

A meeting of the Board of Directors will be held on Wednesday 27 March 2019 at 2.00pm in the Board Rooms, Poole Hospital

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

Karen Flaherty
Trust Secretary

A G E N D A			
Timings		Purpose	Presenter
2.00-2.05	1. WELCOME, APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST Alyson O'Donnell		
2.05-2.10	2. MINUTES OF PREVIOUS MEETING a) Minutes of the meeting held on 30 January 2019 (paper)	Decision	All
2.10-2.15	3. MATTERS ARISING a) Updates to the Actions Log (paper)	Information	All
2.15-2.25	4. Chief Executive's Report	Information	Debbie Fleming
2.25-3.30	5. QUALITY AND PERFORMANCE a) Patient Story (verbal) b) Update on Governor Activity (verbal) c) Improvement Programme 2018/19 Review and 2019/20 Priorities (paper/presentation) d) Medical Director's Report (paper) e) Trust Board Dashboard (paper) f) Performance Report (paper) g) Quality Report (paper) h) Finance Report (paper) i) Workforce Report (paper) j) National Staff Survey Results 2018 (paper)	Information Information Information Information Information Information Information Information Information Information	Paula Shobbrook David Triplow Deb Matthews Ruth Williamson Richard Renaut Richard Renaut/ Donna Parker Paula Shobbrook Pete Papworth Karen Allman Deb Matthews
3.30-3.35	6. STRATEGY AND RISK a) Progress Update on Stakeholder Engagement Outcomes (paper)	Information	David Moss
3.35-4.00	7. GOVERNANCE a) Freedom to Speak Up - Annual Report	Decision	Helen Martin

(paper/presentation)

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|----|--------------------------------------------------------------|-------------|-----------------------|
| b) | Information Governance Annual Report (paper) | Information | <i>Peter Gill</i> |
| c) | Directors' Register of Interests (paper) | Review | <i>Karen Flaherty</i> |
| d) | Audit Committee Terms of Reference (paper) | Decision | <i>Karen Flaherty</i> |
| e) | Finance and Performance Committee Terms of Reference (paper) | Decision | <i>Pete Papworth</i> |

8. NEXT MEETING

Wednesday 29 May at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

9. ANY OTHER BUSINESS

Key Messages for Communication to Staff

4.00-4.15

10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

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

11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

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

Minutes of a Meeting of the **Board of Directors** (the **Board**) of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the **Trust**) held in public at 8.30am on **Wednesday 30 January 2019** in the Conference Room, Royal Bournemouth Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Debbie Fleming	(DF)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Pankaj Davé	(PD)	<i>Non-Executive Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	John Lelliott	(JL)	<i>Non-Executive Director</i>
	Pete Papworth	(PP)	<i>Director of Finance</i>
	Iain Rawlinson	(IR)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Cliff Shearman	(CS)	<i>Non-Executive Director</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Debbie Detheridge	(DD)	<i>Diversity & Inclusion Lead</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>
	Deborah Matthews	(DMA)	<i>Director of Improvement and Organisational Development</i>
	Tracy Mack-Nava	(TMN)	<i>Organisational Development & Leadership Consultant</i>
	Laura Northeast	(LN)	<i>Head of Patient Experience & Engagement (for items 4(a) and 5(c))</i>
	Donna Parker	(DP)	<i>Deputy Chief Operating Officer (for item 6)</i>
	James Rowden	(JR)	<i>Patient Engagement and Clinical Liaison (until item 4(b))</i>
	Dily Ruffer	(DR)	<i>Governor and Membership Manager</i>
	Carla Santos	(CS)	<i>PA to the Trust Secretary's Office</i>
Public/ Governors:	Derek Chaffey		<i>Public Governor</i>
	Paul Higgs		<i>Appointed Governor</i>
	Marjorie Houghton		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Margaret Neville		<i>Member of public</i>
	Roger Parsons		<i>Public Governor</i>
	Rae Stollard		<i>Public Governor</i>
	Phil Warn		<i>Member of public</i>
	Michele Whitehurst		<i>Public Governor</i>
	Sandy Wilson		<i>Public Governor</i>
Apologies:	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Alyson O'Donnell	(AOD)	<i>Medical Director</i>

01/19 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Action

The apologies for absence set out above were **noted**. The Chairperson welcomed Debbie Fleming to her first meeting as Chief Executive of the Trust.

02/19 MINUTES OF PREVIOUS MEETING

(a) Minutes of the meeting held on 28 November 2018 (Item 2(a))

The minutes of the meeting held on 28 November 2018 were **approved** as an accurate record of the meeting.

03/19 MATTERS ARISING

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

The update was **noted** and it was agreed that the action could be closed.

04/19 QUALITY

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

Laura Northeast updated the Board on the work to improve the qualitative data obtained about the patient experience and how patients feel about their care through 'Care Conversations.' A study by the University of Virginia showed that by having five minute conversations with patients, which went beyond evaluating their symptoms, made patients feel that more cared about as individuals. Informal conversations also helped improve the quality of information obtained from patient feedback, which could then be used to further improve the patient experience and services at the Trust.

Care Conversations would be focussed on recurrent themes identified through the Care Campaign audits including patient meals, noise at night, call bells and discharge to help understand the reasons for poorer performance in these areas and identify ways to improve. Volunteers were being trained to sit with patients over a hot drink, letting patients lead the conversation and the subjects that they wanted to discuss. The conversations would be recorded with the patient's consent and it had been very powerful to hear feedback from patients in their own words. This was demonstrated to the Board by playing snippets from some conversations at the meeting.

Themes identified from conversations so far included the importance of managing patient expectations and simple solutions such as earplugs to improve sleep. Plans for the future were to include Dementia Champions were to obtain feedback from this group of patients.

Board members welcomed the approach, which aligned with the Trust's strategic objective of listening to patients and understanding what matters to them in a meaningful way. It was also a good example of humanising care in practice and should have a positive impact on complaints with volunteers being able to resolve concerns with staff on the wards immediately. Directors were interested in getting involved in having these conversations with patients.

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

PS presented the key themes from the report:

- there was an improving trend for Hospital Standardised Mortality Ratio (**HSMR**), Summary Hospital Mortality Indicator (SHMI) and the crude death rate;

- the robust process in place for reviewing patient deaths in hospital;
- the learning points from the internal review of the death of a patient with learning difficulties under the joint care of the teams in Stroke and the Intensive Treatment Unit, including how learning was shared more widely;
- the action plans developed in response to recent Dr Foster alert reviews including cancer of the uterus and the annual review of Acute Kidney Injury (**AKI**) as a high risk condition; and
- the success of the medical examiner pilot which had shortened time for death certification and streamlined processes for Coroner referral.

PG confirmed that the data issues within the e-mortality system highlighted in the report had now been corrected.

PS agreed to share the response from the Coroner following a request for on the requirement for referrals to be made to the Coroner for deaths where patients had undergone a procedure in the last twelve months as this may lead to unwarranted referrals. **PS**

One of the Non-Executive Directors queried whether there should have been greater focus on avoiding AKI in the actions from the annual review and it was explained how the work on prevention was being taken forward through the deteriorating patient quality priority. The Board also discussed the importance of the work around the consent process, particularly in relation to the handover of patients between different teams as had been highlighted in the sections in the report on claims and the learning points from mortality reviews.

05/19 **STRATEGY AND RISK**

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

DF provided an update on progress with the Clinical Services Review (**CSR**) including:

- the importance of ensuring good communication with staff and members of the public to reiterate the purpose for the CSR and put this in context of the wider plan for improving the delivery of care in Dorset and using the available resources differently;
- the focus on prevention and early intervention, strengthening services in the community and linking with primary care partners to reduce inappropriate patient admissions;
- strengthening the workforce and improving efficiency of processes through the use of technology, including the Dorset Care Record, to support the successful implementation of the CSR;
- the release of the NHS long term plan which was consistent with the plans for Dorset;
- the continuing development of the clinical designs, outline business case and capital plan ahead of submission at the end of March; and
- the appointment of a joint Chair and Chief Executive and early work to bring together four key services across the two organisations ahead of merger, providing a clear signal about the coming together of the Trust and Poole Hospital NHS Foundation Trust (**PHFT**).

The Board discussed ways of strengthening communication and engagement with the public to better understand what was meant by prevention at scale

and addressing concerns about the perceived loss of services. The more coordinated approach to communication led by NHS Dorset Clinical Commissioning Group (**Dorset CCG**) including engagement with smaller groups and training of staff across Dorset by The Point of Care Foundation to enable better conversations and more positive engagement with staff and the public to take forward the design of services and wider plans for the CSR.

The Board drew attention to the need for both trusts to continue to deliver safe and good quality care while planning and implementing the CSR, providing a positive position for the future integration of services.

(b) Progress Update on 2018/19 Corporate Objectives (Item 5(b))

The Board **noted** the progress made against the corporate objectives including the challenges around achieving elective and diagnostic waiting times in the face of increasing demand. The Trust was working with Dorset CCG to ensure that activity and capacity planning reflected the increases in demand and to continue to improve productivity and manage demand in 2019/20.

(c) Equality, Diversity and Inclusion Update (Item 5(c))

DM introduced an update on progress on achieving the outcomes in the Leading for Equality, Diversity and Inclusion Strategy in 2018/19 from Tracy Mack-Nava, Debbie Detheridge and Laura Northeast. These aimed to improve the experience of both patients and staff by creating a more inclusive culture at the Trust. Highlights of the work included:

- establishing staff networks for Black Asian and Minority Ethnic (**BAME**), Lesbian Gay Bisexual and Transgender and European Union staff to help develop the Trust's plans;
- expanding inclusive leadership through learning and career development opportunities and mentoring of staff with a reverse mentoring scheme for BAME staff commencing later in 2019;
- supporting staff to increase their self-confidence and willingness to speak up providing a range of ways to facilitate greater engagement including elevator speeches and Schwartz Rounds;
- PD joining as a new member and Deputy Chair to help to raise the profile of the work on equality, diversity and inclusion around the Trust;
- improving communication by updating online resources for staff and promoting initiatives such as 'Humans of our hospitals'; and
- progressing the approach to patient co-design of services with the recruitment of patient voice volunteers and staff patient engagement champions as well as the expansion of work experience and apprenticeships.

Progress and future plans would be developed through data driven decision-making and monitored through compliance against national standards as part of the performance dashboard. The team would also link with Human Resources to promote the recruitment of more BAME staff including work experience opportunities for younger people who were considering careers in the NHS.

The Board recognised the progress that had been made to develop as a more inclusive organisation and wanted to ensure that staff were aware and could

attend the different groups and forums to drive further progress.

06/19 **PERFORMANCE**

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

The paper was **noted** for information.

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

The Board **noted** the performance exceptions to the Trust's compliance with the 2018/19 Single Oversight Framework, national planning guidance and contractual requirements, particularly the challenges around waits for planned care and diagnostic, which reflected the position nationally as identified in the NHS Long Term Plan.

DP provided an update on the Trust's experience to date over winter, which had been much better than the previous winter in the context of an increase in emergency admissions. Highlights included the reduction in the patient length of stay in the lead up to Christmas and New Year reducing bed occupancy, primary care support in the Urgent Treatment Centre, an improved performance in the Emergency Department (**ED**) and support with patient rehabilitation through the Fayrewood ward. However, there had been pressure on beds in the Intensive Treatment Unit and High Dependency Unit.

Staff feedback had been positive about the Operational Pressures Escalation Levels (OPEL) escalation process and actions, which had enabled the Trust to recover better following peaks in pressure, as well as about Fayrewood ward and the frailty pathway and discharge processes in Surgery.

The focus for the remainder of the winter would be:

- continuing to do those things that had worked well to date;
- developing on the areas for improvement identified from the action learning weeks in December and January;
- additional dedicated social care support for particular wards;
- providing advice and guidance to GPs and South Western Ambulance Service NHS Foundation Trust using a single point of access to avoid unnecessary admissions; and
- work to support the trauma service at PHFT and improve pathways for patients.

Concerns were raised about the lack of progress in reducing ED attendances and pressures on primary care, which continued to increase. The Trust was working collaboratively as part of the wider Dorset system on prevention at scale to review initiatives for admissions avoidance and to streamline elective pathways including joint improvement projects with GPs.

The Board thanked DP for her work in leading the operational planning for winter.

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

The following areas from the report were highlighted:

- a never event had been reported in January 2019 and was currently

under investigation and would be reported to the Board in more detail following review by the Healthcare Assurance Committee; and

- despite the busy period feedback from patients had been positive about their care reflecting progress with the work to improve patient experience and engagement.

The Board discussed how staff were being supported to help them cope with the pressures of winter and avoid burnout. Part of the recent action learning weeks had involved appreciative inquiry to understand how it felt for front-line and clinical staff over the winter period, albeit that the pressures had not been consistently as high as the previous winter. A fourth cohort of Change Champions had been recruited and would be running focus groups with staff in February and March. Staff wellbeing initiatives had also been well received and the Trust would continue to develop this area with learning from other trusts, with financial wellbeing being added to the support available.

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

The Trust continued to deliver against its agreed financial control total; with a cumulative surplus of £15 million, £129,000 better than budget. The financial surplus had been achieved through a small number of material, one-off financial improvements together with the associated incentive payment from the Provider Sustainability Fund (**PSF**).

There was a forecast shortfall against the Cost Improvement Programme (**CIP**) and detailed financial recovery plans were in place for each care group to address the gap in CIP and to mitigate the risks arising from increases in the cumulative cost of bank, agency and overtime expenditure in order for the Trust to secure the PSF incentive payment for 2019/20. In addition, it is likely that the base PSF will not be achieved in full given the risk in securing the ED performance elements for quarter 4; together with the possible loss of the system finance PSF in quarter 4

Work was underway with commissioners to agree the budgets and contracts for next year with the opportunity to improve timely access to care through the uplift in national funding.

The Board underlined the importance of securing the PSF incentive payment in order to support the future capital plan for the Trust. Plans were in place to mitigate the risks associated with not achieving the incentive bonus and the gap in the CIP, and there was confidence that the Trust would achieve its control total and receive the incentive payment and be eligible for a further bonus payment.

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

The following key points were highlighted:

- the vacancy rate for December 2018 was 5.31%, which was an increase on the previous month and a slight concern although this could be a result of changes to staffing templates;
- no red flag shifts had been reported in December 2018 demonstrating that the Trust had maintained a safe and stable staffing position;
- the substantive staff headcount remained stable and the Trust performance against the model hospital figures for staff stability was

- significantly higher than most trusts at 88%;
- recruitment initiatives were being progressed alongside joint work with partners to develop the future workforce;
- sickness absence performance had improved slightly but remained an area of focus;
- continued progress in making the flu vaccine available for front-line staff; and
- positive feedback from EU staff on the support with completing the EU settlement scheme documentation.

The Board reflected on the failure to achieve the target for sickness absence and whether a different approach was required to make better progress. The correlation between vacancies and sickness and among staff on lower bands was being analysed as part of a review of the success of the new policy and other initiatives. CS, as chair of the Workforce Strategy and Development Committee, reinforced that he was assured that the Trust was doing all it could on recruitment at all levels and was continuing work to understand the underlying reasons for sickness absence.

(f) BBC News Coverage (Item 6(f))

The Board viewed recent BBC news programme coverage of the impact of winter pressures at the Trust. This had highlighted some of the excellent work led by staff to sustain good quality care. Board members expressed how proud they were of all of the staff for the Trust's achievements. Discussions were underway with the BBC to allow this coverage to be made available on the BBC iPlayer for one year.

07/19 GOVERNANCE

(a) Anti-Slavery and Human Trafficking Statement (Item 7(a))

The Board **approved** the statement setting out its approach to combatting modern slavery and human trafficking.

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

The Board **approved** minor changes to the terms of reference for the Healthcare Assurance Committee.

The Board also **approved** changes to the terms of reference for the Charitable Funds Committee to add a further Non-Executive Director member of the committee and appointed Pankaj Davé as a member of the committee.

08/19 NEXT MEETING

The next meeting will take place on **Wednesday 27 March 2019** at 2.00pm in Board Rooms 1 and 2 at Poole Hospital.

09/19 ANY OTHER BUSINESS

There was no other business.

Key Points for Communication to Staff:

1. Patient Story
2. Winter planning learning
3. Equality, Diversity and Inclusion update
4. CSR

10/19 COMMENTS AND QUESTIONS FROM GOVERNORS AND THE PUBLIC

1. The response to a question raised by a member of public which had been previously submitted to the Board was presented in relation to a patient who had spent eight hours in the Endoscopy Department. The information provided to patients in advance of their appointment advised that patients could spend four to five hours in the department. However, there were a number of reasons why some patients spent longer in the department than others depending on the particular procedure, whether the patient needed to be monitored in the department following the procedure or if they had consumed liquids too close in time to the procedure so had to wait longer so that the procedure could be performed safely. Sometimes, there were delays due to unforeseen circumstances, waits for beds or for relatives to collect the patient where sedation has been given. These reasons should have been explained to the patient the Trust Secretary apologised if this was not the case for this patient. The member of the public reiterated their offer to help the Trust understand the reasons for delays.
2. Public Governors welcomed the positive update on progress with the implementation of the CSR and merger including the increase in joint working across both sites. They supported the need for further engagement with the public to address misconceptions and the work underway to strengthen the future workforce to deliver services.

11/19 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 10.35am

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
30.01.19	04/19	QUALITY			
	(b)	Medical Director's Report			
		PS agreed to share the response from the Coroner following a request for on the requirement for referrals to be made to the Coroner for deaths where patients had undergone a procedure in the last twelve months as this may lead to unwarranted referrals.	AOD	Once received	Clarification has been provided and the Trust is no longer referring for minor or unrelated procedures.
Key:	Outstanding	In Progress	Complete	Not yet required	



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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Chief Executive's Report
Section on agenda:	Not applicable
Supplementary reading:	None
Director or manager with overall responsibility:	Debbie Fleming, Chief Executive
Author(s) of paper:	Debbie Fleming, Chief Executive
Details of previous discussion and/or dissemination:	First Chief Executive's Report
Action required:	Note for information
Summary: The attached report from the Chief Executive provides an update on various areas since the Board meeting in January 2019.	
Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	✓ ✓ ✓ ✓ ✓
Impact on significant risks:	None

BOARD OF DIRECTORS MEETING

March 2019

REPORT OF THE CHIEF EXECUTIVE

1. One Acute Network Update: Developing our Capital Programme

Members will be aware that there has been a large amount of work going on across both Trusts – that is, Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust - to firm up the plans for establishing the major emergency and major planned care sites. Our clinical and managerial teams have been working hard together to finalise the design for the new buildings that will host our services on both sites, for inclusion in the Outline Business Case (OBC) that will allow us to draw down the £147 million capital that the Secretary of State announced for Dorset in 2017. We are now confident that we shall be in a position to submit the OBC to NHS Improvement at the start of April, in accordance with the agreed timescale.

This is a hugely positive step forward for our teams, as they have worked closely together to further develop their ideas and think through how services should run in the future under the new arrangements.

However, it is also recognised that these whilst these plans will result in significant benefits for patients and staff, by achieving improved outcomes and establishing more resilient services, they do represent significant change. As such, the Trusts will be doing even more over the next few weeks and months to engage and communicate effectively to reduce uncertainty, for staff and members of the public alike. Over the past month, a number of new video clips have been produced involving clinicians talking about this work. We have also produced a new poster and leaflet clarifying the role of the 24/7 Urgent Treatment Centre that will be established on the Planned Care site.

We shall be providing more information and arranging more engagement meetings over the next few months, to enable on-going discussion about the details of these changes and the benefits associated with them.

2. Update on the merger

Members will be aware that a draft merger timeline has been agreed with NHS Improvement (NHSI), with a proposed merger date of April 2020. Given the positive progress in developing the Outline Business Case (OBC) for the capital monies (as highlighted above), another meeting with the Competition and Markets Authority (CMA) is planned to take place in April to update on progress and to confirm this timeline.

Once the OBC has been submitted at the end of March, work will commence to review and update the Patient Benefits Case (PBC) to support the merger. The PBC will be amended to take account of the informal feedback received from NHSI last November, and to align with the OBC.

We are expecting NHSI to visit the Trusts to discuss the Patient Benefits Case with our clinicians before finalising their advice to the CMA. The PBC will need to be signed off

formally by the Boards by the end of June, before being submitted to NHSI for consideration in July 2019.

Developing the Merger Business Case will be a top priority for the executive teams from April 2019. This document will include the Post-Transaction Integration Plan (PTIP) and the Long-Term Financial Model (LTFM) that will be required by NHSI as part of the merger process.

Meanwhile, work is ongoing with the Council of Governors to develop the merger transaction criteria and a new draft constitution. Two joint working groups have been set up to undertake this work, and a number of joint Council of Governor briefings will also be taking place during the course of the year.

Finally, it should be noted that the two organisations are increasingly working more closely together. Our joint Hospital Executive Group/Trust Management Board involving our senior staff and senior clinical leaders now meets every two months; the two Boards come together for a joint Development Event every two months, and the two Executive teams meet fortnightly. We are currently advertising internally for four Transformation Clinical Leads, to focus on joining up our four priority services – trauma & orthopaedics, theatres & anaesthetics, older people's medicine and our two emergency departments.

The merger work is therefore going extremely well, with stronger relationships being forged all the time, as we develop our future plans together.

3. EU Exit preparations

EU Exit negotiations are continuing in Parliament but at the time of writing, no agreement has been reached as to how this will be taken forwards. However, nationally and locally, a great deal of planning work is ongoing to prevent/mitigate any negative impact for our patients and staff, should the UK leave the EU without an economic or political deal in place.

Each Trust has established a Task and Finish Group to oversee this work in accordance with national guidance, and the Chief Operating Officer for each organisation is the designated Director responsible for the preparations. The Task and Finish Groups include representation from all departments that might be affected, so as to ensure that all appropriate action is taken.

It should also be noted that partners across Dorset are working together to monitor and mitigate the risks that have been identified locally, as part of the work of the Local Resilience Forum.

In the meantime, the Trusts are taking steps to support and reassure EU staff who may be concerned about the impact of this on their roles, including assisting them in applying for settled status. Both organisations would like to reiterate how much we value our EU employees – we are extremely grateful for them for their continued commitment, hard work and professionalism during these uncertain times.

4. Alignment of NHS England and NHS Improvement

The Boards of NHS England and NHS Improvement have decided to move to a single Chief Executive and single Chief Operating Officer model, which means creating a single, combined post of Chief Operating Officer covering both organisations. The role will report directly to Simon Stevens as the Chief Executive of NHS England, who will lead both

organisations. This decision follows the progress made over the past twelve months in developing the implementation approach for the NHS Long Term Plan and the working arrangements of both organisations. Ian Dalton, the current Chief Executive for NHS Improvement announced his intention to step down from his role earlier this month.

5. Engaging with Members and Local People

Earlier this month, Poole Hospital held a very successful member event at Haskins Garden Centre, focusing on some of the changes associated with the Dorset Clinical Services Review. Members received a presentation from Mr Daniel Webster, Clinical Director for Obstetrics and Sandra Chitty, Head of Midwifery about the Better Births programme, and the plans for the new maternity unit that will be built on the Royal Bournemouth Hospital site. They also received a presentation from Dr Angus Wood, Medical Director regarding the services that will be provided from Poole Hospital in the future, once it becomes the Planned Care site. There was much debate during the course of the meeting, with a lively question and answer session, and everyone agreed that it had been extremely successful and very informative.

Meanwhile, Keith Mitchell, public governor for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has been holding a series of talks in local libraries, providing information to the public regarding the planned changes to local hospital services. These have enabled individual members of the public to discuss the changes on an informal basis, and have been very well-received. The next talk will be held at 12.00 pm on 29 March 2019 in the Poole Central Library.

As highlighted earlier in this report, the Trust plans to hold a range of engagement events over the coming year to ensure that local people are fully informed about the changes, have a chance to discuss them in detail, and are properly briefed about the benefits deriving from them.

6. Celebrating our Maternity Services

Both Poole Hospital NHS Foundation Trust (PHT) and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) were celebrating after the Royal College of Midwives Awards event held in London on 5 March 2019. Gemma Douglas, a trainee nurse associate in the Poole Hospital Maternity Unit won the Maternity Support Worker of the year award, whilst Jillian Ireland, a professional midwifery advocate at the hospital, was shortlisted for the supervisor/professional midwifery advocate award.

At the same event, the RBCH Maternity Leadership Team brought home the Caring For You Award for their work in supporting and engaging staff with initiatives including Caring for You drop-ins, staff forums and away days. In addition, Sera Bailey from RBCH won the Bereavement Care Award for delivering a bespoke postnatal bereavement service - the only one of its kind in Dorset.

We are extremely proud of all the staff working within the two maternity services, and would like to congratulate them on having won these prestigious awards.

Finally, it was good to note that the Dorset Maternity System - a collaboration between local healthcare organisations and the Dorset Clinical Commissioning Group – received the award for partnership working. The collaborative working has enabled a standardised Dorset-wide approach to the postnatal maternity pathway.

7. National award for Macmillan Caring Locally volunteer

I should like to draw attention to the fact that a dedicated Macmillan Caring Locally volunteer has received the Volunteer of the Year award at the Unsung Hero Awards - the only national award for non-medical NHS staff and volunteers who go above and beyond the call of duty. Mandy Preece, a volunteer at the Macmillan Unit based at Christchurch Hospital, was praised for her services in supporting palliative care patients and creating a unique training programme for volunteers. Mandy has volunteered for the Macmillan Unit since 2011, starting as a companion volunteer in the Day Centre. Mandy then volunteered alongside staff within the Macmillan Unit, carrying out roles which directly enhanced patient care such as providing end of life companionship and offering support to patients' families.

It is good to see such dedicated service being recognised at a national level.

Debbie Fleming
Joint Chief Executive



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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Improvement Programme 2018/19 Review and 2019/20 Priorities
Section on agenda:	Quality and Performance
Supplementary reading:	N/A
Director or manager with overall responsibility:	Debbie Fleming, Joint Chief Executive
Author(s) of paper:	Deborah Matthews, Director of Improvement and OD
Details of previous discussion and/or dissemination:	Improvement Programme Board
Action required:	Review and comment
Summary: The RBCH Improvement Programme workbook summarises and evaluates the Improvement Programme objectives for 2018/19 and outlines our work plan for 2019/20.	
Related strategic objective	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Impact on risk profile:	Improving risks relating to patient flow, 18 week RTT and urgent care



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

Improvement Programme

2019/20



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Improvement Programme

Part A – Overview and Context


Part B – QI Priorities

Part C – Productivity and Efficiency

Part D – Building Capacity and supporting a Culture of Improvement

Part E – Programme Management

Appendices



Improvement programme blueprint
CIP track record
2018/19 delivery against target

Improvement Programme

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) Improvement Programme was launched in May 2014.

The programme objectives are designed to support the organisation's vision *'To work in partnership and continually improve our services.'*

We will do this by:

- delivering transformational change and quality improvement projects, resulting in a safer and more caring hospital for patients
- revolutionising our culture towards continuous quality improvement
- creating an environment where all staff have a sense of shared ownership and responsibility and feel enabled to help make our hospital one of the best
- capitalising on the energy and enthusiasm of staff by taking the best ideas for improving the quality and safety of patient care – and encouraging uptake throughout the hospital
- achieving top decile performance in a number of key performance and quality measures
- engaging and empowering staff to deliver and sustain the required change in their workplace
- harnessing individual and collective talent and supporting clinical leaders at every level within the hospital
- providing improvement and change expertise - to give skill and enable learning - for as many staff as possible through direct involvement in projects and sharing of best practice
- achieving a consistent message that improving quality eliminates waste, reduces variation and improves efficiency. **All are of equal importance.**

More specifically, the blueprint emphasises the need to ensure the way money and quality are put together is essentially the same agenda. This will ensure we do not let debates run that crystallise as 'keep control of money OR improve quality'

RBCH Improvement Programme : Blueprint

Vision

To work in partnership and continually improve our services

1. Delivering transformational change and quality improvement projects, resulting in a safer and more caring hospital for patients
2. Revolutionising our culture towards continuous quality improvement
3. Creating an environment where all staff have a sense of shared ownership and responsibility and feel enabled to help make our hospital one of the best
4. Capitalising on the energy and enthusiasm of staff by taking the best ideas for improving the quality and safety of patient care – and encouraging uptake throughout the hospital
5. Engaging and empowering staff to deliver and sustain the required change in their workplace
6. Harnessing individual and collective talent and creating clinical leaders at every level within the hospital
7. Providing improvement and change expertise - to give skill and enable learning - for as many staff as possible through direct involvement in projects and sharing of best practice
8. Achieving a consistent message that improving quality eliminates waste, reduces variation and improves efficiency. **All are of equal importance.**

Outputs

Addresses the gap between the 'as is' organisation and the 'to be' organisation

Programme Office

Review of resources and governance arrangements to ensure it is fit for purpose. Governance and programme plan and monitoring progress against patient quality measures through programme board. Continuously check we are 'adding value' through lessons learnt. Strong communication strategy through the development of intranet site

Building Capacity and Capability

Support skills and expertise within the organisation. Develop and strengthen academy for continuous quality improvement and rolling programme of learning and development for staff, including junior doctors. Spot high potential and encourage mentoring and coaching to 'grow our own' leadership capability.

Delivering quality improvements for patients

Hospital Flow: *Right Patient, Right Time, Right Place* - Emergency Department – Outpatients; **Specialty Pathways:** Ophthalmology
Workforce: Medical Rotas; **Fundamentals of Care:** Clinical Documentation and Communication

Supporting the required change in culture

Create a mind set for innovative change. Encouraging a climate of high expectations with staff looking for ways for service delivery to be even better. Ensure improvement projects set clear standards and hold others to account to reduce variations in the quality of care. Identify the right metrics and measure progress. Ensure real time patient feedback for experiential design of new pathways. Co-produce with patients and carers. Develop external relationships in primary / community care to signal change. Identify opportunities to reward high standards and celebrate success. Active member of Wessex PSC and support Wessex Deanery QI Fellows. Support annual Quality Conference

Productivity and efficiency

Implement tracking and reporting arrangements to secure delivery of 2019/20 CIP. Support early work-up of 2019/20 initiatives to ensure implementation of savings start promptly. Use Model Hospital and other benchmarking and quality initiatives to support productive and effective care. Develop and monitor implementation of improvement and CIP strategy to support delivery of financial plan. Support the implementation of the national GIRFT programme to reduce unwarranted variation in care.

Outcomes

Better patient experience and feedback
Patients feel confident about our services. Patients feel more involved and know what is happening to them.

Better working environment for staff
Staff are less stressed and not under constant pressure. They are working within more ordered processes and protocols, with care based around internal professional standards and evidence based best practice. Staff feel central to everything we are doing – empowered, with the right skills and competencies to do their job effectively. Staff are clear about their accountabilities and responsibilities and feel valued for the contributions they are making to the organisation.

Performance and outcome metrics are moving in the right direction. We are inquisitive and interested in what we can do better and are achieving upper quartile performance and benchmark well across a range of outcome measures. We are viewed as an acute hospital capable of delivering significant improvements.

Delivering a cost effective and value for money service. We are delivering the 2019/20 and efficiency and productivity plan. We are investing our resources wisely and in the most effective way.

Our health system is more integrated.
We will be seen as a catalyst for change and act as a fully engaged participant in making the CSR, merger and Vanguard a success.

Staged Plan

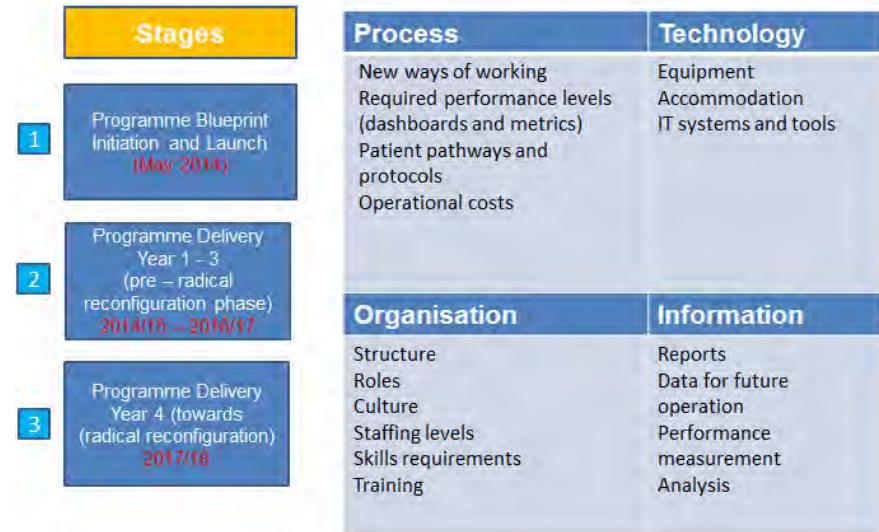
When the Improvement Programme was first launched we adopted a staged approach with 2018/19 acting as the final year (5) with a focus on radical transformation.

2019/20 onwards

With the implementation of the Dorset Clinical Services Review (CSR), the proposed merger with Poole Hospital NHS FT and One Acute Network (OAN) the model of healthcare delivery within Dorset is now set to radically change. Fundamental to this change will be the development of a culture of continuous quality improvement throughout both organisations.

Whilst quality benefits and savings are likely to be substantial, these will be delivered in the medium to longer term. During this transitional period we therefore need to ensure that a focus on quality and safety for patients is maintained whilst delivering our productivity and efficiency agenda.

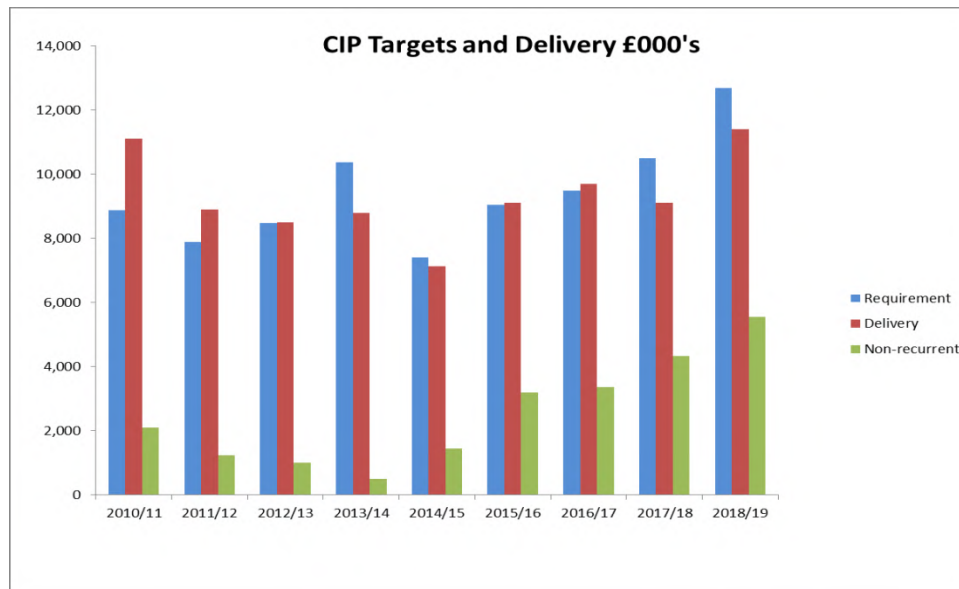
Supporting strategic change is inherent within our work. In 2019/20 we be working with the four 'early transition services' to develop QI and OD methodologies and support their integration plans. In addition, we will maintain our business as usual improvement agenda within RBCH and regularly review the outputs of our work to ensure we maintain a balance between these priorities as required to support the organisation.



In the last six years the Trust has consistently delivered savings in excess of £8m (with the exception of 2014/15 where the Trust focused on the delivery of efficiency savings to support increasing activity).

In 2018/19 we are currently forecasting a £1.395m deficit against our CIP target however we are still forecasting that we will meet our revised control total.

Work has been on-going to maintain and support the efficiency of the hospital through the QI programme and national programmes such as GIRFT and the Model Hospital.



	FOT		
	Target	Forecast	Variance
Surgical	(2,182)	1,609	(573)
Medical	(3,009)	2,044	(1,044)
Specialties	(2,167)	1,866	(318)
Corporate	(1,330)	1,480	150
	(8,688)	6,999	(1,785)
Centrally Managed			
Budgets	(2,102)	2,492	390
Christchurch LLP			
Income	(1,907)	1,907	-
	(4,009)	4,399	390
Organisation Total	(12,697)	11,398	(1,395)

Improvement Programme

Part A – Overview

Part B – Key Actions and 2018/19 Evaluation

Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building Capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices



The improvements we have made

What are the improvements we have made?

Our QI programme has continued to develop with annual evaluation and review and generation of pipeline projects. Revised CIP trackers and QIA documentation were implemented at the beginning of the year, a review by internal audit has informed the analysis below. Additional work on Model Hospital and GIRFT has further developed productivity and efficiency into a larger programme of work focused on supporting the identification of options for review. Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Risk	Description	Achieved	Further Action Required
Inconsistent Communication	Message to staff must legislate against <i>'regardless of the financial pressures created, focus on quality and safety'</i>	Integration of QIA into main CIP document, revised QIA policy.	A review indicates that evidence and information relating to schemes for QIA is not sufficiently detailed and reviewed throughout the year. Implement enhanced focus on analysis and reporting of QIA.
Lack of Accountability for actions not taken	Clarity of Executive accountability of QI and CIP programme.	Development of additional reporting on procurement, model hospital etc. to identify opportunities not taken.	Further reporting within Finance Committee CIP report to expand on progress of CIP opportunities.
Poor time commitment	Time should be prioritised for escalation meetings to progress actions and unblock barriers for delivery.	Operational pressures and competing priorities continue to cause difficulty ensuring full representation.	Ensure planning for project delivery takes into account operational pressures and provide clarity of priorities.
Programme not owned or understood across the organisation	Reporting of progress should be transparent throughout the organisation.	Consistent engagement despite difficulties in delivering new and achievable schemes.	Developing new avenues to explore analysis and benchmarking to support identification of change through model hospital, GIRFT and other benchmarking opportunities. Review of guidance for potential to make changes.

What are the improvements we have made?

Sustainability Score: 76.5

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables																																																																																																																																																																																								
<div>First 24 Hours: Ambulatory Care</div>	<div><div><div>Aim</div><div>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 by increasing the 2017/18 admission avoidance performance by 50%</div><div>Context</div><div>It’s been another tough year BUT we have delivered further improvements for patients despite (to end Feb 2109) a year-on-year increase in ED attendances of 6%; and in non-elective admissions by 3.9%</div><div>Achievements</div><div><ul style="list-style-type: none">an average increase of +19% per month in avoided admissions (all specialties) year-to-date based on 2017/18</div></div><div><div><div>OPAL Admission Avoidance YoY</div><div><table><thead><tr><th>Month</th><th>2017</th><th>2018 OPAL</th><th>Variance (%)</th></tr></thead><tbody><tr><td>Jul</td><td>371</td><td>408</td><td>+9.65%</td></tr><tr><td>Aug</td><td>429</td><td>432</td><td>+0.73%</td></tr><tr><td>Sep</td><td>395</td><td>415</td><td>+5.27%</td></tr><tr><td>Oct</td><td>388</td><td>392</td><td>+0.85%</td></tr><tr><td>Nov</td><td>451</td><td>471</td><td>+4.13%</td></tr><tr><td>Dec</td><td>463</td><td>455</td><td>-1.70%</td></tr><tr><td>Jan</td><td>467</td><td>485</td><td>+1.70%</td></tr><tr><td>Feb</td><td>437</td><td>461</td><td>+5.63%</td></tr><tr><td>Mar</td><td>471</td><td>492</td><td>+4.43%</td></tr></tbody></table></div><div>Significant improvement delivered by the work of the OPAL and Frailty ANP teams in ED</div></div><div><div><div>Admission Avoidance by Month</div><div><table><thead><tr><th>Month</th><th>2017/18</th><th>2018/19</th><th>Variance (%)</th></tr></thead><tbody><tr><td>April</td><td>371</td><td>408</td><td>+9.65%</td></tr><tr><td>May</td><td>429</td><td>432</td><td>+0.73%</td></tr><tr><td>June</td><td>395</td><td>415</td><td>+5.27%</td></tr><tr><td>July</td><td>388</td><td>392</td><td>+0.85%</td></tr><tr><td>August</td><td>451</td><td>471</td><td>+4.13%</td></tr><tr><td>September</td><td>463</td><td>455</td><td>-1.70%</td></tr><tr><td>October</td><td>467</td><td>485</td><td>+1.70%</td></tr><tr><td>November</td><td>437</td><td>461</td><td>+5.63%</td></tr><tr><td>December</td><td>471</td><td>492</td><td>+4.43%</td></tr><tr><td>January</td><td>474</td><td>500</td><td>+5.51%</td></tr><tr><td>February</td><td>516</td><td>543</td><td>+5.16%</td></tr><tr><td>March</td><td>491</td><td>515</td><td>+4.91%</td></tr></tbody></table></div><div>Consistently higher admission avoidance rates throughout 2018-19 compared to 2017-18</div></div><div><div><div>Admission Avoidance by Month - SPC Chart - Number of Admissions Avoided</div><div><table><thead><tr><th>Month</th><th>Number of Admissions Avoided</th><th>Mean</th><th>Process Limit</th></tr></thead><tbody><tr><td>Apr-17</td><td>350</td><td>423</td><td>320</td></tr><tr><td>May-17</td><td>380</td><td>423</td><td>320</td></tr><tr><td>Jun-17</td><td>380</td><td>423</td><td>320</td></tr><tr><td>Jul-17</td><td>450</td><td>423</td><td>320</td></tr><tr><td>Aug-17</td><td>450</td><td>423</td><td>320</td></tr><tr><td>Sep-17</td><td>450</td><td>423</td><td>320</td></tr><tr><td>Oct-17</td><td>450</td><td>423</td><td>320</td></tr><tr><td>Nov-17</td><td>450</td><td>423</td><td>320</td></tr><tr><td>Dec-17</td><td>450</td><td>423</td><td>320</td></tr><tr><td>Jan-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Feb-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Mar-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Apr-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>May-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Jun-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Jul-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Aug-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Sep-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Oct-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Nov-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Dec-18</td><td>500</td><td>423</td><td>320</td></tr><tr><td>Jan-19</td><td>500</td><td>423</td><td>320</td></tr></tbody></table></div><div>Data recalculated in Dec 2017 as it met the SPC test for change in data (8 points above the mean); 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What are the improvements we have made?

Sustainability Score: 76.5

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Workflow

First 24 Hours: Ambulatory Care

Achievements

- Launch of *Consultant Connect* in Dec 2018, enabling GPs to access rapid telephone contact with participating RBCH clinicians is realising good results. To date calls are being answered within 30-40 seconds, and over 50% have resulted in referral avoidance or admission avoidance
- RBCH funded taxi conveyances from GPs to expedite arrival and smooth demand

Average time from booking to arrival (hr:min:sec)

Ambulance	RBCH-funded Taxi
03:17:53	01:23:02

When considered clinically appropriate by GPs, conveyance by taxi is markedly quicker than conveyance by ambulance

Key Deliverables

Call volume by specialism, Jan 2019

Outcomes of calls

Activity data (January 2019 data above) shows a steady increase in call volumes and a consistent outcomes of 50%+ admission or referral avoidance

Admission Hour	Average of LoS (days)
07:00 - 08:00	1.00
08:00 - 09:00	1.35
09:00 - 10:00	1.06
10:00 - 11:00	2.28
11:00 - 12:00	2.76
12:00 - 13:00	2.94
13:00 - 14:00	4.10
14:00 - 15:00	5.19
15:00 - 16:00	6.31
16:00 - 17:00	5.37
17:00 - 18:00	5.15
18:00 - 19:00	5.10
19:00 - 20:00	5.86
20:00 - 21:00	6.17
21:00 - 22:00	7.32
22:00 - 23:00	6.54
23:00 - 24:00	6.66

Patients who are admitted before 1:00pm have < 3 day average LoS

Patients who are admitted after 2:00pm have > 5 day average LoS

Admission Hour	% O Day LoS
6am-8am	60.2%
8am-10am	34.0%
10am-12pm	28.8%
12pm-2pm	24.5%
2pm-4pm	12.6%
4pm-6pm	13.4%
6pm-8pm	7.7%
8pm-10pm	3.1%
10pm-Midnight	0.5%

At least 1 in 4 patients are discharged the same day if they are admitted before 2:00pm

Only 1 in 8 of those admitted between 2:00-6:00pm will go home same day



Very unlikely after 6:00pm

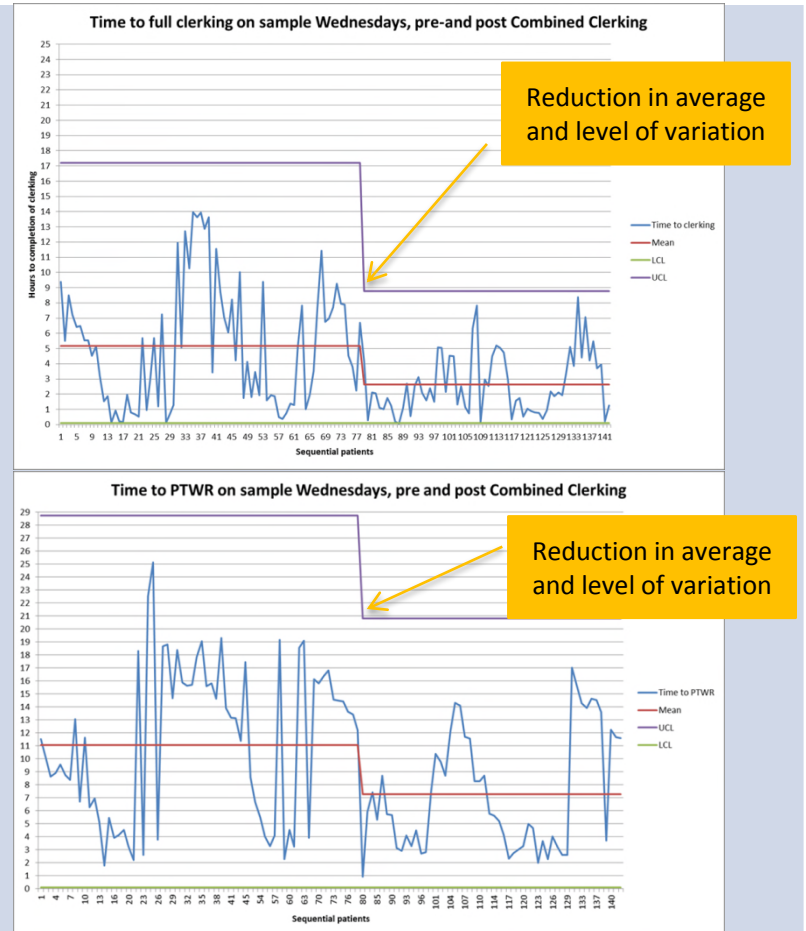
Sooner admission to hospital increases the opportunity for same-day discharge, and in shorter LoS for those requiring an inpatient stay

What are the improvements we have made?

Sustainability Score: 90.0

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)


Workstream	Key Deliverables
<p>First 24 Hours: Combined Clerking</p>	<div> <p>Aim</p> <p>To improve the first 24 hours of our urgent and emergency care pathway to deliver '<i>right patient, right time, right team, right place</i>' by March 2019 by:</p> <ul style="list-style-type: none"> reducing the overlap between ED and AMU/SAU clerking by 50% by March 2019 <p>Context</p> <p>The pro-forma was implemented on 29 October 2018 and has remained in place since then, with further iterative improvements.</p> <p>What we achieved</p> <ul style="list-style-type: none"> 49% improvement on duplication of clerking, with significant reduction in variation 3 hr 45 min improvement to Post Take Ward Round (PTWR) per patient </div> <div>   </div>



2018/19 Programme Evaluation

What are the improvements we have made?

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables
<p>First 24 Hours: Process Mapping</p>	<p>Aim</p> <p>To improve the first 24 hours of our urgent and emergency care pathway to deliver '<i>right patient, right time, right team, right place</i>' by March 2019 by:</p> <ul style="list-style-type: none"> mapping all pathways through and beyond the Front Door, identifying potential improvement opportunities for action by operational / clinical leads undertaking Action Learning Weeks (ALW) in and around ED <p>Achievements</p> <ul style="list-style-type: none"> all Front Door pathways mapped, documented, and signed off by close of Q2 2018/19 each map was colour-coded to highlight the identified issues (pink) and opportunities (green) to enable subsequent review/action by associated teams ALW 1 – a weekend continuous 64 hours monitoring of processes in ED involving > 35 RBCH staff (August 2018) ALW 2 – focus on BREATH, point of care testing and triage streaming (December 2018) 

What are the improvements we have made?

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Sustainability Score: 75.9

Workstream

Key Deliverables

Discharge Planning

Aim

To reduce stranded patients by:

- launching a new policy and standard operating procedure (SOP)
- providing ongoing support, training and education and ALWs

Context

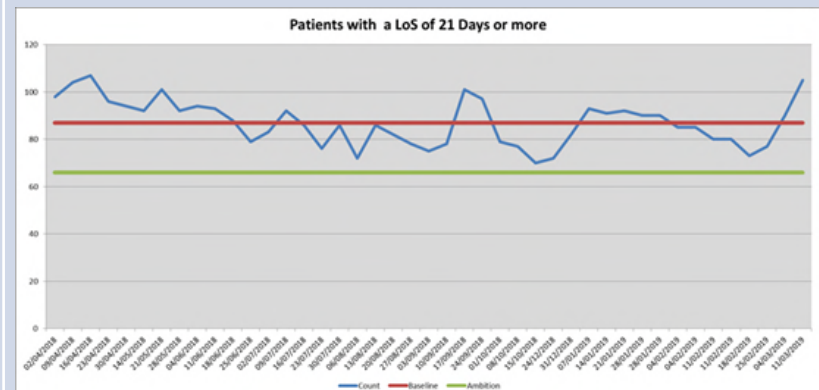
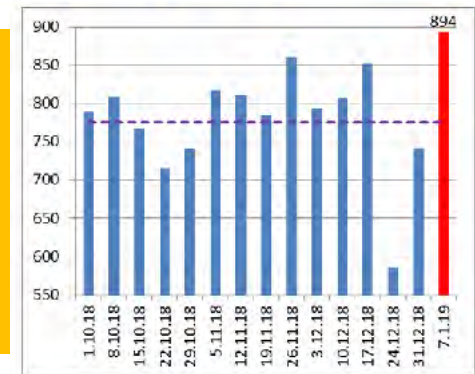
Stranded patients continue nationally to place great strain on NHS services. Improving discharge planning is shown to reduce length of stay for patients and provide better outcomes as patients are at reduced risk of hospital acquired infection and deconditioning.

Achievements

- new discharge planning policy and SOP introduced with new measurement for super-stranded patients (LOS>21 days)
- Perfect weeks and MADE events to improve joint working across the healthcare system and increase discharges; weekly super-stranded patient review meetings with health system partners
- reduction in super-stranded patients in line with new national target (Fayrewood and MacMillan patients excluded)
- better ways of working across the healthcare system including the introduction of a named dedicated social worker to attend Ward 5 board rounds

Total discharges during January 'Perfect week'

We achieved a record number of discharges during action learning week. This was testament to our hard working wards and colleagues across the healthcare system



Trajectory of super-stranded patients with LOS >21 days. Apr 18-Mar 19

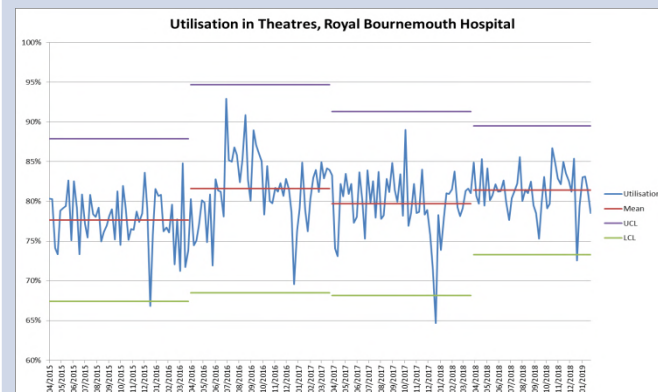
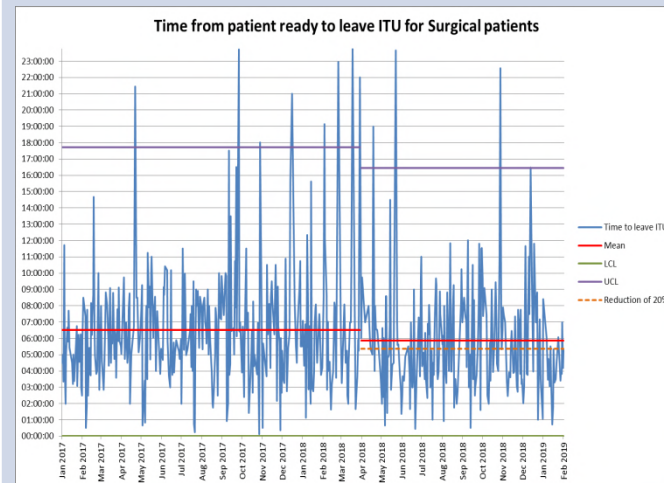
2018/19 Programme Evaluation

What are the improvements we have made?

Sustainability Score: 95

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables
Surgical Flow	<p>Aim</p> <p>To achieve 85% utilisation for theatres and to reduce time delays out of Intensive Care Unit (ITU) by 20% by March 2019</p> <p>Context</p> <p>To improve flow through our operating theatres and Intensive Care (ITU) beds, so that we utilise these expensive resources more efficiently</p> <p>Achievements</p> <ul style="list-style-type: none"> 10% reduction in ITU delays (around 40 minutes on average) from the time the patient was ready to leave, to when they actually left ITU. Much of this was around improvement of flow on the wards as opposed to processes in ITU itself 81.4% utilisation in theatres against a target of 85%, however a rise of nearly 4% from three years ago. There is also now less variation which signifies more stable processes and workforce rationalisation of the Orthopaedic Extended Day, improving utilisation, resilience and adaptability through standardised and consistent staff shift patterns <p><i>Please note: these improvements are documented for Care Group A. Improvements in Eye Theatres are described in the Ophthalmology QI project.</i></p>



What are the improvements we have made?

Sustainability Score: 95

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables
Surgical Flow (continued)	<div> <p>Achievements</p> <ul style="list-style-type: none"> a Surgical Frailty Service established, based on a previous QI project which showed how Geriatric specialist input reduced the length of stay for over 85 year olds undergoing an emergency laparotomy 3 days reduction in LOS for older surgical patients on ward 14 based on current delivery, Surgical Care Group is proposing to a) release beds through expansion of the Surgical Frailty Team and Urology Consultant of the Week (COW) and b) increased day cases </div> <div> <p>Length of stay for 85+ year olds on Ward 14</p> <p>Length of stay for 85 year olds and over has reduced by 3 days on average and there has been a significant reduction in the variation of length of stay</p> </div>

2018/19 Programme Evaluation

What are the improvements we have made?

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Sustainability Score: 83.5

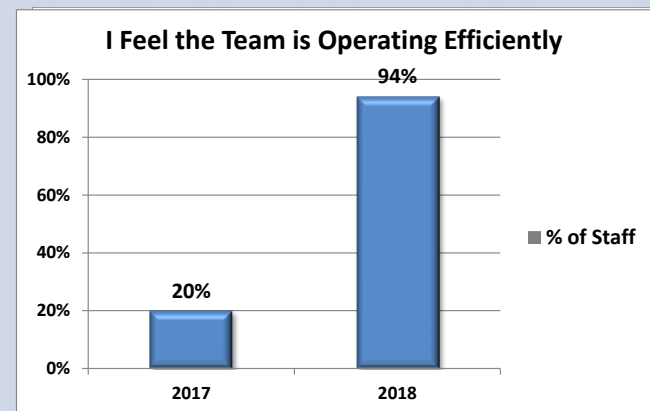
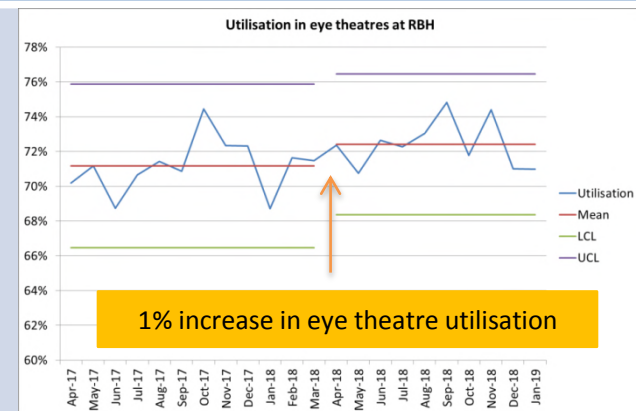
Workstream	Key Deliverables																																																							
Specialty Pathways: Dermatology	<p>Aim</p> <p>All surgical forms completed accurately by August 2018 and zero avoidable hospital reason cancellations by October 2018</p> <p>Achievements</p> <ul style="list-style-type: none"> introduction of an electronic system for booking appointments to replace the paper diary Development of a surgical timings model to assist with slot time calculation when booking appointments. This model also provides a means of recording competencies for consultant, doctor and nurse surgeons Introduction of a Nurse Assessment Clinic. This new service with a nurse immediately following outpatient appointment before patient leaves department to: <ul style="list-style-type: none"> ensure all elements of surgical form completed further clarify procedure with patient, allowing extra time to ask questions arrange surgery appointment date 	<table border="1"> <thead> <tr> <th>Surgical Forms Audit (n=272 for Feb, n=350 for June)</th><th>Feb-18</th><th>Jun-18</th></tr> </thead> <tbody> <tr><td>needed to re-confirm site</td><td>5</td><td>3</td></tr> <tr><td>not enough time allowed</td><td>5</td><td>6</td></tr> <tr><td>lesion larger than indicated</td><td>4</td><td>1</td></tr> <tr><td>wrong list</td><td>2</td><td>0</td></tr> <tr><td>wrong procedure defined</td><td>2</td><td>0</td></tr> <tr><td>transport not specified</td><td>1</td><td>0</td></tr> <tr><td>anticoag not defined</td><td>2</td><td>0</td></tr> <tr><td>innacurate or missing performance status</td><td>9</td><td>0</td></tr> <tr><td>allergy not indicated</td><td>1</td><td>1</td></tr> <tr><td>room move required</td><td>1</td><td>0</td></tr> <tr><td>pt declined second lesion</td><td>1</td><td>1</td></tr> <tr><td>extra lesion</td><td>0</td><td>3</td></tr> <tr><td>lesion resolved</td><td>0</td><td>9</td></tr> <tr><td>required opinion</td><td>0</td><td>2</td></tr> <tr><td>Hoist not indicated</td><td>0</td><td>1</td></tr> <tr><td>Bad photo</td><td>0</td><td>1</td></tr> <tr><td>total</td><td>32</td><td>28</td></tr> </tbody> </table> <p>Some timings issues – further work on the surgical timings model may help reduce this</p> <p>Improved accuracy of form filling e-form version now being developed</p> <p>RBCH - Derm Surgery - Avoidable hospital reason cancellations day before or day of op</p> <p>Current booking process is designed such that there is an expected 0 to 5 cancellations as part of normal variation. Further work required to understand and reduce the variation in the admin process</p>	Surgical Forms Audit (n=272 for Feb, n=350 for June)	Feb-18	Jun-18	needed to re-confirm site	5	3	not enough time allowed	5	6	lesion larger than indicated	4	1	wrong list	2	0	wrong procedure defined	2	0	transport not specified	1	0	anticoag not defined	2	0	innacurate or missing performance status	9	0	allergy not indicated	1	1	room move required	1	0	pt declined second lesion	1	1	extra lesion	0	3	lesion resolved	0	9	required opinion	0	2	Hoist not indicated	0	1	Bad photo	0	1	total	32	28
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2018/19 Programme Evaluation

What are the improvements we have made?

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Workstream	Key Deliverables
Specialty Pathways: Ophthalmology	<p>Aim To improve patient safety and experience by reducing RTT waiting times in Ophthalmology to a maximum of 18 weeks and improving efficiency in eye theatres by March 2019</p> <p>Context RTT performance has declined in Ophthalmology. This project had 3 strands: a) Eye Theatres b) Eye Outpatients and c) Eye Emergencies</p> <p>Achievements</p> <ul style="list-style-type: none"> staffing issues in theatres limited the ability to pursue a). In eye theatres there was a modest increase in utilisation but a slight decrease in cases, which reflects these difficulties Eye Outpatients project commenced October 2018 and has made some early progress with daily team huddles now in place, refined staff allocation and coordination, and clinic templates being changed Eye Emergencies has achieved its aim of increasing morale in Eye Emergencies (94% enjoying their work compared to 50% of staff at the start; and staff feel the team is now operating efficiently) we have revitalised the Ophthalmology project for 2019-20 which will cover further work in Eye Theatres and Eye Outpatients

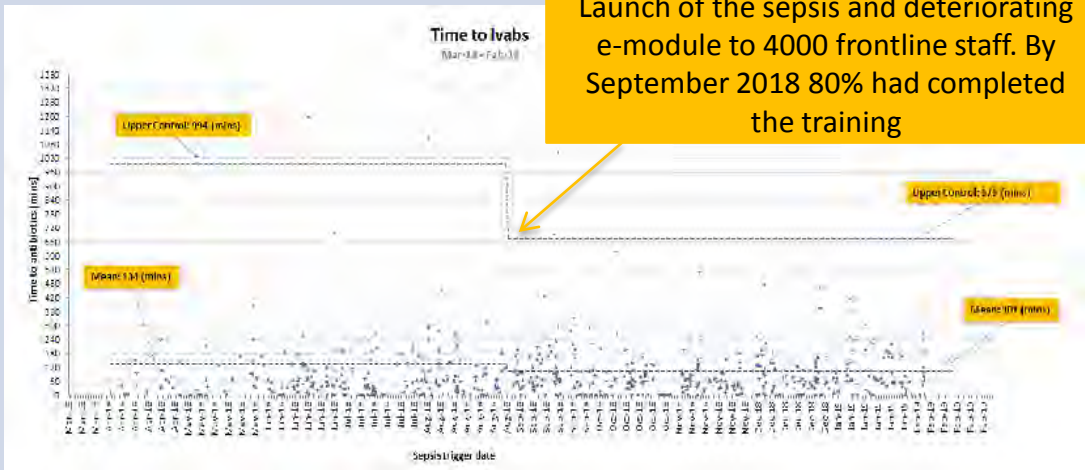



An improvement in the views of staff in the Eye Emergency Department

2018/19 Programme Evaluation

What are the improvements we have made?


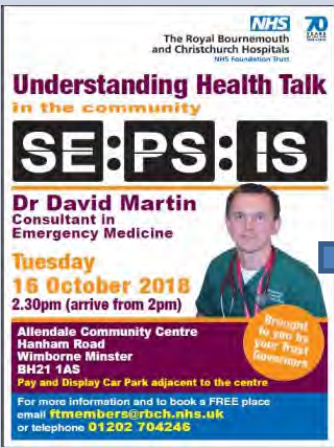

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Workstream	Key Deliverables																																	
Sepsis	<div><div><div><h3>Aim</h3><p>To achieve and sustain 95% of our patients with confirmed high risk sepsis in ED, AMU and SAU receiving intravenous antibiotics within one hour by March 2019</p><p>To improve compliance with our severe pneumonia care bundle in ED, AMU and SAU, CURB-65 by March 2019</p><h3>Context</h3><p>There has been a sepsis QI project at RBCH since 2015. The project team are confident that we continue to improve in our timely identification and treatment of sepsis.</p><p>Unfortunately, capturing consistent metrics to show our improvement has proven to be our biggest challenge</p></div><div><div><h3>Time to Ivabys</h3><p>Mar-18 = Feb-19</p></div><div><p>Launch of the sepsis and deteriorating e-module to 4000 frontline staff. By September 2018 80% had completed the training</p><p>All wards & departments (including ED) performance in delivering intravenous antibiotics following presentation with EWS ≥ 5 and suspicion of sepsis</p><div><h3>Sepsis Performance Report</h3><p>Delivery of intravenous antibiotics within 60 minutes</p><div><h4>Monthly performance</h4><table><thead><tr><th></th><th>Apr-18</th><th>May-18</th><th>Jun-18</th><th>Jul-18</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th></tr></thead><tbody><tr><td>Within 1hr</td><td>45%</td><td>50%</td><td>51%</td><td>62%</td><td>36%</td><td>42%</td><td>57%</td><td>38%</td><td>44%</td><td>33%</td></tr><tr><td>Within 2hr</td><td>86%</td><td>68%</td><td>79%</td><td>76%</td><td>71%</td><td>67%</td><td>81%</td><td>80%</td><td>74%</td><td>69%</td></tr></tbody></table></div><p><small>* The Performance (Selected) metric changes according to any filter options applied to the dataset</small></p></div></div></div></div></div>		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Within 1hr	45%	50%	51%	62%	36%	42%	57%	38%	44%	33%	Within 2hr	86%	68%	79%	76%	71%	67%	81%	80%	74%	69%
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2018/19 Programme Evaluation

What are the improvements we have made?

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Workstream	Key Deliverables	
Sepsis	<p>Achievements</p> <ul style="list-style-type: none"> • launch of the sepsis and deteriorating patient e-learning package. Within the 1st year 96.4% of 4000 frontline staff have successfully completed the training • submission for HSJ Patient Safety Education and Training Award February 2018 • in house monthly mortality review for sepsis by the Mortality Surveillance Group compared data between 2017 (42 deaths) and 2018 (19 deaths) and concluded that overall there was an improvement with the national average being between 15-20 • developed a data collection tool and a report that could be used by wards and departments • 120 members of the public attended a Health Talk on Sepsis in October 2018, presented by Dr David Martin • a repeat of the pneumonia audit of 2015 showed improvement in delivery of first dose antibiotics 	  <p>“The training got me thinking, highlights how critical time is, to save lives, be aware and look for the early warning signs.”</p> <p><i>Band 5 Staff nurse</i></p>  

What are the improvements we have made?

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Sustainability Score: 75.3

Workstream	Key Deliverables
<p>Deteriorating Patient</p> <p>Aim For 65% of appropriate patients with an EWS ≥ 9 to have a documented review by a competent practitioner within 30 minutes, and 100% within 60 minutes, by March 2019</p> <p>Context For the 2018/19 QI programme the deteriorating patient became a separate QI project to sepsis</p> <p>The focus of the deteriorating patient QI team was on three key principles of physical deterioration for patients with an EWS (Early Warning Score) of ≥ 9:</p> <ul style="list-style-type: none"> Recognition – identification, monitoring and assessment Response – reliable and timely activation and communication Escalation – clinical interventions within our escalation parameters 	<p>CND (Critical Notification Dashboard) introduced on most acute wards by September 1st 2018</p> <p>Winter pressures acuity project measures began 12th Jan 2019</p> <p>The upper and lower control limits are 3 standard deviations from the mean. This appears to indicate there have been some improvements in timeliness of reviews by reducing the inconsistency</p>

What are the improvements we have made?


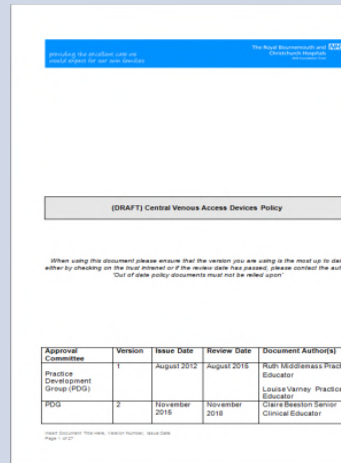

Sustainability Score: 75.3

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Workstream	Key Deliverables																																																																								
Deteriorating Patient	<div><h3>Achievements</h3><ul style="list-style-type: none">Successfully rolled out the Critical Notification Dashboard (CND) to most of our acute wards, AMU, SAU, 14, 15, 16, 17, 2, 3, ASU and soon onto ward 26. This allows a clinician to quickly view the sickest patient on the wardLaunch of the sepsis and deteriorating patient e-learning package to promote recognition and timely review of our sickest patients.Winter pressures acuity PDSA launched on the 12th January. This PDSA is running on every Saturday and Sunday from the 12th January to the 31st March 2019. To date almost 200 patients have been reviewed by this acuity team over the weekendDevelopment of Deteriorating Patient report to enable wards to have an overall picture of patient conditionClose collaboration with NEWS2 project group. Including the design of an in-house observation system</div> <div><div><p>% of patients seen within 30 minutes who have an EWS ≥ 9 (against an aim of 65%)</p><div><h4>Deteriorating Patient Report</h4><p>Monthly performance</p><table><thead><tr><th>Mar-18</th><th>Apr-18</th><th>May-18</th><th>Jun-18</th><th>Jul-18</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th><th>Feb-19</th></tr></thead><tbody><tr><td>38%</td><td>51%</td><td>47%</td><td>44%</td><td>46%</td><td>39%</td><td>48%</td><td>45%</td><td>41%</td><td>41%</td><td>40%</td><td>38%</td></tr><tr><td></td><td></td><td>50%</td><td>45%</td><td>50%</td><td>38%</td><td>53%</td><td>47%</td><td>41%</td><td>41%</td><td>38%</td><td>37%</td></tr></tbody></table><p><small>* The Performance (Selected) metric changes according to any filter options applied to the dataset</small></p></div></div><div><p>% of patients seen within 60 minutes who have an EWS ≥ 9 (against an aim of 100%)</p><div><h4>Deteriorating Patient Report</h4><p>Monthly performance</p><table><thead><tr><th>Mar-18</th><th>Apr-18</th><th>May-18</th><th>Jun-18</th><th>Jul-18</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th><th>Feb-19</th></tr></thead><tbody><tr><td>64%</td><td>71%</td><td>63%</td><td>69%</td><td>63%</td><td>58%</td><td>62%</td><td>66%</td><td>60%</td><td>58%</td><td>71%</td><td>57%</td></tr><tr><td></td><td></td><td>63%</td><td>68%</td><td>64%</td><td>55%</td><td>69%</td><td>67%</td><td>59%</td><td>60%</td><td>70%</td><td>55%</td></tr></tbody></table><p><small>* The Performance (Selected) metric changes according to any filter options applied to the dataset</small></p></div></div><div><p>Importantly, the time written in patient records usually relates to the time of writing which occurs after the clinical assessment/review. Therefore it has been difficult to capture the actual time the reviewer arrives on the ward. Average time of written review 101 minutes</p></div></div>	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	38%	51%	47%	44%	46%	39%	48%	45%	41%	41%	40%	38%			50%	45%	50%	38%	53%	47%	41%	41%	38%	37%	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	64%	71%	63%	69%	63%	58%	62%	66%	60%	58%	71%	57%			63%	68%	64%	55%	69%	67%	59%	60%	70%	55%
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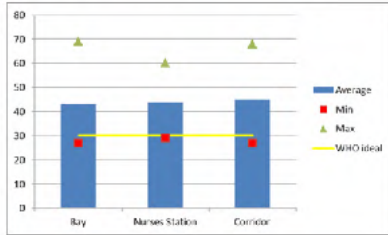
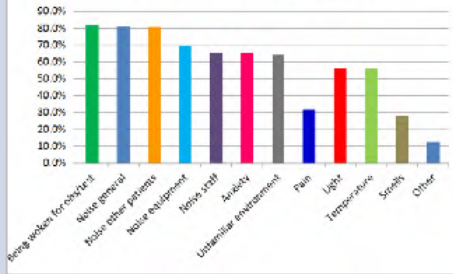

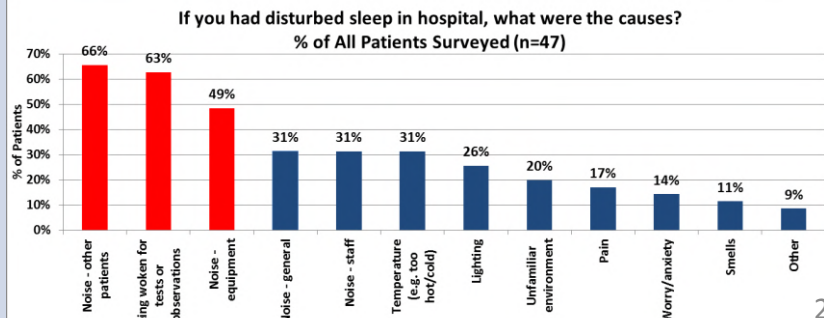
What are the improvements we have made?

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Workstream	Key Deliverables
CVADs	<div> <p>Aim</p> <p>To improve the co-ordination of all Central Venous Access Devices (CVADS), so that we know the status of every patient with a CVAD line inserted by the Royal Bournemouth Hospital by March 2019, and to ensure compliance with the new CVAD SOP</p> <p>Context and Achievements</p> <p>We did not achieve our aim by March 2019, however we have:</p> <ul style="list-style-type: none"> established a group with a high level of engagement rewritten the Standard Operating Procedures so staff have clear guidance in January 2019 the BEAT Team launched the Central Venous Access Devices (CVAD) on to BEAT brain. 600 staff had CVAD competencies though for 263 this had expired. <p>The key to knowing the status of patients is digital record keeping. We have set out what we need and the project success is dependent on wider Trust developments:</p> <ul style="list-style-type: none"> The decision to stop all work on ENA other than NEWS2 development until spring 2019 Recent decision to look at purchasing ICnet (infection control software) across Bournemouth and Poole, which means we will have to decide between this and ENA <p>This project will continue into 2019/20</p> </div> <div>    </div>

What are the improvements we have made?

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Workstream	Key Deliverables
<p>Reducing Unnecessary Interventions</p> <p>Aim To reduce unnecessary diagnostics and/or nursing observations for patients who are medically ready for discharge by March 2019</p> <p>Context A wide range of drivers meant decision taken to focus on the follow three projects</p> <ul style="list-style-type: none"> Sleep Well Project (Lead: Fiona Hoskins) Ward 5: Reducing unnecessary interventions (Lead: Clare Baggett) HANbleep clinical site team project (Lead: Abigail Brelsford) <p>Achievements</p> <ul style="list-style-type: none"> Extensive audits undertaken for patient and staff engagement in what we can do to improve sleep Hospital standards promoting adequate rest and sleep for patients based on national best practice; to be launched with an Action Learning Week on 29th April Ward 5 testing guidelines to reduce the number of unnecessary tests and obs for patients, including blood tests, routine nursing obs, blood glucose and medical review The clinical site team visited wards and encouraged them to review their green calls during the whiteboard round 	<div>  <p>Noise at night </p> <p>The World Health Organisation recommends average night exposure to noise should not exceed 30 dB on a hospital ward.</p> <p>Average noise levels on our wards exceed these guidelines and our audits have recorded areas with a noise level of 69dB</p>  </div> <div> <p>What causes disturbed sleep in hospital?</p>  </div> <div>  </div> <div> <p>If you had disturbed sleep in hospital, what were the causes? % of All Patients Surveyed (n=47)</p>  </div>

What are the improvements we have made?

Full details of 2018/19QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables																																	
Falls	Aim	100% of the patients on Ward 15 have their falls risks identified and an action plan documented daily by 30 April 2019																																
	Context	Operational issues and workload, led to a period of little project activity whilst other activities taking place such as falls awareness week. Project restarted November 2018 following review of comments, ideas, issues raised during falls awareness week. Project team formed on Ward 15 with Debbie Fortune as project lead																																
	Achievements	<ul style="list-style-type: none"> Falls awareness stand and simulation training held at Patient Safety and QI Conference 2018 New Falls prevention posters developed and implemented eNA and Falls eLearning updated to highlight importance of lying and standing blood pressure New lanyard cards on lying and standing blood pressure developed RBCH first Falls Awareness week completed 29th October 2018 First PDSA cycle trialling new documentation took place on Ward 15. Results are currently being evaluated 																																
		<p>Baseline RBCH Data</p> <table> <tr> <th>Risk factors assessed</th><th>2015</th><th>2017</th><th>National Average</th></tr> <tr> <td>Delirium</td><td>29.2%</td><td>36%</td><td>40%</td></tr> <tr> <td>Continence CP</td><td>66.7%</td><td>69%</td><td>67%</td></tr> <tr> <td>Lying and Standing Blood Pressure</td><td>21.7%</td><td>36%</td><td>19%</td></tr> <tr> <td>Medication</td><td>81%</td><td>70%</td><td>48%</td></tr> <tr> <td>Vision</td><td>62.1%</td><td>43%</td><td>46%</td></tr> <tr> <td>Mobility Aid</td><td>60%</td><td>75%</td><td>72%</td></tr> <tr> <td>Call Bell</td><td>89.7%</td><td>99%</td><td>81%</td></tr> </table>	Risk factors assessed	2015	2017	National Average	Delirium	29.2%	36%	40%	Continence CP	66.7%	69%	67%	Lying and Standing Blood Pressure	21.7%	36%	19%	Medication	81%	70%	48%	Vision	62.1%	43%	46%	Mobility Aid	60%	75%	72%	Call Bell	89.7%	99%	81%
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Mobility Aid	60%	75%	72%
Call Bell	89.7%	99%	81%

Lanyard Card





Procedure for measuring lying & standing blood pressure

- Use a manual sphygmomanometer if possible.
- Patient to lie down for 5 minutes. Take BP 1
- Patient to stand. Take BP 2 in the first minute
- Patient to remain standing. Take BP 3 between 5-5 minutes
- Repeat readings via electronic assessment or if manual records

What are the improvements we have made?

Full details of 2018/19QI programme deliverables and end of stage reports are available [here](#)

Workstream	Key Deliverables																																																																			
<div>Pressure Ulcers</div>	<div>Aim</div> <p>Ensure all patients have a full documented SKINS assessment within 6 hours of admission to the Trust</p>																																																																			
	<div>Context</div> <p>The project began in May 2018, with the completion of a 5Ps exercise. Stakeholders were identified in order to form a QI project board.</p>																																																																			
	<div>Achievements</div> <ul style="list-style-type: none">Workshops held with all AMU staff of all levels<ul style="list-style-type: none">Identifying barriers to achieving best practiceHow can these be overcomeIdeas for PDSA cycles3 things to prioritise in their own practiceBaseline assessment data collected from 10 - 16 Sept 18New PU categorisation posters and lanyard cards produced for all areasInternational STOP PU Day celebrated across the Trust (Nov 18)AMU have developed a PU ward improvement planPiloting a PU ward round sticker within OPMTrust wide Wound Care study day held on 14th February	<div><div><div>Pressure Ulcer Ward Round</div><div><div>Patient Name: Patient No:</div><div>Date: Ward:</div></div><table><tr><td>Patient review</td><td>Y</td><td>N</td><td>eNA</td><td></td><td></td></tr><tr><td>PU categories are accurate</td><td></td><td></td><td>MUST score</td><td></td><td></td></tr><tr><td>Equipment is appropriate</td><td></td><td></td><td>Waterlow score</td><td></td><td></td></tr><tr><td>LERN completed</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Documentation review</td><td>Y</td><td>N</td><td>Referrals</td><td>Y</td><td>N</td><td>NA</td></tr><tr><td>Wound care plan</td><td></td><td></td><td>Dietitians</td><td></td><td></td><td></td></tr><tr><td>SKINS bundle</td><td></td><td></td><td>Podiatry</td><td></td><td></td><td></td></tr><tr><td>Care plan</td><td></td><td></td><td>Tissue Viability</td><td></td><td></td><td></td></tr><tr><td>Relevant updates made</td><td></td><td></td><td>Falls/ M&H</td><td></td><td></td><td></td></tr><tr><td>Added to Safety briefing</td><td></td><td></td><td>Medical photography</td><td></td><td></td><td></td></tr></table><div><div>Date of next review:</div><div>Print Name:Signature:</div></div></div></div> <div><div></div><div>Trust Wound Care Day 92 Attendees and 100% rated content as good to excellent</div></div>	Patient review	Y	N	eNA			PU categories are accurate			MUST score			Equipment is appropriate			Waterlow score			LERN completed						Documentation review	Y	N	Referrals	Y	N	NA	Wound care plan			Dietitians				SKINS bundle			Podiatry				Care plan			Tissue Viability				Relevant updates made			Falls/ M&H				Added to Safety briefing			Medical photography			
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What are the improvements we have made?

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

Workstream

Key Deliverables

Learning from deaths

Aim

To ensure that all inpatient deaths have a medical examiners review within 24 hours and full eMortality review within 60 days by the end of March 2019

Context

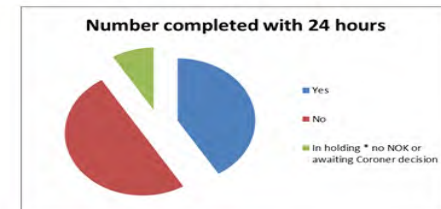
Pilot for RBH deaths started 22 October 2018, ME rota formalised Feb 19, 5 Medical Examiners on rota

Achievements

- New ME office set up
- Junior doctors now given slots to present case to ME. Process more efficient
- ME discusses MCCD with presenting clinician
- MCCD agreed and standard process for completion of all relevant paperwork continues as usual. ME completes Part 2 Cremation Form
- ME completes initial screening on notes (standard template used) and highlights any cases for further review via Trust LERN/SI process
- ME has discussion with family to explain cause of death and ask if family have any initial concerns or questions
- Junior Doctors are attending Patient Affairs Office in a much more timely manner
- In general positive feedback from junior doctors – ME process seen as good educational opportunity. Audit in progress
- Really positive discussions with families. Reducing family anxiety and confusion

Time to Issue MCCD to Family (Oct-Dec 18)

	Yes	No	N/A (No NOK or awaiting Coroner decision)
Number completed with 24 hours	103	125	22
% completed within 24 hours	41%	50%	9%



Family contacted

Contacted	
No	36
Yes	202
Not Applicable	8
Not Recorded	2

Concerns raised	
No	191
Yes	9
Not recorded	2

Examples:

- Patient given penicillin in ED but allergic, allergy clearly documented in notes. LERN Form and investigation already in progress.
- Wife only contacted 10 mins before her husband RIP and not able to attend. Details send to EoLC Steering Group to discuss at next meeting and include in training.
- Poor communication with family
- The family have some concerns about the care on the ward
- Family asked why medication was stopped. Explanation provided
- Family wanted feedback on why patient was given diagnosis of blindness. Explanation provided.
- Family concerned about delay in process, explained that the patient died in ED and required Coroners review

What are the improvements we have made?

Full details of 2018/19 QI programme deliverables and end of stage reports are available [here](#)

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Developing a continuous improvement culture	<ul style="list-style-type: none">Improvement Academy: 427 staff attended 2 day improvement skills training module – course continues to receive very positive feedbackover 100 staff attended additional modules in <i>Measurement for Improvement</i> and <i>Introduction to Project Management</i>Over 230 staff have attended personal productivity training module presented by Peter Gill3rd Junior Doctor QI programme 93 junior doctors have now completed the F1 training programme and 31 more have commenced in January 2019Improvement Team supported local frontline QI projects and teams through coaching and mentoringWessex Fellowships for QI (Team Based)																																																																																																												
	<div><div><h3>QI Skills Training: Attendance split by Directorate</h3><table><caption>QI Training Delegates By Directorate</caption><thead><tr><th>Directorate</th><th>Delegates</th><th>Percentage</th></tr></thead><tbody><tr><td>153 Anaesthetics/Theatre Directorate</td><td>23</td><td>5%</td></tr><tr><td>153 Cancer Care Directorate</td><td>20</td><td>11%</td></tr><tr><td>153 Cardiac Directorate</td><td>26</td><td>9%</td></tr><tr><td>153 Care Group A Management Directorate</td><td>3</td><td>60%</td></tr><tr><td>153 ED Directorate</td><td>33</td><td>11%</td></tr><tr><td>153 Elderly Care Services Directorate</td><td>65</td><td>10%</td></tr><tr><td>153 Estates and Support Directorate</td><td>4</td><td>7%</td></tr><tr><td>153 Facilities Directorate</td><td>8</td><td>3%</td></tr><tr><td>153 Finance and Business Intelligence</td><td>28</td><td>25%</td></tr><tr><td>153 Human Resources Directorate</td><td>19</td><td>22%</td></tr><tr><td>153 Informatics 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quality improvement through a mix of presentation, video, and practical exercises.</p><p>It will support your improvement work, help you to see it in context for systems and your own improvement journey, and give you a chance to try it.</p><p>Some of the topics covered in the course include:</p><ul style="list-style-type: none">system thinkingplanning for improvementplanning improvement and spreading change (e.g. PDCA cycle and process mapping)measurement for improvementunderstanding variation, increased data and its valuethe psychology of improvement<p>For more information, please contact the Improvement Team via Email: improvement@nhs.uk or Telephone: 01202 754000 or visit our website at: http://www.rech.nhs.uk/improvement</p><p>Improve + Change it!</p><p>The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust</p></div></div> <div>Significant improvement in self assessed knowledge and awareness scores post training</div>	Directorate	Delegates	Percentage	153 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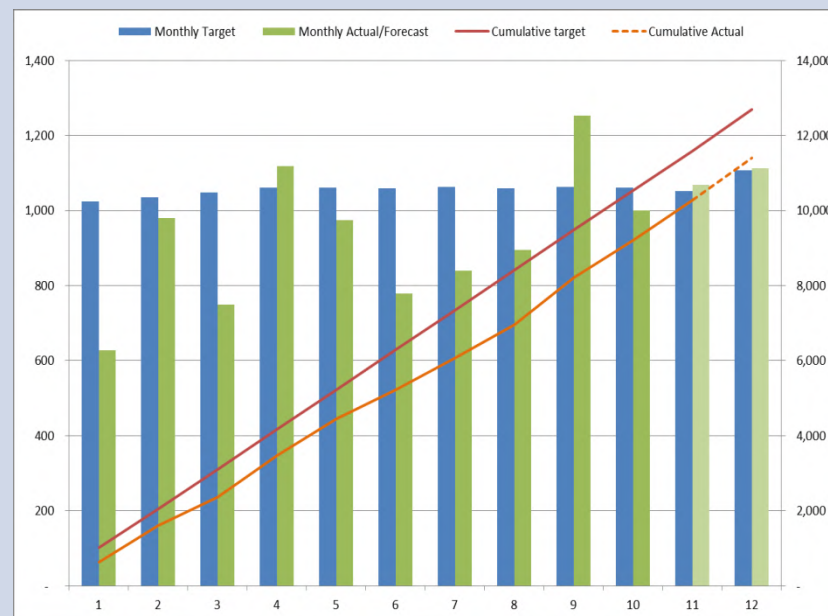
What are the improvements we have made?

Workstream	Key Deliverables
<p>Developing a continuous improvement culture</p> <ul style="list-style-type: none"> 4th Annual Patient Safety and Quality Improvement conference held September 2018: <ul style="list-style-type: none"> 390 staff in total attended activities included masterclasses on sketchnoting and Game of Flow, presentations, open spaces covering QI and patient safety 65 posters displayed 6 posters accepted for the International Forum on Quality and Safety in Healthcare in Glasgow, March 2019 Posters displayed at <i>Our Dorset</i> Staff Engagement Event 5 QI case studies uploaded to NHSE Leading Care Adding Value portal Highly commended in 2018 HSI awards <i>Trust of the Year</i> category 	<div data-bbox="871 378 1477 778"> <p>Opportunity to share our improvement stories and 'duty of candour'</p> <p>Annual Patient Safety and Quality Improvement Conference 2018</p> </div> <div data-bbox="904 806 1304 1363"> <p>Quality Improvement at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust</p> <p>Supporting Carers in the Stroke Early Supported Discharge Service</p> <p>Background</p> <p>Plan</p> <p>Act</p> <p>Study</p> </div> <div data-bbox="1342 806 1845 1363"> <p>A Surgical Frailty Service</p> <p>AIM</p> <p>METHOD</p> <p>IMPROVEMENT</p> <p>LEARNING AND FUTURE PLANS</p> </div>

2018/19 Programme Evaluation

What are the improvements we have made?

Workstream	Key Deliverables
Cost Improvement Programme	<ul style="list-style-type: none"> Trust on target to meet revised control total however reliance on non-recurrent savings to deliver position presents risk to future years Work in our premium cost avoidance and medical workforce TSGs has concentrated on the reduction of expensive agency and locum rates, the effective use of golden shift payments and reducing WLI payments Interrogation and analysis of Model Hospital and GIRFT to identify potential areas for change The PCI future proofing analysis investigated our consumable spend as well as other efficiency opportunities resulting in updated pathways and additional CIP



CIP Target: £12.697m

CIP Forecast: £11.4m (M11 Base Case, up-side £11.5m)

Key Actions and 2018/19 Evaluation

Evolution of the programme: Lessons Learnt?

Learning Point	Description	Next Steps / Action Required
Methodology and Approach	Identifying aspirational aims can be motivating but sometimes unachievable; leading to a sense of failure or a reduced engagement because of the sense that the project cannot deliver.	For 2019/20 we decided not to set aims until the project team has met and initial project scoping has been completed. We also decided to make sure that training is conducted for every QI project so key parties are clear on the QI methodology.
Information and Data	Data collection / production remains challenging.	Ensure sufficient baseline data at the outset of the project.
Support for Change	Change is difficult! Ongoing communication in teams is vital to ensure staff are appropriately supported.	<i>Psychology of Improvement</i> now has great prominence in QI training. QI slots on Leadership development programmes are in place, and the joint work with Organisational Development has accelerated. Coaching work helps build impetus.
Sustainability	<p>Further embedding of improvements into 'business as usual' still required despite use of NHS Sustainability Model. Embedding new processes takes longer than one might expect.</p> <p>Some evidence of sustainability gaps e.g. clinical leadership and support to ensure ownership remains. Staff can find it difficult to release time to get involved in QI projects.</p>	<p>Plan for ensuring reportable measures are included within standard work and performance management within directorates.</p> <p>Review clinical engagement approach for QI, specifically PA time allocation as part of job planning process. Appropriate escalation if membership / attendance is problematic. More focus on roles and responsibilities when QI team is formed</p>
Patient Engagement	<p>We recognise that staff can provide the best care by stepping back and seeing the experiences through the patient's eyes and include this in our QI projects.</p> <p>It is not from lack of will that we have not done this but more a need to understand how to go about it.</p>	<p>Point Of Care training now underway for a group of Poole and Bournemouth staff (25) to expand our inclusion of patients through use of:</p> <ul style="list-style-type: none"> • filmed patient interviews • emotional and process mapping • patient shadowing • patient stories

Key Actions and 2018/19 Evaluation

Evolution of the programme: Lessons Learnt?

Learning Point

Description

Next Steps / Action Required

Integration	To maximise impact and delivery of national strategy 'Developing People – Improving Care'.	Continued work to embed leadership for improvement by the delivery of senior leadership programme. Closer working with clinical audit to maximise impact of roles / responsibilities.
Building Capacity and Capability	Training and development effective but staff need to practice to maintain skills and embed. Increase in training cancellations due to operational pressures.	Encourage as part of talent management approach and appraisal. Development of new training programme.
IT	Some delays within IT due to competing priorities.	Need to identify potential challenges as early as possible to ensure expectations are met.
"Contracting"	Lack of clarity around roles and expectations can lead to difficulties in maintaining project focus and momentum.	Clear statement at beginning of project regarding expectations and how to manage. Will also consider potential operational pressures and how this could impact upon the project.

Despite some barriers the Trust become the second most efficient Acute Hospital in the country according to the Model Hospital and we were Highly Commended at the HSJ Awards 2018!



Improvement Programme

Part A – Overview

Part B – Key Actions and 2018/19 Evaluation


Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices



Hospital Flow
Specialty Pathways
Workforce
Fundamentals of Care

Overview

The Trust has confirmed four domains for quality improvement (QI) to be prioritised in 2019/20. The resulting workstreams will cover a range of projects facilitated directly and indirectly by the Improvement Programme Team (IPT):

Hospital Flow

- *Right Patient, Right Time, Right Place*
- ED
- Outpatients

Specialty Pathways

- Ophthalmology

Workforce

- Medical Rotas

Fundamentals of Care

- Clinical Documentation and Communication

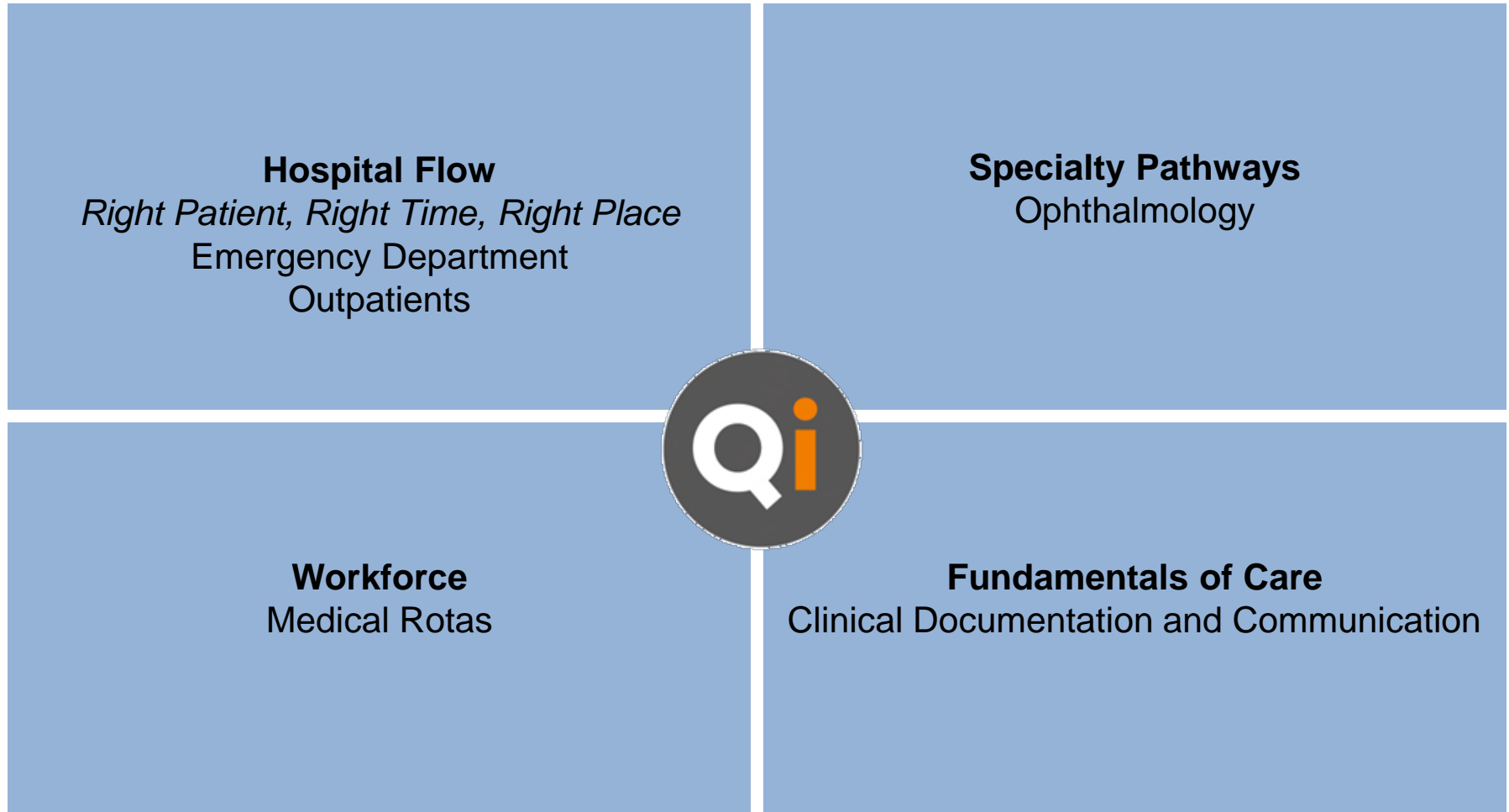
Following wide ranging organisational support, and to support our front line teams and embedding of existing improvements the IPT will continue with a series of Action Learning Weeks (ALW) across the organisation. All projects follow the agreed Trust Improvement methodology (see Appendix 1) by setting clear aims and objectives for the project and using measurement for improvement tools to identify the impact of changes made.

All projects will require clear clinical and operational leadership to ensure that improvements are sustainable. The NHS Sustainability Model together with clear benefits realisation will be key tools during 2019/20. As new and / or local projects are identified they will be scoped to determine their scale and resource requirements before being added into the work programme. These will be agreed directly with speciality and departmental leads.

The Improvement Programme team (IPT) will provide QI coaching and rapid improvement events (30-60-90 days) to ensure support remains agile and adds value to our clinical micro-systems and improvement hubs.

Staff are encouraged to contact the team to explore how best to implement their improvement ideas.

2019/20 Quality Improvement Priorities



Our programme of work this year will be split into four key workstreams. Each area will consist of a range of QI projects managed and supported according to their size, complexity and operational capacity. This will support a culture of continuous improvement and help **spread and sustain improvement capability as part of standard work in our wards and departments**

2019/20 Quality Improvement Priorities

Workstream: Hospital Flow – *Right Patient, Right Time, Right Place*

Purpose:

- To ensure optimal implementation of 'Health of the Ward'
- To continue to expand opportunities for admission avoidance and Same Day Emergency Care (SDEC) for Frailty services across Medicine and Surgery and to reduce length of stay
- To reduce delays to discharge and improve patient experience by delivering further improvements in care planning within 14 hours of admission, best practice board rounds, expected date of discharge (EDD) and reduction in the number of stranded patients

Problem Statement:

1. 'Health of the Ward'
 - Inconsistent compliance with keeping the 'Health of the Ward' tool updated
 - Staff do not recognise the value of doing so (duplication and unresolved issues related to EDD definition, within and across sites)
 - Mix of monitors and whiteboards being used across RBCH
 - Different methodology being adopted between Trusts
2. The opportunity to build on the work undertaken by the F24H ambulatory Group may not be optimised
3. Patients are still being admitted to, and remaining in, hospital unnecessarily
4. 'Discharge Planning'
 - Stranded patient levels continue to exceed national ambition
 - Need to continue monitoring and supporting of consistent compliance with new policy

Context:

- The ambition of NHS Long Term Plan is to have an Acute Frailty Service operational for 70 hours per week, with an assessment completed within 30 minutes of arrival
- The Trust continues to be challenged by not sustaining optimal flow through the hospital
- CST bed management capability increasingly dependant on IT and data accuracy/reliability
- Capacity continues to be adversely affected due to medically fit patients occupying inpatient beds

Exec Sponsor:

Richard Renaut (Chief Operating Officer)

Donna Parker (Deputy Chief Operating Officer)

Workstream: Emergency Department

Purpose:

- To further improve patient pathways to ensure timely assessment, treatment and flow through ED

Problem Statement:

- To deliver ECIST report (December 2018) recommendations
- To work toward eliminating delays in ambulance handover times (see below)

Exec Sponsor: Deb Matthews (Director of Improvement and OD)

Senior Responsible Officer: Rowena Green

Clinical Lead: Dr Farhad Islam

Operational Lead: Kaye Woodward and Leanne Aggas

Context:

- ED continue to face significant challenges in sustained delivery of the EDQI performance standards
- Model Hospital data does not show the Trust as an outlier in performance
- A cultural review supported by the Organisational Development team has identified relational and cultural issues intra and inter-departmentally
- Action learning weeks supported by the QI team have identified a number of themes for potential improvement work. These include the process through BREATH, DTA (Decision to Admit), increasing the utilisation of the UTC (urgent treatment Centre) as an alternative to A&E
- QI initiatives have been slow to start due to competing operational pressures and difficulties in releasing time for clinical staff to lead improvement work
- NHS Long Term Plan published January 2019 highlights the need reform hospital emergency care with further improvements to Same Day Emergency Care ambulatory model



% of ambulance handovers > 15 minutes	NHSI 2017	96.22%	95.05%	78 of 135	
% of ambulance handovers > 30 minutes	NHSI 2017	57.99%	57.82%	75 of 135	
% of ambulance handovers > 60 minutes	NHSI 2017	6.41%	11.70%	80 of 135	

Waiting times - type 1 A&E attendances	Data period	Trust value	Peer median	National median	Chart
Median waiting time (mins) at type 1 A&E - all patients	Oct 2018	173	173	179	
Median waiting time (mins) at type 1 A&E - admitted patients	Oct 2018	219	218	233	
Median waiting time (mins) at type 1 A&E - non-admitted patients	Oct 2018	172	158	161	
Median waiting time (mins) where 4 hour target was breached - all patients	Oct 2018	341	323	363	

Workstream: Outpatients

Purpose:

- To redesign Outpatient services to reduce the number of unnecessary visits for our patients, improve efficiency and free up time for our health care professionals

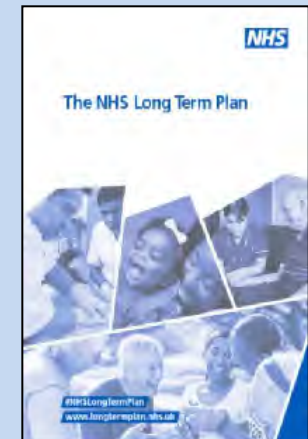
Problem Statement:

- Demand for outpatient services outstrips current capacity leading to challenges in delivering national RTT targets
- According to the NHS Long Term Plan (January 2019) hospital outpatient visits have doubled over the past decade from 54 to 94 million at an estimated cost of £8 billion a year. The traditional model of outpatients is outdated and unsustainable
- Productivity metrics from the Model Hospital indicate a number of specialities where our services are below national median and lowest quartile when measured on their efficiency
- Current measures monitoring outpatients do not fully report on outpatient performance

Exec Sponsor: Peter Gill (Director of Informatics)
Operational Lead: Sarah Knight (in post from 1st April)

Context:

- QI support has been requested to join a pan-Dorset initiative for outpatient and elective care focussing on 'right patient, right referral'
- There is an opportunity to review guidance set out by Royal colleges in a number of specialities in areas such as First: FU ratios which may help to reduce demand
- The NHS Long Term Plan states that *"technology means that an outpatient appointment is often no longer the fastest or most accurate way of providing specialists advice on diagnosis or ongoing patient care"*
- The Royal College of Physicians has suggested that outpatients need a radical overhaul



2019/20 Quality Improvement Priorities

Workstream: Ophthalmology

Purpose:

- To ensure good morale and support for staff in Eye Outpatients and Eye Theatres and to ensure stronger connection to the rest of the Trust. To achieve Eye Theatre efficiency of 80% by March 2020

Problem Statement:

- It is challenging to maintain morale and support staff in a busy operational environment
- The RTT position for Ophthalmology Q3 was 79.7% against the target of 92.0%
- Breaches have risen from ~550 in June 2018 to ~900 in January 2019
- This position is driven by effectiveness and efficiency in outpatients and eye theatres, as well as increasing demand

Key Stakeholders:

Exec Sponsor: Abigail Daughters (Director of Operations)

Project Lead: Louise Neville

Core attendees for project launch:

Minnie Klepacz (Matron), Louise Neville (Directorate Manager), Steve Rowley (Consultant), Christian Zuniga (Theatres Manager), Sally White (Theatres Deputy Manager), Eunice Longden (Scheduling lead), Marc Oborza (Eye Ward / Admissions), Cath Marsh (Clinical Director), Lisa Welch (Manager Outpatients), Non Matthews (Consultant), Roger Brint (Technician), Julie Cartledge (Head Orthoptist), Bev Allen (Administration), Claire Adams (Nurse), Mohammed Rashid (Consultant), Doreen Evangelista (HCA)

Context:

What do we already know?

- Eye theatre efficiency was 71% in January compared to 81% for all other specialties, according to the *Insights* theatre tool. GIRFT recommends 8 cataracts per list (one every 30 mins); we are currently achieving 6
- *Insights* shows 25% more late starts in 2019 than in January a year ago
- The staffing of eye theatres has now settled after difficult period, and it is now the right time to work with the team to deliver; there is eagerness to involve staff in finding solutions to improve efficiency and job satisfaction
- Our Outpatient staff survey showed that the majority of respondents found it difficult to find the right equipment or staff, when they needed them
- However there is a QI project now running and some quick wins being undertaken
- Model Hospital identifies outpatient procedures as being a potential area of inefficiency, and this is being reviewed

Potential Projects in Theatres

- Late start audit - being conducted by QI team March 2019
- Scheduling processes
- Slit lamp PDSA
- Staffing – skills sets and rostering processes
- Patient experience

Potential Projects in Outpatients (QI project already started)

- Equipment usage and best placement
- Templates of clinic slots and co-ordination of testing
- Co-ordination and allocation of staff, including nurse clinic timings
- Stocking of rooms
- Patient experience

Workstream: Medical Rotas

Purpose:

- To optimise the use of medical manpower through the introduction of a consistent process for managing medical rosters, using the most effective digital solutions, thus enabling a clear oversight of sickness absence, annual leave and study leave

Problem Statement:

Concerns raised include:

- “Don’t know where this doctor is”
- “We have huge gaps on this shift. Are there any doctors that can be moved to cover?”
- “The process in medicine is smoother/better than surgery”
- rota sometimes written by consultants where their time could be utilise as DCC rather than SPA
- some areas have no forward planning for rota gaps which potentially leaves services at risk
- no opportunity for Temp Staffing to go out to agency
- rotas not managed consistently –some registrars, some consultants, some admin

Exec Sponsor: Karen Allman (Director of Human Resources)
Medical Lead Sponsor: Alyson O'Donnell (Medical Director)

Context:

- Number of Doctors in Training (approx. 280)
- Number of Consultants (approx. 220)
- Number of Trust doctors (approx. 100)

By 2021, NHS Improvement will support NHS trusts and foundation trusts to deploy electronic rosters or e-job plans.

The adoption of these tools such as e-job planning and e-rostering across the NHS will help ensure staff use their time optimally to provide patient care. This technology also helps providers make the most of their available workforce, thereby reducing the reliance on costly temporary staff.

NHS Long Term Plan 2019 www.longtermplan.nhs.uk

Within the Integrated Urgent Care System it is proposed to use a separate application for rostering called LANTERN. This is a system normally used in GP practices / SWAST and will not interface to Healthroster, although it will interface for pay to ESR.

Workstream: Clinical Documentation and Communication

Purpose:

- To introduce fundamental standards of record keeping within the Trust. To manage how Health Records are filed and to improve the consistency and accuracy of what is recorded in the Health Records

Problem Statement:

- Concerns have been raised at QARC regarding Health Records, what is being filed in medical notes and what is being omitted from medical and nursing documentation. Previous attempts to improve the quality of our Health Records have had limited success
- It is recognised that improvement in the quality of documentation requires cultural change and digital innovation

Themes:

- A local coroner criticised the standard of our Health Records at a recent inquest. This has been repeatedly noted in number of SIs and inquests
- Inconsistency and inaccuracy of the type of information recorded. There is no standard documentation and a failure to date/time or sign documentation also a level of duplication in both written and electronic records
- Poor written recording of interaction/discussions with patients and their families around treatment plans. This also included issues around consent

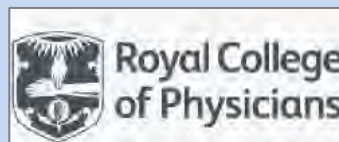
Exec Sponsor:

Paula Shobbrook (Director of Nursing)
Pete Papworth (Director of Finance)

Context:

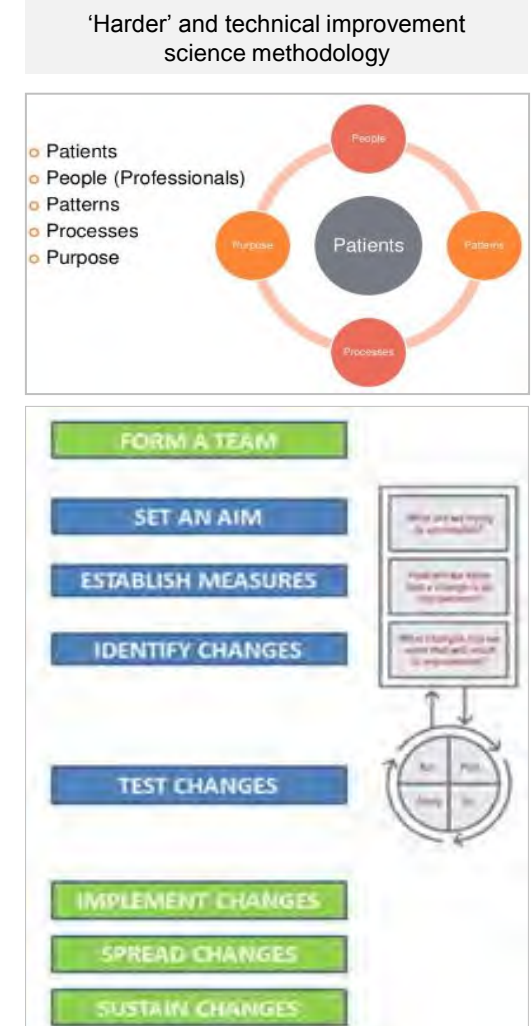
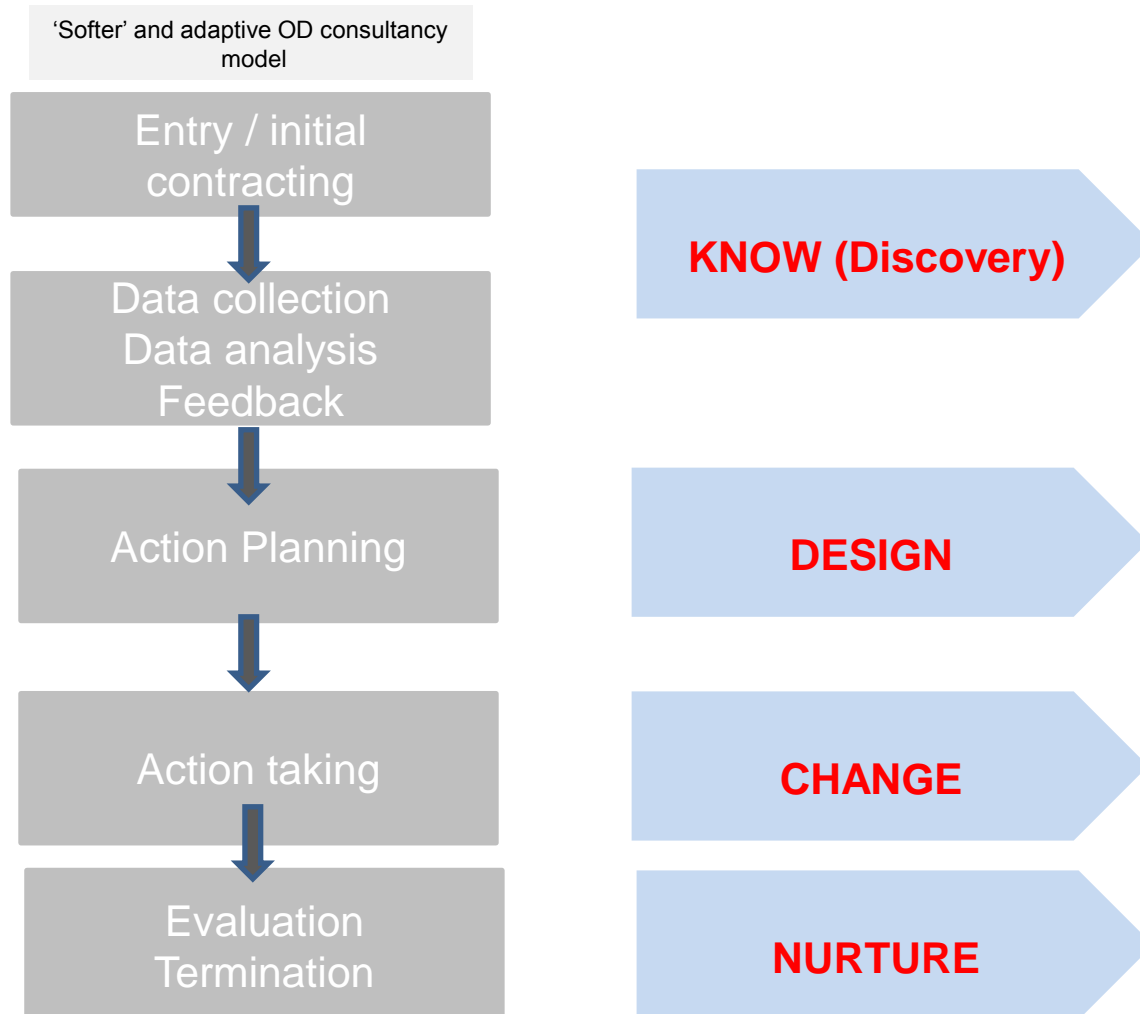
Definition of a Health Record: "A single record with a unique identifier containing information relating to the physical or mental health of a given patient who can be identified from that information and which has been recorded by, or on behalf of, a health professional, in connection with the care of that patient"

- There is a recognition that change to documentation requires cultural change
- The Trust remains largely paper dependant as a way of recording interaction with patients
- A variety of health professionals write in patients health records and previous attempts at improving the quality of documentation have been unsuccessful
- There is variability of documentation currently used within the Trust. This includes the ward checklist and the disconnect between AHP and nursing documentation. There is no standardisation
- The Trust uses both written and electronic formats to record all interactions with patients which can cause duplication
- The work of this project will consider how it can use technology effectively but the focus will remain on the content of the records as other technology development programmes are in place



2019/20 Improvement Priorities

In 2019/20 the Improvement Programme Team (IPT) will also support the transformation and early integration of services as part of our East Dorset clinical reconfiguration programme. Working with our 'four early services', we will apply QI methodology to redesign patient pathways and develop new models of care to create a sustainable future – co-produced with staff, patients and service users and based on national best practice.



Improvement Programme

Part A – Overview

Part B – Key Actions and 2016/17 Evaluation


Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building Capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices



- 2019/20 high level CIP programme
- Model Hospital
- CIP risk assessment
- Key milestones
- Quality Impact Assessment

2019/20 High Level Programme

The IPT has been supporting the development of a 2019/20 CIP programme. As at mid-March 2019 CIP plans for 2019/20 have been developed to meet our financial breakeven position by March 2020. However, significant further work is required to ensure the delivery of a sustainable programme of work to underpin our financial performance.

To ensure there is a clear line of sight from the Board throughout the organisation for accountability, each of the care groups and corporate directorates hold the responsibility for their contribution to financial control and are held accountable for achieving the plan.

The Trust intends to exploit both model hospital and GIRFT data to identify and pursue opportunities for improvement. The previously identified QI opportunities will also support the reduction in inefficiencies and therefore enable potential savings.

	Target	Downside	Variance
Surgical	(2,242)	713	(945)
Medical	(2,581)	228	(2,833)
Specialties	(2,431)	1,009	(1,372)
Corporate and			
Central	(3,198)	2,002	(420)
Organisation			
Total	(10,452)	3,952	(5,569)

	Target	Base Case	Variance
Surgical	(2,242)	1,279	(379)
Medical	(2,581)	465	(2,595)
Specialties	(2,431)	1,214	(1,167)
Corporate and			
Central	(3,198)	2,052	(370)
Organisation			
Total	(10,452)	5,010	(4,511)

	Target	Upside	Variance
Surgical	(2,242)	1,890	232
Medical	(2,581)	733	(2,328)
Specialties	(2,431)	2,147	(234)
Corporate and			
Central	(3,198)	2,467	45
Organisation			
Total	(10,452)	7,237	(2,284)

2019/20 Productivity and Efficiency

Purpose:

To develop, support, implement and monitor a programme of work to support the delivery of the Trust's control total without adversely impacting upon patient care

Getting It Right First Time (GIRFT)

A national clinically led programme designed to reduce variation and improve patient care

Aims:

- to support clinical specialties with the delivery of local and national recommendations.
- to provide assurance that recommendations are being appropriately delivered.

Executive Lead: Alyson O'Donnell

Governance: HAC and GIRFT TSG

Model Hospital (MH)

A national data warehouse designed to enable acute Trust's to assess performance across a wide range of measures

Aims:

- to identify opportunities for improvement through the review and analysis of data held within MH.
- to support operational teams in using the MH to review their practice

Executive Lead: Pete Papworth / Deb Matthews

Governance: Finance Committee and IPB

Cost Improvement Programme (CIP)

Trust programme of schemes designed to generate cash releasing savings

Aims:

- to support operational teams in the identification and implementation of CIP
- to monitor CIP delivery and enable operational teams to be appropriately held to account

Executive Lead: Pete Papworth / Deb Matthews

Governance: Finance Committee and IPB

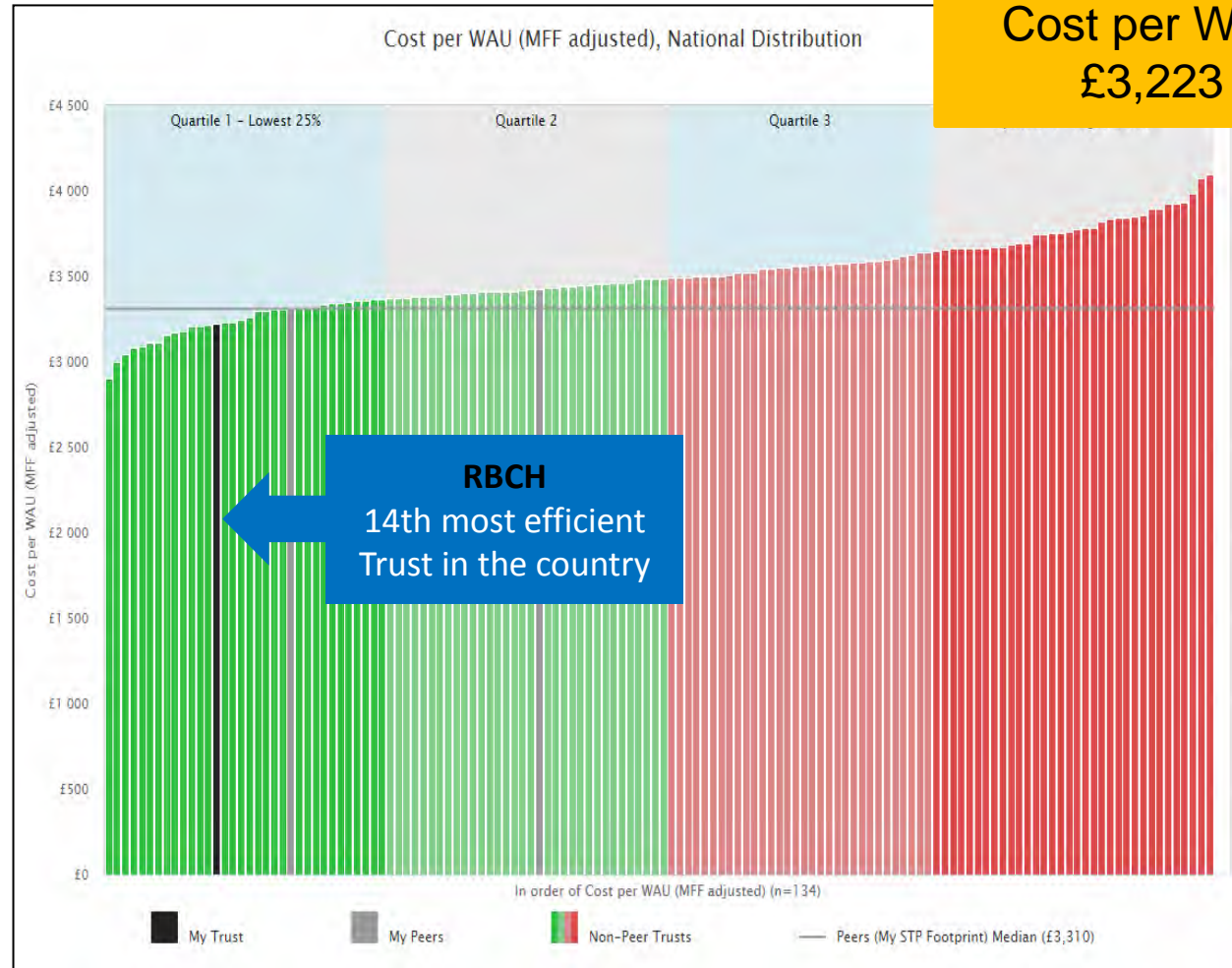
Productivity and Efficiency: Model Hospital

The model hospital provides us with a significant range of performance and contextual metrics setting out how our productivity and quality of care compares to other organisations.

Notwithstanding our strong performance in 2017/18, we believe that this tool will help us identify opportunities to improve.

We will review updates as they are published and report (by exception) on areas of good/poor performance to both senior and operational leaders as relevant.

Reports are regularly timetabled at TSGs where opportunities can be identified and explored (e.g. Premium Cost Avoidance).



Cost per WAU
£3,223

Productivity and Efficiency

In 2019/20 we will:

- Work with specialties to understand the data and how this reflects their understanding of the service
- Work with identified Trust's to review best practice to identify opportunities for change
- Seek to further triangulate data from the model hospital with other performance measures to ensure that decisions are based on a rounded perspective on service outcomes
- Develop action plans and benefits trackers to support the outputs from the model hospital and ensure its effective use

Clinical Specialty	2017/18	2016/17	2015/16
Orthopaedic Surgery			
General Surgery			
Urology			
Obstetrics and Gynaecology			
Breast			
Vascular			
Emergency Medicine			
General Medicine			
Cardiology			
Geriatric Medicine			
Respiratory			
Dermatology			
Gastroenterology			
Diabetes and Endocrinology			
Stroke			
Ophthalmology			
Plastic Surgery and Burns			
Rheumatology			
Medical and Clinical Oncology			

We will be working with individual specialties to identify whether the performance differentials identified within the model hospital represent opportunities for improvement or reflect differences in the type of service we provide.

Work has commenced with Gastroenterology and is due to commence with Orthopaedics, respiratory and cardiology reviewing their data in detail.

Productivity and Efficiency: Getting it Right First Time (GIRFT)

GIRFT is a national programme for clinical improvement focused on reducing unwarranted variation and the delivery of the best care for our patients.

2018/19 has seen a steady increase in the number of specialties involved in this programme and it is only set to increase further (see left for RBCH involvement to date).

In 19/20 we will:

- Continue to develop a steering group and programme approach to support the implementation and delivery of both local and Trust recommendations. This group will provide a forum for monitoring the implementation of change and ensuring appropriate clinical challenge to operational decisions
- Ensure an Action Plan and Benefit Tracker will be maintained to demonstrate the value and impact that this work has had across the Trust

	Contact Made	Data Pack Received	RBCH Visit	National Report published	Observation Notes
Surgical					
Breast Surgery	Yes	No	No	No	
General Surgery	Yes	Yes	18/03/2016	Yes	N/A
Obstetrics and Gynaecology	Yes	Yes	12/10/2017	No	N/A
Ophthalmology	Yes	Yes	12/10/2017	No	Yes
Orthopaedic Surgery	Yes	Yes	07/03/2014 06/12/2018	Phase 1 - Yes Phase 2 - No	Awaiting
Urology Surgery	Yes	Yes	25/09/2017	Yes	N/A
Vascular Surgery	Yes	Yes	15/09/2017	Yes	N/A
Medical					
Acute and General Medicine	Yes	No	No	No	
Anaesthesia and Perioperative medicine	Yes	Yes	10/12/2018	No	Awaiting
Cardiology	Yes	No	No	No	
Dermatology	Yes	Yes	15/01/2018	No	Awaiting
Diabetes	Yes	Yes	07/08/2018	No	Yes
Emergency Medicine	Yes	Yes	TBC	No	
Endocrinology	Yes	Yes	01/02/2019	No	
Hospital Dentistry	Yes	No	No	No	
Respiratory	Yes	No	No	No	
Rheumatology	No	No	No	No	
Stroke	No	No	No	No	

Extract from Long Term Plan

6.16. We have worked with staff across the NHS to identify opportunities to deliver more effective patient care. Our approach is to deliver clinically-led improvement and put the patient in the heart of the system. We deliver this through an approach called Getting It Right First Time (GIRFT). GIRFT will combine with other clinically-led programmes such as *NHS Right Care* and an increased investment in Quality Improvement (QI) to accelerate work to end unjustified clinical practice variation.

Delivering 'real CIP' - NHSI definition

Cost reduction means providing a service at the same or better quality for a lower unit cost, through new ways of working that eliminate excess costs. The costs that are reduced could be on-going or future pay or non-pay expenditure. A simple example is the use of a different orthopaedic prosthesis offering the same or improved clinical quality for a lower unit cost. Cost reduction savings are typically savings that are cash-releasing. Cash can be released on a recurrent, on-going basis (if, for instance, staff costs are reduced) or a one-off, non-recurrent basis. They differ from non-cash releasing savings, which result in more activity or services for the same cost or for an additional contribution.

Cost avoidance is a type of cost reduction but refers specifically to eliminating or preventing future costs arising. Cost avoidance measures may involve some expenditure but at a lower level than the expected future costs to be avoided. They may typically not formally be part of the CIP programme but instead avoid future cost pressures. Examples are the avoidance of using locum doctors by making substantive appointments, reducing (non-budgeted) premium pay spend, or increased use in the future of nursing bank staff to avoid higher cost agency premium pay.

Income generation This applies to non-NHS contract funding schemes that provide a contribution to an NHS body that can be used for improving health services. Examples include charging for certain patient services or facilities such as a private room and television or telephone. NHS bodies can also enter into commercial ventures with private companies to generate income from specific services. The Department of Health provides further details. Income generation schemes are typically cash generating schemes as opposed to cash releasing cost reduction schemes.

Service productivity improvements These schemes aim to improve patient care by changing the way services are delivered so that productivity is increased and financial benefits can be delivered. Service productivity improvements often involve joint working between clinical, operational and finance staff, sometimes across different organisations, to develop new ways of working. Improving service quality and safety are the main priority with the intention of identifying on-going, recurrent efficiency savings and productivity gains through delivering services in the best way. These schemes can make cost savings or can generate an additional contribution.

Transformation Steering Groups

The overall governance structure including escalation arrangements is outlined in Part F: Programme Management.

The Trust has adopted a process of Transformation Steering Groups acting as the key to delivering suitable governance over efficiency and productivity developments.

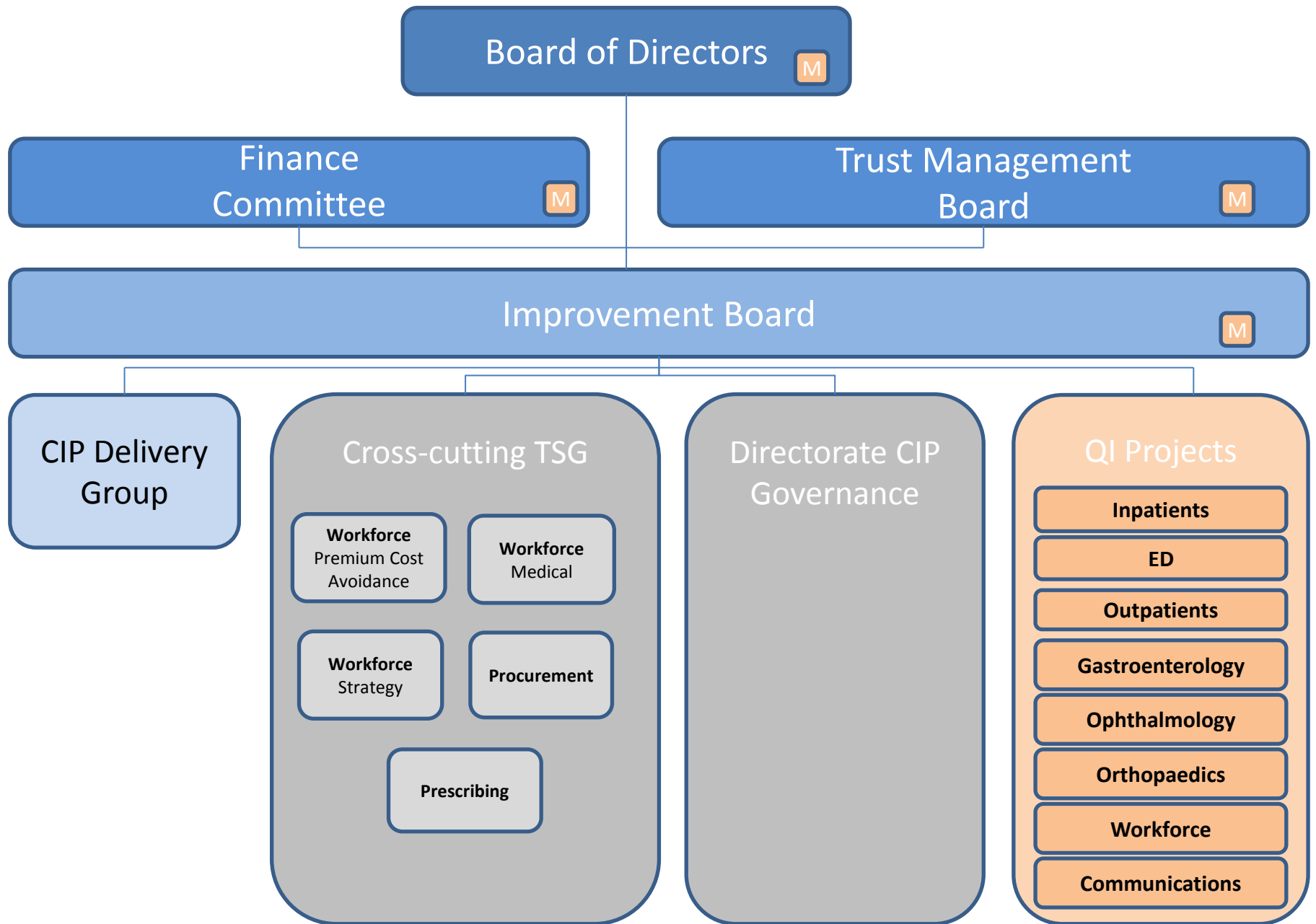
The Terms of Reference for each TSG is to:

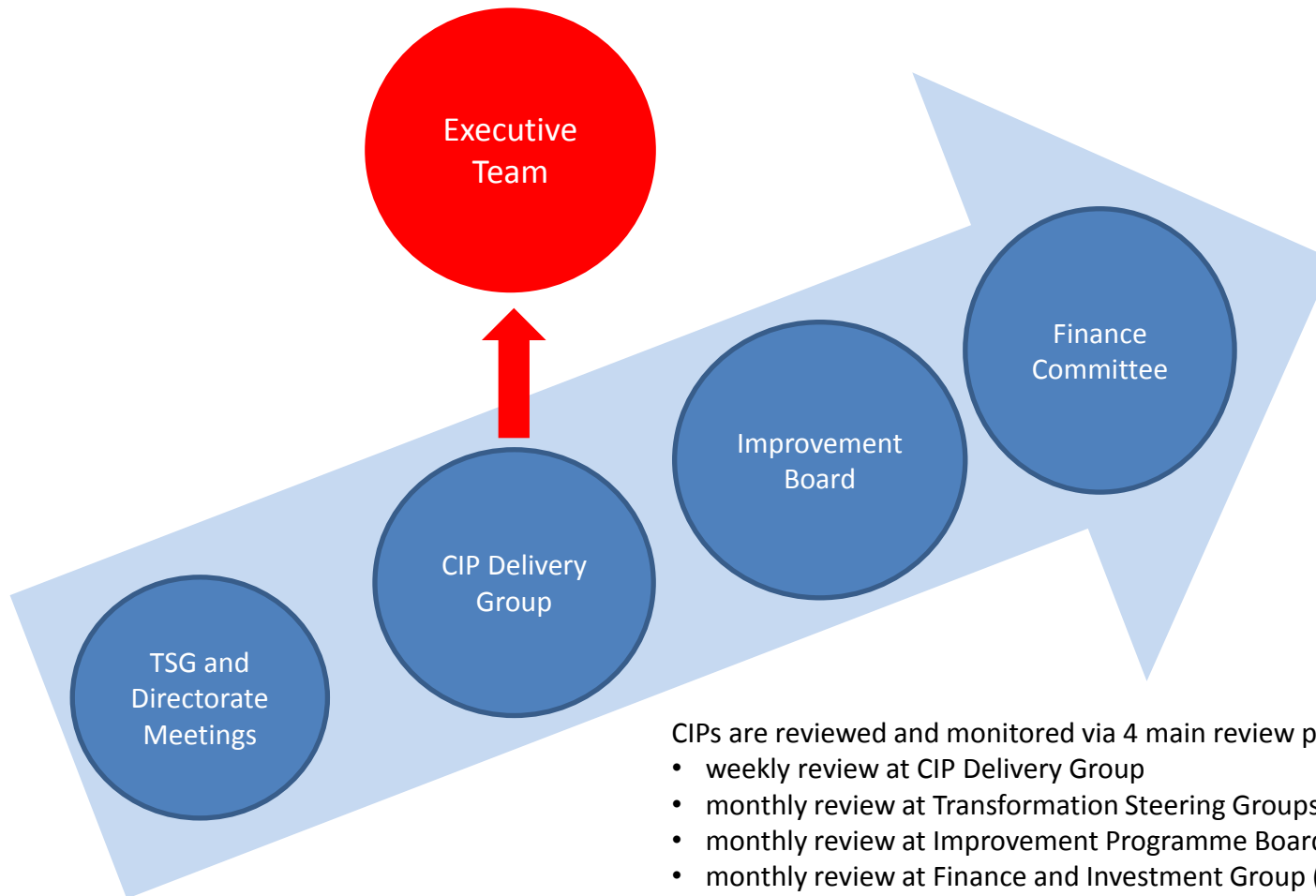
- compile and be accountable for the delivery of a range of schemes and ensure that these are translated into genuine delivery
- consider the full spectrum of opportunity from basic local ideas to radical change for the steering groups to evaluate and convert
- ensure all schemes are fully risk assessed according to the QIA criteria and appropriate actions taken to minimise any identified risks
- encourage the proactive involvement of all staff identified to fully explore associated service transformation opportunities and be responsible for achieving the required goal
- maintain a clear financial overview of individual schemes and make necessary adjustments to ensure delivery of the same
- provide a forum for discussion on local and national guidance and recommendations to support service redesign, delivery and quality assurance
- engage the support of others external to this work in the scoping and development of future project plans
- maintain an iterative approach to continuous ideas development
- ensure that sub groups or individuals produce a rolling action plan and the sub-group or individual delivers the products and provides regular progress reports to the TSG, and in turn to the Improvement Board

The CIP Delivery Group meets regularly to:

- ensure continued grip over the delivery of the current year CIP programme (including metrics and milestones)
- unblock issues and develop mitigations where TSG leads have flagged concerns
- oversee forward planning of future annual CIP programmes in line with our budget setting process;
- confirm benchmarking and / or best practice material to support implementation and ideas generation

Membership includes all TSG SROs (Executive Leads) and their delegated authority. Any immediate action required based on the outputs of the meeting is escalated to the Executive Team within 24 hours.





CIPs are reviewed and monitored via 4 main review processes:

- weekly review at CIP Delivery Group
- monthly review at Transformation Steering Groups (TSG) meetings
- monthly review at Improvement Programme Board
- monthly review at Finance and Investment Group (FIC) – sub committee of the Board of Directors

A fast track escalation process is in place for issues that cannot adequately be resolved by the CIP Delivery Group. These are escalated immediately to the weekly executive team for review and decision.

To ensure that we do not deliver cost savings at the expense of quality for our patients we have implemented a quality impact assessment process. Following a recent Internal Audit review we are planning to refresh and revise our policy to improve the assurance this process provides.

Documentation is submitted as part of the CIP tracker process, including information on how the Directorate has assured itself that it has sufficiently mitigated against quality risks. All information is reviewed by the Medical Director and Director of Nursing and signed off. Any areas of concern are 'called in' to enable more detailed scrutiny.

- does the scheme have an impact upon the quality of patient care?
 - patient safety
 - clinical outcome / effectiveness
 - patient experience
- does the scheme have an impact upon the Trust's workforce?

The Trust recognises that in the current highly challenging financial situation that difficult decisions may be required. For complex or sensitive decisions the Board may be consulted to determine the course of action to take.

Improvement Programme

Part A – Overview

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Appendices



Improvement Academy

Key priorities for 2019/20:~

- develop a QI community of interest with Poole Hospital and explore potential for joint improvement academy
- further develop QI Alumni - a social network for RBCH and PHT improvers
- review and re-vamp QI training offer to coincide with 10% of RBCH staff trained – building capability in a new way including launch of 1 day training module
- expanding the provision of QI coaching support and training and development programmes to frontline teams
- deepening the involvement of patients and carers in our QI work using POCF ambassadors
- embedding local ownership and performance management of improvement projects to sustain front line staff engagement in QI
- experimenting with lunchtime QI masterclasses and webcasts
- further embed a culture for quality improvement in line with *NHSI Developing People – Improving Care Framework*. This will include input into the RBCH Leadership training modules

2 Day Quality Improvement Training

We have now trained **nearly 10%** of our staff with further coaching support to help them deliver front line improvements for staff



RBCH Quality Improvement Model





Be an improvement rebel

Join us in our quest to improve our hospitals for patients and staff

#RBCHQI ext 4401

@QualityImprovement@rbch.nhs.uk







A standard methodology and training method for staff to use at all levels



Junior Doctors QI Programme

A culture of continuous improvement: Action Learning Weeks

The continuation of action learning weeks has been a significant active ingredient in 2018/19.

They have helped us further develop a culture of 'improving and learning together' whereby we focus on open dialogue, creating shared meaning regardless of role or hierarchy.

They providing opportunities to work with multi disciplinary teams from inside and outside the Trust.

The emphasis during the action learning weeks is to improve communication and trust and provide a safe forum where all can share ideas:

- asking rather than telling
- challenge in a positive way
- pragmatic problem solving
- building relationships

During our action learning weeks, together we ask:

- how would we describe what is happening vs. what should be happening?
- why is it happening?
- what would happen if?
- What have we thought of trying?
- what's the problem we are trying to solve?
- what have we looked at already?

ED and Patient Flow

August 2018

A weekend in ED – continuous 64 hours

December 2018

BREATH, point of care testing and triage streaming

January 2019

Patient Flow – Why not home? Why not today?

March 2019

Patient Flow – Why not home? Why not today

Why not home? Why not today?

Action Learning Week 7-11 January

Focussing on getting patients into are readiness ready for discharge home without delay.

Discharge clinic every day
12noon - 1pm
Consultants Lounge: **Mon, Thurs and Fri**
Consultants Room: **Tues and Weds**

Our executive and discharge teams will be taking ward rounds to other sites to support.

There will also be a facility visiting clinical areas: 2.3pm, offering further support.

Why not home? Why not today?

Action Learning Week 4-8 March

Working together with new partners to improve discharge outcomes.

At the end of the week, we will have a focus on the following questions:

1. What is going wrong?
2. What is going to happen next, how today are we going to get better?
3. What (impediments) need to be addressed to get better?
4. How will we ensure to discuss and plan about what needs to happen to ensure for the future?
5. When should we expect to see progress, measured by the number of patients discharged?

Working with Local Authorities, CCGs and Social Services



A different way of working

Inquiry – seeking to understand view of our multidisciplinary teams

Themes

- Inappropriate presentations to Minors
- Staff skills and responsibilities
- Decision making and flow
- Interpersonal relationships
- Environment and equipment
- RATS
- Patients with mental health issues
- Diagnostics



The First 24 Hours Programme

ACTION LEARNING WEEK

Tues 11th to Thurs 13th December 2018

Emergency Department

'Improving Triage and Streaming'

...ing patients are directed onto the appropriate care pathway.

...this process to make it as effective as possible?

...consistency 24/7?

...re learning with primary care colleagues.

...nhs.uk or emma.willett@rbch.nhs.uk

...share your ideas; to get involved etc.

triage

ambulance
emergency
al healthcare

...Share it! ...Share it!



A culture of continuous improvement: Safety and QI Conference 2018

Over 65 QI
posters every year

Sharing
stories and
'duty of
candour'



**Be an
improvement
rebel**

**Join us in
our quest
to improve
our hospitals
for patients
and staff**

#RBCHQI t: ext. 4401
e: QualityImprovementCalendar@rbch.nhs.uk



Improvement Programme

Part A – Overview

Part B – Key Actions and 2016/17 Evaluation

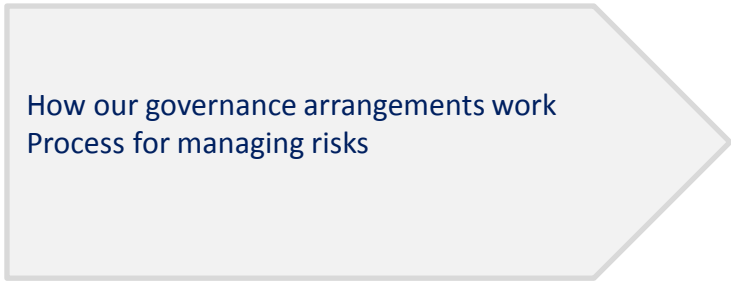
Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building Capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices



How our governance arrangements work
Process for managing risks

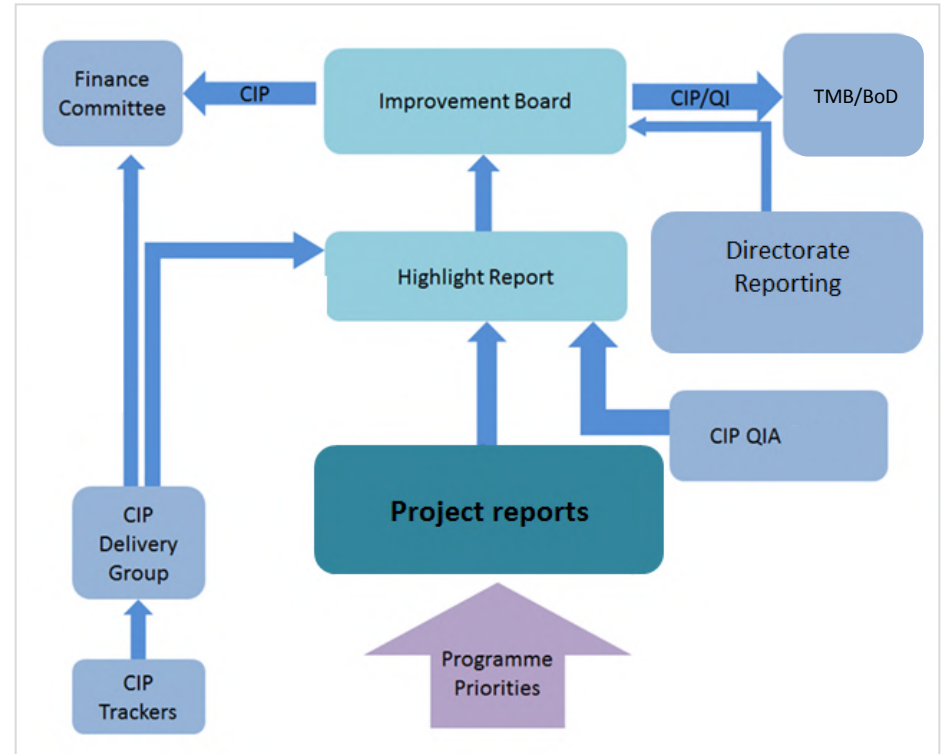
The Improvement Programme Team (IPT) is responsible for supporting and facilitating the implementation of the Improvement Blueprint. The IPT provides assurance on the delivery of progress against the programme objectives and plays a key role in providing project management and improvement expertise to operational and organisational projects.

This assurance is provided to the Improvement Board (a sub-committee to the Trust Board) via a monthly meeting.

A highlight report and set of project reports summarise progress against key deliverables for:

- QI projects
- productivity / efficiency workstreams
- delivery against the cost improvement programme
- delivery on efficiency guidance from NHSI

Further details of the programme governance structure, including CIP reporting arrangements and extracts from the CIP tracker are included in Appendix 3 – 6.



Managing material risks

The Board of Directors manage material risks through the use of the Board Assurance framework (BAF). This focuses attention on high risks where there are gaps in control and / or gaps in assurance, risks which are currently running at a level which is higher than the BoD's risk appetite and to prompt action in those areas.

BAF and associated risks in corporate risk register (CRR) triangulated with IPT programme and risk log to ensure comprehensive record of controls and assurances reported on a monthly basis.

Material risks relevant to this document are detailed in Appendix 2.

These are aligned to our five strategic objectives and the Board Assurance Framework:

- Quality of care that is Safe, Compassionate and Effective
- Quality Improvement
- Support and Develop Staff
- Strategy and Performance
- Value for money

Improvement Programme

Part A – Overview

Part B – Key Actions and 2017/18 Evaluation

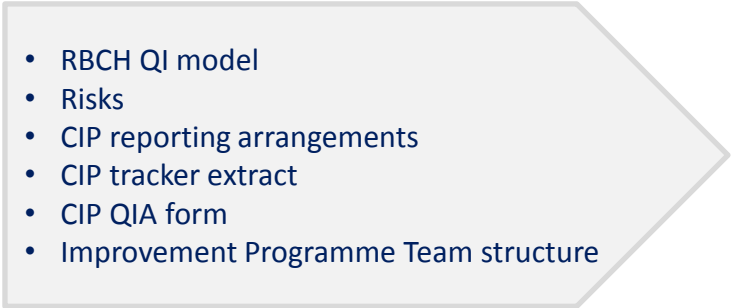
Part C – QI Priorities

Part D – Productivity and Efficiency

Part E – Building Capacity and supporting a Culture of Improvement

Part F – Programme Management

Appendices

- 
- RBCH QI model
 - Risks
 - CIP reporting arrangements
 - CIP tracker extract
 - CIP QIA form
 - Improvement Programme Team structure

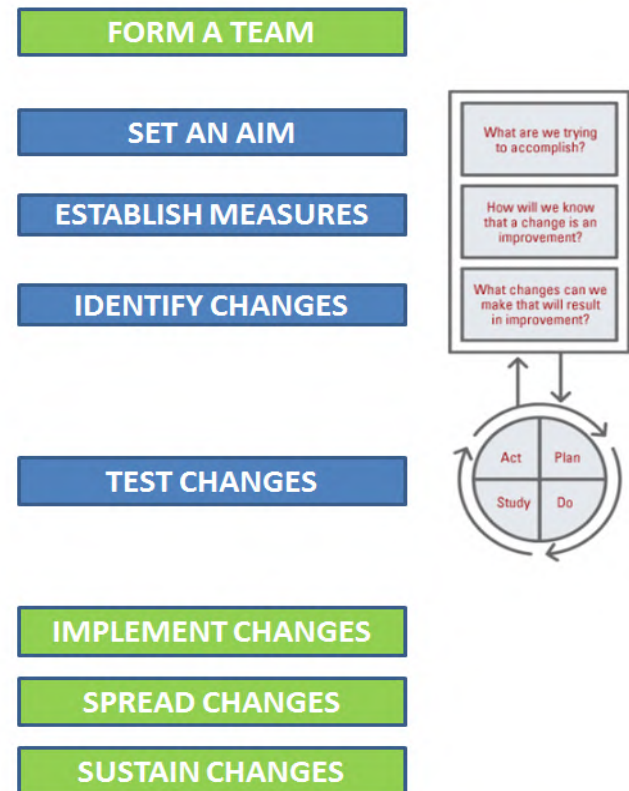
Appendix 1: RBCH Model for Improvement

You must have the **will** to improve




You must have **ideas** about alternatives to the status quo.

Then, you must make it real — **execution**

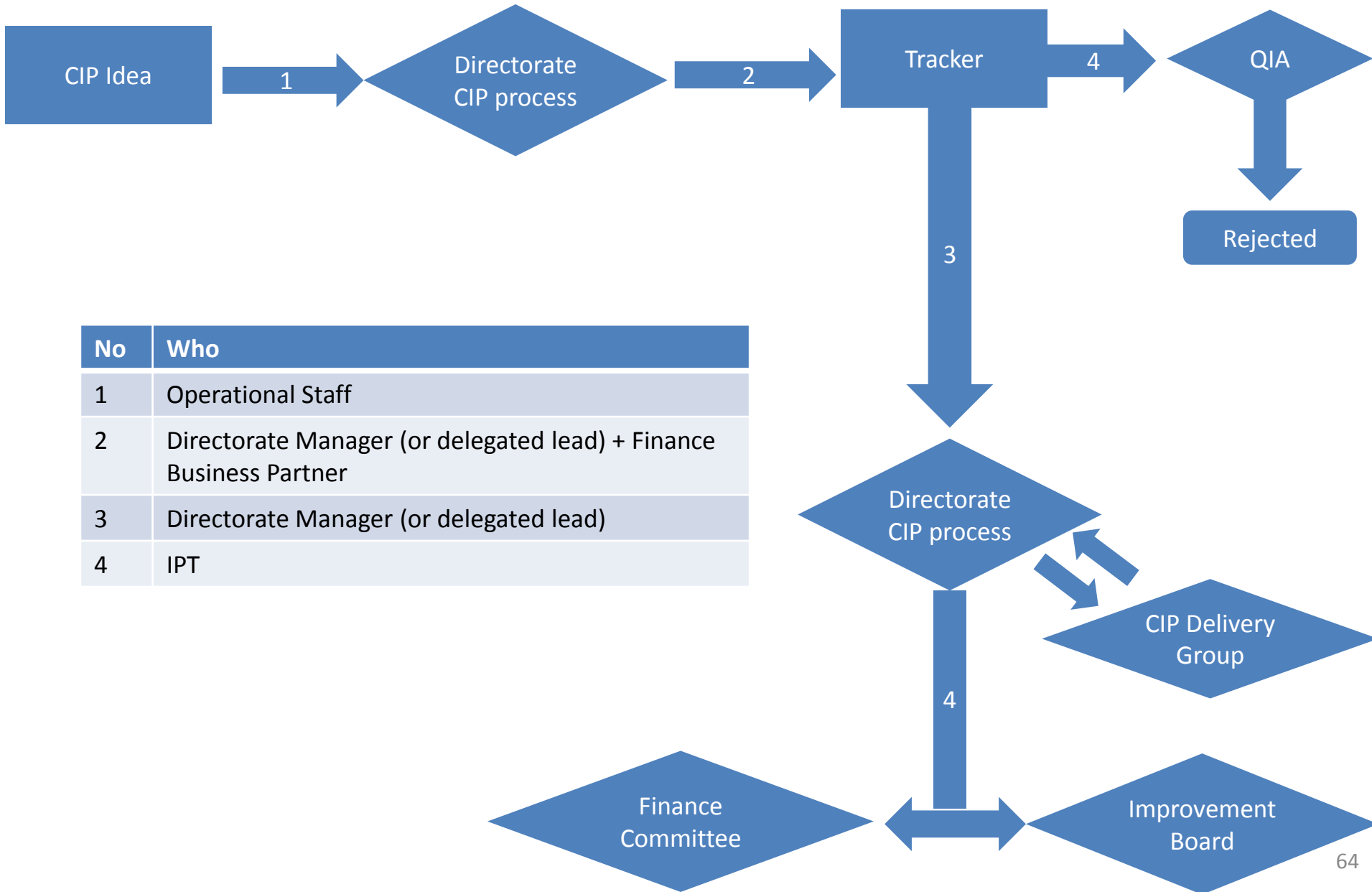
RBCH Quality Improvement Model



Appendix 2: Risks

Principle Risk Description of Risk	Current Risk	Risk Description	Control Measures	Target Risk
Urgent Care –Front Door and Flow. (BAF463)		If patient flow is compromised within the Trust, then there will be avoidable harm to those patients entering any front door to the hospital	ECIST visit in Dec 2018 and have suggested a number of works to be undertaken: Point of care testing, leadership, ED & AMU relationships and pathways. Latest action plan which details current milestones for quality indicator Agreement for implementation of ED zero based budget will see increases to both medical and nursing establishment which will in turn improve flow issues at front door. Full implementation date March 2019	
Responsiveness of services for patients and achieve the national standards of Elective referral to treatment waits (18 weeks RTT) (BAF735)		There is a risk that there will be patient harm from delayed pathways NHSI/E regulatory challenges and premium expenditure requirements if the RTT related targets are not met	PMG focus Jan-Mar on 40+ week wait as priority plus contracts and planning for 19/20 to required to meet national operational plan priorities of: 52ww, 24+ ww or offer alternative provider; and total waiting list. Associate Director - elective being appointed to focus on RTT performance and elective transformation (supporting phase 3 RRRC being led by DCCG).	
Financial Control Total (BAF715)		Trust at risk of failing to deliver against financial control total agreed with NHS Improvement, resulting in the loss of PSF income.		

Appendix 3: CIP Reporting Arrangements

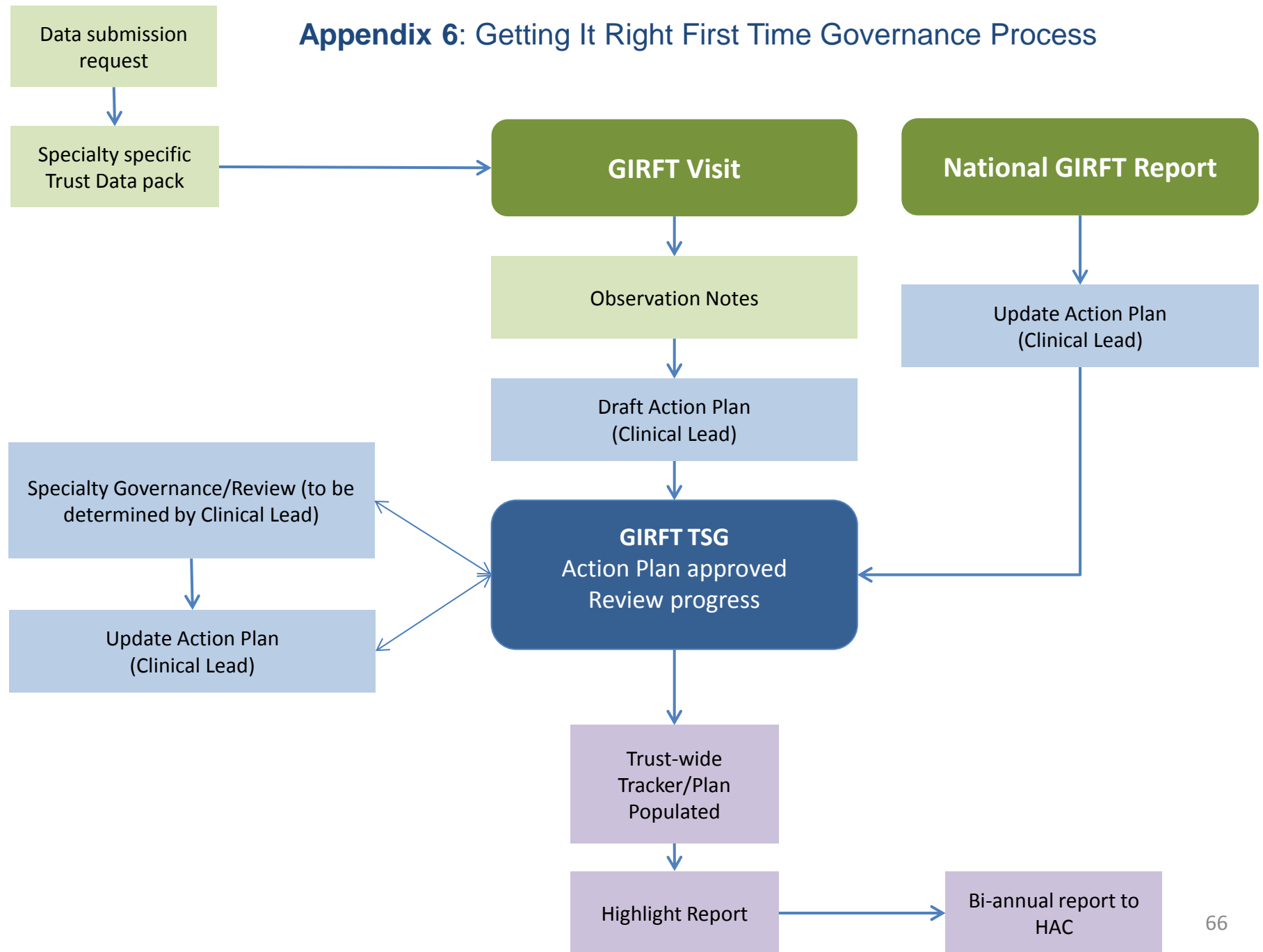


Appendix 4 and 5: Tracker Extract and QIA Form

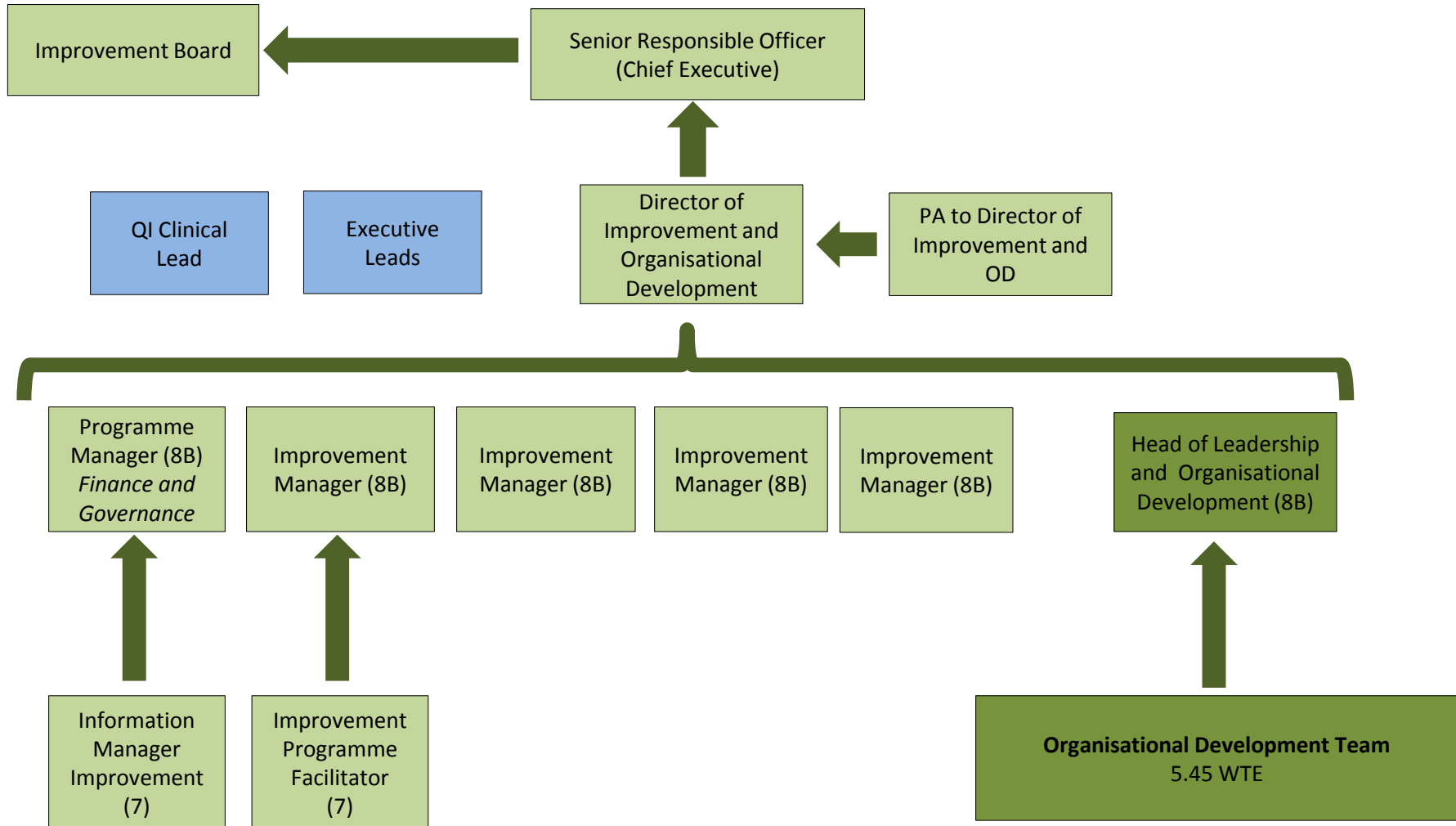
	SUMMARY					SCHEME DETAILS								
Reference	Scheme	NHSI Plan Amount £	Forecast Amount £	FYE?	Recurrence (R / NR)	Brief Description	Lead	Directorate	Spend Category	NHSI Submission category	Project Risk	Risk %	Risk adjusted Forecast £	Project Status
	B/FWD TARGET	683,960	683,960											
	18/19 TARGET	216,667	216,667											
	TOTAL TARGET	900,627	900,627											
	ALLOCATED	167,827	167,827											
	UNALLOCATED	732,799	732,799											
A11819	WLI Reduction	50,000	50,000	New	R	Demand capacity work enabling reduction in extra payments	Corrina Davies	Anaesthetics	Pay (Skill Mix)	Workforce: Medical	Low	100%	50,000	Started - has minor delays
A21819	SSD Tender - Pay	28,125	28,125	New	R	Tender to provide SSD service via an alternative method	Commercial Services	Anaesthetics	Pay (WTE)	Workforce: Other	High	0%	0	Not yet due to start
A31819	SSD Tender - Non-Pay	28,125	28,125	New	R	Tender to provide SSD service via an alternative method	Commercial Services	Anaesthetics	Non-Pay	Other Savings	High	0%	0	Not yet due to start
A41819	SPP theatre caps deal	818	818	FYE	R	SPP Deal	Commercial Services	Anaesthetics	Non-Pay	Procurement	Completed	100%	818	Completed
A51819	Heel Lifts Save	760	760	FYE	R	Change in Spec to move product	Commercial Services	Anaesthetics	Non-Pay	Procurement	Completed	100%	760	Completed
A61819	Medical Agency reduction	60,000	60,000	New	R	Reduce spend on medical agency	Neil Cowan	Anaesthetics	Pay (Skill Mix)	Workforce: Medical	Low	100%	60,000	Started - has minor delays

Reference	SUMMARY					QIA								
	Scheme	NHSI Plan	Forecast	FYE?	Recurrence (R / NR)	Potential to				Quality Review Process used	Additional information	Risks identified	KPI's	KPI Review
		Amount £	Amount £			Greater than £20k (FYE)	Impact quality (directly or indirectly)?	Impact on workforce?	QIA required?					
	B/FWD TARGET	683,960	683,960											
	18/19 TARGET	216,667	216,667											
	TOTAL TARGET	900,627	900,627											
	ALLOCATED	167,827	167,827											
	UNALLOCATED	732,799	732,799											
A11819	WLI Reduction	50,000	50,000	New	R	Y	N	Y	Y					
A21819	SSD Tender - Pay	28,125	28,125	New	R	Y	Y	Y	Y					
A31819	SSD Tender - Non-Pay	28,125	28,125	New	R	Y	Y	Y	Y					
A41819	SPP theatre caps deal	818	818	FYE	R									
A51819	Heel Lifts Save	760	760	FYE	R									

Appendix 6: Getting It Right First Time Governance Process



Appendix 7: Improvement Programme and OD Team Structure





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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Medical Director's Report
Section on agenda:	Quality and Performance
Supplementary reading:	N/A
Director or manager with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of paper:	Alyson O'Donnell, with input from Dr Divya Tiwari
Details of previous discussion and/or dissemination:	Mortality indices and reviews discussed at Mortality 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:	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:	N/A

Medical Director's Report to the Board

Mortality Update

Overall HSMR for the Trust for the last 12 months (December 2017 –November 2018) is 97.6. This is rebased for August 2018 and is in 'as expected' range. The figure for the Royal Bournemouth Hospital (excluding Christchurch Hospital and the Macmillan Unit) is 87.5 and is in the 'better than expected range'. The latest SHMI (Standardised Hospital Mortality Indicator for July 2017-June 2018) is 100.01 which are within expected range. Mortality Steering Group (MSG) has conducted an analysis to better understand the reasons behind the upward trend in SHMI. This seems to be driven by higher proportion of inpatient deaths and a reduction in the number of community deaths. MSG has noted an improving trend in the year-to-date HSMR by 3 points. Reassuringly this is mostly attributable to better outcomes at the Royal Bournemouth Hospital (RBH) site. It is expected that this should be mirrored by a downward trend in SHMI for the next quarter. Mortality metrics for the Macmillan Unit are 'more than expected' but stable. The coding team are continuing to work with the clinical team to improve data quality for vascular procedures and depth of coding for 'elective' versus 'non-elective' activity

The Board is asked to note the improvements in crude mortality rates over the winter months (December/January/February). Month on month the observed rates have been lower than the previous year. This is expected to positively impact on standardised mortality ratios for this financial year. Mortality rates for all high risk conditions (stroke, congestive cardiac failure, acute renal failure, sepsis and pneumonia) are stable and within expected range. Annexe A.

Learning from Deaths

Mortality Report for Board

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

Data as at 08/03/2019

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Deaths in Month	91	120	133	127	100	108	106	110	113	157
eMortality Reviews Completed in Month	55	153	69	76	8	38	84	17	18	209
Category of Death by Month Review Completed										
Grade 0	50	140	64	71	6	29	77	17	17	189
Grade 1	5	13	5	5	2	8	6	0	1	19
Grade 2	0	0	0	0	0	1	1	0	0	1
Grade 3	0	0	0	0	0	0	0	0	0	0
Learning Disability Deaths in Month	3	0	2	0	0	0	1	0	0	0
Learning Disability Deaths Reviewed	3	0	2	0	0	0	0	0	0	0

Medical Examiner (ME) Process

The Medical Examiner process is now being provided consistently at the RBH site with all deaths screened to identify any gaps in care, hospital acquired harm or areas of learning.

A team of five medical examiners are in place supported by the patient affairs team. Deaths are screened using a standardised screening proforma. Relatives are also contacted to ensure they understand the cause of death, have any questions answered and to ensure that any concerns are addressed. Feedback of junior doctor experience has been positive and audit findings are presented in Appendix B.

Reviews of deaths with significant learning or potential avoidability:

As per our mortality review protocol all deaths graded as 2 or 3 are subject to an RCA (root cause analysis) type investigation outside our normal e-mortality process.

An SI panel was held to review a death recorded as a Grade 2 mortality in October 2018. To ensure dissemination of the learning the recommendations were presented and discussed in the departmental Morbidity and Mortality (M&M) meeting in March 2019.

Action plans (all underway)

- Develop Trust wide policy for difficult vascular access in-hours and out of hours;
- Develop consistent referral pathway for nephrology advice and review from Dorchester renal services;
- Develop electronic (e-NA) input/output chart to record fluid balance.

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 the review and internal review process is now complete. All deaths were graded as 0 and no concerns in clinical care were identified. There were no deaths in this category in January, one death reported in February is under review.

Action Plan from the Mortality Surveillance / Reviews

1: Lung diseases due external agents (aspiration pneumonia) (relative risk and Cusum alert)

Mortality review completed with all deaths graded as 0 or 1.

No avoidable deaths. All patients were over 80 years of age, frail and with a background of neurodegenerative disease other than one patient with motor neurone disease.

There was a pattern of multiple admissions before the index leading to death.

70% of patients had recurrent episodes of aspiration in and out of hospital.

SALT assessment was prompt (within 24 hours) in all cases although in 2 referral was delayed.

Feeding information is not always available from the community at the point of admission particularly around decisions to feed at risk. In a small number of patients timely community assessment may have avoided admission.

Findings of the previous pneumonia pathway walkthrough were reassuring. The SALT have also been involved in reviewing these cases as part of MSG.

Actions:

- Further input is required from the SALT team to explore communication with primary care teams and the potential to avoid admissions for aspiration in older adults while waiting for community assessment. It is hoped the roll out of the Dorset Care Record will improve the visibility of decision making and alerts between primary and secondary care;
- To consider the role of upgrading diets in recurrence of aspiration as part of feeding at risk.

Repair of other hernia of abdominal wall: (procedural alert)

The mortality chair for Surgery conducted a review of the single case underlying the alert. Findings were discussed at the February MSG.

Learning and Action plan

- Mortality was graded as 1. Some gaps in clinical care were identified however they did not alter the outcome;
- It was noted that image quality for urgent CT scan was sub-optimal and may have contributed to a delay in reporting Pulmonary Embolism;
- The patient died from a massive pulmonary embolism and earlier diagnosis would not have changed the outcome;
- There is a process already in place to review all out of hour imaging the following morning. Any discrepancies are corrected and clinicians are informed.

Dr Foster alert: Higher mortality for other respiratory procedures

MSG noted an alert in this category as a procedural alert for 'Invasive ventilation'. All patients were intubated and ventilated in ITU (Intensive Treatment Unit) implying an association rather than causation with death. The critical care mortality lead has investigated this upward trend and analysed data for the following outcomes. MSG is reassured that this association is random and no further review is required.

- Trends for predicted ITU mortality are as expected and improving;
- ITU admissions following OOH cardiac arrest for last three years have increased which impacts on increased associated mortality with ventilation. This is a reflection of our status as the cardiac intervention centre for East Dorset;

- There is no significant difference in mortality associated with in hour and out of hour admissions to ITU (2016 to 2018).

Claims Data:

The litigation and claims departments across Poole Hospital and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trusts are being brought together into a single team following the retirement of the litigation manager in Poole Hospital. This is providing opportunities to align processes and responses both for claims and inquest enquiries.

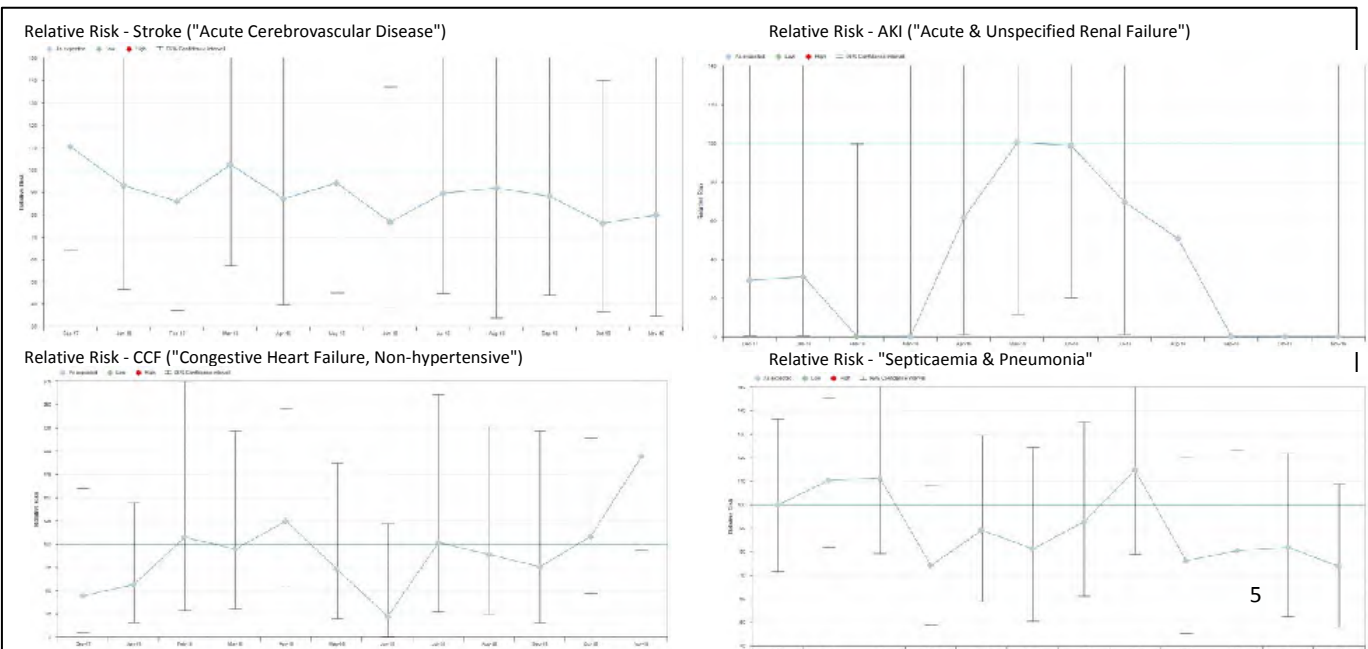
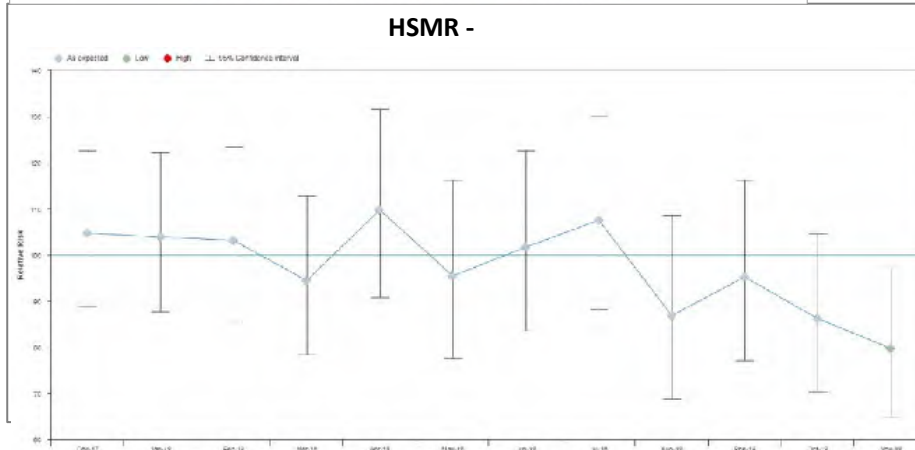
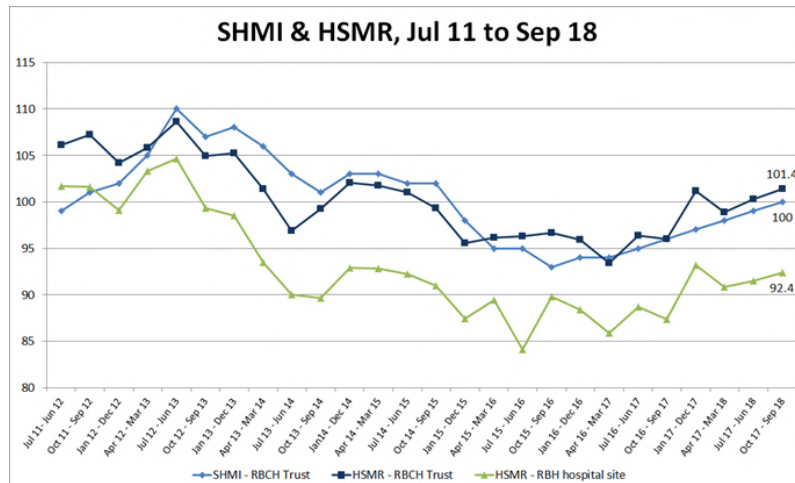
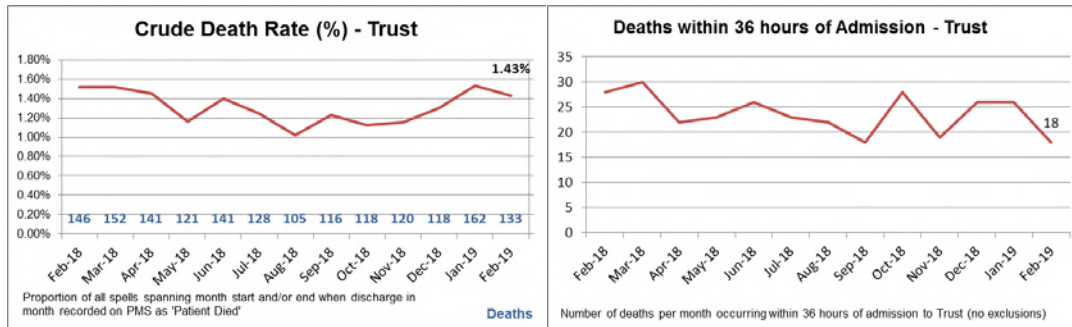
The national Getting it Right First Time (GIRFT) team are now routinely reviewing claims data as part of their reviews. The particular is around learning from claims and how this is disseminated across the Trust. This is now a routine part of our GIRFT transformation steering group agenda. The litigation manager has met with the national team to develop a local action plan. Most of the suggested actions are already matter of routine within our governance processes and day to day claims handling. One focus will be to improve clinician engagement particularly around the spread of learning.

Nationally and locally there is a trend to increasing claims through the Emergency Department (ED), particularly around failure to diagnose and failure to xray. ED are well engaged and are ensuring that processes are reviewed to reflect any lessons learned.

Claims numbers remains static with 2 new claims in February which are currently under investigation. The trust has received 6 disclosure requests in contemplation of litigation. Three claims have been closed following denial of liability by the trust and no further action from the claimant.

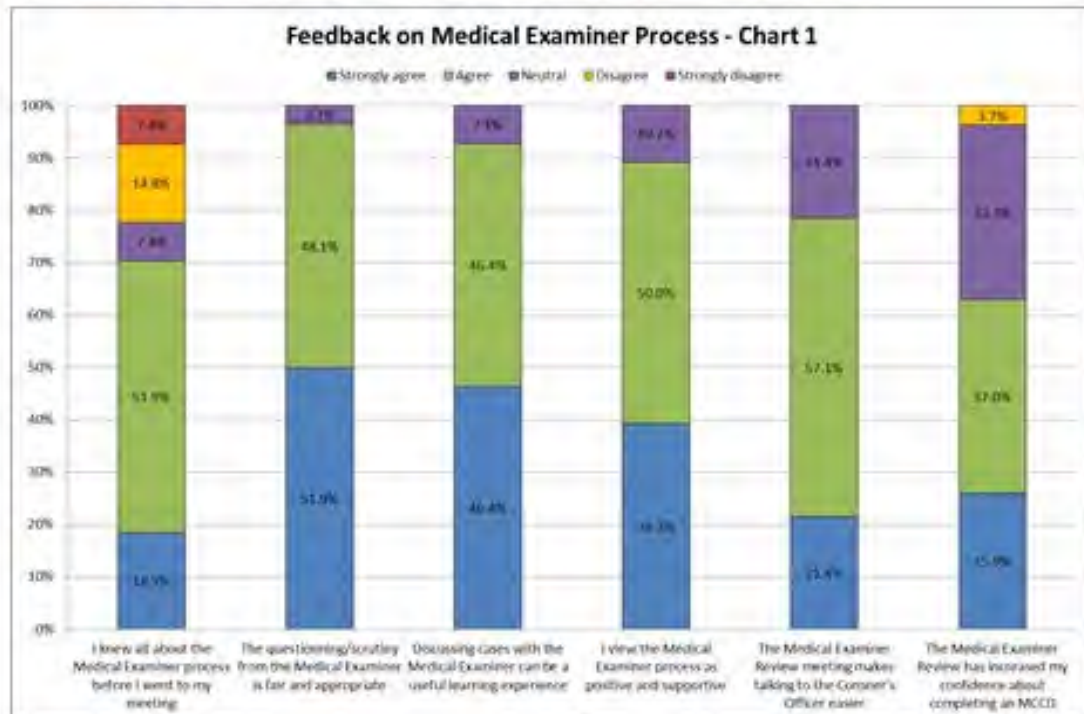
IT are currently working on a claims scorecard to provide an easier solution to mapping and monitoring trends in claims. This will align with the NHS Resolution scorecard data.

Annexe A - Data Review - Mortality Surveillance Group

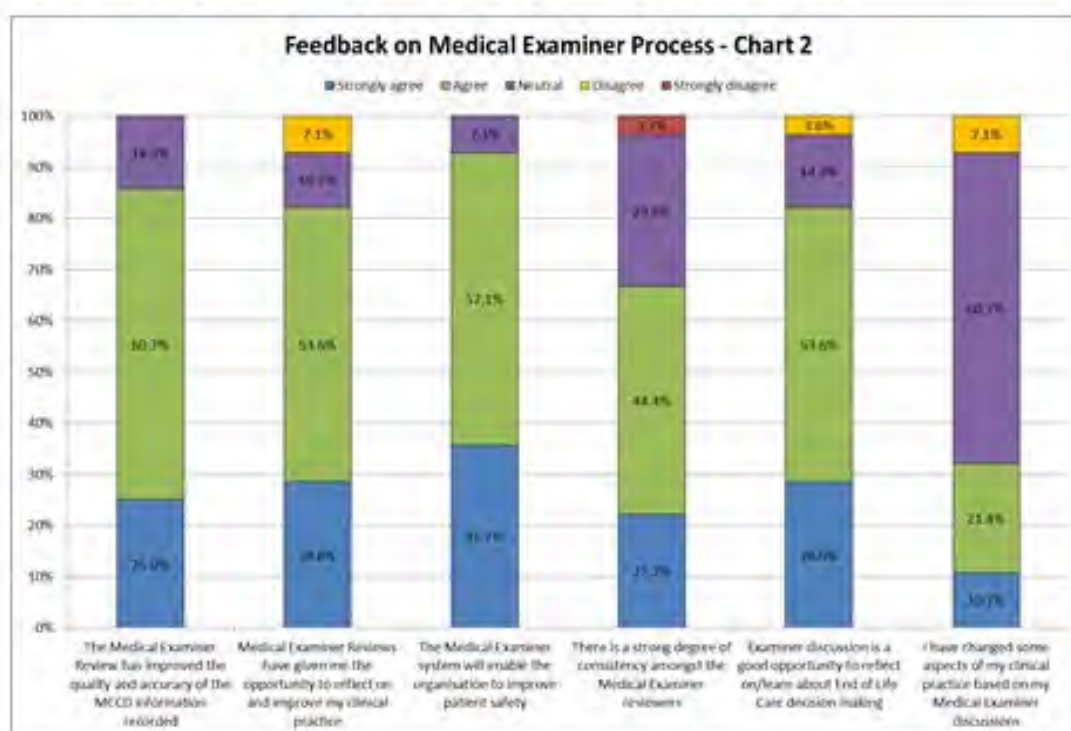


Appendix B: Audit of Junior Doctor Experience of the Medical Examiner Process

What did we achieve? – Junior Doctor Audit Results March 19



What did we achieve? – Junior Doctor Audit Results March 19



Trust Board Dashboard - February 2019

based on Single Oversight Framework metrics

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

Category	Metric	2018/19 Q2			2018/19 Q3			2018/19 Q4			Trend (where applicable)
		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
Quality of care	Caring - A&E scores from Friends and Family Test % positive	89.6%	92.6%	90.9%	90.8%	90.6%	92.1%	89.3%	89.1%		
	Caring - Inpatient scores from Friends and Family Test % positive	97.5%	98.2%	97.4%	97.9%	97.8%	97.6%	98.2%	97.2%		
	Caring - Maternity scores from Friends and Family Test % positive	96.4%	97.8%	99.3%	97.3%	95.9%	100.0%	93.0%	90.1%		
	Caring - Mixed sex accommodation breaches	3	0	5	0	1	0	0	0		
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)		91.7%								
	Caring - Formal complaints	33	40	33	27	32	34	40	34		
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	701	681	627	711	712	711	757	676		
	Effective - Hospital Standardised Mortality Ratio - Weekend (DR) - All Sites	86.9	90.1	98.6	79.3	72.7					
	Effective - Hospital Standardised Mortality Ratio - Weekend (DR) - MAC	228.9	137.2	296.3	259.0	342.1					
	Effective - Hospital Standardised Mortality Ratio - Weekend (DR) - RBH	76.8	83.7	73.9	63.7	67.6					
	Effective - Hospital Standardised Mortality Ratio (DR) - All Sites	100.0	80.8	94.3	85.5	79.7					
	Effective - Hospital Standardised Mortality Ratio (DR) - MAC	179.9	154.2	241.7	187.4	157.5					
	Effective - Hospital Standardised Mortality Ratio (DR) - RBH	90.5	70.4	76.0	78.0	72.7					
	Effective - Summary Hospital Mortality Indicator	0.998	0.998	0.998							
	ED Attendances	8884	8610	8099	8200	7965	8126	8436	7370		
	Elective Admissions	6114	6063	5655	6381	6294	5111	6181	5567		
	GP OP Referrals	6137	5593	5172	6466	5956	4757	5803	5333		
	Non-elective Admissions	3323	3331	3063	3356	3334	3323	3731	3072		
	Organisational health - Staff sickness in month	4.1%	4.3%	4.4%	4.7%	4.5%	4.1%	4.5%	4.5%		
	Organisational health - Staff sickness rolling 12 months	3.9%	4.0%	4.0%	4.1%	4.1%	4.1%	4.1%	4.2%		
	Safe - Clostridium Difficile - Confirmed lapses in care	0	2	0	0	0	1	1	0		
	Safe - Clostridium Difficile - infection rate	17.56	17.56	0	6.12	0	6.12	6.12	0		
	Safe - MRSA bacteraemias	0	0	0	0	0	0	0	0		
	Safe - NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0	1		
	Safe - Occurrence of any Never Event	0	0	1	0	0	0	1	0		
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)		35.16			37.23			26.51		
	Safe - VTE Risk Assessment	96.4%	96.3%	96.3%	96.5%	96.1%	95.6%	95.8%	95.8%		
	Number of Serious Incidents	4	1	2	0	1	0	2	1		
	Appraisals - Values Based (Non Medical) - Compliance	39.2%	59.8%	82.1%	88.9%	90.9%	90.6%	89.8%	89.1%		
	Appraisals - Doctors and Consultants - Compliance	88.9%	89.2%	84.5%	89.1%	91.2%	85.3%	79.5%	83.2%		
	Essential Core Skills - Compliance	93.7%	94.1%	92.9%	93.1%	93.0%	92.8%	93.2%	92.9%		
	Organisational health - Proportion of temporary staff	7.3%	7.9%	7.9%	7.8%	8.0%	8.3%	8.0%			
	Organisational health - Staff turnover	9.4%	9.2%	9.4%	9.3%	9.5%	9.9%	9.7%	9.8%		
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	4	3	1	1	1	1	1			
	Sustainability - Liquidity (YTD score)	1	1	1	1	1	1	1			
	Efficiency - I&E Margin (YTD score)	4	4	1	1	1	1	1			
	Controls - Agency Spend (YTD score)	1	1	1	1	1	1	1			
	Controls - Distance from Financial Plan (YTD score)	1	1	2	2	2	2	2			
	Overall finance and use of resources (YTD score)	3	3	1	1	1	1	1			
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	96.0%	94.1%	92.4%	93.5%	90.4%	89.6%	87.6%	87.9%		
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	75.0%	85.7%	69.2%	100.0%	92.0%	94.4%	88.9%			
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	86.1%	79.8%	77.2%	77.5%	91.8%	89.2%	89.0%			
	Maximum 6-week wait for diagnostic procedures	94.4%	93.9%	93.3%	93.4%	96.5%	93.5%	94.8%	96.7%		
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	88.7%	87.6%	86.8%	86.9%	86.7%	85.7%	85.4%	85.3%		

BOARD OF DIRECTORS	
Meeting date – Info Pack only:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Performance Report
Section on agenda:	Quality and Performance
Supplementary reading:	None
Director or manager with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of paper:	Donna Parker, Deputy Chief Operating Officer David Mills, Associate Director Information & Performance Dawn Ailes, RTT Performance Lead
Details of previous discussion and/or dissemination:	PMG / Finance and Performance 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 SOF, national planning guidance and contractual requirements.</p> <p><i>Note, the narrative report should be read in conjunction with:</i></p> <ul style="list-style-type: none"> • Trust Board Dashboard • Performance Indicator Matrix <p>Executive Summary:</p> <p>This report focuses on February 19 performance where it is available and provides a 'look forward' in light of current/projected trends and actions being taken.</p> <p>Key Highlights & Exceptions:</p> <ul style="list-style-type: none"> • Performance against the 4 hour standard improved slightly in February and remains in the top quartile of Trusts despite an increase in conveyances. • Ambulance conveyances continue to remain above the level seen in the same period last year; SWAST has increased 6.6% YTD (Apr 18 – Jan 19) and SCAS has increased 14.9% YTD • Zero 12 hour decision to admit breaches in February 19 • Zero RTT 52 week breaches year to date • RTT Clocks Still Running total waiting list increased in February and remains above (worse than) the March 19 target for number of patients waiting. • Trust wide RTT performance dropped slightly in February and has now fallen below the national average 86.3% • Endoscopy recovery plan remains on track with compliance against the 6 week standard expected in Q1 2019/20 • Performance against the 62 day cancer standard dropped slightly in January but remains above the national target • Interim report on clinical review of access standards in spring 2019 is now published 	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste

<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>
<p>Impact on risk profile:</p>	<p>Performance metrics are key control measures for the following risks on the Trust Risk Register:</p> <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
February 2019

Richard Renaut
Chief Operating Officer

1. Executive summary

Key highlights and exceptions:-

- Performance against the 4 hour standard improved slightly in February and remains in the top quartile of Trusts despite an increase in conveyances.
- Ambulance conveyances remain above the level seen in the same period last year; SWAST has increased 6.6% YTD and SCAS has increased 14.9% YTD (Apr 18 – Jan 19).
- Zero 12 hour decision to admit breaches in February 19.
- Zero RTT 52 week breaches year to date.
- RTT Clocks Still Running total waiting list increased in February and remains above (worse than) the March 19 target for number of patients waiting.
- Trust wide RTT performance dropped slightly in February and has now fallen below the national average (86.3%).
- Endoscopy recovery plan remains on track with compliance against the 6 week standard expected in Q1 2019/20.
- Performance against the 62 day cancer standard dropped slightly in January but remains above the national target.
- Interim report on clinical review of access standards in spring 2019 is now published.

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 – January 19 / February 19

In February the Trust achieved 87.9% against the 4 hour standard which was a slight improvement on January (87.6%) but below our local trajectory. The Trust remains focussed on working with partners to deliver the 95% Provider Sustainability Fund target for March 2019.

RTT performance deteriorated slightly in February to 85.3% which remains below our local target trajectory. The overall waiting list also increased by 516 during February across a range of specialties mainly due to the planned reduction in elective activity over winter. This has put further pressure on the Trust achieving the March 19 target (the same size waiting list as end of March 18). Positively we continue to have zero 52 week breaches.

January's performance against the 62 day cancer standard was 89% and remains above the national target of 85%. Complex diagnostic pathways were the main reason for breaches. Performance against the 62 day screening standard was 89.9%, 0.1% below the target. Positively all three 31 day cancer targets for January remained above target. Performance against the 2 week wait standard dropped in January to 91.7% and for symptomatic breast patients 90%.

Diagnostic performance continued to improve during February to 96.7% and remains on track to recover to the 99% target in Q1 2019/20.

Operational Performance Report

As at 15/03/2019

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		
				Jan-19	Feb-19	Mar 19 projection
A&E 4hr maximum wait time	95%	88.9% - 95.0%	Mthly & Qtrly	87.6%	87.9%	
RTT 18 week incomplete pathways	92%	88.1% - 88.4%	Mthly	85.4%	85.3%	
RTT - no. of incomplete pathways	≤ March 2018	24,880	Yr End	25,362	25,878	
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	89.0%	est	
Cancer 62 day wait for first treatment from Screening service**	90%	90%	Mthly & Qtrly	88.9%	est	
Maximum 6 weeks to diagnostic test	99%	99%	Mthly	94.8%	96.7%	

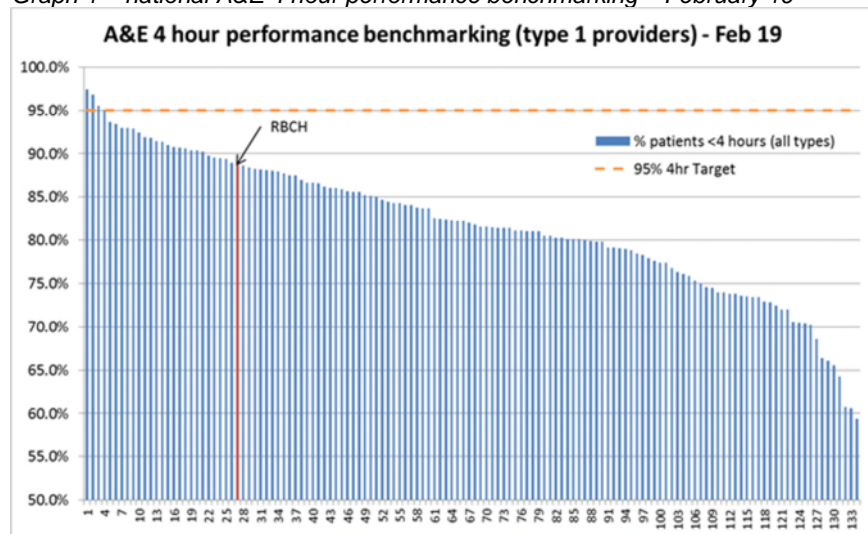
RAG Key: Red - below national target and organisational trajectory; Amber - above trajectory but below national target or 'at risk'; Green - above national target (and trajectory).

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

2.2 National Benchmarking – January 19 / February 19

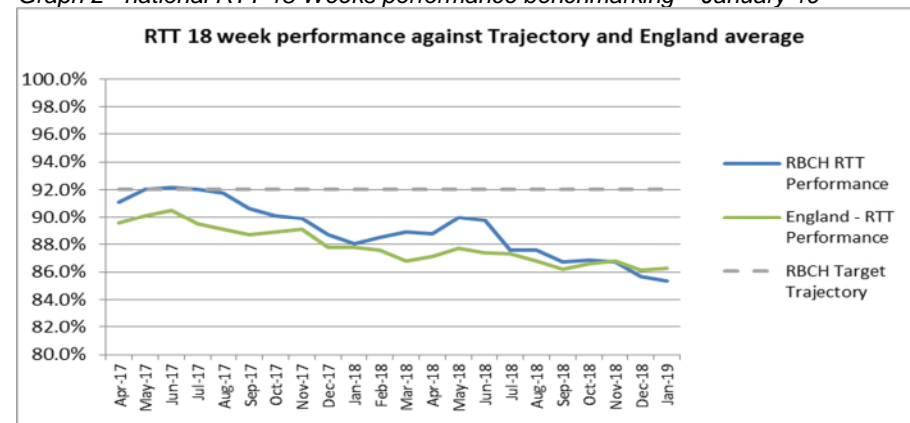
RBCH benchmark position for ED 4 hour performance in February was 27th out of all type 1 trusts nationally (YTD performance is 92.5%).

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



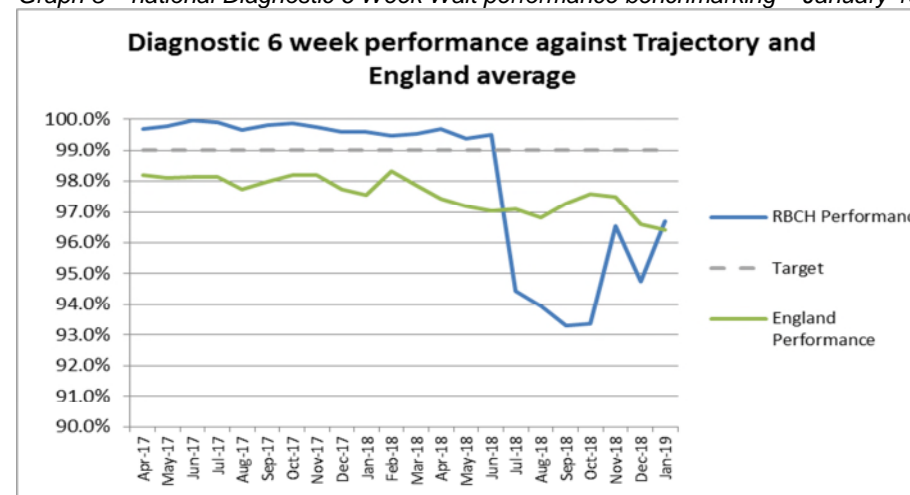
Trust wide RTT performance is just below the national average (86.3%) in January.

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



Diagnostic performance is recovering and now above the national average (96.4%) in January 19.

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

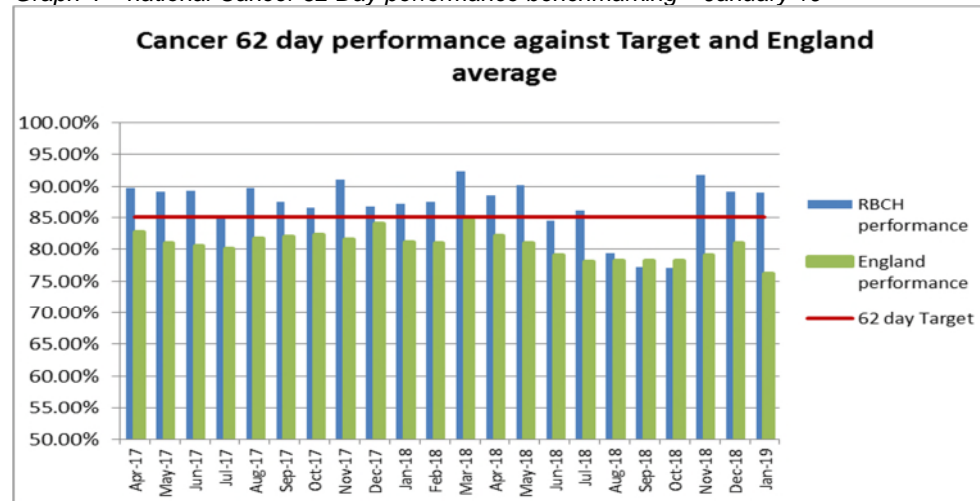


Operational Performance Report

As at 15/03/2019

The Trust's return to compliance against the Cancer 62 day performance standard continued in January 19, achieving the 85% target and being significantly above the National average.

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



3. Forecast Performance, Key Risks and Action

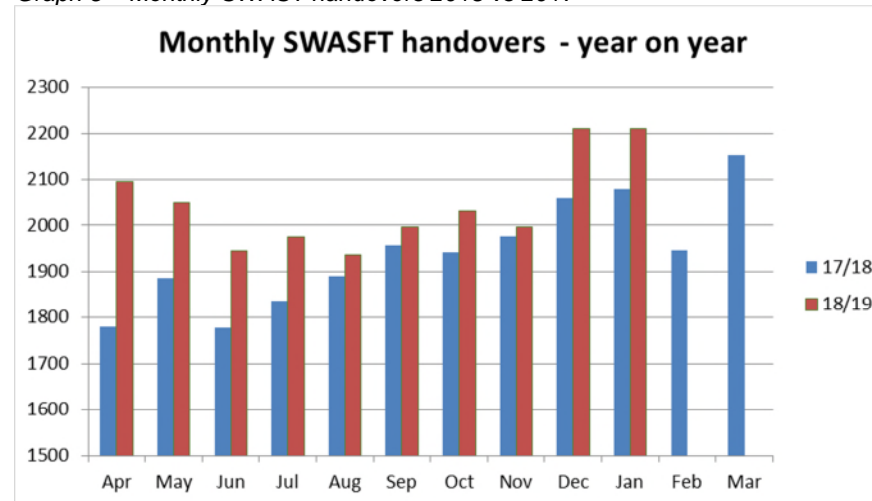
3.1 A&E Targets, PSF and Stranded Patients

Performance against the 4 hour standard increased slightly in February to 87.9% compared with January (87.6%). It continues to remain a challenge to deliver the 95% 4 hour standard with the increase in demand on urgent care across the system, due to winter pressures. There were no 12 hour breaches of the decision to admit standard.

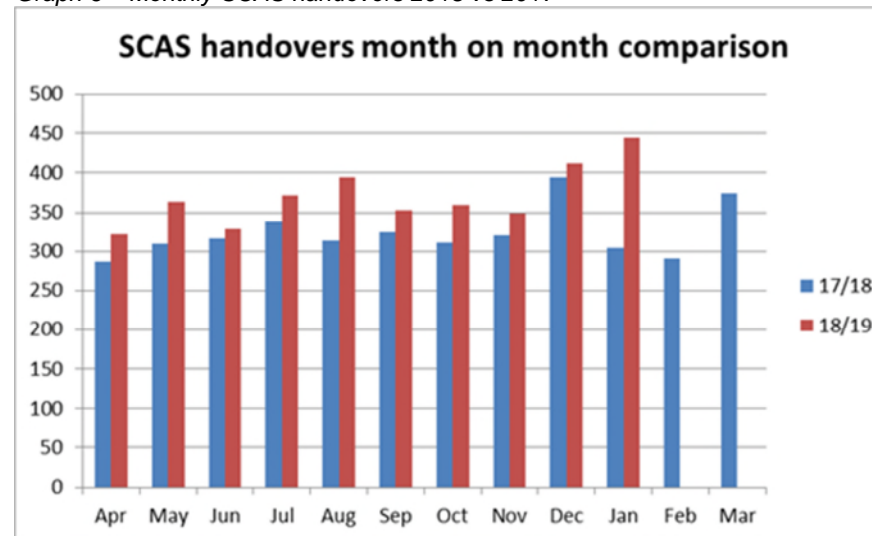
The number of ambulance conveyances increased in January 19 with SWAST up 6.6% and SCAS up 46.1% compared to January 18. Conveyances in 2018/19 have remained above 2017/18 levels

throughout the year as highlighted by graphs 5 and 6. There was an improvement in the number of 60 minute handover breaches in February although 30 minute breaches slightly increased.

Graph 5 – Monthly SWAST handovers 2018 vs 2017

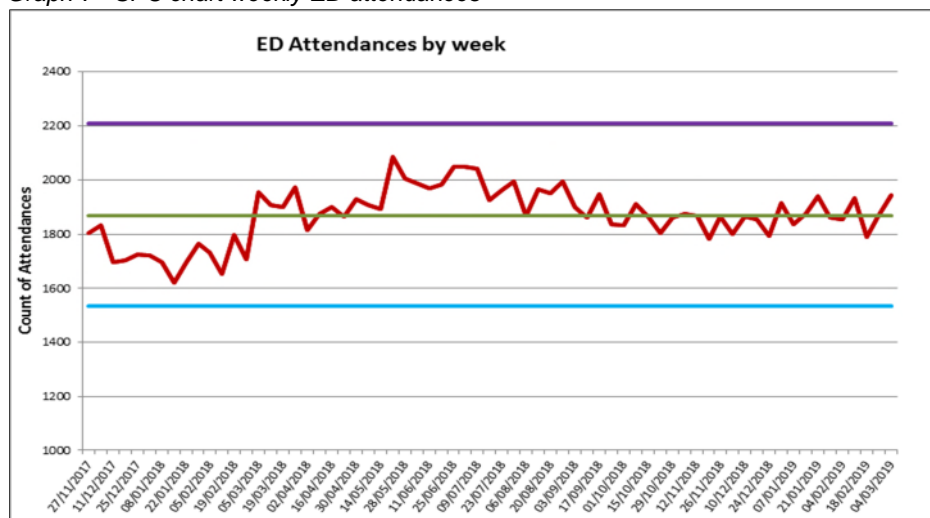


Graph 6 – Monthly SCAS handovers 2018 vs 2017

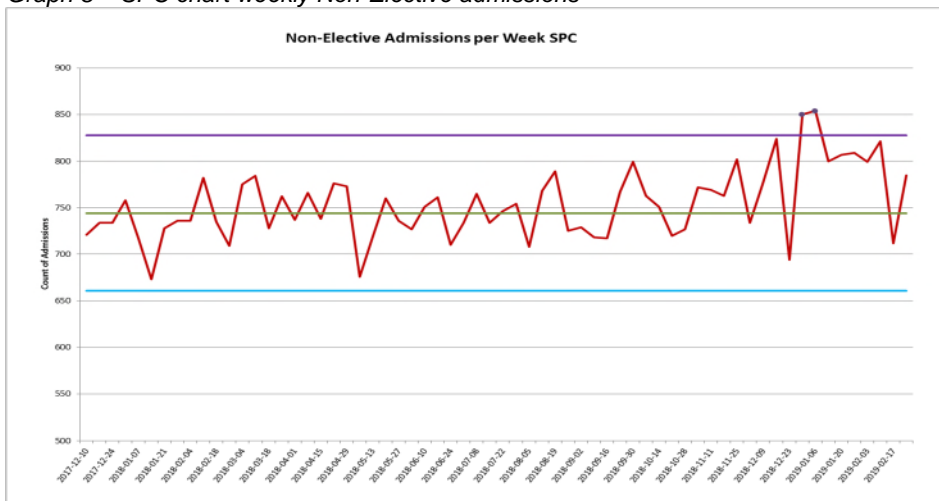


Overall ED attendances in February 19 were 5.8% higher than in February 18 (4.6% YTD) and emergency admissions were up 0.4% in February 19 compared to February 18 (4% YTD). The weekly trends are highlighted in the Statistical Process Control charts below.

Graph 7 – SPC chart weekly ED attendances



Graph 8 – SPC chart weekly Non-Elective admissions



ED and Conveyances

BREATH building works have completed and the increased capacity opened at the end of February. Alongside this the new nursing template to support BREATH being open 24 hours 7 days a week has now been implemented. The band 7 navigator role commenced on the 11th March, responsible for coordinating the whole department and feedback so far is positive.

Relaunch of the consultant of the day model has occurred, with a successful middle grade recruitment resulting in a fully established rota expected by end of May. Focussed QI work continues to improve pathways and flow through the department.

The learning applied from previous years meant that despite increased conveyances and attendances over January and February there were no urgent cancelled operations for the second time and no 28 day breaches despite the pressure at the front door.

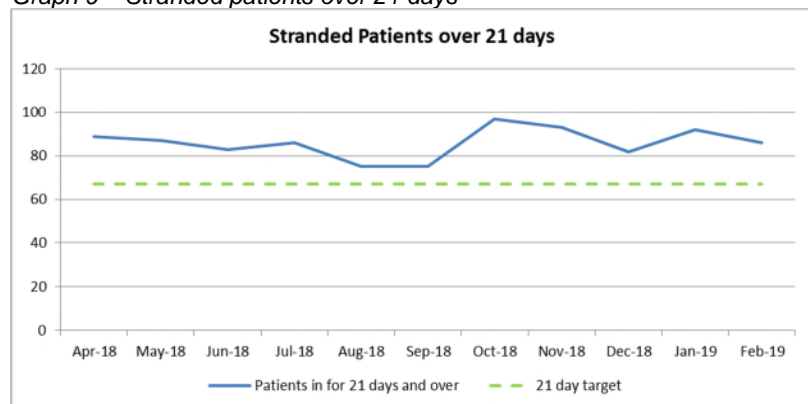
Working with Partners and 21+ Day Stay ('Stranded') Patients

Weekly stranded patient ward meetings occur to work with patient and health care providers to progress complex patients. CHC internal pathways continue to improve and an electronic CHC assessment form is now live.

A really positive outcome from a previous action learning week is social workers have been allocated to wards 5 and 26 which is improving flow through the wards. A further action learning week took place at the beginning of March.

The number of patients who have been in hospital for over 21 days decreased during February; however the overall numbers over 7 days has increased and March remains a challenge.

Graph 9 – Stranded patients over 21 days



Winter Planning Update

The Winter Planning to date has resulted in better overall management of patient flow despite a significant increase in ambulance conveyances alongside an increase in patient acuity. The winter initiatives continue to progress through March.

Actions from now to April will continue to focus on various initiatives including:

- Paramedic / GP support including Single Point of Access
- Consultant Advice and Guidance
- Implementation of new ED rota
- Continued support for Urgent Treatment Centre with increasing referrals clinically streamed now Avg at 24 per day (41 on weekend days), alongside dedicated social care/discharge.

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

RTT pathways remain under pressure with carve out from cancer and increased diagnostic times in endoscopy. NHSI/E's emphasis on

avoiding 52 week breaches continues and the Trust is still able to report no 52 week breaches year to date.

Outpatient waits continue to be a pressure, with a number of specialties waits at over 13 weeks for a first appointment, creating a challenge for these pathways to achieve the 18 week target.

Phasing of elective surgery (in line with national guidance) continued into February to assist with the emergency care pressure on beds. For orthopaedics there was no elective activity for the Derwent for February which has resulted in an increase waiting list size as well as a slight decrease in performance.

Additional funds from Dorset CCG to support Ophthalmology have enabled some additional weekend capacity for cataract surgery during February and throughout March. Clinic templates across Ophthalmology have been revised and new templates have now been implemented increasing capacity and working towards reducing outpatient waits. Locums have been recruited to ensure that the additional capacity is fully utilised. Work continues with PHT to help reduce their current outpatient waits.

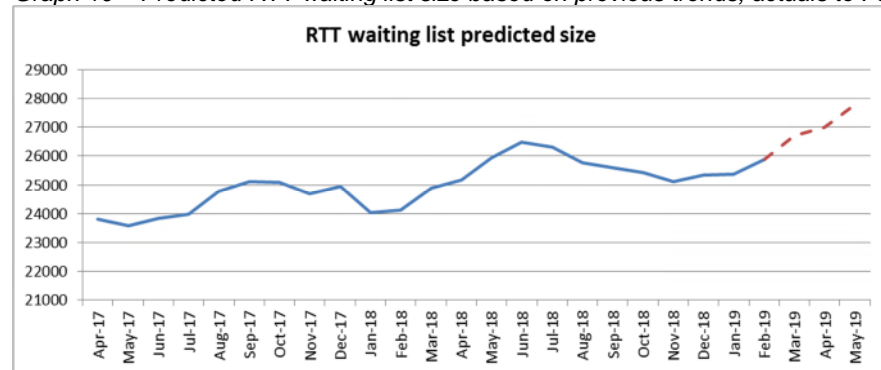
Urology is continuing to use the independent sector for patients on the waiting list, utilising national monies and creating capacity for cancer treatments. This is reflected in a decrease in the long waits for urology admitted pathways.

Dermatology remains a pressure system wide, with Quality Improvement work continuing to focus on additional capacity across Dorset. We are also working closely with Poole Hospital Trust to reduce long waits by offering patients appointments at RBCH. Proactive management of outpatient capacity for the Spring/Summer when fast track referrals increase is underway.

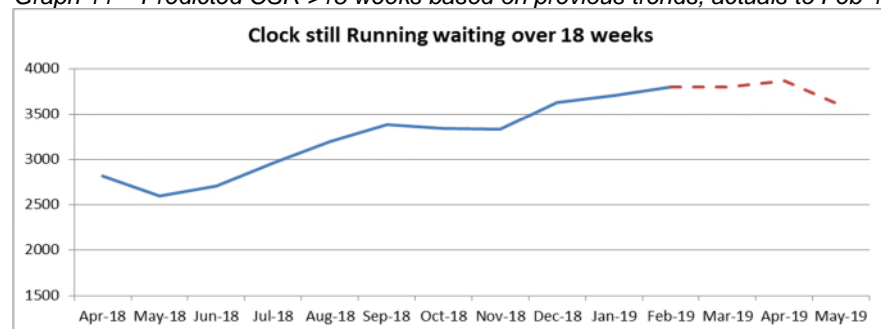
Operational Performance Report

As at 15/03/2019

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



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



The number of over 40 week waits increased slightly (5) in February compared with January.

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	Jan-19	Feb-19
General Surgery	14	13	14	13	18	17	14	28	41	44	40
Urology	30	35	20	18	16	19	20	30	42	34	36
Trauma & Orthopaedics	4	12	11	5	3	4	1	1	3	1	3
Ear, Nose & Throat (ENT)	2	2	5	4	3	1	1	2	1	1	3
Ophthalmology	0	0	1	5	1	1	6	5	11	17	13
Oral Surgery	0	0	1	2	3	2	4	5	2	1	3
Cardiothoracic Surgery	0	0	0	0	0	0	0	0	0	0	0
General Medicine	3	3	1	1	5	5	2	1	1	1	2
Cardiology	1	0	4	5	0	0	4	3	2	1	1
Dermatology	2	4	5	3	10	7	6	1	2	2	4
Thoracic Medicine	0	0	0	0	0	1	1	0	0	0	2
Neurology	0	0	0	0	0	0	0	0	0	0	0
Rheumatology	0	0	0	0	0	0	1	0	0	0	0
Geriatric Medicine	0	0	0	0	0	0	1	3	3	1	0
Gynaecology	4	3	2	4	8	3	3	3	3	3	3
Other	0	1	2	2	5	1	0	1	5	4	5
Total	60	73	66	62	72	61	64	83	116	110	115

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

During 2018/19 there has been a 15% increase in fast track referrals YTD, increasing pressure on outpatient waits, diagnostics and treatment pathways. Fast track referrals in January 19 were below January 18 however, there was an increase in referrals for Gynaecology, Colorectal and Breast.

Despite the increase in demand all cancer standards were achieved in Quarter 3. January's performance against the 62 day cancer standard was 89% above the national target (85%). Complex diagnostic pathways were the main reason for breaches. Performance against the 62 day screening standard was 89.9%, 0.1% below the target.

Quarter 4 still remains a significant challenge for the 62 day standard due to complex pathways both within prostate and lung. However early indications suggest the positive performance has continued for February.

All the 31 day cancer standards have been achieved for January. Performance against the 2 week wait standard dropped in January to 91.7% and for symptomatic breast patients 90%. The drop in performance was primarily due to reduced capacity for 1st outpatient appointments in Urology.

3.4 Diagnostic 6 Week Wait

Diagnostic performance continues to see improvement with a significant increase from 94.8% in January to 96.7% in February. In addition the overall number of patients over their target time continued to decrease during February with the continued use of waiting list initiatives and insourcing. The aim is to continue to decrease the backlog during Q4 with recovery on track for Q1 2019/20.

RBCH endoscopy department have experienced a 10% increase in referrals YTD. Growth is most significantly seen in colonoscopies and gastroscopies at 36% each. RBCH has seen some increase in referrals from outside of its core catchment areas however this is not mirrored in a corresponding drop in referrals to neighbouring Trusts. Future growth analysis indicates the demand for endoscopy lists at RBCH is likely to increase by 6%. The service is sourcing locums at present to address the capacity gaps during Q1.

JAG has informed all Trusts that surveillance guidance will change in November 19 resulting in an increase in procedures required (approx. 200 patients per year).

During February Endoscopy continued to see all Fast Track and urgent patients within the accepted clinical time.

3.5 Clinically-Led review of NHS access Standards

A clinically-led review of NHS access standards has finished and an Interim Report by the NHS National Medical Director has been published. The reports sets out proposals to update several of the existing performance standards set out in the NHS Constitution. The review was commissioned to ensure that the NHS performance measures reflect clinical practice and support the delivery of the long term plan.

The proposed changes will impact on the following areas:

- **Mental Health** - the current access standards to be replaced with 4 access standards:
 - Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services
 - Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments
 - Four-week waiting times for children and young people who need specialist mental health services
 - Four-week waiting times for adult and older adult community mental health teams
- **Cancer** - the current 9 cancer standards (since 2009) to be replaced with 3 access standards:
 - Faster Diagnosis Standard: Maximum 28day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening
 - Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening
 - Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients
- **Urgent and Emergency Care** - the current 4 hour standard (since 2004) and Ambulance standards to be replaced with 4 access standards and 1 supporting indicator:
 - Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments)
 - Time to emergency treatment for critically ill and injured patients
 - Time in A&E (all A&E departments and mental health equivalents - mean waiting times)
 - Utilisation of Same Day Emergency Care
 - Call response standards for 111 and 999
- **Elective Care** - the current standards to be replaced with 2 access standards and 2 supporting standards:
 - Maximum wait of six weeks from referral to test, for diagnostic tests

- Defined number of maximum weeks wait for incomplete pathways, with a percentage threshold OR Average wait target for incomplete pathways
- 26-week patient choice offer
- 52-week treatment guarantee

The recommendation is for these new approaches to be field tested during 2019/20, which will therefore be a transition year between the old targets and updated standards. Field testing will start in Q1 and Q2 with roll out in Q3 and full implementation by spring 2020.

4. Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail

There was 1 C. Difficile case confirmed in February due to a lapse in care, however we remain below (better than) our 2018/19 trajectory.

Recommendation

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

BOARD OF DIRECTORS	
Meeting date:	Wednesday 27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Quality Report
Section on agenda:	Quality and Performance
Supplementary reading:	Nil
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: The Quality report is a summary of the key quality indicators in Month.</p> <p>There were 2 Serious incidents reported in January 2019 and 1 Serious Incident in February 2019.</p> <p>The Trust remains in the top quartile for inpatient FFT for December. ED and OPD FFT rate remained in second quartile.</p> <p>A total of 34 complaints were received in February 2019. 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

February 2019

Paula Shobbrook
Director of Nursing and Midwifery

Quality Report: February 2019

1.0 Introduction

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

2.0 Serious Incidents

One serious incident was reported in February 2019.

A patient presented to the Emergency Department following a fall and head injury. There was a delay in receiving medication which, following the SI investigation, the panel agreed was not directly causative, but may have contributed to the patient's death.

In addition, as an addendum to the January Board report a second serious incident was reported in January 2019.

A patient attended the Endoscopy service for a diagnostic procedure. Following a change of endoscope it was identified that the biopsy had been taken from the wrong location and may not have been required. An investigation is in progress for panel review.

4.0 Patient Experience Report

4.1 Friends and Family Test: February report

National Comparison using NHS England data:

The national performance benchmarking information bullet pointed below is provided by NHS England and represents January 2019 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in January 2019 ranked RBCH Trust 2nd with 16 other hospitals out of 166 placing RBCH in the top quartile based on patient satisfaction. The response rate was sustained above the 15% national standard at 15.5%.
- The Emergency Department FFT performance in January 2019 ranked RBCH Trust 12th with 7 other hospitals out of 136 placing RBCH ED department in the second quartile. The response rate was 9.3% against the 15% national standard.
- Outpatients FFT performance in January 2019 ranked RBCH Trust 3rd with 25 other Trusts out of 247 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

	August	September	October	November	December	January
In-Patient Quartile						
Top	98.643%	98.002%	98.537%	98.578%	98.113%	98.878%
2						
3						
Bottom						

	August	September	October	November	December	January
ED Quartile						
Top						
2	92.604%	90.875%	90.776%	90.557%	92.129%	89.258%
3						
Bottom						
	August	September	October	November	December	January
OPD Quartile						
Top						
2	98.091%	97.098%	97.501%	97.569%	98.304%	97.919%
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	27	26	100.0%	0.0%
Main OPD Xch	0	23	22	81.8%	4.5%
Oral and Maxillofacial	0	1	1	100.0%	0.0%
Outpatients General	0	204	198	97.0%	0.5%
Jigsaw OPD	0	8	8	100.0%	0.0%
Corporate Total		212	206	97.1%	0.5%

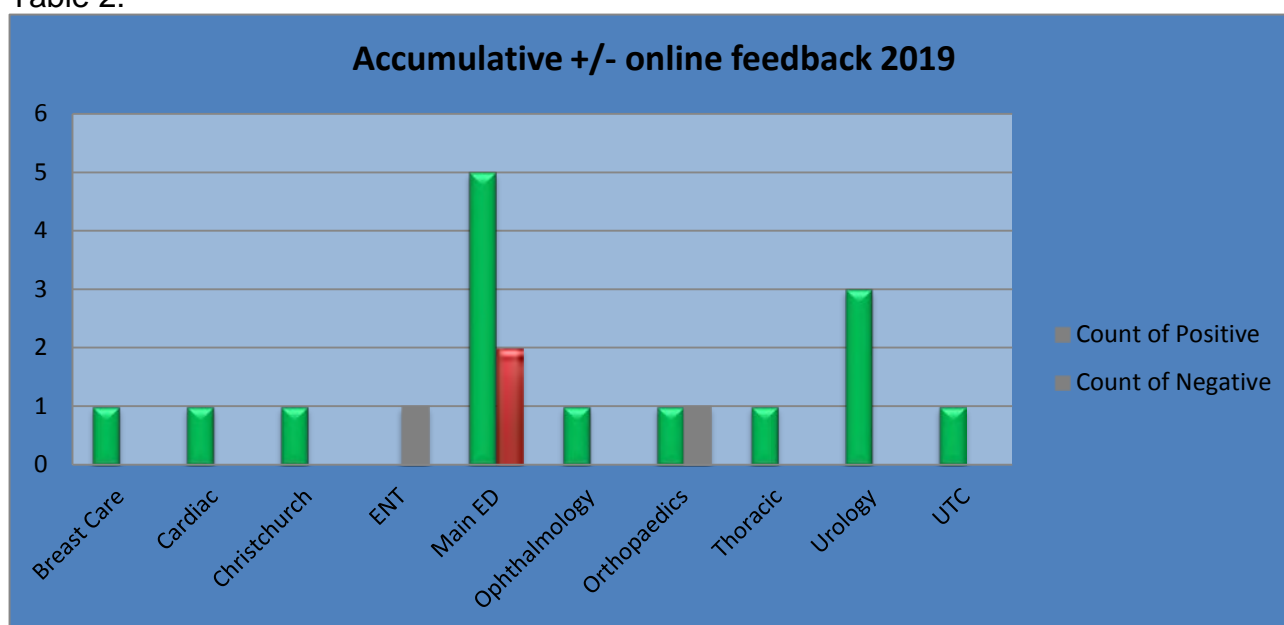
4.3 Patient Opinion and NHS Choices: February Data

Nine patient feedback comments were posted in February, eight expressed satisfaction with the staff attitude, care and professionalism. One negative comment highlighted staff attitude and lack of individual care. 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 2019 to present.

Table 2:



4.5 Care Conversations

Care Conversations continue to be trialled in Care Group A. Audio 'Snippets' of patient feedback are being edited and presented to the Directorate. A final draft has been agreed and additional volunteers are undergoing training prior to a Trust wide launch in April 2019.

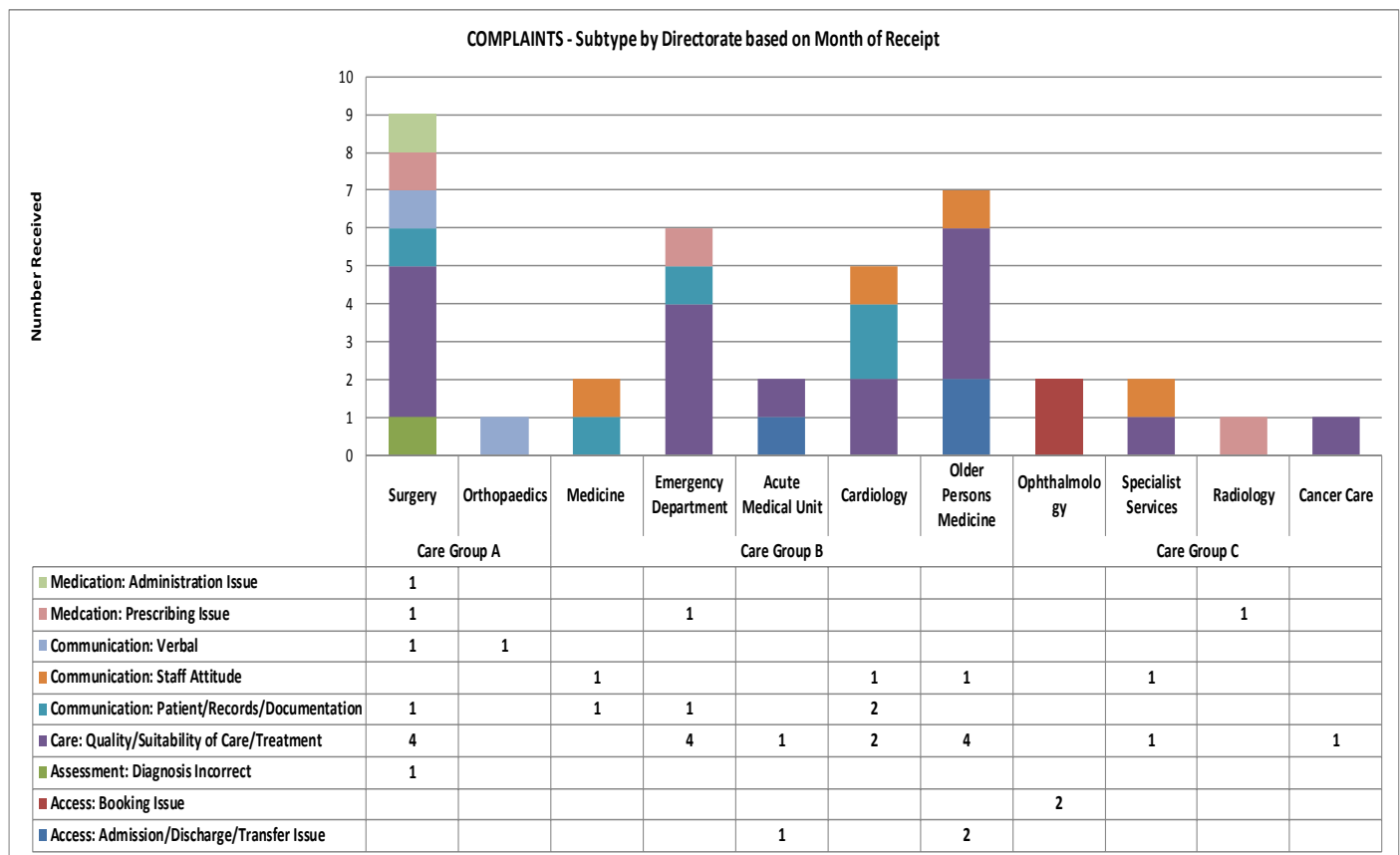
4.6 NHS Inpatient Survey 2018

Both RBCH and Poole Hospital have been working together to identify a joint focus for the 'NHSI Experience of Care week' in April. Our theme for activities will be based around 'great communication'. Following the NHS inpatient survey one topic will be related to reducing noise at night and how staff communication can help reduce distress for our patients when in a busy hospital environment. This will be followed by an action learning week about noise at night with further events and activities to engage with our staff.

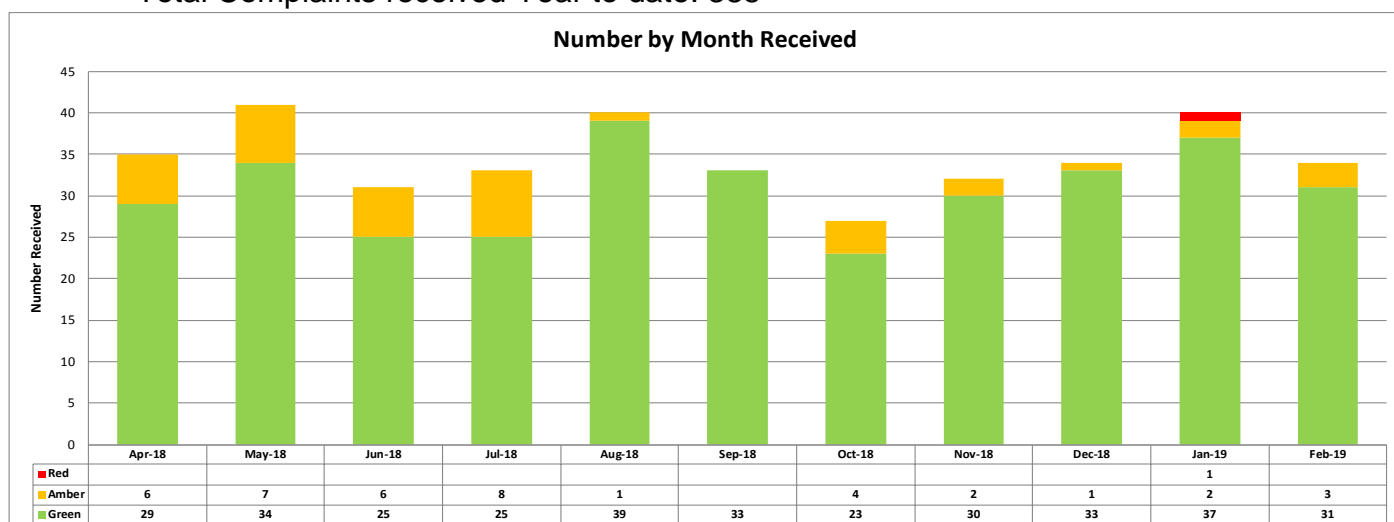
5.0 Complaints

5.1 A total of 34 complaints were received in February all of which were acknowledged within 3 days. The highest themes being:

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



Total Complaints received Year to date: 385



5.2 Complaint response times Year to date:

An increase in the number of complaints is noted and variable response rates are noted since November 2018. This has been raised with the directorates and the focus has been ensuring a full and appropriate investigation and response which has impacted on the timeframes. Teams are meeting on a regular basis to improve the timeliness of response.

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Rolling 12 months
1st Responses Due in Month	11	11	18	14	21	17	16	16	21	13	12	19	13	191
Number Where 1st Response Completed On	9	8	10	9	15	12	11	9	18	8	9	13	7	129
Percent With 1st Response On Time	82%	73%	56%	64%	71%	71%	69%	56%	86%	62%	75%	68%	54%	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:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Finance Report
Section on agenda:	Quality and Performance
Supplementary reading:	yes
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Chris Hickson, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required:	Decision
<p>Summary:</p> <p>The Trust continues to deliver against its agreed financial recovery plan and is now confident in achieving the full year financial control total. The quarter four Provider Sustainability Funding of £2.2 million linked to the Dorset ICS financial control total will not be achieved and has been reflected within the forecast.</p> <p>Full details are included within the attached reports.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on risk profile:	Three 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

28 February 2019

Pete Papworth
Director of Finance

Executive Summary

As at 28 February the Trust has delivered a cumulative surplus of £17.500 million, being £1.262 million worse than budget. This reflects the loss of Provider Sustainability Funding during January and February amounting to £1.470 million associated with the Dorset Integrated Care System failing to achieve its agreed financial control total.

It is important to remember 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 recurrent underlying financial challenge.

The forecast year end position has been updated to reflect the loss of the quarter four Provider Sustainability Fund payment in full due to the Dorset Integrated Care system failing to achieve its full year financial control total.

Income & Expenditure

After adjusting for pass through drugs and devices; income is behind plan by £1.435 million. The main driver for this is private patient income, particularly in relation to the Dorset Heart Clinic.

Expenditure reported underspends of £172,000 after adjusting for pass through drugs and devices. This reflects the significant pressure against pay and drugs budgets (£2.913 million and £1.732 million respectively), offset by underspends 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 £2.913 million, with £2.661 million of this variance within the Medical Care Group.

The Agency expenditure as a percentage of pay budgets has increased further, from 2.27% in January to 2.30% during February. Particular workforce challenges continue within the Medical Care Group with vacancies across both the medical and nursing staff templates, together with additional resource requirements within the Emergency Department.

Cost Improvement Programme

As at 28 February, financial savings of £10.338 million have been achieved. This represents a shortfall of £1.252 million against the year to date planned value of £11.590 million.

The current forecast is for total savings amounting to £11.398 million representing a shortfall of £1.299 million against the full year savings requirement of £12.697 million. The downside forecast is for total savings of £11.302 million with an upside forecast of £11.516 million.

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 (A&E) 4 hour access standard.

The Dorset ICS will fail to achieve its overall financial control total during quarter four, resulting in a loss of £2.206 million system related PSF for the Trust. There is a further risk of £945,000 relating to the Accident and Emergency (A&E) 4 hour access standard trajectory of 95% to be delivered in March. However, the Trust is currently performing well with cumulative performance of 96.5% during March which is within the top decile for type 1 acute Trusts in the South.

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 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. This is currently forecast to be delivered by 31 March 2019 and is not affected by the overall ICS position.

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, following confirmation that the overall Dorset ICS control total will not be achieved, the Trust's forecast outturn has been reduced to reflect the loss of PSF during quarter four. The revised forecast outturn is for a surplus of £22.413 million.

Capital Expenditure

Capital expenditure amounting to £7.810 million has been committed, which is £3.290 million behind budget. This underspend is expected to reduce during March, resulting in a full year capital under spend of £2.526 million. This reflects the reduced expenditure related to the Dorset Clinical Services Review together with slippage into 2019/20 of the Radiology Room 12 building works and associated equipment.

Cash

As at 28 February the Trust is holding a consolidated cash balance of £38.25 million. This is a strong position, and means that no Department of Health support is required.

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 28 February 2019.

Finance Report

As at 28 February 2019

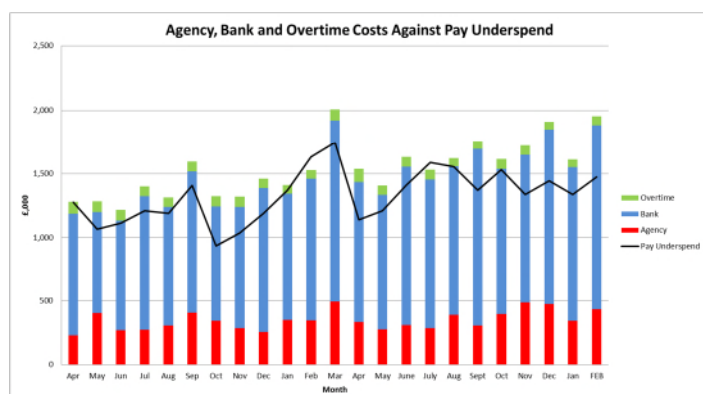
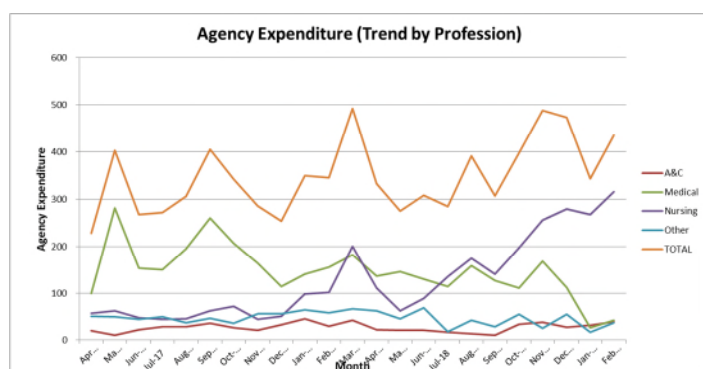
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000	Pass Through £'000	Residual Variance £'000
NHS Clinical Income	241,288	236,649	(4,639)	4,948	309
Non NHS Clinical Income	5,804	5,037	(767)	(57)	(824)
Non Clinical Income	59,996	59,076	(920)	0	(920)
TOTAL INCOME	307,088	300,762	(6,326)	4,891	(1,435)
Employee Expenses	175,182	178,094	(2,913)	0	(2,913)
Drugs	32,689	30,142	2,548	(4,280)	(1,732)
Clinical Supplies	33,353	32,530	823	(611)	212
Misc. other expenditure	47,101	42,495	4,605	0	4,605
TOTAL EXPENDITURE	288,325	283,262	5,064	(4,891)	172
SURPLUS/ (DEFICIT)	18,763	17,500	(1,262)	0	(1,262)

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	168,249	168,242	(7)
NHS England (Wessex LAT)	44,803	40,404	(4,399)
NHS West Hampshire CCG (and Associates)	23,198	23,205	7
Other NHS Patient Income	5,038	4,798	(240)
Provider Sustainability Fund	23,849	22,379	(1,470)
Non NHS Patient Income	5,804	5,037	(767)
Non Patient Related Income	36,147	36,697	550
TOTAL INCOME	307,088	300,762	(6,326)

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%)	5,565	4,095	(1,470)	6,300	4,094	(2,206)
Performance: A&E Trajectory (30%)	2,385	2,385	0	2,700	2,700	0
Trust Control Total Incentive	15,900	15,900	0	18,000	18,000	0
TOTAL	23,849	22,379	(1,470)	27,000	24,794	(2,206)

Agency Expenditure



Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	11,879	10,030	(1,849)
Medical Care Group	6,256	3,098	(3,158)
Specialties Care Group	4,840	4,287	(554)
Corporate Directorates	(33,847)	(33,437)	410
Centrally Managed Budgets	29,634	33,523	3,889
SURPLUS/ (DEFICIT)	18,763	17,500	(1,262)

Cost Improvement Programme

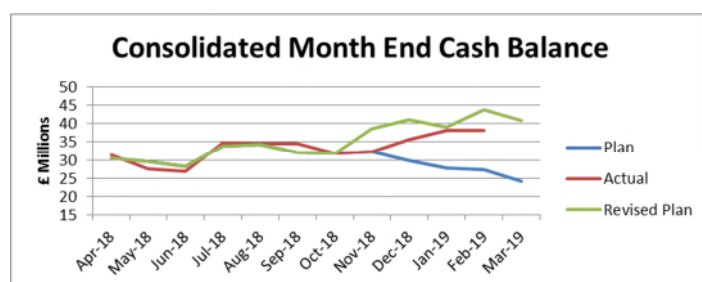
Cost Improvement Programme	Budget £'000	Actual £'000	Variance £'000	Base Forecast £'000
Surgical Care Group	2,001	1,501	(500)	1,609
Medical Care Group	2,758	1,928	(830)	2,044
Specialties Care Group	1,986	1,574	(412)	1,866
Corporate Directorates	4,845	5,335	490	5,879
SURPLUS/ (DEFICIT)	11,590	10,338	(1,252)	11,398



Capital Expenditure

Capital Programme	Budget £'000	Actual £'000	Variance £'000
Estates	4,268	4,574	(306)
IT Strategy	2,794	1,910	884
Medical Equipment	1,520	740	780
Centrally Managed	2,518	586	1,932
SURPLUS/ (DEFICIT)	11,100	7,810	3,290

Cash





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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Workforce Report
Section on agenda:	Quality and Performance
Supplementary reading:	--
Director or manager with overall responsibility:	Karen Allman, Director of Human Resources
Author(s) of paper:	Karen Allman and Fiona Hoskins
Details of previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC, Education & Training Committee
Action required:	Note for information
Summary: The paper shows workforce statistics including turnover, sickness absence, and safe staffing information.	
Related strategic objective:	Valuing our staff. Recognising the contribution of our staff and helping them develop and achieve their potential
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on risk profile:	Recruitment and workforce planning are existing risks on the risk register.



Workforce Report









































For the period to end

February 2019

Karen Allman
Director of Human Resources

Workforce Report for March Board

As at 28th February 2019

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 28 February			Rolling 12 months to 28 February				At 28 February
Surgical	89.3% 	84.6% 	92.7% 	4.18% 	14612 	12.2% 	9.3% 	
Medical	88.4% 	82.0% 	91.7% 	3.79% 	19624 	17.2% 	9.3% 	
Specialities	90.0% 	82.4% 	93.9% 	4.36% 	13988 	10.2% 	11.3% 	
Corporate	89.2% 	100.0% 	95.0% 	4.61% 	15174 	8.7% 	9.4% 	
Trustwide	89.1% 	83.2% 	92.9% 	4.18% 	63399 	12.7% 	9.8% 	

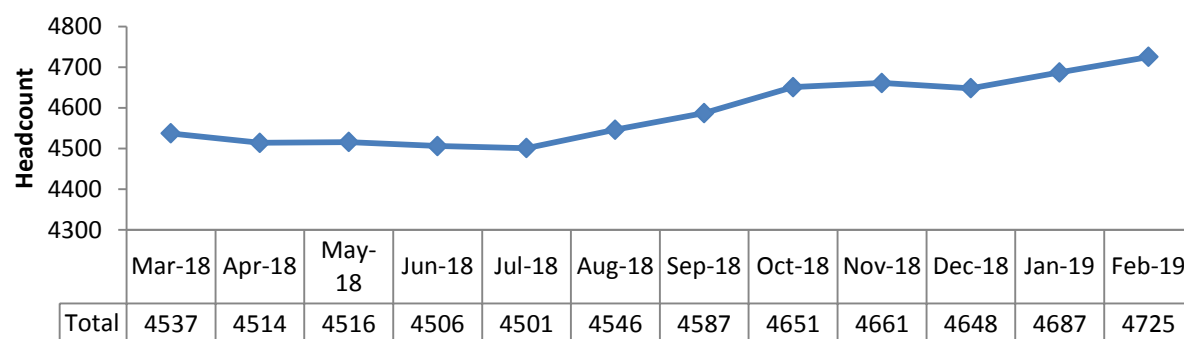
Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 28 February			Rolling 12 months to 28 February				At 28 February
Add Prof Scientific and Technical	94.2%		93.8%	5.55%	2709	14.6%	11.3%	
Additional Clinical Services	86.0%		91.2%	6.00%	16716	23.0%	11.5%	
Administrative and Clerical	90.2%		95.9%	3.85%	12312	9.1%	10.6%	
Allied Health Professionals	92.7%		94.2%	2.55%	2493	15.4%	10.5%	
Estates and Ancillary	89.5%		94.2%	6.99%	8556	12.7%	9.9%	
Healthcare Scientists	94.2%		95.7%	2.95%	1048	5.7%	11.4%	
Medical and Dental		83.2%	88.4%	1.21%	2270	5.4%	5.0%	
Nursing and Midwifery Registered	88.3%		93.7%	4.07%	17295	9.6%	8.5%	
Trustwide	89.1%	83.2%	92.9%	4.18%	63399	12.7%	9.8%	

Workforce Report for March Board

As at 28th February 2019

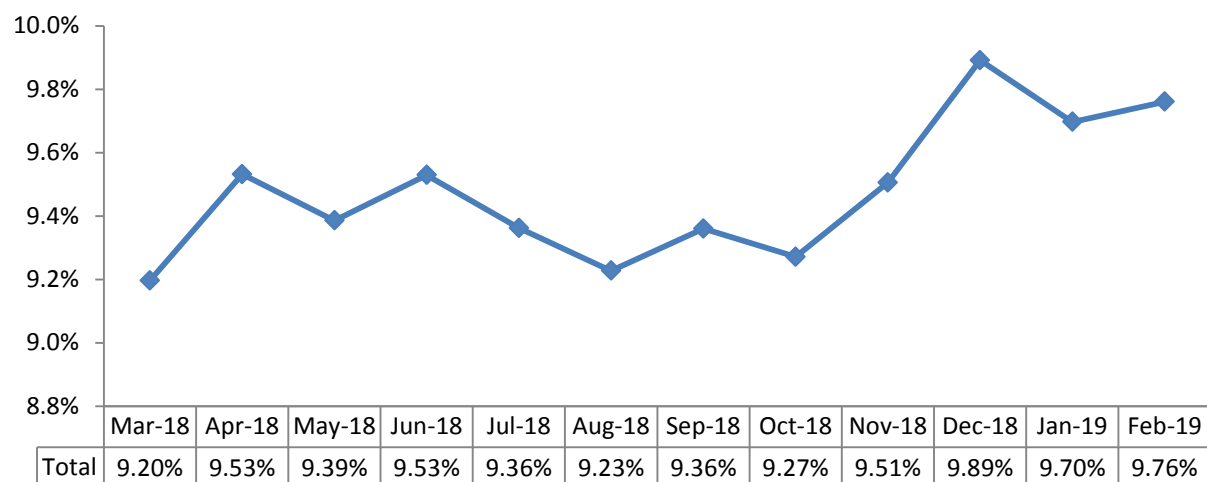
1. Staffing and Recruitment

Substantive Staff (Headcount) Trend



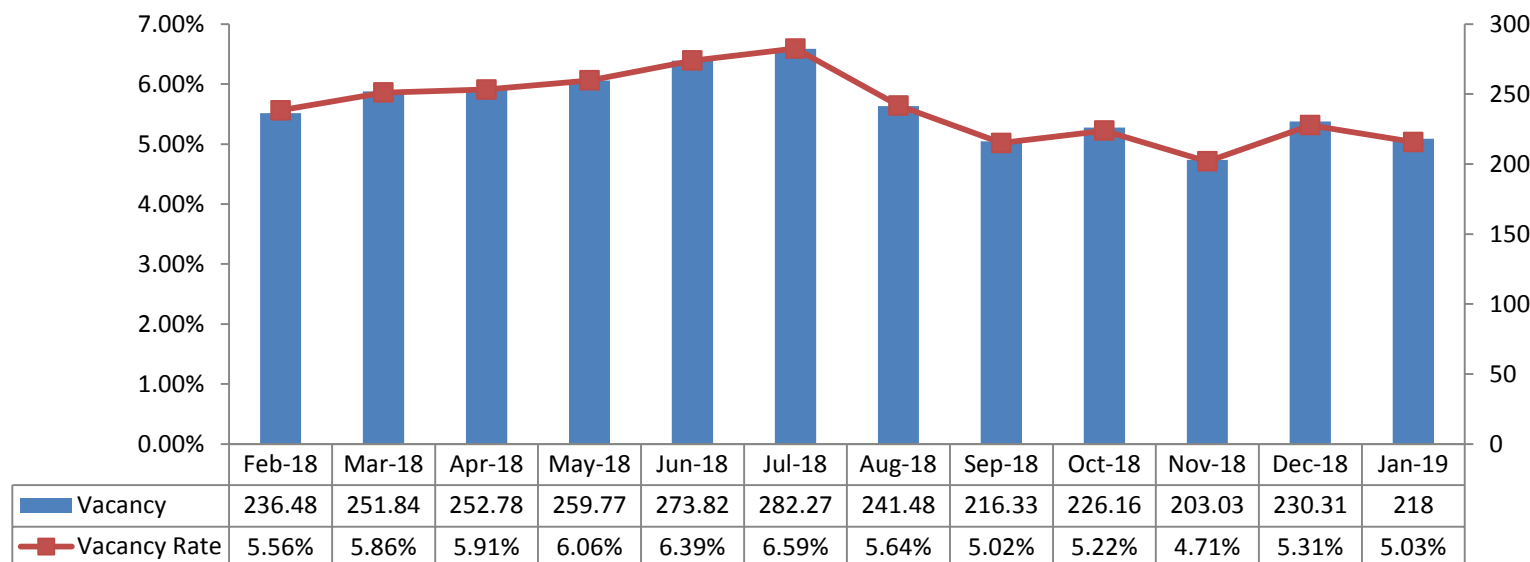
Turnover rate continues in line with the previous month at 9.76% (9.7% at 31/1). The joining rate increased further to 12.7% (12.4% last month); and consistently remains above the turnover rate. As a result, substantive staff headcount continues to increase over last year, up 176 as at 28/2/19 compared to the same point last year (4,549) - an increase of 3.87%, which is a positive.

Permanent Staff Turnover Rate (Headcount)



Vacancy rate at 28/02/19 unavailable at the time of writing. The latest available trend chart is shown below, as at 31/1/19 5.03%.

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



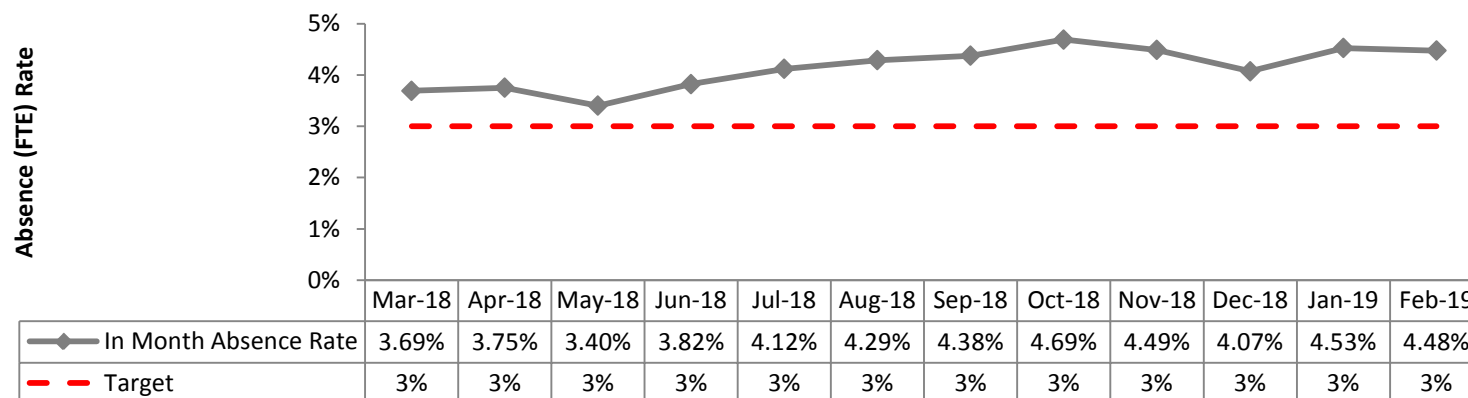
2. Essential Core Skills Compliance

Compliance for February 2019 stood at 92.9%, down very slightly from 93.2% as at 31st January, with small dips across a variety of competencies rather than for any particular subject. Medical and Dental dropped back slightly to 88.4% from 90% the previous month; this continues to be closely monitored by the Medical Director.

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)



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Surgical	4.85%	4.21%	3.70%	4.24%	4.38%	4.12%	4.24%	4.66%	4.02%	3.39%	4.28%	4.71% ↑
Medical	2.88%	3.45%	2.43%	2.77%	3.58%	3.75%	3.91%	4.31%	3.99%	3.98%	4.52%	4.68% ↑
Specialties	3.51%	3.77%	3.66%	3.82%	4.31%	5.08%	5.15%	4.79%	5.44%	4.07%	4.43%	3.80% ↓
Corporate	3.94%	3.73%	4.41%	5.08%	4.53%	4.55%	4.52%	5.26%	4.90%	4.95%	4.89%	4.56% ↓
Trust	3.69%	3.75%	3.40%	3.82%	4.12%	4.29%	4.38%	4.69%	4.49%	4.07%	4.53%	4.48% ↓

Sickness absence dropped back to 4.48% in February, largely due to the good improvement seen for the Specialties care group which saw a reduction of 0.63% and is now amber.

The rolling 12 month figure at 4.18% is marginally up on the previous month (4.10%), and very slightly above the 4.03% figure at the same point last year. A high level of focus continues on managing sickness, and the health and wellbeing initiatives on offer continue to be widely promoted within the Trust. We are continually searching for new ways to support staff and managers in promoting health and wellbeing initiatives, including a financial wellbeing support package which we hope to launch very soon.

Workforce Report for March Board

As at 28th February 2019

4. Safe Staffing February 2019

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 February 2019:

Registered Nurse (RN)	Actual Day	95.6%	HCA Actual Day	98.6%
Registered Nurse (RN)	Actual Night	98.6%	HCA Actual Night	130.1%

NB. At the time of writing this data has not been validated.

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.





There were no red flag shifts reported for February 2019.

Care hours per patient day (CHPPD)

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

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

The Trusts CHPPD Data for Nursing and Midwifery 0.5 below the national median and compares favourably with peer organisations, and suggests that our staffing model is cost effective and safe:

Cost per WAU - Substantive Nursing & Midwifery Staff	2017/18	£671	£671	£710	
Total Nursing & Midwifery FTE	2017/18	1,698.0	1,927.8	2,096.6	
Care Hours per Patient Day - Total Nursing & Midwifery Staff	Dec 2018	7.5	8.0	8.0	
Cost per Care Hour - Total Nursing & Midwifery Staff	Nov 2018	£22.07	£26.59	£25.80	
Cost per Patient Day - Total Nursing & Midwifery Staff	Nov 2018	£174.69	£212.81	£207.32	

Workforce Report for March Board

As at 28th February 2019

This data demonstrates that the average number of care hours a patient receives in a day at the Trust is 7.5 hours (all nursing, midwifery and support staff).



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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	National Staff Survey Results 2018
Section on agenda:	Quality and Performance
Supplementary reading:	The full report from the National Staff Survey 2018 is provided in the reading room.
Director or manager with overall responsibility:	Deborah Matthews, Director of Improvement and Organisational Development
Author(s) of paper:	Bridie Moore, Head of OD, Leadership and Engagement
Details of previous discussion and/or dissemination:	Each Directorate management team has now received their local results and a template to create an action plan.
Action required:	Note for information
Summary: This paper and infographic summarises our 2018 National Staff Survey results. RBCH results are favourable and completion rates are at their highest point. Our engagement score target was also met.	
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:	There are still areas that we need to focus on for future improvements.

National Staff Survey 2018

Report for March Board of Directors 2019

Executive Summary

Building on an excellent survey in 2017, RBCH is very proud of the results of the 2018 National Staff Survey. We had our highest ever number of respondents and we have continued to make incremental progress across almost all measures. We have scored best for the theme of “Immediate Managers” and also scored best (for Acute Trusts) in questions relating to raising and dealing with concerns. For our engagement score we met our target receiving a score that equates to 4.0.

The survey has also helpfully demonstrated the areas that we still need to address and these are reflected in the action plan outlined below.

Background and Context

Over the past three years RBCH has seen improvements in both the completion rates and in many of the key factors as well as our engagement score. We use a full census mixed survey which means all eligible staff employed by the trust on 1st September 2018 received a questionnaire. This gives us a far greater insight into the views of our staff. Over the last few years we have used Picker as our survey provider and a one year contract was entered into for the 2018 survey. Poole Hospital currently uses a different provider, Quality Health.

Picker manages the distribution, data collection and report production, which means it is a completely anonymous process. In September we provide the data of eligible staff from ESR, which can be categorised into 3 levels or localities (Care Group, Directorate, and Team). Taking the data from ESR does present some difficulties in identifying meaningful teams rather than cost centres.

We inform Picker who should receive which type of survey. If an individual has a trust email they automatically get a link to an electronic survey. If they do not have a trust email, they will receive a paper copy which will be sent to their postal location stored on ESR. This request cannot be changed after the data is submitted.

For the 2018 report, the reporting process has been changed following feedback from system users. This means questions have been themed and scores have changed to be out of 10. There are 10 themes:

- Equality, Diversity and Inclusion
- Health & Wellbeing
- Immediate Managers
- Morale
- Quality of Appraisals
- Quality of Care
- Safe Environment – Bullying & Harassment
- Safe Environment – Violence
- Safety Culture
- Staff Engagement

There are three key questions that are used to measure Trusts:

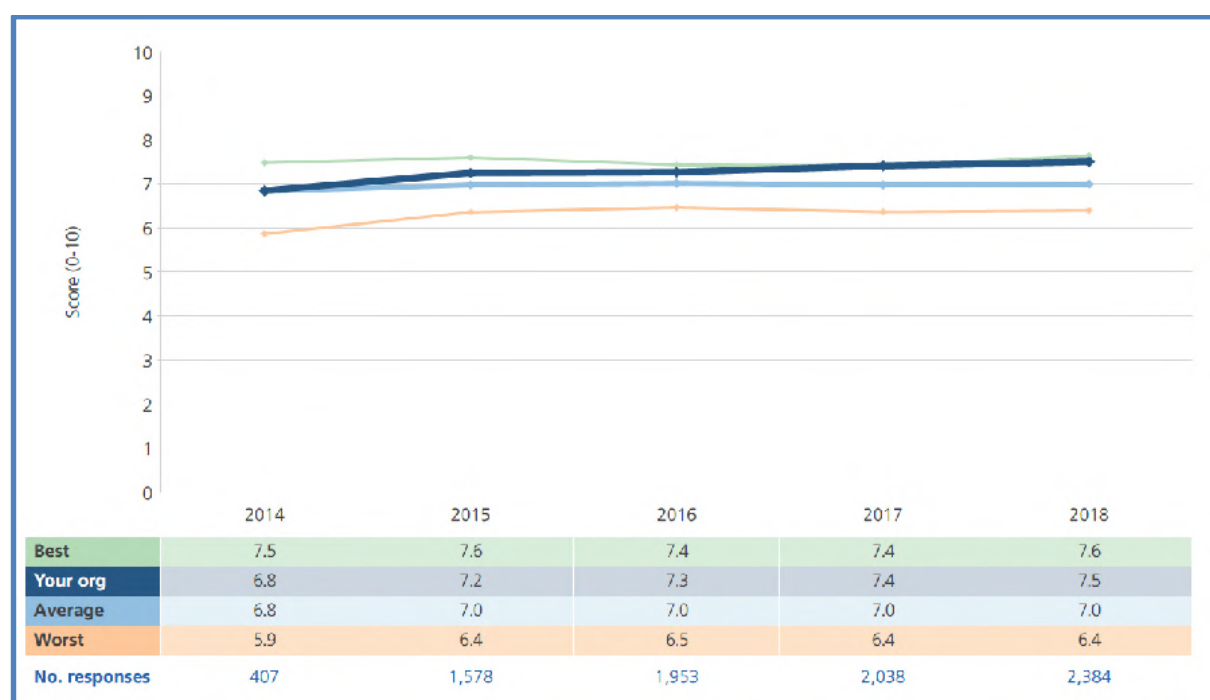
77%	Would recommend organisation as place to work
84%	If friend/relative needed treatment would be happy with standard of care provided by organisation
86%	Care of patients/service users is organisation's top priority

2018 Completion Rates

This year the response rate was 53%, which is a 7% increase from 2017. This is a fantastic increase and means we have the views and experiences of 2,402 staff to shape our focus in 2019.

Engagement Score

Since the start of our cultural change journey we have seen an increase in the Engagement Score. This is devised from the answers to multiple questions that focus on advocacy, motivation and ability to contribute to improvements. In 2017, our engagement score was 3.96 (out of 5). The Board target for 2018 was 4.0. This year the score is reported out of 10 and our score is 7.5. This equates to 4.0 using the old scale. There has been an incremental improvement in our score and we were 0.1 less than the best scoring acute trust.



Celebrating Successes

Overall, RBCH scored better than average in all ten themes.

Picker identified the following areas as the top 5 scores:

	Top 5 scores (compared to Picker average for Acute trusts)
77%	Q21c. Would recommend organisation as place to work
68%	Q4f. Have adequate materials, supplies and equipment to do my work
84%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
58%	Q5f. Satisfied with extent organisation values my work
69%	Q18c. Would feel confident that organisation would address concerns about unsafe clinical practice

Below are the five areas most improved since 2017:

	Most improved from last survey
69%	Q17d. Staff given feedback about changes made in response to reported errors
69%	Q17a. Organisation treats staff involved in errors fairly
81%	Q17c. Organisation takes action to ensure errors are not repeated
37%	Q5g. Satisfied with level of pay
74%	Q12d. Last experience of physical violence reported

When compared nationally against other acute trusts, RBCH scored highest in:

- Percentage of staff able to contribute towards improvements at work

We scored 2nd highest in:

- Recognition and value of staff by managers and the organisation

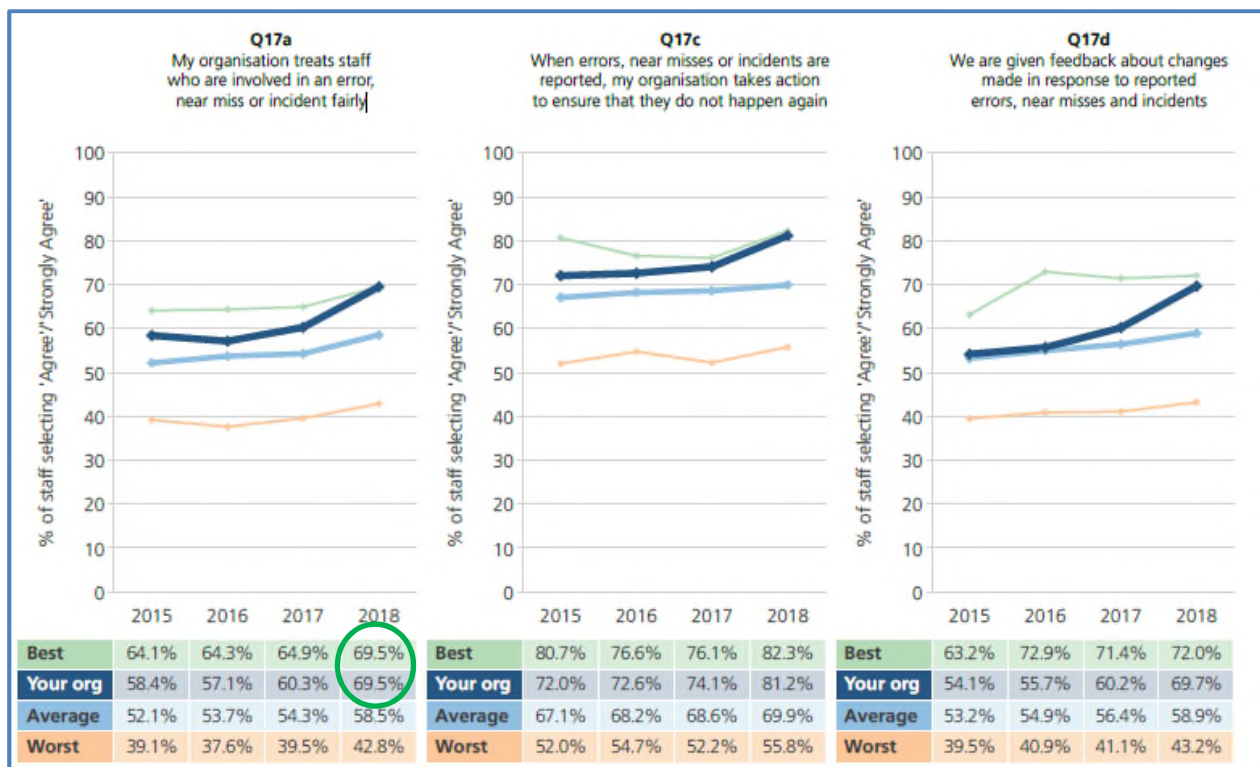
- Staff confidence and security in reporting unsafe clinical practice
- Engagement score

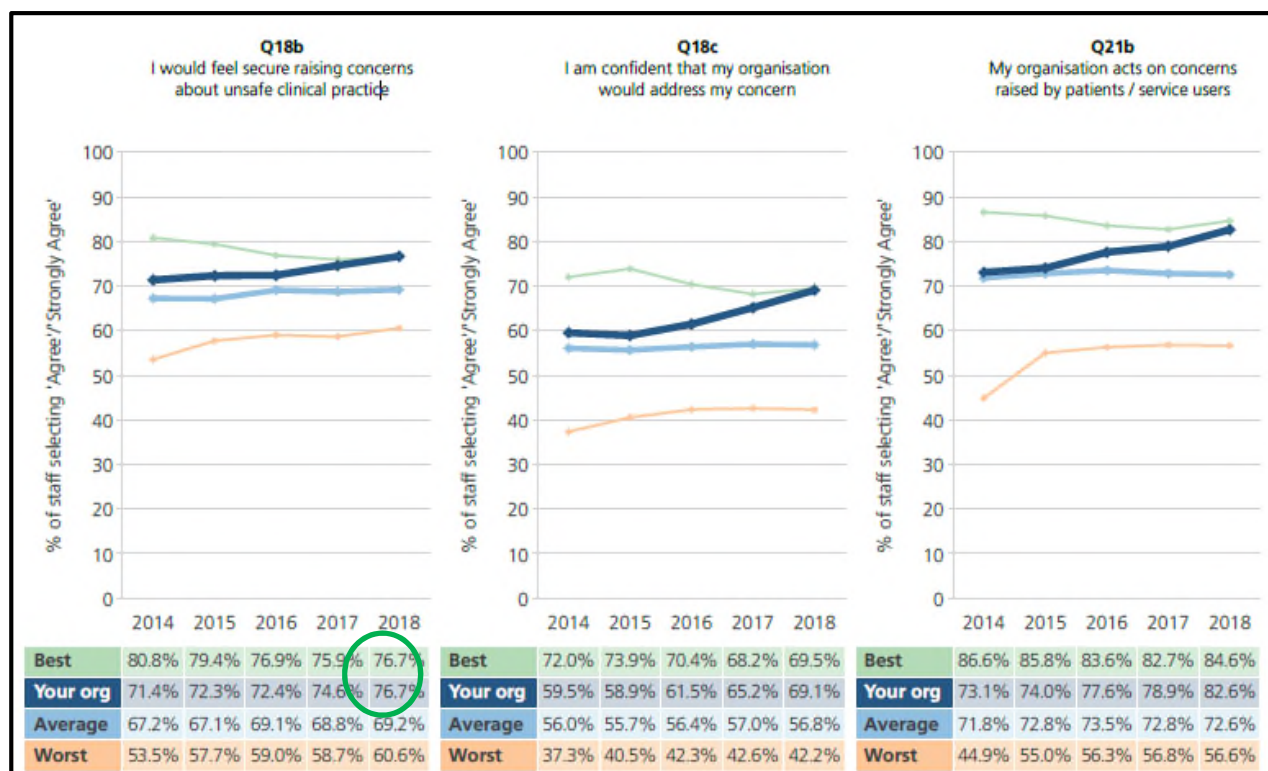
In 2018 we have seen significant improvements in the theme “Immediate Managers”, scoring the best scores for acute trusts in the following:

- My immediate manager gives me clear feedback on my work
- My immediate manager asks for my opinion before making decisions that affect my work
- My immediate manager is supportive in a personal crisis
- My immediate manager takes a positive interest in my health and well-being
- My immediate manager values my work

There are also improvements in questions relating to senior managers. There is evidence to show that people’s opinions about their managers strongly correlate to how they think about their job, and how likely they are to recommend their trust as a place to work or a place for treatment.

We have also scored well in “Safety Culture” (best scores for Acute trusts), indicating a belief that respondents felt safe to raise concerns and that the Trust would deal with issues fairly.





There were also 319 free text anonymous comments. 22% have been classed as positive, 21% as neutral and 57 % negative. The themes of the comments will be fed into the Change Champion engagement work. They some of the key themes are lack of resources, pride for the trust and feeling valued.

Picker have identified that in 2018 there is a national reduction in Health & Wellbeing scores. There has been a national increase in how staff feel about their level of pay and in how organisations treat staff involved in errors fairly.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

There has been a slight improvement in all the WRES measures this year, with 3 out of 4 better than the average for our benchmark group.

The measurement of WDES is new for 2018. It gives us a good indication of the work that needs to be done.

See details in Appendix 1.

Trust Action Plan

1. Violence

The numbers reported relating to experiencing physical violence at work are low but are still concerning. As the health and wellbeing of our staff plays a big role in how engaged they are and how much they feel valued and supported by RBCH. Staff in patient facing roles have told us that they have experienced violence from confused or incapacitated patients. They do not blame the patients or want to report it. However, the trust has a responsibility to protect them.

The recommendation is that this is referred to the Valuing Staff Group and Occupational Health to review the support. We should also look to learn from exemplar trusts.

A small number of respondents said they have experienced physical violence from managers or colleagues. This is not acceptable and individual line managers will be asked to review their results to understand the local situation.

2. Experiences of discrimination or harassment, bullying or abuse

As above there are a small number of respondents who reported experiencing discrimination or harassment, bullying or abuse from patients, managers or colleagues. Whilst we have scored well for most of these questions, we are also not the best scoring acute trust. We will look to learn from others and we hope that the work on the Diversity and Inclusion Strategy will continue to make improvements to the experiences of all our staff members. We also hope to see local level action plans developed by teams or directorates where it has been identified.

3. Appraisal and learning and development

In 2018 the number of respondents answering that they had had an appraisal in the last 12 months dipped very slightly. However we remain one of the highest scoring acute trusts. For this year the appraisal form has been amended in line with feedback from our Appraisal Champions. We hope this will make the appraisal process more valuable for all staff. We will also be creating a leadership development intranet page so all staff will find it easier to understand what development is available. We will also be creating an interim talent management strategy to strengthen our focus on personal development for all.

4. Celebrate our successes

We are very proud of the trust results for Immediate Managers and Safety Culture. We will explain what this means to staff and say thank you. It is proposed that two separate communications (possibly using Core Brief) are created and sent out to all staff between now and September. This will support the “you said, we did” approach we will take for the 2019 campaign.

5. Be curious

We are aware that the Quality of Care theme dipped very slightly in 2018. There are also a number of comments about lack of resources including staffing. This information can be tested against other measures such as the Picker Inpatient Survey, the Friends and Family test. We will also have the Change Champion engagement activities and the local quarterly staff impressions survey.

Directorate plans

We have provided the Care Group and Directorate leads with their local level results and a template to complete to develop an action plan. They have been asked to return a completed copy to Organisational Development and to report on progress at Quarterly reviews and to the Workforce Committee.

Next steps and considerations for 2019

This year when walking round the hospital with trolley to encourage completion, staff told us that they did not want to complete their survey because they did not believe anything would be done. It is important that we are able to show improvements for 2019.

There is still a lot of misunderstanding about how the survey remains confidential. We were able to give assurances in the communications and in one to one conversations but it was apparent that these messages did not reach all. We will need to address this earlier.

We intend to start a social media and communication campaign in the summer and throughout the survey period. This year we held drop in events but they will be limited in effectiveness. The trolley walks did spark conversation.

We will review the completion rates by staff groups and directorates. We would also like to work with IT to understand individual usage of the network, to ascertain how effective it is to issue survey links via email. We would like to trial using more paper copies for particular staff groups, such as ED. This will have an additional cost of £2 plus VAT per head. Currently the budget for the survey does not sit in OD, it is covered centrally.

One further improvement we will make is to ensure the team level data that we submit to our provider is accurate and meaningful for our team leaders.

Finally we should also consider how we align with Poole Hospital in our response to the 2018 results and preparation for 2019. We may also want to consider using the same provider.

Recommendations

The Board of Directors is asked to:

- note the positive results in our 2018 staff survey and areas for further improvement
- support our action plan for 2019 / 20

Bridie Moore

Head of OD, Leadership and Engagement

Appendix 1

WRES Data

Question	2017	2018	Benchmark average
BME staff experiencing harassment, bullying or abuse from patients in the last 12 months	25.4%	23.1%	29.8%
BME staff experiencing harassment, bullying or abuse from staff in the last 12 months	31%	26.1%	28.6%
BME staff believing that the trust provides equal opportunities for career progression or promotion	75.7%	76.4%	72.3%
BME staff experiencing discrimination at work from their manager, team leader or other colleagues in the last 12 months	17.9%	16.4%	14.6%

WDES data

Question	2018	Non-disabled
Disabled staff experiencing at least one incident of harassment, bullying or abuse from patients in the last 12 months	23.7%	21.7%
Disabled staff experiencing at least one incident of harassment, bullying or abuse from their manager in the last 12 months	15.6%	7.2%
Disabled staff experiencing at least one incident of harassment, bullying or abuse from their colleagues in the last 12 months	19.2%	15.1%
Disabled staff or colleague reported their last incident of harassment, bullying or abuse	40.2%	47%
Disabled staff believing that the trust provides equal opportunities for career progression or promotion	87.5%	89.6%
Disabled staff feeling under pressure from their line manager to attend work despite not feeling well enough to perform their duties	29.8%	19.2%
Disabled staff satisfaction with the extent to which their work is valued by the organisation	53%	59.7%
Disabled staff saying adequate adjustments had been made to enable them to carry out their work	81.4%	N/A
Engagement score (trust average 7.5)	7.3	7.6



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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Progress Update on Stakeholder Engagement Outcomes
Section on agenda:	Strategy and Risk
Supplementary reading:	None
Director or manager with overall responsibility:	David Moss, Chairperson
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Board of Directors, September 2017, March 2018 and November 2018 Board and Council of Governors Joint Working Event, July 2017
Action required:	Note for information
Summary: This report provides the latest updates on progress against the stakeholder engagement outcomes identified by the Board of Directors and Council of Governors and subsequently developed into a series of outcomes approved by the Board of Directors.	
Related strategic objective:	Strengthening team working. Developing and strengthening to develop safe and compassionate care for our patients and shaping future health care across Dorset
Relevant CQC domain:	
Are they safe?	✓
Are they effective?	✓
Are they caring?	✓
Are they responsive to people's needs?	✓
Are they well-led?	✓
Impact on significant risks:	None

Progress Update Stakeholder Engagement Outcomes

March 2019

Stakeholder Group	Outcome	Executive Lead(s)
Staff	Ensure that staff receive regular updates aimed at their questions and concerns using existing groups, including the Partnership Forum, Change Champions and Staff Governors, providing an opportunity for staff to respond and then receive feedback	KA, DM, KF
Foundation Trusts in Dorset	Put in place the structures to support Integrated Care System (ICS) working supported by regular contact and organisational development to build relationships and jointly plan and create solutions to deliver better outcomes for patients and benefit taxpayers in Dorset.	DF, RR, Governors
Clinical Leaders (across the system including GPs)	Work jointly with Poole Hospital NHS Foundation Trust to bring clinicians from both organisations together to develop and promote work to improve outcomes for patients and efficient working practices involving colleagues from primary care.	AOD, RW, PS
Dorset CCG	Support activity to develop as a single health system in Dorset through our approach to contracting and risk sharing and coordinating communications and relationships with regulators' regional teams.	PP
Competition and Markets Authority	Work together with Poole Hospital NHS Foundation Trust to develop the patient benefits case for submission to the Competition and Markets Authority.	DF
Patient Groups	Incorporate and involve governors and members in the delivery of the Patient Experience and Public Engagement Plan and participate in governor engagement activity and engagement activity with partner organisations as part of the implementation of the Clinical Services Review (CSR) and the delivery of the Dorset Sustainability and Transformation Plan (STP).	PS

Staff

- Change Champions – fourth cohort of Change Champions appointed.
- Change Champion focus groups in February and March 2019.
- Staff Impressions Surveys in Q1, Q2 and Q4 each year with standard questions and additional focus areas to gain feedback on important issues. Q4 2019 out now.
- Results of the National Staff Survey 2018 with a response rate of 53%, a 7% increase from 2017 - published reports are available to all and local feedback provided to Directorate Managers and Care Groups to produce action plans.
- Diversity and Inclusion walkarounds to raise awareness and listen to staff concerns
- Staff Network groups for LGBT, European staff and Black, Asian and Minority Ethnic (BAME)

Staff

- Monthly joint staff briefings on CSR and merger
- Monthly Q&A drop in sessions with David Moss



Foundation Trusts in Dorset

- Dorset System Leadership team has worked together to develop the Integrated Care System (ICS)
 - operating to a single control total
 - agreement to invest £6 million into community and primary care services
 - work to advance the Dorset Care Record
 - collective endeavour and activity to progress the Clinical Services Review
- Work commenced to develop Dorset's response to the NHS Long Term Plan
- Dorset as a health economy performs above average
- Dorset ICS regarded as in the top 3 of well-developed ICS in England
- Successful joint tender for Integrated Urgent Care Services for Dorset – operational from 1 April 2019

Clinical Leaders

- Joint Hospital Executive Group and Trust Management Board meetings
- One Acute Network clinical design meetings
- Joint leadership programme for medical leaders commenced
- Appointment process in progress for Clinical Transformation Leads as part of joint leadership arrangements for four services



Dorset CCG

- Dorset System Leadership team has worked together to develop the ICS
 - operating to a single control total
 - agreement to invest £6 million into community and primary care services
 - work to advance the Dorset Care Record
 - collective endeavour and activity to progress the Clinical Services Review
- Dorset as a health economy performs above average
- Dorset ICS regarded as in the top 3 of well-developed ICS in England

Competition and Markets Authority

- The patient benefits case has been developed and shared in summary form but awaiting submission once we have an agreed process and timeline for the merger.
- Design work now underway to create the planned care and emergency sites and complete the outline business case
- Agreement to appoint an interim joint chair and chief executive
- Agreement to set up the joint leadership arrangements agreed for four services

Patient Groups

- Head of Patient Experience (HOPE) attends Governors meetings and health talks and listening events to discuss engagement activities.
- Governor representation in Carers Steering Group working on the formation and delivery of the Carers Plan.
- Governors and Patient Partners members of 'Our Dorset' stronger voices forum, attending regular meetings discussing health and social care across Dorset.
- Youth engagement members of the STP helping the HOPE to identify equality, diversity and inclusion projects and sustainability projects that young members of the Trust aged 12- 15 can be involved with. Governor delivery will be essential following identification of local schools and youth groups.
- Governor and HOPE attend the 'our Dorset' Patient and Public Involvement Group.



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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Freedom to Speak Up – Annual report (2018/19)
Section on agenda:	Governance
Supplementary reading:	Not applicable
Director or manager with overall responsibility:	Debbie Fleming, Chief Executive
Author(s) of paper:	Helen Martin, Freedom to Speak Up Guardian
Details of previous discussion and/or dissemination:	Previous update at September 2018 Board of Directors meeting. Annual governance at Audit Committee (November 2018)
Action required:	Decision
Summary: Annual Report, outlining progress of the Freedom to Speak up Team and priorities for 2019. Decision: Renewal Approval for Statement of commitment to the principles of the Freedom to Speak up Publication set out by Sir Robert Francis.	
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:	Approval and support from board will lead the development of our 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.

Freedom to Speak Up (FTSU)

Annual Report 2018/19

1.0 A Vision for Raising Concerns

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication “Freedom to Speak Up”. He recognised that having a healthy speaking up culture helps protect patients and improves the experience of NHS workers. He set out a number of principles which the trust board at RBCH publicly committed to these principles in September 2017 and again in March 2019 (Appendix A). He also mandated that each trust appoint a Freedom to Speak Up Guardian (FTSUG) which has now been part of the NHS standard contract for two years.

Since 2015, training and guidance has been developed and refined supported by the National Guardian Office (NGO) but also from the establishment of local networks. CQC inspections also recognise that listening and responding to people who speak up, and tackling the barriers to speaking up, is a natural ingredient of good leadership and a well led organisation. In April 2018 CQC rated RBCH well led domain as being outstanding and part of that feedback included:

“The role of the freedom to speak up guardian (FTSG) was well embedded at this trust. Staff knew how to access the FTSG, including through the online reporting system. The FTSG was providing a valued service to staff wanting to speak up and ensuring that any trends, themes or concerns were escalated to the trust board”.

The purpose of this paper is to outline the progress of the Freedom to Speak up team and priorities for 2019.

2.0 The RBCH Approach

2.1 Vision and Aim

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.

2.2 The Freedom to Speak Up (FTSU) Team

The Trust Freedom to Speak up Guardian (FTSUG), Helen Martin, was appointed in April 2017. The team has since grown to include 6 Freedom to Speak Up Ambassadors (FTSUA) whose role is to promote, listen, support and provide an impartial view to staff when speaking up. The purpose of this team is to help support the needs of all our staff, no matter where they work or whatever diverse background they come from.



The Team now includes (from left to right):

David Flower	Lead Chaplain/Mortuary Manager
Catherine Bishop	Medical Secretary/Staff Governor
Dominic Reynish	Chief Registrar and Respiratory registrar (left Feb 2019)
Helen Martin	FTSUG and Service Manager
Sally Papworth	Preadmission Assessment Sister
Tom Beaumont	X-Ray Clinical Lead
Hazel Rodriguez	Pensions Lead (absent from photo)

The team was launched in October aligning to the National Guardian Freedom to Speak Up awareness month. A highly decorative roaming trolley was employed and a number of walkabouts occurred focussing particularly on those traditionally hard to reach areas. The success of the roaming trolley was recognised by the National Guardian Office in 2017 when we were runners up in the National Communications Category. We spoke to over 500 staff, received national twitter coverage and were included as a national NGO case study. Six case referrals and a number of enquiries came from this campaign alongside a number of invitations to team meetings. During this month the FTSU team also worked with the board in an interactive development session, benchmarking our culture of speaking up against the NHSI self-review tool. This session was an opportunity to look at how the board role model speaking up and receive concerns, looking at what the barriers to speaking up are and how to overcome these. An improvement action plan was identified and will feed into the FTSU strategy (refer to Appendix B). The FTSUG has been invited to speak at a regional NHSI event later in the year to showcase this approach.

The team has flourished since being in post. The FTSUG has set up monthly team and training sessions using the highly successful change champion model ensuring that the commitment from the FTSUA's are supported with individual development opportunities. Following a comprehensive training package put together using skills from local staff alongside the newly set up local NGO training programme, the FTSUA now listen to concerns from staff.

The development of this team has not only been instrumental in developing our diversity but has also helped improve our access and resilience if the FTSUG was not available. More importantly the team has been support for each-other and has successfully developed a strong team ethos. It is planned that we will use this team to set up a local quality assurance for cases that we hear. This was a key development from the NHSI self-review tool (refer to Appendix B).

3.0 Objectives for 2018/19 and Senior Leadership Support

Key objectives for the FTSU team have been developed to align with the 4 Trust objectives. Significant detail and work plans lie behind these objectives and they are reviewed regularly by the FTSU team, line manager Deborah Matthews, and executive sponsor Tony Spotswood (until Dec 18).

1. **Embed speaking up process, reporting and monitoring system**
2. **Embed a communication and launch strategy**
3. **Embed a strong and open working relationship with Trust board**
4. **Embed a training strategy for FTSUG, new, existing and exiting staff**
5. **Embed a network with neighbouring Trusts**
6. **Develop a FTSU advocate team.**

Executive support continues with mentoring support from Director of Nursing, Director of HR and Chair of the Board. Alex Jablonowski is our non-executive lead and remains another good source of support.

Following the departure of Tony Spotswood in December a proposal for a sustainable joint speaking up arrangement across Poole and Bournemouth was presented to the senior leadership team. The principles of this paper are supported and details are in the process of being finalised. The executive sponsor will remain the chief executive, Debbie Fleming who will provide strategic support with regular access if needed. Monthly feedback and case reviews will occur with the deputy chief executive, Paula Shobbrook.

The progress against these objectives can be reviewed in Appendix C.

4.0 Staff survey results – What do our staff say about our current speaking up culture?

The annual staff survey is a particularly rich source of data informing us on how staff feel about our speaking up culture. A total of 2402 staff completed the 2018 survey, giving a response rate of 53% compared to 46.2% in 2017.

The results from this year's survey are presented in a slightly different way to previous years. This year the scores are represented into ten themes so that a high level overview of the results for an organisation can be viewed more easily. One of those themes is referred to as a safety culture. The table below presents the overview of the safety culture as compared to previous years and in the context of the best, average and worst results for similar organisations. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score.

Table 1: Safety Culture of RBCH in context of the best, average and worst results for similar organisations

Safety Culture (0-10 scale, where a higher score is more positive than a lower score)	2018	2017	2016	2015
Best	7.2	7.0	7.1	7.2
Your organisation	7.2*	6.9	6.8	6.7
Average	6.6	6.6	6.6	6.5
Worst	6.0	5.9	6.0	5.9
No of responses	2298	1996	1903	1516

*statistically significant from 2017

Table 1 illustrates that RBCH scores have improved year on year in terms of how staff view the safety of the organisation. This year, our staff are telling us that we are better than the benchmarking group 'Average' score and in fact, are a leader organisation for this theme.

In order to understand exactly which factors are driving your organisation's theme score, a number of questions feed into the theme and are presented in the table below:

Table 2: Questions driving the Safety Culture Theme Score

	Safety Culture questions (%)	2018	2017	2016	2015
17a	My organisation treats staff who are involved in an error, near miss or incident fairly #	69.5	60.3	57.1	58.4
17c	When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again #	81.2	74.1	72.6	72
17d	We are given feedback about changes made in response to reported errors, near misses and incidents #	69.7	60.2	55.7	54.1
18b	I would feel secure raising concerns about unsafe clinical practice	76.7	74.6	72.4	72.3
18c	I am confident that my organisation would address my concerns about unsafe clinical *	69.1	65.2	61.5	58.9
21b	My organisation acts on concerns raised by patients/service users.	82.6	78.9	77.6	74

*Top 5 score compared to "average" organisation

most improved since last year's survey

Table 2 illustrates that all of the responses to the questions are better when comparing them to that for an average organisation. Indeed, the question relating to the addressing of concerns was seen as one of the top 5 scores for RBCH this year. Three of the six questions (annotated with # on table 2) were also seen as questions which were the most improved since 2017 staff survey.

The NHS staff survey also contains results by directorate level (table 3). This information allows us to look at specific areas which need more focus in 2019 or indeed celebration. The themes are scored on a 0-10 scale, where a higher score is more positive than a lower score.

Table 3: Overview of the safety culture in context of directorate.

Safety Culture (0-10 scale, where a higher score is more positive than a lower score)		
Area	Safety Culture Score	No of responses
Trust RBCH	7.2	2298
Directorate		
Medical	7.3	719
Surgical	7.2	490
Specialities	7.2	525
Corporate	7.0	564
Elderly	7.1	283
Medicine	7.5	238
Anaesthetics/theatres	7.4	209
Surgery	7.0	145
Cardiac	7.4	146
Facilities	7.0	140
Specialist services	7.0	142
Radiotherapy	7.5	126
Cancer Care	7.3	81
Informatics	6.4	102
Pathology	7.2	75
ED	7.2	56
Ophthalmology	6.8	57
Orthopaedics	7.2	83
Finance and business	6.7	72
Outpatients	7.1	50
HR	7.2	53
Maternity	7.2	53
Operational	7.4	39
Estates	6.7	34
Research	6.9	44
Other	7.8	40
Risk	7.5	30

The staff survey is a good barometer to tell us how staff are feeling. These results suggest that staff feel safer at work. Speaking up is integral to sustaining this culture of safety.

5.0 Case Referrals – the headlines

A range of data is collected by the FTSUG. This report will look at this data including the key themes of concerns raised, where concerns have been raised and by whom. Referrals come from a number of routes. One key link has been with the risk and governance tool LERN – raise an issue form which has resulted in referrals but also healthy discussions on potential hot spots at our monthly meetings. Alternatively, referrals have come directly from presentations, the organisation department, word of mouth and recommendation.

5.1 Key Themes of concerns

Table 4 illustrates the number of cases heard through the FTSUG office at RBCH. It is this data that forms part of what is submitted quarterly to the National Guardian Office (NGO).

Table 4: Themes raised through the FTSUG office

Themes	Qtr 1 (April – June)	Qtr 2 (July – Sept)	Qtr 3 (Oct – Dec)	Qtr 4 (Jan – 11 Mar)	Number of concerns raised
Attitudes & Behaviours	9	7	7	7	30
Other	1	2	4	1	8
Performance Capability					
Policies	1	1			2
Quality & Safety			1	1	2
Staffing Levels		1			1
Total	11	11	12	9	43

Table 4 shows up to 70% of cases raised at RBCH have an element of behaviours and attitudes. The NGO recognises bullying and harassment as a key theme and has planned webinars and other training to support the FTSUG and Trusts. Similar themes are seen across the network and whilst we are not an outlier it would be prudent that emphasis is placed at looking at mechanisms to support staff to tackle poor behaviours and attitudes. A work stream has been set up to look at this specific issue with members from organisational development team, FTSU, HR, medical staffing and quality improvement. Its aim is to help provide the tools for staff to role model behaviours which underpin our values, to provide feedback when this does not happen and then feel empowered to tackle poor behaviours if they were to arise.

The staff survey this year also recognised this area as one of its ten themes. It presented questions which described a safe environment in terms of bullying and harassment. Table 5 presents the overview of this theme as compared to previous years and in the context of the best, average and worst results for similar organisations. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. The closer your organisation's result is to the worst score, the more concerning the result.

Table 5: Safe Environment (bullying and harassment) in context of the best, average and worst results for similar organisations.

Safe Environment (0-10 scale, where a higher score is more positive than a lower score)	2018	2017	2016	2015
Best	8.5	8.4	8.6	8.5
RBCH	8.4	8.3	8.2	8.0
Average	7.9	8.0	8.0	7.9
Worst	7.1	7.2	7.1	7.0

These results reveal that staff are reporting a safer environment with fewer incidences of bullying and harassment as compared to 2015. Whilst our results appear to show an improved picture to that of an average trust we still have room to improve. In order to understand exactly which factors are driving your organisation's theme score, a number of questions feed into the theme and are presented in the table below:

Table 6: Questions driving the safe environment theme score

	Safe Environment Questions (%)	2018	2017	2016	2015
13a	In the last 12months how many times have you experienced harassment/bullying from patients	22.6	22.7	24.8	25.9
13b	In the last 12months how many times have you experienced harassment/bullying from managers	8.7	10.9	11.8	12.9
13c	In the last 12months how many times have you experienced harassment/bullying from colleagues	16.1	16.9	17.7	20.3

Table 6 illustrates that within all three questions staff report less likely to have experienced bullying or harassment from patients, managers or colleagues now as compared to that in 2015. This is a great set of data which implies that we are moving in the right direction. We must not however overlook that despite these improvements, over 1 in 5 of our staff still report an incident of harassment from our patients. This clearly needs addressing to support our staff better. Work also needs to continue to improve the behaviours of our manager and colleagues as whilst this data suggests we are improving, alongside the data from this annual report we need to forge forward in addressing poor behaviours as a priority particularly when you see the impact these behaviours have on individuals who report them.

Our Workforce Race, Equality Standard (WRES) data looks specifically at how this behaviour impacts our white staff as compared to our BME colleagues and is illustrated in table 7. This clearly shows the impact to our BME workforce as worse compared to our white staff, particularly on those experiencing bullying or abuse from staff. The FTSU team need to continue to focus of this area within 2019 and support the work of our equality, diversity and inclusion team as outlined in section 5.3.

Table 7: WRES data from 2018 and 2017

		2018	2017
KF25: % staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12months	White	22	24
	BME	25	27
KF26: % of staff experiencing harassment, bullying or abuse from staff in last 12months	White	22	23
	BME	31	27
Q17 In the last 12minths have you personally experienced discrimination at work from any of the following managers, team leaders or colleagues	White	5	6
	BME	18	18

5.2 Where are concerns being raised?

Table 8 shows that there is an even spread across the care group structures where concerns are raised. Significant effort was placed within 2018/19 to ensure that the FTSU team visit and meet all members of staff from all areas of the trust. This piece of work will continue as a key theme for 2019.

Table 8: The number of concerns raised in Clinical Care Groups

Clinical Care Group	Qtr 1 (April – June)	Qtr 2 (July – Sept)	Qtr 3 (Oct – Dec)	Qtr 4 (Jan – Mar)	TOTAL
Clinical Care Group A	3	2	3	2	10
Clinical Care Group B	5	2	2	4	13
Clinical Care Group C	2	4	6		12
Corporate/operational	1	3	1	3	8
Total	11	11	12	9	43

Table 9: Communications completed by FTSUG

Type of Communication	Where this communication has occurred (and number of staff attended)
Presentations	SAS training (30), Governors (30), Leadership Summit (150), Senior Briefing (150 + 60), Board meeting (40), Audit committee (20), Junior Doctor meeting (15), Grand Round (100), Specialist services symposium (60), theatres (66), F1 drs (25), Board (50), Senior Brief (70), Board development (30), BMA training (25), Audit committee (15), HCWA induction (30), theatres and day theatres 50)
Table top open sessions	Diversity week, Christchurch open day, staff wellbeing, patient safety conference, flu rounds (x)9, New Dr induction, QI day (50), Leadership (100)
Team meetings	Maternity (10 +11), Ophthalmology (30), Pharmacy (60), theatres (30), OPAL (30), Dietetics (15), Housekeeping (30), Christchurch day unit (25), orthopaedic (10), Dermatology (15), matrons (13), rheumatology (12), IT (15), AMU (16), DoSH (30), partnership forum (10), charity office (14), Interim team (22), OPM meeting, sisters meeting, post room, housekeeping, therapy services, haematology (10), Stroke Unit (10), admissions (10), secretary meeting (8), volunteers (40), Medical directorate (30), strategic nurse (40), junior dr (40), international medical group (15), Day Hospital (30)

The FTSU team have visited a number of areas, attending team meetings, as table top presentations at conferences or a keynote speaker and using the roaming trolley (refer to table 9). To date over 2500 staff will have heard the message in one form or another. Other routes have also been used to reach other staff such as through the development of intranet site, banner, screen savers and core brief articles. Communications is key to its success and will be integral for 2019.

5.3 Who are raising concerns?

Table 10 shows that Allied Health Professionals (AHPs) are the largest group of professionals who have raised a concern to the FTSUG followed by nursing/HCA. A key focus for 2018 was to pay special attention to engaging with the medical workforce. This has included attending junior doctor meetings, presenting with BMA, attending and presenting to grand round, core induction and working with Medical Director, Guardian of working times and lead Medical Educator. Another key group was administration and clerical. Our FTSUA has been integral in improving our links within this group. A challenge for 2019 will be our catering and cleaning/maintenance experts. Plans are ready in place with booked presentations and future walkabouts.

Table 10: Who are raising concerns in RBCH

	Qtr 1 (April – June)	Qtr 2 (July – Sept)	Qtr 3 (Oct – Dec)	Qtr 4 (Jan – Mar)	
Dr	1	4		1	6
Nurse	3		2		5
HCA	1	2	1		4
Midwives	2		1	1	4
Dentists					
AHPs	2	3	2	1	8
AHP pharmacy		1			1
Admin/Clerical			5	1	6
Cleaning/catering/ maintenance/ancillary				2	2
Board Members					
Corporate service	1				1
Other	1	1	1	2	5
Anon				1	1
Total					
	11	11	12	9	43

Another area of the workforce that needs continued development is that within minority groups of the organisation. The Francis Freedom to Speak Up reviews highlighted that minority staff, including black and minority ethnic (BME) workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in these reviews, also showed that minority staff groups are more likely to suffer detriment for having spoken up. The National Guardian Office (NGO) case reviews at Southport and Ormskirk Hospital NHS Trust highlighted the importance for every Trust and FTUSG to ensure that work reaches this group of staff and that their voice is also being heard.

The staff impressions survey is used as a quarterly opportunity to “check the pulse” of the organisation, completed in quarter 1, 2 and 4. From 6th August to the 7th September 2018 (Q2) the staff impressions survey not only looked at the mandatory questions of what the organisation is like to work at and be treated at but also asked staff the 5 key questions outlined from the Sir Francis report to assess if RBCH has an open and honest reporting culture. The same questions were asked from 8th August -15th September 2017. A total of 612 staff completed the survey, giving a response rate of 13.8% compared to 6% in 2017. Of those who completed the survey:

- 80% were female.
- 10% were black and minority ethnic (BAME).
- 8% of respondents preferred not to declare their ethnicity.

Whilst caution needs to be taken when extrapolating this data due to the low numbers, information can nonetheless come from this including how staff from all backgrounds feel about our speaking up culture. Table 11 shows that staff from BAME backgrounds feel;

- Less confident and safe in speaking up as compared to 2017.
- Less confident that concerns will be investigated as compared to 2017.
- Less confident in raising concerns in 2018 when compared to our white British staff.
- Less confident that concerns will be investigated in 2018 when compared to our white British staff.
- More confident that speaking up makes a difference in 2018 when compared to our white British staff.

Whilst extreme caution needs to be taken with this particular data set, as numbers are small it supports the work from our diversity and inclusion programme.

Table 11: Staff Impressions survey results for BAME staff

	Black and Minority Ethnic (BME; %)		
	2017	2018	% difference
I feel confident to speak up	93	86	-7%
I feel safe to speak up in the future	83	86	+3%
Concerns are investigated	90	79	-11%
Speaking up makes a difference	80	79	-1%
Concerns are well received	79	79	No change

The results from the staff survey can also be used as a barometer to plot the progress in terms of equality, diversity and inclusion within RBCH. One of the ten themes within this year's staff survey was equality, diversity and inclusion. Table 12 presents the overview of this theme compared to previous years and in the context of the best, average and worst results for similar organisations. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score.

Table 12: Equality, diversity and inclusion in context of the best, average and worst results for similar organisations.

Equality, diversity and inclusion (0-10 scale, where a higher score is more positive than a lower score)	2018	2017	2016	2015
Best	9.6	9.4	9.6	9.6
RBCH	9.2	9.1	9.2	9.3
Average	9.1	9.1	9.2	9.2
Worst	8.1	8.1	8.1	8.3

These results reveal that staff report an equality, diversity and inclusion environment which is better than that of an average trust but is not one yet considered as a leader. The results also imply that progress remains relatively static since 2016. In order to understand exactly which factors are driving the organisation's theme score, a number of questions feed into the theme and are presented in the table below:

Table 13: Questions driving the Equality, diversity and inclusion theme score

	Equality, Diversity and Inclusion Questions (%)	2018	2017	2016	2015
Q14	Does your organisation act fairly with regard to career progression regardless of ethnic background, gender, religion, sexual orientation or disability	89.1	86.9	88.5	88.6
Q15a	In the last 12months have you experienced discrimination at work from patients and service users	6.4	6.5	6.7	5.4
Q15b	In the last 12months have you experienced discrimination at work from your manager/team leader/colleague	6.7	7.2	7.4	6.8
Q28b	Has your employer made adequate adjustments to enable you to work	81.8	81.1	78.3	83.2

Table 13 shows that staff who completed the staff survey report concerns regarding increased discrimination from patients and service users since 2015. This result supports the data seen in table 6 where over 1 in 5 of our staff reports an incident of harassment from our patients. Clearly the way our patients and service users interact with our staff needs addressing so that we can support our staff better. Adjustments to enable staff to work are also more sluggish over this time. Positively, progress can be seen with the percentage of staff reporting fairer career progression and less discrimination from managers and clinical leaders. All of the factors in table 13 need to be addressed if we are to become a forward and "best" trust in terms of equality, diversity and inclusion.

Work has started. The FTSUG is an integral member of the Equality, Diversity and Inclusion Committee (EDIC) and Equality, Diversity and Inclusion working group following the appointment of Deborah Matthews, Director of Improvement and Inclusion in 2018. A clear strategy has been presented to the board including:

1. Improve BAME employee experience
2. Improve communications and engagement
3. Develop inclusive leadership capability
4. Develop effective staff networks
5. Improve use of all ED&I data and compliance against national standards
6. Develop patient co-production and engagement

The progress of this group has been exemplary. Accolades include being selected as a NHS Employers Equality and Diversity Partner which will help facilitate partnership working

with other health and social care partners and the voluntary sector. Such a programme will support and contribute to our equality, diversity and inclusion (ED&I) approach. More recently we have been successful in our application to become a Stonewall Diversity Champion, which is Europe's largest lesbian, gay, bi and trans (LGBT) charity. The Stonewall Diversity Champions programme is an excellent framework for creating a workplace that enables LGBT staff to reach their full potential.

Whether through speaking up or through the work of the Diversity and Inclusion Strategy, hearing the voice from all our staff will be key. At the recent leadership summit, Hayley Barnard quoted that *"diversity is a reality; inclusion is a choice that needs an action"*.

The FTSU team are committed to supporting this work further and exploring opportunities to meet these challenges.

6.0 FTSU Objectives 2018/19


In October 2018, the FTSU team facilitated an interactive trust board development session. The purpose of this session was to benchmark our culture of speaking up using the NHSI self-review tool and provide an opportunity for the members of the board to look at how they role model speaking up how they receive concerns and look at what the potential barriers are to this. An improvement plan was agreed and forms the basis of the FTSU strategy. NHSI outline the importance for each trust board to develop a FTSU strategy using a structured approach in collaboration with a range of stakeholders including FTSUG and NGO. Direction and advice is being sort within the FTSU network and a document is in draft, outlining a clear long-term strategy supported by a more detailed work-plan. The greatest influence to this document will be decision on how RBCH and PHT will work together. Discussions are already underway across the senior leadership team and a final decision is anticipated end of this financial year. The paper recommends a joint FTSUG overseas the speaking up process across both sites which is underpinned with a FTSUA team on each site.

The strategy for 2018/19 has been developed to underpin the core trust values and FTSU vision to:

<p>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.</p>

A detailed annual work-plan will be then be agreed with the senior leadership team and bi-annual updates will be provided to the trust board. The broad outline of this will be as illustrated in table 14;

Table 14: 2019/20 Objectives for FTSU

	Trust Objective	FTSU Objective
	Communicate	Embed speaking up process, reporting and monitoring system
	Improving quality and reducing harm	Embed a communication strategy
	Strengthening team working	Embed strong and open working relationship with Trust board
	Valuing our staff	Embed training for FTSUG, new, existing and exiting staff
	Strengthening team working	Embed a network with neighbouring Trusts within Dorset
	Strengthening team working	Embed a FTSU ambassador team, ensuring support and training.

7.0 Summary

The purpose of creating a speaking up culture is to keep our patients safe and at the heart of everything we do. The FTSUG has been successful in initially setting this role up and now with the development of FTSUA's will help facilitate conversations from staff more traditionally harder to reach and engage. The staff survey confirms that we are going the right direction to make our working environment safer. The greatest challenge will be to work with Poole and share this learning. Tackling poor behaviours remains the single most important programme within our trust and clearly this is also being seen on a national level. A great start is to ensure that we ourselves are exceptional role models, challenging our own behaviours, gaining feedback from those who we work with and giving feedback when we see those who do not meet the Trust values.

APPENDIX A:

ROYAL BOURNEMOUTH & CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

Board of Directors' Statement of commitment to the principles of the Freedom to Speak up Publication set out by Sir Robert Francis.

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication Freedom to Speak Up. The Board of Directors is committed to fostering a culture of safety and learning in which all staff feel safe to raise a concern across the Trust.

Speaking up is essential in any sector where safety is an issue. Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up will persist.

The Board supports the key principles of speaking up and is committed to leading the actions required to implement them. The Board will receive support from the Freedom to Speak up Guardian (FTSUG) who is sponsored by the Chief Executive.

The key principles the Board is committed to include:

	Principle	Action
1	Culture of safety	Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.
2	Culture of raising concerns	Raising concerns should be part of the normal routine business of any well led NHS organisation.
3	Culture free from bullying	Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
4	Culture of visible leadership	All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.
5	Culture of valuing staff	Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
6	Culture of reflective practice	There should be opportunities for all staff to engage in regular reflection of concerns in their work.
7	Raising and reporting concerns	All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

8	Investigations	When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
9	Mediation and dispute resolution	Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.
10	Training	Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
11	Support	All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality.
12	Support to find alternative employment in the NHS	Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
13	Transparency	All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14	Accountability	Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns.
15	External Review	There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report
16	Coordinated Regulatory Action	There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns
17	Recognition of organisations	CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
18	Students and Trainees	All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
19	Primary Care	All principles in this report should apply with necessary adaptations in primary care.
20	Legal protection	Should be enhanced to those who make protected disclosures.

National Guardian
Freedom to Speak Up

Appendix B

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a [guide](#) setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	RAG rating		
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.			<ul style="list-style-type: none"> • 6mthly Board meetings from FTSUG • Leadership Summit – with NGO (Sept 17) • NGO emails to CEO/DoN • Monthly meetings with FTSUG and CEO • Mentor meetings bi monthly with FTSUG (DoN and DHR) • Quarterly Meetings with NED and FTSUG • Board development session (Oct 18)
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.			<ul style="list-style-type: none"> • FTSUG Board meetings • FTSU Annual report • Website • FTSU Annual Audit report • Board development session (Oct 18)
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people		Development of website to share themes for all staff	<ul style="list-style-type: none"> • Leadership strategy • Cultural audit (Spring 16) • Key component of the Change champion (CC) programme. FTSUG is a CC • Tackling poor behaviour programme

who speak up.			<ul style="list-style-type: none"> • Good practice at HAC/QARC with key learning disseminated E.g. Top 10 Qarc • Board reports and presentations from FTSUG
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.			<ul style="list-style-type: none"> • Board statement of commitment • Leadership Summit with NGO and launch of FTSUG (Sept 17) • FTSU annual report • FTSU awareness month • FTSUG Board meeting • Mentoring/meetings with senior leadership and FTSUG
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.			<ul style="list-style-type: none"> • FTSU objectives - progress reported in FTSU reports • Annual FTSU report • 6mthly FTSUG Board reports • Vision and objectives link with Risk and governance/OD and staff survey
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.			<ul style="list-style-type: none"> • Review in Oct 19 • Internal review occurred by new ambassador team (Summer 18)
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.			<ul style="list-style-type: none"> • Objectives link with Trust objectives • Objectives include NGO recommendations

Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.			<ul style="list-style-type: none"> • FTSUG Report annually to Audit Committee measuring progress against compliance and objectives using range of data measures. • Review of objectives annually by FTSUG to Board. • Development Board Seminar (October 18)
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.			<ul style="list-style-type: none"> • Board Development Seminar (October 18) included interactive review of speaking up process. • Frequent Board support to FTSUG by range of SLT. • Review of key papers from NGO by SLT and FTSUG • Board development session (Oct 18)
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.			<ul style="list-style-type: none"> • NED and Directors chair key committees such as HAC and QARC. • Cultural programme • QI programme • Board development session (Oct 18)
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.			<ul style="list-style-type: none"> • Board development session (Oct 18)
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.			<ul style="list-style-type: none"> • Monthly CEO meetings with FTSUG • Bi-monthly meetings with DoN/DHR and FTSUG • NED and FTSUG meetings • Chair of the Trust meetings with FTSUG

			<ul style="list-style-type: none"> Board development session (Oct 18)
Senior leaders model speaking up by acknowledging mistakes and making improvements.			<ul style="list-style-type: none"> Board Statement of Commitment (Sept 17) Cultural programme QI programme Board development session (Oct 18)
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.		consider inviting workers who have spoken up to present experience in person	<ul style="list-style-type: none"> CQC feedback re: speaking up and FTSUG Staff survey results Staff impressions (Qtr 2) FTSUG feedback
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.			<ul style="list-style-type: none"> Executive – Tony Spotswood Non executive – Alex Jablonowski
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.		Set up more regular Chair meetings	<ul style="list-style-type: none"> Monthly CEO with FTSUG Quarterly NED with FTSUG
Other senior leaders support the FTSU Guardian as required.			<ul style="list-style-type: none"> Bi monthly DoN and DHR and FTSUG Full support by other members of SLT
Leaders are confident that wider concerns are identified and managed			

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.			<ul style="list-style-type: none"> Barriers to information identified at progress meetings with FTSUG FTSUG presents range of data in board and audit reports. FTSUG reports barriers to speaking up at board and audit committees.
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.			<ul style="list-style-type: none"> Open door policy with senior exec team and FTSUG Monthly/quarterly progress meetings with key SLT as above
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.		FTSU Webpage development to occur and annual report, themes and good practice	<ul style="list-style-type: none"> CQC feedback (May 2018) Board reports from FTSUG FTSUG feedback from people who use process Staff survey Staff impressions
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers		A key development for 2018/19	<ul style="list-style-type: none"> FTSUG key member of D+I working group FTSUG key member of EDIC, and work on joint projects Staff survey D+I staff survey WRES submissions Joint walkabouts the organisation with D+I

Speak up issues that raise immediate patient safety concerns are quickly escalated			<ul style="list-style-type: none"> • Open door policy with FTSUG • DATIX • QARC • HAC
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority			No cases to date
Lessons learnt are shared widely both within relevant service areas and across the trust		FTSU Development of website – page for lessons learned	<ul style="list-style-type: none"> • Good practice with risk and governance and top 10 from Qarc • FTSUG key themes and case examples at presentations at key team meetings
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented		FTSUG to set up internal audit with FTSU Ambassadors (Spring 18)	<ul style="list-style-type: none"> • Governed by Audit committee annually to provide assurance of compliance • FTSUG role in Thames Valley Network where complex cases are discussed • FTSUG role within Dorset Network, recently set up to support, share practice and discuss/audit complex cases
FTSU policies and procedures are reviewed and improved using feedback from workers			<ul style="list-style-type: none"> • FTSU Ambassador review of policies and process in Summer 18 • FTSUG Evaluation feedback analysed
The board receives a report, at least every six months, from the FTSU Guardian.			<ul style="list-style-type: none"> • Sept 17, March 18, Sept 18 • Board development session (Oct 18)
Leaders engage with all relevant stakeholders			

A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.			<ul style="list-style-type: none"> • Change champion focus groups have shaped the cultural journey • FTSU team walkabouts to clinical and non - clinical areas • D+I walkabouts • FTSUG evaluation forms following cases
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.			<ul style="list-style-type: none"> • CQC engagement team/FTSUG meetings • Contract details with NHSI • Board reports available as Part 1 of meeting • Key FTSU contact available to commissioners
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).		consider inviting workers who have spoken up to present experience in person	<ul style="list-style-type: none"> • Sept 17 • March 18 • Sept 18 • Board development session (Oct 18)
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.			<ul style="list-style-type: none"> • Annual Quality account • Board reports from FTSUG • Board development session (Oct 18)
Reviews and audits are shared externally to support improvement elsewhere.			<ul style="list-style-type: none"> • FTSUG contributed to NGO annual report • FTSUG member of Dorset network • FTSUG member Thames Valley Network • HR member of NHS Whistleblowing Committee
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to			<ul style="list-style-type: none"> • NGO comms received • Leadership summit with NGO key speaker (Sept 17) • Statement of commitment from Board (Sept

continually improve the trust's speaking up culture			17)
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians			<ul style="list-style-type: none"> • FTSUG meets with CQC engagement officer • Thames Valley Network • FTSUG chair of Dorset Network
Senior leaders request external improvement support when required.			No cases to date
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.			Board development session (Oct 18)
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.			<ul style="list-style-type: none"> • Networks with Thames Valley and Dorset FTSUGs • Feedback from HR whistleblowing group • FTSUG contributions to NGO publications
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement		FTSUG to produce a formal review of case reviews from NGO and produce action	<ul style="list-style-type: none"> • Discussions of NGO reviews and verbal actions agreed

possibilities.		plan	
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.		? regular challenge	<ul style="list-style-type: none"> Board development session (Oct 18)
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.			<ul style="list-style-type: none"> Review FTSU objectives quarterly with FTSUG Annual and 6mthly reports to board by FTSUG Annual Audit committee report by FTSUG Board development session (Oct 18)
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.			<ul style="list-style-type: none"> Policy review due October 19 Ambassador review (Summer 18) FTSUG evaluation feedback
A sample of cases is quality assured to ensure: <ul style="list-style-type: none"> the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured workers are thanked for speaking up, are kept up 		To set up QA sessions with new ambassador team based on peer action learning sets.	<ul style="list-style-type: none"> Network QA sample of difficult cases and discussions occur at FTSUG level quarterly at Thames Valley and Dorset FTSUG thanks all concerns and closely supports staff during the case. FTSUG asks all staff to complete feedback evaluations once the case is closed.

<p>to date though out the investigation and are told of the outcome</p> <ul style="list-style-type: none"> Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored 			
<p>Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.</p>		Website development	<ul style="list-style-type: none"> FTSUG presents case examples to the board Department presentations illustrate case examples and outcomes
Individual responsibilities			
Chief executive and chair			
<p>The chief executive is responsible for appointing the FTSU Guardian.</p>			<p>Completed Jan 17 and again in March 18 using an expression of interest and interview process</p>
<p>The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in</p>			<p>Meets with FTSUG and challenges process and arrangements when necessary.</p>

their trust.			
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.			Input to Annual Quality report (2017/18)
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.			FTSUG attendance and feedback from network and NGO meetings/conference
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.		More regular meetings with Chair	Monthly meetings in place with CEO and FTSUG
Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.			<ul style="list-style-type: none"> Feedback and discussion at FTSUG meetings
Overseeing the creation of the FTSU vision and strategy.			<ul style="list-style-type: none"> Active role and support to FTSUG Feedback through FTSUG meetings Review and input to FTSU objectives.
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in			<ul style="list-style-type: none"> Completed Jan 17 and March 18

accordance with the example job description and other guidance published by the National Guardian.			
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.			<ul style="list-style-type: none"> • FTSUG has 20hrs allocated to the role. • FTSU ambassador team to cover for planned/unplanned absence.
Ensuring that a sample of speaking up cases have been quality assured.			<ul style="list-style-type: none"> • FTSUG reports cases that need additional support. • FTSUG feedback outcomes and discussions from network meetings
Conducting an annual review of the strategy, policy and process.			<ul style="list-style-type: none"> • Presented in annual FTSU report. • Review strategy and objectives in Annual Audit committee report
Operationalising the learning derived from speaking up issues.			<ul style="list-style-type: none"> • FTSUG feeds back to senior team and Matron meetings at a bi annual basis or as and when needed.
Ensuring allegations of detriment are promptly and fairly investigated and acted on.			<ul style="list-style-type: none"> • Cases which area escalated by FTSUG have been acted upon and feedback to FTSUG.

Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.			<ul style="list-style-type: none"> In conjunction with FTSUG contributes to annual report. Board development session (Oct 18)
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.			Feedback through FTSUG meetings
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.			Supportive to FTSUG at Board meeting. Statement of commitment (Sept 17)
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.			Board meeting support of FTSUG Board development session (Oct 18)
Role-modelling high standards of conduct around FTSU.			Board development session (Oct 18)
Acting as an alternative source of advice and support for the FTSU Guardian.			Feedback through FTSUG meetings

Overseeing speaking up concerns regarding board members.			No cases to date
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.			<ul style="list-style-type: none"> Regular FTSUG and DHR meetings FTSUG meetings with HR senior team Share training e.g. Beachcroft Whistleblowing training
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.			
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.			<ul style="list-style-type: none"> OD leadership programmes Customer care training Conversations training
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding			Feedback through FTSUG meetings FTSUG meets with MD in cases assoc with

issues.			medical workforce
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.			Cases presented to DoN and cases escalated by FTSUG
Ensuring learning is operationalised within the teams and departments that they oversee.			FTSUG feeds back to senior team and Matron meetings at a bi annual basis or as and when needed.

IMPROVEMENT ACTION PLAN

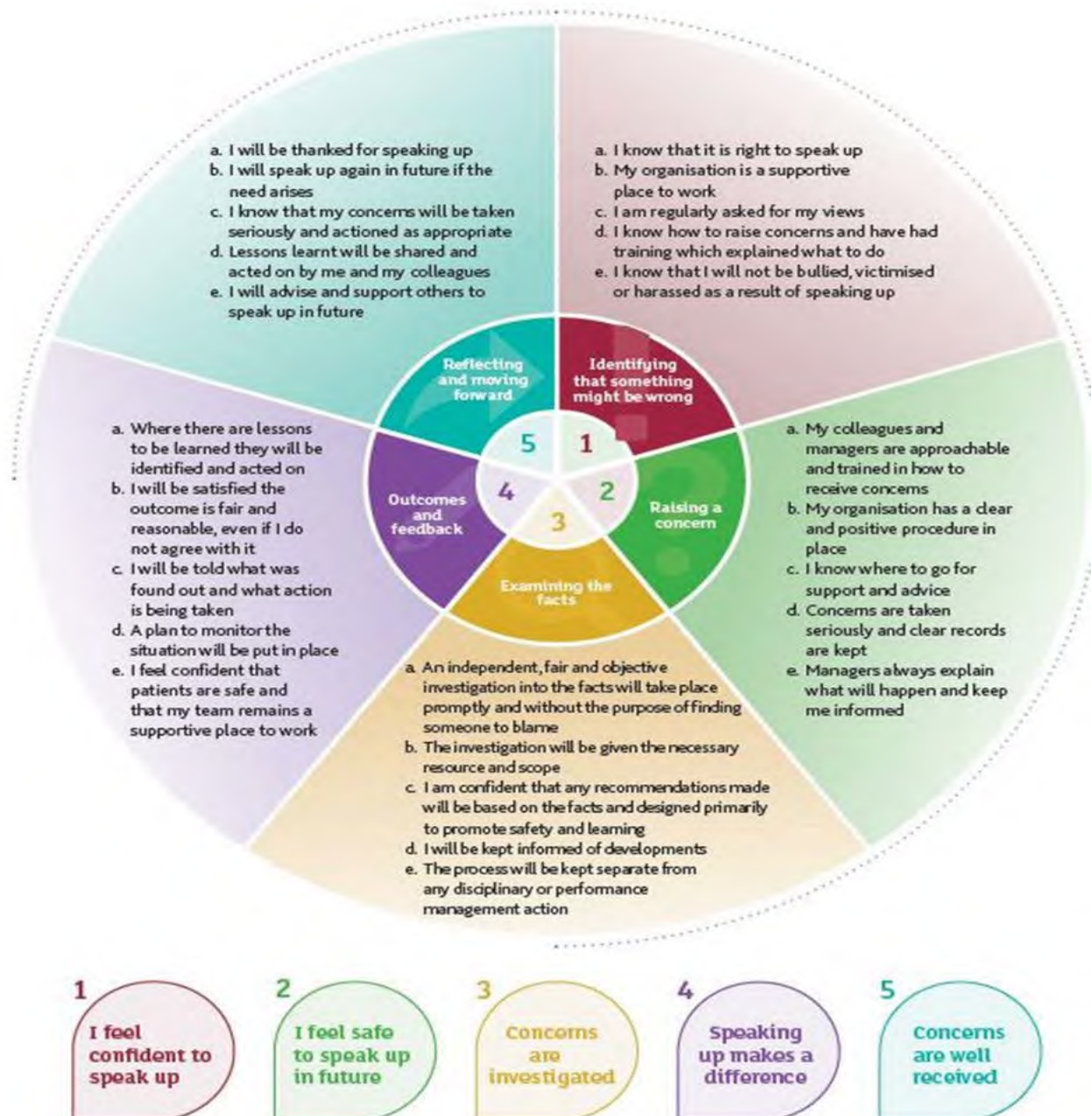
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| <ul style="list-style-type: none"> i) Develop intranet site to include: ii) Ambassador information (completed Dec 18) iii) Annual reports iv) Highlighting good practice and speaking up cases v) Themes and trends | Completed |
| <p>2. Set up and implement local quality assurance of cases raised using the Ambassador model.
 network as a working group.</p> | BY Spring 2019. Discussed at Dorset Guardian |
| <p>3. Produce action plan and benchmark RBCH following NGO case reviews.</p> | Completed. To meet HR |
| <p>4. Consider inviting staff who have spoken up to present experience in person</p> | Summer 19 |
| <p>5. FTSUG to set up more regular meetings with the Chair of the Board</p> | Completed |

APPENDIX C: Freedom to Speak Up

Objectives 2018/19

1.0 A Vision for Raising Concerns

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication “Freedom to Speak Up”. The Trust Board at RBCH publicly committed to these principles in September 2017.



2.0 The RBCH Approach

In April 2018, the Trust appointed a Freedom to Speak up Guardian (FTSUG) – Helen Martin (20 hrs/week).

2.1 Aim

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.

The key roles of the FTSUG are:

- empower staff to raise concerns within organisations
- provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled.
- ensure that organisational policies and processes in relation to the raised concern are in place and followed correctly
- To ensure shared learning amongst local/regional/national Networks
- Produce reports to monitor the outcomes and impact of FTSU

It is not intended that these roles get involved in investigations or complaints.

3.0 Objectives for 2018

The Trust set 4 objectives for 2018:

1. **Valuing our staff** - Recognising the contribution of our staff and helping them develop and achieve their potential
2. **Improving quality and reducing harm** - Focusing on continuous improvement and reduction of waste
3. **Strengthening team working** - Developing and strengthening “Team RBCH” to deliver safe and compassionate care for our patients and shaping future health care across Dorset
4. **Listening to patients** - Ensuring meaningful engagement to improve patient experience

Based on this, the following are key objectives of the FTSUG over this time:

7. **Embed speaking up process, reporting and monitoring system**
8. **Embed a communication strategy**
9. **Embed strong and open working relationship with Trust board**
10. **Embed training for FTSUG, new, existing and exiting staff**
11. **Develop a network with neighbouring Trusts within Dorset**
12. **Develop a FTSU ambassador team, ensuring support and training.**

Table 1: Key Objectives for 2018/19

	Action lead	Timescale Completed/update
1. Embed speaking up process, reporting and monitoring process		
Appoint Trust FTSUG – 1 yr secondment for 20hrs/wk	Trust Executive Board	Completed and post-holders in secondment post from 1 st April 18
Review Trust “speaking up” policy in line with national policy, outlining clear process of reporting concerns.	FTSUG	review October 19. Draft update following TS departure. Awaiting approval.
Self-assessment of current speaking up culture <ul style="list-style-type: none"> Completion of NGO self-review tool. Review of staff survey, Trust grievance data, HR workforce, PALs feedback 	FTSUG and board FTSUG	Completed and submitted 2018 staff survey completed.
Continue case referrals	FTSUG	In progress
Submission of data to NGO including (but not exclusive) <ul style="list-style-type: none"> quarter data, annual census and Annual FTSU Survey 	Quarterly Annual Annual	Completed Qtr 1, Qtr 2, Qtr3 Completed May 2018 Completed June 2018
Carry out annual “taking the pulse” staff survey to measure the culture of the organisation	FTSUG	Qtr 2 Staff impressions – completed Sept 18. To repeat Qtr 2 2019.
Develop sustainable speaking up strategy in line with merger plans with PHT	FTSUG	Joint paper completed and submitted
Contribute to change programme and tackling poor behaviours work-stream/dr engagement	FTSUG	Project Group being established.
Facilitator for trust wide programmes such as resilience training, customer care etc		Completed
Conduct an annual review of strategy, policy and process. Ensure receive feedback from workers	FTSUA	Completed Summer 18 by FTSUA
Sample cases of concern to quality assure and ensure: <ul style="list-style-type: none"> Investigation process of high quality Recommendations are reasonable Workers thanked Investigations are independent and fair 		Via Networks and discussion of complex cases. To develop internal QA with ambassadors
2. Embed a communication strategy		
Communication strategy <ul style="list-style-type: none"> Guardian walkabouts- to increase visibility Presentations/road shows to key areas 	FTSUG	FTSU Awareness Month (Oct 18). Repeat Spring 19 Plan for Spring 19 set with FTSUA In progress and continue

<ul style="list-style-type: none"> Meet and develop relationships with key players Screen savers (Feb 18) Apps Payslip (Jan 18) Banners 		Completed FTSU Awareness month To repeat Spring 2019 To re-fresh Spring 2019
Comms programme visiting all areas of organisation/targeting with information	FTSUG	Completed for FTSU Awareness Month. Continue next walkabout in Spring 19
Be an active member of Diversity and inclusion work-stream	FTSUG	In progress and continue
Develop a lessons learned and share with relevant service areas and across the Trust		Completed
3. Embed strong and open working relationship with Trust board		
<ul style="list-style-type: none"> Set up regular meetings with <ul style="list-style-type: none"> CEO Director of Improvement Responsible FTSU NED Chair of the board Director of Nursing Director of HR Medical Director 		Occurs monthly. DF April 18 Occurs monthly/6weekly Completed 9.10.18. to book Spring 19 Completed 15.1.19. To book June/July Completed 16.1.19. booked 26.3.19 Completed 5.10.18. Re-book Spring 19 Book ad hoc
<ul style="list-style-type: none"> Develop joint sustainable strategy with PHT 		Completed
4. Embed a training strategy for new, existing and exiting staff		
<ul style="list-style-type: none"> Development of training and support programme for first line managers in conjunction with OD leadership programme Incorporate induction programmes Leavers questionnaire 	FTSUG/OD	Completed Board development seminar. Meeting OD for Matron Programme Completed and reviewed Autumn 17. Updated March 19 Joining HCA induction programme and Dr. Launch completed in Summer 18. Meet HR for progress
Training of FTSUG <ul style="list-style-type: none"> National Conference Ad hoc training (CQC inspections, case reviews, training for managers) 	FTSUG	Attended March 18. FTSUA attend March 19 Attend webinars and other dates.
5. Develop a network with neighbouring Trusts (Work to include potential merger)		
Integral member of local FTSUG network	FTSUG	Attended 5.2.19
Develop and lead Dorset FTSUG network	FTSUG	Chaired 18 th September, 8.1.18. next date May 19
Poole Hospital integrated model development	FTSUG	Completed
6. Develop a FTSU ambassador team.		
Development of Trust ambassador to review	FTSUG	Training programme developing. Cases

cases		training Jan 19
Develop support network	FTSUG	In progress
Develop a training programme for new FTSU Ambassador	FTSUG	In progress. Attended local NGO training at Soton 8.2.19



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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Information Governance Annual Report
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Peter Gill, Director of Informatics
Author(s) of paper:	Camilla Axtell, IG Manager
Details of previous discussion and/or dissemination:	Information Governance Committee
Action required:	Note for information
Summary: Annual report outlining the Information Governance work within the Trust for information for the Board of Directors, including a summary of the Data Security and Protection Toolkit audit.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	<input checked="" type="checkbox"/>
Are they effective?	<input type="checkbox"/>
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	<input type="checkbox"/>
Impact on significant risks:	N/A

INFORMATION GOVERNANCE ANNUAL REPORT 2018/19

Introduction

The aim of imbedding good Information Governance practice throughout the Trust is to provide assurance to patients and to the Board that information is managed in a legally compliant fashion – this remains a priority for the Trust during 2018/19.

Much of this year has been devoted to accommodating a number of significant changes affecting Information Governance provision which took place in 2018, with the Data Security and Protection Toolkit replacing the Information Governance Toolkit, and the Data Protection Act 1998 being replaced by the EU General Data Protection Regulation and UK Data Protection Act 2018.

It is hoped that the increased national focus on Information Governance during the year will prove to be positive for the Trust in terms of continuing to push this improvement agenda forwards.

Summary

Below is a high-level summary detailing significant Information Governance statistics from 2017/18 and 2018/19, and the relative percentage differences. These figures are elaborated on within the main report.

	2017/18	2018/19	Projected	+ / -
Information Governance Toolkit compliance	73%	n/a	n/a	n/a
Data Security and Protection Toolkit compliance	n/a	63%*	90%	n/a
Data Protection and Confidentiality Incidents – breaches	142	172*	188**	+32%
Data Protection and Confidentiality Incidents – SIRIs	4	1*	n/a	-75%
Freedom of Information Requests	654	613*	669**	+2%
Information Governance Training (highest % reached)	95.1%	94.9%*	n/a	-0.2%

(*as at 28 February 2019)

(** projection for 31/03/19 based on average by month)

Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSP Toolkit) replaced the Information Governance Toolkit during 2018. This remains a self-assessment audit completed by every NHS Trust and submitted to NHS Digital on 31st March each year. The purpose of the DSP Toolkit is to assure an organisation's IG practices through the provision of evidence around 40 mandatory individual requirements, known as "assertions". This is the most significant single piece of work regularly undertaken by

the Information Governance department.

The DSP Toolkit sets the standard for cyber and data security for healthcare organisations, and places a much greater focus on assuring against modern threats. Based around the National Data Guardian's 10 Data Security Standards, the DSP Toolkit is divided into three categories of leadership obligations: People, Process and Technology. The DSP Toolkit places less emphasis on the provision of documentary evidence (which, in the past, often led to papers being created only for the purpose of meeting IG Toolkit requirements), and instead sets out the standards that organisations are required to meet with an expectation that this will be an ongoing journey towards compliance. It is still true to say that the tenets of good Information Governance can be built around the audit, however it is no longer the case that the audit covers the full breadth of the IG agenda.

A significant portion of this audit is underpinned by work associated with information risk assurance. This involves the identification of the Trust's key information systems (known as information assets), the designation of a senior person who is responsible for each system (known as an Information Asset Owner), and ensuring that each of these systems has in place such measures as appropriate contract clauses, adequate access controls, regular risk assessments and suitable business continuity plans, and to ensure that any information which is transferred into or out of the Trust through this system is risk assessed and appropriately protected. This work is essential to ensure the continuous provision of effective care and to ensure that any risks to the integrity and availability of critical information are mitigated as far as is possible.

A twofold approach is taken to the completion of the DSP Toolkit – requirements are divided into those requiring input from IAOs and those requiring completion by subject matter experts. The IAOs co-operation is critical to the completion of this work, as they take responsibility for providing the required assurance within each separate area of the Trust, meaning that the level of assurance provided within the DSP Toolkit submission covers the whole organisation rather than selected areas. These members of staff are directed by the Information Governance Manager under the jurisdiction of the Director of Informatics, and compliance amongst IAOs is routinely monitored through IG Committee and PMG meetings.

The work that has been undertaken during the last four years to ensure that the tasks required to be completed by IAOs are started and seen through to completion or maintained year on year has stagnated somewhat in 2018/19. This is in part due to the changes in Data Protection legislation and introduction of the DSP Toolkit in a short space of time which has meant that the assurance required from IAOs has changed its focus. The Trust must continue to maintain the traction that it has gathered on this work in order to firmly imbed the concepts as “business as usual” – this must be seen as an ongoing assurance project in order to be successful. It is hoped that the appointment of an IG Project Support Officer during 2019 will help to get this work back on track.

The nature of the IG Toolkit's scoring system was that if one of the requirements was to be deemed non-compliant then the whole audit was scored as “Not Satisfactory”. NHS Digital has confirmed that organisations are expected to achieve a status of “Standards met” on the DSP Toolkit. If any of the mandatory assertions are not

evidenced, the overall grading will show as “Standards not met”. Whilst its compliance level is expected to be high, with this being the first year of the DSP Toolkit the Trust does not expect to be able to evidence all of the new requirements by the end of March. To mitigate this, an improvement plan will be developed for acceptance by NHS Digital, detailing how the Trust intends to comply with the outstanding elements of the DSP Toolkit within 6 months. The Trust’s final position, once confirmed by NHS Digital, will therefore be graded as “Standards not fully met (Plan Agreed)”.

Data Protection and Confidentiality Incidents

There has been an increase in reported breaches of Information Governance during the year, as illustrated in the table above.

Some of the types of incidents reported are recurrent – the most common types being inappropriate disclosures of sensitive information. These vary in nature, however around 31% of incidents reported related to personal data being stored in the wrong person’s record, and 28% relate to inappropriate access to or use of personal data (including instances where patients have received correspondence relating to others).

These tend to be one-off incidents rather than incidents that reoccur within one department, and can therefore generally be attributed to human error rather than lack of appropriate training or processes not being in place. In addition to routine training, further staff awareness campaigns relating to the correct handling of personal and confidential data are planned for 2019/20. In addition, a review of IG incident categories will be carried out to ensure that these are appropriate representative.

During 2017/18, the Trust has reported one Serious Incident Requiring Investigation (SIRI) to the Information Commissioner’s Office (ICO). These are incidents which are categorised as serious in accordance with the guidance provided by NHS Digital and the ICO using criteria such as sensitivity of information involved, number of individuals affected, etc.

In this incident, a patient made complaint as he felt a member of staff within the Trust to whom he was related had accessed his medical records inappropriately. This was confirmed through review of audit trails. There is no evidence of harm coming to the individual affected by this breach or the information involved being disseminated further, and the ICO has confirmed no enforcement action was warranted.

Further awareness-raising will be delivered through appropriate channels during 2019/20 to ensure that all staff are aware of what may constitute an IG breach and therefore what they should be reporting as such.

In May 2018 the EU’s General Data Protection Regulation (GDPR) and Data Protection Act 2018 came into law. Amongst the changes that this has brought are the statutory obligations to report the most serious breaches within 72 hours and to inform data subjects affected by these breaches, and significantly increased financial penalties for a wider range of breaches of the legislation. Successful completion of and compliance with the DSP Toolkit enables the Trust to comply with some of the

requirements of the updated legislation; however it remains essential to ensure that work streams which are key to maintaining GDPR compliance such as data flow mapping and the completion of data protection impact assessments are supported to be considered as a “business as usual” processes.

Freedom of Information

During 2018/19 the Trust has seen a slight increase in the number of Freedom of Information (FOI) requests received from the previous year; 613 as at 28 February 2019. This is up from 595 at the same point last year. A full time IG Officer was recruited during 2016, and to date the vast majority of this role has been dedicated to responding to FOI requests to the detriment of other duties.

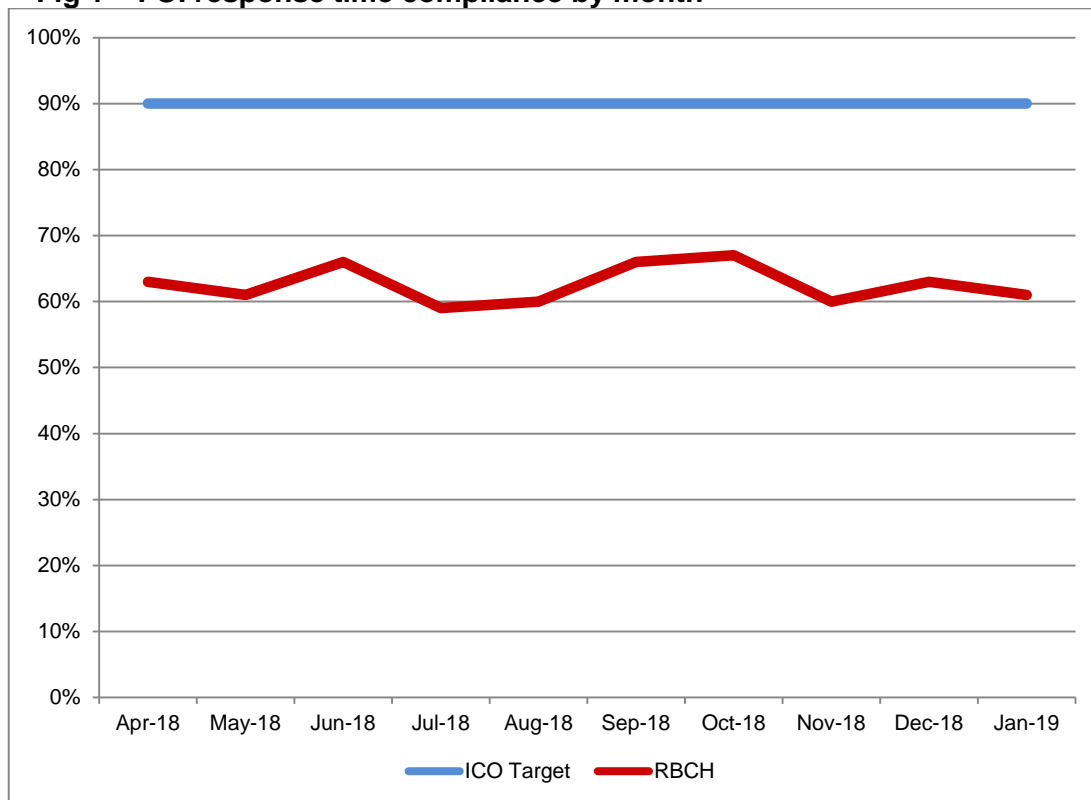
Compliance with the statutory time limit imposed by the FOIA remains markedly removed from the target imposed by the Information Commissioner’s Office; a steady maintenance of compliance can be observed in the chart below. The number of breaches seen generally remains indicative of the large number of requests received, and the increased complexity of these requests which can require a significant amount of work to locate the information requested. Additionally, this can also be attributed to the difficulty of obtaining full and timely responses from staff who are managing competing priorities, and the Trust’s position that critical reporting that is key to patient care and managing the financial affairs of the Trust should take priority over handling FOI requests.

The issue of poor FOI compliance is included within the Trust risk register, and this will continue to be monitored throughout 2019/20.

The ICO will monitor selected organisations to review their performance in adhering to the Freedom of Information Act, targeting those authorities which repeatedly fail to respond to at least 90% of FOI requests received within the appropriate timescales. Monitoring may be a precursor to further action if an authority is unable to demonstrate an improvement. Further action could include the Trust having to sign an undertaking to improve its practices, an enforcement notice, reports to Parliament, or prosecution.

The Trust has recorded the response times for FOI requests over the last 27 full quarters, broken down by month. During this period there has been no month where the required quantity of requests has been responded to within 20 days. During 2018/19 (as at 28th February), the Trust has received an average of 56 requests per month, and a response was provided on average within 17 days. During this period 59% of requests overall have been responded to within the statutory time limit; 129 requests received a response within 5 working days.

Fig 1 – FOI response time compliance by month



Information Governance Training

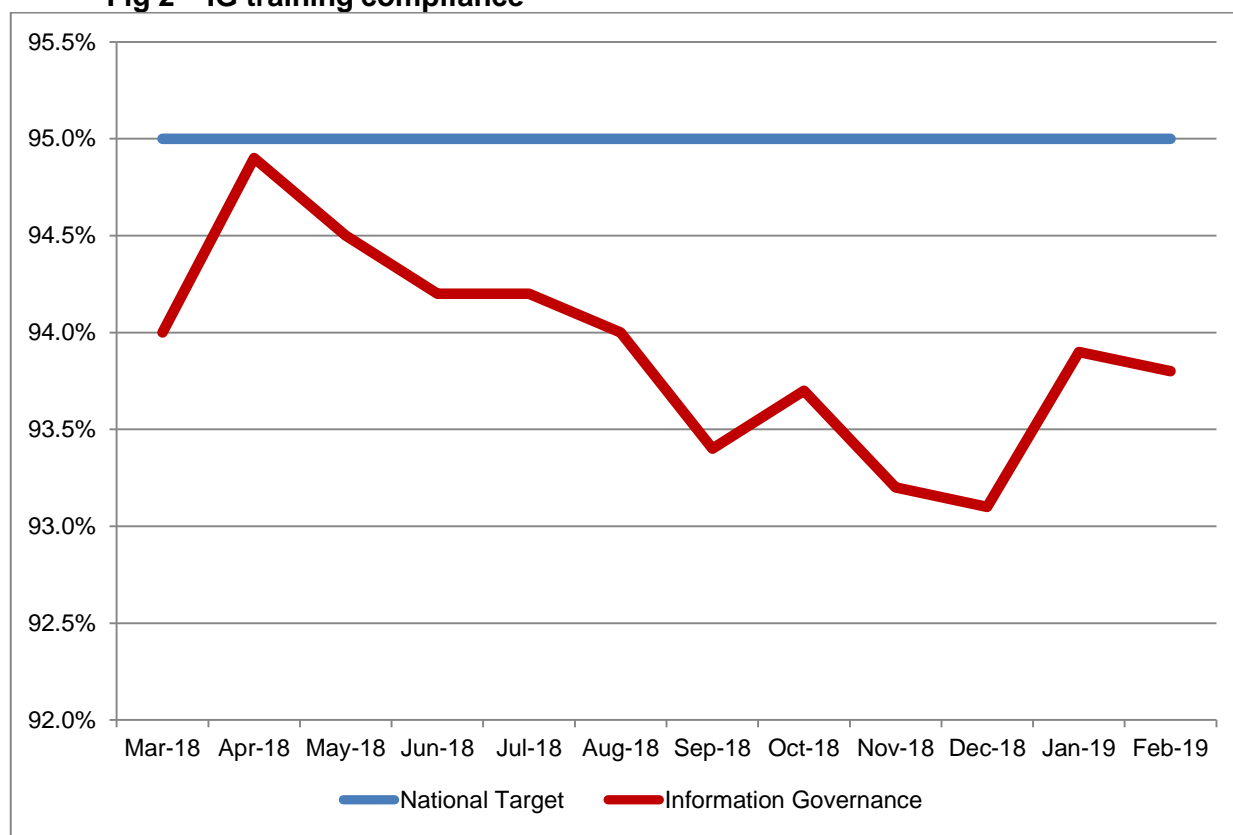
Information Governance training compliance has remained relatively high during the year and at the end of February 2019 sits at 93%.

The concerted campaign of chasing individual non-compliant members of staff and their line managers, led by the Director of Informatics, has continued throughout 2018/19. An automated e-mail reminder is issued weekly to staff who are not compliant with their IG training.

One of the major challenges in attaining compliance is the fact that IG training is an annual competency unlike many other subjects which only require renewing every two or three years, and so requires staff to go out of their way to obtain this competency in the “off years”.

For 2018/19, the in-house IG training content previously used by RBCH was replaced by the national Data Security Awareness e-learning provided by NHS Digital. This new course incorporates changes in data protection legislation, and increased details on cyber security. Feedback from staff has been primarily positive for this course, which has been made available through the usual BEAT VLE platform.

Fig 2 – IG training compliance



Conclusion

Improvements made have been limited during 2018/19, owing in part to the additional pressures associated with changes such as new Data Protection legislation, the new Data Security and Protection Toolkit and Data Security Awareness Training. It must be recognised that the assurance work undertaken under the auspices of the previous IG Toolkit and carried forward into the DSP Toolkit is ongoing and requires continual update and maintenance to ensure that compliance with the relevant legislation and national standards can be sustained. While the initial drive to begin to imbed this initiative is perhaps the most difficult, it is essential that this momentum is sustained to avoid a retrograde slump, negating any achievements realised.

During 2019/20, the priority will be to continue to work towards attaining compliance with the standards imposed through the Data Protection Act 2018, particularly through successful completion of the new DSP Toolkit, as well as continuing work to imbed information risk assurance and improve FOI compliance.

Appendix 1 – Data Security and Protection Toolkit scores

Order	Evidence code	Assertion	Predicted Status
1	Data Security Standard 1		
	All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form.		
	Personal confidential data is only shared for lawful and appropriate purposes. Staff understand how to strike the balance between sharing and protecting information, and expertise is on hand to help them make sensible judgments. Staff are trained in the relevant pieces of legislation and periodically reminded of the consequences to patients, their employer and to themselves of mishandling personal confidential data.		
	Mandatory assertions satisfied – 7 / 8		Incomplete
2	Data Security Standard 2		
	All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.		
	All staff understand what constitutes deliberate, negligent or complacent behaviour and the implications for their employment. They are made aware that their usage of IT systems is logged and attributable to them personally. Insecure behaviours are reported without fear of recrimination and procedures which prompt insecure workarounds are reported, with action taken.		
	Mandatory assertions satisfied – 2 / 2		Complete
3	Data Security Standard 3		
	All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit.		
	All staff complete an annual security module, linked to 'CareCERT Assurance'. The course is followed by a test, which can be re-taken unlimited times but which must ultimately be passed. Staff are supported by their organisation in understanding data security and in passing the test. The training includes a number of realistic and relevant case studies.		
	Mandatory assertions satisfied – 4 / 4		Complete

4	Data Security Standard 4 Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals. The principle of 'least privilege' is applied, so that users do not have access to data they have no business need to see. Staff do not accumulate system accesses over time. User privileges are proactively managed so that there is, as far as is practicable, a forensic trail back to a specific user or user group. Where necessary, organisations will look to non-technical means of recording IT usage (e.g. sign in sheets, CCTV, correlation with other systems, shift rosters etc).	
	Mandatory assertions satisfied – 0 / 3	Incomplete
5	Data Security Standard 5 Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security. Past security breaches and near misses are recorded and used to inform periodic workshops to identify and manage problem processes. User representation is crucial. This should be a candid look at where high risk behaviours are most commonly seen, followed by actions to address these issues while not making life more painful for users (as pain will often be the root cause of an insecure workaround). If security feels like a hassle, it's not being done properly.	
	Mandatory assertions satisfied – 1 / 1	Complete
6	Data Security Standard 6 Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection. All staff are trained in how to report an incident, and appreciation is expressed when incidents are reported. Sitting on an incident, rather than reporting it promptly, faces harsh sanctions. [The Board] understands that it is ultimately accountable for the impact of security incidents, and bear the responsibility for making staff aware of their responsibilities to report upwards. Basic safeguards are in place to prevent users from unsafe internet use. Anti-virus, anti-spam filters and basic firewall protections are deployed to protect users from basic internet-borne threats.	
	Mandatory assertions satisfied – 3 / 3	Complete

7	Data Security Standard 7 A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management. A business continuity exercise is run every year as a minimum, with guidance and templates available from [CareCERT Assurance]. Those in key roles will receive dedicated training so as to make judicious use of the available materials, ensuring that planning is modelled around the needs of their own business. There should be a clear focus on enabling senior management to make good decisions, and this requires genuine understanding of the topic, as well as the good use of plain English.	
	Mandatory assertions satisfied – 2 / 2	Complete
8	Data Security Standard 8 No unsupported operating systems, software or internet browsers are used within the IT estate. Guidance and support is available from CareCERT Assurance to ensure risk owners understand how to prioritise their vulnerabilities. There is a clear recognition that not all unsupported systems can be upgraded and that financial and other constraints should drive intelligent discussion around priorities. Value for money is of utmost importance, as is the need to understand the risks posed by those systems which cannot be upgraded. It's about demonstrating that analysis has been done and informed decisions were made.	
	Mandatory assertions satisfied – 3 / 3	Complete
9	Data Security Standard 9 A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually. [CareCERT Assurance] assists risk owners in understanding which national frameworks do what, and which components are intended to achieve which outcomes. There is a clear understanding that organisations can tackle the NDG Standards in whichever order they choose, and that the emphasis is on progress from their own starting points.	
	Mandatory assertions satisfied – 3 / 3	Complete

10	<p>Data Security Standard 10</p> <p>IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.</p> <p>IT suppliers understand their obligations as data processors under the GDPR, and the necessity to educate and inform customers, working with them to combine security and usability in systems. IT suppliers typically service large numbers of similar organisations and as such represent a large proportion of the overall 'attack surface'. Consequently, their duty to robust risk management is vital and should be built into contracts as a matter of course. It is incumbent on suppliers of all IT systems to ensure their software runs on supported operating systems and is compatible with supported internet browsers and plug-ins.</p>
	<p><i>Mandatory assertions satisfied – 1 / 2</i></p>
	<p>Incomplete</p>



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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Directors' Register of Interests
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	David Moss, Chairperson
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Interests are declared as they arise
Action required:	Review and comment
<p>Summary:</p> <p>The Trust is required to maintain a register of interests for its directors. This facilitates the identification and management of potential conflicts of interests by the Board of Directors. The register is reviewed annually by the Board to ensure that it is up to date as the information will be used in determining any related parties disclosure in the Annual Report and Accounts.</p>	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain:	
Are they safe?	<input type="checkbox"/>
Are they effective?	✓
Are they caring?	<input type="checkbox"/>
Are they responsive to people's needs?	<input type="checkbox"/>
Are they well-led?	✓
Impact on significant risks:	None

REGISTER OF DIRECTORS AND DIRECTORS INTERESTS 2018/19

Director	Appointed/ Reappointed	Resigned/ Removed	Interests Declared	Acquired	Declared	Ceased
Karen Allman Director of HR	01/06/2007		Governor, Queen Elizabeth's School, Wimborne Minster	February 2017	April 2017	
Pankaj Davé Non-Executive Director	I. 01/09/2018		No relevant or material interests.			
Debbie Fleming Chief Executive	I. 01/01/2019		Chief Executive of Poole Hospital NHS Foundation Trust Member of Wimborne Academy Trust	April 2014	January 2019 January 2019	
Peter Gill Director of Informatics	01/06/2016		No relevant or material interests.			
Interim Director of Informatics	01/02/2015	31/05/2016				
Christine Hallett Non-Executive Director	I. 29/06/2015 II. 29/06/2018		No relevant or material interests.			
Alex Jablonowski Non-Executive Director	I. 20/06/2016		Director of Datalytx Ltd Director of High Performance Leadership Ltd Non-Executive Director for Maritime Coastguard Agency Non-Executive Director for Office for National Statistics Programme Board Chair of City Fencing Club Chair of Defence Electronics and Components Agency Member of London Veterans Advisory and Pensions Committee Member Advisory Board Westminster University Business School		June 2016	March 2018
John Lelliott Non-Executive Director	I. 01/06/2016		Wife is a Physiotherapist at Wessex Nuffield Hospital Vice-Chairman of Asthma UK Chairman of Natural Capital Coalition Management Board member of the Christchurch Fairmile Village LLP Non-Executive Director, Covent Garden Markets Authority Non-executive Board member of the Environment Agency	June 2016 July 2016 June 2016 September 2016 January 2018	December 2016 May 2016 July 2016 June 2016 March 2018	June 2017
David Moss Chairperson	I. 13/03/2017 II. 01/01/2019		Chairman of Poole Hospital NHS Foundation Trust	January 2019	January 2019	

REGISTER OF DIRECTORS AND DIRECTORS INTERESTS 2018/19

Director	Appointed/ Reappointed	Resigned/ Removed	Interests Declared	Acquired	Declared	Ceased
Alyson O'Donnell Medical Director	07/11/2016		No relevant or material interests.			
Pete Papworth Director of Finance	29/05/2017		Wife is a HR Business Partner at Dorset Healthcare University NHS Foundation Trust Director of The Bournemouth Private Clinic Limited Director and member of The Bournemouth Healthcare Trust Management Board member of the Christchurch Fairmile Village LLP	May 2017 July 2017 July 2017 August 2017	July 2017 July 2017 July 2017 May 2017	
Iain Rawlinson Non-Executive Director	I. 01/10/2017		Director of the following companies: <ul style="list-style-type: none"> • Crowdcaster Limited • Sibbick Yachts Limited • Charles Sibbick Limited • C. Sibbick & Co. Limited • Online Digital Broadcasting Limited • Online Radio Broadcasting Limited • Studyvox UK Limited • The Parkmead Group PLC • The Online Radio Broadcasting Foundation Limited • Rawlinson Partners Limited • Vico Partners Limited • Walhampton School Trust Ltd • IBTC Portsmouth 	October 2015 June 2012 June 2012 June 2012 April 2011 April 2011 April 2011 December 2010 October 2009 May 2009 October 2017 March 2017 December 2016	March 2018	
Richard Renaut Chief Operating Officer	12/09/2014		Married to Christine Renaut – an employee of the Trust (Pharmacist)	April 2009	April 2009	
Director of Service Development	04/2006	11/09/2014	Director of The Bournemouth Private Clinic Limited Management Board member of the Christchurch Fairmile Village LLP	January 2016 September 2014	July 2016 July 2014	
Cliff Shearman Non-Executive Director	I. 01/04/2017		Company Secretary of Wessex Medical Reporting Limited Member, Council of the Royal College of Surgeons Vice- President, Council of the Royal College of Surgeons Chairman of the Grants Award Committee, Pelican Cancer Foundation Member of Programme Organising Board, Charing Cross International Vascular and Endovascular Symposium	July 2015 2015 April 2018	April 2017 April 2017 May 2018 April 2017 April 2017	

REGISTER OF DIRECTORS AND DIRECTORS INTERESTS 2018/19

Director	Appointed/ Reappointed	Resigned/ Removed	Interests Declared	Acquired	Declared	Ceased
Paula Shobbrook Director of Nursing and Midwifery/ Deputy CEO	05/09/2011		Husband is director of various group companies of Albany Farm Care Homes, Hampshire	February 2014	February 2014	
Tony Spotswood Chief Executive	04/01/2000	31/12/2018	Trustee Board Member of NHS Providers (formerly the Foundation Trust Network) Chair of Clinical Research Network, Wessex National Institute for Health Research - member of the Board and Chair of the remuneration committee Board member, Wessex Academic Health Science Network Director of The Bournemouth Private Clinic Limited Director and member of The Bournemouth Healthcare Trust Director of Tony Spotswood Links Consultancy Limited	April 2010 February 2015 July 2016 May 2015 January 2016 January 2016 14 December 2018	April 2010 February 2015 July 2016 March 2014 December 2018	May 2016 March 2017

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Audit Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Alex Jablonowski, Non-Executive Director and Audit Committee Chair
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Audit Committee, February 2019
Action required:	Decision
<p>Summary:</p> <p>At its meeting in February, the Audit Committee considered changes to its terms of reference for it to assume responsibility for assurance of information governance from the Healthcare Assurance Committee (HAC). This change reflects the increasing focus of the Audit Committee on aspects of information governance including cybersecurity, data protection and business continuity.</p> <p>An amended version of the terms of reference is attached reflecting this change. The terms of reference of each of the HAC and the Information Governance Committee will also need to be updated once the change is approved. It is proposed that this will take effect from 1 April 2019 following submission of the Data Security and Protection Toolkit at the end of March.</p> <p>A further change was requested to the terms of reference to ensure that one of the members of the Audit Committee is a qualified accountant. This reflects the original guidance on audit committees produced by Sir Robert Smith, which stated that it was highly desirable to have at least one member to have one member of the committee with an accountancy qualification.</p> <p>The HAC will retain some oversight for information governance as part of its monitoring compliance with the Care Quality Commission's fundamental standards.</p> <p>The Board of Directors is requested to approve the amendments to the Audit Committee's terms of reference highlighted in the attached document. These changes are proposed to update the terms of reference to reflect minor changes to the role and operation of the Committee and to clarify some existing governance requirements.</p>	



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

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:	None

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

AUDIT COMMITTEE

Terms of Reference

The Audit Committee (the **Committee**) is a committee established by and responsible to the Board of Directors. -The primary aim of the Committee is to monitor and review financial and other risks and associated controls, corporate governance and financial assurance.

1. Membership

- 1.1. The Committee shall be appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust and shall consist of not less than ~~3~~three members, at least one of whom shall ~~have recent and relevant financial experience~~be a qualified accountant. -One member shall be the Chair of the Healthcare Assurance Committee. -The Chairman of the Trust shall not be a member of the Committee.
- 1.2. In addition, the following will attend the Committee to provide advice as required:
 - 1.2.1. the Director of Finance
 - 1.2.2. a representative of the Internal Auditors
 - 1.2.3. a representative of the External Auditors
 - 1.2.4. a representative from the Counter Fraud service
 - 1.2.5. the Freedom to Speak Up Guardian
 - 1.2.6. the Clinical Director for Clinical Audit
 - 1.2.7. the Director of Nursing and Midwifery (also Deputy Chief Executive)
 - ~~1.2.8.~~ the Medical Director
 - ~~1.2.8.1.2.9.~~ the Chair of the Information Governance Committee or Information Governance Manager
 - ~~1.2.9.1.2.10.~~ any other director, as required.
- 1.3. Only members of the Committee have the right to attend Committee meetings.- Any other directors may attend following notification to the Chairman. -The chief executive should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.
- 1.4. There will be one governor attending each meeting as an observer. Observers are not members of the Committee. -This governor has been elected to undertake this role 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.

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- 1.5. Appointments to the Committee shall be for a period of three years, which may be extended for a further three year period.
- 1.6. The Board of Directors shall appoint the Committee Chairman (the **Chairman**) who shall be a Non-Executive Director and member of the Committee. -In the absence of the Chairman and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.
- 1.7. The Committee shall provide an opportunity to meet with the External and Internal Auditors or the representative from the Counter Fraud Service without any Executive Director present.

2. Secretary

- 2.1 The Trust Secretary (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 two members. -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 at least quarterly and otherwise as required.

5. Notice of Meetings

- 5.1 Meetings of the Committee shall be called by the Secretary at the request of any of the Committee members or at the request of External or Internal Auditors if they consider it necessary.
- 5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Trust Secretary or their nominee.
- 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. -Where possible, supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

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6. Minutes of Meetings

- 6.1 The Secretary shall minute the proceedings and resolutions of all Committee meetings, including recording the names of those present and in attendance.
- 6.2 The Secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.
- 6.3 Minutes of Committee meetings shall be agreed by the Committee Chairman prior to being circulated to all members of the Committee unless a conflict of interest exists. The Secretary shall aim to prepare the minutes within one week of the meeting date.

7. Duties

The duties of the Committee are set out below.

7.1 Internal Control, Risk Management and Corporate Governance.

7.1.1 The Committee shall review the implementation and ongoing effectiveness of the system of internal control, risk management and corporate governance, with particular reference to the organisation's assurance framework.

7.1.2 In particular, the Committee will review:

7.1.2.1 The adequacy of all risk and control related disclosure statements, together with any accompanying reports from Internal or External Auditors or other appropriate independent assurance, before making recommendations to the Board of Directors. In reviewing the annual governance statement, the Healthcare Assurance Committee will need to provide assurance on their activities during the year through its Chair.

7.1.2.2 The effectiveness of the foundation trust's internal controls, board assurance framework and risk management systems, including reviewing the board assurance framework for completeness in the context of risks highlighted by external audit, internal audit and counter fraud.

7.1.2.3 The operational effectiveness of relevant policies and procedures including but not limited to:

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as recommended by the appointed Counter Fraud service;

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- The policies and procedures in place for ensuring economy, efficiency and effectiveness in the use of resources.

7.1.2.4 The Clinical Audit Plan to ensure that it is robust, reflecting both national and local priorities, comprehensive and embedded across all clinical teams (management arrangements, planning, reporting, communication and learning) with the outcomes used to drive improvement and enhance the overall quality of clinical care.

7.1.2.47.2 Internal Audit

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7.2 Internal Audit

The Committee will:

- 7.2.1 Appoint the Internal Auditors, set the audit fee and resolve any questions of resignation and dismissal.
- 7.2.2 Ensure that the Internal Audit function is adequately resourced, has appropriate access to information to perform its function effectively and is free from ~~f~~management or other restrictions.
- 7.2.3 Review the internal audit programme, consider major findings of internal audit investigations (and management's response), and ensure co-ordination between the Internal and External Auditors.
- 7.2.4 Report non-compliance with, or inadequate response to, Internal Audit Reports to the Board of Directors.
- 7.2.5 Meet with the Internal Auditors at least once a year, without executive management being present.
- 7.2.6 Conduct an annual review of the internal audit function.

7.3 External Audit

The Committee will:

- 7.3.1 Oversee a market testing exercise and consider the appointment of the External Auditor, the audit fee and any questions of resignation and dismissal based on criteria agreed with the Council of Governors. ~~-~~Make a recommendation to the Council of Governors on appointing the External Auditor for a three year period.
- 7.3.2 Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with Internal Audit and the representative from the Counter Fraud service.
- 7.3.3 Assess the External Auditor's work and fees each year and make a recommendation to the Council of Governors with regard to the continuation of the appointment for the remaining period. ~~-~~This assessment should consider a review of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

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- 7.3.4 Review External Audit reports, including the annual audit letter, together with the management response, and monitor progress on implementation of recommendations.
- 7.3.5 Report non-compliance with, or inadequate response to External Audit Reports to the Board of Directors.
- 7.3.6 Consider any reports on the provision of non-audit services made to the Committee by the Director of Finance.
- 7.3.7 Meet with the External Auditors at least once a year, without executive management being present.

7.4 Counter Fraud Service

The Committee will

- 7.4.1 Appoint the Counter Fraud service, set the fee and resolve any questions of resignation and dismissal.
- 7.4.2 Ensure that the Counter Fraud function has appropriate standing within the organisation.
- 7.4.3 Review the Counter Fraud programme, consider major findings of investigations (and management's response), and ensure co-ordination between the Internal Auditors and Counter Fraud.
- 7.4.4 Report non-compliance with, or inadequate response to, Counter Fraud reports to the Board of Directors.

7.5 Financial Reporting

The Committee will review the annual report, annual governance statement and annual financial statements before submission to the Board to determine completeness, objectivity, integrity and accuracy. -The Committee will focus particularly on:

- 7.5.1 Changes in, and compliance with, accounting policies and practices.
- 7.5.2 Major judgemental areas and explanation of estimates or provisions having material effect.

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- 7.5.3 Significant adjustments resulting from the audit and any reservations and disagreements between the External Auditor and management that have not been satisfactorily resolved.
- 7.5.4 The clarity and completeness of disclosure in the foundation trust's financial reports and the context in which statements are made.
- 7.5.5 All material information presented with the financial statements, such as the annual governance statement and forward plan relating to the audit and risk management.
- 7.5.6 The impact of the Trust's Cost Improvement Programme on clinical risk, as assessed through the Quality Impact Assessment process.

7.6 Whistleblowing

- 7.6.1 The Committee is responsible for approving the Freedom to speak up: raising concerns (whistleblowing) policy.

7.6.2 The Committee will review arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

7.7 Information Governance

The Committee will:

- 7.7.1 Review how cyber security arrangements are being managed including appropriate risk mitigation strategies.
- 7.7.2 Review how business continuity relating to IT is being managed including planning for likely scenarios.
- 7.7.3 Consider the adequacy of assurance provided by the completion of the Data Security and Protection Toolkit annually.
- 7.6.27.7.4 Receive assurance of compliance with regulatory standards relating to information governance with any gaps in compliance, controls or assurance identified.

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8. Reporting Responsibilities

- 8.1 The minutes of the Committee shall be submitted to the Board of Directors after each meeting.
- 8.2 The Committee shall make whatever recommendation to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.
- 8.3 The Committee shall compile a report on its activities to be included in the Trust's annual report.
- 8.4 The Committee shall compile a report on its activities to be submitted to the Board of Directors annually within three months of the end of the financial year.

9. Other matters

- 9.1 The Committee shall:
 - 9.1.1 have access to sufficient resources in order to carry out its duties, including access to the Trust Secretary's Office for assistance as required;
 - 9.1.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
 - 9.1.3 give due consideration to laws and regulations and the provisions of the NHS Foundation Trust Code of Governance;
 - 9.1.4 be responsible for co-ordination of the Internal and External Auditors and Counter Fraud through the Director of Finance;
 - 9.1.5 oversee any investigation of activities which are within its terms of reference;
 - 9.1.6 at least once a year review its own performance and terms of reference to ensure it is operating at maximum effectiveness, including consultation with the Council of Governors, and recommend any changes it considers necessary to the Board for approval.

10. Authority

- 10.1 The Committee is authorised:

- 10.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties;

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10.1.2 to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference;

10.1.3 to call any employee to be questioned at a meeting of the Committee as and when required.

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

BOARD OF DIRECTORS	
Meeting date:	27 March 2019
Meeting part:	Part 1
Reason for Part 2:	Not applicable
Subject:	Finance and Performance Committee Terms of Reference
Section on agenda:	Governance
Supplementary reading:	None
Director or manager with overall responsibility:	Pete Papworth, Director of Finance
Author(s) of paper:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required:	Decision
Summary: The Board is asked to review and agree the attached Finance and Performance Committee Terms of Reference. The reporting sub groups have been updated to reflect the name changes of those groups.	
Related strategic objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ✓
Impact on risk profile:	Three financial and performance risks recorded 2018/19 on the risk register for monthly review by Committee

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

The Finance and Performance Committee is a committee established by and responsible to the Board of Directors.

1 MEMBERSHIP

- 1.1 The Committee shall comprise the Director of Finance, the Chief Executive, the Chief Operating Officer, and four Non-Executive Directors. All appointments to the Committee shall be made by the Board of Directors. The Chairman of the Trust may attend any meeting and contribute to the quorum. Any other Non-Executive Director may attend and contribute to the quorum.
- 1.2 The Board of Directors shall appoint the Committee Chairman who shall be a Non-Executive Director. In the absence of the Committee Chairman and/or any appointed deputy, the remaining members present shall elect one of the Non-Executive Directors present to chair the meeting.
- 1.3 Only members of the Committee have the right to attend committee meetings. Any other Director may attend by giving prior notification to the Chairman. The Deputy Director of Finance, Deputy Chief Operating Officer, Director of Improvement and Directors of Operations shall normally attend meetings to provide information to the Committee. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.
- 1.4 It is expected that members will attend a minimum of eight meetings per year.

2 SECRETARY

- 2.1 The PA to the Director of Finance shall act as the Secretary of the Committee.

3 QUORUM

- 3.1 The quorum necessary for the transaction of business shall be 3 members and should include not less than 2 Non-Executive Directors. A duly convened meeting of the Committee at which a

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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 monthly and at such other times as the Chairman of the Committee shall require.

5 NOTICE OF MEETINGS

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

6 MINUTES OF MEETINGS

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

7 DUTIES

The Committee shall:

- 7.1.1 Review in detail, on behalf of the Board of Directors, the financial and operational performance and controls reporting as necessary. This review to include but not be limited to
- 7.1.1.1 overall financial performance
- 7.1.1.2 financial performance of each Care Group, with the facility to request attendance from representatives of the relevant Care Group

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- 7.1.1.3 cash flow, debtors and creditors
- 7.1.1.4 Transformation Programme
- 7.1.1.5 capital spend against plan and resources available
- 7.1.2 Review in detail, on behalf of the Board of Directors, the Trust's compliance against the agreed national and local operational performance targets in line with the NHS Constitution (eg referral to treatments, cancer waits, Emergency Department waits and others as per regulator or commissioner requirements). This review to include but not be limited to
 - 7.1.2.1 NHS Improvement priority targets and progress against agreed trajectories
 - 7.1.2.2 NHS Improvement's Single Oversight Framework
 - 7.1.2.3 priority contractual/local targets
 - 7.1.2.4 directorate level trends, issues and risks in relation to the above area of performance
 - 7.1.2.5 capacity and demand for services.
- 7.1.3 Take decisions on such financial and performance matters that may be remitted to the Committee for decision from time to time by the Board of Directors
- 7.1.4 Keep under review the quality, quantity and timeliness of financial, performance and analytical information provided to the Board of Directors, and recommend any required changes, particularly in response to changes in national requirements on an annual or more frequent basis.
- 7.1.5 Consider the impact of accounting policies for external reporting, taking into account the requirements of Monitor and other appropriate bodies.
- 7.1.6 Keep under review the quality and efficiency of financial and performance analysis, modelling tools and procedures used to ensure the accuracy and relevance of reporting and decision making.

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7.1.6

- 7.1.7 Review the Trust's financial statements and indicate agreement therewith to the Audit Committee
- 7.1.8 Review performance information in Quality Account
- 7.1.9 Oversee implementation of recommendations from internal and external performance related audits
- 7.1.10 Review the Trust's annual financial business plan (incorporating long term strategic financial planning, capital planning and scenario planning), and make recommendations to the Board of Directors.
- 7.1.11 Review the Trust's annual Performance Strategy and Framework and make recommendations to the Board of Directors.
- 7.1.12 Consider and make recommendations and approve actions and business cases to support sustainability or recovery of performance.
- 7.1.13 Approve or reject tenders, contracts and business cases for capital and revenue schemes to the value set out in the Schedule of Delegation of the Board of Directors.
- 7.1.14 Consider and make recommendations to the Board of Directors on tenders, contracts and business cases for capital and revenue schemes which exceed the value set out in the Schedule of Delegation of the Board of Directors.
- 7.1.15 Review and approve Treasury Management policies and investments.
- 7.1.16 Review and approve the policies and procedures in place for ensuring economy, efficiency and effectiveness in the use of resources.
- 7.1.17 If applicable, review and comment to the Board on borrowing against Prudential Borrowing Code and other ratios.
- 7.1.18 Monitor banking arrangements, including approving tenders of banking services.
- 7.1.19 Support the Trust in fulfilling the requirements of the NHS Litigation Authority Risk Management Standards by complying with relevant legislation, national policies and recommendations for sound financial management

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7.1.20 Support the Trust in fulfilling its strategic objective improving quality and reduce harm by focusing on continuous improvement and reduction of waste..

7.1.21 Support the Trust in fulfilling the requirements of its license and commissioner contracts in relation to key performance indicators.

7.1.22 Review relevant areas of the risk register regularly and report appropriately

8 REPORTING RESPONSIBILITIES

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

8.2 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

8.3 The Committee shall compile a report on its activities to be submitted to the Board of Directors annually within two months of the end of the financial year.

9 OTHER

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

10 AUTHORITY

10.1 The Committee is authorised:-

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

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

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11. SUB GROUPS

11.1 The following groups report to the Finance and Performance Committee:-

Capital Management Group

Coding Strategy & Income (CSI) previously PBR Group

Patient Level Information & Costing System (PLICS) previously

SLR Group

Performance Management Group

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BOARD OF DIRECTORS MEETING – 27 MARCH 2019

PART 2 AGENDA - **CONFIDENTIAL**

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

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

Timings		Purpose	Presenter
12.15	1. STRATEGY AND RISK		
	a) Clinical Services Review - Outline Business Case (paper)	Decision	<i>Richard Renaut/ Steve Killen</i>
	This item will be presented to the boards of directors of the Trust and Poole Hospital NHS Foundation Trust jointly although a decision on the Outline Business Case will be made by each Board of Directors separately.		
	The meeting will be adjourned until the public session of the meeting commences at 2pm.		
4.25	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 30 January 2019 (paper)	Decision	<i>All</i>
4.30	3. MATTERS ARISING		
	a) Updates to the Actions Log (paper)	Discussion	<i>All</i>
4.35	4. QUALITY AND PERFORMANCE		
	a) 7 Day Services Board Assurance Framework (paper)	Decision	<i>Ruth Williamson</i>
4.45	5. STRATEGY AND RISK (continued)		
	a) Capital Plan 2019/20 (paper)	Decision	<i>Pete Papworth/ Richard Renaut</i>
	b) Corporate Objectives 2019/20 (paper)	Decision	<i>Debbie Fleming/ Deb Matthews</i>
	c) Annual Plan 2019/20 (paper)	Decision	<i>Pete Papworth</i>
	d) Operational Revenue Budget 2019/20 (paper)	Decision	<i>Pete Papworth TO FOLLOW</i>
	e) Christchurch Fairmile Village LLP (paper)	Decision	<i>Pete Papworth TO FOLLOW</i>
	f) Integrated Urgent Care Service Contract (paper)	Decision	<i>Richard Renaut</i>
	g) Significant Risk Report (paper)	Discussion	<i>Paula Shobbrook</i>
	h) Brexit Planning and Preparedness Update (paper)	Information	<i>Richard Renaut TO BE TABLED</i>
5.45	6. GOVERNANCE		
	a) Sealing of Deeds (paper)	Decision	<i>Karen Flaherty</i>

7. ANY OTHER BUSINESS

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

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!