

A meeting of the Board of Directors will be held on Wednesday 30 January 2019 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital

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

Karen Flaherty
Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8.30-8.35	1. WELCOME, APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 28 November 2018 (paper)	Decision	All
8.40-8.45	3. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Information	All
8.45-9.10	4. QUALITY		
	a) Patient Story (verbal)	Information	Paula Shobbrook
	b) Medical Director's Report (paper)	Information	Alyson O'Donnell
9.10-9.35	5. STRATEGY AND RISK		
	a) Implementing the Clinical Services Review (presentation)	Information	Debbie Fleming
	b) Progress Update on 2018/19 Corporate Objectives (paper)	Information	Debbie Fleming
	c) Equality, Diversity and Inclusion Update (presentation)	Information	Deb Matthews
9.35-10.20	6. PERFORMANCE		
	a) Trust Board Dashboard (paper)	Information	Richard Renaut
	b) Performance Report (paper/presentation)	Information	Richard Renaut/ Donna Parker
	c) Quality Report (paper)	Information	Paula Shobbrook
	d) Finance Report (paper)	Information	Pete Papworth
	e) Workforce Report (paper)	Information	Karen Allman
	f) BBC News Coverage (presentation/film)	Information	Jamie Donald
10.20-10.30	7. GOVERNANCE		
	a) Anti-Slavery and Human Trafficking Statement	Decision	Deb Matthews

(paper)

- b) Healthcare Assurance Committee Terms of Reference (paper)

Decision

Karen Flaherty

8. NEXT MEETING

Wednesday 27 March at 2.00pm in Board Rooms 1 and 2, Poole Hospital.

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.30-10.45

10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

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

11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

Minutes of a Meeting of the **Board of Directors** (the **Board**) of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the **Trust**) held in public at 8.30am on **Wednesday 28 November 2018** in the Conference Room, Royal Bournemouth Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Pankaj Davé	(PD)	<i>Non-Executive Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	John Lelliott	(JL)	<i>Non-Executive Director</i>
	Alyson O'Donnell	(AOD)	<i>Medical Director</i>
	Pete Papworth	(PP)	<i>Director of Finance</i>
	Iain Rawlinson	(IR)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Debbie Anderson	(DA)	<i>Head of Fundraising, Bournemouth Hospital Charity (for item 5 (a))</i>
	Alison Ashmore	(AA)	<i>Associate Director for Cancer and Outpatients (for item 4(e))</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nikki Manns	(NM)	<i>Ward Sister, Stroke Unit (for item 4(a))</i>
	Deb Matthews	(DMA)	<i>Director of Improvement and Organisational Development</i>
Public/ Governors:	James Rowden	(JR)	<i>Patient Engagement and Clinical Liaison</i>
	Derek Chaffey		<i>Public Governor</i>
	Valerie Chaplin		<i>Pets As Therapy Volunteer (for item 4(a))</i>
	Paul Higgs		<i>Public Governor</i>
	Marjorie Houghton		<i>Appointed Governor</i>
	Margaret Neville		<i>Member of the public</i>
	Roger Parsons		<i>Public Governor</i>
	David Triplow		<i>Public Governor</i>
	Michele Whitehurst		<i>Public Governor</i>
Apologies:	Cliff Shearman		<i>Non-Executive Director</i>

56/18 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Action

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

The Chairperson announced that the Trust had been highly commended in the 2018 Health Service Journal Awards in the 'Trust of the Year' category.

57/18 MINUTES OF PREVIOUS MEETING

(a) Minutes of the meeting held on 26 September 2018 (Item 2(a))

The minutes of the meeting held on 26 September 2018 were **approved** as an accurate record of the meeting.¹

58/18 MATTERS ARISING

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

The update was **noted**.

59/18 QUALITY

(a) Patient Story (Item 4(a))

Nikki Manns and Valerie Chaplin gave an insight into the continuing work on the Stroke Unit to improve the patient experience alongside maintaining its top Level A rating for stroke services in the Sentinel Stroke National Audit Programme (**SSNAP**). This was helping to embed the humanising care ethos established through a joint project between Bournemouth University and the Trust in 2016.

The team had been keen to capture a broader range of softer data than was used for SSNAP to help improve the overall patient experience. This had led to a range of projects aimed at improving the patient and carer journey and their stay in hospital, involving multi-disciplinary teams. A Stroke Quality Improvement Forum had been set up to obtain patient and relative feedback and drive quality improvement and other groups such as the Patient and Carers Forum and a Smoothie Group provided support to patients.

Volunteers had an important role in these improvements including Pets As Therapy, which added a different dimension to therapy on the Stroke Unit. There was lots of evidence that this improved patients' outlook and their experience with debilitating conditions as well as providing comfort to both patients and their relatives. Valerie Chaplin provided more information about the charity, Pets As Therapy, and the work with her dog, Paws, in the Stroke Unit and other areas of the hospital.

PS highlighted pet therapy as a good example of humanising care in practice. KA added how Paws had helped staff who were nervous around dogs to overcome their fears and thanked Valerie on behalf of the Trust and all the patients who had benefitted as a result of the time she dedicated to Pets As Therapy.

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

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

- the Trust's Annual Members' Meeting, very popular Understanding

¹ A minor correction was highlighted following the meeting to amend the presenter's name for the patient story (item 4(a)) to Rachel Jury.

Health talks on Fit for Life and Sepsis and an engagement event in Verwood to explain the planned changes to local hospital services under the Clinical Services Review (**CSR**);

- a series of talks about the Trust in local libraries by public governor, Keith Mitchell;
- closer working with the Patient Experience team to ensure that the feedback from listening events had maximum impact;
- staff governor conversations with staff across both hospitals, with positive feedback about teamwork and the friendly atmosphere and a desire to be involved in the work on CSR, although a few themes had emerged around workforce resilience, IT systems, parking, the impact of the CSR and merger that had been raised with the Board; and
- improving communication with members and the public and promoting the role of the governor through a governor led focus group.

A message was shared from a cardiac patient who had been overwhelmed by the quality of care they had received following their recent admission.

Keith Mitchell, public governor, gave an overview of his role on the End of Life Care Steering Group and the key themes from the surveys he carried out regularly with relative and carers to provide more immediate feedback for the palliative care team to supplement the National Audit of Care at the End of Life. Relatives often appreciated the opportunity to talk and the End of Life Companion volunteers provided valuable support for patients and relatives.

Board members thanked governors for their work in promoting the hospital and its services and confirmed that an action plan was being developed in response to the feedback provided by staff governors.

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

AOD presented the key themes from the report:

- Hospital Standardised Mortality Ratio (**HSMR**) performance for the Trust from August 2017 to July 2018 was within the 'as expected' range, while Royal Bournemouth Hospital's performance (excluding Christchurch Hospital and the Macmillan Unit) was in the 'better than expected' range;
- there had been a significant improvement in the coding of co-morbidities which was likely to lead to a further improvement in HSMR;
- good progress was being made with the medical examiner pilot with greater involvement of junior doctors alongside the medical examiners and 80% of death certificates issued within 24 hours of death;
- the Wessex Academic Health Science Network was working to improve the consistency of reporting on learning from deaths; and
- progress was being made on the actions arising from the Mortality Surveillance Group's reviews of mortality from sepsis and pneumonia and action plans had been developed following reviews of deaths arising from long-line sepsis, respiratory procedures and urinary tract infections.

Ahead of the meeting, CS had highlighted the importance of the sickest patients being seen by a consultant within 14 hours and AOD explained that processes within the Acute Medical Unit had been changed to address this following the seven day services audit.

The Board discussed the significance of the depth of coding on mortality ratios and other measures including the Reference Cost Index and Model Hospital data. AOD and PS emphasised the importance of the detailed mortality reviews in understanding the underlying causes for any alerts or upward trends and any gaps in care. Coding around deaths and co-morbidities was likely to be strengthened further by the new medical examiner roles and death certification process and following an audit to be carried out in December.

(d) Annual Protection and Safeguarding Report (Item 4(d))

Board members received the annual protection and safeguarding report, which was tabled at the meeting. The report summarised the actions and improvements in 2017/18 to safeguard adults and children at the Trust. The report had been reviewed by the Healthcare Assurance Committee (**HAC**), which had been assured that strong processes were in place, and the Trust had complied fully with the internal auditor's recommendations and the internal action plan as well as receiving positive feedback following to external 'line of sight' visits by the Adult Safeguarding Board.

Themes highlighted from the report included:

- all staff now receive level 2 adult safeguarding training;
- 42 adult safeguarding referrals were reviewed with four being substantiated due to poor discharge planning with changes made to the online discharge lounge booking form and a transfer of care checklist developed to improve this process;
- 531 patients with learning disabilities were admitted, a 9% increase on the previous year, with admissions identified daily so support can be provided to these patients;
- the number of requests for deprivation of liberty safeguards (**DOLs**) had increased by 67% compared to the previous year demonstrating the effectiveness of staff training and that the Mental Capacity Act compliance was embedded in everyday practice;
- the local authority was now prioritising complex discharges where there was an increased length of stay in assessing patients with DOLs, although further work was needed to ensure completion of assessments in a timely manner ahead of changes to the legislation; and
- training compliance for safeguarding children remained high with specific actions taken to improve training compliance for staff in the Emergency Department (**ED**).

Safeguarding had been recognised as an area of strength within the latest CQC report and the standard of care provided to this group of the most vulnerable patients reflected well on the Trust.

The Board **reaffirmed** its commitment to the safeguarding of adults and children. This statement and the report would now be published on the Trust's website.

(e) National Cancer Patient Experience Survey (Item 4(e))

Alison Ashmore provided a summary of the positive results from the National Cancer Patient Experience Survey 2017:

- 73% of Trust patients responded to the survey compared with a national

average of 63%;

- performance benchmarked strongly placing the Trust within the top 27 of 144 trusts for patient experience, scoring higher than the expected range in twelve questions and within the expected range for 39 questions;
- the Trust was a negative outlier on one question related to the explanation provided to patients after the operation, which was 1% below the expected range;
- specific areas for improvement had been identified based on the scores and individual comments including providing better explanations and information to patients on how their operations have gone taking account of individual understanding;
- there were a variety of other initiatives underway to improve the patient experience more generally including increased support for holistic needs assessments, health and wellbeing sessions for patients and HOPE courses for staff to develop additional skills to support patients through their cancer care;
- Patient Triggered Risk Stratified Follow Up implementation planned to commence from April 2019 in urology, breast and colorectal sites; and
- as a 28 day faster diagnosis standard pilot site the Trust had identified additional work to achieve the target by its introduction in April 2020 as performance was currently slightly below this.

Richard Renault confirmed that the Trust was trying to increase the number of patients asked about taking part in research through Research Active Dorset and the Dorset cancer strategy to improve patient outcomes as CS had highlighted that this figure appeared low.

(f) Overseas Nurse Recruitment (Item 4(f))

The Board **noted** the summary of recruitment activities for overseas nurses, which had been requested at the Board meeting in September. This had been considered in greater detail by the Workforce Strategy and Development Committee. This work also included putting in place good pastoral support for nurses when they arrived at the Trust.

Board members noted that the vacancy rate for nurses compared favourably with other trusts and welcomed the proposed changes to the accreditation process for overseas nurses to support the recruitment processes.

60/18 STRATEGY AND RISK

(a) Bournemouth Hospital Charity Annual Review 2017/18 (Item 5(a))

AJ, as Chair of the Charitable Funds Committee, encouraged those attending to read the Bournemouth Hospital Charity's Annual Report. Debbie Anderson introduced a short film complementing the annual report and highlighting the work of the charity and fundraising activities in 2017/18 to enhance patient care and the patient experience through projects identified by individual teams and departments.

The team were thanked for their efforts in raising the profile of the hospital charity and professional stewardship of donations. Board members reinforced how fundraising would continue to play a vital role in supporting the hospitals

notwithstanding the additional capital available to implement the CSR. Those attending the meeting were encouraged to help with fundraising for presents for patients in hospital over Christmas.

(b) Implementing the Clinical Services Review (Item 5(b))

TS provided an update on progress with:

- the development of the key build elements on the planned and emergency sites based on the clinical design work with teams to date;
- the identification of sources of funding for any build costs falling outside the £147 million capital amount previously confirmed including the community hospital beds on both sites;
- reaching agreement with NHS Improvement (**NHSI**) and the Competition and Markets Authority on the timetable for merger;
- ongoing discussions with NHSI regarding the resources to underpin the joint leadership arrangements across four services; and
- promoting the reasons for the changes and the benefits of the model of care, with emergency and planned care on separate sites, to the public working with NHS Dorset Clinical Commissioning Group.

It was noted that the scope of work on the clinical redesign and affordability would be presented to the Board at its meeting in January. Organisational development teams were working with staff to ensure that their feedback was being incorporated in the design of both services and facilities and a fourth group of Change Champions had recently started in their roles.

Agenda

(c) Progress Update on 2017/18 Corporate Objectives (Item 5(c))

The Board **noted** the progress made against the corporate objectives.

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

The Board **noted** the progress against the stakeholder engagement outcomes. Patient engagement in particular would be further enhanced through the CSR with funding secured to train ten members of staff in experience-based co-design with The Point of Care Foundation and the recruitment of patient voice volunteers to support the design of services.

Board members encouraged further engagement with local health and social care partners to take forward the work of the integrated care system in Dorset.

(e) Winter Plan Update (Item 5(e))

The Board was updated on progress with the winter plan and improvements since the previous meeting including:

- recruitment of permanent clinical staff in ED;
- closer working with local authorities to develop plans to reduce length of stay once patients were medically ready to be discharged;
- progress with streaming patients to primary care;
- increased capacity with dedicated rehabilitation for patients following the transfer of the Fayrewood Ward from St Leonards Community Hospital;
- good progress with the focus on treatment within the 'first 24 hours' to avoid short stay admissions;

- the creation of a single and more efficient clerking process;
- the introduction of electronic whiteboards and the electronic bed management system 'Health of the Ward' providing better visibility of the sickest patients in order to focus care and of patients who were awaiting discharge;
- focus on discharging the patients who are medically ready before Christmas to create greater capacity for the busy period over Christmas and New Year; and
- improving awareness of operational escalation levels and working differently with other departments in practice.

Actions which were still in progress were also highlighted. In its Board development session later that afternoon, the Board would be hearing from the Trust and system partners about arrangements to better manage non-elective demand.

61/18 **PERFORMANCE**

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

The paper was **noted** for information.

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

The following areas from the report were highlighted:

- ED four hour performance remained strong but the target would be at risk in the third quarter due to the continued growth in emergency demand and the onset of winter,
- referral to treatment (RTT) performance continued to fall short of the target;
- the recovery plan in place for Endoscopy for six week diagnostic waits had now been extended to end of March due to the impact of staff sickness; and
- cancer two week wait performance was likely to recover in the fourth quarter.

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

The following areas from the report were highlighted:

- no serious incidents had been reported in October;
- the Trust remained within the top quartile for inpatient Friends and Family Test (**FFT**) for September; and
- ED and outpatient FFT scores remained in second quartile and the HAC had requested a review of outpatients FFT performance.

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

The Trust continued to deliver against its financial control total. Risks arising from the shortfall in the cost improvement plan (**CIP**) together with localised pressures resulting from activity increases in directorates remained challenging.

The £2 for £1 incentive opportunity from NHSI had been secured, which required the Trust to deliver the refreshed control total to access the incentive

funding. It is important to note that this improvement has been achieved through a small number of material one-off financial improvements that could be used to support the strategic reconfiguration of services.

The provider sustainability fund (PSF) allocation for the third and fourth quarters was significantly at risk given the difficulty in achieving the ED performance target in the Trust and more broadly as a healthcare system. Actions were already being taken across the system to improve ED four hour performance.

A challenging prioritisation process was underway as part of the budget-setting for 2019-20 including identifying potential CIP projects.

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

The following key points were highlighted:

- the vacancy rate had increased to 5.22% although the substantive staff headcount had increased by 140 over the previous year;
- sickness absence performance remained a concern as it continued its upward trend, however rolling twelve month compared favourably to the same point last year;
- essential core skill compliance had improved particularly for the medical and dental staff group;
- a Black Asian and Minority Ethnic staff network group had been launched and the Trust has been awarded Stonewall Diversity Champion accreditation;
- collaborative work was underway with Poole Hospital NHS Foundation Trust (**PHFT**) in Older Persons' Medicine;
- the Trust was one of twelve trusts approached by the General Medical Council following comments about the positive culture around diversity and inclusion work;
- 49% of non-clinical and over 50% of clinical staff had received the flu vaccination which was higher than at the same point the previous year but not as good as many other trusts, including PHFT, and the Trust was looking to learn from these; and
- the Trust had been a finalist in the Dorset Business Awards for the Employee Health and Wellbeing Award and was looking to link with the other finalists to further develop the support offered to staff.

(f) Flu Vaccination Campaign (Item 6(f))

The Board **noted** the information in the checklist that NHS England had requested was reported to the Board although final compliance was not due to be reported until February 2019. Work continued to improve take-up of the vaccination and encourage staff to do this for the right reasons for patients, themselves and their families rather than making vaccination this compulsory, which could risk a backlash. Opportunities to improve performance in future were being explored, such as staff based within teams offering vaccinations.

62/18 GOVERNANCE

(a) Amendments to Trust's Constitution (Item 7(a))

The Board **approved** the amendments to the Trust's Constitution, which had

been proposed by the Constitution Joint Working Group following their annual review and approved by the Council of Governors at its meeting on 25 October 2018.

(b) Emergency Preparedness, Resilience and Response (EPRR) Assurance Declaration (Item 7(b))

The Board **noted** the report and the improvement on the previous year's performance against the core standards.

63/18 NEXT MEETING

The next meeting will take place on **Wednesday 30 January 2019** at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

64/18 ANY OTHER BUSINESS

There was no other business.

Key Points for Communication to Staff:

1. Pets As Therapy
2. Bournemouth Hospital Charity film
3. Winter Planning
4. Progress with overseas staff recruitment.

JD noted that tweets had been posted on the Trust's Twitter social media platform during the meeting.

65/18 COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC

David Triplow noted that governors from the Trust had met with governors at PHFT, including a number of those who had been recently elected. He emphasised the importance of joint working to better understand one other's perspectives.

66/18 RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

The meeting adjourned at 10.50am

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
28.11.18	60/18	STRATEGY AND RISK			
	(b)	Implementing the Clinical Services Review			
		It was noted that the scope of work on the clinical redesign and affordability would be presented to the Board at its meeting in January.	Agenda	January 2019	Included on the agenda for the private session of the meeting in January.
Key:	Outstanding	In Progress	Complete	Not yet required	



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

BOARD OF DIRECTORS	
Meeting date:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Medical Director's Report
Section on agenda:	Quality Item 4B
Supplementary reading:	None
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Alyson O'Donnell Dr Divya Tiwari
Details of previous discussion and/or dissemination:	Mortality indices and reviews discussed at Mortality Steering Group and Claims Report
Action required:	Review and comment
Summary: Monthly Medical Director's Report. To update the Board on the Trust's Mortality performance including claims data.	
Related strategic objective:	Choose an objective
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on risk profile:	N/A

Medical Director's Report to the Board

Mortality Update

Overall Hospital Standardised Mortality Ratio (HSMR) for the Trust for the last 12 months (September 2017 – August 2018) is 101.0, this is rebased for April 2018 and is in 'as expected' range. The figure for RBH (excluding Christchurch and the Macmillan unit) is 90.5 and is in the 'better than expected range'. Latest SHMI (Standardised Hospital Mortality Indicator July 2017-June 2018) is 98.81 which is within the expected range. MSG has noted an improving trend in year-to-date HSMR. The previous issue with the submission of partial codes has been resolved with the coding department now receiving regular reports for ratification. The Dementia team is now routinely providing information about admissions where dementia is recorded. These measures have improved co-morbidity coding (Charleston Index). Further work is ongoing to improve data quality for vascular procedures.

The crude death rate has steadily declined from 1.97% in December 2017. Although there was a small rise to 1.3% in December 2018 this is significantly better than the previous year. Mortality rates for all high risk conditions (stroke, congestive cardiac failure, acute renal failure, sepsis and pneumonia) are stable and within the expected range (Annexe A).

Learning from Deaths

Mortality Report for Board: January 2019

Reviews are deemed completed if either the review or mortality chair review date has been completed, or the review has been marked as complete.
Data as at 11/01/2019

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Deaths in Month	141	121	141	128	103	116	118	121	118
eMortality Reviews Completed in Month	57	151	68	76	8	37	84	17	18
Category of Death by Month Review Completed									
Grade 0	52	139	63	71	6	28	77	17	17
Grade 1	5	12	5	5	2	8	6	0	1
Grade 2	0	0	0	0	0	1	1	0	0
Grade 3	0	0	0	0	0	0	0	0	0
Learning Disability Deaths in Month	3	0	2	0	0	0	1	0	3
Learning Disability Deaths Reviewed	3	0	2	0	0	0	1	0	0

It has recently become apparent that there are data issues within the e-mortality system. This relates to both the allocation of cases and a failure to pull completed reviews through to the finalised list. Work is currently underway to investigate the accuracy of data extraction from the complete queue.

LeDeR Mortality

There were three deaths reported in individuals with learning disability in December. All three deaths have been forwarded to national LeDeR programme for review. Internal reviews are underway and will be forwarded to the LeDeR team when complete. One death occurred under the joint care of the stroke/ITU teams and has been reviewed by both. MSG has forwarded the findings of the internal review to the National LeDeR team as requested.

Learning points and action plan from this review:

Learning Points:

1. There were multiple Stroke and ITU consultants involved in this patients care that, potentially the opportunity was missed to think about limitations to care and even may be preventing the admission to ITU.
2. A collateral history from the patients relatives earlier in the admission or even at the point of deterioration would have been of benefit to understand what Mr P would of wanted for himself.
3. Patient was not highlighted to the learning disabilities team on admission-as they may have given a steer or gathered further information that could have been pertinent to the medical team and in their decision making.

Action Plan:

1. If patient with Learning difficulties and cerebral event that have been transferred to ITU the patient's parent consultant should continue to manage the patient outside of the Stroke unit.
2. Think about escalation plans and collateral history early in the admission in such patients to help with future management.

As per our mortality review protocol all deaths graded as 2 or 3 are subject to an RCA type investigation outside our normal e-mortality process. Currently there are 4 internal SI processes underway for deaths graded as 2. The outcomes are awaited.

Medical Examiner (ME) Process

The ME process pilot has been running since the 22nd October. It is successfully screening deaths using national recommendations for mortality screening and forwards all potential grade 2 or 3 mortalities for 'mortality scoping' in-line with the Trust's risk process. Approximately 2 deaths per week are referred for a more in-depth review (around 7% of total) which is in keeping with the findings from pilot sites. Initial indications are that this process has shortened the time for death certification and streamlined processes for Coroner referral.

A senior Coroner's Officer has attended to observe the process and has taken back particular areas for clarification e.g. referrals to the Coroner for anyone who has undergone a procedure in the last 12 months. Feedback from bereaved families is generally positive about the clinical and nursing care and the junior medical teams have felt supported and found the experience educational.

This project is now ready to move on to the next stage where an electronic version will be launched. 5 consultants have been appointed as Medical Examiners with Jules Cranshaw taking the role as Lead ME. This will now be formalised into the job plans.

Action Plan from the Mortality Surveillance / Reviews

New Dr Foster alerts

Dr Foster alerts in diagnostic categories:

- Lung diseases due external agents (aspiration pneumonia) (relative risk and cusum alert);
- Coma, stupor and brain damage (relative risk alert).

MSG will conduct a full review in both categories focussing on clinical care, communication, coding and death certification.

Dr Foster alerts in procedural categories:

Repair of other hernia of abdominal wall: there is one death in this category post procedure which is under review by the colorectal surgical team, findings, learning points and action plans will be discussed in the February MSG.

Annual review of high risk conditions (Acute Kidney Injury)

Department of Health guidelines (mortality surveillance, 2014) suggest that hospitals should conduct an annual review of high risk conditions to monitor specific mortality trends. AKI specialist nurse Steve Trowbridge discussed findings, learning and action plan in the December MSG.

Overview: January 2018 to November 2018

AKI Stage	1	2	3
Discharged	1701	310	286
Length of Stay	11.2	14	12.3
RIP	214	104	105

MSG noted no change in LOS or mortality rates compared to 2017. There continues to be a service gap over the weekends.

Action Plan:

- Facilitate discharges through AKI clinic follow up where patients are otherwise well and can go home;
- Streamline nephrology referral and use resources effectively (nephrology and radiology);
- Intranet site to advice standard operating procedures for transfer to renal unit in Dorchester and monitor any delays in transfer of care;
- Develop business plan for increased nephrology input and local investigations to avoid delay in diagnosis and therefore management e.g. renal biopsy;

- Collaborate with IT so that renal outpatient letters are available on e-CaMIS;
- Develop a system for medication review in patients undergoing nephrectomies.

Dr Foster alert in cancer of uterus:

The Clinical Lead conducted a themed retrospective mortality review for all 9 deaths in this category, focussing on clinical care, communication, end of life care and coding.

Learning points and action plan was discussed in the January MSG meeting, delayed discharges for newly diagnosed patients with cancer were discussed. Mortality leads share the frustration with processes and in-patient mortality as a consequence for all cancer types.

Summary Findings

- All deaths were graded as 0, no diagnostic delays were identified;
- Clinical care was good, however 2/9 deaths were associated with a delay in the discharge processes related to fast track funding application;
- All deaths were coded correctly and death certificates were correct;
- All patients were on end of life care at the time of death and communication with the family/relatives was good.

Action Plan:

- Trust should review fast track funding processes to facilitate timely discharge to the community.

Claims:

Significant progress continues to be made in triangulating claims with complaints and serious incident processes. This is supporting our ability to look at early settlement or to defend claims.

There is a robust process to review open claims with a monthly meeting between the Medical Director, Associate Director for Clinical Governance and the Claims Manager. 50% of claims do not proceed, but the ability to review at an early stage with an expert opinion allows to settle claims sooner, thereby avoiding the waste of public money, or to appropriately challenge claims.

Key themes from open claims:

- Failure or delay in diagnosis;
- Failure or delay in treatment;
- Failure to recognise complications;
- Consent (likely to be an increasing issue).

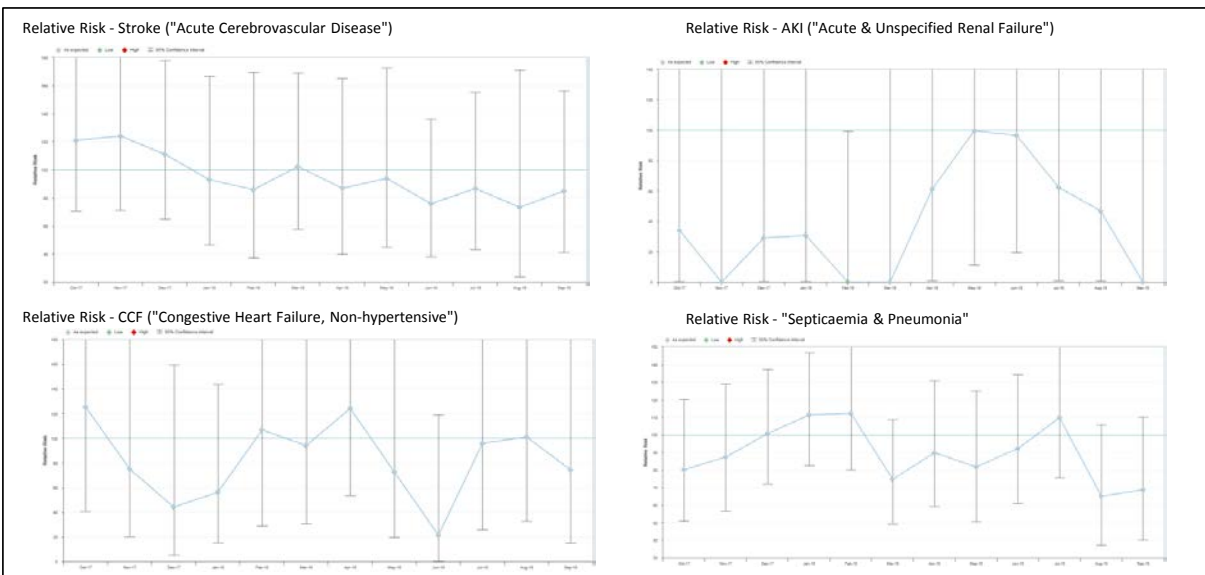
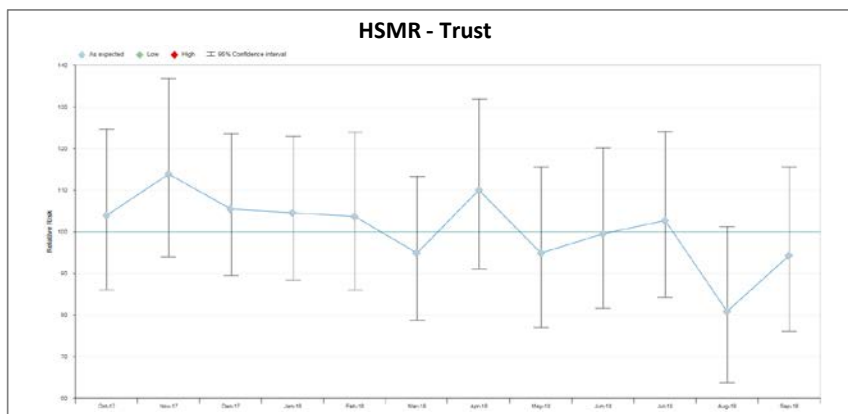
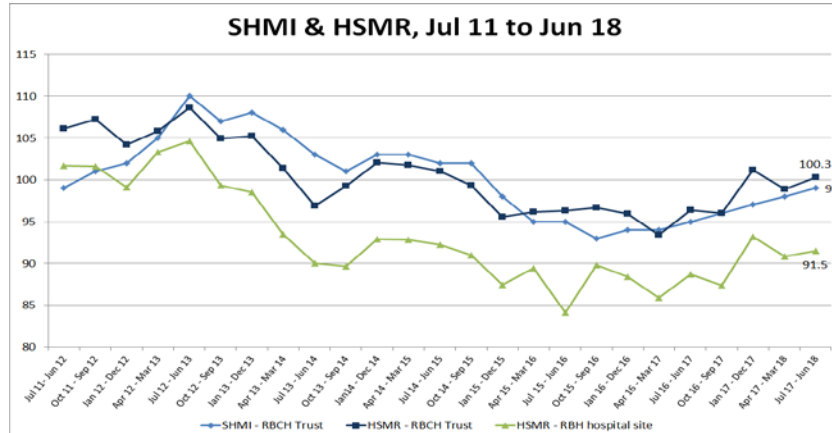
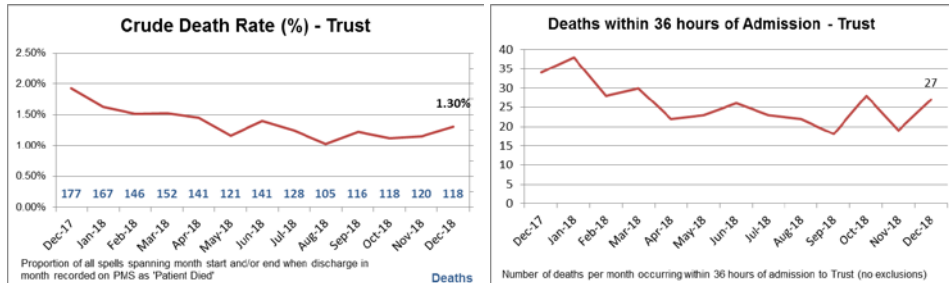
Plans:

- To provide data regularly to Directorate Governance leads on open claims and the outcomes of any cases closed or settled;

- To produce a claims scorecard in-line with NHSR recommendations

Annexe A

Data Review - Mortality Surveillance Group



BOARD OF DIRECTORS	
Meeting date:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Implementing the Clinical Services Review
Section on agenda:	Strategy and Risk
Supplementary reading:	East Reconfiguration & Merger Highlight Report
Director or manager with overall responsibility:	Debbie Fleming, Chief Executive
Author(s) of paper:	Mike Millett, PMO Manager One Acute Network
Details of previous discussion and/or dissemination:	n/a
Action required:	Note for information
<p>Summary:</p> <p>The latest update will be provided by the Chief Executive at the meeting on 30 January. The East Reconfiguration and Merger Highlight report in the reading pack provides an update on the current position.</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 risk profile:	

BOARD OF DIRECTORS	
Meeting date:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Progress Update 2018/19 Corporate Objectives
Section on agenda:	Strategy and Risk
Supplementary reading:	n/a
Director or manager with overall responsibility:	Debbie Fleming, Chief Executive
Author(s) of paper:	Sandy Edington, Associate Director Service Development
Details of previous discussion and/or dissemination:	n/a
Action required:	Note for information
Summary:	
Review of Trust Objectives for 2018/19, to end December 2018.	
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 risk profile:	

			Lead Exec	RAG Rating					
				Q1	Q2	Q3	Q4	Commentary	
OBJECTIVE ONE			Valuing our staff						
Narrative:			Recognising the contribution of our staff and helping them develop and achieve their potential						
Measures:	1.1	Delivery of the Trust's People Strategy with a focus on:							
		a) Developing fit for purpose workforce plans by December 2018	KA						
		b) Further enhancing health and wellbeing support for staff in place by December 2018	KA						
		c) Recruiting, retaining and developing staff in line with the strategy	KA						
	1.2	d) Delivering on key priorities in our diversity and inclusion plan in accordance with the timescales set out in the plan	DM						
		Delivery of the Leadership Strategy Implementation Plan with a focus on:							
		a) Talent management	DM						
		b) Leadership development	DM						
		c) Management Toolkit	DM						
		d) Recognition and Reward – these will be implemented throughout 2018/19 in accordance with the timescales set out within our strategy	KA/DM						
		The measures we will use to track progress focus on:							
		a) Action plans to address issues raised by staff, with the aim of maintaining our staff survey results and aiming to increase the engagement score from 3.9 to 4 over the next two years, demonstrating an improvement year on year	DM						
		b) Improving the Staff Impressions "Mainly Good" overall experience score to exceed 92%	DM						
		c) Maintaining a turnover rate below 12%	KA						
OBJECTIVE TWO			#						
Narrative:			Focusing on continuous improvement and reduction of waste						
	2.1	Urgent and Emergency Care 'First 24 Hours'							
		Aim: To improve the first 24 hours of our urgent and emergency care pathway to deliver 'right patient, right time, right team, right place' by March 2019							
		We will do this by ensuring:							
		all patients receive timely assessments and decisions for clinically appropriate high quality care	RR						
		we convert a third of adult acute admissions to ambulatory care as the preferred option by March 2019	RR						
		patients are either discharged or transferred to a specialty ward within 24-48 hours of arrival by January 2019	RR						
		to improve on our 7 day standards, including for admitted patients having a consultant review in no more than 14 hours.	RR						
		patients are rapidly assessed and treatment begun following referral from ED or primary care by September 2019	RR						
		frail patients are identified as soon as possible as they present in ED and receive specialist high quality care by June 2019	RR						
		Combined clerking test worked well and has landed well with medical staff according to our surveys and monitoring of usage. It is now part of Business As Usual and has contributed to resilience in recent bed pressures. We have "consistently inaccurate" data to prove this, but are now quantifying more precisely through a formal evaluation. The booklet is in place but we will try one more PDSA around a printed "wrapper" in ED which may further improve the quality of clerking, and save on storage (paper and digital) in ED during Q4.							
Admission avoidance performance in 2018/19 has increased compared to equivalent months 2017/18 - on average by +20%.									
In Q3 90% of discharges were < 48 hours; 92% transfers were < 48 hours. Transfers are always dependant on speciality bed availability									
2018 SAMBA audit received Dec 2018 reported 73% compliance (within 12 hours) for RBCH. Internal means of daily performance being developed which will be more evidential and enable identification of trends.									
Combined clerking test working well and indicative figures show average 2 hours saved per patient, being particularly beneficial out of hours. Now in place as Business As Usual									
Frailty ANPs screening ambulance conveyances for appropriate patients and taking immediately post BREATH from Oct 2018. Pilot to continue, supported by ED Consultants									

Measures		<ul style="list-style-type: none"> patients with mental health conditions have access to skilled assessments available 24/7 by June 2019 to deliver the 4 hour performance trajectory and the 95% ED standard by March 2019 	RR				Mapping complete. Next steps and action planning being reviewed by the Mental Health Steering Group
			RR				This is an operational target - which is being supported by QI ref optimising clinical decision making and onward transfer/discharge (Action Learning Weeks etc.) YTD and system trajectories achieved, securing PSF.
2.2		<p>Surgical Flow</p> <p><i>Aim: To improve flow through specialty theatres and intensive care beds, to achieve 85% utilisation (with a stretch target to 90%) for theatres. To also reduce time delays out of ITU by 20% by March 2019.</i></p> <p>We will do this by:</p> <ul style="list-style-type: none"> improving theatre scheduling and start times reducing on the day cancellations redesigning ward processes to increase capacity in recovery areas redesigning ward processes to improve ITU capacity and discharge arrangements redesigning our prioritisation and planning processes to further improving the quality and safety of the WHO checklist in emergency surgery 	RR				1.4% increase in utilisation to date; further opportunities expected to be identified in Q4 through "Insights" theatre tool being piloted and which will help align us with Poole
			RR				The Trust preforms well on the level of on the day cancellations (0.4%), however ITU elective cancellations remain a challenge. Options paper being worked up for Q4.
			DM				Cohorting, enhanced recovery in Gynae, and surgical frailty service all positively affecting bed state which has meant better availability for theatres and ITU.
			DM				ITU processes have been fine-tuned around golden patient identification, and liaison with Clinical Site. This has shown some promising effect. Bed availability is being worked on to potentially take an hour off every transfer to the ward
			DM				Working group has done process mapping and identified key actions; currently working to implement eCamis booking solution used in Poole which would help align practice in the Trusts.
2.3		<p>Supporting our Specialty Pathways</p> <p><i>Aim: To ensure implementation of recommendations outlined in the external cultural review and British Association of Dermatology review in accordance with agreed timelines</i></p> <p>This will include:</p> <ul style="list-style-type: none"> redesign of booking process improved staff training improved patient information Introduction of electronic systems all surgical forms in dermatology are completed accurately by August 2018 and zero avoidable hospital reason cancellations by October 2018 	DM				Complete
			DM				2 clinical staff training weeks in Q1 - complete - staff training now on-going operationally
			DM				New internet page for patient information designed and first stage pages now available for publication. Stage two in design which will include further clinician information.
			DM				New electronic appointment booking form in place. Surgical form being developed in e-forms to replace current paper version. Prototype of surgical form currently being reviewed by clinicians and admin team.
			DM				Was on track to deliver with regular progress monitoring. Some operational challenges have slowed progress on delivery of zero hospital reason calculations. Plans in place to refresh this work as part of operational activity.
2.4		<p><i>Aim: To improve patient safety and experience by reducing RTT waiting times in ophthalmology to a maximum of 18 weeks and outpatient follow up waits. The focus of this work will extend to improving efficiency in eye theatres by March 2019</i></p>	RR				Improved follow-ups, but deteriorated RTT / total waiting list position. A limited amount of additional resource is available from the CCG and internal RTT pressures found to support some backlog reduction. This is alongside demand and capacity planning and transformation initiatives into 19/20.
2.5		<p><i>Aim: To ensure that there are no unnecessary diagnostics and/or nursing observations for patients who are medically ready for discharge by March 2019</i></p>	RR				Guidelines for overnight nursing observations agreed with DDON. Medically ready for discharge pathway being trialled on W5
		<p>Fundamentals of Care</p> <p><i>Aim: "To improve the coordination of Peripherally Inserted Central Catheter (PICC) lines, confirming status of every patient with a PICC line inserted by RBCH and ensuring compliance with the CVAD care bundle by March 2019"</i></p> <p><i>Aim: To continually improve the safety and timeliness of treatment and reduce avoidable patient deterioration on our wards</i></p>	PS				The CVAD QI Subgroup meet regularly. The group has agreed to have the CVAD policy and associated SOPs completed by Q4. Work is underway with procurement and the infection Control Team to finalise the SOPs. The specifications for eNA have been developed and will require testing aiming for Q1. Data sets for line insertion being reviewed.

2.6	<p>We will do this by:</p> <ul style="list-style-type: none">ensuring that every patient with an early warning score (NEWS) of 9 or above, is escalated for review and then seen by an appropriate clinician within 30 minutes of their initial trigger by the end of March 2019. <p><i>Aim: To further improve the identification and management of sepsis in our emergency and admitting areas by March 2019</i></p> <p>We will do this by:</p> <ul style="list-style-type: none">treating all patients with a high risk of sepsis with a first dose of antibiotics within 1 hour of admission/diagnosis of sepsis and all other suspected septic patients within 3 hours by March 2019. <p><i>Aim: To reduce the number of Never Events and promote an open learning culture</i></p> <p>We will do this by:</p> <ul style="list-style-type: none">embedding the learning from Never Events and Serious Incidents and implement agreed actions arising from the human factor work led by the Medical Director, it is ongoing through 2018/19	AOD				Project on track. Ward level metric developed. Delays in implementation of NEWS2	
		AOD				Reporting improved. Antibiotics within 1 hour compliance high. Dr foster metrics all improving>	
		PS				Learning from Never Events discussed and disseminated through QARC and Care Group Governance. Posters and presentations were included in the September QI and Patient Safety Conference. Update report by Medical Director to November Board meeting.	
2.7	<p>Building QI Capacity and Capability</p> <p>To continue to develop our infrastructure for quality improvement at all levels within the organisation by March 2019. We will do this by:</p> <ul style="list-style-type: none">expanding the provision of QI coaching support and training and development programmes to frontline teamsdeepening the involvement of patients and carers in our QI workembedding local ownership and performance management of improvement projects to sustain front line staff engagement in QI	DM				<p>Continued implementation of Improvement Skills Training (circa 400 staff now trained) plus introduction to project management and measurement for improvement; development of coaching / training offer for individual teams also available e.g. podiatry team.</p> <p>Patient involvement in Specialty Pathways projects and reviewing how to include in other areas. Working with the Patient Voice initiative to align patient volunteers with relevant projects. Patient Engagement Champion training to commence in March 2019, 11 RBCH staff being trained to support patient volunteers.</p> <p>Sustainability planning within projects to ensure continuous improvement after close. NHS sustainability model used to evaluate at the end of each stage of project. Additional work to embed within performance management framework on-going.</p>	
		DM					
		PP					
2.8	<p>Efficiency and Productivity</p> <p>We will continue to ensure services are provided in a cost effective manner and that we achieve our financial plan to deliver a deficit of no more than £2.381 million by the end of March 2019.</p>					<p>The Trust achieved its financial control total for Q3, with a small favourable variance. In addition, the Trust has agreed to improve its control total by 3 non recurrent improvements amounting to £9 million which will secure a further £18 million PSF 'incentive' funding. The revised control total is therefore a surplus of £24.619 million.</p> <p>However some risk remains against the base budgets as savings schemes have not yet been identified to meet the cost improvement target in full and mitigating plans are in place.</p>	
2.9	<p>To continue to improve the responsiveness of services for patients and achieve the national standards of:</p> <p>Cancer waits (62 days)</p> <p>Elective referral to treatment waits (18 weeks RTT)</p> <p>Diagnostic waits (maximum 6 weeks)</p>	RR				<p>62 day performance challenged due to nationally recognised pressures from Urology "Fry & Turnbull" demand. Improved position in Q3, supported by national & local recovery funds, though remains at risk.</p> <p>RTT waiting list and [performance currently worse than trajectory. Dorset-wide transformation plan being developed under a new Elective Care Board. Prioritising 40+ week waits for Q4 and planning for 19/20. Diagnostic below target due to pressures in endoscopy. Recovery Plan underway including insourcing, however further capacity challenges will extend timeline. Prioritised work in 19/20 planning.</p>	
		RR					
		RR					
OBJECTIVE THREE		Recovery plan underway including insourcing, with recovery expected in Q4.					
Narrative:		Developing and strengthening Team RBCH to deliver safe and compassionate care for our patients and shaping future health care across Dorset					
Measures:	3.1	Progressing implementation of the Clinical Services Review by completing the clinical design of the planned and emergency sites by July 2018 and securing the lifting of the undertakings placed on the Trusts by the Competition and Markets Authority. The Board will monitor and drive progress in accordance with the project plan agreed for this work.	DF				New interim Chair and Chief Executive now in place as authorised by CMA and NHSI.

	3.2	Strengthen collaborative working and relationships between the Trust and local partners gauged by regular feedback, via a structured qualitative assessment, from partners and in so doing progress the implementation of the Dorset Sustainability and Transformation Plan. To be completed by March 2019.	DF				Relations with key partners are positive. Meetings between new Chair and CEO and partners are in place.
	3.3	Jointly implement the Dorset Care Record (DCR) Phases 1a-2, 1b and 2 in accordance with the timescales in the DCR programme plan.	PG				The Dorset Care Record continues to release iterations: the 3rd iteration has now gone live and includes Pathology, Radiology and Referrals data from DCH; radiology from RBCH/PHFT. We are still finalising the encounters data from RBCH/PHFT (Inpatients, Outpatients and Waiting lists). As such we currently have achieved 20 of the 84 interfaces. The next iteration is being planned currently and targeting 10-20 interfaces. Work will start in Feb 2019 for this iteration.
	3.4	Develop team working by embedding the Aston OD Team Coaching approach across the organisation, helping enhance the delivery of care through heightened team effectiveness. Specific measures will focus on: a) At least 50 teams being engaged with the Aston OD Team Journey by March 2019 b) Achieving an average Trust score of 4 in the NHS Staff Survey key finding for Effective Team Working	DM				Affina delivered a refresher session for Team Coach network. Extension granted to 2nd cohort and 3rd training cohort to be delivered in March. Affina coach network strengthened. Inc. from 3.9 to 3.99; in top 20%. Reporting for 2018 is changing to a different scale but Picker will map across previous results for comparison. Results due 8th Feb 2019
	3.5	To work with partners to submit a successful bid to reshape urgent care services in Dorset. This includes preparing for a "go live" in April 2019. Key aspects are developing the Urgent Treatment Centre (UTC) at RBH, work with GPs on Improving Access especially out of hours, as well as the wider 111 and 111 on line offer to patients, to provide alternatives to A&E attendance.	RR				Current UTC workforce developing successfully and increasingly able to support ED. Multi-partner NHS bid for IUCS now mobilising. Expecting to sign sub-contract with DHC at end January.
OBJECTIVE FOUR Listening to Patients							
Narrative:		Ensuring meaningful engagement to improve patient experience					
Measures:	4.1	Maintain progress in meeting our improvement trajectory for the National Patient Experience benchmarks by March 2019, by: <ul style="list-style-type: none">Maintaining internal focus on patient experience agendasEngaging, listening and responding to patient feedback	PS				Feedback from patients remains positive with FFT results in top quartile for most areas. Care conversations are still being trialled- this is gathering feedback from patients through qualitative conversations. New equipment has been purchased The Trust has produced many 'adverts' for projects where patient representation is required. Patient Voice volunteers are still being recruited and are starting to get involved with teams.
	4.2	Maintain and strengthen community links by March 2019 through: <ul style="list-style-type: none">Running in partnership with our Governors a series of listening eventsEstablishing community focus groups to provide feedback on current services and future proposals for service delivery	DF				A trial of volunteer 'mystery shoppers' observed practice in several waiting areas of the trust- the information gathered was fed back to team leaders. Two patient partners now introduced to Directors in the Trust, working alongside them as part of their leadership development.
	4.3	Actively engage in transitional work with the One Acute Network, ensuring that our patients and population are involved in service redesign from the outset using: Experience based co-design	DM				Regular listening events run by the Trust governors are supported, with excellent public feedback. We have engaged the point of care foundation to work with us to ensure we obtain patient input to the redesign of services.
		Working in partnership with our patients and health care partners to ensure right referral and right care, by March 2019, especially focused on four specialities (Dermatology, Cardiology, Orthopaedics and Ophthalmology), by:					New Workforce and Organisational development Group established as a subcommittee of the OAN East Reconfiguration Board. Experience based co design will be part of the remit. Inaugural meeting of group planned for 15/10/18. Patient Engagement Champion training to commence in March 2019, 11 RBCH staff being trained to support patient volunteers.

	4.4	<ul style="list-style-type: none"> Informing and helping educate our population to access resources appropriate to their need Improve self-care education with a particular focus on chronic diseases 	RR				<p>Work progressing and progress on schemes in ophthalmology, dermatology, cardiac and orthopaedics have continued. However, specific capacity pressures have continued to challenge the services and waiting list / time performance. Referrals continue to be lower than last year overall and in the 4 key specialities. Self-care work continues but likely to move into increased focus in 19/20 under system Outpatient Transformation Programme.</p>
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**The Royal Bournemouth
and Christchurch Hospitals**
NHS Foundation Trust

BOARD OF DIRECTORS	
Meeting date:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Update on Equality, Diversity and Inclusion
Section on agenda:	Strategy and Risk
Supplementary reading:	Our <i>Leading for Equality, Diversity and Inclusion</i> Strategy (2018 – 2020) is included in the Reading Pack for information
Director or manager with overall responsibility:	Deb Matthews, Director of Improvement and Organisational Development
Author(s) of paper:	Deborah Matthews
Details of previous discussion and/or dissemination:	Board authorisation of strategy in May 2018
Action required:	Discussion
<p>Summary:</p> <p>Our <i>Leading for Equality, Diversity and Inclusion</i> strategy demonstrates a three-year forward view of inclusion. A presentation will be provided to a) share progress on our six early priorities and b) proposed next steps to ensure momentum on this important agenda for the organisation:</p> <ul style="list-style-type: none">• Improve BAME employee experience• Develop inclusive leadership capability• Improve communications and engagement• Improve use of all ED&I data and compliance against national standards• Develop patient co-production and engagement	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on significant risks:	

Trust Board Dashboard - December 2018

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	Trust Target	2017/18 Q3			2017/18 Q4			2018/19 Q1			Trend. (where applicable)
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	90%	87.59%	89.61%	89.43%	89.59%	92.60%	90.88%	90.78%	90.56%	92.13%	
	Caring - Inpatient scores from Friends and Family Test % positive	95%	97.74%	98.37%	97.94%	98.21%	98.64%	98.00%	98.54%	98.58%	97.59%	
	Caring - Maternity scores from Friends and Family Test % positive	95%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
	Caring - Mixed sex accommodation breaches	0	0	0	0	3	0	5	0	1	0	
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)			89.44%			91.67%					
	Caring - Formal complaints		35	41	31	33	40	33	28	31	33	
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	< Prev Yr Month AVG	497	513	489	549	575	505	567	562	578	
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	< 100	101.1	100.2	97.9	85.9	90.1	98.6				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - MAC	< 100	0.0	0.0	0.0	0.0	0.0	0.0				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - RBH	< 100	87.3	90.8	89.0	75.9	83.7	73.9				
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	< 100	110.0	94.8	99.5	102.7	80.8	94.3				
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	< 100	242.8	194.4	166.8	180.4	154.2	241.7				
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	< 100	96.4	85.6	90.6	93.4	70.4	76.0				
	Effective - Summary Hospital Mortality Indicator	< 1	0.99	0.99	0.99							
	ED Attendances		8031	8707	8531	8884	8610	8099	8200	7965	8126	
	Elective Admissions		5749	6262	6104	6114	6063	5655	6381	6294	5096	
	GP OP Referrals		5714	6335	5830	6108	5545	5116	6376	5881	4674	
	Non-elective Admissions		3208	3297	3173	3323	3331	3063	3356	3334	3323	
	Organisational health - Staff sickness in month	< 3%	3.750%	3.401%	3.822%	4.119%	4.286%	4.376%	4.689%	4.489%	4.073%	
	Organisational health - Staff sickness rolling 12 months	< 3%	3.98%	3.94%	3.94%	3.94%	3.99%	4.03%	4.09%	4.12%	4.10%	
	Organisational health -Proportion of temporary staff		7.11%	6.47%	7.14%	7.30%	7.90%	7.95%	7.81%	8.02%	8.32%	
	Organisational health -Staff turnover	< 12%	9.53%	9.39%	9.53%	9.36%	9.23%	9.36%	9.27%	9.51%	9.89%	
	Safe - Clostridium Difficile - Confirmed lapses in care	<=14 in Yr / 1.2 per Month	2	0	0	0	2	0	0	0	1	
	Safe - Clostridium Difficile - infection rate	6.9	12.1	0	6.05	17.56	17.56	0	6.12	0	6.12	
	Safe - MRSA bacteraemias	0	0	0	1	0	0	0	0	0	0	
	Safe - NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	
	Safe - Occurrence of any Never Event	0	1	0	0	0	0	0	0	0	0	
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)			37.27			38.66			34.42		
	Safe - VTE Risk Assessment	95%	96.50%	96.93%	96.42%	96.36%	96.30%	96.27%	96.52%	94.89%	94.14%	
	Number of Serious Incidents	<= Last Year	1	2	3	4	1	2	0	1	0	
	Appraisals - Values Based (Non Medical) - Compliance		2.08%	10.94%	22.41%	39.16%	59.84%	82.10%	88.95%	90.90%	90.62%	
	Appraisals - Doctors and Consultants - Compliance		87.06%	88.93%	88.81%	88.85%	89.25%	84.51%	89.08%	91.23%	85.31%	
	Essential Core Skills - Compliance		93.33%	93.35%	93.43%	93.68%	94.07%	92.92%	93.05%	93.00%	92.84%	
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	YTD Plan = 1	4	4	4	4	3	1	1	1	1	
	Sustainability - Liquidity (YTD score)	YTD Plan = 1	1	1	1	1	1	1	1	1	1	
	Efficiency - I&E Margin (YTD score)	YTD Plan = 1	4	4	4	4	4	1	1	1	1	
	Controls - Distance from Financial Plan (YTD score)	N/A	1	1	1	1	1	2	2	2	2	
	Controls - Agency Spend (YTD score)	YTD Plan = 1	1	1	1	1	1	1	1	1	1	
	Overall finance and use of resources YTD score	N/A	3	3	3	3	3	1	1	1	1	
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	91.85%	93.52%	96.37%	95.97%	94.05%	92.41%	93.52%	90.35%	89.60%	
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	100.00%	87.50%	96.00%	73.68%	85.71%	69.23%	100.00%	92.00%		
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	88.56%	90.19%	84.56%	86.13%	79.39%	77.17%	77.12%	91.52%		
	Maximum 6-week wait for diagnostic procedures	99%	99.67%	99.38%	99.49%	94.43%	93.94%	93.31%	93.36%	96.54%	93.46%	
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	88.81%	89.98%	89.79%	88.75%	87.59%	86.77%	86.85%	86.73%	85.68%	

BOARD OF DIRECTORS	
Meeting date – Info Pack only:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Performance Report
Section on agenda:	Performance
Supplementary reading:	Performance Indicator Matrix Stroke SSNAP Report
Director or manager with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of paper:	Donna Parker, Deputy Chief Operating Officer David Mills, Associate Director Information & Performance Dawn Ailes, RTT Performance Lead
Details of previous discussion and/or dissemination:	PMG / Finance Committee
Action required:	Note for information
<p>The Trust Board of Directors is requested to note the performance exceptions to the Trust's compliance with the 2018/19 Single Oversight Framework (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"> • <i>Trust Board Dashboard</i> • <i>Performance Indicator Matrix</i> • <i>Stroke SSNAP Report</i> <p>Executive Summary:</p> <p>This report focuses on December 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"> • Cancer performance in November improved significantly to 91.8%, above the 85% target and anticipate achieving Q3 • ED attendances in December 18 were 4.9% higher than in December 2017 • Performance against the ED handover standard deteriorated from last month due to the increase in demand but was an improvement on December 17 • ED 4 hour target performance continues to benchmark well compared with other Trusts with a type 1 ED Department. • RTT Clocks Still Running total waiting list increased slightly at end of December and still remains slightly above target. • RTT Trust wide performance is in line with the national average, but slightly below our local trajectory • Zero RTT 52 week breaches year to date, though significant increase in 40+ week waiters. • The Trust is expecting to achieve both cancer targets for 2 Week Wait and 31 days for Q3 • Endoscopy recovery plan remains under pressure to achieve recovery by end of Q4 due to further unexpected staff long term sickness. • Note significant pressures on ED and flow reaching OPEL 4 in January though good recovery noted. 	

<ul style="list-style-type: none"> Stroke SSNAP scoring has maintained an “A” grade, and remains in the top 10% nationally. A detailed report is attached. 	
Related strategic objective:	Choose an objective
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	✓ ✓ ✓ ✓ ✓
Impact on risk profile:	Performance metrics are key control measures for the following risks on the Trust Risk Register: <ul style="list-style-type: none"> Flow (463) Stranded patients (452) RTT (735) Right Referral, Right Care (736) Financial - PSF



Operational Performance Report

For the period to end
December 2019

Richard Renaut
Chief Operating Officer

1. Executive summary

Key highlights and exceptions:-

- Cancer performance in November improved significantly to 91.8%, above the 85% target and anticipate achieving Q3
- ED attendances in December 18 were 4.9% higher than in December 2017
- Performance against the ED handover standard deteriorated from last month due to the increase in demand but was an improvement on December 17
- ED 4 hour target performance continues to benchmark well compared with other Trusts with a type 1 ED Department.
- RTT Clocks Still Running total waiting list increased slightly at end of December and still remains slightly above target.
- RTT Trust wide performance is in line with the national average but slightly below our local trajectory
- Zero RTT 52 week breaches year to date.
- The Trust is expecting to achieve both cancer targets for 2 Week Wait and 31 days for Q3
- Endoscopy recovery plan remains under pressure to achieve recovery by end of Q4 due to further unexpected staff long term sickness.
- Significant pressures on ED and flow reaching OPEL 4 in early January, though noting good recovery.
- Stroke SSNAP scoring has maintained an “A” grade, and remains in the top 10% nationally. A detailed report is attached.

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 – December 2018

In December the Trust achieved 89.6% against the ED 4 hour standard which although below the national target was above our local trajectory for December 18. The performance for quarter 3 was 91.2% which put us just below our PSF Q3 target of 91.42%. However the Dorset system achieved its PSF target which enables the Trust to receive the PSF fund for Q3. We continue to avoid breaches of the 12 hour from decision to admit (DTA) target.

RTT performance in December remains below our local trajectory at 85.7%. Total incomplete pathways increased by 231 and we remain above (worse than) our March 19 target. Whilst we have seen our long waits over 40 weeks increase to 116 we continue to have no 52 week wait breaches. Performance is declining mainly due to pressures in Endoscopy, Ophthalmology, Urology and Upper GI. In Ophthalmology, Dorset system monies have been secured for additional capacity (section 3.2). Cancer pathways continue to cause carve out across specialities.

November performance against the 62 day cancer target increased significantly to 91.8%, putting us back above the national target of 85%. Complex diagnostic pathways were again the main reason for breaches. Performance against the 62 day screening target was 92% above the 90% national target. The 2 Week Wait performance slipped slightly to 96.7% but remains above the target of 93%. Securing timely capacity for outpatients and cancer pathways remains under pressure.

December diagnostic performance slipped to 93.5% from 96.54% in November due to further unexpected staff long term sickness.

Operational Performance Report

As at 16/01/2019

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

Single Oversight Framework Indicator	National Target	NHSI Trajectory 18/19	Mth / Qtrly	RAG rated performance against national targets and NHSI submitted trajectories		
				Nov-18	Dec-18	Jan 19 projection
A&E 4hr maximum wait time	95%	84.8% - 95.2%	Mthly & Qtrly	90.3%	89.6%	
RTT 18 week incomplete pathways	92%	88.1% - 88.4%	Mthly	86.7%	85.7%	
RTT - no. of incomplete pathways	≤ March 2018	24,880	Yr End	25,109	25,340	
RTT - no 52 week waiters	0	0	Mthly	0	0	
Cancer 62 day wait for first treatment from urgent GP referral**	85%	84.1-85.4%	Mthly & Qtrly	91.8%	est	
Cancer 62 day wait for first treatment from Screening service**	90%	90%	Mthly & Qtrly	92.0%	est	
Maximum 6 weeks to diagnostic test	99%	99%	Mthly	96.5%	93.5%	

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

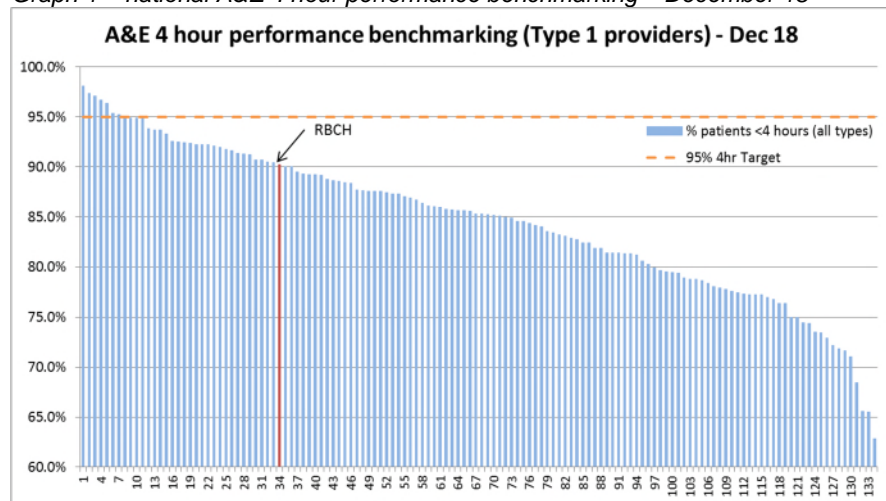
Green - above national target (and trajectory).

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

2.2 National Benchmarking – November / December 2018

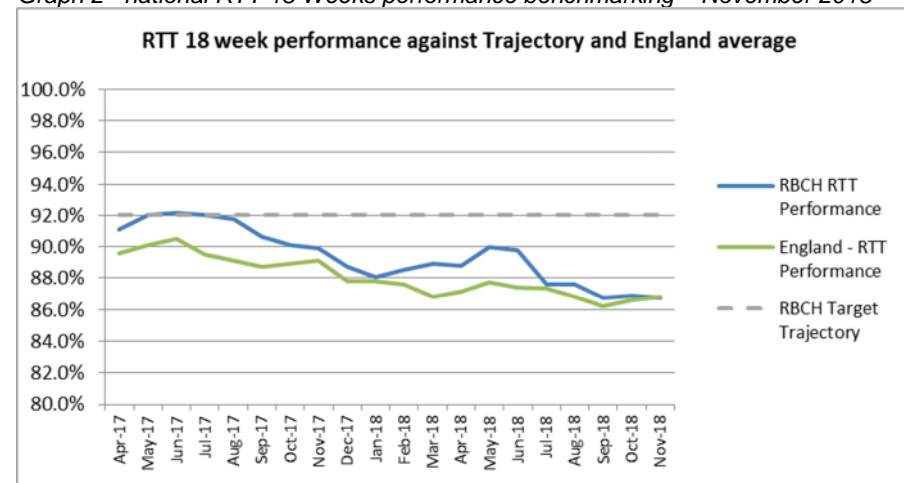
Our benchmark position for ED 4 hour performance in December was 34th out of all type 1 trusts nationally.

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



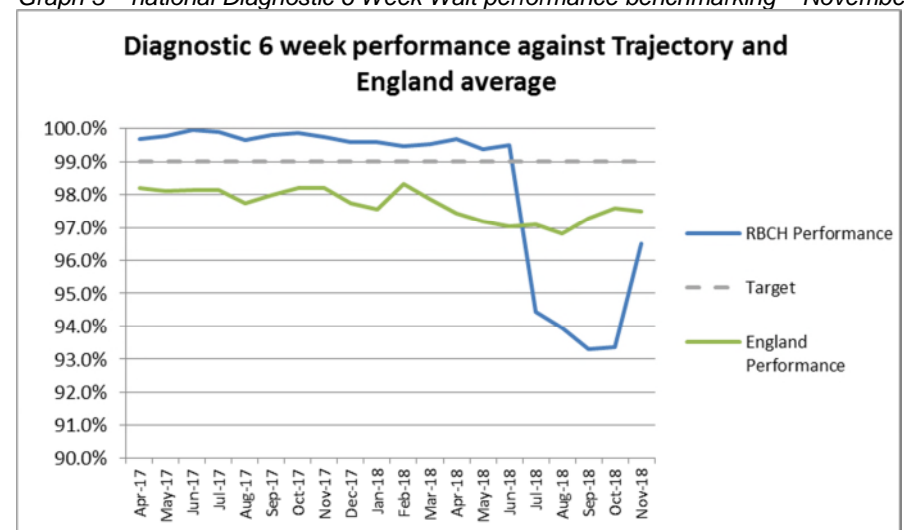
Trust wide RTT performance dropped slightly in November and is now in line with the national average.

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



Despite an improvement in Diagnostic performance we remain below the national average in Nov 18 and drop back to 93.5% in Dec 18.

Graph 3 – national Diagnostic 6 Week Wait performance benchmarking – November 18

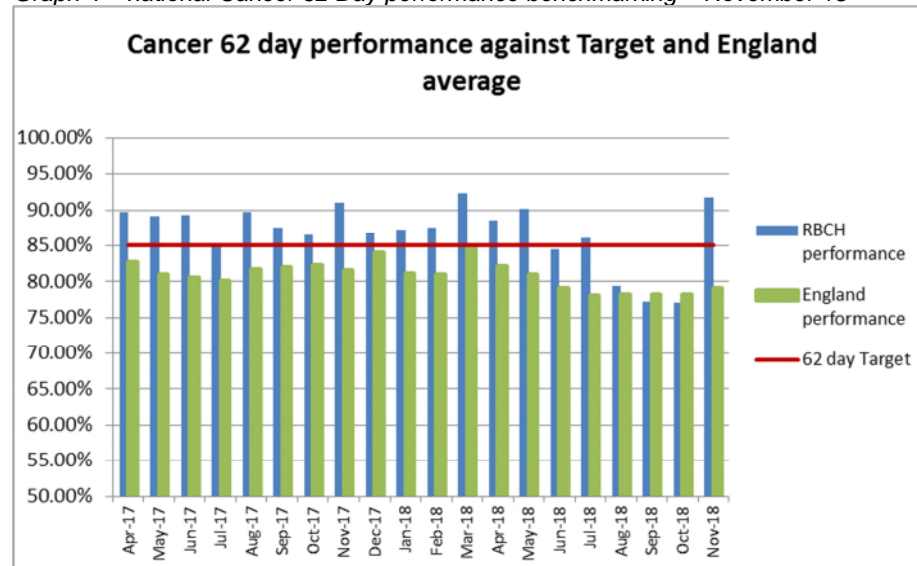


Operational Performance Report

As at 16/01/2019

The Trusts Cancer 62 day performance significantly improved in November 18, achieving the 85% target and being above the National average.

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



3. Forecast Performance, Key Risks and Action

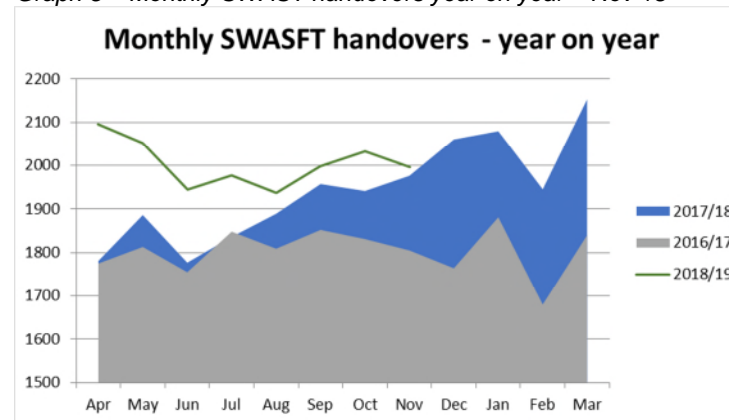
3.1 A&E Targets, PSF and Stranded Patients

December had the highest number of breaches seen YTD in ED, with our performance dropping to 89.6%.

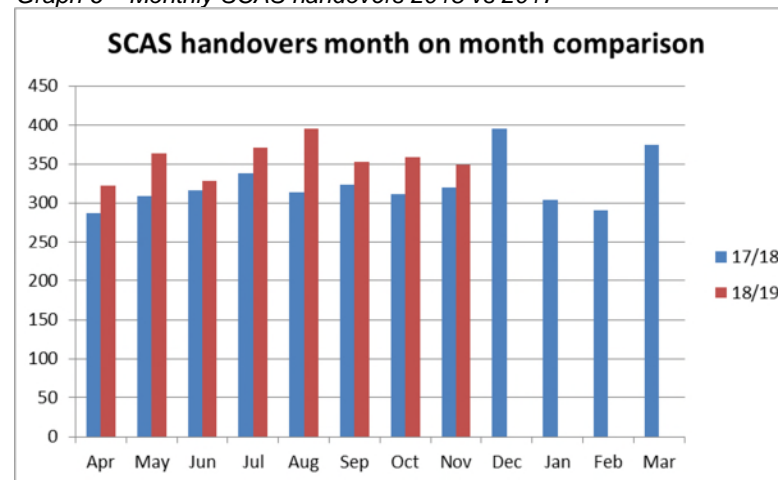
The Trust continues to experience growth in ambulance conveyances with SWAST handovers up 1% and SCAS handovers up 9% in November 18 compared with November 17. This trend appears to have continued in to December 18 but we await confirmation of the final figures. Both 30 and 60 minute hand over breaches rose in

December however despite the overall pressures no 12 hour breaches occurred.

Graph 5 – Monthly SWAST handovers year on year – Nov 18



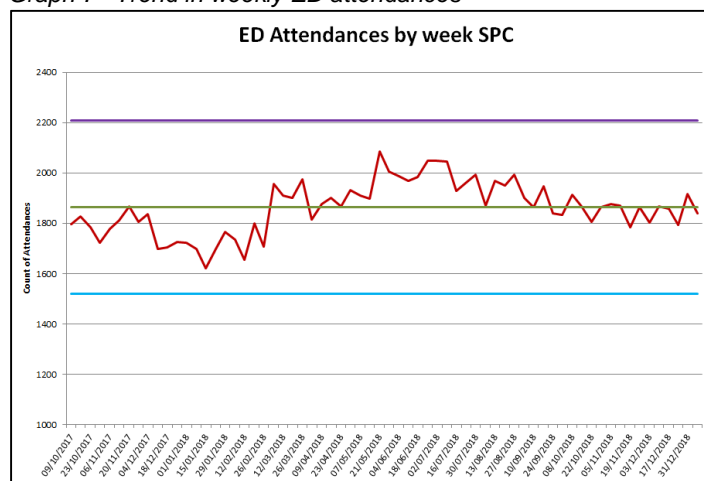
Graph 6 – Monthly SCAS handovers 2018 vs 2017



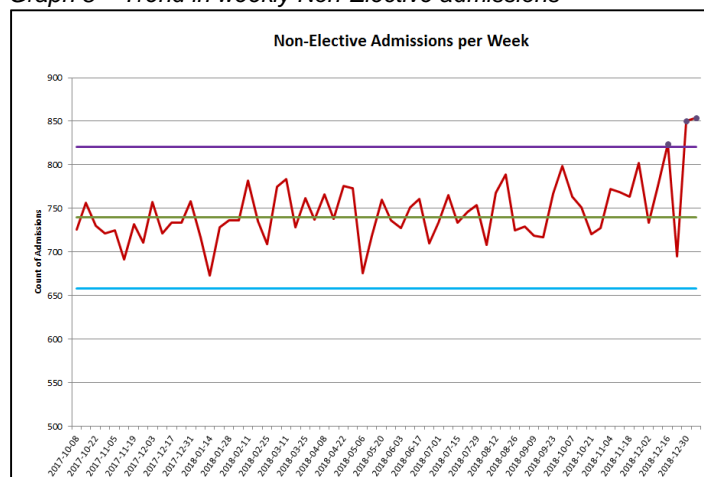
The acuity of patients remains high with the Trust reaching OPEL 3 on some days during December. However, our winter plans meant overall good recovery and many days returning to OPEL 2 and 1.

Overall ED attendances in December were 4.9% higher than in December 17 and emergency admissions were up by 3% in December 18 compared to December 17 overall. In the last couple of weeks of December the Trust experienced a statistically significant increase in the number of admissions as highlighted in graph 8, breaching the upper control limit of the statistical process control chart.

Graph 7 – Trend in weekly ED attendances



Graph 8 – Trend in weekly Non-Elective admissions



ED and Conveyances

Following the ECIST visit in December the final report is awaited. Initial feedback highlighted some key themes with opportunities for further improvement:

- Hampshire transport out of hours.
- Opportunities to reduce SWAST conveyances to ED and optimise alternative pathways
- Improved use of Point of Care Testing
- RATS (rapid assessment and treatment) process
- ED to ambulatory and other pathways

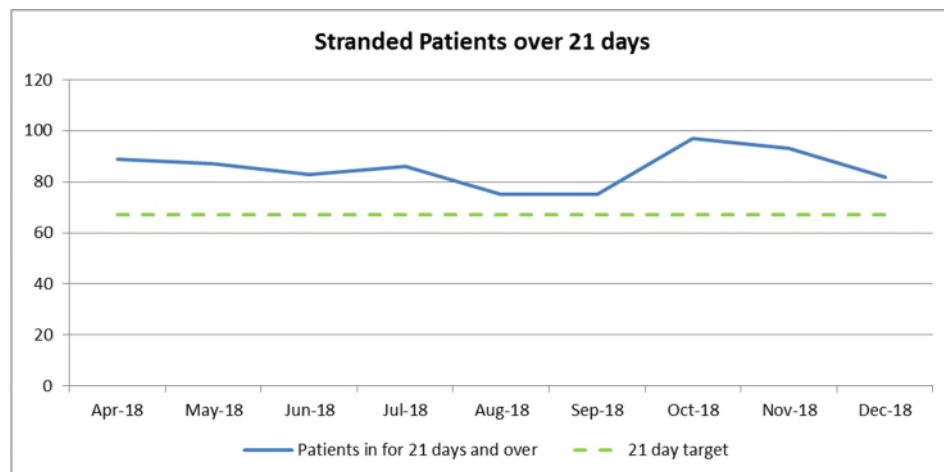
Following recommendations from ECIST Minors pathways are also being reviewed with PDSA Cycles to triage patients and pull patients through the system and release capacity in Majors.

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

Positively the number of stranded patients continued to decrease in December to 81.

Action Learning Week in January focused on stranded patients and timely discharge from hospital. This week involved external agencies including Dorset Health Care Community Matrons and Social Workers. The aim of the week was to work in an integrated way which keeps the patient at the centre of decisions; a theme reflected in the NHS Long Term Plan and the Social Care Green Paper. Integrated within this week was also a focus on the Health of the Ward to ensure that White Board rounds and learning are supported. Reducing stranded patients by 25% remains a challenge (see Graph 9). Dorset is currently taking part in an NHSE deep dive review of this topic.

Graph 9 – Stranded patients over 21 days



Winter Planning Update

Consultant Connect is now fully implemented which enables GPs to get urgent and timely advice from specialist clinicians and consultants with decisions for appropriate clinical pathways for the patient and avoiding ED attendances or admission.

The Trust is constantly reviewing and revising its winter plans in relation to ED attendances, admissions and discharges. Despite the pressure in December the Trust did not declare OPEL 4 for the first time in a December month due to the winter plans in place.

The Single Point of Access (SPOA) service links health professions to related services. As part of the winter plan developments, SWAST are to recruit GPs to support this service. A key feature of this is admission avoidance by providing early, enhanced clinical assessment. Initially recruitment was difficult but from January there is better fill in the GP slots. Bookings directly into the RBH Urgent Treatment Centre from the SPOA GP may have been patients that would otherwise have attended ED and potentially admitted.

The pilot providing GPs with an alternative, non-ambulance conveyance option in the form of a Taxi for clinically appropriate patients to be transported thus releasing time for ambulances is having positive results. Better information to GPs and patients also means those that don't require clinical transport are often coming in earlier by their own means. By expediting patients' arrival at hospital, prompt secondary care and assessment means care pathways are initiated earlier and can reduce unnecessary overnight stays.

There is a significant relationship between arrival time and length of stay, e.g. 63% of patients who arrived between 9-12am went home same day, 42.6% for 12-4pm.

Future objectives include

1. Meet with SWASFT to discuss an audit of Ambulance Chair transfers (e.g. could some patients safely travel in a wheelchair car)
2. Discussions with GPs about transport options, risk and effects
3. Look at end of day transport improvement options (currently 4 hour wait)
4. AMU and flow if end to end transport options were available (less than one hour wait inward and homewards).

Social overnight stays in January and February work has progressed with patients being supported to organise people at home to prevent these patients being cancelled due to pressures on beds.

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

Elective pathways and the deterioration against waiting lists across England remains a concern with further emphasis on reducing the number of 52 week breaches nationally.

December has been a difficult month for RTT with significant issues across endoscopy, Upper GI, Urology and Ophthalmology in relation

Operational Performance Report

As at 16/01/2019

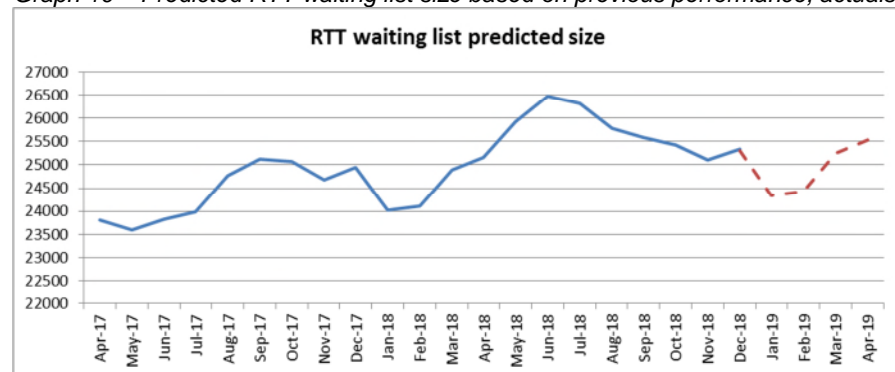
to demand and capacity. Positively our winter plans meant no (non ITU/HDU) surgery was cancelled in December due to bed pressures. Outpatient waits continue to be a significant pressure for some specialities. ENT, Oral surgery, Neurology, Thoracic, Cardiology and Urology continue to improve their RTT performance.

Ophthalmology has been successful in securing monies to support current pressures within the cataract service, in particular with the rise of referrals due to reduced capacity across Dorset. These monies are to reduce long waiters and outpatient waits across Bournemouth and Poole. A paper is being presented to OFRG this January with a clear position on capacity and demand for 2019/20.

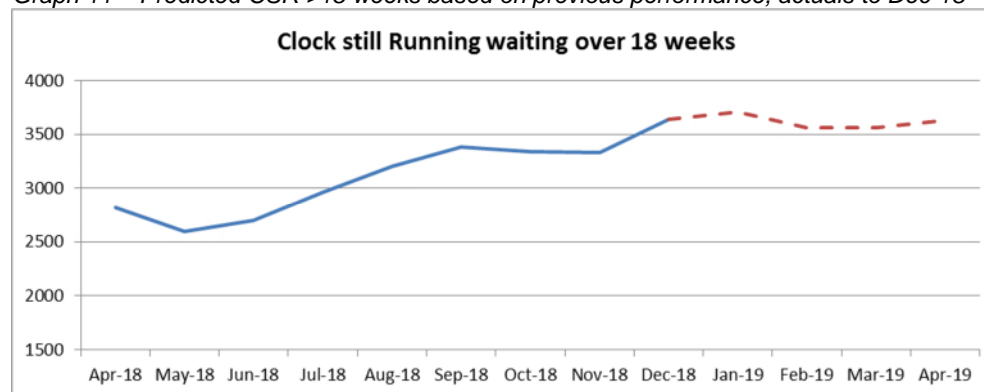
System wide pressures on Dermatology continue. The CCG are currently looking at supporting the Dorset services with additional capacity through insourcing. A paper for the CCG is being prepared for the capacity and funding that would be required to reduce long waiters and achieve similar waiting times across Dorset's 3 Acute Trusts.

Urology is continuing to use the independent sector for patients on the waiting list and with the national monies secured for prostate this is continuing to improve Urology's RTT performance by reducing the impact from increased cancer cases.

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



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



40+ week patients' numbers have increased significantly during December with the majority of these patients on an admitted waiting list. Stringent processes are in place to ensure these patients are pulled through the system whilst avoiding further delays.

Table 2- 40+ week incomplete pathways by specialty

Specialty	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
General Surgery	14	13	14	13	18	17	14	28	41
Urology	30	35	20	18	16	19	20	30	42
Trauma & Orthopaedics	4	12	11	5	3	4	1	1	3
Ear, Nose & Throat (ENT)	2	2	5	4	3	1	1	2	1
Ophthalmology	0	0	1	5	1	1	6	5	11
Oral Surgery	0	0	1	2	3	2	4	5	2
Cardiothoracic Surgery	0	0	0	0	0	0	0	0	0
General Medicine	3	3	1	1	5	5	2	1	1
Cardiology	1	0	4	5	0	0	4	3	2
Dermatology	2	4	5	3	10	7	6	1	2
Thoracic Medicine	0	0	0	0	0	1	1	0	0
Neurology	0	0	0	0	0	0	0	0	0
Rheumatology	0	0	0	0	0	0	1	0	0
Geriatric Medicine	0	0	0	0	0	0	1	3	3
Gynaecology	4	3	2	4	8	3	3	3	3
Other	0	1	2	2	5	1	0	1	5
Total	60	73	66	62	72	61	64	83	116

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

The Trust benchmarks well against other providers for a number of the cancer standards. Performance against the 62 day standard recovered above target in November 18 following a couple of months below target due to a significant increase (9.1% YTD) in fast track referrals due to unprecedented demand in Urology. Despite this the Trust is anticipating achieving the 62 day target for quarter 3. The national funding secured to assist with the urology position has been pivotal in a turnaround compliance with the 62 day standard.

The Trust also anticipates achieving both cancer targets for the 2 week wait standard and 31 day standard for quarter 3.

3.4 Diagnostic 6 Week Wait

December diagnostic performance slipped to 93.5% from 96.54% in November. Endoscopy remains under pressure with further unforeseen staff sickness and recovery may now go into Q1 of 2019/20. There are currently over 1,000 patients who are behind their target time for a scope (including planned/surveillance patients), which increases risk of delay in detection. The backlog is risk stratified, and known cancer and fastrack patients are still being seen in time.

There are a number of action plans in place to address this which include waiting list initiatives, seeking locums, increasing specialist nursing support and insourcing. Discussions are underway to explore system support and our aim remains to significantly reduce delays before end March. Cancer fast track capacity is being prioritised and there are processes in place to monitor clinical priority and risk.

4. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail

In December there was one Ophthalmology patient cancelled on the day of surgery due to an emergency operation. This patient was not rebooked within 28 days due to capacity pressures in the service. The patient has now been treated.

Recommendation

The Board is requested to note the December performance and the Performance Matrix. It should also note the expected performance, risks and actions relating to ongoing 2018/19 requirements.



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

BOARD OF DIRECTORS	
Meeting date:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Quality Report
Section on agenda:	Performance
Supplementary reading:	CQC Insight Report
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>There were no Serious incidents reported in December 18.</p> <p>The Trust remains in the top quartile for inpatient FFT for November. ED and OPD FFT rate remained in second quartile.</p> <p>A total of 33 complaints were received in December 2018. All were acknowledged within three days.</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

December 2018

Paula Shobbrook
Director of Nursing and Midwifery

Quality Report: December 2018

1.0 Introduction

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

2.0 Serious Incidents

No serious incident was reported in December 18.

A new Never Event has been reported on the 14th January 19 following discussion at a scoping meeting. This relates to a patient having gynaecological surgery and whilst there was not clinical harm the incident meets the criteria. There has been full duty of candour with the patient and there were no complications. A full root cause analysis investigation has been initiated.

3.0 CQC

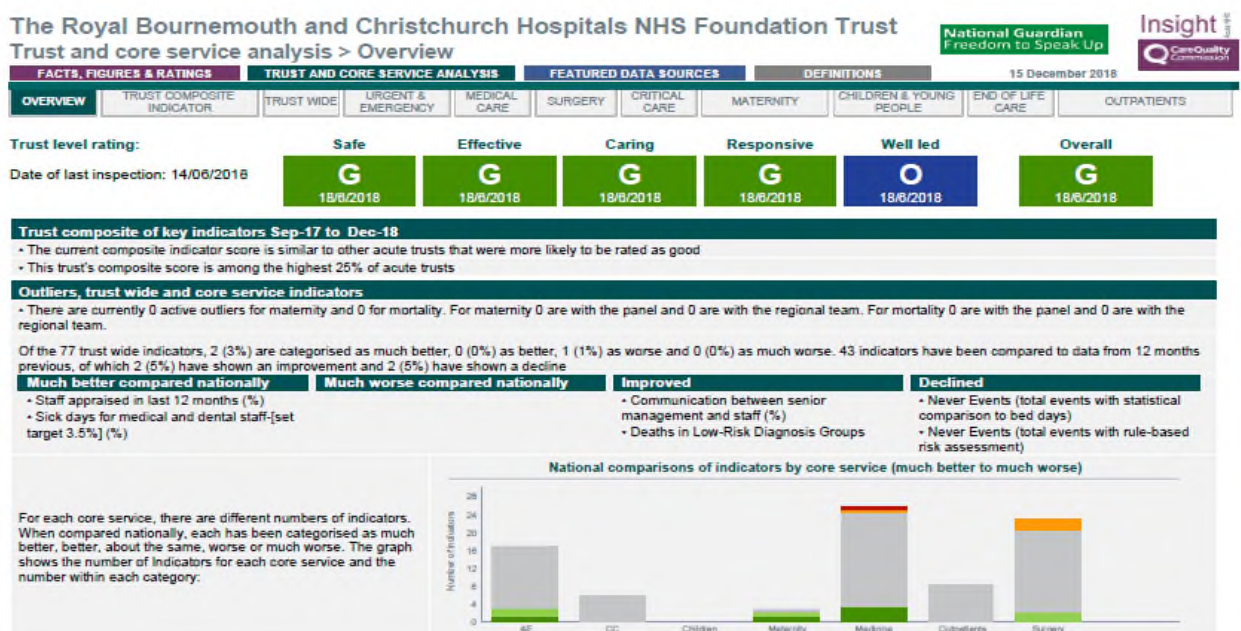
3.1 CQC Insight Model

The CQC Incident Model for the Trust was updated on the 19th December 18

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

Of the 77 trust wide quality indicators, 2 (3%) are categorised as much better.

43 indicators have been compared to data from 12 months previous of which 2 (5%) have shown improvement and 2 (5%) have shown a decline. The decline relates to the Trust reported Never Events. However the decline relates to a slight change in the data metric and time period comparisons and not an increase level of reporting in month.



4.0 Patient Experience Report

4.1 Friends and Family Test: December report

National Comparison using NHS England data:

The national performance benchmarking data bullet pointed below is provided by NHS England which is retrospectively available and therefore, represents November 2018 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in November 2018 ranked RBCH Trust 2nd with 20 other hospitals out of 167 placing RBCH in the top quartile based on patient satisfaction. The response rate was sustained above the 15% national standard at 16.9%.
- The Emergency Department FFT performance in November 2018 ranked RBCH Trust 9th with 6 other hospitals out of 137 placing RBCH ED department in the second quartile. The response rate 10.2% against the 15% national standard.
- Outpatients FFT performance in November 2018 ranked RBCH Trust 3rd with 25 other Trusts out of 243 Trusts, placing the departments in the second quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

Table 1: National Performance Benchmarking data

	June	July	August	September	October	November
In-Patient Quartile						
Top		98.213%	98.643%	98.002%	98.537%	98.578%
2	97.939%					
3						
Bottom						
	June	July	August	September	October	November
ED Quartile						
Top						
2	89.427%	89.591%	92.604%	90.875%	90.776%	90.557%
3						
Bottom						
	June	July	August	September	October	November
OPD Quartile						
Top						
2	97.164%	97.037%	98.091%	97.098%	97.501%	97.569%
3						
Bottom						

4.2 Family and Friends Test: Corporate Outpatient areas

Corporate	Total eligible to respond	No. PEC's completed	No. of FFT Responses	% Recommended	% Not Recommended
Derwent OPD	0	35	35	100.0%	0.0%
Main OPD Xch	0	28	26	92.3%	7.7%
Oral and Maxillofacial	0		0	N/A	N/A
Outpatients General	0	103	102	99.0%	0.0%
Jigsaw OPD	0	6	6	83.3%	0.0%
Corporate Total		172	169	97.6%	1.2%

4.3 Patient Opinion and NHS Choices: December Data

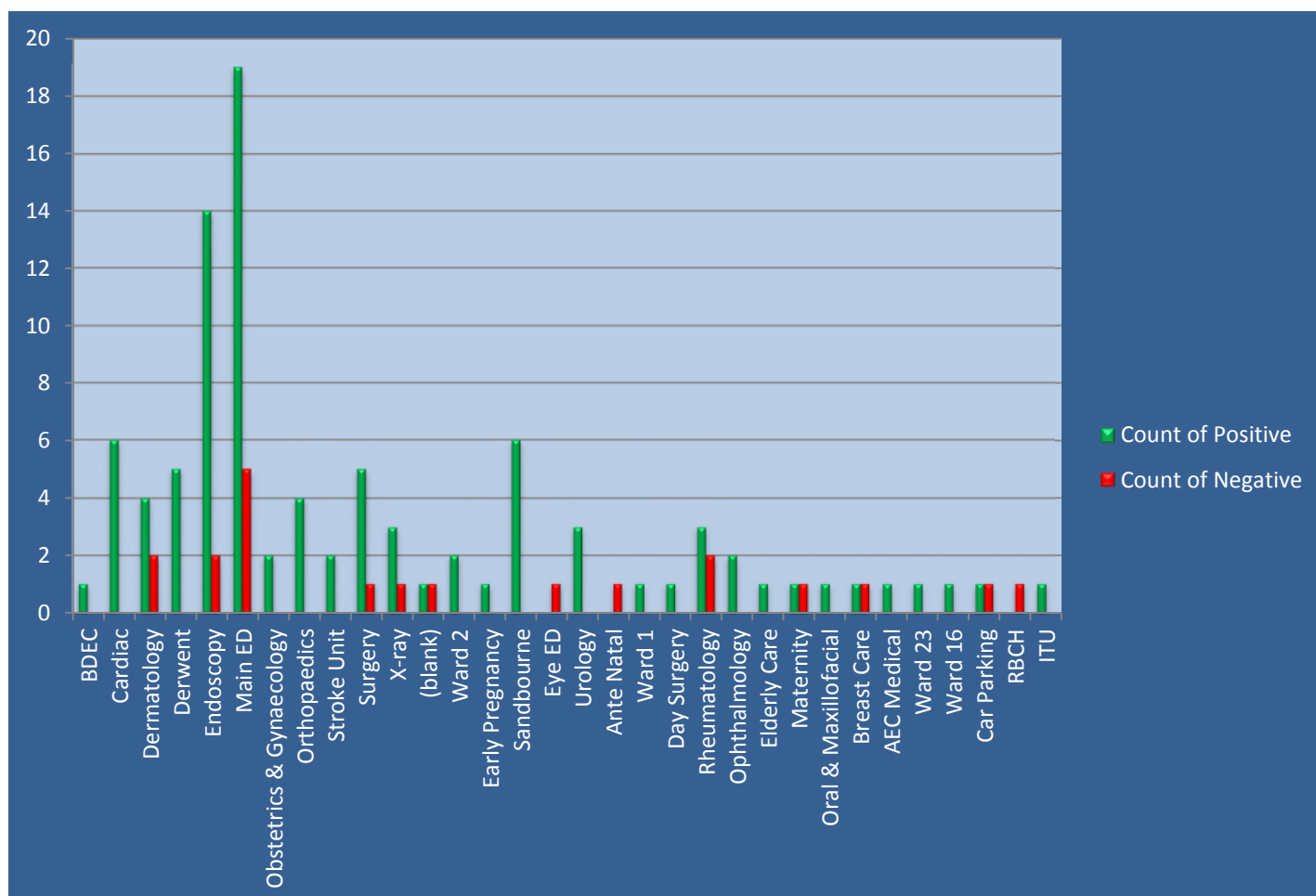
Eight patient feedback comments were posted in December, seven expressed satisfaction with the staff attitude and care. One a mixed comment highlighting the speed of treatment but negative comments about parking.

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

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

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

Table 2:



4.5 Care Conversations

Patients have been participating in audio recorded conversations with survey volunteers. Feedback is powerful, with patients observations on their care being recorded in a way not previously available. Final design of 'Care Conversations' model and agreed structure of documenting findings has been discussed, audio equipment has been sourced and suitable editing software identified. The trial continues.

4.6 Patient Engagement

The Point of Care Foundation (PoCF) has been commissioned to provide specialist bespoke training for both PGH and RBH to embed patient engagement into our Trusts.

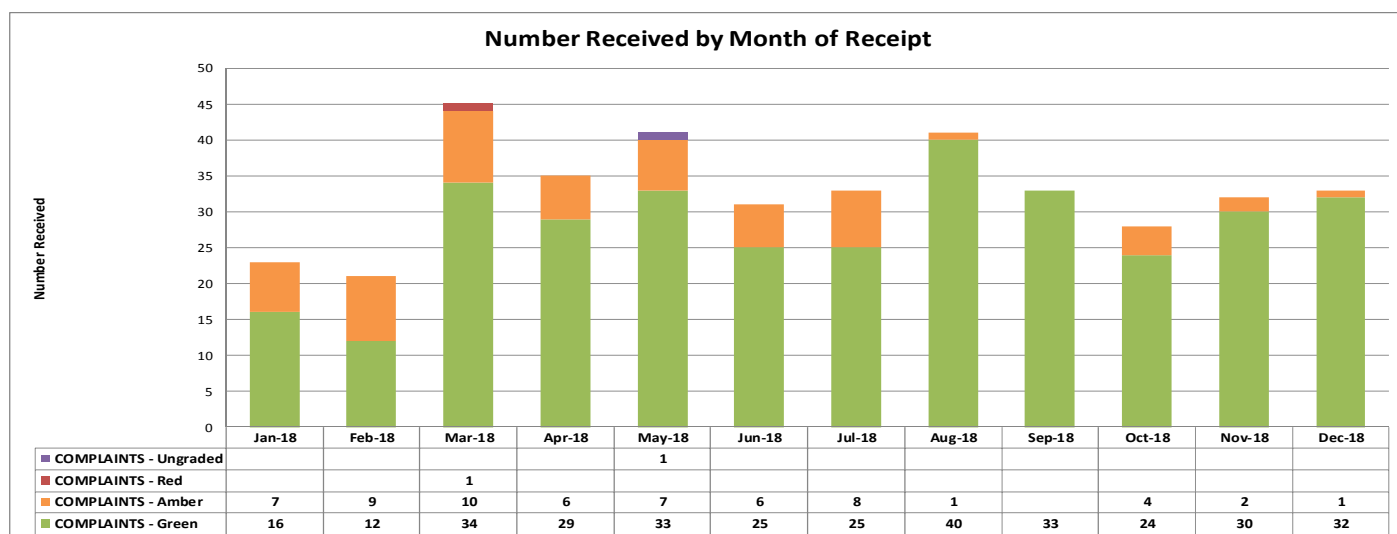
The first PoCF event is being held on the 31 January 2018 at RBH and replicated in PGH shortly after. This event is to explore with staff the importance of engagement in patient experience.

5.0 Complaints

5.1 A total of 33 complaints were received in December all of which were acknowledged within 3 days. Of note complaints have begun to show a downward trend with the highest themes being:

- Care: Quality / Suitability of Care / Treatment
- Communication: Staff Attitude
- Communication: Patient / Records / Documentation

Total Complaints received from April to date: 307



5.2 Complaint response times Year to date:

An increase in complaint response rates is noted for December 2018:

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Rolling 12 months
1st Responses Due in Month	37	29	17	26	43	33	36	40	31	37	41	25	29	387
Number Where 1st Response Completed On Time	26	18	13	17	28	23	26	30	21	18	32	14	22	262
Percent With 1st Response On Time	70%	62%	76%	65%	65%	70%	72%	75%	68%	49%	78%	56%	76%	68%

6.0 Recommendations

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



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

BOARD OF DIRECTORS	
Meeting date:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Finance Report
Section on agenda:	Performance
Supplementary reading:	Yes
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Chris Hickson, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required:	Note for information
Summary: The Trust continues to deliver against its agreed financial control total; however there remains a forecast shortfall against the cost improvement programme. Detailed financial recovery plans are in place and are being closely managed to ensure the Trust achieves its revised regulatory control total.	
Related strategic objective:	
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	<input checked="" type="checkbox"/>
Impact on risk profile:	Two financial and performance risks recorded 2018/19 on the risk register for monthly review by Committee



The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust



Finance Report

For the period to end

31 December 2018

Pete Papworth
Director of Finance

Executive Summary

As at 31 December the Trust has delivered a cumulative surplus of £15.057 million, being £129,000 better than budget.

It is important to note that this financial surplus has been achieved through a small number of material one-off financial improvements together with the associated incentive payment through the Provider Sustainability Fund. There remains a substantial underlying financial challenge; most notably, a material shortfall against the full year Cost Improvement Programme. It is therefore essential that Directorate financial recovery plans are delivered to secure the incentive payment in full.

Income & Expenditure

After adjusting for pass through drugs and devices; income is behind plan by £363,000. The main driver for this is private patient income, particularly in relation to the Dorset Heart Clinic.

Expenditure reported an under spend of £492,000 after adjusting for pass through drugs and devices. This reflects the significant pressure against pay and drugs budgets (£2.157 million and £1.567 million respectively), offset by under spends against non-pay budgets.

Employee Expenses

The Trust continues to carefully manage its workforce, with a relentless focus on recruitment and retention to minimise the need for agency staffing. However, whilst agency expenditure remains comparatively low, the cumulative cost of bank, agency and overtime is higher than the Trust's vacancy budget by £2.157 million.

The Agency expenditure as a percentage of pay budgets has increased from 2.21% in November to 2.29% during December. Particular workforce challenges continue within the Medical Care Group with vacancies across both the medical and nursing staffing templates, together with additional resource requirements within the Emergency Department.

Cost Improvement Programme

As at 31 December, financial savings of £8.306 million have been achieved. This represents a shortfall of £1.172 million against the year to date planned value of £9.478 million.

The current forecast is for total savings amounting to £10.875 million representing a shortfall of £1.822 million against the full year savings requirement of £12.697 million. The downside forecast is for total savings of £10.646 million with an upside forecast of £11.442 million. Further schemes continue to be identified to close this gap.

Provider Sustainability Fund (PSF)

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

The ICS financial control total has been achieved to date, and whilst the Trust failed to achieve the A&E access standard, this was achieved overall by the ICS. As such, the full PSF allocation has been secured to date.

However, the current ICS forecast would not achieve the system control total, resulting in a loss of system related PSF. Additionally, the A&E access standard will be at risk due to the additional pressures facing all Trusts over the winter period. Mitigating actions are being taken within each organisation.

A PSF incentive was offered by NHS Improvement during September, whereby if the Trust agreed to improve its financial control total it would receive a £2 incentive for every £1 improvement. After careful consideration, the Trust has agreed to improve its control total by £9 million resulting in an additional PSF incentive payment of £18 million. This has been achieved through a small number of one-off non recurrent financial improvements.

Forecast Outturn

As a result of the PSF incentive opportunity the Trust improved its financial control total by £27 million (£9 million improvement plus £18 million incentive) from a planned deficit of £2.381 million to a planned surplus of £24.619 million.

However, there remains considerable risk within this forecast given the shortfall against the Cost Improvement Programme and the requirement for Directorates to deliver within their financial recovery plans. As such, a continued focus must remain on delivering the agreed financial recovery actions to ensure the revised control total is achieved and the £27 million Provider Sustainability Fund is secured in full.

In addition, it is likely that the base PSF will not be achieved in full given the risk in securing the A&E performance elements for Quarter 4; together with the possible loss of the system finance PSF in Quarter 4.

Capital Expenditure

Capital expenditure amounting to £6.384 million has been committed, which is £1.186 million behind budget. This reflects the timing of expenditure, particularly in relation to the phasing of the Radiology refurbishment scheme, associated equipment installation and the Dorset Clinical Services Review.

The full year capital expenditure forecast has been reduced by £1.660 million to reflect a reduction in the forecast capital expenditure for 2018/19 mainly related to the Dorset Clinical Services Review.

Cash

As at 31 December the Trust is currently holding a consolidated cash balance of £35.7 million. This is a strong position, and means that no Department of Health support is required.

The cash forecast has been amended following confirmation from NHS Improvement that the PSF incentive payments will not be made until July 2019.

Financial Risk Rating

In line with the revised financial plan, the Trust has achieved a Use of Resources rating of 1 under NHS Improvement's Single Oversight Framework (1 being best and 4 being worst). This is expected to continue for the remainder of 2018/19.

Recommendation

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

Finance Report

As at 31 December 2018

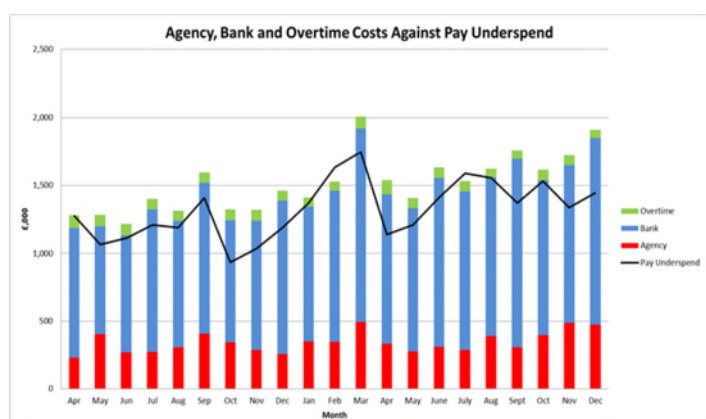
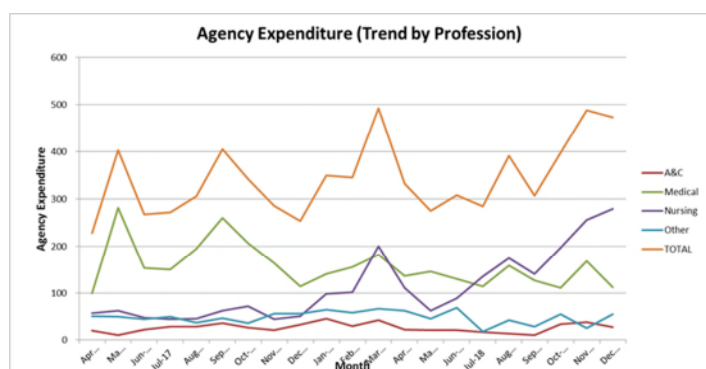
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000	Pass Through £'000	Residual Variance £'000
NHS Clinical Income	197,545	193,680	(3,865)	4,125	260
Non NHS Clinical Income	4,707	4,019	(688)	(29)	(717)
Non Clinical Income	48,034	48,128	94	0	94
TOTAL INCOME	250,286	245,827	(4,459)	4,096	(363)
Employee Expenses	142,293	144,451	(2,157)	0	(2,157)
Drugs	26,696	24,623	2,073	(3,639)	(1,567)
Clinical Supplies	27,419	26,602	818	(456)	361
Misc. other expenditure	38,950	35,095	3,855	0	3,855
TOTAL EXPENDITURE	235,358	230,770	4,588	(4,096)	492
SURPLUS/ (DEFICIT)	14,928	15,057	129	0	129

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	137,673	137,673	0
NHS England (Wessex LAT)	36,663	32,962	(3,701)
NHS West Hampshire CCG (and Associates)	19,037	19,034	(3)
Other NHS Patient Income	4,172	4,011	(161)
Provider Sustainability Fund	17,549	17,549	0
Non NHS Patient Income	4,707	4,019	(688)
Non Patient Related Income	30,485	30,579	94
TOTAL INCOME	250,286	245,827	(4,459)

Provider Sustainability Fund Income	Year to Date			Full Year Forecast		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Financial: System Control Total (70%)	4,094	4,094	0	6,300	6,300	0
Performance: A&E Trajectory (30%)	1,755	1,755	0	2,700	2,700	0
Trust Control Total Incentive	11,700	11,700	0	18,000	18,000	0
TOTAL	17,549	17,549	0	27,000	27,000	0

Agency Expenditure

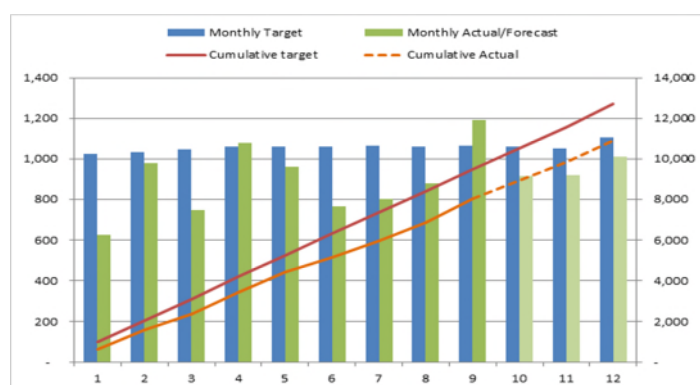


Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	9,833	8,284	(1,550)
Medical Care Group	5,759	3,115	(2,645)
Specialties Care Group	4,114	3,687	(428)
Corporate Directorates	(27,544)	(27,200)	344
Centrally Managed Budgets	22,765	27,171	4,407
SURPLUS/ (DEFICIT)	14,928	15,057	129

Cost Improvement Programme

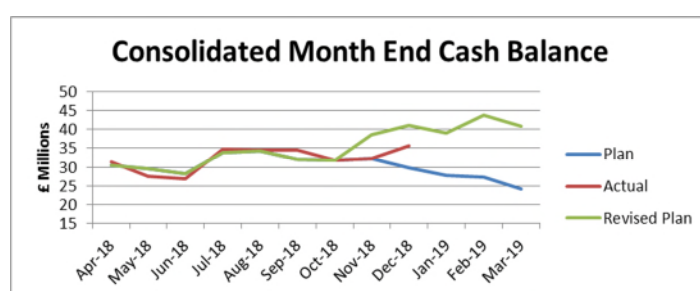
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000	Base Forecast £'000
Surgical Care Group	1,637	1,062	(575)	1,607
Medical Care Group	2,256	1,561	(695)	1,841
Specialties Care Group	1,625	1,188	(437)	1,688
Corporate Directorates	3,960	4,495	535	5,739
SURPLUS/ (DEFICIT)	9,478	8,306	(1,172)	10,875



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	3,492	3,572	(80)
IT Strategy	2,286	1,481	805
Medical Equipment	1,140	1,026	114
Centrally Managed	652	305	347
SURPLUS/ (DEFICIT)	7,570	6,384	1,186

Cash



BOARD OF DIRECTORS	
Meeting date:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Report
Section on agenda:	Performance
Supplementary reading:	n/a
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Karen Allman and Fiona Hoskins
Details of previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC, Education & Training Committee
Action required:	Note for information
Summary: The paper shows workforce statistics including turnover, sickness absence, and safe staffing information.	
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

December 2018

Karen Allman
Director of Human Resources

Workforce Report for December Board pack

As at 31st December 2018

Care Group	Appraisal Compliance		Mandatory	Sickness		Joining Rate	Turnover	Vacancy
	Values Based	Medical & Dental	Training Compliance	Absence	FTE Days			Rate (from ESR)
	At 31 December			Rolling 12 months to 31 December				At 31 December
Surgical	88.7%	89.3%	93.2%	4.12%	14341	12.4%	9.9%	
Medical	90.5%	83.5%	92.3%	3.68%	18966	15.7%	9.2%	
Specialities	92.0%	82.4%	94.5%	4.35%	13926	9.6%	11.5%	
Corporate	91.3%	100.0%	91.3%	4.47%	14578	7.9%	9.4%	
Trustwide	90.6%	85.3%	92.8%	4.10%	61810	11.9%	9.9%	

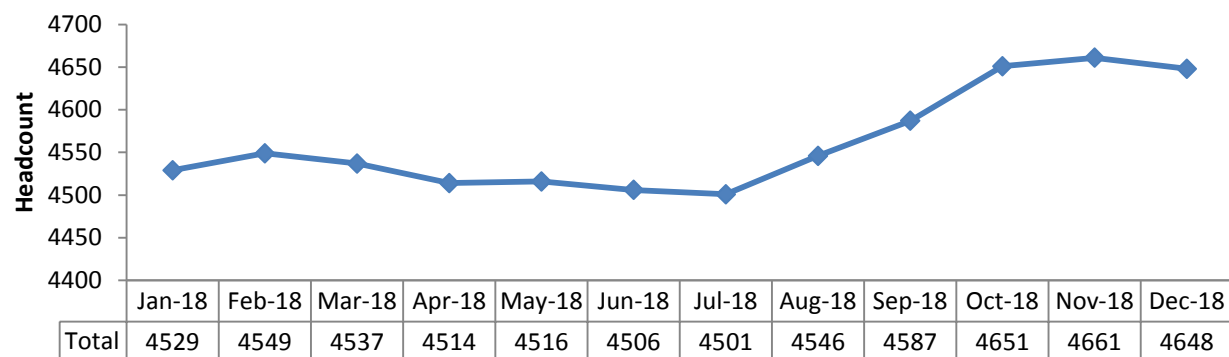
Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 December			Rolling 12 months to 31 December				At 31 December
Add Prof Scientific and Technical	94.9%		94.2%	5.07%	2477	12.8%	12.8%	
Additional Clinical Services	89.1%		92.1%	5.85%	16107	22.0%	11.5%	
Administrative and Clerical	91.8%		95.4%	3.88%	12364	8.6%	11.3%	
Allied Health Professionals	93.0%		94.1%	2.69%	2610	15.0%	11.0%	
Estates and Ancillary	92.6%		91.7%	6.68%	8166	12.1%	9.0%	
Healthcare Scientists	95.1%		96.1%	2.94%	1052	5.6%	8.5%	
Medical and Dental		85.3%	86.0%	1.15%	2137	5.8%	5.0%	
Nursing and Midwifery Registered	88.6%		94.4%	3.97%	16897	8.7%	8.6%	
Trustwide	90.6%	85.3%	92.84%	4.10%	61810	11.9%	9.9%	

Workforce Report for December Board pack

As at 31st December 2018

1. Staffing and Recruitment

Substantive Staff (Headcount) Trend

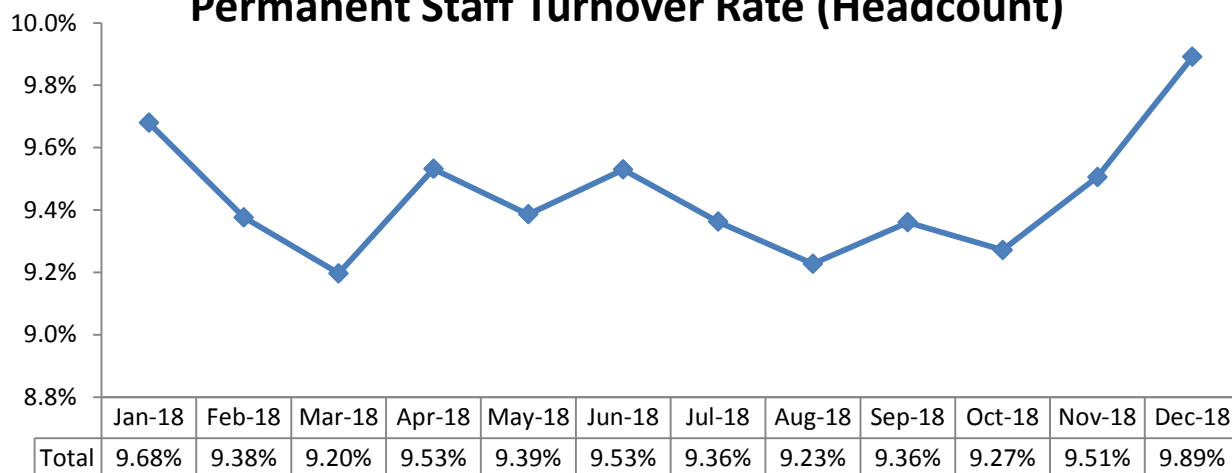


Turnover rate up slightly to 9.89% from 9.51% the previous month, which is a small increase on the same point last year (9.74%). However, the joining rate increased further to 11.9% (11.6% last month), and remains at a level 2% higher than the turnover rate which is a positive.

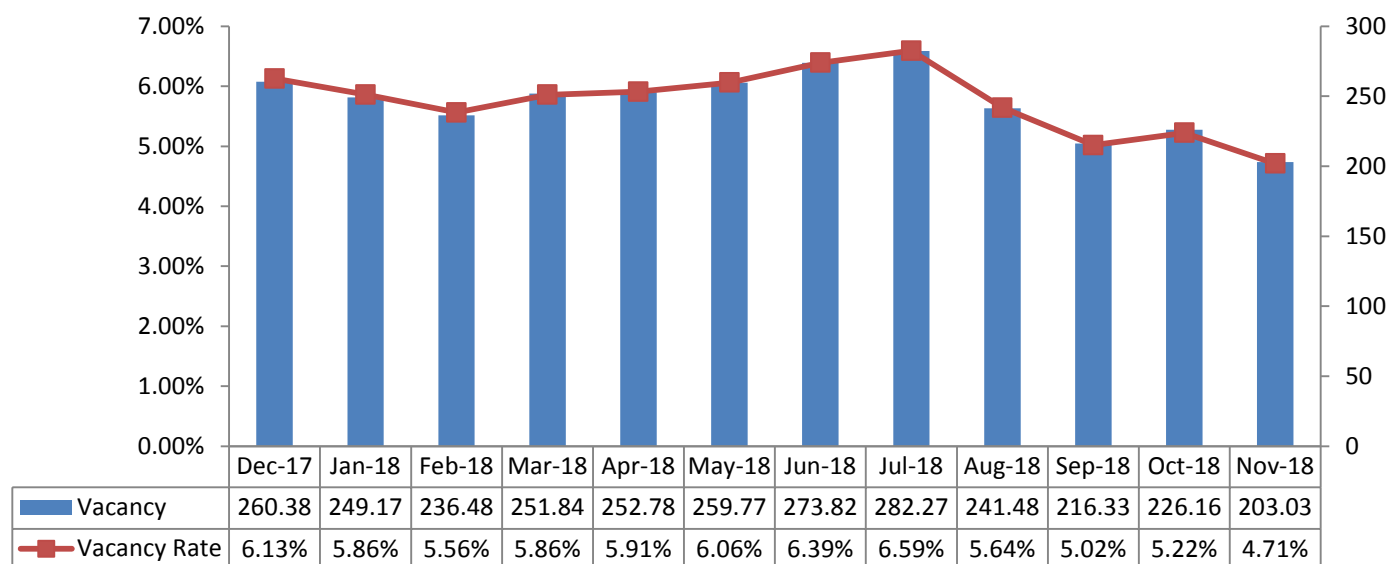
The joining rate has consistently been running at a higher level than the turnover rate throughout 2018, resulting in a substantive staff headcount at 31/12/18 of 4,648 which is 153 higher than at the same point last year (4,495).

Vacancy rate at 31/12/18 unavailable at the time of writing; the graph below reflects the position as at 30/11/18 and shows a rate down to just 4.71% (5.22% the previous month) which is an all-time low for the Trust.

Permanent Staff Turnover Rate (Headcount)



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



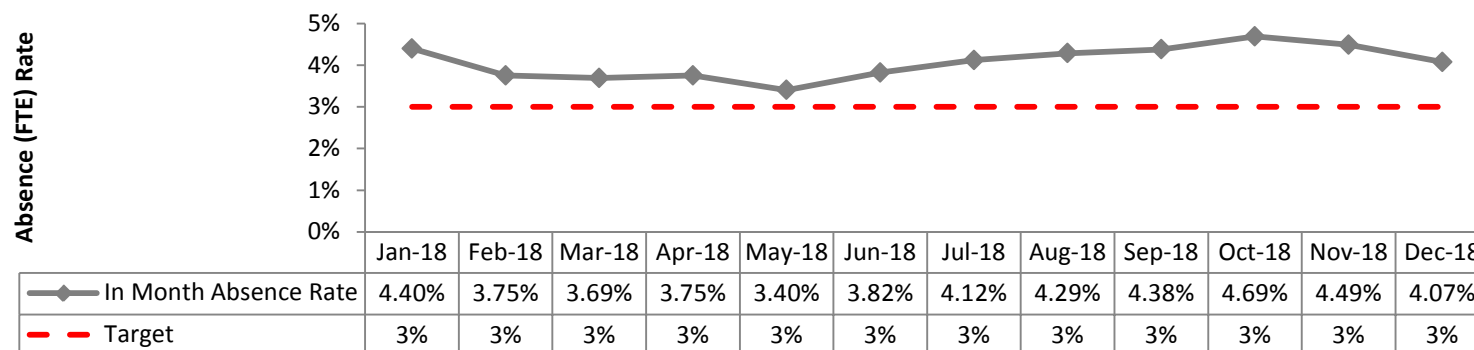
2. Essential Core Skills Compliance

Compliance for December saw a slight drop to 92.8% (93% for November) and due to winter pressures no training sessions are being run in January so it is anticipated we will see a further dip next month also. Medical and Dental remains at 86% and continues to be closely monitored by the Medical Director.

However, focus continues on driving towards our target and working with colleagues across the NHS in Dorset to align training and improve the transferability of skills, thus reducing the need for NHS staff to do the same or similar training more than once. 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)



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Surgical	4.70%	3.90%	4.85%	4.21%	3.70%	4.24%	4.38%	4.12%	4.24%	4.66%	4.02%	3.39% ↓
Medical	4.27%	3.70%	2.88%	3.45%	2.43%	2.77%	3.58%	3.75%	3.91%	4.31%	3.99%	3.98% ↓
Specialties	4.32%	3.79%	3.51%	3.77%	3.66%	3.82%	4.31%	5.08%	5.15%	4.79%	5.44%	4.07% ↓
Corporate	4.35%	3.63%	3.94%	3.73%	4.41%	5.08%	4.53%	4.55%	4.52%	5.26%	4.90%	4.95% ↑
Trust	4.40%	3.75%	3.69%	3.75%	3.40%	3.82%	4.12%	4.29%	4.38%	4.69%	4.49%	4.07% ↓

Sickness absence saw a reduction of 0.42% in December to 4.07% from 4.49% the previous month; this compares favourably with the 4.35% for December 2017.

A reduction of 0.63% was seen for the Surgical care group bringing it back down to an amber rating of 3.39% from 4.02% the previous month. Medical care group continues its amber rating. A good reduction of 1.37% was seen for Specialties after last month's high, although this remains red.

The rolling 12 month figure at 4.10%, although red, does represent a small improvement on the 4.16% seen at the same point last year. There is continued focus being given to managing sickness and the health and wellbeing initiatives being promoted within the Trust.

4. Safe Staffing December 2018

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 December 2018.

Registered Nurse (RN) - Actual Day	94%	HCA - Actual Day	95.7%
Registered Nurse (RN) - Actual Night	96.7%	HCA - Actual Night	120%

The December staffing return to Unify reflects a slight decrease in fill rate from November 2018. This is due to the Trust having capacity over the Christmas period and wards being able to reduce their agency requests to fit patient numbers and acuity.

Overall the Trust maintained a safe and stable staffing position in December 2018. A small percentage of high cost agency was utilised, which continues to be monitored through the Premium Cost Agency meeting. As part of the agency reduction plan the Trust is now trialling a number of new off framework agencies, who have competitive rates.

There were no red flag shifts reported for December 2018.

There were some episodes of templated shift over and under fill, examples of this are:

- Some day time under fill; all appropriately risk assessed as safe.
- HCA usage above 100% due to mitigation for enhanced care needs and RN under fill where appropriate.
- Daily risk assessments undertaken to support enhanced care needs.
- Extra capacity was intermittently opened during December 2018.

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 December Board pack

As at 31st December 2018

The Trusts CHPPD data for Nursing and Midwifery has remained static:

	Trust value	Peer median	National median	Chart
Cost per WAU	■ £671	£671	£710	
Total FTE	■ 1,698.0	1,927.8	2,096.6	
CHPPD	■ 7.7	7.7	7.9	

This data demonstrates that the average number of care hours a patient receives in a day at this Trust is 7.7 hours (all nursing, midwifery and support staff). This is equal to the Trusts peer organisations, and slightly below the national median.

5. EU Settlement Scheme

As advised in last month's report, RBCH took part in the second pilot to get people signed up to the EU Settlement Scheme, which is being financially supported by the Trust. The pilot period ended on 21st December, during which time 114 successful applications were processed. There were a few members of staff who attended appointments but were not able to progress their applications because they did not have the right documentation. There were also periods when the Government app was either taken down, or was failing. Learning and development needs from the pilot have been fed back as appropriate.

Some staff were disappointed that their applications were unable to be processed during the pilot phase, but they have been assured that the HR team will continue to support EU staff wanting to make applications when the full programme opens (by 30th March). The deadline for applying will be 30th June 2021. We have received very positive feedback from the staff who did make successful applications and also from the chairs of the EU staff network.



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

BOARD OF DIRECTORS	
Meeting date:	30 January 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Anti-Slavery and Human Trafficking Statement
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Deb Matthews, Director of Improvement and Organisational Development
Author(s) of paper:	Debbie Detheridge
Details of previous discussion and/or dissemination:	Equality, Diversity and Inclusion Committee, December 2018
Action required:	Decision
<p>Summary: The Equality, Diversity and Inclusion Committee has approved the attached statement setting out how the Trust is run in a socially responsible way and recommends its approval to the Board. The statement has been prepared in conjunction with procurement, safeguarding and recruitment leads.</p> <p>There is no requirement for the Trust to publish a statement under the Modern Slavery Act 2015 on its website or in its annual report as the legislation does not apply to NHS bodies. However, following approval, this statement will be added to the Trust's website and the information in the annual report relating to social, community, anti-bribery and human rights issues will be expanded to include additional information reflecting this statement.</p>	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on significant risks:	Not applicable

Anti-Slavery and Human Trafficking Statement

This statement sets out the approach taken by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH or the Trust) to understand all potential modern slavery risks related to its business, and the actions undertaken to mitigate any such risks during the financial year ended 31 March 2018.

We are committed to delivering high standards of corporate governance and a key element of this is managing the Trust in a socially responsible way. We are absolutely committed to preventing slavery and human trafficking in our corporate activities and supply chains. We also expect the same high standards which we set for ourselves from those parties with whom we engage, such as our suppliers and those who use our services.

The steps we have taken during the previous financial year in relation to combating modern slavery and human trafficking are set out below

In relation to our supply chains, which include the sourcing of all products and services necessary for the provision of high quality healthcare to our patients:

- We expect and require all of our suppliers to comply with all local, national and (where applicable) international laws and regulations.
- All our orders are placed in accordance with standard NHS terms and conditions. Within these terms are provisions requiring suppliers to ensure they conduct business in a manner that is consistent with any anti-slavery policy and to provide us with any reports or other information that we request as evidence of the supplier's compliance with our anti-slavery policy.
- Our suppliers must comply with all relevant laws and guidance and shall use good industry practice in their area to ensure that there is no slavery or human trafficking in their supply chains; and notify us immediately if they become aware of any actual or suspected incidents of slavery or human trafficking in their supply chains.
- We expect all those in our supply chain and contractors to comply with our values.
- We will not support or deal with any business knowingly involved in modern slavery and human trafficking. All suspicions of modern slavery and human trafficking will be reported to the relevant authority.
- We will consider modern slavery issues when making procurement decisions.

In relation to due diligence and risk management (other than our supply chains):

- We undertake appropriate pre-employment checks and require our agencies on approved frameworks to do the same.
- We protect staff from poor treatment and/or exploitation, and comply with all applicable laws and regulations including fair pay rates and terms of conditions of employment.

- We consult and negotiate with Trade Unions on proposed changes to employment, work organisation, and contractual relations.

In relation to our policies and procedures, which set the tone for how we as an organisation operate:

- We have a clear Freedom to Speak Up: raising concerns (whistleblowing) policy that applies to all individuals working for our Trust and is published on our intranet site. If there are any genuine concerns about any wrongdoing or breaches of the law, including modern slavery laws, these concerns can be raised in confidence and without fear of disciplinary action.
- We have appointed a Freedom to Speak Up Guardian and Ambassadors to promote, listen, support and provide an impartial view to staff when speaking up. The aim is to develop a culture of safety within RBCH so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

In relation to the training of our staff:

- Our training for staff includes how to recognise and respond to indicators of human rights abuses.
- We have teams responsible for safeguarding of adults and children, to whom staff are responsible for reporting concerns and who will train staff on how to recognise issues of concern.

This statement will be reviewed annually. This statement was approved by our board of directors in January 2019.

BOARD OF DIRECTORS	
Meeting date:	30 January 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:	Karen Flaherty
Details of previous discussion and/or dissemination:	None
Action required:	Decision
<p>Summary: Following appointment of David Moss as joint chair of the Trust and Poole Hospital NHS Foundation Trust with effect from 1 January 2019, his commitments as Chairperson of the Trust have been reviewed.</p> <p>It is proposed that David is removed a member of the Healthcare Assurance Committee, reducing the number of non-executive director members of the Committee to three with the terms of reference are to reflect this as attached. The number of non-executive director members of the Committee was increased to four in September 2018 following Pankaj Dave's appointment to the Committee. David will continue to attend meetings of the Committee when possible.</p> <p>One additional change is proposed to the terms of reference for the Healthcare Assurance Committee at the same time to reflect the correct name of the sub-committee that deals with adult and child safeguarding.</p>	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓



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

Are they well-led?	
Impact on significant risks:	Not applicable

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

HEALTHCARE ASSURANCE COMMITTEE

TERMS OF REFERENCE

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

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

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

1. Membership

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

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

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

2. Secretary

- 2.1 The PA to the Director of Nursing & Midwifery (the Secretary) or their nominee shall act as the secretary of the Committee.

3. Quorum

- 3.1 The quorum necessary for the transaction of business shall be six members, at least one of which must be a Non-Executive Director and one must be the Medical Director

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

or Director of Nursing & Midwifery (or their nominated Deputy). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4. Frequency of Meetings

- 4.1 The Committee shall meet bi-monthly.

5. Notice of Meetings

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

6. Minutes of Meetings

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

7. Duties

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

7.1 Quality Assurance

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

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

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

8. Reporting Responsibilities

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

9. Other

The Committee shall:

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

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

10. Authority

The Committee is authorised:

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

11. Sub-Committees

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

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Appendix 1: HEALTHCARE ASSURANCE COMMITTEE ASSURANCE MEASURES

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

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

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

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BOARD OF DIRECTORS MEETING – 30 JANUARY 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 **Conference Room** in the **Education Centre, Royal Bournemouth Hospital**

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

Timings		Purpose	Presenter
11.00	1. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 27 November 2018 (paper)	Decision	<i>All</i>
11.05	2. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Discussion	<i>All</i>
11.10	3. STRATEGY AND RISK		
	a) One Dorset Pathology Full Business Case (paper)	Decision	<i>Alyson O'Donnell/ Stephen Harding</i>
	b) Significant Risk Report (paper)	Discussion	<i>Paula Shobbrook</i>
	c) Update on Clinical Design (verbal)	Information	<i>Debbie Fleming/ Alyson O'Donnell</i>
	d) Brexit Planning and Preparedness (verbal)	Information	<i>Richard Renaut/ Donna Parker/ Pete Papworth</i>
12.10	4. GOVERNANCE		
	a) Clinical Excellence Awards 2017 (paper)	Decision	<i>Alyson O'Donnell TO FOLLOW</i>
12.15	5. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff	Discussion	<i>All</i>
	b) Reflective Review	Discussion	<i>All</i>
	– What has gone well?		
	– What do we need more of?		
	– What do we need less of?		

The meeting will be followed by a meeting of the Nomination and Remuneration Committee between 12.25-12.45pm and a joint seminar with the Board of Directors of Poole Hospital NHS Foundation Trust between 12.45-1.45pm

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!