Poole Hospital NHS Foundation Trust

and

Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust

Joint Boards of Directors Part 1

Wednesday 29 July 2020

09:00 – 11:30

Via Microsoft Teams

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Poole Hospital
NHS Foundation Trust

JOINT MEETING OF THE BOARD OF DIRECTORS PART 1
HELD IN PUBLIC

The next meeting of the Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Boards of Directors, held in public will commence at 09:00 on Wednesday 29 July 2020 via Microsoft Teams.

If you are unable to attend please notify the Company Secretary's Team, telephone 01202 448723.

David Moss
Chairman

Please note that mobile devices and laptops may be in use during the meeting to access papers, record actions and notes as appropriate

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AGENDA – PUBLIC MEETING

09:00	1		Welcome & Apologies for Absence: Donna Parker, Peter Gill	
	2		Declarations of Interest	
	3	Joint	Patient Story	P Reid
	4		**APPROVAL OF MINUTES AND ACTIONS**	
	4.1	PHFT	For Accuracy and to Agree: Part 1 Minutes of the Board Meeting held on 29 January 2020	Chairman
	4.2	PHFT	Matters Arising – Action List	Co Sec
	4.3	RBCH	For Accuracy and to Agree: Part 1 Minutes of the Board Meeting held on 29 January 2020	Chairman
	4.4	RBCH	Matters Arising – Action List	Trust Sec
	5	Joint	Chief Executive's Report	CE
09:20	6		**QUALITY AND PERFORMANCE**	
	6.1	PHFT	For discussion	Integrated Quality, Performance & Workforce Report	COO/MD/DoN /DoW&OD
	6.2	RBCH	For discussion	Integrated Quality, Performance & Workforce Report	COO/MD/DoN/D oHR
	6.3	Joint	For information	PHFT Financial Performance Report: Month 3 & RBCH Financial Performance Report: Month 3	JIDoF
	6.4	Joint	For discussion	PHFT Guardian of Safe Hours Q3/4 & RBCH Guardian of Safe Hours Q3/4	MDs
	6.5	Joint	For information	CQC National Inpatient Survey Results (PHFT & RBCH)	DoN's

	6.6	PHFT	For information	Annual Complaints Report	DoN
	6.7	Joint	For approval	Annual Infection Prevention and Control Report - & Statement of Commitment & IPCC Board Assurance Framework Statement	DoN
	6.8	PHFT	For information	Annual Health & Safety Report	DoN
10:20	**7**		**RISK**		
	7.1	Joint	Update on Covid-19 and Recovery*		COO/ED's
10:45	**8**		**GOVERNANCE**		
	8.1	PHFT	For approval	Charitable Funds Expenditure over £25k	JIDoF
	8.2	PHFT	For approval	Quality Assurance for Responsible Officers and Revalidation	MD
	8.3	PHFT	For approval	Board Assurance Framework 2019/20 – sign off	DoN
	8.4	RBCH	For approval	Board Assurance Framework 2019/20 – sign off	DoN
	8.5	Joint	For approval	PHFT & RBCH Board Assurance Frameworks 2020/21	DoN's
	8.6	Joint	For approval	Quality Strategies and Monitoring Plans for 2020/21	DoN's
	8.7	PHFT	For information	Audit and Governance Committee Annual Report	Co Sec
	8.8	PHFT	For information	Quality, Safety & Performance Committee Annual Report	Co Sec
	8.9	Joint	For information	Finance & Investment Committee Annual Report	Co Sec
	8.10	PHFT	For information	Annual Security Report	COO
	8.11	Joint	For information	PHFT Annual SIRO Report & RBCH Annual Information Governance Report	JIDoF/DoIT

9   Questions from the Council of Governors and the Public arising from the agenda

Governors and members of the public are requested to submit questions relating to the agenda by no later than 26/07/2020 to jill.hall@rbch.nhs.uk.

10   Any Other Business

11   Key points of communication to staff

12   Date and Time of Next Meeting:

The last public Board Meetings of Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust will be Wednesday 30 September 2020.

13   Close of Meeting

14   RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

11:30   15   NB: A glossary of abbreviations that may be used in the Board of Directors papers will be found at the back of the Part 1 papers.

*late paper

POOLE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PUBLIC MEETING

Part 1 minutes of the meeting of the Board of Directors held on Wednesday 29 January 2020 at 12.45pm at The Village Hotel, Deansleigh Road, Bournemouth.

Present:	Mr David Moss	Joint Interim Chairman
	Mrs Jacqueline Cotgrove	Director of Workforce and Organisational Development
	Mrs Debbie Fleming	Joint Interim Chief Executive
	Mr Philip Green	Non-Executive Director
	Dr Calum McArthur	Non-Executive Director
	Mr Mark Mould	Chief Operating Officer
	Mr Stephen Mount	Non-Executive Director
	Mr Pete Papworth	Joint Interim Director of Finance
	Mrs Patricia Reid	Director of Nursing
	Dr Matt Thomas	Acting Medical Director
	Mrs Caroline Tapster	Non-Executive Director
	Mr David Walden	Non-Executive Director
	Mr Nick Ziebland	Non-Executive Director

In attendance:	Miss Nicola Gray	Assistant Company Secretary (minute taker)
	Mrs Carrie Stone	Company Secretary

001/2020   Apologies for Absence

There were no apologies to note. Mr Moss welcomed the governors observing the meeting, Laura Croucher, Wessex Chief Resident and Dr Matt Thomas, Acting Medical Director to the meeting.

002/2020   Declarations of Interest

There were no declarations of interest noted.

003/2020   Patient Story

The patient story was not able to be viewed due to technical issues and it was agreed it would be shown at the next part 1 Board of Directors meeting.

004/2020   For Accuracy and to Agree: Part 1 Minutes of the Board Meeting held on 27 November 2019

The minutes were AGREED as a correct record of the meeting.

005/2019   Matters Arising – Action List

It was NOTED and AGREED that all other matters arising unless subject to this or future agendas had been executed.

006/2020   Chief Executive's Report

Mrs Fleming presented her report and highlighted the following key points:

- Winter pressures – both Trusts had been incredibly busy since before Christmas, and for Poole there had been no respite in the past 12 months. Staff had been working extremely hard and there was significant pressure on staff generally for which the Board should extend its thanks for their hard work during such challenging times. Mrs Fleming noted the long term solution for this was around the Dorset System working, which had its own section within the report.
- CQC inspection – Mrs Fleming noted the expectation that the Trust would receive its final report on Friday 31 January. At this stage any information released was embargoed, but the information which had been received so far had been very encouraging. The full report would be publicly shared once received.
- Dorset Integrated Care System - Mrs Fleming noted the amount of work which had been taking place with partners over the previous few months, advising that Dorset was only 1 of a few systems within the country where there was a system wide financial control total. The finances have become increasingly challenging and it was important to consider all the monies going into Dorset and share it across the system providers in such a way that worked well for Dorset residents. In addition to the finances, the partners within the system had been considering how they held each other to account and how to set up the complex agenda in respect of meetings, governance and working well together. Mrs Fleming noted the development day for Chairs and Chief Executives across the system taking place on 15 February 2020, which Mrs Cotgrove would be facilitating. A focus for the day would be considering the best way to move forward next year to ensure the best was achieved as part of the Dorset Wide transformation.
- Merger – The outcome of the Independent Review Panel had been received, which found there had been the correct consultation, and the CSR should go ahead. Mrs Fleming noted it was important to recognise there would still be a lot of public concern about the changes and there was a need to strengthen the involvement of the public, as well as patients, in the design of services going forward through a number of avenues. Mrs Fleming noted the merger work was progressing well, as was the PTIP. The structure of the organisation was being firmed up which was being shared with those involved.
- Development of the Christchurch site – Mrs Fleming noted it was important for the public to be involved and encouraged governors to stay informed.

Mrs Fleming noted that no matter the amount of work being done, the priority was to deliver safe care every day. This was extremely challenging given the pressure on the Hospital and staff.

Mr Moss noted the Poole governors and Board may not be so well sighted on the Christchurch developments and it was an exciting model of developing a patient village. Mr Moss noted the model had generated capital and revenue income for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH), which was important.

The report was NOTED.

007/2020   Integrated Quality, Performance and Workforce Report

Mr Mould presented the report noting the busy position of the hospital which had been continuous over the last year. The bed occupancy and number of beds open,

compared to the previous year, was considerable higher, which had created a challenging starting point for the onset of winter. Mr Mould noted the focus was primarily on the Emergency Department and it should be recognised the busyness was across the whole organisation and how hard people had been working.

Mr Mould noted the following key points:-

- ED – whilst the department had seen days where they were full with patients plans had been put in place to ensure people were kept well, safe and prioritised. The Trust was working closely with the Ambulance Service and in addition the close working between Poole and RBCH enabled some flexible working to alleviate pressure on the Poole site. Paediatric and Trauma cases were still taken to Poole, received and treated appropriately by Poole, as it was still the major Emergency Department for these categories.
- Additional winter monies had been received and it had been agreed to invest these monies into additional support for the Emergency Department.
- 7 Day emergency Theatres were now in place at Poole. This did not mean there was no access to Theatres for emergencies before. What it did mean was there would be no need to cancel or delay planned surgery to accommodate emergencies, which was the procedure before having 7 day emergency Theatres in place.
- Work on improving pathways had been undertaken, with 300 domiciliary hours of care agreed with BCP council between Poole and RBCH, which would enable discharges to take place more quickly. There was still challenge with patients remaining in beds longer than was needed, but work was ongoing to try and alleviate the position.
- Elective care had been granted some national funding of approximately £320k. A proposal had been put in for approximately £1.2m to reduce down the number of people waiting for over 40 weeks, and although the monies had been welcome, £320k would not solve the problem. 11 patients had waited over 52 weeks, but the Trust was working hard to reduce these waits.
- Cancer referrals had seen an increase of 11% across the service which put pressure on the cancer standards. The standard was to see everyone within 14 days and Poole had prided itself on seeing everyone with 7 days, but with the numbers coming through this was no longer possible. The 62 day standard was coming under pressure. The endoscopy capacity was an issue across Dorset, with a 28% increase in referrals. Poole had held its position very well by adding 6 additional clinics over the weekends in January with circa 120 patients still outside the standard. Compared nationally, Poole was doing remarkably well, but not as well has had been seen in the past. A small amount of investment had been identified and work with RBCH was being undertaken to put plans in place for next year.
- #NOF was seeing an improvement which was good news.

Mrs Reid presented the quality section of the IPR noting the patients being admitted were sicker and frailer than they used to be and were therefore staying in hospital longer. There were an additional 166 patients admitted with flu in December, along with Norovirus on several wards. Mrs Reid noted falls had increased. Mrs Reid reported that, despite all of this, the patient experience was still above the national average and there had been better screening of complaints, with clearer communication.

Mrs Reid reported there had been a patient who had suffered harm from surgery. The patient had been treated by the outsourced surgical team and an investigation was taking place. A further patient had suffered harm from a delay in receiving

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anticoagulation which was also under investigation.

Dr Thomas presented the mortality figures, which were the lowest in the country and recognised the team should be commended for this achievement, given the pressures which had been highlighted by Mr Mould and Mrs Reid. There were seasonal variations but the trends remained the same as previous years. Dr Thomas noted there had been a concern over patients with pneumonia who were anticipated to survive their episode but had passed away. Dr Wood and Dr Wheldon had investigated the cases involved and identified the patients who had died had other conditions which had not been identified through the statistical analysis. This had resulted in the concern around pneumonia. The Trust was undergoing a more in depth review of pneumonia in the hospital by one of the Trust's chest physicians and Dr Wheldon in the near future.

Mrs Tapster noted the Quality Safety and Performance Committee had looked at the length of stay issue and it was agreed that progress in addressing the Length of Stay (LOS) over 21 days would be reported to the Quality Safety and Performance Committee in February or March 2020.   **ACTION: MM/PR**

Mrs Cotgrove presented the workforce section of the report noting the national and local workforce challenges which were well known and the delivery of the CSR proposals which had an impact on staffing. Mrs Cotgrove noted the low vacancy rates, with staff showing signs of being engaged and motivated, and the KPI's had not changed markedly. Turnover was still a concern which was higher than wished and had increased slightly in the current month. Mrs Cotgrove reported there was a drive to understand what was causing staff to leave.

Mrs Cotgrove noted sickness continued to be quite favourable against local and national indicators, despite the slight rise. Appraisals and statutory and mandatory training had risen slightly which was positive, but the Trust remained vigilant around appraisals which was a key method of maintaining relationships with staff in respect of their development and support. The statutory and mandatory training remained below the standard set internally. Mrs Cotgrove noted a computerised system was being introduced to help staff complete their mandatory training.

Mrs Cotgrove noted the staff survey results were due.

Mr Moss noted the low vacancy rate and the good work which had been undertaken around international recruitment. Mrs Cotgrove advised that the international nurse recruitment had started to show benefits and noted the number of Trust doctors appointed. Poole had a lower establishment to begin with than other organisations.

The report was NOTED.

008/2020   Ward to Board Report – Surgery, Trauma and Critical Care

Mrs Reid presented the report, explaining that the Matrons and senior nurses would normally attend to present. Mrs Reid noted, following on from the workforce discussions, the Women, Children and Oncology services had very few vacancies.

Mrs Reid reported that Paediatrics had seen a very busy December with a lot of drivers for this, one being the Bronchiolitis season, a number of patients with mental concerns presenting, with associated long stays within Children's services, with work with CAMHS was underway. Mrs Reid further noted the challenges within ED and the 111 service, getting out of hours GP service which was driving paediatrics through the ED. Paediatric nursing had been increased in ED. There was the aim to

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create a co-ordinator role for the senior nurses to have a good balance between the Children's Assessment Unit and ED and flexing staff appropriately.

Mrs Reid reported that the Maternity Unit had been at full capacity and had been escalated with the use of agency being considered for the first time in 2 years, although this was not required ultimately. This was attributable to the flexibility of staff and willingness of staff to assist when times were challenging.

Mrs Reid provided an update on increase in activity in oncology and the challenge of training nursing staff with chemotherapy skills. There were enough to cover the current position but as the service was growing, so the required number of staff with the skillset needed to increase. Consideration was being given as to how to manage and deliver the day treatments to assist with this.

Mrs Reid noted that despite the challenges, quality remained very good across all three areas.

Mr Ziebland expressed concern for the number of children remaining in the hospital who had mental health problems and presumably no physical reason for being in hospital. Mrs Reid noted some of these children were severely autistic, but additionally there were a growing number of children with eating disorders under the age of 14, which was a challenge. Mrs Reid noted the CAMHS were under significant pressure.

Mr Ziebland asked if CAMHS were part of Dorset Healthcare University Hospitals Foundation Trust (DUHFT). Mrs Reid confirmed they were and the Trust was working with DUHFT through the Mental Health Steering group. Mrs Reid advised had been recognised that the bed base in Dorset was very low compared to the national level with a lot of beds out of area. Mrs Reid noted the position was a concern with pressure being felt within the acute setting.

Mr Green noted ward B4 appeared to be a concern and asked if that was around staffing and vacancy as the cleanliness was low. Mrs Reid noted it was a large ward which was difficult to recruit to but the new establishment had just been determined. There was the trial of a High Dependency Unit because when Poole reconfigured, there would be a Surgical Augmented Care Unit to help with the sicker and frailer patients.

Mr Walden noted the impressive friends and family test results given the pressure the hospital was under. The Trauma nurses vacancies created approximately a quarter of the vacancies across the Trust, and Mr Walden asked what the reference to the joint recruitment drive with orthopaedics was. Mrs Reid noted effectively a 4th Trauma ward had been created due to demand and this immediately raised the vacancies. These patients would have been distributed to other areas, and by the creation of the 4th ward, these patients had been brought together to form a therapy led ward which would utilise a different workforce. Mr Walden asked if the recruitment had already started for this and Mrs Reid noted it had, with HCA's being trained up with some physio therapy skills.

Mrs Fleming noted a report on the reconfiguration of beds would be presented at the March 2020 Board of Directors meeting. **ACTION: MM/PR**

The report was NOTED.

009/2020   Financial Performance Report: Month 9

Mr Papworth presented the financial performance for month 9, noting the following key points:-

- A significant underlying deficit had been set of around £18m which, if delivered, the same amount would be received in sustainability funding to report a balanced position. At the end of third quarter the Trust was marginally ahead of the year to date control total of £122k, which meant the whole of the sustainability funding had been secured to date.
- There had been a reduction of Tier 4 agency in December which was encouraging.
- There were some significant challenges in quarter 4 with a number of financial risks. These include the under achievement of the cost improvement plan forecast for the final 3 months of the year, the continued operational pressures and escalation, which had already been discussed, and the associated premium agency cost. There had been some mitigations identified which were included in the forecast which gave some assurance that the year-end control total would be met and therefore achieve the overall financial plan. Those mitigations included some additional income from the CCG.
- The capital forecast had increased due to a number of helpful national allocations around emergency care, imaging etc. which had improved the forecast by £4.6m.
- Cash remained tight and was being managed to ensure there was enough to see the Trust through to the end of the financial year and beyond.

Mr Papworth noted the report did not do justice for the amount of work which is done daily by operational and clinical managers, who were supporting the transformation and dealing with the operational pressures already discussed, whilst ensuring the services provided were safe and provide quality with person centred care. They were also keeping a good grip on the financial performance which had allowed Mr Papworth to report on the position achieved to date and that the Trust will have secured £18m of sustainability funding. Their hard work should be formally recognised.

Mr Ziebland noted his concern of not spending the capital monies on the old equipment within the Trust, which would have gone some way to addressing the staff morale highlighted in the Story of Now report, and asked why the capital was not being spent on rectifying this. Mr Papworth explained there was a timing issue in respect of the capital spend, but it would all have been allocated and spent by year end. However, Mr Papworth noted this did not detract from the very restraining environment staff were in and it was hoped some of the Long Term Financial Model which incorporated some merger capital spend over the next 6 years, would see some significant capital spend.

Mrs Fleming noted Mr Ziebland's concern as to what was being done about the staffing concerns and noted the actions from the Story of Now would be presented back to the Board in the future and the medical budgets for next year had been picked up. In addition, some charitable funds had been used. Mrs Fleming noted the importance of getting the communication back to staff as to what was being done.

Mrs Tapster noted Mr Atkinson had attended the Quality, Safety and Performance Committee to provide an update on the estates work and the impact of the backlog. It was the communication of this to staff which was very important.

The report was NOTED.

010/2020 **Emergency Preparedness, Resilience and Response Core Standards 2019/20**

Mr Mould presented the report noting the core standards were nationally set and presented annually. The process was put in place to ensure the Trust worked towards those core standards and any new standards which are set. Mr Mould noted the Trust would meet with the CCG to discuss work done to date, standards met and work which was still required. Mr Mould noted the meeting had taken place and the outstanding actions were included in table format within the report. However, the Trust was substantially complaint.

Mrs Tapster noted the spelling error in the mass casualty plan which should state "key patient locations".

Mr Mould reported the Corona Virus was very topical and there was no vaccine at present, with identified cases treated by way of being isolated. The tests which had been carried out UK wide had all been reported as negative. Mr Mould noted the Department of Health and Social Care was providing the latest information to be followed and there was a need to be clear with internal processes. Therefore, an exercise would be carried out to test the readiness and preparedness of the Trust should a case be presented and Poole was leading this work across both organisations.

Dr Thomas noted the perception of the public if they see staff around the Trust in PPE and stressed the communications needed to be clear there was an exercise being carried out.

Mr Mould noted staff would be made aware of the test, although they would not know when or where. In addition, Mr Mould noted a discussion would be needed with Mrs Fleming in respect of notifying the media to avoid sensational headlines. It was agreed consideration would be given to the communication around the forthcoming exercise to test the Trust's response to the new Corona Virus.

ACTION:MM/RM

The report was NOTED.

011/2020 **Charitable Funds Expenditure over £25k**

Mr Papworth presented the report noting he had nothing further to add to the content of the written paper.

Mr Walden noted the move to have an aligned investment strategy for Poole and RBCH.

The Board APPROVED the two charitable award decisions and the reclassification of the Cornelia Suite Ward Fund.

012/2020 **Consultant Revalidation – Responsible Officer**

Mrs Fleming presented the report, noting Dr Thomas had been introduced and the process was to formally appoint Dr Thomas in the role of Responsible Officer.

Mrs Fleming noted a copy of the letter confirming Dr Thomas' appointment as Responsible Officer for the Trust would be sent to Mr Michael Marsh, NHSI South West Regional Team

ACTION: CS

The Board APPROVED the appointment of Dr Thomas as the Responsible Officer.

013/2020 Annual Review of the Effectiveness of Third Party Processes and Relationships

Mrs Fleming presented the report noting it was a timely reminder of the effectiveness, responsibilities and the positive relationships the Trust had with third parties.

Mr Walden noted it may be of some worth to mention by name the Healthcare Safety Investigation Unit.

Dr Thomas noted the need to note the inclusion of other Royal Colleges which the Trust interacted with.

It was agreed the list of Third Parties with which the Trust engaged would be amended to include the national health service investigation unit and with regard to the royal colleges the following to be added, "Included but not limited to…"

ACTION: RM

The report was NOTED.

014/2020 HEG Terms of Reference

Mrs Stone presented the HEG terms of reference noting it was the last of the annual reviews and the tracked changed document provided had been supported by HEG.

The HEG Terms of Reference were APPROVED.

015/2020 Clinical Excellence Awards 2018 & 2019

Mr Walden and Mrs Cotgrove presented the report for the public meeting to note the decision made in the private part 2 meeting at the last Board of Directors meeting.

The report was NOTED.

016/2020 Questions from the Council of Governors and the Public

Mr Bufton asked what the procedure would be if a visitor was found to present in the hospital with Corona Virus rather than a patient. Dr Thomas noted the normal procedures would be followed irrespective of who presented which was the purpose of the emergency preparedness plan and would be no different than visitors who present with flu or norovirus. Mr Mould noted however, if potential visitors were suffering from symptoms, the advice remained and should be reinforced to not visit the hospital.

Dr Croucher noted the discussion around children with mental health presenting to the hospital was part of the current societal lifestyle and the hospital was generally the only option for taking them. Once presented the national guidance had to be followed and this meant they had to be seen the following day. The situation was complex with a great many factors contributing.

017/2020 Any Other Business

There was no further business.

018/2020   Key points of communication to staff

Mr Moss noted the following points for communication to staff:-

- Merger progress
- Winter Pressures
- Bed Reconfiguration
- 7 day Theatres
- Performance and the positive finance position
- The good news from the CQC report in respect of maternity services
- The estates points in respect of capital
- Patient engagement work in development of emergency services

019/2020   Date and Time of the Next Public Meeting

The next public meeting of the Board of Directors of Poole Hospital NHS Foundation Trust was to take place at 8:30am on Wednesday 25 March 2020 at Poole Hospital NHS Foundation Trust.

Members of the public were asked to withdraw from the meeting.

Agreed as a correct record of the meeting:

Chairman_____ Date _____

POOLE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1 ACTION LIST – JULY 2020

Meeting Date	Minute No	Matter Arising / Action	Trust / Lead	Due Date	Update
27/03/2019	58/19	The Standing Financial Instructions would be reviewed in 2020 ahead of the March 2020 Board meeting.	Pete Papworth	Jul-20	The Audit & Governance Committee agreed that the existing SFI's would remain in place until 30 September 2020, to be replaced by new SFI's for UHD.
29/01/2020	012/20	A copy of the letter confirming Dr Thomas' appointment as Responsible Officer for the Trust to be sent to Dr Michael Marsh, NHSI South West Regional Team.	Co Sec	Jul-20	Completed: letter sent after January 2020 Board of Directors meeting
29/01/2020	013/20	The list of Third Parties with which the Trust engages to be amended to include the national Health Service Investigation Unit and with regard to the Royal Colleges the following to be added "included but not limited to…"	Richard Moremon	Jul-20	Completed: after January 2020 Board of Directors meeting

Key:	Outstanding	In Progress	Complete	Future Action

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FUTURE ACTIONS

Meeting Date	Minute No	Matter Arising / Action	Trust / Lead	Due Date	Update
02/03/2016	064/16	It was agreed that a future Board Seminar relating to Pharmacy and medicines optimisation would be useful.	Matt Thomas/ Carrie Stone	Future action	Future Board Seminar
27/07/2016	283/16	Education Strategy - Healthcare scientists would be keen to present to the Board in the future on Succession Planning is a very important topic looking to develop strategies.	Matt Thomas	Future action	Future Board Seminar
30/05/2018 25/07/2018	136/2018 188/2018	A Board Seminar on the medical staffing challenges to be held with an invitation to the Guardian of Safe Hours to attend to provide an update from the Guardian of Safe Hours perspective.	|Matt Thomas / Carrie Stone	Future action	Future Board Seminar

Key:	Outstanding	In Progress	Complete	Future Action

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Minutes of a Meeting of the **Board of Directors** (the **Board**) of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the **Trust**) held in public at 8.30am on **Wednesday 29 January 2020** in the Vision Suite, The Village Hotel, Deansleigh Road.

Present:	David Moss	(DM)	*Chairperson*
	Karen Allman	(KA)	*Director of Human Resources*
	Pankaj Davé	(PD)	*Non-Executive Director*
	Debbie Fleming	(DF)	*Chief Executive*
	Peter Gill	(PG)	*Director of Informatics*
	Christine Hallett	(CH)	*Non-Executive Director*
	Alex Jablonowski	(AJ)	*Non-Executive Director*
	John Lelliott	(JL)	*Non-Executive Director*
	Pete Papworth	(PP)	*Director of Finance*
	Iain Rawlinson	(IR)	*Non-Executive Director*
	Richard Renaut	(RR)	*Chief Operating Officer*
	Cliff Shearman	(CS)	*Non-Executive Director*
	Paula Shobbrook	(PS)	*Director of Nursing and Midwifery/Deputy Chief Executive*
In attendance:	James Donald	(JD)	*Head of Communications*
	Jill Hall	(JH)	*Interim Trust Secretary*
	Anneliese Harrison	(AH)	*Assistant Trust Secretary (minutes)*
	Stephanie Heath	(SH)	*TIA/Stroke Nurse Specialist (for item 4)*
	Deborah Matthews	(DM)	*Director of Improvement and Organisational Development*
	Richard Moremon	(RM)	*Head of Communications, Poole Hospital*
	Dily Ruffer	(DR)	*Governor and Membership Manager*
	Carrie Stone	(CS)	*Company Secretary, Poole Hospital*
	Matthew Thomas	(MT)	*Acting Medical Director, Poole Hospital*
	Ruth Williamson	(RW)	*Deputy Medical Director*
Public/ Governors:	Richard Allen		*Public Governor*
	Colin Beck		*Public Governor*
	Mike Bowen		*Public Governor*
	Derek Chaffey		*Public Governor*
	Howard Fincher		*Public Governor*
	Eric Fisher		*Public Governor*
	Paul Hilliard		*Public Governor*
	Marjorie Houghton		*Public Governor*
	Mark Howell		*Public Governor*
	John Lewis		*Public Governor*
	Keith Mitchell		*Public Governor*
	Kevin Steele		*Public Governor*
	Maureen Todd		*Public Governor*
	Michele Whitehurst		*Public Governor*
	Sandy Wilson		*Public Governor*
Apologies:	Alyson O'Donnell	(AOD)	*Medical Director*

		Action
01/20	**WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**	

There were no apologies for absence or declarations of interest to be noted.

The Chairperson welcomed those attending including Lisa Layton from the CQC and Ruth Williamson who was attending on behalf of the Medical Director. A minutes silence was held in remembrance of Guy Rouquette who had been a public Governor at the Trust.

02/20 **MINUTES OF PREVIOUS MEETING**

(a) Minutes of the meeting held on 27 November 2019 (Item 3(a))

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

03/20 **MATTERS ARISING**

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

The updates to the actions were noted.

04/20 **Patient Story (Item 4)**

Stephanie Heath attended the meeting to present the patient story which focused on the development of the stroke service and the opportunities presented as part of the Clinical Services Review (**CSR**). This included the development of the personalised care operating model from NHS England (**NHSE**) which aimed to promote equality of care by valuing individuals through a personal approach.

Feedback from both staff and patients identified a need for more long term support following a stroke within the community and changes were made to the TIA service to reflect this. The team were also using patient activation measures as a tool to help recognise the different needs of those using services and to support patients with self- management.

As a result of these changes the team had formed better relationships with partner organisations, staff were more informed and there was increased access to resources. A case study highlighted the benefits to one patient who felt overwhelmed and concerned about the future following a TIA however by working with the team and having conversations they were able to shape a management plan.

The Board commended the patient story as a fantastic example of team working and the opportunities created as part of the vanguard and the CSR.

05/20 **Chief Executives Report (Item 5)**

The Board noted the report from the Chief Executive and in particular:
- the continued pressures across both hospitals and thanks to all staff for working together to respond to the high level of demand;
- the update on the work of the Dorset Integrated Care System and the development of the Long Term Plan and the work with partners to address pressures on emergency service and increasing waiting

times for routine care;
- confirmation from the Secretary of State for Health, Matt Hancock, that the implementation of the Dorset Clinical Services Review (**CSR**) can proceed following the outcome of the Independent Reconfiguration Panel decision;
- the positive work towards the merger including the phase 1 review by the Competition and Markets Authority (**CMA**) which was due to be completed by April;
- the first meeting of the Shadow Interim Board who would be supporting the establishment of the new 'East Dorset Hospitals NHS FT';
- the positive feedback received at the recent engagement events from both staff and members of the public about the future plans for the Christchurch Hospital site;
- the continued focus on prioritising safe and high quality care during the transitional period.

It was highlighted that a meeting had also been arranged with the leader of the BCP Council to discuss plans and strategies to help address the current pressures on the Dorset system and strengthen relationships further.

A Non- Executive emphasised that the strategic risks associated with the merger needed to be a clear area of focus for the Shadow Interim Board. Assurance was provided that strategic risks were being considered as part of the work feeding into the Post Transaction Implementation Plan (**PTIP**) and the due diligence work which would provide an overview of the risks across both organisations.

06/20   QUALITY AND PERFORMANCE

(a)   Medical Director's Report (Item 6(a))

The key areas in the report were summarised and included:
- Hospital Standardised Mortality Ratio (**HSMR**) performance remained predominantly within the 'better than expected' range;
- the spike in mortality figures for September resulting from changes in coding practices and data submission rules;
- the improvements made to 30 day post procedure mortality as a result of the learning shared from the Mortality Steering Group (**MSG**);
- the reduction in the number of new clinical claims received in 2019 and confirmation that nine to date had been settled.

Assurance was provided that robust processes were in place for the reporting of mortality data which had been reviewed by the Mortality Steering Group and mortality lead. It was not anticipated that the spike in the data set would be replicated. Patient deaths were also reviewed regularly and data triangulated. Learning was being shared with partner organisations including the Dorset- wide Mortality Steering Group and nationally. Further detail would be provided around the spike in the mortality data following the changes to coding outside of the meeting.

PG

(b)   Trust Board Dashboard (Item 6(b))

The item was noted for information.

(c)   Performance Report (Item (c))

Board members **noted** the performance exceptions to the Trust's compliance with the 2019/20 Single Oversight Framework, national planning guidance and contractual requirements as outlined within the report. The following key themes were highlighted:

- performance against the ED 4 hour standard was 75.1% and actions were in place to support performance;
- a new clinical management structure was in place in ED with additional clinicians to improve patient streaming and clinical assessment including direct admission to AMU and to the Urgent Treatment Centre (**UTC**);
- patient safety was being maintained with the sickest patients being prioritised;
- trust wide Referral to Treatment (**RTT**) performance against the 18 week standard HAD decreased below 80% in December and focus remained on prioritising the longest waiting patients;
- diagnostic performance was below the 99% standard however funding had been received from NHS England for insourcing to support recovery plans;
- the Trust had been recognised as one of the top high volume trusts for the 62 day cancer standard.

Board members raised concerns about the lack of progress being made against the national standards particular for ED 4 hours and elective RTT performance. It was anticipated that RTT performance would recover by March following receipt of national funding which would help reduce the backlog for long wait elective patients and this was already beginning to stabilise. Emphasis was placed on the need to review the Trust's contracted activity for next year in light of the current pressures with demand.

The ED 4 hour target remained challenging and a range of indicators were being considered to replace the current standard which was not currently fit for purpose. The department had seen a significant increase in the volume of patients and was having to adapt to work differently and ensure that resources were being used in the best way. Actions were in place within focusing on streaming patients and increasing the impact of the UTC to help reduce pressures.

Patient safety remained a key priority for the Trust with the sickest patients being prioritised and reviewed on a daily basis. Focus was also being placed on pathways and ensuring that patients were in the right environment for their care. The Trust had also invested in staffing and recruitment of nurses to provide support during peak pressures. During December the ambulance queues were clinically managed which meant that patients were clinically prioritised to promote patient safety. Patient safety themes were also triangulated with key performance indicators, FFT feedback from ED and reviewed by the Healthcare Assurance Committee (**HAC**) to ensure that despite pressures safe, patient care was being provided.

Board members were assured that patient safety remained a high priority for the Trust and commended the depth of the debate and the level of actions currently in place to address performance.

(d) Quality Report (Item 6(d))

The key themes from the report were highlighted:
- one serious incident was reported in December relating to a missed Diabetes diagnosis and learning around glucose monitoring was being shared;
- the Trust's composite CQC Insight report score was rated as Good and was the highest 25% of acute trusts;
- Friends and Family Test (**FFT**) feedback in ED had decreased reflecting the pressures being experienced within the department;
- the CQC had issued a new programme of engagement meetings which would include update meetings and focus groups for core service teams;
- the timeframe for responses to complaints had been aligned with PHFT and the team were currently working through the backlog ensuring that thorough responses were being received.

With regards to the serious incident it was noted that the right processes were in place for the detection of diabetes and the learning had been shared with staff on wards. The MSG would have oversight of any themes identified to ensure that this was not a recurrent issue. Work was also underway to develop prompts for optimal diabetic care through the Electronic Prescribing Record (**EPR**) system.

(e)   Finance Report (Item 6(e))

The key themes from the report were summarised and included:
- the significant underlying financial challenge and deficit set for next year;
- the Trust was in a strong position going into Q3 being slightly ahead of plan supported by an additional £422,000 of Provider Sustainability Funding (**PSF**);
- financial pressures within care groups and the shortfall in the Cost Improvement Plan (**CIP**) were being offset by a non-recurrent investment gain;
- the reduction in agency spend continued during November and December;
- despite the significant challenges the Trust was anticipated to achieve the system control total by the end of March;
- the Trust's cash position remained strong and in line with the capital plan;
- clinical, finance and operational teams were all thanked for their support in managing the current financial challenges.

(f) Workforce Report (Item 6(f))

The key updates from the report were:
- positively the vacancy rate was at 4.1% reflecting the recent focus

on recruitment and retention despite the challenges nationally;
- the Dorset Integrated Care System had recently been recognised in the healthcare people management awards for Nursing degree apprenticeships;
- Essential Core Skill compliance (**ECS**) remained strong and work was underway to develop virtual learning at PHFT ahead of the merger;
- sickness absence performance had decreased and this was reflective of the time of year and staff wellbeing initiatives were being reviewed to support this;
- 60% of front line staff had received the flu vaccination and current initiatives and data collection methods were being reviewed to help drive performance.

The Audit Committee Chair noted that sickness absence performance had been highlighted during discussions had recently raised concerns about sickness absence performance and further assurance was requested around the actions in place in specific hotspot areas in light of the financial impact. This remained a high priority for the Trust and a CIP project was underway across RBCH and PHFT supported by PwC in recognition of the issue.

Six monthly Safe Staffing Report
As part of the Trust's requirement to report on Safe Staffing the following themes from the report were summarised:
- the Trust was compliant with NHS England and CQC guidance;
- ward Staffing Template Reviews had been undertaken and changes implemented within the templates for 2019;
- actions were in place to support the reduction of high cost agency staff usage;
- the robust plans in place to support recruitment and retention for hotspot areas with high levels of vacancies;
- the review of nurse staffing against patient needs has been embedded as part of the Trusts routine methodology providing assurance that ward templates are set at the correct level;
- staff were thanked for their support and working as a team which had been recognised within the positive report.

Board members commended the level of collective leadership demonstrated throughout the winter period particularly in relation to the avoidance of agency staff for ward 14 and the reduction of outliers. Emphasis was placed on the importance of the robust processes in place, which enabled the Trust to avoid red flags and predict and adapt to fluctuating levels of demand.

(g) Progress update on 2019/20 Trust Objectives (Item 6(g))

The Board noted the progress against the 2019/20 corporate objectives. The objectives for the new organisation were currently being considered by the Shadow Interim Board and would be shared with staff to help identify the priorities for the important year ahead.

(h) Winter Plan update (Item 6(i))

Board members received an overview of the progress with the winter plan which included:

- the Trust was in a strong position going into the new year despite the increases in demand;
- focus was being placed on ensuring patients were in the right place for their care;
- the Trust had stepped down elective care in response to the increase in the acuity of patients and volume of demand;
- throughout the pressured period there had been good examples of team working and collective leadership and staff were thanked for their resilience;
- further work was underway with partners to strengthen system working;
- learning would be reviewed and shared with staff to obtain feedback which would be incorporated in the planning for this year.

07/20 **GOVERNANCE**

(a) Leaving Hospital Policy (Item 7(a))

The Leaving Hospital Policy had been updated by to incorporate feedback from all relevant organisations across the Dorset ICS to help support timely discharge of patients from an inpatient/community hospital setting to the most appropriate setting to meet a patient's ongoing needs. The policy promoted a patient centred approach for discharge focussing on early and consistent communication to ensure patients are better informed of their options and to prevent deterioration from longer stays in hospital. The implementation of a fair and transparent escalation process had also been included which would only be enacted when all other options had been exhausted.

It was noted that only a small proportion of patients who were medically ready for discharge had refused to leave the hospital and that the policy was reliant upon packages of care being available which was often challenging. The escalation process would be managed sensitively placing emphasis on the need for patients to be in the right environment but was necessary to help support discharge and capacity.

The Board **endorsed** the policy.

(b) Anti- Slavery Statement (Item 7(b))

The Board **approved** the statement setting out its approach to combatting modern slavery and human trafficking and welcomed the training programme for staff to support identifying potential signs in the future.

08/20 **NEXT MEETING**

The next meeting will take place on **Wednesday 25 March 2020** at **12:45pm** in the Board Rooms at Poole Hospital.

09/20 **ANY OTHER BUSINESS**

There was no other business.

Key Messages for Communication to Staff:

1. Patient Story
2. Update on Winter Pressures
3. Leaving Hospital Policy
4. Anti- Slavery Statement

10/20 COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

The responses provided at the meeting to the questions submitted by governors ahead of the meeting were as follows:

1. Recognising the difficulties faced by patients when expected treatment dates are not met, what is the Trust doing proactively to keep patients informed of progress and likely dates for treatment?

   Patients are able to use the 'choose and book' process and if a suitable appointment is not available they are able to call to identify an alternative appointment which is when the current waiting times are highlighted. Some areas were experiencing very long waits however these were being managed very closely and reviewed every week with regular and proactive contact with patients. It was requested that the contact numbers for appointments by department were displayed clearly on the website for patients.   **RR**

2. The excellent work underway within the ED department to help address pressures was recognised. A proposal was currently being considered by the ED leadership team for the reconfiguration of space within the department which would potentially provide space for more beds in majors and chairs for 'Fit to Sit' patients together with desk space for doctors to access computers.

3. Clarification was provided around the circumstances in which the escalation process for the Leaving Hospital Policy would be applied.

11/20 RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

The meeting adjourned at 10:15am.

RBCH Board of Directors Part 1 Actions January 2020

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
29.01.20	06/20	**QUALITY AND PERFORMANCE**			
	(a)	**Medical Director's Report**			
		Further detail would be provided around the spike in the mortality data following the changes to coding outside of the meeting.	**PG**	**18 March**	Complete. Information circulated to Board members by email following the meeting.
	10/20	**COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC**			
	1.	It was requested that the contact numbers for appointments by department were displayed clearly on the website for patients.	**RR**	**18 March**	In progress.
Key:	Outstanding	In Progress	Complete	Not yet required	

JOINT BOARD OF DIRECTORS MEETING
29 July 2020

CHIEF EXECUTIVE REPORT

1. **Governance Arrangements and Meetings**

Members will be aware that following the outbreak of the Covid-19 pandemic our two Trust Boards suspended their full Board Committee structure until 30 June 2020. This came about in response to (a) Government advice/instructions on unnecessary travel, social distancing and isolation, and (b) in recognition of the numerous challenges facing both organisations, and the need to make best use of staff time.

Over the past few months, essential matters have been considered at monthly private Board meetings via Microsoft Teams. In addition, the Quality, Safety and Performance Committee for Poole Hospital and the Health Assurance Committee (RBCH) have continued to meet as virtual meetings, with a streamlined agenda. The same arrangements have been in place for the Joint Finance Committee, and each Trust's Audit Committee. The Workforce Committees of each Trust were both suspended, with important workforce issues being monitored as part of the agenda for the quality committees.

Throughout this time, bi-weekly briefings have been arranged for the Non-Executive Directors of each Trust, whilst Governors have been kept up-to-date by means of a monthly briefing with the Chair and Chief Executive. In addition, Board members and Governors have received copies of the daily bulletin provided for all staff. A public facing report highlighting the key issues being addressed by the Trust has been placed on the web-site for each organisation at the end of May and at the end of June.

Over the past three months, the Boards of Directors have approved the NHS Improvement Annual Board self-certifications. The Registers of Interests and Gifts and Hospitality have also been updated and added to each Trust's website.

We have kept these arrangements under review, and as the immediate pressures on the Trusts has been reducing, it has been agreed that we should recommence our public Board meetings. The advice to avoid face-to-face meetings still stands so we cannot meet in person. However, measures have been put in place so that they can take place virtually. This month we are holding our first public Boards of Directors meetings.

2. **Covid-19 Update**

I am pleased to report that the number of patients within our hospitals with Covid-19 continues to be very low. At the time of writing, there were only three confirmed patients receiving care across our two Trusts, and none of these patients were in intensive care. To date, we have admitted a total of 388 patients; of these, 109 have sadly died, but 286 (74%) have been discharged.

Risk Assessments for Vulnerable Staff
NHS England & NHS Improvement (NHSEI) have asked that all 'at risk' staff are risk assessed by the end of July 2020. I am able to confirm that across both Trusts, this work is well underway. We are risk assessing all of our staff in a stratified way, prioritising those vulnerable individuals - in particular, our Black, Asian and minority ethnic (BAME) staff, This is a significant work programme involving a large number of individuals and further training for line managers, and as such, at the time of writing, we are still collating the information in terms of risk assessment outcomes.

1

During a recent Shadow Interim Board Development Event, we took time out to listen to the experiences of our BAME staff and to better understand their perspective. Board members reaffirmed their strong commitment to ensuring that equality and diversity are embedded as key values within our new organisation, University Hospitals Dorset NHS Foundation Trust. We shall be working with representatives of our BAME networks to develop our understanding of their lived experience of staff within our Trusts. In this way, we should be better placed to introduce meaningful changes, that will ultimately result in every member of staff feeling valued and appreciated in the workplace.

Performance and Recovery

Whilst there has been a significant impact on performance standards as a result of Covid-19, we have been working extremely hard across both Trusts to reinstate services/activities that were paused during phase 1 of the pandemic.

The Covid-19 Recovery plan continues not only across both Trusts but also in conjunction with other partners across Dorset. We are working to take forwards seven work streams, each established with a Senior Responsible Officer (SRO), plus a clinical and a managerial lead. Each of these work streams has a detailed programme of work, with the leads reporting back to a weekly oversight meeting.

Within our Trusts, we have done extremely well in maintaining urgent cancer treatments, but we are concerned about some of the long waiting times for routine surgery within a number of specialities - in particular, oral surgery, ENT, orthopaedics, urology, ophthalmology, gynaecology and general surgery. Work is underway to address the situation, including ensuring that we make best use of the private sector, which is currently undertaking additional work on our behalf.

Meanwhile, it is important to highlight some key achievements as partners have been working together to "step up" our activity:-

- the continuation of surgical cancer pathways;
- the return of routine orthopaedic surgery;
- the insourcing of a mobile unit for Endoscopy at RBH and agreement on the use of day theatres at weekends to tackle the backlog of cases (although it should be noted that diagnostic waits for endoscopy in Dorset remain an area of significant pressure);
- Poole Hospital continuing to be the highest user of "Attend Anywhere" in Dorset, and the Dorset system being the highest user of "Attend Anywhere" across the South West;
- the completion of a number of key stakeholder appreciative inquiry interviews to inform scoping of the ED and Front Door programme;
- the establishment of the "Home First" Delivery Board;
- the maximising use of Independent Sector capacity;
- the recovery of outpatient activity in Dorset being the highest of all systems in the South West

Work on the Covid recovery programme continues to be the top priority for the Dorset Integrated Care System and for our Trusts as we move forwards.

3. Cancer Patient Experience Survey

The Cancer Patient Experience Survey (CPES) 2019 Report was published in June and I am delighted to inform all members of the very encouraging results. The survey contains 52 questions relating to patient experience, and collectively our trusts scored higher than the expected range for 28% of questions. Furthermore, patients are asked to rate their care on a scale of zero (very poor) to 10 (very good) – for Poole Hospital, the rating was 8.9 and for

RBH 9.0 (both higher than the national average of 8.8). This is excellent news and a real testament to the hard-work and dedication of our teams on both sites.

Both RBH and Poole Hospitals have performed as the top Trusts in Wessex for the past 4 years. Following merger, there will be even closer collaboration of the teams, which has already commenced due to the issues raised by Covid-

4. Update on the Merger

Members will be aware that in April, the Competition and Markets Authority confirmed that we could proceed with our plans to merge our two organisations. Since then, our regulator NHS Improvement (NHSI) has agreed that we might work to a planned date for merger of 1 October 2020. A formal "re-start" meeting took place on 30 June 2020, when the Executive was able to provide an update as to the progress that has been made in the development of our plans, since the outbreak of Covid-19. Since then, NHSI has now formally commenced its merger transaction review and assurance process. A number of individual meetings now underway with both NHSI, and with the Reporting Accountant (Ernst and Young), in line with the programme timeline.

All of the work associated with this transaction is going well, with no major concerns regarding the actions that need to be completed in order to for the merger to take place in October. Our priority is for the new merged organisation to be "safe and legal" on 1 October, which means that we shall be concentrating on completing the changes that are necessary for us to be able to function as one organisation.

It is important to note that whilst there are some actions that will need to be taken before 1 October, there are many things that we are planning to address "post-merger". For example work is already underway to appoint to the new structure, starting with those roles that report to executives on the Shadow Interim Board (known as Tier 2 posts). We expect this group of posts to be appointed by early August 2020, in advance of formal merger. However, we not expecting all the posts at the next level (Tier 3) to be filled before the end of the year.

The Shadow Interim Board has approved the Vision and Mission for University Hospitals Dorset NHS Foundation Trust, along with five strategic objectives. Work is now underway to engage with our staff, governors, stakeholders and members of the public, to agree what should be the values for the new organisation. This is very important, in that it is these values that will shape the future culture and guide behaviours within our new Trust.

Members will also be pleased to learn that the Bournemouth University (BU) Board has now formally approved the partnership between BU and the new University Hospitals Dorset. This is excellent news indeed, and builds on all the work that has been carried out over many years, as the three organisations have developed an effective partnership. We shall continue to work with BU to firm up the future governance arrangements and the Memorandum of Understanding, including the work programmes for our key priority areas.

In summary, there is a great deal of work underway to take forwards our plans to merge, and we expect our new organisation to be formally established on 1 October 2020, which is really positive news. We know that we can serve local people much better as the larger, more resilient University Hospitals Dorset NHS Foundation Trust, and that the merger will bring about huge benefits for patients and staff alike. The new Trust will be better placed than either of its predecessor organisations to recruit and retain staff, and as such, will be much better placed to improve the quality of care provided for our patients

5. Estates / Capital Programme

A great deal of work has been carried out in recent months refreshing the Outline Business Case for the capital that will enable us to create the major emergency hospital and the major planned care hospital. The final document is due to be submitted at the end of July, along with the Capital Investment Appraisal (CIA) model.

Earlier this month, we were delighted to learn that the DHSC Capital Development Committee (CDC) has confirmed that they will support our revised business case for the sum of £201.8m, which is an increase in the total amount of national monies that will be made available to us to support this development. This is the figure that will now be incorporated within our OBC, which means that a smaller sum of money will need to be raised locally. This is great news indeed.

The project team will now be turning their attention to the Full Business Case, which is expected to be completed in March 2021, once we have been able to confirm the Guaranteed Maximum Price for the development.

Meanwhile, the Planning Application for the new Maternity, Children's, Emergency and Critical Care Centre (MCEC) on the Royal Bournemouth site is due to be considered at the planning committee on 23 July 2020 and has been recommended for approval. This is a hugely exciting development, and is described in detail in a new brochure. The new building will include a new purpose built Maternity unit, a new purpose built Children's Unit, a new, large Emergency Department and a new Critical Care Unit (Intensive Care Unit), with capacity for up to 30 beds. As part of our development plans we are also seeking permission to extend the multi-story car park and build a new Pathology hub, which will provide laboratory services for the whole of Dorset.

Environmental sustainability is key to the building and site plans, and the Trust has committed to spending around one million pounds to support the development of more sustainable and healthy travel options. We know that reducing travel congestion is an important priority for the BCP council and for local people, and the Trust is a key partner in this work. We are proud of the fact that the local NHS is leading the way in promoting alternatives to single occupancy car journeys.

The planning application for the Poole Theatres is now registered and is expected to be considered by the end of July.

The planning application for the Christchurch site and the development of the new MacMillan Unit was submitted in March this year, although there is still further work to be done before this can be formally registered. Work is underway with our partners to further develop the site plan, including the provision of a Faith Centre.

6. Developing the Dorset Integrated Care System - "System by Default"

Members will recall that earlier this year, NHS England & NHS Improvement (NHSEI) shared their ambition to fundamentally change the NHS operating environment to be 'System by Default'. In the summer of 2019, NHSEI had been asked to consider where it may be appropriate to provide clarification and guidance to the sector on the operating arrangements of Integrated Care Systems (ICS), to support delivery of the Long Term Plan ambition that all systems should become ICSs by April 2021. In reviewing the situation, they engaged with leaders from across the health and social care landscape, including system leads, trusts chief executives, CCG accountable officers and council leads.

One of the changes introduced from April 2021 was that all systems in England now hold responsibility for two important areas of work within the NHS - system transformation and

system performance. Therefore, NHSEI expected to adopt a "system by default" approach from April 2020, which broadly represents the way in which we have been working throughout the Covid-19 pandemic. Nevertheless, it is important to note this development, as over time, it will mean working very differently. It is planned that from April 2021, all systems should be regarded as fully integrated care systems, which means that in everything that NHSEI do, they will always interact with system leaders as well as individual organisations. More significantly, it means that the plans, business cases and funding allocations for individual Trusts will need to be agreed/approved by the wider system.

The details as to how this will work in practice still need to be worked through - and clearly, this will be a very important matter for consideration by partners within the Dorset system. We have held a number of development events over the past few months, and have been thinking carefully about how we might operate most effectively together to serve local people, taking into account our different roles, responsibilities and areas of expertise. More information about working as a "system by default" will be shared as this becomes available.

7. Latest GP Patient Survey – 2020 results

The GP Patient Survey (GPPS) is an England-wide survey, providing practice-level data about patients' experiences of their GP practices. Members will be pleased to note the results for NHS Dorset CCG.

A total of 21,813 questionnaires were sent out and 9,478 were returned completed, representing a response rate of 43%. Overall, 88% of patients rated their experience of their GP practice good, which is higher than the national average of 82% and a 1% improvement on last year. More detailed information can be found on the Dorset CCG web-site.

8. Welcome back to our volunteers

I am pleased to report that both Trusts' have started to welcome back our hugely valued and highly regarded volunteer community. Usually, hundreds of volunteers help out across our three hospitals, providing an invaluable service in many wards and departments. However, due to Covid-19, the majority of the volunteers had to temporarily "stand down"at the start of the pandemic with many shielding at home.

Now as our hospitals are seeing an increase in the number of outpatients coming in, as well as a return of visitors, a number of volunteers have also made a welcome comeback. At the Royal Bournemouth Hospital and at Poole, volunteers have been really helpful manning the various entrances to the hospital, handing out face masks and hand gel, and assisting with way finding. It is hoped that more and more volunteers will eventually be deployed in different roles and departments across the hospitals.

9. NHS' 72nd Birthday

In the midst of all our hard work in managing Covid, taking forwards the merger and developing our capital plans, it is important to note that on 5 July 2020, the NHS celebrated its 72nd birthday! The NHS birthday is always an important event, but this year, it was particularly poignant, allowing us the opportunity to reflect on what has probably been the most challenging year in NHS history. We were collectively able to pay our respects to all those who have lost their lives, to celebrate the achievements of all our healthcare colleagues, and to say an enormous thank you again, to those who have risked so much to keep us safe. We were all very proud to take part in the special "nationwide clap" at 5.00 pm on 5 July- to applaud the commitment, courage and sacrifice shown by so many.

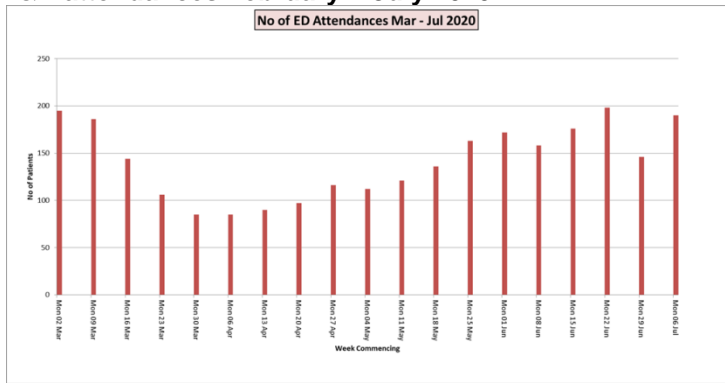**Mrs Debbie Fleming**
Joint Chief Executive

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.1

Subject:	Integrated Performance Report (IPR) June 2020

Prepared by:	Kate Thomas - Performance & Business Intelligence Manager
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To inform the members of the Board of Directors on the performance of the Trust during June 2020.

Background:	Our integrated performance report is published monthly and includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience and operational performance. It gives the public and staff better quality information about the performance of our hospitals in the areas that matter to them. It shows the indicators that are used to measure performance for each of the Trust's operational areas and how well it is delivering its key services.
	
	The IPR is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny.
	
	Over the Month of March and April Trust the focus of the Trust was been redirected to COVID–19 preparations and response including the response to time dependent surgery during increasing demands for critical care capacity creating workforce challenges.
	
	17th MARCH 2020 From NHS England and NHS Improvement
	IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19
	  a. Free-up the maximum possible inpatient and critical care capacity.
	    • Assume that you will need to postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months. However you also have full local discretion to wind down elective activity over the next 30 days
	    • Urgently discharge all hospital inpatients who are medically fit to leave.
	    • Nationally we are now in the process of block-buying capacity in independent hospitals.
	  b. Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
	  c. Support staff, and maximise their availability.
	  d. Play our part in the wider population measures newly announced by Government.
	  e. Stress-test operational readiness.
	  f. Remove routine burdens, so as to facilitate the above.
	
	At the end of April further guidance was received. The **letter from Simon Stevens, NHS Chief Executive and Amanda Pritchard, NHS Chief Operating Officer on 29 April 2020** further sets out priorities for secondary care over the following 6 weeks, including the return to pre-Covid-19 levels of activity in some areas and 'locking in' the beneficial change we have brought about in the last few weeks. The ask for all organisations:
	  – To work with regional colleagues to fully to step up **non-Covid19 urgent services**

	- as soon as possible over the next six weeks. – Make judgements in next 10 days on whether there is further capacity for at least some **routine non-urgent elective care**. – Make full use of all contracted independent sector hospital and diagnostic capacity. – Lock in beneficial changes brought about in recent weeks.

Key points for Board members:	**Operational Performance** **Areas of Board Focus on operational standards** • Impact of Covid-19 on organisation **Emergency Care Pathway:** *Poole Hospital is one of 14 trusts across England testing the proposed new urgent and emergency care standards. Note: During field testing we will be monitoring the new measures so reporting against the 4-hour standard is not be required. Trusts will, however, report performance against Field Testing standards* (since 22nd May 2019) **Operational (Field testing standards)** • Mean time in the department – **201 mins v 200 mins (Target)** • Time to Assessment **– 1 minute v 15 min target** **Internal Care Standards** • Time to triage - 5 mins (target 15 mins) • Time to first clinician seen - 73 mins (target 60 mins) • Time taken to refer/discharge - 121 mins (target 60 mins) • Time waited for a bed - 78 mins (target 60 mins) During April demand for ED reduced to around 50 per cent of usual attendance levels, now rising to around two thirds of normal. **Table 1: No. of A&E attendances February - July 2020** Non-elective activity in Month 3 has increased again from last month in line with ED attendances. All non – elective admissions were down 27.1% compared with the same period last year. **Table 2 : Hospital admissions April 19- June 20**

all Admissions

Referral to Treatment (RTT)
Providers and commissioners are required to plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2020 than in March 2019 14,608 (assuming March 2019 was less than March 2018; which was the case at Poole)

Referral to treatment	June 2020	50.0 %	Qtr. 1	57.7 %
Waiting List Size	Apr 2019	14,608	June 2020	12,768
Incomplete Pathways at 52+ weeks			June 2020	576

- Overall Waiting lists have reduced but over the last few weeks a small increase as more referrals are being received, and elective capacity remains constrained.
- A notable increase is seen in numbers waiting in 26 /40 /52 week time bands
- 52 -week breaches occurring at month end increased to 576 at the end of June 2020 due to cancellation of routine elective surgery in qtr 1 and the focus on clinical priorities as outlined the NHSi /NHSE

DM01 (Diagnostics report)
Less than 1% of patients should wait 6 weeks or more for a diagnostics test.

Total Waiting List	< 6weeks	>6 weeks	Performance
3557	2518	1009	71.4%

Impact of COVID on diagnostic waits due to elective and diagnostic activity reduction as per national requirement resulted in a reduction in performance, but this is now improving in June

Cancer Standards
Six NHS Improvement cancer waiting time targets were met in April. Considerable pressure on the cancer pathways and treatment capacity.

Cancer Standards	May 2020	3/8	62 day (85%)	72.2%
	Qtr 4	6/8	Qtr 4	77.6%

The Opportunity
The COVID-19 outbreak has changed some of the ways we deliver services beyond recognition in the Trusts. New models and innovations have been implemented in weeks, which would have previously taken years. As we live alongside COVID-19 we can expect that the months ahead will not be characterised by the usual V-shaped return to 'normal' which happens after an emergency incident, rather it is likely to be characterised by a series of peaks and toughs. As the scale of the current surge within the Trusts diminishes, we now need to take stock of the transformation which has happened and understand what we want to hold onto / leave behind as we start to transition to a 'new normal'.

Quality, Safety, & Patient Experience

Infection Control

Slight increases in MSSA and C.diff in May and June will be monitored and may represent normal fluctuation.

The trust IPCT continue to work to implement and strengthen the response to COVID-19 including advising on the safe working practices required to move into the next phase of the pandemic and re-start of normal services. Detailed work has commenced to identify cases of hospital attributable COVID-19 which has been flagged as a concern nationally. The trust is submitting data in accordance with the national categories; patients with a positive specimen <= 2 days from admission, 3-7 days after admission, 8-14 days after admission and 15 days or more after admission.

There have been no known cases of hospital attributed COVID-19 during June. Work to progress implementation of the surveillance software ICNet has commenced with an anticipated implementation date of October 2020. This will significantly improve the efficacy and reliability of surveillance and administration of microorganisms in the trust.

The trust continues to work hard to oversee and implement national guidance for control of COVID-19. Work is now underway to undertake a full review of any hospital acquired case of COVID -19 in accordance with national requirements. This data will be published in future editions of the IPR. Given the potential incubation period of up to 14 days it is those cases occurring after 14 days that are of most concern.

Patient Safety : Pressure ulcers
Although there are monthly fluctuations in pressure ulcer incidence there remains a trend for increasing levels of pressure related skin damage. For all categories of pressure ulcers the rate for June is 3.21 per 1000 bed days and the rate of category 3 and 4 pressure ulcers is 0.87. There have been no category 4 pressure ulcers in June. Further national guidance has been released to support the COVID related issues.

Patient Safety : Falls
The overall number of falls has remained consistent with last month although 3 patients sustained moderate or severe harm following a fall. Investigations are underway to identify any learning from these cases.

Patient Experience
At the end of March 2020, NHSE/NHSI advised all providers to suspend FFT data collection and to pause the investigation of any new and open complaints. However, the Trust continues to listen to patients and to give people the opportunity to give their feedback or raise concerns about our services via the Patient Experience Centre. All complaints continue to be acknowledged within 3 working days and a response provided within the agreed time frame with patients.

Support mechanisms for patients remain in place including:
•   A patient parcel drop off point
•   A new dedicated email for family and friends to keep in touch by sending their messages and pictures to their loved one
•   Hand painted pebbles as a way of the family staying connected with the patient, particularly at end of life.
•   Ward based iPads for video messaging has commenced partially whilst awaiting receipt of the appropriate iPad covers.

	Workforce **Turnover** • The turnover rate for June 2020 was 0.63%. • The 12 month rolling turnover rate fell to 12.67% • The rate was 13.23% in May and at the same stage in 2018-19 it stood at 13.84%. **Sickness Absence** • The sickness absence rate for June 2020 was 3.17%. • The 12 month rolling sickness rate stood at 3.84% at the end of June 2020. • The rate was 3.88% in May 2020 and at the same stage in 2018-19 it stood at 3.80%. **Appraisal** • The overall appraisal rate has continued to reduce since March and is now 55% in June. **Statutory and Mandatory Training** • The Trust's mandatory and statutory training compliance rate has continued to reduce since March and is now 82.15% in June.
Options & decisions required:	No decisions required
Recommendations:	**Members are asked to note:** **Operational Standards** • The operational standards delivered and the escalation plans detailed. • Challenges in the system relating to COVID – 19. **Quality, Safety, & Patient Experience Indicators** **Staffing & Organisational Standards**
Next steps:	Work will continue in addressing the actions raised as part of the escalation reports.

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register

Strategic Objective:	**AF1:**Deliver safe, responsive, compassionate, high quality care **AF2:**Attract, inspire and develop staff **AF4:**Ensure all resources are used efficiently, effectively and economically to deliver key operational standards and targets **AF5:** Be a well governed and well managed organisation that operates collaboratively with local partners.
Corporate Risk Register: (if applicable)	**1038 Risk** of failure in achieving National Targets for Emergency Department **1074 Risk** associated with breaches of RTT 18 week standard **1015 Risk** associated with breaches of National Cancer standards (62 day)
CQC Reference:	Urgent & Emergency Care – Responsive /Well led Domain All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	Date
Trust Board	July 2020
QSPC	July 2020
FIC	July 2020
COG	-
SDOP	July 2020
CCG Contracting Group	July 2020
Staff Partnership Forum	July 2020
HEG	July 2020

INTEGRATED PERFORMANCE REPORT

June 2020

The Poole Approach

"Friendly, professional, patient-centred care with dignity and respect for all"

Author: Kate Thomas Performance & Business Intelligence Manager
Executive Lead: Mark Mould, Chief Operating Officer
Title of Report: Performance Report

CONTENTS

During the COVID -19 pandemic NHS Trusts have been directed to reduce mandatory and standard reporting in order to accomodate extra reports and returns to support COVID-19. As a result many returns have been stood down with the exception of constitutional access standards which form the focus of this shorter than usual version of the integrated performance report. Pertinent but reduced sections on Quality,Safety have also been included. Workforce is being reported seperately .

NHS IMPROVEMENT

Executive Lead: Director of Finance

	Jun-20			
	Target	**current Month**	**Current qtr. to date**	**DQAF rating**
Referral to treatment waiting time (18 week standard) for incomplete pathways	92%	50.0%	57.7%	H
Referral to treatment incomplete pathways	14608	12768	12768	H
DM01 diagnostic waits over 6 weeks	<= 1%	28.6%	28.6%	H
A&E : Percentage of patients within the 4 hour target , Poole and MIUs combined *(RAG rated based on 95% standard)*	95%			H

RTT

Number of Incomplete Pathways (bar) measured in 2019/20 against March 19 baseline (14,608) and % waiting 18 weeks or less (line) measured against 92% standard

Bar values: Mar-19 14608, Apr-19 14412, May-19 14451, Jun-19 14426, Jul-19 15104, Aug-19 15259, Sep-19 15103, Oct-19 14808, Nov-19 14925, Dec-19 14869, Jan-20 14450, Feb-20 14282, Mar-20 13752, Apr-20 12526, May-20 12227, Jun-20 12768

DM01

		Total	% up to 6 weeks
Imaging	Magnetic Resonance Imaging	823	80.0%
	Computed Tomography	436	72.2%
	Non-obstetric ultrasound	1382	71.9%
	Barium Enema	-	-
	DEXA Scan	-	-
Physiological Measurement	Audiology - Audiology Assessments	-	-
	Cardiology - echocardiography	211	95.7%
	Cardiology - electrophysiology	-	-
	Neurophysiology - peripheral neurophysiolo	129	100.0%
	Respiratory physiology - sleep studies	0	-
	Urodynamics - pressures & flows	4	-
Endoscopy	Colonoscopy	76	40.8%
	Flexi sigmoidoscopy	192	51.6%
	Cystoscopy	-	-
	Gastroscopy	274	32.5%
Total		3527	71.4%

The Trust is currently engaged in a national pilot study of new ED metrics as a result performance against the 4 hour standard will not be reported from May 2019 until the pilot has been concluded and the results are published.

Cancer targets are as at April 2020

		May-20	**q4**	
Maximum 62 day wait from referral to treatment for all cancers	85%	72.2%	77.6%	H
62 day wait for 1st treatment - consultant screening service	90%	75.0%	86.7%	
31 day wait for 2nd or sub treatment : Anti cancer drug treat	98%	100.0%	98.7%	
31 day wait for 2nd or sub treatment : Surgery	94%	68.8%	95.0%	
31 day wait for 2nd or sub treatment : Radiotherapy	94%	99.2%	96.4%	
31 days wait decision to start of 1st treatment: All cancers	96%	94.7%	98.7%	
2 week wait from urgent GP referral to 1st apt (susp cancer)	93%	98.3%	97.1%	
2 week wait for Symptomatic Breast Patients	93%	90.0%	94.6%	

POOLE PERFORMANCE	Target	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Comparison between May 20 and April 20
Fast Track referral for suspected cancer to 1st appointment	93%	97.2	98.8	98.4	90.2	98.3	▲
2WW - Symptomatic breast referral to 1st appointment	93%	90.9	100.0	92.3	100.0	90.0	▼
31 day - decision to treat to 1st treatment	96%	97.7	99.2	98.8	96.7	94.7	▼
31 day subsequent treatment (surgery)	94%	95.5	100.0	95.7	92.3	68.8	▼
31 day subsequent treatment (anti-cancer drugs)	98%	100.0	100.0	98.8	100.0	100.0	▶
31 day subsequent treatment (radiotherapy)	94%	100.0	100.0	97.6	98.3	99.2	▲
62 day - Fast Track GP/GDP referral to 1st treatment	85%	76.0	76.2	78.5	77.8	72.2	▼
62 day – Screening to 1st treatment	90%	81.5	87.5	92.6	100.0	75.0	▼
62 day - Consultant Upgrade to 1st treatment	90%	76.5	87.5	80.0	92.3	82.6	▼

1

Executive Lead: Director of Finance

Activity levels remained lower than usual (previous years) during June, but recovery in continued in June following the onset of COVID-19 in March and associated government action.

Referrals in June are lower than the same period last year (and year to date) but higher than the previous month. Referrals have now overtaken the number of clock stops / removals and the number of incomplete pathways has grown as a result in June.

For month 3 new and followup **outpatient** attendance levels improved but still less than last year as a result of clincs being reduced. The percentage of non face to face attendances has increased substantially.

Elective activity levels in month 3 overall improved but remain lower than last year as a result of COVID-19. Long waiters will have increased as a result.

Non-elective activity in Month 3 has increased from last month in line with ED attendances.

During April demand for **ED** reduced to around 50 per cent of usual attendance levels. As with other activity areas, there has been a month on month increase but levels are still below the same period in previous years .

All Referrals- starting 01/04/17
Baseline calculated on first 12 values

Year on Year Comparison				
	GP /GDP referrals		All referrals	
Current Month	-1115	-22.59%	-2134	-22.69%
Year to date	-6803	-47.54%	-11725	-42.55%
12 months Rolling	-7127	-12.36%	-11835	-10.81%

— Mean
▲ High or low point
◆ Special cause - concern
– – – Process limits - 3σ
◆ Special cause - improvement
– – – Target

New Outpatient Activity

Total Outpatient Activity

Daycase Activity

Elective Inpatient Activity

Non-Elective Activity

A & E Activity (Poole site only)

June 2020	year to date activity month 3			
	2019/20 actual	2020/21 actual	yr on yr change	%
New Outpatients	22,152	13,120	-9,032	-40.8%
Follow -up Outpatients	37,555	26,975	-10,580	-28.2%
Sub Total	**59,707**	**40,095**	**-19,612**	**-32.8%**
Outpatient Procedures				
New to follow up ratio	1.70	2.06	0.36	21.3%
Daycases (incl RDA)	9,174	3,978	-5,196	-56.6%
Elective Inpatients	860	455	-405	-47.1%
Elective Sub Total	**10,034**	**4,433**	**-5,601**	**-55.8%**
Non elective	9,408	6,862	-2,546	-27.1%
Maternity	1,219	1,314	95	7.8%
Non Elective Sub Total	**10,627**	**8,176**	**-2,451**	**-23.1%**
Elective Excess Bed Days				
Non Elective Excess Bed Days				
Non Elective Non Emer EBDs				
Sub Total				
A&E (incl GP streaming)	18,880	12,046	-6,834	-36.2%
MIU	5,046	2,613	-2,433	-48.2%
Sub Total	**23,926**	**14,659**	**-9,267**	**-38.7%**

KEY PERFORMANCE INDICATORS

**Please note attendances to ED continue to be lower than usual throughout June 2020 although numbers are gradually returning to 'normal'. This was due to the general public being told to stay indoors and socially distance themselves due to COVID-19 from 20 March 2020. Restrictions started to be eased from 11th May in a 3 step process. The second step in relaxation of lockdown occured on 1st June and the third step is expected to take place in early July. **

ED Attendances

4753 patients attended ED in June 2020. This is a increase of just under 500 patients compared to last month (12%). Until May, attendances have been dropping month on month however attendances are increas For comparison, in February this year 5507 patients attended in just 29 days.

GP Streaming

112 patients were streamed from ED to the primary care facility, this is a decrease of 27 on last month (139). This is due to an increase of minors patients being sent to ED ANPs at the UTC and remaining under the care of ED rather than transferring the care to a General Practitioner.

Mean clinician seen time (CST)

The mean CST for this <u>month</u> was 73 and increase of 19 minutes on last month (54) and just outside of the national KPI of 60 mins. (Chart pictured right shows <u>weekly</u> average mean times which have increased throughout June).

Triage time

Average time to triage this month remains very low at 5 minutes . This is well within the 15 min Average Time to Triage KPI. The reason for such a low, sustained triage time is due to the introduction of front door streaming which ensures all patients are seen within minutes of entering ED.

Ambulance Handover times

Average ambulance handover time was 14m 06s, a small increase on last month (13m 30s). This is based on SWAST reported data (W020).

Specialty 'Expected' patients

The department received 83 patients diverted

No of ED Attendances Mar - Jul 2020

Clinician Seen Time (60min target)

Time to Initial Assessment (15min target)

Mean time in Department (200min target)
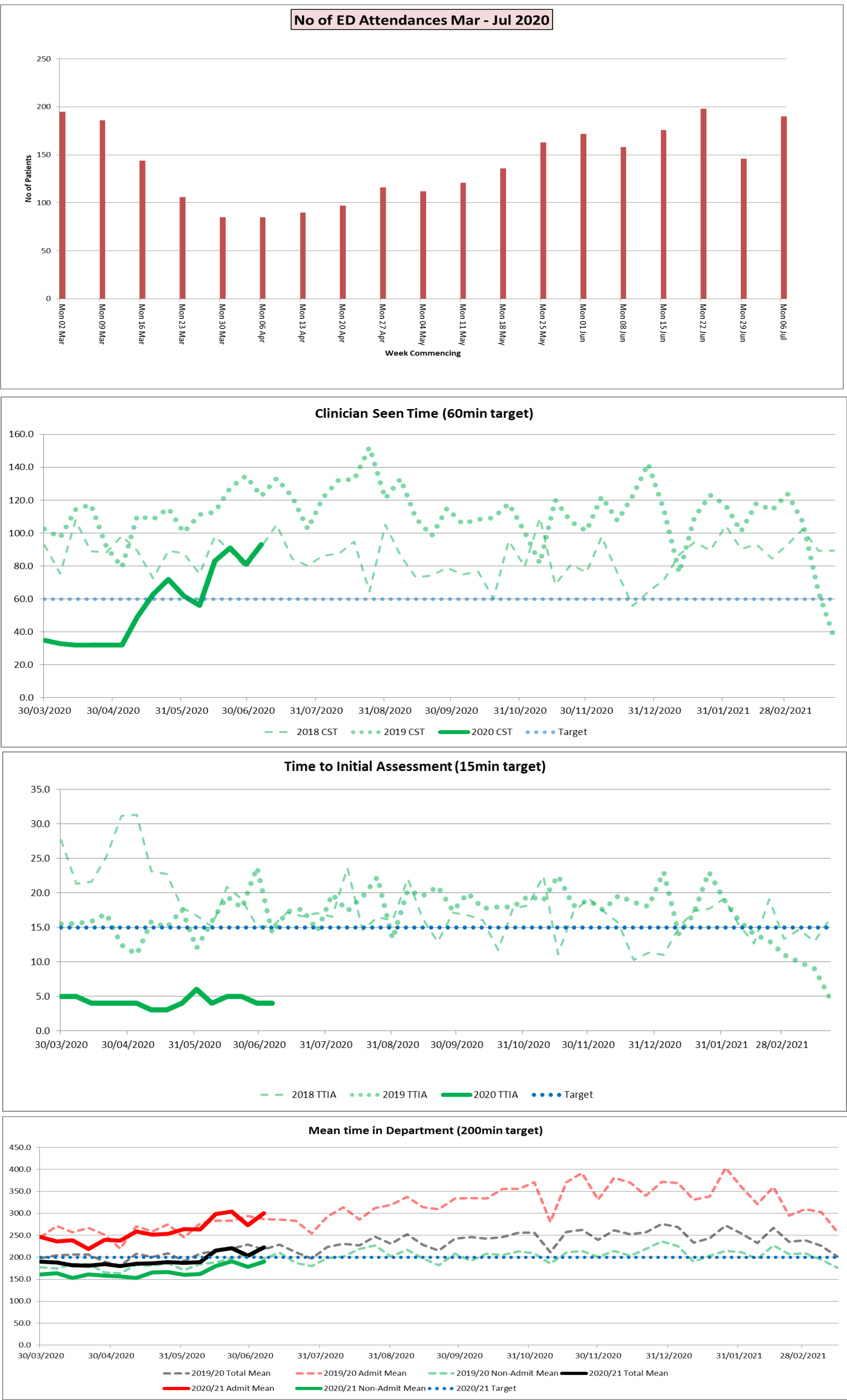
	Target	Month	Qtr
Accident & Emergency		**Jun-20**	**Q1**
Unplanned re-attendance rate (now using unlinked rate)	5%	6.6%	6.4%
Left without being seen rate*	5%		
Time to initial assessment (ambulance arrivals): 95th percentile	15mins	1	1
Time to 1st clinician seen	60mins	73	56
Number of 12 hour trolley waits in A&E	0	0	0

some data items cannot yet be replicated on Hector reports following the upgrade to Symphony

Ambulance		**Jun-20**	**Q1**
Clinical Handovers >30 minutes but <60 minutes of arrival at A&E - Number of patients	0	71	151
Clinical handover >60 minutes of arrival at A&E - number of patients	0	10	13
Discharge			
Delayed Transfers of Care	3.5%		
Patients discharged < 12pm (incl LOS <1)			

The Trust is currently engaged in a national pilot study of new ED metrics as a result performance against the 4 hour standard will not be reported until the pilot has been

3

Emergency Care Pathway

What is driving the underperformance ?	What actions have been taken to improve performance ?

Internal Care Standards

ED patient attendances still remain low throughout June due to the COVID-19 pandemic due to general public lockdown and social distancing. As illustrated in the graph to the right, attendances have continued to increase through May, June and into July. However we are still 24% down on June 2019 when 6241 patients came to ED, in June 2020 just 4753 attended.

As Lockdown and social distancing measures are ease we expect to return to our usual numbers and stay there consistently as we head towards the Winter months.

GP referred patients (expected patients) that were directed into the department have had a increase of 30 patients in June. 83 patients came to the hospital via ED in June 2020. This is still a large reduction on our usual intake, this will be down to GPs keeping as many patients out of hospital as possible during the COVID-19 pandemic.

Due to the steady increase in attendances, the Emergency Department are now beginning to struggle to provide a timely 'clinician seen time' this will continually be reviewed.

Agreed internal care standards continue to be monitired closely as follows:

- Time to triage - **5 mins** (target 15 mins)
- Time to first clinician seen - **73 mins** (target 60 mins)
- Time taken to refer/discharge - **121 mins** (target 60 mins)
- Time waited for a bed - **78 mins** (target 60 mins)

These measures form an overall picture of a patients pathway through the emergency department. There are some clear pressures, specifically witihin the emergency department, with continued extended waits for patients.

No of ED Attendances Mar - Jul 2020

Total GP Expected per Month

Bed Request to Ready (60min target)
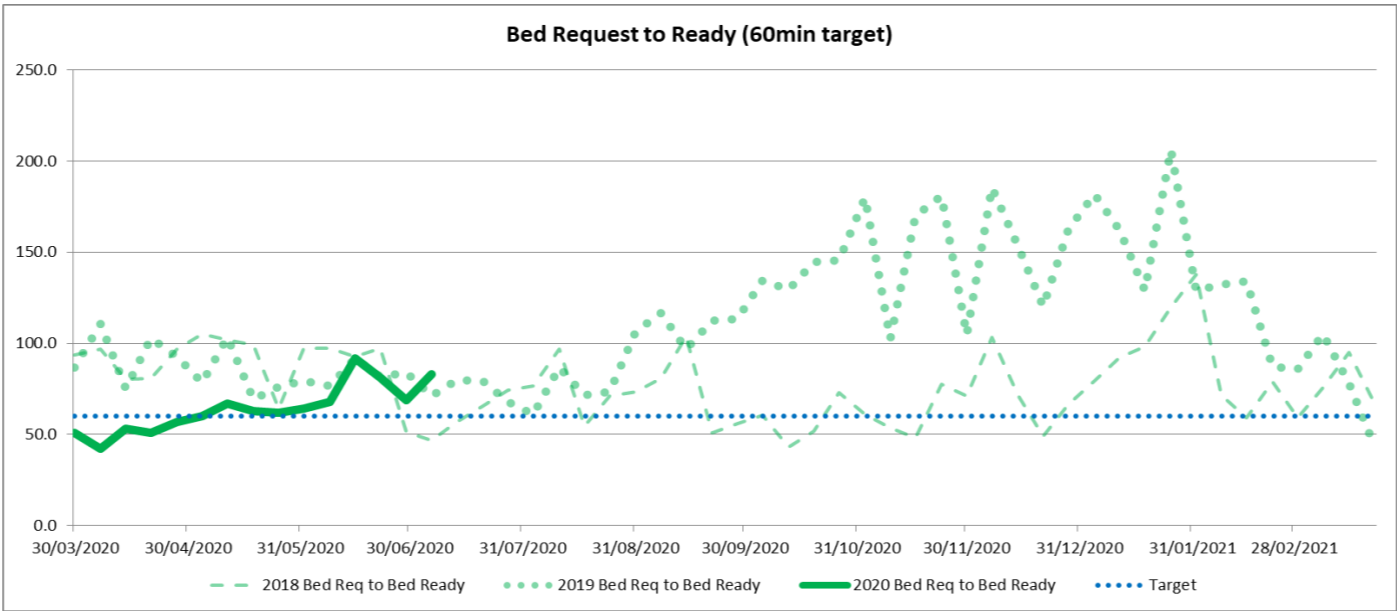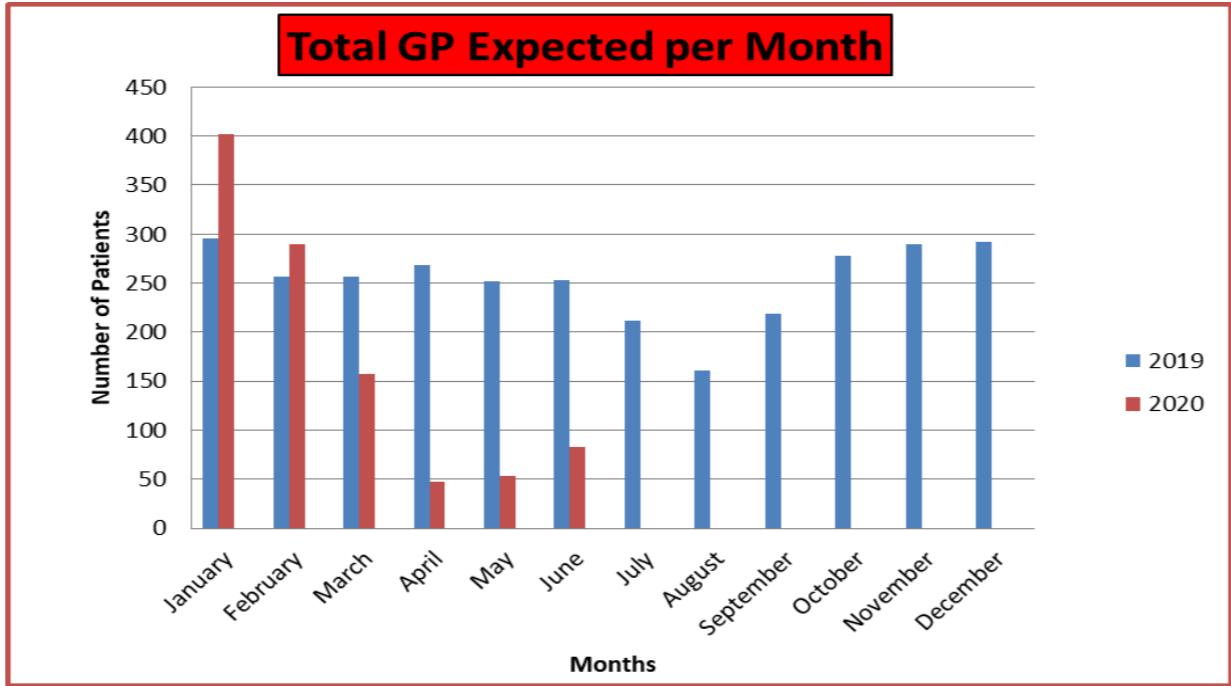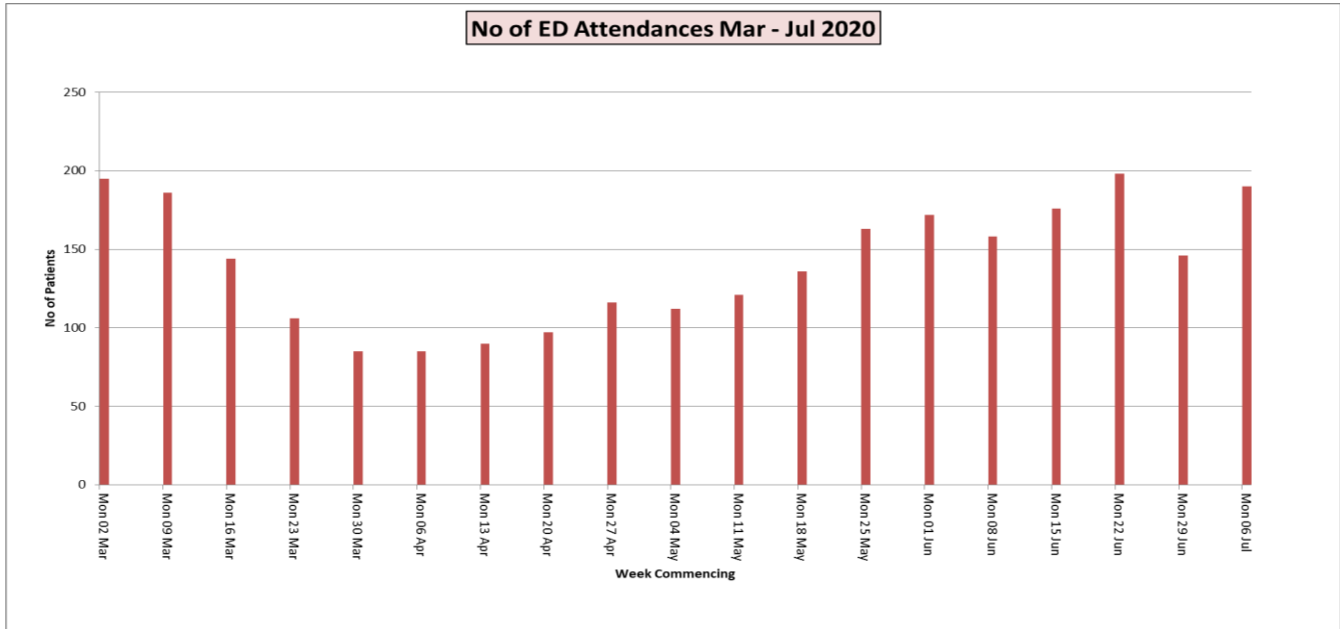
EEarly decision making
ED clinicians have moved from clerking booklets to single page clerking in a bid to improve junior doctor time spent working up patients. A 'Senior review dashboard' located in Majors now provides absolute visibility of patients awaiting review. Pathways are being devolped by both AMU and RACE allowing direct streaming of relevant patients from ED triage.

Improve flow within ED
The minors space has undergone a facelift, converting the curtained trolley/chair area into consultation rooms. This has given each nurse practitioner a dedicated space from which to work with the aim of increased efficiency. There is now an increase in ED staff located in, and working from the Urgent Treatment Centre. This has freed up physical space in ED allowing for safer escalation spaces for 'majors' patients.

Escalation triggers
ED have developed escalation pathways for all key metrics within ED: triage, ambulance triage, clinician seen time. These triggers drive an early response to rising pressure. These have recently been revisited with our consultant body with some alterations and additions in an attempt to make the process more consistent and extra visual triggers have been added to trust-wide dashboards

Urgent Treatment Centre
Work to extend the UTC is complete. The Centre now comprises 8 consultation/exam rooms, a triage room and a treatment room. ED minors has now moved to the UTC in its entirety.

ED Minors to UTC
This is now operational. Patients still walk-in to ED initially and are quickly assessed by ED band 7 nurse practitioners. A decision is made as to whether patients are unwell enough for 'ED Majors' care. If not, patients are sent to the UTC. This provides a more clinically suitable service for patients with minor injuries and ailments.

Overcrowding
Defined as having a full ED majors department sustained for 2+ hours. A data-fed tool has now been developed to provide a consistent 'crowded' trigger driven by real-time metrics. This tool is now live and the ED dashboard will display an alert whenever the ED department is crowded.

Crowding has reduced dramatically since the start of the COVID-19 pandemic, with the majority of days incurring no corridor nursing at all.

Executive Lead	Mark Mould	Trustwide Lead	Mark Major	Author	Toby Mulvey

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Executive Lead: Chief Operating Officer

Trust wide Lead : S Jordan

18 Weeks Referral to Treatment
The Trust failed to achieve the incomplete pathways standard (65.2% against 92% standard) in June . The backlog now stands at 5,139 pathways, an increase on last month .

The Trust was required to ensure that by March 2020 the number of incomplete pathways does not exceed the March 2019 positon (14,608). this was achieved .

52 -week breaches occurring at month end increased to 363 at the end of May 2020.

All activity levels and referrals increased on previous month but remained lower than the same period in previous years in June following the onset of COVID-19 and associated government action in March .

Elective activity levels in month 3 overall improved but remain lower than last year as a result of COVID-19. Long waiters will have increased as a result.

For month 3 new and followup outpatient attendance levels improved but still less than last year as a result of clincs being reduced. The percentage of non face to face attendances has increased substantially.

Elective Demand
Referrals in June are lower than the same period last year (and year to date) but higher than the previous month. Referrals have now overtaken the number of clock stops / removals and the number of incomplete pathways has grown as a result in June.

The recovery plan that was in place is paused in the short term, and restart plans are being developed and deployed .

JAG accreditation scheme In August 2017 a temporary tolerance related to some JAG accreditation standards in support of increasing demand and waiting time pressures on Endoscopy services was given. It has been agreed that the tolerances will continue for a further 12 months until November 2019. This guidance will be reviewed again after

Year on Year Comparison

	GP /GDP referrals		All referrals	
Current Month	-1115	-22.59%	-2134	-22.69%
Year to date	-6803	-47.54%	-11725	-42.55%
12 months Rolling	-7127	-12.36%	-11835	-10.81%

Elective Pathway Indicators

	Target	Month	Qtr. to date or yr if indicated	period
		Jun-20		
18 Weeks - Incomplete Pathways	92%	50.0%	57.7%	year to date
(92% standard and volume of pathways by March 2019)	14,608 pathways	12768		**Jun-20**
RTT Waits of more than 26 weeks		3640		
RTT Waits of more than 40 weeks		1573		
RTT Waits of more than 52 weeks	zero	576	576	year to date
Diagnostic tests >6 weeks	<1%	28.6%		**Jun-20**
Cancelled operations rebooked <28 days	zero			
Urgent operations cancelled 2nd time	zero			
Theatre Utilisation - Main Theatre	85%			
Theatre Utilisation - Day Theatre	80%			

	Target	Actual	Speciality Specific Performance - below standard for Unify specialties
Incomplete Pathways	92% standard	50.0%	The total number of incomplete pathways : 12,768 at 30th June 2020
	14,608 pathways by March 2019	12,768	

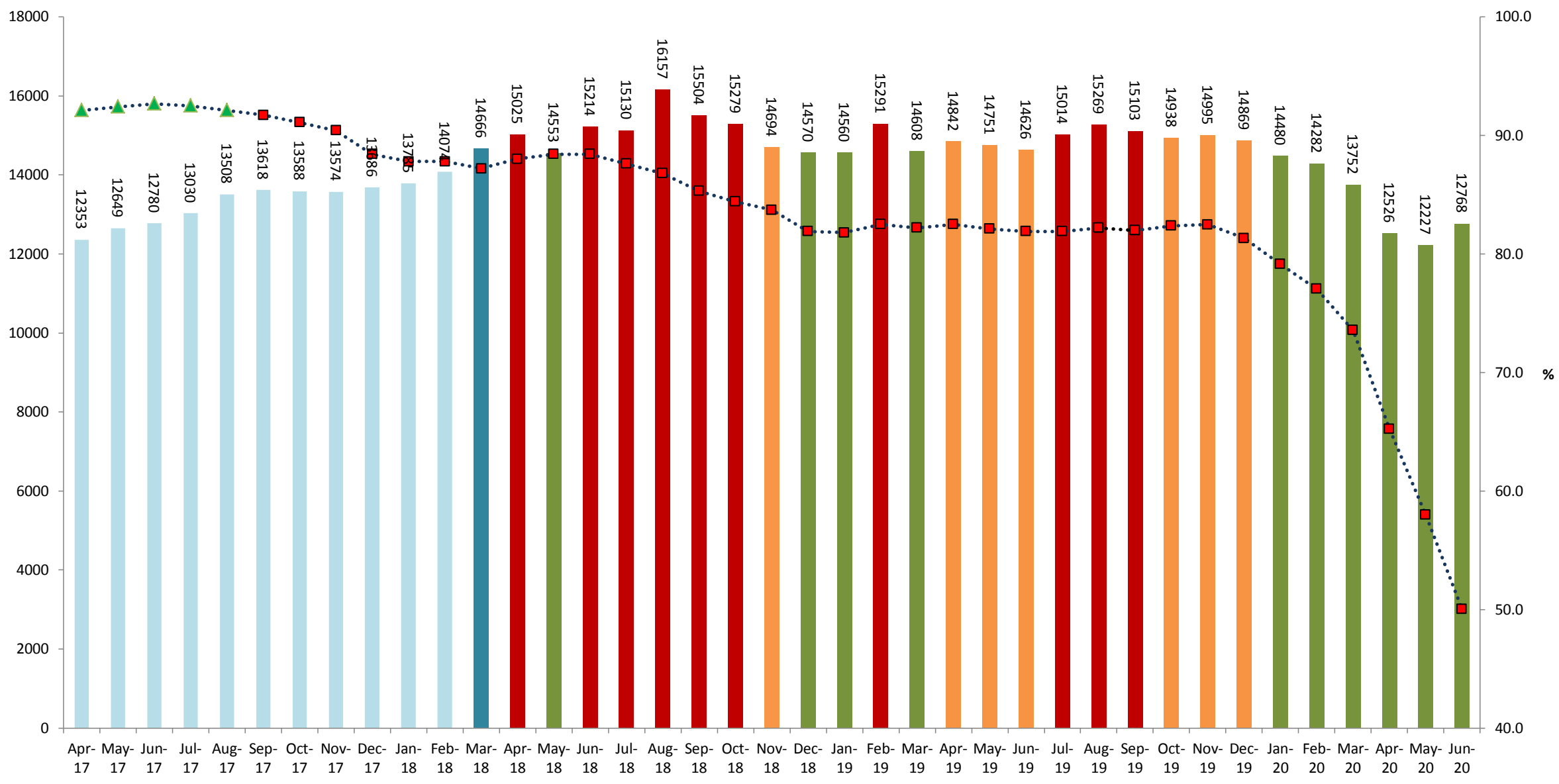**Number of Incomplete Pathways (bar) measured in 2019/20 against March 19 baseline (14,608) and % waiting 18 weeks or less (line) measured against 92% standard**

RTT 18 week backlog
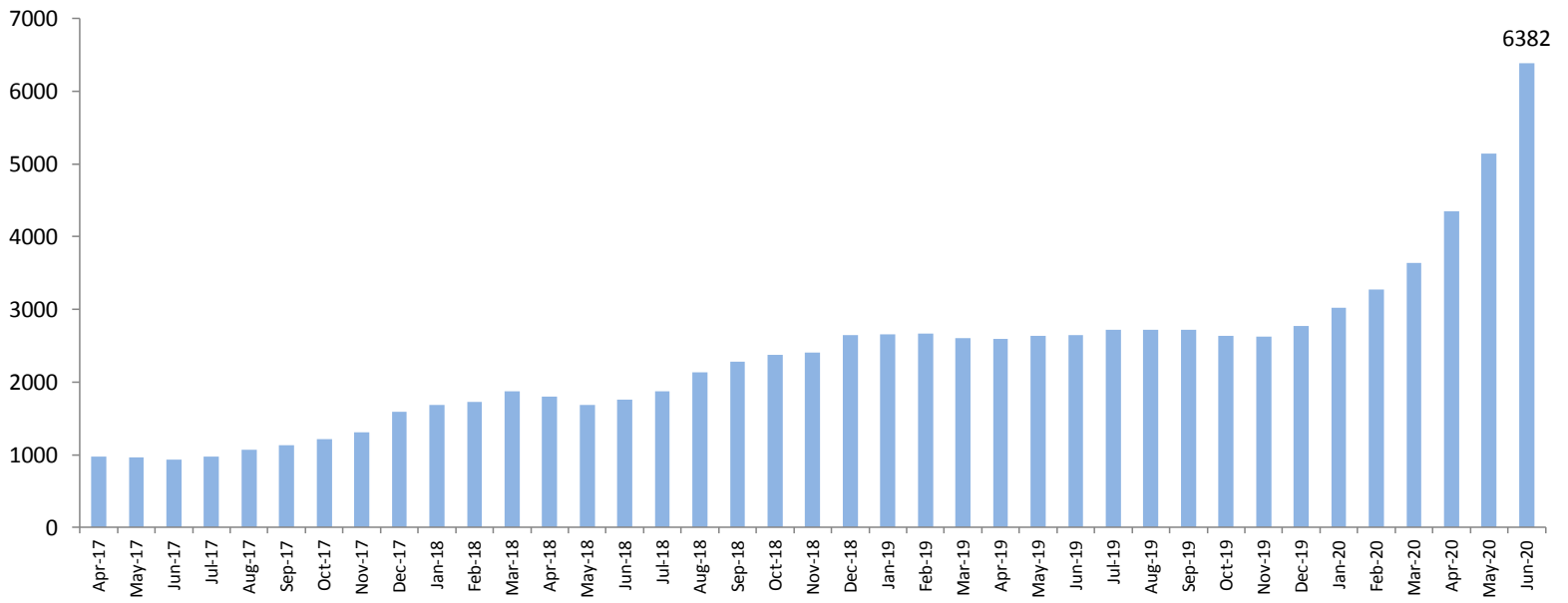
RTT backlog of incomplete pathways

5

Executive Lead: Chief Operating Officer

Trust wide Lead : S Whitney
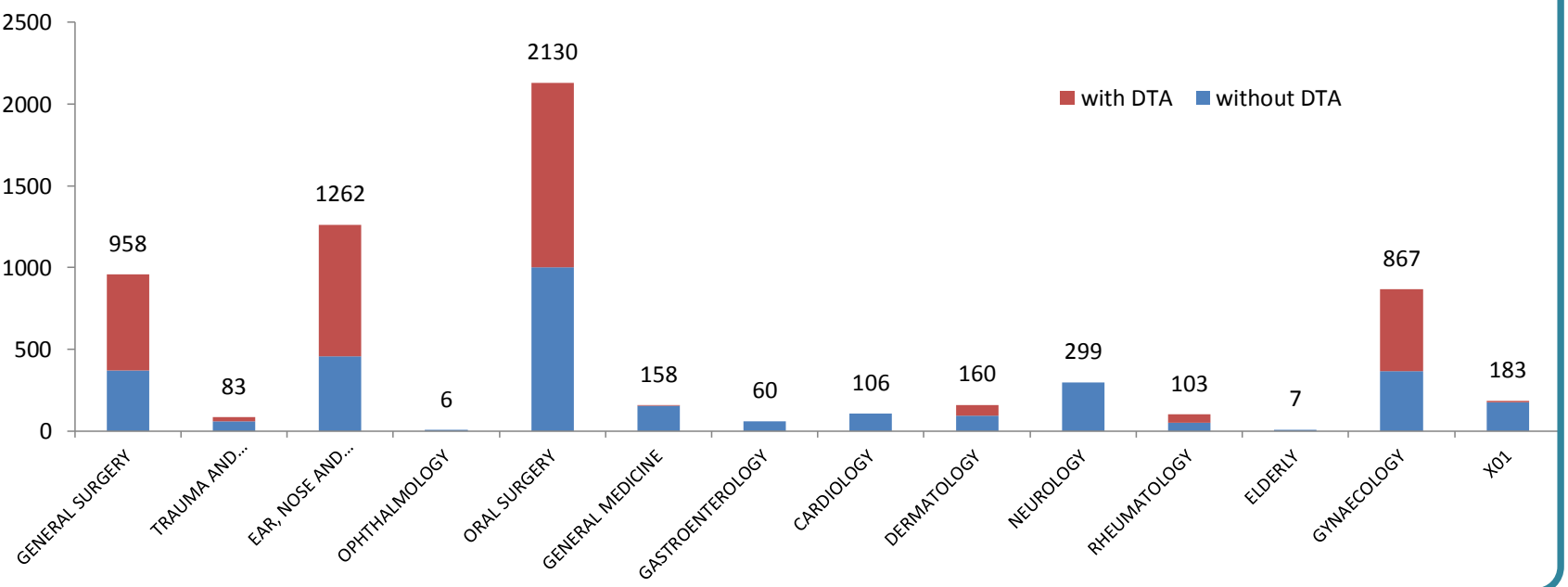
Performance Summary:
May 2020 - Three out of nine NHSI Targets were achieved in the month

62 Day - Fast Track GP/GDP referral to 1st treatment

The standard was not achieved in May 2020 - 72.2% based on 50:50 allocation (72.4% based on 6 scenarios). The limiting factors for not achieving in the month was mainly due to delays within the diagnostic pathway and limited surgical treatment capacity due to Covid-19. We also had a number of patients referred to the Trust for treatment that were late / passed their 62 day target.

Due to the Covid-19 pandemic the majority of patients waiting for either a diagnostic test or treatment have been delayed. Some patients who have been diagnosed with a cancer have received an alternative treatment such as hormone treatment whilst the surgery is on hold which does stop the clock on this pathway. Chemotherapy and radiotherapy are being offered to patients with some treatment plans being amended appropriately given current conditions. Endoscopy restarted sessions at the end of May and the number of patients who were on hold awaiting a diagnostic test in particular colorectal and upper GI referrals reduced significantly (90 colorectal patients on hold at the end of April compared with 19 in July). The majority of patients within the diagnostic pathway now have dates for their investigations, however there are some patients who are still shielding until the end of July. All referrals are being clinically triaged to ensure patients have their investigation in order of priority and urgency. Other diagnostic tests including CT colo's, surgical biopsy and panendoscopy have restarted. Both breast and colorectal screening programmes are still on hold. 2ww referrals did reduce from 9th March, however these started to increase from 20th April. Work has commenced to review site specific pathways identifying bottlenecks and where improvements could be made including what has worked well during the Covid-19 pandemic and what could continue as good practice in the future. RBH and PHT are jointly reporting a weekly Covid dashboard which identifies all patients being tracked on the 62 day pathway. All pathways that are delayed due to Covid-19 are coded, reported and tracked and each are being clinically reviewed regularly.

2ww Breast Symptomatic Standard

The standard was not achieved in May 2020 - 90.0% against a target of 93%. Referral numbers against this standard are low (10). One patient chose not to have an appointment within the 14 day standard.

31 Day Decision to Treat to 1st Treatment Standard / Subsequent Treatment (surgery) Standard

Both standards were not achieved in May 2020 - (31 day 1st treatment 94.7% against a target of 96%, 31 day subsequent surgery 68.8% against a target of 94%). All breaches were due to reduced theatre capacity during Covid-19 pandemic.

62 Day Screening Standard

The standard was not achieved in May 2020 - 75% against a standard of 90%. Treatments numbers were extremely low due to both breast and colorectal screening programmes closed due to Covid-19. One breast patient breached due to having a complex diagnostic pathway.

62 Day Upgrade Standard

The Standard was not achieved in May 2020 - 82.6% against a standard of 90%. Treatment numbers are low against this standard. 3 patients breached the standard, 1 was a late referral from another trust and 2 were due to complex diagnostic pathways.

Overview of 62 Day Referral to 1st Treatment Performance

62 Day Referral to 1st Treatment (50:50 allocation)

	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Poole Performance	77.5	82.3	86.3	84	78.2	83	70.2	76	76.2	78.5	77.8	72.2
Target	85	85	85	85	85	85	85	85	85	85	85	85
Quarter Performance	83.7			83			77.6			77		

Breaches Per Cancer Site

	Breast	Colorectal	Gynae	H&N	Lung	Skin	Urology
No of breaches	1	4	1.5	6.5	2.5	1	1
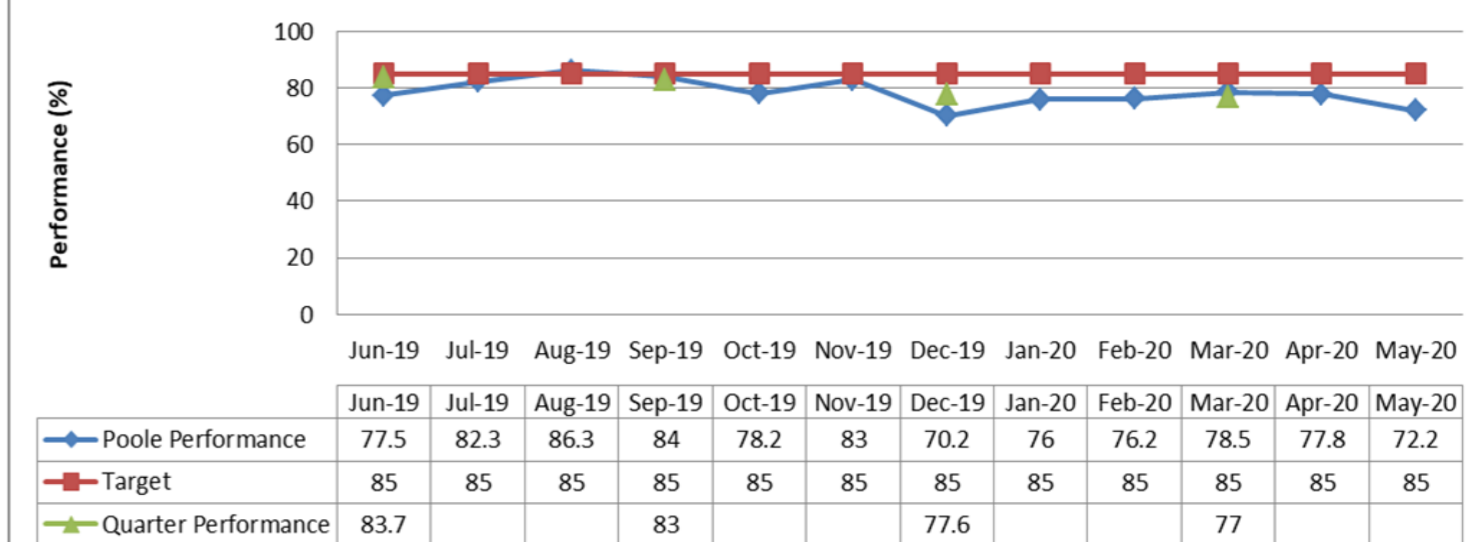
Overview off Performance

62 Day Screening to 1st Treatment

31 Day Decision to Treat to 1st Treatment

31 Day Subsequent Treatment - Radiotherapy

2ww Breast Symptomatic

62 Day Upgrade to 1st Treatment

31 Day Subsequent Treatment - Surgery

31 Day Subsequent Treatment - Drug

2ww Performance
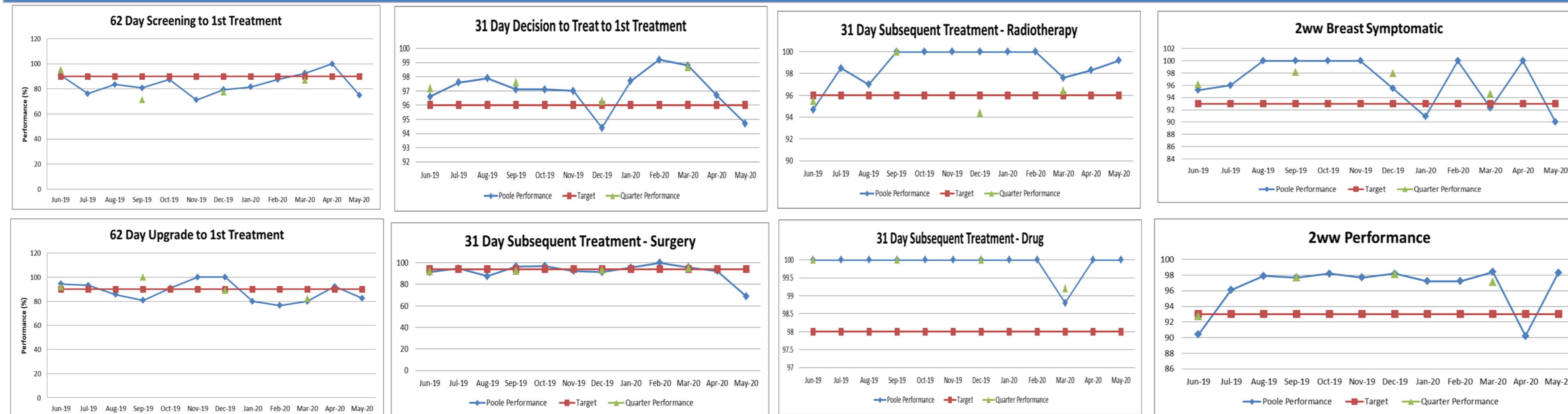
104 Backstop Breaches for May 2020

Joint weekly backstop meetings are now taking place with RBH to discuss all potential backstops.

In May, there were a total of 5.0 (6 patients) breaches who were treated after day 104:-

► 1 colorectal patient treated on day 119 surgery delay due to Covid-19

► 1 gyane patient treated on day 116, late referral from Salisbury Hospital on day 87

► 1 head & neck patient treated on day 109, initially was for surgery but then this was changed to radiotherapy due to Covid-19

► 1 head & neck patient treated on day 109, diagnostic delay due to Covid-19

► 1 head & neck (thyroid) patient treated on day 105, diagnostic delay due to Covid-19

► 1 lung patient treated on day 210, late referral from Bournemouth Hospital on day 178.

Update on Cancer Waiting Times during Covid-19

►As a Dorset system all trusts are working to align with NHS National Guidance to continue to treat patients on cancer pathways.
►National codes are being used across Dorset for any patient's pathway affected by Covid.
►Patient records will document any pathways that are 'on hold' or patients having a 'holding treatment'.
►Each patient is reviewed clinically and discussed through local MDT, ensuring clinical risk and changes to treatment plans are captured and shared with GPs and patients.
►Cancer Nurse Specialists are continuing to support patients via additional telephone clinics during this period.
►Theatre capacity within the Trust is increasing with cancer cases given priority. All Chemotherapy continues to be delivered in the Independent Sector.

6

Cancer Standards

| What is driving the underperformance ? | What actions have been taken to improve performance ? |

62 day Referral to 1st Treatment

Breaches Per Cancer Site

No of breaches	Breast	Colo	Gynae	H&N	Lung	Skin	Urology
No of breaches	1	4	1.5	6.5	2.5	1	1
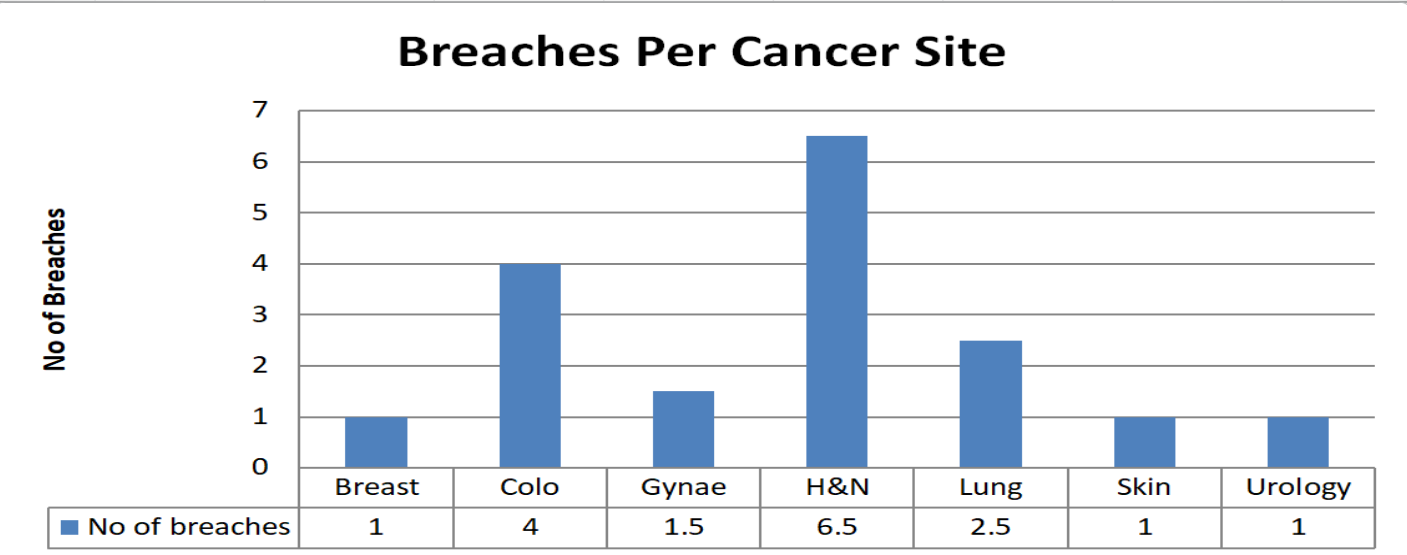
The main breach reasons were:
Covid-19 pandemic:
  - diagnostic delay
  - surgical capacity
  - late referrals from referring trusts
  - complex diagnostic pathways

2ww Breast Symptomatic Referral
There are low referral numbers against this standard (10). One patient chose not to have an outpatient appointment within the 14 day target, there were seen on day 16.

31 Day Decision to Treat to 1st Treatment and 31 Day Subsequent Treatment (Surgery)
All breaches were due to a reduction in theatre capacity due to Covid-19.

62 Day Screening
Treatments numbers were extremely low due to both breast and colorectal screening programmes closed due to Covid-19. One breast patient breached due to having a complex diagnostic pathway.
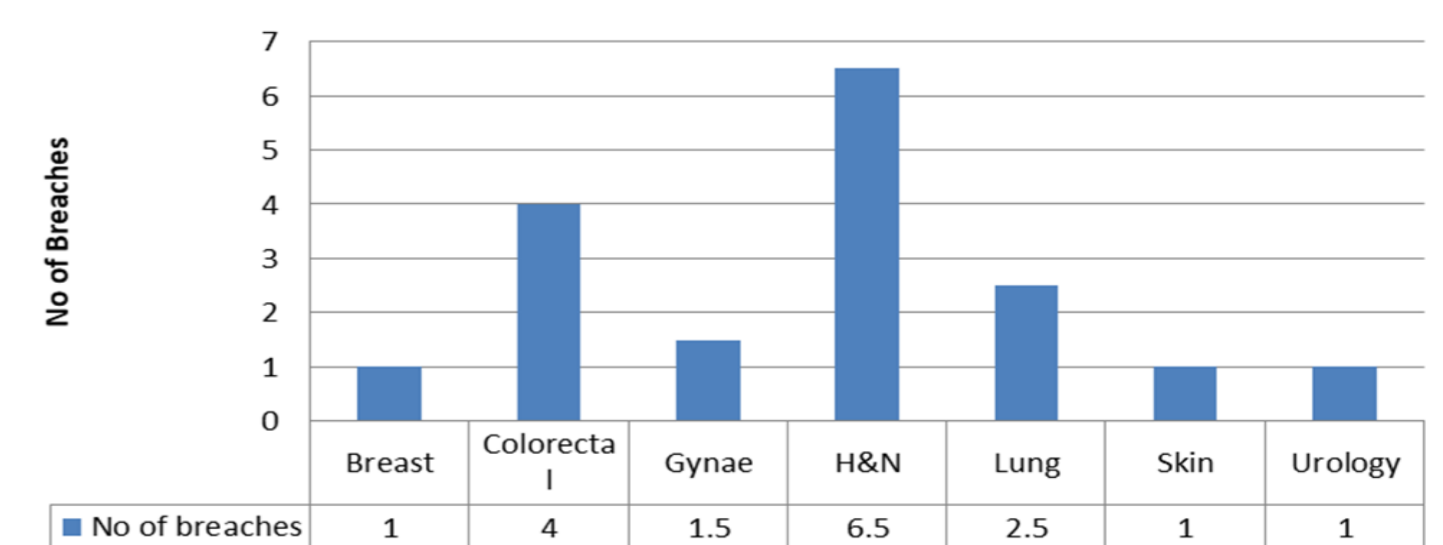
62 Day Upgrade
Treatment numbers are low against this standard. 3 patients breached the standard, 1 was a late referral from another trust and 2 were due to complex diagnostic pathways.

POOLE PERFORMANCE	Target	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Comparison between May 20 and April 20
Fast Track referral for suspected cancer to 1st appointment	93%	97.2	98.8	98.4	90.2	98.3	▲
2WW - Symptomatic breast referral to 1st appointment	93%	90.9	100.0	92.3	100.0	90.0	▼
31 day - decision to treat to 1st treatment	96%	97.7	99.2	98.8	96.7	94.7	▼
31 day subsequent treatment (surgery)	94%	95.5	100.0	95.7	92.3	88.8	▼
31 day subsequent treatment (anti-cancer drugs)	98%	100.0	100.0	98.8	100.0	100.0	▶
31 day subsequent treatment (radiotherapy)	94%	100.0	100.0	97.6	98.3	99.2	▲
62 day - Fast Track GP/GDP referral to 1st treatment	85%	76.0	76.2	78.5	77.8	72.2	▼
62 day – Screening to 1st treatment	90%	81.5	87.5	92.6	100.0	75.0	▼
62 day - Consultant Upgrade to 1st treatment	90%	76.5	87.5	80.0	92.3	82.6	▼

Recovery Actions:

Weekly Site Specific PTL meetings continue via MS Teams with good attendance from relevant managers. All patients on the site specific PTL are reviewed and actioned in accordance with the escalation policy. Weekly joint backstop meetings with Bournemouth have commenced and are proving to be successful in pulling patients through their pathway to avoid further backstops.

A collection of reports are now available via a dashboard. This has been made available to managers at Poole. The reports include site specific performance against all CWT standards, 2ww reports and reports showing diagnostic delays for patients affected during the Covid-19 pandemic.

We were able to utilise a medical student to review a couple of cancer pathways including aligning the pathways with Bournemouth. Unfortunately we only had the medical student a few weeks, however we are reviewing the findings from the work he was able to complete jointly with Bournemouth to help us identify bottlenecks and alignment of pathways across both Trusts.

Site specific services are reviewing different ways of working that worked well during the Covid-19 pandemic and what could continue as good practice. The skin service have set

Current service provision:

Panendoscopy /biopsy capacity continues to only be available on an urgent basis in the treatment centre or/and in surgical setting depending on the severity. All cases are prioritised on a clinically urgent basis. All OMF referrals are currently being sent to Poole, and are either virtually or telephone triaged by clinicians. There are also a number of see and treat clinics in place for appropriate patients. Endoscopy Service restarted sessions at the end of May running at approximately 50% capacity, however this continues to increase for the majority of endoscopy procedures, the backlog of OGD requests is taking a little longer due to the delays between each procedure due to Covid-19. Cases are clinically prioritised.

Radiology restarting a 7 day service, working with the private sector to work through backlog of current patients.
Surgery are currently operating 2 harbour all day lists each day to support urgent elective and cancer activity on a green site. The PHFT theatres are providing up to 3 all day cancers lists each day. All cases are prioritised by the specialty teams and discussed at a weekly clinical prioritisation meeting.
Chemotherapy and Pharmacy continue to deliver a reduced service from The Harbour. Review of service underway to look at options to increase the service to meet the patient numbers.
Radiotherapy continues to run as normal and working to accommodate changes in fractions and treatments with current Covid pathway delays.

2ww referrals continue to increase following the reduction due to Covid-19. Head & Neck, Breast and Skin have seen the biggest increases. Gynae fast tracks have also increased over the past few weeks and additional PMB clinics have been set up.
Skin Service have been running a one stop service, where a patient will be seen in clinic and will be treated on the same day if appropriate. This was initially to reduce the number of patient visits to the hospital during Covid-19, and this will continue as good practice.

| Executive Lead | Mark Mould | Trustwide Lead | Sue Whitney | Author Sian Wliiams |

Executive Lead: Director of Nursing and Patient Services / Medical Director

Trends

Quality Indicators

	Target	Month	year to date	Forecast
		Jun-20		
Discharges with 2 or more ward moves				
Discharges with 2 or more ward moves out of hours (sub set of above)				
Infection Control - MRSA	=<1	0	0	(YE)
Number of Never Events	0	0	2	Apr-20
Number of serious incidents (incl falls)	0%			
Ward transfers out of critcal care				
Ward transfers out of critcal care 4pm to 8pm				
Ward transfers out of critcal care 8pm to 10pm				
Ward transfers out of critcal care 10pm to midnight				
Ward transfers out of critcal care midnight to 8am				
Total				

Infection Control Commentary:

A consistent picture with key alert organisms was seen in June.

The trust IPCT continue to work to implement and strengthen the response to COVID-19 including advising on the safe working practices required to move into the next phase of the pandemic and re-start of normal services. Detailed work has commenced to identify cases of hospital attributable COVID-19 which has been flagged as a concern nationally. The trust is submitting data in accordance with the national categories; patients with a positive specimen <= 2 days from admission, 3-7 days after admission, 8-14 days after admission and 15 days or more after admission.
There have been no known cases of hospital attributed COVID-19 during June.

Infection Control-Count of Ecoli bacteria occuring in hospital starting 01/04/17

Infection Control-MSSA starting 01/04/17

Infection Control-Count of C diff ocurring in hospital starting 01/04/17

8

Executive Lead: Medical Director   **Operational Lead : D Richards**

Commentary & Trends
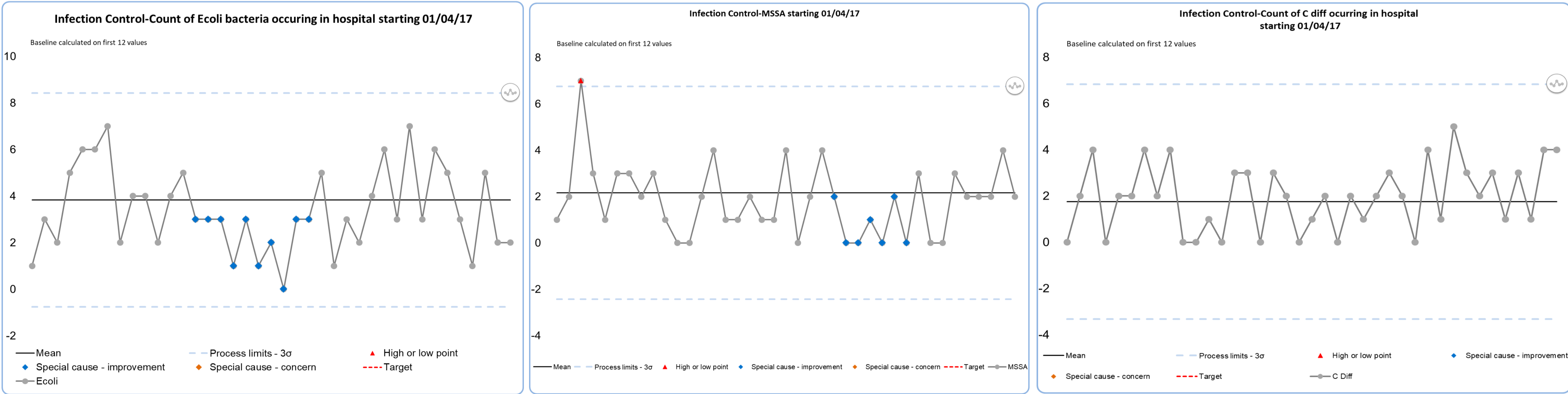
Scorecard - Falls and Pressure Ulcers   Apr-19 to Jun-20

| Description | Most recent value Apr-19 to Jun-20 | Historical trend | Variation |

Falls

Apr-19 to Jun-20

Number of Falls in inpatient areas both as an overall number and per 1,000 occupied bed days.

The rate per 1,000 bed days is RAG-rated red if it is over 7.

69

5.98
per 1,000 bed days

Wards where number of falls exceeds threshold for concern. Total / (per 1,000 bed days)

Lulworth 14 (20.2)   Stroke Care Unit Rehab 4
RACE 6 (14.0)   (12.6)
A5 6 (7.8)   A4 4 (7.8)
AMU 5 (8.1)   C2 Trauma 4
B5 4 (23.8)   B4 3 (4.8)
B3 4 (14.3)   Lytchett 3 (4.3)

Falls with harm

Apr-19 to Jun-20

Number of Falls in inpatient areas that resulted in harm to the patient both as an overall number and per 1,000 occupied bed days.

The rate per 1,000 bed days is RAG-rated red if it is over 0.2.

3

0.26
per 1,000 bed days

Wards where falls with severe/moderate harm occurred. Total number

Stroke Care Unit Rehab 2
Sandbanks 1

Acquired Pressure Ulcers

Apr-19 to Jun-20

Number of Pressure Ulcers acquired at the trust in inpatient areas, both as an overall number and per 1,000 occupied bed days.

37

3.21
per 1,000 bed days

Wards with most acquired PUs last month. Total / (per 1,000 bed days)

Critical Care 4 (46.0)   Lulworth 3 (4.3)
A4 4 (7.8)   ACU 2 (14.2)
Forest Holme 3 (20.5)   B3 2 (7.2)
Sandbanks 3 (9.2)   AMU 2 (3.3)
RACE 3 (7.0)   Lytchett 2 (2.9)
E3 3 (4.6)

Acquired Pressure Ulcers Grade 3 & 4

Apr-19 to Jun-20

Number of Grade 3 and Grade 4 Pressure Ulcers aquired at the trust in inpatient areas, both as an overall number and per 1,000 occupied bed days.

10

0.87
per 1,000 bed days

Wards with Grade 3 / 4 acquired Pressure Ulcers. Total number

Grade 3   Grade 4
A5 2   No Grade 4 PU's
Critical Care 2
E3 2
A4 1   Unstageable
Lulworth 1
Sandbanks 1   No unstageable PU's
Postnatal 1

Falls –The overall number of falls has remained consistent with last month although 3 patients sustained moderate or severe harm following a fall. Investigations are underway to identify any learning from these cases.   The overall rate of falls per 1000 bed days is 5.98. The trust is participating in the National Audit of In-patient Falls with an action plan in place to address key learning including compliance with post-fall care. In June over 100 staff received 'tool box' training at ward level to support this work.

Pressure ulcers – Although there are monthly fluctuations in pressure ulcer incidence there remains a trend for increasing levels of pressure related skin damage. For all categories of pressure ulcers the rate for June is 3.21 per 1000 bed days and the rate of category 3 and 4 pressure ulcers is 0.87. There has been no category 4 pressure ulcers in June. The requirement to prone patients in critical care as part of the management of COVID-19 has seen a rise in pressure damage related to close fitting face masks and respiratory equipment. The tissue viability nurse is linking with critical care to ensure optimum prevention strategies are in place in this high risk area. The trust has made a significant investment in hybrid pressure relieving mattresses this year which will provide wards with high risk patients a higher specification of mattress immediately on admission.

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WELL LED : Staffing and Organisational Development (1)

Executive Lead: Director of Human Resources and Organisational Development

Commentary & Trends

Turnover

The turnover rate for June 2020 was 0.63% , the monthly rates are plotted in the SPC chart (right).

The 12 month rolling turnover rate fell to 12.67%
The rate was 13.23% in May and at the same stage in 2018-19 it stood at 13.84%.

Poole Hospital Workforce - Turnover (monthly)

Sickness

The sickness absence rate for June 2020 was 3.17% , the monthly absence rates are plotted in the SPC chart (right).

The 12 month rolling sickness rate stood at 3.84%. in June 2020
The rate was 3.88% in May 2020 and at the same stage in 2018-19 it stood at 3.80% .

Poole Hospital Workforce-Sickness Absence

10

Executive Lead: Director of Human Resources and Organisational Development

Commentary & Trends

Appraisal

The overall appraisal rate at the end of June 2020 fell to 55% against a target of 95%.
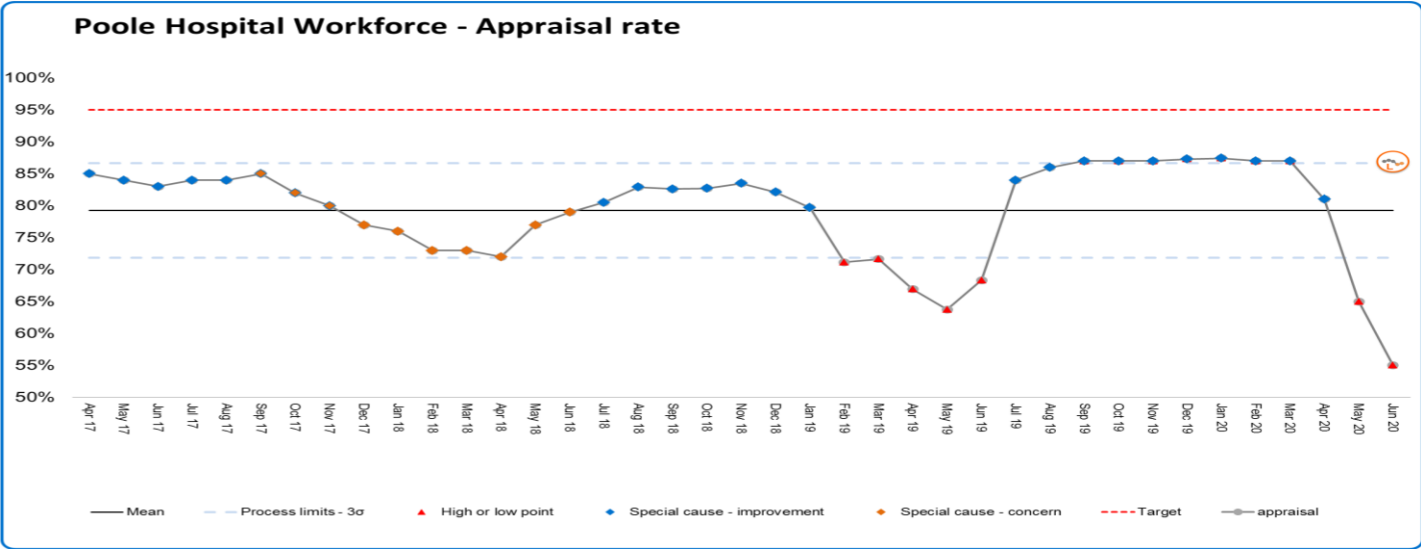
Poole Hospital Workforce - Appraisal rate

Statutory and Mandatory Training

The Trust's mandatory and statutory training compliance rate in June 2020 was 82.15% against a target of 90%.

Poole Hospital Workforce - Statutory and Mandatory Training
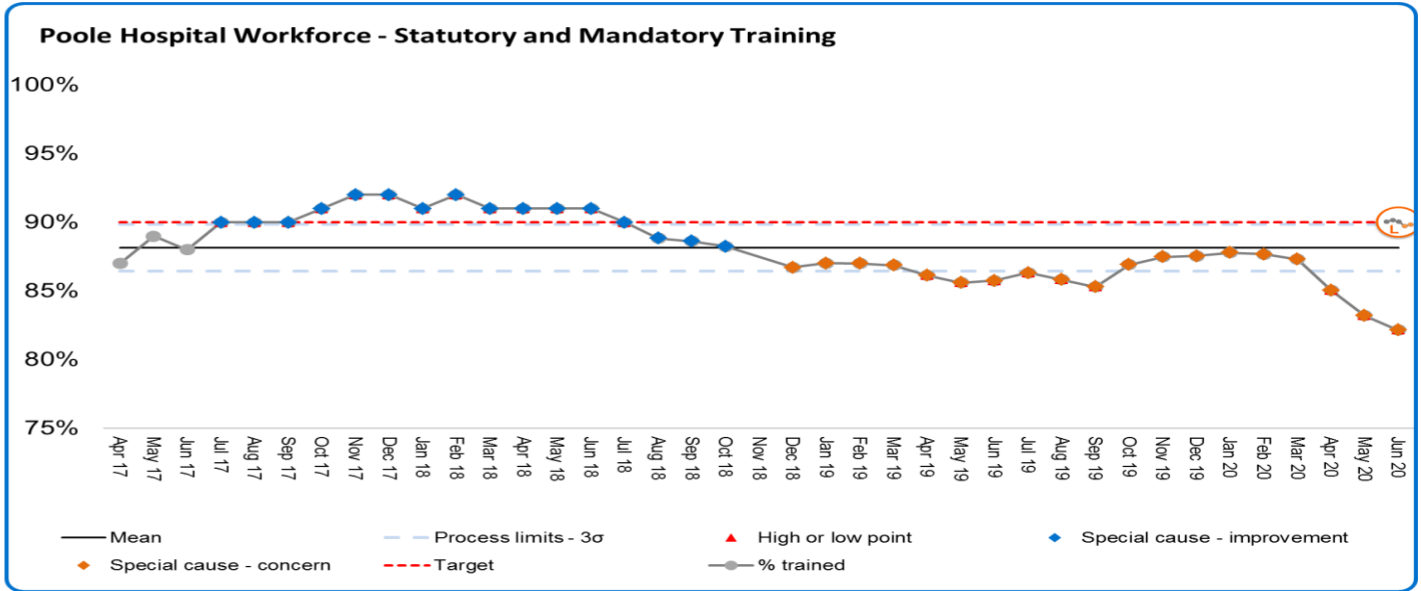
Statutory and Mandatory Training : General Observation Since November 2018

In November 2018 the national reporting module in ESR was replaced. Previously staff who completed training, but is wasn't a requirement of their job role, received the competency and this turned green. The new system only picks up staff who completed training where it was a requirement of their job role. Those staff are recorded as completing the training and receive a blue "non-requirement" competency. The effects was an initial drop in compliance in November 2018, which had stayed level until April 2019.

Statutory and Mandatory Training : Safeguarding Children Level 3 – April 2019

Following the publication of the Intercollegiate document, which provided a clear framework for identifying the roles and competencies for Healthcare staff, the Trust reviewed and defined the requirement for Level 3

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JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.2

Subject:	Performance Report

Prepared by:	Sarah Knight, Associate Director, Planning & Elective Transformation David Mills, Associate Director Information & Performance Dawn Ailes, RTT Performance Lead
Presented by:	Donna Parker, Acting Chief Operating Officer

Purpose of paper:	Note for information
Background:	This paper sets out how the Trust is performing against the National performance targets set out within the 2020/21 operational plan
Key points for members:	Key highlights and exceptions – June 2020:- • Significant impact on performance standards as a result of required planning and response to Covid-19 • Performance against the 4 hour standard worsened slightly in June to 91.2% from 93.6% in May, though remains above last year's performance • There were no 12-hour decision to admit breaches • At June month-end there were 440 patients whose RTT wait was over 52 weeks • At June month-end there were 2353 patients whose RTT wait was over 40 weeks • The Trust wide RTT performance against the 18 week standard decreased to 38.2% • Trust performance against the Faster Diagnostic standard was achieved above 75% at 76% • Performance against the 62 day cancer standard for May was below the 85% target at 75.5% • Performance against 31 day standard from decision to first treatment in May was achieved at 96.2% • There were no patients who received treatment who had breached the 'Cancelled Operation - patients offered a binding appointment in 28 days' standard • Diagnostic 6 week performance improved somewhat to 43.9% and remains a priority for the Trust. This report accompanies the Board Dashboard and Performance Indicator Matrix which should be referred to for further detail.

Options and decisions required:	The Joint Finance & Regulatory Performance Committee is requested to note the performance exceptions to the Trust's compliance with the 2019/20 SOF, national planning guidance

	and contractual requirements.
	Note, the narrative report should be read in conjunction with: • Trust Board Dashboard • Performance Indicator Matrix • Finance & Performance Committee Risk Register
Recommendations:	Note for information
Next steps:	

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective(s):	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference(s):	

Committees/Meetings at which the paper has been submitted:	Date

Operational Performance Report

For the period to end

June 2020

Donna Parker
Acting Chief Operating Officer

Operational Performance Report

1. Executive summary

Key highlights and exceptions – June 2020:-

- Significant impact on performance standards as a result of required planning and response to Covid-19
- Performance against the 4 hour standard worsened slightly in June to 91.2% from 93.6% in May, though remains above last year's performance
- There were no 12-hour decision to admit breaches
- At June month-end there were 440 patients whose RTT wait was over 52 weeks
- At June month-end there were 2353 patients whose RTT wait was over 40 weeks
- The Trust wide RTT performance against the 18 week standard decreased to 38.2%
- Trust performance against the Faster Diagnostic standard was achieved above 75% at 76%
- Performance against the 62 day cancer standard for May was below the 85% target at 75.5%
- Performance against 31 day standard from decision to first treatment in May was achieved at 96.2%
- There were no patients who received treatment who had breached the 'Cancelled Operation - patients offered a binding appointment in 28 days' standard
- Diagnostic 6 week performance improved somewhat to 43.9% and remains a priority for the Trust.

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 – June 2020

Whilst the Trust has begun to reinstate services/activities that were paused during phase 1 of the Covid-19 pandemic, a number of staff have continued to support other areas of the hospital. This together with the impact of government and Royal College guidelines, has meant our Key Performance Metrics have continued to be affected.

ED type 1 attendances continued to rise throughout June and are now back within the lower end of normal. Maintaining both Covid and non-Covid pathways, a rise in attendances and sustained conversion (to admission) rates above 30%, have led to a small decrease in performance against the 4 hour standard to 91.2%. However, positively this remains above last year's performance.

RTT 18 week performance has further deteriorated during June as elective activity continues to be limited to patients who have been reviewed and risk assessed according to national Covid-19 NHS guidelines. 38.2% of patients on an RTT pathway are within 18 weeks, with 15,890 patients now breaching this standard. 440 patients had waited over 52 weeks at the end of June. Overall the waiting list remained relatively stable as referrals remained lower.

Diagnostic performance improved somewhat in June to 43.9%. Patients continue to be prioritised on clinical grounds, including an assessment of Covid-19 risk and are treated within relevant PPE and infection control protocols. The latter reduces the number of patients on lists. Further diagnostic capacity has been increased in both imaging diagnostics and endoscopy (due to insourcing) resulting in activity increasing by 1,770 procedures in June. All patients who have been deferred remain on the waiting list

Table 1 – Operational and Contracting Guidance- KPIs 2019/20 – actuals & forecast July 2020

Single Oversight Framework Indicator	National Target	NHSI Trajectory 19/20	Mth / Qtrly	RAG rated performance against national targets and NHSI submitted trajectories		
				May-20	**Jun-20**	**July-20 Predictions**
A&E 4hr maximum wait time	95%	TBC	Mthly & Qtrly	93.60%	91.20%	
RTT 18 week incomplete pathways	92%	TBC	Mthly	50.76%	38.20%	
RTT - no. of incomplete pathways	24,880	TBC	Yr End	25,613	25,710	
RTT - no 52 week waiters	0	TBC	Mthly	213	440	
Cancer 62 day wait for first treatment from urgent GP referral*	85%	85.50%	Mthly & Qtrly	75.50%		
Cancer 62 day wait for first treatment from Screening service*	90%	100%	Mthly & Qtrly	66.70%		
Maximum 6 weeks to diagnostic test	99%	TBC	Mthly	36.3%	43.6%	

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).

The production of an NHSI Trajectory for 2020/2021 has been put on hold during the pandemic.

As the Covid-19 pandemic continued, the Trust through June supported essential emergency/urgent services whilst continuing to promote national guidelines on social/physical distancing, shielding and self isolation. A number of patients continued to express a wish to proactively stay away from the Trust.

Risk strategies have and are constantly being being developed and reviewed to deal with the impact on patients. Recovery planning to manage this and minimise negative effects is underway; however, many complexities (including testing, staffing, PPE and infection control practices) will impact on the level and timescales for this. National 'phase 3' guidance is expected imminently.

2.2 National Benchmarking

NHS national statistics have suspended publishing the national data during this pandemic. Unfortunately currently for this report no new national benchmarking information/graphs are available. However, we recognise that RTT and diagnostic long waiting patients remain a challenge and focus for Dorset and the South West.

3. Forecast Performance, Key Risks and Action

3.1 A&E Targets, PSF and Stranded Patients

As reported last month and as the aspects of lockdown continue to be reduced we are seeing ambulance conveyences to the Emergency Department continue to rise.

Graph 1 – Monthly SWAST handovers 2019/20 vs 2020/21
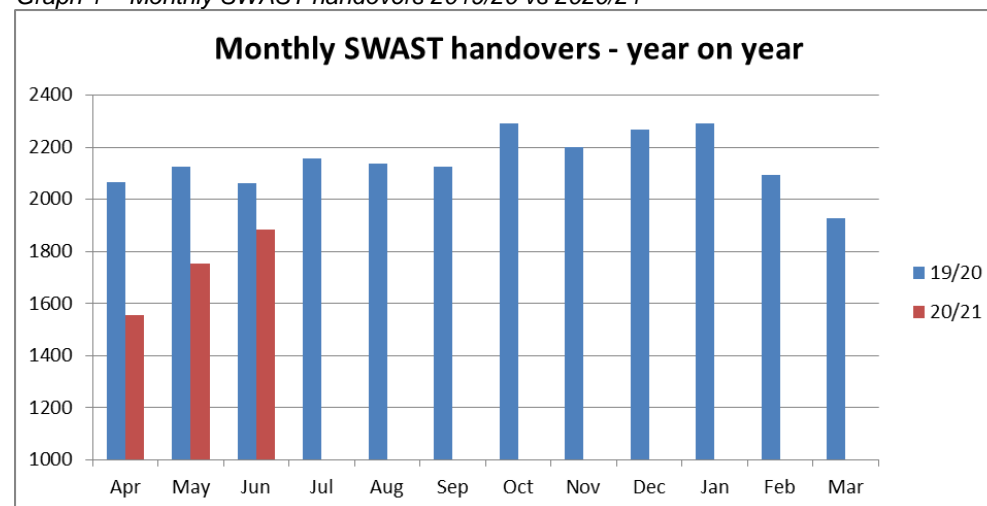
The four hour performance deteriorated slightly in June (91.2%) alongside the increase in conveyances and attendances, alongside continued Covid/Non Covid pathways. However, this remains a better position that last year, supported by additional physical and workforce capacity. The latter has to date been provided by transferring appropriately skilled staff from other services which have been reduced.

Clinical care remains the priority as well as avoiding an overcrowded ED department to maintain social which is challenging at times. The footfall of ED majors has increased by 12 trolleys, to maintain NHS guidelines on streaming both Covid and non-Covid patients.

Operational Performance Report

Type 1 attendances saw an increase of 13.5% with Type 2 also increasing by 8%. (Table 2) compared to May.

Acuity remains high and this in turn is reflected in the increasing number of non-elective admissions and conversion rate. Positively despite this increasing pressure both the 30 and 60 minute handover breaches show a decrease in numbers and no ED 12 hour breaches was maintained. Attendance numbers are continuing to increase weekly and are now within the numbers reached last year (Graph 2).

Graph 2 ED attendances this year Vs last Year: Type 1 & 2 Attendances
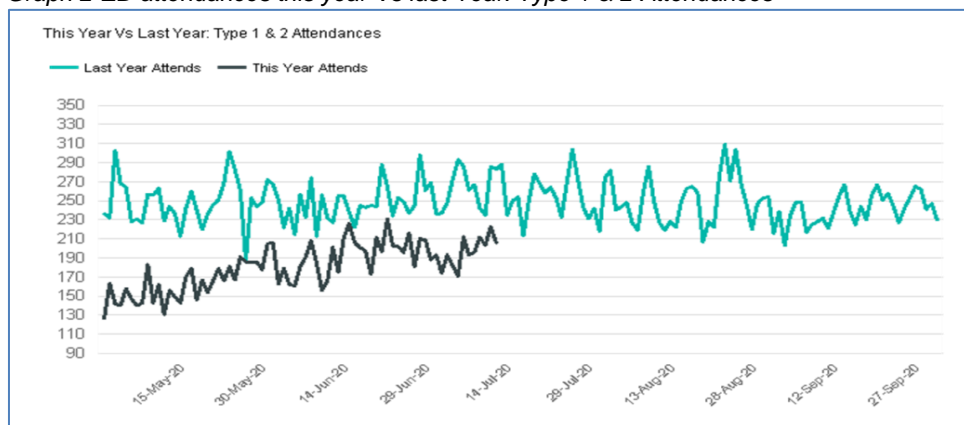
Graph 3 ED Attendances and Performance 12 month rolling
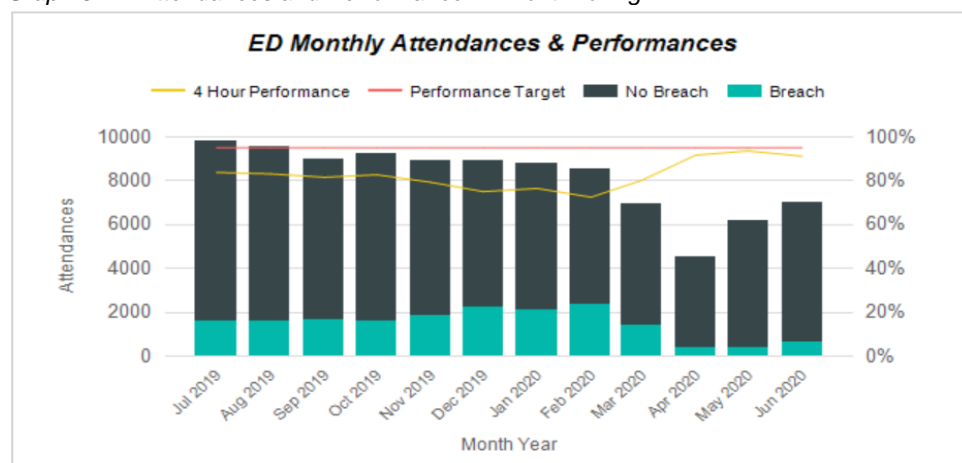
Table 2 Monthly ED attendances Jan 2020 to June 2020

ED Attendances	Month					
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Type 1	9567	6337	5251	3681	5009	5689
Type 2	1281	1215	1090	765	1077	1163
Type 3 RBH	467	427	263	5	11	98
Type 3 B&S	508	572	357	371	92	75
Type 3 *subtotal*	975	999	620	376	103	173
Total	8823	8551	6961	4822	6189	7025

Non-elective admissions continue to rise and starting to reach lower levels of normal, with a corresponding increase in bed occupancy. Overall occupancy for the Trust is coming under more pressure. This is exacerbated by elective surgery slowly increasing, cohorting of patients to ensure appropriate physical distancing and supporting staffing for both Covid and non-Covid areas which currently have 2 distinct areas i.e. Acute Medical Units. All non-elective patients have a covid swab on admission and flow from ED can be compromised when there is a delay in results as patients are delayed moving to other (non Covid) wards.

Graph 4 – SPC chart weekly Non-Elective admissions

55 OF 363

Operational Performance Report
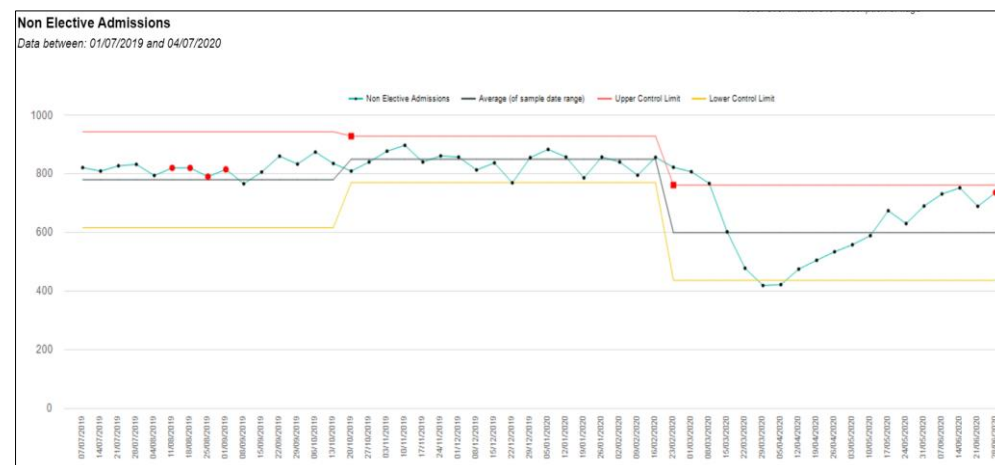
Graph 5 Weekly bed occupancy rates
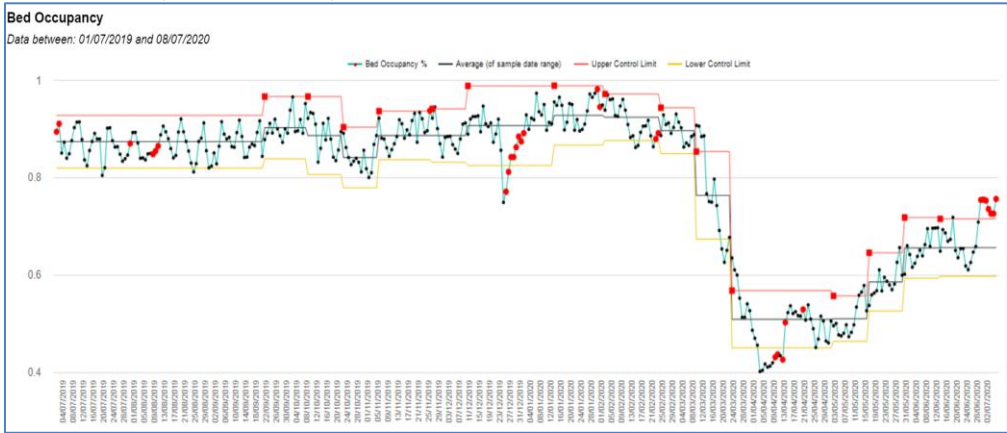
Graph 6 Monthly and YTD Non – Elective admissions/attendances/conversion rates
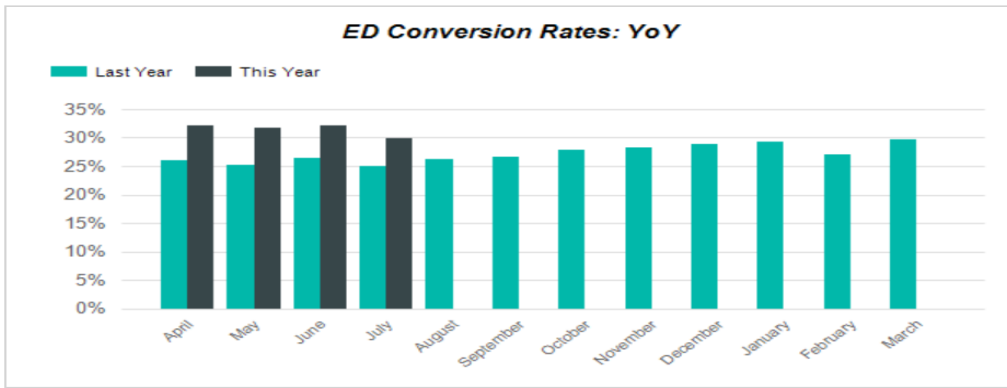
Conversion rates (to admission) in ED continue to be above last year's level. This suggests that the number of patients attending and needing admission correlates more closely than when the overall ED attendance numbers are higher. (Those higher numbers tending to include patients who are less acutely unwell).

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

Positively the number of days delayed in month has stabilised for June at 88 days a decrease of 82.5% (415 days) compared to June 2019.

Two of the standards relating to stranded patients continued to show a slight increase month on month. This still remains a much improved position on previous levels.

Weekly meetings continue, supported by a Dorset-wide Covid-19 response group. Patients are reviewed Trust-wide, to support patient experience and the need for acute beds. A Reset Workstream with our partners has been established to ensure that the improved patient pathways implemented during Covid-19 are sustained. Whilst positive work is underway, we are beginning to see some increase in length of stay so this continues to be closely monitored.

Table 3 Monthly and YTD Stranded patients

Stranded Patients	May-20	Jun-20	&Variance	Jun-19	Jun-20	%Variance
Number of patients who have been in hospital for >7 days	114	136	19.30%	245	136	-44.50%
Number of patients who have been in hospital for >21 days	22	27	22.70%	94	27	-71.30%
Number of patients who have been in hospital for >21 days who are medically fit for discharge	7	4	-42.85%	43	4	-90.70%

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

During this unprecedented time of the Covid-19 pandemic the Trust, along with the Dorset-wide system is continuing to clinically review patients according to the national guidance. Performance against the 18 week standard of 92% continues to decrease; at 38.2% for June

RTT performance is currently expected to decrease month on month as reduced activity continues and referrals remain lower.

Table 4 Clocks still running totals YOY

	Month		
	Jun-19	**Jun-20**	**% Variance**
Clocks Still Running	27978	25710	-8.11%

Clinical reprioritisation of all patients on a surgical waiting list is now complete against Royal Collage Guidelines and systems are in place for this prioritisation to continue for all new patients added. Our new report is now live which operationally, will improve scheduling. It is anticipated that this will also help to reduce cancellations on day and DNAs as the report has all the information required for scheduling in one place. The report shows the reprioritisation categories against where each patient is on their 18 week pathway.

This report is now being rolled out and developed in collaboration with Poole and Dorchester; aiming in the next 2 to 3 weeks to have a fully operational report which will be able to show how many of each category is booked/requires booking for each speciality and where in their 18 week pathway across the three Trusts. A Dorset-wide view of capacity and clinical prioritisation will be clear for each speciality.

Positively, our Surgical Directorate are reporting good progress against booking for the higher priority patients (urgent/<8 weeks).

For those patients on an Outpatient pathway, reprioritisation continues weekly for video consultations, telephone consultations or face-to-face appointments.

The Outpatient Reset group is overseeing an improvement action plan which incorporates a review of patients, including those who may be awaiting a follow-up who have not been booked. A reprioritisation exercise is also underway for all patients on an outpatient pathway, whether on an active RTT 'clock' or being clinically monitored.
A report has been developed in line with Poole Hospital's report which supports the above.

The majority of patients on a surgical waiting list have been telephoned to keep them up to date and this is ongoing. As clinicians are reviewing patients (on a surgical or outpatients pathway) many are telephoning patients there and then to inform them of what is happening. A Joint Workstream is reviewing this and looking at the most positive ways to inform patients.

Graph 7 RTT Backlog for 18, 26 and 40 weeks
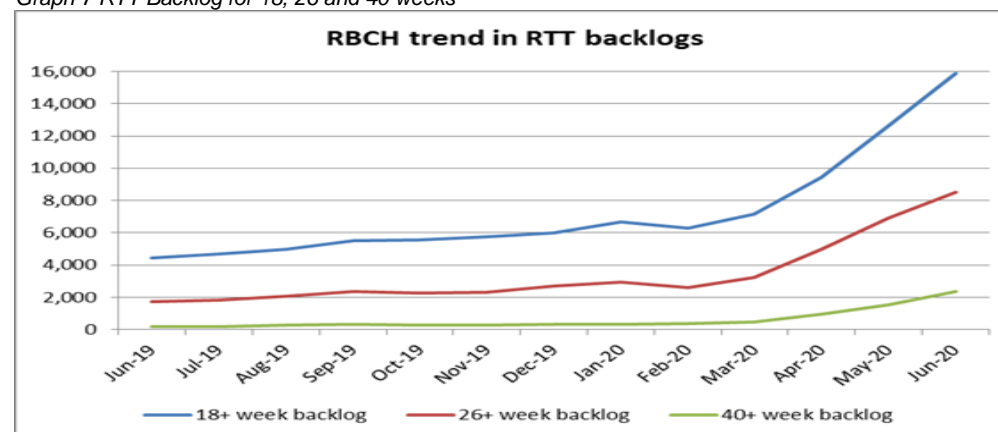
Overall total number of clocks still running remains stable however the numbers of patients who are over 18, 26, 40 and 52 weeks, continue to rise exponentially. (Graphs 7, 8; Table 5).

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Work with consultants continues to review and reprioritise these long waiting patients. Where possible and clinically indicated, additional outpatient clinics and elective surgery are being run whilst still maintaining the emergency Covid-19 response.

We are also working with commissioners on a trigger process for review of patients with long delays over 52 weeks. In a number of the cases that we will see moving forward, the delays are likely to be as a result of services being paused/reduced or as a result of some patients adhering to national guidance on self-isolating, 'lockdown' or shielding. There will however, be cases where there are opportunities for local learning and it is important that these are not missed.

Review of working practices in outpatients continues with specialities and many are now using virtual (telephone/video consultations). By way of example, our Rheumatology Team were keen to provide this service to their patients. Their experience since the pandemic has meant they will now continue to accommodate a mix of all three ways of seeing patients *(telephone, video, face-to-face).*

The Trust continues to maximise the use of the independent sector for Elective surgery for cancer patients and patients that are urgent and long waiting.

Graph 8 - Number of patients waiting over 52 weeks
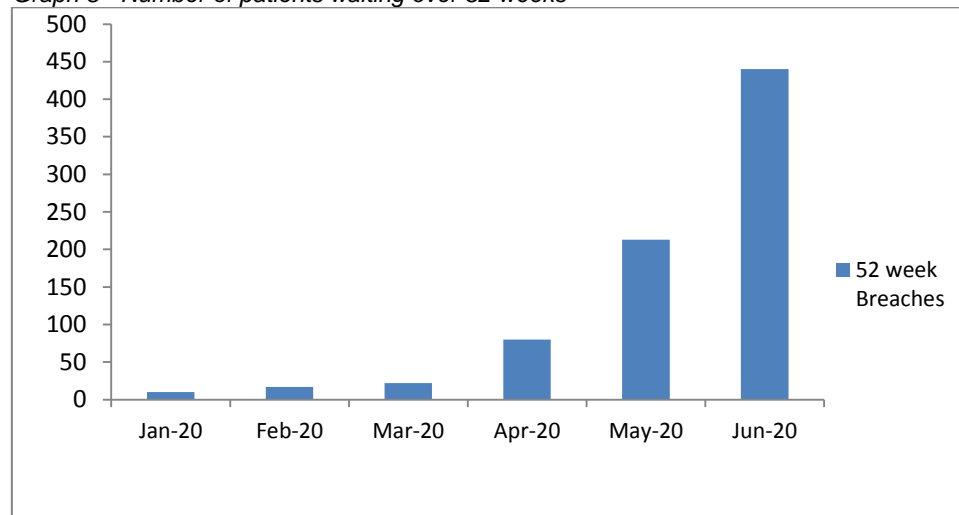
At the end of June there were 440 patients who had waited longer than 52 weeks The continued increase in 18 and 52 week breaches continues to be reliant on the pace and level at which the Trust can increase elective activity and the impact of the work on restructuring outpatient appointments. Current predictions for the end of July are:

Table 5 - 40+ week incomplete pathways by specialty

Specialty	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
General Surgery	40	46	57	81	99	118	109	102	106	91	108	131	226	302	369
Urology	58	55	48	58	74	83	69	71	66	60	73	81	130	170	212
Trauma & Orthopaedics	4	4	2	2	5	8	8	3	7	16	15	39	119	327	614
Ear, Nose & Throat (ENT	2	0	1	1	3	9	7	5	6	10	12	23	35	52	131
Ophthalmology	18	38	36	28	60	62	38	29	29	22	27	40	104	188	359
Oral Surgery	5	6	1	2	11	5	8	18	30	22	31	34	76	120	171
Cardiothoracic Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Medicine	5	5	3	2	6	5	9	6	15	9	13	31	58	79	110
Cardiology	4	1	4	2	10	8	11	21	26	24	29	17	30	54	66
Dermatology	1	0	0	1	0	0	0	1	1	1	3	1	2	4	6
Thoracic Medicine	1	0	1	1	0	1	0	0	1	4	0	1	3	4	10
Neurology	0	0	1	0	1	0	2	2	2	4	3	1	5	10	14
Rheumatology	0	0	0	1	0	0	0	0	0	1	0	1	1	1	2
Geriatric Medicine	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Gynaecology	5	8	15	16	18	19	23	19	25	32	29	40	80	110	155
Other	2	8	9	7	7	13	18	15	21	20	33	41	78	109	134
Total	145	171	178	203	294	332	302	292	335	316	376	481	947	1530	2353

Table 6 - Numbers of patient's predicted to be past 18 weeks

Predicted RTT Breaches	Jul-20
Breaching 52 weeks	788
Breaching 40 weeks	3198
Breaching 26 weeks	9772
Breaching 18weeks	18878

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

Graph 9 – RBCH weekly Fast Track Referrals
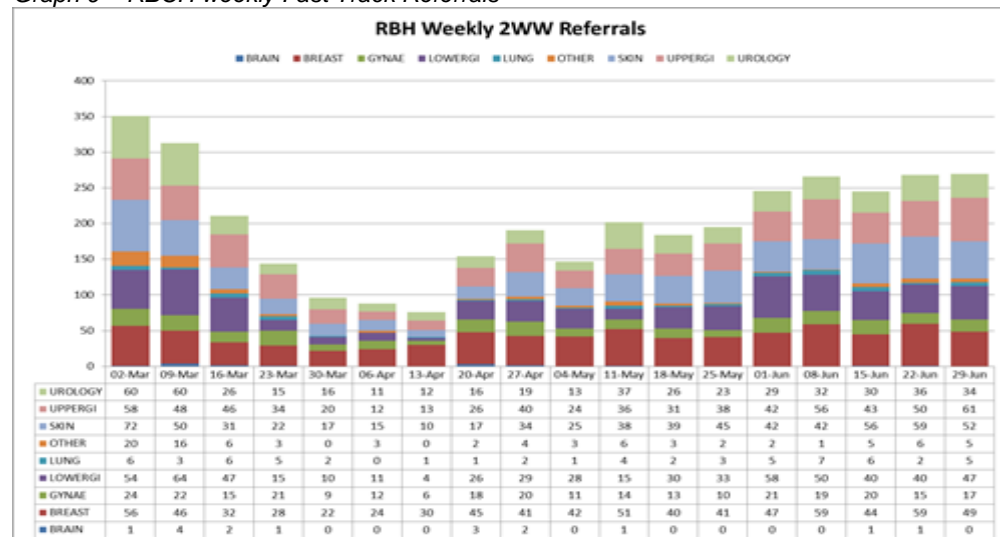
Fast Track Referrals continued to increase over the month of June. With some specialities within pre-Covid ranges of referrals.

Table 7 - 2020/21 Cancer Performance

	Measure	Target	Apr-20	May-20
Bournemouth	Cancer Two Week Wait (RBH currently not being monitoired)	93%	N/A	N/A
	Cancer Plan 62 Day Standard	85%	83.1%	75.50%
	62 Day Screening Standard (Tumour)	90%	60.0%	66.70%
	31 Day First Treatment (Tumour)	96%	98.2%	96.20%
	Subsequent Treatment – Surgery	94%	100.0%	100.00%
	Subsequent Treatment – Anti Cancer Drugs	98%	100.0%	100.00%
	Faster Diagnostics	75%	65.5%	76.70%

The Trust performance for the month of May for 62 days was 75.5% The Trust fell short of the 85% threshold for 62 days performance due to the impact of Covid-19, as did all Dorset Trusts.

Positively, the Trust achieved all of the 31 day cancer standards as well as Faster Diagnostic Standard achieving over 75%

The number of patients between 62 and 103 days reached 159 by mid-May with the impact of Covid-19. Due to significant work and prioritisation this is now decreasing and has continued to significantly improve during June to below 60 patients. (Graph 10)

The number of patients waiting longer than 104 days on a cancer pathway continued to increase during June. This is a direct result of deferrals by both the hospital in line with national guidance and by patients themselves, alongside the decrease in activity due to infection control requirements for PPE and terminal cleaning. From the end of June the number of patients over 104 days has started to decrease and this is expected to continue throughout July.

Graph 10 – 62 day pathway backlog
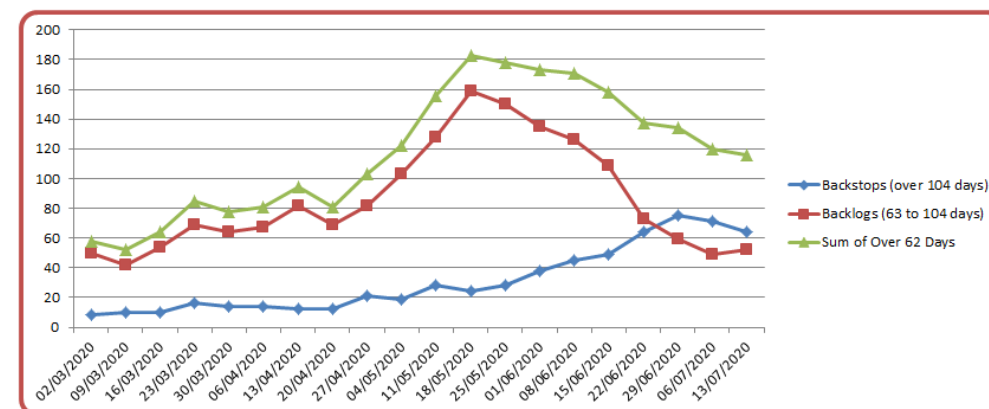
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The majority of the patients waiting over 62 days now have agreed dates for treatment. There are 3 patients who do not have a treatment date who have been clinically reviewed and are not clinically appropriate for referral to the Wessex Cancer Hub due to associated co-morbidities.

3.4 Diagnostic 6 Week Wait

June diagnostic performance improved to 43.9%. Activity and the current extended waits, along with ensuring suspected cancer and urgent patients receive their tests, are a significant priority.

Graph 11 Diagnostic performance against target
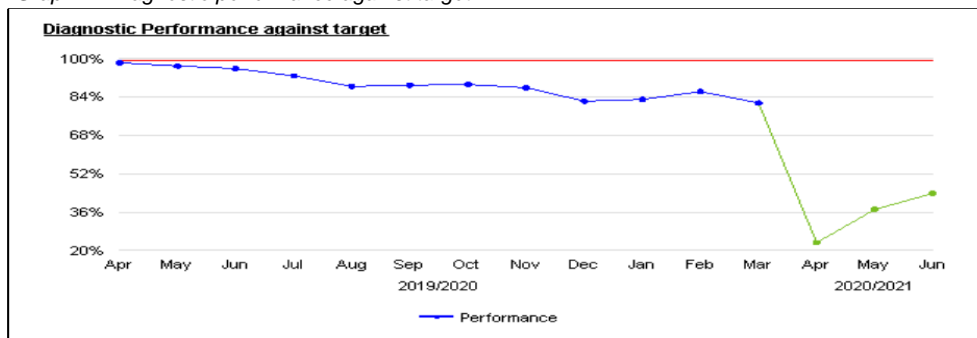
Imaging diagnostics have increased the capacity on both Bournemouth and Christchurch sites. They have reduced the number of patients on their waiting list by 6.65%% and number of patients waiting over 6 weeks from 644 to 365.Use of the independent sector has also helped sustain scanning activity.

Table 8 – Total numbers of patients awaiting a diagnostic procedure June 2020

Diagnostic	May-20	Jun-20	Number Change	%Change
Imaging	1685	1573	-112	-6.65%
Cardiology	778	984	206	26.47%
Scopes	1741	1738	-3	-0.20%
Totals	4204	4295	91	2.16%

Graph 12 - Numbers of patients waiting over 6 weeks for a diagnostic
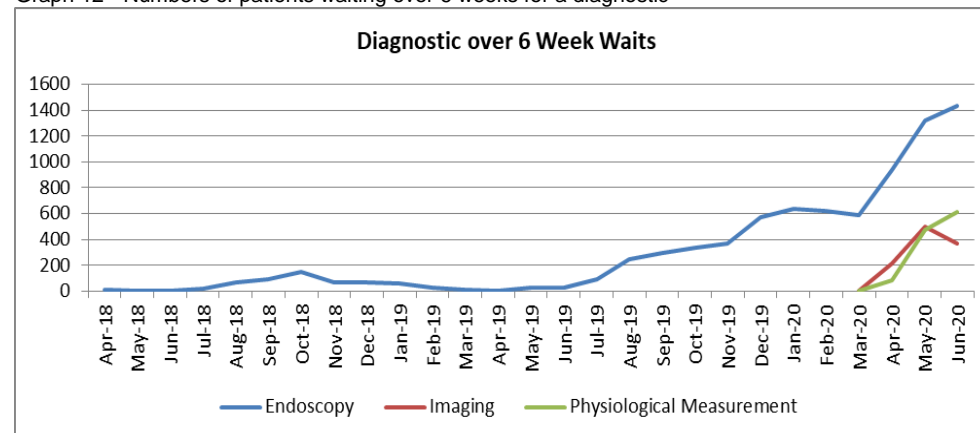
The number of endoscopies taking place remains limited due to activity reductions and PPE requirements implemented in line with national guidance. During June the endoscopies have continued to be undertaken in the independent sector and insourcing has been reinstated both during the week and at weekends.

Primary care and the Dorset-Wide System group are currently supporting work on how to best manage clinical pathways and keep patients safely under review. All urgent and Fast Track patients across both Bournemouth and Poole have to be booked first. Poole have been able to offer capacity to Bournemouth in order for both Trusts to be able to book these patients first prior to booking the remaining patients.

Positively with increasing activity for endoscopy the overall waiting list stabilised in June. The Trust also saw for the first time since Pre-Covid, no increase in patients waiting over 6 weeks for an endoscopy procedure.

With approval for a mobile van and medical staffing investment due to commence in mid-August, we expect to substantially increase activity further.

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Table 9 – Diagnostic Activity June 2020

Diagnostic	May-20	Jun-20	Number Change	%Change
Imaging	5483	6564	1081	19.70%
Cardiology	453	820	367	81.10%
Scopes	273	600	327	119.00%
Totals	6209	7984	1775	28.50%

Graph 13 – Diagnostic Activity June 2020
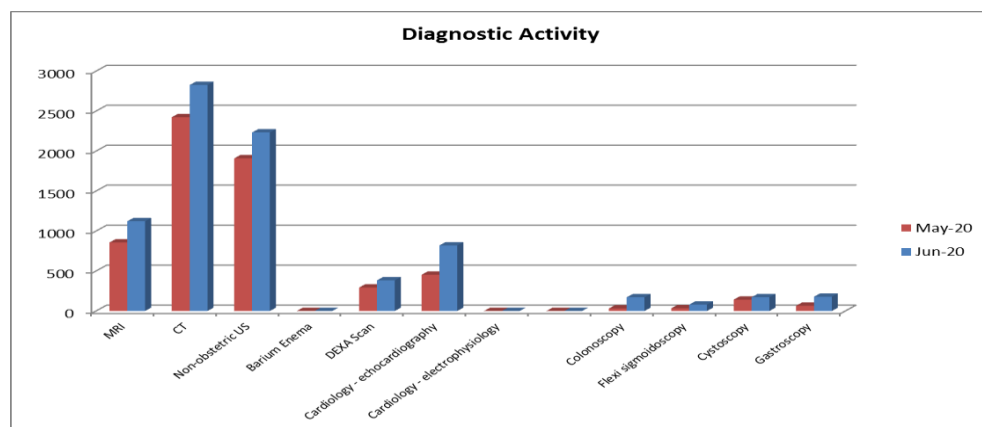
Graph 14 - Diagnostic month end total waits June 2020
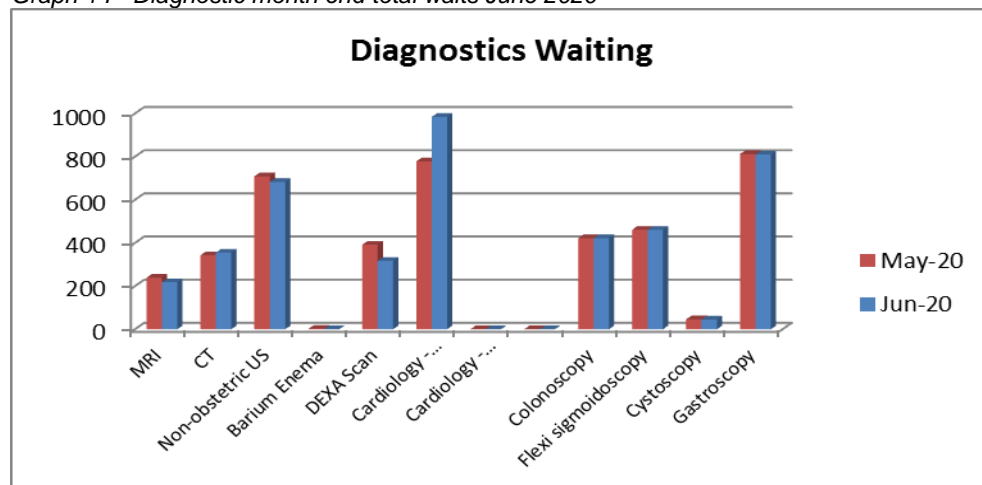
Other Indicators - Exception Reporting

See Performance Indicator Matrix for full performance detail

For Stroke Services overall performance has remained consistent and internal monitoring suggests we remain at SSNAP level A. National reporting has currently been suspended but we expect this to recommence in Q2 and to be a joint report with Poole from Q3. We have observed a drop in our performance in Domain 1 – imaging - since the start of COVID.   This is primarily due to our change in processes at the front door relating to CT direct access to accommodate the impact of Covid and cleaning protocols in place between patients in radiology. This has understandably impacted on the median time taken to scan and % scanned within 1 hour.

There were no other exceptions to report this month.

Recommendation

The Board is requested to note the June 2020 performance and the Performance Matrix. It should also note the expected performance, risks and actions.

Trust Board Dashboard - June 2020
based on Single Oversight Framework metrics

Category	Metric	2019/20 Q3 Oct-19	Nov-19	Dec-19	2019/20 Q4 Jan-20	Feb-20	Mar-20	2020/21 Q1 Apr-20	May-20	Jun-20	Trend (where applicable)
Quality of care	Caring - A&E scores from Friends and Family Test % positive	87.8%	84.0%	86.0%	87.3%	83.3%					
	Caring - Inpatient scores from Friends and Family Test % positive	96.3%	97.1%	97.4%	97.3%	97.1%					
	Caring - Maternity scores from Friends and Family Test % positive	98.8%	99.1%	99.0%	100.0%	98.4%					
	Caring - Mixed sex accommodation breaches	4	0	0	6	7					
	Caring - Staff Friends and Family Test % recommended - care (Quarterly)										
	Caring - Formal complaints	39	43	48	47	42	36	19	25	26	
	Effective - Emergency re-admissions within 30 days following an elective or emergency spell at the provider	749	810	783	836	758	636	384	462	618	
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - All Sites	67.8	86.7	86.1	99.6	109.1	95.3				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - MAC	242.1	210.8	202.8	425.4	0.0	367.7				
	Effective - Hospital Standardised Mortality Ratio - Weekend (DFI) - RBH	63.0	78.9	79.8	88.3	109.1	84.9				
	Effective - Hospital Standardised Mortality Ratio (DFI) - All Sites	74.2	84.7	82.5	86.0	86.8	88.1				
	Effective - Hospital Standardised Mortality Ratio (DFI) - MAC	200.5	260.2	163.5	237.9	216.5	213.0				
	Effective - Hospital Standardised Mortality Ratio (DFI) - RBH	94.0	73.5	76.9	75.1	78.1	78.2				
	Effective - Summary Hospital Mortality Indicator	0.862	0.864	0.861	0.859						
	ED Attendances	9241	8885	8905	8804	8542	6965	4509	6190	7005	
	Elective Admissions	5874	5438	4966	5677	5333	4440	1705	1814	2931	
	GP OP Referrals	6569	5913	5284	6054	5572	3872	1083	2303	3336	
	Non-elective Admissions	3736	3716	3635	3788	3401	2840	1996	2713	3021	
	Organisational health - Staff sickness in month	4.1%	4.2%	4.3%	4.3%	3.9%	5.7%	7.8%	5.1%	4.0%	
	Organisational health - Staff sickness rolling 12 months	3.9%	4.0%	4.0%	4.0%	4.0%	4.2%	4.5%	4.6%	4.6%	
	Safe - Clostridium Difficile - Confirmed lapses in care	3	1	0	1	0	0	0	0	0	
	Safe - Clostridium Difficile - infection rate	30.61	18.98	6.14	18.43	0	0	0	18.43	6.35	
	Safe - MRSA bacteraemias	0	0	0	0	0	0	0	0	0	
	Safe - NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	
	Safe - Occurrence of any Never Event	0	0	0	0	0	0	0	1	2	
	Safe - Potential under-reporting of patient safety incidents (Quarterly reporting rate)		37.66			30.51					
	Safe - VTE Risk Assessment	96.4%	96.7%	96.1%	96.3%	96.2%	96.0%	94.9%	94.8%	96.5%	
	Number of Serious Incidents	1	5	1	1	0	0	1	4	2	
	Appraisals - Values Based (Non Medical) - Compliance	86.2%	88.2%	88.8%	88.2%	87.7%	86.6%	0.2%	4.1%	12.6%	
	Appraisals - Doctors and Consultants - Compliance	80.5%	80.1%	84.1%	79.0%	74.1%	77.8%	78.1%	70.9%	68.2%	
	Essential Core Skills - Compliance	94.6%	94.7%	94.8%	94.8%	94.9%	94.3%	93.7%	93.0%	92.5%	
	Organisational health - Proportion of temporary staff	7.4%	7.7%	7.5%	7.1%	8.5%	9.2%	7.2%	6.3%		
	Organisational health - Staff turnover	10.4%	10.1%	9.9%	10.1%	10.0%	9.8%	9.7%	9.4%	8.9%	
Finance and use of resources	Sustainability - Capital Service Capacity (YTD Score)	2	3	3	3	3	3				
	Sustainability - Liquidity (YTD score)	1	1	1	1	1	1				
	Efficiency - I&E Margin (YTD score)	2	2	2	2	3	2				
	Controls - Agency Spend (YTD score)	1	1	1	1	1	1				
	Controls - Distance from Financial Plan (YTD score)	2	2	1	1	1	1				
	Overall finance and use of resources (YTD score)	2	2	2	2	2	2				
Operational performance	A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	82.7%	79.3%	75.1%	76.5%	72.5%	80.2%	91.7%	93.6%	91.2%	
	Cancer maximum 62-day wait for first treatment from NHS cancer screening service referral	72.7%	36.8%	44.0%	36.4%	62.5%	72.2%	60.0%	66.7%		
	Cancer maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85.4%	88.1%	86.2%	86.8%	79.2%	84.9%	83.1%	75.5%		
	Maximum 6-week wait for diagnostic procedures	89.2%	87.9%	82.3%	83.0%	86.3%	76.9%	23.3%	36.3%	43.9%	
	Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	81.2%	81.0%	79.9%	77.8%	78.6%	74.4%	64.0%	50.8%	38.2%	

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

Royal Bournemouth & Christchurch Hospitals
NHS Foundation Trust

Indicator	Target 19/20	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Against Previous Month	Forecast - Next Month	Forecast - Quarter	RAG > trajectory	RAG <= trajectory
Single Oversight Framework Operational Performance Metrics																																	
A&E - 4hr maximum waiting time from arrival to admission/transfer/discharge	95%	91.9%	93.5%	96.4%	95.97%	94.0%	92.4%	93.5%	90.3%	89.6%	87.6%	87.9%	96.5%	91.1%	92.8%	86.1%	83.8%	83.2%	81.8%	82.7%	79.4%	75.1%	76.5%	72.5%	80.2%	91.7%	93.6%	91.2%	↓			<95%	≥95%
18 weeks Referral to Treatment Incomplete pathways	92%	88.8%	90.0%	89.8%	88.7%	87.6%	86.8%	86.9%	86.7%	85.7%	85.4%	85.3%	84.6%	84.0%	85.0%	84.2%	83.4%	82.7%	81.0%	81.2%	81.0%	79.9%	77.8%	78.6%	74.5%	64.0%	50.8%	38.2%	↓			<92%	≥92%
Cancer 62 day wait for first treatment from urgent GP referral for suspected cancer	85%	88.6%	90.2%	84.5%	86.1%	79.4%	77.2%	77.1%	91.8%	89.2%	89.1%	86.7%	89.1%	87.3%	87.6%	84.5%	89.8%	86.5%	84.5%	85.8%	84.0%	86.3%	79.2%	86.4%	83.1%	75.5%					<65%	≥65%
Cancer 62 day wait for first treatment from NHS cancer screening service referral	90%	100.0%	87.5%	96.0%	73.7%	85.7%	69.2%	100.0%	92.0%	94.4%	88.9%	69.2%	90.0%	100.0%	100.0%	88.9%	75.0%	92.9%	93.8%	80.0%	36.8%	44.0%	36.4%	62.5%	72.2%	60.0%	66.7%		↑			<90%	≥90%
Diagnostics - % of patients waiting less than 6 weeks for a diagnostic test	>99%	99.7%	99.4%	99.5%	94.4%	93.9%	93.3%	93.4%	96.5%	93.5%	94.8%	96.7%	99.3%	98.3%	96.9%	95.8%	92.8%	88.4%	88.9%	89.2%	87.9%	82.3%	83.0%	86.3%	81.5%	23.3%	36.3%	43.9%	↑			<99%	≥99%
Other Key National and Contractual Indicators																																	
Mixed Sex Accommodation - minimise no. of patients breaching MSA	0	0	0	0	3	0	5	0	0	0	0	0	0	10	0	3	1	5	9	4	0	0	6	7					↑	amber		> 0	0
MRSA Bacteraemias - number of hospital acquired MRSA cases	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→			>0	0
Clostridium difficile - C. Difficile cases due to lapses in Care	30 (2 pcm)	2	0	0	0	2	0	0	0	1	1	0	0	1	2	0	0	0	2	0	1	0	1	0	0	0	0	0	→	amber		>1	≤1
Cancer 62 day Consultant upgrade - following decision to upgrade the patient priority	90%	81.3%	66.7%	37.5%	50.0%	100.0%	100.0%	58.3%	76.9%	0.0%	70.0%	93.3%	92.3%	86.7%	50.0%	85.7%	72.7%	71.4%	80.0%	100.0%	58.3%	66.7%	100.0%	100.0%	57.1%	100.0%	0.0%		↑			< 90%	≥90%
Cancer 2 week wait from referral to date first seen - all urgent referrals	93%	85.8%	91.6%	91.0%	95.2%	92.4%	92.6%	97.7%	96.7%	93.6%	91.7%	96.7%	95.5%	94.5%	96.4%	90.7%	92.1%	86.3%	62.1%	73.9%	55.9%	67.2%	73.7%	72.5%	70.9%	70.3%	92.1%		↑			<93%	≥93%
Cancer 2 week wait from referral to date first seen - for symptomatic breast patients	93%	90.0%	100.0%	100.0%	88.9%	95.7%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	78.6%	90.9%	89.7%	77.8%	55.9%	59.3%	72.5%	47.6%	7.0%	76.7%	100.0%			↑			<93%	≥93%
Cancer 31 day wait from diagnosis to first treatment	96%	98.7%	99.1%	98.5%	99.5%	96.7%	94.4%	97.5%	96.4%	96.4%	96.2%	99.5%	99.2%	99.5%	98.2%	98.0%	99.0%	99.0%	99.5%	99.0%	100.0%	98.9%	98.4%	99.5%	98.0%	98.2%	96.2%		↓			<96%	≥96%
Cancer 31 day wait for second or subsequent treatment - Surgery	94%	95.8%	97.0%	96.8%	94.3%	93.8%	91.3%	92.3%	100.0%	92.6%	97.0%	96.0%	100.0%	100.0%	96.4%	96.0%	100.0%	100.0%	96.8%	100.0%	100.0%	96.2%	100.0%	100.0%	96.0%	100.0%	100.0%		↓			<94%	≥94%
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		→			<98%	≥98%
Stranded Patients - Number of patients who have been in the hospital for >7 days		228	222	223	219	204	271	227	247	241	248	267	237	250	225	245	220	198	247	210	210	236	255	227	112	104	114	136	↑				
Stranded Patients - Number of patients who have been in the hospital for >21 days		89	87	83	86	75	75	97	85	82	92	86	84	94	92	94	86	71	76	68	68	80	84	62	42	21	22	27	↑				
Stranded Patients - Number of patients who have been in the hospital for >21 days who are medically fit for discharge				39	51	42	33	49	48	38	52	42	34	49	34	43	44	34	32	30	21	28	36	30	11	4	7	4	↓				
DTOC - Total numbers of days delayed within the month		476	493	400	392	336	459	417	443	405	471	516	520	453	564	503	556	575	538	401	368	396	353	424	206	102	87	88	↑				
Admission via A&E - No. of waits from decision to admit to admission over 12 hours	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	→			≥1	0
Ambulance Handovers - No. of breaches of the 30 minute handover standard	0	107	54	55	56	82	103	71	58	93	67	86	80	129	74	49	78	86	55	95	160	200	182	172	129	43	74	57	↓	n/a	n/a		tbc
Ambulance Handovers - No. of breaches of the 60 minute handover standard	0	11	2	1	1	4	11	3	2	11	11	7	2	6	7	0	3	1	4	10	28	23	17	22	37	4	7	2	↓	n/a	n/a		tbc
Cancelled Operations - No. of patients not offered a binding date within 28 days	0	0	0	0	1	0	0	0	0	1	0	0	1	0	0	1	0	0	2	1	3	1	0	1	0	1	0	0	→	amber		≥1	0
Cancelled Operation - No. of urgent operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→	amber		≥1	0
Stroke SNAPP Score (*Based on internal unvalidated reporting)			A			A				A			A			A			A*			A*		A*	A*				→				
RTT																																	
Referral to Treatment - Clocks still running over 52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	3	5	7	5	7	4	10	17	22	80	213	440	↑			≥1	0
Referral to Treatment - Clocks still running over 40 weeks	<75	60	73	66	62	72	61	64	83	116	110	115	131	145	171	178	203	294	329	302	292	335	316	376	481	947	1530	2353	↑				tbc
Referral to Treatment - Clocks still running Total	24885	25163	25926	26471	26310	25776	25587	25421	25109	25340	25362	25878	26411	26653	27614	27978	28248	28971	28873	29592	30114	29975	30028	29348	27979	26155	25612	25710	↑				tbc
RTT Clocks still running Combined by Specialty:																																	
100 - GENERAL SURGERY	92%	93.7%	93.9%	94.0%	91.3%	89.1%	88.3%	87.8%	87.5%	86.5%	86.7%	87.1%	87.1%	85.4%	85.7%	85.4%	84.2%	83.7%	82.8%	83.8%	84.0%	82.9%	83.2%	83.1%	78.4%	70.0%	59.4%	53.4%	↓			<92%	≥92%
101 - UROLOGY	92%	84.4%	86.3%	85.8%	84.5%	80.3%	77.8%	78.1%	76.8%	77.2%	76.0%	77.7%	74.8%	72.1%	72.9%	71.0%	72.3%	74.2%	73.4%	73.6%	73.2%	73.9%	73.1%	72.8%	68.4%	56.4%	41.1%	36.8%	↓			<92%	≥92%
110 - TRAUMA AND ORTHOPAEDICS	92%	81.3%	85.1%	87.7%	88.9%	90.3%	88.4%	88.2%	88.0%	85.8%	85.5%	83.9%	82.4%	81.3%	84.5%	83.5%	84.0%	81.7%	79.2%	78.9%	79.1%	77.4%	69.2%	70.7%	65.1%	53.5%	38.7%	26.5%	↓			<92%	≥92%
120 - EAR NOSE AND THROAT	92%	79.0%	82.0%	79.3%	82.6%	84.2%	85.2%	86.7%	87.7%	89.1%	90.5%	89.8%	88.3%	87.3%	89.3%	86.2%	82.2%	82.7%	76.8%	75.6%	74.1%	73.0%	66.8%	67.4%	59.6%	44.8%	30.5%	16.7%	↓			<92%	≥92%
130 - OPHTHALMOLOGY	92%	87.8%	87.7%	85.1%	83.0%	82.0%	81.8%	81.4%	79.9%	77.9%	76.9%	76.7%	76.1%	75.1%	76.9%	77.2%	76.1%	75.6%	73.3%	73.4%	73.5%	72.9%	74.2%	75.1%	74.4%	63.2%	50.3%	32.4%	↓			<92%	≥92%
140 - ORAL SURGERY	92%	81.6%	81.5%	78.2%	75.4%	72.1%	70.8%	67.7%	70.2%	72.8%	75.1%	80.2%	79.7%	79.6%	77.4%	76.3%	70.7%	70.5%	69.5%	70.2%	64.9%	60.0%	58.6%	63.4%	55.5%	45.7%	38.5%	17.7%	↓			<92%	≥92%
170 - CARDIOTHORACIC SURGERY	92%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	50.0%	20.0%	↓			<92%	≥92%
300 - GENERAL MEDICINE	92%	95.6%	96.2%	95.7%	96.3%	95.4%	93.5%	94.2%	94.6%	93.1%	94.7%	94.8%	94.1%	95.8%	95.3%	93.9%	93.9%	92.0%	91.9%	91.8%	91.6%	89.6%	87.2%	86.3%	81.7%	71.9%	57.0%	40.4%	↓			<92%	≥92%
320 - CARDIOLOGY	92%	94.5%	93.9%	93.9%	94.5%	92.2%	92.6%	91.4%	93.1%	93.2%	92.7%	92.7%	91.3%	91.6%	91.8%	90.4%	90.3%	86.7%	88.8%	89.0%	88.3%	86.6%	89.1%	88.5%	78.6%	63.6%	45.6%		↓			<92%	≥92%
330 - DERMATOLOGY	92%	69.6%	73.8%	79.9%	81.5%	82.5%	87.2%	92.9%	94.0%	95.1%	94.1%	90.0%	92.6%	94.0%	94.2%	94.6%	94.4%	94.9%	93.1%	93.2%	93.0%	94.2%	94.0%	94.7%	93.6%	88.6%	77.4%	71.0%	↓			<92%	≥92%
340 - THORACIC MEDICINE	92%	94.0%	95.9%	95.4%	96.3%	95.3%	91.1%	89.3%	89.5%	85.0%	84.0%	84.9%	86.4%	88.3%	91.4%	90.3%	89.9%	86.3%	87.8%	86.0%	83.7%	82.6%	84.8%	85.3%	84.2%	79.0%	63.5%	49.0%	↓			<92%	≥92%
400 - NEUROLOGY	92%	86.2%	88.9%	91.7%	89.7%	88.3%	84.0%	85.2%	91.0%	90.7%	86.1%	85.7%	89.8%	94.8%	92.6%	93.9%	90.1%	84.0%	81.8%	80.2%	78.1%	78.0%	74.2%	77.7%	70.6%	61.0%	48.5%	46.8%	↓			<92%	≥92%
410 - RHEUMATOLOGY	92%	98.3%	99.2%	98.7%	96.1%	97.2%	96.6%	98.3%	97.4%	97.6%	96.4%	96.4%	95.9%	96.4%	96.2%	95.4%	94.6%	95.5%	96.5%	96.5%	93.4%	93.2%	90.0%	89.5%	87.2%	79.4%	67.6%	66.0%	↓			<92%	≥92%
430 - GERIATRIC MED	92%	93.0%	90.2%	87.1%	89.7%	87.3%	90.9%	90.4%	88.6%	90.4%	91.3%	87.7%	87.4%	88.0%	86.5%	87.4%	86.2%	89.2%	90.9%	89.6%	92.4%	93.9%	92.3%	93.6%	87.7%	83.9%	69.7%	47.9%	↓			<92%	≥92%
502 - GYNAECOLOGY	92%	90.2%	91.9%	91.6%	91.2%	89.1%	88.4%	88.8%	88.9%	87.8%	85.6%	87.2%	86.9%	87.1%	87.2%	82.5%	80.7%	79.1%	78.4%	78.4%	74.2%	73.2%	70.0%	61.9%	49.1%	38.8%			↓			<92%	≥92%
Other	92%	96.2%	95.4%	93.8%	91.6%	91.2%	91.3%	92.9%	93.4%	93.7%	93.9%	93.6%	91.4%	90.0%	90.0%	89.1%	90.8%	90.9%	89.0%	88.7%	87.7%	85.6%	84.5%	86.5%	83.7%	74.5%	62.9%	47.0%	↓			<92%	≥92%
Cancer 62 day by Tumor Site by specialty																																	
Brain/central nervous system	85%						100.0%																					100.0%	↑	n/a	n/a	<85%	≥85%
Breast	85%	100.0%	92.9%	75.0%	93.3%	92.9%	90.0%	82.6%	100.0%	80.0%	92.3%	100.0%	93.5%	91.2%	87.5%	87.5%	82.6%	94.1%	93.3%	87.5%	90.0%	66.7%	94.1%	57.1%	94.3%	100.0%	77.8%		↓	n/a	n/a	<85%	≥85%
Children's cancer	85%																													n/a	n/a	<85%	≥85%
Gynae	85%	80.0%	100.0%	100.0%		100.0%	33.3%	62.5%	100.0%	100.0%	88.9%	81.8%	77.8%	96.9%	33.3%	88.0%	100.0%	81.8%	66.7%	57.1%	83.3%	83.3%	40.0%	100.0%	83.3%	80.0%	0.0%		↓			<85%	≥85%
Haematology	85%	66.7%	100.0%	100.0%	80.0%	75.0%	42.9%	71.4%	100.0%		100.0%	100.0%	66.7%	100.0%	80.0%	33.3%	50.0%	66.7%	33.3%	46.7%	100.0%	100.0%	40.0%	66.7%	60.0%	54.6%	100.0%		↑			<85%	≥85%
Head & Neck	85%	100.0%		100.0%	0.0%			0.0%	100.0%			92.6%	100.0%	81.8%	0.0%		100.0%		50.0%	0.0%	100.0%								→			<85%	≥85%
Lung	85%	100.0%	100.0%	44.4%	58.3%	66.7%	100.0%	93.8%	72.7%	100.0%	80.0%	69.2%	73.3%	94.1%	70.0%	70.0%	71.4%	88.9%	80.0%	100.0%	81.8%	88.2%	50.0%	68.8%	100.0%	57.9%	50.0%		↓			<85%	≥85%
Other cancer	85%	100.0%	100.0%	66.7%	100.0%	0.0%	0.0%	100.0%	100.0%	0.0%	100.0%				100.0%	50.0%			100.0%	100.0%		50.0%		100.0%					↑			<85%	≥85%
Sarcoma	85%	100.0%	100.0%	66.7%	100.0%	25.0%	66.7%	100.0%	50.0%	100.0%	50.0%		71.4%	71.4%		0.0%	50.0%	0.0%			100.0%	66.7%							→			<85%	≥85%
Skin	85%	91.2%	97.3%	96.8%	100.0%	96.7%	94.8%	92.6%	98.5%	94.5%	98.3%	100.0%	97.5%	97.1%	100.0%	95.7%	96.4%	96.7%	100.0%	95.8%	96.2%	100.0%	95.6%	96.5%	100.0%	88.9%			↓			<85%	≥85%
Testicular	85%								100.0%	100.0%	100.0%				100.0%				100.0%								100.0%		↑			<85%	≥85%
UGI	85%	83.3%	37.5%	91.7%	57.1%	100.0%	70.0%	81.8%	100.0%	66.7%	100.0%	75.0%	100.0%	95.7%	82.4%	80.0%	100.0%	75.0%	58.3%	71.4%	80.0%	100.0%	66.7%	80.0%	92.3%	100.0%	68.8%		↓			<85%	≥85%
Urology	85%	83.2%	85.8%	77.2%	77.5%	69.0%	54.8%	61.4%	83.3%	85.5%	84.1%	78.9%	85.6%	91.1%	79.3%	80.5%	92.9%	79.6%	76.7%	85.7%	85.6%	87.8%	90.1%	72.6%	74.1%	81.8%	75.5%		↓			<85%	≥85%

Note 1: Forecast RAG - green if above national target/trajectory; amber - if below national target but above trajectory or target at risk; red - below national target/trajectory

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.2

Subject:	RBCH Quality Report June 2020

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk Fiona Hoskins, Deputy Director of Nursing and Midwifery Laura Northeast, Head of Patient Engagement Christina Harding, Complaints and PALS Improvement Lead
Presented by:	Paula Shobbrook, Director of Nursing, The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust

Purpose of paper:	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 2020/21 The report provides quality data for June 2020
Background:	As above
Key points for Board members:	To note improvements to 100% in complaints response times for Care Groups A & C
Options and decisions required:	To note
Recommendations:	Nil
Next steps:	Nil

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	All
BAF/Corporate Risk Register: (if applicable)	Yes
CQC Reference:	All domains

Committees/Meetings at which the paper has been submitted:	Date
Joint Quality, Safety and Performance Committee	27.07.2020

NHS
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Quality Report

For the period to end

July 2020

Paula Shobbrook
Director of Nursing and Midwifery

1

Quality Report: July 2020

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 2020/21.

2.0   Serious Incidents (SI)

2 Serious Incidents were reported in June 2020

1. Dermatology – the wrong area had been biopsied which met the criteria of a Never Event. The primary learning is in relation to the need for a written and consistent approach to site marking for biopsies. The report is with the CCG for consideration for closure at the Never Event panel on the 15/07/2020.

2. Interventional Radiology - the side punctured was not that which was agreed with the team at the point of checklist, which meets Never Event criteria at scoping and an investigation is in progress. There was an immediate action identified to review the relevant checklist and to consider observational audit of practice.

2.1   CQC Insight Report

The CQC Insight is used to monitor potential changes to the quality of care that the Trust provides. CQC inspectors check the Insight report regularly and if it suggests an improvement or decline in the quality of care for a service they may follow up between inspections, request further information or request explanations during one of the regular relationship management meetings. It may also help the CQC to decide what, where and when to inspect and provides analysis to support the evidence in their inspection reports. The Insight report is supported by a monthly data sheet from which the CQC Insight Report is generated.

The CQC Insight Model for the Trust was updated on the 14th June 2020

Trust level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Date of last inspection: 14/06/2018	**G** 18/6/2018	**G** 18/6/2018	**G** 18/6/2018	**G** 18/6/2018	**O** 18/6/2018	**G** 18/6/2018

Trust composite of key indicators Feb-19 to May-20
• The current composite indicator score is similar to other acute trusts that were more likely to be rated as requires improvement
• This trust's composite score is among the highest 25% of acute trusts

Outliers, trust wide and core service indicators
• There are currently 0 active outliers for maternity and 0 for mortality. For maternity 0 are with the panel and 0 are with the regional team. For mortality 0 are with the panel and 0 are with the regional team.

Of the 79 trust wide indicators, 6 (8%) are categorised as much better, 7 (9%) as better, 0 (0%) as worse and 0 (0%) as much worse. 60 indicators have been compared to data from 12 months previous, of which 6 (10%) have shown an improvement and 1 (2%) have shown a decline

Much better compared nationally	Much worse compared nationally	Improved	Declined
• Summary Hospital-level Mortality Indicator (SHMI) • Morale • Hospital Standardised Mortality Ratio (Weekday) • Sick days for medical and dental staff-[set target 3.5%] (%) • Hospital Standardised Mortality Ratio (HSMR) • Immediate managers		• Morale • Digital maturity infrastructure score (%) • Summary Hospital-level Mortality Indicator (SHMI) • Digital maturity capabilities score (%) • Hospital Standardised Mortality Ratio (HSMR) • Hospital Standardised Mortality Ratio (Weekday)	• NRLS - Proportion of reported patient safety incidents that are harmful (%)

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

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

66 OF 363
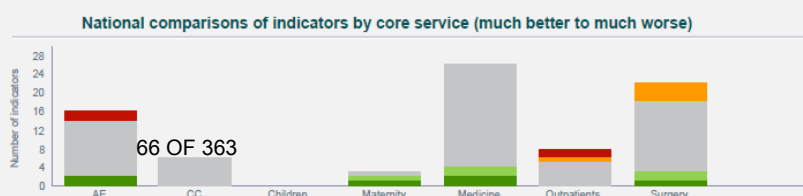
2.2

Alert Reference	Alert Title	Background summary to alert	Issue Date	Closed on CAS system	Actions and follow up
No new National Patient Safety Alerts issued in June 2020.					

3.0 Patient Experience and Engagement

3.1 FFT

A new question will be implemented for the family and friends test as outlined below. The Trust is awaiting confirmation of the national start date from NHSE/I.

Thinking about your recent visit to our hospital, overall, how was your experience of our service?

Very good | Good | Neither good nor poor | Poor | Very poor | Don't know

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

The below table shows the response breakdown both positive and negative themes by area, based on an accumulation of feedback from January 2020 to present.

Table 2:

3
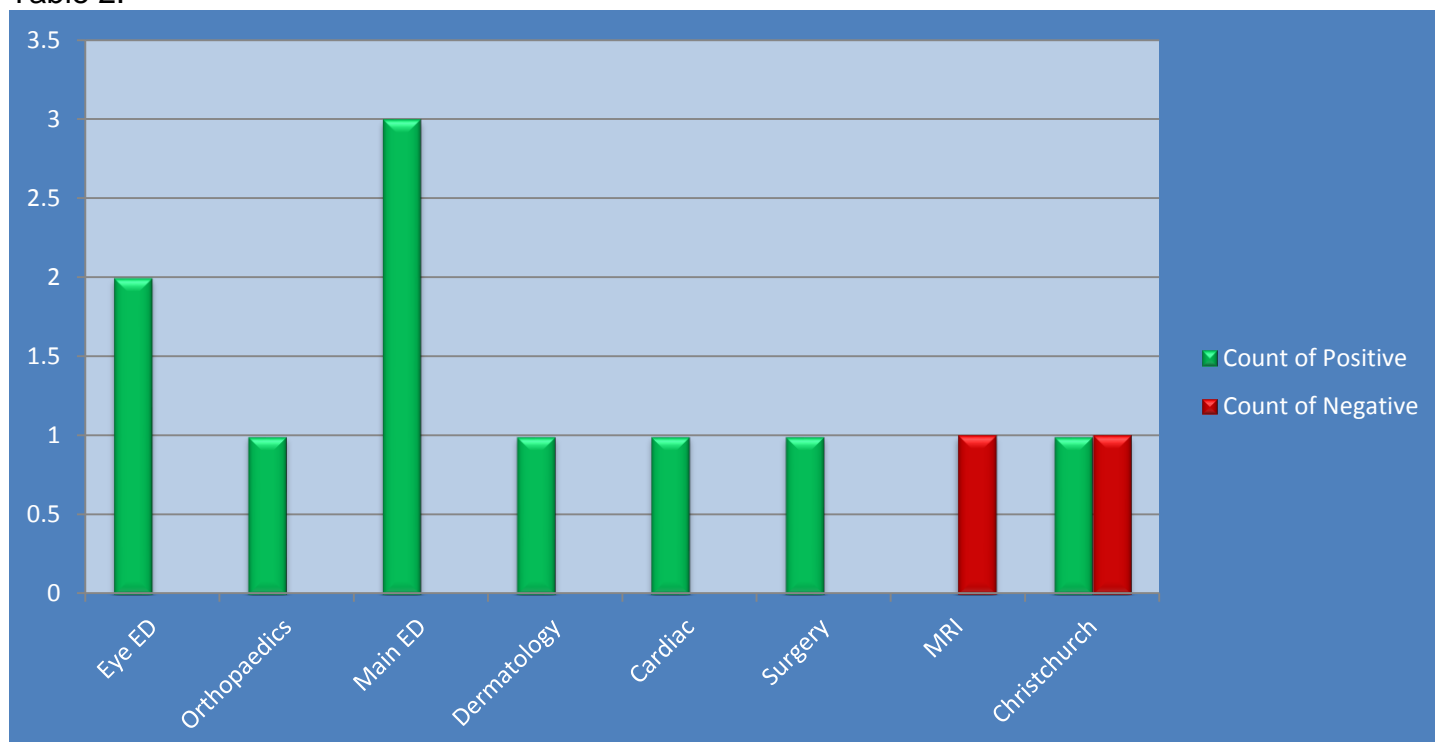
3.3   Care Conversations

As of 24 March 2020 Care Conversations have paused in line with the Government position on reducing contact and increasing social distancing in response to the COVID-19 pandemic.

3.4   Compliments

Many areas receive thank you cards from service users and to date RBCH has 33 cards logged on the system since the beginning of November 2019, with the highest themes being compassion/kindness, individualised care, team working.

4.0   Complaints

4.1   A total of 26 new complaints and 2 reopened complaints were received in June 2020 all of which were acknowledged within 3 days. The highest themes being:

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

To note: The new 1st response timeframe of 35 days for green complaints commenced from the 1st September 2019.

Total Complaints received financial year to date (April to current month): 71

Number by Month Received

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Red		2	1			1	2				1	
Amber	1	2	2	3	5	1					1	
Green	46	30	26	36	38	46	45	42	36	19	24	26

4
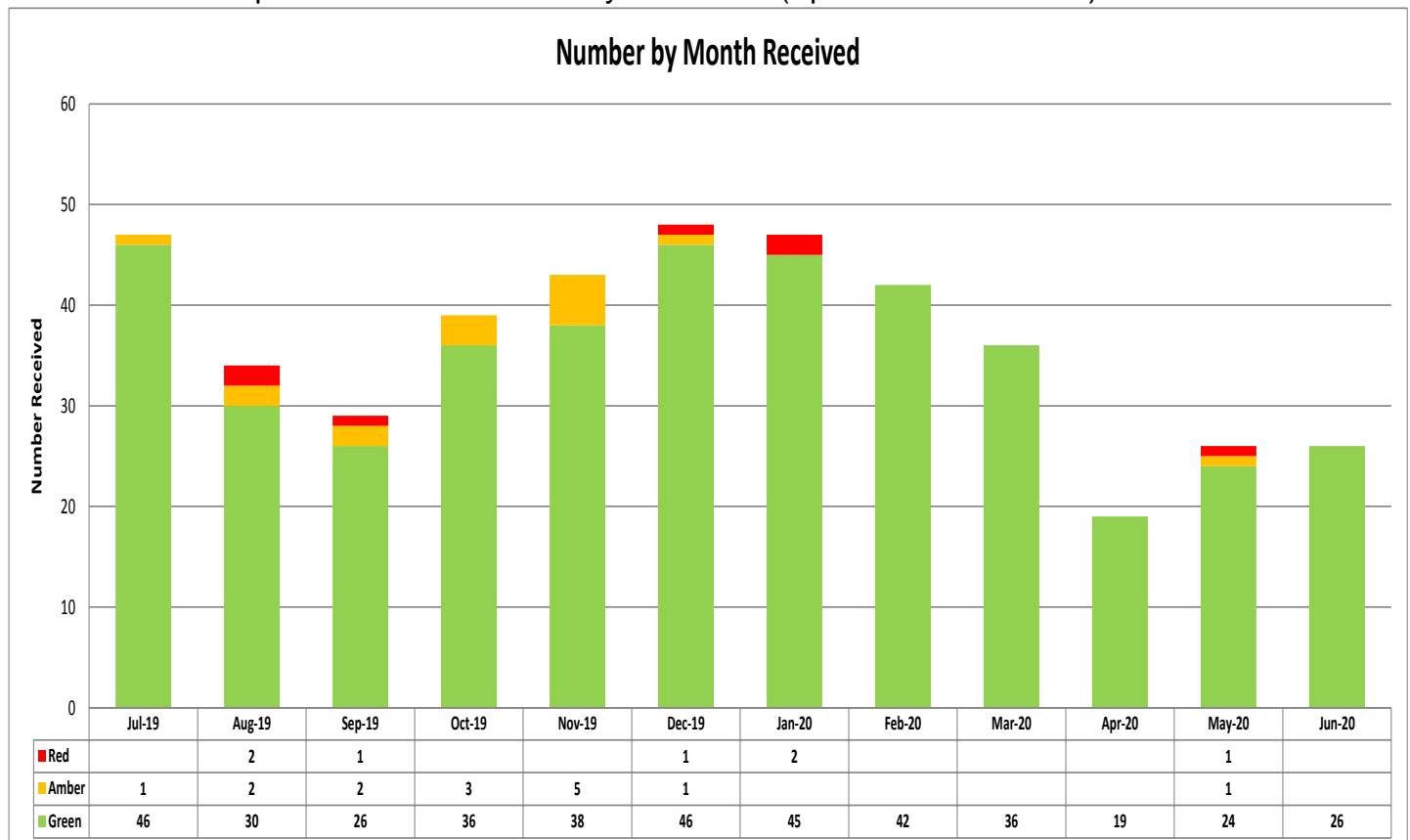
4.2 Complaint response times Year to date

An improvement is noted in the complaints response time for May and June 2020

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Rolling 12 months
1st Responses Due in Month	46	37	32	22	33	36	50	47	44	49	19	27	442
Number Where 1st Response Completed On	22	15	18	17	22	28	45	33	31	30	15	25	301
Percent With 1st Response On Time	48%	41%	56%	77%	67%	78%	90%	70%	70%	61%	79%	93%	68%

There was also further improvement in the overdue clearance in May and June.

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
1st Responses Overdue at Month Start	16	15	16	20	9	8	6	1	9	9	22	9
Number cleared in Month	12	12	7	15	7	7	5	1	5	2	15	6
Percentage cleared in month	75%	80%	44%	75%	78%	88%	83%	100%	56%	22%	68%	67%

5.0 Recommendations

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

CLAIMS AND INQUESTS REPORT JANUARY – JUNE 2020

SUMMARY FOR BOARD PART 1

1.   CLINCAL NEGLIGENCE CLAIMS

There were twenty nine new requests for disclosure of records intimating that a clinical negligence claim is being considered. Seventeen new claims were received in the period which are currently under investigation. Seven claims settled in the period and fifteen claims concluded. There are currently 79 active claims with the total value being £37,109,061 inclusive of claimant and defence costs.

2.0   NON-CLINICAL CLAIMS

There are currently nine open non-clinical claims against the Trust with the total estimated value being £194,250.00. Two new claims was reported in the period and three were closed with two claims settling and one successfully being defended.

3.0   INQUESTS

Thirty five inquests were heard in the reporting period with twenty two inquests being documentary and thirteen requiring witnesses from the Trust to attend. Owing to Covid-19 the Coroner adjourned all witness inquest hearings from the end of March to 1st September 2020.

The Coroner was satisfied that the Trust had put in place appropriate actions to address any patient safety issues and the Trust did not receive any Prevention of Future Death Recommendations in the reporting period.

The number of open inquests is currently sixty five.

Jennie Moffat
Head of Litigation and Inquests

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.3

Subject:	Month 3 Financial Performance

Prepared by:	Andrew Goodwin, Deputy Chief Finance Officer Chris Hickson, Associate Director of Finance
Presented by:	Pete Papworth, Chief Finance Officer

Purpose of paper:	For information.
Background:	In response to the COVID-19 pandemic, national interim financial arrangements have been implemented, effective until at least 31 August 2020 (extended by 1 month). Consistent with this, the Trusts income is no longer conditional upon activity levels and financial performance, with income received as follows: • a fixed monthly payment from commissioners reflecting income reported within the December 2019 financial returns, uplifted for inflation; • a fixed monthly 'top-up' payment based on the average expenditure reported during November 2019, December 2019 and January 2020; and • a retrospective 'true-up' payment to cover specific COVID-19 costs and income losses and support a financial break-even position. As a result of these arrangements; despite setting a deficit budget (due to a number of non-recurrent financial benefits during November 2019, December 2019 and January 2020), the Trust is expecting to report a financial break-even position each month, supported by a variable retrospective 'true-up' payment.
Key points for members:	• Both Trusts have reported a YTD financial break-even position; inclusive of accrued income in relation to the retrospective 'true-up' payment (RBCHFT £1.198m; PHFT £2.720m). This reflects the net deficit after taking into account the budget deficit, the direct impact of COVID-19 (revenue costs and lost income), off-set by under spends against base budgets reflecting the reduced activity and bed occupancy during April.

	• Capital spend to date totals £3.031m at RBCHFT (of which £563,000 related to the Trusts COVID-19 response) and £1.718m at PHFT (of which £697,000 directly related to COVID-19). Non COVID-19 capital spend reflects the first year of the agreed joint six-year capital programme. • Both Trusts are holding significant cash balances (RBCHFT £86.1m; PHFT £32.6m), inclusive of the fixed contractual and 'top-up' payments for June (RBCH £23m; PHFT £19.7m). This reflects the new cash regime and is expected to support all invoices being paid within 7 days of receipt.
Options and decisions required:	No decisions are required at this time.
Recommendations:	Members are asked to note the financial performance to 30 June 2020.
Next steps:	Continued close monitoring and strong financial governance given the unprecedented circumstances and associated volatility.

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
FIC	July 2020
HEG	July 2020

Finance Report

June 2020

Pete Papworth
Joint Director of Finance

Key Points - June 2020

In response to the COVID-19 pandemic, national interim financial arrangements have been implemented. Consistent with this, the Trusts income is no longer conditional upon activity levels and financial performance, with income received as follows:

 - a fixed monthly payment from commissioners reflecting income reported within the December 2019 financial returns, uplifted for inflation;
 - a fixed monthly 'top-up' payment based on the average expenditure reported during November 2019, December 2019 and January 2020;
 - a retrospective 'true-up' payment to cover specific COVID-19 costs and income losses and support a financial break-even position.

As a result of these arrangements; despite setting a deficit budget (due to a number of non-recurrent financial benefits during November 2019, December 2019 and January 2020), the Trust is expecting to report a financial break-even position each month, supported by a variable retrospective 'true-up' payment.

During June the Trust has reported additional costs of £1,557,000 and income losses of £516,000 in responding to the COVID-19 pandemic. This results in a net deficit of £2.238 million when added to the budget deficit of £165,000. However this has been partially off-set by significant under spends against the baseline pay, drugs and clinical supplies budgets due to the cancellation of elective activity and a significantly reduced bed occupancy. As a result, the retrospective 'true-up' requirement to achieve a break-even position is £1,194,000, which has been accrued.

Capital expenditure at the end of June amounted to £1,718,000 (YTD) of which £697,000 related to specific COVID-19 requirements and is expected to be reimbursed. The full year capital programme reflects the first year of the joint (with The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust) six year capital programme and totals £27.5 million. This will be monitored closely given the potential impact of the pandemic and risk of slippage.

The Trust is currently holding a consolidated cash balance of £32.6 million, however this includes the July contractual and top-up payments, received in advance (£19.7 million).

As reported previously, interim financial governance arrangements have been put in place to ensure all COVID-19 costs are appropriately considered and approved in advance.

Income & Expenditure

NHS Poole Hospital NHS Foundation Trust

Income

Income is £531k favourable in month due to the additional top-up payment accrued to deliver a break-even position of £1,194k. Contract income is per the block contract payment plan. Education & Trainng income is ahead of plan by £163k, but is offset with cost. Other operating income is behind plan by £516k as a direct consequence of lower activity as a result of COVID-19 in areas such as private patient income, overseas visitors, recharge income and car park & catering.

Operating Expenditure

Total expenditure is £317k adverse to plan.

This includes £1,557k of expenditure related to COVID-19. Pay is underspent due to lower than plan expenditure on agency which relfects the lower activity levels, as are clinical supplies and drugs.

For a further breakdown of pay expenditure, see Pay section of this report.

Agency costs in June were £414k, being significantly below the costs incurred in February & March reflecting the reduced activity and bed occupancy.

STATEMENT OF COMPREHENSIVE INCOME	In Month (£'000)			Year to Date (£'000)			Full Year (£'000)		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Operating income from patient care activities: Dorset CCG	14,793	14,793	0	44,355	44,354	(1)	177,364	177,364	0
Operating income from patient care activities: NHSE	4,547	4,547	0	13,641	13,634	(7)	54,564	54,564	0
Operating income from patient care activities: West Hampshire CCG	365	365	0	1,095	1,095	0	4,380	4,380	0
Operating income from patient care activities: Other CCG	0	0	0	0	(9)	(9)	0	0	0
Operating income from patient care activities: Other (inc. Non NHS)	338	(224)	(562)	914	379	(535)	3,294	3,294	0
Other operating income	4,272	5,365	1,093	12,955	15,206	2,251	52,226	52,226	0
Operating Income	**24,315**	**24,846**	**531**	**72,960**	**74,659**	**1,699**	**291,828**	**291,828**	**0**
Charitable Income	102	102	0	307	307	0	1,800	1,800	0
Total Income	**24,417**	**24,948**	**531**	**73,266**	**74,966**	**1,700**	**293,628**	**293,628**	**0**
Employee expenses	(16,395)	(16,661)	(266)	(49,488)	(50,210)	(722)	(199,593)	(199,593)	0
Clinical supplies expenses	(1,658)	(1,243)	415	(4,979)	(4,924)	55	(19,927)	(19,927)	0
Drugs expenses	(2,286)	(2,168)	118	(6,762)	(6,321)	441	(26,789)	(26,789)	0
Purchase of healthcare and social care	(29)	(55)	(26)	(88)	(257)	(169)	(353)	(353)	0
Depreciation and amortisation expense	(659)	(644)	15	(1,975)	(1,919)	56	(7,900)	(7,900)	0
Clinical Negligence expense	(880)	(880)	0	(2,641)	(2,641)	0	(10,559)	(10,559)	0
Premises & Fixed Plant	(701)	(1,156)	(455)	(2,103)	(2,626)	(523)	(8,393)	(8,393)	0
Other operating expenses	(1,653)	(1,771)	(118)	(4,811)	(5,251)	(440)	(19,786)	(19,786)	0
Operating Expenses	**(24,261)**	**(24,578)**	**(317)**	**(72,847)**	**(74,149)**	**(1,302)**	**(293,300)**	**(293,300)**	**0**
Net finance costs	(321)	(434)	(113)	(963)	(1,007)	(44)	(3,852)	(3,852)	0
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0	0	0	0	0
SURPLUS/ (DEFICIT)	**(165)**	**(64)**	**101**	**(544)**	**(190)**	**354**	**(3,524)**	**(3,524)**	**0**
Consolidation	0	0	0	0	0	0	0	0	0
Surplus/ (Deficit) after Consolidation	**(165)**	**(64)**	**101**	**(544)**	**(190)**	**354**	**(3,524)**	**(3,524)**	**0**
Less:									
Impairment adjustment	0	0	0	0	0	0	0	0	0
Capital donations/grants income impact	(5)	64	69	135	190	55	40	40	0
Subtotal	**(170)**	**0**	**170**	**(409)**	**0**	**409**	**(3,484)**	**(3,484)**	**0**
Control Total	0	0	0	0	0	0	0	0	0
Variance from Control Total	**(170)**	**0**	**170**	**(409)**	**0**	**409**	**(3,484)**	**(3,484)**	**0**

Performance against Control Total

Due to the national interim financial arrangements, the Trust is not required to agree a financial control total at present. Instead, the Trust is expecting to report a financial break-even position each month supported by the retrospective 'true-up' payment to cvoer specific COVID-19 related costs. These interim arrangements will be in place until at least 31 August 2020

Care Group Performance and Forecast

NHS Poole Hospital NHS Foundation Trust

Care Group Performance

The Surgical Care Group were £219k favourable. Critical Care Non Pay £128k favourable due to Theatres consumables. Critical Care Pay £101k favourable vacancies and agency budget allocation.

The Medical Care group were £635k favourable. General Medicine's Non Pay £242k favourable due to Bowel Scope Screening SLA recharges. General Medicine's Pay £220k favourable due to vacancies and agency budget allocation.

Clinical & Operational Support were £298k favourable. Pathology Non Pay £270k favourable due to ROCHE 2019-20 contract corrections in Biochemistry.

Womens, Childrens & Oncology were £391k favourable. Oncology Non Pay £219k favourable due to CDF drugs and Radiotherapy Physics Maintenance contract spends.

Directorate	In Month (£'000)			Year to Date (£'000)			Full Year (£'000)		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Critical Care	(2,268)	(2,087)	181	(6,800)	(6,245)	555	(27,509)	(27,509)	0
Surgery	(1,184)	(1,139)	45	(3,562)	(3,499)	64	(14,260)	(14,260)	0
Trauma & Orthopaedics	(918)	(925)	(7)	(2,797)	(2,856)	(59)	(11,274)	(11,274)	0
Surgical Care Group	**(4,369)**	**(4,150)**	**219**	**(13,159)**	**(12,599)**	**560**	**(53,043)**	**(53,043)**	**0**
General Medicine	(3,022)	(2,580)	442	(9,133)	(8,204)	928	(37,973)	(37,973)	0
Specialist Medicine	(1,091)	(1,022)	69	(3,254)	(3,002)	252	(12,751)	(12,751)	0
Emergency & Ambulatory Care	(1,247)	(1,123)	124	(3,737)	(3,555)	182	(15,073)	(15,073)	0
Medical Care Group	**(5,361)**	**(4,726)**	**635**	**(16,123)**	**(14,761)**	**1,362**	**(65,797)**	**(65,797)**	**0**
Radiology & Therapies	(1,692)	(1,563)	129	(5,082)	(4,780)	303	(20,615)	(20,615)	0
Pharmacy & Pathology	(1,262)	(958)	303	(3,790)	(3,750)	40	(15,320)	(15,320)	0
Operational Support & Outpatients	(748)	(883)	(134)	(2,236)	(2,662)	(427)	(9,006)	(9,006)	0
Clinical & Operational Support	**(3,702)**	**(3,404)**	**298**	**(11,108)**	**(11,192)**	**(84)**	**(44,942)**	**(44,942)**	**0**
Oncology and Cancer Services	(2,245)	(1,972)	274	(6,744)	(6,117)	627	(26,976)	(26,976)	0
Women's Services	(1,234)	(1,157)	77	(3,675)	(3,555)	120	(14,923)	(14,923)	0
Children's Services	(1,399)	(1,359)	40	(4,095)	(3,979)	116	(15,842)	(15,842)	0
Women, Children & Oncology	**(4,878)**	**(4,487)**	**391**	**(14,514)**	**(13,651)**	**863**	**(57,741)**	**(57,741)**	**0**
Corporate	(3,546)	(3,568)	(22)	(10,908)	(10,694)	214	(42,214)	(42,214)	0
Corporate	**(3,546)**	**(3,568)**	**(22)**	**(10,908)**	**(10,694)**	**214**	**(42,214)**	**(42,214)**	**0**
Centrally Managed Budgets	(1,221)	(3,359)	(2,138)	(3,652)	(8,497)	(4,845)	(14,166)	(14,166)	0
Trust-Wide Income	22,911	23,630	719	68,921	71,204	2,283	274,380	274,380	0
Centrally Managed	**21,690**	**20,271**	**(1,419)**	**65,269**	**62,707**	**(2,561)**	**260,214**	**260,214**	**0**
Total Surplus/ (Deficit)	**(165)**	**(64)**	**101**	**(544)**	**(190)**	**354**	**(3,524)**	**(3,524)**	**0**

Dorset Integrated Care System (ICS)

NHS
Poole Hospital
NHS Foundation Trust

Dorset ICS Financial Position

Due to the national interim financial arrangements, there is currently no requirement to agree financial control totals. Instead, all NHS organisations are expecting to report financial break-even positions each month supported by fixed payments from commissioners, a national 'top-up' payment reflective of the underlying cost base, and a retrospective 'true'up' payment to cover specific COVID-19 related costs. These interim arrangements will be in place until at least 31 August 2020.

The position reported across the Dorset ICS is shown below.

Financial Position by Organisation (incl. Sustainability Funding)	In Month (£'000)			Year to Date (£'000)			Full Year (£'000)		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Dorset County Hospital NHS FT	0	0	0	0	0	0	0	0	0
Dorset Healthcare University NHS FT	0	0	0	0	0	0	0	0	0
Poole Hospital NHS FT	(170)	0	170	(409)	0	409	(3,485)	0	3,485
Dorset Clinical Commissioning Group	0	0	0	0	0	0	0	0	0
Royal Bournemouth & Christchurch Hospitals NHS FT	(315)	0	315	(411)	0	411	(2,930)	0	2,930
Dorset ICS Surplus/(Deficit)	**(485)**	**0**	**485**	**(820)**	**0**	**820**	**(6,415)**	**0**	**6,415**

System Control Total	0	0	0	0	0	0	0	0	0
Sustainability Funding attributable to system	0	0	0	0	0	0	0	0	0

Pay Expenditure

Pay Expenditure: Key Points

Total pay for the Trust was £722k adverse against budget year to date.

Substantive pay was £4,500k favourable against budget, mainly as a result of vacancies, with this offset by expenditure on Overtime (£323k), Bank (£3,508k) and Agency staffing (£1,390k).

The Surgical Care Group had the highest Overtime expenditure of £152k; the majority of this spend relating to the Critical Care Directorate (£149k). The Care Group also had the highest Agency usage of £337k. The Critical Care Directorate Agency spend (£150k) was predominantly for Theatre agency staff, whilst the Trauma & Orthopaedics Directorate (£133k) spend was mainly for Registered Nursing agency staff.

The Medical Care Group spend had the highest bank spend of £1,114k, mainly in Emergency & Ambulatory Care (£605k) and General Medicine (£380k). £441k of spend in Emergency & Ambulatory care related to Medical staff bank, with £88k relating to Registered Nursing. £230k of General Medicine Bank spend related to Registered Nursing with £86k related to Unregistered nursing.

The largest variance was a £2,495k overspend against Centrally Managed Budgets. £2,340k of this spend related to COVID-19 staffing which included £279k of agency spend (£150k Consultant agency and £88k Registered Nurse agency) and £948k of bank spend (£427k Registered Nurse bank, £266k Medical bank and £151k Unregistered Nurse bank).

Directorate	Year To Date (£'000)						
	Budget	Substantive	Pay Underspend	Overtime	Bank	Agency	Variance
Critical Care	5,102	4,611	491	149	25	150	166
Surgery	3,342	2,974	368	3	223	54	88
Trauma & Orthopaedics	2,613	2,212	401	0	353	133	(85)
Surgical Care Group	**11,057**	**9,797**	**1,260**	**152**	**601**	**337**	**170**
General Medicine	7,714	6,724	990	10	380	120	480
Specialist Medicine	1,585	1,349	236	2	128	55	50
Emergency & Ambulatory Care	3,714	2,821	893	3	605	87	198
Medical Care Group	**13,013**	**10,894**	**2,119**	**15**	**1,114**	**262**	**728**
Radiology & Therapies	4,546	3,987	559	34	111	143	271
Pharmacy & Pathology	2,806	2,420	386	11	41	95	239
Operational Support & Outpatients	2,191	2,024	167	16	92	52	8
Clinical & Operational Support	**9,543**	**8,431**	**1,112**	**61**	**243**	**290**	**518**
Oncology and Cancer Services	3,755	3,371	384	22	187	103	72
Women's Services	3,525	3,256	269	1	194	22	52
Children's Services	3,302	3,123	180	1	101	(2)	78
Women, Children & Oncology	**10,582**	**9,749**	**833**	**25**	**483**	**123**	**203**
Corporate	4,052	3,722	330	70	80	24	155
Corporate	**4,052**	**3,722**	**330**	**70**	**80**	**24**	**155**
Centrally Managed Budgets	636	1,790	(1,154)	0	986	355	(2,495)
Trust-Wide Income	604	604	0	0	0	0	0
Centrally Managed	**1,240**	**2,394**	**(1,154)**	**0**	**986**	**355**	**(2,495)**
Totals	**49,488**	**44,988**	**4,500**	**323**	**3,508**	**1,390**	**(722)**

Agency, Bank and Overtime Costs Against Pay Underspend

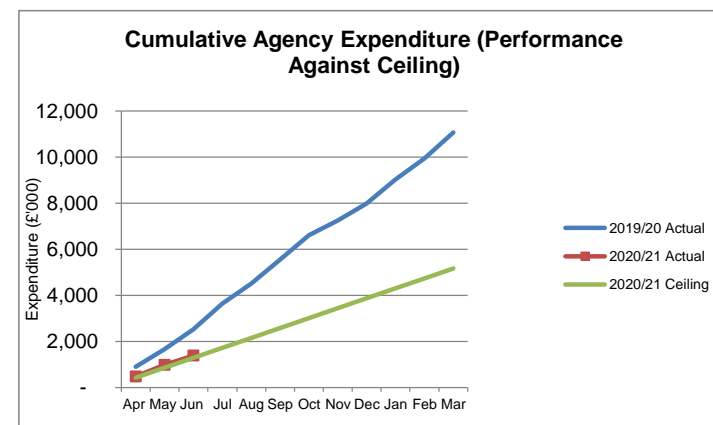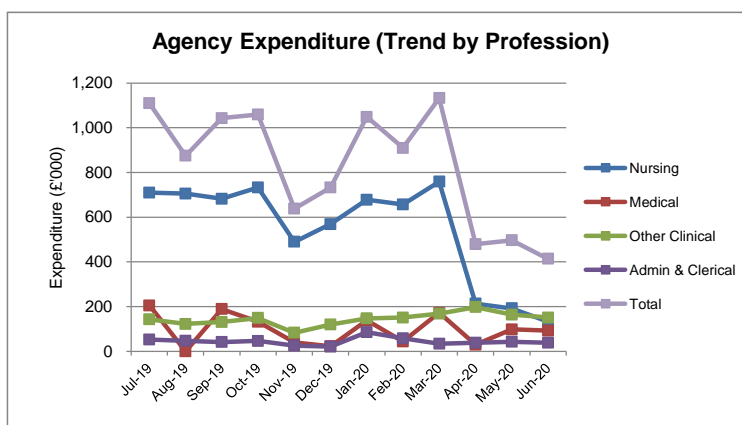# Pay Expenditure

NHS
Poole Hospital
NHS Foundation Trust
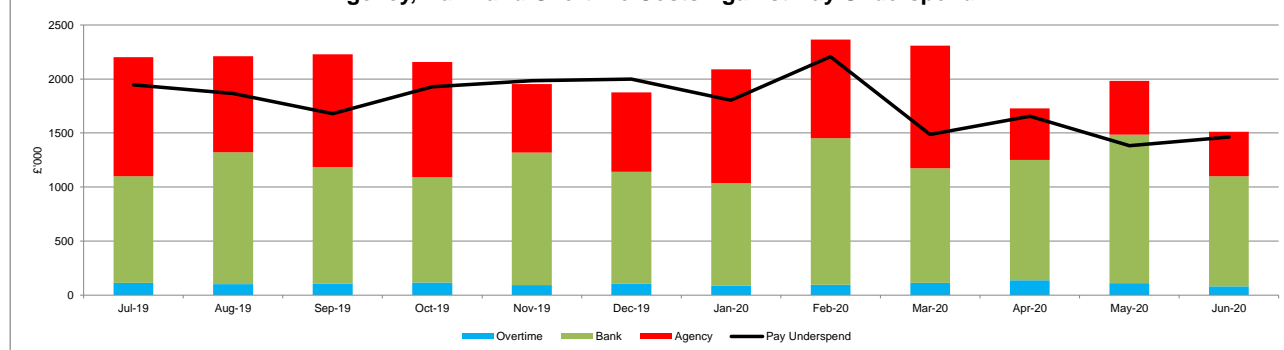
Agency Expenditure

Total agency staff expenditure for Month 3 was £414k (compared to £497k in Month 2), against a £431k NHSI target. At £133k nursing agency staff accounted for the largest staff group spend, followed by £92k on Medical staff, £65k on Allied Health Professionals (Radiotherapy and Radiology agency staff) and £59k on Allied Health Professionals (Theatres agency staff).

Of the total agency spend, £114k related to COVID-19 (compared to £97k in Month 2).

Pay Metrics	In Month Actual	Year to Date Actual	Full Year		
			Budget	Forecast	Variance
Total pay costs as % of total operating income	67.1%	67.3%	68.4%	68.4%	0.0%
Agency expenditure as % of total pay	2.5%	2.8%	4.2%	4.2%	0.0%

Agency Expenditure (Trend by Profession)

Cumulative Agency Expenditure (Performance Against Ceiling)

Agency Spend by Profession (£'000)	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Nursing	710	706	682	733	490	569	678	657	759	213	192	133
Medical	205	0	189	132	40	23	138	44	172	29	98	92
Other Clinical	143	122	131	149	83	120	147	151	168	198	164	151
Admin & Clerical	52	47	41	46	25	21	86	58	34	38	43	38
Total	**1,110**	**875**	**1,043**	**1,060**	**638**	**733**	**1,049**	**910**	**1,133**	**479**	**497**	**414**

Cash and Working Capital

NHS
Poole Hospital
NHS Foundation Trust

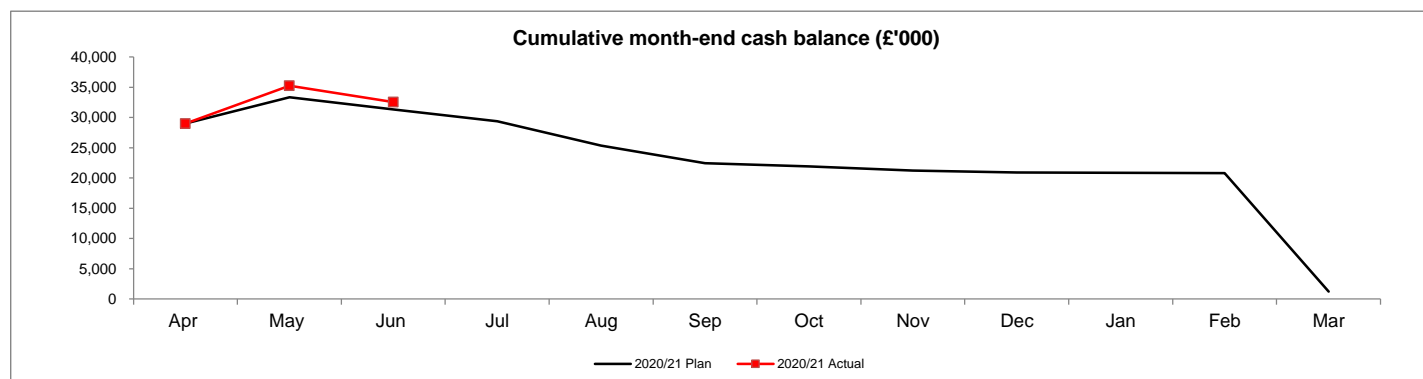**Cash Balance**

The closing cash balance is £32.6m which includes the July block contract payments of £19.7m. The 2019/20 Q4 PSF was received in May (£5.5m).

This cash balance under the interim financing arrangements assumes that cash support is not required.

The cash position continues to be monitored on a daily basis. The cash plan assumes that the block contract payments are in place for the whole financial year.

Cumulative month-end cash balance (£'000)

Cumulative cash balance	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
2020/21 Plan	29,005	33,328	31,320	29,377	25,339	22,440	21,904	21,226	20,929	20,875	20,799	1,249
Of which												
Uncommitted Term Loan	0	0	0	0	0	0	0	0	0	0	0	0
2020/21 Actual	29,005	35,254	32,555									
Of which												
Uncommitted Term Loan	0	0	0									

Public Sector Payment Policy: Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

As part of the public sector response to COVID-19, public sector organsations have been instructed to pay all suppliers within 7 working days of receipt of invoice/delivery of goods. The Trust is therefore making daily payments for all invoices that are approved. During the first quarter no on-account payments have been made.

Better Payment Practice Code	In Month		Year to Date	
Non-NHS Invoices	No.	£'000	No.	£'000
Total bills paid	4,092	10,987	15,925	38,835
Total bills paid within target	3,998	10,248	14,761	35,858
Percentage of bills paid within target	97.7%	93.3%	92.7%	92.3%
NHS Invoices				
Total bills paid	291	3,901	762	4,865
Total bills paid within target	286	3,885	650	4,511
Percentage of bills paid within target	98.3%	99.6%	85.3%	92.7%
Total				
Total bills paid	4,383	14,888	16,687	43,700
Total bills paid within target	4,284	14,133	15,411	40,369
Percentage of bills paid within target	97.7%	94.9%	92.4%	92.4%

Capital Programme

New capital arrangements are in place for 2020/21, with capital allocations made at Integrated Care system level, rather than at individual organisation level.

The Dorset ICS allocation has now been received and detailed capital plans were submitted to NHS England and Improvement on 29 May.

The Trust's proposed capital programme for 2020/21 amounts to £24.4 million. This represents ths Trusts element of the agreed joint (with The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust) six year capital programme. This excludes COVID-19 related capital expenditure which is separately reimbursed.

Capital expenditure at the end of June amounted to £1,718k. Specific capital costs relating to the Trusts response to COVID-19 pandemic totalled £697k.

Capital Programme	Year to Date (£'000)			Full Year (£'000)		
	Budget	Actual	Variance	Budget	Forecast	Variance
Estates	75	39	36	3,524	3,524	0
Estates	**75**	**39**	**36**	**3,524**	**3,524**	**0**
EPMA	0	97	(97)	220	220	0
IT Schemes	272	174	98	2,546	2,546	0
IT Schemes	**272**	**271**	**1**	**2,766**	**2,766**	**0**
COVID-19	697	697	0	697	697	0
Medical Equipment	515	19	496	5,154	5,154	0
Linac at Poole	0	0	0	0	0	0
Donated Assets	263	0	263	1,764	1,764	0
Medical Equipment	**1,475**	**716**	**759**	**7,615**	**7,615**	**0**
Theatres Programme	1,116	323	793	7,765	7,765	0
CSR Acute Reconfiguration - WCEC	951	369	582	3,392	3,392	0
Centrally Managed	**2,067**	**692**	**1,375**	**11,156**	**11,156**	**0**
Grand Total	**3,889**	**1,718**	**2,171**	**25,061**	**25,061**	**0**

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

Finance Report

June 2020

Pete Papworth
Joint Director of Finance

Executive Summary

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Key Points - June 2020

In response to the COVID-19 pandemic, national interim financial arrangements have been implemented. Consistent with this, the Trusts income is no longer conditional upon activity levels and financial performance, with income received as follows:

 - a fixed monthly payment from commissioners reflecting income reported within the December 2019 financial returns, uplifted for inflation;
 - a fixed monthly 'top-up' payment based on the average expenditure reported during November 2019, December 2019 and January 2020;
 - a retrospective 'true-up' payment to cover specific COVID-19 costs and income losses and support a financial break-even position.

As a result of these arrangements; despite setting a deficit budget, the Trust is expecting to report a financial break-even position each month, supported by a variable retrospective 'true-up' payment.

During June the Trust has reported additional costs of £1,746,000 and income losses of £310,000 in responding to the COVID-19 pandemic. This results in a net deficit of £2.371 million when added to the budget deficit of £315,000. However this has been partially off-set by significant under spends against the baseline, drugs, devices and clinical supplies budgets due to the cancellation of elective activity and a significantly reduced bed occupancy. As a result, the retrospective 'true-up' requirement to achieve a break-even position is £1,030,000 which has been accrued.

Capital expenditure to June amounted to £3.031 million of which £563,000 related to specific COVID-19 requirements and is expected to be reimbursed. The full year capital programme reflects the first year of the joint (with Poole Hospitals NHS Foundation Trust) six year capital programme and totals £34.3 million. This will be monitored closely given the potential impact of the pandemic and risk of slippage.

The Trust is currently holding a consolidated cash balance of £86.1 million, however this includes the July contractual and top-up payments, received in advance (£23 million).

As reported previously, interim financial governance arrangements have been put in place to ensure all COVID-19 costs are appropriately considered and approved in advance.

Income & Expenditure

NHS
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Income

Income is £677,000 favourable in month due to the additional top-up payment of £1.030 million which has been accrued to deliver a break-even position. Contract income is per the block contract payment plan.

Operating income from patients activities is £174,000 behind plan mainly due to reduced private patient income. Other operating income is ahead of plan by £851,000 due to the top up payment however this is offset by shortfalls in car parking, catering and research income.

Operating Expenditure

Total expenditure is £400,000 adverse to plan.

This includes £1.746 million of expenditure related to COVID-19. Pay is overspent by £657,000 however £791,000 relates to COVID-19 pay. Lower activity levels are driving underspends in clinical supplies, general drugs and high cost devices.

For a further breakdown of pay expenditure, see Pay section of this report.

Agency costs in June were £316,000, being significantly below the costs incurred in February & March reflecting the reduced activity and bed occupancy.

STATEMENT OF COMPREHENSIVE INCOME	In Month (£'000)			Year to Date (£'000)			Full Year (£'000)		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Operating income from patient care activities: Dorset CCG	16,832	16,832	0	50,495	50,495	0	214,751	214,751	0
Operating income from patient care activities: NHSE	3,911	3,911	0	11,734	11,734	0	48,059	48,059	0
Operating income from patient care activities: West Hampshire CCG	2,252	2,252	0	6,755	6,755	0	27,022	27,022	0
Operating income from patient care activities: Other CCG	255	255	0	764	764	0	3,054	3,054	0
Operating income from patient care activities: Other (inc. Non NHS)	808	634	(174)	2,302	1,686	(615)	8,732	8,732	0
Other operating income	3,477	4,328	851	9,821	10,023	202	20,869	20,869	0
Operating Income	**27,534**	**28,211**	**677**	**81,870**	**81,457**	**(414)**	**322,487**	**322,487**	**0**
Charitable Income	172	151	(21)	532	513	(19)	189	189	0
Total Income	**27,706**	**28,362**	**656**	**82,402**	**81,969**	**(433)**	**322,676**	**322,676**	**0**
Employee expenses	(17,757)	(18,415)	(657)	(52,939)	(55,036)	(2,097)	(209,651)	(209,651)	0
Clinical supplies expenses	(2,631)	(2,180)	451	(7,681)	(5,747)	1,934	(35,626)	(35,626)	0
Drugs expenses	(2,980)	(2,595)	385	(8,566)	(7,002)	1,564	(35,002)	(35,002)	0
Purchase of healthcare and social care	(435)	(345)	90	(1,277)	(1,350)	(74)	(4,405)	(4,405)	0
Depreciation and amortisation expense	(688)	(765)	(77)	(2,063)	(2,287)	(224)	(8,252)	(8,252)	0
Clinical Negligence expense	(390)	(390)	(0)	(1,170)	(1,170)	(0)	(4,681)	(4,681)	0
Premises & Fixed Plant	(1,174)	(1,597)	(422)	(3,250)	(3,951)	(701)	(11,879)	(11,879)	0
Other operating expenses	(1,385)	(1,555)	(170)	(4,128)	(3,791)	337	(9,758)	(9,758)	0
Operating Expenses	**(27,441)**	**(27,841)**	**(400)**	**(81,075)**	**(80,335)**	**740**	**(319,254)**	**(319,254)**	**0**
Net finance costs	(579)	(569)	10	(1,738)	(1,731)	6	(6,951)	(6,951)	0
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0	0	600	600	0
SURPLUS/ (DEFICIT)	**(315)**	**(48)**	**266**	**(411)**	**(97)**	**314**	**(2,930)**	**(2,930)**	**0**
Consolidation	0	21	21	0	16	16			
Surplus/ (Deficit) after Consolidation	**(315)**	**(27)**	**287**	**(411)**	**(81)**	**330**	**(2,930)**	**(2,930)**	**0**
Less:									
Impairment adjustment	0	0	0	0	0	0	0	0	0
Capital donations/grants income impact	0	27	27	0	81	81	0	0	0
Subtotal	**(315)**	**0**	**315**	**(411)**	**0**	**411**	**(2,930)**	**(2,930)**	**0**
Control Total		0			0		0	0	
Variance from Control Total	**(315)**	**0**	**315**	**(411)**	**0**	**411**	**(2,930)**	**(2,930)**	**0**

Performance against Control Total

Due to the interim funding arrangements following the COVID-19 pandemic the Trust is working to a breakeven position with any shortfall in expenditure funded through the True up process. The current guidance advises that these interim arrangements will be in place until 31 August 2020.

Care Group Performance and Forecast

NHS
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Care Group Performance

Care Group positions are underspent due to the current arrangements in place concerning Elective activity and the redeployment of clinical staff.

This underspend is being directly offset with £3.979 million year to date spend in relation to COVID-19 which is reported within Centrally Managed Budgets.

Directorate	In Month (£'000)			Year to Date (£'000)			Full Year (£'000)		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Anaesthetics and Theatres	(1,951)	(1,929)	22	(5,832)	(5,630)	202	(23,318)	(23,318)	0
Maternity	(298)	(314)	(15)	(892)	(909)	(17)	(3,579)	(3,579)	0
Orthopaedics	(939)	(527)	412	(2,842)	(1,888)	954	(11,419)	(11,419)	0
Surgery	(2,285)	(2,235)	50	(6,782)	(6,264)	518	(27,157)	(27,157)	0
Surgery Management	(80)	(72)	8	(268)	(251)	17	(1,130)	(1,130)	0
Surgical Care Group	**(5,554)**	**(5,077)**	**477**	**(16,617)**	**(14,942)**	**1,675**	**(66,603)**	**(66,603)**	**0**
Cardiology	(1,677)	(1,651)	27	(4,913)	(4,633)	280	(19,816)	(19,816)	0
ED and AMU	(1,861)	(1,813)	47	(5,516)	(5,666)	(149)	(22,178)	(22,178)	0
Medicine	(2,362)	(2,323)	39	(6,913)	(6,671)	242	(27,907)	(27,907)	0
Older People's Medicine	(2,579)	(2,608)	(29)	(7,733)	(7,794)	(62)	(30,960)	(30,960)	0
Medical Care Group	**(8,479)**	**(8,395)**	**84**	**(25,075)**	**(24,764)**	**311**	**(100,861)**	**(100,861)**	**0**
Cancer Care	(1,960)	(1,897)	63	(5,654)	(5,216)	438	(23,045)	(23,045)	0
Ophthalmology	(1,127)	(983)	145	(3,288)	(2,822)	466	(13,396)	(13,396)	0
Pathology	(242)	(97)	145	(785)	(528)	257	(3,128)	(3,128)	0
Radiology	(812)	(828)	(16)	(2,473)	(2,350)	123	(9,861)	(9,861)	0
Specialist Services	(1,634)	(1,371)	264	(4,921)	(4,075)	846	(19,712)	(19,712)	0
Specialties Management	(3)	(6)	(3)	(9)	(9)	0	(34)	(34)	0
Research	0	(174)	(174)	0	(344)	(344)	0	0	0
Specialties Care Group	**(5,778)**	**(5,354)**	**424**	**(17,129)**	**(15,344)**	**1,785**	**(69,177)**	**(69,177)**	**0**
Corporate	(3,204)	(3,511)	(308)	(9,646)	(10,135)	(489)	(38,334)	(38,334)	0
Corporate	**(3,204)**	**(3,511)**	**(308)**	**(9,646)**	**(10,135)**	**(489)**	**(38,334)**	**(38,334)**	**0**
Centrally Managed Budgets	(1,985)	(2,500)	(515)	(5,944)	(8,951)	(3,008)	(24,043)	(24,043)	0
Trust-Wide Income	24,685	24,790	105	73,999	74,040	40	296,087	296,087	0
Centrally Managed	**22,701**	**22,290**	**(411)**	**68,056**	**65,088**	**(2,967)**	**272,044**	**272,044**	**0**
Total Surplus/ (Deficit)	**(315)**	**(48)**	**266**	**(411)**	**(97)**	**314**	**(2,930)**	**(2,930)**	**0**
Consolidation	0	21	21	0	16	16			
Surplus/(Deficit) after Consolidation	**(315)**	**(27)**	**287**	**(411)**	**(81)**	**330**	**(2,930)**	**(2,930)**	**0**
Less:									
Impairment adjustment	0	0	0	0	0	0	0	0	0
Capital donations/grants income impact	0	27	27	0	81	81	0	0	0
Subtotal	**(315)**	**0**	**315**	**(411)**	**0**	**411**	**(2,930)**	**(2,930)**	**0**
Control Total		0	0	0	0			0	
Variance from Control Total	**(315)**	**0**	**315**	**(411)**	**0**	**411**	**(2,930)**	**(2,930)**	**0**

Dorset Integrated Care System (ICS)

NHS
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Dorset ICS Financial Position

Due to the national interim financial arrangements, there is currently no requirement to agree financial control totals. Instead, all NHS organisations are expecting to report financial break-even positions each month supported by fixed payments from commissioners, a national 'top-up' payment reflective of the underlying cost base, and a retrospective 'true'up' payment to cover specific COVID-19 related costs. These interim arrangements will be in place until at least 31 August 2020.

The position reported across the Dorset ICS is shown below.

Financial Position by Organisation (incl. Sustainability Funding)	In Month (£'000)			Year to Date (£'000)			Full Year (£'000)		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Dorset County Hospital NHS FT	0	0	0	0	0	0	0	0	0
Dorset Healthcare University NHS FT	0	0	0	0	0	0	0	0	0
Poole Hospital NHS FT	(170)	0	170	(409)	0	409	(3,485)	0	3,485
Dorset Clinical Commissioning Group	0	0	0	0	0	0	0	0	0
Royal Bournemouth & Christchurch Hospitals NHS FT	(315)	0	315	(411)	0	411	(2,930)	0	2,930
Dorset ICS Surplus/(Deficit)	**(485)**	**0**	**485**	**(820)**	**0**	**820**	**(6,415)**	**0**	**6,415**

System Control Total				0	0	0	0	0	0
Sustainability Funding attributable to system				0	0	0	0	0	0

Pay Expenditure

NHS
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Pay Expenditure: Key Points

Total pay for the Trust was £2.097 million adverse against budget year to date.

Substantive pay was £3.326 million favourable against budget, mainly as a result of vacancies, with this offset by expenditure on Overtime (£297,000), Bank (£4.093 million) and Agency staffing (£1.032 million).
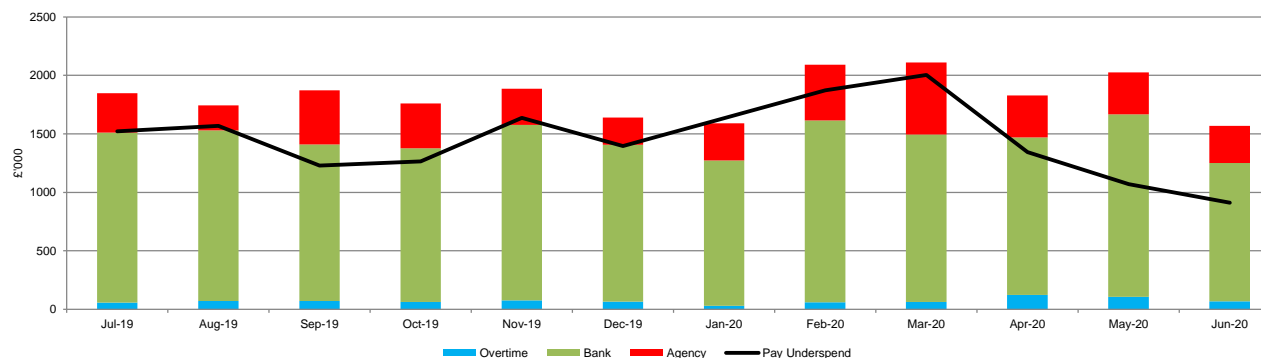
The Medical Care Group had the highest Overtime expenditure of £83,000; the majority of this spend relating to Older Peoples Medicine (£40,000). The Care Group also had the highest Agency usage of £459,000 mainly within Emergency & Ambulatory specialties.

The Medical Care Group had the highest bank spend of £2.207 million, again mainly in Emergency & Ambulatory Care (£1.271 million) and Older Peoples Medicine (£558,000).

The largest variance was a £2.726 million overspend against Centrally Managed Budgets. £2.493 million of this spend related to COVID-19 staffing which included £311,000 of agency spend (£77,000 Consultant agency and £234,000 Registered Nurse and non medical agency) and £858,000 of bank spend (£397,000 Registered Nurse bank, £158,000 Medical bank, £236,000 Unregistered Nurse bank and Other Health Care professionals of £67,000).

Directorate	Year To Date (£'000)						
	Budget	Substantive	Pay Underspend	Overtime	Bank	Agency	Variance
Anaesthetics and Theatres	4,989	4,933	56	30	73	11	(58)
Maternity	609	608	1	0	12	0	(11)
Orthopaedics	1,790	1,521	269	4	75	(1)	191
Surgery	5,118	4,790	328	9	225	16	77
Surgery Management	236	207	29	0	2	21	5
Surgical Care Group	**12,742**	**12,059**	**683**	**44**	**387**	**48**	**204**
Cardiology	3,266	3,113	153	4	80	1	67
ED and AMU	4,687	3,577	1,110	15	1,271	21	(197)
Medicine	4,332	4,009	323	24	298	246	(244)
Older People's Medicine	7,117	6,420	697	40	558	190	(91)
Medical Care Group	**19,402**	**17,119**	**2,283**	**83**	**2,207**	**459**	**(465)**
Cancer Care	2,220	2,005	215	0	113	3	98
Ophthalmology	1,840	1,708	132	17	37	56	21
Pathology	1,642	1,329	313	6	77	67	163
Radiology	2,532	2,332	200	10	96	13	81
Specialist Services	2,880	2,453	427	4	36	24	363
Specialties Management	0	0	0	0	0	0	0
Research	556	564	(8)	1	0	0	(9)
Specialties Care Group	**11,669**	**10,391**	**1,278**	**38**	**360**	**163**	**717**
Corporate	9,081	8,493	588	24	341	49	174
Corporate	**9,081**	**8,493**	**588**	**24**	**341**	**49**	**174**
Centrally Managed Budgets	45	1,551	(1,506)	109	799	313	(2,726)
Trust-Wide Income	0	0	0	0	0	0	0
Centrally Managed	**45**	**1,551**	**(1,506)**	**109**	**799**	**313**	**(2,726)**
Totals	**52,939**	**49,613**	**3,326**	**297**	**4,093**	**1,032**	**(2,097)**

Agency, Bank and Overtime Costs Against Pay Underspend

Pay Expenditure

NHS
The Royal Bournemouth and Christchurch Hospitals
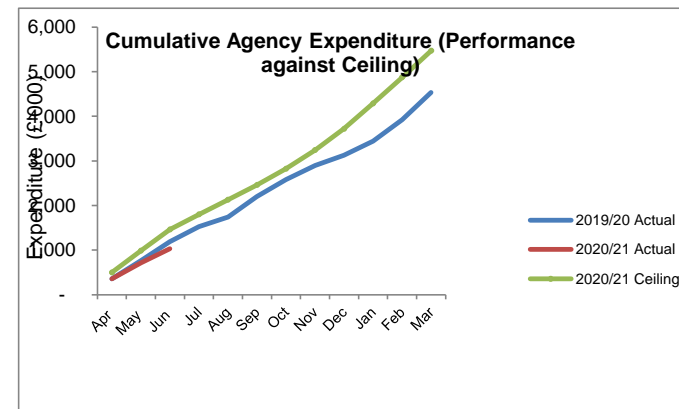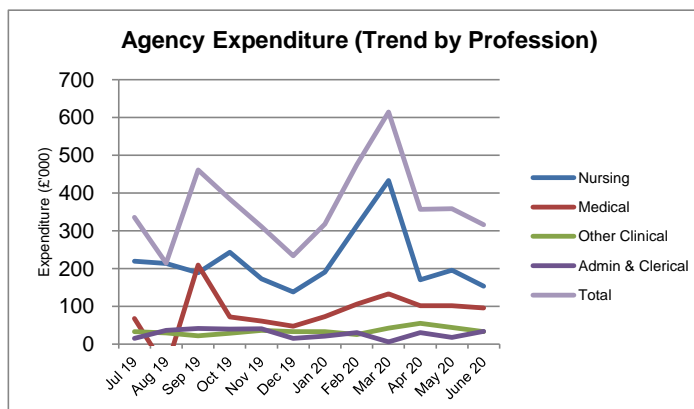NHS Foundation Trust

Agency Expenditure

Agency costs were £157,000 below the NHS Improvement agreed trajectory for June.

June 2020 Agency spend is £316,000 compared to June 2019 agency spend of £426,000 reflecting the impact of COVID-19 in relation to elective activity and redeployment of staff.

Of the total agency spend, £98,000 relates to COVID-19 (compared to £186,000 in May).

Pay Metrics	In Month Actual	Year to Date Actual	Budget	Full Year Forecast	Variance
Total pay costs as % of total operating income	65.3%	67.6%	65.0%	65.0%	0.0%
Agency expenditure as % of total pay	1.7%	1.9%	0.6%	2.2%	-1.5%

Agency Expenditure (Trend by Profession)

Cumulative Agency Expenditure (Performance against Ceiling)

Agency Spend by Profession (£'000)	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	June 20
Nursing	220	214	189	243	173	138	191	314	433	170	196	154
Medical	68	(66)	209	72	61	47	73	106	133	101	101	96
Other Clinical	33	30	22	29	36	33	33	26	42	55	44	33
Admin & Clerical	15	36	41	40	41	15	21	30	6	30	17	34
Total	**336**	**214**	**461**	**384**	**311**	**234**	**318**	**476**	**614**	**357**	**359**	**316**

Cash and Working Capital

NHS
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Cash Balance

As at 30 June, the Trust (excluding grouped entities) is holding £84.1 million in cash reserves. This increases to £86.1 million upon consolidation.

This cash balance includes July 2020 block payments from Commissioners received mid June 2020 of £23 million. This funding mechanism is currently forecast to continue to year end however further guidance is expected.
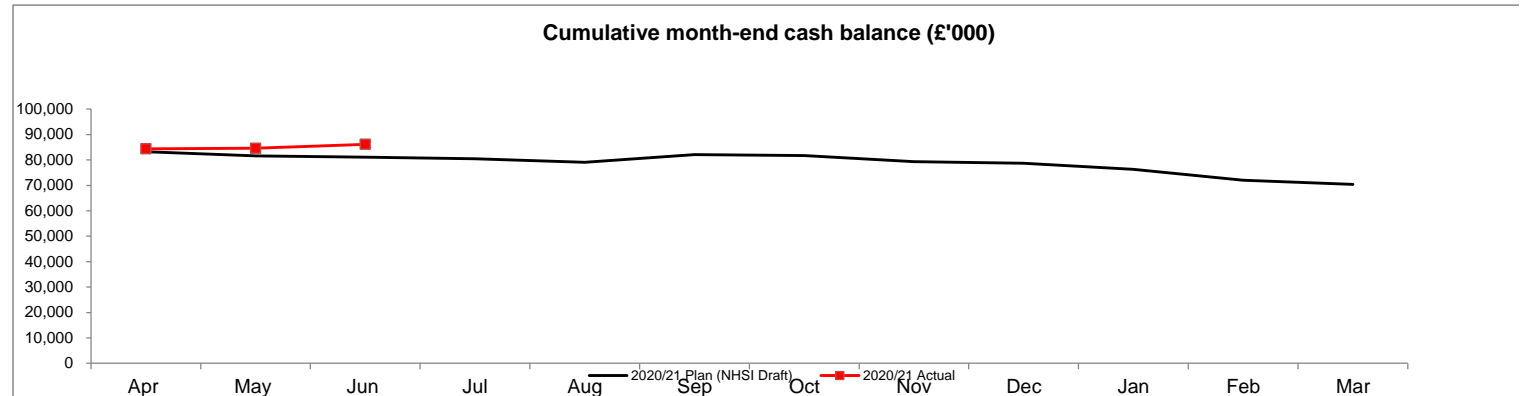
Cumulative month-end cash balance (£'000)

Cumulative cash balance	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
2020/21 Plan (NHSI Draft)	83,256	81,533	81,031	80,462	79,032	82,063	81,650	79,314	78,632	76,248	72,050	70,348
Of which												
Uncommitted Term Loan	0	0	0	0	0	0	0	0	0	0	0	0
2020/21 Actual	84,365	84,561	86,134									
Of which												
Uncommitted Term Loan	0	0	0	0	0	0	0	0	0	0	0	0

Public Sector Payment Policy: Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

As part of the public sector response to COVID-19, public sector organsations have been instructed to pay all suppliers within 7 working days of receipt of invoice/delivery of goods. The Trust is therefore making daily payments for all invoices that are approved.

Better Payment Practice Code	In Month		Year to Date	
Non-NHS Invoices	No.	£'000	No.	£'000
Total bills paid	3,981	12,678	12,009	38,581
Total bills paid within target	3,707	11,177	10,996	35,199
Percentage of bills paid within target	93.1%	88.2%	91.6%	91.2%
NHS Invoices				
Total bills paid	143	2,081	631	7,982
Total bills paid within target	135	1,437	578	6,378
Percentage of bills paid within target	94.4%	69.1%	91.6%	79.9%
Total				
Total bills paid	4,124	14,759	12,640	46,563
Total bills paid within target	3,842	12,614	11,574	41,577
Percentage of bills paid within target	93.2%	85.5%	91.6%	89.3%

Capital Programme

New capital arrangements are in place for 2020/21, with capital allocations made at Integrated Care system level, rather than at individual organisation level.

The Dorset ICS allocation has now been received and detailed capital plans were submitted to NHS England and Improvement on 29 May.

The Trust's proposed capital programme for 2020/21 amounts to £34.3 million. This represents this Trusts element of the agreed joint (with Poole Hospitals NHS Foundation Trust) six year capital programme. This excludes COVID-19 related capital expenditure which is separately reimbursed.

Capital expenditure at the end of June amounted to £3.031 million against a plan of £4.112 million. The variance reflects the timing of actual expenditure against plan with the Medical Equipment Committee (MEC) approving £570,000 of medical equipment in July. Specific capital costs relating to the Trusts response to COVID-19 pandemic totalled £563,000.

Capital Programme	Year to Date (£'000)			Full Year (£'000)		
	Budget	Actual	Variance	Budget	Forecast	Variance
Estates	55	27	28	1,585	1,585	0
Estates	**55**	**27**	**28**	**1,585**	**1,585**	**0**
EPMA	0	377	(377)	1,132	1,132	0
IT Schemes	323	1,027	(704)	5,031	5,031	0
LIMS	258	7	251	1,144	1,144	0
IT Schemes	**581**	**1,410**	**(829)**	**7,307**	**7,307**	**0**
COVID-19	563	563	0	563	563	0
Medical Equipment	1,001	0	1,001	4,004	4,004	0
Donated Assets	113	113	1	452	452	0
Medical Equipment	**1,677**	**675**	**1,002**	**5,019**	**5,019**	**0**
Macmillan Unit	271	70	201	4,210	4,210	0
Pathology Hub	50	0	50	5,120	5,120	0
Women Children Emergency Centre	956	848	108	3,627	3,627	0
Infrastructure	266	0	266	2,249	2,249	0
Patients and Visitors Concourse	133	0	133	999	999	0
Decants	81	0	81	2,101	2,101	0
Merger	2	0	2	262	262	0
Community Hub XCH	20	0	20	1,100	1,100	0
Multi-Storey Car Park	0	0	0	600	600	0
Other	20	0	20	98	98	0
Centrally Managed	**1,799**	**918**	**881**	**20,366**	**20,366**	**0**
Grand Total	**4,112**	**3,031**	**1,081**	**34,277**	**34,277**	**0**

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Poole Hospital
NHS Foundation Trust

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.4

Subject:	Guardian of Safe Working Hours Report January- March 2020

Prepared by:	Dr. Jayaprakash
Presented by:	Dr. Thomas

Purpose of paper:	For scrutiny. To summarise the number of exception reports in Quarter 4 2020
Background:	The Guardian post was created as part of the 2016 Junior Doctor contract, to ensure hours worked, and levels of supports, are safe for doctors and patients, based on exception reports
Key points for Board members:	There was increased number of exception reports in this quarter from previous one. The majority of the exception reports were generated from the general medical, general surgery rotas. There is good attendance at the junior doctor forum and exception reporting is actively encouraged by the trust. There have been 14 patient safety concerns raised which is the highest received since exception reporting began, highlighting the need to ensure that appropriate number of staff are required to maintain safe levels of care
Options and decisions required:	Consider funding for further medical and non-medical staff to support junior doctors (such as physician associates, advanced nurse practitioners and prescribing pharmacists) particularly in the specialties with the highest number of exception reports
Recommendations:	Continue to support the process of exception reporting and therefore identifying problems early. Ongoing presence of executive team for the junior doctors forum
Next steps:	Awareness of the role of Guardian of Safe Working and ongoing commitment to the process of exception reporting and addressing concerns raised

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	
Committees/Meetings at which the paper has been submitted:	Date

Guardian Report January 2020, for the period 1st January – 31st March 2020

Executive summary front page

High level data

Number of doctors / dentists in training (total):   208

Number of doctors / dentists in training on 2016 TCS (total):   208

Amount of time available in job plan for guardian to do the role: 1 PAs/4hrs per week

Admin support provided to the guardian (if any):   0.13 WTE

Exception reports

Speciality	Exceptions raised 1st Jan. – 31st March 2020	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Surgical	84	14	0	84	0
Medicine	44	2	0	44	0
Total	128	16	0	128	0

Brief Overview of Exception Reports Raised

There were a total of 128 exception reports from 1st January to 31st March 2020, an increase of 56 reports in comparison to the last quarter at 72.

The exception reports were generated from various departments: General Medical, Elderly Care, General Surgery, Trauma and Orthopaedics, Oncology/Haematology, Emergency, Cardiology and the ENT rota. The majority of exception reports were from the surgical ENT rota accounting for 73% of the surgical exceptions.

Of the 72 exceptions raised there were 14 patient safety concerns of which additional information is provided below. This is a significant increase from previous and is clearly a very worrying development. The previous highest total of patient safety concern exception reports was five per quarter. Out of the 14 patient safety reports- 5 were from the Surgical ENT rota, 9 general medical rota (of which 8 were from junior doctors working on A5 and 1 was from a junior doctor from A4)

1. ENT/ surgical rota

There is clearly significant concern about patient safety about this rota. 73% of all the exception reports were from this rota. Unfortunately this has been previously highlighted and the measures that were previously put in place were insufficient to meet the demands of the service. The clinical supervisor looking after the junior doctor in question felt these concerns were valid and appropriate. Given the number of exception reports there was significant involvement from the Director of Medical Education, Foundation Program Director and the clinical leads.

The issues with the ENT rota are summarised below:

- Historically the trust failed to respond to changing working patterns (MMC, EWTD, NEW contacts 1 and 2) with increased staffing levels to compensate for reduced hours of juniors and new shifts.
- In addition there has been a slow steady increase in basic work levels.
- Currently the crisis's in primary care and ED seems to be resulting in increased referral level particularly from ED where triage direct to speciality referrals seem to be far more common.
- In addition the problems in OPD mean appointment cannot be sourced there so GPs have no option in patients that cannot wait many months, but to refer as an emergency to the oncall F2.
- Most of this is beyond the directorate and indeed trusts ability to influence, however extra staffing could be provided, or routine work by consultants and SAS staff cancelled to provide more capacity (but this will just exacerbate issues elsewhere).
- Modifying ED referral patterns may help to a degree, but again this will impact ED functioning.

The following actions resulted from a meeting with the ENT department and the Director of Medical Education: Lynn Poynter:

1. Mark Pitchers will liaise with nursing team to try to "collect up" jobs to reduce bleep frequency (short term action). Bleep diary currently being collated by juniors which may help to work out where further resource is needed

2. I have been re-assured that the double booking of clinic that was reported to our Chief Resident is no longer happening.

3. Some clinical oversight of the rota is needed to ensure new starters are not put immediately onto nights.

4. ENT clinicians and surgical management team to look at increasing ANP staffing to run a clinic dealing with the slightly less acute ENT work (e.g. Otitis Media) which is currently directed into the acute clinic as no other way to be seen promptly. (long term action

5. ANP to take GP calls (long term action). In the interim consider GP bleep being held by registrar in the morning (more senior, possibly better triage of calls and also aiming to stagger workload as patients often have to wait for senior review anyway)

6. Discussed option of registrar of the day but the overall feeling is this would be detrimental to training of registrars as theatre time would be reduced. Therefore stick with registrar support in morning.

7. ENT senior clinicians/managers to work with ED to support appropriate pathways as currently this is causing issues

8. ENT clinicians to explore alternative pathways for epistaxis and quinsy to reduce bed occupancy

9. ANP/PA input on wards as well as clinics. Turnover large in ENT with lots of demand for IDS etc.

From August 2020 and a further junior doctor (Foundation Year 2 will be attached to the firm which will provide some much needed resource. To understand whether this is sufficient I would advise the ENT juniors to continue to exception report. Interim measures were in place to recruit a locum junior doctor to fulfil this role in March- however the COVID-19 pandemic has resulted in a significant change in working patterns and a reduction in referrals

General Medical Rota (8 patient safety reports from doctors based on A5 and 1 report from doctors based on A4)

There is a clear disparity on Ward A5, between the workload and safe staffing levels which has resulted in a number of safety concern exception reports from the junior doctors. The reports were made by junior doctors covering both the Cardiology and Gastroenterology firms. It highlights the particular problem of ward teams covering the acute take as well as looking after patients on their base wards (A5 and the Acute Coronary Unit)

The response from the clinical director of medicine is as follows:

In terms of ward cover and on-call, this shouldn't be covered at the same time but there has been a lot of junior doctor sickness which has left us with less than minimum numbers. We always go out to locum in this scenario but we cannot always find the people to fill the shifts. We have the extra 6 F3s in post in medicine, but the A5 one has been off for a month getting married. We had a business case for an extra 6 which currently has not been approved due to finance issues. Staffing levels have been exacerbated by sickness and pre-approved wedding leave.

The following changes have been made by the department:

1. One of the Core Medical Trainees has been helping the departments devise a rota to ensure that there are staff number of junior doctors on the ward
2. The juniors are now not cardiology or gastroenterology trainees but both, all will rotate to ACU
3. We have a Tuesday am ward meeting at 8.30 with gastroenterology and cardiology consultant to look at staffing over the following two weeks

There is a particular issue with cardiology in that 2 of the consultants are only cardiology trained (rather than Cardiology/ General Medicine) They have therefore struggled to move to a consultant of the week system like gastroenterology. They suggest that ideally they would

be removed from the general medical rota as some of the patients on A5 are general medicine rather than cardiology. They have been unable to do because of unfilled medical consultant posts.

Patient Safety Concerns Raised- as detailed in the reports

Rota/Dept	Grade	Detail
Medicine/ Cardiology (A5)	F1	Large workload due to clinical need of patients on ACU, coupled with there being 2 cardiology juniors for A5, ACU, outliers and weekend PTWR. Further to my previous exception reports, I think this again highlights the issue with including the ACU F1 within the cardiology/A5 staffing numbers. Stayed late to complete jobs and ensure patient safety to the best of my ability. There were still a number of jobs left for the next day.
Medicine/ Cardiology (A5)	F1	I was the only doctor rota'd to be working on cardiology on A5, gastro were unable to provide cover as they only had one SHO and one F1 themselves. The SHO rota'd to be working on cardiology that day had been off sick all week and informs me that she had communicated that she would not be working on the day in question to the rota coordinator. I believe that there is a problem with including the F1 working on ACU in the A5 numbers due to the variability in workload that occurs- often. The workload on ACU is so heavy that it becomes impossible to help out on the ward (as was the case for the vast majority of the date in question). This resulted in me, as an F1, doing a Friday ward round on many of our patients on my own as well as having to complete most of the jobs solo. As a result I also stayed 1 hour late, but this is not my main focus of this exception report. As it was, I was lucky with the workload of the day but, had any patients been more unwell/required more input, then I believe that I would have struggled to cope without forsaking the safety of my patients as a whole.
Medicine/ Gastro (A5)	F1	On the 6th March- only myself and a trust grade SHO covering the A5 inpatients and the on call patients from the take. Unwell patients on the ward- not reviewed by senior medical personnel due to staffing levels and sickness (SpR- off sick, CT1- on study leave). This left the ward understaffed. No patient harm. Dr. P reviewed unwell patients- high NEWS score. At some points I was the only junior looking after 30 patients some of whom were very unwell. ?Need for staff- PA/ ANP/ more junior doctors
Medicine (A5)	CMT2	Below minimum numbers on ward; no staff from elsewhere
Medicine (A5)	CMT2	Below minimum numbers on ward; no staff from elsewhere
Medicine (A5)	CMT2	Below minimum numbers on ward; no staff from elsewhere

Medicine (A4)	CMT2	Below minimum numbers on ward; no staff from elsewhere
Medicine (A5)	CMT2	Only 2 junior doctors on ward, minimum safe staffing level of 4. No additional support available from locums or other teams due to low staffing levels on all wards. Gastro reg + cons remained on ward most of day to see patients instead. Had to cover Cardiology job on own. Mixture of leave, sickness and on calls.
Medicine/ Gastro/Cardio (A5)	F1	Monday morning there were only two junior doctors for the gastro/cardio in-patients -27 beds on A5 plus the outliers ~10. This is not a safe number of medical staff. I was present for the whole day working with them prioritising the work. There were many jobs that could not be completed such as inter-professional referrals, chasing up of outstanding results which has an impact on LOS and diagnostic efficiency. There are obvious risks to patient safety and quality of care not to mention well-being of the junior doctors with this level of staffing. Solutions to resolve the issue were tried re: communication with medical rota coordinator, other wards were short staffed, ACU FY1 did assist with some cannulas in the afternoon. The issue with junior staffing being erratic at times is not new and I am aware of measures to mitigate with F3 jobs. On the rota one junior doctor called in sick and another was rostered but apparently was on annual leave and I am unable to clarify. I was also not able to attend scheduled teaching.
Surgical/ ENT	F2	As per previous report. Unable to take break due to workload and unwell patient.
Surgical/ ENT	F2	1 regular SHO, 1 locum SHO on ward (not previously worked as ENT SHO). Ward round finished at 1400. Clinic patient required review. Multiple ward jobs and bleeps. 20 minute lunch break at 1500 interrupted by bleeps. Unwell patient requiring input from multiple teams throughout the day. Patient had medical emergency call during handover to F1 on late shift. No registrar on ward during afternoon. Discharges and treatment delayed for other patients. This is the 4th day I have worked late in a row making total hours worked over past 4 days 42.5 hours. Not able to attend teaching. Escalation to seniors (NEWs and MET calls) for unwell patient
Surgical/ ENT	F2	Highlighted by other colleagues working today also. Today has been beyond manic. There is no time to think let alone provide adequate care for patients. We have detailed issues in multiple emails to foundation school. Today things felt truly unsafe. We are three f2s and cannot manage alone with the current extreme workload. When responding to these safety concerns I am reminded that the trust has not yet taken any action to mitigate against further issues. Note also missed SHO teaching.

| Surgical/ ENT | F2 | 3 SHOs. Inpatient ward round, full SHO clinic, multiple acute admissions and several referrals for SHO clinic appointments. Unwell patient requiring NEWS calls x 2 and regular review and escalation to medical team during ward round and throughout day. Ward round finished after 1300. Patients required senior advice and assessment in SHO clinic which could not take place until after ward round. Severe delays to ward discharges and review of new acute admissions. No ENT registrar on ward during afternoon. 1 x 20 minute break to eat lunch - interrupted by bleeps. Unable to attend SHO teaching. Finding volume of work unmanageable despite 3 SHOs working to the best of our ability and working overtime for the third day in a row. This shows the increase in workload that has precipitated the current issues in ENT, pressures in ED and primary care have pushed work onto ENT emergency services, that have had no increase in capacity, this is the predictable result. |
| Surgical/ ENT | F2 | There were only two junior doctors on the rota on the 1/1/20. After 5pm, when the other junior left, I was the only one covering general surgery on call and ENT on call. This was discussed with Mr Pitchers who believes this was a mistake/unsafe |

Reasons for Exceptions Raised

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks
86	10	5	5	22

Reporting Grades for this Period

FY1	FY2	ST1	ST2	CT1	CT2	ST3	ST4
37	62	3	8	2	9	5	2

Outcomes agreed

Overtime payment	Time off in lieu	No further action	Request for more info	Compensation and Work Schedule Review
40	51	36	0	1

Locum Bookings via Bank

Locum bookings (Bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Emergency	536	235	4441	2827
ENT	31	12	246	83
General Surgery	58	43	492	408
General Medicine	547	420	4268	3406
O&G	17	13	136	134
Oncology	47	43	389	466
Trauma & Orthopaedics	522	501	2829	4642
Paediatrics	60	52	600	378
TOTAL	**1818**	**1319**	**13401**	**12344**

(Source: Locums Nest)

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	61	31	488	534
F2	27	17	224	616
ST/CT1/2	1343	1042	9422	9438
ST3+	387	229	3267	1756
TOTAL	**1818**	**1319**	**13401**	**12344**

(Source: Locums Nest)

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts Worked**	**Number of hours Requested**	**Number of hours Worked**
Adhoc	136	133	963	1290
Annual Leave	94	52	885	515
Coronavirus	44	35	415	346
Deanery Vacancy	159	119	1361	1116
Trust Vacancy	829	682	5105	6237
Escalation	135	37	1141	454
LTFT Cover	2	2	25	25
Sickness	161	109	1425	914
Urgent Clinical Need	6	5	52	184
Study Leave	48	19	427	212
Service Demand	175	98	1320	842
Maternity/Paternity Leave	29	28	282	209
TOTAL	**1818**	**1319**	**13401**	**12344**

(Source: Locums Nest)

Locum Bookings via Agency

Locum bookings (Bank) by department		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	Data not available	4
Foundation Year 2	Data not available	10
ST1/2 - CT1/2	Data not available	9
Specialty Registrar	Data not available	15
TOTALS	**Data not available**	**38**

(Source: Temporary Staffing Office)

Vacancies 1st January – 31st March 2020

24 vacancies in total

Department	Number of vacancies
Emergency	3
Elderly medicine	2
Oncology	0
Specialist Medicine (general)	2
Anaesthetics	2
T&O	6
OMF	3
O&G	2
Paediatrics	2
General Surgery	1
Histopathology	1
Other	0

(Source: Medical Staffing)

<u>Fines</u>

There were no fines this quarter.

<u>Junior Doctors Forum Meetings</u>

There was one Junior Doctor Forum meeting held between 1st January and 31st March 2020 which was well attended and was also attended by Carole Chamberlain from the BMA. Contracts were discussed as were breaks. It was highlighted that in the ED rota breaks are are scheduled in the rota. Further discussions were around exception reporting the Fatigue and Facilities Charter in particular the progression of rest facilities and to ensure the monies from HEE are spent provided to ensure safer working for junior doctors.

<u>Developments</u>

The report includes the last week of March where the hospital had to adopt emergency measures and emergency rotas to cope with the coronavirus pandemic. This has led to the temporary cessation of the exception reporting but would hope that would be remedied once we have come out of these measures. The junior doctors have been commendable in their response to these needed urgent changes and different ways of working. I hope the trust learn lessons gained from the pandemic and encourage new ways of working where patient care continues to be at the centre and junior doctors continue to work in a safe environment. I would encourage the junior doctors to continue to exception report once we are back online. The process clearly highlights pockets of concern and is needed to monitor for developments in the standards of care

Dr Ram Jayaprakash

Guardian of Safe Working, Poole NHS Foundation Trust

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.4

Subject:	RBCH Quarterly Report on Safe Working Hours for Doctors in Training

Prepared by:	Tanzeem Raza
Presented by:	Alyson O'Donnell

Purpose of paper:	To summarise the number of exception reports for the period Jan-March 2020.
Background:	The 2016 trainee doctors' contract requires specific, detailed, individual work schedules for every trainee on each placement. This contract also mandates a regular report from the Guardian for Safe Working Hours to be submitted to the Management Board on quarterly basis by. Under this contract, trainees are expected to raise an exception report whenever they have to work beyond their contracted hours as defined in their work schedule. This report covers the period from 15 September 2019 to 30 March 2020.
Key points for members:	Since the last report presented to the board on 21 September 2019, another 330 new exception reports have been submitted until 30 March 2020. The total reports submitted so far, since the introduction of new contract now stand at 1169 as on 30 March 2020.
Options and decisions required:	n/a
Recommendations:	n/a
Next steps:	Our repeat survey of trainees as well as their supervisor may inform us further about the attitudes and concerns about the low volumes of exception reporting.

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trusts Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	
Committees/Meetings at which the paper has been submitted:	**Date**

Quarterly Report on Safe Working Hours for Doctors in Training: Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust

Executive summary:

The 2016 trainee doctors' contract requires specific, detailed, individual work schedules for every trainee on each placement. This contract also mandates a regular report from the Guardian for Safe Working Hours to be submitted to the Management Board on quarterly basis by. Under this contract, trainees are expected to raise an exception report whenever they have to work beyond their contracted hours as defined in their work schedule.

This report covers the period from 15 September 2019 to 30 March 2020.

Since my last report presented to the board on 21 September 2019, another 330 new exception reports have been submitted until 30 March 2020. The total reports submitted so far, since the introduction of new contract now stand at 1169 as on 30 March 2020.

Exception reports are a mechanism for trainees to highlight any work that they end up doing which is beyond their contracted hours of work. As the Guardian for Safe Working Hours, I monitor those exception reports, ensure that all exception reports are acted upon in a timely manner and make a judgment where further intervention might be required.

1. Introduction:

The role of Guardian of Safe Working Hours is an integral part of the 2016 trainee doctor's contract with a fundamental remit to ensure that the doctors working hours remain safe.

The guardian is responsible for:

- Protecting the safeguards outlined in the 2016 contract TCS for doctors in training.
- Ensuring that issues of compliance with safe working hours are addressed.
- Providing assurance to the trust board that doctors' working hours remain safe.

All junior doctors, including Trust grade doctors in this Trust are now on 2016 contract.

2. Issues:

The 2016 employment contract is fully embedded now. Following recent (May 2019) discussions between the BMA and NHS Employers, further tweaks to the 2016 contract have been made. Main new changes include:

- Maximum weekend frequency no more than 1:3
- Ability to complete exception reports for ARCP/portfolio requirements
- An increase to weekend and night shift pay
- Additional pay for less than full time trainees
- Extension in pay protection until 2025

However strict limitations on the maximum working hours and length of individual shifts etc remain unchanged with implications on the flexibilities in any rota, affecting swaps or ability to cover colleagues.

1

Since the introduction of this contract in December 2016 and August 2017 followed by non-training doctors in August 2019 there have been a total of 1169 exception reports; 330 since my last report to TMB in September 2019. Further details of these new exception reports are provided later in this report.

3. Exception Reports between September 2019 to March 2020:

Number of trainee doctors on 2016 contract: 221

Trust doctors on 2016 contract since August 2019:   80 (approx.)

Amount of time available in job plan for guardian to do the role: 1.5 PAs per week

Admin support provided to the guardian (if any):   0.25 WTE - temporary

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

4. Exception reports:

The total number of exception reports now stands at 1159 – with an addition of 320 since my last report to the Board, which demonstrates an increase compared to the previous periods. However it might be a reflection of an increase in number of doctors on this contract. Of the 320 exception reports raised since my last report, 304 were in relation to working beyond contracted hours and 7 each were related to educational or rota pattern issues.

Here is the breakdown of specialties where the exception reports originated from:

Specialty	New exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	38	38	0
Medicine	288	288	0
Haematology	0	0	0
Ophthalmology	0	0	0
O & G	0	0	0
Others	4	4	0
	330	307	14

288 exception reports in Medicine are from following sub specialties

Gastroenterology	71
Respiratory	10
OPM	54
Cardiology	22
General Medicine	129
Acute Medicine	2

Engagement from educational/clinical supervisors in timely completion of exception reports is highly appreciated**.**

2

5. Work schedule reviews:

As mentioned in my last report, the number of exception reports from Gastroenterology continues to raise concern. Guardian for Safe working met with all the trainee doctors in Gastro on 30 October followed by another meeting Dr Simon Whiteoak, the lead for junior doctors and again. It is apparent that the workload in Gastroenterology along with Dr Al-Shama in an attempt to find a solution to excessive workload within Gastro. A few practical suggestions were agreed and in the follow up meeting on 31 January we were informed that a there is increased consultant presence and a business case for nurse practitioner is under consideration. We will keep the situation under review.

We also had a meeting with ED colleagues along with Ms Rowena Green, Ms Karen McCarthy and others on 18 February to discuss the implications of changes to the contract on weekend frequency which will need to change to a maximum of 1:3 latest by August 2020

6. Exception report audit

Following on from the last audit of trainee doctors' understanding and engagement with the process of exception reporting system, currently another survey is in process. In addition another survey is in process were we are collating information from all consultants about their understanding and attitude towards exception reporting. I would hope to submit results with my next report.

7. Locum usage:

The need to cover shifts in Medicine/OPM, since my last report, seems to have decreased significantly. Between September and February a total of 137 shifts needed to be covered by locums as compared to as many as 272 shifts in the three months preceding September.

Unfortunately Emergency Medicine and the surgical directorate were unable to provide me any data in this period.

8. Trainees committee

Trainee committee has struggled to meet every month with very variable attendance from junior doctors. The last meeting was held on 16 December and the next meeting is scheduled for 30 March. The Guardian for Safe Working hours and the Director of Medical Education regularly attend these meetings.

9. Fines

No fines were imposed during the period of this report.

3

10. Vacancies:

Here is the list of current vacancies in trainees' recruitment from the deanery. The Trust has successfully filled in most of the vacancies in Medical specialties

Specialty	Gaps *approx.*
F1 - Surgery	0.3 (LTFT in FT post)
F2 – ED	0.2 (LTFT in FT post)
CMT - Gastro	0.2 (LTFT in FT post)
Acute Medicine	1 (Acting-up Consultant)
Cardiology ST3	1
Geriatric Medicine ST3	0.4 (1 LTFT in FT post)
Respiratory Medicine ST3	0.2 (1 LTFT in FT post)
Emergency Medicine ST4	2
GU Medicine ST3	1
Palliative Medicine ST3	0.2 (LTFT in FT post)
Rheumatology ST3	0.4 (LTFT in FT post)
Ophthalmology ST1/2	1
Anaesthetics ST3	1 - 1.4 (1 LTFT in FT post)
General Surgery – Upper GI	1
Vascular Surgery	0.2 (LTFT in FT post)
Urology ST3	0.4 (LTFT in FT post)
Obs & Gynae ST3	1

11. Next Steps:

2016 contract now cover all junior doctors in this Trust and non-trainee doctors are also able to fill in the exception reports. Each doctor on this contract is provided with a specific work schedule which specifies their working hours, rota and training opportunities available to them. Our previous survey suggested that a significant number of doctors are choosing not to complete exception reports for a variety of reasons. Most exception reports continue to be generated by Foundation or Core Trainees rather than registrars, who have generally tended not to complete exception reports. It is therefore

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impossible to conclude that the exception reports are accurately capturing all work completed by trainees beyond their contracted hours. Our repeat survey of trainees as well as their supervisor may inform us further about the attitudes and concerns about exception reporting.

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Dr Tanzeem H Raza OBE

Guardian for Safe Working Hours

21 July 2020

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.5

Subject:	PHFT: 2019 National Inpatient Survey Results

Prepared by:	Jenny Williams, Head of Patient Experience
Presented by:	Patricia Reid, Director of Nursing

Purpose of paper:	This paper describes the results of the 2019 national inpatient survey and explains how the Trust intends to use the results to improve the patient experience.
Background:	The national inpatient survey is undertaken annually. Results are published by the CQC and used as part of their monitoring and regulation.
Key points for Board members:	• The 2019 national inpatient survey scores were released under embargo in February 2020 and the national results published by CQC on 02 July 2020. • The results are positive overall. The Trust performed better than other Trusts on one question; and for all other questions the Trust results fall within the national average range. • The survey results, historic trends, complaints and other patient feedback has been analysed and five key themes identified for improvement. The Care Groups have been asked to utilise this data to develop their Improvement Plans. • Two Trust Patient Experience Volunteers have analysed the inpatient survey comments to offer a lay perspective to theming, interpreting and understanding what matters to our patients. The feedback will be shared for local action. • Sharing results and best practice across the PHFT and RBCH sites provides opportunities for learning and improving the patient experience.
Options and decisions required:	None
Recommendations:	For information
Next steps:	None

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	AF1
BAF/Corporate Risk Register: (if applicable)	None
CQC Reference:	Responsive, caring, effective, responsive, well led

Committees/Meetings at which the paper has been submitted:	Date
Joint Quality, Safety and Performance Committee and Healthcare Assurance Committee.	27.07.20

2019 NATIONAL INPATIENT SURVEY RESULTS

1.   Introduction

1.1   The purpose of this report is to provide background to the National Inpatient Survey, present the 2019 results for Poole Hospital and provide details about how these results are being used and disseminated.

2.   Background

2.1   The National Inpatient Survey is undertaken annually, asking patients who have recently used hospital services to feedback about their experiences of care and treatment. The survey involves 144 acute and specialist NHS Trusts across England.

2.2   Patients are asked to answer a series of 64 questions about different aspects of care and treatment. For each question, the individual responses are converted into a score from 0 to 10. A score of 10 represents the best possible response and a score of 0 the worst. The higher the score, the better the Trust is performing.

2.3   Quality Health (QH) is commissioned to undertake Poole Hospital's (PHFT) national survey. This took place in July 2019, involving a sample size of 1250 patients, aged 16 years or over and who have spent at least one night in hospital. The response rate for Poole Hospital was 49% (national response rate 45%), with 583 usable responses.

2.4   Alongside the survey results, QH publish an Inpatient Survey Comments Report. Patients are asked to respond to 3 questions: 'was there anything particularly good about your hospital care?'; 'was there anything that could be improved?' and 'any other comments?'

2.5   The inpatient survey is part of the NHS National Survey Programme. The results are aggregated to produce a picture of the experience of care, across different types of services in England. A summary of Poole Hospital results can be seen in Graph 1, showing that overall, the Trust achieves or exceeds national average across all the different surveys.

2.6   The results of all national surveys are routinely used in the regulation, monitoring and inspection of NHS Trusts.

Graph 1: Poole Hospital results from the national survey programme (blue circle), compared to the national picture (grey circles), collated July 2020
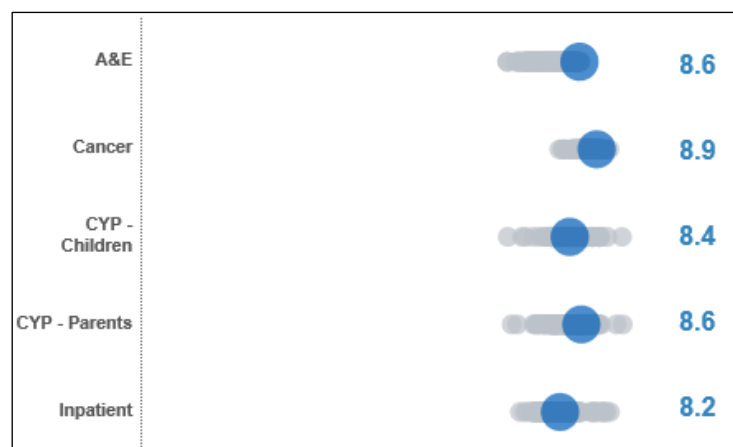
Data source: NHSI national survey benchmarking tool
Key: CYP: children and young people

3.   Results

3.1   Embargoed results were available from QH, February 2020. These results provide a comparison against the scores of the QH cohort of 31 Trusts and builds a picture of Trust performance.

3.2   The national comparison (144 Trusts) was published by the CQC, 02 July 2020. The national results are standardised for age, gender and admission method and so are comparable.

3.3   The survey questions are compared with the full range of scores for all other Trusts using an analysis technique called the 'expected range'. The results for each Trust are presented as 'about the same', 'better' or 'worse' in comparison with most other trusts.

3.4   Results can be used by Trusts to assess performance and progress, and to inform priorities for quality improvement programmes.

4.   Key findings for England

4.1   Positive findings from the national survey:

- Improvement in most questions about being treated in a respectful and dignified manner.
- Better communication between staff and patients before and after an operation.
- Positive responses to questions about hospital cleanliness, environment and choice of food.
- Confidence in doctors and nurses.

4.2   Results that indicate there are areas in need of improvement:

- Less positive experiences for communication and follow up support at the point of discharge.
- Decline in results about information sharing regarding purpose and side effects of medicines.
- Consistently high number of patients who report shortages in nursing staff.

4.3   Certain groups of patients consistently report poorer experiences of their time in hospital, including: patients with dementia or Alzheimer's; younger patients (aged 16 to 35); and patients who are admitted in an emergency.

5   Key findings for Poole Hospital

5.1   The national results published by CQC on 02 July 2020 show that the Trust has performed better than other trusts on the question:

         After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?

5.2   For all other questions, the Trust results fall within the national expected range. There are no scores that fall below this.

5.3   The survey questions are grouped into sections and Poole Hospital section results can be found at Table 1. The full survey results can be found at Appendix A.

5.4   Positive findings from the national survey

- Scores for the Emergency Department (section S1) lie towards the better performing Trusts and this was reflected in the National Urgent & Emergency Care Survey, previously reported in the 2019/20 Q3 patient experience report.

Table 1: Poole Hospital section scores from the National Inpatient Survey 2019

S1. The Accident & Emergency Department (answered by emergency patients only)

S2. Waiting list or planned admissions (answered by those referred to hospital)

S3. Waiting to get to a bed on a ward

S4. The hospital and ward

S5. Doctors

S6. Nurses

S7. Your care and treatment

S8. Operations and procedures (answered by patients who had an operation or procedure)

S9. Leaving hospital

S10. Feedback on care and research participation

S11. Respect and dignity

S12. Overall experience

Best performing trusts (green)	'Better/Worse' — Only displayed when this trust is better/worse than most other trusts
About the same (grey)	This trust's score (NB: Not shown where there are fewer than 30 respondents) ◆
Worst performing trusts (orange)	

- Patient feedback from those waiting for a planned admission (S2) and those arriving at hospital and waiting for a bed (S3) is orientated towards a more positive experience than the national picture.

- The results reported in the sections about the hospital and the ward (S4), our doctors (S5) and leaving hospital (S9) are also orientated towards a more positive experience:

  o The S4 hospital and ward results include: a score of 7.3 for staff explaining why a ward move was required (lowest-highest range 5.3-8.7); a score of 6.7 for being bothered by noise at night from other patients (lowest-highest range 5.1-9.1); and 9.0 for being offered a choice of food (lowest-highest range 7.8-9.6). The latter is also reflected in the national positive findings.

  o Feedback about our doctors (S5) includes a score of 9.1 for confidence and trust (lowest-highest range 8.4-9.8) and a score of 8.9 when asked about doctors talking in front of them (lowest-highest range 7.8-9.4). This also reflects the national picture.

  o Scores for S9, leaving hospital show a rating of 7.3 for professional support to help recovery following discharge (lowest-highest range 5.0-8.2); a score of 8.5 given for

explaining the purpose of medication (lowest-highest range 7.3-9.5); and 8.0 for written information about medicines (lowest-highest range 6.5-8.7). These scores indicate a significant achievement given that the national scores have declined.

5.5   Results that indicate there are areas in need of improvement:

- Results for S10 lie towards the worse performing scores. This includes a score of 1.0 for discussions about participation in a research study (lowest-highest range 0.5-3.8) and 1.9 when asked about the visibility of information explaining how to complain (lowest-highest range 0.8-4.3).

- There are no other section scores that indicate a clear need for improvement, but further analysis of the questions within each section has identified areas where we should consider making improvements (see section 4.2 below). This analysis has been undertaken from the perspective of both the national benchmarking and Poole Hospital historic trends. Most noteworthy is the score of 7.4 in getting a member of staff's attention within a reasonable time; a statistically significant deterioration compared to the previous survey.

5.6   Key points about the demographic profile of patients who responded to this survey include: a 57% female to 43% male split; a higher proportion of patients aged 66 and over older (71% compared to national profile of 65%); and a less diverse ethnic group than other Trusts (96% respondents describe themselves as white compared to 92% of national respondents).

5.7   The Overall Patient Experience Score is a nationally published composite score constructed using results from the different NHS Patient Surveys. This is usually available on the same day as CQC publication of survey results, but has been suspended this year due to the pressures of COVID-19 work.

6   Interpretation and dissemination of results

6.1   Understanding what people think about their care provides the Trust with the opportunity to develop quality improvement initiatives, based on what is important to patients.

6.2   Whilst there are no scores that fall below the national average, the three-year historic trend in results for Poole Hospital demonstrate deterioration in scores for some questions. These scores have been triangulated with themes from PALS concerns, complaints and other feedback, to provide a more comprehensive view of what patients are saying about our services. The full data set was shared at NMG in March 2020 (Appendix B) and from this, 5 workstreams have been identified:

- Information and explanations are effective and provided in a way that the patient understands.
- Patients and carers feel listened to and empowered as partners in care
- Patients are treated with kindness, respect and compassion; and their privacy & dignity needs respected.
- Patients feel safe whilst on our wards and can get help when they need it.
- Peoples' views and experiences are gathered and acted on to shape & improve services and monitor quality

6.3   Care Groups have been asked to review the thematic analysis and improvement plan and agree actions against each workstream. The action plans will be monitored by the care groups and TQGG and progress reported in the Quarterly Patient Experience Report. The Patient Experience Team action plan can be found at Appendix C.

6.4   The results from the PH and RBCH surveys have been reviewed and compared, with the ambition to learn and improve. Specifically, in relation to section S9 leaving hospital, RBCH

scores better than the national average in 5 out of the 15 questions, providing opportunity to share best practice and improve the experience for all patients across East Dorset.

6.5   The narrative available in the QH inpatient comment report offers us additional data to help interpret and understand the survey results and the experience of care at Poole Hospital. Two of our Patient Experience Volunteers were invited to review the QH inpatient comments report, with the request to identify any specific themes or comments the Trust should take note of, to learn and improve.

6.6   Patient and public interpretation of these comments compliments the work already taken and supports the Trust's Patient Involvement Strategic aims for 2019/20: that people feel listened to and feedback is used to help us make decisions; and working in partnership with people who can represent their own and others views in the evaluation of services.

6.7   The Patient Experience Volunteers took different approaches to sorting, analysing and theming the feedback comments and whilst the purpose of the review was to focus on improvements, it was also recognised that the majority of comments were positive and patients are extremely appreciative of our staff (see Graph 2)

Graph 2: National Inpatient Survey 2019: inpatient survey comment categories

- Particularly good: 306, 42%
- Could be improved: 245, 33%
- Other comments: 184, 25%
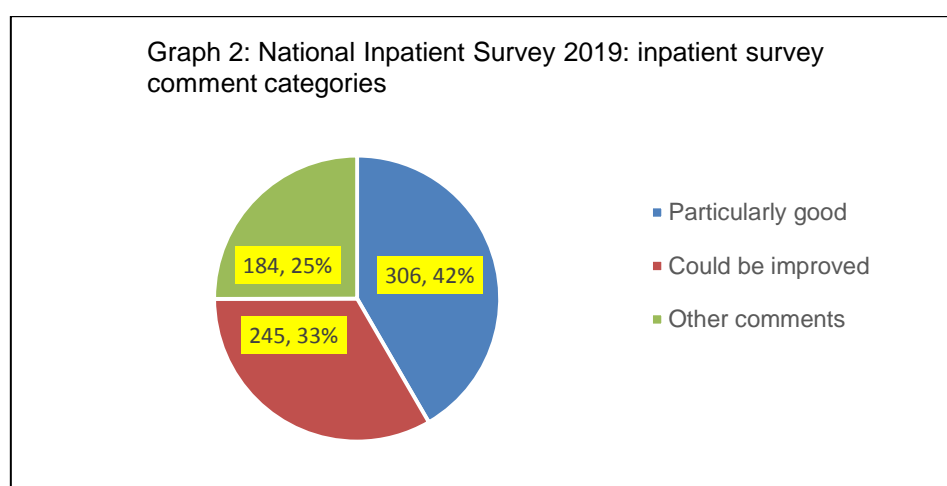
6.8   Some of the comments were found to be contradictory. For example, under the theme of food, comments ranged from ghastly to brilliant.

6.9   Certain comments were considered to be trivial, or repetitive grumbles. Whilst this can be helpful in identifying trends or hotspots, this type of comment cannot always be translated into an action or improvement

6.10   Some of the themes extracted by the volunteers overlap with the workstreams identified at section 4.2 and the individual patient feedback comments have added greater granularity to the workstreams (see box 1).

Box 1: Trust workstreams overlaid with patient feedback from the national inpatient survey comments report

Workstream 1: Information and explanations are effective and provided in a way that the patient understands.

The provision of written information was enormously helpful, as was the responsiveness over the telephone of the named nurse specialist contacts

This was my first hospital stay and I had to ask what the daily routine would be. It was bewildering not knowing. Explanations were often given too fast for me to absorb.

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> *My son did not get any information and his telephone calls were not returned*

Workstream 2: Patients and carers feel listened to and empowered as partners in care

> *A fully integrated, rapid approach which involved me at all stages*
>
> *I felt one of the doctors didn't really listen to me; I could tell they just wanted me out of the hospital"*
>
> *On ward over the weekend with a throat thrush infection; needed a doctor to OK medication; repeatedly asked but not given mouth medication until Monday*

Workstream 3: Patients are treated with kindness, respect and compassion; and their privacy & dignity needs respected.

> *The level of care, consideration and respect I was shown by every member of staff was above and beyond what I had expected.*
>
> *I cannot read or write, so it was difficult to use the TV and no one had time to help me.*
>
> *Underlying medical conditions should not be asked about openly across the bays – it is private*

Patients feel safe whilst on our wards and can get help when they need it.

> *The hospital was kept very clean and I always had help available*
>
> *In the night the buzzer was not answered by staff*
>
> *Cleaning the ward could include disinfecting door handles and door edge: this is where most people touch with their hands*

6.11   Other feedback categories were identified by the Patient Experience Volunteers (Table 2) and the inpatient feedback comments will be disseminated to the relevant specialist group or roles, to share with teams and take action where appropriate. The completed actions will be collated and displayed in You Said, We Did reports.

6.12   Particular attention will be given to feedback that requires action from different staff groups and where responsibility for completing the action is not always clear, for example:

One of your showers didn't have any shelves for soap etc. The floor is a long way down when aged 84

Table 2: Category of feedback from the inpatient survey comments report

Theme or category	Dissemination to specialist group or role
Nursing and nursing staff	Matrons and Ward Sisters/Charge Nurse
Noise	Matrons and Ward Sisters/Charge Nurse
Food & catering	Catering Manager and Nutrition Steering Group
Cleanliness and infection control	Lead Nurse Infection Control and Prevention
Discharge	Matrons and Discharge Team
Clinical	Matron & Lead Clinician
Transport	Head of Operations
Estates and building	Estates Manager
Where ward/department is recognisable	Matron or Manager for local action

7.   **The National Inpatient Survey 2020**

7.1   Fieldwork for the 2020 survey will follow a 'push-to-web' approach where patients are offered the option of completing the questionnaire either online or by paper. The fieldwork is planned to close in May 2021 and the expected publication date of November 2021.

7.2   This approach may increase the response rate from younger patients and hopefully reach a more diverse range of patients.
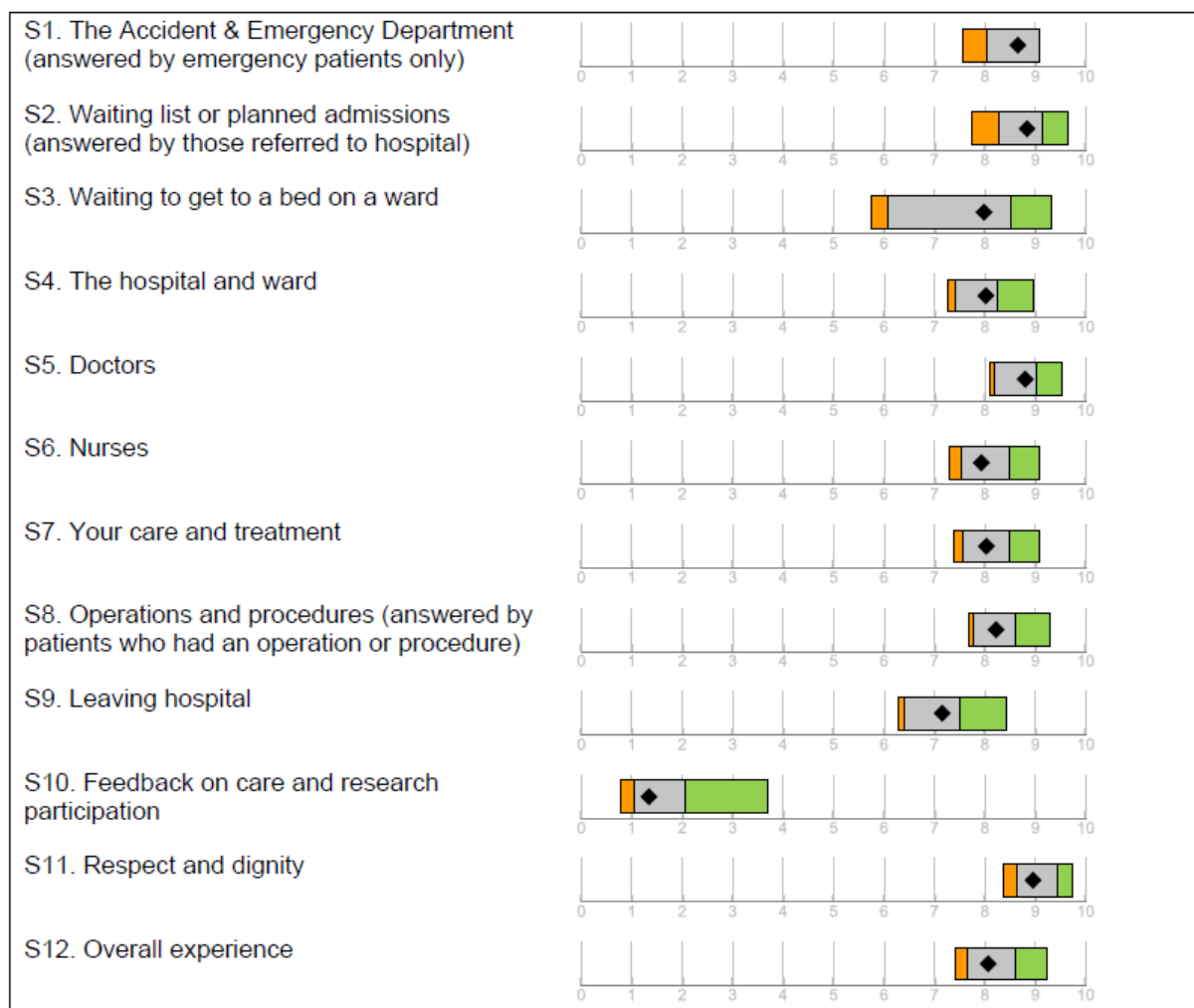

8.   **Conclusions and recommendations**

8.1   The 2019 national inpatient survey scores were released under embargo in February 2020 and the national results published by CQC on 02 July 2020.

8.2   The results are positive overall. The Trust performed better than other Trusts on one question; and for all other questions the Trust results fall within the national average range. There are no questions where the Trust performed worse than other Trusts.

8.3   The survey results, historic trends, complaints and other patient feedback has been analysed and five key themes identified for improvement. The Care Groups have been asked to utilise this data to develop their improvement plan.

8.4   Two Trust Patient Experience Volunteers have analysed the inpatient survey comments to offer a lay perspective to the theming, interpreting and understanding of what matters to our patients. The feedback will be shared with specialist Trust groups and roles, for local action.

8.5   Sharing the inpatient survey results and best practice across the PH and RBCH sites provides opportunities for learning and improving the experience of all patients across East Dorset.

Appendix A: Results of the 2019 National Inpatient Survey

Adult Inpatient Survey 2019
Poole Hospital NHS Foundation Trust
Section scores

The Accident & Emergency Department (answered by emergency patients only)

🟩 Best performing trusts	'Better/Worse' Only displayed when this trust is better/worse than most other trusts
⬜ About the same	◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)
🟧 Worst performing trusts	

Waiting list or planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?

Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

The hospital and ward

Q11. Did you ever share a sleeping area with patients of the opposite sex?

Q13. Did the hospital staff explain the reasons for being moved in a way you could understand?

Q14. Were you ever bothered by noise at night from other patients?

Q15. Were you ever bothered by noise at night from hospital staff?

Q16. In your opinion, how clean was the hospital room or ward that you were in?

Q17. Did you get enough help from staff to wash or keep yourself clean?

Q18. If you brought your own medication with you to hospital, were you able to take it when you needed to?

Q19. How would you rate the hospital food?

Q20. Were you offered a choice of food?

Q21. Did you get enough help from staff to eat your meals?

Q22. During your time in hospital, did you get enough to drink?

Q72. Did you feel well looked after by the non-clinical hospital staff?

Doctors

Q23. When you had important questions to ask a doctor, did you get answers that you could understand?	
Q24. Did you have confidence and trust in the doctors treating you?	
Q25. Did doctors talk in front of you as if you weren't there?	

Nurses

Q26. When you had important questions to ask a nurse, did you get answers that you could understand?	
Q27. Did you have confidence and trust in the nurses treating you?	
Q28. Did nurses talk in front of you as if you weren't there?	
Q29. In your opinion, were there enough nurses on duty to care for you in hospital?	
Q30. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	

■ Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
■ About the same		This trust's score (NB: Not shown where there are fewer than 30 respondents)
■ Worst performing trusts	◆	

Your care and treatment

Q31. Did you have confidence and trust in any other clinical staff treating you?

Q32. In your opinion, did the members of staff caring for you work well together?

Q33. Did a member of staff say one thing and another say something different?

Q34. Were you involved as much as you wanted to be in decisions about your care and treatment?

Q35. Did you have confidence in the decisions made about your condition or treatment?

Q36. How much information about your condition or treatment was given to you?

Q37. Did you find someone on the hospital staff to talk to about your worries and fears?

Q38. Do you feel you got enough emotional support from hospital staff during your stay?

Q39. Were you given enough privacy when discussing your condition or treatment?

Q40. Were you given enough privacy when being examined or treated?

Q42. Do you think the hospital staff did everything they could to help control your pain?

Q43. If you needed attention, were you able to get a member of staff to help you within a reasonable time?

Operations and procedures (answered by patients who had an operation or procedure)

Q45. Did a member of staff answer your questions about the operation or procedure in a way you could understand?

Q46. Were you told how you could expect to feel after you had the operation or procedure?

Q47. Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?

Leaving hospital

Q48. Did you feel you were involved in decisions about your discharge from hospital?

Q49. Were you given enough notice about when you were going to be discharged?

Q51. Discharge delayed due to wait for medicines / to see doctor / hospital transport.

Q52. How long was the delay?

Q54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?

Q55. When you left hospital, did you know what would happen next with your care?

Q56. Were you given any written or printed information about what you should or should not do after leaving hospital?

Q57. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

Q58. Did a member of staff tell you about medication side effects to watch for when you went home?

Q59. Were you given clear written or printed information about your medicines?

Q60. Did a member of staff tell you about any danger signals you should watch for after you went home?

Q61. Did hospital staff take your family or home situation into account when planning your discharge?

Q62. Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?

Q63. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Q64. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?

Better

Q65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

Q66. After being discharged, was the care and support you expected available when you needed it?

Feedback on care and research participation

Q69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?

Q70. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

Respect and dignity

Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Overall experience

Q68. Overall...

I had a very poor experience

I had a very good experience

Appendix B: What patients are saying about our service: triangulation of national inpatient survey results and themes from conerns and complaint

National Inpatient Survey: Poole Hospital scores, 2017-2019 linked to themes from PALS and complaints									
Survey question	Questions ranked most important to patients (picker)	Poole Hospital result 2017	Poole Hospital result 2018	Poole Hospital result 2019	Poole Hospital 3-year trend	QH average score	QH ranking	Link to PALS & complaint themes	Overall rating
The Emergency Department									
While you were in ED, how much information about your condition or treatment was given to you?	✓	86.2	88.8	85.1	↓	80.7	G		B
Were you given enough privacy when being examined or treated in ED?		89.0	90.6	88.2	↓	87.7	A		Y
Waiting list or planned admission									
How do you feel about the length of time you were on the waiting list before admission to hospital?		**88.4**	**81.0**	**79.3**	↓	78.5	A	X	R
Was your admission date changed by the hospital?		94.2	92.7	90.8	↓	90.2	A		Y
Had the specialist who saw you in hospital been given all of the necessary information about your condition or illness from the person who referred you?		87.8	90.3	92.1	↑	90.4	G		G
All types of admission									
From the time you arrived at hospital, did you feel you had to wait a long time to get a bed on a ward?		**83.5**	**83.0**	**79.2**	↓	70.2	G		A
The hospital and ward									
While in hospital, did you ever share a sleeping area with patients of the opposite sex?		96.0	93.2	93.1	↓	90.8	A		Y
Did hospital staff explain the reasons for being moved in a way you could understand?		**80.2**	**73.4**	**71.8**	↓	66.4	G	X	R
Were you ever bothered by noise at night from other patients?		64.3	64.6	65.8	↑	61.6	G		G
Were you ever bothered by noise at night from hospital staff?		81.4	80.8	80.3	↓	79.7	A		Y
In your opinion, how clean was the hospital room or ward that you were in?	✓	88.5	87.6	87.5	↓	89.3	A	X	A
Did you get enough help from staff to wash and keep yourself clean?	✓	80.7	77.6	80.0	↓	80.5	A	X	A
If you brought your own medication with you to hospital, were you able to take it when you needed to?		**81.6**	**79.0**	**74.3**	↓	70.4	A		A
How would you rate hospital food?		59.8	62.4	59.8	↔	56.0	G		G
Were you offered choice of food?		91.1	91.8	90.6	↓	87.7	A		Y
Did you get enough help from staff to eat your meals?	✓	71.5	73.7	71.5	↔	72.2	A	X	A
During your time in hospital, did you get enough to drink?	✓	92.7	92.8	92.9	↔	93.4	A		Y
Doctors									
When you had important questions to ask a doctor, did you get answers that you could understand?	✓	86.4	81.7	83.7	↓	80.9	G	X	A
Did you have confidence and trust in the doctors treating you?	✓	91.4	89.7	90.6	↓	88.9	A		Y
Did doctors talk in front of you as if you weren't there?		89.5	90.2	89.2	↔	86.6	A		Y
Nurses									

Question									
When you had important questions to ask a nurse, did you get answers that you could understand?	✓	**88.6**	**83.3**	**83.9**	↓	82.8	A	X	R
Did you have confidence and trust in the nurses treating you?	✓	90.5	88.2	87.8	↓	88.6	A		Y
Did nurses talk in front of you as if you weren't there?		92.8	91.8	92.2	↓	90.2	G		B
In your opinion, were there enough nurses on duty to care for you in hospital?	✓	74.9	75.1	73.8	↓	73.8	A	X	A
Did you know which nurse was in charge of looking after you?		61.2	57.6	58.6	↓	64.4	R	X	R
Care and treatment									
Did you have confidence and trust in any other clinical staff treating you (eg. Therapists)?	✓	85.9	88.3	85.7	↔	86.1	A		Y
Did the members of staff caring for you work well together?	✓	89.6	85.0	87.3	↓	**86.6**	A	X	A
Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	✓	**85.5**	**81.9**	**81.9**	↓	**80.0**	A	X	R
Were you involved as much as you wanted to be in decisions about your care and treatment?	✓	77.4	74.6	74.8	↓	**71.9**	G		B
Did you have confidence in the decisions made about your condition or treatment?	✓	87.0	84.4	84.4	↓	**82.4**	A		Y
How much information about your condition or treatment was given to you?	✓	90.1	88.1	89.2	↓	**86.8**	A	X	A
Did you find someone on the hospital staff to talk to about your worries or fears?	✓	**60.1**	**59.3**	**55.7**	↓	**53.6**	A	X	R
Did you feel you got enough emotional support from hospital staff during your stay?	✓	**74.2**	**71.1**	**69.7**	↓	**70.0**	A		A
Were you given enough privacy when discussing your condition or treatment?	✓	87.4	87.8	86.2	↓	**85.0**	A		Y
Were you given enough privacy when being examined or treated?	✓	96.1	96.1	94.6	↓	**94.5**	A		Y
Do you think hospital staff did everything they could to help control your pain?	✓	84.1	82.8	81.6	↓	**81.6**	A	X	A
If you needed attention, were you able to get a member of staff to help you within a reasonable time?	✓	**82.8**	**79.5**	**74.5**	↓	**76.5**	R	X	R
Operations and procedures									
Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand? operation or procedure?	✓	91.5	88.5	88.5	↓	**89.3**	A		Y
Beforehand, were you told how you could expect to feel after you had the operation or procedure?		75.6	75.1	76.0	↑	**74.1**	A		B
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?		82.8	78.3	80.6	↓	**79.1**	A		Y
Leaving hospital									
Did you feel involved in decisions about your discharge from hospital?	✓	73.1	70.5	71.0	↓	**67.7**	G	X	A
Were you given enough notice about when you were going to be discharged?	✓	**77.1**	**71.4**	**71.9**	↓	**69.6**	A	X	R
On the day you left hospital, was your discharge delayed for any reason?		60.5	61.8	61.0	↔	58.1	A		Y
How long was the delay?		78.7	77.7	75.4	↓	73.1	A		Y
After leaving hospital did you get enough support from health or social care professionals to help you recover and manage your condition?		77.1	65.0	74.4	↓	65.6	G		B
When you left hospital, did you know what would happen next with your care?		**73.5**	**68.1**	**68.7**	↓	65.9	G	X	R
Before you left hospital were you given any written information about what you should or should not do after leaving hospital?		**67.1**	**63.7**	**62.1**	↓	60.1	A	X	R
Did a member of staff explain the purpose of the medications you were to take home in a way you could understand?	✓	85.6	84.9	85.0	↓	80.9	G	X	A
Did a member of staff tell you about the medication side effects to watch for when you went home?	✓	52.1	50.6	51.8	↔	43.9	G		G

Question	✓							X	
Were you given clear written or printed information about your medicines?		80.4	76.7	80.5	↔	74.5	G		G
Did a member of staff tell you about any danger signals you should watch for after you went home?	✓	54.7	50.1	52.1	↓	49.3	A	X	A
Did hospital staff take your family or home situation into account when planning your discharge?	✓	76.2	75.6	74.6	↓	71.3	G	X	A
Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	✓	**68.2**	**60.7**	**64.0**	↓	60.6	G	X	R
Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	✓	80.1	75.3	77.0	↓	73.3	A	X	A
Did hospital staff discuss with you whether you would need any additional equipment or adaptations in your home, after leaving hospital?	✓	79.7	85.5	81.0	↑	80.8	A		B
Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	✓	82.9	81.7	86.2	↑	81.2	G		G
Was the care and support you expected available when you needed it?	✓	n/a	85.2	84.0	↓	79.7	G		B
Overall									
Overall, did you feel you were treated with respect and dignity while you were in hospital?	✓	92.2	91.9	89.6	↓	89.9	A	X	A
Overall, how would you rate your experience?		82.4	81.1	80.9	↓	80.7	A		Y
During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?		n/a	10.5	11.4	↓	12.8	A		Y
During your hospital stay, were you ever asked to give your views on the quality of your care?		**15.6**	**11.5**	**10.2**	↓	13.5	A		A
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?		21.9	16.3	19.6	↓	17.3	G		B
Did you feel well looked after by the non-clinical hospital staff (eg, cleaners, porters, catering staff)?		92.4	91.2	90.2	↓	91.3	A		Y

Key

Green	Questions where the Trust scores well. The Trust needs to maintain good practice in these areas. Score criteria: • PH results have improved or remained the same • Scores are in the top 20% of QH survey results • Not linked to PALS or complaint themes
Blue	Questions where Trust scores are satisfactory but results indicate action plans should refreshed and momentum continued, to secure improvements. Score criteria: • PH results have improved or remained the same & scores in intermediate 60% of survey, or historic deterioration in PH results <3.5% but scores in top 20% in QH survey. • Scores are in the intermediate 60% of QH survey results • Not linked to PALS or complaint themes
Yellow	Questions where the national survey indicates performance is about the same as other Trusts but historic scores indicate the Trust may be performing less well. Actions should be considered, particularly relating to questions ranked as most important by patients. Score criteria: • PH scores have remained the same or deteriorated <3.5% • Intermediate 60% in the QH survey • not linked to PALS or complaint themes
Amber	Ratings indicate the Trust is performing less well and Care Groups should review the questions ranked as most important to patients and consider where action should be taken to improve performance. Score criteria: • PH scores have remained the same or deteriorated <3.5%, in intermediate 60% or top 20% of QH results & linked to PALS & complaint theme • Or, PH scores have deteriorated >3.5% & in the intermediate 60% or top 20% of QH results
Red	Ratings indicate that these areas require improvement and this is where the Trust should focus attention. Score criteria: • Historic deterioration in PH results > 3.5% & in intermediate 60% or top 20% of QH results • Or, historic scores remain unchanged but ranked in lower 20% results in QH survey • And linked to PALS or complaint themes

Appendix C

Complaints and Patient Feedback: Thematic Analysis and Improvement Plan 2020/21

Care Group/Directorate: PATIENT EXPERIENCE TEAM
Date action plan completed: 18 May 2020

Workstreams: learning from complaints & feedback	Examples from complaints, surveys, feedback. What Matters to Our Patients…	Care Group Actions	Anticipated evidence of learning/change	Lead	Timeframe
Information and explanations are effective and provided in a way that the patient understands.	• Getting understandable answers to important questions. • Staff routinely answer family phone calls to the ward. • Reasons for a bed move are explained in an understandable way. • Different members of staff do not giving conflicting information. • Adequate notice of discharge is given, mindful of different family situations. • Patients leave hospital knowing what happens next with their care & who to contact if they are worried. • Having written information on discharge that explains what patients should and should not do. • DNACRP decisions are made, involving the family in discussions. • Outliers and their family have the opportunity to meet with consultant & other staff. Communication and care is timelier. • Staff fully explain what they are going to do and why, prior to any observation, test or procedure.	Translate the following commonly requested patient information leaflets into easy read: planned admission for surgery, Staying Safe; patient property; Have Your Say; DNACRP & discharge.	At least one new easy read leaflet produced by the end of each quarter and made available to wards & departments.	KU	30/06 30/09 31/12 31/03
		Update the patient experience page on the Trust website, ensuring all information is contemporary and easier to find. Seek patient/user feedback to guide development.	By the end of Q2, information available on the website is accurate and developed in line with patient/user feedback	SW	30/09
		Work with colleagues at RBCH to align patient information leaflet format and approval processes	Patient information production will be aligned	JW/ KU	31/03
		Undertake a complainant satisfaction survey to understand the actions required to improve the experience of making a complaint	Report findings to TQGG and develop actions in response to the complainant satisfaction survey	All	30/09
		Develop patient experience metrics that can be measured and monitored on a quarterly basis.	Patient Experience and complaint measures in place	JW	30/06
		Review & update interpreters policy, including use of video interpreting	Procedure for interpreting and translation will be updated and the policy available on the intranet	PJ	30/09
Patients and carers feel listened to and empowered as partners in care	• Patients and carers are involved in decisions about care, at the level they want to be. • Carers are welcomed, listened to, supported , informed & involved • Carers/family given the right level of information on discharge, to enable them to care for the patient at home; including preparing to go home at end of life. • Not ignoring issues raised by people who are expert in managing their own healthcare conditions. • Answer questions & allowing time for discussion as part of obtaining informed consent. • Agreeing individualise reasonable adjustments for all	Review and re-launch Carers Passport	Carers Passport will be launched during Carers Week	KU	30/06
		Maintain carer involvement in Trust induction programme.	Carer presents on at least 10/12 Trust induction programmes	KU	31/03
		Review staff training opportunities, utilising carer involvement	Carers willing to participate in developing staff training are recruited by end Q1. Carer involvement in staff training plans agreed by end Q2	KU	30/06 30/09

Workstreams: learning from complaints & feedback	Examples from complaints, surveys, feedback. What Matters to Our Patients…	Care Group Actions	Anticipated evidence of learning/change	Lead	Timeframe
	who require them, specifically people with LD/autism	Identify baseline & monitor complaints about reasonable adjustment	Patient Experience and complaint measures in place	JW	30/06
Patients are treated with kindness, respect and compassion; and their privacy & dignity needs respected.	• Staff should always introduce themselves • Patients feel they are listened to. • Staff are kind & demonstrate that they care. • Patients are able to find someone to talk to about their worries and fears. • Staff do not treat patients with an attitude that could be perceived as patronising. • Discussions should be held in a suitable place; mindful that behind a curtain is not always the right place. • Discharge home outside core hours should be by exception. Patients should be dressed appropriately & family kept informed.	Identify whether complainants feel listened to, via complainant satisfaction survey	Report findings to TQGG and develop actions in response to the complainant satisfaction survey	All	30/09
		Develop patient experience metrics that can be measured and monitored on a quarterly basis. This may include patient walkabouts/mystery shopper events (consider impact of COVID 19)	Patient Experience measures in place	JW	30/09
		Develop training packages suitable for a range of staff groups/teams: • Communication & customer care • Why complaints matter • Avoiding the avoidable & managing the inevitable	At least one training package complete and available to deliver by end Q2. Completed by end Q3	EB /HS	30/06 30/09
Patients feel safe whilst on our wards and can get help when they need it.	• Knowing which nurse is in charge of looking after them • When patients need attention, they can get help within a reasonable timeframe. • Patients receive time sensitive medication, on time. • Professionals do not promise something on behalf of another professional (unless previously agreed). • Patients know who to escalate concerns to. • People with complex needs or high anxiety/emotional needs tend to have more confidence in staff they already know & benefit from continuity. • Hearing staff say they are too busy, haven't had a break, need a holiday does not reassure. • Being called an outlier, a bed blocker, a bed pressure, or stranded patient does not instil confidence in staff.	Set up local surveys to monitor patient feedback and share this with care groups to demonstrate any emerging trend or hotspot.	Undertake a local patient survey in one care group per quarter & report findings to the care group. Q1: review pilot survey in surgery; Q2: medicine: Q3 W, C & Onc; Q4: surgery	SH	30/06
		Work with one clinical team to agree 'reasonable timeframe' for answering call bells and set up system to monitor on a quarterly basis	Agree standard and the process for auditing call bell response times, across one ward or group of wards	JW/ JH	30/09
		Work with patients/users to identify what it means to feel safe	Patient definition of what it means to feel safe complete	JW	31/12
Peoples' views and experiences are gathered and acted on to shape & improve services and monitor quality.	• People know they can have their say & their feedback will help us make decisions. • Ask for people's views, ideas & observations about services & use this to review & improve. • Value people's lived experience & use this to help evaluate, develop new ideas and improve services. • Work in partnership with people who can represent their own and others views to design, redesign, evaluate & improve services.	Review terms of reference for Patient Experience & Engagement Steering Group, working with RBCH to consider preferred approach for merged organisation	Revised patient involvement objectives 2020/21	JW	30/06
		Quarterly audit of availability of Have Your Say posters and leaflets	Audit results available each quarter, from Q2	JH	30/09
		Identify new approaches to engagement as a consequence of COVID 19. Work with all care groups to identify and plan at least one patient engagement event 2020/21	Plans in place for at least one engagement event per care group	JW	30/09

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.5

Subject:	2019 Inpatient Survey Results - RBCH

Prepared by:	Laura Northeast, Head of Patient Experience
Presented by:	Paula Shobbrook, Director of Nursing, The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust

Purpose of paper:	This paper sets out the findings of the National In-Patient Survey Results in relation to RBCH. Plans for dissemination of learning are set out within. The Board is requested to note the results
Background:	The National In Patient Survey was undertaken in July 2019, across 144 acute and specialist trusts. RBCH sample size of 1245 patients aged 16 or over.
Key points for Board members:	RBCH scored: • Better than most Trusts in 6 questions. • Worse than most Trusts in 0 questions. • For all other questions the Trust was in the national average.
Options and decisions required:	Nil
Recommendations:	To note
Next steps:	The inpatient survey results are being reviewed for RBCH and Poole as part of the joint working and sharing of best practice

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	All
BAF/Corporate Risk Register: (if applicable)	No
CQC Reference:	All Domains

Committees/Meetings at which the paper has been submitted:	Date
Joint Quality, Safety and Performance Committee/HAC	27 July 2020

NHS

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

2019 NATIONAL INPATIENT SURVEY RESULTS: Summary Report
Royal Bournemouth and Christchurch Hospitals

1.   Introduction

1.1   The purpose of this summary report is to provide background to the National Inpatient Survey, present the 2019 results for Royal Bournemouth and Christchurch Hospitals and provide details about how these results are being disseminated.

1.2   The National Inpatient Survey is undertaken annually, asking patients who have recently used hospital services to feedback about their experiences of care and treatment. The survey involves 144 acute and specialist NHS Trusts across England.

1.3   Patients are asked to answer a series of 64 questions about different aspects of care and treatment. For each question, the individual responses are converted into a score from 0 to 10. A score of 10 represents the best possible response and a score of 0 the worst. The higher the score, the better the Trust is performing.

1.4   The inpatient survey is part of the NHS National Survey Programme. The results are aggregated to produce a picture of the experience of care, across different types of services in England. The Trust achieves or exceeds national average across all the surveys included in the National Programme.

1.5   The results of all national surveys are routinely used in the regulation, monitoring and inspection of NHS Trusts.

2.   Results

2.1   Embargoed results were available from Picker in February 2020. These results provide a comparison against the scores of the Picker cohort of 74 Trusts and builds a picture of Trust performance. This was reported through the Healthcare Assurance Committee as an interim report. RBCH ranked 10th out of 74 Trusts that used Picker as their chosen survey provider.

2.2   The national comparison (144 Trusts) was published by the CQC, 02 July 2020. The national results are standardised for age, gender and admission method and so are comparable.

3   Key findings for Royal Bournemouth and Christchurch Hospitals

3.1   The national results published by CQC on 02 July 2020 show that the Trust has shown an improvement since last year, as detailed in Table 1.

Table 1. The Royal Bournemouth and Christchurch Hospital	
IP 2018	IP 2019
'Better' than most Trusts for 4 questions	'Better' than most Trusts for 6 questions
'Worse' than most Trusts for 1 question	'Worse' than most Trusts for 0 questions

3.2   For all other questions, the Trust results fall within the national expected range. There are no scores that fall below this.

3.3   The survey questions are grouped into sections. The Trust results can be found at Table 1. The full survey results were reviewed at the joint Quality, Safety and Performance Committee/Healthcare Assurance Committee.

Table 1: The Royal Bournemouth and Christchurch Hospital section scores from the National Inpatient Survey 2019

Section	Chart
S1. The Accident & Emergency Department (answered by emergency patients only)	
S2. Waiting list or planned admissions (answered by those referred to hospital)	
S3. Waiting to get to a bed on a ward	
S4. The hospital and ward	
S5. Doctors	
S6. Nurses	
S7. Your care and treatment	
S8. Operations and procedures (answered by patients who had an operation or procedure)	
S9. Leaving Hospital	Better
S10. Feedback on care and research participation	
S11. Respect and Dignity	
S12. Overall experience	

3.4   Positive findings from the national survey

- For the third year, our patients continue to report that their discharge was not delayed and that communication with family and carers was positive. For the section 'leaving hospital' RBCH were a 'better' performing Trust, this result is a culmination of several questions relating to discharge communication, information and process. (Q51,52, 60, 61 and 62)

- Patients reported confidence and trust in our hospital staff (Q31) where results found RCBH as a 'better' performing Trust.

3.5   Results that indicate there are areas in need of improvement:

- RBCH reported in 2018 that patients were being bothered by Noise at Night from staff, this score was significantly 'Worse' than other Trusts. An action plan, led by Senior Nurses which included a quality improvement project focused on 'settling down' in the Trust. RBCH has shown an improvement in this score and is now within the expected range but this question remains one of the lowest scoring questions for RBCH. Although in the expected range, another question (Q30) related to patients knowing who is in charge of their care is one of the lowest scoring questions.

- RBCH had a statistically significantly lower score for two questions from the 2018 results, these results still fell high in the national average range. The two questions were as follows in Table 3;

Table 3. RBCH	IP 2018 score	IP 2019 score
Admission: Waiting for a bed on the ward	9.0	8.2 ↓
Nurses: Feeling that there were not enough nurses on duty	8.3	7.9 ↓

4   Conclusions and recommendations

4.1   The results are positive overall. The Trust performed better than other Trusts on one section, which comprised of 15 questions. For all other questions the Trust results fall within the national average range. There are no questions where the Trust performed worse than other Trusts.

4.2   The survey results have been analysed along with data from Care Conversations and free text comments and two key themes identified for improvement.
   o Visible Leadership
   o Noise at night from staff and patients

4.3   Sharing the inpatient survey results and best practice across the PH and RBCH sites provides opportunities for learning and improving the experience of all patients across East Dorset.

4.4   The template for reporting of the 2019 inpatient survey has been mirrored across the organisations to allow for comparison. A joint approach to future methods of analysis of results and subsequent action planning is being developed.

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.6

Subject:	PHFT: 2019/20 Annual Complaints Report

Prepared by:	Jenny Williams, Head of Patient Experience
Presented by:	Patricia Reid, Director of Nursing

Purpose of paper:	To provide the Board of Directors with assurance that complaints are fully investigated and responded to, and that where appropriate, action is taken to review and improve services.
Background:	The National Health Service Complaints (England) Regulations 2009 requires that all Trusts provide an annual report on the handling and consideration of complaints. The required inclusions to meet this statutory requirement are detailed in this report.
Key points for Board members:	- Trust policy and procedures are in place to meet the statutory requirements (UK Statutory Instrument, 2009, No. 309). - The Trust received 222 complaints and 246 complex concerns (early, informal resolution) this year. - Over half of complaints received relate to clinical care and a third to relational aspects of care. - Achievements against the 2019/20 improvement plan are presented. - Recurring complaint themes and other patient insight have been analysed and five key workstreams for improvement identified for 2020/21. The care groups have been asked to review these workstreams and develop their improvement plans. - Other improvements to the way the Trust is learning from complaints have been identified, as part of the CQC action plan. - The Trust achieves the statutory targets but is underperforming against 2 internal targets: number of investigations overdue and responding to complaints within 35 working days. - Complainant equality monitoring has been introduced, with a 24% response rate this year. Further analysis will be undertaken as more data becomes available. - Complainants were invited to complete a satisfaction survey during Q4. Results are expected to be available, 2020/21 Q1. - The Trust has seen an improvement in the complaints re-opened rate, from 16% to 10%. One complaint has been partially upheld by the PHSO.
Options and decisions required:	None

Recommendations:	For information
Next steps:	Learning from complaints to be published on the public website

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	AF1
BAF/Corporate Risk Register: **(if applicable)**	None
CQC Reference:	Responsive, caring, effective, responsive, well led

Committees/Meetings at which the paper has been submitted:	**Date**
Joint Quality, Safety and Performance Committee and Healthcare Assurance Committee.	27.07.20

POOLE HOSPITAL NHS FOUNDATION TRUST

2019/2020
ANNUAL COMPLAINTS REPORT

1. INTRODUCTION

1.1   The National Health Service Complaints (England) Regulations 2009 requires that all Trusts provide an annual report on the handling and consideration of complaints. The required inclusions to meet this statutory requirement are detailed in this report.

1.2   The Chief Executive is responsible for ensuring compliance with the arrangements made under these regulations. The Trust delegates this responsibility to the Director of Nursing. The Head of Patient Experience is responsible for the handling and considering of complaints in accordance with these regulations.

1.3   This report describes how complaints are managed at Poole Hospital, details the number and nature of complaints received during 2019/20 and demonstrates the Trust's commitment to learning and improvement.

2. THE PROCESS FOR MANAGING CONCERNS AND COMPLAINTS

2.1   The Trust's policy and procedure for the management of complaints meets the statutory NHS regulations for England and the responsibilities set out in the NHS Constitution. The policy ensures that all staff have clear guidance on the procedure and standards for the handling of complaints.

2.2   The combined complaint handling and PALS service, based in the Patient Experience Centre, aims to facilitate a prompt resolution to patient concerns and complaints, as close to the point of care delivery as possible; and/or support people through the complaints procedure. The Trust procedures and practices reflect the user-led vision for raising concerns, 'my expectations' (Parliamentary and Health Service Ombudsman).

2.3   There is one point of entry for service users, giving them the opportunity to: discuss the key issues; agree how their enquiry, concern or complaint will be handled; discuss a mutually agreeable timescale; and to offer a named contact at the outset. Where appropriate, local resolution meetings are arranged, often reducing the need for a more protracted formal process.

2.4   For reporting purposes, the Trust differentiates between a concern, complex concern and complaint. However, this is difficult to define; there is no clear demarcation between what constitutes a complex concern and what constitutes a complaint. This is determined by the nature and severity of the issues raised and the mode of resolution (informal or formal) preferred by the complainant. A complex concern can also be viewed as an informally diffused complaint; importantly, both pathways to resolution provide opportunity for the Trust to learn and improve.

2.5   The Patient Experience (PE) team offer an element of impartiality, away from the clinical area where the care complained about was provided. This gives people the opportunity to talk through their experience in a neutral environment, whilst offering assurance that concerns and complaints are taken seriously.

2.6   The PE team assess each complaint and where possible, listens to and works with the complainant to pull out the key questions/themes to be answered, before then planning the investigation. The PE team work with the care group to ensure the complaint is

escalated to the appropriate level and the right staff are involved in the investigation. The Trust aims to get the written response to the complaint right the first time, by providing a full, fair and honest response that meets the expectations of the complainant.

2.6   'Have Your Say' posters and leaflets are available across the Trust, reflecting the principles of PALS, the opportunity to give feedback, and information about making a complaint. All complainants are routinely offered independent support through complaint advocacy services.

3. CONCERNS AND COMPLAINTS RECEIVED

3.1   Table 1 shows the breakdown of persons making a complaint and their method of communication. The breakdown of persons making a complaint is similar to the national picture (KO41a reporting). The mode of communication has seen a steady change over the last 5 years, with complaints received by letter falling from 32% in 2015/16 to 8% in 2019/20.

Table 1: Complainant profile and mode of communication, 2019/20

Person making the complaint		Mode of communication	
Patient	59%	Phone	39%
Spouse	11%	Email	32%
Parent	11%	In person	21%
Relative/Carer	19%	Letter	8%

3.2   This year, the Trust received 222 complaints, 246 complex concerns and 1,910 PALS concerns. The monthly trend in complaints and complex concerns can be seen in Graph 1; no definitive reasons for peaks in volume have been identified.

Graph 1: Comparison in trend of complaints and complex concerns received, by month, April 2018 – March 2020
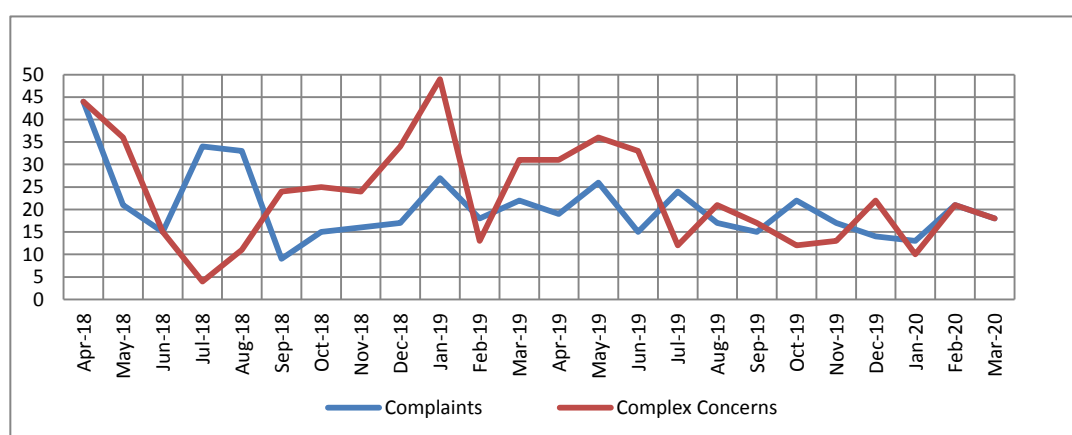
3.3   A breakdown of the number of complaints, complex concerns and PALS concerns received by Care Group, by month can be found at Appendix A. The number of complaints and complex concerns received, by Care Group is summarised in Graphs 2 and 3.

3.4   The highest volume of complex concerns and complaints are consistently seen in the Medical Care Group, followed by Surgery. However, this is unsurprising as these care groups see the highest volume of patients.

Graph 2: 2019/20 complaints received by Care Group
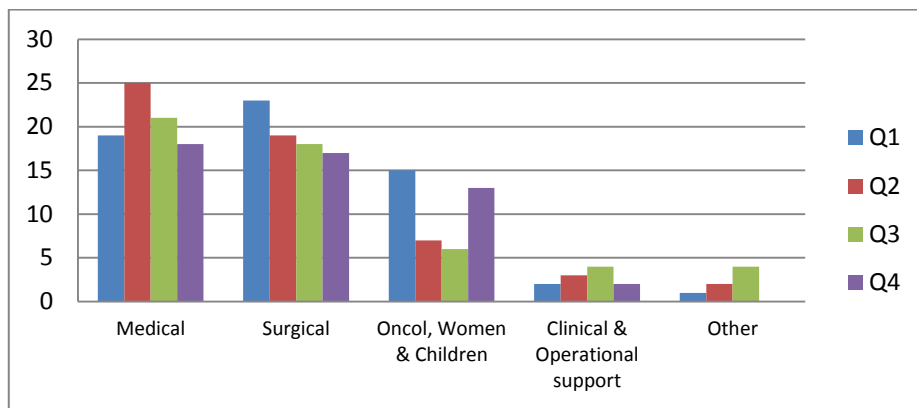
Graph 3: 2019/20 complex concerns received by Care Group
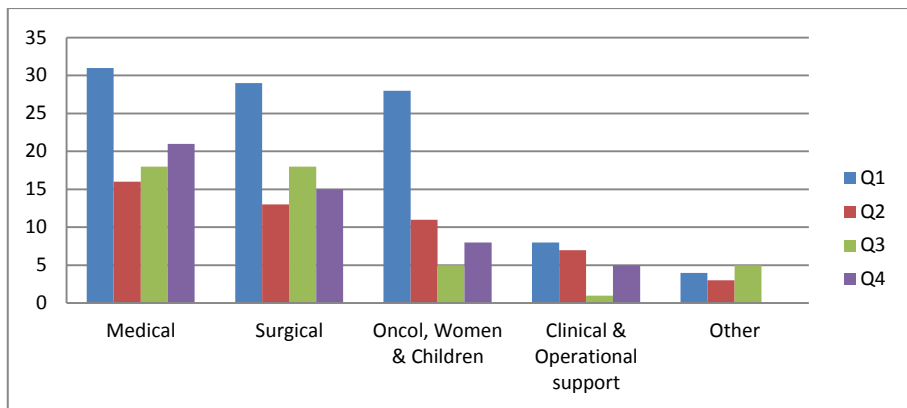
3.5   Graph 4 shows the breakdown of complaints by grade. The 3-year trend reflects two changes in process rather than an actual change in the grade of complaints received:

- The assessment and grading of a complaint has moved from a risk based grading tool, to an assessment tool that better reflects the subjective nature of complaints. This shows that when complaints are assessed against a broader range of descriptors, a more well-rounded range of grades is obtained and therefore the level of escalation and type of investigation is considered from a much broader perspective.
- Cases that are managed as a complex concerns and therefore not included in this data, would predominantly be graded as 'green'.
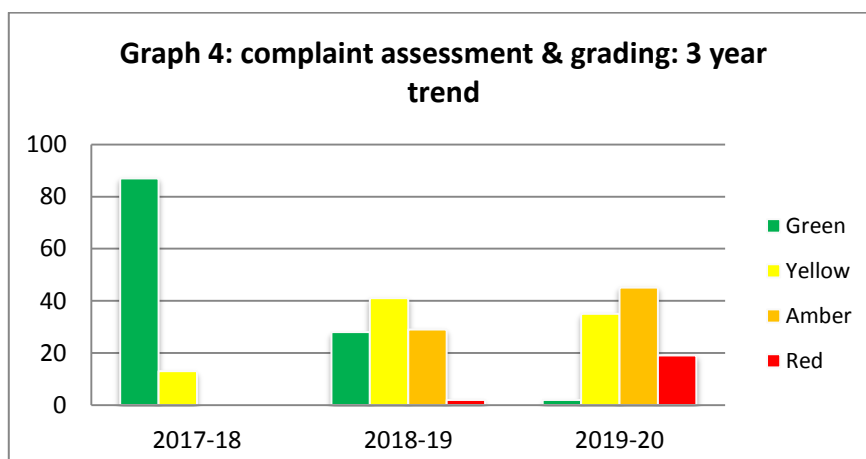
3.6 Equality monitoring forms are now sent to all complainants at the point the complaint is acknowledged. A total of 24% (54 out of 222 people) responded. It is important to understand the equality profile of our complainants, to: help identify if the profile is reflective of our local population; and to be able to make changes to the service that reflect the needs of our service users. Equality profile of complainants 2019/20:

- 63% were female
- 39% have a long standing health problem
- 17% have a disability
- 91% describe themselves as white; 2% as Asian/British Asian; and 2% Black/Black British

This is the first year that the Trust has collected complainant equality data. The data will continue to be collected and further analysis undertaken as more data becomes available.

4 ACKNOWLEDGEMENT AND RESPONSE TIMES

4.1 The complaint handling key performance targets are based on both statutory and locally agreed requirements. KPIs are monitored and reported: monthly via the IPR and CCG score card; and quarterly via the patient experience report and the KO41a report to the DH.

4.2 Table 2 demonstrates that six out of ten KPI's have consistently been achieved. The number of re-opened cases has a RAG of amber; this target has seen in-year improvements and is on-target to be achieved next quarter. One complaint has been investigated and partially upheld by the PHSO this year, showing as an amber rating (see Table 8).

Table 2: Complaint handling targets, 2019/20

Complaint handling target	2019/20						KPI 18/19
	Q1	Q2	Q3	Q4	Ave	RAG	
Number of complaints received	60	56	54	52	56	G	↔
% complaints acknowledged within 3 working days	100%	100%	100%	100%	100%	G	>97%
% response within timescale agreed with complainant	100%	99%	100%	100%	99%	G	>95%
% response within 35 day internal target	33%	37%	66%	40%	40%	R	>75%
% investigations overdue from care groups	46	42	40	37	41	R	<20/month
% complaint (subjects) upheld/ partially upheld this quarter.	67%	81%	51%	69%	67%	G	<65% +/-
Number re-opened complaint investigations	16%	9%	7%	6%	10%	A	<10%
Complaints under investigation by the PHSO	4	3	4	4	na	G	↔
PHSO investigations closed (& upheld/partially upheld)	1(0)	2(0)	1(0)	1(1)	na	A	(0)

4.3 The Trust has underperformed against two KPIs: the number of overdue investigations (ie. where a response from the care group is still outstanding); and the % response within the 35 day internal target for responding to complaints. These two measures are interdependent, but there are other reasons why the 35 day internal target has not been achieved and these should be considered as part of a Trust review of the internal target:

- Response times agreed with the complainant can exceed 35 days, based on the complexity of the issues raised or at the request of the complainant
- Staff who are key to the investigation are on annual leave
- The internal quality assurance process identifies further work is required to get the complaint response right the first time

4.4 The number of overdue investigations has been broken down by care group at Table 3. Whilst the highest number of overdue investigations is reported in medicine, when

viewed as a % of total complaints received, the care group where performance requires greater improvement is clinical and operational support.

Table 3: Monthly breakdown of over-due complaint investigations, by Care Group

COMPLAINT INVESTIGATION OVERDUE/ DELAY IN STATEMENTS	Apr-19 Overdue	May-19 Overdue	Jun-19 Overdue	Jul-19 Overdue	Aug-19 Overdue	Sep-19 Overdue	Oct-19 Overdue	Nov-19 Overdue	Dec-19 Overdue	Jan-20 Overdue	Feb-20 Overdue	Mar-20 Overdue	Care Group Totals	As % of total complaints received
Medical	4	7	7	4	5	5	9	3	6	6	5	4	**65**	**22%**
Surgical	6	6	2	6	5	7	4	3	6	4	4	6	**59**	**24%**
Clinical & Ops support	0	0	1	1	0	0	0	1	1	1	1	1	**7**	**37%**
Women, Child & Oncology	5	4	4	3	4	2	5	0	2	1	1	3	**34**	**22%**
Trust Total	**15**	**17**	**14**	**14**	**14**	**14**	**18**	**7**	**15**	**12**	**11**	**14**	**165**	

5 THEMES AND LEARNING FROM COMPLAINTS

5.1 All themes contained within a complaint are captured, to provide a full picture of the patient experience. This year, the 222 complaints received have generated 550 complaint themes.

5.2 All complaint themes are extrapolated into three over-arching complaint categories:
- **Clinical**: quality, safety & effectiveness
- **Management**: environment, systems & well led
- **Relational**: communication, attitude, dignity & respect.

5.3 The Trust-wide split of complaint themes by category for 2019/20 can be found in Graph 5, showing the highest proportion have been categorised as clinical.

Graph 5: Breakdown of complaints received by overarching category, 2019/20

Relational 30%
Clinical 55%
Managerial 15%
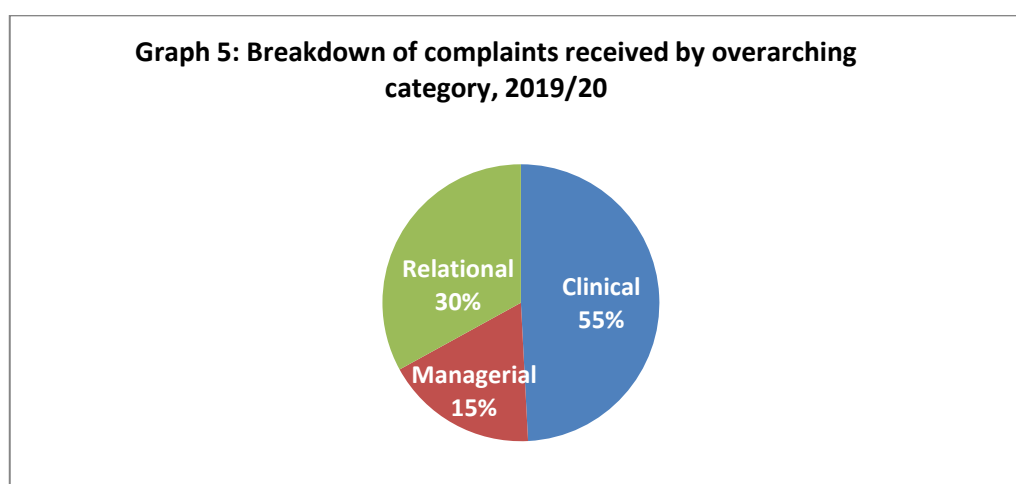
5.4 Each category has been broken down into sub-themes to aid understanding of the key areas of dissatisfaction for our patients. The top 3 recurring themes for each category can be found at Table 4. The themes are similar to previous years, with the exception of 'disputing appropriateness of treatment' and 'accuracy of records'. There are no obvious hotspots by clinical area or professional group, but the data will continue to be monitored.

Table 4: Top 3 areas of dissatisfaction for patients across the three complaint categories			
	2017/18	**2018/19**	**2019/20**
Clinical	Clinical care and treatment	Missed/delay in observation, assessment or diagnosis	Disputing appropriateness of treatment
	Delay in having treatment or procedure	Care needs not identified or monitored	Missed/delay in observation, assessment or diagnosis
	Missed/delay in observation, assessment or diagnosis	Delay in having treatment or procedure	Delay in having treatment or procedure
Managerial	Patients' property and expenses	Long wait for admission or clinic appointment	Long wait for admission or clinic appointment
	Discharge and transfer arrangements	Cleanliness of the environment	Accuracy of records
	Admission arrangements	Failure to follow procedure	Discharge arrangements (management decision)
Relational	Unprofessional attitude or manner	Unprofessional attitude or manner	Unprofessional attitude or manner
	Communication/information to patients	Inadequate or delay in communication/information	Inadequate or delay in communication/information
	Inadequate/conflicting information given	Inadequate/conflicting information given	Not being involved in decisions / plans

5.5   The categorisation of a complaint is based on the complaint narrative as received from the patient or their representative. A recent review of nine complaints that were categorised as clinical, alleging harm or a near-miss, found that in eight out of nine cases, the clinical treatment was found to be entirely appropriate; the root cause of these complaints was a failure in relational aspects of care. The information, explanation and on-going communication led the patient to believe that clinical care had been incorrect. Whilst no assumptions or generalisations can be made on the basis of this review, it does emphasis the need to focus our learning and improvement work on relational aspects of care. In all these cases, these aspects of care did fall below our expected standard and therefore the care group are taking action to prevent reoccurrence.

5.6   The CQC inspection, autumn 2019, identified effective learning from complaints as an area for improvement, and specifically the structure of reports to Board, to more clearly provide: assurance of learning; and evidence that learning from complaints is making a difference to patient care.

5.7   Learning from concerns and complaints can occur: a) in response to a specific upheld concern or complaint where the responsibility for learning and improvement sits with the care group concerned; and b) in response to recurring themes from complaints, concerns and other forms of feedback; where wider dissemination of learning is required.

5.8   Learning from specific upheld complaints

5.8.1   To ensure the data about complaints and complaint themes is more accessible to the Care Groups, a Datix complaints dashboard has been introduced, offering scope for

specialty level, real-time reporting opportunities. Care Group teams are now able to monitor their own performance and themes and are not reliant on the production of quarterly PE reports.

5.8.2 Complaints performance is presented as a regular item at the Trust Quality Governance Group. This supports integration of complaints into the quality governance agenda, including wider dissemination of learning. The detailed data will also be reported and monitored through the quarterly patient experience report.

5.8.3 Plans are in place for all Care Group governance meetings to include complaints as a regular agenda item. This should include the review of any action identified by the Care Group in response to the complaint, for evaluation and sign off once complete.

5.8.4 Examples of learning from upheld complaints have been shared at the Joint Quality, Safety and Performance committee and Healthcare Assurance Committee.

5.9 Learning from recurring complaint themes

5.9.1 Recurring complaint themes, triangulated with other patient experience intelligence, have previously been used to develop the annual patient experience objectives. Progress against these objectives has been reported in the quarterly PE report. However, this learning has not been included in the annual complaints report to Board and hence the opportunity to provide assurance of learning has been missed.

5.9.2 The year-end report can be found at Appendix B. Highlights include:

- **Improving patient information and communication**
  - Patient Information Placemat developed and launched on Ward A4. Template available for all wards and departments to utilise.
  - Who's, Who Uniform guide developed and displayed outside all wards and departments.
  - Procedure for developing patient information updated and 30 patient information leaflets reviewed by the Readership Panel now available for use.
  - Four Video Interpreting Units now available across the Trust, improving timely access to interpreting services.
  - Project to identify barriers to effective communication undertaken on Ward C3. Results to be shared with the ward team Q1 and to review any learning for wider dissemination.
  - Content and format of training most likely to have greatest impact on relational aspects of care reviewed. Plans in place to develop three levels of training: communication & customer care; why complaints matter; and avoiding the avoidable & managing the inevitable.
  - The number of relational based complaints, as a % of total, saw a reduction from 38% in Q1 to 23% in Q4.

- **Improving the experience of carers at Poole Hospital**
  - Funds successfully secured from the Leonardo Trust to purchase two carer chair-beds for the Elderly Medicine wards.
  - The 'Think Patient, Think Carer' Trust campaign was launched to further promote the importance of caring for carers and increase awareness of parking and dining room discounts.
  - Development of a new volunteer Carer Companion role, with successful recruitment of 4 volunteers.

- **Improving patient experience of mealtimes**
  - Additional 15 volunteers have been recruited to support the wards at mealtimes

- o 12 volunteers completed training in supporting mealtime preparation and delivery of meals
- **Understand the experience of patients who are hearing impaired**
  - o Small group of hard of hearing patient/public volunteers followed the patient journey in ED, from reception to treatment. Their feedback was used to develop an information leaflet for staff: 'communicating with people who are hard of hearing'.

5.9.3 The learning from recurring complaint themes will be shared on the public website.

5.9.4 Going forwards, to ensure that learning from complaints is captured and integrated into our quality governance meetings, insight from complaints, surveys, other feedback and incomplete actions from 2019/20 improvement plan have been analysed; culminating in five key workstreams for improvement:

- Information and explanations are effective and provided in a way that the patient understands.
- Patients and carers feel listened to and empowered as partners in care
- Patients are treated with kindness, respect and compassion; and their privacy & dignity needs respected.
- Patients feel safe whilst on our wards and can get help when they need it.
- Peoples' views and experiences are gathered and acted on to shape & improve services and monitor quality.

5.9.4 For each workstream, examples of the care complained about have been included, to aid staff understanding of what really matters to our patients.

5.9.5 The thematic analysis and improvement plan has been shared with the care groups with a request to review the improvement plan at their governance meetings and agree their actions for 2020/21. Progress against these plans will be monitored at Trust Quality Governance Group and in more detail in the quarterly patient experience report.

6 OUTCOME OF COMPLAINTS

6.1 Following the complaint investigation, a conclusion is drawn and decision made as to whether a complaint is upheld, partially upheld or not upheld.

6.2 This year, 24% of Trust complaints were upheld and 36% partially upheld, total 60%. This aligns with the national average for upheld/partially upheld complaints of 63%.

7 REOPENED COMPLAINTS

7.1 A total of 23 complainants were dissatisfied with the investigation and response to their complaint this year. This is a 10% return rate; an improvement from 16% during 2018/19.

7.2 Reasons for the return are themed to assess the quality of our complaint handling and the PE team are committed to improving this and getting the complaint response 'right the first time'. To support this, a complainant satisfaction survey is now in place. During Q4, all contacts from complaints closed in Q2 and Q3 and who are not registered with the national data opt out, have been invited to complete the survey by phone or by post. The findings from the survey will be available 2020/21 and will help to plan improvements to the PALS and complaint service.

8. REQUESTS TO THE PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)

8.1 Complainants are signposted to the PHSO if they are not satisfied with the outcome of their complaint. The PHSO makes final decisions on complaints that have not been resolved by the NHS.

8.2 Table 8 details Poole Hospital complaint activity undertaken by the PHSO during 2019/20. A steady number of complaints are accepted for investigation by the PHSO, the majority of which have not been upheld.

Table 8: Poole Hospital complaints investigated by the PHSO, 2019/20.

Reporting period	Complaints B/F from previous quarter	New complaints accepted for investigation	Outcome of PHSO investigations	
			Not upheld	Upheld/partially upheld
Q1	3 (from 2018/19)	2	1	0
Q2	4	1	2	0
Q3	3	2	1	0
Q4	4	1	0	1
Carried forward to 2020/21	4			

8.3 One complaint has been partially upheld this year: more information should have been given about the medication that might have been needed after being discharged from hospital in October 2018. Whilst the PHSO identified that the Trust had accepted and apologised for this, the PHSO concluded that we should have explained in our response to the complainant, how we intend to measure/monitor information sharing about discharge medications in order to minimise the risk of something similar happening again. Learning has been undertaken in the Care Group and actions in place. This will be detailed in an action plan to the PHSO next quarter.

10. CONCLUSIONS & RECOMMENDATIONS

10.1 The Trust has policy and procedures in place to manage concerns and complaints and this meets the statutory requirements laid out in the Local Authority Social Services and National Health Service Complaints (England) Regulations, 2009.

10.2   This year, the Trust received 222 complaints, 246 complex concerns and 1,910 PALS concerns.

10.3   The statutory acknowledgement and response targets for complaints have been achieved consistently.

10.4   The Trust continues to underperform against two internal targets: the number of overdue investigations and the 35 day internal target for responding to complaints. The introduction of real-time monitoring aims to support performance monitoring capability at Care Group level.

10.5   The 35 day internal target for responding to complaints should be reviewed as part of the complaint handling policy in the new merged organisation. There are valid reasons why it has not always been feasible to achieve this timeframe, and this requires further consideration.

10.6   This year, the 222 complaints received have generated 550 complaint themes: The categorisation of these themes is: 55% clinical; 30% relational; and 15% managerial.

10.7   The three-year trend of top recurring themes under each of these categories is identified. These recurring themes, together with other patient insight have been analysed, culminating in five key workstreams for improvement. Care Group teams have been asked to review the workstreams and develop an improvement plan for their area. This will be monitored at the Trust Quality Governance Group and in more detail in the quarterly patient experience report.

10.8   Other improvements to the way the Trust is learning from complaints have been identified as part of the CQC action plan following the last inspection, autumn 2019.

10.9   Achievements against the 2019/20 improvement plan are presented, with actions completed regarding: patient communication and information; improving the experience of carers at Poole Hospital; improving the mealtime experience; and gaining insight into the experience of people who are hearing impaired.

10.10   The Trust has seen an improvement in the rate of re-opened complaints, from 16% to 10% in year. Six complaints have been accepted for investigation by the PHSO and one complaint has been partially upheld. An action plan is under development.

10.11   Complainant equality monitoring is now in place and a more detailed analysis will be undertaken as more data becomes available.

10.12   A complainant satisfaction survey has been developed and complainants were invited to complete the survey during Q4. Results will be analysed and used to plan improvements to the PALS and complaint service.

Appendix A: breakdown of the number of complaints, complex concerns and PALS concerns received by Care Group, by month.

NEW PALS CONCERNS & COMPLAINTS RECEIVED IN MONTH	Apr-19			May-19			Jun-19			Jul-19			Aug-19			Sep-19		
	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns
Medical	7	9	36	7	10	50	5	12	40	9	4	55	7	7	59	9	5	38
Surgical	7	10	35	10	9	42	6	10	51	11	4	17	3	6	41	5	3	37
Clin & Op	1	1	18	1	4	30	0	3	22	1	3	37	1	2	19	1	2	16
Women, Child & Onc	4	8	26	7	13	27	4	7	22	2	1	21	5	6	22	0	4	29
Other	0	3	17	1	0	15	0	1	13	1	0	38	1	0	32	0	3	30
Trust Total	19	31	132	26	36	164	15	33	148	24	12	168	17	21	173	15	17	150

NEW PALS CONCERNS & COMPLAINTS RECEIVED IN MONTH	Oct-19			Nov-19			Dec-19			Jan-20			Feb-20			Mar-20		
	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns	Complaints	Complex concerns	PALS concerns
Medical	9	3	51	6	5	26	6	10	38	5	7	54	6	9	49	9	5	36
Surgical	7	5	48	6	6	42	5	7	25	4	1	36	8	8	30	5	6	27
Clin & Op	0	0	22	3	1	19	1	0	13	1	0	10	1	1	6	0	4	7
Women, Child & Onc	4	2	17	1	1	12	1	2	13	3	2	17	6	3	23	4	3	14
Other	2	2	25	1	0	20	1	3	19	0	0	19	0	0	21	0	0	204
Trust Total	22	12	163	17	13	119	14	22	108	13	10	136	21	21	129	18	18	288

Appendix B: Learning from recurring complaint themes

Progress against the 2019/20 patient experience objectives, including learning from complaints

Actionable areas for improvement	Evidence of learning or change	Monitoring of progress	Q3-Q4 progress	RAG
Improve the quality, consistency and accessibility of patient information. Compliance with Accessible Information Standard.	Good quality sources of health information will be identified and made available to patients.	• Good quality sources of information identified through library services. • Plans in pace to open the Patient Experience Hub, as part of front entrance redevelopment scheme. Hub opened October; used to promote health information, wellbeing initiatives, way-finding, patient and carer feedback & engagement events. • Three PCs installed for use by patients/public to access sources of information. • Hub temporarily closed in March to divert the space for use by HR as part of the Trust's response to COVID-19.	⇔	
	Good quality sources of easy read symbols will be identified to support the development of Trust easy read leaflets	• 12 month subscription to Photosymbols in place, to facilitate development of easy read leaflets	⇔	
	Revise and update the process of developing information leaflets. Increase membership of the Trust Readership Panel, supporting lay feedback as an integral part of patient information production.	• Procedure for developing patient information revised, updated and available on the intranet. Number of leaflets reviewed by the Readership Panel reported quarterly. Q1: 4; Q2: 6; Q3:13; Q4:7. Total: 30 • Early work started with RBCH towards a shared process of developing information leaflets. • Recruited 5 new members to the Readership Panel.	⇧	
	Develop different formats for delivering patient information, including the Place Mat approach & video interpreting to ensure timely support available.	• Patient information placemat developed and introduced on A4. Template available for use across all wards and departments. • Who's who uniform guide developed and displayed outside all wards and departments. • Four video interpreter units now available across the Trust, improving timely access to an interpreter for patients who need it. • Work underway to develop a Service Level Agreement for our British Sign Language Interpreters.	⇔	
	All wards/departments to agree the top five frequently accessed	• Record of the commonly used information leaflets currently being developed,	⇔	

Actionable areas for improvement	Evidence of learning or change	Monitoring of progress	Q3-Q4 progress	RAG
	patient information leaflets and ensure they are visible to patients. Monitor availability in wards/departments.	to aid in prioritising of easy read leaflets. • Plans to recruit a volunteer to support auditing of visibility of patient information leaflets. INCOMPLETE. C/F to 2020/21		🟧
Communication: further develop staff understanding of the impact of poor communication and information giving and be able to identify what's important to the patient.	Identify any barriers to good communication and customer care. Identify positive role models and engage in local training plans. Reduce the number of concerns and complaints received relating to communication and information giving by 15%	• Project underway on C3, working with staff to identify barriers to effective communication • Volunteer-led electronic patient survey focusing on obtaining feedback about communication developed. Pilot completed and roll-out of survey planned for Q4. To work towards making this feedback available real-time to staff Q4 onwards. • Monitoring of complaint themes relating to relational aspects of care. • Plans in place Q4 to consider the content and format of training most likely to have greatest impact on relational aspects of care (INCOMPLETE. C/F to 2020/21)	⇧	🟧
	Develop opportunities for real-time patient feedback	• Patient Experience Volunteers have been recruited to support our plans to develop real-time patient surveys. Complaint themes and the results of the 2018 National Inpatient Survey are telling us that staff-patient communication requires improvement and so this will be the focus of the first volunteer-led patient survey.	⇧	🟩
Reduce the number of concerns and complaints received relating to communication and information giving by 15%	Monitor the number of concerns and complaints relating to communication and information giving. Complaint themes relating to communication are monitored for trends.	(see table below)	⇧	🟩

Quarter	No. complaints received	No. themes extrapolated	Relational themes	Relational themes as % of total
Q1	60	133	51	38%
Q2	56	136	42	31%
Q3	52	146	36	25%
Q4	52	133	30	23%

Actionable areas for improvement	Evidence of learning or change	Monitoring of progress	Q3-Q4 progress	RAG
On-going implementation of Dorset Carers Strategy & improving the experience of carers at PH	Monitor the number of referrals to the Carer Support Service to be assured that this is maintained or increasing. Engage with carers to identify any unmet support needs.	• A system of recording the number of carers referred to and supported by the Trust Carer Support Service set up. Number of carers supported is currently 25-30 per month. • Carer chair-beds. Funds were successfully secured from the Leonardo Trust to purchase two carer chair-beds for the Elderly Medicine wards. Donation of the carer beds took place 14 June 2019. • The **'Think Patient, Think Carer'** Trust campaign was launched to further promote the importance of caring for carers; and increase awareness of parking and dining room discounts. • Development of a new volunteer Carer Companion role, with successful recruitment of two volunteers. • Patient (carer) story to Trust Board. • Outreach to carers, increasing awareness to Oakley Friends Dementia Support Group and the Trust Open Day.	⇧	
To improve the meal time experience, including provision of support to help patients to eat and drink	Target the recruitment of volunteers to increase availability during mealtimes Consider implementation of the recommendations detailed in the Trust paper 'improving the patient experience of mealtimes'.	• Additional 15 volunteers have been recruited to support the wards at mealtimes • General volunteer training delivered in supporting mealtime preparation and delivery of meals; 12 volunteers completed this in Q3 • Specific meal time companion training offered and 10 volunteers have attended • A mealtime/nutrition training session for volunteers set up for 21 March was subsequently cancelled in line with the Trust's COVID 19 response. • Recommendations not implemented but under review	⇔	
Understand the experience of patients who are hearing or sight impaired	Understand the experience of people who have a hearing loss and co-design actions for improvement	• Small group of hard of hearing patient/public volunteers followed the patient journey in ED, from reception to treatment. Their feedback used to develop an information leaflet for staff: 'communicating with people who are hard of hearing'. • Plans in place to co-produce a video with the Deaf community, to demonstrate good communication (C/F to 2020/21)	⇔	

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Actionable areas for improvement	Evidence of learning or change	Monitoring of progress	Q3-Q4 progress	RAG

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.7

Subject:	Infection Prevention and Control Committee (IPCC) Board Assurance Framework (BAF)

Prepared by:	Denise Richards – Deputy Director of Nursing PHFT
Presented by:	Paula Shobbrook, Director of Nursing & Midwifery, RBCH and Patricia Reid, Director of Nursing, PHFT

Purpose of paper:	This had been reviewed by the joint Quality Committee to demonstrate assurance of the IPCC framework to the joint Boards.
Background:	NHSE/I have developed a board assurance framework to support providers in self-assessment against compliance with Public Health England and other COVID-19 related infection prevention and control guidance. From 22 June 2020, starting with NHS Acute and Mental Health Provider, the CQC will start Emergency Support Framework (ESF) conversations focusing on establishing whether Trusts had full assurance on IPC in the COVID-19 emergency and recovery scenarios. The NHSE/I guidance is not mandatory; however, if Trusts chose not to use it, the CQC would expect Trusts to demonstrate how the Boards had assurance using other equally rigorous methods.
Key points for members:	The IPCC BAFs have been signed off by the respective Infection Prevention and Control Committees for both Trusts. The BAF was published on 22nd May and there have been ongoing changes to guidance since then. This work will therefore remain under regular review. There were a minimum number of areas where work was ongoing at the time of the BAF completion. Much of this is now complete or nearing completion. These are: • Compliance with increased cleaning frequency standards • Ventilation standards assurance. • Auditing of PPE use and other action cards. The urgency at the time of the outbreak necessitated prompt action by both trusts. Since then the opportunities to work together and develop joint solutions to the challenge of COVID have been embraced and continue to develop.

	The enclosed Excel report provides a summary of both reports and sets out where the organisations can support and learn from each other in order to build on the existing high level of compliance with the framework. Much of the IPC COVID policies and procedures are currently contained with a suite of action cards/flowcharts. This format supports the frequent updates that are required. Once stability is achieved in the guidance these will be brought together into one COVID-19 policy for both organisations.
Options and decisions required:	-
Recommendations:	To support the planned work of the Infection Control Teams in working together to ensure full compliance with national guidelines for IPC.
Next steps:	The IPC cell meeting and Infection Control Committees will join over the summer and will oversee further updates of the IPC BAF.
**Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register**
Strategic Objective:	AF1: Delivering safe, responsible, compassionate, high quality care.
BAF/Corporate Risk Register: **(if applicable)**	RBCH – Risk 879 overarching COVID-19 risk. PHFT - Risk overarching COVID-19 risk.
CQC Reference:	Well led
Committees/Meetings at which the paper has been submitted:	**Date**
Quality	27/07/2020

NHS

Infection prevention and control board assurance framework

22 May 2020, Version 1.2

Updates since version 1, published on 4 May 2020, are highlighted in yellow.

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assess measures taken, in line with the current guidance, and assure directors of infection prevention and control, medical directors and directors of nursing. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can be used to assure trust boards.

Using this framework is not compulsory; however, its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Ruth May

Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence- based way to maintain the safety of patients, service users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful to directors of infection prevention and control, medical directors and directors of nursing, rather than imposing an additional burden. This is a decision that will be taken locally, but organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk, and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions/Actions for implementation**
Systems and processes are in place to ensure:			
• infection risk is assessed at the front door and this is documented in patient notes	Triaged by streaming nursing or ambulance staff in discussion with nurse in charge of ED. Documented in notes on arrival. On admission patients are clinically assessed and swabbed accordingly in order to inform clinical pathway to be followed: F2 medical admissions pathway F6 cardiac pathway F7 surgical pathway F9 ED admissions All overnight admissions are now swabbed		
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or	Agreed blue pathway augmented by specialty areas and monitored through daily tactical/operational bed meetings involvement from		

reduces the risk of transmission	IPCT/CST. Blue cohorting plan designed to support F2 has 5 levels of escalation Possible/confirmed patients remain on blue pathway until discharge – F8 F7 AC12		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	AC50 – transfer of patients to care homes and domiciliary care. All AC's are reviewed and updated in line with national guidance. Active involvement in the Dorset system wide discharge group. In line with testing for discharge to residential homes. AC36 – Discharge AC55 – non urgent patient transfer. AC56 - Swabbing		
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	AC1, supported by regular comms updates and posters. Reflected guidance in visitor information. Staff training in donning and doffing. AC1 AC44 & 48. This is auditable.		
• national IPC guidance is regularly checked for	Infection Control Cell reviews national guidance and meets 3 times a week. Guidance from		

updates and any changes are effectively communicated to staff in a timely way	Royal Colleges reviewed and escalated as required when outside of PHE guidance. Local processes determined and ratified by Clinical Polices Group and approved by DoN and MD. Daily tactical cell meetings, daily cascades.to all staff in the Trust. These decisions are kept under fortnightly review. Staff are updated via intranet alerts, key clinical comms and all staff emails		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Central point for incoming guidance and process for circulation supported by a dedicated team. COVID-19 project support team maintains a live governance tracker for incoming guidance, action cards, flowcharts and additional clinical information. Clinical Policies Group also has a live governance tracker which includes revised NICE rapid CG's, recording trust compliance. Daily operational and flow meetings (infection control cell and tactical) identify any immediate risks and document the mitigating actions taken, group decision to escalate to Silver/Gold command		

• risks are reflected in risk registers and the Board Assurance Framework where appropriate	The Trust Risk Register has one overarching Covid risk entry 879. Under this entry is a risk log which lists all the related direct and indirect risks across the organisation and at a service level. Risk log is circulated to the leads weekly, who review their held risks and update as required, returning the next day. This weekly review is then saved as a PDF file and uploaded to the Trust Risk Register. Quality & Risk team then review the updates and provide a themed report. The Trust risk register governance process continues		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Trust standard policies and procedures remain in place. IPCC meets quarterly. Daily review of side rooms is undertaken by CST and IPCT. AC 56, 59, blue major SOP, co-horting plan green.		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• designated teams with appropriate training are	All covid 19 isolation and cohorting areas staff are appropriately trained to care		

assigned to care for and treat patients in COVID-19 isolation or cohort areas	for patients. Specialist staff sent to ITU and ED with appropriate bespoke update training package implemented. Covid training on green brain ITU additional staff trained & signed off. Documented on Nursing/AHP Strategic COVID Workforce plan		
• designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas	AC 9, 22, 63. Technical assessments + SOP. PPE list Staff rota's – wherever possible designated staff are assigned to permanent areas. All staff trained in current techniques and use of PPE		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Healthcare cleaning manual. Specific terminal clean checklist for Covid Terminal Clean sheets for each requested decontamination are completed, signed and electronically stored.		
• increased frequency, at least twice daily, of	Each clinical area in the Trust has been risk assessed and risk level agreed, from Low to	Not able to provide a second clean within current service (funding and human resource)	Will add risks of gaps onto risk register for monitoring in facilities Governance Risk

cleaning in areas that have higher environmental contamination ==rates== as set out in the PHE and other national guidance	very high in terms of cleaning requirement. This is documented in the Trust cleanliness policy. (insert hyperlink) High Risk /Very High Risk cleanliness audit Monthly / fortnightly. If audit failed, re-audited within 24 hours. Cleaning frequencies for each area via SLA displayed. Terminal clean of all vacated rooms after isolation is recorded signed off and stored electronically.	for high risk/very high risk areas. Public areas frequent touch points only cleaned weekly apart from Atrium which is daily. Possibility to incorporate with frequently touched surfaces as the second clean. No current evidence to support completion of barrier cleans. This is undertaken in conjunction with the ward NIC	Meeting and for overview at IPCC. Weekly infection control walkabouts to support audit and monitoring Working with HK and facilities to devise a process for monitoring barrier cleaning and documenting its completion. Implementing a system for collaborative working and direction for HK staff by NIC Business case has been undertaken to support extra cleaning schedules of public areas and signed off.
• Attention to the cleaning ==of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas==	Public toilets – two cleans daily + two checks cleans sign off sheets completed, scanned and held electronically. Ward toilets cleaned once daily + two check cleans recorded as above.		
• cleaning is carried out with ==neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of==	Standard Operating Procedures + COSHH safety data sheets + manufacturer's instructions.		

1,000ppm available <mark>chlorine,</mark> as per national guidance. If an <mark>alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses</mark>			
• manufacturer s' guidance <mark>and recommended product 'contact time' must be</mark> followed for all cleaning/ disinfectant solutions/products	Infection control team consulted when required to step outside of normal guidance. Correspondence and emails held on infection control drive. COSHH safety data sheets + manufacturer's instructions available.		
• 'frequently touched' <mark>surface, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice</mark> daily and when known <mark>to be</mark> contaminated with secretions, excretions or body fluids	Once per day + spot cleaning – Cleaning frequency + SOP's policy change decisions discussed at at risk and cleaning meeting. Minutes available (monthly)	Second clean currently not being undertaken routinely	Part of signed off business case to increase compliance as above.
• Electronic equipment, eg mobile phones, desk	Ward Staff clean patients equipment. Equipment Users	Unsure if areas have designated staff who clean as	Need to agree a process responsibilities for equipment

phones, tablets, desktops and keyboards should be cleaned at least twice daily	for other cleaning.	they go? This is unlikely to happen twice daily and there is no evidence of this.	training with evidence sheet
• Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	All rooms cleaned once daily by HK and evidenced on daily cleaning schedules Donning and Doffing areas cleaned daily and evidenced on cleaning schedules		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen is managed in line with National guidance and the Standard Precautions policy and documented in Infection Control Policy. Laundry service contracted to local private provider and monitored through quarterly contract review meetings and audit of linen with reported of concerns as they arise. Facilities team have a clear process for linen that does not meet hygiene requirements to ensure that is isn't used		
• single use items are used where possible and according to single use policy	Single use items are used appropriately and in line with medical devices and ICT policies. Medical Equipment Group oversees and monitors new purchases including consumables.		
• reusable equipment is	Reusable equipment is		

appropriately decontaminated in line with local and PHE /national guidance.	managed through decontamination policy and medical equipment policy. Saving lives audit, Weekly cleaning schedules in clinical area. Decontamination report. Issued monthly and shared with Matrons to action non – compliance.		
• Decontaminated in line with local, PHE and other national guidance. Review and ensure good ventilation in/on admission and waiting areas to minimise opportunistic airborne transmission	Local policies generated in line with national guidance. Decontamination audit to identify issues shared at Matrons meeting. Trust ventilation lead as part of estates team	Currently no department of health guidance detailing the requirements for these areas..	Moving forward we are going to add the ventilation requirements onto the IPC walk-arounds

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• arrangements around antimicrobial stewardship are maintained	AMS is well embedded in practice at RBCH and reported monthly and monitored through IPCC. There are no concerns about AMS activity at RBCH - antibiotic usage data during the COVID period is typical of this time of year and had not really increased.	COVID has removed most of any dedicated time the AMT can spend on this activity. The monthly antibiotic audit was suspended Mar- May 2020 as we were unable to data collect due to the impact of COVID. This restarted it for June 2020	There is monitoring antibiotic usage data. AMS ward rounds are likely to restart in June.
• mandatory reporting	Antimicrobial stewardship	The monthly antibiotic audit	Antibiotic audit has restarted in

requirements are adhered to and boards continue to maintain oversight	including audit is part of standard IPPC reporting and documented in the meeting minutes.	was suspended March- May as the team were unable to data collect due to the impact of COVID. This restarted it for June.	June and will continue as normal henceforth.

4. **Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion**			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• implementation of national guidance on visiting patients in a care setting	Trust responds to National and PHE guidance and revises as guidance changes. Evidence provided from daily comms and tactical comms. Visitor information on intranet and updated as guidance changes in line with national direction.		
• areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	Some signs in place and updated as guidance changes. Restricted access by staff permit	Poor signage	Refer to communications teams and dept managers for action when this is recognised. Good reporting of poor signage through tactical group to ensure proactive management of issues.
• information and guidance on COVID-19 is available on all trust websites with easy read versions	Information available on Trust Intranet for staff with hyperlinks to relevant national websites. Available in easy read & browse aloud		
• Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19	AC 12 Clear blue, green and yellow pathways and discussed on handing patient over to new clinical area		

patient needs to be moved			

5.	**Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**		
	Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
	Systems and processes are in place to ensure:			
•	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance	Separate Blue and Green ED ,entrances with screening nurse. Separate Blue and Green AMU/ SAU F/C 9 Streaming of ED patients on arrival F/C 2 Admission flow chart Covid categories FC 7 Surgical emergency patients with suspected Covid 19 infection		
•	mask usage is emphasized for suspected individuals	For suspected individual masks are offered whilst not isolated in a side room as per national guidance.	No evidence	To add to relevant flow chart
•	ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	Perspex screens are now in reception areas to provide staff protection. Covid secure areas identified from 15/6. Risk assessments available and will be documented by managers		
•	for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract	Contact Tracing completed as part of normal practice for any infection including outbreaks and documented. Documented on ICT outbreak spread sheet		

<mark>tracing as soon as possible</mark>	Patient isolated & contacts cohorted. Contact tracing via ICT for notifiable diseases i.e. TB. Outbreak spread sheet		
• patients with suspected COVID-19 are tested promptly	Trust Swabbing team in place and supported out of hours with Clinical Site team Process and policies discussed at infection control cell and ratified by clinical policies group .AC 3, 56,59		
• patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Patients stay on blue ward in designated bays and are retested as per national guidance. IPC team record potential contacts on outbreak spread sheet. Covid cohorting plan.		
• patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	National guidance is followed and documented in patient notes.		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working	All have access to action cards All staff undertake Trust and Local induction and mandatory training on commencing employment when they start in the trust, health & safety induction for contractor when		

environment is safe	they come onto site. Induction record on-line have this data, Training is documented on " electronic brain"		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it	Fit testing and Donning and doffing training sessions – data held on spread sheets.		
• a record of staff training is maintained	On-line and spread sheets.		
• appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed	Training masks are being collected in the event of PPE being decontaminated and re-used, currently not in place.		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	N/A		
• adherence to PHE national guidance on the use of PPE is regularly audited	Not specific to CoVID. Saving lives audits completed and compliance available on electronic spread sheet via excel.	Buddy checking is in place for Blue areas but nothing is documented No written documentation.	Staff report any non-compliance or misunderstanding of the use of PPE though appropriate escalation route and staff are encouraged to challenge in supportive way . Clarification and extra training/communication is provided appropriately.
•staff regularly undertake	Monthly audits undertaken and		

hand hygiene and observe standard infection control precautions	evidenced as above/ Action plans put into place by individual teams as appropriate and reported through strategic assurance group		
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Change from Hand Driers to paper towels underway for completion on the 8th June 2020. Documented in the minutes of the risk and cleaning meeting.		Task underway. New hand towel dispensers ordered and new bins to enable switch off.

All paper towel dispensers are in place, Estates to complete switch off following final delivery of bins. |
| guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas | This is in place and evidenced by information posters in these areas
Including hand washing technique. | | |
| • staff understand the requirements for uniform laundering where this is not provided on site | Uniform Policy and IPC policy and also supported by daily tactical comms briefings. | | |
| all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of | On-line learning for CoVID which is auditable and liaison with Occupational Health and their records. | | |

the symptoms			

7. Provide or secure adequate isolation facilities

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure:			
• patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Blue pathway and are co-horted appropriately F2 and co- horting plans		
• areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Blue pathway and are co-horted appropriately F2 and co- horting plans		
patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Side room list , reviewed and updated daily in conjunction with infection control and site teams and clinical based staff.		

8 Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure:			
• testing is undertaken by competent and trained individuals	All tests are undertaken in hospital UKAS accredited laboratories by HCPC Registered Biomedical		

	Scientists Swabs that cannot be undertaken within the hospital due to capacity are sent to PHE Bristol. System wide approach to testing in place with a variety of assays to maximize availability and flexibility of testing.		
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Patient and staff testing is available and reviewed in an on-going basis as new guidance is released. There is a system wide approach.		
• screening for other potential infections takes place	Reduced routine screening for other infections takes place following triage from Consultant Microbiologist.		This is in line with Royal College Guidance and reviewed by Microbiology Consultants monthly Pan Dorset. Issues escalated via normal governance routes and at daily tactical command meetings.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• staff are supported in adhering to all IPC policies, including those for other alert organisms	As reported in section one		

• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	As reported in section one.		
• all clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance	Trust guidance and policies already in place. Reviewed in line with national guidance related to Covid19 and policies remain compliant.		
PPE stock is appropriately stored and accessible to staff who require it	Regular top-ups from materials management who hold record and deliver to designated areas.		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure:			
• staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported	Clear Trust wide risk assessment tool in place to enable managers to work with vulnerable staff members to assess and manage risk. Tool developed with by Occupational Health in conjunction with HR and senior clinical staff. Staff redeployed, working from home or		

	shielding. Enhanced Psychological support provided for all staff to access and increased resource for BAME network lead to support BAME staff. Staff well-being champions in place coordinated by re-designated team (OD) and well-being areas in set up across the Trust.		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Fit testing in place (FFP3) and staff who fail have access to respiratory hood through a designated process led by site and equipment library .Spread sheet maintained to record which staff have been tested with which mask. Fit testing available 7 days a week from 0900-2100 in designated fit testing hub.		
• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Matron seconded to support staff reallocation across the Trust and working with DDON, HON, Operational Matrons and Workforce Lead. Managed through staffing plan and reviewed thrice weekly. Twice daily staffing meetings in place and operational matron out of hours and at weekends		
all staff adhere to national guidance on social	Adhered to across the Trust and covid risk assessment in		

distancing (2 metres) ==wherever possible, particularly if not wearing a facemask and in non-clinical areas==	place in in line with national guidance. Two Trust project groups consistently reviewing and identifying solutions to safe working and maximisation of staff ability to work at home , supported by remote access and Microsoft teams		
• staff absence and wellbeing are monitored and staff who are self- isolating are supported and able to access testing	Absence monitoring through nursing/AHP and medical workforce cell and discussed daily at operational meetings. Nurse staffing meeting twice daily at 12md and 1600 and coordinated by matrons on rota basis. Shielding and isolating staff reported daily and monitored on		
• staff who test positive have adequate information and support to aid their recovery and return to work	National guidance in terms adhered to and staff have access to all above well-being facilities. All staff have personal phone call informing them of the outcome of their swab and supported with information at the time.		

NHS E /I Board Assurance Framework for Infection Prevention and Control during COVID -19

Systems and processes are in place to ensure:	1. **Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users**			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	Infection risk is assessed at the front door and this is documented in patient notes	Action card 6 eNA Infection Control Assessment.	• Compliance with action card not formally assessed. • Documentation not audited. • eNA compliance April = 24% @ 6hrs and 52% @ 24 hrs.	?what is role of HoTW in This?
2.	Patients with possible or confirmed COVID-19 are not moved unless this is essential for their care or reduces the risk of transmission	Action card 6	• Compliance with action card not formally assessed.	
3.	Compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	Action card 6	• Compliance with action card not formally assessed.	
4.	All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• Action card 1 and associated PHE poster guidance. • Record of all staff PPE training at the beginning of the pandemic created but needs an ongoing tool. • PPE clinical coordinator post in place.	• Contemporaneous record of PPE training not held.	• Develop online learning package. • Develop competence assessment. • Create PPE buddy on each ward and department
5.	National guidance is regularly checked for updates and any changes	• Role of Lead	• Not all depts. attend	• Create PPE buddy

	are effectively communicated to staff in a timely way	ICN/ICN • Weekly briefing to all wards and departments	briefing	on each ward and department with role specification.
6.	Changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Quarterly IPC report. • Risk register in place. • Verbal reports to executives.	• Regular formal report on PHE guidance not collated for board members.	• Report to QSPC to be made monthly.
7.	Risks are reflected in risk registers and the Board Assurance Framework where appropriate	• COVID risk register in place		
8.	Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens.	• Surveillance for key alert organisms in place. • IPR process in place.		

Systems and processes are in place to ensure:	2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	**Designated teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas**	• Staff are cohorted to green and purple areas.		• Need to maintain this segregation across all patient facing staff as purple areas reduce.
2.	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• All Interserve staff have received training in cleaning for this Pandemic	-	-
3.	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance	• All Interserve staff have received training in cleaning for this Pandemic • Action card xx in place. • Protocol for turning purple to green in place.	-	-
4.	Increased frequency, at least twice per day, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	• Enhanced cleaning recommended 2 times per day in all areas focussing on common touch points	• Audit is outcome focussed and therefore not assured that twice daily is achieved.	• Review process and resource with Interserve.

5.	Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	• Enhanced cleaning recommended 2 times per day in all areas focussing on common touch points	• Audit is outcome focussed and therefore not assured that twice daily is achieved.	• Review process and resource with Interserve
6.	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	**Action card 8**	• Audit is outcome focussed and therefore not assured that twice daily is achieved.	• Review process and resource with Interserve
7.	Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	**Action card 8**	• Audit is outcome focussed and therefore not assured that twice daily is achieved.	• Review and reinstate decontamination training and competency with nursing teams. • Review process and resource with Interserve
8.	As per national guidance: 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• **Action card 8** • N.B. for most areas PPE is constantly being removed and there are no clear periods to define.	• Non clinical and clinical areas are included in working safely toolkit.	• Implement safe working toolkit. • See action for 4,5,6,7
9.	Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	• All linen managed as infected linen from COVID19	-	-

		wards and suspected patients		
10.	Single use items are used where possible and according to Single Use Policy	• Single use items managed as per decontamination of medical devices policy	-	-
11.	Reusable equipment is appropriately decontaminated in line with local and PHE national guidance	• Action card 19 • Risk assessment for FFP3 masks	-	-
12.	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• Assessment completed for respiratory physiology dept theatres and critical care A, CCU and C2.	• Not all areas have reviewed ventilation.	• Estates and IPC Team to review with Departmental leads / Matrons.

Systems and processes are in place to ensure:	3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	Arrangements around antimicrobial stewardship are maintained	• All patients flagged who require Microbiology input have a review. • The team review the orthopaedic septic patient list daily – a weekly MDT virtual review takes place with microbiologist • The microbiologists go to ICU daily and Haematology ward round on a Friday.	• ARK audits haven't been maintained over the past couple of months. • Weekly AMS rounds are planned but due to COVID19 pressure have not been delivered.	AMS rounds need supporting. CMM support for this is essential
2.	Mandatory reporting requirements are adhered to and boards continue to maintain oversight			ICG needs to include this in the next planned meeting (June).

Systems and processes are in place to ensure:	4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	Implementation of national guidance on visiting patients in a care setting	• National guidance implemented. • Advice published on internet	-	-
2.	Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	• All areas restricted to essential staff only. • Specific coloured posters used to highlight COVID and Non COVID areas	-	-
3.	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• All in place https://www.poole.nhs.uk/patients--visitors/coronavirus-guidance.aspx • Some easy read information on 3 key topics.	-	-
4.	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Specific action card for isolation, discharge and transfer of patients in place. Action card 6	-	-

NHS E /I Board Assurance Framework for Infection Prevention and Control during COVID -19

Systems and processes are in place to ensure:	5. **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID19 cases to minimise the risk of cross-infection	• All assessment pathways have specific COVID and Non COVD admission routes	-	-
2.	Mask use is emphasized for suspected individuals	Action card 6- Included in weekly update 26.5.20	-	-
3.	Ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	• Working safely toolkit in development	• Toolkit needs to be rolled out asap	
4.	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Action card 6 and Action card 5		• Designated ICN to lead on this work
5.	Patients with suspected COVID-19 are tested promptly	Action card 4a	• Subject to availability of rapid swabs	
6.	Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Action card 6 and Action card 5	•	• Designated ICN to lead on this work
7.	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• No routine appointments currently being delivered without a COVID19 assessment, those at high risk	-	-

		of a severe infection are regularly screened.		

NHS E /I Board Assurance Framework for Infection Prevention and Control during COVID -19

Systems and processes are in place to ensure:	6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	All staff (clinical and nonclinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	• FFP3 training /FIT • Working safely toolkit in development	Limited evidence of other training and not contemporaneous	See section 4,5 for actions Toolkit to be rolled out asap
2.	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it framework	• FFP3 training/FIT	Limited evidence of other PPE training and not contemporaneous	See section 4,5 for actions
3.	A record of staff training is maintained	• FFP3 training/FIT	Limited evidence of other and not contemporaneous	See section 4,5 for actions
4.	Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• CAS alerts are routinely monitored and shared with key staff. Reuse of PPE has been reviewed by the Trust and associated action card has been developed	-	-
5.	Any incidents relating to the re-use of PPE are monitored and appropriate action taken	• Incidents related to PPE are documented on the Datix system and reviewed on a monthly basis	-	-
6.	Adherence to PHE national guidance on the use of PPE is regularly	• No formal audit	• No formal audit in	• AUDIT on PPE use to

	audited	in place. • PPE nurse and ICNs monitor during all staff interactions.	place	be completed.
7.	Staff regularly undertake hand hygiene and observe standard infection control precautions	• Audit on HH	-	-
8.	Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• Hand towels are in place in all clinical areas.	• Non clinical areas have air dryers	• Trust to review the location of all hand towels to ensure they are not at risk of droplet contamination (IPC and Estates). • Trust to replace all air dryers with hand towels
9.	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Not present in all areas	•	• Posters to be revamped alongside the social distancing posters
10.	Staff understand the requirements for uniform laundering where this is not provided for on site.	• Standard policy. • Fabric bags provided. • Guidance issued through weekly briefings.	-	-
11.	All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of household display any of the symptoms.	• Standard policy. • Sickness absence figures support this. • Staff screening in place for staff and family	-	-

Systems and processes are in place to ensure:	7. Provide or secure adequate isolation facilities			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate	• The Trust has followed a process to segregate COVID from Non COVID patients • Rapid screening where possible	-	-
2.	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Assessment of ward spacing completed.	• Bed spacing is not adequate in some ward areas .	• Implement new bed footprint within high risk areas.
3.	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Standard Hospital policy is to isolate and review patients with MDRO. Due to the reduction in numbers of patients admitted this has not been challenged by the pandemic	-	-

Testing is	8. Secure adequate access to laboratory support as appropriate				
undertaken by competent and trained individuals	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	
1.	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance	- Action card for screening of staff has been developed and adhered to. - Screening of patients follows national guidance - Increased use of fast swabs where possible	-	-	
2.	Screening for other potential infections takes place	Influenza A has been included on the respiratory screens if requested by the clinical team	-	-	

Systems and processes are in place to ensure:	9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	Staff are supported in adhering to all IPC policies, including those for other alert organisms	• IPC Team visit areas on a daily basis. Lots of training and reference materials	-	-
2.	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• National policy changes are reviewed and implemented into actions cards as soon as possible. • Daily updates with all clinical teams is carried out to ensure that these changes are disseminated. • Major.incidnet in box reviewed daily by EPRR lead.	-	-
3.	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance	• Waste policy and action cards follow national [guidance](#)	-	-
4.	PPE stock is appropriately stored and accessible to staff who require it	• A dedicated member of the team is allocated	-	-

	to working with the logistics team to ensure that the appropriate PPE is used in each area.
	• This allows for better use and understanding of the clinical requirements for PPE.

Appropriate systems and processes are in place to ensure:	10. **Have a system in place to manage the occupational health needs and obligations of staff in relation to infection**			
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
1.	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Risk assessment process in place for staff including BAME/pregnant	• Audit of how many staff have a formal risk assessment.	• Propose audit to HR.
2.	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• FIT testing for all staff required to wear FFP3 masks is carried out by fully trained personnel in line with HSE and	-	-

		FTF guidance with oversight from the IPC Team • Each member of staff is given a record of their assessment t0 indicate what mask they will need to wear. • A record of who is fit tested is kept by each ward/ departmental lead for their staff. • FIT tested is a skill in E-roster • Risk assessment in place. • Decontamination guidance in place		
3.	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Staff are cohorted as much as feasibly practical. • Where clinical expertise is required across the Trust staff visit non covid areas first always adhering to IPC principles to avoid transmission events		• Need an associated policy or action card
4.	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask	• New culture and behaviours work	• Not all staff consistently	• Implement safe working toolkit.

	and in non-clinical areas	- under way. - New signposting	following guidance .	
5.	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific are	- New culture and behaviours work under way. - New signposting	Not all staff consistently following guidance .	Implement safe working toolkit.
6.	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff well being and absence is monitored with a clear action card to enable them to access	-	-
7.	Staff that test positive have adequate information and support to aid their recovery and return to work	Staff that test COVID19 detected are followed up by the occupational health team	-	-

Systems and processes are in place to ensure:	1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	RBCH Compliance	PHFT Compliance	Opportunities for joint working
	Key lines of enquiry			
	1 Infection risk is assessed at the front door and this is documented in patient notes			Development of eNA for IPC initial assessments. Audit of compliance with existing action cards.
	2 Patients with possible or confirmed COVID-19 are not moved unless this is essential for their care or reduces the risk of transmission			Audit of compliance with existing action cards.
	3 Compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients			Audit of compliance with existing action cards.
	4 All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance			Use of the auditable e-learning platform green brain/heart in PHFT to create contemporaneous record of training. Development of joint competencies for all PPE training.
	5 National guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way			PHFT to join the IPC at RBCH to form a single COVID focused IPC group.
	6 Changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted			Plans are in place to join the PHFT and RBCH Policies and Procedures groups and IPC cell meetings.
	7 Risks are reflected in risk registers and the Board Assurance Framework where appropriate			RBCH overarching COVID risk 879 on risk register. PHFT overarching COVID risk 1342 on risk register Risk Assessment for submission to the Risk Register regarding the amalgamation of blue/green pathways has been circulated for comment & agreement prior to sign off.
	8 Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens.			

Systems and processes are in place to ensure:	2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	RBCH Compliance	PHFT Compliance	Opportunities for joint working

	Key lines of enquiry			
1	**Designated teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas**			
2	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.			
3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance			PHFT audit process for terminal cleans to be shared with RBCH.
4	Increased frequency, at least twice per day, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance			Both organisations have assessed and costed the required cleaning regimes with guidance from IPC on the required areas for increase.
5	Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas			Both organisations have assessed and costed the required cleaning regimes with guidance from IPC on the required areas for increase.
6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses			
7	Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products			
8	As per national guidance: 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)			Both organisations have assessed and costed the required cleaning regimes with guidance from IPC on the required areas for increase.
9	Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken			
10	Single use items are used where possible and according to Single Use Policy			
	Reusable equipment is appropriately decontaminated in line with local			

		RBCH Compliance	PHFT Compliance	
	11 and PHE national guidance	🟩	🟩	
	12 Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	🟧	🟧	Both organisations are joining together to form an IPC focused ventilation group to guide further actions and assurance processes.

Systems and processes are in place to ensure:	3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	RBCH Compliance	PHFT Compliance	Opportunities for joint working
	Key lines of enquiry			
	1 Arrangements around antimicrobial stewardship are maintained	🟩	🟩	AMS activity has picked up following COVID peak and ther are no specific concerns. Opportunities to strengthen AMS in the mererd IPCT are being explored.
	2 Mandatory reporting requirements are adhered to and boards continue to maintain oversight	🟩	🟩	AMS activity has picked up following COVID peak and ther are no specific concerns. Opportunities to strengthen AMS in the mererd IPCT are being explored.

Systems and processes are in place to ensure:	4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	RBCH Compliance	PHFT Compliance	Opportunities for joint working
	Key lines of enquiry			
	1 Implementation of national guidance on visiting patients in a care setting	🟩	🟩	Joint approach and principles developed.
	2 Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	🟩	🟩	The trusts are actively working to agree joint signage wherever posible
	3 Information and guidance on COVID-19 is available on all Trust websites with easy read versions	🟩	🟩	
	4 Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	🟩	🟩	

Systems and processes are in place to ensure:	5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	RBCH Compliance	PHFT Compliance	Opportunities for joint working
	Key lines of enquiry			
	1 Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID19 cases to minimise the risk of cross-infection			Joint risk appraisal and risk assessment for Risk Register proposals regarding the need to geographically combine the blue/green pathway due to the increase in greeen planned/unplanned activity and the decreasing rate of positve infection rates. Approved by Joint DoN's, MD's and COO's and DIPC on 15/07/2020. Mitigating actions and montioring triggers in place
	2 Mask use is emphasized for suspected individuals			
	3 Ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff			
	4 For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible			
	5 Patients with suspected COVID-19 are tested promptly			
	6 Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced			
	7 Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately			

Systems and processes are in place to ensure:	6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	RBCH Compliance	PHFT Compliance	Opportunities for joint working
	Key lines of enquiry			
	1 All staff (clinical and nonclinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe			
	2 All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it framework			Opportunity to implement single competency assessment across both organisations.

		RBCH Compliance	PHFT Compliance	Opportunities for joint working
3	A record of staff training is maintained	🟩	🟩	Implementation of BEAT at PHFT provides opportunity to have central contemporaneous record. Records currently held at department level.
4	Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	🟩	🟩	
5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken	🟩	🟩	
6	Adherence to PHE national guidance on the use of PPE is regularly audited	🟧	🟧	Opportunities to strengthen oversight though implementation of a standard observation audit.
7	Staff regularly undertake hand hygiene and observe standard infection control precautions	🟩	🟩	
8	Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	🟩	🟩	Work has been completed to remove hand dryers.
9	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	🟩	🟧	Posters being updated in Poole with opportunity to standardise with RBCH.
10	Staff understand the requirements for uniform laundering where this is not provided for on site.	🟩	🟩	
11	All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of household display any of the symptoms.	🟩	🟩	

Systems and processes are in place to ensure:	**7. Provide or secure adequate isolation facilities**	**RBCH Compliance**	**PHFT Compliance**	**Opportunities for joint working**
	Key lines of enquiry			
1	Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate	🟩	🟩	Joint approach to developing operational protocols is in place, this remains the case once blue/green pathwyas are geographically combined.

				Shared methodology to assess bed spacing to be employed
2	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance			across both trusts to provide consistent risk based approach.
3	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement			

Testing is undertaken by competent and trained individuals	8. Secure adequate access to laboratory support as appropriate	RBCH Compliance	PHFT Compliance	Opportunities for joint working
	Key lines of enquiry			
	1 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance			The trusts are developing a joint leadership approach and protocols and competencies for COVID testing
	2 Screening for other potential infections takes place			

Systems and processes are in place to ensure:	9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	RBCH Compliance	PHFT Compliance	Opportunities for joint working
	Key lines of enquiry			
	1 Staff are supported in adhering to all IPC policies, including those for other alert organisms			
	2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff			Principles of joint communications with staff are established for cross site issues. Joint IPC cell supports consistent apporach.
	3 All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance			
	4 PPE stock is appropriately stored and accessible to staff who require it			Arrangemets to support mutual aid are in place.

Appropriate systems and processes are in place to ensure:	10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	RBCH Compliance	PHFT Compliance	Opportunities for joint working
	Key lines of enquiry			
	1 Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported			Joint trust risk assessments with process for completion and recording in place.
	2 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained			FIT testing to be included into the new 'green heart' training record in RBCH and then Poole.
	3 Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance			
	4 All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas			PHFT Safe Working Toolkit and high way code has been developed with RBCH participation.
	5 Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific are			Both organisations are looking at additional covered space to support social distancing during breaks.
	6 Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing			RBCH and Poole can provide cross cover for staff testing.
	7 Staff that test positive have adequate information and support to aid their recovery and return to work			

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 6.8

Subject:	PHFT Annual Health and Safety Report 2019/2010

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk
Presented by:	Patricia Reid, Director of Nursing and Midwifery, PHFT

Purpose of paper:	To provide a report on Health and Safety and Fire Safety activity for 2019/2020
Background:	Annual Reporting requirement.
Key points for members:	This report advises the Board of Directors, Health & Safety Group, Risk Management and Safety Group, of activities relating to Health and Safety in the period of 1st April 2019 to 31st March 2020
Options and decisions required:	For approval
Recommendations:	For approval
Next steps:	No further action required

FOR POOLE USE ONLY

Links to Poole Hospital NHS Foundation and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trusts Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	All
BAF/Corporate Risk Register: (if applicable)	Yes
CQC Reference:	All Domains

Committees/Meetings at which the paper has been submitted:	Date
Health, safety and Fire Group	Quarterly

Health, Safety and Fire Annual Report 2019 - 2020

Annual Report for the Period: 1st April 2019 – 31st March 2020

Contents Page

1. INTRODUCTION

1.1 This report advises the Board of Directors, Health & Safety Group, Risk Management and Safety Group, of activities relating to Health and Safety in the period of 1st April 2019 to 31st March 2020.

1.2 This report provides analysis of the standard of health and safety throughout our Trust for the financial year 2019/20.

1.3 The Health and Safety at Work Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work. This framework requires organisations to provide and maintain:

- Policy and Procedure
- A safe and secure working environment
- A system that proactively identifies, controls and manages risk
- Information and training as necessary
- Staff welfare
- Safe systems of work that have identified and controlled the risks

2. BACKGROUND

2.1 Every organisation should have an effective Health and Safety Management system which is based around four key elements: Plan, Do, Check, Act. These elements are used to measure performance and to ensure the trust meets its moral, professional, and legal responsibilities.

2.2 The Risk Management Team, under the leadership of the Director of Nursing, leads on the overall direction of health and safety in order to improve performance through the monitoring and progress via the annual report and action plan. The Trust's Health and Safety Group meets every other month to receive reports from all departments and provides the latest information on current issues and education directives.

3. REPORTED ADVERSE INCIDENTS

3.1 During the period from 1st April 2019 to 31st March 2020 there were a total of: **1716** non clinical incidents reported, compared to **1558** in the previous year, an increase of 10.1%.

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017-2018	111	136	149	131	149	144	130	108	130	106	90	145	1529
2018-2019	143	138	144	173	138	98	157	104	116	132	118	97	1558
2019-2020	109	124	131	147	162	168	192	151	112	180	113	127	1716

Comparison year on year

Incidents by Incident date (Financial month) and Incident date (Financial year)
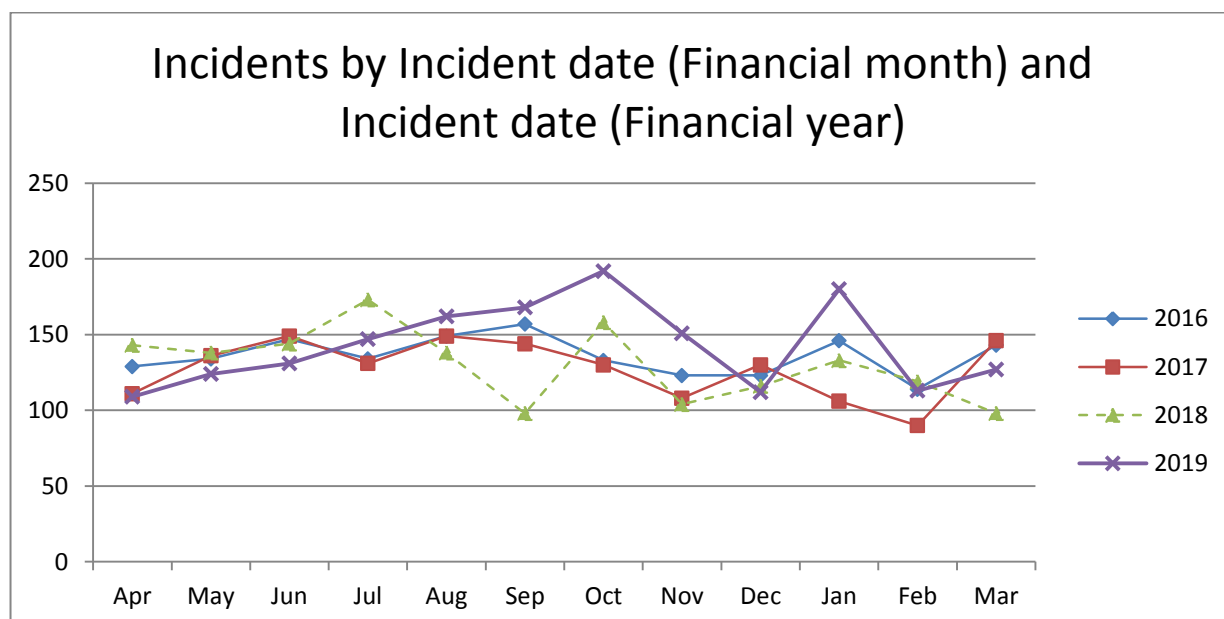
Non-clinical incidents by category.

2019-2020	Apr-19	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-20	Feb	Mar	Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	14	22	18	15	25	25	22	23	7	28	8	19	226
Other Service Disruptions/ Infrastructure Incident	1	2	6	6	16	12	29	16	4	6	4	4	106
Human Resource Availability (includes strikes/work stoppages)	10	7	4	10	6	19	5	12	12	8	6	2	101
Exposure to Hazardous Substances	4	8	7	5	8	6	6	9	5	13	9	13	93
Exposure to Unsafe Environmental Conditions	2	7	5	7	5	6	14	5	4	3	8	11	77
Service Provision Insufficiencies/Failures/closures	0	3	7	8	2	5	6	11	4	13	4	3	66
Workplace Stressors/Demands	6	6	4	4	9	7	11	5	3	6	0	4	65
Contact with Sharps	9	4	7	4	3	3	9	2	4	9	4	7	65
Other	4	2	5	5	3	6	4	4	7	9	4	5	58
Lifting/Manual handling	1	3	2	4	4	2	6	3	2	6	1	0	34

3.2   The information above is interpreted as: Inappropriate aggressive behaviour towards staff by a patient shows a decrease by 12% on last year's figure of 256; however there has been an increase of aggressive behaviour towards staff by staff of 75% and staff by a visitor with an increase of 53%. Workplace stressors demands show a decrease of 17% on last year's figure of 78 to 65 in this year.

Exposure to hazardous substances is up by 75% from 53 to 93 incidents. Slip trip and falls are up by 51%, contact with sharps shows a decrease of 7%. Lifting/Manual handling 34 incidents have stayed the same as last year.

Incidents by Severity year on year

RMSG Severity choice Type excludes external
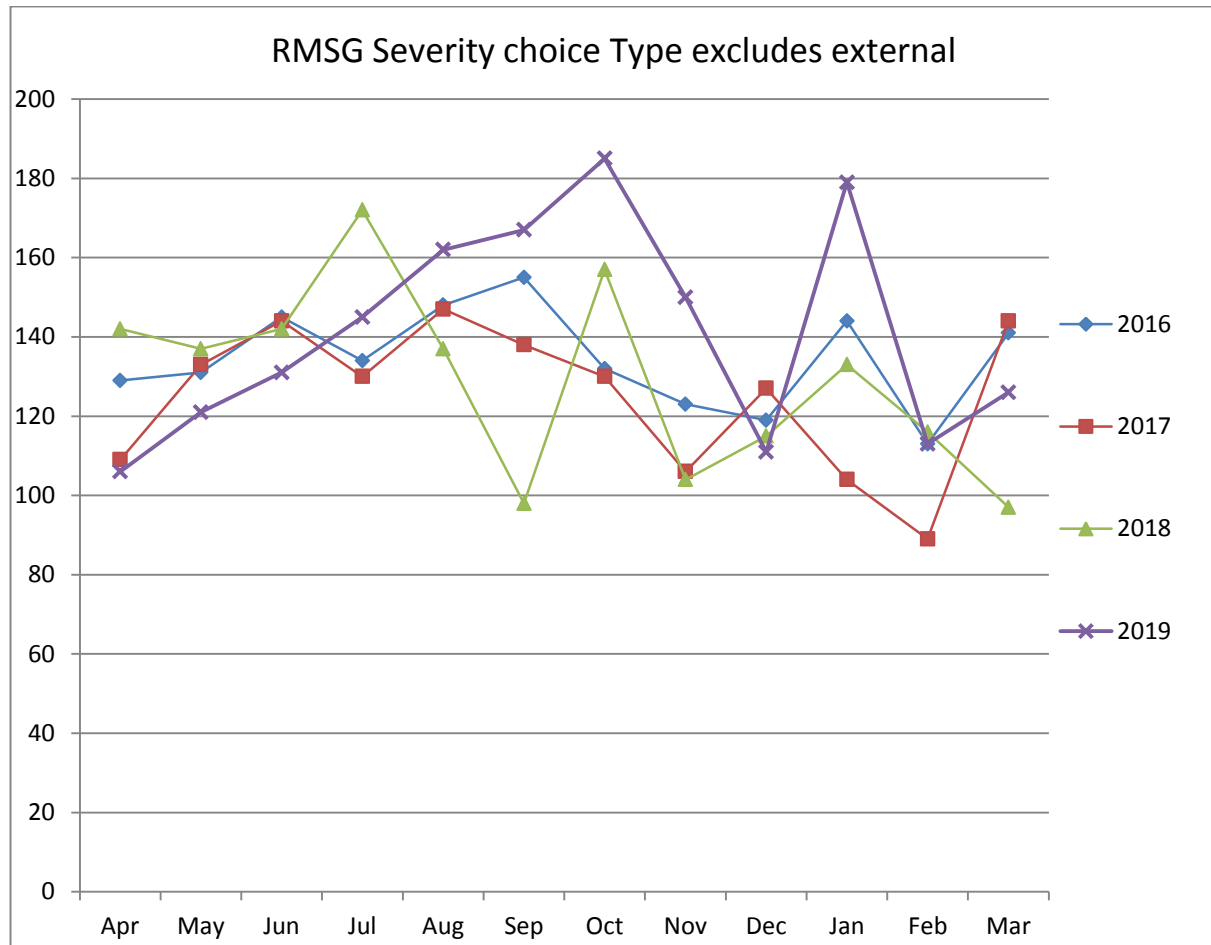
2019 - 2020	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
No Harm	80	90	99	116	118	137	141	122	85	137	97	102	1324
Minor	24	28	27	23	41	22	38	21	23	39	15	22	323
Moderate	2	2	5	6	3	8	6	7	3	3	1	1	47
Severe	0	1	0	0	0	0	0	0	0	0	0	1	2
Total	106	121	131	145	162	167	185	150	111	179	113	126	1696

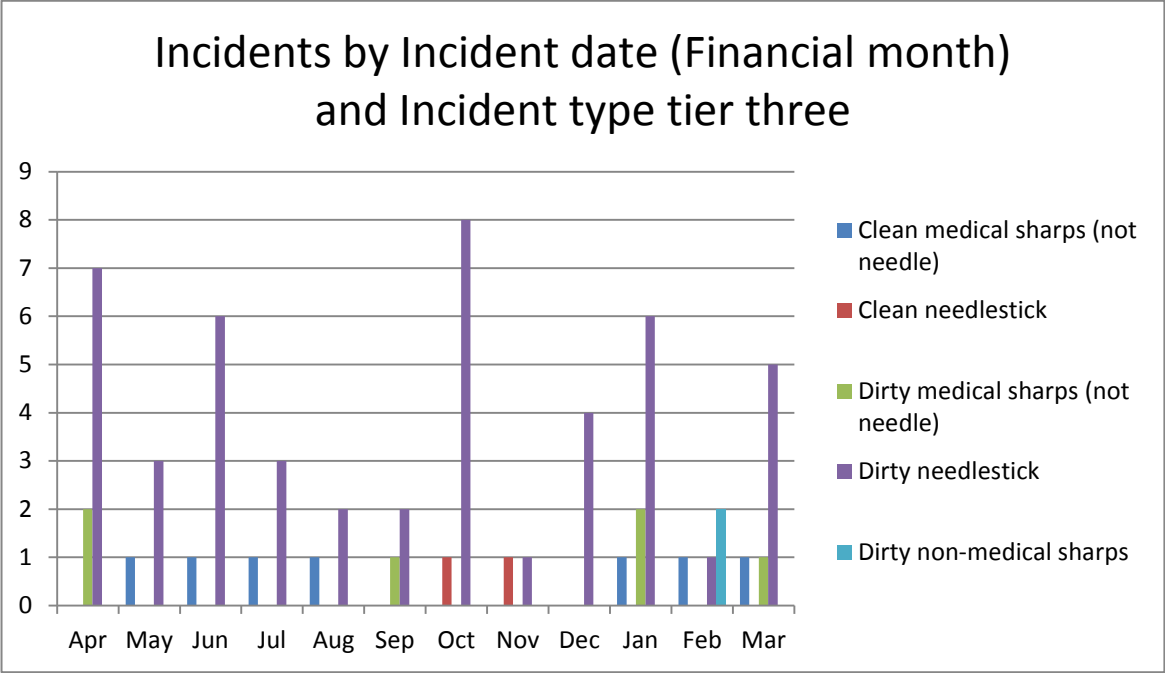|	Apr-19	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-20	Feb	Mar	Total
Contact with Sharps	1	0	1	0	0	0	1	1	0	1	0	0	5
Contact/Collision with Objects/Animals (not sharps)	0	0	0	0	0	1	1	0	0	0	0	0	2
Entrapment	0	0	0	1	0	0	0	0	0	0	0	0	1
Exposure to Hazardous Substances	0	2	1	0	1	1	0	2	0	1	1	0	9
Exposure to Unsafe Environmental Conditions	0	0	0	1	0	1	1	0	0	0	0	0	3
Hardware/device/equipment	0	0	0	0	0	0	0	0	0	1	0	0	1
Inappropriate/Aggressive Behaviour towards Staff by a Patient	0	0	0	0	1	1	2	0	1	0	0	1	6
Lifting/Manual handling	0	0	0	0	0	1	1	1	0	0	0	0	3
Other	1	0	0	1	0	1	0	0	0	0	0	0	3
Other Service Disruptions/ Infrastructure Incident	0	0	0	0	0	0	0	1	0	0	0	0	1
Service Provision Insufficiencies/Failures/closures	0	0	1	0	0	0	0	0	0	0	0	0	1
Slip/Trip or Fall	0	0	2	3	1	1	0	2	2	0	0	0	11
Utility/Infrastructure Failures/Disruptions (Excluding Fire Alarm Systems)	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	2	2	5	6	3	8	6	7	3	3	1	1	47

Top ten List of moderate incidents by type

3.3   Incidents are graded moderate due to seriousness of the incident, and the level of harm suffered. Examples would be accidents in which staff are of unable to work for a prolonged period of time, or certain types of injury such as broken bones and include contaminated needle stick injuries or body fluid splashes. These are reported to the Health & Safety Executive (HSE) under the Reporting of Diseases and Dangerous Occurrences Regulations (RIDDOR). It should be noted that not all RIDDOR reportable incidents are moderate harm, and that not all moderate harm safety incidents are RIDDOR reportable.
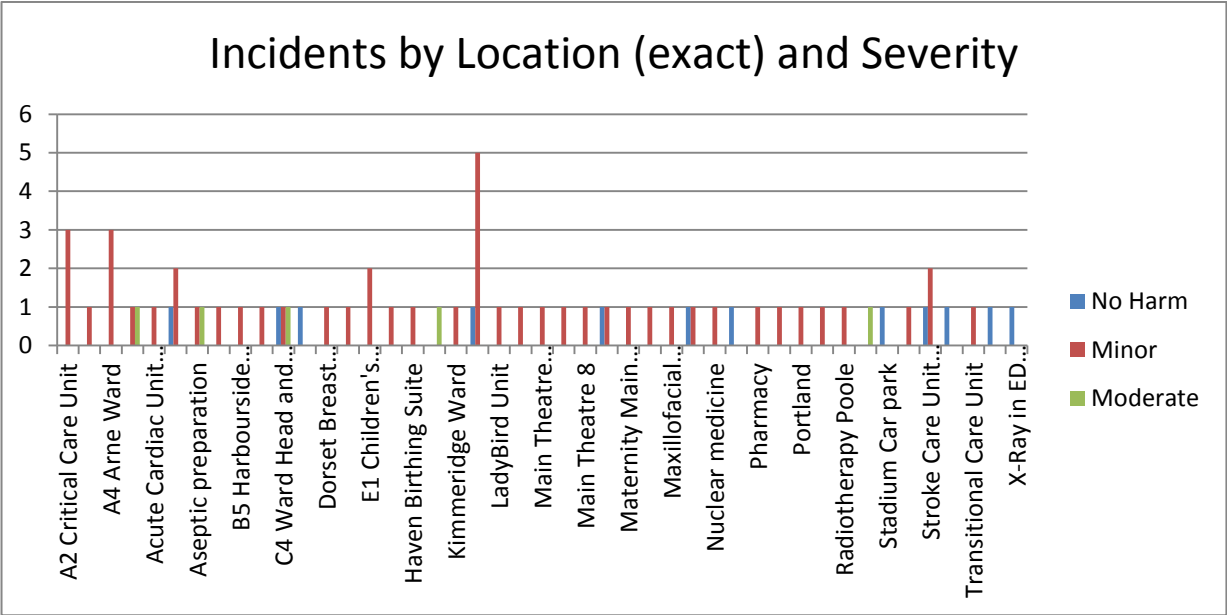
4. SHARPS & HAZARDOUS SUBSTANCE INCIDENTS

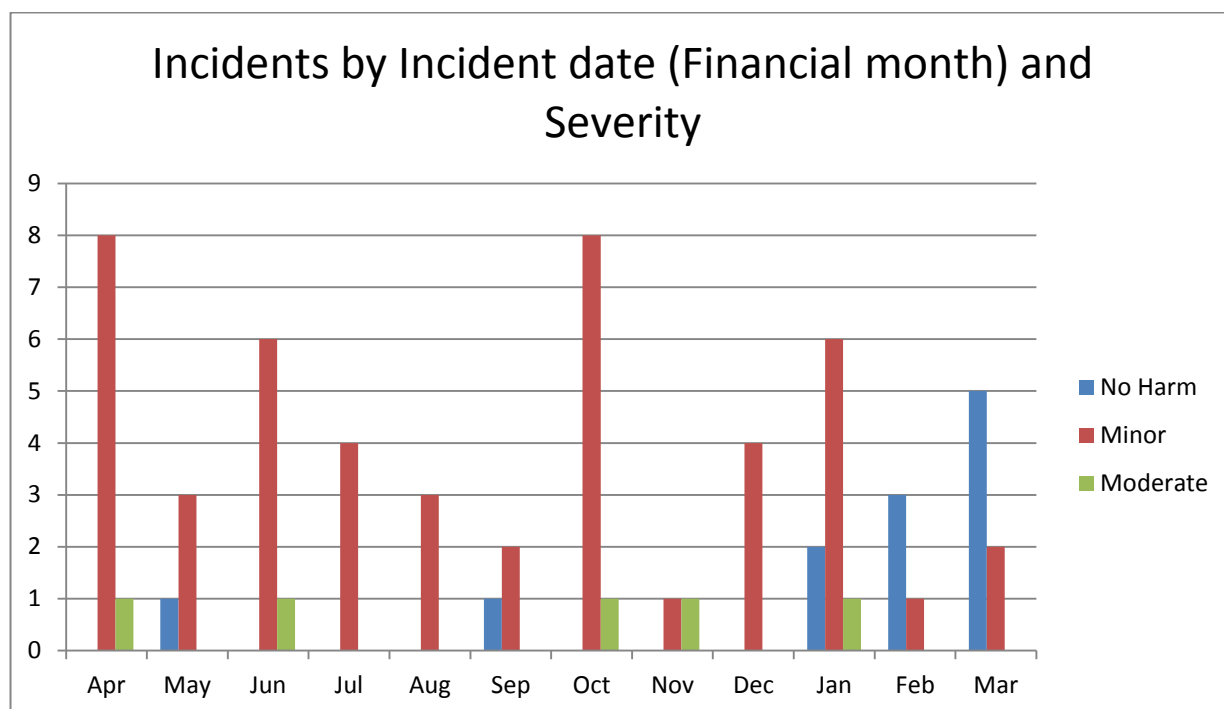|	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Clean medical sharps (not needle)	0	1	1	1	1	0	0	0	0	1	1	1	7
Clean Needlestick	0	0	0	0	0	0	1	1	0	0	0	0	2
Dirty medical sharps (not needle)	2	0	0	0	0	1	0	0	0	2	0	1	6
Dirty Needlestick	7	3	6	3	2	2	8	1	4	6	1	5	48
Dirty non-medical sharps	0	0	0	0	0	0	0	0	0	0	2	0	2
Total	9	4	7	4	3	3	9	2	4	9	4	7	65

Top 5 Sharps and Hazardous Substances

4.1 There were a total of 65 incidents in the year April 2019 to March 2020. The majority are Dirty Needlestick injuries.
This shows a 46% decrease on last year which had 120 sharps and hazardous substance incidents between 1st April 2018 and 31st March 2019.

Incidents by Incident date (Financial month) and Incident type tier three

Incidents by month

Incidents by Location (exact) and Severity

Location of Incidents

Incidents by Incident date (Financial month) and Severity

Needlesticks Incidents 2019-2020

4.2 The table below shows total figures for the last three years

Date	Total incidents		Moderates		RIDDOR	
	Exposure	**Sharps**	**Exposure**	**Sharps**	**Exposure**	**Sharps**
2019/20	95	65	12	5	2	0
2018/19	53	70	4	8	1	1
2017/18	65	65	10	13	6	3

4.3 The total number of sharps incidents has increased year-on-year.

5. REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS (RIDDOR) 2019/20.

5.1 A total of 18 RIDDOR reportable incidents occurred during the reporting period.

These were broken down into the following categories:

2019/2020	Total
Slip/Trip or Fall	11
Lifting/Manual handling	3
Exposure to Hazardous Substances	2
Other	1
Entrapment	1
Total	18

Staff/Contractor Incidents

5.2   All staff related injuries are followed up by the Risk Management team. Managers are required to inform the risk team if any of their staff are off sick as a result of an accident or illness at work, particularly if the sickness period is over 7 days from the day after the accident, as these have to be reported to the HSE under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Line Managers should complete a RIDDOR accident investigation form which will be supplied to them by Risk Management. It is also available on the intranet located on the health and safety pages.

5.3   11 Slip/Trip or Falls are the highest type of incidents reported to the HSE under RIDDOR. Wet floors and spillages accounted for the majority of the incidents reported.

6.   TRAINING

6.1   The Health & Safety, and the Fire training are carried out by the Quality Governance team, with support from Education.

6.2   Compliance with the mandatory update training target of 90% is variable by staff group. The mandatory training completion as of March 2020 is as follows:-

Care Group	Health & Safety	Fire
Clinical & Operational Support	88%	95%
Medical	84%	86%
Surgical	92%	93%
Women, Children's & Oncology	91%	94%

7.   FIRE REPORT

7.1   It should be noted that the Trust did not have a Fire Advisor/Manager for the period of March – September 2019

7.2   Fire awareness and evacuation training is delivered on Trust Induction and Core-skills sessions. Some areas have staff members who deliver regular tool box talks at staff meetings and local induction, the tool box talk sessions are an excellent way of embedding safety information in short regular sessions at team meetings. It is imperative that all areas particularly wards and those with clinical responsibilities have annual fire and evacuation refresher training in light of the new training plan issued by the training department.

Summary of actual fires

Ref	Incident date	Department	Location (exact)	Incident type tier one	Incident type tier three	Severity	Description	Action taken
E44834	04/11/2019	Emergency and Ambulatory Care Medicine	AMU (Ansty)	Fires, Fire Alarms and Fire Procedures	Extinguished by persons at the scene	No Harm	on the night shift of 4/11/19, small fire in the vital pac cupboard short circuited, fire extinguisher got and small fire put out	fire extinguisher got and small fire put out
E48228	06/02/2020	Critical Care Services Directorate	Main Theatres	Exposure to Environmental Hazards	Electrical hazard	No Harm	Calima forced air warming system was plugged into hanging electrical socket pendant. A bang was heard and sparks were created. The plug was missing its fuse holder but the fuse was insitu exposed. Fuse earthed against a screw on socket.	Calima forced air warming system removed from service and sent to clinical engineering. Estates informed of loss of electricity. (Fixed Later that evening)

7.3   Breakdown of Actual Fires

Above are the only Fire incidents that have been reported on Datix. However there have been other incidents that the Fire Officer has been made aware of that are noteworthy:-

Instances of plug fuse holders being removed in a variety of locations were reported in February. This seemingly deliberate action has had the potential of causing electric shock and electrical fires. Further reports were found in Maternity in June. Estates were requested to rectify these issues.

Key causes of fire alarm activations were by smoking in toilets, activation of aerosol canisters such as deodorants and cooking (toast/microwave).

8.   CENTRAL ALERT SYSTEM (CAS) ALERTS

8.1   All CAS alerts come via e-mail into Risk Management and are aknowleged with 24 hours. The alert is discussed and diseminated to appropiate persons and teams for action, all processes are recorded as are all reponses for a clear audit trail.
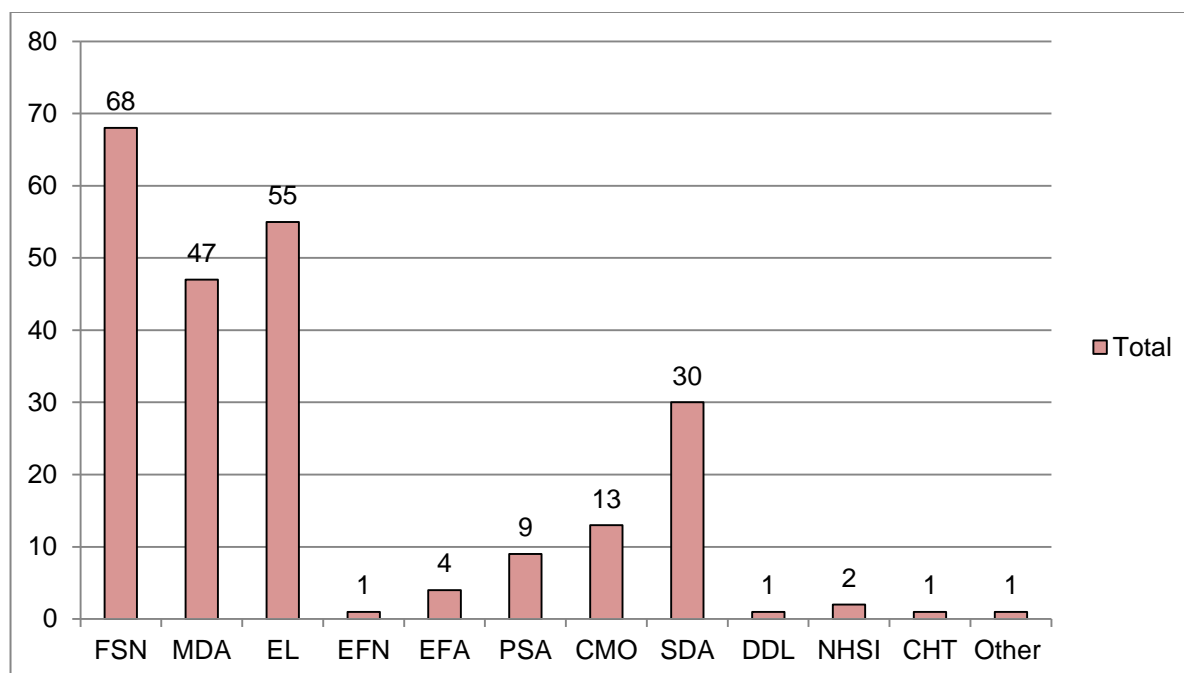
Figure 16. Breakdown of CAS alerts received 2019-2020.

- CMO – Chief Medical Officer
- CHT – Central Alert System Helpdesk Alert
- DDL – Dear Doctor Letter
- EFA – Estates and Facilities Alert
- EFN – Estates and Facilities Notification
- EL – MHRA Drug Alerts
- FSN – Field Safety Notice
- NHSI – Estates and Facilities Alert Information Alert
- MDA – Medical Device Alert
- PSA – Patient Safety Alert
- SDA – Supply Disruption Alert
- Other – Alert from another Trust

8.2 To ensure these are properly investigated and closed off it is important that anyone who is requested for infromation responds quickly and clearly all communications are kept including read reciepts to ensure a full audit trail.

9. THE HEALTH AND SAFETY GROUP

9.1 The Health & Safety Group is well attended but would benefit from more regular attendance from all clinical departments. Matters for escalation from this group are received by the Trust Quality Governance Group.

10. ACTIONS

In 2020/21 we plan to:

- Align policies from Poole and RBCH in readiness for the newly formed Trust.

- Update COSHH assessments for general use accessed through DATIX Web; develop an e-learning programme for all users.

- Update Display Screen Equipment training using BEAT e-learning this will be used at induction and reassessments carried out with department movers and when there is a change when new equipment is supplied to Staff.

- Combine the existing WASH and GAT to develop a new audit system which can be used through Formic.

- Align Health and Safety training via "Green Brain"

- Fire training aligned along with equipment used for Poole and RBCH

- Develop a plan to align Fire Risk Assessments to ensure compliance in Poole and RBCH.

- Align Fire Training, Policies and Equipment.

July 2020

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.1

Subject:	**CHARITABLE FUNDS EXPENDITURE OVER £25,000**

Prepared by:	Pete Papworth, Joint Interim Director of Finance
Presented by:	Pete Papworth, Joint Interim Director of Finance

Purpose of paper	For approval.
Background	Following award decisions made by the Charitable Funds Committee (CFC), the Board of Directors are asked to support the receipt of charitable funds in each case.
Key points for Board members	The Trust Board is asked to support the investment decisions considered by the CFC on 12 March 2020.
Options and decisions required	The following awards require approval by the Board of Directors ahead of receipt: 1. **Surface Guided Radiotherapy -** The CFC APPROVED in principle the purchasing of Surface Guided Radiotherapy Equipment (SGRT) at a total cost of £884,967 from the Robert White Legacy Fund, subject to final approval by Mr Papworth when written confirmation was received from the specialist commissioners. 2. **Additional Costs associated with upgrade to Restaurant** - The CFC APPROVED in principle on the basis it was explored whether additional audio visual technologies could be included in the original £220,000 investment previously agreed.
Recommendations	Members are asked to support the receipt of charitable funds in each of the two cases as listed.
Next steps	Where appropriate, benefits realisation reviews are undertaken on specific investments through the Investment Planning Group.

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective	AF4 - Ensure all resources are used efficiently, effectively and economically to deliver key operational standards
BAF/ Corporate Risk Register	Not Applicable
CQC Reference	Use of Resources

Committees/Meetings at which the paper has been submitted:	Date
Charitable Funds Committee	21 January 2020

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.2

Subject:	Quality Assurance for Responsible Officers and Revalidation

Prepared by:	Louise Stafford, Medical Revalidation Administrator
Presented by:	Matt Thomas, Medical Director

Purpose of paper:	The purpose of this report is to reassure the Board that the Trust is taking the matter of appraisal/revalidation seriously and doing all it can to support the senior doctors in this process
Background:	Revalidation was introduced in 2012 since then all doctors have been revalidated, and some are beginning a second round. An essential part of revalidation is that doctors have an annual appraisal.
Key points for Board members:	At 31st March 2020 there were 344 doctors with a prescribed connection to the Trust. The number of completed appraisals within the appraisal year (1st April 2019 – 31st March 2020) was 253 (73%). This is a 17% decrease from last year. The number of doctors prescribed to the Trust has increased by 23% There is a requirement for us to find and train additional appraisers within the Trust. The number of doctors being employed is rising, and it is expected that we appraise both substantive and temporary employees. . The policy for Appraisal and Revalidation has been redrafted ready for a joint policy to be in place for the new organisation.
Options and decisions required:	Board is asked to approve the report and approve the Statement of Compliance.
Recommendations:	
Next steps:	To ensure finance is available for the additional training of appraisers to meet the need of the Trust.
Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch NHS Foundation Trusts Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	
Committees/Meetings at which the paper has been submitted:	**Date**

Designated Body Annual Board Report

Section 1 – General:

The Board of Poole Hospital Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year was not submitted.

   > Date of AOA submission:
   >
   > Action from last year:
   >
   > Comments: The AOA was not requested from NHS England in April 2020 due to Covid 19.
   >
   > Action for next year: Continue to provide support and guidance on appraisal and revalidation for the growing number of doctors we have responsibility for.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   > Action from last year: As it is likely that PHFT and RBCH will be merged in 2020, the responsibility of the two current responsible officers may need to be reviewed.
   >
   > Comments: Dr Matt Thomas was awarded the role of Acting Medical Director as of 1st January 2020 and became the Responsible Officer for the Trust. He has completed the training for the role.
   >
   > Action for next year: With the merger of the two Trusts set for October, the responsible officer will need to reviewed.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   > Action from last year: An additional 5-10 appraisers will be required over the next 6 - 12 months.
   >
   > Comments: 4 additional appraisers were trained in the year and these are now appraising a number of doctors which has eased some of the pressure. The increase in doctors in the period was 65 (an increase of 23% from the previous year) the increase in administration work that this creates is substantial particularly as a large proportion of these are one year fixed term contracts and training and informing new starters takes time.
   >
   > Refresher Training took place in the autumn for our appraisers which 35 attended.
   >
   > Action for next year: Review how appraisers are allocated and in particular work with the departments who have few or no appraisers to change this.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

> Action from last year: To continue with current processes, aligning where appropriate with RBCH.
>
> Comments: Premier IT – our appraisal system is kept regularly updated, and is linked to GMC Connect. Both systems are updated during day to day processes, and are checked to be accurate in detail quarterly for the NHS England returns.
>
> Action for next year: To continue with current processes, aligning where appropriate with RBCH, a larger review of the Premier IT system is going to take place as part of the Merger.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

> Action from last year: Have one policy for the joint trusts.
>
> Comments: We have reviewed the RBCH policy, and amendments and additions to this are currently being prepared by RBCH revalidation team to put forward for agreement by the Joint Local Negotiation Committee (JLNC).
>
> Action for next year: To have a joint policy agreed and in place.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

> Action from last year: To understand when it is likely for a peer review to take place.
>
> Comments: The latest peer review was on July 6th 2015,
>
> Action for next year: To understand from NHS England when a review is likely to take place.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

> Action from last year: To embed the short term / bank worker policy.
>
> Comments: All non-training doctors directly employed by PHFT on a contract of at least 4 months will be given access to Premier IT and allocated with an appraiser employed by the Trust. These are all invited to meet with the revalidation administrator or lead to look at the system and go through the GMC, NHS England and PHFT expectations for appraisal and revalidation.
>
> Those employed for a shorter term than 4 months or through the bank will be looked at on a case by case basis dependent on the regularity of their work at the Trust. Due to the limited number of appraisers in the Trust, and the time and cost of each appraisal we would not be able to appraise all short

term employees. We will ensure that we provide any support / access to documentation that they may need, to fulfil their revalidation requirements.

Action for next year: To continue with this, in line with the joint policy.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

   Action from last year: Liaise with the Patient Advisory Service (PALS) to work on a proactive approach to getting the information in advance for both the doctor and appraiser to be aware of any complaints prior to the meeting.

   Comments: The current process is established and all new doctors to the Trust are directed to the PALs team for information. Appraisers expect to see information from PALs as well as the reflective notes from the doctor as part of the portfolio of information and will reject this if it is not included.

   For the revalidation administrator to collate this in advance and distribute has not been accomplished in this period. Initial discussions have been had with the PALS department on how this could work.

   Action for next year: To work with the RBCH team and PALS on a more efficient way to get the information required.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

   Action from last year: To continue to encourage and support doctors with appraisal.

   Comments: Supporting all doctors through the appraisal process is our priority. Where delays in appraisal occur, we take the approach to understand why there has been a delay, and support them to complete the appraisal within an acceptable timeframe. Where there is not an acceptable reason, the non-engagement procedure will be activated.

   Action for next year: To continue to encourage and support doctors with appraisal in line with the new policy.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

   Action from last year: To combine the PHFT and RBCH appraisal policies to be in place across both sites.

   Comments: The current appraisal policy is active and in line with guidance. This was agreed by the LNC in October 2017.

> We have reviewed the RBCH policy, and amendments and additions to this are currently being prepared by RBCH Revalidation Team to put forward for agreement by the JLNC.
>
> Action for next year: For the Joint Policy to be in place and practiced across both sites.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

> Action from last year: To recruit an additional 5 -10 appraisers to ensure we have enough appraisers to cover our increasing number of doctors.
>
> Comments: The Trust currently has 52 trained appraisers with responsibility of around 345 doctors and numbers increasing annually, at a much higher rate than our appraisers. We have regular pushes to recruit new appraisers, and need to increase this once again in the next 12 months. A number of existing appraisers retire, and return part time with a limited amount of SPA.
>
> When we merge in October this may give more flexibility to appraise doctors across both sites.
>
> Action for next year: To recruit additional appraisers in departments where there are few or no appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

> Action from last year: Look at ways of providing engaging workshops and forums in house.
>
> Comments: Refresher training was carried out in the autumn of 2019, 35 of our appraisers attended this. We have historically held biannual meetings and forums chaired by the Revalidation Lead which were not possible in the spring of 2020. RBCH deliver a very robust internal workshop which we would hope to widen to both sites in the future.
>
> Action for next year: Joint workshops and forums with the RBCH site offered to all appraisers.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

> Action from last year: The last Board Report was presented on September 25th 2019
>
> Comments: This is being presented to the Board as this document.
>
> Action for next year: Continue to update the Board annually; this may become more frequent in line with RBCH policy.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

   > Action from last year: To continue with the current process – All recommendations or deferrals for revalidation are completed by the Responsible Officer in advance of the date required.
   >
   > Comments: The GMC put back all revalidation dates between 17th March 2020 and 31st March 2021 by 12 months to cope with the demand on doctors' time during the Covid pandemic. The Trust has therefore not submitted any recommendations for doctors since April 1st 2020. The GMC have now announced that the Responsible Officer can now revalidate those doctors when they have the capacity to do so. Our aim is to review these and where possible revalidate those who were put back as soon as possible.
   >
   > Action for next year: For doctors to all be revalidated or deferred and the process managed as per the policy.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

   > Action from last year: To ensure we are 3 months ahead with the planning for revalidation, we currently plan ahead at between 1-2 months.
   >
   > Comments: We were actively making recommendations 3 months ahead where possible before the GMC altered revalidation dates. This will once again be the case when we begin this process again.
   >
   > A number of deferrals in the previous period were due to the 360 feedback not being completed. To prevent this going forward we have now contacted all doctors who are due to be revalidated before the end of 2021, and the 360 is either complete or in progress.
   >
   > With all revalidation situations once recommendations have been submitted, the doctor will receive an email to confirm that the Responsible Officer has recommended their revalidation. Where deferral or non-engagement is made the Responsible Officer will have discussed this beforehand. These outcomes are not unexpected by the doctor as they will have been in discussions with the revalidation lead and revalidation administrator to prepare / plan for this.
   >
   > Action for next year: To ensure all 360 feedbacks are in progress or completed for those due by the end of 2022

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

> Action from last year: Continue with current practise and review as necessary
>
> Comments: Doctors are expected to participate in each department's rolling Clinical Governance half day meetings held on a monthly basis, maintain their own skills and competencies through CPD, participate in Clinical Audit and Effectiveness work and Research and Development, as appropriate.
>
> Action for next year: Continue with current practise and review as necessary

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> Action from last year: Continue with current practise and review as necessary
>
> Comments: The Patient Advice and Liaison Service (PALS) provide doctors a record of all complaints or significant events which they have been named in or carried clinical or managerial responsibility for to reflect on in preparation for appraisal. We ensure all doctors have had a 360 multisource feedback at least once per revalidation cycle, which provides feedback from both colleagues and patients.
>
> Action for next year: Continue with current practise and review as necessary

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> Action from last year: To review the document and ensure the content is current.
>
> Comments: The Maintaining High Professional Standards policy covers all of the above mentioned, and was agreed by the Joint Local Negotiating Committee (JLNC) in January 2017. A joint policy is currently being written ready for consideration by the JLNC in August 2020 to be ready for the planned merger date in October.
>
> Action for next year: To have a joint Maintaining High Professional Standards Policy in place across both sites.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

> Action from last year: Continue with current practise and review as necessary
>
> Comments: The Workforce Group is accountable to the Workforce and Organisational Development Committee which is a formal Sub-Committee of the Board of Directors. The Workforce Group provide assurance to the Workforce and Organisational Development Committee that effective performance management systems are in place, in support of the Trust in its delivery of improving capability and capacity to provide high quality, safe patient care.
>
> Action for next year: Continue with current practise and review as necessary

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

> Action from last year: Continue to monitor the NHS England guidelines for transferring information between Responsible Officers.
>
> Comments: We use the Medical Practice Information Transfer Forms (MPIT) to transfer information between Responsible Officers. This form enables us to request information of note from previous employers, and share information with new or other employers.
>
> Action for next year: Continue to monitor the NHS England guidelines for transferring information between Responsible Officers.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

> Action from last year: Continue to review the policies in line with NHS guidelines
>
> Comments: We have two policies which are in place to ensure the above, Maintaining High Professional Standards policy and the Raising Concerns policy. We also have a Speak up Guardian working within the Trust.
>
> Action for next year: Continue to review the policies in line with NHS guidelines

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

> Action from last year: To work in line with NHS Employers guidance.
>
> Comments: Medical Staffing follow the guidance set by NHS Employers for recruitment of doctors. This includes checks that they are on the GMC register, and any undertakings that they may have.
>
> Action for next year: Continue to work in line with NHS Employers guidance.

Section 6 – Summary of comments, and overall conclusion

> Please use the Comments Box to detail the following:
>
> - General review of last year's actions
>
> We have continued to support the appraisal and revalidation process for all consultant/SAS/non-training grade doctors, with additional support to those who have required this. An increase of 23% in our numbers has meant the time spent with new starters has increased, a number of these new starters are new to the UK, and appraisal and revalidation is new to them so they need additional support.
>
> There is ongoing audit of output forms to ensure high quality appraisal.
>
> Two newsletters were issued during the year to keep all doctors (not in training) aware of the current issues and guidance from the General Medical Council and Responsible Officers and Revalidation Lead Network.
>
> There was a change in Responsible Officer in January 2020 from Dr Wood, to Dr Thomas.
>
> - Actions still outstanding
>
> To find a more efficient way for both Doctors and the PALS team to issue the information required for appraisal.
>
> To understand from NHS England when a review is likely to take place.
>
> - Current Issues
>
> As a number of appraisals were delayed and cancelled due to Covid 19, we have a period of time to catch up with these, this will increase the demand on our appraisers time.

The number of doctors is increasing annually, we need to keep up with the demand on time for both appraisers and revalidation support.

Our Revalidation Lead Dr Jones has stepped down from the role and Dr Goodwin, the Revalidation Lead at RBCH has taken on the joint role as an interim.

- New Actions:

To agree the joint policy for the new organisation and have this in place.

- Overall conclusion:

The local appraisal process is well established and is providing the support to doctors as they seek to be relicensed. We expect the year ahead will be finding a way to get back on track following the delays due to Covid, and as part of a new organisation.

Section 7 – Statement of Compliance:

The Board of Poole Hospital Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Poole Hospital Foundation Trust**

Name: Debbie Fleming   Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date:

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: Wednesday 29 July 2020

Agenda item: 8.3

Subject:	Board Assurance Framework 2019-20 year-end update

Prepared by:	Jo Sims – Interim Head of Quality Governance & Risk - Poole Hospital NHS Foundation Trust, Associate Director Quality, Governance & Risk RBCH
Presented by:	Patricia Reid, Director of Nursing

Purpose of paper:	To provide the Board with a year-end update on the Board Assurance Framework (BAF) for scrutiny
Background:	The BAF for 2019/20 was formally approved by the Board in May 2019 and supports the delivery of the Trust's strategic objectives. Each quarter the related Board subcommittee reviews the updated BAF and associated risks. All related risks with a rating of 12 (significant) and above that sit on the Trust risk register are aligned with the relevant section of the BAF. The BAF includes an action plan to support any gaps in control / assurance. These action plans have been updated quarterly throughout the year by the relevant subcommittees.
Key points for Board members:	On the 31 March 2020 there were a total of 32 related risks rated 12 or above on the Trust Risk register (an increase on the previous year's 25). Of these, 1 was rated 20, 1 is rated 16 and 3 are rated 15 (significant risks). See summary below (grey shade = reduced risk post 31/3/20): The table below shows the spread of risk across the BAF in comparison to the previous year:

Rating	March 2019				March 2020			
	AF1	AF2	AF3	AF4	AF1	AF2	AF3	AF4
20		1	1			1		
16		2				1		
15	1	1		1		1		2
12	2	7		9	6	9	1	8
Total	3	11	1	10	9	12	1	10

Below is a summary of all open risks on the risk register by type:

Type	Very low 1 - 3	Low 4 - 6	Moderate 8 - 12	High 15 - 25	Total
Patient Safety	0	9	21	1	**31**
Estates	4	17	7	0	**28**
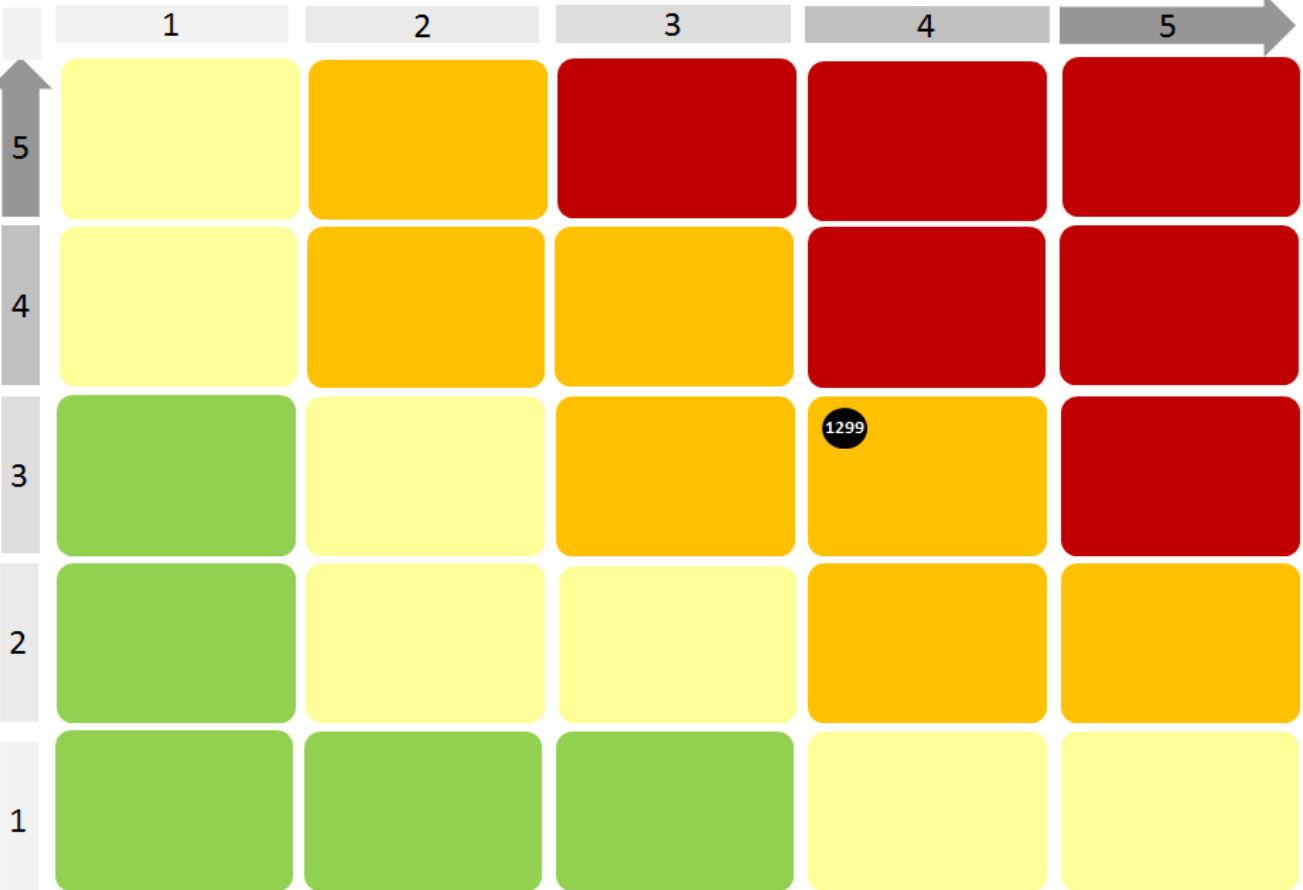
Workforce	0	6	11	2	19
Trust Continuity / Capacity	0	4	7	0	11
Information Technology	0	3	3	1	7
Equipment	1	1	5	0	7
Targets	0	1	4	1	6
Compliance with policy	0	3	2	0	5
Staff Safety	0	2	3	0	5
Specific Risk	0	0	4	0	4
Training	0	2	2	0	4
Environment	0	1	0	0	1
Corporate risk	0	0	1	0	1
Financial	0	0	1	0	1
Total	**5**	**49**	**71**	**5**	**130**

The BAF heat maps are attached along with the summary risk register for reference.

A new BAF has been produced for 2020/21 and is aligned to the new Board objectives.

Options and decisions required:	None
Recommendations:	The Board is asked to approve the year-end review of the Board Assurance Framework 2019-20
Next steps:	None

Links to Poole Hospital NHS Foundation Trust AND Royal Bournemouth & Christchurch Hospital NHS Foundation Trusts Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Yes
BAF/Corporate Risk Register: (if applicable)	Yes
CQC Reference:	All

Committees/Meetings at which the paper has been submitted:	Date

NHS Poole Hospital NHS Foundation Trust

ASSURANCE FRAMEWORK ONE (AF1) Deliver safe, responsive, compassionate, high quality care	LEAD DIRECTOR/S Patricia Reid – Director of Nursing Matt Thomas – Medical Director	RESPONSIBLE COMMITTEE Quality, Safety & Performance Committee

CQC link to five key questions: Safe, Effective, Caring, Responsive, Well Led

CONSEQUENCE

Risk matrix (Likelihood vs Consequence):

- Consequence 2, Likelihood 5: 1284, 1320, 1335
- Consequence 2, Likelihood 4: 1308
- Consequence 3, Likelihood 4: 1312, 1313
- Consequence 3, Likelihood 3: 995, 1128, 1186, 1233, 1234, 1277, 1286, 1300, 1301, 1315, 1340, 1331
- Consequence 4, Likelihood 3: 1290, 1319, 1329, 1332, 1338
- Consequence 4, Likelihood 2: 851, 1216, 1224, 1289, 1333

Key controls: *Quality Strategy, Quality Improvement Plans, Quality Account, Risk Management Strategy, Risk Management Policies, CQC action plan*

Assurance on controls: *Audit & Governance Committee, Annual Reports, Internal Audit Reports, Internal & External Peer Reviews, Quality Account External Scrutiny, CQC re-inspection report & subsequent action plan Quality Safety and Performance Committee.*

Positive Assurances: *Annual reports & action plans, internal outcomes & annual summary report, Quality Account monitoring tool, Ward to board reports, Infection control reports, Integrated performance reports. CQC final report post inspection rated 'Good'*

Gaps in Control:

Gaps in Assurance: *Risks rated red-* None identified

Update of Risks (8 and above) The next report will indicate changes: Key: purple = ↑ risk, orange = ↓ risk, black ←→ risk * will indicate no movement from previous period , blue = new risk, (grey = closed)

Summary risk register activity; Q4 update
4 new risks; 1319, 1335, 1338, and 1340. One risk increased 1315 – Inconsistent multi-professional support to patients with complex nutritional needs through the MDT Nutrition Team
3 risks closed – 1312 Emergency surgical patients unable to access theatre due to lack of all-day CEPOD theatre list 7 days a week, 1286 Cabinets in theatres do not comply with BS EN ISO 16442 & HTM 01-06 requirements and 1289 Limited ability to provide bedside Obstetric USS in Maternity using portable scanner

NHS
Poole Hospital
NHS Foundation Trust

ASSURANCE FRAMEWORK TWO (AF2) Attract, inspire and develop staff	LEAD DIRECTOR/S Jacqueline Cotgrove – Director of Workforce and Organisational Development	RESPONSIBLE COMMITTEE Workforce and Organisational Development Committee

CQC link to five key questions: Safe, Responsive, Well Led

CONSEQUENCE

LIKELIHOOD

(Risk matrix — Consequence 1–5 across, Likelihood 5–1 down)

- Likelihood 5: 1043 (Consequence 2); 1136 (Consequence 3)
- Likelihood 4: 1163 (Consequence 2); 1193, 1275, 1283, 1295, 1296, 1317 (Consequence 3); 1281 (Consequence 4); 1343 (Consequence 5)
- Likelihood 3: 1084 (Consequence 2); 1056, 1122, 1207, 1260, 1288, 1311, 1318, 1321 (Consequence 3); 1221, 1303, 1327 (Consequence 4)
- Likelihood 2: 1232, 1306 (Consequence 4)

Key controls: *Recruitment and retention strategy, Workforce plans, Education, training and development strategy, Development of a People Strategy*

Assurance on controls: *Internal audit report, Staffing establishment reports, Safer staffing compliance, Annual staff survey, Staff friends and family test, New recruitment tracking system in place to ensure timely recruitment process*

Positive Assurances: *Workforce reports to the Board, Workforce quarterly IPR performance meetings, Quarterly Care group/ directorate workforce reports Ward to board reports*

Gaps in Control:

Gaps in Assurance: Risk rated red-
1136 - High level Trauma ward vacancies
1281 - Radiation Physics Support Staffing Levels
1343 – Insufficient workforce due to the impact of COVID 19

Update of Risks (8 and above) The next report will indicate changes:
Key: purple = ↑ risk, orange = ↓ risk, black ←→ risk* will indicate no movement from previous period , blue = new risk (grey= closed)

Summary risk register activity: Q4 update
1 new red risk 1343 Insufficient nursing workforce due to the impact of COVID19 . 1 risk with increased rating 1317 – Fail to maintain high standard patient care due to limited speech & language therapy staffing & resource. 1 risk with reduced rating 1084 – Skill mix in theatres. 2 Closed risks; 1311 – Staff could be harmed due to substandard working conditions in the mould room workshop and 1306 Insufficient Band 7 nursing leads to meet the demands of the Emergency Department

ASSURANCE FRAMEWORK THREE (AF3) Work with partners to develop new models of care and reconfigure services so that clinically and financially sustainable arrangements are in place across Dorset	**LEAD DIRECTOR/S** Pete Papworth - Director of Finance	**RESPONSIBLE COMMITTEE** Finance and Investment Committee Board of Directors

CQC link to five key questions: Effective, Responsive, Well Led

CONSEQUENCE

Key controls: *Full participation in the Dorset CSR and STP planning processes. In addition work progressed through the Trust's internal planning processes. SLT, Trust estate strategy, capital planning processes and long term financial plan modelling, including balance sheet strength to support borrowing, Emerging East Dorset Health and Social Care Accountable Care Partnership*

Assurance on controls: *Oversight and review of key milestones by Executive team, HEG, FIC, Trust Board and Governors*

Positive Assurances: *Dorset Senior Leadership Team (SLT), and local GPs and voluntary sector in East Dorset, NHS England, NHS Improvement and External Auditors (going concern)*

Gaps in Control:

Gaps in Assurance: Risks rated red
None

Update of Risks (8 and above) The next report will indicate changes: **Key: purple = ↑ risk, orange = ↓ risk, black ←→ risk*** will indicate no movement from previous period , **blue = new risk** (Grey = closed)	**Summary risk register activity; Q4 update** Risk 1299 - Failure to deliver within agreed 2019/20 financial control total parameters – has remained the same

ASSURANCE FRAMEWORK FOUR (AF4) Ensure all resources are used efficiently, effectively and economically to deliver key operation standards and targets	LEAD DIRECTOR/S Pete Papworth – Director of Finance	RESPONSIBLE COMMITTEE Finance and Investment Committee

CQC link to five key questions: Effective, Responsive, Well Led

CONSEQUENCE / LIKELIHOOD matrix

Columns (CONSEQUENCE): 1, 2, 3, 4, 5
Rows (LIKELIHOOD): 5, 4, 3, 2, 1

- Likelihood 5, Consequence 3: 1074
- Likelihood 4, Consequence 2: 1053, 1140, 1273, 1282, 1323
- Likelihood 4, Consequence 3: 1015, 1024, 1026, 1131, 1263, 1267, 1292
- Likelihood 3, Consequence 3: 999, 1042, 1257, 1276, 1307, 1341
- Likelihood 3, Consequence 4: 1255, 1297, 1342
- Likelihood 3, Consequence 5: 1298
- Likelihood 2, Consequence 3: 1328
- Likelihood 2, Consequence 4: 1141, 1172, 1197, 1214, 1231, 1294, 1326, 1336
- Likelihood 2, Consequence 5: 1222

Key controls: *Operational plan, Rolling financial outlook, Trust bed capacity plan, Trust activity capacity planning, Trust/cluster action plans for delayed transfers of care, CIP monitoring and control process, Nursing Directorate monitoring of CQUIN performance, IPR Operational escalation plan, Daily emergency dashboard, IT service level agreement with RBCH, IT capital programme*

Assurance on controls: *CCG contract monitoring, CQC 'Good', Monthly reporting FIC/Board/Monitor/NHS England, Associated monitoring to CCG (SRG), NHS England, Poole cluster (accountable care), fortnightly partnership meeting, Poole informatics steering group, Investment planning group, internal audit.*

Positive Assurances: *Annual report to trust board on agreed capacity plans –, IPR presented monthly to board, Daily/monthly reporting of delayed discharges, CQUIN monthly reports and quarterly updates, Weekly/monthly monitoring of cash position, Monthly performance review meetings with care groups / clinical directorates, IT updates to FIC/full Board, , IT review as part of Dorset acute care collaboration programme*

Gaps in Control: *Lack of granular financial and capacity model at a system level at this stage of CSR development, Insufficient capacity to address identified requirement for the winter period. Insufficient/affordable local authority capacity to meet demand, Reduction in allocated resources for system partners to access, Project prioritisation/responsiveness to service need within available resource.*

Gaps in Assurance: Risks rated red-
1074 - Breaches to RTT targets
1298 - Failure to maintain and develop the Trust's IT services in line with Clinical and operational requirements

Update of Risks (8 and above) The next report will indicate changes: **Key: purple = ↑ risk, orange = ↓ risk, black ←→ risk*** will indicate no movement from previous period, **blue = new risk** (Grey = closed)	Summary risk register activity: Q4 update Three new risks rated 8 and above; 1341, 1342 and 1336. Two risks decreased 1053 and 1328 – air conditioning failure affecting temperature regulation in Endoscopy and two closed 1267 – Implication of a 'no deal' exit from European Union and 1255 – Inability to provide systemic drug management & monitoring for dermatology patients due to capacity and unprecedented demand.

ASSURANCE FRAMEWORK FIVE (AF5) Be a well governed and well managed organisation that operates collaboratively with local partners	LEAD DIRECTOR/S Debbie Fleming – Chief Executive	RESPONSIBLE COMMITTEE Trust Board

CQC link to five key questions: Effective, Well Led

Heat Map – Assurance Framework Five

CONSEQUENCE

LIKELIHOOD

Key controls: Strategic objectives, revised governance structure

Assurance on controls: External and internal audit NHS Improvement, Well Led framework, Annual Governance statement, CQC, Dorset SLT provides leadership and oversight to a (a) STP (b) Better Together Programme, Data quality audit

Positive Assurances*: Q3 2016-17 Trust participated in the 3 yearly national well led review with a positive outcome and no red/ amber rated issues. **January 2020** update rated good by the CQC for the well led element on inspection in November 2019.*

Gaps in Control:

Gaps in Assurance:

Update of Risks (8 and above) The next report will indicate changes: Key: purple = ↑ risk, orange = ↓ risk, black ←→ risk* will indicate no movement from previous period , blue = new risk	Actions required: No current risks identified

Summary Risk Listing as at 2 April 2020

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
1338	Unsuitability of using Endoscopy recovery space for inpatient escalation beds	04/02/2020	04/02/2020	4 Major	3 Possible	12	Moderate 8 - 12	Medical Care Group	Keal, Andrew	AF1
1332	We may fail to manage patients safely and in the most appropriate environment due to overcrowding in ED	29/11/2019	29/01/2020	4 Major	3 Possible	12	Moderate 8 - 12	Medical Care Group	Mulvey, Toby	AF1
1329	Failed radiology image transfer between hospitals; typically Southampton & Royal Free Hospital.	25/11/2019	15/01/2020	4 Major	3 Possible	12	Moderate 8 - 12	Medical Care Group	Ayres, Lachlan	AF1
1319	Inability to care for patients requiring non-invasive ventilation (NIV) in a designated bay as per British Thoracic Society (BTS)	24/10/2019	06/02/2020	4 Major	3 Possible	12	Moderate 8 - 12	Medical Care Group	Bryant, Jody	AF1
1313	Risk that we fail to satisfy the Royal College of Surgery's recommendations following the invited Head and Neck services review	01/10/2019	09/01/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Surgical Care Group	Leigh, Ben	AF1

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
1290	Management of Mental Health patients in the Emergency Department	18/07/2019	27/11/2019	4 Major	3 Possible	12	Moderate 8 - 12	Medical Care Group	Hopkins, Bruce	AF1
1335	There is an increased risk of infection due to the inability to regulate the main theatres temperature and humidity	02/01/2020	NA	2 Minor	5 Almost Certain	10	Moderate 8 - 12	Surgical Care Group	Ward, Andrew	AF1
1320	Lack of a designated area for performing pleural procedures for patients	24/10/2019	06/02/2020	2 Minor	5 Almost Certain	10	Moderate 8 - 12	Medical Care Group	Bryant, Jody	AF1
1284	Inability to comply with the recommended MRI Safety Zoning guidance	20/06/2019	13/01/2020	2 Minor	5 Almost Certain	10	Moderate 8 - 12	Clinical and Operational Support Care Group	Reed, David	AF1
1340	There is a risk that the Children's Safeguarding on-call Rota will destabilize due to loss of consultant workforce.	17/02/2020	NA	3 Moderate	3 Possible	9	Moderate 8 - 12	Oncology, Women & Children's Care Group	Hannington, David	AF1
1331	Bathroom facilities on AMU unfit for purpose due to safety and infection control issues.	27/11/2019	10/01/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Medical Care Group	Ringrose, Emma	AF1
1315	Inconsistent multi-professional support to patients with complex nutritional needs	02/10/2019	05/02/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Clinical and Operational Support Care Group	Rochfort, Lucie	AF1

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
	through the MDT Nutrition Team						Moderate			
1301	Physical and Emotional harm to patients and staff. Disruption to the service and impact on safe effective patient care.	14/08/2019	10/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Surgical Care Group	Hewett, Belinda	AF1
1300	We are unable to provide consistent 24hr specialist care for children (under 18 years) who have mental health needs.	29/07/2019	15/01/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Oncology, Women & Children's Care Group	Lourence, Lynne	AF1
1277	Reduced specialist care for trauma patients on non trauma wards	30/04/2019	13/10/2019	3 Moderate	3 Possible	9	Moderate 8 - 12	Surgical Care Group	West, John	AF1
1234	Inability to access sufficient medical equipment for clinical use	26/06/2018	13/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Finance and Estates	Pickett, John	AF1
1233	Inability to evidence medical device training and competence	26/06/2018	13/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Finance and Estates	Pickett, John	AF1
1186	Caring for patients with mental health issues on The Acute Medical Unit	31/03/2017	10/01/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Medical Care Group	Smith, Dr Hannah	AF1
1128	The risk of Pressure Ulcer development and/or deterioration of existing ulcers	15/02/2016	18/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Nursing & Patient Services Directorate	Richards, Denise Ann	AF1

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
995	Backlog of maintenance	21/10/2014	10/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Finance and Estates	Gillespie, Norman	AF1
1333	Staff exposure to monoclonal antibodies due to reconstitution being carried out by nursing staff	11/12/2019	NA	4 Major	2 Unlikely	8	Moderate 8 - 12	Clinical and Operational Support Care Group	Bolton, Nicholas	AF1
1308	Care pathway/service for pregnant women 14-17 +6 weeks gestation	19/09/2019	17/03/2020	2 Minor	4 Likely	8	Moderate 8 - 12	Oncology, Women & Children's Care Group	Garner, Vicky	AF1
1224	Insufficient specialised pharmacy support to child health services	05/04/2018	08/11/2019	4 Major	2 Unlikely	8	Moderate 8 - 12	Oncology, Women & Children's Care Group	Fernley, Karen Maria	AF1
1216	Requests for MRI made without undertaking the required safety checks.	06/12/2017	07/02/2020	4 Major	2 Unlikely	8	Moderate 8 - 12	Clinical and Operational Support Care Group	Reed, David	AF1
851	Risk of Severe Cold Weather impacting on business as usual	12/06/2018	08/11/2019	4 Major	2 Unlikely	8	Moderate 8 - 12	Operations	Beesley, Libby	AF1
1343	Insufficient Nursing workforce due to the impact of COVID 19	19/03/2020	NA	5 Catastrophic	4 Likely	20	High 15 - 25	Nursing & Patient Services Directorate	Richards, Denise Ann	AF2
1281	Radiation Physics Support Staffing Levels	07/06/2019	13/01/2020	4 Major	4 Likely	16	High 15 - 25	Clinical and Operational Support Care Group	Brooks, Michael	AF2
1136	Reduction in quality of care to patients across the trauma wards	07/03/2016	06/12/2019	3 Moderate	5 Almost Certain	15	High 15 - 25	Surgical Care Group	West, John	AF2

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
1327	There is a risk that staffing levels are not adequate for the level of service on Oncology Day Care	28/10/2019	27/01/2020	4 Major	3 Possible	12	Moderate 8 - 12	Oncology, Women & Children's Care Group	Reader, Sara	AF2
1317	There is a risk that we fail to maintain high standard patient care due to limited Speech Language Therapy staffing and resource	15/10/2019	27/03/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Clinical and Operational Support Care Group	Rochfort, Lucie	AF2
1303	Insufficient inpatient therapy staff to provide time effective and therapy for patients' acute needs.	10/09/2019	08/11/2019	4 Major	3 Possible	12	Moderate 8 - 12	Clinical and Operational Support Care Group	Thorne, Carol	AF2
1296	Insufficient skilled Nursing Workforce to meet the demands of AMU	19/07/2019	04/11/2019	3 Moderate	4 Likely	12	Moderate 8 - 12	Medical Care Group	Darville, Tanya	AF2
1295	Risk of patient harm from inappropriate chemotherapy dosing due to insufficient skilled staff in pharmacy cancer services team	19/07/2019	06/03/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Clinical and Operational Support Care Group	Bolton, Nicholas	AF2
1283	There is a risk that we cannot adequately staff radiotherapy radiographer roles due to vacancies and maternity	20/06/2019	28/02/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Oncology, Women & Children's Care Group	Frost, David	AF2

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF	
	leave.										
1275	Impact on Patient Care due to Unstaffed Clinic - SAU	26/04/2019	05/03/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Surgical Care Group	Young, Suzanne	AF2	
1221	Medical Staffing Shortage at Junior and Middle Grade Level Medicine and DME	14/02/2018	07/02/2020	4 Major	3 Possible	12	Moderate 8 - 12	Medical Care Group	Drew, Heather	AF2	
1193	A risk to the quality of care on Ward B4 due to vacancies and increasing numbers of patients with complex specialist needs	02/05/2017	10/03/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Surgical Care Group	Hunter, Yvonne	AF2	
1043	NBTC Blood Transfusion Competencies	03/12/2014	07/02/2020	2 Minor	5 Almost Certain	10	Moderate 8 - 12	Clinical and Operational Support Care Group	Trevett, Michael	AF2	
1321	Lack of Skilled workforce to continue providing a Nurse Led DVT service	01/11/2019	10/01/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Medical Care Group	Ringrose, Emma	AF2	
1318	There is a risk that we fail to maintain high standards of patient care due to limited Adult Dietetic staffing and resources.	15/10/2019	27/02/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Clinical and Operational Support Care Group	Rochfort, Lucie	AF2	
1288	Consultant microbiologist staffing levels	04/07/2019	17/12/2019	3 Moderate	3 Possible	9	Moderate 8 - 12	Clinical and Operational Support Care Group	Barber, Andrew	AF2	

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
1260	Insufficient resources to meet ever increasing estates requirements of the organisation	12/12/2018	27/01/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Finance and Estates	Gillespie, Norman	AF2
1207	T&O Medical Staffing Shortage at Junior and Middle Grade Level	04/09/2017	13/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Surgical Care Group	West, John	AF2
1122	Insufficient Clinical Pharmacy Staff to ensure prompt medicines review of inpatients & maintenance of related polices	21/01/2016	02/01/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Clinical and Operational Support Care Group	Bolton, Nicholas	AF2
1056	Inability to provide a fully established nursing workforce in accordance with the agreed establishment template.	27/01/2015	18/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Nursing & Patient Services Directorate	Richards, Denise Ann	AF2
1232	Inability to evidence staff immunization status	21/06/2018	04/10/2019	4 Major	2 Unlikely	8	Moderate 8 - 12	Workforce & Organisational Development	McKeown (RBCH), Matthew	AF2
1163	Inability to support acute oncology hotline service with current staffing levels	07/10/2016	09/12/2019	2 Minor	4 Likely	8	Moderate 8 - 12	Oncology, Women & Children's Care Group	Moxham, Andrea J	AF2
1299	Failure to deliver within agreed 2019/20 financial control total parameters	23/07/2019	NA	4 Major	3 Possible	12	Moderate 8 - 12	Finance and Estates	Papworth, Pete	AF3

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
1298	There is a risk that we fail to maintain and develop the Trust's IT services in line with Clinical and operational requirements	19/07/2019	22/11/2019	5 Catastrophic	3 Possible	15	High 15 - 25	Informatics	Gill, Peter	AF4
1074	Risks associated with breaches of 18 week Referral to Treatment and 52 week wait standards.	05/05/2015	30/03/2020	3 Moderate	5 Almost Certain	15	High 15 - 25	Finance and Estates	Thomas, Kate	AF4
1342	The inability to meet national guidance in provision of services to screen and treat patients with suspected COVID 19	02/03/2020	18/03/2020	4 Major	3 Possible	12	Moderate 8 - 12	Nursing & Patient Services Directorate	Beesley, Libby	AF4
1297	There is a risk that we fail to maintain and develop the Trust estate in line with Clinical requirements	19/07/2019	15/11/2019	4 Major	3 Possible	12	Moderate 8 - 12	Finance and Estates	Atkinson, George	AF4
1292	Outpatient Follow-Up appointment waiting list/booking processes	19/07/2019	29/08/2019	3 Moderate	4 Likely	12	Moderate 8 - 12	Clinical and Operational Support Care Group	Roberts, Michele	AF4
1263	Increase in Diagnostic Colonoscopy Breaches	31/12/2018	13/03/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Medical Care Group	Roberts, Hayley	AF4

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
1131	Inability to effectively place patients in the right bed at the right time	16/02/2016	27/03/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Clinical and Operational Support Care Group	Willes, Stuart	AF4
1026	There is a risk of patients receiving delayed radiotherapy treatment due to breakdown of the Trust's linear accelerators	28/10/2014	27/03/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Oncology, Women & Children's Care Group	Lee, Jonny	AF4
1024	Risks associated with continuity, capacity and staffing during Pandemic Infectious Disease and seasonal flu	28/10/2014	09/01/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Operations	Beesley, Libby	AF4
1015	Failure to achieve the National Cancer Waiting Times targets	27/10/2014	15/01/2020	3 Moderate	4 Likely	12	Moderate 8 - 12	Oncology, Women & Children's Care Group	Graham, Chris	AF4
1222	Equipment for monitoring seizures now uses a permanent hardwire for data transfer	15/02/2018	14/01/2020	5 Catastrophic	2 Unlikely	10	Moderate 8 - 12	Medical Care Group	Dunning, Judith	AF4
1341	Risk of failure of EBM Cold Storage (Fridge/Freezers)	17/02/2020	NA	3 Moderate	3 Possible	9	Moderate 8 - 12	Oncology, Women & Children's Care Group	Lockyer, Daniel M	AF4
1307	Maternity urgent/emergency inter-hospital transportation	19/09/2019	17/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Oncology, Women & Children's Care Group	Garner, Vicky	AF4

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
1276	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients	30/04/2019	13/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Surgical Care Group	West, John	AF4
1257	Risk of non replacement of the Gamma cameras in nuclear medicine	06/12/2018	28/02/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Clinical and Operational Support Care Group	O'Shaughnessy, Emma	AF4
1042	Delayed Discharges Critical Care	14/11/2014	02/01/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Surgical Care Group	Gooby, David J	AF4
999	Fire safety issues	21/10/2014	10/03/2020	3 Moderate	3 Possible	9	Moderate 8 - 12	Finance and Estates	Gillespie, Norman	AF4
1336	The estates Building Management System nearing end of life and requires replacement	08/01/2020	30/03/2020	4 Major	2 Unlikely	8	Moderate 8 - 12	Finance and Estates	Gillespie, Norman	AF4
1326	There is a risk that the new process for setting up radiotherapy patients could cause transcribing errors.	06/11/2019	10/02/2020	4 Major	2 Unlikely	8	Moderate 8 - 12	Oncology, Women & Children's Care Group	Branson, Deborah	AF4
1323	Lack of capacity in county wide Bowel Cancer Screening Programme	04/11/2019	27/02/2020	2 Minor	4 Likely	8	Moderate 8 - 12	Medical Care Group	Roberts, Hayley	AF4
1294	Assessment of the Risk of using Re-usable drill bits for the Head and Neck Plating Systems	19/07/2019	05/03/2020	4 Major	2 Unlikely	8	Moderate 8 - 12	Surgical Care Group	Roberts, Samantha	AF4

ID	Title	Opened	Date of last review (as at 1 April 2020)	Consequence	Likelihood	Rating	Risk level	Clin.Group	Handler	BAF
1282	Volume of unattended estates work masking urgent or high risk requests	14/06/2019	30/03/2020	2 Minor	4 Likely	8	Moderate 8 - 12	Finance and Estates	Gillespie, Norman	AF4
1273	Cyber Security Risks, Threats and Vulnerabilities	26/04/2019	06/04/2020	2 Minor	4 Likely	8	Moderate 8 - 12	Informatics	Davis, Martin	AF4
1231	Major Incident with possible mass casualties	12/06/2018	06/01/2020	4 Major	2 Unlikely	8	Moderate 8 - 12	Operations	Beesley, Libby	AF4
1214	Lack of maintenance and quality control of Patient Point of contact equipment.	10/11/2017	03/10/2019	4 Major	2 Unlikely	8	Moderate 8 - 12	Clinical and Operational Support Care Group	Tanner, Mandy	AF4
1197	Supplementary radiology and histology reports	31/05/2017	07/02/2020	4 Major	2 Unlikely	8	Moderate 8 - 12	Clinical and Operational Support Care Group	Clark, Sarah	AF4
1172	Failure to meet contractural target for all Monitored organisms	15/12/2016	19/03/2020	4 Major	2 Unlikely	8	Moderate 8 - 12	Nursing & Patient Services Directorate	Richards, Denise Ann	AF4
1141	Positive Legionella results in A block	24/05/2016	27/01/2020	4 Major	2 Unlikely	8	Moderate 8 - 12	Finance and Estates	Gillespie, Norman	AF4
1140	Use of Day Surgery Facility in Escalation	27/04/2016	09/01/2020	2 Minor	4 Likely	8	Moderate 8 - 12	Surgical Care Group	Leigh, Ben	AF4
1053	Unable to reduce bed occupancy due to delays in transfers of care	14/01/2015	27/03/2020	2 Minor	4 Likely	8	Moderate 8 - 12	Clinical and Operational Support Care Group	Taylor, Alison V	AF4

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.4

Subject:	RBCH Board Assurance Frameworks 2019/20 Sign off

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk
Presented by:	Paula Shobbrook, Director of Nursing and Midwifery RBCH

Purpose of paper:	The Board Assurance Framework is a systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals. The assurance framework contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.
Background:	In accordance with the Trust Risk Management Strategy the Board Assurance Framework is reviewed quarterly at the Audit Committee and 6 monthly by the Quality Committee and the Board of Directors. The final Q4 BAF is presented each year to the Audit and Governance Committee and Board of Directors for sign off as part of the annual governance cycle.
Key points for Board members:	For approval
Options and decisions required:	For approval
Recommendations:	For approval
Next steps:	

Links to Poole Hospital NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	Date

Principle Objective	Metrics and Milestones	Executive Director Lead	Risk Lead	Current Risk on Risk Register	Risk Title / Description	Q1 Initial Risk Rating	Q4 Current Risk Rating	Current controls and assurances	Target Risk Rating	Monitoring Group
Valuing our staff - Recognising the contribution of our staff and helping them develop and achieve their potential	Deliver the Trust's People Strategy with a focus on: ☐ recruiting new staff to keep the vacancy rate below 6% ☐ developing sustainable workforce solutions that link to a flexible and local workforce	Karen Allman (Director of HR)	Karen Allman	BAF - 300	Risk of not developing alternative roles to support delivery of core services means reliance on hard to recruit roles to provide key clinical services, and more reliance on agency staff with associated higher costs.	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	[12/03/2020] Since the risk was opened in 2015 there has been considerable development of alternative roles: Trainee Nursing Associates, Physicians Associates, internal and external RNDAs (Registered Nurse Degree Apprentices); We are working with Solent University to offer a bespoke conversion course offering our Assistant Practitioners the opportunity to become Nursing Associates. We are recruiting for a new cohort of combined internal and external RNDAs for Sept 20 and expect 10 to join the Trust. We are supporting current qualified overseas HCSWs to complete their OSCEs and become qualified nurses. There are several new apprenticeship courses available. Agency spend is rigorously monitored via PCA and is reducing. However, whilst progress is being made, it is considered the risk should remain open at its current low rating pending merger.	2 (L) x 2 (S) = 4 (Low)	Workforce Committee
	Maintain a turnover rate below 12%	Karen Allman (Director of HR)	Karen Allman	BAF - 260	Risk of not being able to recruit/retain appropriately trained staff due to uncertainties around the scale of change in Dorset	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	[02/03/2020] Risk reviewed at Senior HR meetings and current rating remains appropriate. Turnover of 10.08% as at 31/01/20 continues at a lower rate than the joining rate, resulting in an increased substantive headcount - up 152 (3.24%) over the same point the previous year. Vacancy rate down to a new low of 3.71%.	2 (L) x 2 (S) = 4 (Low)	Workforce Committee
	Develop a talent management programme in line with our leadership strategy to ensure we develop staff with the capabilities and behaviours needed for a sustainable future: ☐ introduce a talent review and succession planning process ☐ improve talent conversations as part of the annual appraisal round	Deborah Matthews (Director of Improvement and OD)	Bridie Moore	BAF-817	If the Trust fails to implement a robust talent management programme then there is a risk that the organisation will lose talent (staff) during the transition phase towards merger and CSR. Risk that the Trust will not maximise the skills and energy of staff resulting in higher staff turnover, dissatisfaction and low morale.	2 (L) x 2 (S) = 4 (Low)	2 (L) x 2 (S) = 4 (Low)	31/3/20/ Low risk. Working closely with Dorset and SW on Talent Management and part of OD PTIP. BAF closed	1 (L) x 2 (S) = 2 (Very Low)	Workforce Committee
	Maintain our 2018 staff survey results and completion rate over the next two years: ensure we deliver on 'you said, we did', publicising and promoting positive outcomes and interventions to support staff retention	Deborah Matthews (Director of Improvement and OD)	Bridie Moore	BAF-818	If the Trust fails to maintain to listen and respond to staff comments about how it feels to work at RBCH then risk that staff survey results will deteriorate. Risk of increased scrutiny by the CQC. Risk of deterioration in Trust culture and values leading to lower staff morale, higher turnover and increased sickness absence.	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	31/3/20 BAF risk closed. Excellent 2019 staff survey results achieved.	1 (L) x 3 (S) = 3 (Very Low)	Workforce Committee

Strategic Objective	Objective	Exec Lead	Risk Owner	Ref	Risk Description	Initial Risk	Current Risk	Update	Target Risk	Committee
	Deliver key priorities in our diversity and inclusion plan:Increasing Black, Asian and Minority Ethnic (BAME) representation across our leadership teams ▢ Continue to improve our Workforce Race Equality Standard (WRES) results to ensure our BAME staff do not experience higher levels of bullying, harassment or discrimination	Deborah Matthews (Director of Improvement and OD)	Debbie Detheridge	BAF-819	If the Trust fails to implement and sustain a diverse and inclusive culture and EDI strategy then risk of not meeting CQC and NHS workforce race equality standards. Risk that BAME and other staff with protected characteristics do not feel adequately supported leading to increased sickness absence, turnover and low morale.	3 (L) x 3 (S) = 9 (Moderate)	2 (L) x 3 (S) = 6 (Low)	31/3/20. RBCH D&I strategy in place with robust governance and accountability. BAF risk closed	1 (L) x 3 (S) = 3 (Very Low)	Workforce Committee
Improving Quality and Reducing Harm - Focusing on continuous improvement and reduction of waste	Hospital Flow: a) expanding opportunities for admission avoidance and reducing delays to discharge and b) improving ambulance handover times and ensuring timely assessment, treatment and flow through the emergency department (ED) QI programme "make every day count"	Richard Renaut (Chief Operating Officer)	Donna Parker	BAF 806	Risk of patient harm and/or inefficiency caused by flow and care/treatment delays through urgent admission/inpatient pathways if : • 18/19 bed occupancy levels are not sustained and/or reduced • Demand/capacity mismatch (e.g. during surges) delay patients getting into the hospital • Demand/capacity mismatch (e.g. during surges) delay patients getting to the right ward	3 (L) x 4(S) = 12 (Moderate)	4 (L) x 4(S) = 16 (High)	[02/03/2020] Risk review and update presented at Feb HAC. Risk grading supported. Remains under regular monitoring.	2 (L) x 4 (S) = 8 (Moderate)	Improvement Board, Board of Directors
	Outpatients: reducing the number of unnecessary visits for our patients	Richard Renaut (Chief Operating Officer)	Sarah Knight	BAF -807	Risk that the Trust fails to respond to the challenge of changing models of outpatient care in line with National trend information relating to population growth and aging population needs. Developing innovation and new models of care is essential to future-proof access to relevant clinical intervention and advice in a timely way.	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	Vision shared with Poole team and PWC. Plan to include business cases for IT investment in 2020/21 budget setting round. System wide group has secured licences for Dorset in Attend Anywhere product (via NHSI). Project group established and agreed first wave of specialties for roll-out of video consultation. Project group and monthly review not established fully internally, working jointly with system group. Capacity to do the work with RTT risk taking priority is limited.	2 (L) x 2 (S) = 4 (Low)	Improvement Board, Board of Directors
	Ophthalmology: ensuring good morale and support for staff in eye outpatients and achieving eye theatre efficiency of 85%	Richard Renaut (Chief Operating Officer)	Abigail Daughterss	BAF-810	If unable to achieve theatre efficiency of 85% or above there is a risk that some patients will experience a delay in their treatment pathway due to the context of continued high level of referrals which have impacted in particular on waiting times for cataract procedures.	3 (L) x 2 (S) = 6 (Low)	3 (L) x 2 (S) = 6 (Low)	[05/03/2020] Theatre efficiency continues to be monitored with high level of efficiency being achieved consistently. QI work continues	2 (L) x 1 (S) = 2 (Very Low)	Healthcare Assurance Committee, Audit Committee

	Objective	Executive Lead	Assurance Lead	Ref	Risk Description	Initial Score	Current Score	Actions/Mitigation	Target Score	Committee
	Medical Rotas: optimising medical manpower and management of medical rosters using the most effective digital solutions	Alyson O'Donnell (Medical Director)	Sarah Davidson	BAF-797	E-roster compliance. Very few doctors are e-rostered within a system that meets national standards resulting in lack of transparency, communication between rosters, consistency and appropriate access. There a potential of sub-optimal rostering and inability to flex staff to cover patient need and safety	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	QI project group set with good cooperation with and between rota coordinators. Internally Medirota being rolled out but this is being impacted by the Dorset wide bid for national money. This will mean agreeing a single system across Dorset and it is hoped the selection and tendering process will start shortly as soon as bid results are formally released	2 (L) x 1 (S) = 2 (Very Low)	Workforce Committee
	Medical Rotas: optimising medical manpower and management of medical rosters using the most effective digital solutions	Alyson O'Donnell (Medical Director)	Ruth Williamson	BAF - 798	7 Day Services - If we continue to demonstrate a deteriorating performance in relation to the NHSE/I National Standards for 7 day working there is a potential risk that of patient safety concerns in addition to reputational and contractual failure. If we continue to demonstrate a deteriorating performance in relation	2 (L) x 2 (S) = 4 (Low)	2 (L) x 2 (S) = 4 (Low)	Recent audit shows a drop in performance but the narrative that sits behind it suggests that processes are robust and job planning is providing enough sessions for compliance. There is some work to be done re consistency of approach between clinicians in teams as this impacted the figures with some counting board round as a review for prioritisation but most not. This has been picked up with the CD	1 (L) x 2 (S) = 2 (Very Low)	Healthcare Assurance Committee, Audit Committee
	Clinical Documentation and Communication: improving the consistency and accuracy of what is recorded in the health record, how it is stored and improving communication between teams through digital innovation	Alyson O'Donnell (Medical Director)	Emma Willett	BAF-802	Clinical Documentation - If compliance with regulatory standards of documentation continues to be sub-optimal then there will be risk to patients as a result and the Trust's ability to evidence care to the Coroner or within litigation process	3 (4) x 3 (S) = 12 (Moderate)	3 (4) x 3 (S) = 12 (Moderate)	Work continues to develop documentation and approaches to improve documentation whilst raising awareness through induction, informal peer feedback, review and resulting actions from incidents and SIs. Further actions and mitigation are currently under consideration but challenging given the scope of the issue	2 (L) x 2 (S) = 4 (Low)	Improvement Board, Healthcare Assurance Committee, Board of Directors
	Fundamentals of Care: to improve the care of patients with enhanced needs due to acuity and dependency	Alyson O'Donnell (Medical Director)	Dr Wheble	BAF- 631	Risk that the Trust fails to consistently recognise, escalate and manage deteriorating patients; failure to do so will potentially cause harm to patients.	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	BAF risk closed. Phase 1 eObs implementation completed.	2 (L) x 2 (S) = 4 (Low)	Improvement Board, Healthcare Assurance Committee, Board of Directors
	Fundamentals of Care: improve the provision and documentation of discussions with patients about the risks and benefits of treatment options (consent processes)	Alyson O'Donnell (Medical Director)	Alyson O'Donnell	BAF - 803	If trust processes are not in line with shared decision making in the context of individual risk (inc. no treatment), legal standards , duty of care and appropriately documented then there is a risk of inappropriate treatment , poor patient experience and future litigation	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	Scoping week undertaken in November 19 to understand current awareness of policy etc. This has feed in to the planning of further education or QI sessions towards the end of Q4	1 (L) x 3 (S) = 3 (Very Low)	Improvement Board, Healthcare Assurance Committee, Board of Directors
	To continue to ensure services are provided in a cost effective manner and that we achieve our financial plan to deliver a financial breakeven position by the end of March 2020	Pete Papworth (Director of Finance)	Pete Papworth	BAF - 795	Financial Control Total 2019/20 - Trust at risk of failing to deliver against 2019/20 Financial control total agreed with NHS Improvement, resulting in loss of sustainability funding of £5.3m and regulation intervention.	3 (L) x 3 (S) = 9 (Moderate)	3 (L) x 3 (S) = 9 (Moderate)	[13/03/2020] The Committee reviewed the risk and agreed for the risk to remain as a moderate risk	2 (L) x 3 (S) = 6 (Low)	Board of Directors, Finance and Performance Committee
	To continue to deliver efficiency and productivity opportunities using Getting it Right First Time (GIRFT) and Model Hospital benchmarking data to reduce unwarranted variation in our clinical and non-clinical services.	Pete Papworth (Director of Finance)	Helen Rushforth	BAF - 809	Risk of not achieving efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision.	3 (L) x 3 (S) = 9 (Moderate)	3 (L) x 3 (S) = 9 (Moderate)	[05/03/2020] Reviewed - current status correct	2 (L) x 3 (S) = 6 (Low)	Board of Directors, Finance and Performance Committee

	Objective	Executive Lead	Risk Owner	Ref	Risk Description	Initial Risk	Current Risk	Controls / Mitigating Actions	Target Risk	Monitoring
	To continue to improve the responsiveness of services for patients and achieve the national standards relating to: Cancer waits	Richard Renaut (Chief Operating Officer)	Alison Ashmore	BAF-812	If continued year on year increase in referrals then risk to compliance with CWT standards. Risk may be increased if unable to recruit and retention of key clinical staff (oncologist and histopathologists) in particular in sub specialisation areas that rely on a single handed practitioner.	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	[05/03/2020] On-going monitoring Identified controls in place Continuing to improve the responsiveness of services for patients on the cancer pathway at all times to achieve the national standards for Cancer Patients.	2 (L) x 2 (S) = 4 (Low)	Improvement Board, Healthcare Assurance Committee, Board of Directors
	To continue to improve the responsiveness of services for patients and achieve the national standards relating to: Elective referral to treatment waits	Richard Renaut (Chief Operating Officer)	Donna Parker	BAF - 808	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 for 18/19 are not met, namely: 1) Mar 19 total waiting list to be less than Mar 19 2) No 52 week waiters 3) RTT improved on Mar 18 with recovery stretch to 92% (national NHS constitution target)	3(L) x4 (S) = 12 (Moderate)	4(L) x4 (S) = 16 (High)	12/03/2020] End Feb Performance: 52ww: 16 Total Waiting List (Jan 2020 - 30,028): 29,200 RTT Performance: 78.1% 40+ww: 372 RTT Recovery Programme established to increase governance and improve performance; this includes: • Emphasis on over 40 week waiters and preventing 52 week breaches (weekly patient level meetings) • National validators programme being used to validate RTT waiting list • Working with PHT to reduce the high risk 52 week breaches of Oral surgery patients • Identifying capacity working with private providers and in sourcing companies for key risk specialties (see below on 50:50 spend areas) • Intensive work to book and plan additional endoscopy lists using in sourcing • Demand and Capacity planning for 2020/21 in progress and budget setting discussions underway • Tracking of patients and pulling through pathways continues, Specialities able to see live data on where patients are in pathways. • Validation and analysis of waiting list to ensure scheduling in clinical then chronological order. • Updating Access Policy and SOPs • Review and implementation of high level e-learning package on green brain. Reviewing and devising training module at operational levels for individual areas e.g. Admission clerks, Health Records	2 (L) x 3 (S) = 6 (Low)	Improvement Board, Healthcare Assurance Committee, Board of Directors
	To continue to improve the responsiveness of services for patients and achieve the national standards relating to: Diagnostic waits	Richard Renaut (Chief Operating Officer)	Rohana Lustig	BAF- 424	Risk of losing list capacity in Endoscopy due to gaps on the rotas caused by vacancies, maternity, secondment, long term sickness & new staff requiring training/competency sign-off. Could result in non-compliant waiting times. Compounded by demand growth in Endoscopy of 7% that has had to be managed within the Block contract.	2 (L) x 4 (S) = 8 (Moderate)	Closed		2 (L) x 3 (S) = 6 (Low)	Directorate RAGG, HAC
	To continue to improve the responsiveness of services for patients and achieve the national standards relating to: Diagnostic waits	Richard Renaut (Chief Operating Officer)	Kaye Woodward	BAF-876	If demand continues to outweigh capacity in Endoscopy services then there is a risk of harm to patient due to delayed diagnosis or treatment		4 (L) x 3 (S) = 12 (Moderate)	[06/03/2020] Demand and capacity continue to be a pressure for Endoscopy, current projects being worked on to help manage this are: Insourcing every weekend until the end of March Mobile Endoscopy Unit on site to clear backlog Additional Lists @ Nuffield Additional Lists @ Wimborne Implement IT scheduling solution QI support On-going nurse recruitment Dorset Endoscopy Network Task and Finish Group Dedicated CCG support Admin recruitment Awaiting outcome of budget setting for Gastro Consultants	2 (L) x 3 (S) = 6 (Low)	Improvement Board, Healthcare Assurance Committee, Board of Directors

Objective	Exec Lead	Owner	BAF ref	Risk description	Score	Score	Progress / Actions	Target	Assurance Committee
To continue to improve the responsiveness of services for patients and achieve the national standards relating to: A&E waits	Richard Renaut (Chief Operating Officer)	Rowena Green	BAF - 801	ED 4 hour compliance - If patients experience delay in assessment, treatment, admission and discharge then there may be avoidable harm to those patients	4 (L) x 3 (S) = 12 (Moderate)	4 (L) x 4 (S) = 16 (High)	On-going work in ED focusing on Ambulance handover delays, safety in the Ambulance queue and processes in RATS. In reach PDSA starting on 27/01 medical Registrar based in ED 17.00 - 21.30 5 days a week to pull medical patients to AMU. Further PDS's planned to test working arrangements between EPIC (Consultant in charge) and NIC (Nurse in charge). HALO increasing to 7 day cover. PDSA in RATS continues - to be reviewed in line with QI methodology. SHINE audits continue. Streaming commenced Friday and Monday evening and weekends.	2 (L) x 2 (S) = 4 (Low)	Improvement Board, Board of Directors
To jointly implement the remaining component parts of the Dorset Care Record (DCR) in accordance with the timescales in the DCR programme plan	Peter Gill (Director of Informatics)	Sarah Hill	BAF - 655	Without DCR risk that care is delivered in the absence of important clinical information and patient history. Associated risk that more admissions take place than would be otherwise the case, discharges are longer and patient care is sub optimal	2 (L) x 3 (S) = 6 (Low)	2 (L) x 3 (S) = 6 (Low)	DCR Recovery continues. 3 more component parts have been deployed since Oct 2019 - currently 22 (of 87) parts delivered. Recovery expected to run to at least April 2020 with approx. 50 parts expected to be delivered in that phase. Risks remain the same until more content and Single Sign On delivered	3 (L) x 2 (S) = 6 (Low)	Board of Directors, IT Steering Group
Clinical applications: ☐ implement the three core trust wide clinical applications (strategic electronic patient record, order communications, electronic prescribing and medicines administration) and support the clinical leaders of these programs transform clinical processes to achieve the maximum benefit from these investments	Peter Gill (Director of Informatics)	Sarah Hill	BAF- 805	If the planned deployment projects strategic electronic patient record (SEPR), order communications (OCS), electronic prescribing and medicines administration (EPMA))) across inpatient, day case and outpatients for 2019/20 are delayed or managed ineffectively there is a risk of: 1. the trust not meeting its strategic objectives 2. delayed benefit realisation 3. continued clinical risk associated with paper and electronic processes coexisting. 4. financial impact of cost overruns	3 (L) x 3 (S) = 9 (Moderate)	3 (L) x 2 (S) = 6 (Low)	OCS Pathology now being scheduled. SEPR to move into Business as Usual effective March 2020 when all aspects will be complete. CaMIS / eCaMIS upgrade for windows 10 compliant likely to be closer to June 2020 but work in progress. PACS upgrade due in April 2020 EPMA still due to pilot in April.	2 (L) x 2 (S) = 4 (Low)	Board of Directors, IT Steering Group
IT infrastructure: ☐ complete the wired network upgrade project to provide fast and resilient network services ☐ migrate all devices to Windows10 and mitigate against all IT security threats	Peter Gill (Director of Infomatics)	Martin Davis	BAF-763	There are risks related to cyber security that, potentially, can affect the resilience of the Trust's IT systems and data. This could adversely affect all trust business.	4 (L) x 2 (S) = 8 (Moderate)	4 (L) x 2 (S) = 8 (Moderate)	This is an ongoing risk to remain open due to the ever present risk of a threat or vulnerability, both known and unknown, being used to affect the resilience of the Trust's IT systems and data	3 (L) x 2 (S) = 6 (Low)	Board of Directors, IT Steering Group

Strategic Objective	Risk / Action	Owner	Lead	Ref	Description	Initial Risk	Current Risk	Update / Controls	Target Risk	Assurance
Strengthening Team Working - Developing and strengthening Team RBCH to deliver safe and compassionate care for our patients and shaping future health care across Dorset	Progressing implementation of the Clinical Service Review by: ☐ obtaining approval for the Outline Business Case from NHS Improvement (NHSI) and developing the Full Business Case that will enable the development of the planned and emergency sites ☐ agreeing the merger timetable with the Competition and Markets Authority and obtaining approval from NHSI for the Merger Business Case	Debbie Fleming (CEO)	OAN Team	(BAF) 605	The risk in not being able to progress the Clinical Service Review; it will manifest in a number of ways. Firstly, the failure to comply with national recommendations regarding the provision of safe, sustainable emergency care due to the inability to create critical mass and respond to known workforce challenges. Secondly, the frustration of plans to obviate future expenditure and therefore maintain services within the funding allocated via the tariff system. This will result without subsidy in the Board not being able to maintain a financially sustainable Trust and service portfolio. Risk also that the Judicial Review hearing scheduled for 17th and 18th of July ,may result in proposed changes being temporarily halted	3 (L) x 5 (S) = 15 (High)	Closed			Board of Directors
	Progressing implementation of the Clinical Service Review by: ☐ obtaining approval for the Outline Business Case from NHS Improvement (NHSI) and developing the Full Business Case that will enable the development of the planned and emergency sites ☐ agreeing the merger timetable with the Competition and Markets Authority and obtaining approval from NHSI for the Merger Business Case	Debbie Fleming (CEO)	OAN Team	BAF-848	There is an overarching Risk that the One Acute Network Portfolio of Programmes will fail to deliver to Time, Cost and Quality requirements.		3 (L) x 4 (S) = 12 (Moderate)	[12/03/2020] Both Boards have approved the merger business case, the post transaction integration plan and the long term financial model. The CMA has started its investigation. NHS Improvement have started their transaction assurance process.	2 (L) x 3 (S) = 6 (Low)	Board of Directors
	Ensure that patients and members of the public are actively involved in the transformation of our services by routinely utilising experience based co-design, design thinking and digital service design within the One Acute Network (OAN) Programme	Paula Shobbrook (Director of Nursing)	Laura Northeast	BAF-811	If patient codesign not implemented as part of OAN programme then risk that the services will not be specifically designed around the needs of patients. Risk of reputational damage from public scrunity of engagement strategy.	2 (L) x 2 (S) = 4 (Low)	2 (L) x 2 (S) = 4 (Low)	BAF closed.	2 (L) x 1 (S) = 2 (Very Low)	Board of Directors, Healthcare Assurance Committee

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.5

Subject:	PHFT and RBCH Board Assurance Frameworks 2020/21

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk
Presented by:	Paula Shobbrook, Director of Nursing and Midwifery RBCH Patricia Reid, Director of Nursing and Midwifery, PHFT

Purpose of paper:	The Board Assurance Framework is a systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals. The assurance framework contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.
Background:	In accordance with the Trust Risk Management Strategy the Board Assurance Framework is reviewed quarterly at the Audit Committee and 6 monthly by the Quality Committee and the Board of Directors. The draft BAF is presented each year to the Audit and Governance Committee at its meeting by June and a Q1 statement is presented to the Board of Directors for approval at its meeting at the end of July as part of the annual governance cycle. For 2020/21 The BAF development process has been completed as follows:

25/03/2020	Draft Annual objectives agreed at Board
29/04/2020	Annual objectives reviewed at Board in light of covid and recommendations for amendment discussed.
08/05/2020	Updated objectives circulated to Executive Directors for comment
11/05/2020	Draft BAF presented to Senior Leadership team for review. Executive leads requested to consider risks to achieving each objective at both Trusts. Decisions recorded.

	11/05/2020 – end May 20	Executive leads to confirm risk details (title, current risk rating, risk controls, target risk rating) for all new BAF risks.
	23 June 2020	Q1 BAF presented to Audit Committee
	29 July 2020	Q1 BAF to be presented to Board of Directors for approval
Key points for Board members:	For approval	
Options and decisions required:	For approval	
Recommendations:	For approval	
Next steps:		

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trusts Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**

Principle objective	Specific Objective	Executive Director Lead	Current Risk on Risk Register	New BAF risk needed Y/N	Risk Title / Description	Q1 Initial Risk Rating	Current controls and assurances	Target Risk Rating	Monitoring Group
To be a great place to work, by creating a positive and open culture, and inclusive culture and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best.	Maintain our positive staff survey results and completion rates, especially for team work and a positive experience of work. To achieve this by ensuring our survey action plan delivers on 'you said, we did', publicising and promoting positive outcomes and interventions to support staff retention.		*No*	*On RBCH BAF 20/21. Will link on merger.*	*Risk that the Trust does not maintain the 2019/20 staff survey results and completion rates as a result of the impacts of covid*	*S(3) x L(2) = 6 Low Risk*	*Controls:* • *Internal staff survey results and completion rates* • *External staff survey results and completion rates* • *Completion of External survey action plan* • *Completion of any internal survey action plan* • *Effective and consistent promotion of positive outcomes* • *Staff recruitment and retention levels* • *Staff absence levels* • *Freedom to Speak up Guardian feedback* • *Number of Issue LERNs (decrease)* • *Number of Staff related incident LERNs (increased) with associated decreased severity*	*S(2) x L(2) = 4 Low Risk*	*Workforce* *Board of Directors* *Quality Committee* *TQGG*
	For at least 90% of staff to have a structured appraisal, before the end of the financial year. For this to include developing capabilities, values, behaviours and talent management conversations		*No*	*On RBCH BAF 20/21. Will link on merger.*	*Risk that impact of covid will result in failure to carry out high quality annual appraisals (inc. of developing capabilities, values, behaviours and talent management conversations) across the Trust and achieve the objective of 90% of all eligible staff to be appraised within the financial year.*	*S(2) x L(4) = 8 Moderate risk*	*Controls:* • *structured appraisal process* • *Delivery of planned training to appraisers and appraisees* *Assurances:* • *Previous appraisal rates*	*S(2) x L(2) = 4 Low Risk*	*Workforce* *All Governance Groups*
	Take action to ensure safe staffing, better matching capacity and demand and reducing reliance on agency staff as measured via reduced agency spend, and maintaining low levels of red flag shifts for staffing levels.	PR	Yes	1056	Inability to provide a fully established nursing workforce in accordance with the agreed establishment template	S(3)xL(3) = 9 , Moderate Risk	Controls: • Enhancements to recruitment process. Marketing materials, media and public screensavers. Staff accommodation policy for Trust residences. Weekly pay for Bank staff. Robust management of ward acuity and patient needs on a daily basis Regular assessment of patient dependencyRobust staff rota management to ensure satisfactory skill mixOutreach support for acutely unwell patientsReview of AIRS and complaints related to patient safety and staff quality measureMonitoring of patient experience through friends and family questionnaires Use of bank and agency nurses to supplement numbers Assurances: • Low levels of 'red flag' shifts	S(3)xL(2) = 6 , Low Risk	Workforce
		PR	Yes	1136	Reduction in quality of care to patients across the trauma wards	S(2)xL(3) = 6 , Low Risk	Actively supporting overseas RGN's and are involved in the up and coming work on band 4 development posts to bridge the gap. Ward leads have also been asked to look into the utilisation of band 3 roles to support the nursing deficit. Trialling a discharge band 3 coordinator on B3 to take the pressure off of the nursing establishment. TAU Green is up to establishment and supporting the remaining wards admirably. Off duty planning across the wards. Request bank and agency staff to agreed daily levels of trained staff. Monitoring standards of care and investigating issues that occur. Actively recruiting new staff. Internal moves of staff from across surgery in trauma to minimise the impact of shortfalls. Placing an open advert for trained staff for Trauma. Pursuing overseas recruitment.	S(3) x L(1) = Very Low Risk	Workforce
		PR	Yes	1317	There is a risk that we fail to maintain high standard patient care due to limited Speech Language Therapy staffing and resource	S(3)xL(4) =12 , Moderate Risk	Absence management, skillmix, rota management, HR policies, triage by senior staff	S(2)xL(3) = 6 , Low Risk	Workforce

		PR	Yes	1303	Insufficient inpatient therapy staff to provide time effective and therapy for patients' acute needs.	S(4)xL(3) =12 , Moderate Risk	Bank shift allocation, benmarking with similar Trusts, skill mix, HCA allocation, Therapy lead units, Enhanced recuritment of Band 5s, cultural change programme,	S (4) x L(2) = 8 Moderate Risk	Workforce
			Yes	1275	Impact on Patient Care due to Unstaffed Clinic - SAU	S(4)xL(3) =12 , Moderate Risk	Staffing, recrutiment, HR policies, Datix, Red flags	S(2)xL(3) = 6 , Low Risk	Workforce
		PR	Yes	1296	Insufficient skilled Nursing Workforce to meet the demands of AMU	S(4)xL(3) =12 , Moderate Risk	Robust monitoring of staff sickness absence and performance through the Managing Attendance policy Robust attendance at mandatory training within the required time frames Staff development and training to be supported Review of skill mix within budget Regular appraisals and probationary reviews with new staff there has been no incidence reported due to the junior staffing levels as we have mitigated successfully. but it does remain an issue preparation for senior staff nurses to step up into acting positions to cover the vacancy of maternity leave Daily staffing reviews Review and monitoring of working practice to be as productive and efficient as possible. Nurses supported and encouraged to take breaks and leave on time.	S(2)xL(3) = 6 , Low Risk	Workforce
			Yes	1193	A risk to the quality of care on Ward B4 due to vacancies and increasing numbers of patients with complex specialist needs	S(3)xL(3) =9 , Moderate Risk	Regular Agency staff are block booked to increase continuity of care. International recruitment of EU and Non EU staff. Daily safe staffing meeting undertaken trust wide to reassign staff to wards with highest dependency and nursing shortfalls. Recruitment is ongoing including return to practice Surgical Nursing Fellowship Programme: this programme has days allocated to various specialities like T&O and Medical/DME to support the outlier activity for the non-complex cases	S(2) x L(2) = 4 Low Risk	Workforce
		PR	Yes	1224	Insufficient specialised pharmacy support to child health services	S (4) x L(2) = 8 Moderate Risk		S(2) x L(2) = 4 Low Risk	Workforce
	Deliver the Trust's People Strategy with a focus on: recruiting new staff to keep the vacancy rate below 6%, developing sustainable workforce solutions that link to a flexible and local workforce; maintain a turnover rate below 12%		*No*	*On RBCH BAF 20/21. Will link on merger.*	*Risk of not being able to recruit/retain appropriately trained staff due to uncertainties around the scale of change in Dorset*	*S(3)xL(2) = 6 , Low Risk*	*Controls:* *• Vacancy rate below 6%* *• Staff turnover rate below 12%* *• Delivery of the principles of the Trust's People Strategy* *Assurances:* *• Progress regarding the principles of the Trust's People Strategy* *Current vacancy rate* *• Current Staff turnover rate* *• Link to other (local) Staffing risks - 725/794/854/850/331/669*	*S(2) x L(2) = 4 Low Risk*	*Workforce* *Quality Committee* *TQGG* *All Governance Groups*
	Deliver key priorities in our diversity and inclusion plan: Increasing Black, Asian and Minority Ethnic (BAME) representation across our leadership teams; Continue to improve our Workforce Race Equality Standard (WRES) results to ensure our BAME staff do not experience higher levels of bullying, harassment or discrimination		*No*	*On RBCH BAF 20/21. Will link on merger.*	*If the Trust does not maintain positive engagement with all staff networks during and following covid then there is risk that Black, Asian and Minority Ethnic (BAME) and other vulnerable staff do not feel adequately suported leading to increased sickness absence, turnover and low morale.*	*S (4) x L(2) = 8 Moderate Risk*	*Controls:* *• Delivery of the key priorities in the diversity and inclusion plan* *• Workforce Race Equality Standard (WRES)* *• Increased BAME representation across our leadership teams* *• Number of allegations of bullying, harassment or discrimination (comparator - BAME vs Non-BAME)* *• Diversity, HR, Appraisal, BEAT policies* *• NHS Employers D&I programme* *• CQC Well led standards, Peer review and self assessment* *• Staff survey* *• EIA (policies and procedures)* *Assurances:* *• Current status delivery of the diversity and inclusion plan*	*S(2) x L(2) = 4 Low Risk*	*Workforce* *Quality Committee*

To ensure that all resources are used efficiently to establish financially sustainable services and deliver key operational standards and targets.	Implement the Cost Improvement Programme (CIP) and merger savings programme and achieve the level of savings and efficiency required	PP	No	*To be developed and approved by Finance Committee end of July 2020*				
	Ensure the covid reset, early merger benefits, and system working benefits are tracked with integrated goverance and reporting in place.		No	No risk identified by SLT. BAF risk not required.				
	The objective to continue to deliver efficiency and productivity opportunities using Getting it Right First Time (GIRFT) and Model Hospital benchmarking data has been interrupted by Covid-19. However in resetting services opportunities exist to reduce unwarranted variation in our clinical and non-clinical services both across sites and between services. This will be tracked and outcomes presented in an annual report by March 2021	*PP*	*No*	*On RBCH BAF 20/21. Will link on merger.*	*GIRFT and Model Hospital* *Risk of not achieving efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision.*	*S(3)x L(3) = 9 , Moderate Risk*	*Controls:* *• Model Hospital metrics* *• Trust performance metrics* *• Link to CIP risk (once written and live)* *Assurances:* *• Current status of the GIRFT QI/transformation programme*	*S(3)xL(2) = 6 , Low Risk*	*Audit Committee* *Board of Directors* *Finance and Performance* *Quality Committee* *Trust Management Board*
	To measure, and reduce our carbon footprint, as part of a multi-year sustainability strategy, to be developed by the new Trust and agreed by the Board by December 2020.	MM	*No*	*On RBCH BAF 20/21. Will link on merger*	*Sustainabilty Strategy* *If we do not deliver the Trust's Sustainability Strategy there is a risk that the Trust will not either measure or reduce it's carbon footprint*	*S(2) x L(3) = 6 , Low Risk*	*Controls:* *• Delivery of the Trust's Sustainability Strategy* *• Accurate monitoring of carbon footprint* *• Evidence of a reduction in carbon footprint* *. PTIP programme* *. Policies and Procedures* *Assurances:* *• Progress regarding the Trust's Sustainability Strategy*	*S(2) x L(2) = 4 Low Risk*	*Board of Directors* *Quality Committee* *Estates Governance*
To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience	Outpatients: reducing the number of unnecessary visits for our patients, with a five year target of a 33% reduction in face to face appointments.	MM	Yes	1292	Outpatient follow up appointments waiting list and booking processes	S(4)xL(3) = 12 , Moderate Risk	Weekly performance meeting reviews supporting understanding of challenges to deliver for sustainability and plans for improvement discussed. Capacity & Demand modeling reviews being undertaken across all specialties to understand the opportunities to deliver FU care differently i.e.: PIFU's/Virtual. HECTOR reports (circulated by the trust Information Team)utilized by opd managers and specialty teams to manage waiting lists. Patient outcome slips currently retained and matched against HECTOR reports.Clinic management via CaMIS determines every patient should have an outcome on each appointment	S(3)x L(3) = 9 , Moderate Risk	Finance and Performance
	Ophthalmology transformation programme, with partners, to implement the system plan to improve quality and sustainability of the service	MM	No	No risk identified by SLT. BAF risk not required.				

	To use regular audit to assess the deployment of digital innovation to improve clinical documentation - including consistent and accurate health records, standardising storage and building on communications between teams.	PG	No	No risk identified by SLT. BAF risk not required.				
	Fundamentals of Care: to improve the care of patients with enhanced needs due to acuity and dependency, measured using NEWS 2.	MT	No	NEWS2 implemented across the Trust via eObs. BAF risk not required.				
	For patients with suspected cancer to achieve the national standards relating to: Cancer waits at 62 days for treatment, and 28 days to diagnosis.	MM	Yes	1015	Cancer waits Failure to meet national cancer waiting time targets	S(4)xL(4) = 12 , Moderate Risk	Controls: • CWT pathway (62 days for treatment, and 28 days to diagnosis.) • National standards • Cancer Peer review • Dorset strategy • Patient experience • Performance standards and performance monitoring • Recruitment and retention strategy Assurances: • Case load status – days to diagnosis/days to treatment	S(3) x L(1) = Very Low Risk	Finance and Performance Operational Management Group Oncology, Radiology RaGGs Workforce
	For patients with routine elective care, reduce the number of people waiting longer than 52 weeks for their treatment, compared to 2019/20, working towards zero referral to treatment (RTT) waits over 52 weeks and total waiting numbers no greater than January 2020.	MM	Yes	1074	Risks associated with breaches of 18 week Referral to Treatment and 52 week wait standards	S(3)xL(3) = 9 , Moderate Risk	Controls: Monitor waiting lists, pathways and clock stops against an indicatorValidation process of clock stops currently 3,500 with 10,000 patients on the waiting list at any one timePathway facilitation - reviewing capacity and patient demandWeekly review of RTT predictor toolWeekly review of 26 + waiters and their individual patient plans Assurances: • Waits over 52 weeks against Jan 2020 threshold	S(2) x L(3) = 6 Low Risk	Finance and Performance Operational Management Group
	For patients requiring diagnostics to improve the responsiveness and by year end to recover the national standards relating to 99% within 6 weeks	MM	Yes	1263	Increase in diagnostic colonoscopy breaches	S(2)xL(4) = 8 , Moderate Risk	Controls: • 99% patients undergo required diagnostics within 6 weeks (by March 2021) • Implementation of Monitoring metrics by specialty • Performance by Specialty • Efficient patient pathways Assurances: • Waits over 6 weeks for diagnostics	S(2) x L(2) = 4 Low Risk	Finance and Performance Operational Management Group Surgical/Medical RaGGs
		MM	Yes	1348	Covid related pause to Dorset Bowel Cancer Screening Programme and potential diagnostic delay	S(4)xL(4) = 16 , High Risk	Controls: Assurances:Managing screenings in line with available capacity	S(2) x L(2) = 4 Low Risk	Finance and Performance Operational Management Group Surgical/Medical RaGGs

	Support the National field testing and subsequent implementation on the new A&E standards. Improve Urgent and Emergency Care (UEC) performance to be better than 2019/20	MM	Yes	1332	Failure to manage patients safely and in the most approporiate environment due to overcrowding in ED	S(4)xL(3) = 12 , Moderate Risk	Controls: • Compliance with National Standards • Performance review against metrics (ie to improve on 2019/20 –performance) • Efficient patient pathways with in UEC care • Link to Risk 691 (Ambulance Queues) • Link to Risk 813 (UTC Capacity) • Link to Risk 806 (Making Every In-Patient day count) Assurances: • Current UEC performance	S(2)xL(4) = 8, Moderate Risk	Finance and Performance Operational Management Group Emergency and Urgent Care RaGG
		MM	Yes	1038	Risk of failure in achieving national targets for Emergency Department	S(2) x L (3) = 6 Low risk	Controls: • Compliance with National Standards • Performance review against metrics Assurances: • Current performance	S(2) x L(2) = 4 Low Risk	Finance and Performance Operational Management Group Emergency and Urgent Care RaGG
	Achieve 92% bed occupancy, by a mix of reducing patients "stranded" in hospital, when not requiring acute inpatient care, and increasing same day and inpatient capacity.	MM	Yes	1053	Unable to reduce bed occupancy due to delays in transfers of care	S(2)xL(4) = 8, Moderate Risk	The PHFT DTOC Figure remains above the contracted 3.5% The trust is currently reporting monthly to NHS England due to a DTOC rate in excess of 5%A trust action plan has been developed to support achievement of a 3.5% DTOCAll external partners are working in collaboration to support initiatives that will assist the DTOC achievementThe Trust is currently scoping the ability to implement a Integrated Discharge Team strategy which encompasses co-location of the LA discharge and trust discharge support TeamsThe Trust has initiated a dedicated 2016 resolution " There's no place like Home" with targeted "Breaking Barriers" weeks focusing on specific topics that support patient flow and safe discharge.- The SAFER Care Bundle- EDD - Red /Green Days- Nuggets of Best Practice- Gold and Silver patients	S(3) x L(2) = 6 Low Risk	Finance and Performance Operational Management Group Medical RaGG

	Objective	Owner	On BAF	Risk ID	Risk Description	Current Risk	Controls and Assurances	Target Risk	Committee
	Achieve 92% bed occupancy, by a mix of reducing patients "stranded" in hospital, when not requiring acute inpatient care, and increasing same day and inpatient capacity (SDEC) and fully embedding the Dorset Integrated Care System "Discharge to Assess" (DSA) model across all of our hospitals.	MM	Yes	1131	Inability to effectively place patients in the right bed at the right time	S(3)xL(4) = 12, Moderate Risk	Daily Operational dashboard Policy and procedure Business Continuity Plan Inpatient Capacity Plan Internal Escalation Plan -Departmental and Corporate Action cards External escalation plan Individual ward level escalation plans ED and Admission Divert protocol and Flow chart Daily Operational/Bed meetings Trust wide- Communication of current bed status Review of Elective admissions Efficient Discharge planning Escalation of delayed discharges Additional escalation beds made available to ensure no patient is cared for on an ED trolley, patients to be individually risk assessed for requirements Specialties and Department will invoke Level 4 escalation plans Re-prioritise time/meetings to support patient flow Attend ED, RACE and EAU regularly through-out the day Identify cause for pressures and develop remedial actions Liaise with external organisations regarding delays as appropriate, expediting discharge as a matter of urgency Review delays with Discharge Matron Ensure daily delays sent to PCT and Las In extreme level 4 escalation include communication re bed state	S(3) x L(2) = 6 Low Risk	Finance and Performance Operational Management Group
	Continue snapshot audits of compliance with core 7 day service standards, which will inform the impact of workforce changes made in response to Covid-19		No	On RBCH BAF 20/21. Will link on merger	7 day services If we continue to demonstrate a deteriorating performance in relation to the NHSE/I National Standards for 7 day working there is a potential risk that of patient safety concerns in addition to reputational and contractual failure	S(2)xL(2) = 4 , Low Risk	Controls: • Compliance with Standard 2 – consultant review within 14 hours • Compliance with Standard 8 – twice daily of patients with high acuity needs • Compliance with Contractual requirements • Improved performance against audit of standards 2 and 8 • Incidents/complaints Assurances: • Current performance against the two standards	S(2) x L(1) = 2, Very Low Risk	Audit Committee Board of Directors Quality Committee Workforce
	Provide excellent infection prevention and control to minimse the number of hospital acquired infections including MRSA, Cdiff, MSSA and Covid-19.	PR	Yes	1172	Failure to meet contractual target for all monitored organisms	S(2)xL(4) = 8, Moderate Risk	Controls: • Performance against trajectory • NHS Improvement aim to reduce the number of reported gram negative bacteraemia's by 50% by 2021 • National Benchmarking • Effective Screening process (Sepsis and deteriorating patient protocols) • Rates of gram negative Hospital acquired urinary tract infections • Rates of gram negative Hospital acquired bacteraemia's • Fully implemented Post infection review toolkit • Compliance with Hand Hygiene policy • Compliance with management of urinary catheters policy • Compliance with prevention of HCAI policy • Compliance with WHO safe surgery checklist • Compliance with use of antimicrobials policy • RBCH Action plan linked into the Dorsetwide action plan. policy • CVAD policy Assurances: • Current performance against trajectory	S(3) x L(2) = 6 Low Risk	Finance and Performance Operational Management Group IPCC

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To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people	Strengthen and improve communications/engagement with staff, governors, patients, local people and key stakeholders through a communication and engagement plan, delivered over the year and reviewed by February 2021	DF	No	No risk identified by SLT. BAF risk not required.				
	Complete the merger transaction in 2020/2021. Establish the new governance arrangements for the new organisation including managing the governor elections and ratification of the new Board.	DF	*No*	*On RBCH BAF 20/21. Will link on merger*	*Completion of merger and implementation of governance arrangements* *Risk of merger transaction not being completed within delivery timescales (inclusive of Tier 2/3 recruitment)*	*S(4) x L (2) = 8 Moderate Risk*	*Controls:* *• Merger Transaction plans and outline business case (for 01/10/2020 merger date)* *• Governance arrangements and Risk Management Strategy agreed by SIB* *• Governor election process* *• External Quality governance review (E&Y)* *• Merger PTIP completion* *' Recruitment process* *Assurances:* *• Progress against PTIP*	*S(3)xL(2) = 6 , Low Risk*	*Board of Directors* *Audit Committee*
	Recruit to the new management structure at Tier 2 by July 2020, and Tier 3 by December 2020	DF	No	No risk identified by SLT. BAF risk not required.				
	Continue to implement the integration and organisation development plans, bringing services together and developing ownership for the shared vision and values, with a review of progress by March 2021.	DF	No	No risk identified by SLT. BAF risk not required.				
	Develop the University partnership, including agreeing the MOU and a multi-year programme of collaboration.	DF	No	No risk identified by SLT. BAF risk not required.				
			No	No risk identified by SLT. BAF risk not required.				
To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	Commencing work on the Theatres development at Poole Hospital by July 2020.		No	No risk identified by SLT. BAF risk not required.				
	Securing approval for the OBC for the £147 million, for the creation of the planned and emergency sites, to be agreed by July 2020.	DF	*No*	*On RBCH BAF 20/21. Will link on merger*	*There is an overarching risk that the One Acute Network Portfolio of Programmes (inlcuding OBC) will fail to deliver to Time, Cost and Quality requirements.*	*S(4) x L(3) = 12 Moderate Risk*	*Extensive and effective Planning and Scoping stage* *Developing and agreeing its Outline Business Case (OBC)* *Full Business Case (FBC)agreed* *Identified Time, Cost and Quality requirements* *Confirmation of the viability of delivery of the Portfolio scope to Time, Cost and Quality.* *Achievement of the required Portfolio outcomes.*	*S(3)xL(2) = 6 , Low Risk*	*Board of Directors* *Trust Management Board* *Estates*
	Developing and implementing a decant plan for the two sites by June 2020	DF	No	No risk identified by SLT. BAF risk not required.				

	Agreeing and implementing a new Sustainable Travel Plan with staff and BCP Council to meet the trajectory required for the planning approval and to provide an annual review and update	DF	No	*On RBCH BAF 20/21. Will link on merger*	*If a there is not a Sustainable Travel Plan for agreed with staff and Bournemouth, Christchurch and Poole Council within requirements this may potentially impact on the success of the merger*	*S(3) x L(3) = 9 Moderate Risk*	*Controls:• Agree and implement a new Sustainable Travel Plan with staff and BCP Council to meet the trajectory required for the planning approval • Provide an annual review and update of the agreed Travel PlanAssurances:• Progress to agreed plan*	*S(2)xL(2) = 4 , Low Risk*	*Board of Directors*
	Establishing robust arrangements for taking forwards Health Infrastructure Plan (HIP) with Dorset partners and NHSI/E, such that a Dorset programme Strategic Outline Case is submitted before March 2021	DF	No	*On RBCH BAF 20/21. Will link on merger*	*Progression of Health Infrastructure Plan (HIP)To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.*	*S(2)xL(2) = 4 , Low Risk*	*Controls:• Arrangements for taking forwards Health Infrastructure Plan (HIP) with Dorset partners and NHSI/E agreed• Dorset programme Strategic Outline Case submitted before March 2021Assurances:• Progress to submissionDorset Steering Group established & project team being formed. Very large & complex multi-site set of projects, so will require significant programme management*	*S(2) x L(1) = 2, Very Low Risk*	*Board of Directors*
	Continue to build effective relationships with all local partners, including the two new local authorities, especially through full engagement with the Health and Wellbeing Boards (HWBs), with an annual self-assessment to measure progress;	DF	No	*On RBCH BAF 20/21. Will link on merger*	*Effective relationships with local partnerTo transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.*	*S(2)xL(2) = 4 , Low Risk*	*Controls:• Full engagement with the Health and Wellbeing Boards (HWBs)• Prioritise the two new local authorities• Completion of annual self - assessmentAssurances:• Outcome of self-assessment*	*S(2) x L(1) = 2, Very Low Risk*	*Board of Directors*
	Play an active part in creating effective governance and implementation arrangements that will 'de-clutter' the Dorset ICS, improve performance and allow for 'System by Default' with an annual self-assessment to measure progress;								
	Play an active part in the key Dorset transformation plans programmes, including Digital Dorset, by implementing four core clinical applications (Dorset Care Record, order communications, electronic prescribing and medicines administration, health of the ward) and support the clinical leaders of these programs transform clinical processes to achieve the maximum benefit from these investments; migrate all devices to Windows10, stabilise the underlying infrastructure and mitigate against all IT security threats	PG	Yes	1298	There is a risk that we fail to maintain and develop the Trust IT services in line with clinical and operational requirements	S(5)xL(2) = 10 , Moderate Risk	Controls: Each of these projects is fully budgeted and carefully managed using the nationally recognised project management methodology PRINCE Stakeholders engagement for each project including, and crucially, executive leadership, clinical engagement, clinical safety officers in an assurance role. • Communications strategy • Delivery of milestones in line with project plan • Compliance with financial controls • Project specific issues logs • Effective stake holder engagement and management • LERN submissions/Complaints/patient experience • Staff experience • Project specific Business Continuity Plans Assurances: • Progress against implementation. Strategic electronic patient record - Fully live and in Business as Usual Order communications - Radiology full live and in Business as Usual. Pathology order comms linked and moved to be part of the Pathology LIMS replacement. Electronic prescribing and medicines administration - on hold post COVID 19	S(4)xL(2) = 8 , Moderate Risk	Operational Management Group Information Governance
		PG	Yes	1273	Cyber Security Risks, Threats and Vulnerabilities- There are risks related to cyber security that, potentially, can affect the resilience of the Trust's IT systems and data. This could adversely affect all trust business.	S(2)xL(4) = 8 , Moderate Risk	All Trust owned IT Hardware is up to date, patched and supported (significant gaps) All Trust owned IT Software is up to date, patched and supported(significant gaps) Deviations to Hardware and Software are known and accepted (minor gaps)	S(2)xL(3) = 6 , Low Risk	Operational Management Group Information Governance

| | | PG | Yes | 1093 | Telecommunication quality | S(3)xL(2) = 6 , Low Risk | BCPs | S(1) x L(1) = 1, Very Low Risk | Operational Management Group

Information |
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| | To actively engage in the other Dorset ICS portfolios, (Prevention at Scale, Integrated Community and Primary Care, Leading and Working Differently) to support progress against the annual plans of these work programmes. | DF | No | No risk identified by SLT. BAF risk not required. | | | | | |
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Principle objective	Specific Objective	Executive Director Lead	Risk Lead	Risk Register Ref	Risk Title / Description	Q1 Initial Risk Rating	Current controls and assurances	Target Risk Rating	Monitoring Group
To be a great place to work, by creating a positive and open and inclusive culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best.	Maintain our positive staff survey results and completion rates, especially for team work and a positive experience of work. To achieve this by ensuring our survey action plan delivers on 'you said, we did', publicising and promoting positive outcomes and interventions to support staff retention.	KA	Bridie Moore	818	Risk that the Trust does not maintain the 2019/20 staff survey results and completion rates as a result of the impacts of covid	S(3) x L(2) = 6 Low Risk	Controls: • Internal staff survey results and completion rates • External staff survey results and completion rates • Completion of External survey action plan • Completion of any internal survey action plan • Effective and consistent promotion of positive outcomes • Staff recruitment and retention levels • Staff absence levels • Freedom to Speak up Guardian feedback • Number of Issue LERNs (decrease) • Number of Staff related incident LERNs (increased) with associated decreased severity Assurances: • Current Internal staff survey results • Current External staff survey results • Staff retention	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Workforce Strategy Committee • Board of Directors • Health Assurance Committee • QARC
	For at least 90% of staff to have a structured appraisal, before the end of the financial year. For this to include developing capabilities, values, behaviours and talent management conversations	KA	Bridie Moore	896	Risk that impact of covid will result in failure to carry out high quality annual appraisals (inc. of developing capabilities, values, behaviours and talent management conversations) across the Trust and achieve the objective of 90% of all eligible staff to be appraised within the financial year.	S(2) x L(4) = 8 Moderate risk	Controls: • structured appraisal process • Delivery of planned training to appraisers and appraisees Assurances: • Previous appraisal rates	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Workforce Strategy Committee • Senior HR meeting • All Care Group and Directorate Governance Groups
	Take action to ensure safe staffing to match capacity and demand and reduce reilance on agency staff as measured via reduced agency spend, maintaining low levels of red flag shifts for staffing levels	KA	KA	300	Risk of not developing alternative roles to support delivery of core services/reliance on hard to recruit roles.	S(3)xL(2) = 6 , Low Risk	Controls: The development Band 4 roles, Physicians Assistant; introduction of the Apprenticeship Levy. Agency spend is closely monitored. Reviewed at Workforce Committee. Assurances: Trainee Nursing Associates, Physicians Associates, internal and external RNDAs (Registered Nurse Degree Apprentices); We are working with Solent University to offer a bespoke conversion course offering our Assistant Practitioners the opportunity to become Nursing Associates. We are recruiting for a new cohort of combined internal and external RNDAs for Sept 20 and expect 10 to join the Trust. We are supporting current qualified overseas HCSWs to complete their OSCEs and become qualified nurses. There are several new apprenticeship courses available. Agency spend is rigorously monitored via PCA and is reducing	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Workforce Strategy Committee • Health Assurance Committee • QARC • All Care Group and Directorate Governance Groups
		PS/AOD	Kate Horsefield	331	Critical Care Pharmacy Provision - RBH ICU currently only has 0.2 Clinical Pharmacy provision.Risk to patient safety and outcome.	S(4) x L(1) = 4 Low Risk	Guidelines for the Provision of Intensive Care Services'. Reccomendation No 1: - Where Critical Care pharmacy services are provided for more than the traditional Monday-Friday (5-day) model, the minimum staffing level of 0.1 wte per Level 3 bed (or two Level 2 beds) should be increased proportionately.	S(2) x L(1) = 2, Very Low Risk	Directorate Governance Group

PS/AOD	Louise McGraw	332	Supernumerary Coordinator ND in ICU. Lack of supernumerary 'runner'. Risk of non compliance with ICS and CQC standards resulting in regulatory action.	S(3)xL(2) = 6 , Low Risk	Guidelines for the Provision of Intensive Care Services: 4.There will be a supernumerary clinical coordinator (sister/charge nurse bands 6/7) on duty 24/7 in Critical Care Units. 1.2.5 Units with greater than 10 beds will require additional supernumerary (this person is not rostered to deliver direct patient care to a specific patient) registered nursing staff over and above the clinical coordinator to enable the delivery of safe care. The number of additional staff per shift will be incremental depending on the size and layout of the unit (e.g. multiple single rooms).	S(2) x L(1) = 2, Very Low Risk	Directorate Governance Group
PS/AOD	Louise McGraw, Michelle Scott	669	Inadequate out of hours medical staffing for critical care. Risk of non compliance with ICS and CQC standards resulting in regulatory action.	S(3)xL(2) = 6 , Low Risk	Current standards for staffing of critical care units recommend: 1.1.3 In general, the Consultant/ Patient ratio should not exceed a range between 1:8 – 1:15 and the ICU resident/Patient ratio should not exceed 1:8. Looking at our bed occupancy we exceed this 1:8 ratio 50% of the time. This was highlighted in our CQC report. Business case in progress which incorporates increased nursing and addresses the working pattern	S(1) x L(1) = 1, Very Low Risk	Directorate Governance Group
PS/AOD	Marie Miller	725	Ability to Maintain Safe Staffing(nursing) in Haematology and Oncology. This is on a background of a recognised national shortage of cancer nurses especially those with Chemo therapy training. The impact of this is reduced safety for a vulnerable group of patients and decreased staff morale.	S(2) x L(5) = 10 Moderate risk	[13/06/2020] Band 5 recruitment has been successful including the arrival of the oversea's nurses. Both are awaiting to complete their OSCE assessment, which has been delayed due to COVID-19. 1 x nurse has completed her SACT training and returned to Ward 11. Aim for 1 nurse to commence their training at the end of July and 1 x nurse in September, to increase SACT trained nurses on Ward 11	S(1) x L(3) = 3, Very Low Risk	Directorate Governance Group
PS/AOD	Grainne Ford	752	Risk that if there continues to be no Dietetic Service delivered to patients in Cancer Care at Christchurch hospital then there is no ability to assess and manage the treatment plans of these patients in order to optimise their nutritional status resulting in unnecessary compilations for the patient and staff and potential harm	S(2) x L(2) = 4 Low Risk	Dietitian will see new patients with a MUST score of 2 within 2 working days • Dietetic review of enterally fed patients (every 1-3 days depending on clinical situation) • Number of related incidents/complaints • Compliant with relevant NICE guidance • Telephone service offer in core hrs	S(2) x L(1) = 2, Very Low Risk	Directorate Governance Group
PS/AOD	Nathan Bourne	756	Risk that there is insufficient skill mix to cover the 24/7 service needed to maintain a Haematology/ Transfusion laboratory service. Recent recruitment of staff are not currently competent to help with this service which leaves a limited number of staff available.	S(3) x L(3) = 9 Moderate risk	Senior staff to continue to uphold quality so that the laboratories maintain JACIE, MHRA and UKAS accreditation. Part time staff have been flexible with their shift patterns to cover any deficiencies in the rota and routine work	S(1) x L(3) = 3, Very Low Risk	Directorate Governance Group

	PS/AOD	Jacqui Bowden	788	There is a reduced Clinical Pharmacy service to the wards due to significant levels of pharmacy vacancies, sick and maternity leave. The impact of reduced Clinical Pharmacy for inpatients is the reduction in pharmacist clinical screening during in-patient stay. Ultimately this could lead to patient harm and increased LoS. There are additional risks to pharmacy staff : • Reduced training of new staff may result in significant prescribing errors being missed. • Failure to deliver on mandatory training and appraisals. • Reduction in project work being undertaken, CQUIN and other cost saving and improvement projects being delayed or not achieved and subsequent reduction in CQUIN funding etc. • Adverse impact on health & wellbeing	S(3)xL(2) = 6 , Low Risk	Continue the presence of pharmacists on PTWR on AMU. • All patients should be clinically screened in high risk and admission areas where possible eg ICU, AMU, SAU, CCU, ward 26. • Spreading the pharmacy staff across the wards so that all in-patients receive an equitable service to minimise risk as far as possible. • Tracking and handover of patients on high risk drugs or with AKI etc • Senior pharmacists backfilling vacancies in junior staff.	S(2) x L(2) = 4 Low Risk	Directorate Governance Group
	PS/AOD	James Knowles	794	Risk that reduced staffing levels in Interventional Radiology will impact on routine and out of hours emergency treatment.	S(3)xL(2) = 6 , Low Risk	Recruitment to template - Resilience of Interventional Radiographer staffing template. - Waiting times of fast track and routine procedures - No cancellations of routine or emergency cases due to reduced staffing. - Training of appropriate staff in Interventional Radiology - Maintain safe service using bank and Agency staff - Financial balance	S(1) x L(3) = 3, Very Low Risk	Directorate Governance Group
	PS/AOD	Eleanor Thickett	827	Delayed Patient Care and Health risks to staff due to insufficient consultant cover in orthodontics. Impact on waiting lists, clinical supervision and staff morale	S(3) x L(3) = 9 Moderate risk	Waiting list at 6-9 months - Successful recruitment to template of consultants - Number of hospital initiated cancellations for treatment - Number of complaints related to the waiting time - Number of additional sessions for waiting list review - Sickness and absence percentage for the department	S(1) x L(3) = 3, Very Low Risk	Directorate Governance Group
	PS/AOD	Karen Bowers	681	OPM are currently carrying a significant number of vacancies for both RN & HCAs which has increased and therefore there is a potential adverse impact on quality and safety of patient care	S(2) x L(4) = 8 Moderate risk	• 'red flag incidents' relating to the delivery of patient care • Staff turnover and sickness/absence • Use of bank/agency/tier 3 (financial risk) • Incidents/Complaints/Claims/Patient Experience • Full recruitment to template • Optimised Staffing profile/Skill mix • Mandatory Training uptake • Staff appraisal rate • Number of Stranded patients • Length of stay/Re-admission rates	S(1) x L(3) = 3, Very Low Risk	Directorate Governance Group
	PS/AOD	RW	205	Risk to patient care due to reliance on locum consultant cover in Elderly Care .	S(3) x L(4) = 12 Moderate risk	Implementation of non-medical consultant posts Job planning Availability of good quality locums Achievement of financial balance Increased length of stay, stranded patient numbers,re-admissions and numbers of outliers (impact on flow- see linked risks) Review & Recruitment to consultant staffing template Incidents/Complaints/Patient Experience Key performance indicators National Standards/Guidance/Audit	S(2) x L(2) = 4 Low Risk	Directorate Governance Group
	PS/AOD	Morwenna Gower	854	Stoke Outreach Reduced Cover - risk to patient safety and outcome. Risk to staff safety and well being	S (4) x L(2) = 8 Moderate Risk	SSNAP performance - Domains 1 to 4. Sickness rates within team Number of shifts unable to be covered.	S(2) x L(1) = 2, Very Low Risk	Directorate Governance Group

	Deliver the Trust's People Strategy with a focus on: recruiting new staff to keep the vacancy rate below 6%, developing sustainable workforce solutions that link to a flexible and local workforce; maintain a turnover rate below 12%	KA	KA	260	Risk of not being able to recruit/retain appropriately trained staff due to uncertainties around the scale of change in Dorset	S(3)xL(2) = 6 , Low Risk	Controls: • Vacancy rate below 6% • Staff turnover rate below 12% • Delivery of the principles of the Trust's People Strategy Assurances: • Progress regarding the principles of the Trust's People Strategy Current vacancy rate • Current Staff turnover rate • Link to other (local) Staffing risks - 725/794/854/850/331/669	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Workforce Strategy Committee • Health Assurance Committee • QARC • All Care Group and Directorate Governance Groups
	Deliver key priorities in our diversity and inclusion plan: Increasing Black, Asian and Minority Ethnic (BAME) representation across our leadership teams; Continue to improve our Workforce Race Equality Standard (WRES) results to ensure our BAME staff do not experience higher levels of bullying, harassment or discrimination	KA	Debbie Detheridge (Diversity & Inclusion Lead)	819	If the Trust does not maintain positive engagement with all staff networks during and following covid then there is risk that Black, Asian and Minority Ethnic (BAME) and other vulnerable staff do not feel adeqautely suported leading to increased sickness absence, turnover and low morale.	S (4) x L(2) = 8 Moderate Risk	Controls: • Delivery of the key priorities in the diversity and inclusion plan • Workforce Race Equality Standard (WRES) • Increased BAME representation across our leadership teams • Number of allegations of bullying, harassment or discrimination (comparator - BAME vs Non-BAME) • Diversity, HR, Appraisal, BEAT policies • NHS Employers D&I programme • CQC Well led standards, Peer review and self assessment • Staff survey • EIA (policies and procedures) Assurances: • Current status delivery of the diversity and inclusion plan	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Workforce Strategy Committee • Health Assurance Committee
To ensure that all resources are used efficiently to establish financially sustainable services and deliver key operational standards and targets.	Implement the Cost Improvement Programme (CIP) and merger savings programme and achieve the level of savings and efficiency required	PP	*Peter Papworth*	*To be developed and approved by Finance Committee end of June 2020*			
	Ensure the Covid reset, early merger benefits, and system working benefits are tracked with integrated governance and reporting in place.	RR	DP	No risk identified by SLT. BAF risk not required.			
	To continue to deliver efficiency and productivity opportunities using Getting it Right First Time (GIRFT) and Model Hospital benchmarking data in the context of Covid-19 response. This includes resetting services in ways to reduce unwarranted variation in our clinical and non-clinical services both across sites and between services. This will be tracked and outcomes presented in an annual report by March 2021	AOD	Helen Rushforth	809	GIRFT and Model Hospital Risk of not achieving efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision.	S(3)x L(3) = 9 , Moderate Risk	Controls: • Model Hospital metrics • Trust performance metrics • Link to CIP risk (once written and live) Assurances: • Current status of the GIRFT QI/transformation programme	S(3)xL(2) = 6 , Low Risk	Monitoring Committee: • Audit Committee • Board of Directors • Finance and Performance Committee • Healthcare Assurance Committee • Trust Management Board

	To measure, and reduce our carbon footprint, as part of a multi-year sustainability strategy, to be developed by the new Trust and agreed by the Board by December 2020.	RR	Edwin Davies	897	Sustainabilty Strategy If we do not deliver the Trust's Sustainability Strategy there is a risk that the Trust will not either measure or reduce it's carbon footprint	S(2) x L(3) = 6 , Low Risk	Controls: • Delivery of the Trust's Sustainability Strategy • Accurate monitoring of carbon footprint • Evidence of a reduction in carbon footprint . PTIP programme . Policies and Procedures Assurances: • Progress regarding the Trust's Sustainability Strategy	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Board of Directors • Healthcare Assurance Committee • Estates Committee
To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience	Outpatients: reducing the number of unnecessary visits for our patients, with a five year target of a 33% reduction in face to face appointments.	DP	Sarah Macklin	807	Re-designing outpatient services for future demand Risk that the Trust fails to respond to the challenge of changing models of outpatient care in line with National trend information relating to population growth and aging population needs. Developing innovation and new models of care is essential to future-proof access to relevant clinical intervention and advice in a timely way.	S(3) x L(2) = 6 , Low Risk	Controls: • 33% reduction in face to face appointments by 2025 • Delivery of the QI/Transformation programme o Delivery of the Maximising Efficiency work stream – DNA reduction, template review, reducing late cancellations o Delivery of the Offering Alternatives work stream – advice & guidance, patient initiated follow-up, straight-to-test pathways, introduction of RAS to make efficient use of slots (resource implications) o Delivery of the Digital Administration of pathways work stream including virtual clinics and patient self-care or monitoring o Delivery of the Digital Automation options for minimising unused clinic slots • Monthly current performance review by specialty (patients waiting for new and follow up, DNA rates) • Information reporting available to monitor control against standard operating procedures • Benchmarking exercise - GIRFT • Outpatient performance metrics Assurances: • Current Outpatient performance	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Finance & Performance Committee • Healthcare Assurance Committee • Audit Committee • Trust Management Board
	Ophthalmology transformation programme, with partners, to implement the system plan to improve quality and sustainability of the service	DP	Barry Alborough - Duell	810	Ophthalmology: achieving eye theatre efficiency of 85%	S(2) x L(3) = 6 , Low Risk	Controls: • Delivery of the Ophthalmology QI/Transformation programme • Benchmarking exercise - GIRFT • Ophthalmology performance metrics Assurances: • Current Ophthalmology performanceTheatres have been utilised for urgent and emergency activity only during Covid-19 escalation. Prior to this theatre capacity was sustaining >85% and will be monitored with the thought of closing this risk when activity resumes.	S(2) x L(1) = 2, Very Low Risk	Monitoring Committee: • Finance & Performance Committee • Healthcare Assurance Committee • Ophthalmology Directorate Governance Group • Care Group C - Governance Meeting
	To use regular audit to assess the deployment of digital innovations to improve clinical documentation - including consistent and accurate health records, standardising storage and building on communications between teams.	AOD/PS	AOD/PS	No risk identified by SLT. BAF risk not required.				
	Fundamentals of Care: to improve the care of patients with enhanced needs due to acuity and dependency, measured using NEWS 2.	AOD/PS	AOD/PS	NEWS2 implemented across the Trust via eObs. BAF risk not required.				

	Objective		Lead	Risk ID	Risk	Initial Risk Score	Controls / Assurances	Residual Risk Score	Monitoring Committee
	For patients with suspected cancer to achieve the national standards relating to: Cancer waits at 62 days for treatment, and 28 days to diagnosis.	DP	Alison Ashmore	812	**Cancer waits** If continued year on year increase in referrals then risk to compliance with CWT standards. Risk may be increased if unable to recruit and retention of key clinical staff (oncologist and histopathologists) in particular in sub specialisation areas that rely on a single handed practitioner.	S(3)xL(2) = 6 , Low Risk	Controls: • CWT pathway (62 days for treatment, and 28 days to diagnosis.) • National standards • Cancer Peer review • Dorset strategy • RCA and LERNs • Patient experience • Performance standards and performance monitoring • Recruitment and retention strategy Assurances: • Case load status – days to diagnosis/days to treatment	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Board of Directors • Healthcare Assurance Committee • QARC • Finance and Performance Committee
	For patients with routine elective care, reduce the number of people waiting longer than 52 weeks for their treatment compared to 2019/20, working towards zero referral to treatment (RTT) waits over 52 weeks and total waiting numbers no greater than January 2020.	DP	Donna Parker/ Sarah Macklin	808	**Risks to regulatory performance compliance, patient delay and dissatisfaction if RTT related targets for 2020/21 are not met** 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 for 2020/21 are not met, namely: 1) Total waiting list to be no greater than Jan 2020 2) No 52 week waiters 3) RTT delivers to agreed operational plan trajectory for 2020/21 4) Recognise RTT standard is 92% (national NHS constitution target) and should be delivered where possible	S(4) x L(4)=16 High Risk	Controls: • RTT performance (total waiting list, 18wks, 26wks, 52wks) • Monthly performance meetings • Validation and tracking process • SOPs in place for booking • Polling ranges managed to support booking within target dates • Review services with hub and spoke model of service (visiting Clinicians) between RBH and PGH in order to ensure equitable timely access • RCA for any 52 week wait breaches and learning in place & deep dive into 40+ week waiting list • CCG monitoring and NHSI • Capacity and demand tool utilisation • Links to outpatient QI – capacity release Assurances: • Waits over 52 weeks against Jan 2020 threshold	S(3) x L(2) = 6 , Low Risk	Monitoring Committee: • Audit Committee • Board of Directors • Healthcare Assurance Committee • Trust Management Board • Finance and Performance Committee
	For patients requiring diagnostics to improve the responsiveness and by year end to recover the national standards relating to 99% within 6 weeks	DP	DP	No risk identified by SLT. BAF risk not required.					
	Support the National field testing and subsequent implementation of the new A&E standard. Improve Urgent and Emergency Care (UEC) performance in the Emergency Departments, to be better than 2019/20.	DP	DP	801	**Urgent and Emergency Care (UEC) performance** There is a potential risk to patients waiting in excess of National Standards	S(4) x L(4)=16 High Risk	Controls: • Compliance with National Standards • Performance review against metrics (ie to improve on 2019/20 –performance) • Efficient patient pathways with in UEC care • Link to Risk 691 (Ambulance Queues) • Link to Risk 813 (UTC Capacity) • Link to Risk 806 (Making Every In-Patient day count) Assurances: • Current UEC performance	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • QARC • Board of Directors • Healthcare Assurance Committee • Trust Management Board • Finance and Performance Committee • Care Group and Directorate Governance Meetings

	Objective	Lead	Risk Owner	ID	Risk Description	Current Risk	Controls & Assurances	Target Risk	Monitoring Committee
	Achieve 92% bed occupancy*, by a mix of reducing patients "stranded" in hospital, when not requiring acute inpatient care, increasing same day emergency care (SDEC) and fully embedding the Dorset Integrated Care System 'Discharge to Assess' (D2A) model across all of our hospitals. *consistently reviewed and parameters adjusted accordingly in light of Covid.*	DP	Donna Parker	806	Making Every Inpatient Day Count Programme Risk of patient harm and/or inefficiency caused by flow and care/treatment delays through admission/inpatient pathways	S(4) x L(4)=16 High Risk	Controls: • QI Programme governance structure/process in place • Overall QI Programme progress against milestones • Non elective admission levels stabilised or reduced • Bed occupancy % • Length of Stay reduced/sustained, • Outliers reduced • Stranded patients reduced to national target level • Sitrep escalation reports • Delayed transfers of care • Serious incidents/LERNs/complaints • Agreed bed configurations achieved • Patient moves • QI Programme specific issues/risk log Assurances: • Current performance against bed occupancy %	S(2) x L(4) = Moderate Risk	Monitoring Committee: • Board of Directors • Healthcare Assurance Committee • Trust Management Board • Finance and Performance Committee
	Continue snapshot audits of compliance with core 7 day service standards, which will inform the impact of workforce changes made in response to Covid-19	AOD	Ruth Williamson	798	7 day services If we continue to demonstrate a deteriorating performance in relation to the NHSE/I National Standards for 7 day working there is a potential risk that of patient safety concerns in addition to reputational and contractual failure	S(2)xL(2) = 4 , Low Risk	Controls: • Compliance with Standard 2 – consultant review within 14 hours • Compliance with Standard 8 – twice daily of patients with high acuity needs • Compliance with Contractual requirements • Improved performance against audit of standards 2 and 8 • Incidents/complaints Assurances: • Current performance against the two standards	S(2) x L(1) = 2, Very Low Risk	Monitoring Committee: • Audit Committee • Board of Directors • Healthcare Assurance Committee • Medical Staff Committee
	Provide excellent infection prevention and control to minimise the number of hospital acquired infections below trajectory for MRSA,Clostridium difficile, MSSA, Ecoli and Covid-19.	PS	Trish Turton	686	Prevention of healthcare associated gram negative blood stream infections. There is a potentially avoidable risk of patient harm for those patients who contract hospital acquired gram negative infections.	S(2)xL(3) = 6 , Low Risk	Controls: • Performance against trajectory • NHS Improvement aim to reduce the number of reported gram negative bacteraemia's by 50% by 2021 • National Benchmarking • Effective Screening process (Sepsis and deteriorating patient protocols) • Rates of gram negative Hospital acquired urinary tract infections • Rates of gram negative Hospital acquired bacteraemia's • Fully implemented Post infection review toolkit • Compliance with Hand Hygiene policy • Compliance with management of urinary catheters policy • Compliance with prevention of HCAI policy • Compliance with WHO safe surgery checklist • Compliance with use of antimicrobials policy • RBCH Action plan linked into the Dorsetwide action plan. policy • CVAD policy Assurances: • Current performance against trajectory	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Infection Control Committee • Healthcare Assurance Committee
		PS	Trish Turton	898	Risk that staff and patients may contract hospital acquired covid infection as a result of inadequate or insufficient infection prevention and control processes and procedures	S(4) x L(3) = 12 Moderate Risk	Screening, PPE standards, visitors policy, staff testing, green and red patient pathways, NICE guidance, PHE guidance, monitoring, single room criteria, cohorting policy, contact tracing	S(2)xL(3) = 6 , Low Risk	Monitoring Committee: • Infection Control Committee • Healthcare Assurance Committee
To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people	Strengthen and improve communications/engagement with staff, governors, patients, local people and key stakeholders through a communication and engagement plan, delivered over the year and reviewed by February 2021	DF	DF	No risk identified by SLT. BAF risk not required.					

	Action			Ref	Risk	Risk Rating	Controls / Assurances	Target Rating	Monitoring Committee
	Complete the merger transaction in 2020/21. Establish the new governance arrangements for the new organisation including managing the governor elections and ratification of the new Board	DF	DF	899	Completion of merger and implementation of governance arrangements Risk of merger transaction not being completed within delivery timescales (inclusive of Tier 2/3 recruitment)	S(4) x L (2) = 8 Moderate Risk	Controls: • Merger Transaction plans and outline business case (for 01/10/2020 merger date) • Governance arrangements and Risk Management Strategy agreed by SIB • Governor election process • External Quality governance review (E&Y) • Merger PTIP completion ' Recruitment process Assurances: • Progress against PTIP	S(3)xL(2) = 6 , Low Risk	Monitoring Committee: • Board of Directors • Audit Committee • Trust Management Board
	Recruit to the new management structure at Tier 2 by September 2020, and Tier 3 by December 2020								
	Continue to implement the integration and organisation development plans, bringing services together and developing ownership for the shared vision and values, with a review of progress by March 2021.	RR	RR	No risk identified by SLT. BAF risk not required.					
	Develop the University partnership, including agreeing the MOU and a multi-year programme of collaboration by November 2020.	RR	RR	No risk identified by SLT. BAF risk not required.					
To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	Commencing work on the Theatres development at Poole Hospital by July 2020	RR	RR	No risk identified by SLT. BAF risk not required.					
	Securing approval for the OBC for the £147 million, for the creation of the planned and emergency sites,with submission to NHS I by July 2020.	DF	DF	848	There is an overarching risk that the One Acute Network Portfolio of Programmes (inlcuding OBC) will fail to deliver to Time, Cost and Quality requirements.	S(4) x L(3) = 12 Moderate Risk	Extensive and effective Planning and Scoping stage Developing and agreeing its Outline Business Case (OBC) Full Business Case (FBC)agreed Identified Time, Cost and Quality requirements Confirmation of the viability of delivery of the Portfolio scope to Time, Cost and Quality. Achievement of the required Portfolio outcomes.		Monitoring Committee: • Board of Directors • Trust Management Board • Estates Committee
	Developing and implementing a decant plan for the two sites by July 2020	RR	RR	No risk identified by SLT. BAF risk not required.					
	Agreeing and implementing a new Sustainable Travel Plan with staff and BCP Council to meet the trajectory required for the planning approval and to provide an annual review and update	RR	RR	1006	If a there is not a Sustainable Travel Plan for agreed with staff and Bournemouth, Christchurch and Poole Council within requirements this may potentially impact on the success of the merger	S(3) x L (3) = 9Moderate Risk	Controls: • Agree and implement a new Sustainable Travel Plan with staff and BCP Council to meet the trajectory required for the planning approval • Provide an annual review and update of the agreed Travel Plan Assurances: • Progress to agreed plan	S(2) x L(2) = 4 Low Risk	Monitoring Committee: • Board of Directors • Trust Management Board • Health Assurance Committee • Workforce Strategy Committee
	Establishing robust arrangements for taking forwards Health Infrastructure Plan (HIP) with Dorset partners and NHSI/E, such that a Dorset programme Strategic Outline Case is submitted before March 2021	RR	RR	1007	Progression of Health Infrastructure Plan (HIP) To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	S(2) x L(2) = 4 Low Risk	Controls: • Arrangements for taking forwards Health Infrastructure Plan (HIP) with Dorset partners and NHSI/E agreed • Dorset programme Strategic Outline Case submitted before March 2021 Assurances: • Progress to submission Dorset Steering Group established & project team being formed. Very large & complex multi-site set of projects, so will require significant programme management	S(2) x L(1) = 2, Very Low Risk	Monitoring Committee: • Board of Directors • Trust Management Board • Audit Committee

	Continue to build effective relationships with all local partners, including the two new local authorities, especially through full engagement with the Health and Wellbeing Boards (HWBs), with an annual self-assessment to measure progress;	DF	DF	1008	Effective relationships with local partner To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	S(2) x L(2) = 4 Low Risk	Controls: • Full engagement with the Health and Wellbeing Boards (HWBs) • Prioritise the two new local authorities • Completion of annual self - assessment Assurances: • Outcome of self-assessment	S(2) x L(1) = 2, Very Low Risk	Monitoring Committee: • Board of Directors • Trust Management Board • Audit Committee
	Play an active part in creating effective governance and implementation arrangements that will 'de-clutter' the Dorset ICS, improve performance and allow for 'System by Default' with an annual self-assessment to measure progress;	DF	DF	1008	Effective relationships with local partner To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	S(2) x L(2) = 4 Low Risk	Controls: • Full engagement with the Health and Wellbeing Boards (HWBs) • Prioritise the two new local authorities • Completion of annual self - assessment Assurances: • Outcome of self-assessment	S(2) x L(1) = 2, Very Low Risk	Monitoring Committee: • Board of Directors • Trust Management Board • Audit Committee
	Play an active part in the key Dorset transformation plans programmes, including Digital Dorset, by implementing four core clinical applications (Dorset Care Record, order communications, electronic prescribing and medicines administration, health of the ward) and support the clinical leaders of these programs transform clinical processes to achieve the maximum benefit from these investments; migrate all devices to Windows10, stabilise the underlying infrastructure and mitigate against all IT security threats	PG	Sarah Hill	805	Clinical Information Systems deployment If the planned deployment projects strategic electronic patient record (SEPR), order communications (OCS), electronic prescribing and medicines administration (EPMA)), Health of the Ward across inpatient, day case and outpatients are delayed or managed ineffectively there is a risk of: 1. the trust not meeting its strategic objectives 2. delayed benefit realisation 3. continued clinical risk associated with paper and electronic processes coexisting. 4. financial impact of cost overruns	S(2)xL(3) = 6 , Low Risk	Controls: Each of these projects is fully budgeted and carefully managed using the nationally recognised project management methodology PRINCE Stakeholders engagement for each project including, and crucially, executive leadership, clinical engagement, clinical safety officers in an assurance role. • Communications strategy • Delivery of milestones in line with project plan • Compliance with financial controls • Project specific issues logs • Effective stake holder engagement and management • LERN submissions/Complaints/patient experience • Staff experience • Project specific Business Continuity Plans Assurances: • Progress against implementation. Strategic electronic patient record - Fully live and in Business as Usual Order communications - Radiology full live and in Business as Usual. Pathology order comms linked and moved to be part of the Pathology LIMS replacement. Electronic prescribing and medicines administration - on hold post COVID 19	S(2)xL(2) = 4 , Low Risk	Monitoring Committee: • Audit Committee • Board of Directors • Informatics Steering Group
		PG	Martin Davis, IT Security Manager	763	Cyber Security Risks, Threats and Vulnerabilities- There are risks related to cyber security that, potentially, can affect the resilience of the Trust's IT systems and data. This could adversely affect all trust business.	S(2)xL(4) = 8 , Moderate Risk	All Trust owned IT Hardware is up to date, patched and supported (significant gaps) All Trust owned IT Software is up to date, patched and supported(significant gaps) Deviations to Hardware and Software are known and accepted (minor gaps) Prompt response to CareCERT and other supplier notifications (adequate controls) Robust Business Continuity planning (adequate controls) Endpoint Protection is installed on all Trust devices (adequate controls) Mandatory cyber security staff training (adequate controls) Number and severity of security breaches monitored (adequate controls)	S(2)xL(3) = 6 , Low Risk	Monitoring Committee: • Audit Committee • Board of Directors • Informatics Steering Group
		PG	Sarah Hill	655	Delays to the implementation of the Dorset Care Record	S(2)xL(3) = 6 , Low Risk	Assurances; achieved 33 component parts (out of 92). Progress is being made but the risk remains.	S(2)xL(3) = 6 , Low Risk	Monitoring Committee: • Audit Committee • Board of Directors • Informatics Steering Group

		PG	Russell King	302	Risk Telecomms Service could be unavailable. The Trust is currently served by two different telecoms service suppliers for its incoming and outgoing lines. Should the route become damaged, the Trust will experience a complete loss of service outbound and inbound.	S(2)xL(2) = 4 , Low Risk	Phase 1 - Migration of oubound lines to new digital technology - complete Poole and RBH Phase 2 - Migration of our inbound services - Business case produced, due to be reviewed on 22th July. If funding is secured, work to begin Sept/Oct 2019. [08/06/2020 09:31:09] Work still ongoing – the first part of the Inbound work should have been completed on Friday last week (05th June), but had to be postponed as the Service Provider (Gamma) had not completed configuration at their end. Waiting for a new date. The migration of inbound has been delayed due to the Covid19 situation – all parties involved being on reduced staffing levels and restricted working.	S(1)xL(1) = 1 , Very Low Risk	Monitoring Committee: • Audit Committee • Board of Directors • Informatics Steering Group
		PG	Sarah Hill	286	There is a risk of total outage of the computing services at RBCH if the single point of failure of electrical supply fails	S(3)xL(1) = 3 , Very Low Risk	Server migration from RBH Data Centre to Poole Data centre - 69 out of 131 services/servers have been completed Essential Power supply - this is already in place - but feeds the UPS which is the single failure 03/05/2019] Many virtual ones have moved, but still housing about 20-30 servers, including CaMIS servers. The main risk is the single point of failure on electrical supply but although the impact is high the liklihood is low with the generator on site. Therefore reducing the risk but also putting review in 3 months as progress is slow	S(1)xL(1) = 1 , Very Low Risk	Monitoring Committee: • Audit Committee • Board of Directors • Informatics Steering Group
To actively engage in the other Dorset ICS portfolios, (Prevention at Scale, Integrated Community and Primary Care, Leading and Working Differently) to support progress against the annual plans of these work programmes.		AOD	AOD	No risk identified by SLT. BAF risk not required.					

JOINT BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.6

Subject:	Quality Strategy and Monitoring plans for 2020/21

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk
Presented by:	Paula Shobbrook, Director of Nursing and Midwifery RBCH Patricia Reid, Director of Nursing and Midwifery, PHFT

Purpose of paper:	To approve the 2020/21 Quality Strategy and associated monitoring tool for Poole Hospital NHS Foundation Trust. To approve the 2020/21 Quality Strategy and associated monitoring tool for The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust. The Quality Strategy for each Trust will apply and will be monitored quarterly until planned merger on the 1st October 2020.
Background:	A Quality Strategy was approved by the Shadow Interim Board for the University Hospitals Dorset NHS Foundation Trust in March 2020 for 2020/21. As merger has been delayed, separate Quality Strategy documents have been developed for each Trust. A monitoring tool for each Trust has also been developed and is based upon the quality improvement priorities (pages 13-15) within the strategy. The quality priorities in all 3 Quality Strategy documents are the same. The monitoring tool is triangulated to the CQC key lines of enquiry, strategic objectives and the separate Trust Risk Registers.
Key points for members:	Separate Quality Strategy documents will be in place for each Trust until merger. Separate monitoring tools will be in place for each Trust until merger. Progress will be monitored via the Joint Quality Committee.

	Monitoring will commence in July 2020, with the first formal progress report being submitted to the joint Quality Committee at the end of Quarter 2 in September 2020. Once populated, the front summary sheet of the monitoring tool will complete automatically to give an overview of progress as it is linked to the individual components. Please note that the text in red is an example only and does not reflect the final actions for the coming year Q3 and Q4 reports will be submitted to the joint Quality Committee of the merged Trust as per the reporting cycle.
Options and decisions required:	For approval
Recommendations:	For approval
Next steps:	Following formal approval of the Quality Strategy and monitoring tool, for use in the interim pre-merger period, monitoring will be implemented from July 2020 for each Trust.

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Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trusts Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	All
BAF/Corporate Risk Register: (if applicable)	Yes
CQC Reference:	All Domains

Committees/Meetings at which the paper has been submitted:	Date
Quality Strategy only to Shadow Board	March 2020

NHS
Poole Hospital
NHS Foundation Trust

Quality Strategy

2020 - 2022

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Foreword

Debbie Fleming
Chief Executive

I am delighted to present our Quality Strategy for the years 2020 - 2022 which reaffirms and strengthens our commitment to deliver high quality care in Poole Hospital NHS Foundation Trust

This Strategy supports the achievement of our strategic objectives and specifically sets out the mechanisms that will provide robust quality governance arrangements whilst we continue to develop our services and work towards our goal of delivering outstanding care to our patients and their families.

The delivery of high quality care is dependent on the trust continuing to build its capacity and capability for learning and applying methods of Quality Improvement (QI). As a trust we understand that adopting a systematic approach to drive improvements in quality can enable us to build on our good foundations ensuring sustainability in our improvement.

A key focus for the next two years therefore, will be to harness the enthusiasm and skill of our early pioneers in improvement science and QI to develop and build a clear organisational framework across the trust that also recognises the changing face of healthcare in Dorset. The increasing importance for organisations to work together will be crucial if we are to achieve high quality care during reconfiguration and service development.

Our Strategy, as always, continues to support the core values of compassion, openness, respect, accountability, and safety and it is so important that these values remain at the heart of everything we do.

Introduction

A quality strategy details the aims, objectives, time-scales, responsibilities and monitoring processes of how to achieve the Trust strategic goals for patient safety, patient outcome and patient experience.

The overall aim of the Quality Strategy is to ensure that there is a robust quality framework in place which will assure the Board of Directors that the organisation has the ability to provide safe, high quality care, is compliant with the CQC regulations, and continues to strive for further quality improvements.

High quality care is at the centre of everything we do and maintaining and improving the quality of patient care remains the top priority for the trust. This vision is underpinned by the Trust's values and is delivered through the five key strategic objectives:

- To be a great place to work, by creating a positive, open and inclusive culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best
- To ensure that all resources are used efficiently to establish financially sustainable services and deliver key operational standards and targets
- To continually improve the quality of care so that services are safe, compassionate, timely and responsive - achieving consistently good outcomes and an excellent patient experience
- To be a well-governed and well-managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people
- To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community

We recognise that our most valuable asset is our staff and the Quality Strategy dovetails into other important strategic documents such as the trust Annual plan, Annual Quality Report, Risk Management Strategy and People Strategy. Together these documents set out our commitment to improve the quality of learning, education and training. Central to this is developing the collective leadership for quality improvement and a culture that enables individuals and teams to flourish.

> *'Improvements in the quality of care do not occur by chance. They come from the intentional actions of staff equipped with the skills needed to bring about changes in care, directly and constantly supported by leaders at all levels'*
>
> The Kings Fund [1]

This strategy also takes into account the key changes taking place across the NHS (as set out in the NHS Long Term Plan, January 2019) to ensure that as a Trust we meet not only our own aspirations for improving quality, but also the expectations of our partners in the newly emerging Integrated Care System.

Background

In 2008, a national review of quality by Lord Darzi, led to the widespread implementation of his recommendations to achieve 'High Quality Care for All' (2008). The report set out an ambition for quality to be at the heart of everything we do and determined that in the NHS quality includes the following dimensions:

- Patient safety.
- Patient experience.
- Patient Outcomes.

> *'High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. [2]*

In support of quality, governance processes must ensure that:

- There is clarity about what high quality care looks like and how it is measured;
- It is shared openly with patients and professionals;
- There is provision of strong and supportive clinical leadership to empower staff, recognise success and encourage innovation;
- Internal and external scrutiny and regulation provides assurance to patients and the public.

The Darzi report was followed by the Government's commitment to quality through legislation (the Health and Social Care Act, 2008). To ensure organisations operate within this legislation, the Care Quality Commission (CQC) was established as the official regulator of the NHS. The CQC continually reviews NHS performance against 'fundamental standards of quality and safety' (CQC 2014). Additionally the measures of quality have been explicitly set down in the recent governmental white paper entitled 'Equity and Excellence for All' (Department of Health (DoH) 2010) and its associated document 'The NHS Outcomes Framework' (DoH 2010). The Francis Reports 2010 and 2013 also cite the importance of clear vision and transparent operating partnered with a duty of candour to ensure quality is embedded and appropriately risk assessed in any process within the Trust.

In February 2016, NHS Improvement published, *Implementing the Forward View: Supporting providers to deliver.*

A single shared view of quality

High-quality, person-centred care for all, now and into the future

The NHS Five Year Forward View confirms a national commitment to high-quality, person-centred care for all and describes the changes that are needed to deliver a sustainable health and care system.

For people who use services

Building on our existing definition of quality, the areas which matter most to people who use services:

- **Safety**: people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned.
- **Effectiveness**: people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.
- **Positive experience**:
  - **Caring**: staff involve and treat you with compassion, dignity and respect.
  - **Responsive and person-centred**: services respond to people's needs and choices and enable them to be equal partners in their care.

For those providing services:

We know that to provide high-quality care, we need high performing providers and commissioners working together and in partnership with, and for, local people and communities, that:

- Are **well-led**: they are open and collaborate internally and externally and are committed to learning and improvement.
- **Use resources sustainably**: they use their resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture.

Are **equitable for all**: they ensure inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

Well-led / Positive experience (caring and responsive) / High-quality, person-centred care for all / Effective / Safe / Sustainable use of resources

The Trust Quality Strategy supports all of the above guidance and recommendations. The strategy also meets the National Quality Board "Shared Commitment to Quality".

Trust Objectives

Strategic Objectives 2020/21

1. To **be a great place to work**, by creating a positive, open and inclusive culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best

2. To ensure that all **resources are used efficiently** to establish financially sustainable services and deliver key operational standards and targets

3. To continually improve the **quality of care** so that services are safe, compassionate, timely and responsive - achieving consistently good outcomes and an excellent patient experience

4. To be a **well-governed** and well-managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people

5. To **transform and improve our services** in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community

Roles and Responsibilities for Quality Governance

Whilst frontline individuals and clinical teams are responsible for delivering high quality care, it is the responsibility of the Board of Directors to create a culture within the organisation that enables clinicians and clinical teams to work at their best.

The overall responsibility for delivery of the quality agenda rests with the Chief Executive. This responsibility is delegated to the Director of Nursing, in conjunction with the Medical Director, who has executive responsibility for ensuring that risk management, patient safety, quality and patient experience is delivered throughout the organisation and remains a Trust priority and an integral part of the Trust policies and procedures.

Leadership of Quality

Trust Board: Responsible for assurance, oversight and sponsorship of quality priorities.

Chief Executive: Accountable for the overall quality of trust services.

Quality Safety and Performance Committee: responsible for ensuring the trust delivers and drives the key principles of quality and assures safe, clinically effective, patient centred care.

Director of Nursing and Medical Director: Accountable for the delivery of the quality strategy.

Associate Director of Quality Governance and Risk: Manages and coordinates the quality agenda.

Care Group Leadership Team: Responsible for monitoring quality metrics and leading work to improve quality within all services.

All staff: Responsible for compliance with professionals standards and trust policies, raising concerns when there are potential threats to quality and working collaboratively to improve services.

Figure 1. Leadership of Quality

All Executive, Non-Executive Directors and Senior Leaders in the trust engage with front line staff, patients and carers through a variety of forums to enable them to contextualise the information they receive and become familiar with the care environment and clinical practice including:

- Filmed patient stories and Care Conversations.
- Executive Walkabouts.
- Internal peer reviews
- Themed engagement events
- Focus groups
- Staff briefing sessions
- Open days and engagement events.

Measurement of our performance

Quality Governance describes the structures and processes in place to provide adequate leadership and scrutiny of quality to ensure high quality care is delivered and risks are understood and managed at all levels of the organisation. Our comprehensive reporting frameworks for the Board and its subcommittees promote transparent and open reporting and are underpinned by directorate structures that provide identification and early resolution of problems.

We measure our quality performance using a broad range of indicators (Figure 1). These indicators are triangulated through Trust and Directorate governance meetings and Ward to Board reporting.

Patient and family feedback including patient surveys, focus groups, complaints, complements	**Measures of harm**	**Measures of the reliability of critical safety processes**
National and local audit	**NICE Compliance**	**Capacity to respond to and learn from safety information**
Data on staff satisfaction attitudes, awareness and feedback	**Death in hospital reviews, mortality, inquest and Medical Examiner process indicators**	**Staffing levels and skill mix**
Compliance with fundamental standards of care	**Incident reports and reporting levels**	**Claims and litigation**

Figure 2. Sources of data for measurement of quality

Scrutiny of our services

Reporting our performance

Mechanisms are in place to provide two way transfer of information from the front line staff up to the board and back again. Quality reporting through established governance structures supports to review, analysis and delivery of key metrics related to patient experience, safety and effectiveness of services up to the board of directors.

All Performance and Quality reporting in the new organisation will be based on the CQC key lines of Enquiry (Safe, Caring, Responsive, Effective and Well Led). Board and Board subcommittee reporting will support wider quality assurance processes such as peer review, annual self-assessment and internal and external audit.

Information in the Board and Quality Committee reports will routinely include:

- Locally defined priorities and performance against them
- National requirements and performance against them
- High priority outcomes and actions
- Exception reporting and risk based narrative commentary
- Trends – current and future risk, assurance and quality issues
- Internal comparisons and external benchmarks
- Directorate, specialty, ward and consultant level data where appropriate
- Quantitative and qualitative data
- Patient stories
- Statistical interpretation and analysis

Specific metrics will include:

Monitoring Committee/Group	CQC Key line of Enquiry	Quality Metrics
Board Quality Report	Safe	Serious Incidents Never Events CAS Alerts CQC Insight KPIs
	Caring	Privacy and dignity, single sex accommodation
	Effective	CQUIN (quarterly), National Patient Survey results Mortality
	Responsive	Complaints Actively engaging with patients
	Well Led	Risks 12+
Quality Safety and Performance Committee	Safe	Patient safety Incidents Staff Accidents Medication Incidents Radiation Incident (CQC) Hospital Acquired Infections, Saving Lives KPIs
	Caring	Privacy and dignity, single sex accommodation
	Effective	Mortality(HSMR, SHMI, learning from deaths, Medical examiner results) NICE compliance National Clinical audits NCEPOD / Mental Health Act
	Responsive	Complaints, Safeguarding Incidents (Inc. Cause for concerns, DOLS)

Monitoring Committee/Group	CQC Key line of Enquiry	Quality Metrics
	Well led	External reports, including Royal College reports
Trust Quality Governance Group		As above
Directorate Risk and Governance Groups		As above – Key metrics to be included as standard agenda items (as set out in the Trust Risk Management Strategy).
Ward Meetings	Safe	Patient safety Incidents Staff Accidents Medication Incidents Hospital Acquired Infections, Saving Lives KPIs, Hand hygiene
	Caring	Privacy and dignity, single sex accommodation
	Effective	eNA, eObs, VTE risk assessment, Dementia risk assessment
	Responsive	Complaints, Patient moves, outliers, delayed transfers,
	Well led	Risks 12+, Essential Core skills, Staffing and skill mix, staff survey results

The Board additionally monitors the effectiveness of quality governance through progress against the annual quality plan and the Board Assurance Framework.

External

Externally, the Trust is reviewed by a range of external organisations and stakeholders. These include:

- CQC – review of compliance against the CQC regulatory framework and Key Lines of Enquiry (KLOE) via announced and unannounced reviews and inspections.
- NHSI – review of compliance against NHS Improvements Well-led Framework
- Clinical Commissioning Groups – review of compliance against National and local CQUIN targets and contractual quality provisions, outcomes and assurance, routine and ad hoc inspections
- Local Healthwatch – review and publically comment on the Trust Annual Quality Report
- Council of Governors – routine monitoring of patient safety, patient experience and patient outcome measures, risks and performance
- Local Health Overview and Scrutiny Committees -review and public comment on the

Trust Annual Quality Report

- External Auditors - review and public comment on the Trust Annual Quality Report, completion of annual Internal Audit plan.
- Dorset Quality Surveillance Group as part of the Integrated Care System.

Sharing progress with patients and the public occurs through the Trust Member Newsletter, meetings and open days. The Annual Quality Account reports on the quality of trust services including progress with our quality priorities and is published on our public website in June each year.

Developing our quality governance

The NHS is facing unprecedented changes and the landscape of healthcare in Dorset is developing to meet the future needs of the population. The formation of the One Acute Network and the wider Integrated Care System (ICS) is supporting the development of new and stronger relationships with partner agencies.

The merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust on the 1 October 2020 also introduces new challenges and opportunities for patient safety and quality. The merger provides a catalyst for us to review our governance processes, amalgamate and implement the best of both and ensure that they align with the changing face of healthcare.

During the life of this strategy we will:

- Review our care group and directorate based risk and governance processes to ensure they reflect the organisation of services and effective triangulation of quality metrics.
- Embed our Risk Management Strategy. The strategy has been aligned with the ICS risk framework and will provide a robust structure for identifying and controlling all risks, whether clinical, financial, organisational or reputational.
- Embed a Quality improvement culture across the Trust and empower staff to improve services and processes in place.
- Seek to further develop the use of quality assurance processes such as 'Peer review' and 'back to the floor Friday' to provide opportunities for senior nursing and therapy staff to spend time in practice directly observing care whilst listening to staff and patient.
- Establish a new series of executive quality walkabouts to provide senior managers, executive directors and non-executives the opportunity to engage with a wider range of clinical and non-clinical areas.

Our quality priorities

The relationship between our values, strategic objectives and quality priorities are expressed within the Quality Wheel [5] (Figure 1.)

The trust's quality priorities are arranged within the domains of quality; safety, patient experience and clinical effectiveness (clinical outcomes). High quality care can only be achieved when all three of these domains are present equally and simultaneously. Additionally we recognise the fundamental role that our staff play in delivering high quality care and our people strategy therefore forms the fourth domain of our quality strategy.

Individual priorities within each domain are derived from the national guidance and triangulation of internal data from a variety of sources including patient feedback, external stakeholders, regulators, governors and incident reports.

We take an inclusive approach in the way we deliver quality improvement, recognising that a variety of techniques can lead to improvement.

A. Approach philosophy
B. Pillars of Quality – focus of priorities
C. Workstreams and processes
D. Strategic goals
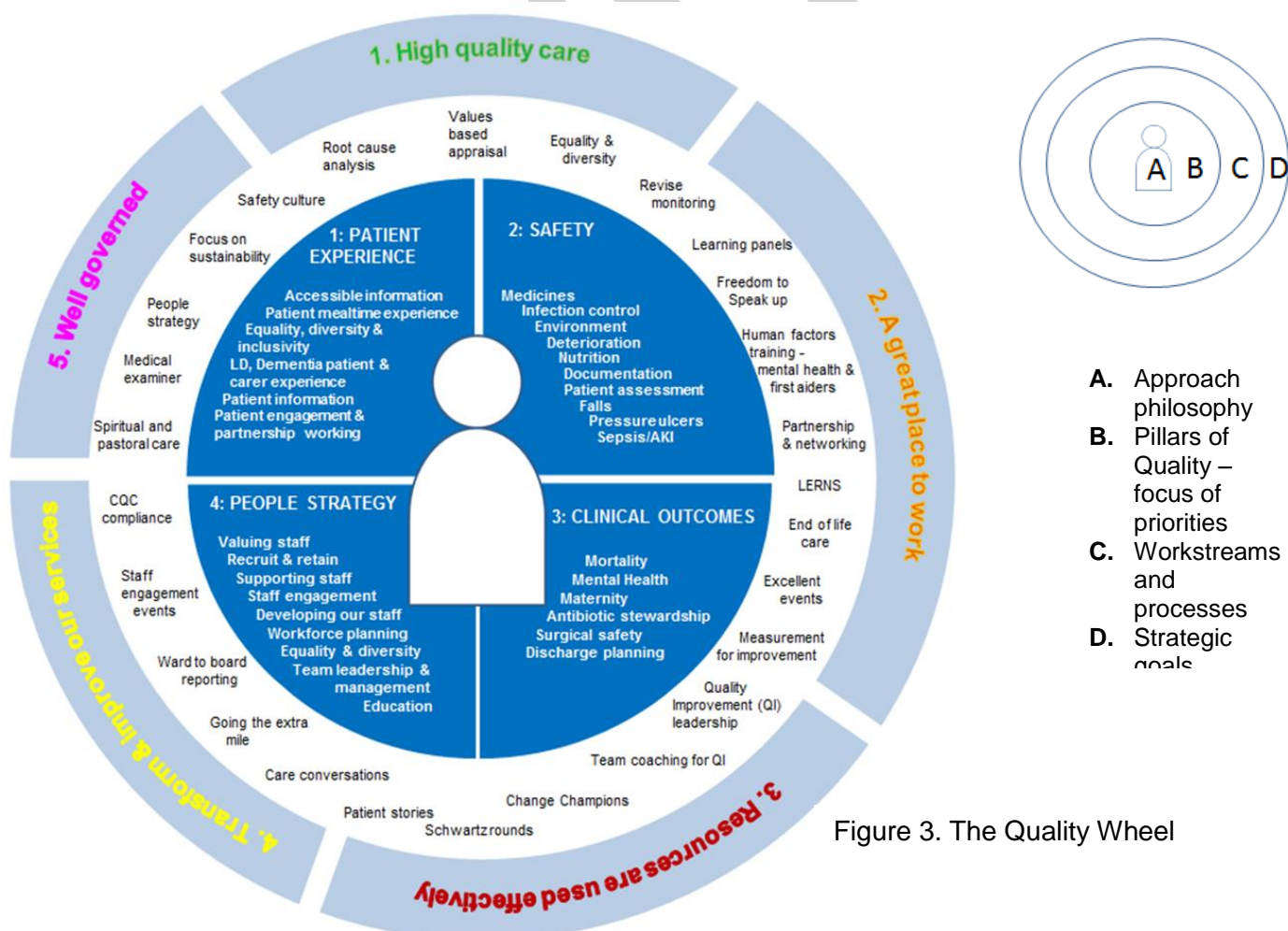
Figure 3. The Quality Wheel

Patient experience

The involvement of patients and their families in care is central to developing a positive patient experience. Fundamentally, we aspire to care for all patients as individuals and devise care plans which are personal to their needs. When developing services we aspire for patients and the public to have a voice in that planning process and when possible lead it. In support of this we adopt the two dimension engagement model in figure 4 below. Establishing this model fully and further improving our patient experience is a cornerstone of strategy for high quality care.

Dimension of engagement: a continuum from basic levels of involvement with limited decision making, towards higher levels of engagement where power and decision making are shared.

Co-production (co-lead)

Collaboration (partnership working)

Involvement (opinions used to make decisions)

Feedback or Consultation (surveys, seeking collective opinions & views)

Dimension of healthcare: individual patient care, ward or service level, organisation, whole pathway, policy/strategy development.

Figure 4: Patient engagement model, promoting two dimensions of engagement

Our priorities to further improve patient experience are:

Patient information and effective communication:

- Increase availability of accessible information
- Enhance communication with patients, carers and families in ways that are effective and delivered with care and compassion
- Review access and quality of translation/interpreter services
- Work with partner agencies to align the quality and format of patient information
- Work with the Patient Information Forum to develop and pilot a new National Quality Mark for Patient Information.
- Establish a new Patient Information Group for University Hospitals Dorset NHS Foundation Trust.

Further develop the way we engage with patients, carers, family and friends:

- Develop our Expert by Experience programme, with a focus on inclusivity.
- Establish a new Patient Experience group for University Hospitals Dorset NHS Foundation Trust.
- Create and recruit Patient Partners in our Quality Improvement Projects.
- Develop Trust-wide engagement through the Patient Experience and Engagement

programmes such as Care Conversations.

- Engage our volunteers in developing new ways to support improvements in patient experience.
- Continue implementation of the Dorset Carers strategy.

Develop the way patient experience intelligence is collected and utilised:

- Develop and implement an audit programme incorporating the national patient experience standards and assessment of the care environment
- Further develop the way patient experience intelligence is shared with and utilised by the Care Groups.
- Improve the identification and dissemination of learning from complaints across the Trust.
- Review how patient experience intelligence is utilised and translated into quality improvements. Review how patient experience intelligence is triangulated and translated into quality improvements.
- Utilise patient experience data to help evaluate and assess effectiveness of Quality Improvement projects.

Patient safety

The Trust is committed to continue to engage with any new national patient safety campaigns and any safety collaborative established by the Academic Health Science Networks, CCG or NHS Improvement.

Our priorities for patient safety are:

Pressure ulcer prevention

- To ensure all patients are risk assessed with the Waterlow tool within 6 hours of admission and within 12 hours of transfer between hospital wards.
- For all patients to have a documented personalised care plan for pressure ulcer prevention.
  .

Reducing the number of falls and falls with injury

- To ensure all patients are risk assessed within 6 hours of admission and within 12 hours of transfer between hospital wards.
- For all patients to have a documented personalised care plan for falls prevention.
- To ensure all patients have a lying and standing blood pressure taken and recorded during their admission
- To ensure all patients at risk of falls have a recorded medication review during their admission.

Nutrition

- To ensure all patients are risk assessed using the Malnutrition Universal Screening Tool (MUST) on admission and at regular intervals and that plans are in plan to support nutritional needs.

Improving Mental Health pathways for patients

- To develop a trust Mental Health Strategy.
- Develop mental health champions and Mental Health First Aiders across the Trust.
- Develop training programmes in partnership with mental health partners.

Medication safety

- To introduce electronic prescribing across the Trust
- Implement ward to board reporting and reflection to maximise learning from medication safety incidents
- Standardise policies, procedures and training for the safe prescription and administration of anticoagulants
- Standardise policies, procedures and training for fluid management
- To improve standards for the safe storage of medicines
- To adhere to legislative requirements for controlled drugs

Clinical Effectiveness

At Poole Hospital NHS Foundation Trust to reduce variation and ensure the best possible clinical outcomes, we strive to ensure our patients are provided the most effective evidence-based care. It is recognised that to ensure the best possible clinical outcomes, the key fundamentals of quality are realised as illustrated in the Quality Wheel (figure 1). The Trust participates in a robust clinical audit and clinical outcomes programme and over the forthcoming years our quality priorities are to:

- Participation in all relevant national clinical audits.

- Ensure effective triangulation and use of our performance data including data from claims, incidents and complaints.

- To further develop our capacity to learn from adverse incidents through review of how our learning panels are conducted and the processes for dissemination of learning.

- Deliver effective seven-day services.

- Improve compliance with the ten maternity standards (NHS Resolution).

- Maintain current high standards for HMSMI (hospital summary mortality index) aspiring to top quartile "lower than expected" mortality.

- Further develop our processes for learning from deaths in hospital including standardising Mortality and Morbidity (M&M) governance structures and implementing a Medical Examiner process for all inpatient deaths.

- Achieve compliance with the "WHO" check list for all invasive procedures.

- Ensure Local Safety Standards for Invasive Procedures (LocSSIPs) are in place for all invasive procedures.

- Improve surgical outcomes by learning from GIRFT (Getting It Right First Time) with full participation in the GIRFT programme.

Keeping on track and strategy delivery

Each of the three pillars of quality; Patient Safety, Patient Experience, Clinical Outcomes/Clinical Effectiveness are monitored through the respective reporting groups in the trust governance framework (Appendix A). Through these groups specific measurable objectives will be set and monitored. This strategy overall will be reviewed annually by the Trust wide Quality Safety and Performance Committee.

The Director of Nursing and Medical Director will monitor the process for governing quality locally to ensure it is being complied with in respect of this strategy. This will be reported at the Care Group and Directorate governance meetings.

Aspects of quality and governance implementation will be subject to monitoring through the annual internal audit review and Annual Quality Account.

References

- The Kings Fund (2016) Improving Quality in the English NHS: A strategy for action.
- Department of Health (2008) High Quality Care for All. NHS next stage review final report.
- Department of Health (2014) Five Year Forward View.
- NHS Improvement (2016) Implementing the Five Year Forward View.
- Luton and Dunstable University Hospital (2018) Quality and Safety Strategy.
- Institute for Healthcare Improvement (2016) Science of Improvement: How to improve.
- NHS Long Term Plan (2019) #longtermplan www.longtermplan.nhs.uk

Bibliography

- National Quality Board (2011) Quality Governance in the NHS – a guide for provider boards.
- National Advisory Group on the safety of patients in England (2013) A promise to learn- a commitment to act: Improving the safety of patients in England. (The Berwick Report).

Related trust documents

- The People Strategy 2

QUALITY STRATEGY MONITORING TOOL 2020-21 - SUMMARY DRAFT1

QUALITY PRIORITIES		Executive Lead	Operational Lead	CQC KLOE	Q1			Q2			Q3			Q4		
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Pressure Ulcer Prevention	1.1	Director of Nursing	Denise Richards - Deputy DoN	S3.2												
	1.2			S3.2												
	1.3			S3.1												
Reducing the number of falls and falls with injury	2.1	Director of Nursing	Denise Richards - Deputy DoN	S3.2												
	2.2			S3.2												
	2.3			S3.1												
	2.4			S3.2												
	2.5			S4.7												
Nutrition	3.1	Director of Nursing	Denise Richards - Deputy DoN	S3.2												
	3.2			S2.5												
	3.3			E1.5												
Improving Mental Health pathways for patients	4.1	Medical Director	John Stephens - Liaison Psychiatrist	E1.1												
	4.2			E1.2												
	4.3			E1.4												
Medication safety	5.1	Medical Director	Nick Bolton - Chief Pharmacist	S4.4												
	5.2			S6.3												
	5.3			S4.2												
	5.4			S4.2												
	5.5			S4.1												
	5.6			S4.2												
Patient information and effective communication	6.1	Director of Nursing	Jenny Williams - Head of Patient Experience	C1.6												
	6.2			C2.1												
	6.3			C2.2												
	6.4			C2.3												
	6.5			C2.3												
	6.6			C2.4												
Further develop the way we engage with patients, carers, family and friends	7.1	Director of Nursing	Jenny Williams - Head of Patient Experience	W7.2												
	7.2			C2.6												
	7.3			C2.5												
	7.4			C2.6												
	7.5			E3.6												
	7.6			S3.4												
Develop the way patient experience intelligence is collected and utilised	8.1	Director of Nursing	Jenny Williams - Head of Patient Experience	R1.1												
	8.2			R2.2												
	8.3			R4.5												
	8.4			R2.1												
	8.5			W6.4												

1.	Pressure Ulcer Prevention
AF1	**To continually improve the quality of care so that services are safe, compassionate, timely and responsive - achieving consistently good outcomes and an excellent patient experience**

Executive Lead:	Director of Nursing	Operational Lead:	Denise Richards - Deputy DoN

Named contact : Edwina Harrocks - Tissue Viability Nurse

Ref	Aim	How will we achieve this	Measure	CQC KLOE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monitoring Committee
					Q1 update			**Q2 Update**			**Q3 update**			**Q4 Update**			
1.1	To ensure all patients are risk assessed with the Waterlow tool within 6 hours of admission.	All nursing staff to be appropraitely trained in the use of eNA Waterlow tool	Percentage eNA compliance within 6 hours	S3.2													Trust Quality Governance group
	Associated risks : ID only ID 1128																
1.2	Patients reassessed within 12 hours of transfer between hospital wards	Patients to be reassessed on transfer ward to ward		S3.2											1.2		Trust Quality Governance group
	Associated risks : ID only ID 1128																
1.3	For all patients to have a documented personalised care plan for pressure ulcer prevention	All nursing staff to be appropraitely trained in the use of eNA Waterlow tool	Percentage compliancewith completion of the Waterlow pressure tool	S3.1													Trust Quality Governance group
	Associated risks : ID only ID 1128																

2.	Reducing the number of falls and falls with injury

AF1 To continually improve the quality of care so that services are safe, compassionate, timely and responsive - achieving consistently good outcomes and an excellent patient experience

Executive Lead:	Director of Nursing	Operational Lead:	Denise Richards - Deputy DoN

Named contact : Fran Rose - Falls Prevention Nurse

					Q1 update			Q2 Update			Q3 update			Q4 Update			
Ref	Aim	How will we achieve this	Measure	CQC KLOE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monitoring Committee
2.1	To ensure all patients are risk assessed within 6 hours of admission.	All nursing staff to be appropraitely trained in the use of eNA	Percentage eNA compliance within 6 hours	S3.2													Trust Quality Governance group
Associated risks : ID only None																	
2.2	Patients reassessed within 12 hours of transfer between hospital wards	Patients to be reassessed on transfer ward to ward	eNA	S3.2													Trust Quality Governance group
Associated risks : ID only None																	
2.3	For all patients to have a documented personalised care plan for falls prevention	All nursing staff to be appropraitely trained in the use of eNA	Percentage compliance with completion of the falls risk assessment	S3.1													Trust Quality Governance group
Associated risks : ID only None																	

2.4	To ensure all patients have a lying and standing blood pressure taken and recorded during their admission	All nursing staff to be appropriately trained in the use of eNA	Percentage eNA complaince	S3.2												Trust Quality Governance group
Associated risks : ID only None																
2.5	To ensure all patients at risk of falls have a recorded medication review during their admission	All nursing staff to be appropriately trained in the use of EPMA	Percentage complaince with medication reviews	S4.7												Trust Quality Governance group
Associated risks : ID only None																

3.   Nutrition

AF 1 To continually improve the quality of care so that services are safe, compassionate, timely and responsive - achieving consistently good outcomes and an excellent patient experience

Executive Lead:	Director of Nursing	Operational Lead:	Denise Richards - Deputy DoN

Named contact : Lucie Rochfort (Camilla Collins) - Therapy Lead Dietetics

Ref	Aim	How will we achieve this	Measure	CQC KLOE	Q1 update Apr	May	Jun	Q2 Update Jul	Aug	Sep	Q3 update Oct	Nov	Dec	Q4 Update Jan	Feb	Mar	Monitoring Committee
3.1	To ensure all patients are risk assessed using the Malnutrition Universal Screening Tool (MUST) on admission	All nursing staff to be appropraitely trained in the use of eNA	Percentage compliance with the Malnutrition risk assessment	S3.2													Nursing & Midwifery Group
	Associated risks : ID only ID 1318 ID 1315																
3.2	Patients are reviewed at regular intervals		Percentage compliance with the Malnutrition risk assessment	S2.5													Nursing & Midwifery Group
	Associated risks : ID only ID 1318 ID 1315																
3.3	Plans are in place to support nutritional needs			E1.5													Nursing & Midwifery Group
	Associated risks : ID only ID 1318 ID 1315																

4.	Improving Mental Health pathways for patients
AF4	**To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community**

Executive Lead:	Medical Director	Operational Lead:	John Stephens - Liaison Psychiatrist

Named contact : Nikki Dawson - Matron Mental Health

Ref	Aim	How will we achieve this	Measure	CQC KLOE	Q1 update			Q2 Update			Q3 update			Q4 Update			Monitoring Committee
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
4.1	To develop a trust Mental Health Strategy	To establish a robust Mental Health Strategy and governance framework which provides assurance of the standards of care for people with challenges to mental health via a Mental Health strategic group. To ensure compliance with relevant legislation i.e. Mental Health Act , Mental Capacity Act. To support the Dorset Crisis Care Concordat. ** ** taken from PHT MH Strategy Plan on a page 2018/21	Establish a quarterly activity and perfromance report. Agree KPI's for key areas of practice. Ensure trust representation on relevent external groups and projects **	E1.1													Trust Quality Governance Group
	Associated risks : ID only ID 1290 ID 1300																
4.2	Develop mental health champions and Mental Health First Aiders across the Trust	For staff to feel safe and well whilst working in the trust. For staff to recognise mental ill health in themselves or colleagues and know how to secure help and support. For staff to feel confident to raise concerns about mental health issues e.g. stress **	a.To introduce and deliver Mental Health First Aid Training across the trust. To communicate the crisis protocol and occupational health pathways. To review key HR procedures to ensure they promote mental wellbeing and are supportive to the needs of those with mental illness **	E1.2													Trust Quality Governance Group
	Associated risks : ID only ID 1290 ID 1300																
4.3	Develop training programmes in partnership with mental health partners	For staff to have the knowledge and skills to meet the needs of patients with mental ill health whilst awaiting specialist assessment and intervention. For staff to feel confident in their ability to care for patients with mental ill health **	To map the current educational provision to staff. To undertake a training needs analysis of staff. To devise a clear training plan for staff which reflects a continuum of knowledge from awareness and mental health first aid to crisis intervention. **	E1.4													Trust Quality Governance Group
	Associated risks : ID only ID 1290 ID 1300																

5.   Medication safety

AF3   To ensure that all resources are used efficiently to establish finantially sustainable services and deliver key operational standards and tagets

Executive Lead:	Medical Director			Operational Lead: Nick Bolton - Chief Pharmacist

Named contact : Ellen Sinden - Pharmacist

Ref	Aim	How will we achieve this	Measure	CQC KLOE	Q1 update			Q2 Update			Q3 update			Q4 Update			Monitoring Committee
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
5.1	To continue the roll out of electronic prescribing across the Trust	EPMA project team will oversee effective implementation on the wards*	EPMA rollout will ensure a reduction in incidents around omitted doses, transcription errors and increase compliance to medication policy and treatment logarithms as well as formulary adherence*	S4.4													Medicines safety & Medicines Optimisation Group
Associated risks : ID only																	
	ID 1295 ID 1224	ID 1334 ID 1333	ID 1239 ID 1223														
5.2	Implement ward to board reporting and reflection to maximise learning from medication safety incidents	Discussion at Medicines Safety and Directorate Risk Meetings and oversight by Medicines Optimisation (MO) Group Quarterly Medicines Optimisation reports to HEG. Shared learning at the DoN, ward leads meetings *	Decrease in number of medication errors. Themes identified reported medication incidents causing severe of moderate harm. Evidence of actions taken ensuring medication safety and shared learning with Medicines Optimisation Group members*	S6.3													Medicines safety & Medicines Optimisation Group

Associated risks : ID only																	
ID 1295 ID 1224	ID 1334 ID 1333	ID 1239 ID 1223															
5.3	Standardise policies, procedures and training for the safe prescription and administration of anticoagulants			S4.2													Medicines safety & Medicines Optimisation Group
Associated risks : ID only																	
ID 1295 ID 1224	ID 1334 ID 1333	ID 1239 ID 1223															
5.4	Standardised policies, procedures and training for fluid management			S4.2													Medicines safety & Medicines Optimisation Group
Associated risks : ID only																	
ID 1295 ID 1224	ID 1334 ID 1333	ID 1239 ID 1223															
5.5	To improve standards for the safe storage of medicines	Regular Peer reviews and medicines management audits Audit results discussed at NMG with Matrons, Sisters/Charge Nurses*	Reduction in Datix incidents around safe storage of medicines*	S4.1													Medicines safety & Medicines Optimisation Group
Associated risks : ID only																	
ID 1295 ID 1224	ID 1334 ID 1333	ID 1239 ID 1223															
5.6	To adhere to legislative requirements for controlled drugs	Monitor adherence to updated Controlled Drugs Policy. Controlled drug audit implemented every 4 months. Daily CD checks. Quarterly CD NHSE reporting tool*	Reduction in Datix incidents around discrepancy in CD running balance and around Governance and Record keeping*	S4.2													Medicines safety & Medicines Optimisation Group
Associated risks : ID only																	
ID 1295 ID 1224	ID 1334 ID 1333	ID 1239 ID 1223															

6.	Patient information and effective communication

AF5 To be a well-governed and well-managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people

Executive Lead:	Director of Nursing		Operational Lead:	Jenny Williams - Head of Patient Experience

Named contact : Jenny Williams - Head of Patient Experience

Ref	Aim	How will we achieve this	Measure	CQC KLOE	Q1 update			Q2 Update			Q3 update			Q4 Update			Monitoring Committee
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
6.1	Increase availability of accessible information	Develop different formats for delivering patient information Increase the number of easy read information leaflets available across the Trust* Working with colleagues at RBCH towards a shared process of developing patient information and monitoring availability of leaflets. Text from 18/19 tool*	Monitor availability of patient information on the wards/departments Monitor the number of easy read leaflets available*	C1.6													Nursing and Midwifery Group
	Associated risks : ID only		None														
6.2	Enhance communication with patients, carers and families in ways that are effective and delivered with care and compassion	Identify any barriers to good communication and customer care Develop opportunities for real-time patient feedback Engage patients and the public to support the design of new staff training opportunities that are easily accessible to front line staff Identify positive role models and engage in local training plans*	Barriers to communication identified and action plan in place Observation of real-time ward/department based communication and customer care*	C2.1													Nursing and Midwifery Group
	Associated risks : ID only																

6.3	Review access and quality of translation/interpreter services	Review provission/contracts in place Review related policy and proceudures	Audit access Quality feedback form users	C2.2										Nursing and Midwifery Group
Associated risks : ID only			*None*											
6.4	Align the quality and format of patient information	Working with partner agencies revise the process of developing information leaflets and increase membership of the newly formed Trust Readership Panel, supporting patient and public feedback as an integral part of patient information production*	Sources of electronic and paper information available in the Patient Experience Hub Monitor the number of leaflets reviewed by the readership panel*	C2.3										Nursing and Midwifery Group
Associated risks : ID only			None											
6.5	Develop and pilot a new National Quality Mark for Patient Information	Work with the Patient Information Forum		C2.3										Nursing and Midwifery Group
Associated risks : ID only			*None*											
6.6	Establish a new Patient Information Group for University Hospitals Dorset NHS Foundation Trust			C2.4										Nursing and Midwifery Group
Associated risks : ID only			*None*											

7. Further develop the way we engage with patients, carers, family and friends

AF5 To be a well-governed and well-managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people

Executive Lead:	Director of Nursing	Operational Lead:	Jenny Williams - Head of Patient Experience

Named contact : Jenny Williams - Head of Patient Experience

Ref	Aim	How will we achieve this	Measure	CQC KLOE	Q1 update			Q2 Update			Q3 update			Q4 Update			Monitoring Committee
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
7.1	Develop our Expert by Experience programme, with a focus on inclusivity			W7.2													Nursing & Midwifery Group
Associated risks : ID only			None														
7.2	Establish a new Patient Experience group for University Hospitals Dorset NHS Foundation Trust	Implement the trusts patient experience 10 key objectives and annual plan 2019/20 -PHT QA report 19/20		C2.6													Nursing & Midwifery Group
Associated risks : ID only			None														
7.3	Create and recruit Patient Partners in our Quality Improvement Projects			C2.5													Nursing & Midwifery Group
Associated risks : ID only			None														

7.4	Develop Trust-wide engagement through the Patient Experience and Engagement programmes such as Care Conversations			C2.6													
Associated risks : ID only			None														
7.5	Engage our volunteers in developing new ways tos upport improvements in patient experience			E3.6												Nursing & Midwifery Group	
Associated risks : ID only			None														
7.6	Continue implementation of the Dorset Carers strategy			S3.4												Nursing & Midwifery Group	
Associated risks : ID only			None														

8.   Develop the way patient experience intelligence is collected and utilised

AF5   To be a well-governed and well-managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people

Executive Lead: Director of Nursing

Operational Lead: Jenny Williams - Head of Patient Experience

Named contact : Jenny Williams - Head of Patient Experience

Ref	Aim	How will we achieve this	Measure	CQC KLOE	Q1 update			Q2 Update			Q3 update			Q4 Update			Monitoring Committee
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
8.1	Develop and implement an audit programme incorporating the national patient experience standards and assessment of the care environment			R1.1													Nursing & Midwifery Group
	Associated risks : ID only		None														
8.2	Further develop the way patient experience intelligence is shared with and utilised by the Care Groups			R2.2													Nursing & Midwifery Group
	Associated risks : ID only		None														
8.3	Improve the identification and dissemination of learning from complaints across the Trust			R4.5													Nursing & Midwifery Group
	Associated risks : ID only		None														

8.4	Review how patient experience intelligence is utilised and translated into quality improvements. Review how patient experience intelligence is triangulated and translated into quality improvements			R2.1													Nursing & Midwifery Group
Associated risks : ID only		None															
8.5	Utilise patient experience data to help evaluate and assess effectiveness of Quality Improvement projects			W6.4													Nursing & Midwifery Group
Associated risks : ID only		None															

NHS
The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust

NHS
Poole Hospital
NHS Foundation Trust

JOINT BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.7

Subject:	Audit and Governance Committee Annual Report

Prepared by:	Carrie Stone, Company Secretary
Presented by:	Philip Green, Non-Executive Director and Chairman of the Audit and Governance Committee

Purpose of paper:	To set out how the Audit and Governance Committee satisfied its terms of reference during 2019/20 and to seek to provide the committee and Board with evidence relevant to its responsibilities for the annual governance statement (previously known as the statement of internal control).
Background:	The attached report is prepared on an annual basis and was submitted to the Audit and Governance Committee on 16 July 2020, prior to submission to the Board of Directors.
Key points for members:	The Committee has complied with its terms of reference during 2019/20 during which time it has: i) reviewed reports prepared by Internal and External Auditors together with the ensuing management actions, where appropriate; ii) reviewed reports prepared by the Counter Fraud Service together with the ensuring management actions, where appropriate; iii) reviewed the risk register and received regular updates; iv) reviewed any Board Assurance Framework Exception Reports and the Annual Board Assurance Framework.
Options and decisions required:	For the Board to note the annual report
Recommendations:	For the Board to note.
Next steps:	The report will be presented to the Council of Governors in July 2020 for information.
Links to Poole Hospital NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	AF5
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well Led

Committees/Meetings at which the paper has been submitted:	Date
Audit and Governance Committee (PHFT)	16/07/2020

POOLE HOSPITAL NHS FOUNDATION TRUST

AUDIT AND GOVERNANCE COMMITTEE

ANNUAL REPORT 2019/20

1   PURPOSE OF THE REPORT

1.1   The Audit and Governance Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference during 2019/20 and seeks to provide the Board with evidence relevant to its responsibilities for the Annual Governance Statement (previously known as the Statement on Internal Control).

1.2   The Audit and Governance Committee terms of reference, which cover the main aspects of the NHS Audit Committee Handbook (HFMA), sets out the constitution, membership, frequency of meetings, quorum, accountability, authority, responsibilities, relationships with other committees, reporting mechanisms, process, communication, monitoring and review.

2   OVERVIEW

2.1   The existence of an independent audit committee is the central means by which a Board ensures effective control arrangements are in place. In addition, the Audit and Governance Committee provides an independent check upon the executive arm of the Board of Directors together with the Quality, Safety and Performance Committee, Finance and Investment Committee and Workforce and Organisational Development Committee.

2.2   The Committee independently reviews, monitors and reports to the Board of Directors on the attainment of effective control systems and financial reporting processes. In particular, the Committee's work focuses on the framework of risk, control, and related assurances that underpin the delivery of the Trust's objectives.

2.3   The Committee receives and considers reports from both internal and external auditors, counter fraud specialists and scrutinises the Trust's annual accounts, financial statements and the annual report.

2.4   A governance cycle detailing which papers are to be expected at each Audit and Governance Committee is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was reviewed in March 2020 and is attached as **Appendix 1**.

3   MEMBERSHIP

3.1   The Committee membership in respect of the financial year 2019/20 comprised of:

- Mr Philip Green, Non-Executive Director and Committee Chairman
- Mr Stephen Mount, Non-Executive Director
- Mr David Walden, Non- Executive Director
- Mr Nick Ziebland, Non-Executive Director

4   COMPLIANCE WITH TERMS OF REFERENCE

4.1   A substantive review of the Committee's terms of reference was undertaken in September 2015 to ensure compliance with the revised governance structure of the Trust and the best practice principles as set out in the HFMA handbook. Membership of the committee was reviewed to ensure that this included a non-executive director with

relevant and recent financial experience. Since that time the terms of reference have been subject to annual review and were noted by the Council of Governors in February 2018 and January 2019.

4.2   The Committee is composed of four Trust non-executive directors. The Trust Chairman may attend meetings at the invitation of the Audit and Governance Committee Chairman. From October 2019 a governor from the Trust's Council of Governors has attended Committee meetings as an observer.

4.3   All meetings in 2019/20 were quorate.

4.4   The Chairman makes himself available should either the External or Internal auditors wish to discuss any matters. It is usual for the External and Internal auditors to attend all formal meetings of the Committee. Non-executive directors of the Trust considered items for internal audit to cover in its 2020/21 plan.

5   MEETINGS

5.1   Six formal meetings were held during the year:

- 16 May 2019
- 22 May 2019 (Special meeting with the Finance and Investment Committee)
- 18 July 2019
- 2 October 2019
- 21 January 2020
- 12 March 2020

5.2   Meeting attendance is detailed in **Appendix 2**.

5.3   The format of the meeting changed in October 2019, the separate Part 2 section having been removed.

6   AUDIT AND COUNTER FRAUD PROVISION

Internal Audit

6.1   Internal audit was provided by BDO during 2019/20.
       External Audit

6.2   The Trust's external auditors to 31 March 2020 were and continue to be KPMG.

6.3   Following a competitive tender and evaluation, KPMG was appointed by the Council of Governors in October 2017 as the Trust's external audit provider for an initial 3-year term from 1 April 2018 to 31 March 2021 with options to extend for a further 2 financial years.

6.4   An assessment of performance was undertaken by members of the finance department and presented to the Committee in October 2019.

6.5   The External Audit Plan for 2019/20 was presented to the Council of Governors in January 2020.

Counter Fraud

6.6   Counter fraud services for 2019/20 were provided by RSM UK. Nationally, Counter fraud services have operational responsibility for ensuring all instances of suspected

fraud and corruption within the NHS are properly investigated and RSM provides this service across Dorset.

7   DUTIES AND FINDINGS

7.1   The Committee's terms of reference require the Committee to review the establishment and maintenance of effective systems of:

Integrated Governance

7.2   The Trust's non-executive directors have a standing invitation to attend the Trust's executive committees.

7.3   The Committee received for scrutiny senior information risk officer (SIRO) reports for information governance across the Trust. These reports were received in May 2019, October 2019, January 2020 and March 2020.

7.4   The Committee received working documents of the Board Assessment of the Terms of Licence and compliance with NHS Improvement's Code of Governance.

Risk Management

7.5   The Committee received a report at every meeting on new red and amber risks added to the Trust's Risk Register since the previous meeting. The Committee also received an annual report on the Trust's Risk Register.

7.6   The Local Counter Fraud Specialist (RSM) formally reported to the Committee meetings held in May, July and October 2019 and January and March 2020 with the Counter Fraud Annual Report for 2018/19 being presented at the May 2019 meeting. The Committee is satisfied that adequate arrangements are in place to counter fraud.

7.7   The Counter Fraud Work Plan for 2019/20 was submitted in May 2019.

Internal Control

7.8   The Committee scrutinised the Trust's draft Annual Governance Statement in May 2019.

7.9   The Committee reviewed the register of authorisations of tenders in excess of £50k at each meeting.

7.10   The Committee reviewed the losses incurred and special payments made by the Trust at each meeting.

7.11   The Committee reviewed the Annual Data Assurance and Framework report.

7.12   During 2019/20 the Committee paid particular attention to the following areas:

i) Recommendations from the Estates Helpdesk Internal Audit Report;
ii) Progress on recommendations from the Consultant Job Planning Internal Audit Report;
iii) Implementation of Windows 10;
iv) The Fraud Risk Assessment Review conducted by Counter Fraud;
v) Audit of Non-Clinical Policies;
vi) Draft Annual Report and Accounts;
vii) The recording and authorising of invoices;
viii) The volume and appropriateness of Single Tender Waivers at the Trust, following the Counter Fraud benchmarking exercise;

ix) NHS Improvement's Terms of Licence – draft compliance report and the going concern position.

Internal Audit

7.13 The Internal Audit work plan for 2020/21 was approved at the March 2020 meeting.

7.14 At each meeting the Committee received details of recent internal audit work together with a schedule of management's progress in implementing agreed actions. A schedule of all of the internal audits undertaken in 2019/20 is attached as **Appendix 3.**

7.15 The Committee received the Internal Audit annual report for 2019/20 in May 2019.

7.16 The Committee has overseen and supported the work of Internal Audit through:

- Agreeing the Audit Plan including the prioritisation of work;
- Considering the results of internal audit reviews;
- Suggesting areas which Internal Audit might review;
- Reviewing and agreeing the Head of Internal Audit Opinion.

7.17 The Committee is satisfied that the delivery of the Internal Audit plan for 2019/20 has given it assurance that controls are effective and action plans are developed for improvement. Internal audit was able to confirm that the level of cooperation received from the Trust was appropriate and that the Trust had a good record of addressing recommendations arising from internal audit reviews.

Board Assurance

7.18 In May 2019, the Committee received the Head of Internal Audit opinion on the effectiveness of the system of internal control at Poole Hospital NHS Foundation Trust for the period 1 April 2018 to 31 March 2019. This opinion was based on the Trust's Assurance Framework and Internal Audit's own work. A "moderate assurance" opinion was given to the Trust in respect of its system of internal control.

Production of the Annual Report and Accounts

7.19 In May 2019, the Committee received the draft Annual Report (including the Quality Report). The document was scrutinised and minor amendments agreed prior to being submitted to the Board of Directors for approval.

7.20 The Committee reviewed the Board Statements/Certifications and Going Concern statements.

8   CONCLUSION

8.1 The Committee has complied with its terms of reference during 2019/20, during which time it has:

i) reviewed reports prepared by Internal and External Auditors together with the ensuing management actions, where appropriate;
ii) reviewed reports prepared by the Counter Fraud Service together with the ensuring management actions, where appropriate;
iii) reviewed the risk register and received regular updates;
iv) reviewed any Board Assurance Framework Exception Reports and the Annual Board Assurance Framework.

Philip Green
Chairman of Audit and Governance Committee, July 2020

POOLE HOSPITAL NHS FOUNDATION TRUST

AUDIT AND GOVERNANCE COMMITTEE
GOVERNANCE CYCLE
March 2020

REGULAR REPORTS

Audit and Governance Committee Minutes	Chairman
Register of Authorisation of Tenders	DoF
Review of Losses and Special Payments by exception £15K>	DoF
Risk Register: New Red and Amber Risks	DoN
SIRO Information Governance Report (Quarterly Mar/May/Oct/ Jan)	DoF
Board Assurance Framework Exception Report Update	DoN
External Audit	
External Auditors Update Report	KPMG
Internal Audit	
Internal Audit Progress Report	Internal Audit
Counter Fraud	
Counter Fraud Report (part 1 and 2)	LCFS

AD HOC REPORTS

Other reports as requested by Chairman	TBA
Payroll Concerns (By exception)	DoF (Oral)
Draft Annual Report Audit View – Risks & Going Concern (By exception)	External Audit

ANNUAL REPORTS

External Audit KPMG		
KPMG Audit Plan	October 2020	KPMG
Annual Governance/Quality Report (including recommendations)	May 2020	KPMG
Internal Audit (BDO)		
Internal Audit Annual Report	May	Internal Audit
Internal Audit Workplan • Draft • Final	 January March	Internal Audit
Counter Fraud Service		
Counter Fraud Annual Report (part 1 and 2)	May	LCFS
Counter Fraud Draft Workplan	January	LCFS
Counter Fraud Final Workplan	March	LCFS
Chairman		
Review of Terms of Reference	October 2020	Chairman
Audit and Governance Committee Annual Report to include self-assessment	May	Chairman

Company Secretary		
Timeline for Annual Report and Accounts	January	CS
Audit and Governance Committee Governance Cycle	March	CS
Review of Scheme of Delegation (3 yearly) –See SFIs	May 2020	CS
Audit of Non-Clinical Policies	October	CS
Register of Interests and Gifts and Hospitality	July	CS
Chief Executive		
Monitor's Terms of Licence –Draft Compliance Report	March	CEO
Monitor's Code of Governance – Draft Compliance Report	March	CEO
Draft Annual Governance Statement (Annual Report)	March/May	CEO (DoN)
Quality Governance Framework	May	CEO (DoN)
Final Draft Annual Report & Accounts (inc Quality)	May*	CEO (DoF/ DoNPS/HoC)
Annual Letter of Representation (re Financial Statement)	May*	CEO (DoF)
Draft Assurance for Board Governance Statement (APR)	May	CEO (DoF)
Director of Finance		
Review of External Auditors' Performance	October	DoF
Review of Internal Auditor's Performance (from October 2015)	October	DoF
Review of Counter Fraud Service Performance (from October 2019)	October	DoF
Review of Standing Financial Instructions (annually)	March 2020	DoF
Annual Review Going Concern	March	DoF
Annual Certificate Availability of Resource	May	DoF
Final Draft Annual Financial Statement (Final Accounts)	May*	DoF
Annual Data Assurance and Framework Report	October	DoF
Annual Review of Losses and Special Payments	May	DoF
Director of Nursing		
Risk Register Review (To inform next year Audit Plan)	January	DoN
Annual Risk Register Report	May	DoN
Draft Annual Governance Statement and process for the production of the Annual Governance Statement (coming year)	March	DoN
Quality Impact Assessment Process	May	DoN
Chief Operating Officer		
Emergency Preparedness, Resilience and Response	May	COO
CBRN Plan	October	COO
	May	DW&OD
Medical Director		
Clinical Audit Work Plan	May 2020	MD
Progress Report on the Clinical Audit Work Plan	January 20212021	MD

*Joint meeting with Finance and Investment Committee in May to consider Annual Report and Accounts

POOLE HOSPITAL NHS FOUNDATION TRUST
COMMITTEE MEETING ATTENDANCE RECORD
2019/20

NAME OF COMMITTEE:	AUDIT AND GOVERNANCE COMMITTEE					
REPORTS TO :	BOARD OF DIRECTORS					
Membership (as per Terms of Reference).	MEETING DATES					
	16 May 2019	22 May 2019*	18 July 2019	2 October 2019	21 January 2020	12 March 2020
PHILIP GREEN Chairman / non-executive director	✓	✓	✓	✓	✓	✓
STEPHEN MOUNT Non-executive director	x	x	x	x	✓	x
DAVID WALDEN Non-executive director	✓	✓	✓	✓	✓	✓
NICK ZIEBLAND Non-executive director	x	x	✓	✓	✓	✓
In attendance:						
DAVID MOSS Trust chairman	x	✓	✓	x	✓	
Executive Directors/Deputies	✓	✓	✓	✓	✓	✓
External Audit	✓	✓	✓	✓	✓	✓
Internal Audit	✓	✓	✓	✓	✓	✓
Counter Fraud	✓	x	✓	✓	✓	✓
Was the meeting quorate? Y/N	Y	Y	Y	Y	Y	Y

* Special meeting of the audit and governance committee and finance and investment committee

POOLE HOSPITAL NHS FOUNDATION TRUST
INTERNAL AUDIT RESOURCE CONTROL SCHEDULE
1 APRIL 2019 to 31 March 2020

Report Issued	Design	Operational Effectiveness
Falls Pathway	Moderate	Moderate
Procurement	Substantial	Moderate
Fire Safety	Moderate	Moderate
Clinical Audit Outcomes	Moderate	Moderate
IT Applications	Substantial	Moderate
Estates Help Desk Follow Up	Moderate	Limited
Data Security and Protection Toolkit	Substantial	Substantial
Data Quality – 62 day cancer waits	Moderate	Moderate
Freedom to Speak Up – joint report with RBCH	Substantial	Moderate
Outpatient Department Follow up processes	Substantial	Moderate

Consultant Job Planning – Joint with RBCH	**N/A Advisory Review**	**N/A Advisory Review**
Emergency Planning – joint with RBCH	**N/A Advisory Review**	**N/A Advisory Review**
Performance Reporting – joint with RBCH	**N/A Advisory Review**	**N/A Advisory Review**
Medical Examiner Role – Joint with RBCH	**N/A Advisory Review**	**N/A Advisory Review**

NHS

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

NHS

Poole Hospital
NHS Foundation Trust

JOINT BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.8

Subject:	Quality Safety and Performance Committee Annual Report 2019/20

Prepared by:	Carrie Stone, Company Secretary
Presented by:	Carrie Stone, Company Secretary

Purpose of paper:	To set out how the Quality Safety and Performance Committee satisfied its terms of reference during 2019/20 and to seek to provide the Committee and Board with evidence relevant to its responsibilities for assuring that high standards of care are provided by the Trust and in particular, adequate and appropriate clinical governance structures, processes and controls are in place throughout the Trust.
Background:	Monitor's (NHS Improvement) Code of Governance advises that the Board of Directors should undertake a formal and rigorous evaluation, not only of its own performance, but also that of its committees. This is the fourth annual report of the Quality Safety and Performance Committee to be received by the Board.
Key points for members:	- The Quality Safety and Performance Committee complied with its terms of reference; - All meetings for 2019/20 were quorate; - The Board Assurance Framework was received and discussed; - The Quality Account was received and discussed prior to submission as part of the Annual Report for 2019/20 and noted a number of new quality improvement topics had been identified for the following year; - The integrated performance report as it relates to quality and performance was scrutinised at each meeting; - During the financial year the Committee gave particular scrutiny to the improvement plan for Theatres and Emergency Services, the impact on patient safety as a result of the Estates backlog of work and the outcomes from free flap surgery and the independent review following the visit from the Royal College of Surgeons and the outcome of the CQC Ionising Radiation Medical Exposure Regulations inspection.
Options and decisions required:	For the Board to note the annual report
Recommendations:	For the Board to note.

Next steps:	
Links to Poole Hospital NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	AF1: Delivering safe, responsible, compassionate, high quality care.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well Led

Committees/Meetings at which the paper has been submitted:	Date
Joint Quality, Safety and Performance Committee and Healthcare Assurance Committee	June 2020

POOLE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS

QUALITY, SAFETY AND PERFORMANCE COMMITTEE ANNUAL REPORT 1 April 2019 to 31 March 2020

1   PURPOSE OF THE REPORT

1.1   The Quality, Safety and Performance Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference between 1 April 2019 and 31 March 2020and seeks to provide the Board with evidence relevant to its responsibilities for assuring that high standards of care are provided by the Trust and in particular, adequate and appropriate clinical governance structures, processes and controls are in place throughout the Trust.

2   OVERVIEW

2.1   The existence of the Committee is the central means by which the Board ensures there are adequate and appropriate clinical governance structures, processes and controls in place throughout the Trust.

2.2   The Committee independently scrutinises and monitors the Board Assurance Framework as it relates to the principle strategic objective of delivering safe, responsible, compassionate, high quality care (AF1). In particular the Committee's work focuses on clinical governance and performance, compliance with the Care Quality Commission registration, NICE exception and compliance reports, claims, complaints and serious incidents and the associated continuous learning across the organisation.

2.3   The Committee receives a number of annual reports appropriate to its purpose. See paragraph 6.7 for further detail.

2.4   A governance cycle detailing which papers are to be expected at each Quality, Safety and Performance Committee is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was reviewed and approved in October 2019 as a consequence of the annual review of the Committee's Terms of Reference, when consideration was given to transferring some of the quarterly reports to the Trust's Quality Governance Group or the Nursing and Midwifery Group.   The updated governance cycle is attached as **Appendix 1.**

3   MEMBERSHIP

3.1   The Committee membership in respect of the financial year 2019/20 comprised   of:

- Dr Calum McArthur, Non-Executive Director and Committee Chairman
- Mr Philip Green, Non-Executive Director
- Mrs Caroline Tapster, Non-Executive Director
- Mr Mark Mould, Chief Operating Officer
- Mrs Patricia Reid, Director of Nursing
- Dr Angus Wood, Medical Director (until 31 December 2019)
- Dr Matt Thomas, Acting Medical Director (from 1 January 2020)

4   COMPLIANCE WITH TERMS OF REFERENCE

4.1   The Committee is composed of three non-executive directors (one of which chairs the committee), the Medical Director, Director of Nursing and Chief Operating Officer

4.2   Eleven meetings took place during 2019/20 and all were quorate.

4.3   The annual review of the terms of reference was undertaken in September 2019. A review of the Committee's compliance with its own terms of reference was undertaken by the Company Secretary who scrutinised the agendas and minutes of the eleven Committee meetings which took place between April 2019 and March 2020.

4.4   This review indicates that reports were received, scrutinised and discussed in accordance with the committee's constitution as set out in its terms of reference. By way of example, the committee scrutinised the Board Assurance Framework on a quarterly basis with any gaps in control clearly identified. The Annual Clinical Audit Report was received in August 2019 and the significant work undertaken regarding clinical audit activity for 2018/19 was noted, alongside the focus for the following year. The final Quality Account from the previous year was presented to the Committee in April 2019: the report noted a number of new quality improvement topics had been identified for 2019/20. The Committee subsequently received quarterly updates on progress against the improvement topics. The Committee also considers national reports and guidance and in June 2019 received a report on the Trust's position in relation to usage of vaginal mesh for treatment of uterine prolapse and stress urinary incontinence in light of NICE updated guidance and subsequent restrictions imposed by NHSI and NHSE. In October 2019, the Committee considered a "Delivery and Quality of Food Report", following the national concerns raised relating to pre-packed sandwiches from onsite retail outlets. On an exception basis, the Committee receives SBAR reports.   In the financial year, the following SBAR reports were scrutinised:

- PET/CT Scanner;
- Urgent and Emergency Care;
- Creta Placenta.

5   MEETINGS

5.1   Eleven formal meetings were held during the year:

- Monday, 29 April 2019
- Tuesday, 28 May 2019
- Monday, 24 June 2019
- Monday, 29 July 2019
- Tuesday, 27 August 2019
- Monday, 23 September 2019
- Monday, 28 October 2019
- Monday, 25 November 2019
- Monday, 27 January 2020
- Monday, 24 February 2020
- Monday, 23 March 2020

5.2   Meeting attendance is detailed in **Appendix 2.**

6   DUTIES AND FINDINGS

6.1   The Committee's terms of reference require the Committee to receive detailed quality, safety and performance reports so that it can ensure patient safety and quality of services to meet registration and compliance requirements.

Board Assurance Framework (BAF)

6.2   The Committee received, and discussed the 2018/19 year end position in May 2019 and quarterly reports thereafter in July 2019, November 2019 and January 2020.   These reports identified any gaps in control and new risks identified.

Clinical Governance and Performance

6.3   The Integrated Performance Report (quality and performance) was received and discussed at each meeting during the financial year. The Committee considered quality impact assessments on identified CIP's.   Annual reports to provide assurance in respect of Clinical Audit, Claims and Complaints processes were received and discussed. A number of annual reports were received including the Annual Safeguarding Report for Children, Young Adults and Adults, the outcome from the national inpatient survey and the report from the National Hip Fracture Database. The CQUIN report and progress against each CQUIN was also considered. As had been the case in the previous year the Committee received regular Maternity Unit reports, including the CNST Maternity Safety Actions and bimonthly Maternity Safety Champions Reports. The latter provided updates on emerging guidance for maternity services, reviewed published national and local inspection reports and feedback from women and their families. The report also escalated locally identified issues of concern. Mortality Reports received regular scrutiny, via quarterly reports.

6.4   During the course of the financial year, the Committee continued to give particular scrutiny to the Improvement Plan for Theatres, including the unannounced CQC visit on 9 April 2019 and Emergency Services, receiving regular updates on the Improvement Plans for both during the course of the year.   The Committee also kept under review the impact on patient safety as a result of the Estates backlog of work and the outcomes from Free Flap Surgery and the independent review following the visit from the Royal College of Surgeons. In October 2019, the Committee received a report to update on the outcome of the CQC Ionising Radiation Medical Exposure Regulations (IR(ME)R) inspection in August 2019.   Medicines Optimisation Reports were received regularly, together with the minutes from the Medicines Optimisation Group.   In March 2020, members of the Committee received the key inspection findings and recommendations from the CQC inspection visit in October and November 2019, the CQC having assessed the Trust as "good" overall and "outstanding" in the "caring" domain. As a consequence of the Covid pandemic and the streamlining of governance arrangements, the report was deferred to April 2020 (outside the reporting period).   In the lead up to the inspection in 2019, members of the Committee received briefings and the Chairman of the Committee was interviewed by members of the CQC inspection team.

6.5   During the course of the year the Committee gave particular focus on a number of quality issues, receiving a number of "deep dive" reports on the following:

- Validation of the Outpatients Waiting list;
- Reducing falls;
- NHSI action plan update for the Emergency Department;
- Report on the impact on patient safety as a result of the Estates backlog of work;
- Improvement plan for Free Flap Surgery;

6.6   During the financial year, the Committee received quarterly quality reports from a number of directorates: Therapies, Critical Care, Theatres, Trauma, Surgery and Child Health.

Bi- Annual and Annual Reports and Declarations

6.7   The Committee received and discussed the following:

- Annual Adult and Children Safeguarding Report;
- Bi-annual Claims Reports;
- Annual Complaints Report;
- Annual Patient Survey;
- Annual Patient Experience Report;
- Annual report from the National Hip Fracture Database;
- Quality Account;
- Clinical Audit Annual Report

7   CONCLUSION

7.1   The committee has complied with its terms of reference during 2019/20, during which it has:

i)   Reviewed the Board Assurance Framework as it relates to the principle strategic objective of delivering safe, responsible, compassionate, high quality care (AF1);
ii)   Reviewed and discussed a number of reports covering clinical governance and performance as per paragraph 6.3;
iii)   Focused on the impact on patient safety as a result of the Estates backlog of work;
iv)   Focused on the improvement plan for Theatres;
v)   Focused on free flap surgery;
vi)   ED Improvement plan;
vii)   Reviewed and scrutinised annual reports and declarations, as outlined in paragraph 6.7.

Carrie Stone, Company Secretary on behalf of Dr Calum McArthur
Chairman of Quality Safety and Performance Committee
June 2020

POOLE HOSPITAL NHS FOUNDATION TRUST

QUALITY SAFETY & PERFORMANCE COMMITTEE

GOVERNANCE CYCLE

OCTOBER 2019

REGULAR REPORTS

Quality Safety & Performance Committee Minutes	Chairman
Trust Quality Governance Group	MD
Medicines Optimisation & Safety Group Minutes	MD
Nursing and Midwifery Group Minutes	DoN
Theatre Leadership Group Minutes	COO
Trust Integrated Performance Report	COO/MD/DoN
Risk Register: New Red and Amber Risks	DoN

EXCEPTION/SBAR REPORTS

Trust-wide Audit Reports	MD/DoN/COO
CQC Reports/Submissions	DoN
NICE	MD
NCEPOD	MD
Clinical Benchmarking (of concern)	MD/DoN/ COO
Medicines Governance, Management & Optimisation (SBAR)	CP
Clinical Risks Report (SBAR)	DoN
Same Sex Accommodation Declaration	DoN

BIMONTHLY REPORTS

Serious Incidents Detailed Report (summary to Board of Directors) (January, March, May, July, September, November)	MD
Maternity Champions Safety Report (February, April, June, August, October, December)	Head of Midwifery
CQC Insight Report (Dec, Feb, Apr, Jun, Aug & Oct)	DoN

QUARTERLY REPORTS

Review Board Assurance Framework changes relating to quality and safety (Q1 - July; Q2 - Nov; Q3 – Jan; Q4 May)	DoN
Quality Account: quality improvement plan monitoring (Q1 – August; Q2 – December; Q3 – February;; Q4 – May)	DoN
Patient Experience Report (Summary to BoD) (plus one annual report – July) (Q3 – March; Q4 – June; Q1 - September; Q2 -	DoN

November)	
Directorate Quality Reports (monthly from individual directorates on a rolling programme, see separate schedule)	COO
Medicines Governance, Management & Optimisation detailed report (Q3 – Feb: Q4 – May; Q1 – September; Q2 – December)	CP
Safeguarding Report (Q3 – March; Q4: June; Q1 – September; Q2 – December)	DoN
Infection Prevention & Control (Q3 – February; Q4 – May; Q1 – August; Q2 – October)	DoN
Mortality Report (Q3 – February; Q4 – May; Q1 – August; Q2 – November)	MD
CQUIN – focus (January; April; July; October)	DoN

½ YEARLY / ANNUAL REPORTS

	Lead	½ Yearly	Annual Reports
REVIEW REPORTS			
Quality Accounts (Future Plans)	DoN		December
Quality Accounts Draft Annual Report	DoN		April
Annual Inpatient Patient Surveys	DoN	-	When published
Annual Safeguarding Report (Children, Young Adults & Adults) and to include Annual Learning Disabilities access statement	DoN		September
Claims and Litigation Detailed Report (summary to Board of Directors)	MD	January (April – September	July (October – March)
Getting it Right First Time (GIRFT) Report	MD	February	August
Annual Complaints and Patient Experience Detailed Report (Summary to Board of Directors)	DoN	(see also quarterly reporting)	July (Annual Report)
CQC Report	DoN		When published
Annual Quality Strategy Review	DoN	-	July
Quality Safety & Performance Committee Governance Cycle (for approval)	Chairman		March
Quality Safety & Performance Committee Terms of Reference	Chairman		September
Quality Safety and Performance Committee Annual Report	Chairman		May/July
Maternity Staffing Review	DoN	December/June	

CLS October 2019

QUALITY, SAFETY AND PERFORMANCE COMMITTEE ATTENDANCE REGISTER 2019/20

NAME OF COMMITTEE:	QUALITY, SAFETY AND PERFORMANCE COMMITTEE										
REPORTS TO :	BOARD OF DIRECTORS										
Membership (as per Terms of Reference).	MEETING DATES										
	29 April 2019	28 May 2019	24 June 2019	29 July 2019	27 August 2019	23 September 2019	28 October 2019	25 November 2019	27 January 2020	24 February 2020	23 March 2020
CALUM MCARTHUR (chairman) Non-executive director	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
PHILIP GREEN Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MARK MOULD Chief operating officer	✓	✓	X	✓	✓	✓	X	✓	✓	✓	✓
PATRICIA REID Director of Nursing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CAROLINE TAPSTER Non-executive director	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
ANGUS WOOD Medical director	✓	✓	✓	X	✓	✓	✓	✓			
MATT THOMAS Acting Medical Director									✓	✓	✓
In attendance:											
DEBBIE FLEMING Chief executive	✓	✓	X	X	✓	✓	X	X	✓	X	✓
DAVID MOSS Trust chairman	X	✓	✓	✓	X	✓	X	✓	X	✓	X
SHARON COLLETT Governor Observer					✓	✓	✓	✓	✓	✓	✓
Chief pharmacist	X	X	✓	X	X	X	X	X	X	X	X
Internal auditor	X	X	X	X	X	X	X	X	X	X	X
Was the meeting quorate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Angus Wood ended his role as Medical Director 31 December 2019
Matt Thomas began his role as Acting Medical Director on 1 January 2020

JOINT BOARD OF DIRECTORS – PART 1
COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.9

Subject:	Finance and Investment Committee and Finance and Regulatory Performance Committee Annual Report 2019/20

Prepared by:	Carrie Stone, Company Secretary
Presented by:	Carrie Stone, Company Secretary

Purpose of paper:	To set out how the Finance and Investment Committee and the Finance and Regulatory Performance Committee satisfied their terms of reference during 2018/19 and to seek to provide the committees and Board with evidence relevant to its responsibilities for ensuring that there are adequate and appropriate financial planning controls in place and for assuring that the use of the Trust's financial resources are robust.
Background:	Monitor's (NHS Improvement) Code of Governance advises that the Board of Directors should undertake a formal and rigorous evaluation, not only of its own performance, but also that of its committees. This is the third annual report of the Finance and Investment Committee to be received by the Committee
Key points for members:	- The Finance and Investment Committee and the Finance and Regulatory Performance Committee complied with their terms of reference; - All meetings for 2019/20 were quorate; - From November 2019 the Committee met with RBCH Finance and Regulatory Performance Committee; - The Board Assurance Framework was received and discussed; - A number of reports covering reference costs audit, contracts, tenders and business cases, estate revaluation, debtors on a quarterly basis. - Relevant annual reports were received and discussed including, but not limited to: Annual Operational Plan, Draft Annual Accounts and Annual Report, Annual revenue Budget, draft Annual Capital Programme.
Options and decisions required:	None
Recommendations:	For the Board to note the performance and effectiveness of the Finance and Investment Committee and the Finance and Regulatory Performance Committee during the financial year 2019/20.
Next steps:	

FOR POOLE USE ONLY

Links to Poole Hospital NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective(s):	AF4 and AF3
BAF/Corporate Risk Register: (if applicable)	
CQC Reference(s):	Well Led

Committees/Meetings at which the paper has been submitted:	Date
Joint Finance and Investment Committee & Finance and Regulatory Performance Committee	29 06 2020

POOLE HOSPITAL NHS FOUNDATION TRUST and ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

FINANCE AND INVESTMENT COMMITTEE ANNUAL REPORT 1 April 2019 to 31 March 2020
FINANCE AND REGULATORY PERFORMANCE COMMITTEE ANNUAL REPORT 1 April 2019 to 31 March 2020

1   PURPOSE OF THE REPORT

1.1   The Finance and Investment Committee and the Finance and Regulatory Performance Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference during 2019/20 and seeks to provide the Board with evidence relevant to its responsibilities for assuring that the use of the Trust's financial resources is robust and for setting the policy for cash investments, detailed business cases, overseeing the progress of agreed capital investments and reviewing financial planning and budgeting processes.

2   OVERVIEW

2.1   The existence of the Committee is the central means by which the Board ensures there are adequate and appropriate financial planning controls in place throughout the Trust. The Committee monitors financial performance against budget on a monthly basis and examines requests for capital expenditure. It provides expertise and advice on the long term financial strategic plans, level of capital investment and the financial risk appetite of the Trust.

2.2   The Committee independently scrutinises and monitors the Board Assurance Framework as it relates to the principle strategic objective of ensuring all resources are used efficiently, effectively and economically to deliver key operational standards and targets (AF4) and together with the Board of Directors, the principle strategic objective of working with partners to develop new models of care and reconfigure services so that clinically and financially sustainable arrangements are in place across Dorset (AF3).

2.3   The Committee receives a number of annual reports appropriate to its purpose which include, but are not limited to, Reference Costs Submission, Annual Estates Report, Annual Energy Performance Review Annual Review of Going Concern, draft annual Operational Plan, draft Annual Accounts and Annual Report.

2.4   In November 2019 the Committee commenced joint meetings with the Finance and Regulatory Performance Committee of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

2.5   A governance cycle detailing which papers are to be expected at each Finance and Investment Committee meeting is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was reviewed and then implemented from April 2019. The governance cycle is attached as Appendix 1. An updated governance cycle taking into account the joint meetings and the requirements of each has now been developed in consultation with the Joint Interim Director of Finance.

3   MEMBERSHIP

3.1   The Finance and Investment Committee membership in respect of the financial year 2019/20 comprised of:

- Mr Stephen Mount, Non-Executive Director and Committee Chairman;
- Mr David Moss, Joint Interim Chairman;
- Mrs Caroline Tapster, Non-Executive Director and Chairman of the Committee in Mr Mount's absence;
- Mrs Debbie Fleming, Chief Executive;
- Mr Mark Orchard, Director of Finance (left the Trust 30 September 2019);
- Mr Pete Papworth, Joint Interim Director of Finance (joined the Trust 1 October 2019);
- Mr Mark Mould, Chief Operating Officer.

3.2   The Finance and Regulatory Performance Committee membership in respect of the financial year 2019/20 comprised of:

- Mr John Lelliott, Non-Executive Director and Committee Chairman;
- Mr David Moss, Joint Interim Chairman;
- Mr Pankaj Dave, Non-Executive Director;
- Mr Alex Jablonowski, Non-Executive Director;
- Mr Iain Rawlinson, Non-Executive Director;
- Mrs Debbie Fleming, Chief Executive;
- Mr Pete Papworth, Director of Finance;
- Mr Richard Renaut, Chief Operating Officer.

4   COMPLIANCE WITH TERMS OF REFERENCE

4.1   The Finance and Investment Committee is composed of three non-executive directors, the Director of Finance, the Chief Operating Officer and the Chief Executive.

4.2   All meetings for 2019/20 were quorate.

4.3   The terms of reference are reviewed annually and the last review took place in September 2019, when no material changes were made.   A review of the Committee's compliance with its own terms of reference was undertaken by scrutiny of the agendas and minutes of the 12 Committee meetings (plus one extraordinary meeting) which took place between   April 2019 and March 2020.

4.4   This review indicates that reports were received, scrutinised and discussed in accordance with the Committee's constitution as set out in its terms of reference. By way of example, the Committee scrutinised the Board Assurance Framework on a quarterly basis with any gaps in control clearly identified. The Annual Accounts both draft and final were scrutinised and the Annual Report was also scrutinised at the Joint Audit and Governance committee and Finance and Investment Committee in May 2020, prior to submission to NHS Improvement. The pre-submission Costing Plan with supporting information was submitted to the Committee in April 2019 where it was confirmed that the processes in place were sufficient to complete the mandated cost submission. The National Costs Collection was thereafter submitted to the Committee in August 2019 with a completed self-assessment. Contracts, tenders and business cases were appropriately scrutinised by the Committee.

4.5   The Finance and Regulatory Performance Committee is composed of four non-executive directors, the Director of Finance, the Chief Operating Officer and the Chief Executive.

4.6   All meetings for 2019/20 were quorate.

4.7   The Terms of Reference are reviewed annually and the last review took place in September 2019. The following two amendments were agreed, subject to final approval by the Board of Directors (RBCH):

- Amendment to remove Ms D Matthews, Director of Improvement & Organisational Development to section 1.3 as a representative who would normally attend the Committee to provide information
- Amendment to add Ms H Rushforth, Improvement Manager, Productivity & Efficiency to section 1.3 a representative who would normally attend the Committee to provide information

A review of the Committee's compliance with its own Terms of Reference was undertaken by scrutiny of the agendas and minutes of the 12 Committee meetings (plus three extraordinary meetings) which took place between April 2019 and March 2020.

5   MEETINGS

5.1   12 formal meetings of the Finance and Investment Committee were held during the year. As per paragraph 2.4, from November 2019, the Committee met jointly with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Finance and Regulatory Performance Committee:

- 23 April 2019 (extraordinary)
- 29 April 2019
- 28 May 2019
- 24 June 2019
- 24 July 2019
- 27 August 2019
- 23 September 2019
- 28 October 2019
- 25 November 2019
- 27 January 2020
- 24 February 2020
- 23 March 2020

5.2   On 22 May 2019 a joint Audit and Governance Committee and Finance and Investment Committee meeting took place to receive the Annual Report and Accounts.

5.3   Meeting attendance is detailed in Appendix 2.

5.4   12 formal meetings of the Finance and Regulatory Performance Committee were held during the year. As per paragraph 2.4, from November 2019, the Committee met jointly with Poole Hospital NHS Foundation Trust's Finance and Investment Committee:

- 23 April 2019
- 23 May 2019 (extraordinary)
- 28 May 2019
- 24 June 2019
- 29 July 2019
- 27 August 2019
- 23 September 2019
- 28 October 2019
- 25 November 2019
- 27 January 2020
- 24 February 2020
- 23 March 2020

5.5   On 23 May 2019 a joint Audit Committee and Finance and Regulatory Performance Committee meeting took place to receive the Annual Report and Accounts.

6   DUTIES AND FINDINGS

6.1   The Committee's terms of reference requires the Committee to receive   detailed financial reports so that it can ensure there are adequate and appropriate financial planning controls in place.

Board Assurance Framework (BAF)

6.2   PHFT: The Committee received and scrutinised the year-end related sections of the BAF at its April 2019 meeting. The Committee subsequently received quarterly reports in July 2019 (quarter 1), October 2019 (quarter 2) and January 2020 (quarter 3). A monthly review report was submitted in February 2020 (month 10) and in March 2020 (month 11).

Financial Performance, budgets and capital investment

6.3   **Specific to PHFT** Financial performance was scrutinised at each meeting during the financial year. The Committee examines the financial performance of the Trust against budget on a   monthly basis and seeks explanations for material variances. In addition, the Committee examines requests for capital expenditure. Where necessary, the Committee will request more detailed analyses.   In April 2019 the Committee received the year end position, noting that NHS Improvement had confirmed that the Trust was eligible for the general distribution of unallocated PSF national income of £3.6m, which had improved the Trust's position for 2018/19, but had no revenue benefit.   Discussion took place in relation to the Dorset system, noting that resilience of the system was important. The level of agency spend and the Trust's Agency Reliance Reduction Programme continued to receive significant scrutiny. In April 2019 the Committee noted the pay overspend position relating mainly to agency spend was the most significant financial concern, totalling £8.6m for the year 2018/19. Agency reliance remained a key focus for the Committee for the remainder of the year, with regular, stand-alone agenda items from May to November 2019. Discussions were focussed on actions versus impact of the programme, the exposure of the Trust in relation to delivery of the CIP programme, the importance of retention and concerns regarding the ability of European nurses to achieve the necessary English language exams. The Committee dealt with and approved a number of requests to approve Interim Revenue Finance from NHS Improvement to support the Trust's cash position and noted in November 2019, a contract cash

advance from NHS Dorset Clinical Commissioning Group of £3m. At the same time, the Chairman of the Committee requested a paper from PwC to explore what a regime under Financial Special Measures would look like for the Trust. July 2019 was another busy month for the Committee.   Reports dealing with the Capital Programme: Q1 year to date and year-end projections plus CIP Q1 assessment and full-year financial risk and year-end forecast were received and scrutinised. With regard to the latter, the Committee noted that whilst the Trust was ahead of plan, the loss of the DCH commercial transaction caused a gap which required mitigating across the system. In July 2019, the Committee also received the first deep dive into budget performance of the Care Groups, the first being the Surgical Care Group. In September 2019 the Committee considered the Dorset ICS Long Term Plan and in October received the budget setting process and timetable. The Committee discussed the increasing reliance on a system solution to delivery of the control total and the importance of working collaboratively. Concerns were noted relating to the interaction with budget setting for 2020/21 and the impact on the Going Concern assessment by the External Auditors. Discussions also took place in October and thereafter with regard to the challenges of agreeing to and signing up to a system Long Term Plan for 5 years. Other issues that received a focus were the debt relating to the surgical robot and mediation parameters. The Committee noted the commissioning of PwC in relation to merger support and CIP diagnostic work, discussing this jointly with members of the Finance and Regulatory Performance Committee (RBCH) and the outcomes of the diagnostic work in July and August 2019 respectively. The Digital Transformation Strategy was presented to both Committees in July2019 to discuss the future vision and the different options and an update was provided in November 2019, the first formal joint meeting of both Committees. The Productivity and Efficiency Programme to meet the CIP was also scrutinised in November 2019. Discussion centred around providing productivity and efficiency to gain maximum benefits for future funding for a system-wide CIP and the need for a balanced and credible plan. An update was subsequently received in January 2020. The Committee received a presentation on Non-NHS Resolution cover in January 2020 when some material differences in approach between the two Trusts was identified. As a consequence, the Chairman asked for an update of the at-risk summary and a proposal on the appropriate levels of cover, having regard to the practical risks at a future meeting. The Q3 financial forecast position was also received in January 2020 and the underpinning assumptions and risks were highlighted to the Committee. The mitigations for both Trusts were acknowledged and the position of other partners in the system discussed. Governance in relation to the ICS to achieve the system control total was highlighted. The support and endorsement of the Committee was also requested for the Long Term Plan and the LTFM, whilst recognising the level of demand in the system. The Capital Programme was also received for one year and subsequent 5 years. In February 2020 the Committee scrutinised the Final Merger Business Case and PTIP, ahead of submission to the Boards of Directors of both Trusts. The agenda for March 2020 was streamlined in light of Covid-19 and guidance from the regulator. The Committees did, however, receive an update on the integrated urgent care system and considered the annual review of Going Concern for both Trusts and agreed both were a Going Concern. The 2021/21 budget was also received and reviewed.

6.4 **Specific to RBCH**. Financial performance was scrutinised at each meeting during the financial year. The Committee examines the financial performance of the Trust against budget on a   monthly basis and seeks explanations for material variances. In addition, the Committee examines capital expenditure. Where necessary, the Committee will request more detailed analyses.   In April 2019 the Committee received the year end position, noting that NHS Improvement had confirmed that the Trust was eligible for the general distribution of unallocated PSF national income and

a further bonus, which had improved the Trust's position for 2018/19. Discussion took place in relation to the Dorset system, noting that resilience of the system was important. The value and risk associated with the CIP programme was a consistent theme throughout the year with monthly updates scrutinised in depth. The Committee considered and approved the Trusts commercial strategy, including the outline proposal for the second phase of the Christchurch development. The outline case for the new multi-storey carpark was also supported to allow the full business case to be worked up. The Project Southgate proposal was discussed in detail on a number of occasions and was ultimately not supported.The Committee considered the Dorset ICS Long Term Plan and in October received the budget setting process and timetable. The Committee discussed the increasing reliance on a system solution to delivery of the control total and the importance of working collaboratively. Discussions also took place in October and thereafter with regard to the challenges of agreeing to and signing up to a system Long Term Plan for 5 years. The Committee considered and approved the second LLP transaction relating to the Christchurch Fairmile Grange LLP to achieve a significant investment gain and off-set the CIP shortfall to ensure the full year control total was achieved.

6.5 **Consistent with PHFT** The Committee noted the commissioning of PwC in relation to merger support and CIP diagnostic work, discussing this jointly with members of the Finance and Regulatory Performance Committee (RBCH) and the outcomes of the diagnostic work in July and August 2019 respectively. The Digital Transformation Strategy was presented to both Committees in July2019 to discuss the future vision and the different options and an update was provided in November 2019, the first formal joint meeting of both Committees. The Productivity and Efficiency Programme to meet the CIP was also scrutinised in November 2019. Discussion centred around providing productivity and efficiency to gain maximum benefits for future funding for a system-wide CIP and the need for a balanced and credible plan. An update was subsequently received in January 2020. The Committee received a presentation on Non-NHS Resolution cover in January 2020 when some material differences in approach between the two Trusts was identified. As a consequence, the Chairman asked for an update of the at-risk summary and a proposal on the appropriate levels of cover, having regard to the practical risks at a future meeting. The Q3 financial forecast position was also received in January 2020 and the underpinning assumptions and risks were highlighted to the Committee. The mitigations for both Trusts were acknowledged and the position of other partners in the system discussed. Governance in relation to the ICS to achieve the system control total was highlighted. The support and endorsement of the Committee was also requested for the Long Term Plan and the LTFM, whilst recognising the level of demand in the system. The Capital Programme was also received for one year and subsequent 5 years. In February 2020 the Committee scrutinised the Final Merger Business Case and PTIP, ahead of submission to the Boards of Directors of both Trusts. The agenda for March 2020 was streamlined in light of Covid-19 and guidance from the regulator. The Committees did, however, receive an update on the integrated urgent care system and considered the annual review of Going Concern for both Trusts and agreed both were a Going Concern. The 2021/21 budget was also received and reviewed.

Contracts and Business Cases

6.6 During the course of the financial year, the Finance and Investment Committee received and discussed contracts and business cases pertaining to:

- Payroll Services;
- Water and Sewage Contract;

- Overseas Nurse Recruitment;
- Trauma Contract Extension;
- Supply of EMIS;
- Clinical Waste Services;
- Main Entrance Proposal to extend Leasehold interest;
- RTT Recovery Programme – 3rd party contracted activity;
- PwC contract;
- Car park services;

6.7   During the course of the financial year, the Finance and Regulatory Performance Committee received and discussed contracts and business cases pertaining to:

- Health Records;
- Blood Glucose & Ketone Monitoring;
- Network Support Services;
- Strategic Outline Case – Christchurch phase 2
- Project Southgate;
- Commercial Insurance;
- IT Capital Virement Proposal;
- IT windows 10 Migration Project;
- Generator Exhaust Emissions Abatement
- Radiology Equipment for Xray Rooms 1, 5 & 7;
- Colonoscopies & Gastroscopes;
- Payroll management Services
- Windows 10 Roll out
- X-ray rooms building works;
- Contrast Media & Barium Extension
- Domestic Waste Collection;
- ICE Order Communications
- PwC Contract

6.8   Jointly from November 2019 the two Committees jointly received and discussed contracts pertaining to:

- Supply of brady pacemakers, cardiac resynchronisation pacemakers and implantable loop recorders;
- PwC Phase 2 CIP
- Pharmacy Stock Control System;
- Radiology Image Intensifiers;
- Camera Stacks;
- Dorset Care Record – phase 3;
- Stroke reconfiguration;
- CISCO Informatics Hardware;
- Gamma Camera Loan Drawdown;
- Repair and Maintenance Framework;
- Transactional Finance Services;
- Infection Surveillance System;
- HSCN Supplementary System Extension;
- Healthroster OPTIMA System;
- Graphnet Support Services;
- EMIS Patient Administration System.

NHS Improvement

6.9 PHFT: monthly submissions to NHS Improvement were scrutinised by the Committee prior to their respective submission dates for the early part of the year, but were then removed from the governance cycle, given the submissions were made ahead of meetings. The Committee received reports on Consultancy Costs throughout the year. The Committee received updates as part of the Monthly Financial Performance reports on the Trust's performance against the agency cap and the imposed ceiling.

Debtors

6.10 Through the financial year the Committee considered the Trust debtors' position, including monies owed by both third parties and those within the Dorset system.

IT Services

6.7 The governance cycle includes an annual IT review in February. A review was not performed as the creation of a new Digital Transformation Strategy was presented, as per paragraph 6.3 of this report.

Minutes

6.8 As per its terms of reference and the Governance Map, the Committees received some minutes or summary reports from the Investment Planning Group, the Local Informatics Steering Group minutes and the Information Governance Steering Group, Capital Management Group, Coding Strategy and Income Group, Patient Level Costing Steering Board and Performance Management Group.

7 CONCLUSION

7.1 The Committee remained compliant with its terms of reference during 2019/20, working increasingly on a joint basis with our colleagues in Bournemouth. The finance and wider executive team work very closely with the Committee, and consult with it on an appropriate and timely basis - both within and outside of the scheduled meeting dates. As with most other acute trusts, the level of financial and operational challenges continued to escalate during the year, culminating with the biggest challenge ever to face the NHS as a whole in the form of Covid-19. Without the considerable investment in joint and integrated working between Poole and RBCH and with the wider Dorset integrated care system that took place during the year, East Dorset's response to the current pandemic would have been far less effective. It is gratifying that a number of initiatives and developments previously championed by management and considered by the committee were capable of being scaled-up and deployed to significantly improve both hospitals' abilities to respond to the pandemic. Hopefully the sum of such initiatives across the NHS will provide a worthy legacy for the loss, suffering and disruption brought by CV19. They will be needed to help clear the current backlog and deliver sustainable improvements in healthcare in East Dorset for the longer term.

Prepared by Carrie Stone, Company Secretary on behalf of Mr Stephen Mount
Chairman of Finance and Investment Committee: June 2020

POOLE HOSPITAL NHS FOUNDATION TRUST

FINANCE AND INVESTMENT COMMITTEE

GOVERNANCE & MEETING CYCLES

April 2019

<u>REGULAR & EXCEPTIONAL (E) ITEMS</u> • Minutes of Previous FIC meeting • Approve FIC Governance Cycle(E) • Approve Draft Annual Report and Accounts • Approve Interim Revenue Financing Facility (E) • Scrutinise Detailed Draft Investment and Business Case • Scrutinise Audit Reports (E as appropriate) • Scrutinise Investment Planning Group Summary Report Minutes • Scrutinise Joint Poole Hospital/RBCH Local Informatics Steering Group minutes • Scrutinise Information Governance Steering Group minutes	
<u>MONTHLY REPORTS FOR SCRUTINY</u> • Financial Performance Report • Capital Plan Report • Review of CIP • Review of variable staff costs and actions taken/planned • Cash Forecast • Supplier Payments over £25k • Clinical Contract Income • Contract Decision Timetable	
<u>QUARTERLY REPORTS FOR SCRUTINY</u> • Debtors Detail Report • Board Assurance Framework: Quarterly review strategic risks relating to finance, investment and strategy • Consultancy Commitments • Model Hospital/Use of Resources	Jul/Oct/Jan/Apr Jul/Oct/Jan/Apr July/Oct/Jan/Apr Feb/May/Aug/Nov
<u>½ YEARLY REPORTS FOR INFORMATION</u> • Financial Systems Development Updates • Reference Cost Index	 Sept/June June/Nov
<u>ANNUAL REPORTS FOR SCRUTINY</u> • National Costs Submission Assurance • Reference Costs Report • Trust Draft Operational Plan • Trust Draft Annual Accounts and Annual Report • Draft Commissioner Contract • Budget Setting Process and Timetable • Draft Annual Revenue Budget for BoD Approval • Draft Annual Capital Programme for BoD Approval • FIC Terms of Reference Review • FIC Annual Report	 Aug Oct Jan/Feb Apr Mar/Apr Oct/Nov Mar Mar Sept May May

• Annual IT review • Annual Energy Performance Contract Review	Nov

Joint meeting with A&G in mid May to consider Annual Report and Accounts

April 2019
Carrie Stone

FINANCE AND INVESTMENT COMMITTEE ATTENDANCE REGISTER 2019/20

NAME OF COMMITTEE	FINANCE & INVESTMENT COMMITTEE											
REPORTS TO:	BOARD OF DIRECTORS											
Membership (as per Terms of Reference).	MEETING DATES											
	29 April 2019	16 May 2019*	28 May 2019	24 June 2019	29 July 2019	27 August 2019	23 September 2019	28 October 2019	25 November 2019**	27 January 2020**	24 February 2020**	23 March 2020**
STEPHEN MOUNT (chairman) Non-executive director	✓	x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
DEBBIE FLEMING Chief executive	✓	✓	✓	x	x	✓	✓	x	✓	✓	✓	✓
DAVID MOSS Trust chairman	x	✓	✓	✓	x	x	x	x	✓	✓	✓	✓
MARK MOULD Chief operating officer	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
MARK ORCHARD Director of finance	✓	✓	✓	✓	✓	✓	✓					
PETE PAPWORTH Joint Interim Director of Finance								✓	✓	✓	✓	✓
CAROLINE TAPSTER Non-executive director	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	X
In attendance:												
Deputy director of finance	✓	x	✓	x	✓	✓	x	✓	✓	✓	✓	✓
Was the meeting quorate? Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

*Electronically facilitated finance and investment committee meeting
** Meetings with RBCH Finance and Regulatory Performance Committee from November 2019
Mr Papworth began his tenure as Joint Interim Director of Finance on 1 October 2019
Mr Orchard ended his role as Director of Finance on 30 September 2019

FINANCE AND REGULATORY PERFORMANCE COMMITTEE ATTENDANCE REGISTER 2019/20

NAME OF COMMITTEE	FINANCE REGULATORY PERFORMANCE COMMITTEE										
REPORTS TO:	BOARD OF DIRECTORS										
Membership (as per Terms of Reference).	MEETING DATES										
	23 April 2019		28 May 2019	24 June 2019	29 July 2019	27 August 2019	23 September 2019	29 October 2019	25 November 2019**	27 January 2020**	24 February 2020**	23 March 2020**
JOHN LELLIOTT (chairman) Non-executive director	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DEBBIE FLEMING Chief executive	✓		✓	✓	x	✓	x	✓	✓	✓	✓	✓
DAVID MOSS Trust chairman	✓		x	x	x	x	✓	x	✓	✓	✓	✓
RICHARD RENAUT Chief operating officer	✓		x	✓	✓	x	✓	x	✓	✓	✓	✓
PETE PAPWORTH Director of finance	x		✓	✓	✓	✓	✓	x	✓	✓	✓	✓
ALEX JABLONOWSKI Non-executive director	✓		x	x	✓	x	✓	✓	✓	✓	✓	✓
PANKAJ DAVE Non-Executive director	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IAIN RAWLINSON Non-executive director	✓		✓	✓	x	✓	✓	✓	✓	✓	✓	✓
In attendance:												
Deputy director of finance	✓		✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Was the meeting quorate? Y/N	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

** Meetings with PHFT Finance and Investment Committee from November 2019

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.10

Subject:	Annual Security Report

Prepared by:	D Bennett A.S.M.S.
Presented by:	M Mould C.O.O

Purpose of paper:	To provide an Annual Security Report to the Hospital Executive Group for the 2019 - 20
Background:	This is the third annual report of the current LSMS. The Security Report is a requirement under Service Condition 24 of the NHS Standard Contract.
Key points for Board members:	This report has been constructed around the proposed template for all security related reporting within the merged organisation. This is an ongoing piece or work with both ASMS identifying cross site data sets for future inclusion The Report contains information on: • Self-Review Tool (SRT) • Reported Physical Assaults (RPA) • Security Related Incidents (Datix) The report data is taken from the period 01 April 2019 – 31 March 2020
Options and decisions required:	
Recommendations:	The BoD are requested to receive and review the Annual Security Report
Next steps:	The report, Self-Review Tool and associated work plan will be requested by the CCG at some point this year as part of governance checks

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	Date

TRUST BOARD

SECURITY REPORT 2019 - 2020

1.   Purpose and Background

The purpose of this paper is to provide an Annual Security Report to the Trust Board for 2019/20 this is a requirement under Service Condition 24 of the NHS Standard Contract 2019/20.

NOTE "NHS Protect disbanded in March 2017" with no current provision put in place to continue the support, advice and networking which was its main function.

Locally a small group of trusts in the south have formed which is the Wessex Area Security Partnership (WASP) with the aim of continuing to support security management work streams locally.

This report is the first attempt to identify a single Security reporting template and data used in preparation for future reporting in the merged organisation.

The report data is taken from the period 01st April 2019 – 31st March 2020.

2.   Security Standards

Self-Review Tool (SRT) (Service Condition 24.3)

The SRT comprises of five Sections. Section one is general information about the Organisation. Sections two to five form the body of the SRT.

These Sections are subdivided into the standards, it is against these standards that the Trust assesses its position and allocates a RAG rating. The final element comprises of providing 'evidence' to support the rating submitted.

Sections are identified as follows:
- Strategic Governance
- Inform &Involve
- Prevent & Deter
- Hold to Account

Rating Definitions

RED – a risk has been identified but no action has been taken to mitigate the risk, or the action taken is very limited in scope.	R
AMBER – a risk has been identified and action has been taken to mitigate the risk. There is evidence of compliance through outputs. However, the effectiveness of the work conducted has not yet been evaluated or there is no reduction of the risk. There is therefore little or no evidence of outcomes.	A
GREEN – a risk has been identified, activity has been conducted and there has been measurement undertaken to evaluate the effectiveness of the work conducted. The risk has been mitigated or significant progress has been made in mitigating the risk. Outcomes are therefore present.	G

Each sections rating are automatically compiled to give an overall rating for the completed SRT with the final rating for the submitted review is Green.

The table below indicated the allocation of RAG rating by section

With the demise of NHS Protect there is no requirement for this to be submitted to that organisation. The SRT and Annual report may however be submitted to the CCG on request.

The number of standards contained within the SRT are indicated in the table below, it is to be noted that one standard from each or the first 4 sections has been ignored in the response as specifically refer to NHS Protect, hence the anomaly in the number of standards listed and the RAG rated totals

Section	Number of Standards	Green	Amber	Red
Strategic Governance	5	4	0	0
Inform & Involve	6	5	0	0
Prevent & Deter	16	11	2	1
Hold to Account	4	3	1	0
Total Standards	**31**	**24**	**3**	**0**

The standard returned as red is as follows:

> *3.8   The organisation has departmental asset registers and records for business critical assets worth less than £5,000.*

Finance Comment:

> *Items below £5,000 in value are deemed to be consumable and would be treated in the same way as other items such as drugs, small value equipment items, etc. It would not be feasible to include all such items on a register due to the volume and small intrinsic value.*

The standard returned as Amber is as follows:

> *4.4   The organisation has a clear policy on the recovery of financial losses incurred due to security related incidents, and can demonstrate its effectiveness.*

Guidance is still being sought from HR and Finance with regards the Trust ability to fulfil this standard, that is not to say that it does not exist but more investigations required to provide evidence to support.

3.0   Reported Physical Assaults (RPA)

In November 2003 the Secretary of State for Health issued Directions to NHS bodies on 'measures to deal with violence against NHS staff.' The Directions introduced a new common definition for physical assaults against staff for recording and reporting purposes, and required health bodies to report all incidents of physical assault on NHS staff to NHS Protect.

(Note, similar to the SRT there is no formal route to submit the data)

The requirement to report is also contained in Clause 37 of the new NHS Standard Contract

All health bodies and those providing services under the contract are required to record incidents locally and report them.

Definition of Physical Assault against NHS Staff

The intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort
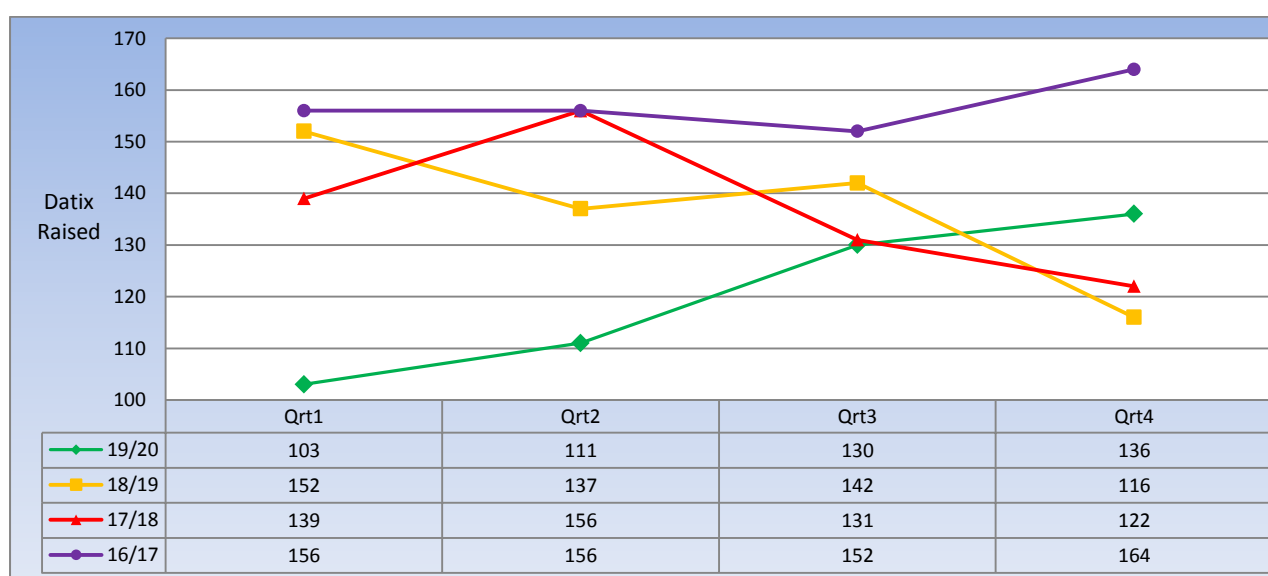
The Table below provides 3 year comparative data

Year	Total Assaults	Assaults Involving Medical Factors	Assaults Not Involving Medical Factors	Assaults per 1000 staff	Declared Sanction
2017/18	104	84	20	22	18
2018/19	145	117	22	32	20
2019/20	111	99	12	24	12

Total assaults within definition appear down, it is believed that there is still an element of under reporting, with some staff appearing to accept or are unwilling to report incident. The ASMS will be working this year to investigate means of supporting and encouraging staff to report all incidents and in particular those that result in actual assaults.
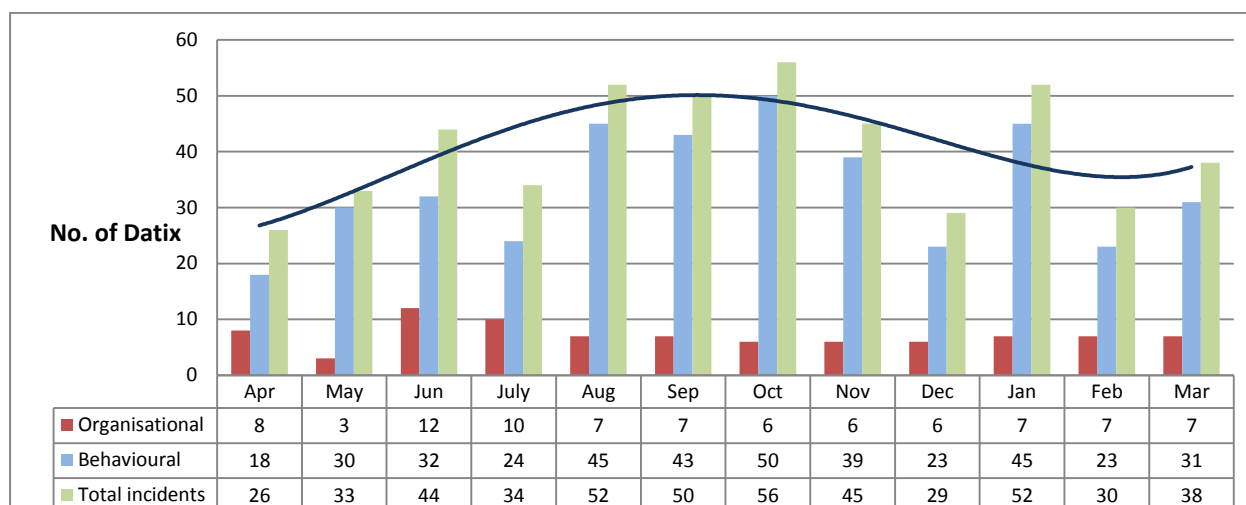
4.0 Security Related Datix

The table below provides a trend comparison for the total number of security related incidents by quarter, for the past 4 years

	Qrt1	Qrt2	Qrt3	Qrt4
19/20	103	111	130	136
18/19	152	137	142	116
17/18	139	156	131	122
16/17	156	156	152	164

It can be seen that Q1 and 2 reported incidents were lower than previous years with a sharp rise in the Q3 and 4. Investigation has shown that the rise in reported incident could in the main be attributable to a small number of patient repeatedly displaying episodes of challenging behaviours.

The graph below gives a representation of incidents by month and type.

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Organisational	8	3	12	10	7	7	6	6	6	7	7	7
Behavioural	18	30	32	24	45	43	50	39	23	45	23	31
Total incidents	26	33	44	34	52	50	56	45	29	52	30	38

Security related incident by type

Security incidents at Tier 2	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	14	22	18	15	25	26	23	23	7	28	8	19	228
Inappropriate/Aggressive Behaviour towards Staff by Staff	0	5	1	0	7	5	10	2	6	3	7	5	51
Missing/Lost Property	5	3	6	5	3	4	4	5	1	3	5	0	44
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	3	1	6	2	4	2	5	2	5	2	2	4	38
Missing Patient (absconded/abducted patient)	1	1	2	3	1	4	3	1	1	2	2	0	21
Inappropriate/Aggressive Behaviour towards a Patient by Staff	0	0	3	2	4	0	3	4	1	1	0	1	19
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	0	0	0	1	3	2	2	1	1	5	2	1	18
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)	0	0	1	1	2	1	3	3	1	4	0	0	16
Theft (proven, alleged or suspected)	2	1	1	2	0	1	0	1	1	2	1	1	13
Use/Possession of Prohibited/Stolen Goods	0	1	1	1	2	0	0	0	2	0	0	3	10
Trespassing/Intrusion	0	0	0	0	2	0	1	0	0	1	1	1	6
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	0	0	1	0	0	2	0	1	1	0	0	0	5
Unconsented or Unauthorised use	0	0	2	0	0	1	0	0	1	0	0	1	5
Break in/Forced Entry (proven, alleged or suspected)	1	0	0	1	0	1	0	0	0	0	0	1	4
Patient Restraint Processes	0	0	1	0	0	0	1	1	0	0	1	0	4
Vandalism (proven, alleged or suspected)	0	0	1	1	0	0	1	0	0	1	0	0	4
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	0	1	0	1	0	0	0	0	0	0	0	0	2
Persons Performing Unauthorised Acts	0	0	0	0	1	0	0	0	0	0	0	1	2
Inappropriate/Aggressive Behaviour towards Visitor by Staff	0	0	0	0	0	0	0	1	0	0	0	0	1
Total	26	35	44	35	54	49	56	45	28	52	29	38	491

5.0   Work Undertaken – Groups Attended

A summary of work undertaken is provided below

- Policies Reviewed
  - Lockdown – post development of Entrance South
  - Restraint policy
  - Security strategy
  - Missing patient policy – Baby Abduction exercise scoped for Aug/Sep 2020
  - Violence and Aggression

- Continued roll out of Restraint Training for Security Response Teams
  - 5 day course in addition to core conflict resolution training
  - Investigation of alternative provision of 2 day intensive course
- Additional door access control across site to include application to treatment rooms
- Application accepted for Upgrade of CCTV systems
- Chair of the bi-monthly Wessex Area Security Partnership (WASP), a small group of acute, mental health and Ambulance trust security managers
- Working closely with RBCH ASMS with regards merger
  - Intentions to have one reporting template and matrix of information for reports across both site
  - Production of single security related policies across site

Groups attended

- Risk Management & Safety Group
- Emergency Preparedness Sub Group
- Security Management Group
- Integrated Safeguarding adult/child
- Chair of the Wessex Area Security Partnership

6.0   2020/21 Planning /Delivery

As directed by the assurance reports above the ASMS focus for the coming year will be in the areas of *Prevent and Deter & Hold to Account* within the Self Review Tool.

The aim is to achieve a higher level of compliance within those areas whilst awaiting further guidance from NHSE/I on the future of security management within the wider NHS arena.

Continue to develop an effective Security culture across the merged Organisation.

7.0 Recommendations

The Board is asked to receive the Annual Security Report

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.11

Subject:	ANNUAL SENIOR INFORMATION RISK OWNER REPORT: INFORMATION GOVERNANCE

Prepared by:	Peter Nicholas, Information Governance Manager
Presented by:	Pete Papworth, Director of Finance and Senior Information Risk Owner

Purpose of paper:	For scrutiny.
Background:	This report provides a summary of the Trust's information governance (IG) and data security responsibilities and how we provide assurance of compliance with the necessary requirements. The core internal and external assurance mechanism for IG is the annual national toolkit assessment. Assurance is also monitored through compliance against legislation such as the Freedom of Information (FOI) Act 2000, Data Protection Act (DPA) 2018 and the General Data Protection Regulation (GDPR). This is an annual report provided to the Joint Trust Board and supplements more frequent detailed reporting to the Audit & Governance Committee, Hospital Executive Group and the Information Governance Steering Group.
Key points for Board members:	Annual Toolkit Submission 1. In 2018, the IG Toolkit was revised and relaunched as the Data Security and Protection (DSP) Toolkit, providing an updated mandatory framework, focusing more on digital information and cyber security across ten data security standards. The DSPT was reviewed and updated by NHS digital for 2019/20. 2. The Trust's 2019/20 DSP Toolkit assessment was submitted at the end of March 2020, and was 100% compliant in all 116 mandatory requirements. However, significant work is still required within 2020/21 specifically around information assets and the new joint Information Asset Register (IAR). IG Annual Training Compliance 3. During 2019/20, the Trust just exceeded the minimum 95% target for IG mandatory training compliance, with 95.5% of all staff having renewed their training within the last twelve months as at 28 February 2020. This mandatory target will continue into 2020/21. General Data Protection Regulation (GDPR) 4. The new GDPR came into force on 25 May 2018, supported by the updated Data Protection Act 2018,

	and has been embedded as business-as-usual within the Trust.
	Information Risk Management
	5. In 2018, NHS Digital released new guidance on the grading criteria and reporting thresholds for IG incidents (i.e. issues which have or could compromise the confidentiality, availability and/or integrity of information). This has been fully implemented by the Trust and applies to all IG incidents since 25 May 2018, scored as Green, Yellow, Amber and Red instead of Near-Miss, Level 0, Level 1 and Level 2. All Red and Amber incidents are reportable to the ICO, and Red incidents must also be reported to the DHSC (reportable within 24hrs (Red) or 72hrs (Amber)).
	6. In 2019/20, there were 510 IG-related incidents logged in Datix, all were appropriately reviewed and followed up, and there were no incidents recorded that met the requirement to be reported to the Information Commissioner's Office (ICO).
	Freedom of Information (FOI) Requests
	7. 707 FOI requests were received in 2019/20 and 99.7% responses were released within the 20 working day deadline. There were two breaches in 2019/20.
	Subject Access Requests (SARs)
	8. 2,505 SARs were received in 2019/20; all requests were released within the permitted legal deadline.
Options and decisions required:	No decisions are required of Members at this time.
Recommendations:	For scrutiny.
Next steps:	SIRO to formulate and monitor the 2020/21 work plan with the IG Team based on the required improvement work for the DSPT Toolkit, with internal audit assurance at key milestones.

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Ensure resources are used efficiently, effectively and economically
	Be a well governed and well managed organisation
BAF/Corporate Risk Register: (if applicable)	AF4
CQC Reference:	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 (Good governance)

Committees/Meetings at which the paper has been submitted:	Date

JOINT BOARD OF DIRECTORS PAPER

29 July 2020

ANNUAL SENIOR INFORMATION RISK OWNER REPORT 2019/20

Introduction

This report provides a summary of the Trust's main responsibilities in relation to information governance and how we provide assurance of compliance with the necessary requirements. It also explains the roles of the Senior Information Risk Owner (SIRO) and the Caldicott Guardian, held by the Director of Finance and Medical Director respectively. This is an annual report provided to the Joint Trust Board.

Overview

Information governance (IG) is a "framework for handling information in a confidential and secure manner to appropriate ethical and quality standards in a modern health service". UK legislation and frameworks enforced by the Information Commissioner's Office (ICO), NHS Digital and the Department of Health & Social Care, determine what policies, procedures and practices the Trust must have in place in relation to IG to be able to support its staff and service users.

The Trust's IG Team is accountable to the SIRO and comprises:

- an Information Governance Manager / DPO (1.0 whole time equivalent (wte));
- an Information Governance Officer (1.0 wte);
- an Information Governance Assistant (0.52 wte); and
- a Freedom of Information Coordinator (0.48 wte)

IG is monitored via the Information Governance Steering Group (IGSG), which meets bi-monthly and is chaired by the SIRO (the Caldicott Guardian is the vice-chair). The IGSG is accountable to the Hospital Executive Group and also reports to the Finance and Investment Committee. The Trust's Audit & Governance Committee also receive regular detailed progress reports.

Data Protection Legislation

The General Data Protection Regulation (GDPR) is now in force alongside the updated Data Protection Act 2018, which together form revised data protection legislation in the UK. This has now been embedded in the Trust as business-as-usual. The Trust must demonstrate ongoing compliance as previously but the updated requirements are more detailed and comprehensive – hence the additional work/resource required for preparation, implementation and ongoing monitoring.

A key project from the GDPR implementation plan was the introduction of a new in-house electronic Information Asset Register (IAR) to capture details of all data processing in the Trust. This system will enable a more efficient method for completing and recording data audits and privacy impact assessments, including data flows and risks, to the level of detail required to meet legislative and regulatory requirements. The new IAR is in the final stages of development and will be used across both PHFT and RBCH.

New DSP Toolkit 2018/19

The core internal and external assurance mechanism for IG in the Trust is the national annual toolkit assessment. This was previously known as the IG Toolkit but was relaunched in April 2018 by NHS Digital as the Data Security and Protection (DSP) Toolkit with a revised mandatory framework and a greater focus on digital information and cyber security, across the ten data security standards recommended by Dame Fiona Caldicott, the National Data Guardian for Health and Care, as part of the Caldicott 3 Review. The

DSP Toolkit also supports existing best practice such as ISO27001 and Cyber Essentials Plus, and elements will also be used to support the 'Well Led' inspections by the CQC.

The new DSP Toolkit was reviewed and updated by NHS digital for 2019/20 and now includes 179 evidence requirements (30 more than 2018/19 across 44 assertions (4 more than 2018/19, 116 evidence requirements are mandatory and the remaining 63 are best practice. The Trust must be 100% compliant in all mandatory areas in order to have a satisfactory submission.

The first DPS Toolkit assessment for 2019/20 was a mid-year baseline submitted in October 2019.
The final assessment for 2019/20 was submitted in March 2020 and reached 100% for all mandatory requirements. It is recognised there are areas that require improvement and these are specifically around information assets, and the completion and release of the new joint Information Asset Register.

New IG Incidents Grading Criteria and External Reporting Requirements

In 2018, NHS Digital released new guidance on the grading criteria and reporting thresholds for IG incidents based on the requirements of the GDPR, DPA and DSP Toolkit. IG incidents are those which compromise (or have the potential to compromise) the confidentiality, integrity and/or availability of information.

Previously, all IG incidents were graded based on the number of individuals affected and the application of low and high sensitivity factors. The outcome from this would be Near-Miss, Level 0, Level 1 or Level 2.

Only Level 2 incidents were reportable to the ICO under the previous guidance, based on the traditional view that a personal data breach is only externally reportable when data falls into the wrong hands. This has been replaced by the concept that any personal data breach which creates a risk to the rights and freedoms of the individual (data subject) could be reportable if it reaches a certain threshold.

The updated guidance includes a new 5x5 breach assessment matrix (severity vs likelihood) and additional thresholds for cyber incidents under the Security of Network and Information Systems ("NIS") Regulations. If the breach is likely to result in a high risk to the rights and freedoms of individuals, the Trust must also inform the affected individuals about the breach without undue delay, unless specific criteria applies.

The updated guidance has been incorporated into the Trust's IG processes and the IG review form in Datix. The new criteria have been retrospectively applied to all incidents identified or reported since 25 May 2018.

All IG incidents now receive a grading of Green, Yellow, Amber or Red. **All Red and Amber incidents are reportable to the ICO, and Red incidents must also be reported to the Department for Health and Social Care. Red incidents must be reported within 24 hours, and Amber incidents within 72 hours.**

Key Responsibilities

With support from the SIRO and Caldicott Guardian, the IG Team is currently responsible for supporting the organisation in the following:

1. Working with key areas in the organisation to maintain sufficient levels of evidence within the **DSP Toolkit** to achieve and maintain the equivalent of a 'satisfactory' rating.
   - Year-end assessment reached 100% for all mandatory requirements.

2. Providing sufficient training resources and mechanisms to ensure that the Trust reaches the minimum compliance level of 95% in **annual IG training**.
   - Overall compliance of **95.5% achieved in 2019/20.**

   This means that the vast majority of our staff understands the importance of dealing with confidential and sensitive information, together with the rules around when and how this information should be shared. This is of course important in ensuring that the confidentiality of our patients and staff is

maintained.

3. Fully investigating and reporting any information risks, breaches and near-misses, and supporting with any remedial action as required.
   - 510 IG-related incidents were logged in 2019/20, none of these incidents recorded met the requirement to be reported to the Information Commissioner's Office.

4. Recording and processing all requests made under the Freedom of Information (FOI) Act 2000, to ensure that the Trust meets its legislative responsibilities.
   - 707 FOI requests received in 2019/20, with a total of 11424 questions
   - 99.7% deadline compliance in 2019/20 (2 breaches).

5. Supporting with the recording and processing of Subject Access Requests (SARs) made under data protection legislation, to ensure that the Trust meets its legislative responsibilities.
   - 2,505 SARs received in 2019/20, with 100% compliance.

   Since 1st May 2018, in accordance with the requirements of the GDPR, the Trust has not been able to charge a fee for subject access requests (unless the request is vexatious or a duplicate), and the deadline for providing information reduced from 40 to 28 calendar days.

6. Supporting internal and external stakeholders and groups with IG queries and issues, and providing key and additional support to areas such as Medico-Legal, Legal Services, Patient Experience, Safeguarding Teams, HR and IT when dealing with information requests, complaints and incidents. This includes monitoring and auditing systems to ensure that all access is appropriate.

7. Implementing and monitoring information sharing agreements with third parties, as and when required. This includes Dorset-wide projects such as the Dorset Information Sharing Charter and Dorset Care Record, to enable more collaborative working across organisations for the benefit of our patients.

8. Reviewing the impact of and supporting the implementation of new legislation, guidelines and procedures, working with key stakeholders to ensure that the Trust meets the necessary requirements.

9. Identifying, assessing and registering all information assets on the central Information Asset Register, and working with the allocated 'owners' and 'administrators' to ensure that appropriate documentation is completed, including data privacy impact assessments. This also links to the DSP Toolkit work.

10. Reviewing all Trust related research studies and clinical audits to ensure that appropriate documentation is in place and the correct procedures are followed.

11. Evaluating the critical patient information (CPI) process to ensure that an appropriate and robust procedure is in place and followed. The IG Team are also responsible for the allocation of certain CPI flags against individual patient records.

The Senior Information Risk Owner (SIRO)

All NHS organisations are required to have an Executive Director (or other senior member of the Board) allocated as the Senior Information Risk Owner (SIRO). SIROs must be familiar with information risks and the organisation's response to risk to ensure they can provide the necessary input and support to the Board and to the Accounting Officer. The SIRO is responsible for coordinating and overseeing the development and implementation of the Trust's Information Risk and Security Policy, and ensuring that systems, policies, processes and standards are in place to ensure rigorous IG compliance. This includes responsibility for the on-going development and day-to-day management of the Trust's Risk Management Programme for information privacy and security, and ensuring that information assets are identified, assessed and registered on the central Information Asset Register with an allocated 'owner' and 'administrator' for each

asset. The SIRO also provides a focal point for the discussion and resolution of information risk issues, advising on information security and risk management strategies and providing periodic reports and briefings on progress, to ensure that the Board of Directors is adequately updated on IG issues within the organisation. The SIRO is also responsible for authorising the release of information in response to requests made under the Freedom of Information Act 2000, chairing the IGSG, submitting the IG/DSP Toolkit assessments, and generally overseeing the Trust's IG Team and work streams.

The Trust's Director of Finance currently holds the role of SIRO.

The Caldicott Guardian

All NHS organisations are required to have a Caldicott Guardian, as recommended by the 1997 Caldicott Report, and mandated in Health Service Circular 1999/012. The Caldicott Guardian must be an existing member of the senior management team, a senior health or social care professional, and the person with responsibility for promoting clinical governance. The Caldicott Guardian acts as a champion for data protection and confidentiality at Board level and is responsible for the confidentiality, integrity and availability of all patient and service user information across the Trust. The Caldicott Guardian acts as the 'conscience' of the organisation, and is responsible for the implementation of the seven Caldicott principles, ensuring that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff. The Caldicott Guardian will oversee all disclosures, arrangements, protocols and procedures involving the sharing of patient and clinical information, including those to or with other public sector agencies and other outside interests, with particular attention being paid to those disclosures which are not routine. The Caldicott Guardian maintains details of any unauthorised disclosures that have been reported, and the measures that have been taken to ensure that such disclosures are not repeated. The Caldicott Guardian is also able to authorise the release of information in response to requests made under the Freedom of Information Act 2000, and is vice chair of the IGSG.

The Trust's Medical Director currently holds the role of Caldicott Guardian.

Peter Nicholas
Information Governance Manager
22 July 2020

JOINT BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 July 2020

Agenda item: 8.11

Subject:	RBCH Annual Information Governance Report

Prepared by:	Camilla Axtell, Information Governance Manager/DPO
Presented by:	Peter Gill, Director of Informatics

Purpose of paper:	Information Governance performance for 2019/20, to be noted for information.
Background:	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.
Key points for Board members:	• Data Security and Protection Toolkit originally non-compliant owing to COVID-19 response. • Since time of writing, action plan agreed with NHS Digital and subsequently completed, meaning Data Security and Protection Toolkit is now compliant. • Note compliance with Freedom of Information Act 2000 remains poor.
Options and decisions required:	Note for information.
Recommendations:	Note for information.
Next steps:	Note for information.

Links to Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Improving quality and reducing harm. Focusing on continuous improvement and reduction of waste.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Safe; Effective

Committees/Meetings at which the paper has been submitted:	Date
Information Governance Committee	11/03/2020
Audit Committee	23/06/2020

**INFORMATION GOVERNANCE
ANNUAL REPORT 2019/20**

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 2019/20.

With the changes of 2018 – specifically introduction of the GDPR and Data Security and Protection Toolkit – further embedded within the Trust's practices, focus has moved towards aligning processes with Poole Hospital with a view to the potential for the organisations merging in the coming year.

It is hoped that the ever-increasing national focus on Information Governance 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 2018/19 and 2019/20, and the relative percentage differences. These figures are elaborated on within the main report.

	2018/19	2019/20	*Projected*	+ / -
Data Security and Protection Toolkit compliance	100%	79%*	*100%*	0%
Information Governance Training (highest % reached)	95.8%	96.1%*	n/a	+0.3%
Data Protection and Confidentiality Incidents – breaches	190	195*	*213**	+12%
Data Protection and Confidentiality Incidents – SIRIs	1	0	n/a	-100%
Freedom of Information Requests	654	645*	*704**	+8%

(*as at 28 February 2020*)
(** *projection for 31/03/20 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.

Owing to the Coronavirus (COVID-19) outbreak during early 2020, NHS Digital has confirmed that organisations that are unable to submit their DSP Toolkit by the end

1

of March owing to operational pressures would be granted a six-month extension on this deadline. The Trust will continue to monitor the changing advice, but intends to publish a compliant DSP Toolkit by the end of March if possible.

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 sets out the standards that organisations are required to meet with an expectation that this will be an ongoing journey towards compliance. The tenets of good Information Governance can be built around the audit, however the audit does not cover the full breadth of the IG agenda and therefore additional assurance work is necessary.

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.

The work that has been undertaken during the last few 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 been reinvigorated during 2019/20. Following a lull in 2018/19 due to the changes in Data Protection legislation and introduction of the DSP Toolkit in a short space of time, this work has now regained momentum. The Trust must continue to maintain the traction that is 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. A greater deal of joint working between RBCH and Poole IG teams has been undertaken in the last year, and looking forwards, a joint Information Asset Register will be implemented in 2020/21 which will further assist in imbedding this agenda.

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". For the 2018/19 submission, the Trust was unable to comply by the end of March deadline and

therefore submitted an action plan, meaning its final rating was "Standards not fully met (Plan Agreed)". On completion of this plan, the status was subsequently updated to "Standards met". For 2019/20, the Trust expects to be able to declare compliance with all mandatory requirements, meaning that by the end of March the submission will be "Standards met".
NB: Please note additional comments at the end of the document.

Information Governance Training

Information Governance training compliance has remained relatively high during the year and at the end of February 2020 sits at 94%. However, the DSP Toolkit explicitly states that the training compliance year runs from April to March; this is reflected in the question:

> Have at least 95% of all staff, completed their annual Data Security awareness training in the period 1 April to 31 March?

This effectively means that, in spite of achieving over 95% in year, the Trust will not be compliant with this requirement unless it also reaches 95% compliance at the end of March.

As noted in the section above, NHS Digital has granted an extension to the deadline for the 2019/20 DSP Toolkit. Clarification is currently being sought as to how this affects the deadline for training compliance.

The concerted campaign of chasing individual non-compliant members of staff and their line managers, led by the Director of Informatics, has continued throughout 2019/20. An automated e-mail reminder is issued weekly to staff who are not compliant with their IG training, with additional emails being sent in the month prior to compliance lapsing.

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 2019/20, the national Data Security Awareness e-learning provided by NHS Digital was implemented at RBCH. This includes increased details on cyber security, and has been supplement with some local content covering changes in data protection legislation. Feedback from staff has been generally positive for this course, which has been made available through the usual BEAT VLE platform. For 2020/21, the Trust will look at bringing the creation of the e-learning content back in house in order to exercise greater control over this. This work will be undertaken in concert with Poole Hospital with a view to the potential merger.

Fig 2 – IG training compliance
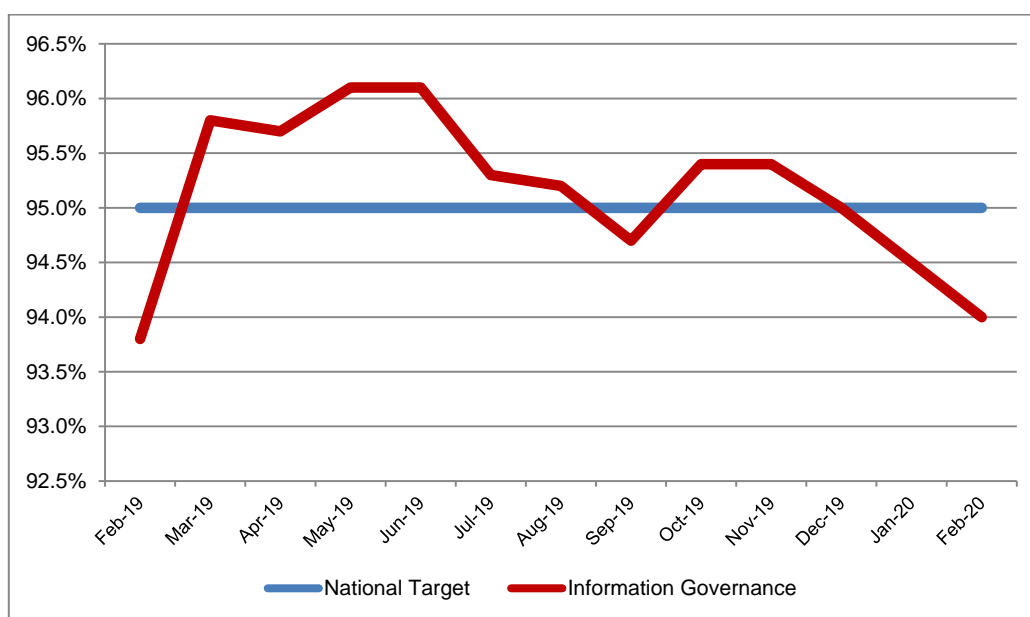
Data Protection and Confidentiality Incidents

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 44% of incidents reported (86) related to personal data being stored in the wrong person's record, and 24% (47) relate to inappropriate access to or use of personal data. The latter includes 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 2020/21. In addition, a review of IG incident categories will be carried out to ensure that these are appropriate representative.

During 2019/20, the Trust has not reported and 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.

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 78 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 2019/20 the Trust has seen an increase in the number of Freedom of Information (FOI) requests received from the previous year; 645 as at 28 February 2020. This is up from 613 at the same point last year. A full time IG Officer is in place, and the vast majority of this role is 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 will continue to be monitored throughout 2020/21. During January 2020 the Trust implemented a new IT system for handling FOI requests as a step towards bringing processes in line with Poole Hospital. It is hoped that this change will see an improvement in compliance as the year progresses.

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 32 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 2019/20 (as at 28th February), the Trust has received an average of 59 requests per month, and a response was provided on average within 18 days. During this period 60% of requests overall have been responded to within the statutory time limit.

Fig 1 – FOI response time compliance by month
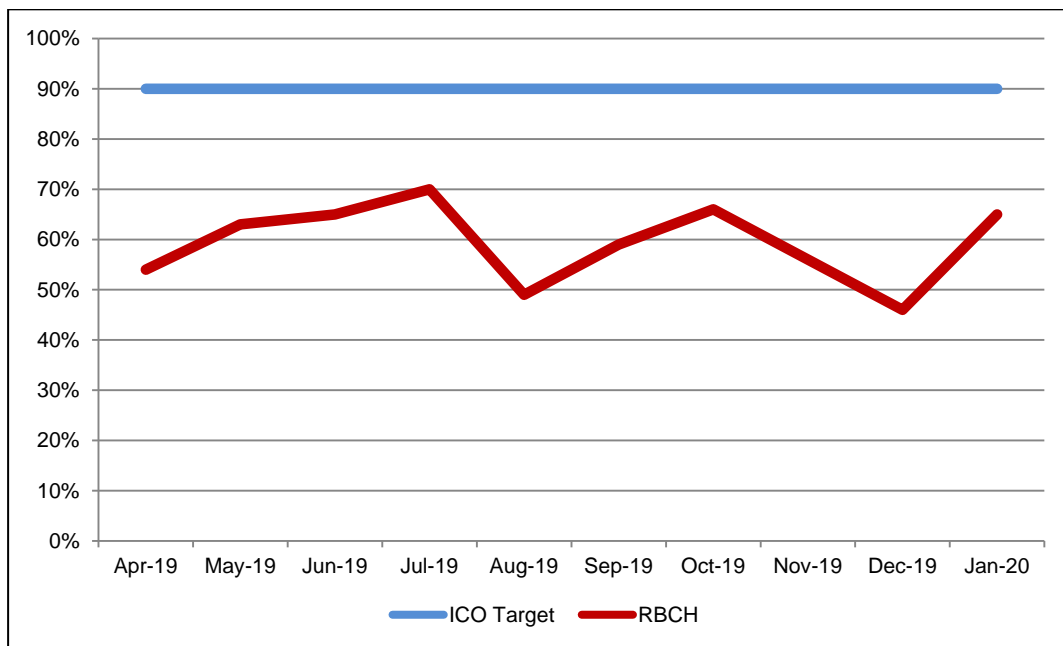
Conclusion

Improvements made have been limited during 2019/20, owing in part to the additional pressures associated with continuing to embed changes to legislation and assurance mechanisms. 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 2020/21, the priority will be to improve upon the current level of compliance with regard to FOI and information risk assurance, whilst maintaining current levels in other areas. This will be set against the backdrop of the potential merger, which will generate a large number of IG-related issues which must be worked through between the two extant IG teams.

Update 01/04/2020
Owing to the COVID-19 response, the Trust did not meet the 95% target for IG Training compliance by the end of March, and therefore was unable to declare 100% on the DSP Toolkit return. An improvement plan has been agreed with NHS Digital, which confirms that the Trust will meet this target by 30th September 2020. The DSP Toolkit result at submission was therefore "99%, Standards Not Fully Met (Plan Agreed)".

Update 16/07/2020
The target for IG training was reached w/c 13/07/20; the assessment has been resubmitted and now stands at "100%, Standards Met".

Appendix 1 – Data Security and Protection Toolkit scores (predicted by 31/03/20)

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 – 8 / 8	Complete
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 – 5 / 5 Complete
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 – 2 / 2 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 – 3 / 3	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 – 4 / 4	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 – 7 / 7	Complete

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10	**Data Security Standard 10** 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. 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.	
	Mandatory assertions satisfied – 2 / 2	Complete

GLOSSARY OF ABBREVIATIONS

A

A&E	*Accident and Emergency*
A&G	*Audit and Governance Committee*
ACT	*Alcohol Care Team*
ADHD	*Attention deficit hyperactivity disorder*
AF	*Atrial fibrillation*
AfC	*Agenda for Change*
AHPs	*Allied Health Professionals*
AHSN	*Academic Health Science Network*
AI	*Artificial intelligence*
AIRS	*Adverse Incident Reporting System*
ALB	*Arm's Length Body*
AMM	*Annual Members' Meeting*
API	*Application programming interface*
AQP	*Any Qualified Provider*
ASI	*Appointment Slot Issues*

B

BAF	*Board Assurance Framework*
BAME	*Black, Asian and Minority Ethnic*
BCF	*Better Care Fund*
BMA	*British Medical Association*
BMI	*Body mass index*
BoD	*Board of Directors*

C

CAS	*Clinical Assessment Service*
CAU	*Clinical Assessment Unit*
C.Diff	*Clostridium difficile*
CCG	*Clinical Commissioning Group*
CCIO	*Chief Clinical Information Officer*
CCU	*Coronary Care Unit*
CE	*Chief Executive*
CEA	*Clinical Excellence Awards*
CEPOD	*Confidential Enquiry into Perioperative Death*
CETR	*Care, Education and Treatment Review*
CGG	*Clinical Governance Group*
CHKS	*A national independent provider of comparative performance and healthcare data*
CI	*Confidence interval*
CIO	*Chief Information Officer*
CIP	*Cost Improvement Plan*
CMA	*Competition and Markets Authority*
CNST	*Clinical Negligence Scheme for Trusts*
COAST	*Children's Observations and Severity Tool*
CoG	*Council of Governors*
COO	*Chief Operating Officer*
COPD	*Chronic obstructive pulmonary disease*
CoSRR	*Continuity of Service Risk Rating*
CP	*Chief Pharmacist*
CPD	*Continuing professional development*

CPR	*Cardiopulmonary resuscitation*
CQC	*Care Quality Commission*
CQUIN	*Commissioning for Quality and Innovation*
CRES	*Cost Releasing Efficiency Saving*
CRN	*Clinical Research Network*
CRT	*Clinical Record Tracking*
CSR	*Clinical Services Review*
CSTR	*Community Service Treatment Requirement*
CT	*Computerised Tomography*
CTR	*Care and Treatment Review*
CVD	*Cardiovascular disease*

D

Datix	*National Software Programme for Risk Management*
DBS	*Disclosure and Barring Service*
DHSC	*Department of Health and Social Care*
DNA	*Did not attend*
DoF	*Director of Finance*
DoH	*Department of Health*
DoN	*Director of Nursing*
DDoN	*Deputy Director of Nursing*
DoW&OD	*Director of Workforce and Organisational Development*
DoS	*Director of Strategy*
Dr Foster	*Provides health information and NHS performance data to the public*
DToC	*Delayed Transfer of Care*

E

EBITDA	*Earnings Before Interest, Taxation, Depreciation and Amortisation*
EBME	*Electrical, Biomedical Equipment*
ECDS	*Emergency Care Data Set*
EEA	*European Economic Area*
EHCH	*Enhanced Health in Care Homes*
eNEWS	*National Early Warning Score*
ENT	*Ear, Nose and Throat*
EPR	*Electronic patient record*
EPRR	*Emergency Planning Resilience & Reponse*
EPS	*Electronic Prescription Service*
ERCP	*Endoscopic Retrograde Cholangiopancreatography*
ESBL	*Extended Spectrum Beta Lactamase (producer) Klebsiella*
ESCAPE-pain	*Enabling Self-management and Coping with Arthritic Pain through Exercise*
ESR	*Electronic Staff Record*
EWTD	*European Working Time Directive*

F

FCE	*Finished Consultant Episode*
FCP	*First Contact Practitioner*
FFCE	*First Finished Consultant Episode*
FFT	*Friends and Family Test*
FH	*Familial Hypercholesterolemia*
FIC	*Finance and Investment Committee*
FOI	*Freedom of Information*
FRP	*Financial Recovery Fund*

FT	*NHS Foundation Trusts*
FTE	*Full-time equivalent*
FPPRG	*Future Plans and Priorities Reference Group.*
FRP	*Financial Recovery Plan.*

G

GBD	*Global Burden of Disease*
GDE	*Global Digital Exemplar*
GDP	*Gross domestic product*
GIRFT	*Getting It Right First Time*
GMC	*General Medical Council*
GP	*General practitioner*
GTDRG	*Governor Training & Development Reference Group*
GVA	*Gross Value Added*

H

H@N	*Hospital at Night*
HDU	*High Dependency Unit*
HEE	*Health Education England*
HEI	*Higher Education Institution*
HFMA	*Healthcare Financial Management Association*
HFSS	*High in fat, salt and sugar*
HoC	*Head of Communications*
HPV	*Human papilloma virus*
HR	*Human Resources*
HRG	*Healthcare Resource Group*
HSE	*Health & Safety Executive*
HSMR	*Hospital Standardised Mortality Ratios*

I

I&E	*Income and Expenditure*
IAPT	*Improving Access to Psychological Therapies*
ICP	*Integrated Care Provider*
ICS	*Integrated Care System*
ICU or ITU	*Intensive Care Unit or Intensive Therapy Unit*
IG	*Information Governance*
IPG	*Investment Planning Group*
IPR	*Integrated Performance Report*
IPS	*Individual Placement and Support*
ISDN	*Integrated Stroke Delivery Network*
IT or IM&T	*Information Technology or Information Management & Technology*

K

| **KPI** | *Key Performance Indicator* |
| **KSF** | *Knowledge & Skills Framework* |

L

| **LCFS** | *Local Counter Fraud Specialist* |

LeDeR	*Learning Disabilities Mortality Review Programme*
LGBT+	*Lesbian, Gay, Bisexual, Transgender*
LHCR	*Local Health and Care*
LHRP	*Local Health Resilience Partnership*
LiNAC	*Linear Accelerator*
LNC	*Local Negotiating Committee*
LocSSIPs	*Local Safety Standards for Invasive Procedures*
LoC	*Letter of Claim*
LoS	*Length of Stay*
LTFM	*Long Term Financial Model*
LTP	*Long Term Plan*

M

MARS	*Mutually Agreed Resignation Scheme*
MCP	*Multispecialty community provider*
MD	*Medical Director*
MDT	*Multi-Disciplinary Team*
MERG	*Membership Engagement and Recruitment Group*
Mortality rate	*The ratio of total deaths to total population in relation to area and time.*
MRI	*Magnetic Resonance Imaging*
MRSA	*Methicillin Resistant Staphylococcus Aureus*
MSC	*Medical Staffing Committee*
MSK	*Musculoskeletal*

N

NatSSIPs	*National Safety Standards for Invasive Procedures*
NCEPOD	*NCEPOD (National Confidential Enquiry into Perioperative Death)*
NED	*Non-Executive Director*
NEWS2	*National Early Warning Score 2*
NHS	*National Health Service*
NHSI	*NHS Improvement - The independent regulator of NHS Foundation Trusts*
NHSIQ	*NHS Improvement Quality*
NHSLA	*National Health Service Litigation Authority*
NICE	*National Institute for Health & Clinical Excellence*
NICU	*Neonatal Intensive Care Unit*
NIHR	*National Institute for Health Research*
NMC	*Nursing and Midwifery Council*
NMG	*Nursing and Midwifery Group*
NOF	*Neck of Femur*
NPfIT	*National Programme for Information Technology*
NPSA	*National Patient Safety Agency*
NREC	*Nominations, Remuneration & Evaluations Committee*
NRLS	*National Reporting and Learning System*
NSF	*National Service Framework*
NVQ	*National Vocational Qualification*

O

OD	*Organisational Development*
OECD	*Organisation for Economic Co-operation and Development*
OFRG	*Operational Finance Reference Group*
OFT	*Office of Fair Trading*
OMF	*Oral Maxillo Facial*

P

PA/SPA	*Programmed Activities and Supporting Professional Activities*
PACS	*Picture Archiving and Communications System – the digital storage of x-rays or Primary Acute Care Systems*
PALS	*Patient Advice and Liaison Service*
PBC	*Practice Based Commissioning*
PbR	*Payment by Results*
PEAT	*Patient Environment Action Team*
PET	*Position emission tomography scanning system*
PEWS	*Poole Early Warning System*
PFI	*Private Finance Initiative*
PHB	*Personal health budget*
PHE	*Public Health England*
PHFT	*Poole Hospital NHS Foundation Trust*
PHR	*Personal health record*
PID	*Project Initiation Document*
PLICS	*Patient Level information and costing systems – data collection system*
PMO	*Project Management Office*
PROM	*Patient Recorded Outcomes Measures*
PST	*Patient Safety Thermometer*
PTIP	*Post Transaction Implementation Plan*
PYLL	*Potential Years of Life Lost*

Q

QI	*Quality Improvement*
QIA	*Quality Impact Assessment*
QIPP	*The Quality, Innovation, Productivity and Prevention Programme*
QNI	*Queen's Nursing Institute*
QOF	*Quality and Outcomes Framework*
QPR	*Quarterly Performance Review*
QSPC	*Quality, Safety & Performance Committee*

R

R&D	*Research and development*
RACE	*Rapid Assessment and Consultant Evaluation for older people*
RBH	*Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust*
RCI	*Reference Cost Index*
RDC	*Rapid Diagnostic Centre*
RTT	*Referral to Treatment. The current RTT Target is 18 weeks.*

S

SaaS	*Software as a Service*
SALT	*Speech and Language Therapy*
SAU	*Surgical Assessment Unit*
SBLCB	*Saving Babies Lives Care Bundle*
SCCL	*Supply Chain Coordination Limited*
SDEC	*Same Day Emergency Care*
SHMI	*Summary Hospital Mortality Indicator*
SFIs	*Standing Financial Instructions*

SI	*Serious Incident*
SID	*Senior Independent Director*
SIRO	*Senior Information Risk Owner*
SLA	*Service Level Agreement*
SLM	*Service Line Management*
SLR	*Service Line Report*
SMR	*Standardised Mortality rate – see Mortality Rate*
SPF	*Staff partnership Forum*
SpR	*Specialist Registrar – medical staff grade below consultant*
SSNAP	*Sentinel Stroke National Audit Programme*
STEIS	*Strategic Executive Information System*
STAMP	*Supporting Treatment and Appropriate Medication in Paediatrics*
STOMP	*Stopping over medication of people with a learning disability autism or both*
STP	*Sustainability and Transformation Plan*
SUS	*Secondary Uses Service*

T

TAL	*NHS Direct provides The Appointments Line service as part of Choose & Book*
TIAA	*The trust's internal auditors*
TOR	*Terms of Reference*

U

UCLH	*University College London Hospitals*
UNICEF	*United National International Children's Emergency Fund*
UTC	*Urgent Treatment Centre*

V

VCSE	*Voluntary, Community and Social Enterprise*
VFC	*Virtual Fracture Clinic*
VfM	*Value for Money*
VIP Score	*Visual Infusion Phlebitis of intravenous cannuloe – scoring system*
VSM	*Vey Senior Manager*
VTE	*Venous Throboembolism*

W

WODC	*Workforce and Organisational Development Committee*
WTE	*Whole Time Equivalent*

Y

YTD	*Year to Date*

January 2019