

A meeting of the Board of Directors will be held on Wednesday 27 November 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 Jill.Hall@rbch.nhs.uk.

Jill Hall
Interim Trust Secretary

A G E N D A

Timings		Purpose	Presenter
2.15-2.20	1. WELCOME, APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
	Deb Matthews, Cliff Shearman		
2.20-2.30	2. Patient Story (verbal)	Information	Paula Shobbrook/ Clare Bent/ James Donald
2.30-2.35	3. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 25 September 2019 (paper)	Decision	All
2.35-2.40	4. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Information	All
	b) Chief Executive's Report (paper)	Information	Debbie Fleming
2.40-3.30	5. QUALITY AND PERFORMANCE		
	a) Update on Governor Activity (verbal)	Information	David Triplow
	b) Medical Director's Report (paper)	Information	Alyson O'Donnell
	i. Annual Report on Safe Working Hours from Director of Medical Education		
	c) Trust Board Dashboard (paper)	Information	Richard Renaut
	d) Performance Report (paper)	Information	Richard Renaut
	e) Quality Report (paper)	Information	Paula Shobbrook
	f) Finance Report (paper)	Information	Pete Papworth
	g) Workforce Report (paper)	Information	Karen Allman
	h) Annual Protection and Safeguarding Report and Statement of Commitment (paper)	Decision	Paula Shobbrook
	i) 7- Day Service Board Assurance Framework	Decision	Alyson O'Donnell
3.30-3.40	6. STRATEGY AND RISK		
	a) Progress Update on 2019/20 Corporate Objectives (paper)	Information	Debbie Fleming

3.40-4.00

7. GOVERNANCE

- | | | | |
|----|---|-------------|------------------------|
| a) | Emergency Preparedness, Resilience and Response Statement of Compliance (paper) | Information | <i>Richard Renaut</i> |
| b) | Healthcare Assurance Committee Terms of Reference (paper) | Decision | <i>Paula Shobbrook</i> |
| c) | Workforce Development and Strategy Committee Terms of Reference (paper) | Decision | <i>Karen Allman</i> |
| d) | Charitable Funds Committee Terms of Reference (paper) | Decision | <i>Pete Papworth</i> |
| f) | Update on establishment of the Shadow Interim Board (paper) | Information | <i>Debbie Fleming</i> |

8. NEXT MEETING

Wednesday 29 January 2020 at 8.30am in the Conference Room, Education Centre.

9. ANY OTHER BUSINESS

Key Messages for Communication to Staff

4.00-4.15

10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

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

11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

To 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 25 September 2019** in the Conference Room, Royal Bournemouth Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Pankaj Davé	(PD)	<i>Non-Executive Director</i>
	Debbie Fleming	(DF)	<i>Chief Executive</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	John Lelliott	(JL)	<i>Non-Executive Director</i>
	Alyson O'Donnell	(AOD)	<i>Medical Director</i>
	Pete Papworth	(PP)	<i>Director of Finance</i>
	Iain Rawlinson	(IR)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Cliff Shearman	(CS)	<i>Non-Executive Director</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery/Deputy Chief Executive</i>
In attendance:	Hazel Allen	(HA)	<i>Consultant Nurse, Gastroenterology</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	Rowena Green	(RG)	<i>Director of Operations, Medical Care Group</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Helen Martin	(HM)	<i>Freedom to Speak Up Guardian</i>
	Deborah Matthews	(DMA)	<i>Director of Improvement and Organisational Development</i>
	James Rowden	(JR)	<i>Patient Engagement and Clinical Liaison</i>
	Dily Ruffer	(DR)	<i>Governor and Membership Manager</i>
Public/ Governors:	Colin Beck		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Howard Fincher		<i>Public Governor</i>
	Eric Fisher		<i>Public Governor</i>
	Paul Hilliard		<i>Appointed Governor</i>
	Marjorie Houghton		<i>Public Governor</i>
	Dr Maggie Kirk		<i>GP, Providence Surgery (member of public)</i>
	John Lewis		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Margaret Neville		<i>Member of Public</i>
	Sue Parsons		<i>Public Governor</i>
	Kevin Steele		<i>Public Governor</i>
	William Thomas		<i>Liaison Workforce (member of public)</i>
	David Triplow		<i>Public Governor</i>
	Michele Whitehurst		<i>Public Governor</i>
	Sandy Wilson		<i>Public Governor</i>
	Brian Young		<i>Public Governor</i>
Apologies:			

44/19 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Action

There were no apologies for absence or declarations of interest to be noted. The Chair welcomed those attending the meeting including the newly appointed governors and Dr Maggie Kirk of the Providence Surgery.

The Board were informed that Mark Orchard had been appointed as the Director of Finance at Portsmouth Hospitals NHS FT and would sadly be leaving Poole Hospital NHS FT. Pete Papworth was also congratulated on his recent appointment as joint interim Finance Director for RBCH and PHFT.

45/19 **MINUTES OF PREVIOUS MEETING**

(a) Minutes of the meeting held on 31 July 2019 (Item 2(a))

The minutes of the meeting held on 31 July 2019 were **approved** as an accurate record of the meeting subject to the following amendment:

- 37/19 (g) that the Trust's performance for Friends and Family Test (FFT) was within the second quartile for outpatients.

46/19 **MATTERS ARISING**

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

There were no actions from the last meeting.

Chief Executives Report (Item 4)

The item was taken after 5(a). The Board **noted** the report from the Chief Executive and in particular:

- the volume of work currently underway across both Trusts in preparation for the merger and Clinical Services Review (**CSR**) establishing sustainable services;
- the recent approval of the planning application to upgrade theatres at Poole Hospital;
- recognition of the current level of challenges including increasing demand and national workforce shortages; and appreciation to all staff for their dedicated work;
- the respective Annual Members' meetings which provided an opportunity to reflect on events over the past year and meet members of the public;
- the successful #Thank you day event held at RBCH celebrating the value of the Trust's amazing staff;
- the Volunteers Tea event held at RBH recognising the contribution made by the volunteers;
- Poole Hospitals' 50th Anniversary celebrations;
- congratulations to Pete Papworth following his successful appointment as the Joint Interim Director of Finance.

47/19 **QUALITY AND PERFORMANCE**

(a) Patient Story (Item 5a)

Hazel Allen attended the meeting to provide an overview of the work to support homeless patients and help improve experiences at the Trust for these vulnerable patients.

The patient story focused on the experiences of one homeless patient whom Hazel met during her work with the Healthbus that provides accessible services for those living on the streets. This patient had acquired a groin infection from the use of intravenous drugs that developed into a leg deep vein thrombosis and sepsis. Following six weeks of treatment at the Trust he was discharged back on to the streets. As a last resort he committed a crime to get into prison in order to beat his opiate addiction.

The benefits of this patient's admission had largely been undone as essential support had not been put in place. As part of the Trust's obligation under the Homelessness Reduction Act 2017 to identify and refer these patients at the earliest opportunity, the team sought best practice from the Pathway organisation which promotes a multidisciplinary pathway team approach for the referral and signposting of these patients to appropriate services.

A business case was being developed across both Trusts to invest in care to improve experiences for both patients and staff and reduce the readmission rates thereby generating savings for the Trust.

The Board of Directors commended the excellent work underway for this group of vulnerable patients and supported the development of a business case across both sites.

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

The key areas in the report were summarised and included:

- mortality metrics for both Hospital Standardised Mortality Ratio (**HSMR**) and Standardised Hospital Ratio (**SMR**) were broadly within the 'better than expected range' being the best recorded performance for the Trust;
- the ongoing work with the coding department to improve data quality assurance;
- the review of a spike in the crude mortality rate for August and variables such as the peak period of escalation and Junior Doctor changeover.

Non- Executive Directors raised concerns about the potential impact Junior Doctors changeover had in relation to the spike in mortality. The Board was given assurance that appropriate policies were in place to support the changeover process, however this was being considered to ensure it was not a contributory factor.

Non- Executive Directors also queried the level of exception reports generated by Junior Doctors as highlighted in the Quarterly Report on Safe Working Hours, and if similar themes had been identified through the Freedom to Speak Up Guardian (**FTSUG**) to ensure there were no underlying issues. The Board noted that themes from the quarterly reports showed the Trust had a positive culture of exception reporting. Work

patterns and additional support was being reviewed in areas with high volumes of reporting, particularly surgery, following feedback from the General Medical Council (**GMC**) survey. It was also noted that all junior doctors were now on the new contract. The Trust had incurred its first fine that related to a trainee who had agreed to work an additional shift; this would be a learning point for the rest of the organisation.

The mitigations in place to address the risk arising from the review of Acute Kidney Injury (**AKI**) was discussed. It was noted that this was a theme across organisations nationally. A safety collaboration was being considered to identify a solution together with the internal development of the electronic management of a fluid balance system.

(c) Trust Board Dashboard (Item 5(c))

The Board noted that the data relating to the recorded case of Clostridium Difficile was yet to be validated and confirmed or not as hospital acquired. A revised e dashboard would be circulated outside of the meeting to reflect **AH** this.

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

Board members noted the performance exceptions to the Trust's compliance with the 2019/20 Single Oversight Framework, national planning guidance and contractual requirements.

During discussion, the Non-Executive Directors raised concerns around the scale of the significant increases in demand and the impact this was having on performance. It was noted that this continued rise could impact on and increase the risk of breaches to the 52 week standard as a result of demand and workforce pressures due to the impact of changes to the NHS pension rules for doctors. Additional recruitment was underway to provide support in some areas and alternative options were being explored including the potential to outsource some general surgery to support recovery plans.

Patient communication had been stepped up with a dedicated central team for 40+ week waits to ensure that high-risk patients were being escalated.

Performance against the diagnostic 6 week target had also decreased with a backlog of patients in endoscopy. The Trust remained focused on the sustainable recovery of the 99% target in 2019/20. This would require additional investment and activity to recover the position. A long-term solution was being developed to address capacity with the recruitment of substantive staff due to commence in Endoscopy from September.

ED remained under pressure with high numbers of attendances with the Trust having achieved 83.2% against the 4 hour standard in August. The Board noted the current levels of demand were unlikely to reduce. Additional focus was being placed on pathways and capacity overnight and at weekends to promote the best use of resources. Discussions were also underway with partners across Dorset to address demand.

Board members reinforced their concerns around the current levels of

performance and the impact this had on patient safety and staff and supported further development of the actions outlined to support recovery of the position.

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

The key themes from the report were highlighted:

- a number of serious incidents were reported in August reflecting the recent operational pressures;
- one incident met the criteria for a never event and would be reviewed in detail;
- inpatient Friends and Family Test (FFT) national performance placed the Trust in the top quartile for patient satisfaction;
- ED FFT data was being aligned with themes from the Care Conversations to identify areas for improvement;
- following a benchmarking exercise of complaints response timescales across Dorset a recommendation was approved to increase the Trust response timescale from 25 to 35 working days.

Focus would continue to be placed on maintaining high standards of quality care particularly during pressured periods.

(f) Finance Report (Item 4(f))

The board noted that whilst the Trust broadly continued to deliver the financial control total a significant number of non- recurrent financial underspends within the first five months had off set a larger deficit driven by the shortfall in the Cost Improvement Plan (**CIP**) amounting to £3.8 million. In addition to the financial recovery plans alternative non- recurrent mitigations were also being sought to provide a greater level of confidence, however this remained a considerable risk.

Operational risks were also highlighted including challenges in endoscopy, winter pressures and RTT that would require additional funds to offset these costs. Similar pressures were being seen across Dorset and the Trust continued to work closely with partners to support the system achieving the targets to secure the PSF allocation.

There had been considerable slippage within the capital position following late notification of the national funding for the One Dorset Pathology Laboratory Information Management System building works however the full year forecast was consistent with the revised capital programme.

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

The key updates from the report were:

- the significant increase in the recruitment of registered nurse apprentices as a result of the collaborative programme developed across Dorset;
- the need to monitor Essential Core Skills compliance ahead of winter to help the Trust achieve the internal target of 95%;
- the slight increase in sickness absence performance which would continue to be closely monitored;
- the launch of the Flu Campaign which had been incorporated with in

the Winter Plan.

Board members were encouraged by the successful work underway across all three trusts in Dorset to develop the future workforce.

48/19 **STRATEGY AND RISK**

(a) Winter Plan 2019/20 (Item 6(a))

The Board received an overview of the actions in place to support the provision of safe and quality care during peak pressures over the winter period. The key themes within the plan included:

Building on learning from previous years

- Demand and capacity planning
- Sustainable ongoing quality and service improvement (QI programme)
- Specific planning and investment for winter capacity
- Clear escalation plans
- Communication and engagement with our staff, partners, patients and public
- Partnership working that secures capacity and resilience across the Dorset system.

49/19 **GOVERNANCE**

(a) Freedom to Speak Up – Bi-Annual Report (paper/presentation) (Item 7(a))

Helen Martin, Freedom to Speak Up (FTSU) Guardian, presented the key themes from the report including:

- progress with the development of a joint 'speaking up model' across both sites to establish the culture and provide support to staff ahead of the proposed changes to healthcare services and in anticipation of merger;
- the growth of the FTSU team and function which had now been established within the culture of the Trust reflected by the positive results in the FTSU Index conducted by NHS Improvement;
- the development of further links with national and regional networks and other trusts locally to share learning and good practice;
- overall the Trust has a positive reporting culture and staff feel supported to raise concerns;
- the positive results from the last NHS Staff Survey which was due to commence again in the next quarter;
- the further work planned to address themes raised from concerns including attitudes and behaviours and supporting the work to develop a more inclusive culture for Black Asian and Minority Ethnic (BAME) staff.

Benchmarking for the recent recommendations published by the National Guardian Office to improve the quality, clarity and consistency of training on speaking up was also being developed focusing on how line managers welcome, handle and feedback concerns.

(b) Meeting Dates for 2020 (Item 7(b))

The item was noted for information.

50/19 **NEXT MEETING**

The next meeting will take place on **Wednesday 27 November 2019** at 2pm in the Board Rooms, Poole Hospital.

51/19 **ANY OTHER BUSINESS**

There was no other business.

Key Messages for Communication to Staff:

1. Patient Story;
2. RTT Performance and the Winter Plan;
3. Freedom to Speak Up headlines;
4. #Thank you Day;
5. Recruitment, ECS compliance and low vacancy rate
6. Flu Campaign;
7. Teamwork in Urology.

52/19 **COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC**

One of the newly appointed governors reflected on his role as a volunteer in the ED department and provided assurance of the positive feedback received from patients. He noted the recent pressures and queried what more could be done to promote the alternative services available for minor ailments. Emphasis was placed on the need to educate members of the public about the alternative and more appropriate services available and to build confidence in the NHS 111 service to help reduce pressures with demand. The importance of the streaming service in the Urgent Treatment Centre was also working to support the recent demand, however further work was required with partners with increased investment to strengthen GP and local community services including pharmacies.

The process for the prescribing of antibiotics was raised in relation to the recent serious incident involving a patient with possible meningitis. National guidelines for the prescribing of antibiotics were being implemented and the Trust continued to report low numbers for hospital acquired infections.

53/19 **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 10.40pm.

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
25.09.19	47/19	QUALITY AND PERFORMANCE			
	(c)	Trust Performance Dashboard			
		A revised version of the dashboard would be circulated outside of the meeting to reflect this.	AH		Circulated to Board members after the meeting.
Key:	Outstanding	In Progress	Complete	Not yet required	



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

BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Chief Executive's Report
Section on agenda:	Not applicable
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 September 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

November 2019

CHIEF EXECUTIVE REPORT

1. Update on the merger and establishment of the Shadow Interim Board

As members may be aware, we have made significant progress over the past two months in taking forwards our plans to merge our two organisations. We have agreed with our regulator NHS Improvement (NHSI) that we shall schedule our work programme with a view to the merger taking place on 1 July 2020. Earlier this month, I wrote to the Competition and Markets Authority (CMA), formally requesting that the undertakings signed by both Trust Boards in 2013 should be lifted. These undertakings prohibit the two Trusts from merging without CMA permission for a period of ten years. We expect a response to this letter in due course.

Another important milestone is that the two Trusts have completed their due diligence work (apart from the financial due diligence which is scheduled to be completed early in the new year). The result of this work will be used by the two Boards, the two Council of Governors and NHSI to identify the risks associated with this transaction, and provide assurance that plans are in place to mitigate them. To date, the results of this work indicate that all the risks identified can be effectively managed. The two Boards will be reviewing the due diligence report at their November Board meetings, with each Council of Governors reviewing the report in January.

In the meantime, we are continuing with our merger work and integration planning, with the full merger business case expected to be submitted to NHSI in March 2020.

There was another significant step forwards in November, when we were able to announce the establishment of the new Shadow Interim Board. The Shadow Interim Board will be overseeing the establishment of our new organisation and the future planning of our services, and will be meeting for the first time in the new year. The full membership of the Shadow Interim Board will be formally announced in due course, along with the name of the new organisation.

It is important to note that decisions taken by the Shadow Interim Board will need to be ratified by the two existing Boards, who will retain their current statutory duties and responsibilities right up until the establishment of the new organisation. In the meantime, this is clearly an extremely important milestone in our merger programme.

2. Naming our New Organisation

Over the past few weeks, we have been going through an exercise involving staff, governors, volunteers and interested stakeholders to select a name for our new organisation. Whilst each of our three hospitals will retain their individual site name going forwards, they will all form part of the new merged organisation, which will, of course, have a new name.

A large number of suggestions were initially put forward, which were reviewed last month by a shortlisting panel. Since then, we have been engaging with staff to seek their views on a shortlist of four names that meet the NHS naming criteria, as laid down in national guidance.

The new name will be agreed at the joint Board meeting on 27 November and this will be formally announced in December.

3. Winter Pressures

Both Trusts continue to be extremely busy, with an on-going increase in demand compared to previous years. There have been increased attendances within the Emergency Department, particularly at the weekends and going into the evenings, along with an increase in the acuity of patients being admitted, and this continues to place great pressures on our staff. The increase in emergency activity, coupled with national/local staff shortages and other pressures, means that waiting times across both organisations have increased in recent months.

Partners across Dorset have been working together to establish more capacity over the winter, and to support each other in meeting this level of demand. Additional resources have been used to increase capacity, and both Trusts have opened additional beds in order to better meet demand. There are also Quality Improvement projects established within each organisation, aimed at improving flow and reducing any unnecessary internal delays. Working with local partners, we have health and social care teams co-located on both hospitals sites, working together as integrated teams to support early discharge planning and avoid unnecessary admissions. As well as creating additional capacity within the acute sector, it is essential that additional capacity is created in the community. Only in this way can we ensure that across Dorset, all patients are treated in the right place at the right time.

It is recognised that this on-going increase in demand is reflected across the country, and as such, is receiving attention at a number of levels. Within Dorset, this continues to be a significant priority, with action being taken by all partners across all sectors. Within the acute hospitals, the priority is to take the action necessary to maintain safe care during this busy period, and to support our staff as they seek to do this under significant pressure.

4. Refreshing the Dorset System Plan

Members will be aware that work has been going on across the Dorset system to refresh the Dorset Sustainability and Transformation Plan. All partners are committed to developing healthier communities, and supporting people to live longer, healthier lives. However, the challenge is to transform services and “invest upstream”, in the face of the current patterns of demand. We are continuing to work with our partners to agree how best we can use our collective resources, in a way that will enable us to meet that demand, whilst at the same time, transforming services for the future.

This work is on-going, and will continue to be reported to the Board.

5. CQC Inspection

Members will be aware that both Trusts have been planning for an inspection by the CQC in 2019/20. I am pleased to confirm that the inspection of Poole Hospital finished earlier this month, and whilst there are some issues that the Trust will need to address, this appears to have gone well. The Trust has recently received a brief letter confirming the initial feedback, which will be made public in due course. The full report is expected to be received in early January.

The Royal Bournemouth and Christchurch Hospitals is also due for inspection, and this is expected to take place at some point in the new year.

6. Poole Hospital “Story of Now”

Poole Hospital has recently completed a Listening Exercise with its staff, known as “The Story of Now”. Eighteen “People Champions” have gathered views from nearly 400 staff, in a wide range of roles and services between July and September, and this report was presented to the Workforce and Organisation Development Committee in October. This is a very important piece of work, that will supplement the feedback received from our annual and quarterly Staff Surveys.

At present, the priority has been to share this report within the organisation so that senior leaders are clear on the messages and able to respond appropriately to them. The People Champions have made a number of recommendations that will need to be addressed, with progress against them then being monitored by the Board.

The Change Champions within The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) completed a similar exercise earlier in the year and the output of this work has already been fed back to the Board. There are plans to share both sets of feedback at the Joint Leadership Forum due to take place in December. This will provide the opportunity for our clinical leaders to reflect on this feedback and help to shape the actions going forward. The outputs of this work will be important in developing the organisation development plan for our new, merged organisation.

7. Encouraging Staff to Speak Up

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication “Freedom to Speak Up”, mandating that each Trust appoint a Freedom to Speak Up Guardian (FTSUG). A joint speaking up model now exists across both PHFT and RBCH, developed in response to the significant changes that will be taking place as we reconfigure services across Dorset and in anticipation of the merger.

Helen Martin, formerly FTSUG for RBCH now works across both Trusts, and fulfilling a very important role across both organisations. In 2018, RBCH had an index score of 84%, which was the highest index score for within an acute trust for staff speaking up. This is seen as a very positive indicator - a sign of an open culture.

Within Poole Hospital, the work of the new FTSUG was formally launched on 13 September 2019 at the #thankyou Friday event. Over 20 referrals to the FTSUG have been received since the launch, with a number of staff having since applied to become one of the FTSU ambassadors.

8. Celebrating Diversity

Members will be aware that both Trusts are committed to developing a more diverse workforce. In this way, we shall be better placed to make use of all the talent available to us, and will be better placed to deliver high quality services to our increasingly diverse local population. Approximately 14% of the workforce within RBCH is made up of staff from a black or minority ethnic background, whilst within Poole Hospital, this figure is just under 10%. Through our staff engagement work, we know that more needs to be done to provide appropriate development opportunities for BAME staff, and to ensure that all members of staff - whatever their background, race, ethnicity, or sexual orientation - feel valued for the contribution that they make within our organisations.

With this in mind, I am pleased to report that both Trusts celebrated October’s “Black History Month”. This presented a great opportunity to recognise and celebrate the various contributions of people from Africa and AfroCaribbean descent. and the significant

contribution that they are making to the work of our hospitals. It is important that we continue to create the best possible working environment for all our staff, and act on the feedback that we receive, in the creation of our new merged organisation.

9. National Cancer Patient Experience Survey

The results of the 2018 National Cancer Patient Experience Survey were published in September 2019 and the results for both Trusts are excellent. Respondents were asked to rate their care on a scale of zero (very poor) to 10 (very good); they gave an average rating of 9.03 to Poole Hospital NHS Foundation Trust (PHFT) and 9.0 to The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH), compared to a national average of 8.80.

PHFT Hospital scored better than the national average in 20 out of 59 questions, whilst RBCH scored higher than the expected range in 15 questions. Some of the highlights were in the following themes:

- Being involved in decisions about care and treatment – both Trusts scored 81% (national average 79%)
- Knowing the name of the Clinical Nurse Specialist who would support them through their treatment - 95% for Poole and 90% for Bournemouth (national average 91%) and finding it easy to make contact with them 92% for Poole and 89% for Bournemouth (national average 85%)
- Treated with dignity and respect whilst in hospital – 89% for both Trusts (equal to national average)
- Hospital staff told the patient who to contact if they were worried about their condition or treatment after they left hospital – 95% for Poole and 96% for Bournemouth (national average 94%)
- Patients thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment – 67% for Poole and 64% for Bournemouth (national average 59%).

There are no results where PHFT or RBCH falls below the national expected range, however, there are areas where we can see opportunity for improvement and the Care Groups are putting actions in place to support further improvements e.g. for Bournemouth, raising the profile of cancer research trials and at Poole, on-going focus to ensure patients are given information on getting financial help.

10. Dorset Care Record

In developing integrated services for our local population, partners across Dorset have prioritised the development of the Dorset Care Record (DCR). The Dorset Care Record aspires to create a single, central, electronic repository of clinical and social care data for all residents in Dorset, which can be accessed at the point of care, 24 hours a day, 7 days a week. The repository will be created from 87 individual 'feeds' of data from existing systems within the seven health and social care partners of Dorset. Consequently, each partner has approximately 10 to 15 feeds to "enliven"

An updated version of the DCR was released in October, which contains even more data than before. Currently, 22 feeds are live and we are planning the switching on of the remaining 65 over the next 12 months.

At the present time, there are approximately 1000 **users** of the DCR each month, and approximately 2000 **uses** each month. The major benefit of the DCR is that it contains all coded clinical data from every GP practice in Dorset.

PHFT and RBCH currently have 12 of their 26 feeds live and in the near future, it will include Pathology and ED encounters. Users from both Trusts will be able to launch the DCR via our Graphnet Electronic Patient Record, with a single "sign on".

Another service hosted by the DCR is multiagency pathways - that is, the ability to create electronic forms within DCR that can be accessed and updated by all health and social care partners in Dorset. We have recently gone live with the first of these in maternity.

In the New Year, the DCR will include community and mental health data, as well as correspondence from Dorset County Hospital. This represents excellent progress and is really good news, as it will bring each patient's health details together, so that medical and social care staff across the system can provide coordinated and safer care. It will also remove the need for patients to repeat their details to different professionals.

Both Boards will wish to note this progress as we work together with partners to establish the Dorset Care Record.

11. Improving Patient Experience

An exciting initiative has been introduced within RBCH to improve patient experience within the interventional radiology department. In the first trial of its kind in the UK, Dr Clare Bent is testing video glasses that allow personal entertainment to be viewed during clinical procedures. The goggles have been sent from iTV Goggles in America, and can be used as a means of relaxing patients and making them feel more comfortable. Their use can also lessen the amount of sedation that the patient requires, which means they can return home more swiftly. Should the goggles be adopted on a permanent basis, this would result in cost-savings as the need for a sedation nurse within the department would be reduced. Other departments within the Trust are now looking at adopting this approach - for example, the endoscopy and cardiology departments. Great Ormond Street Children's Hospital is also looking to trial the goggles.

Debbie Fleming
Joint Chief Executive



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

BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Medical Directors Report
Section on agenda:	Quality and Performance 5B
Supplementary reading:	N/A
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Alyson O'Donnell, with input Michael Vassallo
Details of previous discussion and/or dissemination:	Mortality indices and reviews discussed at Mortality Steering Group
Action required:	Review and comment
Summary: Monthly Medical Director's Report. To update the Board on the Trust's Mortality performance. This report includes including Annual Report from Director of Medical Education on all work schedule reviews relating to education and training.	
Related strategic objective:	
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on significant risks:	N/A

Medical Director's Report to the Board

Mortality Update

It is encouraging to note that the bulk of mortality indicators for the Trust sit in the better than expected range, even when Macmillan Unit activity is included.

Overall the position is very encouraging with both HSMR and SHMI figures showing consistent improvement over last 6 months and with good concordance in both indicators. This provides assurance on the quality of clinical data submitted and should provide headroom for expected annual winter mortality spike.

The figures for Hospital Standardised Mortality ratio (HSMR) and Standardised Mortality Ratio are for the last 12 months (Aug 18-July 19) and have been re-based in February 2019. The latest SHMI (Standardised Hospital Mortality Indicator) which includes deaths up to 30 days post discharge is for the year July 2018-June 2019.

Indicator	Site	Value	Range
HSMR	Trust	91.3	Better than expected
SMR	Trust	90.2	Better than expected
	RBH	81.3	Better than expected
SMHI	Trust	90	As expected
	RBH	82	Better than expected
	Christchurch	272	Higher than expected

Although benchmarking is 'higher than expected' the figure for the Macmillan Unit is predictable and relates to the specialist palliative care unit provision.

There is an ongoing piece of work to improve data quality/coding for vascular procedures and also the depth of coding for 'elective' versus 'non-elective' activity. This work is progressing and has been strengthened following a recent GIRFT visit which included an offer to work with their coding team. MSG is assured that general data quality is high and expects that any outstanding data quality issues will be resolved soon.

The Trust observed single spike in crude mortality rate in August 2019 when compared to August 2018. There has been a subsequent improvement in crude mortality ratios for September and October 19. However, rates remains above those observed last year. There are no clear trends or patterns that may indicate any areas of concern, see Annex 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 12/11/2019

Month	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Deaths in Month	120	118	162	133	133	121	118	109	121	130	131	132
eMortality Reviews Completed in Month	18	18	210	71	119	13	61	14	100	80	77	4
Category of Death by Month Review Completed												
Grade 0	18	17	190	63	108	12	48	9	82	67	69	4
Grade 1	0	1	19	8	11	1	11	4	18	13	8	0
Grade 2	0	0	1	0	0	0	2	1	0	0	0	0
Grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disability Deaths in Month	0	0	0	0	0	0	0	0	0	0	0	2
Learning Disability Deaths Reviewed	0	0	0	0	0	0	0	0	0	0	0	0

LeDeR Mortality

There were two deaths reported in patients with a learning disability in October 2019. Both deaths have been reported to the national (LeDeR) programme. One death was expected and the Consultant in charge has been notified to conduct a prompt internal review. The second death was not expected and has been reported to the Coroner. A post-mortem has been conducted and the findings are awaited. As part of our normal processes this has been passed to the Risk and Governance team for consideration of a mortality Scoping meeting and RCA investigation. Once these reviews are completed MSG will widely disseminate the findings and any learning.

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: Congestive Cardiac Failure

The purpose of this annual review is to monitor mortality in hospital and within 30 days of discharge from Congestive Cardiac Failure (CCF). This has been identified as a high risk condition for mortality in previous Department of Health Guidance (2015). The annual HSMR for CCF is within the expected range (Annex A). The SHMI figure for last 12 months is just above average but remains in the expected range (observed mortality 83, expected 70.3). The lead Cardiologist for heart failure services has presented his annual review to MSG to provide assurance around trends in mortality, length of Stay and readmission rates.

Learning Points

- Mortality rates are above national average for CCF at Royal Bournemouth site (10% vs 13.5%) but this is likely to relate to our population demographic as mortality more than doubles between <75 years and >75 years
- Mortality is lower when care is provided by the specialist Cardiology service vs provision in other specialities (9% vs 20.5%)
- Average length of stay improved from 13 days to 10 days after introduction of heart failure services in 2016 but has increased again this year to an average of 11.4 days. The reasons for this are not clear but may represent 'saturation' of the service
- Readmission rates are highest regionally when compared to peers.

Action Plan

- Expansion of the service provided with another heart failure consultant is being planned with the view to start early supported discharges for CCF.
- Advertise and promote use of 'heart failure app' information by all other professionals and caregivers which will improve recognition of status and medication on discharge etc
- MSG supported a potential early business case for CardioMEMs (an early warning device to predict decompensation and prompt early management) to reduce hospital admission rates. This would require an invest to save approach being taken with commissioners.
- MD and clinical lead to meet with DHUFT Medical Director to explore the potential for improved join up between primary and secondary care heart failure services.
- MSG to conduct a mortality review for heart failure deaths within 30 days of discharge.

Discharge Pathways for Complex Care

One of our speciality doctors who is also a QI fellow presented the findings of her recent audit in to discharge for patients requiring complex packages of care. She conducted a retrospective review of 50 complex discharges. The review suggested significant delays in discharges related to various steps in processes and paperwork completion.

Hospital pathway solutions: The findings have also been presented to TMB for information and to help find solutions, one of which is the development of an online referral forms as the current paper system was an obvious source of delay.

Good Save

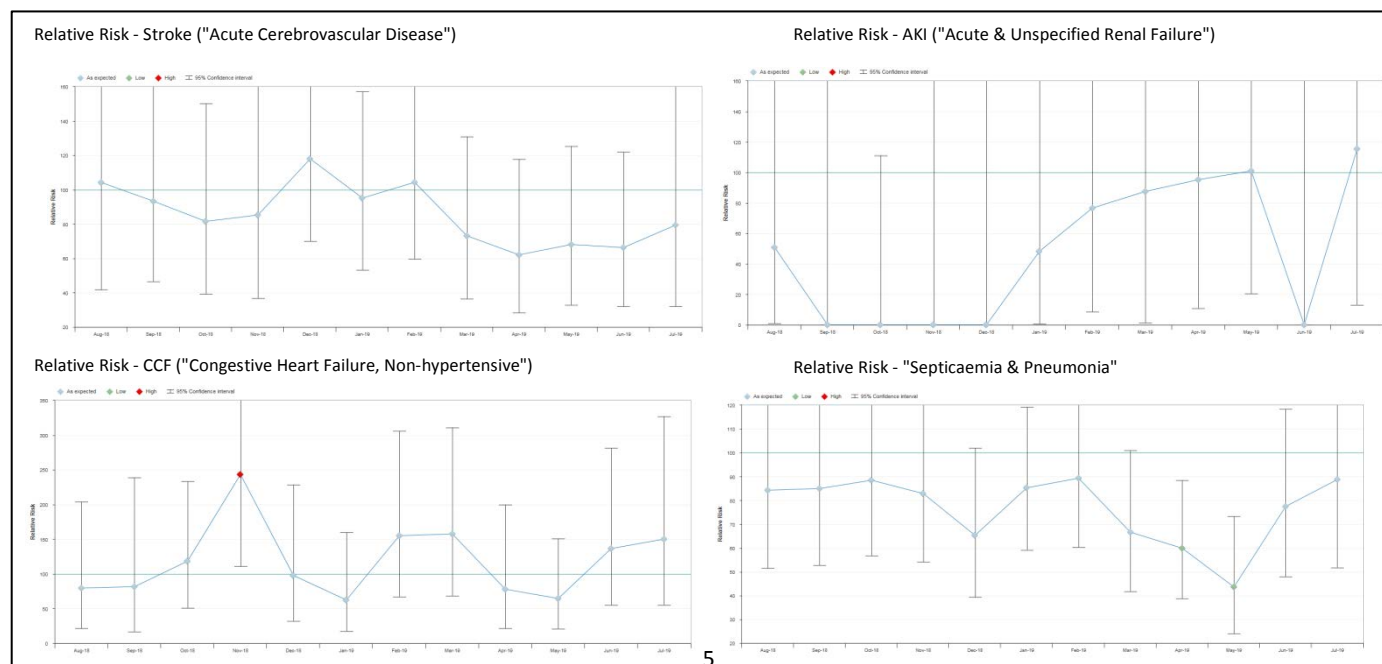
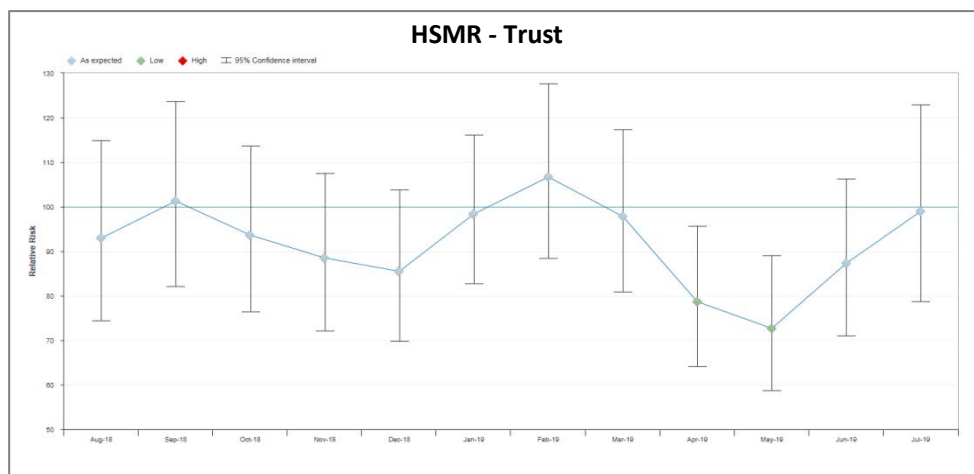
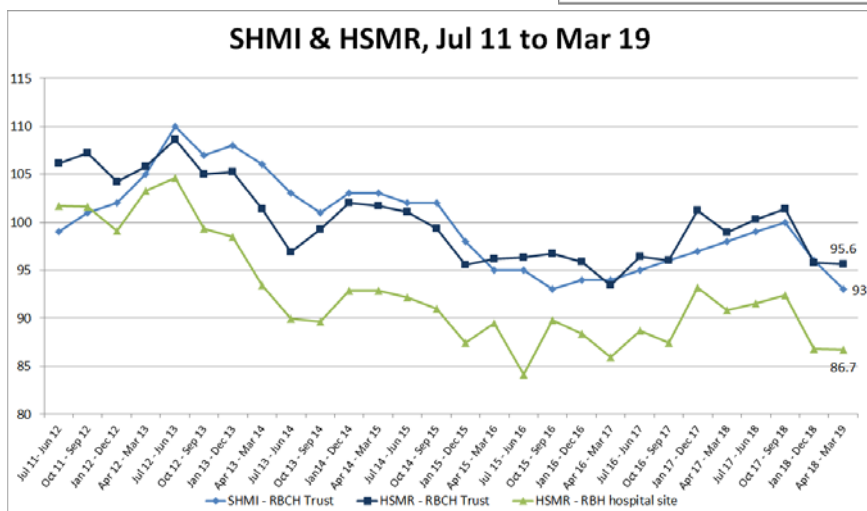
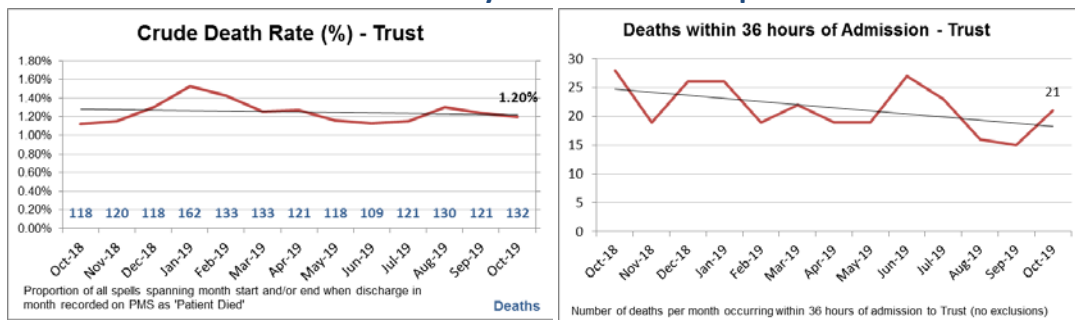
MSG focuses on and promotes learning from mortality reviews and examples of excellence in care (good saves) in order to widen the spectrum of learning and improving overall clinical outcomes.

One of our Specialist Registrars presented a case where a good multidisciplinary approach and prompt management of NSAID (Brufen) induced severe acute renal failure meant that this patient returned to normal kidney function.

Prompt recognition of anuria and excellent input output charting by nursing staff, combined with early recognition of NSAID induced renal failure and saved this patients' life.

SUBSEQUENT BLOOD TEST RESULTS				
	Admission	Day 5	Day 9	Day 53
Urea	8	22.3	40.6	5.4
Creatinine	84	565	819	65
eGFR	56	6	4	75

ANNEX A - Data Review - Mortality Surveillance Group



Trust Board Dashboard - October 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	2019/20 Q1			2019/20 Q2			2019/20 Q3			Trend (where applicable)
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	88.1%	87.7%	84.1%	86.6%	86.7%	83.7%	87.8%			
	Caring - Inpatient scores from Friends and Family Test % positive	98.3%	96.4%	97.9%	97.9%	98.5%	98.3%	96.3%			
	Caring - Maternity scores from Friends and Family Test % positive	97.1%	98.6%	97.8%	99.3%	98.7%	99.4%	98.8%			
	Caring - Mixed sex accommodation breaches	10	0	3	1	5	9	4			
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)		89.5%								
	Caring - Formal complaints	37	59	36	46	34	29	39			
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	737	710	720	796	728	753	752			
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	64.1	88.5	89.8	105.4						
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - MAC	137.4	217.3	299.8	310.6						
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - RBH	62.3	77.5	84.2	96.7						
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	76.2	83.4	87.3	99.0						
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	159.9	230.9	174.9	204.9						
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	69.2	68.2	81.7	89.5						
	Effective - Summary Hospital Mortality Indicator										
	ED Attendances	8889	9344	9157	9778	9565	8946	9241			
	Elective Admissions	5119	5539	5152	5605	5196	5060	5870			
	GP OP Referrals	5812	6159	5844	6455	5544	5859	6277			
	Non-elective Admissions	3333	3501	3458	3655	3564	3450	3656			
	Organisational health - Staff sickness in month	3.9%	3.6%	3.7%	3.8%	3.6%	3.7%	4.1%			
	Organisational health - Staff sickness rolling 12 months	4.2%	4.2%	4.2%	4.2%	4.1%	4.0%	3.9%			
	Safe - Clostridium Difficile - Confirmed lapses in care	1	2	0	0	0	2	3			
	Safe - Clostridium Difficile - infection rate	18.98	12.25	6.33	6.12	18.37	6.33	30.61			
	Safe - MRSA bacteraemias	0	0	0	0	0	0	0			
	Safe - NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0			
	Safe - Occurrence of any Never Event	1	0	0	1	1	0	0			
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)		41.23			39.52					
	Safe - VTE Risk Assessment	95.7%	96.5%	96.7%	96.6%	96.3%	96.1%	96.3%			
	Number of Serious Incidents	3	3	0	2	5	2	1			
	Appraisals - Values Based (Non Medical) - Compliance	2.1%	9.0%	20.7%	37.4%	55.9%	78.1%	86.2%			
	Appraisals - Doctors and Consultants - Compliance	83.7%	83.5%	82.5%	81.5%	83.2%	80.1%	80.5%			
	Essential Core Skills - Compliance	93.6%	93.9%	94.4%	94.5%	94.8%	94.1%	94.6%			
	Organisational health - Proportion of temporary staff	8.3%	10.7%	8.0%	7.7%	7.9%	7.8%				
	Organisational health - Staff turnover	10.2%	10.6%	10.5%	10.4%	10.5%	10.0%	10.4%			
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	3	2	2	2	1	2				
	Sustainability - Liquidity (YTD score)	1	1	1	1	1	1				
	Efficiency - I&E Margin (YTD score)	4	3	3	2	2	2				
	Controls - Agency Spend (YTD score)	1	1	1	1	1	1				
	Controls - Distance from Financial Plan (YTD score)	2	2	1	1	2	1				
	Overall finance and use of resources (YTD score)	3	2	2	1	1	1				
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	91.1%	92.8%	86.2%	83.8%	83.2%	81.6%	82.7%			
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	100.0%	100.0%	88.9%	75.0%	92.9%	93.8%				
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	86.9%	88.0%	84.5%	90.6%	87.1%	84.5%				
	Maximum 6-week wait for diagnostic procedures	98.3%	96.9%	95.8%	92.8%	88.4%	88.9%	89.2%			
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	84.0%	85.0%	84.2%	83.4%	82.7%	81.0%	81.2%			

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

The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Performance Report
Section on agenda:	Performance
Supplementary reading:	n/a
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>Summary: The Trust Board of Directors is requested to note the performance exceptions to the Trust's compliance with the 2019/20 SOF, national planning guidance and contractual requirements.</p> <p><i>Note, the narrative report should be read in conjunction with:</i></p> <ul style="list-style-type: none"> • Trust Board Dashboard • Performance Indicator Matrix <p>Executive Summary: This report focuses on October 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 was 82.7%, continuing below the national target and local trajectory • Type 1 ED attendances were up 11.9% and emergency admissions up 12.1% in Oct 19 compared with Oct 18. • There were no 12-hour decision to admit breaches • Ambulance handovers increased and remained worse than trajectory • At month end there were 5 patients whose RTT wait was over 52 weeks • The total numbers of patients on an RTT pathway increased in October by 719 • The Trust wide RTT performance against the 18 week standard remained stable at 	



The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

<p>81.2%</p> <ul style="list-style-type: none"> • Performance against the 62 day cancer standard for September was not achieved at 84.5% (below the 85% national standard) although the overall position for Quarter two was above the target at 87.4% • 2 week Fast Track referrals continue to be at 14.9% above the same period as last year (calendar YTD) • All three standards relating to stranded patients continue to improve, thus remaining on track for the NHSI trajectory to be achieved. • Diagnostic 6 week performance improved slightly to 89.2%. In October 2019 JAG accreditation was removed, pending recovery and re-application. 	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>
Impact on high risks:	<p>Performance metrics are key control measures for the following risks on the Trust Risk Register:</p> <ul style="list-style-type: none"> • Inpatient QI (Flow) Programme (806) • ED 4hr (801) • Stranded patients • RTT (808) • Outpatients <p>Financial</p>



Operational Performance Report

For the period to end
October 2019

Richard Renaut
Chief Operating Officer

1. Executive summary

Key highlights and exceptions – October 2019:-

- Performance against the 4 hour standard was 82.7%
- There were no 12-hour decision to admit breaches
- At month end there were 5 patients whose RTT wait was over 52 weeks
- The total numbers of patients on an RTT pathway increased in October by 719
- The Trust wide RTT performance against the 18 week standard remained stable at 81.2%
- Performance against the 62 day cancer standard for September was not achieved at 84.5% (below the 85% national standard) although the overall position for Quarter two was above the target at 87.4%
- 2 week Fast Track referrals continue to be at 14.9% above the same period as last year (calendar YTD)
- All three standards relating to stranded patients continue to improve, thus remaining on track for the NHSI trajectory to be achieved.
- Diagnostic 6 week performance improved slightly to 89.2%. In October 2019 JAG accreditation was removed, pending recovery and re-application.

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 – October 19

Performance against the 4 hour standard rose slightly to 82.7% in October 2019. Increases in ambulance conveyances have continued through September compared to last year.

RTT performance increased to 81.2% in October. Performance has dropped below the local target trajectory for 2019/20. The overall waiting list size continues to grow. However, there has been a slight decrease (1.2%) in the number of patients waiting over 18 weeks at the end of October. The Trust has reported five patients who have waited longer than 52 weeks at the end of October, and a further 11 patients were treated beyond 52 weeks in-month. All of these patients are continuing to be closely tracked and medically reviewed. The Trust is targeting action to avoid patients waiting over 52 weeks using financial recovery agreed with the CCG.

Diagnostic performance improved slightly in October to 89.2% though this remains below the 99% standard. The overall number of patients waiting continues to increase due to endoscopy pressures. The Trust remains focused for 2019/20 on the sustainable recovery of the 99% target through recovery plans in endoscopy.

Operational Performance Report

As at 19/11/2019

Table 1 – Operational and Contracting Guidance - KPIs 2019/20 – actuals & forecast Oct19

Single Oversight Framework Indicator	National Target	NHSI Trajectory 19/20	Mth / Qtrly	RAG rated performance against national targets and NHSI submitted trajectories		
				Sep-19	Oct-19	Nov 19 projection
A&E 4hr maximum wait time	95%	90%	Mthly & Qtrly	81.8%	82.7%	
RTT 18 week incomplete pathways	92%	83%	Mthly	81.0%	81.2%	
RTT - no. of incomplete pathways	24,880	26,400	Yr End	28,876	29,592	
RTT - no 52 week waiters	0	0	Mthly	7	5	
Cancer 62 day wait for first treatment from urgent GP referral**	85%	83.3-85%	Mthly & Qtrly	84.50%	est	
Cancer 62 day wait for first treatment from Screening service**	90%	100%	Mthly & Qtrly	100.00%	est	
Maximum 6 weeks to diagnostic test	99%	99%	Mthly	88.9%	89.2%	

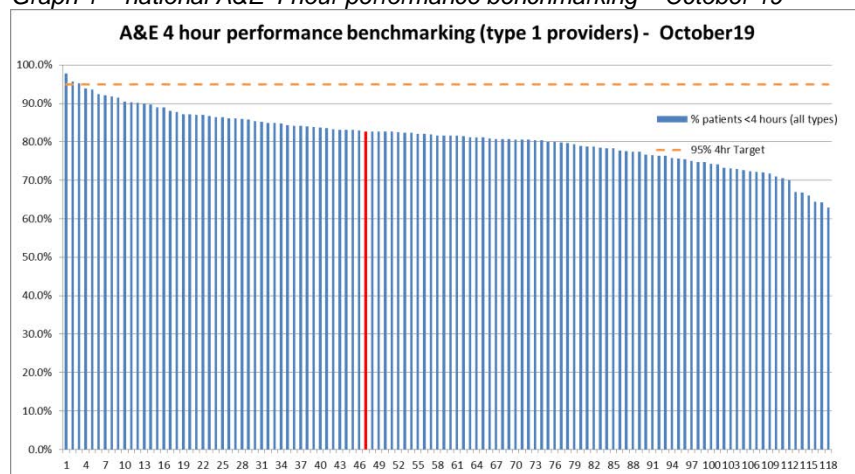
RAG Key: Red - below national target and organisational trajectory; Amber - above trajectory but below national target or 'at risk'; Green - above national target (and trajectory).

**Final validated Oct 19 performance upload will be completed early Dec 19

2.2 National Benchmarking – September/October 19

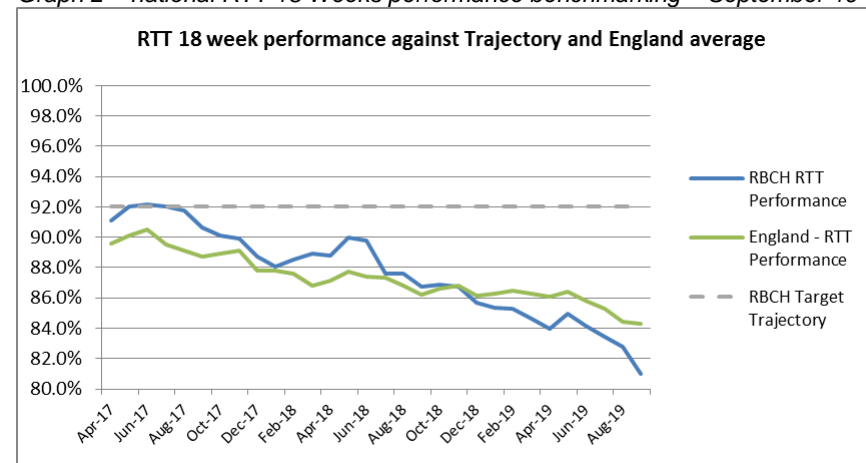
RBCH benchmarked 47th out of all type 1 Trusts nationally for ED 4 hour performance in October. A number of Trusts are excluded from the chart below while piloting the NHS Clinical Review of Access Standards.

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



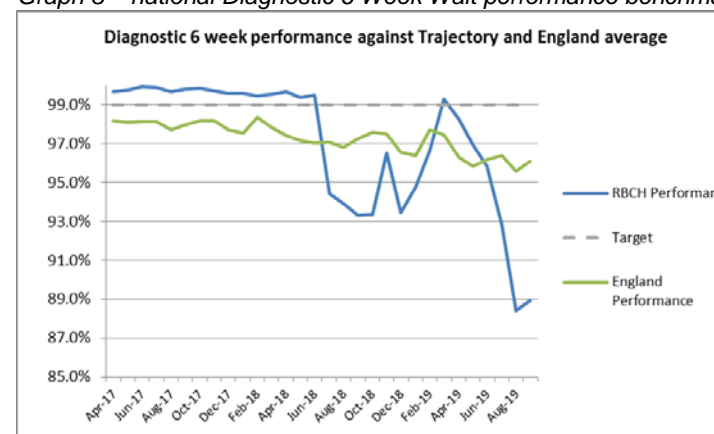
Trust wide RTT performance remained below the national average in September 19.

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



RBCH continues to benchmark below the national average Diagnostic performance in September and this is expected to continue until the recovery plans are fully implemented (October19 at 89.2%).

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

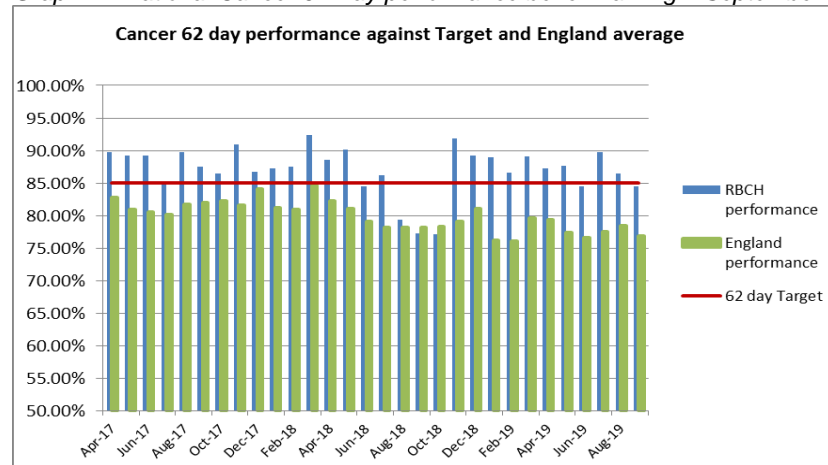


Operational Performance Report

As at 19/11/2019

RBCH benchmarked 84.5%, below the national 62-day standard performance in September '19, although remaining above the national performance. The increase in cancer referrals continues, at 14.9% above that of last calendar year.

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

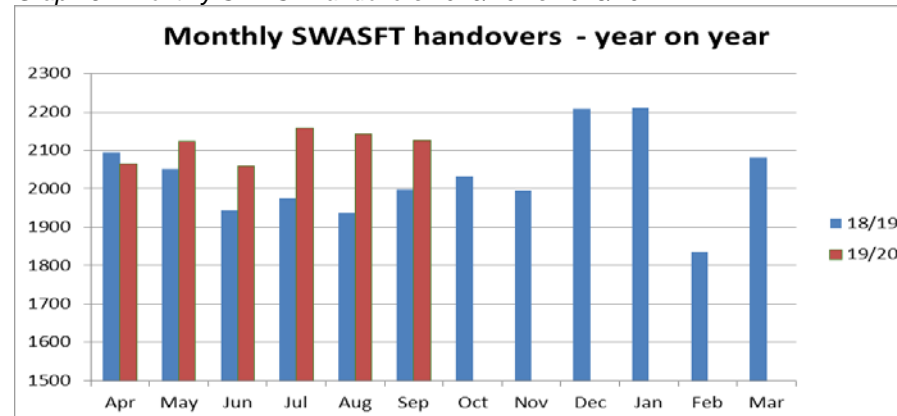


3.Forecast Performance, Key Risks and Action

3.1 A&E Targets, PSF and Stranded Patients

Ambulance conveyances continue to increase compared with the same period in 2018/19 (SWAST 5.6% (Apr-Sep) SCAST 17.0% (Apr-Oct)).

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



Performance against the 4 hour improved slightly to 82.7% in October. Despite the improvement in performance, both 30 minute and 60 minute handover delays increased during October. The SPC chart shows an increase in attendances compared with last year although this has stabilised during October. October 19 attendances show an increase in type 1 attendances of 11.9% (750 patients) to RBH compared to October '18. Alongside an increase of 6.3% YTD.

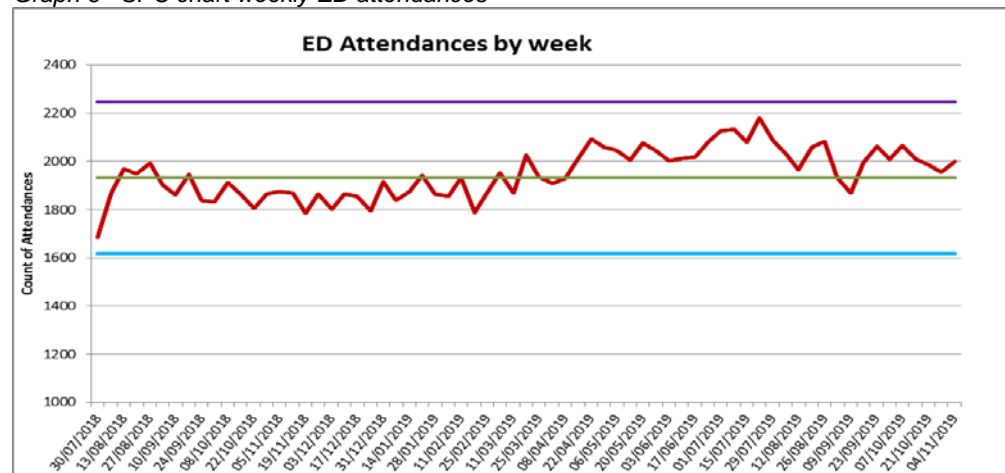
Table 2 Monthly and YTD ED attendances

	Month			YTD		
	Oct-18	Oct-19	% Variance	Apr-Oct 18	Apr-Oct 19	% Variance
Type 1	6,282	7,032	11.9%	47,004	49,969	6.3%
Type 2	1,381	1,403	1.6%	9,398	9,435	0.4%
Type 3- RBH	526	421	-20.0%	2,569	2,532	-1.4%
Type 3- B&S (reported monthly)	357	385	7.8%	2,297	2,648	15.3%
Total	8,546	9,241	8.1%	61,268	64,584	5.4%

Operational Performance Report

As at 19/11/2019

Graph 6 –SPC chart weekly ED attendances



Work is being planned for a PDSA to trial in November where an Acute Medical Unit Consultant will inreach to ED by working in the Rapid Access Treatment Service to identify patients that can be streamed directly to AMU. The intention is to improve both streaming and flow of patients through ED through this initiative.

The winter ward was opened in October as planned, increasing the bed capacity as part of the winter plans.

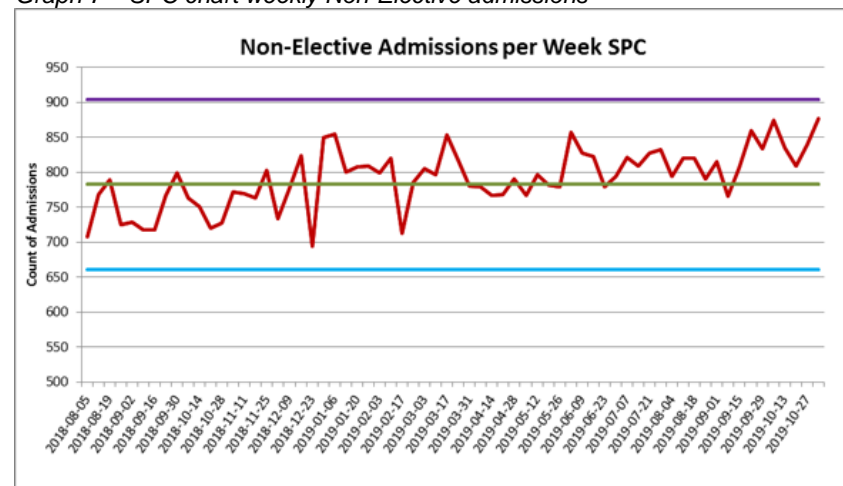
Streaming to the Urgent Treatment Centre (UTC) has achieved above 4% for the first time. Dorset IUCS partnership continues to work on increasing slot capacity ensuring more patients continue to be seen in a timely manner in the most appropriate setting.

Table 3 – ED Streaming figures

Quarter	Reported Month	DTA Breaches 4-12 Hour	DTA Breaches 12+ Hour	Streamed	% Streamed
Quarter 1	Apr 2019	88	0	279	3.28%
	May 2019	76	0	336	3.73%
	Jun 2019	96	0	307	3.53%
Total		260	0	922	3.52%
Quarter 2	Jul 2019	119	0	276	2.94%
	Aug 2019	118	0	348	3.85%
	Sep 2019	284	0	332	3.94%
Total		521	0	956	3.56%
Quarter 3	Oct 2019	216	0	356	4.02%

Emergency admissions were up 12.1% in October 19 compared with October 18 and (8.1% increase YTD) see graph 7.

Graph 7 – SPC chart weekly Non-Elective admissions

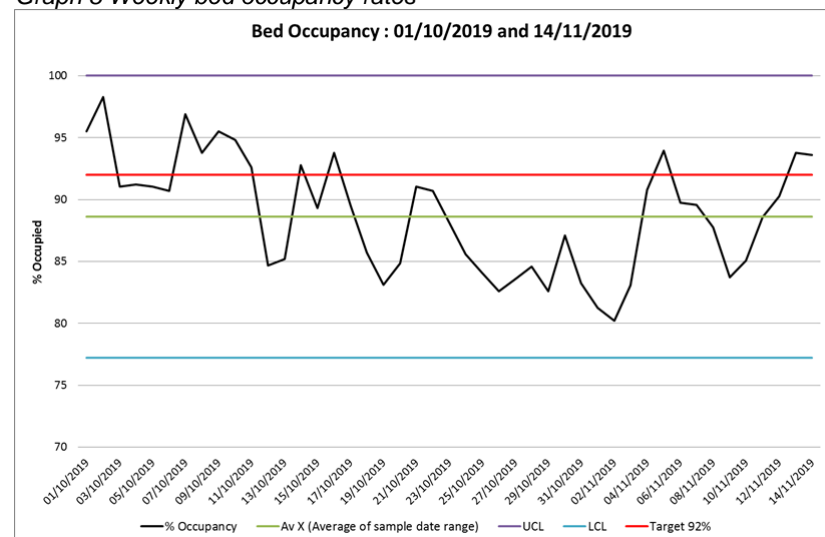


Operational Performance Report

As at 19/11/2019

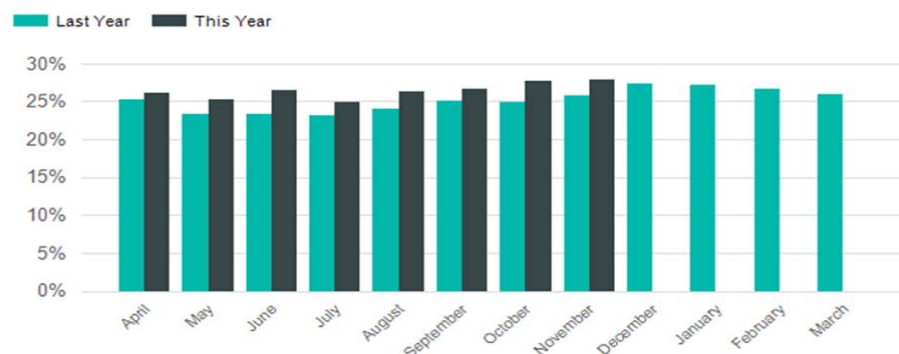
This is putting more pressure on patient flow from ED, which is reflected in the following Graph 8 showing an higher bed occupancy during October.

Graph 8 Weekly bed occupancy rates



Graph 9 Monthly and YTD Non –Elective admissions/attendances/conversion rates

ED Conversion Rates: YoY



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

The number of patients who have been in hospital for longer than 21 days who are medically fit for discharge is the lowest it has been since the Trust started to measure this standard. All three standards continue to improve remaining on track for the NHSI trajectory to be achieved.

Table 4 Monthly and YTD Stranded patients

	Month		
	Oct-18	Oct-19	Variance
Number of patients who have been in hospital for > 7 days	227	210	-7.5
Number of patients who have been in hospital for > 21 days	97	68	-29.9
Number of patients who have been in hospital for > 21days who are medically fit for discharge	49	30	-38.8

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

The Dorset wide system is working together to improve the overall performance within Dorset for more patients to achieve their first treatment within 18 weeks. The focus is on the following KPIs

- Zero 52 week waiters by Mar 2020
- Aim for zero over 40 week waiters by March 2021
- To achieve March 2019 RTT performance and waiting list numbers by March 2023 (reduction in the waiting list of 3,181)

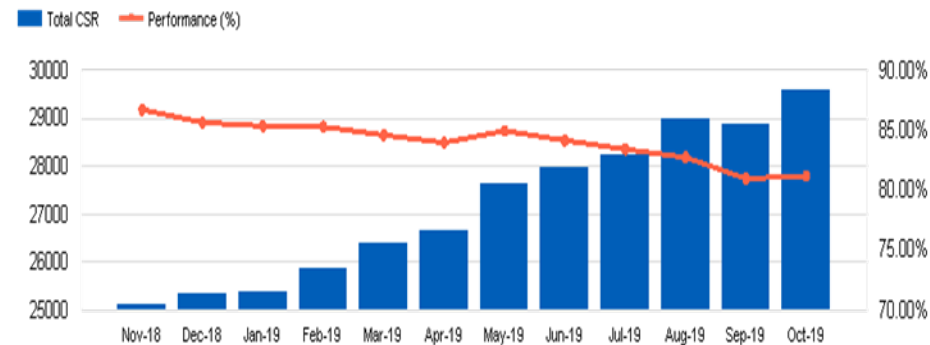
RTT performance stabilised during October the first non-decrease in performance since May 18.

Operational Performance Report

As at 19/11/2019

Graph 10 RTT Clocks still running increase vs Performance national target 92%

Total Clock still Running and Performance



The total number of patients with a clock still running continued to increase during October Table 5

Table 5 Clocks still running increase

	Month			YTD Increase		
	Oct-18	Oct-19	%Variance	Apr-Oct 18	Apr-Oct 19	Variance
Clocks Still Running	25421	29592	16.4%	258	2939	1039.1%

Weekly meeting continues to focus on patients waiting over 40 weeks. There was a decrease in the number waiting over 40 weeks at the end of October (Graph 11). Alongside this Demand and Capacity meetings using the Trust tools are concentrating on specialties where long waiters are occurring particularly in General Surgery and Urology linking to the KPIs above and to help inform budget setting.

Graph11– Monthly trend in 40+ week incomplete pathways

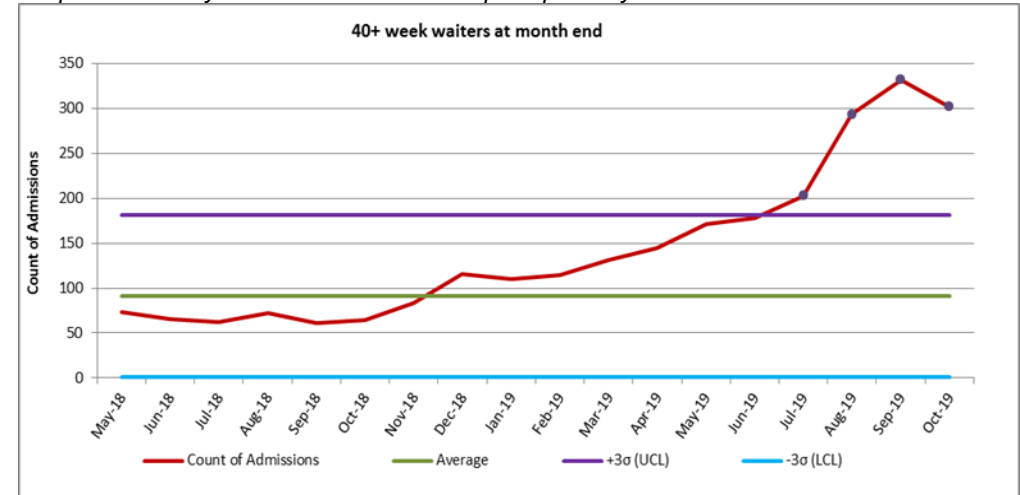
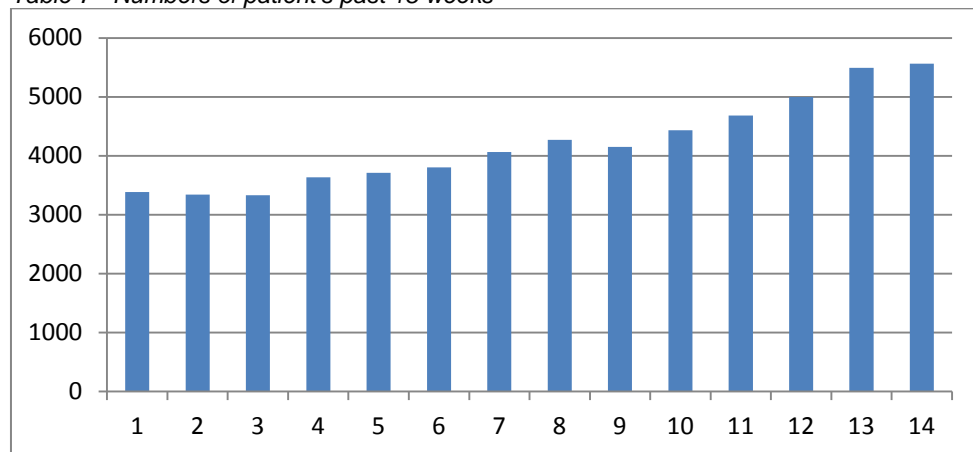


Table 6- 40+ week incomplete pathways by specialty

Specialty	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
General Surgery	40	46	57	81	99	118	109
Urology	58	55	48	58	74	83	69
Trauma & Orthopaedics	4	4	2	2	5	8	8
Ear, Nose & Throat (ENT)	2	0	1	1	3	9	7
Ophthalmology	18	38	36	28	60	62	38
Oral Surgery	5	6	1	2	11	5	8
Cardiothoracic Surgery	0	0	0	0	0	0	0
General Medicine	5	5	3	2	6	5	9
Cardiology	4	1	4	2	10	8	11
Dermatology	1	0	0	1	0	0	0
Thoracic Medicine	1	0	1	1	0	1	0
Neurology	0	0	1	1	0	1	2
Rheumatology	0	0	0	1	0	0	0
Geriatric Medicine	0	0	0	0	1	0	0
Gynaecology	5	8	15	16	18	19	23
Other	2	8	9	7	7	13	18
Total	145	171	178	203	294	332	302

Overall the number of patients waiting over 18 weeks has stabilised in the last month with the aim of decreasing the number of waiting further during Q3

Table 7 - Numbers of patient's past 18 weeks



Pressures, for example increasing cancer referrals, have not reduced throughout the year and continue to be prioritised

System-wide discussions have resulted in additional funds to prioritise long waits. The Trust is working through its plans to ensure the most efficient and clinically optimised use of funds. In-sourcing for Endoscopy has been agreed as it remains a high priority as this impacts on long waiters in multiple specialities. In sourcing for other specialties remains an option due to the impact of the pensions taper and inability to secure WLI capacity.

At the end of October there were five patients who had waited over 52 weeks and 11 patients who had waited beyond 52 weeks treated prior to month end

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

Table 8: 2-Week Fast Track Referrals calendar YTD

Calendar Year to Date			
Row Labels	2017	2018	2019
Brain	28	28	4
Breast	976	1001	1160
Colorectal	761	851	1168
CUP		2	5
Gynaecology	433	443	525
Haematology	36	45	33
Head and Neck	242	302	326
Lung	203	217	271
Other	17	15	16
Paediatric	5	6	
Sarcoma	58	92	90
Skin	1215	1370	1556
Upper GI	504	442	403
Urology	1045	1089	1224
Grand Total	5523	5903	6781
Increase on Previous year		380	878
% Increase		6.9%	14.9%

The above table demonstrates the continued increase in the 2 Week Fast Track referrals to the Trust increasing by 14.9% calendar YTD, this impacts on services which have seen the largest increase like Colorectal, Skin and Urology.

The Trust is now participating in the national Pilot for 28 day standards, which focuses more attention on patients receiving a diagnosis within 28 days, shifting the focus away from simply being seen in 2 weeks. The national aim is to ensure patients are guaranteed diagnosis earlier in the pathway and that the focus is on outcomes not appointment times. Unfortunately in month the Trust performance against this new anticipated target has dropped due to capacity challenges in several areas most marked being Dermatology and Colorectal.

Operational Performance Report

As at 19/11/2019

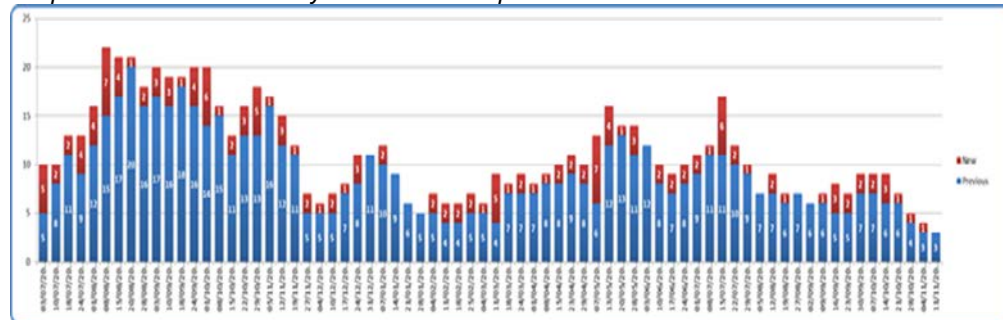
Table 9 shows month on month performance of the Trust against the current cancer KPIs. It is evident from this graph that although the 2 week wait target is currently challenged this is not a reportable target currently for the Trust. For this financial year the Trust has achieved both Q1 and Q2 for 62 days only falling short of the target by 0.5 % for two of the months. For September this relates to 3 patients. The apparent difficulties within the 62 day screening target are due to the very small numbers of referrals e.g. 4 referrals and 2 patients exercise patient choice performance drops to 50%

Table 9 – Cancer KPIs

Measure	Target	April 19- FINAL	May 19- FINAL	June 19- FINAL	Q1 2019/20- FINAL	Jul-19	Aug-19	Sep-19	Q2 2019/20
Cancer Two Week Wait	93%	94.5%	96.4%	90.7%	94.0%	92.1%	86.7%	62.1%	81.1%
Breast Symptom Two Week Wait	93%	100.0%	100.0%	100.0%	100.0%	78.6%	90.9%	89.7%	87.0%
31 Day First Treatment (Tumour)	96%	99.5%	98.2%	98.0%	98.4%	99.0%	98.9%	99.5%	99.2%
Cancer Plan 62 Day Standard (Tumour)	85%	87.3%	87.6%	84.5%	85.6%	89.8%	86.5%	84.5%	87.4%
62 Day Screening Standard (Tumour)	90%	100.0%	100.0%	88.9%	97.6%	75.0%	92.9%	93.8%	89.5%

The Trust reports to NHSI weekly against the 104 day backstop target (graph 12). This shows a steady decrease in number of patients treated over 104 days. Backstops are now 0.33% of our total Cancer PTL and current backlog is 4.79% (patients over 62 days).

Graph 12 Number of 104 day Cancer Backstops.



3.4 Diagnostic 6 Week Wait

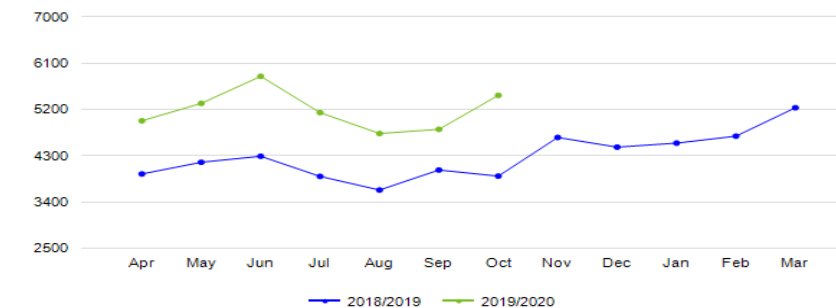
The overall diagnostic waiting list continues to grow with an increase in the backlog as well. The main area for increase in both areas is endoscopy which counts for over 95% of the breaches.

Table 10 – Number of patients breaching 6 week wait YTD

Oct-18	Month		Apr18-Oct18	YTD	
	Oct-19	% Variance		Apr18-Oct19	% Variance
259	590	127.80%	1027	2533	146.60%

Graph 13- Diagnostic month end waits

Diagnostic Month end waits



Graph 14-Diagnostic Performance

Diagnostic Performance against target

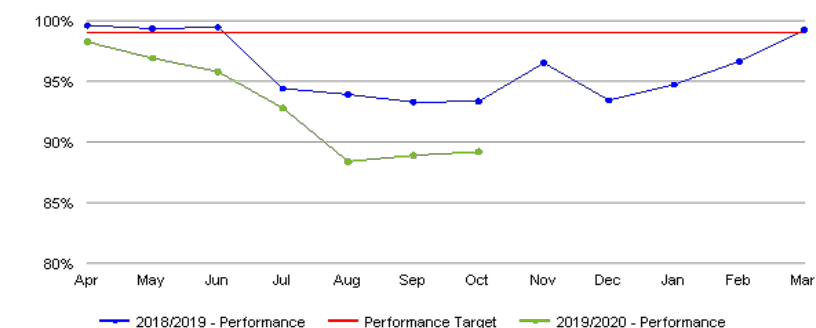
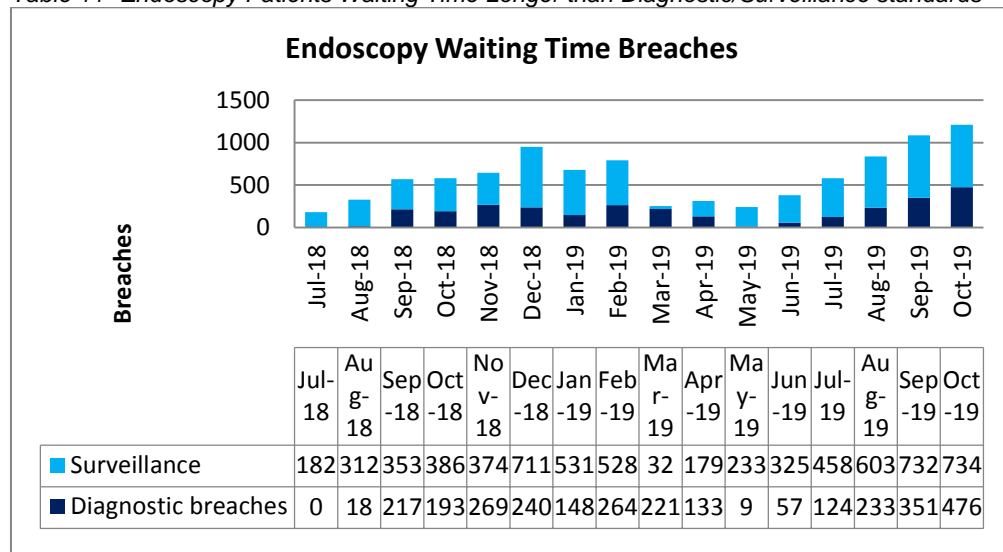


Table 11- Endoscopy Patients Waiting Time Longer than Diagnostic/Surveillance standards



There are an increasing number of endoscopy patients at risk of breaching RTT 52 weeks. These are now being highlighted and discussed at weekly meetings. Escalation process is now in place to avoid 52 week breaches whilst managing clinical priority lists.

Changes are being proposed for how Bowel Cancer screening is delivered system- wide including better communications between commissioners, improved understanding of future expectations and impact on current capacity.

A request to increase the risk score to high has been submitted to Risk Management with a plan to amalgamate all endoscopy capacity risks to link to the High risk relating to the RTT performance. This will go to Decemblers HAC for review and approval.

JAG accreditation has now been removed pending recovery and re-application.

3. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail

The Trust will be reporting 4 cases of Mixed Sex Breach accommodation. This was in the Acute Lung Unit due to pressure across the Trust and on the service.

Recommendation

The Board is requested to note the October 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:	27 November 2019
Meeting part:	Not applicable
Subject:	Quality Report
Section on agenda:	Quality and Performance
Supplementary reading:	CQC Insight Report October 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> <p>BOD are asked to note the increased timescales for responding to complaints.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on significant risks:	Not Applicable



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Quality Report

For the period to end

October 2019

Paula Shobbrook
Director of Nursing and Midwifery

Quality Report: October 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)

One (1) Serious Incident was reported in October 19.

The patient underwent a procedure to insert a medication and feeding tube into her stomach via her abdomen. Post procedure the patient suffered a significant bleed which may have been connected to the medication she was taking. The investigation has been completed and the report is to be finalised.

2.1 CQC Insight Report – October 19

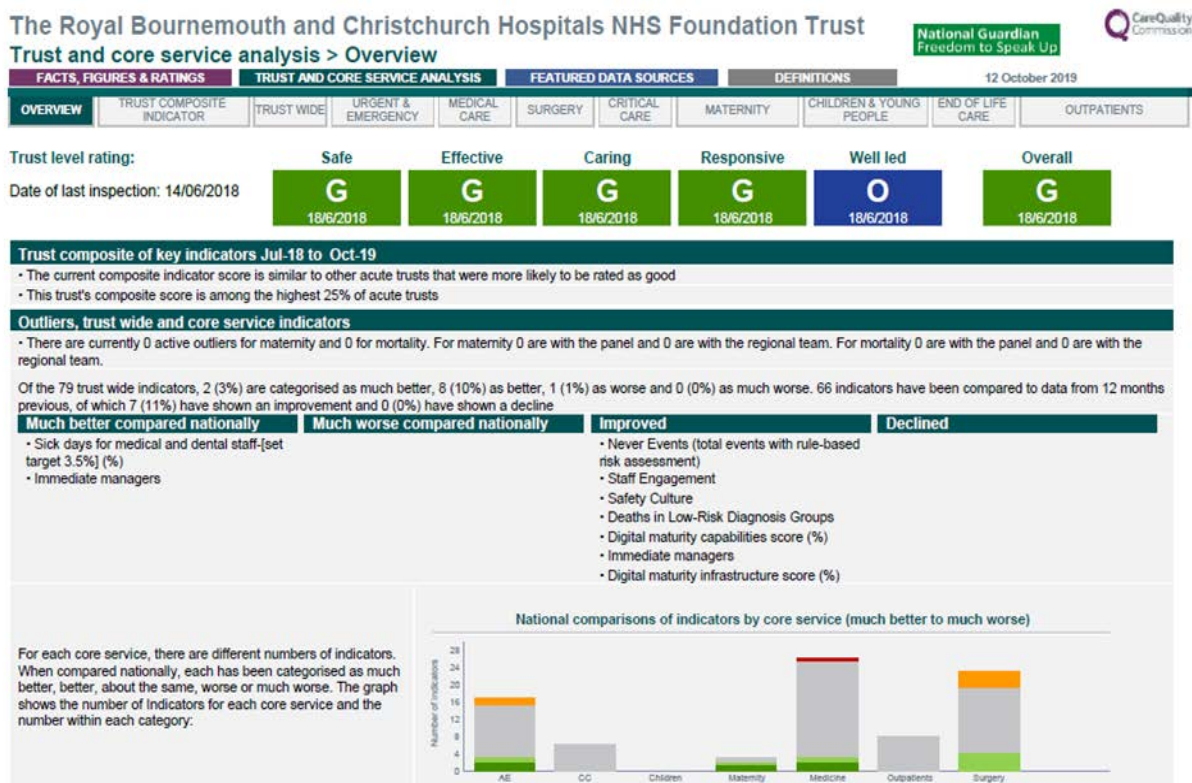
The CQC Insight Model for the Trust was updated on the 12th October 2019 (published on the 18/10/19)



CQC Insight report
Oct 19.pdf

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

Of the 79 quality indicators, 2 (3%) are categorised as much better, 8 (10%) as better and 1 (1%) as worse. 66 indicators have been compared to data from 12 months previous of which 7 (11%) have shown improvement and 0 (0%) have shown a decline.



2.2 CQC Engagement

The most recent CQC Engagement meeting was held on the 23rd October 2019.

CQC inspectors Alison Giles and Lisa Leyton met with the Director of Nursing, Medical Director, Chief Operating Officer and Associate Director Quality and Risk. The meeting also included a presentation by the OD team on the Trust diversity and inclusion programme.

Following the meeting the CQC inspectors met with service leads for Outpatients.

Regular service leads meetings forms part of the CQCs new methodology and provides an opportunity for the CQC to meet with core service leads on an informal basis.

3.0 Patient Engagement

3.1 FFT

National Comparison using NHS England data:

- Inpatient and day case Friends and Family Test (FFT) national performance in September 2019 ranked RBCH Trust 2nd with 19 other hospitals out of 169 placing RBCH in the top quartile based on patient satisfaction.
- The Emergency Department FFT performance in September 2019 ranked RBCH Trust 15th with 4 other hospitals out of 135 placing RBCH ED department in the third quartile.
- Outpatients FFT performance in September 2019 ranked RBCH Trust 4th with 15 other Trusts out of 235 Trusts, placing the departments in the second quartile.

Table 1: National Performance Benchmarking data

	April	May	June	July	August	September
In-Patient Quartile						
Top	98.650%		98.610%	98.283%	98.807%	98.714%
2		97.244%				
3						
Bottom						

	April	May	June	July	August	September
ED Quartile						
Top						
2	88.103%	87.674%		86.594%	86.667%	
3			84.086%			83.652%
Bottom						

	April	May	June	July	August	September
OPD Quartile						
Top					98.173%	
2	98.175%	97.001%	97.439%	97.973%		97.306%
3						
Bottom						

3.2 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	31	29	100.0%	0.0%
Main OPD Xch	N/A	71	68	95.6%	4.4%
Oral and Maxillofacial	N/A	N/A	N/A	N/A	N/A
Outpatients General	N/A	184	179	98.3%	1.1%
Jigsaw OPD	N/A	4	4	100.0%	0.0%
Corporate Total		290	280	97.9%	1.8%

3.3 Patient Opinion and NHS Choices: October Data

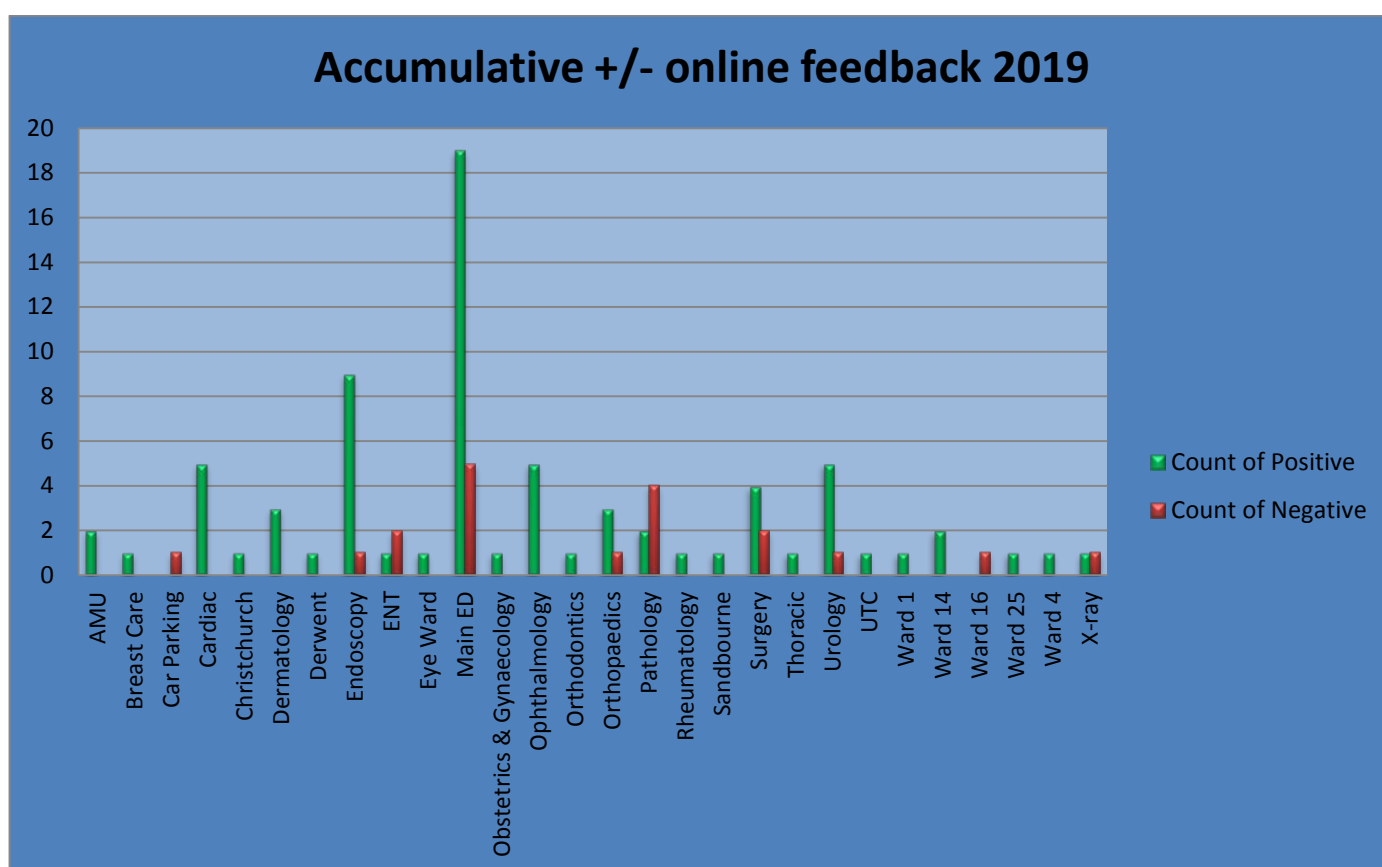
Five patient feedback comments were posted in October, 4 expressed satisfaction with the care, staff attitude and team work. 1 comment was negative relating to poor staff attitude or information.

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

3.4 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:



3.5 Care Conversations

Snippets of care conversations are being used across the Trust for various training and education sessions. Snippets are accessible through the patient experience team and clinical leads for departments and wards.

3.6 CQC Urgent and Emergency Care Survey 2018

National data for the CQC UEC survey has now been published. A report of the key findings and recommendations will be presented through the Care Group report.

3.7 PLACE Audit

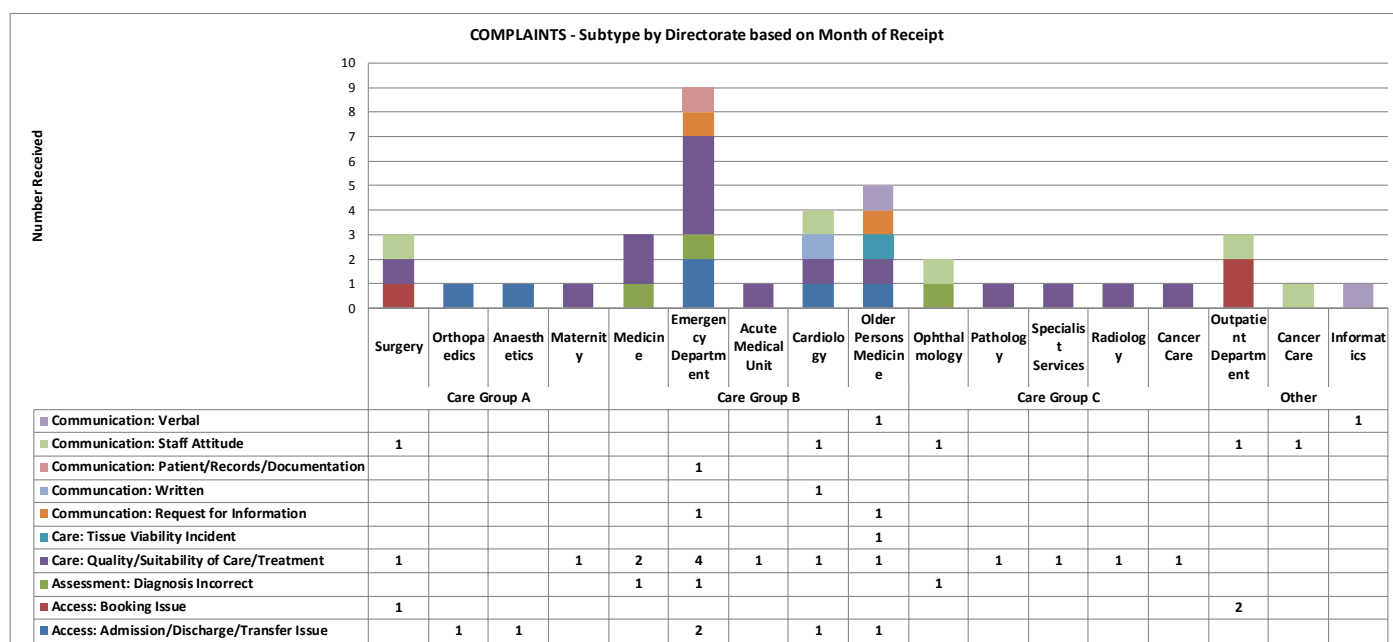
The PLACE audit has been completed in October 2019. Data has been uploaded to NHS Digital and subsequent reports and action plans will be reported through HAC.

4.0 Complaints

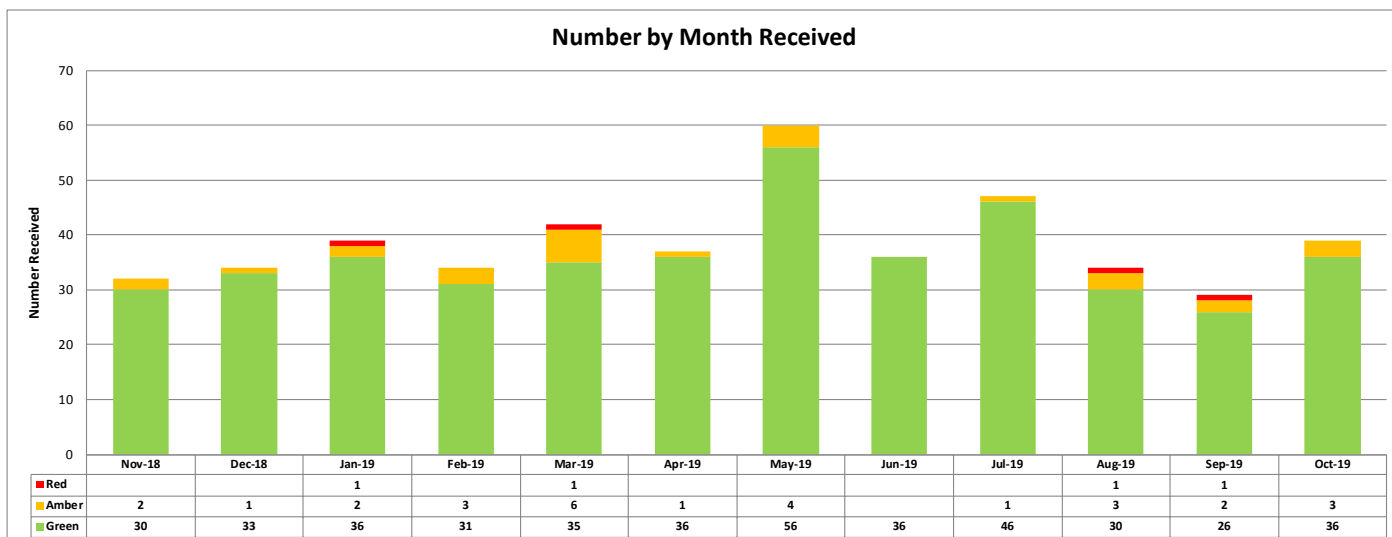
4.1 A total of 39 new complaints and 1 reopened complaint were received in October 2019 all of which were acknowledged within 3 days. The highest themes being:

- Care: Quality / Suitability of Care / Treatment
- Access: Admission / Discharge / Transfer Issue
- Communication: Staff Attitude

To note: The new 1st response timeframe of 35 days for green complaints commences from the 1 September 2019. The impact of this change will not be noticeable until the Trust reports on the October 2019 data, which will reflect the September complaints due dates.



Total Complaints received financial year to date: 282



4.2 Complaint response times Year to date

A decrease in the number of complaints is noted.

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Rolling 12 months
1st Responses Due in Month	25	28	41	33	35	33	49	54	46	37	32	22	435
Number Where 1st Response Completed On	14	21	27	21	25	20	31	26	22	15	18	17	257
Percent With 1st Response On Time	56%	75%	66%	64%	71%	61%	63%	48%	48%	41%	56%	77%	59%

Whilst a decrease in first response rates is noted there has been steady clearance of the overdue responses.

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
1st Responses Overdue at Month Start	724	7	8	7	8	8	4	12	18	16	16	19
Number cleared in Month	3	4	6	4	6	8	3	10	13	13	8	15
Percentage cleared in month	0%	57%	75%	57%	75%	100%	75%	83%	72%	81%	50%	79%

4.3 Complaints performance by Care Group

Care Group	Complaints																	Trend
	Number Due	Number on time	% 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	% on time July 2019	% on time August 2019	% on time September 2019	Change	
CGRPA	9	7	64	44	79	50	80	33	64	92	71	79	62	57	33	78	▲	
CGRPB	16	7	63	35	81	64	67	72	54	53	62	52	26	32	32	44	▲	
CGRPC	7	4	100	50	50	0	71	88	75	100	29	63	71	40	50	57	▲	
OTHER	0	0	0	0	50	0	0	75	67	0	0	100	33	67	67	0	▼	
PRIVATE	0	0	0	0	0	100	0	0	0	0	0	0	0	0	0	0	=	
GRAND TOTAL	32	18	65	41	76	55	72	67	59	71	59	63	46	41	38	56	▲	

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

Care Group	Concerns																Change	Trend
	Number Due	Number on time	% 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	% on time July 2019	% on time August 2019	% on time September 2019		
CGRPA	39	36	100	100	78	72	67	95	84	85	76	87	76	89	87	92	▲	
CGRPB	54	44	100	100	63	56	49	91	69	78	75	76	74	71	77	81	▲	
CGRPC	42	37	100	100	76	61	75	100	89	80	87	93	90	80	80	88	▲	
OTHER	60	65	100	100	72	82	88	98	95	91	91	94	96	98	94	92	▼	
PRIVATE	0	0	0	100	0	0	0	0	100	0	0	0	0	100	0	0	=	
GRAND TOTAL	200	177	100	100	70	68	66	94	84	85	80	85	84	85	84	89	▲	

5.0 Recommendations

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



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

Choose a meeting	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Financial Reports
Section on agenda:	Quality & 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 & Regulatory Performance Committee
Action required:	Decision
<p>Summary: As at 31 October, the Trust is reporting a surplus of £2.109 million representing a favourable variance of £589,000. This is mainly being driven by an additional £422,000 of Provider Sustainability Funding following the national accounts process for 2018/19. After adjusting for this and other excluded items, the Trust is reporting an adverse variance of £103,000 against the year to date control total.</p> <p>A revised stretch target of £731,000 has been applied following a detailed review of forecast outturn positions with Care Groups</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Impact on high risks:	There are currently 15 financial and performance risks recorded on the risk register for monthly review by Committee



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Finance Report

For the period to end

31 October 2019

Pete Papworth
Director of Finance

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 31 October, the Trust is reporting a surplus of £2.109 million representing a favourable variance of £589,000. This is mainly being driven by an additional £422,000 of Provider Sustainability Funding following the national accounts process for 2018/19. After adjusting for this and other excluded items, the Trust is reporting an adverse variance of £103,000 against the year to date control total.

Income & Expenditure

After adjusting for pass through drugs and devices; income is ahead of plan by £1.054 million. This is mainly being driven by the additional PSF allocation together with higher than planned specialist income, particularly Ophthalmology outpatients and emergency activity within Gastroenterology and General Surgery. The Trust has also received £306,000 additional income in relation to non-contracted out of area activity.

Expenditure reported a net overspend of £465,000 after adjusting for pass through drugs and devices. This includes overspends against the pay budget of £2.206 million reflecting both the shortfall in the Care Group cost improvement programmes and a continued usage of premium cost agency staff. This has been partially offset by underspends in non pay budgets. Targeted action continues to be taken in both areas to mitigate this level of overspend.

Cost Improvement Programme

The Trust has set a challenging target to achieve £10.45 million of savings during 2019/20, and as at 31 October schemes amounting to £10.52 million have been identified. This represents a significant improvement on the previous forecast and reflects a material non recurrent investment gain which has been added to the programme and will be realised within November. There remains some risk that not all schemes will deliver to the extent currently forecast, and this will continue to be managed closely.

Provider 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 £4.3 million relates to this Trust. As at 31 October the ICS is £781,000 ahead of plan, largely reflecting the phasing of identified savings. However significant risk remains within the full year forecast across all partners and work continues across the ICS to mitigate this.

Finance Report

As at 31 October 2019

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	(3,630)	(3,487)	143	0	0	0
Dorset HealthCare University NHS Foundation Trust	(2,550)	(1,295)	1,255	2,036	2,036	0
Poole Hospital NHS Foundation Trust	(2,843)	(3,357)	(514)	0	0	0
Dorset Clinical Commissioning Group	1,167	1,167	0	2,000	2,000	0
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1,521	1,418	(103)	0	0	0
SURPLUS/ (DEFICIT)	(6,335)	(5,554)	781	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 31 October the Trust is holding a consolidated cash balance of £49.55 million. The cash position will improve further during November following the realisation of an investment gain.

Capital

Capital expenditure amounting to £6.178 million has been committed to date, which is £3.571 million behind the year to date 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. This is expected to recover in the remaining months of the year.

Recommendation

Members are asked to note the Trust's financial performance for the period ending 31 October 2019.

Finance Report

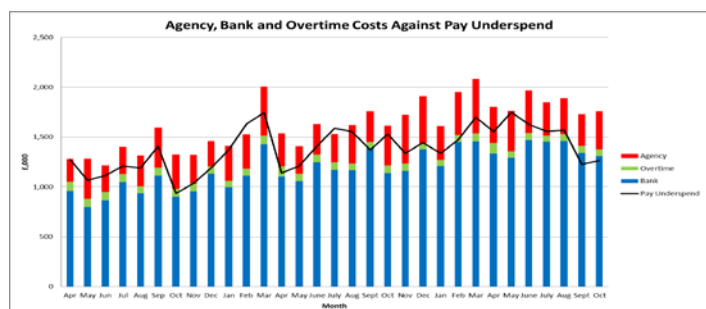
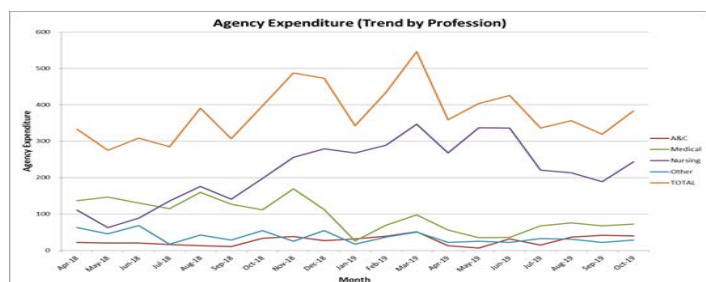
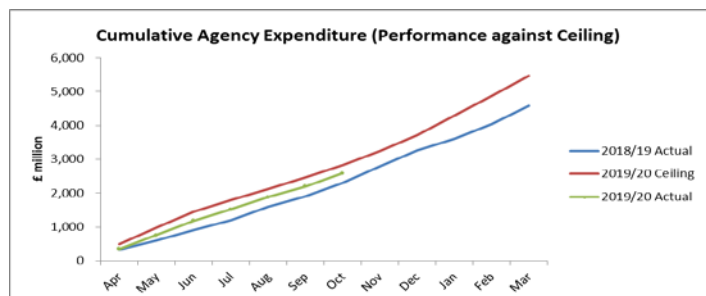
As at 31 October 2019

Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000	Pass Through £'000	Residual Variance £'000
NHS Clinical Income	164,303	165,107	804	(72)	732
Non NHS Clinical Income	2,323	2,276	(46)	0	(46)
Non Clinical Income	21,323	21,692	368	0	368
TOTAL INCOME	187,949	189,075	1,126	(72)	1,054
Employee Expenses	117,931	120,137	(2,206)	0	(2,206)
Drugs	20,049	20,066	(18)	478	461
Clinical Supplies	21,461	20,839	622	(407)	215
Misc. other expenditure	26,989	25,924	1,065	0	1,065
TOTAL EXPENDITURE	186,429	186,966	(537)	72	(465)
SURPLUS/ (DEFICIT)	1,520	2,109	589	(0)	589

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	115,846	115,846	0
NHS England (NHSE South West)	27,728	28,174	447
NHS West Hampshire CCG (and Associates)	15,435	15,435	0
Other NHS Patient Income	6,245	6,599	354
Non NHS Patient Income	2,323	2,279	(44)
Non Patient Related Income	18,006	17,953	(54)
Provider Sustainability Fund	1,917	2,339	422
Financial Recovery Fund	450	450	0
TOTAL INCOME	187,949	189,075	1,126

Agency Expenditure

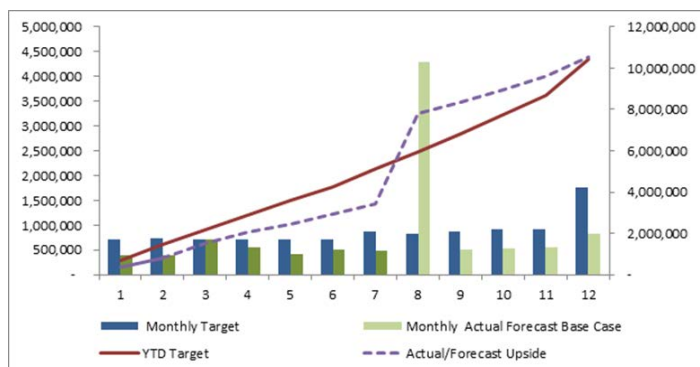


Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	7,606	6,741	(864)
Medical Care Group	7,902	6,110	(1,792)
Specialties Care Group	3,347	3,913	566
Corporate and Trust-wide Budgets	(17,334)	(14,656)	2,678
SURPLUS/ (DEFICIT)	1,520	2,109	589

Cost Improvement Programme

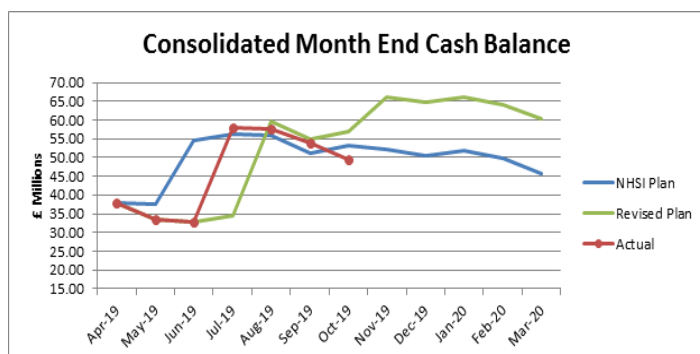
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	893	637	(256)
Medical Care Group	1,506	545	(961)
Specialties Care Group	1,418	1,084	(334)
Corporate and Trust-wide Budgets	1,323	1,179	(144)
TOTAL	5,139	3,444	(1,695)



Capital Expenditure

Revised Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	1,716	1,479	237
IT Strategy	3,952	1,418	2,534
Medical Equipment	2,046	1,295	751
Centrally Managed	2,035	1,986	49
SURPLUS/ (DEFICIT)	9,749	6,178	3,571

Cash



BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Report
Section on agenda:	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, and includes updates of this year's flu campaign and staff survey.	
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.



Workforce Report

For the period to end

October 2019

Karen Allman
Director of Human Resources

Workforce Report for November Board

As at 31st October 2019

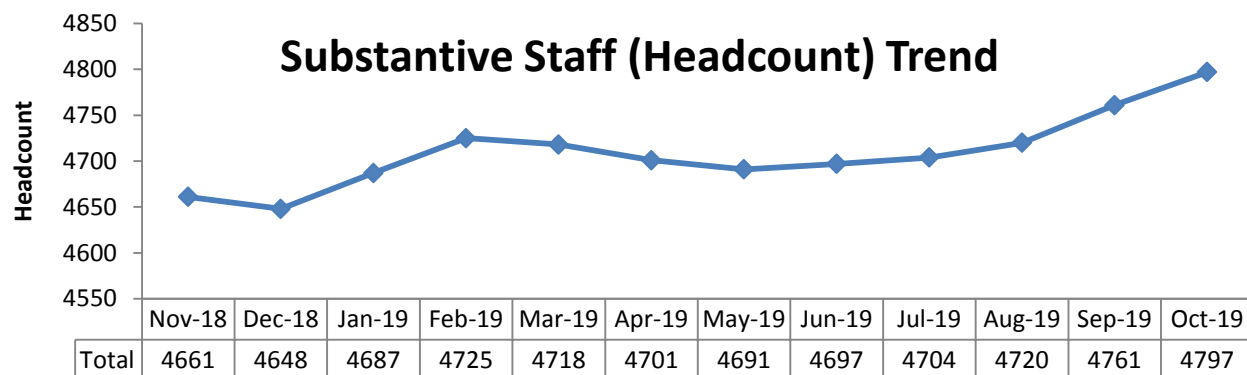
Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 October			Rolling 12 months to 31 October			At 31 October	
Surgical	83.4%	83.3%	94.0%	3.88%	13459	9.6%	7.9%	
Medical	85.9%	73.5%	94.3%	4.03%	21243	14.4%	11.5%	
Specialities	86.3%	85.4%	95.0%	3.76%	11848	13.3%	12.6%	
Corporate	89.0%	100.0%	95.8%	4.04%	13486	10.7%	8.9%	
Trustwide	86.2%	80.5%	94.6%	3.94%	60037	12.3%	10.4%	

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 October			Rolling 12 months to 31 October				At 31 October
Add Prof Scientific and Technical	88.7%		93.3%	3.66%	1784	20.1%	13.6%	
Additional Clinical Services	85.3%		94.9%	5.99%	17021	19.7%	14.2%	
Administrative and Clerical	85.6%		96.8%	3.68%	11854	10.4%	10.9%	
Allied Health Professionals	92.2%		95.2%	2.35%	2274	12.6%	11.7%	
Estates and Ancillary	88.1%		94.7%	5.67%	6900	12.5%	8.8%	
Healthcare Scientists	88.9%		95.0%	3.46%	1175	6.6%	9.4%	
Medical and Dental		80.5%	91.0%	1.27%	2436	5.9%	7.4%	
Nursing and Midwifery Registered	84.7%		94.7%	3.92%	16593	9.4%	7.9%	
Trustwide	86.2%	80.5%	94.6%	3.94%	60037	12.3%	10.4%	

Workforce Report for November Board

As at 31st October 2019

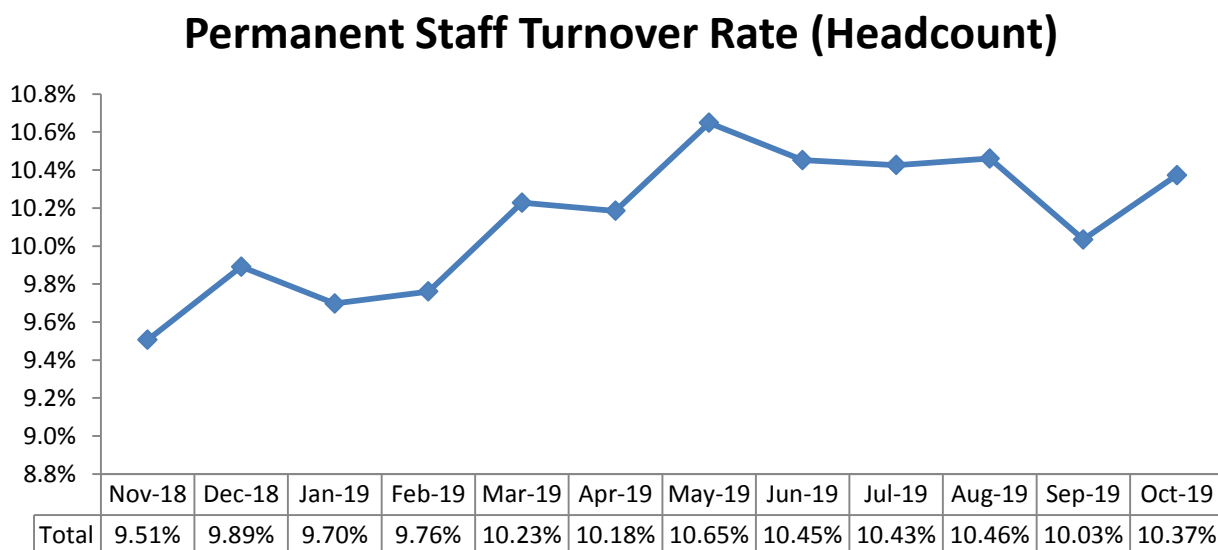
1. Staffing and Recruitment



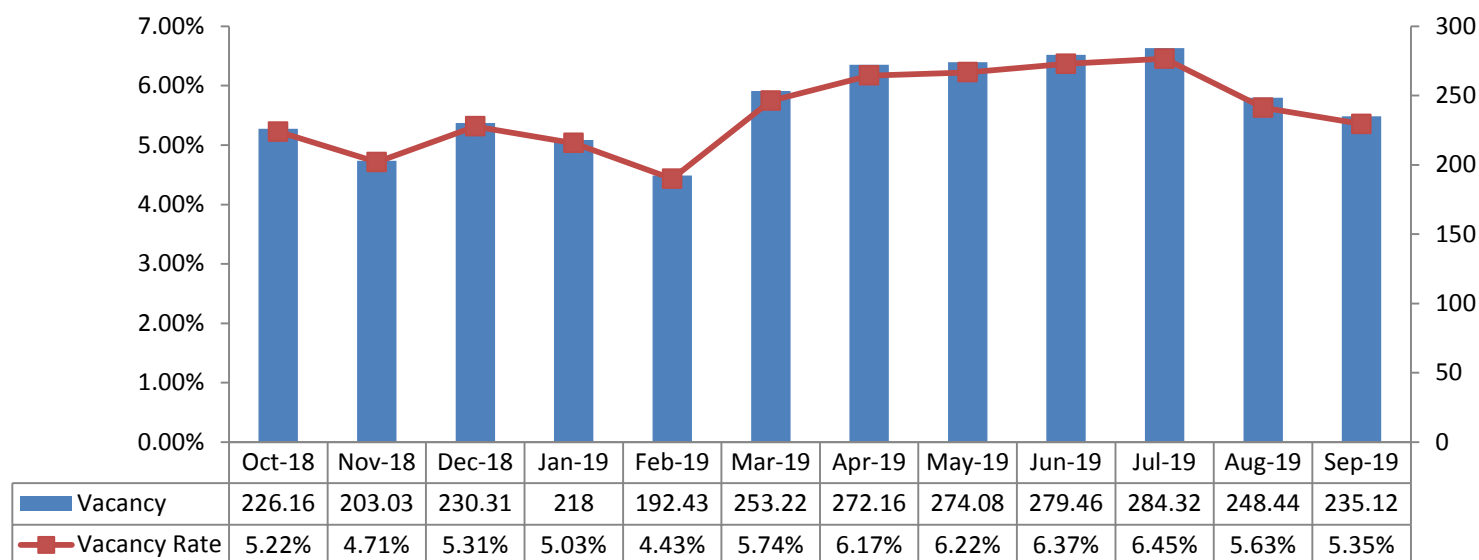
Turnover rate for October increased slightly to 10.3% from 10% in September.

The joining rate at 12.3% continues to run at a higher rate than turnover which is a positive. As a result, substantive staff headcount continues to rise, currently at 4,797 representing an increase of 146 (3.14%) over the 4,651 seen at the same point last year.

Vacancy rate for October unavailable at the time of writing. September 5.35%, down from 5.63% the previous month; trend chart below.



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



2. Essential Core Skills Compliance

Following the slight reduction for September at 94.1%, compliance increased in October, back up to 94.6%. Medical and Dental also saw an increase, up to 91% from 89% the previous month.

Fire training continues its steady increase since moving to e-learning and now stands at 97.9%.

Managers are asked to ensure that staff attend booked face-to-face sessions; in the event this not be possible, this should be advised via ESR or informing the Education department directly in order to free up valued spaces which can then be offered to others. Lack of training space continues to be an issue with the unavailability of training room 1 (risk 727 on the risk register refers). This issue has been raised at the Senior Leadership Team meeting and received their support; the necessary form was therefore submitted to the Space Utilisation Group but we have been advised no meeting of that group is currently planned.

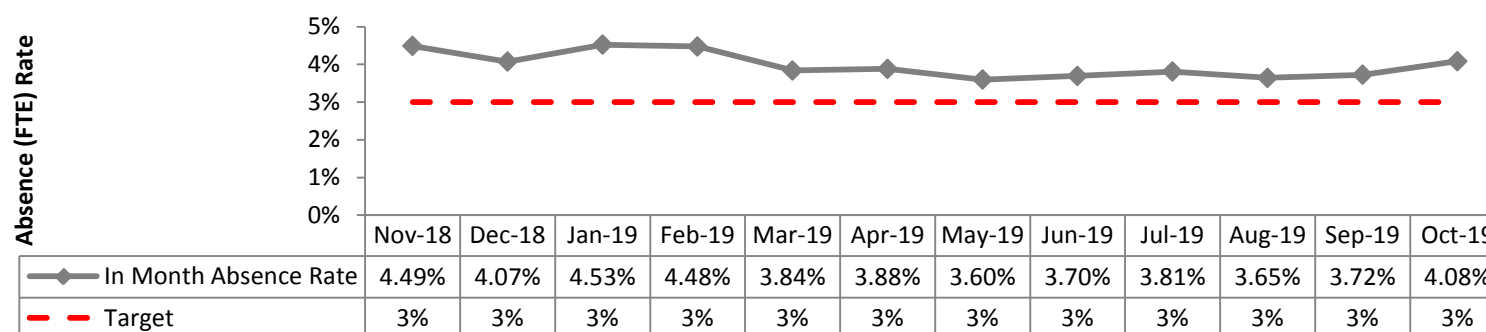
Workforce Report for November Board

As at 31st October 2019

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.

3. Sickness Absence

In Month Absence Rate (FTE)



	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Surgical	4.02%	3.39%	4.28%	4.71%	4.38%	3.97%	3.42%	3.47%	4.07%	4.17%	3.77%	4.20% ↑
Medical	3.99%	3.98%	4.52%	4.68%	3.92%	4.08%	4.20%	4.23%	4.04%	3.45%	3.51%	3.88% ↑
Specialties	5.44%	4.07%	4.43%	3.80%	3.07%	3.34%	2.95%	2.96%	3.57%	3.55%	3.65%	4.08% ↑
Corporate	4.90%	4.95%	4.89%	4.56%	3.87%	3.98%	3.45%	3.79%	3.41%	3.50%	4.08%	4.29% ↑
Trust	4.49%	4.07%	4.53%	4.48%	3.84%	3.88%	3.60%	3.70%	3.81%	3.65%	3.72%	4.08% ↑

The in-month sickness absence rate slipped into the red for the first time since February, increasing to 4.08% from 3.72% the previous month, with increases seen for all care groups, although Medical maintained its amber rating. This is, however, an improved position compared to the same point last year, which saw an absence rate of 4.69% for October 2018.

The 12-month rolling figure to 31/10/19 remains amber at 3.94% (compared to 4.09% at this point last year).

Workforce Report for November Board

As at 31st October 2019

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.

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 October 2019:

Registered Nurse (RN)	Actual Day	97.8%	HCA	Actual Day	96.7%
Registered Nurse (RN)	Actual Night	97.4%	HCA	Actual Night	119.8%

From September 2019 the Trust is required to report on Allied Health Professional (AHP) numbers that are counted in the ward templates. At RBCH AHPs are currently included in the ward template on ward 9 during the day:

AHP Trained	Actual Day	86.3%	AHP Untrained	Actual Day	33.4%
-------------	------------	-------	---------------	------------	-------

This is a new initiative and the role is not fully recruited to yet.

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

There were no reportable red flag shifts for October 2019. One LERN form was received, however the shift was appropriately mitigated and safe staffing maintained.

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.

Workforce Report for November Board

As at 31st October 2019

The latest Trust CHPPD data available is:

Measurement	Data Period	Trust Value	Peer Value	National Value	Chart
Cost per WAU - Substantive Nursing & Midwifery Staff	2017/18	£671.1	£686.1	£710.1	
Cost per WAU - Registered Substantive Nurses & Midwives	2017/18	£519.5	£519.5	£554.3	
Cost per WAU - Healthcare Support Workers	2017/18	£151.6	£166.4	£154.7	
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	Aug 2019	7.9	7.7	8.2	
Care Hours per Patient Day - Total Nursing and Midwifery staff	Aug 2019	7.9	7.7	8.1	
Care Hours per Patient Day - Registered Nurses & Midwives	Aug 2019	4.6	4.6	4.7	
Care Hours per Patient Day - Healthcare Support Workers	Aug 2019	3.3	3.3	3.3	
Care Hours per Patient Day - Registered Nursing Associates	Aug 2019	0.0	0.0	0.0	
Care Hours per Patient Day - Unregistered Trainee Nursing Associates	Aug 2019	0.0	0.0	0.0	
Care Hours per Patient Day - Total AHPs staff	Aug 2019	0.0	0.0	0.0	
Cost per Care Hour - Total Nursing and Midwifery staff	Q4 2018/19	£23.4	£23.7	£23.7	
Cost per Patient Day - Total Nursing and Midwifery staff	Q4 2018/19	£184.5	£185.6	£189.6	

The national CHPPD data reflects a slight increase from 7.8 to 7.9 between July and August 2019, this is due to an increase in the HCA numbers. All the other statistics have remained the same since last reported.

5. Flu Update

This year's campaign started in October and as at 18th November the percentage of total staff vaccinated stands at 51%; percentage of frontline staff: 43%. 40 peer vaccinators have been trained across 17 different clinical areas.

Workforce Report for November Board

As at 31st October 2019

The flu campaign continues to be publicised in weekly bulletins, on the intranet, Twitter and a screensaver, with the jab being available at the following regular times/venues:

Mondays: 12-13.30 Restaurant/Education Centre
Tuesdays: 12-13.30 Occupational Health Department
Wednesdays: 12-13.30 Atrium
Thursdays: 12-13.30 Occupational Health Department
Fridays: 12-13.30 Grand Round

Plus Monday/Wednesday/Friday: wards 10-12

Weekends: The flu trolley is visiting clinical areas every weekend alternate Saturdays/Sundays

In addition, the flu trolley and vaccines are available in the Clinical Site office for out of hours; vaccines are also available in the emergency fridge outside ED. The opportunity to have the jab is offered at Induction. Peer vaccinators are covering twilight 18:00-22.00 and the OH team are available via Flu Bleep.

Good verbal feedback is being received regarding the UNICEF “have a jab, give a jab” initiative.

Whilst this is an encouraging start and uptake is at a quicker pace than at the same point last year, it is important to maintain momentum and the following action plan has been devised to further improve uptake and hopefully better last year’s 75% overall:

- Identify clinical areas of low uptake and target
- Increase trolley times
- Longer times in fixed points
- Matrons to take responsibility for uptake in clinical areas
- Improved communication campaign incorporating flu cases in Trust
- Collaboration between statisticians in RBH and Poole to ensure consistent process

6. Staff Survey

This year’s staff survey closes on 29 November and the completion rate currently stands at 40% (as at 18/11). The team are making a concerted push towards increasing this by taking the trolley around the Trust, talking to staff and encouraging them to complete the survey so their voice can be heard, and the survey continues to be highlighted in the weekly staff bulletin and on the intranet.

Choose a meeting	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	n/a
Subject:	7 day services Board Assurance Update
Section on agenda:	Quality and Performance
Supplementary reading:	
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Ruth Williamson
Details of previous discussion and/or dissemination:	A draft of this was presented at the board development meeting on 30 th October 2019
Action required:	Decision
Summary: The Board is asked to review and approve for submission the BAF prior to submission to NHSI on 29 th November 2019.	
Related strategic objective:	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Impact on high risks:	

7 Day Services

Clinical Standard 2:

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

Self-assessment of performance:

Audit of 1:4 acute admissions staying in hospital for >14 hours was undertaken.

Detailed case note review of all patients breaching the 4 hour target was undertaken with validation of results and narrative explanations received.

During the audit week performance varied between 95% (Tuesday) and 70% (Saturday), although the numbers each day were small (1-4 patients).

Consultants are available 7/7 to review acute admissions between 0800 and 2030, medicine and 18:30 or later in surgery.

Breaching patients fell into two broad categories.

Medical patients admitted through the acute medical unit have time of admission recorded as time of arrival. The ability to clerk these patients depends on capacity of junior staff. All bar two of the breaching medical patients was reviewed within 14 hours of completion of clerking but the combined effect of the clerking plus time to review created the breach. Surges in medical admissions during the afternoons and early evening contribute to the difficulty in assessing patients in a timely fashion but there was good evidence that those prioritised for consultant review were the sickest, or those who had been seen by the most junior staff. This is more pronounced on weekdays than at weekends and the number of admissions is greater. Only one breaching patient had a NEWS score >3, and all bar one were reviewed by the duty medical registrar within 14 hours of admission.

It was noted that a significant proportion of medical patients are admitted for under 14 hours which further skews the data as these patients are prioritised for consultant review in order to achieve a timely and safe discharge.

In Surgery a comprehensive evening review of all patients took place. This did not always, however include a face to face review with surgical consultants prioritising a board round approach looking at results, imaging and discussing the clinical picture and plans for the night at formal surgical handover. A total of 4 patients were recorded as breaching for this reason. This has proved an effective use of resource but is not a documented clinical pathway approved by the CCG.

Consultant job plans deliver a consultant presence on the acute medical unit from 8 am till 830 pm 7 days a week. Recruitment and job planning has allowed there to be two consultants in the evening during the week. At weekends two consultants provide morning ward rounds, one consultant an afternoon ward round and there is a single consultant working in the evening. In surgery there is an on call surgeon to do morning and evening ward/ board rounds 7/7. Urology offers a consultant of the week model with 7 day availability of a consultant working in conjunction with experienced specialist registrars and specialty doctors who offer an onsite service from 0800 till 2000.

Hospital mortality indicators are as expected HSMR and better than expected SHIMI, with no significant weekend variation. There is an established medical examiner role with all deaths reviewed to identify if care could have been improved. There has been no feedback to date to suggest that weekend care has been an issue.

Clinical Standard 5:

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- within 1 hour for critical patients
- within 12 hours for urgent patients
- within 24 hours for non-urgent patients.

Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?

These diagnostic tests are routinely available with periodic reviews to ensure that capacity and demand are matched. Some clinical pathways are defined to optimise use of resources e.g. scanning renal colic during working hours rather than overnight.

Clinical Standard 6:

Hospital inpatients must have timely 24-hour access; seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear written protocols.

Q: Do inpatients have 24-hour access to the following consultant-directed interventions seven days a week, either on site or via formal network arrangements?

These have been routinely available for some years now and are embedded in clinical practice.

Clinical Standard 8:

All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The sample of acute admissions did not include sufficient patients admitted to intensive or coronary care to obtain meaningful data on twice daily reviews. Intensive care has consultant presence available to provide twice daily review 7/7. Coronary care has a daily consultant ward round. The evening round is delegated to a cardiology fellow. Most of these are post CCT but some may be CESR applicants. There is always a consultant available to review patients over whom there are clinical concerns. Consultants are available to review patients 7/7 in general surgery, urology, gastroenterology, stroke, geriatrics, acute medicine. Not all patients are seen by consultants every day but there was evidence of daily review being appropriately delegated to junior medical or specialist therapy team members in order to expedite safe discharge. A weekend clinician review list is handed over to duty consultants at weekends to allow prioritisation of patients for whom consultant review will affect ongoing care. The data indicates that consultant reviews are less likely to take place at weekends but that this is mitigated by junior and allied health professional staff. The rationale for delegated reviews is not routinely recorded in the notes but can usually be inferred

from the narrative. Mortality indicators continue to improve with HSMR 97.9 (2018) compared with 101.5 (2017). There is minimal difference between weekends (97.8) compared with weekdays (96.9).

Self-assessment of performance against clinical standards 1, 3, 4, 7, 9 and 10

Standard 1

There is evidence in the notes of discussions of the initial management plan with patients and ongoing information sharing both with families and where appropriate family members. There is a MDT approach to this, particularly with respect to discharge planning. In general medical notes are less comprehensive than those written by nursing and allied health professional staff.

Question: Do we have FFT information which could triangulate to indicate if there is any difference in the extent to which patients feel their needs are met at weekends and during the week.

Standard 3

Assessment of emergency inpatients for complex or ongoing needs within 14hrs by MDT with EDD, therapy assessment, medicines reconciliation and discharge criteria within 24 hours.

There are high levels of MDT involvement in care but data is not available to confirm medicines reconciliation within 24 hours at this stage. EPMA scheduled for 2020 should facilitate this data collection. The acuity of our patients and the combination of medical and ongoing needs means that it is not always realistic to complete comprehensive assessment within the first 24hours of admission. There is however 7 day availability of the MDT to facilitate ongoing needs assessment.

Standard 4

Handovers take place twice a day led by medical and surgical consultants.

Clinician inpatient worklists are generated using name, date of birth and hospital number as three point identification. NHS number is not currently used.

Standard 7

Liaison mental health services are available 24/7 but challenges remain sourcing inpatient beds for patients in need of acute mental health care.

Standard 9

Transfer to community, primary and social care.

Resources to achieve this are in place. Stranded patients have been reduced by a multidisciplinary and multi agent approach to managing patients with complex needs. The 40% reduction in patients staying over 21 days has been sustained for the last 8 weeks.

Standard 10

RBCH has high levels of engagement with quality improvement. There is a dedicated QI team and QI training has been delivered to a range of staff working at all levels. All consultants are involved and appraised against maintain up to date reviews of mortality and attending clinical governance meetings. Action plans are developed from any constructive feedback for doctors in training and there is a robust exception reporting for doctors in training where there are compromises to their work plan.



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

BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Trust Objectives 2019/20
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	Debbie Fleming, Chief Executive
Author(s) of paper:	Deborah Matthews, Director of Improvement and Organisational Development
Details of previous discussion and/or dissemination:	Board of Directors, May 2019
Action required:	Note for information
<p>Summary:</p> <p>This paper provides an overview of progress against the Trust's objectives for 2019/20 as agreed by the Board of Directors at its meeting March 2019.</p> <p>These annual priorities are in line with our vision and four strategic objectives: Valuing Staff; Improving Quality and Reducing Harm; Strengthening Team Working; Listening to Patients and Staff.</p>	
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

			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: • 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 KA					Vacancy rate remains under or very near 6% and we continue to focus on recruiting and retaining staff Turnover rate overall below 12% with a strong focus on retaining staff	
	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: • introduce a talent review and succession planning process • improve talent conversations as part of the annual appraisal round	DM DM					RBCH interim talent management plan in place. Aim to be a part of Dorset ICS Talent Management Diagnostic tool pilot and develop accompanying action plan in Q2-3 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 was piloted in Q2	
	1.3	Maintain our 2018 staff survey results and completion rate over the next two years: • 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 the summer. Directorsate and Care Group action plans presented to Workforce Committee. Provider for 2019 secured in partnership with PHT. Intention to provide more paper copies to see if it impacts the completion rates.	
	1.4	Deliver key priorities in our diversity and inclusion plan: • 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 DM					Delivery against D&I Strategy and 6 objectives. EDIC report to Board including WRES and WDES data. BAME Staff survey infographic produced to support the business case for positive action programmes such as BAME reverse mentoring. Affina coach identified for BAME network. Future measure - 2019 Staff Survey results.	
	OBJECTIVE TWO		Improving quality and reducing harm						
Narrative:			Focusing on continuous improvement and reduction of waste						
2.1	To continuously improve the quality of care and outcomes for patients as part of our 2019/20 improvement programme. Priorities include: •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) • Outpatients: reducing the number of unnecessary visits for our patients •Ophthalmology: ensuring good morale and support for staff in eye outpatients and achieving eye theatre efficiency of 80% • Medical Rotas: optimising medical manpower and management of medical rosters using the most effective digital solutions		DM DM RR DM					a)The 'making every inpatient day count' programme consists of 4 workstreams Stranded Patients; Ward Processes; Frailty Pathway; Admission Avoidance), designed to act as enablers, aiming to support operational bed reconfiguration targets: To increase O-Day LoS via OPAL/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 HoW on Wards 22, 26 & 15. To reduce long-stay stranded patients with a LOS >21 days by 40% by March 2020. b) ED - QI meetings arranged and project leads identified for the following projects front door, patient pathways, minors and UTC processes, recruitment and retention through "JoyInWork" project and IT. KPIs 95% of patients presenting to ED achieve waits of no more than 4hrs, triage within 15 minutes, ambulance handover times and reduction in the number of complaints and improvement in FFT completion rates Q1 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. 80.1% most recent quarter Introduction of an electronic medical staffing rostering system in all specialities by April 2020. 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. In the meantime the QI project is looking at use of existing systems within the Trust as well as non-IT related improvements to consistency and resilience.	

Trust Objectives 2019-2020

Priorities and Measures:		<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 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					QI project on digital clerking on hold due to IT work pressures. QI project on improving documentations standards yet to start as no clinical lead currently identified. AOD and PS reviewing thorough improvement board
			PS					ME process implemented and lead ME produced first quarterly report to MSG in July 19. Themes for action and learning identified. MD included in July 19 Board report.
	2.2	<p>Efficiency and Productivity</p> <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					At the end of Quarter 2 the Trust was £20,000 ahead of the year to date financial control total and continues to forecast the full year achievement. Some risks remain, and mitigation plans are in place and continue to be proactively monitored through the Finance and Performance Committee.
			PP					The Trust continues to benchmark well across a range of productivity and efficiency indicators and is currently ranked 14th overall in the Model Hospital. A GIRFT Transformation Steering Group has been established to ensure effective oversight of recommendations arising from national GIRFT visits. A new Productivity and Efficiency Team has been established to work across both RBCHFT and PHFT to develop a joint approach to identifying and reducing unwarranted variation. This programme is being monitored through the Finance and Performance Committee.
	2.3	<p>To continue to improve the responsiveness of services for patients and achieve the national standards relating to:</p> <ul style="list-style-type: none"> Cancer waits Elective referral to treatment waits Diagnostic waits A&E waits 	RR					Achieving KPI especially regarding 62 day referral to diagnosis
OBJECTIVE THREE			RR					RTT below national average mainly due to lower than required funding plus workforce constraints, (especially Pensions for medical staff). Focus on reducing 52 week breaches.
			RR					Compliant in all diagnostics except Endoscopy, where longterm sickness has led to a backlog. Dorset wide plan to respond in place.
			RR					Significant rise in demand, especially Ambulance conveyance. Actions plans at Dept, Trust and system level, as well as winter plan, to maintain safety.
	2.4	<p>Digital Transformation</p> <p>To jointly implement the remaining component parts of the Dorset Care Record (DCR) in accordance with the timescales in the DCR programme plan</p> <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 <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					6 of the component parts that RBCH is responsible for have been delivered
			PG					SEPR is live and working through snagging issues; order comms is live for radiology and in the pre-deployment phase for pathology; electronic prescribing is in a pre-deployment phase expecting to deploy at rbch in April 2020
Priorities and Measures:			PG					84 of the 104 wired edge switch devices have been deployed at rbch.
			PG					28% of the Windows devices have now been deployed as Windows 10(approximately 1000 of the approximately 3750 devices at rbch)
			PG					
			PG					
			PG					
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					The OBC is currently with NHSI (awaiting approval) and will go via Treasury for approval too. A draft of the FBC has commenced, however, the majority of work for this will be completed towards the end of the 2019/20 financial year.
			DF					Agreed with NHSI that the work programme will be scheduled with a view to merge on 1 July 2020. In early November wrote to the CMA asking them to lift the undertakings. Merger Business Case will be approved in February 2020 and NHSI will start assessment in March 2020 (currently in quality check with PwC).
			DF					Members will be aware that work has been going on across the Dorset system to refresh the Dorset Sustainability and Transformation Plan. All partners are committed to developing healthier communities, and supporting people to live longer, healthier lives. However, the challenge is to transform services and "invest upstream", in the face of the current patterns of demand, we are continuing to work with our partners to agree how best we can use our collective resources, in a way that will enable us to meet that demand, whilst at the same time, transforming services for the future. This work is on-going, and will continue to be reported to the Board.
	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
			DM					Measure to receive a favourable evaluation from clinical transformation leads with 4 early services evidencing effective team working and collaborative relationships.
	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					OD leads currently supporting the 4 priority areas with different needs and interventions, shaped by a self assessment tool.

		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:	DM	<div><div></div></div>				Staff survey results 2019
	3.4	<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	<div><div></div></div>				Staff survey results 2019
OBJECTIVE FOUR Listening to patients and staff								
Narrative:		Ensuring meaningful engagement to improve patient and staff experience						
Priorities and Measures:	4.1	Maintain progress in meeting our improvement trajectory for the National Patient Experience benchmarks by March 2020, by: <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	<div><div></div></div>				<p>77% feedback remains in the top quartile for inpatients consistently now for 12 months, many times being one of the top 10 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 ME process. Families invited to attend SI panels but approach needs to be more consistent. HoPE approached to identify a patient partner to work with the Quality and Risk Team and support SI process and review of SI reports.</p>
	4.2	Maintain and strengthen communications and engagement with local people by March 2020 through: <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 DF/PS	<div><div></div></div>				<p>Both RBLH and PHFT comms 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 comms strategies. Comms teams have also been involved in public engagement work, including managing 2 public engagement events at RBCH and PHFT around the future designs of our hospitals.</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	<div><div></div></div>				<p>HOPE from PGH and RBCH have been allocated to OAN workstreams attending planning meetings and meeting with teams. Patients will actively participate in the pathway designs for services. Several 'patient voice' volunteers have enrolled to RBCH to specifically work with teams to ensure pathways are co-designed.</p>

BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Emergency Preparedness, Resilience and Response (EPRR) Assurance Declaration
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of paper:	Malcolm Keith, BJ Waltho, Richard Renaut
Details of previous discussion and/or dissemination:	Not applicable
Action required:	Note for information
<p>Summary:</p> <p>The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.</p> <p>NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer (AEO) in each organisation is responsible for making sure these standards are met and is supported by an Emergency Planning Officer (EPO).</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>
Impact on risk profile:	

Emergency Preparedness, Resilience and Response (EPRR)

Executive Summary

It is an annual process for Dorset Clinical Commissioning Group (CCG) to assess our Emergency Preparedness, Resilience and Response. This is against the national standards, and uses an evidence based assessment. Each year a 'deep dive' is also undertaken. This year the subject was Severe Weather and Adaptation.

This formal assessment is then reported to NHS England/Improvement to form a national picture of preparedness across the country.

EPRR Compliance

At the date of this report the Trust was found to be fully compliant for 5 of the 64 core standards and partially compliant for 6, based upon DCCG's feedback and the actions already underway to address compliance..

Overall the Trust has been rated as **substantially compliant** for the third year running.

The standards which were found to be partially compliant will form the work plan for the emergency planning officer (EPO) for the coming year. This work will be monitored by the Trusts Emergency Planning Sub Group (EPSG) and supported by the Local Health Resilience Partnership (LHRP). The time scales and specific actions have been agreed with Dorset CCG.

The summary of partial compliance actions are mainly around improving the plans and policies, and fully evidencing the work undertaken.

The level of assurance is based upon the CCGs expert assessment and an open and transparent engagement by our EPRR team (BJ Waltho and Malcolm Keith). Both should be praised for the year on year progress against an ever more complex and challenging environment.

The nature of emergencies and resilience work is one where complete assurance can never be possible. However the external assessment provides evidence that the preparedness we have undertaken meets the national requirements and gives substantial assurance

Whilst not part of the formal assurance process 'the deep dive' did highlight the gap in work around severe weather / climate change adaptation and the EPO also has this on the work plan for improvement. The lead for sustainability for the Trust has also completed a review with an action plan in place.

Training and Exercising

The Trust was found to be compliant with this section with good work completed around staff engagement and completion of individual training needs analysis (TNA). This has been achieved by targeted application and attendance at training opportunities.

There have also been 3 exercises carried out this year, one on the ability to lockdown the Trust and the second on the failure of the electrical system and the back-up generators. Third happened on the 15th November and was a joint exercise with Poole Hospital and Public Health England.

Summary of incidents

The main focus has been on the ability to maintain the IT and Telecommunications systems across both Trusts. Resilience work earlier in the year has greatly reduced the potential impact and frequency of the IT drop outs. This has been fed into the IT business continuity plan and demonstrates progress in addressing root cause issues

The severe weather incident in 2018 repeated itself in early 2019. The lessons learnt from the earlier event minimised the impact experienced by the Trust. i.e. confidence in and response to the Met Office weather reports.

Extensive work has been carried out preparing the Trust for EU Exit work streams in addition to overall EPRR work. Brexit work is currently on hold. This work has been reported to the Board previously.

Lessons learnt

The Trust is always striving to improve the performance across the range of services provided and no more so when there are opportunities to improve as a result of an incident. One example is the uses of spontaneous volunteers to enable staff travel during severe weather, which on the day worked well.

Business Continuity Plans (BCP)

One of the opportunities that has come out of the EU Exit work stream is the ability to review and update BCP plans in the event of a range of potential shortages, such as staff, resources, supplies and impacts, such as lack of transport due to fuel shortages. Each BCP lead was asked to review their plans and complete a template to add as an appendices focusing on known issues.

Additional information

Alex Jablonowski is the new Non-Executive Director champion for EPRR. There continues to be close working relationship with Poole's EPRR lead. As a result there is a closer alignment of policies and practices between the Trusts, as well as greater resilience by combining resources. Plans are already progressing to support the amalgamation of the EPRR teams, potentially ahead of formal, legal merger, and this is supported by DCCG and other partners.



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

BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Healthcare Assurance Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of paper:	Joanne Sims, Associate Director Quality, Governance & Risk
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee Audit Committee
Action required:	Decision
<p>Summary:</p> <p>Minor changes are proposed to the terms of reference for the Healthcare Assurance Committee reflecting changes to its membership and reporting and sub-committee structure. The proposed changes are shown on the attached version of the terms of reference. These changes have been reviewed by the Healthcare Assurance Committee and are recommended for approval.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on high risks:	None



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

BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Strategy & Development Committee – Terms of Reference
Section on agenda:	Performance
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:	July Board
Action required:	Note for information
Summary: The Terms of Reference for the Workforce Strategy and Development Committee went to Board in July for ratification following their annual review. The updated version now tabled shows one amendment under Membership, reflecting the change in the number of Non Executive Directors on the Committee from three to two.	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 ✓ ✓ <input type="checkbox"/> <input type="checkbox"/> ✓
Impact on risk profile:	-

WORKFORCE STRATEGY AND DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

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

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

1. Membership

- 1.1 The Committee Chairman (the **Chairman**) shall be a Non-Executive Director. In the absence of the Chairman the deputy Chair shall be the Director of Human Resources.
- 1.2 Standing members of the Committee shall include ~~three~~two 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.
---------------	---

- 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

Choose a meeting	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Charitable Funds Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	No
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Pete Papworth, Director of Finance
Details of previous discussion and/or dissemination:	Charitable Funds Committee
Action required:	Decision
Summary: The Charitable Funds Committee terms of reference is presented for annual review and to note the change in attendance.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Impact on high risks:	There are currently 15 financial and performance risks recorded on the risk register for monthly review by Committee

CHARITABLE FUNDS COMMITTEE

Terms of Reference

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

1 MEMBERSHIP

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

2 SECRETARY

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

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	September 2018 (amended January 2019) <u>November 2019</u>	September 2019 <u>November 2020</u>	Pete Papworth

3 QUORUM

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

4 FREQUENCY OF MEETINGS

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

5 NOTICE OF MEETINGS

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

6 MINUTES OF MEETINGS

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

7 DUTIES

- 7.1 The Committee shall:

7.1.1 endeavour to make an adequate return on prudent investments;

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	September 2018 (amended January 2019) <u>November 2019</u>	September 2019 <u>November 2020</u>	Pete Papworth

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

8 REPORTING RESPONSIBILITIES

- 8.1 The minutes of the Committee meetings shall be submitted to the Board after each meeting.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	September 2018 (amended January 2019) <u>November 2019</u>	September 2019 <u>November 2020</u>	Pete Papworth

- 8.2 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.
- 8.3 The Committee shall provide a report on its activities to be included in the Trust's annual report.

9 OTHER

- 9.1 The Committee shall, at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.
- 9.2 All affiliate charity income should be routed through the charity to ensure all spend is subject to the same application process as funds direct to the charity this includes VAT implications.
- 9.3 All approaches to the affiliate charities should be coordinated through the charity office to ensure process is followed and spend meets the charity's objectives.

10 AUTHORITY

10.1 The Committee is authorised:

- 10.1.1 To oversee and authorise expenditure from charitable funds (subject to all process being in accordance with the Trust's Standing Orders and Standing Financial Instructions).
- 10.1.2 To seek any information it requires from any employee of the Trust in order to perform its duties.
- 10.1.3 To obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	September 2018 (amended January 2019) <u>November 2019</u>	September 2019 <u>November 2020</u>	Pete Papworth



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

BOARD OF DIRECTORS	
Meeting date:	27 November 2019
Meeting part:	Part 1
Reason for Part 2:	n/a
Subject:	Update on establishment of the Shadow Interim Board
Section on agenda:	Governance
Supplementary reading:	n/a
Director or manager with overall responsibility:	Debbie Fleming, Chief Executive
Author(s) of paper:	Alan Betts, Programme Director One Acute Network Carrie Stone, PHFT Company Secretary
Details of previous discussion and/or dissemination:	Board of Directors and One Acute Network: East Reconfiguration Board meetings
Action required:	Note for information
<p>Executive Summary:</p> <p>The NHS Improvement Transaction Guidance outlines the process by which the Trust Board of a merged trust is established. Upon merger, the boards of the merging trusts fall away as a consequence of the dissolution of the legacy trusts. The constitution of the new foundation trust comes into effect on the day the merger takes effect (Day 1).</p> <p>On or after Day 1, the new foundation trust's governance structures, including its council of governors and board, can be established. This process can take several months. Until then (and prior to the merger date), a subset of directors is chosen from the directors of each existing trust to become members of an interim board (referred to hereafter as the Shadow Interim Board). The Shadow Interim Board should comprise of Executive and Non-Executive members that would usually be expected to be members of a Foundation Trust Board.</p> <p>During July 2019, both Trust Boards approved the Terms of Reference of the Shadow Interim Board. A selection process was then completed to determine the membership of the Board and this was completed in November 2019. The Shadow Interim Board is expected to hold its first meeting in January 2020.</p> <p>The Shadow Interim Board's main duties will involve developing and working on the future strategy, vision and values of the merged Trust and programmes and relating to this (specifically the merger programme and the capital/estates development programme).</p> <p>The Board will have a range of duties pre-transaction completion to ensure successful completion of the transaction, as outlined in the Terms of Reference. The Board will be an advisory body to both existing statutory Boards, making recommendations and</p>	



The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

providing advice to these Boards. The Shadow Interim Board is not a formal sub-committee of each statutory Board and does not hold delegated powers from each statutory Board (see Terms of Reference for details). This method of constitution of an interim board is standard practice in an NHS merger transaction and follows advice provided by the Trusts legal advisors.

The Shadow Interim Board will not be involved in the day to day operational delivery of contracted services or any aspect of the regulatory obligations of governance of each Trust as currently constituted.

The duties of the East Reconfiguration Board (previously the One Acute Network Board) will be assumed by the Shadow Interim Board from January 2020 and as such the East Reconfiguration Board will have its final meeting in December 2019.

The Shadow Interim Board will meet for the first time on January 2020 and will meet monthly thereafter. The December East Reconfiguration Board will meet for the final time in December 2019. If the merger is approved on the 1st July 2020 the Shadow Interim Board will evolve into the Interim Board of the new, merged Trust.

Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	

BOARD OF DIRECTORS MEETING – 27 November 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
11:35	A working lunch will be provided at the beginning of the joint meeting		
	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.		
11:45	2. GOVERNANCE		
	a) Establishment of the Shadow Interim Board and next steps (verbal)	Information	Debbie Fleming
	b) Name of the new organisation (paper)	Decision	Jacqueline Cotgrove
	c) Due Diligence Report (paper)	Decision	Pete Papworth/ Alan Betts
	d) Digital Transformation Strategy (paper)	Decision	Peter Gill
	e) Dorset System Long Term Plan (paper)	Information	Debbie Fleming/ Pete Papworth
	f) Pensions Update (paper)	Information	Pete Papworth/ Karen Allman TO FOLLOW
13.45	<p>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.</p> <p><i>The meeting will be adjourned until the public session of the meeting commences at 1.45pm.</i></p>		
4.30	3. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 25 September 2019 (paper)	Decision	All
4.35	4. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Discussion	All
4.40	5. STRATEGY AND RISK		
	a) Significant Risk Report (paper)	Discussion	Paula Shobbrook

- | | | | |
|----|--|-------------|-----------------------|
| b) | Christchurch Fairmile Village LLP (paper) | Decision | <i>Pete Papworth</i> |
| c) | Brexit Planning and Preparedness Update (verbal) | Information | <i>Richard Renaut</i> |

5.15

6. 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



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