	11
	% infected	1.9%	5.0%
	No. post-discharge confirmed	0	2
	% infected	0.0%	0.9%
	No. patient reported	0	0
	% infected	0.0%	0.0%
	All SSI	1	13
	% infected	1.9%	6.0%

General surgery SSIS (Gastro)

Table 1: No. of operations and completed post-discharge questionnaires with rates of SSI by selected period (Jul-Sep 2018) and the last 4 periods for which data are available (Jul-Sep 2018, Jul-Sep 2017, Jul-Sep 2016, Oct-Dec 2015) at your hospital.

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	15	107
	No. with PQ given	0	0
	% PQ completed	0.0%	0.0%
Surgical Site Infection	No. inpatient/readmission	0	1
	% infected	0.0%	0.9%
	No. post-discharge confirmed	0	0
	% infected	0.0%	0.0%
	No. patient reported	0	0
	% infected	0.0%	0.0%
	All SSI	0	1
	% infected	0.0%	0.9%

SSIS for small bowel surgery identified 4.6% patients with post-operative wound infections. This is in line with national 5 year reporting percentage of 8.0%. Follow up of individual cases has not highlighted any trends for concern.

SSIS for large bowel surgery for the period July to September identified 6.0% patients with post-operative infections. This is lower than the national percentage of 11.3%

SSIS for gastric surgery was completed during July to September, the percentage of identified infection for this period was 0.9% compared to the 5 year average of 3.3%

Vascular SSIS

Vascular surgery

April - June 2018

Table 1: No. of operations and completed post-discharge questionnaires with rates of SSI by selected period (Apr-Jun 2018) and the last 4 periods for which data are available (Apr-Jun 2018, Apr-Jun 2017, Oct-Dec 2016, Apr-Jun 2015) at your hospital.

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	58	268
	No. with PQ given	0	2
	% PQ completed	0.0%	100.0%
Surgical Site Infection	No. inpatient/readmission	0	5
	% infected	0.0%	1.9%
	No. post-discharge confirmed	0	0
	% infected	0.0%	0.0%
	No. patient reported	0	0
	% infected	0.0%	0.0%
	All SSI	0	5
	% infected	0.0%	1.9%

SSIS for limb amputation identified 0.0% patients with post-operative wound infections. Nationally the figure for this is 4.0% which would put us in the outlier bracket for low reporting. However the previous four periods have identified 1.9% patients with post-operative wound infections,

Hand hygiene and saving lives

	April	May	June	July	August	September	October	November	December	January	February	March
All elements	97%	97%	97%	96%	96%	97%	97%	96%	97%	97%	96%	97%
Hand hygiene	98%	99%	98%	99%	94%	97%	98%	98%	97%	98%	97%	97%
PVC insertion	97%	97%	99%	99%	98%	96%	98%	97%	99%	98%	98%	97%
PVC ongoing	89%	92%	91%	89%	88%	90%	87%	93%	91%	91%	86%	91%
Urinary catheter insertion	99%	99%	100%	100%	100%	100%	97%	100%	100%	100%	95%	100%
Urinary catheter ongoing	97%	92%	91%	92%	86%	96%	94%	84%	92%	93%	88%	92%

Monthly audits including the above categories are completed by staff in all wards and department. Overall the trust scores well but individual areas for audit have required individual and Trust wide actions plans to address.

Monitoring of Peripheral Venous Cannula (PVC ongoing) has been an area for concern this year and has been included in a QI project looking at vascular access devices. The Director of Nursing is leading on this group and improvements in the way that the insertion and ongoing care of these devices are documented. An electronic system for recoding invasive device insertion and ongoing care is planned for introduction into the Trust for quarter 1 of next year.

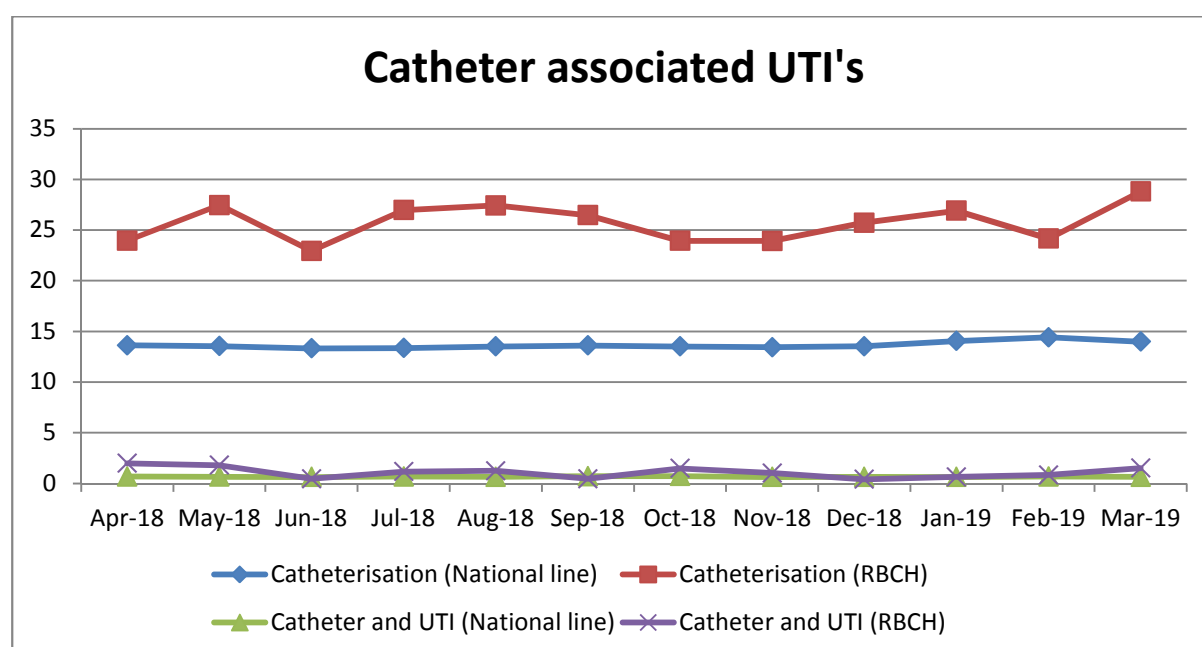
Several post infection reviews of patients with blood stream infections have identified poor care of their peripheral venous cannula as a potential contributing factor.

Intermittent poor audit findings have been found with ongoing urinary catheter care but no trends in this audit were identified.

Catheter associated urinary tract infection (CaUTI)

Data for the Trust shows that we have a higher than national proportion of patients with a urinary catheter inserted but we have a nationally comparable proportion with a confirmed urinary tract infection.

As part of the work we have carried out looking at gram negative infections, urinary catheters have been regularly audited. Patient records indicate appropriate insertion, timely removal and for any patients that need a community led “trial without catheter” good communications are made with the Dorset service.



Criterion 6

Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

It is the aim of the IPC team to make Infection Prevention and Control second nature to all staff. We have been able to ensure that all staff joining the Trust view the RBCH Infection Control video and have the opportunity to ask questions directly to the team. We are keen to ensure that all levels of staff access this training. At the Board of Directors public meeting, a statement of commitment with the Infection Prevention and Control Committee is signed, this is published on the Trust website.

Once staff are in the clinical environment they then have access to all our training materials and policies via the intranet. Each department has one or more Infection Control Resource staff. It is their role to ensure that IPC is audited regularly and that all staff have access to the latest information and advice. Each ward and department does this differently but many have Infection Prevention and Control boards and folders with information that is regularly updated. The IPC team enjoys strong links with these staff members and rely upon them to report back issues with new ways of working and raise IPC concerns directly with the team.

Specific IPC sessions are delivered on wards and in departments. In addition to this the team also sends out monthly topics with tips to the Infection Control Resource staff for them to disseminate via teaching sessions, posters and the ever popular "learning on the loo".

More in depth training sessions have been delivered via the Cavendish Care training for Health Care Assistants and Preceptorship Nurses. This has been scenario based training getting the new staff to understand the importance of IPC and how they can make a key difference.

Overall this year the Trust has had over 90% of its staff compliant with Infection Control mandatory training. This is in line with the overall competency trends for the Trust.

Criterion 7

Provide or secure adequate isolation facilities.

The Trust has 550 beds and 100 side rooms including 5 wards with an ICEpod each. Current evidence indicates that on an average day 60% of the side rooms within the Trust are used for patients carrying infectious bacteria. With the rising threat from resistant bacteria and new and emerging infections it is essential that we continue to look at new areas to isolate patients and novel methods to decontaminate areas after the patient leaves the hospital. These methods are coming to market and will be investigated in due course.

Management of side room usage is a complex process. The IPC team work closely with ward staff and the clinical site team to ensure that these are appropriately used. The scoring system for side room allocation has been reviewed and reissued by the IPC team this year

On a number of occasions this year, particularly when the Trust is at OPEL 3 and 4, there is considerable pressure to identify and use side rooms. The IPC team and CST have worked closely with IT to develop a live system accessible to help manage side rooms across the Trust. This has been valuable over the past 18 months. There is a future wish to incorporate this data into the Health of The Wards tool.

Isolation of infectious patients within the Trust is a constant challenge. As new and emerging diseases are identified and the threat of multi resistant organisms (in particular CPO and Candida Auris) we need to ensure within that Trust has enough side rooms to deal with future threats. At each new build the Trust takes on IPC staff are involved at the earliest stages with the Estates team and are able to work closely with them to ensure that adequate isolation and IPC facilities are built in to any new designs.

Criterion 8

Secure adequate access to laboratory support as appropriate.

The Infection Control team enjoy a very good working relationship with all staff within the laboratory at the Trust. Whilst we are not part of the Pathology structure we have ensured that the working relationships continue by ensuring attendance at laboratory meetings and having face to face meetings on a daily basis when requesting tests and discussing results.

There is now a weekly meeting attended by all the IPC team and Microbiologists. Complex patients are discussed as well as current infection control challenges. This year the IPC team have presented at various lab staff education sessions including a presentation on influenza.

The IPC Senior Nurse meets on a monthly basis with Senior Lab staff and microbiologists. Representation from the IPC team is also made at the monthly laboratory staff updates and journal clubs.

Strong links are also held with Consultant Microbiologists and the Infection Control Teams at neighbouring Acute Trusts. Out of hours the infection control team have access to laboratory staff as well as the on call microbiologist.

Criterion 9

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Trust has a number of IPC related policies all of which are available to staff on the intranet within a specific IPC section which has recently been updated to make it easier to use http://rbhintranet/infection_control/infection_index.shtml .

Links to other policies are also shared within the IPC intranet pages including those used by Poole General Hospital and wider national guidance from Public Health England.

The Trust works closely with members of the Dorset IPC Integrated Care system and is invested in the IIPC ICS plan to have shared Dorset policies on many of our common issues over the next few years.

Criterion 10

Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Working within the healthcare environment can mean that you are confronted with potentially infectious diseases. To protect staff a multitude of factors are employed to ensure their safety. All staff employed within the Trust go through an Occupational Health (OH) screen to ensure that they are up to date with appropriate vaccination schedules. Any staff member who due to health circumstances become vulnerable to infection are given advice by OH in conjunction with the IPC team to ensure their risk of illness as a result of exposure are reduced to a reasonably practical level.

Guidance on infectious diseases and actions for staff to take is available on the intranet and directly from the IPC team. Stocks of personal protective equipment (PPE) are available in all departments relevant to the type of activities carried out in that area and the type of transmission risk.

Staff compliance with PPE is part of regular IPC audit as well as hand hygiene. These build into the wards saving lives figures which are used as part of the information boards on each ward.

Training plays a key part in preparing staff to protect themselves, the patient and respond to organisms with the potential to cause and spread infections. The infection control team deliver regular sessions at induction and at other times in wards and departments on various topics. These are either follow a seasonal pattern (influenza training before influenza season, Norovirus preparation before the winter etc.) or by staff requests based on current news items of concern.

Training sessions on bacteria and viruses will usually cover epidemiology, personal protective equipment, treatment, signs and symptoms and key points for infection control. However many other topics are covered by the IPC team including how to isolate a patient, how to carry out deep cleans following outbreaks, management of the patient with CDI and how to remove and put on PPE.

Trust Board Dashboard - June 2019

based on Single Oversight Framework metrics

Annual Declaration

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

Category	Metric	2018/19 Q3			2018/19 Q4			2019/20 Q1			Trend (where applicable)
		Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	90.8%	90.6%	92.1%	89.3%	89.1%	88.3%	88.1%	87.7%	84.1%	
	Caring - Inpatient scores from Friends and Family Test % positive	97.9%	97.8%	97.6%	98.2%	97.2%	98.0%	98.3%	96.4%	97.9%	
	Caring - Maternity scores from Friends and Family Test % positive	97.3%	95.9%	100.0%	93.0%	90.1%	98.0%	97.1%	98.6%	97.8%	
	Caring - Mixed sex accommodation breaches	0	1	0	0	0	0	10	0	3	
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)					85.7%					
	Caring - Formal complaints	27	32	34	40	34	43	37	59	36	
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	711	712	711	757	677	750	737	711	720	
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	79.3	72.7	115.3	81.3	92.1	80.6				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - MAC	259.0	342.1	428.9	282.5	251.1	148.4				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - RBH	63.7	67.6	107.2	75.9	82.6	73.0				
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	85.5	79.7	81.0	89.6	97.3	91.4				
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	187.4	157.5	199.7	178.3	195.5	171.5				
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	78.0	72.7	75.4	82.9	89.0	84.9				
	Effective - Summary Hospital Mortality Indicator	0.949	0.949	0.949	0.949						
	ED Attendances	8189	7948	8075	8422	7350	9042	8889	9009	8688	
	Elective Admissions	6639	6513	5161	6336	5677	6455	5357	5391	5603	
	GP OP Referrals	6490	5999	4799	5881	5458	5842	5714	6010	5672	
	Non-elective Admissions	3334	3338	3326	3725	3073	3583	3215	3272	3294	
	Organisational health - Staff sickness in month	4.7%	4.5%	4.1%	4.5%	4.5%	3.8%	3.9%	3.6%	3.7%	
	Organisational health - Staff sickness rolling 12 months	4.1%	4.1%	4.1%	4.1%	4.2%	4.2%	4.2%	4.2%	4.2%	
	Safe - Clostridium Difficile - Confirmed lapses in care	0	0	1	1	0	0	1	2	0	
	Safe - Clostridium Difficile - infection rate	6.12	0	6.12	6.12	0	0	18.98	12.25	6.33	
	Safe - MRSA bacteraemias	0	0	0	0	0	0	0	0	0	
	Safe - NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	1	0	0	0	0	
	Safe - Occurrence of any Never Event	0	0	0	1	0	0	1	0	0	
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)		41.26			37.1			40.4		
	Safe - VTE Risk Assessment	96.5%	96.1%	95.6%	95.8%	95.8%	96.2%	95.7%	96.4%	96.7%	
	Number of Serious Incidents	0	1	0	2	1	1	3	3	0	
	Appraisals - Values Based (Non Medical) - Compliance	88.9%	90.9%	90.6%	89.8%	89.1%	88.4%	2.1%	9.0%	20.7%	
	Appraisals - Doctors and Consultants - Compliance	89.1%	91.2%	85.3%	79.5%	83.2%	84.0%	83.7%	83.5%	82.5%	
	Essential Core Skills - Compliance	93.1%	93.0%	92.8%	93.2%	92.9%	93.0%	93.6%	93.9%	94.4%	
	Organisational health - Proportion of temporary staff	7.8%	8.0%	8.3%	8.0%	8.7%	9.3%	8.3%	10.7%		
	Organisational health - Staff turnover	9.3%	9.5%	9.9%	9.7%	9.8%	10.2%	10.2%	10.6%	10.5%	
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	1	1	1	1	1	1	3	2	2	
	Sustainability - Liquidity (YTD score)	1	1	1	1	1	1	1	1	1	
	Efficiency - I&E Margin (YTD score)	1	1	1	1	1	1	4	3	3	
	Controls - Agency Spend (YTD score)	1	1	1	1	1	1	1	1	1	
	Controls - Distance from Financial Plan (YTD score)	2	2	2	2	2	1	2	2	1	
	Overall finance and use of resources (YTD score)	1	1	1	1	1	1	3	2	2	
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	93.5%	90.3%	89.6%	87.6%	87.9%	96.6%	91.1%	92.8%	96.6%	
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	100.0%	92.0%	94.4%	88.9%	69.2%	90.0%	100.0%	100.0%		
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	77.5%	91.8%	89.2%	89.1%	86.7%	89.1%	87.3%	87.6%		
	Maximum 6-week wait for diagnostic procedures	93.4%	96.5%	93.5%	94.8%	96.7%	99.3%	98.3%	96.9%	95.8%	
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	86.9%	86.7%	85.7%	85.4%	85.3%	84.6%	84.0%	85.0%	84.2%	

BOARD OF DIRECTORS	
Meeting date – Info Pack only:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Performance Report
Section on agenda:	Quality and 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 Sarah Knight, Associate Director, Planning & Elective Transformation David Mills, Associate Director Information & Performance Dawn Ailes, RTT Performance Lead
Details of previous discussion and/or dissemination:	PMG / Finance Committee
Action required:	Note for information
<p>The Trust Board of Directors is requested to note the performance exceptions to the Trust's compliance with the 2019/20 Single Oversight Framework, national planning guidance and contractual requirements.</p> <p><i>Note, the narrative report should be read in conjunction with:</i></p> <ul style="list-style-type: none"> • Trust Board Dashboard • Performance Indicator Matrix <p>Executive Summary:</p> <p>This report focuses on June 2019 performance where it is available and provides a 'look forward' in light of current/projected trends and actions being taken.</p> <p>Key Highlights & Exceptions:</p> <ul style="list-style-type: none"> • Performance against the 4 hour standard fell to 86.21%. • Zero 12 hour decision to admit breaches in June 2019. • Q1 30 minute handover breaches fell by 34%, which is two consecutive months of improvement • Overall ambulance conveyances are up 4.86% YTD (Apr-June) compared to 2018/19; SWAST conveyances in June are 5.97% higher than June 2018 and SCAS conveyances are up 25.61%. • One patient continued on 52+ week pathway at end of June. • The total numbers of patients on an RTT pathway increased by 364 in June compared to 961 in May. • Trust wide RTT performance against the 18 week standard decreased slightly to 84.16% for June. • Performance against the 62 day cancer standard was achieved above the 85% national standard and continued to improve from the previous month to 87.6%. • 62 day cancer screening target hit 100% in May. 	

<ul style="list-style-type: none"> • All three cancer 31 day standard targets achieved in May 2019. • Cancer referrals have seen a 14.9% increase YTD. • Endoscopy JAG accreditation is at high risk of not being maintained due to waiting times. • Diagnostic 6 week performance dropped to 95.8% in June. 	
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:	Performance metrics are key control measures for the following risks on the Trust Risk Register: <ul style="list-style-type: none"> • Inpatient QI (Flow) Programme (806) • ED 4hr (801) • Stranded patients • RTT (808) • Outpatients • Financial



Operational Performance Report

For the period to end
June 2019

Richard Renaut
Chief Operating Officer

1. Executive summary

Key highlights and exceptions:-

- Performance against the 4 hour standard fell to 86.21%.
- Zero 12 hour decision to admit breaches in June 2019.
- Q1 30 minute handover breaches fell by 34%, which is two consecutive months of improvement
- Overall ambulance conveyances are up 4.86% YTD (Apr-June) compared to 2018/19; SWAST conveyances in June are 5.97% higher than June 2018 and SCAS conveyances are up 25.61%.
- One patient continued on 52+ week pathway at end of June.
- The total numbers of patients on an RTT pathway increased by 364 in June compared to 961 in May.
- Trust wide RTT performance against the 18 week standard decreased slightly to 84.16% for June.
- Performance against the 62 day cancer standard was achieved above the 85% national standard and continued to improve from the previous month to 87.6%.
- 62 day cancer screening target hit 100% in May.
- All three cancer 31 day standard targets achieved in May 2019.
- Cancer referrals have seen a 14.9% increase YTD.
- Endoscopy JAG accreditation is at high risk of not being maintained due to waiting times.
- Diagnostic 6 week performance dropped to 95.8% in June.

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

2. PSF, Single Oversight Framework and National Indicators

2.1 Current performance – May/June 19

Performance against the 4 hour standard fell to 86.21% in June 2019. Increases in ambulance conveyances have continued through June compared to last year.

RTT performance decreased by 0.8% to 84.16% in June. Performance remains above the local target trajectory for 2019/20. The total waiting list is still continuing to rise along with an increase in the number of patients who have breached 18 weeks.

As previously highlighted a patient's pathway breached 52 weeks and was reported at the end of May. Although their pathway continued at the end of June, the patient is receiving close medical input and is due for procedure in July.

The Trust achieved all the Cancer standards in May 2019 apart from Cancer 62 day consultant upgrade. Performance against the overall 62 day cancer standard for May was 87.6% (above the national target of 85%).

Diagnostic performance slipped in June to 95.8% below the 99% standard. The focus for 2019/20 remains the sustainable recovery of the 99% target, though recruitment and substantive capacity that will come on line from September. Endoscopy remains under pressure continues to impact on the diagnostic target (see section 3.4)

Operational Performance Report

As at 17/06/2019

Table 1 – Operational and Contracting Guidance - KPIs 2019/20 – actuals & forecast July19

Single Oversight Framework Indicator	National Target	NHSI Trajectory 19/20	Mthly / Qtrly	RAG rated performance against national targets and NHSI submitted trajectories		
				May-19	Jun-19	Jul -19 Projection
A&E 4hr maximum wait time	95%	91.3-91.8%	Mthly & Qtrly	92.75%	86.10%	
RTT 18 week incomplete pathways	92%	83%	Mthly	84.96%	84.20%	
RTT - no. of incomplete pathways	24,880	26,400	Yr End	27,614	27,978	
RTT - no 52 week waiters	0	0	Mthly	1	1	
Cancer 62 day wait for first treatment from urgent GP referral*	85%	84-85%	Mthly & Qtrly	87.60%	est.	
Cancer 62 day wait for first treatment from Screening service*	90%	90%	Mthly & Qtrly	100.00%	est.	
Maximum 6 weeks to diagnostic test	99%	98-99%	Mthly	96.9%	95.8%	

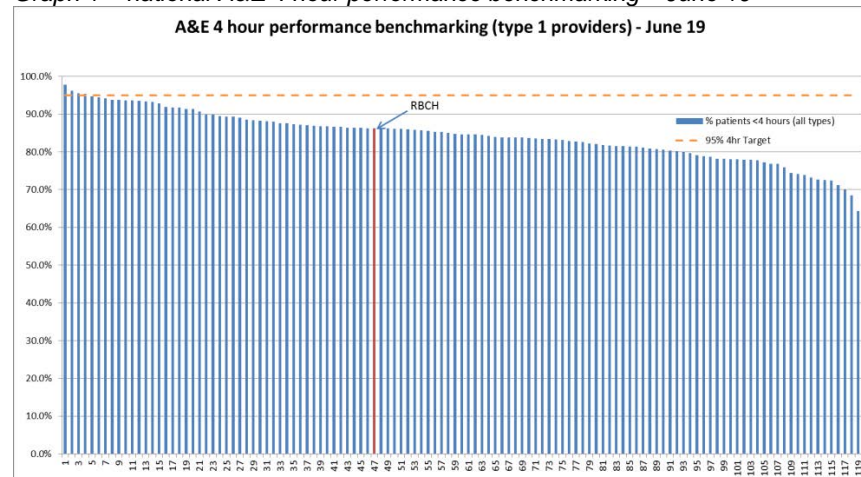
RAG Key: Red - below national target and organisational trajectory; Amber - above trajectory but below national target or 'at risk'; Green - above national target (and trajectory).

**Final validated June performance upload will be completed early August 19

2.2 National Benchmarking – May / June 19

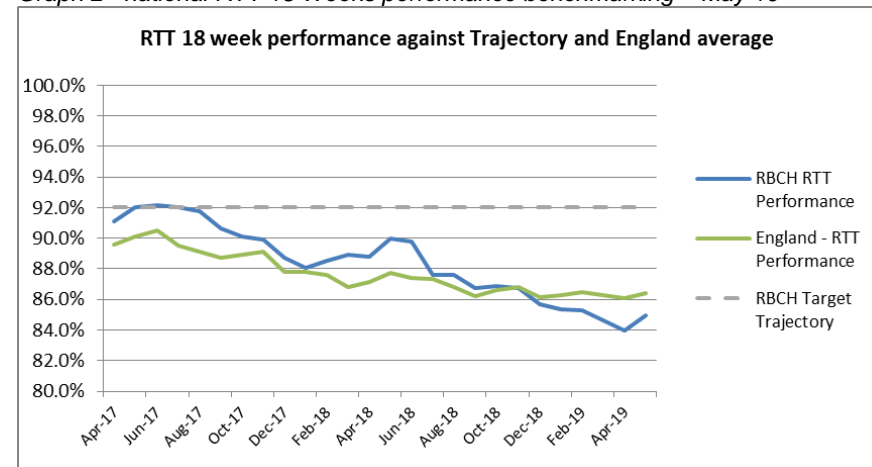
RBCH benchmarked 47th out of all type 1 Trusts nationally for ED 4 hour performance. A number of Trusts are excluded from the chart below whilst they participate in the NHS Clinical Review of Access Standards Pilot.

Graph 1 – national A&E 4 hour performance benchmarking – June 19



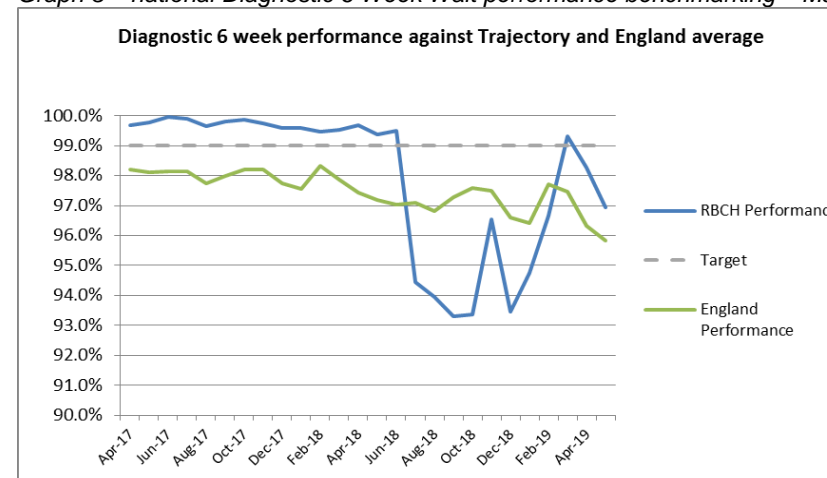
Trust wide RTT performance (84.96%) remained below the national average in May.

Graph 2– national RTT 18 Weeks performance benchmarking – May 19



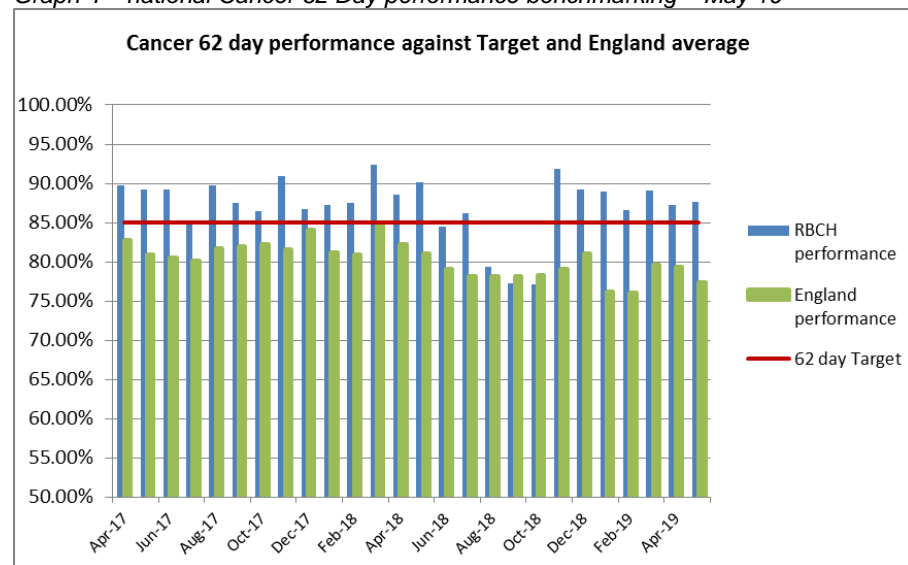
RBCH benchmarked above the national average Diagnostic performance (96.93%) in May 19. Whilst the trust was just below the target for May we still envisage remaining above the national average.

Graph 3 – national Diagnostic 6 Week Wait performance benchmarking – May 19



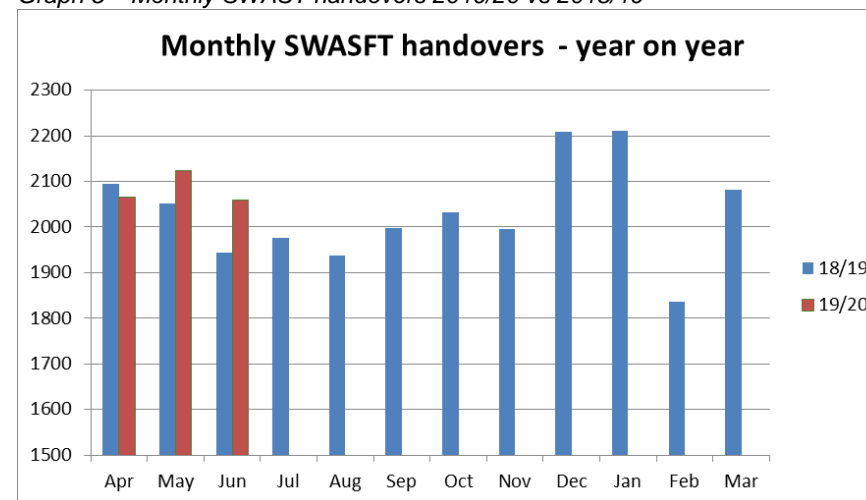
RBCH continued to benchmark above the national average 62 day standard performance (87.9%) in May 19. The increase in cancer referrals is now at 14.9%YTD.

Graph 4 – national Cancer 62 Day performance benchmarking – May 19



Continuing the trend seen in 2018/19 the Trust is experiencing a 4.86% increase in ambulance conveyances YTD (Apr-June). In June 2019 the number of SWAST ambulance conveyances increased by 5.97% compared with June 18 and SCAS conveyances were up 25.61%, as highlighted by graphs 5 and 6.

Graph 5 – Monthly SWAST handovers 2019/20 vs 2018/19



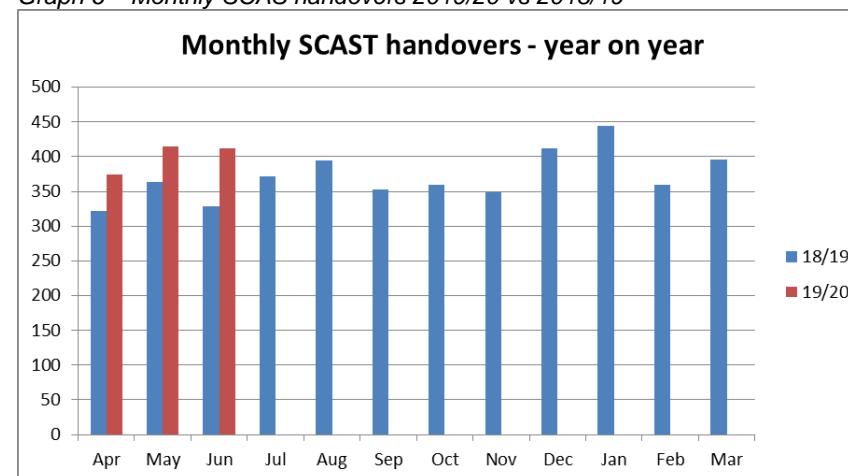
3. Forecast Performance, Key Risks and Action

3.1 A&E Targets, PSF and Stranded Patients

Performance against the 4 hour standard decreased in June. Improvements were seen during June in ambulance handover times, with June seeing both the 30 minute and 60 minute ambulance handover times at their lowest since April 2017 and there were no 60 minute handover breaches.

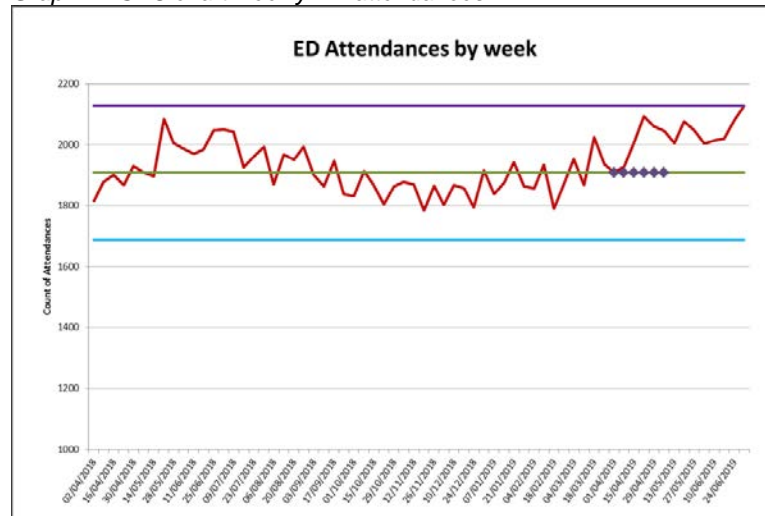
Q1 2019/20 saw an increase of 3.7% in ED attendances compared to Q1 2018/19; this equates to an additional 968 patients.

Graph 6 – Monthly SCAS handovers 2019/20 vs 2018/19

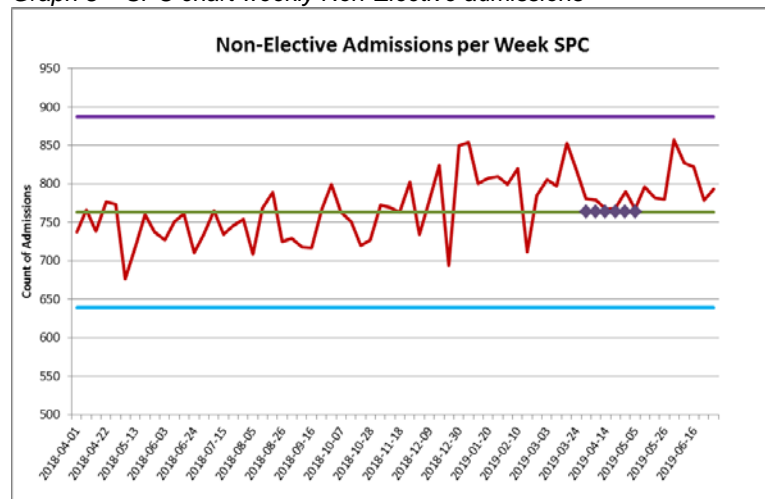


As the Statistical Process control charts show, the increase in attendances continues and requires continuous monitoring to see if activity levels revert back to the natural variation.

Graph 7 –SPC chart weekly ED attendances



Graph 8 – SPC chart weekly Non-Elective admissions



ED and Conveyances

ED remains extremely challenged with the combination of increased attendances, ambulance conveyances, surges, minors attendances alongside high acuity and majors attendances, as well as increased non elective admissions. It has been identified that minors ED performance drops with higher acuity/conveyances in majors. The trust is currently working through data with Dorset partners to understand the impact of the new Urgent Treatment Centre model and the 111 service.

QI work continues to progress and focus on cultures and processes to improve and embed an improved ED flow, with a particular focus on the rapid assessment hub. This is also linked with the inpatient flow QI which is concentrating on stranded and frail patients; ward processes and flow, alongside admission avoidance including an ambulance hotline via consultant connect.

Dorset Adult Integrated Respiratory Service (DAIRS) are starting a PDSA learning week where a DAIRS specialist nurse will be working at the Front Door in ED from 08:00 – 18:00. The nurses will also look proactively at all patient data for those admitted with COPD or Asthma through this week. There will be a focus on supporting early discharge and admission avoidance. The findings will be presented to the Discharge and Admission Avoidance Steering Groups.

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

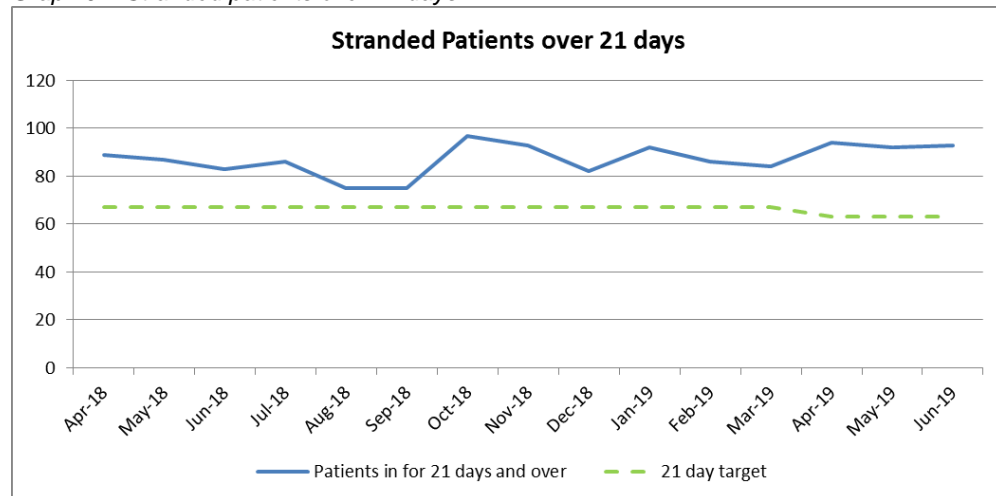
The number of patients who have been in hospital for over 21 days has remained steady during June. Executive oversight with weekly meetings with partnerships continues. The Continuing Health Care (CHC) in-reach coordinator is now in post to support CHC processes and there has been positive feedback to date. This continues to be monitored to ensure changed processes do not have a negative impact on patients remaining in hospital.

Operational Performance Report

As at 17/06/2019

Senior attendance at the South West workshop took place in June and ECIST will be reviewing the current model. The Trust is currently on target to deliver the agreed trajectory.

Graph 9 – Stranded patients over 21 days

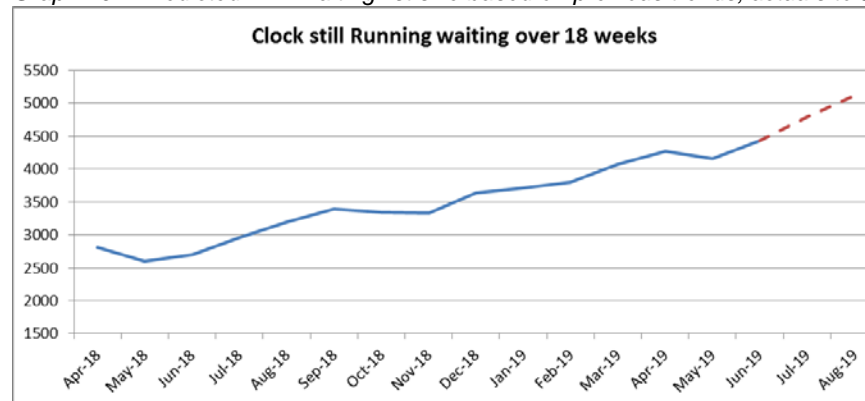


3.2 RTT Incomplete Pathways (18 week), Total Incomplete Pathways and 52 Week Breaches

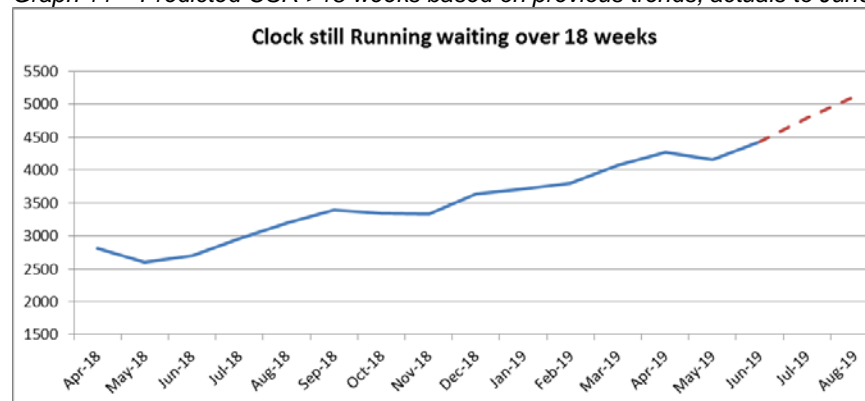
RTT performance remained above 84% in June. However the number of patients waiting over 18 weeks increased by 278. The number of patients with an open clock still running continues to rise throughout June.

Pressures from Cancer pathways and increased diagnostics waits continues to create carve out from the RTT pathways. Outpatient waits remain above 13 weeks in many specialities and waits for the admitted pathways continue to climb for these patients.

Graph 10 – Predicted RTT waiting list size based on previous trends, actuals to June-19



Graph 11 – Predicted CSR >18 weeks based on previous trends, actuals to June-19



Dermatology remains under extreme pressure. A meeting was held in June at the Dorset Development Hub with colleagues from the CCG, Public Health, Primary Care, Private sector, Intermediate care and representatives from the three acute Trusts. This focussed on agreeing a vision for Dermatology across Dorset and what the current challenges are.

Carve out is being created by cancer referrals which reached a seasonal peak during June averaging 90 per week for Dermatology

and is expected to increase by a further 35% in July. Maximising all opportunities to utilise staff and appointment slots as efficiently as possible and providing additional nurse-led fast track clinics and waiting list initiatives will mitigate the increases to an extent. However, these are limited due to lack of Consultant supervision capacity. Poole Hospital is also experiencing the same peak in cancer referrals. Work is ongoing in the CCG to target GPs with the aim of reducing unnecessary referrals in. The team are piloting review of fast track referrals before they are booked, and using Nurse Led Photo Assessment clinics.

Urology RTT overall performance slightly decreased during June with the numbers over 18 week's increasing. Some of the urology clinics at Poole are being repatriated along with long waiters and a risk of 52 week breaches for the Trust. Urology Consultants have confirmed commencement of the Consultant of the Week (COW) resident seven day consultant support model from 1st October 2019, and patient engagement continues on the new delivery model. Two new Consultant surgeons have commenced in post with two more due to start by the end of this calendar year.

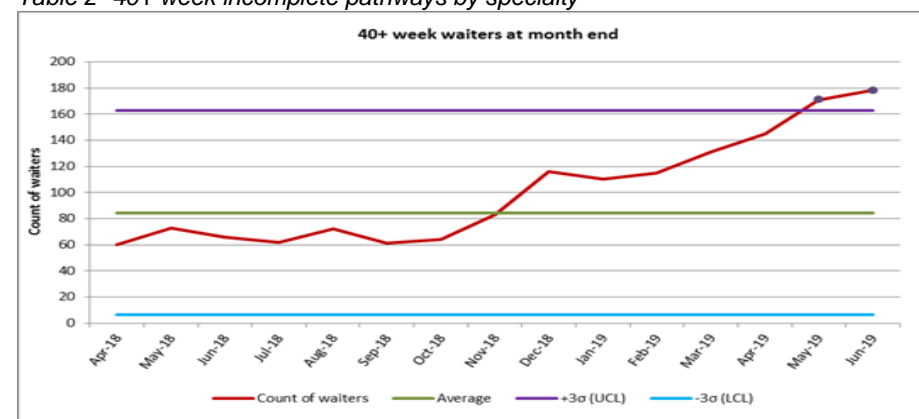
The Breast Service has been under significant pressure due to sickness. This led to the carve out of routine waits and the 2 week cancer standard not being met in June which will be repeated in July. This is despite the good support and actions including assistance from PHT colleagues. Medical staffing plans have helped to mitigate but the demand and leave commitments have had an impact.

Ophthalmology continues to experience significant levels of demand particularly within the macular service. In addition a reduction in medical staff capacity due to sickness and other extenuating circumstances has compounded the situation during June and July and this will continue through August. The potential to move activity to alternative providers is being explored to support the current short term staffing issues whilst the Directorate continues to work on longer

term solutions to reduce waiting times. The Directorate is working collaboratively with Dorset CCG and other providers to identify other options to improve capacity. This was supported by a recent workshop.

The number of over 40 week waits has continued to increase during June. The majority of patients waiting over 40 weeks are for general surgery in particular Upper GI surgery. Upper GI surgery performance stays challenging, it is multifactorial but the immediate significant cause is the limited staffing for theatre lists. Job plans are being reviewed to address the future service needs.

Table 2- 40+ week incomplete pathways by specialty



One patient remained on an over 52 week pathway at end June (reported end May), though consultant level care is ensuring full diagnostics and treatment options. Treatment is anticipated in July and actions are already being progressed as a result of the learning from the RCA.

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

The Trust achieved all the Cancer standards in May 19 apart from Cancer 62 day consultant upgrade. The Trust reported performance of 87.6% for the 62 day cancer standard however currently for June the predicted performance is sitting at 84.3%. On a positive note, the trust has achieved the aggregated performance for Q1 at 86.4%

In May the Trust achieved the 2 week wait standard, however for June it is expected that the Trust will fail this standard at 90.7% with anticipated recovery in July. This performance reflects the pressure on teams due to a 14.9% increase in referrals YTD where the greatest challenges in service delivery have been in Breast, Head and Neck and Lung.

Nationally it is expected the 2 week standard will be replaced when the 28 day faster diagnostic standard is introduced in April 2020. The Trust is currently reporting around 80% compliance for the 28 day standard (threshold yet to be confirmed).

31 day standard was achieved in May and is expected to hold for June.

3.3A 104 Day Backstop Report

Currently 23 patients are being reported by the Trust as a 104 day backstop. The main reasons for this being complex pathways and patient choice.

There are 33 patients that the Trust is managing as part of the backlog that is over the 62 days and under 104 days. It is anticipated by robustly managing these patients the number of 104 day backstops will decrease. For all patients with a pathway exceeding 104 days the

responsible clinician is contacted to ensure that no clinical harm has come to the patient as a result of the protracted pathway.

3.4 Diagnostic 6 Week Wait

At the end of June there are approximately 558 patient endoscopy breaches (routine and planned), equating to approximately 85 lists (due to the previously reported ongoing long term sickness in the department). The Trust has appointed 2 permanent Gastroenterology Consultants. However, they are now expected to start mid-October and 2 locum Consultants in September. This has meant that following the improvements through outsourcing earlier in the year, there has been a delay to securing the substantive capacity for sustainable recovery. The Trust has not lost JAG accreditation, but this looks likely as we are unable to recover in the short term. JAG had previously given the service until 1st August 2019 to evidence three months of achieved diagnostic & surveillance performance which has not been achieved. We are looking at insourcing again to try and clear the backlog though noting this is outside of budgeted funding.

The Trust achieved 95.8% in June 19 which is below the 99% standard. The number of patients waiting over 6 weeks increased by 81 with the main reason being patients awaiting endoscopy and interventional radiology diagnostics.

4. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail

The Trust will be reporting one incident of Mixed Sex Breach accommodation which resulted in 3 patient breaches for June within the Acute Lung Unit. Significant bed pressures meant a delay in moving a patient out of the unit when they no longer required the higher level of acuity care.

There was one operation cancelled on the day and not re-booked within 28 days. The patient needed to see a specific consultant who wasn't available within 28 days. The patient has now been treated.

The Trust has reviewed the trend in the number of emergency re-admissions. Initial indications suggested an increasing trend; detail at specialty level has shown some increases in elderly care. Further analysis continues and regular monitoring with SPC data is in place.

Recommendation

The Board is requested to note the June 19 performance and the Performance Matrix. It should also note the expected performance, risks and actions relating to on-going 2019/20 requirements.

BOARD OF DIRECTORS	
Meeting date:	31 July 2019 Information Pack
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Quality Report
Section on agenda:	Quality and Performance
Supplementary reading:	CQC Insight Report June 19
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Fiona Hoskins: Deputy Director of Nursing and Midwifery Jo Sims: Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Not Applicable
Action required:	Note for information
<p>Summary:</p> <p>The Quality Report is a summary of the key quality indicators in month.</p> <ul style="list-style-type: none"> • There were no serious incidents reported in June • The CQC Insight report notes the Trust is in the highest 25% of acute trusts • Complaints response times have deteriorated in this quarter and the number of complaints have increased. This is being reviewed. 	
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 significant risks:	Not Applicable



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Quality Report

For the period to end

June 2019

Paula Shobbrook
Director of Nursing and Midwifery

Quality Report: June 2019

1.0 Introduction

This report accompanies the Trust Quality Dashboard and outlines the Trust's actual performance against key patient safety and patient experience indicators. In particular it highlights progress against the trajectories for the priority targets set out in the Board objectives for 2019/20.

2.0 Serious Incidents (SI)

- No Serious Incidents were reported in June 2019

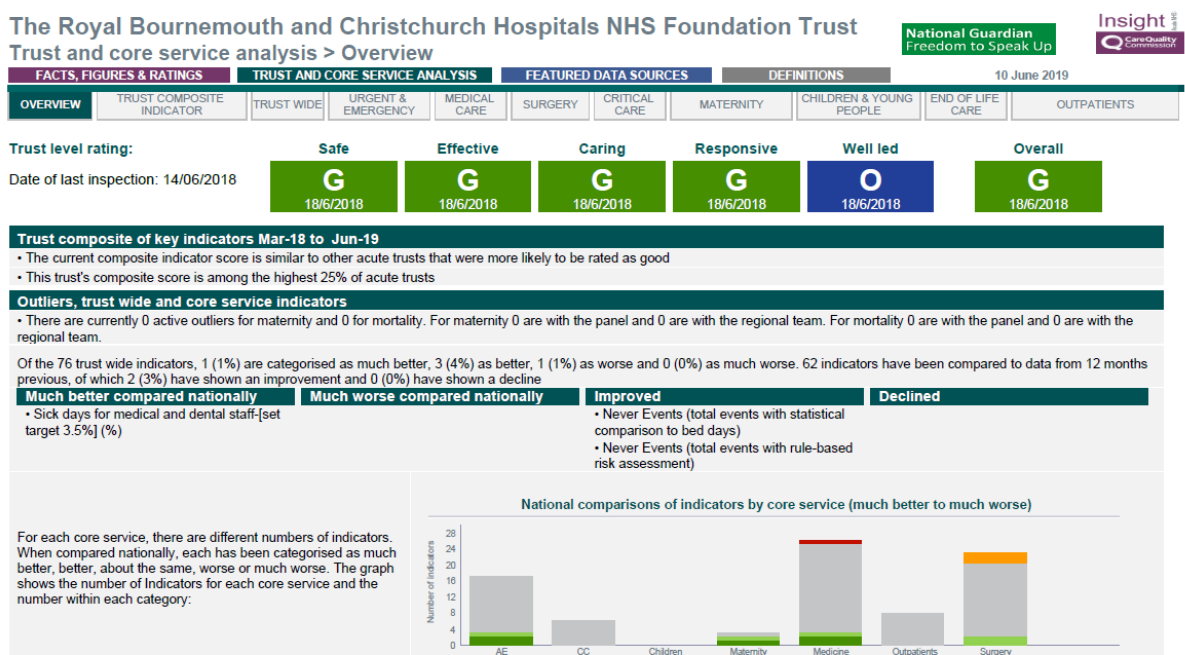
3.0 CQC Insight Report – June 2019

The CQC Insight Model for the Trust was updated on the 10th June 2019

Overall the Trust's composite score is rated as Good and is in the highest 25% of acute trusts.

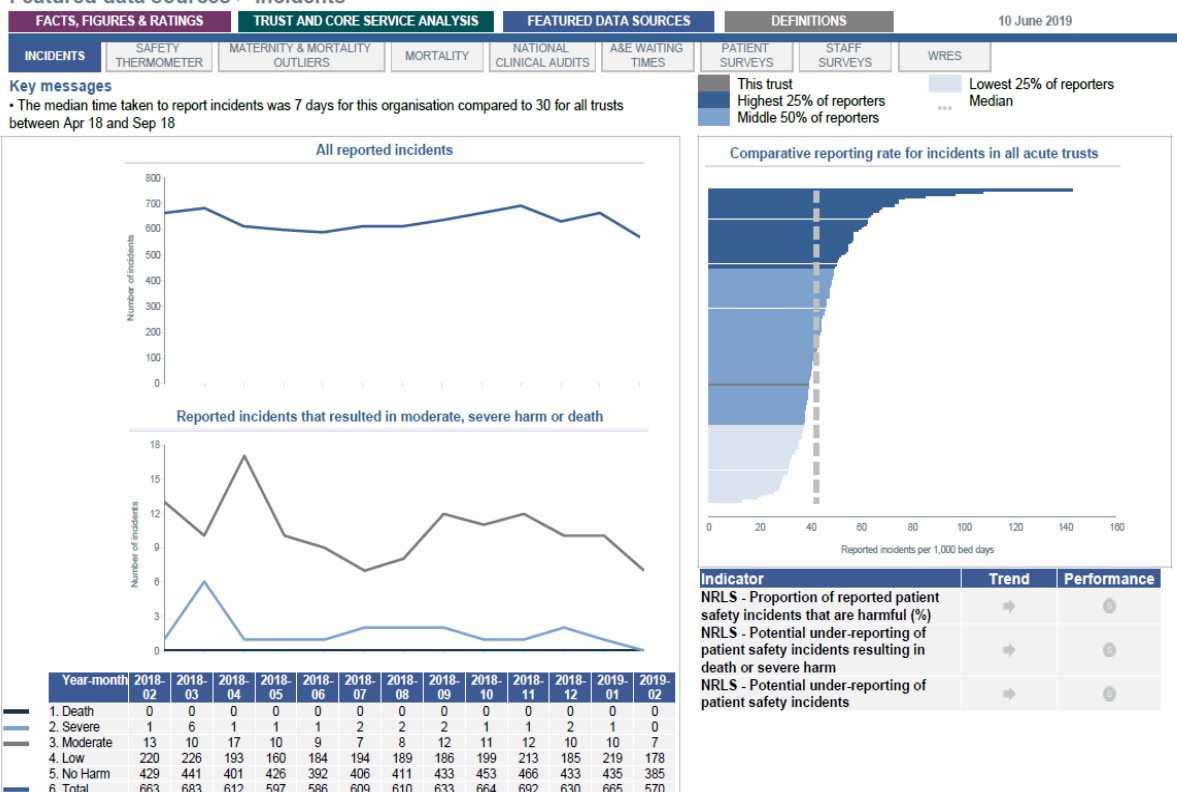
Of the 76 quality indicators, 1 (1%) are categorised as much better, 3 (4%) as better and 0 (0%) as much worse.

62 indicators have been compared to data from 12 months previous of which 2 (3%) have shown improvement and 0 (0%) have shown a decline.



The Trust is no longer an outlier for the total number of Never Events reported, however we remain an outlier for the number of Never Events reported in Surgery.

The Trust remains in the middle quartile for incident reporting to the National Reporting and Learning System (NRLS).



3.1 CQC Engagement

CQC inspectors Lisa Layton and Sam Bereket held a very positive engagement meeting with the Surgical Care Group on the 12 July 19. The meeting with the clinical leads from surgery and critical care and forms part of the CQC's new methodology and provided an opportunity for the CQC to meet with core service leads on an informal basis. The CQC also held a focus group with Band 3 and 4 Healthcare Assistants and Associate Practitioners on the 12 July 2019.

The Trust's quarterly engagement meeting with the CQC took place on 19 July. The CQC also met with our Freedom to Speak Up Guardian and held a focus group with BAME staff.

12 July 2019	Lisa Layton Sam Bereket	Meeting with clinical leads: Surgical Division Critical care	13.30 – 14.30
		Focus Group: Nursing staff bands 3 and 4.	14.45 – 15.30
19 July 2019	Alison Giles Lisa Layton Sam Bereket	Meeting with DoN Paula Shobbrook	13.30 – 15.00
	Lisa Layton/Sam Bereket	Focus group: BAME	15.15 – 16.00
	Alison Giles	Interview with: Freedom to Speak guardians	15.15 – 16.00

4.0 Patient Engagement

4.1 FFT

National Comparison using NHS England data:

- Inpatient and day case Friends and Family Test (FFT) national performance in May 2019 ranked RBCH Trust 4th with 33 other hospitals out of 167 placing RBCH in the second quartile based on patient satisfaction.
- The Emergency Department FFT performance in May 2019 ranked RBCH Trust 13th with 8 other hospitals out of 134 placing RBCH ED department in the second quartile.
- Outpatients FFT performance in May 2019 ranked RBCH Trust 4th with 25 other Trusts out of 244 Trusts, placing the departments in the second quartile.

Table 1: National Performance Benchmarking data

	December	January	February	March	April	May
In-Patient Quartile						
Top	98.113%	98.878%	98.220%	98.450%	98.650%	
2						97.244%
3						
Bottom						

	December	January	February	March	April	May
ED Quartile						
Top						
2	92.129%	89.258%	89.113%	88.346%	88.103%	87.674%
3						
Bottom						

	December	January	February	March	April	May
OPD Quartile						
Top						
2	98.304%	97.919%	97.759%	97.879%	98.175%	97.001%
3						
Bottom						

4.2 Family and Friends Test: Corporate Outpatient areas

Corporate	Total eligible to respond	No. PEC's completed	No. of FFT Responses	% Recommended	% Not Recommended
Derwent OPD	N/A	42	42	88.1%	2.4%
Main OPD Xch	N/A	17	17	100.0%	0.0%
Oral and Maxillofacial	N/A	N/A	N/A	N/A	N/A
Outpatients General	N/A	132	128	96.9%	0.8%
Jigsaw OPD	N/A	5	5	80.0%	20.0%
Corporate Total		196	192	94.8%	1.6%

4.3 Patient Opinion and NHS Choices: June Data

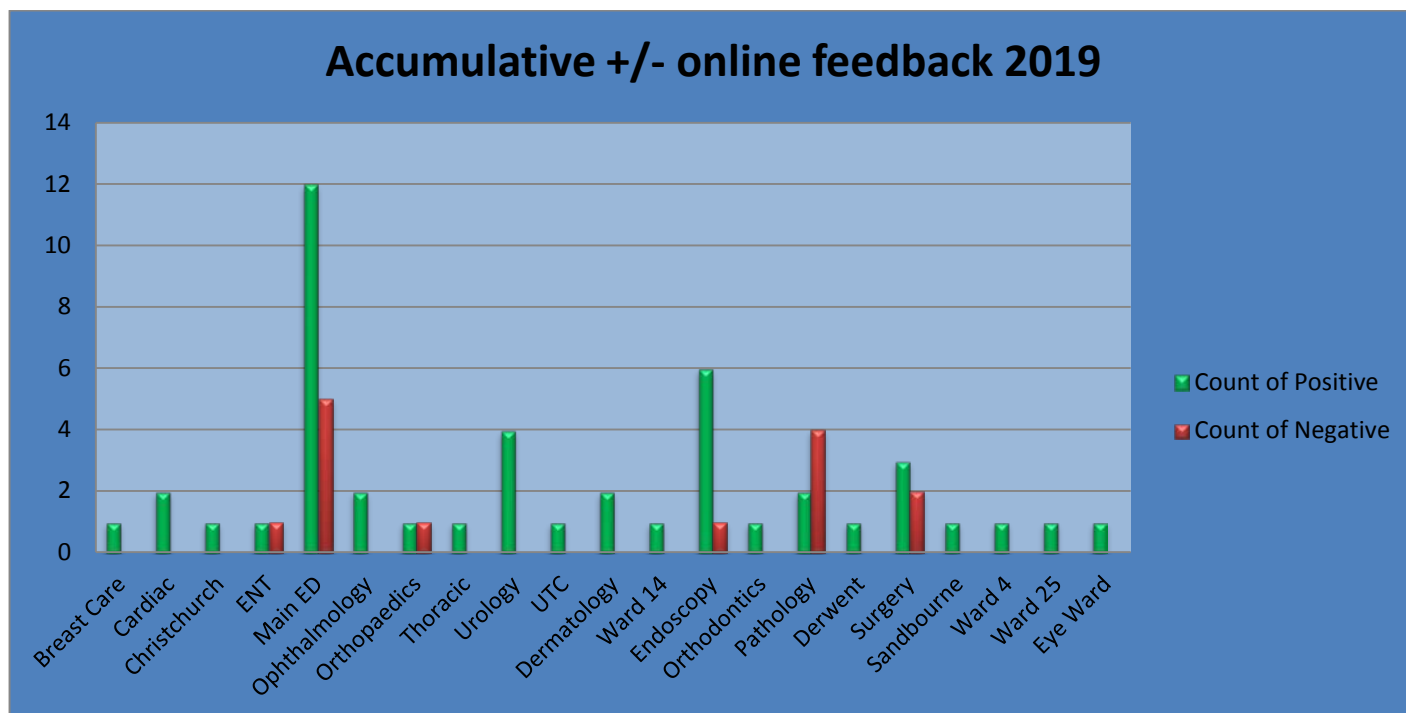
Nine patient feedback comments were posted in June, 5 expressed satisfaction with the staff attitude, care and professionalism. 2 expressed concerns over staff attitude, waiting time and Communication. Two further returns had mixed reviews.

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

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

The below table shows the response breakdown both positive and negative themes by area, based on an accumulation of feedback from January 2019 to present.

Table 2:



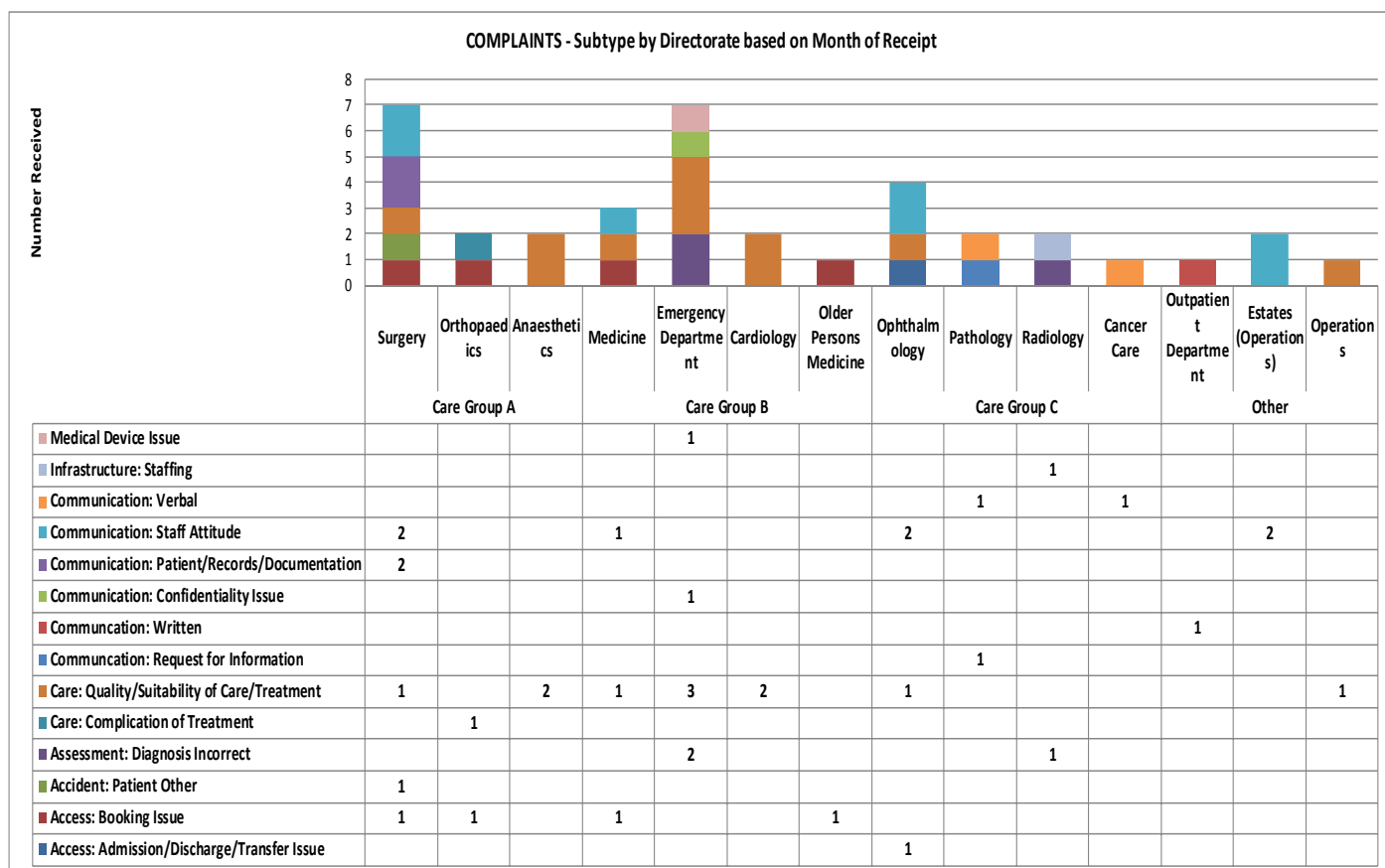
4.5 Care Conversations

Care conversations continue across in patient areas. Feedback remains mainly positive for patient experience. Conversations are indexed by CQC domain KLOEs to provide the themes and learning from this feedback.

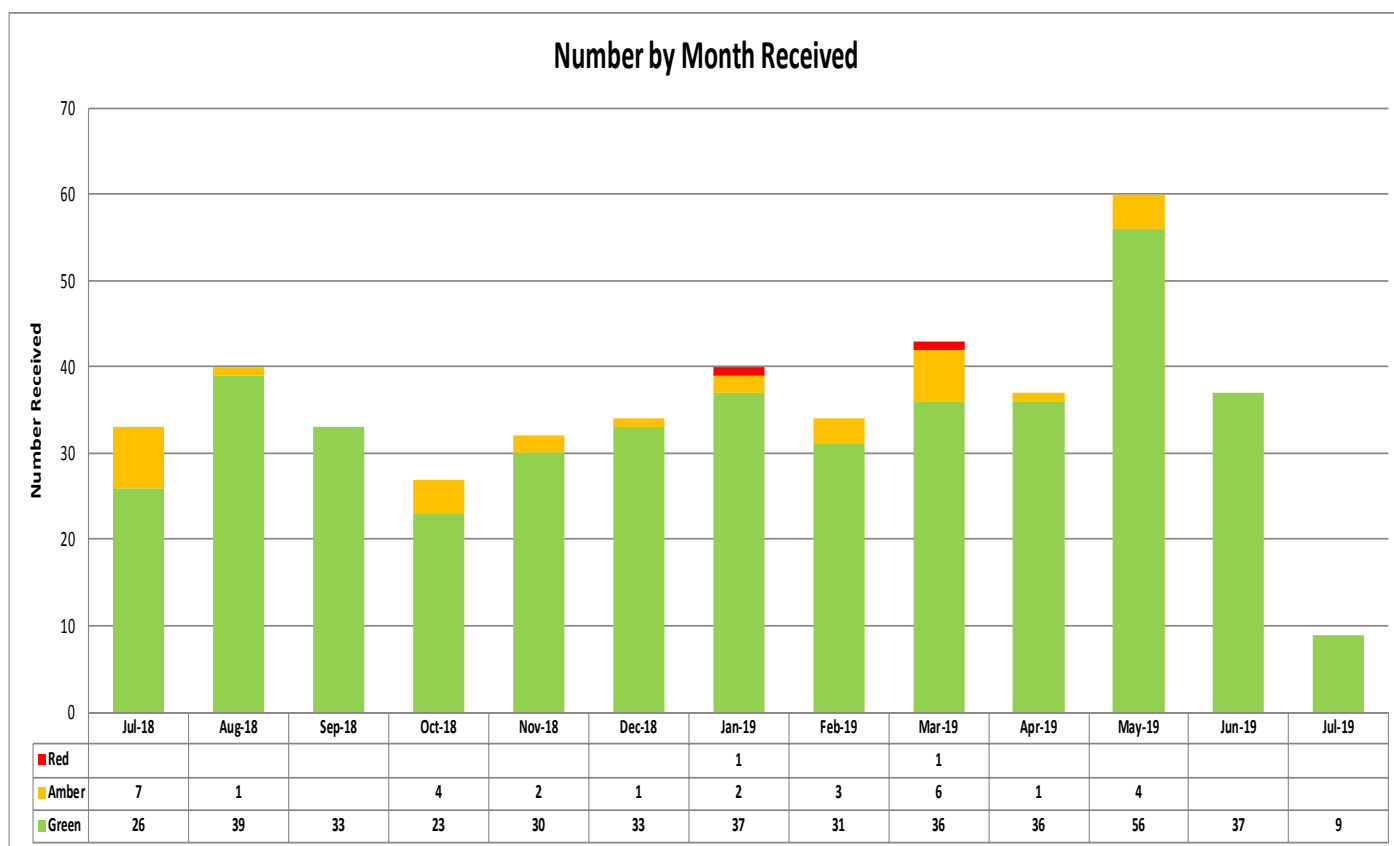
5.0 Complaints

5.1 A total of 37 new complaints and 5 reopened complaints were received in June 2019 all of which were acknowledged within 3 days. The highest themes being:

- Care: Quality / Suitability of Care / Treatment
- Communication: Staff Attitude
- Access: Booking Issue



Total Complaints received financial year to date: 134









5.2 Complaint response times Year to date







An increase in the number of complaints and reduction in the time for first responses is noted.

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Rolling 12 months
1st Responses Due in Month	40	31	36	41	24	29	40	34	35	34	49	54	447
Number Where 1st Response Completed On	30	21	18	32	13	22	27	21	25	20	31	25	285
Percent With 1st Response On Time	75%	68%	50%	78%	54%	76%	68%	62%	71%	59%	63%	46%	64%

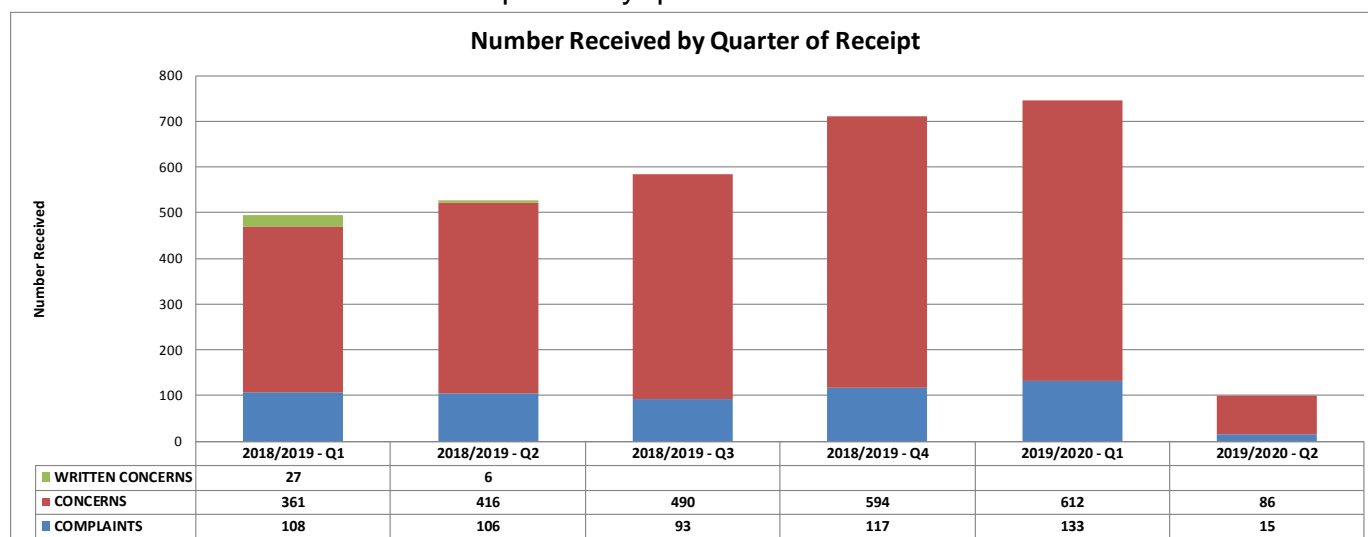
5.3 Complaints performance by Care Group

Care Group	Complaints															
	Number Due	Number on time	% on time July 2018	% on time August 2018	% on time September 2018	% on time October 2018	% on time November 2018	% on time December 2018	% on time January 2019	% on time February 2019	% on time March 2019	% on time April 2019	% on time May 2019	% on time June 2019	Change	Trend
CGRPA	21	13	74	64	44	79	50	80	33	64	92	71	79	62	▼	
CGRPB	23	6	71	63	35	81	64	67	72	54	53	62	52	26	▼	
CGRPC	7	5	100	100	50	50	0	71	88	75	100	29	63	71	▲	
OTHER	3	1	100	0	0	50	0	0	75	67	0	0	100	33	▼	
PRIVATE	0	0	0	0	0	0	100	0	0	0	0	0	0	0	=	
GRAND TOTAL	54	25	75	65	41	76	55	72	67	59	71	59	63	46	▼	

Concerns performance by care group: (response time frame of five working days)

Care Group	Concerns															Change	Trend
	Number Due	Number on time	% on time July 2018	% on time August 2018	% on time September 2018	% on time October 2018	% on time November 2018	% on time December 2018	% on time January 2019	% on time February 2019	% on time March 2019	% on time April 2019	% on time May 2019	% on time June 2019			
CGRPA	29	22	93	100	100	78	72	67	95	84	85	76	87	76	▼		
CGRPB	86	64	88	100	100	63	56	49	91	69	78	75	76	74	▼		
CGRPC	44	41	77	100	100	76	61	75	100	100	89	80	87	93	▲		
OTHER	51	49	95	100	100	72	82	88	98	95	91	91	94	96	▲		
PRIVATE	0	0	100	0	100	0	0	0	0	100	0	0	0	0	=		
GRAND TOTAL	210	176	100	100	100	70	68	66	94	84	85	80	85	84	▼		

PALS concerns and Complaints by quarter.



6.0 Recommendations

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



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

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Finance Report
Section on agenda:	Quality and Performance
Supplementary reading:	Yes
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Chris Hickson, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required:	Note for information
<p>Summary:</p> <p>The Trust has ended the first quarter marginally ahead of its financial control total, thereby securing the quarter one Financial Recovery Fund income. The Dorset ICS also achieved its aggregate financial control total for the first quarter securing the associated Provider Sustainability Fund income.</p> <p>Despite this positive position, significant financial risk remains both internally and across the ICS. As such, financial recovery actions must now be prepared with some urgency to mitigate these risks.</p> <p>Members are asked to note the financial performance as at 30 June 2019.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on risk profile:	Four financial and performance risks recorded 2019/20 on the risk register for monthly review by Committee

Executive Summary

The Trust has set a full year break-even budget, consistent with the financial control total agreed with NHS Improvement. Achieving this budget supports access to £4.3 million in Provider Sustainability Funding and secures £1 million in Financial Recovery Funding.

As at 30 June, the Trust is reporting a deficit of £99,000 representing a favourable variance of £418,000. This is mainly driven by an additional £422,000 of provider sustainability funding following the national accounts process. After adjusting for this and other excluded items, the Trust is reporting a favourable variance of £12,000 against the year to date control total.

Income & Expenditure

After adjusting for pass through drugs and devices; income is ahead of plan by £571,000. This is mainly being driven by the additional PSF allocation together with higher than planned specialist income, particularly within Ophthalmology and Gastroenterology.

Expenditure reported a net over spend of £154,000 after adjusting for pass through drugs and devices. This includes an over spend against the pay budget of £600,000 which is a significant concern at this early part of the financial year. This reflects both the shortfall in the cost improvement programme together with a continued increase in agency premium expenditure. Action continues to be taken in both areas to mitigate this level of over spend.

Cost Improvement Programme

The Trust set a challenging target to achieve £10.5 million of savings during 2019/20. As at 30 June schemes amounting to £7.5 million have been identified, representing a shortfall of £3 million, with a further risk that schemes may not deliver fully. This shortfall includes £1 million linked to a Dorset ICS commercial transaction which will now not progress.

This is the primary area of financial focus, and further schemes continue to be identified to close this shortfall.

Sustainability Funding

The Dorset Integrated Care System (ICS) has accepted an overall 'system' control total. As such, all providers secure their individual Provider Sustainability Fund (PSF) if this system control total is achieved.

The collective Provider Sustainability Fund allocation for the ICS is £14.3 million, of which £4.260 million relates to our Trust. As at 30 June the ICS is £788,000 ahead of plan and continues to forecast achievement of the aggregate control total. However, there remains significant risk within this forecast and work continues across all partners to mitigate this.

Dorset Integrated Care System	Year to date			Full year		
	Budget £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Dorset County Hospital NHS Foundation Trust	(2,341)	(2,114)	227	0	0	0
Dorset HealthCare University NHS Foundation Trust	(1,052)	(588)	464	2,036	2,036	0
Poole Hospital NHS Foundation Trust	(2,396)	(2,317)	79	0	0	0
Dorset Clinical Commissioning Group	500	500	0	2,000	2,000	0
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	(517)	(505)	12	0	0	0
SURPLUS/ (DEFICIT)	(5,806)	(5,024)	782	4,036	4,036	0

The Trust has also been allocated funding through the national Financial Recovery Fund (FRF). This amounts to £998,000 and is dependent upon the Trust alone achieving its agreed financial control total.

Cash

As at 30 June the Trust is holding a consolidated cash balance of £32.7 million. This is a strong position, and will improve significantly upon receipt of the 2018/19 Provider Sustainability Funding expected during quarter two.

Capital

Capital expenditure amounting to £1.7 million has been committed to date, which is £3.3 million behind budget. This reflects the timing of expenditure, particularly in relation to the One Dorset Pathology Laboratory Information Management System, replacement Medical Equipment and the Dorset Clinical Services Review.

Following a request from NHS Improvement the Trust has reduced it's in year capital programme by £4.147 million equal to 19.9%. This represents the slippage of some schemes into 2020/21 on a risk based approach, rather than the cancellation of schemes, and will result in a higher capital investment in 2020/21 than was originally planned.

Recommendation

Members are asked to note the Trust's financial performance for the period ending June 2019.

Finance Report

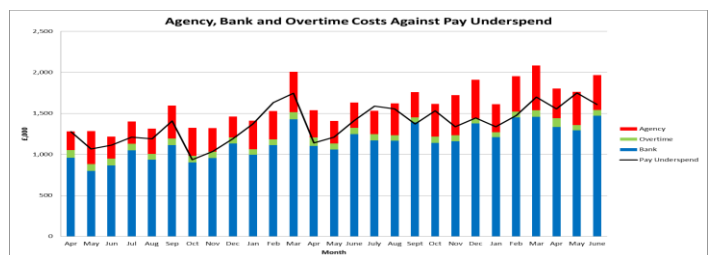
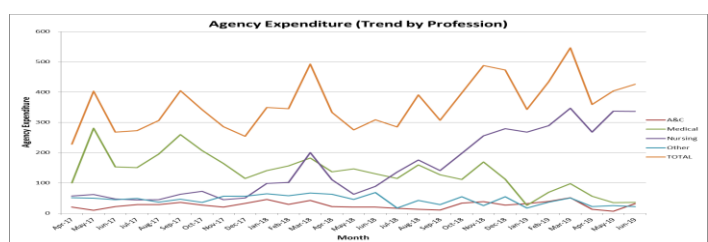
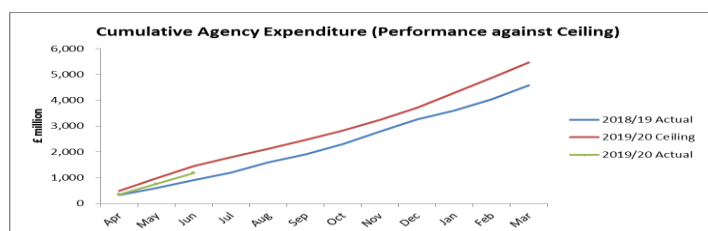
As at 30 June 2019

Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000	Pass Through £'000	Residual Variance £'000
NHS Clinical Income	68,497	69,304	807	(356)	451
Non NHS Clinical Income	1,406	1,330	(76)	7	(69)
Non Clinical Income	8,535	8,725	190	0	190
TOTAL INCOME	78,438	79,359	920	(349)	571
Employee Expenses	50,483	51,084	(600)	0	(600)
Drugs	8,337	8,609	(272)	307	35
Clinical Supplies	9,034	8,932	102	42	144
Misc. other expenditure	11,101	10,834	268	0	268
TOTAL EXPENDITURE	78,955	79,458	(503)	349	(154)
SURPLUS/ (DEFICIT)	(517)	(99)	418	0	418

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	48,725	48,725	0
NHS England (Wessex LAT)	11,151	11,908	757
NHS West Hampshire CCG (and Associates)	6,485	6,485	0
Other NHS Patient Income	2,544	2,593	50
Non NHS Patient Income	1,406	1,330	(76)
Non Patient Related Income	7,339	7,107	(232)
Provider Sustainability Fund	639	1,061	422
Financial Recovery Fund	150	150	0
TOTAL INCOME	78,438	79,359	920

Agency Expenditure

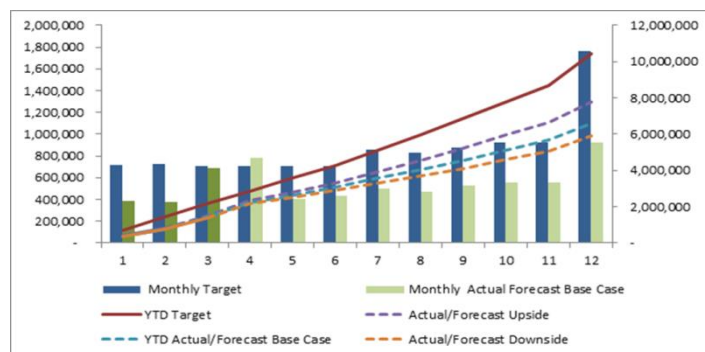


Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	2,515	2,286	(229)
Medical Care Group	3,007	2,237	(770)
Specialties Care Group	1,133	1,500	367
Corporate and Trust-wide Budgets	(7,172)	(6,123)	1,049
SURPLUS/ (DEFICIT)	(517)	(99)	418

Cost Improvement Programme

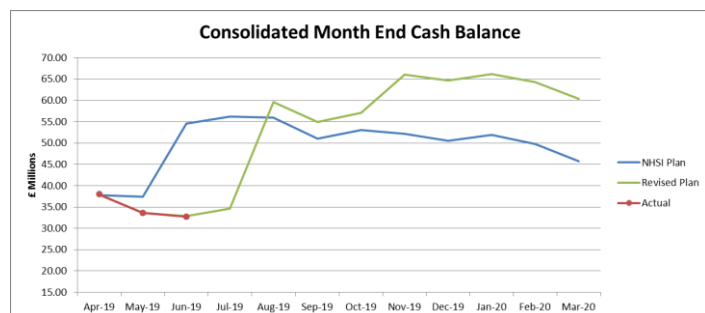
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	330	271	(58)
Medical Care Group	645	261	(385)
Specialties Care Group	608	408	(200)
Corporate and Trust-wide Budgets	567	573	6
TOTAL	2,149	1,512	(637)



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	867	499	368
IT Strategy	2,079	355	1,724
Medical Equipment	1,176	479	697
Centrally Managed (includes Donated)	888	345	543
SURPLUS/ (DEFICIT)	5,010	1,678	3,332

Cash





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

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Report
Section on agenda:	Quality and Performance
Supplementary reading:	--
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, sickness absence, and safe staffing information. As requested by the Board, this month's report also includes an update on the apprenticeship levy.	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 ✓ ✓ <input type="checkbox"/> <input type="checkbox"/> ✓
Impact on risk profile:	Recruitment and workforce planning are existing risks on the risk register.



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust

Workforce Report

For the period to end




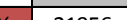
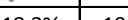














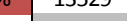
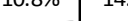






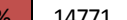
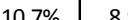











June 2019

Karen Allman
Director of Human Resources



Workforce Report for July Board

As at 30th June 2019

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 June			Rolling 12 months to 30 June			At 30 June	
Surgical	18.3% 	83.3% 	94.4% 	4.03% 	14248 	12.2% 	8.0% 	
Medical	23.3% 	79.1% 	93.5% 	4.18% 	21956 	18.3% 	10.5% 	
Specialities	20.0% 	84.9% 	95.4% 	4.21% 	13529 	10.8% 	14.5% 	
Corporate	19.8% 	100.0% 	95.7% 	4.43% 	14771 	10.7% 	8.9% 	
Trustwide	20.7% 	82.5% 	94.4% 	4.21% 	64504 	13.6% 	10.5% 	

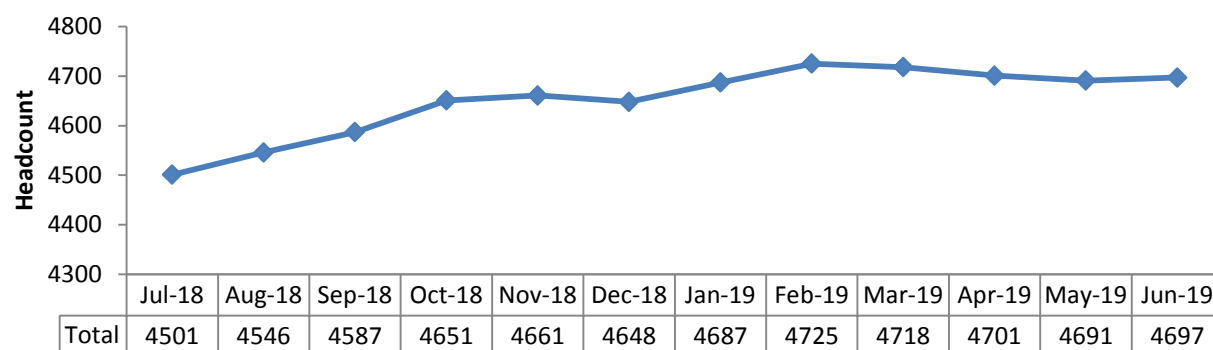
Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 June			Rolling 12 months to 30 June				At 30 June
Add Prof Scientific and Technical	22.7%		94.7%	5.29%	2589	17.8%	14.5%	
Additional Clinical Services	16.2%		94.3%	6.22%	17729	23.5%	13.6%	
Administrative and Clerical	23.6%		96.6%	3.75%	12171	11.0%	10.1%	
Allied Health Professionals	19.2%		95.4%	2.39%	2348	14.0%	12.0%	
Estates and Ancillary	13.2%		94.1%	6.52%	8008	13.8%	10.7%	
Healthcare Scientists	13.0%		96.0%	3.29%	1151	4.8%	9.6%	
Medical and Dental		82.5%	90.8%	1.19%	2266	4.2%	5.7%	
Nursing and Midwifery Registered	24.4%		94.6%	4.26%	18242	11.0%	8.7%	
Trustwide	20.7%	82.5%	94.4%	4.21%	64504	13.6%	10.5%	

Workforce Report for July Board

As at 30th June 2019

1. Staffing and Recruitment

Substantive Staff (Headcount) Trend

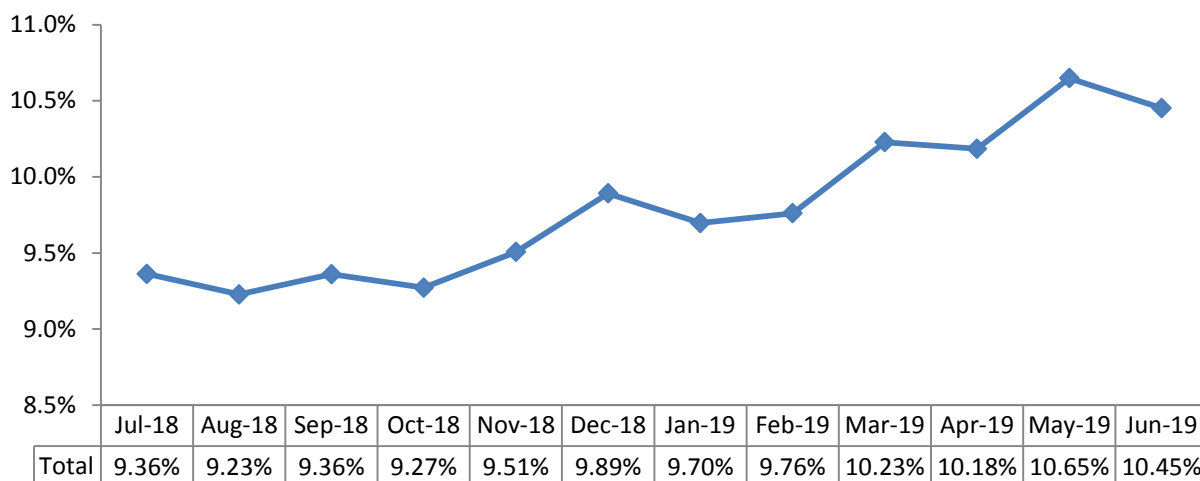


The turnover rate for June was down 0.2% to 10.45% from 10.65% in May.

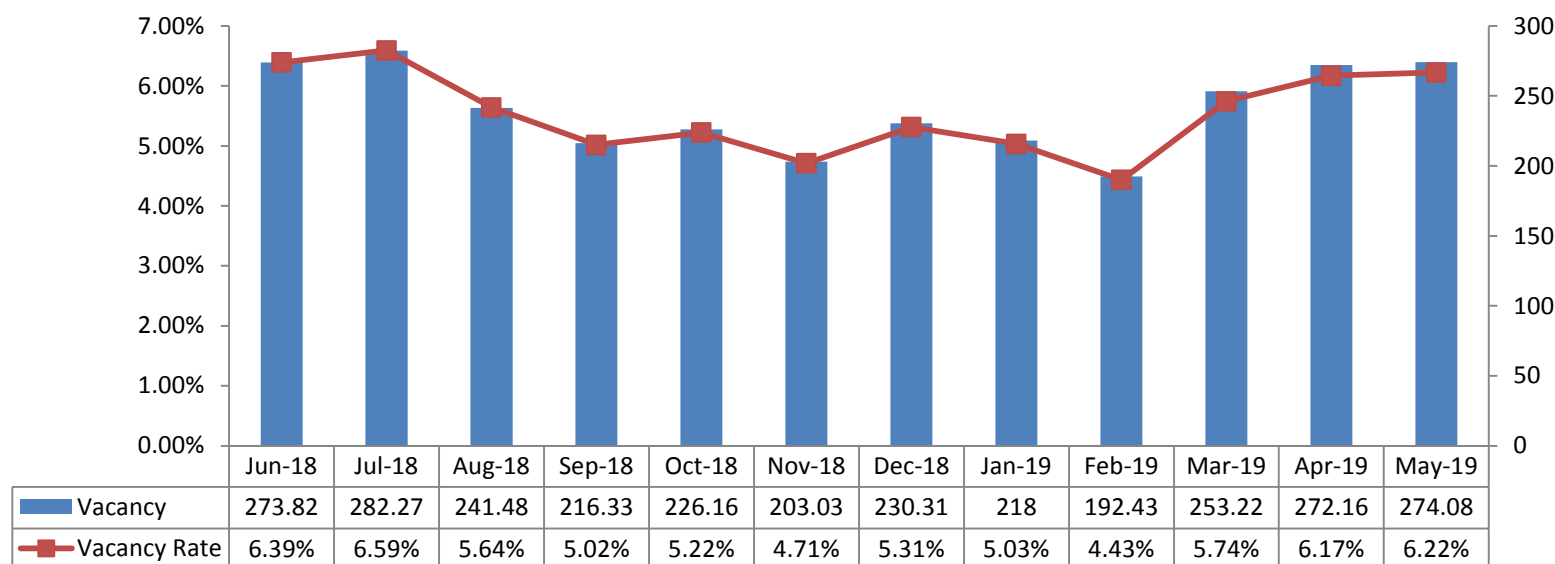
The joining rate is unchanged at 13.6% and continues to run at a higher rate than turnover, currently over 3% higher, which is a positive. As a result, substantive staff headcount continues to rise, currently at 4,697 representing an increase of 191 (4.23%) over the 4,506 seen at the same point last year.

Vacancy rate at 30/06/19 is not available at the time of writing; the trend chart below reflects the position as at 31/05/19 at 6.22%.

Permanent Staff Turnover Rate (Headcount)



Vacancy Trend For All Care Groups, All Directorates, All Staff Groups



2. Essential Core Skills Compliance

Compliance for June 2019 increased to an all-time high of 94.4%, up from 93.9% as at 31st May. Medical and Dental also recorded a 2% increase to 91%. All other staff groups are at 94% and above. As previously advised, Fire training moved to e-learning from April 2019 and compliance has increased month by month since, now standing at 94.4% as at 30th June; this compares to a figure of 80.7% at the start of the year so an excellent result.

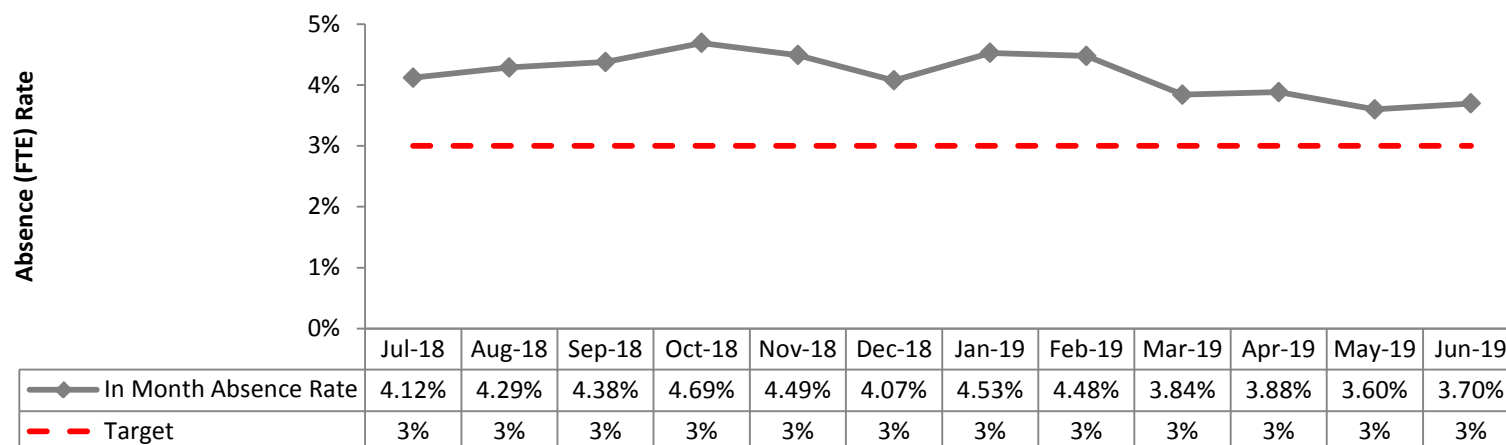
As always, we continue to work closely with colleagues across the NHS in Dorset to align training and improve the transferability of skills. The BEAT team continue to review and adapt mandatory training wherever possible to make it as user-friendly and less time-intensive as possible.

Workforce Report for July Board

As at 30th June 2019

3. Sickness Absence

In Month Absence Rate (FTE)



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Surgical	4.38%	4.12%	4.24%	4.66%	4.02%	3.39%	4.28%	4.71%	4.38%	3.97%	3.42%	3.47% ↑
Medical	3.58%	3.75%	3.91%	4.31%	3.99%	3.98%	4.52%	4.68%	3.92%	4.08%	4.20%	4.23% ↑
Specialties	4.31%	5.08%	5.15%	4.79%	5.44%	4.07%	4.43%	3.80%	3.07%	3.34%	2.95%	2.96% ↑
Corporate	4.53%	4.55%	4.52%	5.26%	4.90%	4.95%	4.89%	4.56%	3.87%	3.98%	3.45%	3.79% ↑
Trust	4.12%	4.29%	4.38%	4.69%	4.49%	4.07%	4.53%	4.48%	3.84%	3.88%	3.60%	3.70% ↑

The in-month sickness absence rate maintained its amber rating, albeit with a small increase to 3.7% from 3.6% in May. The Specialties care group maintained its green rating in June at 2.96% which is excellent news. Medical care group remains red.

A high level of focus continues on managing sickness, and the health and wellbeing initiatives on offer continue to be widely promoted within the Trust. We continue to search for new ways to support staff and managers in promoting health and wellbeing initiatives.

As part of the 2019-20 Internal Audit plan a review is being undertaken of the 2016 sickness audit to assess how embedded actions have become in operational processes across the Trust. Feedback and actions will be discussed at the Workforce and Audit Committees.

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 June 2019:

Registered Nurse (RN)	Actual Day	94.8%	HCA Actual Day	97.6%
Registered Nurse (RN)	Actual Night	100.5%	HCA Actual Night	121.3%

Overall the Trust maintained a safe and stable staffing position in June 2019. A small percentage of high cost agency was utilised, which continues to be monitored through the Premium Cost Agency meeting.

The new pricing structure for agency tier one contracts are ready for signing and the structure is on track for an end of July implementation date.

There were no reportable red flag shifts for June 2019.

No impact has been noted from the decision to cease using agency Health Care Assistants.

Care hours per patient day (CHPPD)

CHPPD is a measure of ward productivity and provides transparency to the variation of staff to patients across wards, units and Trusts.

Simplistically, low rates may indicate a potential patient safety risk and high rates could suggest unproductive wards or inefficient staff rostering processes.

The latest Trust CHPPD data available is:

Workforce Report for July Board

As at 30th June 2019

Measurement	Data Period	Trust Value	Peer Value	National Value	Chart
Cost per WAU - Substantive Nursing & Midwifery Staff	2017/18	£671	£686	£710	
Total Nursing & Midwifery FTE	2017/18	1,698.0	1,845.3	2,096.6	
Care Hours per Patient Day - Total Nursing & Midwifery Staff	Apr 2019	7.7	7.9	8.1	
Cost per Care Hour - Total Nursing & Midwifery Staff	Mar 2019	£23.42	£23.73	£23.65	
Cost per Patient Day - Total Nursing & Midwifery Staff	Mar 2019	£184.50	£185.61	£189.65	
Average Staff Cost - All Nursing & Midwifery Staff	2016/17	£33,181	£34,872	£35,334	

The CHPPD data has been updated since last reported in June 2019. It demonstrates that the average number of care hours a patient received in a day in February 2019 at the Trust was 7.7 hours (all nursing, midwifery and support staff). This was 0.4 below the national median of 7.9 and measures equitably (within 0.2) of peer organisations. On analysis the data suggests that the current staffing model is cost effective and safe.

5. Apprenticeship Levy

Background:

The Apprenticeship Levy was introduced in April 2017 requiring all employers with a pay bill of £3m per annum or more to contribute the equivalent of 0.5% of their total payroll to a central fund designed to promote the spread and development of apprenticeship programmes. The NHS is subject to a public-sector apprenticeship target, and needs to ensure at least 2.3% of its workforce starts an apprenticeship every year. The objective of the Levy is to ensure the NHS makes full use of the funds to offer high quality apprenticeship programmes, develop the workforce skills mix and build a sustainable domestic workforce for the NHS. The money cannot be spent on salaries, backfill or infrastructure costs.

In common with other NHS organisations we have struggled to spend our Levy pot. The reasons for the underspend are multifactorial as in order to procure an apprenticeship course the supporting standards need to be agreed, provider/s needs to offer a suitable

programme, procurement processes take place, and employers need to identify any backfill or salary support as the levy cannot be used for anything other than the course fees.

The amount going out will vary depending on the number of apprentices that are 'live' on the Levy and the amount being paid in will vary depending on our Trust headcount. For example, between 01/04/18 and 31/03/19 we put £904k into the levy (based on £75k per month payment) and over this same period we drew down £322k (based on £27k per month).

We have 47 apprentices on various courses on the Apprenticeship Levy. This number will increase in September 2019 to 86 with the addition of new apprenticeship courses following the statutory procurement processes. We currently use six providers and all apprentices are required to complete an apprenticeship agreement and a commitment statement. All programmes are required to last a minimum of 12 months and the training fees are taken from the Levy each month.

Dorset System:

As a Dorset system we are keen to drive and motivate the apprenticeship market by working collaboratively with other NHS and Healthcare organisations. After two years we are at risk of losing some of our Levy funds with no guarantee that this funding will remain in the NHS and, as an example of system working, we have offered to provide financial support from our Levy to the Our Dorset Primary Care Network to ensure funding stays both within the NHS and within the Dorset System as a whole.

A further example includes recruiting 50 external Registered Nurse Degree Apprentices who are due to start in September 2019. These apprentices will be new to healthcare; 14 of them are expected to start at RBCH and will rotate across different providers as part of their training. We hosted an event to publicise the RNDA plans earlier in the spring and were pleased with the profile and response; a similar event was hosted by Dorset County.

The lag in spending the Levy has been due to a combination of factors including the procurement process, and the delay in developing national standards, development of training providers etc. Once confirmed, we then advertise the programme, ensure eligible staff meet the required entry criteria and then add staff on to the Levy. The Board will be aware of the pressure on pharmacy staffing and we hope to be able to add pharmacy apprenticeships to the Levy from February 2020 to meet future workforce demands.

We are keen to substantively increase the amount of apprenticeships available at RBCH and there is an extensive marketing programme in place to facilitate this. This includes both clinical and non-clinical apprenticeship opportunities. We try to ensure that all vacancies at the Trust are considered as possible apprentices via the vacancy review processes. We are also working to support higher and degree level apprenticeships - this will include leadership and management courses.

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Safe Staffing Report (Nurse)
Section on agenda:	Quality and Performance
Supplementary reading:	Six month Safe Staffing Report October 2018-April 2019 (in the Reading Pack)
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) June 2019 was discussed and noted at the Workforce Strategy and Development Committee on 10 June 2019. Following this meeting there are no additional issues to escalate to the Board.
Action required:	Note for information
<p>Summary: This paper is a summary of the Six Month Safe Staffing Report that was presented to the Workforce Strategy and Development Committee in June 2019 (presented in the Reading Pack). The paper reports on the Trust's Nursing and Midwifery Staffing position for the period of October 2018-April 2019.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>✓</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
Impact on significant risks:	Not Applicable

**Trust Board Summary of Six Month Safe Staffing Report:
October 2018-April 2019**

In June 2019 the bi- annual Safe Staffing Report was presented to the Workforce Strategy and Development Committee. This report provides 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:

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.

Subsequent to this NHS England has mandated that all Trusts report monthly on the Model Hospital Data to their Trust Boards.

Items of note for the Board within the June 2019 Safe Staffing Report were:

1. Ward Staffing Template Reviews were undertaken during quarter three in preparation for budget setting. All the staffing templates meet the criteria for safe staffing from national reviewed benchmarking and professional judgement. The outcome of these reviews is set out in Appendix one. Highlights from the latest reviews are:
 - a. Surgical Care Group: Following the 2018 quarter one investment in template increases, no further investment was required in quarters three and four.
 - b. Medical Care Group: The Emergency Department (ED) Template was uplifted to reflect new initiatives implemented in the department. Older Persons Medicine has designed and is piloting a hybrid nursing / allied health professional template on one ward.
 - c. Specialities Care Group: Some minor template adjustments undertaken in quarters three and four. Mostly around the banding of specialist chemotherapy trained nurses.
2. On-going robust management and oversight of the ward staffing continues using:

- a. Eroster clinics to encourage best roster practice.
- b. Safe Care Electronic Staffing tool for daily management and balance of staffing and acuity.
- c. Monthly upload and review of the national Unify Data; demonstrating the Trust maintains a good overall planned to actual staffing fill rate.
- d. Monitoring and reporting of local red flag criteria. During quarters three and four there were three potential red flag shifts reported all of which were appropriately mitigated.
- e. Care Hours per Patient Day (CHPPD) latest data published in February 2019 suggests that the nurse staffing levels in the Trust are cost effective and given our performance against quality metrics running an efficient nursing workforce.

3. Exception reporting for vacancies highlighted the following areas:

- a. Medical Care Group: The area with the highest number of vacancies is Older Persons Medicine (OPM). Focused recruitment work in this area is on-going with early successes noted in the recruitment of HCAs. Practice Educator roles have been implemented in OPM, ED and the Acute Medical Unit (AMU).
- b. Surgical Care Group: High vacancies were noted on ward 16, which were being mitigated with block booked agency staff; and in theatres.
- c. Specialities Care Group: Areas of greatest challenge noted to be pharmacy and interventional radiology. Ward 11 and Haematology and Oncology Day Unit (HODU) vacancies for experienced Chemotherapy Nurses remain high, due to maternity leave.

4. Recruitment remains a key focus for the Trust with a variety of recruitment initiatives being explored including:

- Trainee Nursing Associates
- Registered Nurse Degree Apprentices
- Assistant Practitioners
- Overseas Recruitment

5. Premium Cost Avoidance Transformation Steering Group (PCATSG)

Work continues in this group to drive down high cost temporary staffing. An increase in overall nursing and Health Care Assistant (HCA) expenditure has been noted and a number of initiatives are being initiated or refreshed to overcome this; these include:

- Ceasing the use of agency HCA staff.
- A review of the management and use of Tier three agencies.
- A plan to reduce and remove Thornbury Nursing Agency
- Continue Growth and development of band 4 workforce.

Further details of the above reported subjects can be found in the full copy of the Six Month Safe Staffing Report October 2018 – April 2019, which is available in the Reading Room.

Appendix One:

Outcome of Template Reviews (winter 2018/2019)

Care Group A

Clinical Area	Agreed Template RN WTE	Agreed Template Non RN WTE	Template Techs	Increase	Decrease	Comment /Impact
AEC	3.67	1.83	N/A	0	0	
Pre-Assessment	15.71	8.44	N/A	0	0	
Sandbourne	14.25	4.63	N/A	0	0	
Ward 12	19.35	10.22	N/A	0	0	
Ward 14	16.73	8.05	N/A	0	0	
Ward 15	19.32	13.15	N/A	0	0	
Ward 16	23.03	16.92	N/A	0	0	
Ward 17	17.67	12.48	N/A	0	0	
BPC	9.23	2.17	N/A	0	0	Template for 6 day working
SAU	20.25	8.08	N/A	0	0	
ICU/ HDU	48.63	N/A	N/A	0	0	
CCOT	7.03	N/A	N/A	0	0	
Pain Service	3.4	N/A	N/A	0	0	
Recovery	30.32	3.34	2.91 WTE Band 3 ARP	0	0	ARP = Assistant Recovery Practitioner
Derwent	16.63	12.80	N/A	0	0	
Ward 7	17.77	15.05	N/A	0	0	
Midwifery	40.78	12.98	N/A	0	0	
Theatres	93.05	53.85	N/A	0	0	

Orthopaedic Outpatients	6.19	10.32	N/A	0	0	
Jigsaw	2.73	1.02	N/A	0	0	

Care Group B

Clinical Area	Agreed Template RN WTE	Agreed Template Non RN WTE	Template Techs	Increase WTE	Decrease WTE	Comment /Impact
Ward 1	21.25	11.62	N/A	0	0	
Ward 2	20.43	11.87	N/A	0	0	Ward 2 experiences an increase in acuity during the winter and sometimes the summer months re: respiratory patients. The template may need to consider a flex approach moving forward.
Ward 3	15.07	21.79	N/A	+6.62	-3.06	The non RN includes 5.37 B4 ASP.
Ward 4	18.32	19.78	N/A	+0.2	0	
Ward 5	15.98	23.54	N/A	+0.3	0	The non RN includes 5.37 B4 ASP.
Ward 9	17.81	28.9	N/A	+8.05	0	The non RN includes 2.68 B4 ASP.
Stroke	34.22	19.67	N/A	+0.8	0	
AMU	53.24	34.87	N/A	0	0	
ED	65.97	43.75	N/A	+9.7	0	The non RN includes 13.52 B4 ASP.
Ward 22	18.6	15.42	N/A	+2	0	
Ward 23	22.73	9.2	N/A	+2.6	0	
CCU	28.31	5.37	N/A	0	0	
Ward 24	15.67	22.72	N/A	+5.37	0	The non RN includes 5.37 B4 ASP.
Ward 25	18.25	21.35	N/A	+1.17	0	

Ward 26	22.78	20.85	N/A	+2.62	0	
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Care Group C

Clinical Area	Agreed Template RN WTE	Agreed Template Non RN WTE	Template Techs	Increase	Decrease	Comment /Impact
Eye Ward	18.62	5.42	0	0	0	No change since last report
Eye Theatre	18.25	6.65	0	0	0	Slight reduction (Nov 18) in trained and increased untrained. Requires further uplift to reflect new Wimborne Service(20.29WTE trained; 4.46 untrained) This to be discussed at next template review in June 2019
ARC	12.19	0	4	0	0	No change
Eye OPD	10.53	11.00	3	0	0	No change since last report
Ward 11	19.6	3.8 (inc 1.0 DCF)	0	0	0	Skill mix review reduced band 5 and increased band 6. Head count remained static
Mac Unit	15.49	11.43	0	0	0	No change since last report
HODU	12.16	2.72 band 4 2.0 band 2	0	0	0.77	Skill mix review reduced band 5 and increased band 6. Slight reduction in RN



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

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	CQC National Inpatient Survey 2018
Section on agenda:	Quality and Performance
Supplementary reading:	Picker report and Inpatient survey report
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Laura Northeast Head of Patient Experience Fiona Hoskins Deputy Director of Nursing and Midwifery
Details of previous discussion and/or dissemination:	Interim report - Picker Report and overview of national results discussed in HAC June 2019
Action required:	Note for information
Summary: The results from the CQC National Inpatient survey 2018 were published by our survey provider (Picker) in comparison to other trusts who used Picker. The national results were published in July 2019 and a summary is provided in the enclosed report. There are actions in place to address priority areas: noise at night, visible ward leadership, gathering feedback and knowing how to complain.	
Related strategic objective:	Listening to patients. Ensuring meaningful engagement to improve patient experience
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	<input type="checkbox"/>
Impact on high risks:	

CQC National Inpatient Survey 2018

1.0 Introduction

The National CQC Inpatient Survey 2018

The National Inpatient Survey was completed by Picker for RBCH in July 2018. The results were initially compared with other Trusts who used Picker as their chosen survey provider and this was discussed at the Healthcare Assurance Committee, Senior Nurse meeting and the Trust Management Board. The national results were published in July 2019. This is a summary report of the findings.

2.0 Summary of Picker results

The Picker results demonstrated that 98% of our patients had confidence in medical and nursing staff, they reported being treated with respect and dignity.

Over the past two years the Trust has shown and maintained significant improvement in results with questions relating to discharge from the Hospital. Our patients have reported that their discharge was not delayed and they received information about danger signals to look for following discharge.

Disappointingly, despite small improvements from 2016 and 2017 the results still show a lower than average score in comparison to other Picker surveyed Trusts for patients knowing which nurse is in charge of their care.

Patients reported not being fully aware how to complain or being asked about their experience of care. The inpatient survey was completed during a time of change from Care Campaign Audit to the trial of Care Conversations in some inpatient areas meaning the frequency of patients being surveyed by volunteers was reduced during training and planning of this model. However, the Friends and Family Test response return rate has remained above the NHSE recommended level of 15% with an average return rate of 30% for in patient areas.

Patients reported being disturbed by noise from staff at night, which has been an area of concern for the Healthcare Assurance Committee. Noise at night is being addressed as a priority by the Senior Nurse team in conjunction with the QI team. An action learning week was held in April 2018 launching the 'settling down' policy. Patients are being prompted to talk about their experience of rest and sleep through care conversations to get a deeper understanding of interruptions experienced by our patients.

It was reported by Picker that the Trust needs to consider addressing patients sharing sleeping areas with members of the opposite sex. There is a robust reporting system for mixed sex breaches. During the in-patient survey period there were no nationally reported single sex breaches for the Trust.

3.0 CQC National Inpatient Survey results

3.1 National comparison published July 2019

The National Inpatient survey results were published in July 2019 on the CQC website. Nationally, the results for the 2018 Adult Inpatient Survey have slightly declined for all Trusts since last year or remained static.

- Nationally, patients are reporting that they are waiting too long at admission and longer than previous years at discharge.
- Nationally, there has been a decline in patients perception of being asked about their experiences of care and knowing how to complain.
- Nationally, trust in doctors and nurses remains relatively high but has declined slightly since the survey was last carried out in 2017.

3.2 Results for RBCH

- The inpatient survey results have remained static for ten out of the eleven survey sections, with the responses 'as expected'.
- Performance in one section of the survey has improved relating to timely admission.
- RBCH has been identified as a 'better' performing Trust for patients waiting for a bed at admission in national comparison.
- Our Trust has an improved survey result for providing our patients with enough help from staff to eat meals.
- Our patients felt there were enough staff on duty to care for them and the result is 'better' than other Trusts. This result has improved on last year's survey results.
- Our patients report being disturbed by noise at night from staff. In comparison to other Trusts this is our lowest scoring question on the survey.
- The lowest scoring section in the survey related to patients knowing how to complain
- Patients are not always aware who is in charge of their care.

3.3 Priority Areas for Action

The key priorities to address remain as identified in the interim report:

- Visible Ward Leadership
- Gathering feedback and explaining how to complain
- Noise at night from staff

The action plan is in progress, which will be taken forward through the Strategic Senior Nurse meetings and Quality Forum. This will be monitored by the Healthcare Assurance Committee.

4.0 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 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Chief Executive's Report
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Debbie Fleming, Chief Executive
Author(s) of paper:	Debbie Fleming, Chief Executive
Details of previous discussion and/or dissemination:	Regular agenda item
Action required:	Note for information
Summary: The attached report from the Chief Executive provides an update on various areas since the Board meeting in May 2019.	
Related strategic objective:	All
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 high risks:	None

BOARD OF DIRECTORS MEETING

July 2019

REPORT OF THE CHIEF EXECUTIVE

1. Visit by the Secretary of State for Health and Social Care

Earlier this month, we were delighted to welcome the Rt. Honourable Matt Hancock, our Secretary of State for Health and Social Care, when he made a short visit to The Royal Bournemouth Hospital. We were joined by senior leaders from across the Dorset System, and were pleased to have the opportunity to highlight some of the challenges that we face in meeting the needs of our population, and to update him on our plans to reconfigure our services in order to improve outcomes for local people. Secretary of State visited the Stroke Unit where he met with members of the Stroke team, including staff from Poole Hospital, and where he was able to engage directly with patients. It was clear that he really enjoyed hearing directly from frontline staff about the work they are doing to improve the stroke pathway, which is an excellent example of how we are transforming services together. The visit ended with a Question and Answer session, at which a wide range of issues were raised, including the future funding arrangements for social care, recent changes to the pension arrangements, and the workforce challenges that are being felt across the NHS.

Secretary of State has since told us how very much he enjoyed his visit to Dorset. He was very impressed by the enthusiasm and dedication of our staff, and the commitment of local partners in working together to meet local needs. We look forward to welcoming him again at some point in the future.

2. Poole Hospital – 50th anniversary celebration

The 11 July 2019 was a very special day for Poole Hospital, as it was exactly 50 years ago on that day that Her Majesty The Queen opened the building in 1969. To celebrate this anniversary, special anniversary cakes were distributed to all wards and departments in the hospital, and the Chairman and I planted a tree (donated by Haskins Garden Centre) outside the Dolphin Restaurant, with a plaque to mark the occasion. Later in the day, we took the opportunity to celebrate the reopening of Durlston Garden, which had been closed during the construction of the new main entrance. We thanked the staff and volunteers for their patience whilst this work took place, with a particular mention of those volunteers who did such a wonderful job in supporting patients and visitors in “wayfinding” around the Trust throughout this period.

The Trust will be formally celebrating its Golden Jubilee at a series of events centred around the Annual Members Meeting in September, including be a Public Open Day due to take place on Saturday 14 September

3. Update on Merger

Our two Trusts are working together extremely well as we develop our plans to merge the two organisations. The Competition and Markets Authority (CMA) has now authorised us to bring together seven clinical services – that is, Emergency Department, Anaesthetics &

Theatres, Older People's Medicine, Trauma & Orthopaedics, stroke, maternity and cardiac services – along with our business support services, such as HR, finance, and governance. This gives a real focus for the work, and is allowing us to bring together teams in phases, in a way that makes sense locally.

At this stage, we are not able to confirm the date of the merger, as this is dependent on the approval of our Outline Business Case for the £147m, which is needed to implement our estates plans. This is not expected to be approved until later this year. In the meantime, we are still working to the date of April 2020, and seeking to get as much done by then as possible - recognising that the actual date may slip a little to later in 2020.

The two Trusts are currently finalising the composition and process for setting up the Shadow Interim Board for the new organisation, which it is anticipated will be established by December 2019. The Shadow Interim Board will oversee the setting up of the new organisation, recognising that the two Trusts will continue to operate as formal separate entities until such time as the merger transaction is complete. After that, it will continue as the Interim Board, until such time as new Governors have been appointed, and the final permanent Board appointments can be made.

In the meantime, the Trusts are continuing with their development work, seeking to strengthen relationships at Board level, Executive level, amongst Governors, clinical leaders and frontline staff. During the autumn, we shall be formally starting our work to develop the vision, values and strategy of the new organisation, building on the strengths of the existing trusts. We shall also be commencing an inclusive process of developing the name for the new organisation.

Overall, things are progressing well, as the Trusts seek to join together in order to take forwards their shared clinical strategy, and implement the Dorset system plan.

4. Pressures on the Hospitals

Members will be aware that both Trusts have continued to be exceptionally busy throughout June and July, with more patients attending the Emergency Department than anticipated for this time of year and more acutely ill patients being cared for in both hospitals. This is a source of concern, given that it often means opening additional beds, which in turn creates pressure on staff and on budgets.

It is not clear exactly why it is that the Trusts are so busy, but it is recognised that this is a challenge for the whole Dorset system, and not something that can be tackled by the Trusts in isolation. Whilst much work is underway as part of the Integrated Community and Primary Care Services Programme to reduce admissions and speed up discharge, more needs to be done to ensure that this has the desired impact within the acute setting.

This issue is actively being discussed at the System Leadership Team and at other key meetings amongst partners. The strategic solutions are clear and have been agreed by partners within Dorset. The challenge as always is the speed at which our plans can be implemented – particularly when there are so many challenges associated with the NHS workforce.

In the meantime, it is important that staff continue to be supported in managing these higher than anticipated activity levels.

5. Building Plans

As highlighted elsewhere, the plans for the building work at Poole Hospital and The Royal Bournemouth Hospital have now been submitted to the Bournemouth, Christchurch and Poole Council for approval. These plans represent a once-in-a-lifetime opportunity to secure £147m Treasury investment for the NHS in Dorset, to develop our two hospital sites.

The developments at The Royal Bournemouth Hospital will enable the establishment of a new Maternity Unit, a new Children's Unit, an expanded Emergency Department and expanded Critical Care facilities – all of which will be vitally important in meeting the future health needs of the local population. The need for a new Maternity Unit is very well understood in the area, with various plans for a new facility having been submitted on several occasions in the past. However, now that funding has been set aside at a national level to support this development, a new purpose-built Maternity Unit - with adjacent purpose-built Children's facilities - can become a reality for local people.

There is also an urgent need to expand and update the operating theatres at Poole Hospital, which will enable patients to have far better care, in modern, purpose-built facilities. Our current day case theatres are lacking space, privacy and dignity for patients, essentially reflecting the fact they were designed and built in the 1960s. If planning permission is granted, it will enable us to open new, state of the art theatres, which will allow us to expand capacity, and enable patients from across the area to gain swifter access to essential surgery. The development of the Poole site also includes creating a new 24/7 Urgent Treatment Centre, expected to treat between 50,000 and 60,000 patients each year.

Clearly, these developments cannot go ahead without planning permission from the local authority. The Trusts are keen that staff and patients confirm their support for these developments, which represent the opportunity to achieve a step-change in the quality of NHS provision in the local area.

6. System Partnership Board

Members will be aware that the Dorset system is currently working to refresh its Sustainability and Transformation Plan, for resubmission in the autumn. Given that there has been so much organisational change in Dorset over the past few months, partners have been focusing on getting to know each other, creating positive relationships that will enable us to take forwards our shared ambitions for local people.

There have been a number of informal meetings over the past few weeks, including a Development Event on 27 June. There are many priorities that are shared by Dorset partners, and it is recognised by all that in working together, we can maximise our impact on improving services and outcomes for local people.

7. Interim NHS People Plan

8. NHS Improvement, NHS England and HEE have recently published the interim NHS People Plan which sets out the national strategic framework for the workforce in the NHS over the next five years. During the first quarter of 2019, a national steering group was set up to support engagement with key stakeholders and ensure wide input into the interim plan from across the NHS. The plan has 6 key domains:

- Making the NHS the best place to work;
- Improving the leadership culture;
- Tackling the nursing challenge;
- Delivering 21st Century care;
- A new operating model for workforce
- Developing the full people plan.

Within Poole Hospital NHS FT and The Royal Bournemouth and Christchurch Hospitals NHS FT, these are already recognised as important issues, with work already underway to address them. In bringing together the two organisations, we shall be developing a joint People Strategy as part of our merger plans, consistent with the national plan. At the same time, our work needs to inform and complement the development of the wider Dorset system workforce plan. Within Dorset, as an Integrated Care System, our Directors of Workforce and Organisational Development routinely work collaboratively together to ensure that we maximise the benefits of system working and tackle our workforce issues together. This will continue to be important in taking forwards the NHS People Plan.

9. Learning lessons to improve our people practices

Following a very tragic event that occurred at a London NHS hospital three years ago, an independent inquiry was undertaken into the investigation and disciplinary process adopted by the hospital and made a number of recommendations. Subsequently, NHS Improvement established an Advisory Group to consider to what extent the failings identified in the case were either unique to the London hospital or more widespread across the NHS and what learning could be applied.

Baroness Dido Harding, Chair, NHS Improvement has now written to all NHS Foundation Trust chairs and chief executives outlining the additional guidance relating to the management and oversight of local investigation and disciplinary procedures and asking that Human Resources Teams and Boards of Directors review them and assess current procedures and processes in comparison and, importantly, make adjustments where required to bring hospitals in line with best practice.

In Dorset, this is being reviewed by the Dorset Human Resource Directors' Network, with an action plan being developed to ensure that the guidance is implemented in a consistent way across all NHS organisations. This will then be followed up within each organisation's individual Workforce Committee.

Debbie Fleming
Chief Executive

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Organisational Development Update
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Deborah Matthews, Director of Improvement and Organisational Development
Author(s) of paper:	Bridie Moore
Details of previous discussion and/or dissemination:	Trust Objectives for 2019 / 20
Action required:	Note for information
Summary: This paper provides a progress update on our RBCH Organisational Development (OD) plan for 2019/20	
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 significant risks:	

ORGANISATIONAL DEVELOPMENT UPDATE

Introduction

In June 2019, NHS Improvement (NHSI) published the interim NHS People Plan, outlining how the NHS will support and develop NHS leaders and set the conditions for an improved working culture throughout the NHS.

This paper provides a summary of activities and progress against our 2019 / 20 organisational development plan in support of our culture of continuous improvement. It also describes some early and important work with Poole Hospital NHS Foundation Trust to establish a joint approach to developing our staff, encouraging dialogue across teams and promote a positive organisational culture for the future.

Leadership and Talent Management

Leadership Development

The first joint senior leadership development programme *Leading through Change* was launched last year and comes to a close in July 2019. This will be peer evaluated and reviewed to feed into the second cohort starting in November 2019 with a 2 day development centre. We will be advertising this multi-professional leadership development opportunity across Poole and RBCH in late summer.

We are also co-delivering two joint cohorts of Poole's *Leadership in Action Programme*, for staff in leadership roles such as Clinical Leaders (Ward Sisters), Service Managers and Senior Team Leaders who are responsible and accountable for the delivery of a service. The first nine RBCH delegates have been selected following an application process and will begin their programme in September 2019.

A joint *Medical Leadership Programme* involving over 30 senior clinicians from RBCH and Poole was launched in January 2019, focusing on the role of clinical leadership, quality improvement and learning from serious untoward incidents (SUIs) and near misses.

November 2019 is our *Leadership Month* when we will host a number of leadership speakers in bite-size masterclasses in an attempt to reach a broader audience. The month will be an opportunity to publicise and share what leadership development opportunities are available within our hospitals and how staff can access them. There will also be a display of quality

improvement (QI) posters and stories from RBCH leaders who have led projects and teams through change effectively.

Unconscious Bias training has been added to the leadership development opportunities and has been delivered to ad hoc groups on request. *Difficult Conversations* is continuing to be delivered by our partners Practive, feedback is good and future sessions are planned.

We are also looking to align all leadership development activities at Poole / RBCH and the wider Dorset system prior to merger. A more detailed paper will be prepared to inform Board of Directors in due course.

Talent Management

As part of the Dorset Integrated Care System (ICS), the trust is taking part in a pilot of the *National Talent Management Diagnostic Tool*. This will give us a comprehensive report on how we currently meet the expectations around talent management and provide an excellent baseline to shape the focus of our work in five key domains:

- Enabling a culture of talent management
- Equality, diversity and inclusion in talent management
- Identifying, managing and retaining talent
- Developing and mobilising talent
- Connecting to our local health and care system

The information for both RBCH and Poole will be an important data source for a joint cultural audit prior to merger and will help us to shape our interim people strategy for the new organisation. Our data will be shared with the other members of the ICS to form a Dorset wide view of talent management and help us benchmark against the national framework. National tools will be available to support this work.

Our *2019 / 20 Appraisal Calendar* was created and launched by Appraisal Champions in April to promote the importance of appraisals for staff. A simplified appraisal form has been introduced for 2019 / 20 with the scoring removed as a result of feedback via focus groups and there has been good feedback so far. We have created appraisal guidance in Portuguese, Polish and Italian in response to feedback as additional support and there are 24 current Appraisal Champions from different roles and teams across the organisation. We

are also piloting a *Mentoring and Coaching Conversations Skills* course designed to support managers to have better development conversations.

The appraisal completion rate at 14th July was 25.41% which is a similar position to the same time last year.

Building a Coaching Culture

We have 20 in-house coaches who are involved in at least 45 coaching relationships and coaching requests are increasing, particularly from participants on leadership development programmes. Our coaches have been offered a first group supervision session which was well evaluated and we are looking at how we “advertise” coaching as part of the leadership development offer. We are also working with Dorset to share coaches and align our practices to give greater opportunities for our coachees and coaches.

Leadership Behaviours and Expectations

All our RBCH interventions are designed using our leadership model and our values based behaviour framework, which identify what good leadership looks like.

On 11 November and as part of *Leadership Month*, Chris Turner from *Civility Saves Lives* will join us to share the science of the impact of incivility in healthcare. The *Civility Saves Lives* campaign is a collective voice for the importance of respect, professional courtesy and valuing each other. It aims to raise awareness of the negative impact that rudeness (incivility) can have in healthcare so that we can understand the impact of our behaviours. The session will be widely publicised and open to all staff.

Over the next few months we will be signposting and educating specific groups on impact of poor behaviour and incivility and ongoing support to create a feedback culture.

Diversity and Inclusion

RBCH has been accepted to continue as part of the *NHSE Partner Programme* for a second year and we continue to focus on our key equality, diversity and inclusion priorities.

Our first *Reverse Mentoring* training begins with mentor (BAME representatives) training on 22 October and mentee (senior leadership team) training on 23 October. This cohort is to expressly support our BAME network and we intend to extend this approach and training to other networks and a wider audience across both to support integration and bringing our

teams together. We have commissioned Professor Stacy Johnson, University of Nottingham (School of Health Sciences) to support a 'train the trainer' approach.

The *National Leadership Academy Stepping Up Development Programme* for bands 5 to 7 BAME staff has been promoted and we are aware of at least two candidates applying for places. On the 19 July there will be a *CQC Focus Group* expressly for our BAME staff and attendance has been encouraged.

A bespoke inclusion session was designed and delivered for the Medical Care Group, which included a session on unconscious bias, the rainbow badge campaign and a talk from Rosie Martin, a transgender patient champion.

The trust supported *Bourne Free 2019*, the Bournemouth PRIDE event as part of a Dorset NHS joint activity. The rainbow lanyards and badges have been given to those RBCH staff making pledges to support the inclusivity agenda and they have been hugely popular.

The *Workforce Race Equality Standard (WRES)* data is being prepared for submission. This year there is also a requirement to provide data for the *Workforce Disability Equality Standard (WDES)* so there will be an increased interest from national bodies in our disability information. EDIC will manage the submission of data and will monitor subsequent action plans. We also continue to work with our patient partners to improve patient experience from a diversity and inclusion lens.

An *Inclusion Champions and Staff Network Groups Programme* was successfully launched on 16 July to encourage individuals from both trusts to be more involved in our staff network groups. The objective of the programme is to provide skills and personal development to individuals who are interested in taking lead roles in our network groups and to support our networks to develop to their full potential.

We now have the following *Staff Network Groups*:

- Black, Asian and Minority Ethnic (BAME)
- Lesbian, Gay, Bisexual and Transgender (LGBT)
- European Staff

The purpose of these employee-led groups is to provide support and guidance to other employees and also to provide insight and guidance to the organisation to assist in improving the culture and experience.

The network meetings are an opportunity to discuss challenges, progress and also provide many opportunities for self and team development. Each staff network has a chair with key roles and responsibilities and has been provided with resource boxes, an Affina Team Coach and all members are offered the option of an individual coach. It is envisaged our staff networks will develop and evolve over time.

Teamwork

The Organisational Development (OD) team receives requests monthly to provide development for teams and individuals, including group MBTI or Belbin sessions, 360 feedback, coaching and facilitation. We now have over 30 Affina Team Coaches who are actively working with team leaders to coach them through their Affina Team Journeys.

Culture and Staff Engagement

#ThankYou

This year's *#ThankYou! Day* takes place on Tuesday 24 September 2019 at RBH and Friday 27 September at Christchurch. This celebration will be an excellent opportunity to reflect on the last 12 months and recognise the efforts and achievements of our staff. It will be a drop in event to encourage as many staff as possible to attend. As usual, there will be lots to see and do, with some surprises. We have tried to respond to feedback too, so there will be some differences. There will be a role for all our senior leaders on the trolleys around the trust and on the door and supporting in busy areas to release staff. We will also be asking the members of the senior leadership team to write a personal thank you that we can display on the day. A business case for *#ThankYou! Pot 2019* has been submitted to the Charity Committee to fund vouchers for this year.

Medical Engagement

The OD team are working with teams on local interventions for multi-professional teams as pilots for a wider medical engagement programme post-merger.

Staff Surveys

Following our positive 2018 NHS Staff Survey results, individual Directorate action plans from 2018 are still being monitored to allow us to run a “*You said, we did*” campaign over the summer. The 2019 survey will go live at the end of September and this year there will be a higher percentage of paper copies to areas that find accessing emails more difficult. We will also be out with the trolley to answer questions and encourage completion to support us to maintain our completion rate of over 50% of eligible staff.

We also use the *Staff Impressions Survey* as a comparative measure. 2019 Q1 scores (Table 1) are hugely positive but do show a slight drop. This may be explained by our future change agenda and pressures felt in teams working towards early integration.

Table 1

Q1	2014	2015	2016	2017	2018	2019
Recommend as place to work	60%	68%	67%	77%	77%	76%
Recommend as place for treatment	73%	84%	83%	89%	89%	89%
Overall Impression – Mainly Good	86%	92%	88%	94%	94%	93%
Completed by	739	544	303	579	1061	838

The Q2 survey will be live in July 2019 and will include the Freedom to Speak Up measures.

Change Champions

Our Change Champions for the *RBCH Culture Programme: Implementation Phase* have facilitated focus groups, reviewed the survey data and interviewed the senior leaders to find out how it feels to work here today. They have also been working hard to empower staff at all levels to make local improvements. They will be presenting the themes they have heard at the September Board of Directors.

Mel Baldwin (NHSE / NHSI) joined the Change Champions Workshop in June to interview our champions about their experiences and the long term impact of the role with a view to publishing nationally as part of their cultural change research. Mel commented that she was “blown away” by their achievements and enthusiasm.

We are currently supporting Poole to develop their engagement champions and listening exercise, with a view to conducting a joint culture programme and Discovery Phase eight months prior to merger.

Supporting East Dorset Reconfiguration and PHT / RBCH Merger

A joint Workforce and Organisational Development Group (WODG) was established in January 2019 to acknowledge the support required for staff during a time of complex organisational change. It aims support engagement and collaboration in a programme of transformation – *building on the best of what we do* – to ensure the provision of compassionate care for patients, carers and their families. The work of WODG will be critical in establishing a positive culture within the new merged organisation.

Summary

The Board of Directors is asked to:

- note this report
- continue to support RBCH organisational development activities during 2019 / 20.



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

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Progress Update on 2019/20 Corporate Objectives
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Debbie Fleming, Chief Executive
Author(s) of paper:	Executive Directors
Details of previous discussion and/or dissemination:	Board of Directors, March and May 2019
Action required:	Note for information
Summary: The attached report provides an update on progress against the Trust objectives for 2019/20 for the first quarter.	
Related strategic objective:	All
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 high risks:	Various risks highlighted in the Board Assurance Framework

Trust Objectives 2019-2020

		Lead Exec	RAG Rating				Commentary
			Q1	Q2	Q3	Q4	
OBJECTIVE ONE	Valuing our staff						
Narrative:	Recognising the contribution of our staff and helping them develop and achieve their potential						
Priorities and Measures:	1.1	Deliver the Trust's People Strategy with a focus on: <ul style="list-style-type: none"> recruiting new staff to keep the vacancy rate below 6% developing sustainable workforce solutions that link to a flexible and local workforce and maintain a turnover rate below 12% 	KA				Vacancy rate is around 6%. Work continues on recruiting to vacant posts.
			KA				Turnover remains around 10% level
	1.2	Develop a talent management programme in line with our leadership strategy to ensure we develop staff with the capabilities and behaviours needed for a sustainable future: <ul style="list-style-type: none"> introduce a talent review and succession planning process improve talent conversations as part of the annual appraisal round 	DM				RBCH interim talent management plan in place. Aim to be a part of Dorset Integrated Care System (ICS) Talent Management Diagnostic tool pilot and develop accompanying action plan in Quarters 2-3 2019/20. Appraisal Champion feedback to Board on talent conversations as part of the annual appraisal round and any pilot activity. Coaching and mentoring skills for development conversations being piloted in Quarter 2 2019/20.
			DM				
	1.3	Maintain our 2018 staff survey results and completion rate over the next two years: <ul style="list-style-type: none"> ensure we deliver on 'you said, we did', publicising and promoting positive outcomes and interventions to support staff retention 	DM				Staff Survey 2019 results and evidence of 'You said, we did' campaign over summer. Directorate and Care Group action plans presented to Workforce Strategy and Development Committee. Provider for 2019 secured in partnership with Poole Hospital NHS Foundation Trust. Intention to provide more paper copies of survey to see if it impacts the completion rates.
	1.4	Deliver key priorities in our diversity and inclusion plan: <ul style="list-style-type: none"> increasing Black, Asian and Minority Ethnic (BAME) representation across our leadership teams continue to improve our Workforce Race Equality Standard (WRES) results to ensure our BAME staff do not experience higher levels of bullying, harassment or discrimination 	DM				Delivery against Diversity and Inclusion Strategy and six objectives. Equality, Diversity and Inclusion Committee report to Board including Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data Black and Minority Ethnic (BAME) Staff survey infographic produced to support the business case for positive action programmes such as BAME reverse mentoring. Afiria coach identified for BAME network. Future measure - 2019 Staff Survey results

Trust Objectives 2019-2020

OBJECTIVE TWO									
Improving quality and reducing harm									
Narrative:		Focusing on continuous improvement and reduction of waste							
Priorities and Measures:	2.1	To continuously improve the quality of care and outcomes for patients as part of our 2019/20 improvement programme. Priorities include:				DM			
		<ul style="list-style-type: none"> • Hospital Flow: a) expanding opportunities for admission avoidance and reducing delays to discharge and b) improving ambulance handover times and ensuring timely assessment, treatment and flow through the emergency department (ED) 							<ul style="list-style-type: none"> a) The 'making every inpatient day count' programme consists of four workstreams (Stranded Patients; Ward Processes; Frailty Pathway; Admission Avoidance), designed to act as enablers, aiming to support operational bed reconfiguration targets: <ul style="list-style-type: none"> • To increase 0 Day Length of Stay via Older Persons' Assessment and Liaison (OPAL) and Ambulatory Emergency Clinic (AEC) teams by 10% compared to 2018/19 levels. • To work collaboratively with primary care, community care and ambulance services; to sustain or reduce conveyances compared to 2018/19 levels. • To increase utilisation of Health of the Ward (electronic whiteboards) on Wards 22, 26 and 15. • To reduce long-stay stranded patients with a Length of Stay over 21 days by 40% by March 2020. b) Emergency Department (ED) - Quality Improvement meetings arranged and project leads identified for the following projects: front door, patient pathways, minors and Urgent Treatment Centre processes, recruitment and retention through "JoininWork" project and IT. KPIs: 95% of patients presenting to ED achieve waits of no more than four hours, triage within 15 minutes, ambulance handover times and reduction in the number of complaints and improvement in Friends and Family Test completion rates.
		<ul style="list-style-type: none"> • Outpatients: reducing the number of unnecessary visits for our patients 				DM			<ul style="list-style-type: none"> Quarter 1 activity has been deliberately spent scoping the programme for outpatients. There has been work to understand the metrics in place currently, the innovation ideas beginning to emerge and the system-wide launch of outpatient transformation work. The likely next steps are heavily reliant on IT systems and developments and system-wide cohesion to deliver these. Theatre utilisation is now at 83% for eye theatres. Theatre staff are undertaking a range of projects. Eye Outpatients has identified various opportunities, with some opportunities require regional agreement. Outpatients is being refurbished and staff are trying to improve flow. Initial measures suggest a reduction of seven minutes in the time that patients spend in the department from start to end of Quarter 1 2019/20.
		<ul style="list-style-type: none"> • Ophthalmology: ensuring good morale and support for staff in eye outpatients and achieving eye theatre efficiency of 80% 				RR			<ul style="list-style-type: none"> There is a Dorset-wide project looking at the introduction of an integrated rostering system for the medical workforce and includes consultant planning. The business case is being prepared and planned for Quarter 3 2019/20. In the meantime the Quality Improvement project is looking at use of existing systems within the Trust as well as non-IT related improvements to consistency and resilience.
		<ul style="list-style-type: none"> • Medical Rotas: optimising medical manpower and management of medical rosters using the most effective digital solutions 				DM			<ul style="list-style-type: none"> Introduction of an electronic medical staffing rostering system in all specialities by April 2020.
		<ul style="list-style-type: none"> • Clinical documentation: improving the consistency and accuracy of what is recorded in the health record, how it is stored and improving communication between teams through digital innovation 				PS			<ul style="list-style-type: none"> There is a Dorset-wide project looking at the introduction of an integrated rostering system for the medical workforce and includes consultant planning. The business case is being prepared and planned for Quarter 3 2019/20. In the meantime the Quality Improvement project is looking at use of existing systems within the Trust as well as non-IT related improvements to consistency and resilience.
		<ul style="list-style-type: none"> • Fundamentals of Care: embedding the Medical Examiner process for all inpatient deaths to improve a) the accuracy and timeliness of the death certification process and b) the care of patients with enhanced needs due to acuity and dependency and c) the provision and documentation of discussions with patients about the risks and benefits of treatment options (consent processes) 				PS			<ul style="list-style-type: none"> Awaiting IT resources for digital form development. Proposed date middle of August 2019. KPI would be 100% capture of date, time and signature.
	2.2	Efficiency and Productivity				PP			Medical Examiner process implemented and lead Medical Examiner produced first quarterly report to Mortality Surveillance Group in July 2019. Themes for action and learning identified. Medical Director has included in July 2019 Board report.
		<p>To continue to ensure services are provided in a cost effective manner and that we achieve our financial plan to deliver a financial breakeven position by the end of March 2020.</p> <p>To continue to deliver efficiency and productivity opportunities using Getting it Right First Time (GIRFT) and Model Hospital benchmarking data to reduce unwarranted variation in our clinical and non-clinical services.</p>				PP			<p>The financial control total for Quarter 1 has been achieved. However considerable financial risk remains due to a material forecast shortfall against the full year cost improvement programme. Work is in hand to mitigate this, overseen through the monthly Finance and Performance Committee.</p> <p>The Trust benchmarks very well within the Model Hospital and continues to receive positive feedback through the national GIRFT programme. A comprehensive governance structure is in place to support further progress. However, further opportunities are still available and there remains a substantial shortfall in the cost improvement programme requiring further focus.</p>
	2.3	To continue to improve the responsiveness of services for patients and achieve the national standards relating to:				RR			<p>The Trust achieved all the Cancer standards in May 2019 apart from Cancer 62 day consultant upgrade. Performance against the overall 62 day cancer standard for May was 87.6% (above the national target of 85%).</p> <p>Referral to treatment performance decreased by 0.8% to 84.16% in June. Performance remains above the local target trajectory for 2019/20. The total waiting list is still continuing to rise along with an increase in the number of patients who have breached 18 weeks. Dermatology remains under extreme pressure and work is ongoing to agree a vision for Dermatology across Dorset and identify the current challenges.</p> <p>Diagnostic performance slipped in June to 95.8% below the 99% standard. The focus for 2019/20 remains the sustainable recovery of the 99% target, through recruitment and substantive capacity that will come on line from September in Endoscopy.</p> <p>Performance against the four hour standard fell to 86.21% in June 2019. Increases in ambulance conveyances have continued through June compared to last year, however, improvements were seen during June in ambulance handover times, which were at their lowest since April 2017.</p>
		<ul style="list-style-type: none"> • Cancer waits 				RR			
		<ul style="list-style-type: none"> • Elective referral to treatment waits 				RR			
		<ul style="list-style-type: none"> • Diagnostic waits • A&E waits 				RR			
	2.4	Digital Transformation				PG			<p>Dorset Care Record Programme is still finding it hard to progress the component parts at the pace which all stakeholders require. We are currently engaging external support to recover and accelerate our progress.</p> <p>Electronic Patient Record is live on pilot wards at RBCH. Planning is underway to enliven order comms and Electronic Prescribing and Medicines Administration over the next few months.</p> <p>84 of the 104 edge switches have been deployed.</p> <p>Around 650 of 7,500 devices migrated to Windows 10. Project scheduled to run till end December 2020.</p>
		To jointly implement the remaining component parts of the Dorset Care Record (DCR) in accordance with the timescales in the DCR programme plan				PG			
		<p>Clinical applications:</p> <ul style="list-style-type: none"> • Implement the three core trust wide clinical applications (strategic electronic patient record, order communications, electronic prescribing and medicines administration) and support the clinical leaders of these programs transform clinical processes to achieve the maximum benefit from these investments 				PG			
		<p>IT infrastructure:</p> <ul style="list-style-type: none"> • complete the wired network upgrade project to provide fast and resilient network services • migrate all devices to Windows10 and mitigate against all IT security threats 				PG			

Trust Objectives 2019-2020

OBJECTIVE THREE: Strengthening team working									
Narrative:		Developing and strengthening team working across RBCH and with colleagues at Poole Hospital to deliver safe and compassionate care for our patients and shaping future health care across Dorset							
Priorities and Measures:	3.1	<p>Progressing implementation of the Clinical Service Review by:</p> <ul style="list-style-type: none"> obtaining approval for the Outline Business Case from NHS Improvement (NHSI) and developing the Full Business Case that will enable the development of the planned and emergency sites agreeing the merger timetable with the Competition and Markets Authority and obtaining approval from NHSI for the Merger Business Case <p>Play a proactive role within the Dorset system, maintaining positive relationships and effective joint working with partners to implement the Dorset Sustainability and Transformation Plan.</p>	DF						Outline Business Case is with NHS Improvement (NHSI) - regional director sign off is 31 July, followed by national NHSI sign off end of September and HMA Treasury sign off from December 2019. A draft timetable for merger in April-September 2020 was agreed with NHSI in July. Aiming to agree a final merger timetable with the Competition and Markets Authority in September 2019. The merger business case is due to be submitted to NHSI by December 2019. Support from Bournemouth, Christchurch and Poole Council, including three positive meetings with Lead Councillor Vikki Slade. Visit by Matt Hancock to showcase the Dorset system and future plans was well received.
	3.2	<p>To support the transformation and early integration of services as part of our East Dorset clinical reconfiguration programme:</p> <ul style="list-style-type: none"> support a cultural change programme and discovery workshops with RBCH and Poole Hospital staff to ensure an inclusive approach to the development of our future vision and values as a single merged organisation provide bespoke change management support to our clinical transformation leads to encourage effective team working and foster collaborative relationships 	DM						Joint cultural audit plan in place, with findings of Discovery phase to be reported to new merger Trust Board on Day 1. Joint leadership development programmes to build relationships and develop common language about leadership skills and expectations. Measure to receive a favourable evaluation from clinical transformation leads with four early services evidencing effective team working and collaborative relationships. OD leads currently supporting the 4 priority areas with different needs and interventions, shaped by a self assessment tool.
	3.3	Develop a system wide risk and governance framework across RBCH and Poole Hospital to support the identification, escalation and mitigation of risks to patient safety and quality	PS						Joint Board Risk Appetite seminar held in June 2019. Shared risk matrix agreed. First shared risk report (to identify all RBCH, Poole Hospital NHS Foundation Trust and One Acute Network risks with a risk score of 12 or above) to go to Board in July 2019. Further work required to agreed single risk appetite statement and risk management strategy.
	3.4	<p>To further develop team working at all levels within the organisation using the Affina team journey and other interventions, thereby securing an improvement in our 2018 staff survey scores for:</p> <ul style="list-style-type: none"> The team I work in has a set of shared objectives The team I work in often meets to discuss the team's effectiveness 	DM						Numerous ad hoc team development sessions, including Myers-Briggs Type Indicator (MBTI) and Belbin. Increasing number of Affina team coaches currently working towards accreditation. Increasing number of request for team journeys. Staff survey results 2019 Staff survey results 2019

Trust Objectives 2019-2020

OBJECTIVE FOUR									
Listening to patients and staff									
Narrative:		Ensuring meaningful engagement to improve patient and staff experience							
Priorities and Measures:	4.1	<p>Maintain progress in meeting our improvement trajectory for the National Patient Experience benchmarks by March 2020, by:</p> <ul style="list-style-type: none"> • Maintaining internal focus on patient experience agendas • Engaging, listening and responding to patient feedback in the serious incident and Medical Examiner processes to support improvement and learning 				PS			<p>Friends and Family Test feedback remains in the top quartile for inpatients consistently now for 12 months. Many times being one of the top trusts in the country. We have developed the way we gather feedback from our patients with the introduction of 'Care Conversations' in May 2019. This method is qualitative in nature ensuring that the feedback we receive is more inclusive and representative of our patients' experience.</p> <p>Routine discussions with families now in place as part of Medical Examiner process. Families invited to attend Serious Incident panels but approach needs to be more consistent. Head of Patient Engagement approached to identify a patient partner to work with the Quality and Risk Team and support Serious Incident process and review of Serious Incident reports.</p>
	4.2	<p>Maintain and strengthen communications and engagement with local people by March 2020 through:</p> <ul style="list-style-type: none"> • playing an active part in developing and implementing the Dorset-wide communications and engagement strategy • working in partnership with Governors to carry out a series of listening events/community focus groups to provide feedback on current services and proposals for future service delivery 				DF			<p>Both RBCH and Poole Hospital NHS Foundation Trust Communications teams are closely involved with planning communications and engagement across Dorset. Work and meet with colleagues from NHS Dorset CCG, Dorset County Hospital, Dorset Healthcare, Public Health Dorset and the local councils on numerous communications strategies. Communications teams have also been involved in public engagement work, including managing two public engagement events at RBCH and PHFT around the future designs of our hospitals.</p> <p>The Governors held listening events were held at Christchurch Library and Castlepoint in Quarter 1, with Governors from Poole Hospital NHS Foundation Trust also taking part in the event at Castlepoint. Governors also used Understanding Health talks arranged in the community on 1 and 22 May to update those attending on the changes to local hospital services. Governors also supported the public engagement events in June.</p>
	4.3	Ensure that patients and members of the public are actively involved in the transformation of our services by routinely utilising experience based co-design, design thinking and digital service design within the One Acute Network (OAN) Programme				PS			



**The Royal Bournemouth
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BOARD OF DIRECTORS	
Meeting date:	31 July 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Clinical Audit Plan 2019/20
Section on agenda:	Governance
Supplementary reading:	N/A
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Dr Guy Titley, Consultant Lead for Clinical Audit Jo Sims, Associate Director Quality, Governance and Risk Craig Murray, Clinical Effectiveness Manager
Details of previous discussion and/or dissemination:	Audit Committee Clinical Audit and Effectiveness Group (CAEG)
Action required:	Note for information
<p>Summary:</p> <p>The Trust Clinical Audit Plan 2019/2020 includes all relevant National Audits, plus a representative selection of at least five local projects per directorate chosen for their potential impact on patient care.</p> <p>CAEG have asked directorates to consider the trust quality objectives, quality priorities, CQC and NICE guidelines when formulating their audit plans. We have also asked directorates to try to link at least one project per directorate with an identified risk on the Risk Register.</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?	✓



**The Royal Bournemouth
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Impact on significant risks:	N/A
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Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Clinical Audit Plan 2019 - 2020

Title	Care Group	Directorate
Quality Account Audits (Audits featuring on the NHS England Quality Accounts List 2019/20)		
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	B	Medicine/ED
BAUS Urology Audit - Cystectomy	A	Surgery
BAUS Urology Audit - Nephrectomy	A	Surgery
BAUS Urology Audit - Percutaneous Nephrolithotomy	A	Surgery
BAUS Urology Audit - Radical Prostatectomy	A	Surgery
Care of Children in Emergency Departments	B	Medicine/ED
Case Mix Programme (ICNARC)	A	Anaesthetics
Child Health Clinical Outcome Review Programme - Long-term ventilation in children, young people and young adults	B	Medicine
Elective Surgery (National PROMs Programme) - Hip and Knee replacement	A	Orthopaedics
Endocrine and Thyroid National Audit	A	Surgery
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit Inpatient Falls	B	OPM
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	B	Medicine
Major Trauma Audit	B	Medicine/ED
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	C	Pathology
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries	A	Maternity
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality surveillance and mortality confidential enquiries	A	Maternity
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal morbidity and mortality confidential enquiries	A	Maternity
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	A	Maternity
Medical and Surgical Clinical Outcome Review Programme - Dysphagia in Parkinson's Disease	B	OPM
Medical and Surgical Clinical Outcome Review Programme - In Hospital Management of Out of Hospital Cardiac Arrests	B	Anaesthetics
Mental Health - Care in Emergency Departments	B	Medicine/ED

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care	B	Medicine
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	B	Medicine
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary rehabilitation	B	Medicine
National Audit of Breast Cancer in Older People (NABCOP)	A	Surgery
National Audit of Cardiac Rehabilitation (NACR)	B	Cardiology
National Audit of Care at the End of Life (NACEL)		
National Audit of Dementia	B	OPM
National Audit of Seizure Management in Hospitals (NASH3)	B	Medicine/ED
National Bariatric Surgery Registry (NBSR)	A	Surgery
National Cardiac Arrest Audit (NCAA)	B	Anaesthetics
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)		
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	B	Cardiology
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	B	Cardiology
National Cardiac Audit Programme (NCAP)- National Heart Failure Audit	B	Cardiology
National Diabetes Audit - Adults - NaDIA-Harms	B	Medicine
National Diabetes Audit - Adults - National Core Diabetes Audit	B	Medicine
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	B	Medicine
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDIA)	B	Medicine
National Diabetes Audit - Adults - National Diabetes Transition	B	Medicine
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	B	Medicine
National Early Inflammatory Arthritis Audit (NEIAA)	C	Specialist Services
National Emergency Laparotomy Audit (NELA)	A	Surgery
National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit (NBOCA)	A	Surgery
National Gastro-intestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA)	A	Surgery
National Joint Registry (NJR)	A	Orthopaedics
National Lung Cancer Audit (NLCA)	B	Medicine
National Maternity and Perinatal Audit (NMPA)	A	Maternity
National Ophthalmology Audit (NOD) - Adult Cataract surgery	C	Ophthalmology
National Prostate Cancer Audit	A	Surgery
National Smoking Cessation Audit	B	Medicine

National Vascular Registry	A	Surgery
Perioperative Quality Improvement Programme (PQIP)	A	Anaesthetics
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption	C	Pathology
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship	C	Pathology
Sentinel Stroke National Audit programme (SSNAP)	B	OPM/Stroke
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	C	Pathology
Society for Acute Medicine's Benchmarking Audit (SAMBA)	B	Medicine
Surgical Site Infection Surveillance Service	A	Surgery
UK Parkinson's Audit - Elderly Care Stream	B	OPM
UK Parkinson's Audit - Occupational Therapy Stream	B	OPM
UK Parkinson's Audit - Physiotherapy Stream	B	OPM
Other national audits		
FSRH Emergency Contraception National UK Benchmarking Audit 2019	Corporate	Specialist Services
Safety Thermometer	Corporate	
Patient-Led Assessments of the Care Environment (PLACE) Project	Corporate	
Breast and Cosmetic Implant Registry (BCIR)	A	Surgery
National Comparative Audit of Blood Transfusion programme - 2019 Re-audit of the Medical Use of Blood	C	Pathology
Perinatal Mortality Review Tool	A	Maternity
GIRFT RBH Assessment	C	
BASHH National Audit 2019 of times to appointment, test results and treatment	C	Specialist Services
Phototherapy service guidelines	C	Specialist Services
NCEPOD - Dysphagia in People with Parkinson's Disease	B	OPM

Directorate audits		
Anaesthetics Directorate - Audit Lead Dr Warwick Pepper		
PACU Bottlenecks	A	Anaesthetics
Identifying previous anaesthetic problems on Evolve EPR	A	Anaesthetics

Day case uni-knee pathway	A	Anaesthetics
Peiroperative temperature management	A	Anaesthetics
Management of diabetes during anaesthesia	A	Anaesthetics
Regional anaesthesia documentation	A	Anaesthetics
Orthopaedic Directorate - Audit Lead Mr Simon Richards/Mr Heath Taylor		
Outcome of Unicompartmental Knee Replacement and Assessment to Perform the Surgery as a Day Case	A	Orthopaedic
STOP MOMENT Safety Check List Audit	A	Orthopaedic
Theatre Cancellations Due to CSSD Issues (re-audit)	A	Orthopaedic
Audit of the Usage of Post THR Bed Splinting (055-1920)	A	Orthopaedic
Retrospective Review of Patients with Long (>3 hour) Tourniquet Time for Orthopaedic Lower Limb Surgery	A	Orthopaedic
Surgical Directorate - Audit Lead Mr Ismail Mallick		
Audit of compliance with NICE NG147 regarding Intermittent Claudication	A	Surgical
The use of contra-indicated medications prescribed with existing use of methotrexate and possible preventative measures	A	Surgical
Surgical Laterality Audit	A	Surgical
Elective Colorectal Surgical Patients Complication Rates	A	Surgical
Surgical Site Infection Surveillance Service	A	Surgical
Maternity Directorate - Audit Lead Audrey Wareham		
Continuity Of Care in ANC	A	Maternity
LFGA	A	Maternity
Patients Satisfaction With Screening	A	Maternity
Continuity Of Midwife Care Throughout Pregnancy	A	Maternity
Measurement Of Fetal Size In Women With Increased BMI	A	Maternity
TAMBA Review Of Implemented Change	A	Maternity
Review Of Care Given To Women Taking SSRIs	A	Maternity
Record Keeping	A	Maternity
NNST- Compliance With Sample Collection	A	Maternity
Medical Directorate - Audit Lead Dr David Morgan		
The Speciy Triage Pathway	B	Medicine
Ambulatory Management of Pulmonary embolus	B	Medicine
Oxygen Prescribing at RBH	B	Medicine
Mental health triage in ED	B	Medicine
Elderly Medicine Patients Review in Acute Medical Unit	B	Medicine

Older Person's Medicine Directorate - Audit Lead Dr David Sell		
Escalation Planning in Elderly Medicine	B	OPM
Appropriateness of Transfers to outlying wards	B	OPM
Consultant Reviews of Outlying patients	B	OPM
Timeliness of collateral history on Frailty unit	B	OPM
Advanced Care Planning Documentation and Communication	B	OPM
Emergency Department - Audit Lead Dr David Martin		
Mental health triage in ED	B	ED
Pain management in adults	B	ED
Adult Sepsis Audit	B	ED
Fractured NOF	B	ED
Stroke Services - Audit Lead Dr Michelle Dharmasiri		
AF detection in TIA- cross site audit with Poole	B	OPM
Investigating the quality of continence assessments	B	OPM
VTE prevention in stroke (Re-Audit)	B	OPM
Cholesterol Checking on ASU	B	OPM
Cardiac Monitoring on ASU		
Cardiology Directorate - Audit Lead Dr Georgios Mangouretsios		
Re-audit compliance to ESC guidelines on the Risk factors checked on admission for suspected CAD	B	Cardiology
Retrospective evaluation of patient early re-admission post-PCI	B	Cardiology
Audit appropriateness of ambulatory ECG monitor for patients with syncope	B	Cardiology
Radial Artery Occlusion Rates in Radial Coronary Angiography/Angioplasty	B	Cardiology
Taka-Tsubo Cardiomyopathy	B	Cardiology
Ophthalmology Directorate - Audit Lead Dr Mohammed Rashid		
RBCH Diabetic Retinopathy Laser Book Audit	C	Ophthalmology
An audit of patient episode cancellations in the eye department at RBCH	C	Ophthalmology
Audit of Endophthalmitis after Cataract Surgery	C	Ophthalmology
An audit of corneal scrapes for microbial keratitis	C	Ophthalmology
Audit of Endophthalmitis after Anti-VEGF Intravitreal Injections	C	Ophthalmology
Radiology Directorate - Audit Lead Dr John Oakes		
Fast track CT investigating abnormal Chest X-ray	C	Radiology

Gallbladder polyp surveillance	C	Radiology
CT investigation of iron deficiency anaemia	C	Radiology
Re-audit of compliance with IR pre-procedure checklists	C	Radiology
	C	Radiology
Specialist Services Directorate - Audit Lead Dr Ellie Thickett		
NICE NG100 - Rheumatoid arthritis in adults: management	C	Rheumatology
Are We Following NICE Guidance in Our Use of Secukinumab in Psoriatic Arthropathy (TA445) and in Ankylosing Spondylitis (TA407)?	C	Rheumatology
Audit of the Assessment of Rheumatology Patients on Glucocorticoids for Fracture Risk	C	Rheumatology
An Audit to Assess the Number of Fixed Appliance Breakages Within the Orthodontic Department in 2018	C	Specialist Services
WHO Checklist Audit	C	Specialist Services
Fast Track Downgrade and Treatment Plan Audit	C	Specialist Services
Surgical Form Audit	C	Specialist Services
Bristol Surgical Log Audit	C	Specialist Services
Melanoma Audit	C	Specialist Services
Pathology Directorate - Audit Lead Dr Joe Chacko		
Surgery and invasive procedures on patients with bleeding disorders	C	Pathology
Management of bleeding disorder patients within the emergency department	C	Pathology
MDT coagulation disorders discussion outcomes	C	Pathology
Understanding sample rejection in Transfusion	C	Pathology
Local audit pre-surgical optimisation of patients with haematinic deficiencies	C	Pathology
Cancer Care Directorate - Audit Lead Dr Ros Pugh		
Audit of Intravenous and Oral Iron Use in Pre-Operative Iron-Deficiency Anaemia	C	Cancer Care
Audit of Discharge Delays in Patients known to the Hospital Palliative Care 2018/19	C	Cancer Care
Audit of the completion of the Personalised Care Plan for the Last Days of Life	C	Cancer Care
Haematology antifungal audit	C	Cancer Care
Electrolyte and fluid management	C	Cancer Care
	C	Cancer Care
Nursing, Quality and Risk Directorate - Audit Lead Joanne Simms		
Hand Hygiene Audit	Corporate	
Monitoring Mortuary Capacity	Corporate	
Products of Conception; The Robustness of the Policy – Analysing Time from Clinical Procedure to Sensitive Disposal	Corporate	
Saving Lives - Infection Control Audit	Corporate	

Trust Wide Audit of Patient Pillows	Corporate	
Chaplaincy Referrals – Analysing Type of Chaplaincy Encounter	Corporate	
Wound Care Plan Audit (CQUIN Compliance)	Corporate	
Tissue Viability - Patient Evaluation of Service	Corporate	
Waterlow Assessment Audit (Compliance v Accuracy)	Corporate	
Falls & Bed rails assessment (Compliance v Accuracy)	Corporate	
Mobility & frailty assessment (Compliance v Accuracy)	Corporate	
Medical Examiner - Audit of Junior Doctor experience of ME process	Corporate	
Governance Audit Tool	Corporate	
LERN Policy Audit	Corporate	
Death verification audit - pre and post eForm implementation	Corporate	
Operations Directorate - Audit Lead BJ Waltho		
Patient Transport Services (PTS) - Evaluation of Staff and Unescorted, Wheelchair Patient Experience in Outpatient Clinics	Corporate	
Time from allocation of a bed to actual transfer time- out of hours	Corporate	
Comparison of HaN bleep calls numbers and reasons	Corporate	
Terminal Cleans priority and response times	Corporate	
Identify reasons for food waste	Corporate	
Porters response to 'immediate portering assistance' calls	Corporate	
Effectiveness of ED prescription 'promise to pay' forms	Corporate	



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

BOARD OF DIRECTORS	
Meeting date:	31 July 2019
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:	--
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Karen Allman
Details of previous discussion and/or dissemination:	Workforce Committee 10/6/19
Action required:	Note for information
<p>Summary:</p> <p>The Terms of Reference for the Workforce Strategy and Development Committee (Workforce Committee) have undergone their annual review and were discussed at the Workforce Committee meeting on 10th June.</p> <p>It was agreed the Terms of Reference remain appropriate and are therefore unchanged apart from two small amendments to job titles under "Membership".</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?	<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 STRATEGY AND DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

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

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

1. Membership

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

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

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

2. Secretary

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

3. Quorum

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

4. Frequency of Meetings

The Committee shall meet every two months.

5. Notice of Meetings

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

6. Minutes of Meetings

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

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

7. Duties

The duties of the Committee can be categorised as follows:

7.1 People Strategy

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

7.2 Workforce Development and Planning

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

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

7.3 Recruitment and Retention

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

7.4 Training and Development

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

7.5 Organisational Development and Leadership

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

7.6 Equality, Diversity and Inclusion

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

8. **Risk Management**

8.1 Role of the Workforce Development and Strategy Committee

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

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

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

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

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

8.2 Role of Directors

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

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

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

9. **Reporting Responsibilities**

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

Regulation 18	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 c. where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.
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- 9.3 The Committee will have a framework in place for monitoring the Key Lines of Enquiry for the CQC and provide annual assurance to the Board of Directors.

10. **Other**

The Committee shall:

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

11. Authority

The Committee is authorised:

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

12. Supported Strategic Goals

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

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

13. Sub-Committees

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

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

BOARD OF DIRECTORS MEETING – 31 July 2019

PART 2 AGENDA - **CONFIDENTIAL**

The following will be taken in closed session i.e. not open to the public, press or staff in the **Board Rooms, Poole Hospital**

The reasons why items are confidential are given on the cover sheet of each report

Timings		Purpose	Presenter
11.45	1. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS		
	To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.		
11.46	2. GOVERNANCE		
	a) Establishing the Shadow Interim Board of Directors:	Decision	Jacqueline Cotgrove
	<ul style="list-style-type: none"> • Terms of Reference for Shadow Interim Board of Directors • Proposed Shadow Interim Board Composition • Proposed Shadow Interim Board Appointments Process • Proposed Procedure for Naming the New Organisation 		
12.15	BREAK		
12.45	3. STRATEGY AND RISK		
	a) Digital Transformation Strategy (paper)	Decision	Peter Gill/ Rupert Page/ Tim Shaw
	The above items will be presented to the boards of directors of the Trust and Poole Hospital NHS Foundation Trust jointly although decisions will be made by each Board of Directors separately.		
	The meeting will be adjourned until the public session of the meeting commences at 2.15pm.		
4.30	4. MINUTES OF PREVIOUS MEETINGS		
	a) Minutes of the meetings held on 23 May and 29 May 2019 (paper)	Decision	All
4.35	5. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Discussion	All
4.40	6. QUALITY AND PERFORMANCE		
	a) Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (paper)	Decision	Paula Shobbrook/ Carmen Cross TO FOLLOW

	b) CQC Statement of Purpose (paper)	Decision	<i>Paula Shobbrook TO FOLLOW</i>
4.55	7. STRATEGY AND RISK (continued)		
	a) Board Assurance Framework 2019/20 (paper)	Discussion	<i>Paula Shobbrook</i>
	b) Significant Risk Report (paper)	Discussion	<i>Paula Shobbrook</i>
	c) Commercial Strategy Update (paper)	Discussion	<i>Richard Renaut TO FOLLOW</i>
	d) Brexit Planning and Preparedness Update (verbal)	Information	<i>Richard Renaut</i>
	e) Key issues from the Audit Committee (paper)	Information	<i>Alex Jablonowski</i>
5.45	8. ANY OTHER BUSINESS		
	a) Key Messages for Communication to Staff	Discussion	<i>All</i>
	b) Reflective Review	Discussion	<i>All</i>
	– What has gone well?		
	– What do we need more of?		
	– What do we need less of?		

Our Charter

As a Board team we will:

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

