

A meeting of the Board of Directors will be held on **Friday 26 June 2015** at 8.30am in the **Conference Room, Education Centre, Royal Bournemouth Hospital**.

If you are unable to attend on this occasion, please notify me as soon as possible on 01202 704777.

SARAH ANDERSON
TRUST SECRETARY

A G E N D A

| TIMINGS | | | APPENDIX |
|--------------------|--|-----------------|----------|
| | 1. APOLOGIES FOR ABSENCE | | |
| | Basil Fozard (Ruth Williamson attending), Stuart Hunter (Pete Papworth attending), | | |
| | 2. DECLARATIONS OF INTEREST | | |
| 8.30-8.35 | 3. MINUTES OF THE PREVIOUS MEETING | | |
| | (a) To approve the minutes of the meeting held on Friday 29 May 2015 | | A |
| 8.35-8.40 | 4. MATTERS ARISING | | |
| | (a) Update to Actions Log | All | B |
| 8.40-9.10 | 5. QUALITY IMPROVEMENT | | |
| | (a) Patient Story | Paula Shobbrook | Verbal |
| | (b) Feedback from Staff Governors | Jane Stichbury | Verbal |
| | (c) CQC inspection October 2015 (including new standards Guidance for Providers) | Paula Shobbrook | C |
| 9.10-10.00 | 6. PERFORMANCE | | |
| | (a) Performance Exception Report | Richard Renaut | D |
| | (b) Quality Performance Report | Paula Shobbrook | E |
| | (c) Financial Performance | Stuart Hunter | F |
| | (d) Workforce Report | Karen Allman | G |
| | (e) Stroke SSNAP Report | Richard Renaut | H |
| 10.00-10.15 | 7. STRATEGY AND RISK | | |
| | (a) Clinical Services Review | Tony Spotswood | Verbal |
| 10.15-10.20 | 8. DECISION | | |
| | (a) 'Freedom to Speak Out' | Paula Shobbrook | Verbal |
| 10.20-10.25 | 9. INFORMATION | | |
| | (a) Communications Update (including June Core Brief) | Karen Allman | I |
| | (b) Corporate Events Calendar | Sarah Anderson | J |
| | (c) Board of Directors Forward Programme | Sarah Anderson | K |

10. NEXT MEETING

Friday 31 July 2015 at 8.30am in the Committee Room, Management Offices, Royal Bournemouth Hospital

10.25-10.30

11. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.30-10.45

12. COMMENTS AND QUESTIONS FROM THE GOVERNORS

Board Members will be available for 10-15 minutes after the end of the Part 1 meeting to take comments or questions from the Governors on items received or considered by the Board of Directors at the meeting.

13. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS
NHS FOUNDATION TRUST

Part I Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Board of Directors** held on **Friday 29 May 2015** in the Committee Room, Royal Bournemouth Hospital

| | | | |
|----------------|--|------|---|
| Present: | Jane Stichbury | (JS) | <i>Chairman (in the chair)</i> |
| | Tony Spotswood | (TS) | <i>Chief Executive</i> |
| | Karen Allman | (KA) | <i>Director of Human Resources</i> |
| | Stuart Hunter | (SH) | <i>Director of Finance</i> |
| | Ian Metcalfe | (IM) | <i>Non-Executive Director</i> |
| | Steven Peacock | (SP) | <i>Non-Executive Director</i> |
| | Paula Shobbrook | (PS) | <i>Director of Nursing and Midwifery</i> |
| | Dave Bennett | (DB) | <i>Non-Executive Director</i> |
| | Derek Dundas | (DD) | <i>Non-Executive Director</i> |
| | Basil Fozard | (BF) | <i>Medical Director</i> |
| In attendance: | Anneliese Harrison | (AH) | <i>Assistant Trust Secretary (minutes)</i> |
| | Donna Parker | (DP) | <i>Deputy Chief Operations Officer</i> |
| | Paula Rayson | (PR) | <i>Matron, Cardiology</i> |
| | Anthony Young | (AY) | <i>Nurse Practitioner, Cardiology</i> |
| | Nicola Hartley | (NH) | <i>Director of Organisational Development</i> |
| | James Donald | (JD) | <i>Head of Communications</i> |
| | Ruth Williamson | (RW) | <i>Proposed Interim Medical Director</i> |
| | Dily Ruffer | (DR) | <i>Governor Coordinator</i> |
| | Philip Copson | (PC) | <i>Hospital Volunteers</i> |
| | Mike Allen | (MA) | <i>Public Governor</i> |
| | Colin Pipe | (CP) | <i>Public Governor</i> |
| | Carole Deas | (CD) | <i>Public Governor</i> |
| | Roger Parsons | (RP) | <i>Public Governor</i> |
| | Paul Higgs | (PH) | <i>Public Governor</i> |
| | Bob Gee | (BG) | <i>Public Governor</i> |
| | Guy Roquette | (GR) | <i>Public Governor</i> |
| | Margaret Neville | | <i>Chair of the Friends of the Eye Unit</i> |
| | Michelle Dharmasiri | | <i>Member of Public</i> |
| Apologies: | Peter Gill, Richard Renaut, Bill Yardley, Alex Pike. | | |

43/15 **DECLARATIONS OF INTEREST**

None.

44/15 **MINUTES OF THE MEETING HELD ON 24 APRIL 2015 (Appendix A)**

The minutes of the meeting on 24 April 2015 were confirmed as an accurate record subject to amendments.

45/15 **MATTERS ARISING (ACTIONS LOG) (Appendix B)**

(a) **To provide updates to the action log**

The action log was discussed and updated.

- KA commented that corporate language issues had not been identified within training and that a post implementation review in the autumn would provide further information.
- PS added that a consultation was underway for the 'freedom to speak up' review and following this guidance would be sought for the appointment of guardians.
- KA advised that the 100% target for mandatory training of eligible staff would be challenging to achieve and that the 'eligible' criteria required further work.

(b) **Briefing Paper – Nutrition (Appendix C)**

PS outlined the briefing paper provided by the Nutrition Steering Group. SP queried the standards and the gaps between patient expectations. PS advised that the Trust conducts an audit on a regular basis and that changes are based upon patient opinion. When a patient is not satisfied with the options available the catering department are contacted in order to provide an alternative. It was stressed that patient nutrition is paramount and this is recognised by all staff. Menus are designed by the nutrition team based upon national best practice and patient feedback.

DD commented that patients may not always be aware of the alternatives and these should be promoted. TS added that this is a continually evolving process that the Trust provides to improve patient experience.

46/15

QUALITY IMPROVEMENT

(a) **Patient Story (Verbal)**

AY and PR presented the patient story to the Board. It concerned a complaint within the cardiology directorate, following the delayed discharge of a patient, who had been admitted after a heart attack. The patient had originally been advised they would be able to leave earlier in the day however, following a delay with results within the catheter lab and issues with the dispensing of medication; the patient was not discharged until later the next day.

Following this the team took action to improve patient pathways and to increase hospital flow overall. An audit was conducted and upon review of the results the team implemented changes which resulted in increased laboratory capacity, to ensure results are received more efficiently, and applying more focus to improving front door admission and flow.

Upon further review of the changes made the team identified that the discharge process required further improvements. Funding has now been secured from the governance team for an interim pharmacist which will improve the efficiency of dispensing medication during the discharge process. The 'length of stay' Board has also been approached in order to establish more permanent and dedicated

pharmacy support. Nurses are being utilised more by increasing their skill sets, to include medication prescribing, and the team is also working with doctors to improve the discharge process through a combined team effort. There is now a criterion to follow which can be adapted for in patients and a protocol is being developed and agreed for nurse led discharge.

PS commented that this was a good example of continual improvements being made and that teams were not being complacent. Further she noted the exciting development of nurse led discharge.

KA added that the presentation had been helpful and that increasing pharmacy prescribers was an area of focus for the Trust and the development of nurse's roles and education which will aid flow throughout the Trust.

IM queried how technology was being used. BF added that electronic prescribing will impact upon the logistics of the process once introduced. BF queried the current paper process and whether there was a way to improve this in the meantime. Further he queried why consultant prescribing was not being utilised and emphasised that it was essential to consider the whole pathway and make changes all at once.

PR responded that the team was working with consultants in relation to prescribing to form a consistent process. AY added that recent figures had increased due to activity volumes but the cardiology team were working with AHPs to reduce length of stay in ED and AMU and pressures at the front line.

DB supported that this was a good example of improvements being made and team work. He added that it was important to incorporate the learning in different areas and that this would also help to deliver cost improvements.

The Board discussed that the patient story should become a case study and it should be promoted across the organisation that staff are doing this in practice. JS emphasised that recording this as a reference point for the Trust would be beneficial.

PS/JD

(b) Feedback from Staff Governors (Verbal)

The Chairman updated the Board on the recent Staff Governors feedback from the meeting on 26 May highlighting the following:

- Arrangements for the new staff governor inductions were raised; **DR/SA**
- The staff 'Question Time' event videos are available on the intranet;
- The 'Question Time' event identified important themes which staff governors wanted to emphasise:
 - Ø Themes of harassment and bullying following the staff survey,

- Ø Staff needing efficient IT support,
- Ø Increased visibility of new matrons on the wards,
- Ø Staff recruitment and retention,
- Ø Site access and car parking,
- Ø The Trust's values and culture and involving staff in more decisions around the Trust;
- Ø Staff governors praised the new appraisal system and organisational development work although they noted a time demand in completing the process;
- Ø Staff concerns surrounding the CSR and the future of the Trust.

PS assured that any issues with the clinical visibility of matrons would be addressed although the feedback contrasted the messages received from ward staff. **PS**

The Board discussed the importance of providing feedback to staff on these concerns noting that in some areas the feedback may be on an individual basis rather than of a general view. TS added that in relation to the CSR the Trust has a clear view that the provision of emergency services should remain at RBCH and a rationale would be provided.

(c) Annual Inpatient/Outpatient Survey results (Appendix D)

PS presented the survey to the Board noting that it was an annual survey and it provided an example of the improvement journey the Trust has been on over the last year.

- The Trust was ranked green in four areas and has significantly improved compared to last year where it ranked green in one area;
- The areas that require improvement relate to signage on bathrooms and mixed sex bathrooms;
- 42 areas of improvement out of 60 questions;
- CQC highlighted 8 statistical areas of improvement;
- RBCH was within the top 20% and is benchmarking well against other local trusts.

PS emphasised that the Trust was not complacent and are preparing for the next survey which will be sent to patients who are in hospital in June and July.

SP commented that the overall picture was positive but there was still a journey ahead for the Trust. PS added that 10 areas had deteriorated in comparison to 29 last year. She assured the Board that she considered further improvements will be made this year which will be supported through the focus on the Trust's values and behaviours. The Board noted that this was an encouraging message for staff and that it will be important to communicate what will be needed to improve further within the next survey.

(d) CQC Intelligent Monitoring Report (Appendix E)

PS outlined the report noting the following key information:

- There were no elevated risks but 3 risks were identified which included knee related PROMS indicators, SSNAP domain rating and in-hospital mortality- neurological conditions;
- The Trust has received the best band rating of 6 from band 1 in 2013 which is reflective of the improvement journey so far.

BF commended the improvements in comparison to last year and noted that the Trust as a whole had responded well to the alerts. He noted that the in hospital mortality and neurological conditions was not a significant risk but a further review was due to be implemented. He noted there had been significant work within orthopaedics with two knee surgeon appointments and felt positive that the Trust would continue to make good progress over the next year.

The Board discussed the positive messages within the report and suggested that the full report was circulated to the Board and governors. TS added that it was important to compare this to the Trust's position last year and produce an encouraging message for staff.

PS

47/15

PERFORMANCE

(a) Performance Exception Report (Appendix F)

DP outlined the report highlighting the following expected performance to the Board:

- Q1 onwards- the Trust is expected to be compliant for the 2 week wait cancer standard due to operational changes in the management of 2 week waits, patient choice, matching of clinic capacity and daily escalation of issues. The Trust will strive for continued improvements throughout the year;
- 62 day cancer standard- planned breach due to a recurrent backlog within urology from additional patients and template biopsy waiting lists from Dorchester. Patients are being managed with additional capacity and the CCG have commissioned a template biopsy service at RBCH;
- RTT non admitted- as per the Trust's action plan to bring forward long waiters in Q1 across all specialities and focus on securing recovery in Q2;
- ED 4 hour- 95% compliance for May following a slight decrease due to activity levels and a heavier case mix in April.

Action plans:

- The reduction in the orthopaedics RTT admitted back log has been much quicker than the trajectory as a result of capacity planning. Challenges remain in some specialties however the current trajectory indicates a compliant aggregate position going forward;
- Improvements in compliance for 62 day cancer performance will

relate to the success of the template biopsy service although it will be necessary to clear the back log before pathway benefits will be seen. Robot weeks will continue and Dorchester surgeon capacity has increased;

- Within dermatology consultant cover over the summer is being secured and the Trust is working with the CCG to develop joint management;
- Capacity work within endoscopy is being outsourced to improve the back log and administrative processes;
- There are pressures around the Poole visiting specialties and the Trust is working with the CCG on capacity;
- Embedding the new PTL tracking process and the BREATH model within ED continues to aid with flow;
- Stroke- striving to improve on the previous 'SSNAP' position and improvements are being seen. There are some issues around direct access and length of stay however weekly reports reflect an improved position;
- Focus will remain on implementing the action plans across specialties and to maintain the improvement in standards especially for 2 week cancer waits which is expected to continue.

TS emphasised the QI programme and encouraged Board members and governors to visit ward 2 to view the impact of the work. Further TS noted that it was necessary to discuss the non-admitted pathway breaches from the Poole based specialties with Poole and identify whether these could be joint breaches.

RR

PS added that in relation to c difficile performance the rate for the Trust was significantly better compared to local trusts from the PHE data for 2015.

IM queried whether the recent ED breaches were caused by the impact of the Easter increased activity and whether in future this could be better planned for. DP advised that norovirus was unexpected and impacted five wards however the Trust will be applying the learning to future planning. IM requested information for August holiday period and how the planning will be addressed.

RR

The Board emphasised the importance of learning from planning during increased activity periods.

(b) Quality Performance Report (Appendix G)

- Harm free care- safety thermometer benchmarking has improved and the Trust has set a trajectory of 95%. Current data reflects 92%;
- Two SIs were confirmed and reported this month;
- Harm free care- pressure damage, falls and UTIs, no serious incidents this month for pressure damage;

- Risk assessment compliance- majority above 95%. There are areas requiring improvement but assurance has been provided through discussions with teams;
- FFT benchmarking data highlights that out of 167 Trusts- 8 trusts scored 100% and 10 Trusts scored 99%. RBCH scored 98% and is within the top quartile;
- Annual statistics show an improvement across a number of indicators and HAC will continue to review the challenges.

DB commented that there were some areas that are impacting upon the overall scoring but others were performing well. Recurrent areas have been identified and issues relate to staffing and change in leadership. The Trust is now rotating staff from areas that are performing well to areas that are not performing as well.

The Board emphasised that leadership was essential and that further work around recruitment will help sustain performance.

(c) Financial Performance (Appendix H)

SH outlined that the Trust had agreed a deficit budget in the current year of £12.9 million. SH drew attention to areas of pressure within the system which include excluded devices and excluded drugs and emphasised that the Trust needs to manage its expenditure this year.

It was noted that currently the Trust was performing below the agency trajectory set for this year. The annual plan has been submitted to Monitor who are due to visit in June to discuss the Trust's finances and planning with regards to capacity and demand. Further information will be provided in the finance report for the June Board meeting.

IM added that the finance committee had been assured by the Trust's performance in month one and emphasised that the messaging around cost improvements to staff must be consistent. He noted the positive achievement in the agency spend although this must be maintained.

(d) Workforce Report (Appendix I)

KA updated the Board on the workforce report noting the following key themes:

- Appraisal compliance has been reset to reflect the introduction of the new system. There is a cascade approach in place and training so far has been positive;
- Essential score skills- there has been strong progress although extra focus is required from doctors. This issue should be addressed at care group meetings to ensure there is consistency;
- Supportive measures are being piloted in areas where sickness absence is high;
- The vacancy rate is down. The recent open day for nurses was

successful and received positive feedback with good staff involvement also;

- Apprenticeships are being explored for both existing and new staff;
- Care certificate- Health Education Wessex are supporting the certification for HCAs to complete.

JS outlined BY's comments in his absence noting his disappointment with the mandatory training figures and those for medical staff. BF added that this was an area of focus. TS commented that linking mandatory training with the clinical excellence awards was being considered together with the importance of linking with local priorities. He emphasised that mandatory training should be up to date for all clinical staff and this should be used as a lever to move compliance forward. BF noted that complex mandatory training could be linked with the appraisal and revalidation process.

SP commented on the recent press commentary concerning overseas recruitment and the standards of credentials. He queried the Trusts' processes in light of this. KA outlined that this had been identified also as part of the Savile review and that the Trust followed national guidance. The process is due to be reviewed again to ensure that both agencies and the Trust are completing robust checks.

48/15

STRATEGY AND RISK

(a) Clinical Services Review (Appendix J)

TS updated the Board on the CSR developments, noting the key information from the papers provided:

- The CCG met last week and agreed to move forward with five decisions. Legal advisors have indicated that provisions for out of hospital services will need to be more clearly defined. These decisions will not proceed to consultation without an informed approach;
- Six criteria have been used to evaluate the decisions around where emergency care is to be provided. The advantages and benefits have also been provided. Moving forward it is expected that fewer people within Dorset will come to harm and more will live due to 24/7 consultant care and improved stroke services;
- Access to care- 7 day provision, important savings around future spend, issues around sustainable workforce and education;
- Time frame- it is expected that the public consultation will take place around 17 August and decision making in March 2016. It will take a further 2/3 years until the full implementation of the review and it will be important to provide assurance to staff about these changes. A separate seminar for governors will be held to outline the implications for the Trust and how the Trust will respond;

- Proposals- out of hospital provision in the East there will be two large hubs, one at a major planned care centre and one within a local hospital. 5-7 hubs and GP practices brought together for out of hours care services;
- The key aspects concern the major redesign of services.
- There will be two options. One ED site may close and become a GP care centre with high volume low complexity services being completed at a non-emergency site;
- Community hospital bed sites;
- Planned care site will not have a birthing facility;
- There is a debate as to what integrated frailty services will be provided;
- Clinical support has been provided for planned care and the emergency services model;
- Currently a debate around obstetrics and paediatrics services and these options will be considered by the Wessex senate;
- The three main factors that will be considered will be access , affordability and deliverability;
- Capita are currently calculating the cost of development of both Poole and RBH sites;
- The design of the RBH site is better suited for development and could be more efficient to develop however further detailed work is necessary.

(b) Annual Plan 2015/16 (Appendix K)

The item was noted for information. DP emphasised there would be a focus on the Trust's priorities for this year and maintaining finances.

49/15

DECISION

(a) Standing Financial Instructions (SFIs) 2015/16 and amendment to the Board Standing Orders (Appendix L)

SH outlined that the standing orders had been amended and that annex 7 had been placed within the SFIs in line with other Trusts and as financial delegation. He noted that this had been approved by the Council of Governors and that these would be crucial to financial controls going forward.

A summary SFI document will be prepared and provided to every budget holder to ensure it is clear what can be authorised by delegation of the Board. He noted that it is a disciplinary offence to breach the provisions of the SFIs and this must be made clear to staff.

IM supported that this must be well communicated to budget holders and ensure that staff understand their responsibilities and authority. SH advised that the summary would be available within two weeks.

The Board **approved** the amendments of the Board Standing Financial Instructions and the Board Standing Orders in Annex 7 of the

Constitution.

50/15

INFORMATION

(a) Communications Update (including May Core Brief) (Appendix M)

The item was noted for information.

(b) Policies for visitors in Clinical Areas (Appendix N)

The item was noted for information.

(c) Corporate Events Calendar (Appendix O)

The item was noted for information.

(d) Board of Directors Forward Programme (Appendix P)

The item was noted for information.

(e) Easter Review (Appendix Q)

The item was noted for information.

51/15

DATE OF NEXT MEETING

Friday 26 June 2015 at 8.30am, Conference Room, Education Centre, Royal Bournemouth Hospital

52/15

ANY OTHER BUSINESS

Key Points for Communication to Staff

1. CSR
2. Patient story
3. Inpatient survey
4. CQC intelligent monitoring
5. Finance
6. Transformation leading to financial improvements

53/15

QUESTIONS FROM GOVERNORS

1. BG congratulated TS and BF on the letter to Tim Goodson regarding the CSR.

There being no further business the meeting closed at 10:25am
AH

CORPORATE EVENTS CALENDAR 2015

| Date and Time | Event Description | Venue | Contact Details |
|--------------------------------|-----------------------------------|---|-----------------|
| Thursday 25 June | Simply Health | Between the RBCH restaurants | 01202 726159 |
| Friday 26 June | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |
| Monday 29 June – Friday 3 July | 5 Daily Actions | Between restaurants | 01202 704229 |
| Tuesday 30 June | Estates | Atrium | 01202 704394 |
| Tuesday 14 July | Blood Pressure machine evaluation | Atrium | 01202 704394 |
| Wednesday 15 July | Council of Governors' Meeting | Conference Room, Education Centre, Royal Bournemouth Hospital | 01202 704246 |
| Saturday 18 July | Sky Dive | Bournemouth Hospital Charity | 01202 704060 |
| Friday 31 July | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |
| Saturday 12 September | Volunteer's Tea Party | Invitation Only- Volunteer's Office | 01202 704253 |
| Monday 21 September | Understanding Diabetes | The Village Hotel | 01202 704271 |
| Wednesday 23 September | Annual Members' Meeting | The Village Hotel | 01202 704246 |
| Friday 25 September | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |
| Sunday 27 September | Pedal Power | 10am New Forest | 01202 704060 |
| Saturday 3 & Sunday 4 October | Bournemouth Marathon | Bournemouth Hospital Charity | 01202 704060 |
| Friday 30 October | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |

| | | | |
|-------------------------|---|---|--------------|
| Friday 16 October | Light up the Prom- for Oncology & Haematology | 8pm Bournemouth Pier | 01202 704060 |
| Thursday 5 November | Council of Governors' Meeting | Conference Room, Education Centre, Royal Bournemouth Hospital | 01202 704246 |
| Friday 27 November | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |
| Friday 4 December (TBC) | Understanding Knee Pain | The Village Hotel | 01202 704271 |
| Friday 18 December | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |

Key

| | |
|--|---------------------------------------|
| | Surveys and audits |
| | Meetings |
| | Volunteer events |
| | Health and other talks |
| | Stakeholder groups, events and forums |
| | Stands at local/community events |
| | Bournemouth Hospital Charity events |
| | Staff Events |
| | Other activities/events |

| BOARD OF DIRECTORS | |
|--|---|
| Meeting Date and Part: | 26 th June 2015 Part 1 |
| Subject: | CQC Inspection Report |
| Section: | Quality |
| Executive Director with overall responsibility | Paula Shobbrook, Director of Nursing |
| Author(s): | Joanne Sims, Associate Director of Quality and Risk |
| Previous discussion and/or dissemination: | N/A |
| <p>Action required: To note the dates of the CQC inspection. There will be a presentation at the board meeting to update on the process of the inspection and the fundamental standards.</p> | |
| <p>Summary: The Chief Executive was informed on 16th June 2015 that the CQC will conduct a full Inspection of the Trust on the 20-23 October 2015, from which we will receive a rating. The Inspection will be led by Joyce Fredrick's, a Regional Inspection lead. The Director of Nursing is the nominated lead for the Trust, supported by the Medical Director and CEO in liaising with the CQC.</p> <p>The ratings will be given for the relevant service under the domains of safe, caring, effective, responsive and well led; and this will be aggregated to a Trust level rating.</p> <p>In addition, the Trust has received details of an intended change in the inspection process in 2016. The Secretary of State for Health has asked CQC's Chief Inspector of Hospitals to look at use of resources as part of his inspections of NHS hospitals. This work will be developed as part of CQC's new strategy for 2016 onwards and will focus on organisations' ability to deliver high quality patient care that is also efficient and sustainable.</p> <p>The CQC will be working with partners, patient organisations, stakeholders, providers and commissioners to develop a common, comparable measure of the use of resources in the NHS – so that judgments of hospitals' performance are informed by assessments of patient care and use of resources alongside each other.</p> <p>The proposed new inspection criteria is still in the early stages of development. There will be public consultation as part of CQC's future strategy in December 2015. It is then likely that the enhanced approach will be piloted in NHS trusts and foundation trusts from April 2016. There will be an initial focus on developing an assessment of the use of resources in NHS trusts and foundation trusts, but consideration will also be given to how a wider approach could be applied in the future for the other sectors CQC regulates.</p> | |
| Related Strategic Goals/ Objectives: | All |
| Relevant CQC Outcome: | Safe, Caring, Effective, Responsive & Well Led |
| <p>Risk Profile:</p> <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No | |

| BOARD OF DIRECTORS | |
|---|--|
| Meeting Date and Part: | 26 th June 2015 - Part 1 |
| Subject: | Performance Report |
| Section: | Performance |
| Executive Director with overall responsibility | Richard Renaut |
| Author(s): | Donna Parker/David Mills |
| Previous discussion and/or dissemination: | PMG |
| Action required: <p>The Board of Directors is asked to consider the information provided and support any actions highlighted in relation to non-compliant or 'at risk' indicators.</p> | |
| Summary: <p>The attached Performance Indicator Matrix and Performance Report outlines the Trust's performance exceptions against key access and performance targets for the month of May 2015.</p> <p>The Matrix also incorporates an indicative RAG rating for expected performance in the following month based on internal monitoring to date, as well as an indication of Trust level risk in relation to the metrics in the next reporting quarter for each metric.</p> <p>As an overview of the key risks for Q1, these are non-admitted waits (especially Dermatology, Orthopaedics, GI and Poole based specialties), Cancer 62 day and 4 hour ED compliance. The report also includes some key updates on progress against our detailed recovery action plans.</p> | |
| Related Strategic Goals/ Objectives: | Performance |
| Relevant CQC Outcome: | Section 2 – Outcome 4: Care and welfare of people who use services. Outcome - 6 Co-operating with others. |
| Risk Profile: <p>The following risk assessments remain on the risk register:</p> <ul style="list-style-type: none"> i. Cancer 62 & 31 day wait non-compliance and potential risk to the trust's authorisation, due to ongoing risks. ii. 4 hour target due to the continued high level of ambulance conveyances, attendances and admissions and our continued non-compliance, though noting strong March and May performance. iii. RTT non-admitted and admitted speciality and aggregate performance due to speciality pressures. <p>The urgent care impact risk assessment remains on the Trust Risk Register given the continued activity pressures, 4 hour non-compliance and other indicators such as the increase in outliers. However, due to some early indication of improvement the risk score has reduced slightly.</p> | |
| Reason paper is in Part 2 | N/A |

Performance Report June 2015/16 For May 2015

1. Introduction

This report accompanies the Performance Indicator Matrix and outlines the Trust's actual and predicted performance exceptions against key access and performance targets. These targets are set out in *Forward View into Action – Planning for 15-16*, the *Monitor Risk Assessment Framework (RAF)* and in our contracts.

The report also includes some key updates on progress against measures not required by Monitor, such as for diagnostics. A detailed report on Stoke is included as a separate paper.

This report also highlights key changes that have been signalled by NHS England in relation to RTT targets.

2. Risk assessment for 2015/16 - update

There is currently no change to our risk assessment against the Monitor Framework based on our performance for Q1 to date and current projections. All indicators continue to have some risk but current predictions continue to place us below the trigger score of 4. Our assessment will be reviewed monthly. Our performance will also be monitored against the new guidance in relation to the national RTT targets, but based on information to date, we do not anticipate being below threshold.

| Monitor Risk Assessment Framework: 2015-16 Prediction | Q1 | Q2 | Q3 | Q4 |
|---|-----|-----|-----|-----|
| Referral to treatment time, 18 weeks in aggregate, admitted patients | No | No | Yes | No |
| Referral to treatment time, 18 weeks in aggregate, non-admitted patients | Yes | Yes | No | No |
| Referral to treatment time, 18 weeks in aggregate, incomplete pathways | No | Yes | No | No |
| A&E Clinical Quality- Total Time in A&E under 4 hours | Yes | No | No | Yes |
| Cancer 62 Day Waits for first treatment (from urgent GP referral) | Yes | Yes | No | No |
| Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) | No | No | No | No |
| Cancer 31 day wait for second or subsequent treatment - surgery | No | No | No | No |
| Cancer 31 day wait for second or subsequent treatment - drug treatments | No | No | No | No |
| Cancer 31 day wait for second or subsequent treatment - radiotherapy | No | No | No | No |
| Cancer 31 day wait from diagnosis to first treatment | No | No | No | No |
| Cancer 2 week (all cancers) | No | No | Yes | Yes |
| Cancer 2 week (breast symptoms) | No | No | No | No |
| Clostridium Difficile -meeting the C.Diff objective | No | No | No | No |
| Compliance with requirements regarding access to healthcare for people with a learning disability | No | No | No | No |

The non-admitted RTT performance in Q1 continues as a 'planned' breach, especially due to pressures previously outlined and as backlog waits are reduced in a proactive way. Recovery is planned for Q2, although particular risk is flagged due to the ongoing work with the CCGs, Poole Hospital and NHS England in relation to ENT, Oral Surgery and Neurology. There are also pressures on Endoscopy. In addition, the work to reduce clinic waits across specialities runs the risk of a surge of patients being added to admitted waiting lists. This is why the Incomplete Pathways and Admitted

RTT indicators are flagged as risks for Q2 & Q3 respectively. These will though, continue to be closely managed to minimise the risk.

As confirmed previously, Cancer 62 day waits will breach in Q1 & Q2 as a result of reducing Urology patients waiting (discussed below in relevant section). Recovery is strongly on track for the Cancer Two Week Wait and other cancer targets for Q1. The final NICE Guidance on Two Week Wait referrals may double referrals in some specialities and remains a risk for Q3 & 4. This is especially so in already pressured areas such as GI/Endoscopy and Dermatology.

Unfortunately we were just below the 95% threshold for the 4 hour ED target in May, at 94.69%, though good improvement was seen compared to April. Q1 performance to date currently stands at 93.26% reflecting the continued risk indicated in our assessment.

3. Infection Control

Number of Hospital acquired C. Difficile due to lapses in care
Number of Hospital acquired MRSA cases

Guidance is now focused on those cases attributed to lapses in care. A challenging national target for 15/16 has been confirmed as a maximum of 14 C.Diff cases 'due to lapses in care'. Actions are being developed in conjunction with the Nursing Directorate and Infection Prevention and Control Committee.

For April 2015, two cases of C. Difficile were reported on the Wards, however, in line with the national guidance, none were due to lapses in care. For May 2015, a further one case of C. Difficile was reported on the wards. This is currently being investigated to determine cause.

There have been no reported cases of MRSA.

4. Cancer

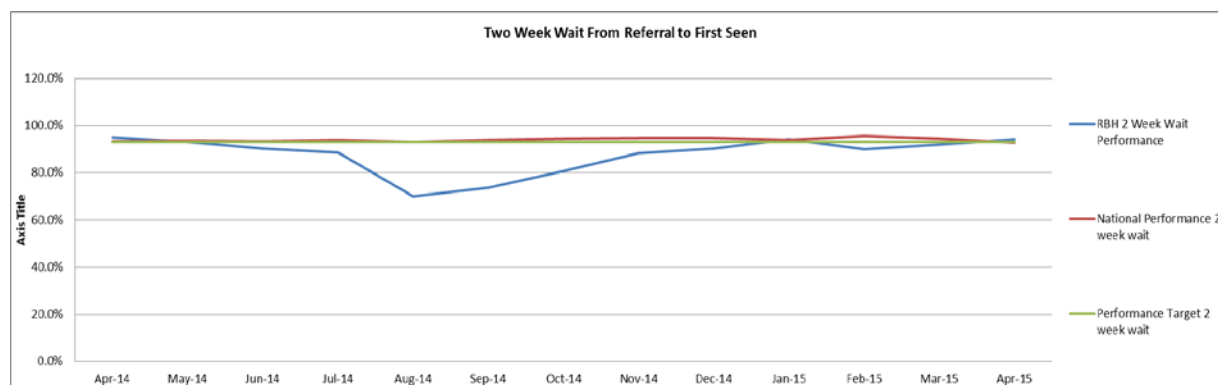
Performance against Cancer Targets

| Key Performance Indicators | Threshold | Qtr 4 | Apr-15 | May Predicted |
|---|-----------|-------|--------|---------------|
| 2 weeks - Maximum wait from GP | 93% | 91.6% | 94.3% | 97.5% |
| 2 week wait for symptomatic breast patients | 93% | 98.1% | 96.3% | 100% |
| 31 Day – 1st treatment | 96% | 96.2% | 98.8% | 96.9% |
| 31 Day – subsequent treatment - Surgery | 94% | 86.1% | 97.0% | 100% |
| 31 Day – subsequent treatment - Others | 98% | 100% | 100% | 100% |
| 62 Day – 1st treatment | 85% | 81.9% | 85.2% | 84.9% |
| 62 day – Consultant upgrade (<i>local target</i>) | 90% | 83% | 67% | 71.4% |
| 62 day – screening patients | 90% | 89.6% | 100.0% | 81.8% |

Two Week Wait

The overall improvement against the Two Week Wait target has been sustained with compliance being achieved for April and continuing through May and June to date, resulting in anticipated compliance for Q1. Endoscopy capacity remains a risk. However, all areas are currently being managed through targeted capacity and prioritisation, together with a clear escalation process.

The below graph shows our improved performance since last year and against the national position.

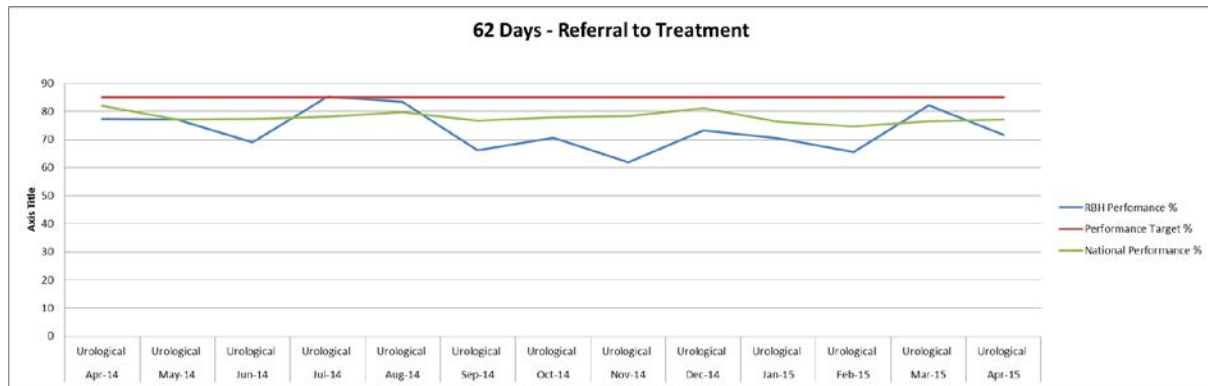


The Breast symptomatic target also continues to be achieved.

62 Day Referral to Treatment

Whilst the number of 'breach' patients treated in April means we achieved 85% target, we currently remain non compliant for Q1, as we continue our focus on treating the longer waiting patients in Urology. The success of the 'robot weeks' for prostatectomies has continued and the plan has been extended with the aim of clearing the current backlog by September, subject to clinical urgency of cases over the period. This plan also incorporates clearing the current known backlog at Dorchester, however, this will remain under review as confirmed diagnoses are made. As highlighted previously, positively, the local template biopsy service has now commenced which will reduce delays in diagnostic pathways for Urology once the existing waiting list has been cleared which is expected in the Autumn. The overall backlog clearance in Urology, together with some delays in Lung patient pathways across providers, is currently challenging a Q2 compliance trajectory and this is therefore, projected for Q3.

The below graph compares RBH with the national Urology 62 day performance. This is a challenging service for the whole of England. RBCH is especially affected as Urology makes up a disproportionate element of workload.



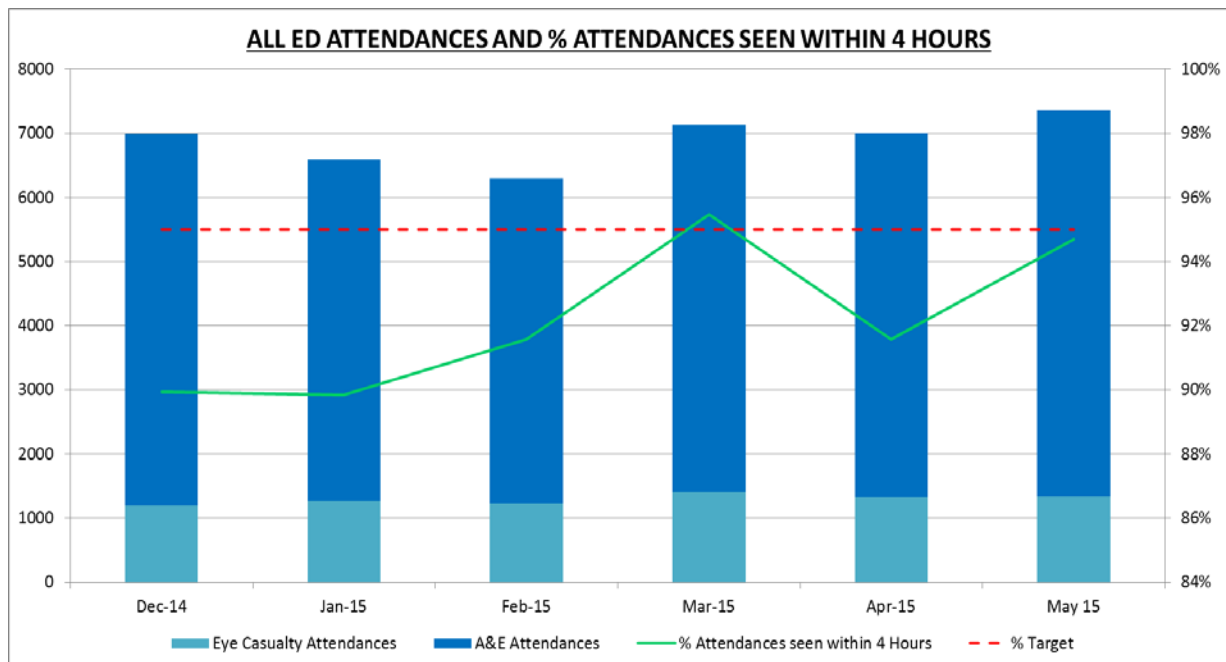
31 Day First Treatment, Subsequent Surgery and 62 Day Screening

April has shown positive improvement against these standards with all returning to compliance. This is expected to be a sustainable trend since cover for Skin and Breast Services has now improved. These small number performance targets, often relying on a small number of specialist staff, can experience a handful of patient breaches that can tip these into non-compliance. Therefore, an underlying risk remains.

5. A&E

95% of patients waiting less than 4 hours from arrival to transfer/discharge

May saw an increase in ED attendances compared to April (+362, +5.17%), with a decrease in ED breaches (198 fewer, -33.6%). Emergency admissions were up 1.3% (+33) in May compared to April. Non-Elective admissions (e.g. transfers in) were down -23 in May compared to April, however this reflects seasonal trends. Growth has been more significant in June to date, for both admitted and attenders.



The ED performance in May increased to 94.69%. Whilst still under the 95% target, it is an improvement compared to 91.58% reported for April.

Analysis of the continuation of below threshold performance in May shows 63.2% of the breaches in May were within the ED itself, with 85.4% of the breaches being attributed to clinician assessment delay. This is expected to improve when the BREATH model is extended to 10pm from late June and further supported by a move to increase Nurse Practitioner cover in July as well as commencement of an additional consultant in August. The team in ED are currently re-reviewing the rotas and locum cover to ensure key shifts have allocated 'senior decision makers'. Policies are also being developed to support joint working and faster access to specialist opinions, direct admission where appropriate and pathways for reattendances.

We have started to see the shift towards increased minors attendances, reflecting the seasonal summer trend and we will be monitoring this closely against previous/expected activity levels. A review of pathways direct from ED to the Out of Hours service is also underway to support this activity trend. Work with partners to avoid "batching" of GP admissions and ambulance conveyances in late evening is being requested.

6. Learning Disability

Patients with a learning disability: Compliance with requirements to healthcare access

Both Q4, April and May were compliant with requirement to healthcare access. We anticipate meeting the Q1 15-16 target.

7. Diagnostics

99% of patients to wait less than 6 weeks for a diagnostic test

Unfortunately Mays' diagnostic result of 97.9% missed the 99% threshold due to Endoscopy waits (specifically Gastroscopy with 50.54% of the >6wk patients). Additional work and outsourcing within Endoscopy has continued through May and June to continue to alleviate some of the pressures and to ensure appropriate and timely clinical care for patients. The QI improvement project related to admin and booking processes commenced on 25 May and is now well underway working on the design and implementation of new lean processes. This, together with a significant piece of work analysing demand and capacity analysis, will inform our forward looking trajectory which is expected within the next month. A decision on staffing levels is also required.

Radiology and Cardiology diagnostics remain compliant despite increases in demand, which continues to be testament to the flexibility and dedication of these services.

8. Stroke

A separate paper reporting the latest Stroke Sentinel Audit data is being presented to the Board of Directors. At a headline level, the report for RBCHFT shows our score has improved from 57 to 66, moving us for the first time into C rating, with the highest score in Wessex (against the previous quarter).

9. Referral to Treatment Times (RTT) – Aggregate and Speciality Level

90% of patients on an admitted pathway treated within 18 weeks
95% of patients on a non-admitted pathway treated within 18 weeks
92% of patients on an incomplete RTT pathway within 18 weeks

Non Admitted RTT

The Trust performed as planned on the RTT targets, with non compliance against the aggregate Non Admitted target (93.97%) due to the focus on reducing the backlog of non admitted long waiting patients. The specialities which were non-compliant were: Orthopaedics, ENT, Oral Surgery, General Medicine, Neurology and Gynaecology. The ongoing work to reduce backlogs is also now starting to see an improving position on our Incomplete Pathways (see below), which remained compliant at 93.9% and is beginning to put us on a stronger footing for more sustainable performance across the RTT targets. The biggest risks to non admitted pathways remain the visiting specialities of ENT, Oral Surgery and Neurology. Other risks are pressures in Gastroenterology/Colorectal and Endoscopy (as indicated above), plus increases in late transfers from other providers (e.g. Orthopaedics and Dermatology) and medical staffing gaps.

An action plan has been agreed with our commissioners regarding the visiting specialities and Dermatology. However, due to the cross provider and/or specialist commissioning complexities relating to these services, together with the need for detailed demand and capacity analysis, this is unlikely to be fully resolved in Q1. We continue to seek additional, 'ad hoc' capacity in the meantime wherever possible, in order to reduce waits for patients whilst also continuing to ensure that GPs are fully informed of our waiting times and choices available for patients.

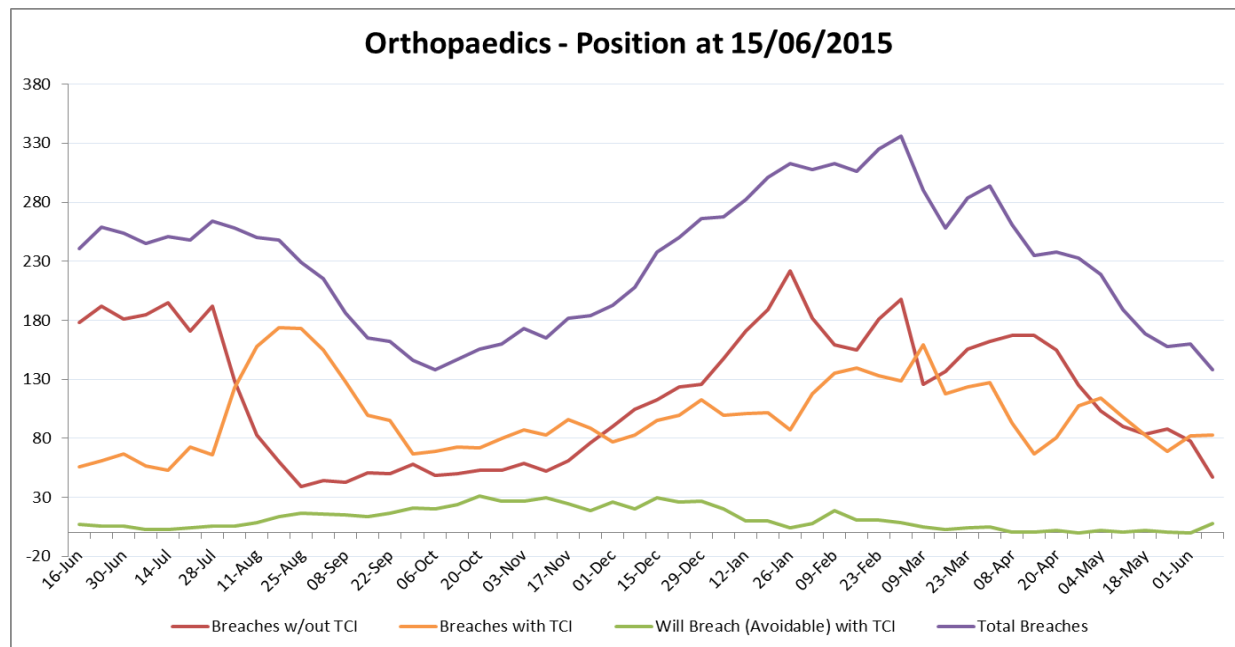
Admitted and Incomplete Pathways

Admitted aggregate and Incomplete Pathways were above threshold with a return of 91.3% and 93.9% respectively. Again this reflects trajectories and the results and/or impact of previous and ongoing work to reduce backlogs

The Admitted RTT backlog has now reduced significantly in Orthopaedics (see graph below) together with outpatient waits, and we have commenced some specific

targeted pathway work in some specialities where we have seen some smaller increases in backlogs (e.g. Gynae and Vascular). Specialist surgical capacity remains

a challenge in Dermatology due to current medical gaps. Additional sessions are being secured to provide capacity and we are also reviewing the external demand/capacity modelling that is being undertaken, as well as reviewing current pathways and approaching referring providers in relation to joint work on late transfers.



RTT National Measures – Going Forward

Going forward, NHS England have announced plans to improve access and simplify measurement of some waiting times standards. Whilst the NHS Constitution standards relating to 18 weeks continue to be fully endorsed, the RTT indicators will be rationalised to focus on one measure which tracks the complete patient experience – the Incomplete Pathway measure. National guidance providing additional clarity and confirming the timescale for this change is awaited however, NHS England have indicated that this should happen quickly.

As previously reported, since April the Trust moved fully to the new recording system (PPW) which has significantly improved our patient tracking processes. This move is key to full tracking and ‘pull’ of patients on incomplete pathways and has put us in a strong position as we move towards the focus on the Incomplete Pathways measure.

The table below shows our May Incomplete Pathways (‘clocks still running’) and the progress made to date through Q1 to reduce backlogs and increase the percentage of patients still within 18 weeks on their pathway. The total backlog of patients waiting on admitted or non admitted pathways for *more* than 18 weeks currently stands at 1,181 (6.0%), within the national threshold of 8%.

| | Apr-15 | May-15 |
|------------------|--------------|--------------|
| General Surgery | 91.1% | 93.0% |
| Urology | 89.9% | 90.1% |
| Orthopaedics | 89.2% | 92.9% |
| ENT | 87.8% | 87.4% |
| Ophthalmology | 97.4% | 97.3% |
| Oral Surgery | 80.5% | 73.3% |
| Cardiothoracic | 100.0% | 100.0% |
| General Medicine | 93.0% | 94.6% |
| Cardiology | 94.6% | 94.9% |
| Dermatology | 84.6% | 89.3% |
| Thoracic | 97.9% | 99.4% |
| Neurology | 86.7% | 85.6% |
| Rheumatology | 97.1% | 96.1% |
| Elderly Medicine | 97.8% | 97.0% |
| Gynaecology | 91.8% | 95.1% |
| Other | 97.3% | 97.7% |
| TOTAL | 92.6% | 93.9% |

Whilst the risks highlighted throughout this section of the report currently continue to challenge our RTT performance, the progress to date on our incomplete pathways, tracking processes and the action plans in place in relation to these risks, mean that we currently expect a return to compliance on the measures in Q2.

10. Recommendation

The Board of Directors is requested to note the performance exceptions to the Trust's compliance with the 2015/16 Monitor Framework and 'The Forward View into Action' planning guidance requirements.

2015/16 PROPOSED PERFORMANCE INDICATOR MATRIX FOR BOARD OF DIRECTORS

| Area | Indicator | Measure | Target 15/16 | Monitor | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 | Forecast - Next Month | Forecast - Quarter | RAG Thresholds | | |
|---|--|--|---------------------|---------|--------|--------|--------|--------|--------|--------|--------|--------|-----------------------|--------------------|----------------|------|---------------|
| Monitor Governance Targets & Indicators | | | | | | | | | | | | | | | > trajectory | | <= trajectory |
| Infection Control | Clostridium difficile | Total number of hospital acquired C. Difficile cases under review | n/a | 1.0 | 5 | 9 | | | | | 2 | 1 | n/a | n/a | | | |
| | Clostridium difficile | C. Difficile cases due to lapses in Care | 14 (1 pcm) | | - | - | | | | | 0 | tbc | | | >1 | <=1 | |
| Referral to Treatment | RTT Admitted | 18 weeks from GP referral to 1 st treatment – aggregate | 90% | 1.0 | 88.1% | 90.2% | | | | | 90.1% | 91.3% | | | <90% | ≥90% | |
| | RTT Non Admitted | 18 weeks from GP referral to 1st treatment – aggregate | 95% | 1.0 | 95.6% | 91.9% | | | | | 93.0% | 94.0% | | | <95% | ≥95% | |
| | RTT Incomplete pathway | Patients on an 18 week pathway awaiting treatment – aggregate | 92% | 1.0 | 95.0% | 92.6% | | | | | 92.6% | 93.9% | | | <92% | ≥92% | |
| Cancer | 2 week wait | From referral to to date first seen - all urgent referrals | 93% | 1.0 | 86.1% | 91.6% | | | | | 94.3% | | | | <93% | ≥93% | |
| | 2 week wait | From referral to date first seen - for symptomatic breast patients | 93% | | 91.5% | 98.1% | | | | | 96.3% | | | | <93% | ≥93% | |
| | 31 day wait | From diagnosis to first treatment | 96% | | 93.0% | 96.2% | | | | | 98.8% | | | | <96% | ≥96% | |
| | 31 day wait | For second or subsequent treatment - Surgery | 94% | 1.0 | 94.2% | 86.1% | | | | | 97.0% | | | | <94% | ≥94% | |
| | 31 day wait | For second or subsequent treatment - anti cancer drug treatments | 98% | | 100.0% | 100.0% | | | | | 100.0% | | | | <98% | ≥98% | |
| | 62 day wait | For first treatment from urgent GP referral for suspected cancer | 85% | | 82.3% | 81.9% | | | | | 85.2% | | | | <85% | ≥85% | |
| | 62 day wait | For first treatment from NHS cancer screening service referral | 90% | 1.0 | 90.7% | 89.6% | | | | | 100.0% | | | | <90% | ≥90% | |
| A&E | 4 hr maximum waiting time | From arrival to admission / transfer / discharge (Type 1 & 2) | 95% | 1.0 | 92.32% | 92.39% | | | | | 91.58% | 94.69% | | | <95% | ≥95% | |
| LD | Patients with a learning disability | Compliance with requirements regarding access to healthcare | n/a | 1.0 | | | | | | | | | | | No | Yes | |
| TOTAL | CURRENT QUARTERLY MONITOR (PREDICTION) / SCORE | | 0.0 | 0.0 | 5 | 5 | | | | | (3) | | n/a | n/a | n/a | | |
| Indicators within The Forward View into Action: Planning for 2015/16. | | | | | | | | | | | | | | | | | |
| MSA | Mixed Sex Accommodation | Minimise no. of patients breaching the mixed sex accommodation requirement | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | > 0 | | 0 |
| Infection Control | MRSA Bacteraemias | Number of hospital acquired MRSA cases | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | >0 | | 0 |
| Cancer | 62 day – Consultant upgrade | Following a consultant’s decision to upgrade the patient priority * | 90% | | 100.0% | 60.0% | 100.0% | 100.0% | 100.0% | 100.0% | 66.7% | | | | < 90% | | ≥90% |
| VTE | Venous Thromboembolism | Risk assessment of hospital-related venous thromboembolism | 95% | | 94.2% | 94.7% | 95.0% | 95.5% | 95.8% | 96.1% | | | | | <95% | | ≥95% |
| Diagnostics | Six week diagnostic tests | More than 99% of patients to wait less than 6 wks for a diagnostic test | >99% | | 99.8% | 98.9% | 97.0% | 94.2% | 94.8% | 98.4% | 94.8% | 97.9% | | | ≤99% | | ≥99% |
| A&E | Admission via A&E | No. of waits from decision to admit to admission over 12 hours | 0 | | 0 | 0 | 1 | 2 | 5 | 0 | 0 | 0 | | | ≥1 | | 0 |
| | Ambulance Handovers | No. of breaches of the 30 minute handover standard | 0 | | 75 | 74 | 72 | 66 | 55 | 49 | 20 | 20 | n/a | n/a | tbc | | |
| | Ambulance Handovers | No. of breaches of the 60 minute handover standard | 0 | | 13 | 13 | 27 | 31 | 31 | 6 | 5 | 2 | n/a | n/a | tbc | | |
| Cancelled Operations | 28 day standard | No. of patients not offered a binding date within 28 days of cancellation | 0 | | 1 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | | | ≥1 | | 0 |
| | Urgent ops Cancelled for 2nd time | No. of urgent operations cancelled for a second time | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | ≥1 | | 0 |
| Stroke & TIA | SSNAP indicator | % of Stroke patients are treated on a dedicated stroke ward for 90% of spell | SSNAP threshold tbc | | 70.0% | 59.3% | 61.4% | 66.7% | 83.7% | 72.7% | 51.1% | 69.4% | tbc | tbc | tbc | | |
| | SSNAP indicator | Direct admission to Stroke Unit within 4 hours of admission | SSNAP threshold tbc | | 66.2% | 60.7% | 54.2% | 64.9% | 68.1% | 70.0% | 53.3% | 75.0% | tbc | tbc | tbc | | |
| | SSNAP indicator | Patients receive CT Scan within 24 hours of admission | SSNAP threshold tbc | | 96.9% | 98.4% | 100.0% | 98.2% | 97.9% | 98.1% | 96.7% | 100.0% | tbc | tbc | tbc | | |
| | SSNAP indicator | Patients with acute stroke receive brain imaging within 1 hr | SSNAP threshold tbc | | 26.2% | 39.3% | 35.6% | 35.1% | 42.6% | 55.8% | 46.7% | 41.1% | tbc | tbc | tbc | | |
| | SSNAP indicator | Thrombolysis Rate | SSNAP threshold tbc | | 9.2% | 9.8% | 12.0% | 14.0% | 19.1% | 17.3% | 13.3% | 12.5% | tbc | tbc | tbc | | |
| | SSNAP indicator | % appropriate patients receiving thrombolysis (within 1 hour of clock start) | SSNAP threshold tbc | | 16.7% | 33.3% | 14.0% | 37.5% | 33.3% | 11.0% | 50.0% | 14.3% | tbc | tbc | tbc | | |
| | TIA indicator | High risk TIA cases investigated and treated within 24hrs | SSNAP threshold tbc | | 53.0% | 68.0% | 58.0% | 75.0% | 70.0% | 71.0% | 67.2% | 63.0% | tbc | tbc | tbc | | |
| Referral to Treatment | TIA indicator | Low risk TIA cases, seen within 7 days | SSNAP threshold tbc | | 84.0% | 85.0% | 79.0% | 76.0% | 86.0% | 91.0% | 89.2% | 92.0% | tbc | tbc | tbc | | |
| | Clocks still running - 52 weeks | Zero tolerance of over 52 week waiters (Incomplete Pathways) | 0 | | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | ≥1 | | 0 |
| | Clocks still running - admitted | Total number of patients with an admitted incomplete pathway | tbc | | n/a | n/a | n/a | n/a | n/a | n/a | 5976 | 6097 | n/a | n/a | tbc | | |
| | Clocks still running - admitted | Number of patients with an admitted incomplete pathway over 18 weeks | tbc | | n/a | n/a | n/a | n/a | n/a | n/a | 656 | 600 | n/a | n/a | tbc | | |
| | Clocks still running - non admitted | Total number of patients with an non admitted incomplete pathway | tbc | | n/a | n/a | n/a | n/a | n/a | n/a | 14169 | 13434 | n/a | n/a | tbc | | |
| Planned waits | Clocks still running - non admitted | Number of patients with a non admitted incomplete pathway over 18 weeks | tbc | | n/a | n/a | n/a | n/a | n/a | n/a | 826 | 581 | n/a | n/a | tbc | | |
| | Planned waiting list | % of patients overdue from their planned date | 0 | | n/a | n/a | n/a | n/a | n/a | n/a | | | | | tbc | | |
| RTT Specialty | RTT Admitted | 100 - General Surgery | 90% | | 84.7% | 85.1% | 84.1% | 86.9% | 88.7% | 85.5% | 84.3% | 86.6% | | | <90% | | ≥90% |
| | RTT Admitted | 101 - Urology | 90% | | 92.5% | 90.1% | 92.7% | 88.4% | 93.3% | 92.8% | 90.7% | 91.7% | | | <90% | | ≥90% |
| | RTT Admitted | 110 - Orthopaedics | 90% | | 84.0% | 80.3% | 80.1% | 82.3% | 86.2% | 84.7% | 84.7% | 85.7% | | | <90% | | ≥90% |
| | RTT Admitted | 130 - Ophthalmology | 90% | | 83.2% | 85.0% | 85.6% | 91.9% | 88.6% | 92.9% | 92.5% | 92.2% | | | <90% | | ≥90% |
| | RTT Admitted | 300 - General medicine | 90% | | 99.4% | 98.3% | 98.0% | 99.4% | 98.3% | 97.6% | 98.6% | 98.8% | | | <90% | | ≥90% |
| | RTT Admitted | 320 - Cardiology | 90% | | 89.3% | 92.8% | 92.7% | 94.5% | 93.5% | 91.3% | 92.5% | 94.6% | | | <90% | | ≥90% |
| | RTT Admitted | 330 - Dermatology | 90% | | 91.7% | 87.6% | 82.0% | 84.3% | 84.8% | 85.3% | 84.8% | 87.9% | | | <90% | | ≥90% |
| | RTT Admitted | 410 - Rheumatology | 90% | | 98.1% | 94.5% | 97.1% | 98.2% | 100.0% | 96.9% | 96.0% | 96.3% | | | <90% | | ≥90% |
| | RTT Admitted | 502 - Gynaecology | 90% | | 85.7% | 75.7% | 87.6% | 84.4% | 78.9% | 77.7% | 81.1% | 82.6% | | | <90% | | ≥90% |
| | RTT Admitted | Other | 90% | | 99.4% | 97.7% | 98.9% | 97.8% | 100.0% | 99.3% | 97.8% | 98.8% | | | <90% | | ≥90% |
| | RTT Non admitted | 100 - General Surgery | 95% | | 90.9% | 96.4% | 95.5% | 95.1% | 92.5% | 93.4% | 94.1% | 95.5% | | | <95% | | ≥95% |
| | RTT Non admitted | 101 - Urology | 95% | | 99.5% | 96.5% | 99.4% | 96.2% | 92.8% | 97.0% | 91.2% | 98.4% | | | <95% | | ≥95% |
| | RTT Non admitted | 110 - Orthopaedics | 95% | | 96.7% | 91.4% | 91.8% | 87.9% | 82.9% | 83.2% | 88.4% | 87.6% | | | <95% | | ≥95% |
| | RTT Non admitted | 120 - ENT | 95% | | 92.6% | 89.9% | 87.6% | 83.6% | 85.4% | 84.6% | 84.6% | 91.9% | | | <95% | | ≥95% |
| | RTT Non admitted | 130 - Ophthalmology | 95% | | 100.0% | 96.4% | 96.3% | 95.5% | 89.3% | 96.1% | 95.1% | 96.5% | | | <95% | | ≥95% |
| | RTT Non admitted | 140 - Oral surgery | 95% | | 91.0% | 90.6% | 78.7% | 76.0% | 68.2% | 72.2% | 65.7% | 68.0% | | | <95% | | ≥95% |
| | RTT Non admitted | 300 - General medicine | 95% | | 93.3% | 96.5% | 99.1% | 95.7% | 96.8% | 96.3% | 93.9% | 92.5% | | | <95% | | ≥95% |
| | RTT Non admitted | 320 - Cardiology | 95% | | 95.8% | 93.4% | 93.4% | 95.5% | 96.5% | 97.1% | 95.8% | 99.1% | | | <95% | | ≥95% |
| | RTT Non admitted | 330 - Dermatology | 95% | | 100.0% | 94.5% | 85.0% | 80.4% | 81.3% | 82.1% | 90.3% | 97.4% | | | <95% | | ≥95% |
| | RTT Non admitted | 340 - Thoracic medicine | 95% | | 97.5% | 98.5% | 98.9% | 96.9% | 100.0% | 95.8% | 98.0% | 99.3% | | | <95% | | ≥95% |
| | RTT Non admitted | 400 - Neurology | 95% | | 97.4% | 96.4% | 95.3% | 87.5% | 81.0% | 82.1% | 87.8% | 83.5% | | | <95% | | ≥95% |
| | RTT Non admitted | 410 - Rheumatology | 95% | | 95.9% | 95.3% | 97.5% | 97.9% | 97.3% | 98.5% | 98.8% | 96.4% | | | <95% | | ≥95% |
| | RTT Non admitted | 502 - Gynaecology | 95% | | 98.3% | 96.2% | 98.2% | 93.0% | 94.4% | 91.0% | 94.8% | 92.1% | | | <95% | | ≥95% |
| | RTT Non admitted | Other | 95% | | 98.8% | 99.3% | 98.8% | 99.5% | 99.3% | 99.1% | 98.7% | 98.9% | | | <95% | | ≥95% |
| SUS Submissions | NHS Number Compliance | Completion of NHS Numbers in SUS Submission (IPS/OPS) | 99% | | 99.8% | 99.8% | 99.8% | 99.8% | 99.9% | 100% | tbc | tbc | | | <99% | | ≥99% |
| | NHS Number Compliance | Completion of NHS Numbers in SUS A&E Submissions | 95% | | 97.3% | 97.4% | 97.5% | 97.5% | 97.6% | 98% | tbc | tbc | | | <95% | | ≥95% |

* Local standard of 90% with a de minimis of 2 breaches per month or 6 per quarter
NHS Number Compliance is YTD

| BOARD OF DIRECTORS | |
|---|--|
| Meeting Date and Part: | 26 th June 2015 Part I |
| Subject: | Quality Report |
| Section: | Performance |
| Executive Director with overall responsibility | Paula Shobbrook, Director of Nursing and Midwifery |
| Author(s): | Joanne Sims, Associate Director Quality & Risk Ellen Bull, Deputy Director of Nursing |
| Previous discussed at: | To be discussed at HAC 25th June 2015 |
| Action required: The Board of Directors is asked to receive the report which will be reviewed at the Healthcare Assurance Committee on 25 th June 2015. | |
| Executive Summary: This report provides a summary of information and analysis on the key performance and quality (P&Q) indicators linked to the Board objectives for 15/16. The Trust level dashboard provides information on patient safety and patient experience indicators including: <ul style="list-style-type: none"> • Serious Incidents • Safety Thermometer – Harm Free Care • Patient experience performance | |
| Related Strategic Goals/ Objectives: | See list of current goals/objectives agreed by Board |
| Relevant CQC Outcome: | Safe, Caring, Effective, Responsive & Well Led |
| Risk profile <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No | |

Quality & Patient Safety Performance Exception Report - May 2015

1. Purpose of the Report

This report accompanies the Quality/Patient Performance Dashboard and outlines the Trust's performance exceptions against key quality indicators for patient safety and patient experience for the month of May 2015

2. Serious Incidents

Four Serious Incidents (SI's) were confirmed and reported on STEIS in May 2015.

3. Safety Thermometer

All inpatient wards collect the monthly Safety Thermometer (ST) "Harm Free Care" data. The survey, undertaken for all inpatients the first Wednesday of the month, records whether patients have had an inpatient fall within the last 72 hours, a hospital acquired category 2-4 pressure ulcer, a catheter related urinary tract infection and/or, a hospital acquired VTE. If a patient has not had any of these events they are determined to have had "harm free care".

| NHS SAFETY THERMOMETER | 14/15 Trust Average | 14/15 National Average | 15/16 Target | Apr | May |
|--|---------------------|------------------------|--------------|--------|--------|
| Safety Thermometer %Harm Free Care | 90.68% | 93.80% | 95% | 92.56% | 92.51% |
| Safety Thermometer % Harm Free Care (New Harms only) | 97.18% | 97.59% | 98% | 96.78% | 97.86% |

| | April 2015 | May 2015 | |
|---------------------|------------|----------|--|
| New Pressure Ulcers | 12 | 6 | |
| New falls (Harm) | 2 | 2 | |
| New VTE | 0 | 0 | |
| New Catheter UTI | 2 | 2 | |

| | Jan 2015 | Feb 15 | Mar 15 | April 15 | May 15 |
|----------------------------|----------|--------|--------|----------|--------|
| Risk assessment compliance | | | | | |
| · Falls | 86% | 88% | 88% | 90% | 89% |
| · Waterlow | 91% | 91% | 91% | 91% | 96% |
| · MUST | 74% | 76% | 81% | 83% | 87% |
| · Mobility | 87% | 88% | 89% | 89% | 92% |
| · Bedrails | 88% | 90% | 89% | 92% | 93% |

4. Patient Experience Report

4.1 Friends and Family Test: National Comparison using the NHS England data base

In-Patients Family and Friends Test ranking

| | March 2015 | April 2015 |
|--|---|---|
| FFT Ranking | 3 rd (with 21 others out of 167 hospitals) | 3 rd (with 13 others out of 167 hospitals) |
| Our score Number of patients who would recommend | 98% | 98% |
| All Trusts - sample size | 167 | 167 |
| Top score | 100% | 100% |
| Lowest score | 78% | 85% |

The table above shows the Trust is 3rd out of 167 hospitals with 98% of patients recommending the Trust. This is the same score as 13 other hospitals in the 167 sample.

Emergency Department (ED) - Family and Friends Test ranking

| | March 2015 | April 2015 |
|--|---|---|
| FFT Ranking | 8 th (with 13 others out of 139 hospitals) | 6 th (with 11 others out of 139 hospitals) |
| Our score Number of patients who would recommend | 92% | 94% |
| All Trusts - sample size | 139 | 139 |
| Top score | 99% | 100% |
| Lowest score | 58% | 61% |

The table above depicts the FFT score is 6th with 11 other hospitals when comparing scores with other Trusts. This is an improved position from the previous month (NHS England data for April is not yet available).

4.2. In Month FFT responses results and compliance (May data)

The table below is shown for consistency and comparison to previous reports

| Ward/Area | Recommended (%) | | Not Recommended (%) | | Compliance Rate | |
|---------------------|-----------------|----------|---------------------|----------|-----------------|----------|
| | May-15 | (Apr-15) | May-15 | (Apr-15) | May-15 | (Apr-15) |
| Trust | 96% | (97%) | 2.0% | (1.4%) | - | - |
| All ED Depts | 92% | (94%) | 7.0% | (5.2%) | 7% | (5%) |
| All Inpatient Depts | 97% | (97%) | 0.5% | (0.7%) | 43% | (32%) |
| All Daycases | 99% | (100%) | 0.6% | (0.0%) | 7% | (6%) |
| All Maternity Depts | 99% | (98%) | 0.9% | (2.3%) | - | - |
| All Outpatients | 96% | (97%) | 1.9% | (1.1%) | - | - |

The table above demonstrates the total in month FFT scores for submission areas with the previous month for comparison. In-Patient, Maternity and ED compliance rates have improved in month. There is no compliance target for outpatients (OPD).

4.3 Extremely Unlikely results from FFT – April data

There have been 46 “extremely unlikely” to recommend from a total of 3216 FFT responses on the cards completed (excluding “don’t know” respondents) within submission areas throughout In-Patient, ED, Maternity and OPD, and 64 ‘unlikelys and extremely unlikelys’. This is an increase from last month, although the total respondents have also significantly increased.

| Unlikely & Extremely Unlikely Responses | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15** | May-15** |
|---|--------|--------|--------|--------|---------------|---------------|
| FFT submission areas | | | | | | |
| No of FFT responses for submission areas only: Unlikely or Extremely Unlikely to recommend (exc. don't know). | 15 | 29 | 34 | 33 | 32 | 64 |
| No of FFT responses | 1262 | 1469 | 1325 | 1362 | 2347 | 3216 |
| % Unlikely or Extremely Unlikely to recommend from FFT responses | 1.2% | 2.0% | 2.6% | 2.4% | 1.4% | 2.0% |
| % Unlikely or Extremely Unlikely from total activity | 0.2% | 0.4% | 0.5% | 0.4% | Not available | Not available |

The table below shows the proportion of ‘Unlikely and Extremely Unlikely to Recommend’ FFT responses from across the Whole Trust - For internal Monitoring only

| Unlikely & Extremely Unlikely Responses | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 |
|--|--------|--------|--------|--------|--------|--------|
| FFT Trust wide | | | | | | |
| No of FFT responses for all areas Trust wide Unlikely or Extremely Unlikely to recommend | 37 | 48 | 59 | 49 | 35 | 65 |
| No of FFT responses for all areas Trust wide (exc. don't know). | 2347 | 2916 | 2818 | 2802 | 2361 | 3234 |
| % Unlikely or Extremely Unlikely to recommend | 1.5% | 1.6% | 2.1% | 1.8% | 1.5% | 2.0% |

4.4 Patient Opinion and NHS Choices: April Data

Ten patient opinion comments were left in May; five express satisfaction with the service they received and five portrayed negative comments. The themes of pain management, communication and treatment are detailed in the negative comments. These are all answered by the Patient experience team who liaise with relevant teams.

5. Recommendation

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

| BOARD OF DIRECTORS | |
|--|--|
| Meeting Date and Part: | 26 June 2015 – Part I |
| Subject: | Financial Performance |
| Section: | Performance |
| Executive Director with overall responsibility | Stuart Hunter, Director of Finance |
| Author(s): | Pete Papworth, Deputy Director of Finance |
| Previous discussion and/or dissemination: | Finance Committee and Trust Management Board |
| Action required: The Board of Directors is asked to note the financial performance for the period ending 31 May 2015. | |
| Summary: Activity during May continued the trend seen in April, with additional elective activity (2% above budget) off-setting reduced emergency department attendances (3% below budget) and reduced non elective admissions (1% below budget). Outpatient activity was broadly in line with plan meaning that overall, activity is currently 1% below budget year to date. Despite activity being below budget; the Trust reports an adverse financial position as at 31 May. The Trust budgeted a net deficit of £2.354 million in month, against which an actual deficit of £2.532 million was reported. This represents an adverse variance of £178,000, and takes the year to date over spend to £202,000. Further and immediate action must be taken to ensure that costs are contained within the agreed budget lines. Where this is not possible, additional savings opportunities must be identified to ensure that these unavoidable cost pressures are managed within the agreed financial plan. Continued over spends of this scale will cause serious financial challenges for the Trust both in the current and future years. Income has over achieved by £45,000 to date, with reduced private patient income off-set by additional public health related income and non-patient related income. Expenditure reports an over spend of £247,000 to date, driven mainly by additional high cost drugs and devices; most notably in relation to cardiac CRT devices. Agency staffing costs remain very high, off-set by under spends from vacant posts; and the Trust has welcomed the Department of Health's support in establishing consistent national controls to help NHS provider organisations control temporary staff expenditure effectively. Cost improvement schemes delivered savings of £597,000, against a target of £592,000. Capital spend reported an under spend of £198,000 in May, reducing the year to date over spend to £98,000. This reflects the timing of agreed capital commitments and the forecast for the year remains in line with the agreed capital programme. | |

| | |
|---|---------------------------------|
| The Trust Continuity of Services Risk Rating remains at 3, in line with the agreed plan. | |
| Related Strategic Goals/ Objectives: | Goal 7 – Financial Stability |
| Relevant CQC Outcome: | Outcome 26 – Financial Position |
| Risk Profile: No new risks have been added to the Trust risk register, and none have been removed or reduced. | |
| Reason paper is in Part 2 | N/A |

THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST
FINANCIAL PERFORMANCE FOR THE PERIOD TO 31 MAY 2015

| KEY FINANCIALS | 2014/15 YTD ACTUAL £'000 | CURRENT YEAR TO DATE | | | | IN MONTH | | | |
|--------------------------|--------------------------------|----------------------|-----------------|-------------------|---------------|---------------|-----------------|-------------------|---------------|
| | | PLAN £'000 | ACTUAL £'000 | VARIANCE £'000 | VARIANCE % | PLAN £'000 | ACTUAL £'000 | VARIANCE £'000 | VARIANCE % |
| NET SURPLUS/ (DEFICIT) | (1,915) | (4,288) | (4,490) | (202) | 5% | (2,354) | (2,532) | (178) | 8% |
| EBITDA | 365 | (1,844) | (2,046) | (202) | 11% | (1,124) | (1,299) | (175) | 16% |
| TRANSFORMATION PROGRAMME | 695 | 592 | 597 | 5 | 1% | 234 | 220 | (14) | (6%) |
| CAPITAL EXPENDITURE | 2,165 | 2,666 | 2,759 | (93) | (3%) | 1,596 | 1,398 | 198 | 12% |

| ACTIVITY | 2014/15 YTD ACTUAL NUMBER | CURRENT YEAR TO DATE | | | | IN MONTH | | | |
|----------------------------------|---------------------------------|----------------------|------------------|--------------------|---------------|----------------|------------------|--------------------|---------------|
| | | PLAN NUMBER | ACTUAL NUMBER | VARIANCE NUMBER | VARIANCE % | PLAN NUMBER | ACTUAL NUMBER | VARIANCE NUMBER | VARIANCE % |
| Elective | 11,179 | 10,928 | 11,191 | 263 | 2% | 5,406 | 5,681 | 275 | 5% |
| Outpatients | 54,768 | 53,082 | 52,872 | (210) | (0%) | 26,185 | 25,770 | (415) | (2%) |
| Non Elective | 5,446 | 5,537 | 5,490 | (47) | (1%) | 2,838 | 2,738 | (100) | (4%) |
| Emergency Department Attendances | 14,706 | 14,875 | 14,361 | (514) | (3%) | 7,560 | 7,361 | (199) | (3%) |
| TOTAL PbR ACTIVITY | 86,099 | 84,422 | 83,914 | (508) | (1%) | 41,989 | 41,550 | (439) | (1%) |

| INCOME | 2014/15 YTD ACTUAL £'000 | CURRENT YEAR TO DATE | | | | IN MONTH | | | |
|----------------------------------|--------------------------------|----------------------|-----------------|-------------------|---------------|---------------|-----------------|-------------------|---------------|
| | | PLAN £'000 | ACTUAL £'000 | VARIANCE £'000 | VARIANCE % | PLAN £'000 | ACTUAL £'000 | VARIANCE £'000 | VARIANCE % |
| Elective | 11,051 | 10,698 | 10,649 | (49) | (0%) | 4,983 | 4,961 | (22) | (0%) |
| Outpatients | 5,102 | 5,112 | 5,101 | (11) | (0%) | 2,564 | 2,569 | 4 | 0% |
| Non Elective | 9,092 | 9,406 | 9,386 | (20) | (0%) | 4,765 | 4,750 | (15) | (0%) |
| Emergency Department Attendances | 1,423 | 1,627 | 1,615 | (13) | (1%) | 881 | 879 | (2) | (0%) |
| Non PbR | 10,879 | 11,519 | 11,597 | 78 | 1% | 5,598 | 5,640 | 42 | 1% |
| Non Contracted | 4,288 | 4,074 | 4,082 | 8 | 0% | 2,243 | 2,270 | 27 | 1% |
| Research | 316 | 284 | 327 | 43 | 15% | 138 | 138 | (0) | (0%) |
| Interest | 25 | 15 | 25 | 9 | 59% | 8 | 13 | 5 | 69% |
| TOTAL INCOME | 42,176 | 42,736 | 42,781 | 45 | 0% | 21,182 | 21,220 | 39 | 0% |

| EXPENDITURE | 2014/15 YTD ACTUAL £'000 | CURRENT YEAR TO DATE | | | | IN MONTH | | | |
|---------------------------|--------------------------------|----------------------|-----------------|-------------------|---------------|---------------|-----------------|-------------------|---------------|
| | | PLAN £'000 | ACTUAL £'000 | VARIANCE £'000 | VARIANCE % | PLAN £'000 | ACTUAL £'000 | VARIANCE £'000 | VARIANCE % |
| Pay | 26,937 | 28,347 | 28,144 | 203 | 1% | 14,309 | 14,125 | 184 | 1% |
| Clinical Supplies | 5,592 | 6,054 | 6,149 | (96) | (2%) | 2,999 | 3,141 | (142) | (5%) |
| Drugs | 4,898 | 4,686 | 5,019 | (334) | (7%) | 2,194 | 2,293 | (99) | (5%) |
| Other Non Pay Expenditure | 3,926 | 5,077 | 5,050 | 27 | 1% | 2,603 | 2,758 | (154) | (6%) |
| Research | 315 | 306 | 349 | (43) | (14%) | 153 | 152 | 0 | 0% |
| Depreciation | 1,571 | 1,569 | 1,575 | (6) | (0%) | 785 | 791 | (6) | (1%) |
| PDC Dividends Payable | 853 | 986 | 985 | 1 | 0% | 493 | 492 | 1 | 0% |
| TOTAL EXPENDITURE | 44,091 | 47,024 | 47,271 | (247) | (1%) | 23,535 | 23,752 | (217) | (1%) |

| STATEMENT OF FINANCIAL POSITION | 2014/15 YTD ACTUAL £'000 | CURRENT YEAR TO DATE | | | |
|---------------------------------|--------------------------------|----------------------|-----------------|-------------------|---------------|
| | | PLAN £'000 | ACTUAL £'000 | VARIANCE £'000 | VARIANCE % |
| Non Current Assets | 160,111 | 174,205 | 174,292 | 87 | 0% |
| Current Assets | 67,007 | 66,252 | 66,545 | 293 | 0% |
| Current Liabilities | (28,606) | (30,854) | (31,501) | (647) | 2% |
| Non Current Liabilities | (5,254) | (18,937) | (18,872) | 65 | (0%) |
| TOTAL ASSETS EMPLOYED | 193,258 | 190,666 | 190,464 | (202) | (0%) |
| Public Dividend Capital | 78,674 | 79,665 | 79,665 | 0 | 0% |
| Revaluation Reserve | 72,999 | 74,608 | 74,608 | 0 | 0% |
| Income and Expenditure Reserve | 41,585 | 36,393 | 36,191 | (202) | (1%) |
| TOTAL TAXPAYERS EQUITY | 193,258 | 190,666 | 190,464 | (202) | (0%) |

| CONTINUITY OF SERVICE RISK RATING | 2014/15 YTD ACTUAL METRIC | CURRENT YEAR TO DATE | | | |
|--|---------------------------------|----------------------|------------------|----------------|--------------------|
| | | PLAN METRIC | ACTUAL METRIC | RISK RATING | WEIGHTED RATING |
| Debt Service Cover | 0.45x | (1.76)x | (1.95)x | 1 | 1 |
| Liquidity | 47.9 | 38.9 | 38.4 | 4 | 2 |
| CONTINUITY OF SERVICE RISK RATING | 3 | | | | 3 |

| BOARD OF DIRECTORS | |
|---|---|
| Meeting Date and Part: | 26 th June 2015 - Part 1 |
| Subject: | Workforce report |
| Section: | Information |
| Executive Director with overall responsibility | Karen Allman |
| Author(s): | Karen Allman |
| Previous discussion and/or dissemination: | |
| Action required: The Board of Directors is asked to: Note the content of the report. | |
| Summary: The report shows the performance of the Trust by care groups across a range of workforce metrics: Appraisal, Mandatory Training, Turnover and Joiner rates, Sickness and Vacancies. This month's report includes an update on the Widening Participation agenda. | |
| Related Strategic Goals/ Objectives: | To listen to, support, motivate and develop our staff |
| Relevant CQC Outcome: | Outcomes 12, 13 & 14 - Staffing |
| Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No | |
| Reason paper is in Part 2 | N/A |

WORKFORCE REPORT – JUNE 2015

The monthly workforce data is shown below, both by care group and category of staff. A revised Trust target of 100% appraisal compliance (as per the Board discussion in March) and 3% sickness absence have been set and performance has been RAG rated against these targets.

| Care Group | Appraisal Compliance | | Mandatory Training Compliance | Sickness | | Joining Rate | Turnover | Vacancy Rate (from ESR) |
|-------------|----------------------|------------------|-------------------------------|-----------------------------|----------|--------------|----------|-------------------------|
| | Values Based | Medical & Dental | | Absence | FTE Days | | | |
| | At 31 May | | | Rolling 12 months to 31 May | | | | At 31 May |
| Surgical | 0.9% | 75.0% | 77.8% | 4.62% | 14958 | 12.7% | 10.9% | 2.8% |
| Medical | 0.7% | 63.0% | 77.3% | 3.95% | 18247 | 18.4% | 12.9% | 9.6% |
| Specialties | 3.4% | 78.8% | 75.1% | 3.96% | 11864 | 11.3% | 11.3% | 8.5% |
| Corporate | 2.4% | 50.0% | 74.8% | 3.66% | 10794 | 11.4% | 16.4% | 4.9% |
| Trustwide | 1.7% | 71.0% | 76.5% | 4.05% | 55862 | 14.0% | 12.8% | 6.9% |

| Staff Group | Appraisal Compliance | | Mandatory Training Compliance | Sickness | | Joining Rate | Turnover | Vacancy Rate (from ESR) |
|-----------------------------------|----------------------|------------------|-------------------------------|-----------------------------|----------|--------------|----------|-------------------------|
| | Values Based | Medical & Dental | | Absence | FTE Days | | | |
| | At 31 May | | | Rolling 12 months to 31 May | | | | At 31 May |
| Add Prof Scientific and Technical | 1.5% | N/A | 75.4% | 3.44% | 1472 | 13.3% | 14.8% | 13.6% |
| Additional Clinical Services | 0.4% | N/A | 77.9% | 6.40% | 15395 | 22.8% | 13.5% | 3.9% |
| Administrative and Clerical | 2.6% | N/A | 74.5% | 3.47% | 10616 | 12.6% | 14.2% | 7.1% |
| Allied Health Professionals | 1.5% | N/A | 81.9% | 1.86% | 1676 | 11.1% | 11.9% | 4.6% |
| Estates and Ancillary | 0.0% | N/A | 72.1% | 5.78% | 6806 | 13.3% | 20.4% | 5.6% |
| Healthcare Scientists | 0.0% | N/A | 89.6% | 3.60% | 759 | 19.5% | 17.9% | 2.5% |
| Medical and Dental | N/A | 71.0% | 60.4% | 1.05% | 1626 | 9.0% | 6.7% | 4.4% |
| Nursing and Midwifery Registered | 2.6% | N/A | 81.3% | 4.31% | 17514 | 11.0% | 9.9% | 9.7% |
| Trustwide | 1.7% | 71.0% | 76.5% | 4.05% | 55862 | 14.0% | 12.8% | 6.9% |

As noted previously, Turnover in Corporate Directorate and Estates & Ancillary and Administrative & Clerical staff groups include the transfer of 29 Commercial Services staff to Poole ESR.

As advised last month, appraisal compliance was reset to zero with the introduction of the new values based appraisal. 573 staff attended the training as at 31st May, with more sessions planned (an updated figure will be provided at Board) and good feedback continues to be received. The cascade process has therefore begun from those Managers who have completed the training and we will now see appraisal completion rates start to rise.

The appraisal forms have been slightly modified following user feedback. Lots of resources are available on the intranet which is continually being added to. The upload to the Virtual Learning Environment is now live, with instructions provided to staff on how to do this and also recording in ESR.

The number of appraisals reported is under the trajectory but it is thought that figures are underreported due to delays in uploading completion into ESR. The importance of this part of the process is being reiterated.

2. Essential Core Skills Compliance

Overall compliance has increased to 76.5% (75.7% for April). There have been some good increases in compliance for Medical and Dental staff overall, increasing from 56% to 60%, but this still is a lot lower than other staff groups. Health Care Scientists also increased significantly from 78% to 90% compliant.

Compliance reports by cost centre for each subject are circulated each month and followed-up with those departments showing lower compliance.

It is vital that we ensure the basic training needs of our staff are met, particularly with the planned CQC inspection as this was one of the areas picked up in the last report. Communications to this effect have already gone out reinforcing the importance of compliance.

3. Sickness Absence

The Trust-wide sickness rate has increased to 4.05% for May (3.99% for April) and whilst this is only a very small (0.06%) increase, this now represents a red rating.

The Surgical care group continues to be red-rated at 4.62%, up from 4.57%.

By staff group, 3 areas remain red-rated, all showing small increases on the previous month:

| | | |
|---------------------------------|-------|------------------|
| § Additional Clinical Services: | 6.40% | (6.31% in April) |
| § Estates & Ancillary: | 5.78% | (5.70% in April) |
| § Nursing & Midwifery: | 4.31% | (4.17% in April) |

A new pilot for sickness absence reporting will have launched by the time the Board meets on the 26th and will include Theatres, Facilities and Estates – three areas with higher sickness rates than the norm. The proposals were discussed in detail at the last workforce committee and will be regularly reviewed at care group and corporately as appropriate to inform the future plans.

4. Turnover and Joiner Rate

The joining rate has increased to 14% from 13.4% last month and continues to exceed the turnover rate at 12.8%.

5. Vacancy Rate

The vacancy rate is reported as the difference between the total full time equivalent (FTE) staff in post (including locums and staff on maternity leave) and the funded FTE reported by Finance, as a percentage of the funded FTE. Trust-wide our vacancies are 6.9% of funded posts, up from 6.5% last month and the area of increase is in medical and dental posts.

6. Recruitment Initiatives

Work continues on the recruitment actions and initiatives for the Trust. These include a stand at the RCN National Conference in Bournemouth at the BIC from the 21-25 June, exhibiting in Birmingham on the 2/3 July at the RCN job fair.

Newly qualified recruitment has gone well with 7 vacancies remaining for the autumn intake and plans in place to fill these. Overseas recruitment continues with eight overseas nurses who joined the Trust on 15 June, with a further 6-10 due to start at the beginning of July and more planned for August.

7. Staff Impressions

The Q4 results have now been published and RBCH is at the mid-point against national results. Our results were slightly behind those of Salisbury and Poole, but better than others. A couple of headline figures of note:

Nationally, 77% would recommend their trust as a place for treatment; RBCH: 82%.
Nationally, 62% would recommend their trust as a place to work; RBCH: 65%

The Q1 survey is now open, which includes questions on violence at work. An extra tier of reporting has been added down to team level, which will enable us to more specifically identify where any problems are. The survey remains open until the end of June.

8. Education & Training

Widening Participation is an agenda that supports workforce planning and development of staff across the NHS.

Widening Participation aims to:

- widen access and opportunity of learning, development and employment opportunities within Bands 1-4
- promote the wide range of careers and progression routes available within healthcare through information and guidance
- involve healthcare staff in learning by developing learning cultures

There are several strands of work that support this in the Trust. We have developed strong recruitment and development programmes for the Health Care Support Workforce and will be working in partnership with education providers to improve the profile of apprenticeships in the Trust and locally. As part of the HCA (Healthcare Care Assistant) recruitment planning we have been running open days that attract potential recruits who come in and hear about the organisation in a consistent and coordinated way. These events have been organised by matrons working closely with HR and Training colleagues and include values based focus groups as well as simulation based scenarios based on 15 fundamental standards. Those that perform

well through this process then proceed through to interviews. The induction programme provided for HCSW is a three week supported programme with a mixture of classroom and work based training. More details regarding the future of the Care Certificate assessment and level 2 and 3 Apprenticeship frameworks will be discussed at the next workforce committee.

On another positive note the first “Time to Lead” cohort has just completed this leadership programme. Time to Lead encompassed an 18 month personal development programme experienced by all ward sisters and charge nurses in post at the time of launch. Feedback has been extremely positive from delegates with many describing the scale of the changes they have experienced.

9. Safe Staffing

The actual versus planned figures for nursing staff for the Trust inpatient and Day surgery areas in May 2015 is summarised below

| | |
|--|--------|
| 1. Days - RN/RM (Nurse and Midwife) fill rate | 92.9% |
| 2. Days - HCA (Health Care Assistant) fill rate | 104.5% |
| 3. Night RN/RM fill rates | 100.9% |
| 4. Nights HCA fill rate | 121% |

There are variations between different ward and department areas but all risks have been mitigated through local judgement. There are ‘Specials’ – these are shift specifically created to care for patients who require one to one care - on ward areas and this accounts for areas over the staff template. The nursing teams are working together to manage processes with quality care balanced with cost efficient resources. Controls have been tightened at a local level and authorisation of temporary staff from agencies is in place with a range of actions to drive down agency usage and tight controls.

| BOARD OF DIRECTORS | |
|---|---|
| Meeting Date and Part: | 26 th June 2015 – Part 1 |
| Subject: | Stroke Services Update |
| Section: | Performance |
| Executive Director with overall responsibility | Richard Renaut, Chief Operating Officer |
| Author(s): | Claire Stalley, Stroke Services, Neurotherapy & Stroke Manager |
| Previous discussion and/or dissemination: | Monthly Performance Reports |
| Action required: The Board of Directors is asked to note the progress made against the measures of an effective stroke service. | |
| Summary: This report gives an update on the following: § Most recent published stroke performance using SSNAP (January to March 2015) § Our internal assessment of performance for April and May (Quarter to date) § Details actions the service is taking to improve performance into the upper quartile, with no area below C, and the majority moving to B or better. | |
| Related Strategic Goals/ Objectives: | 1. to offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care 2. to promote and improve the quality of life of our patients 3. to strive towards excellence in the services and care we provide 4. to be the provider of choice for local patients and GPs 5. to listen to, support, motivate and develop our staff |
| Relevant CQC Outcome: | Safe, effective, responsive and well led |
| Risk Profile: i. Have any risks been reduced? Yes, compliance with Stroke Standards on Assurance Framework ii. Have any risks been created? No | |
| Reason paper is in Part 2 | N/A |

Stroke Services Update

1. Introduction

This paper covers:

- § Most recent published stroke performance using SSNAP (January to March 2015)
- § Our internal assessment of performance for April and May (Quarter to date)
- § Details actions the service is taking to improve performance into the upper quartile, with no area below C, and the majority moving to B or better.

The quality of stroke services is measured via the quarterly SSNAP results. The more recent covers January to March 2015, in which RBCH achieved SSNAP level C. This is a significant improvement from Q3, with an increase in SSNAP score from 57.8 to 66.7.

To put this result into context with the rest of Wessex, for the last SSNAP report (Q3) the highest score in Wessex was The Royal Hampshire County Hospital who achieved a SSNAP score of 65. Poole Hospital achieved a SSNAP score of 40.

Ensuring sustainability of improvements over the next 12 months relies upon completed recruitment to the Stroke Outreach team, expansion of the radiology service out of hours and management of risks. By delivering the overall plan our trajectory is achieve the next level (B) by Quarter 2 2015/16.

2. Summary of SSNAP

The SSNAP performance is based on 10 domains covering 44 key indicators and the results benchmarked against national performance. A summary of our most recent performance is provided below.

| Quarter | Apr-June 2014 | July-Sep 2014 | Oct-Dec 2014 | Jan-March 2015 | National Average |
|--------------------------------|---------------|---------------|--------------|----------------|------------------|
| SSNAP level | D | D | D | C | |
| SSNAP score | 55.3 | 55.3 | 57.8 | 66.7 | |
| Case ascertainment band | A | A | A | B | |
| Audit compliance band | D | D | D | C | |
| 1) Scanning | D | D | D | C | C |
| 2) Stroke unit | D | D | D | C | D |
| 3) Thrombolysis | C | C | D | C | C |
| 4) Specialist Assessments | D | D | D | D | C |
| 5) Occupational therapy | A | C | A | A | A |
| 6) Physiotherapy | B | B | B | A | B |
| 7) Speech and Language therapy | C | C | A | A | C |
| 8) MDT working | B | B | B | B | C |
| 9) Standards by discharge | B | B | B | B | B |
| 10) Discharge processes | B | A | B | A | B |

We have made significant improvements or sustained performance in the majority of domains. Notably Scanning, Stroke unit, Thrombolysis and Audit Compliance have all improved from a level D to level C and we continue to perform strongly with the Therapy and Discharge domains.

It is extremely positive that these improved results have been achieved before the implementation of our new Stroke Outreach service (impact from 1st May onwards). The Stroke Outreach service is now providing a weekday service of 7am to 10pm and weekends from 7am to 5pm and this will further expand once the remaining recruitment for the team is complete.

These changes will further significantly improve our performance with Domains 1 to 4 and also with Audit Compliance. The Specialist Assessments Domain continues to be a Level D however we anticipate that this will be addressed for Q1 by the Stroke Outreach service and we would expect to achieve a Level C for this domain for Q1.

3. Other stroke actions

We have now completed the recruitment into the vacant Stroke Consultant posts. Dr Becky Jupp will commence as lead Stroke Consultant from 22nd June. Dr Kami Thavanesan is joining the team in October and she will be working full-time in the Trust, 0.5 wte as a Stroke Consultant and 0.5 wte as an ACM Consultant. Dr Michelle Dharmasiri will start in January as a 1.0 wte Stroke Consultant. We have a 1.0 wte Locum Stroke Consultant in post until December 2015.

The CQC in their Intelligent Monitoring Report (May 2015) highlighted our team-centred performance for Domain 2: Stroke Unit being Level D as a risk. For Q4 we achieved Level C and are therefore no longer in the risk zone for this metric. It is essential however that this performance is sustained; this point is addressed further in section 4.

The specific actions arising from the last CQC visit have also been addressed (Stroke outreach, and staff training).

4. Stroke Performance and Delivery Plan

The Stroke Service remains fully focused on continuing to improve across all areas and ensure where performance is already high to sustain this. We have a clear performance and delivery plan (see Annex) and a clear understanding where we can improve on our SSNAP score.

A SSNAP Level B (score of 70+) is certainly achievable and we would hope to achieve this by Q2 this year.

The Stroke Services performance and delivery plan details in the Annex the following for each of the SSNAP key indicators: the key indicator information with the performance required to achieve a SSNAP level A; the performance level plan for the key indicator; the latest SSNAP result; and where available the quarter to date performance. We are working with the Information Department to be able to have up-to-date performance data for each individual key indicator.

5. Risk Mitigation

Ensuring sustainability of improvements over the next 12 months relies upon completed recruitment to the Stroke Outreach Team, the Locum Stroke Consultant staying in post until December and further vacancies in both Nursing and Therapy teams being filled. It is relevant to note that the Therapy teams (OT, PT and SALT) have a number of unfilled posts (due to vacancy and maternity leave) which may detrimentally impact Q1 performance. The recruitment process is ongoing for these vacancies; unfortunately appropriate locums are unavailable at this time.

Risks remain in achieving the targets; these include access to stroke beds due to timely discharges and the surge in Trust admissions leading to non-stroke patients outlying on the ward. This will be mitigated through the wider urgent care work and the specific actions on discharge. The Stroke Service will also be undertaking a Quality Improvement project with the Trust Quality Improvement Team to focus specifically on achieving robust and sustainable improvement to Domain 2 i.e. access to the stroke unit and 90% stay on the Stroke Unit as, whilst improvement has been achieved for Q4, significant improvement is still needed.

We also say goodbye to Dr Damian Jenkinson, who leaves the Trust in June, having led stroke services locally and nationally to great effect and we wish him well. The new team of consultants and other staff will be able to continue to develop the local service.

6. Recommendation

The Board is asked to receive this report, and to note the progress made against the measures of an effective stroke service.

A one hour detailed seminar for Governors and board members on Stroke services is set for September 15th which will allow a more detailed analysis of SSNAP process and action plan.

ANNEX: STROKE PERFORMANCE & DELIVERY PLAN – JUNE 2015 – ONE PAGE SUMMARY(Quarter to date results is for April and May, **please note these have not been fully validated**. Where there are gaps the data is not available internally)

| DOMAIN | SSNAP Q3 (Sept to Dec) | SSNAP Q4 (Jan to Mar) | Plans | Comments/Risks |
|-------------------------------|------------------------------|-----------------------------|--|--|
| 1 Scanning | D | C | § New CT request by Non-Consultant staff in use § OOH Scanning Service developments | § On track |
| 2 Stroke Unit | D | C | § Stroke Outreach § Stroke QI Project to address patient flow | § Stroke Outreach still to recruit to remaining 0.65 wte § Stroke Outreach to review all breaches for direct access |
| 3 Thrombolysis | D | C | § Validation process in place for all thrombolysis patients § Door to Needle working party underway | § On track |
| 4 Specialist Assessments | D | D | § Stroke Outreach § WSS training in ED and on SU | § Stroke Consultant - 7 day provision § SALT recruitment |
| 5 Occupational Therapy | A | A | § More efficient timetabling § Twice weekly OT groups | § On track |
| 6 Physiotherapy | B | A | § More efficient timetabling § Twice weekly exercise group | § PT vacancies may impact therapy intensity |
| 7 Speech and Language Therapy | A | A | § Twice a week Communication Group § Assistant staff to do Oral trials | § SALT vacancies may impact therapy intensity |
| 8 MDT Working | B | B | § Review option for Therapy twilight/extended day & "Time to Therapy Assessment" project | § Therapy vacancies may impact time to assessment |
| 9 Standards by discharge | B | A | § Induction for new staff § Validation process for nutrition screen/Dietician | § On track |
| 10 Discharge Processes | B | B | § Validation for AF breaches in place | § |
| Audit compliance | D | C | § NIHSS training to be completed for 85% of SU Nurses in June | § Nurse staffing number to enable training to be completed |
| Case ascertainment | A | B | § Monthly lockdown checks will be performed on both 72hr and discharge lists | § All requests for record unlocks and data changes to go through SSNAP administrator § To review case ascertainment figure with SSNAP |
| SSNAP Level | D | C | | |
| SSNAP Score | 57.8 | 66.7 | | |

ANNEX Domain 1: Scanning - Domain Leads: Matt Benbow/Arnie Drury and Steph Heath

| DOMAIN KEY INDICATORS | Plan (B) | Last SSNAP (C) | Quarter to date | Key Improvement Actions |
|---|--------------|----------------|-----------------|--|
| 1.1 Proportion of patients scanned within 1 hour of clock start (A = 48%) | 48% (A) | 41.5% (C) | 46% (B) | § Implementation of new CT scan request protocol and process complete – to monitor new system § Ensure training available for new staff to complete in a timely manner i.e. Stroke Outreach, new starters etc § Undertake monthly breach analysis for any 12 hour scan breaches § Promote greater understanding of the stroke timescales throughout Trust § Improve pathways to get CT request to CT both in-hours and OoH § To ensure properly completed CT request arrives at CT in a timely manner § Implementation of the CT OoH business case – phase 1 and phase 2 |
| 1.2 Proportion of patients scanned within 12 hours of clock start (A = 95%) | 90% (B) | 83.6% (D) | 89% (B) | |
| 1.3 Median time between clock start and scan (A = < 60mins) | < 75mins (B) | 01:23 (C) | 01:17 (C) | |

Domain 1: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|---|--------------------------|---|
| 1. Monthly breach analysis for 12 hour scan breaches | Ongoing | |
| 2. To review options to ensure patients arriving between 7pm and 9pm have their scan within 12 hours of arrival | June 2015 | § Joint meeting with Radiology and Stroke Outreach – June 22 nd 2015 |
| 3. Promote updated protocol so that all are aware including the fact that scans should be done within 1 hour or 12 hours | June 2015 | § Comms Team to promote in June § Grand Round to update |
| 4. Staff to have training on IRMER, NIHS and completing request form correctly | Ongoing | § Need rolling programme for new staff and to ensure staff have timely updates |
| 5. Audit CT request form completion and timeliness (monthly) | Ongoing | § CT to collate all CT request forms and SH to review and provide feedback to individuals incorrectly completing form |
| 6. OoH: Phase 1 - existing staff provide as additional sessions | April 2015 | § This is now happening |
| 7. OoH: Phase 2 – fully staffed OoH through additional recruitment and submit 3 rd scanner in ED business case | Sept 2015 | § Case approved by Board, planning to have interim Sept-March 16, prior to CT3 go live. |

Domain 2: Stroke Unit - Domain Leads: Claire Stalley & Katherine Chambers

| DOMAIN KEY INDICATORS | Plan (B) | Last SSNAP (C) | Quarter to date | Key Improvement Actions |
|---|--------------------|----------------|-----------------|--|
| 2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (A = 90%) | 75% (B) | 66.9% (C) | 70% (C) | § Establish a pre-alert for all stroke patients being transferred to RBH by SWAST § Ensure CST are fully informed about stroke patients and timescales for transfer to SU § Continue to implement Stroke Outreach Team and extend hours of service as increase recruitment § Immediate re-triage of any non-stroke patients on the SU to facilitate transfer off SU § Stroke Outreach to review and update current stroke admission pathways and protocols § Stroke Quality Improvement project and mapping event to address stroke patient flow on/off the unit. |
| 2.2 Median time between clock start and arrival on stroke unit (hours:mins) (A = Median < 2 hrs) | Median < 3 hrs (B) | 03:19 (C) | 03:20 (C) | |
| 2.3 Proportion of patients who spent at least 90% of their stay on stroke unit (A = 90%) | 85% (B) | 81.1% (C) | 73% (C) | |

Domain 2: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|---|--------------------------|--|
| 1. To complete a breach analysis of every patient not achieving direct transfer to SU and not achieving 90% stay | ongoing | § |
| 2. To commence shadow reporting for 90% target with a stop the clock of when no longer needing stroke team input | June 2015 | § To start from May and to use the therapy NFI /stroke team input no longer needed to informally stop the clock. |
| 3. Ensure all non-stroke patients on the SU have appropriate re-triage in place to facilitate transfer off the SU | June 2015 | § To proactively move non-stroke patients off the stroke unit rather than waiting until SU full |
| 4. To undertake QI project with QI Team to address patient flow on/off the stroke unit | June 2015 | § Aim to commence in June. CS to liaise with DM |
| 5. Ensure all SU/CST staff are aware not to move stroke patients whilst medical patients on the ward. | ongoing | § Stroke Outreach to update CST re. stroke patients and timescales for transfer to SU |
| 6. To implement Stroke Outreach Service | ongoing | § On track for 7am to 10pm 7-days by end of July |
| 7. To implement hospital pre-alert for all stroke patients | April 2015 | § KC in liaison with ED/SWAST re implementation of pre-alert for all stroke patients |
| 8. To promote stroke pathway throughout Trust clearly identifying care stroke patient should receive and by when | July 2015 | § To meet with Comms in April (complete) and time promotion of Stroke pathway as Stroke Outreach becomes fully operational |
| 9. Review current Stroke Unit admission policies i.e. direct admissions, GP admissions and update | June 2015 | § Audit current systems as part of Stroke Outreach Service commencing § ? consider option of adding screening to GP pathway |

Domain 3: Thrombolysis - Domain Leads: Becky Jupp & Steph Heath

| DOMAIN KEY INDICATORS | Plan (B) | Last SSNAP (C) | Quarter to date | Key Improvement Actions |
|---|--------------|----------------|-----------------|---|
| 3.1 Proportion of all stroke patients given thrombolysis (A=20%) | 20% (A) | 16.4% (B) | 14.1% (C) | § To maintain good standards of awareness of acute stroke identification and management, including thrombolysis eligibility across the Trust. § To ensure that all patients eligible for thrombolysis are appropriately and prompted screened for consideration for treatment. § To review the coding process for thrombolysis pathway on SSNAP and ensure data input is an accurate reflection of clinical decision making. § To reduce door to needle times for thrombolysis treatment through engagement with stakeholders involved in the pathway. § To use stakeholder engagement to identify training needs and areas for service improvement to optimise prompt and effective care and decision making. § Consider sustainability of providing stroke thrombolysis rota considering staffing resource – undertake options appraisal for longer-term arrangements. |
| 3.2 Proportion of eligible patients given thrombolysis (A=90%) | 80% (C) | 96% (A) | | |
| 3.3 Proportion of patients who were thrombolysed within 1 hour of clock start (A=55%) | 40% (C) | 26.9% (E) | 44.4% (C) | |
| 3.4 Proportion of applicable patients directly admitted to a stroke unit within 4 hours of clock start and received thrombolysis or have a pre-specified justifiable reason ("no but") for why it couldn't be given (A = 65%) | 65% (A) | 66.2% (A) | | |
| 3.5 Median time between clock start and thrombolysis (A=< 40mins) | < 60mins (C) | 01:30 (D) | 01:08 (D) | |

Domain 3: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|--|--------------------------|---------|
| 1. Stroke team to identify all potential 'missed thrombolysis' cases and review of case at weekly thrombolysis MDT | ongoing | |
| 2. RCA to be completed for all 'missed thrombolysis' cases to identify implications/learning for future practice. | ongoing | |
| 3. To support developing stroke outreach service with skills to support thrombolysis pathway to help speed to stroke specific assessment and reduce door to needle time. | June 2015 | |
| 4. To develop at working party initially involving medical registrars involved in thrombolysis to explore reasons for potential delay in door to needle time and identify areas for service improvement. | June 2015 | |

Domain 4: Specialist Assessments - Domain Leads: Becky Jupp, Louise Johnson and Nikki Manns

| DOMAIN KEY INDICATORS | Plan (C) | Last SSNAP (D) | Quarter to date | Key Improvement Actions |
|--|-------------|----------------|-----------------|---|
| 4.1 Proportion of patients assessed by a stroke consultant within 24hrs of clock start (A=95%) | 80% (C) | 76.1% (D) | 72.7% (D) | § Explore options to deliver Stroke Consultant cover at the weekend – network approach? § Stroke Consultant recruitment – now complete: 0.5 wte Stroke Consultant starts October 2015, 1.0 wte Stroke Consultant starts January 2016. Locum in place until December 2015 |
| 4.2 Median time between clock start and being seen by stroke consultant (hrs:mins) (A=<6hrs) | <12hrs (C) | 16:26 (E) | 15:18 (E) | |
| 4.3 Proportion of patients who were assessed by a nurse trained in stroke management within 24hrs of clock start (A=95%) | 95% (A) | 90.6% (B) | 85.9% (B) | § Stroke Outreach § Ensure 85% of Stroke Nurses are competent in NIHSS, WSS and complete these as a priority with patients on arrival to SU if they have not already been completed |
| 4.4 Median time between clock start and being assessed by stroke nurse (A=< 60mins) | < 3 hrs (C) | 3:02 (D) | 02:35 (C) | |
| 4.5 Proportion of applicable patients who were given a water swallow screen within 4hrs of clock start (A=85%) | 75% (D) | 66.7% (D) | 71% (C) | § Sub-analysis of patients who fail WSS target to further understand the limitations and gaps in current provision § Stroke Outreach; all trained to do WSS § Stroke Unit; all B5 and B6 nurses to be trained and competent in WSS § Organise rolling programme of training in ED/SU § Establish and monitor register of competent staff (to be held by SALT) § Ensure consistent/accurate documentation for patients who immediately fail WSS (i.e. too drowsy) and that this is inputted accurately into SSNAP |
| 4.6 Proportion of applicable patients who were given a formal swallow assessment within 72hrs of clock start (A=85%) | 85% (A) | 95.2% (A) | 100% (A) | § Understand any risks to sustaining this level of performance i.e. SALT recruitment challenges § SALT continues to prioritise formal swallow assessment within existing service; impact of reduced staffing should be minimal. |

Domain 4: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|--|--------------------------|---|
| 1. Complete options appraisal for 7-day Stroke Consultant cover/ward rounds | July 2015 | § Options appraisal - ? how delivered at other Trusts |
| 2. Review patients for last quarter who breached being assessed by Stroke Consultant within 24 hours of clock start | March 2015 | § Complete – all breaches were for patients admitted at the weekend/BH and also not on the Stroke Unit |
| 3. Review patients for last quarter who breached being assessed by Stroke Nurse within 24 hours of clock start | March 2015 | § Complete – all breaches were for patients not on the Stroke Unit – will be addressed by Stroke Outreach |
| 4. Stroke Outreach to work alongside ED Practitioners and determine best way to up-skill for WSS for the hours that won't be covered by Stroke Outreach i.e. midnight to 7am | May 2015 | § Stroke Outreach will cover ED WSS from 7am to midnight § Look at alternate options to train ED staff i.e. on-the-job training |
| 5. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in WSS | April 2015 | § Put in place a training plan to achieve 85% compliance with Band 5 and 6 Nurses § All new staff to complete training and be signed off as competent within 3 months of starting on unit |
| 6. To review alternate screening option for ED staff to use | June 2015 | § |
| 7. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in NIHSS | June 2015 | § Put in place a training plan to achieve 85% compliance with Band 5 and 6 Nurses § All new staff to complete training and be signed off as competent within 3 months of starting on unit |
| 8. Ensure up-to-date register is held of all staff who are deemed competent to complete WSS | February 2015 | § Complete § Register to be held and monitored by Band 7 SALT |
| 9. Ensure up-to-date register is held for all staff who are deemed competent to complete NIHSS | March 2015 | § Complete § Register to be held and monitored by SU CL |
| 10. SALT staffing recruitment plan – SALT unable to provide full service provision over the weekend in March | ongoing | § Band 7 post recruited into to start in July. Locum cover booked for May and June. § To re-advertise Band 6 vacancy (again!) § Band 5's joining weekend rota in April and June when appropriate level of competence and experience is achieved § Full weekend rota to re-start in April |

Domain 5: Occupational Therapy - Domain Leads: Louise Johnson and Anna Perrin

| DOMAIN KEY INDICATORS | Plan (A) | Last SSNAP (A) | Quarter to date | Key Improvement Actions |
|---|--------------|----------------|----------------------------|---|
| 5.1 Proportion of patients reported as requiring occupational therapy (A=80%) | 80% (A) | 86.6% (A) | 61.3% (E) Not validated | § Ensuring consistent data entry for SSNAP regarding eligibility for OT; training with teams around this to ensure accuracy |
| 5.2 Median number of minutes per day on which occupational therapy is received (A= >32 mins) | >32 mins (A) | 45 (A) | 38.8% (A) | § Ensure end dates for OT are being inputted; B7 mentors for each therapy team to support this § Review timetabling process to increase efficiency of therapy planning and release time for therapy § Review Band 3 competencies to optimise role (in future - consider B2/B3 skill mix within team – currently 1x B3 and 3 x B2 on SU) § Establish consistent therapy groups on the unit § Ensure all new therapy assistants have achieved their competencies § Note B6 Physiotherapy rotations end of March; B5 OT's/PT's rotate beginning of May – ensure SSNAP is clearly covered in induction |
| 5.3 Median % of days as an inpatient on which occupational therapy is received (A=>70%) | >70% (A) | 73.4% (A) | 64.3% (C) Not validated | |
| 5.4 Compliance (%) against the therapy target of an average of 25.7 minutes of occupational therapy across all patients (A=80%) | 80% (A) | Not given | | |

Domain 5: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|--|--------------------------|--|
| 1. More efficient process for timetabling therapy input now in place - formal timetabling to take place no more than 2x per week – to monitor this | ongoing | § Completed in March – to monitor |
| 2. Establish twice weekly OT groups (gardening and tell your story) | ongoing | § Completed in March – to monitor |
| 3. To implement group cancellation protocol | June 2015 | § To ensure groups are only cancelled by Band 7+ staff |
| 4. Ensure all staff know to complete Therapy SSNAP form in a timely/complete manner and implement monitoring system | June 2015 | § Ensure this is robustly implemented |
| 5. To remind all staff of the need to NFI patients in a timely manner and implement monitoring system | June 2015 | § Ensure this is robustly implemented |

Domain 6: Physiotherapy - Domain Leads: Louise Johnson and Emily Carter

| DOMAIN KEY INDICATORS | Plan (A) | Last SSNAP (A) | Quarter to date | Key Improvement Actions |
|--|--------------|----------------|----------------------------|---|
| 6.1 Proportion of patients reported as requiring physiotherapy (A=85%) | 85% (A) | 82.6% (B) | 62.9% (E) Not validated | Ensuring consistent data entry for SSNAP regarding eligibility for PT; training with teams around this to ensure accuracy |
| 6.2 Median number of minutes per day on which physiotherapy is received (A=>32 mins) | >32 mins (A) | 37.5 (A) | 32.9 (A) | § Ensure end dates for PT are being inputted; B7 mentors for each therapy team to support this § Review timetabling process to increase efficiency of therapy planning and release time for therapy § Review Band 3 competencies to optimise role (in future - consider B2/B3 skill mix within team – currently 1x B3 and 3 x B2 on SU) § Establish consistent therapy groups on the unit § Ensure all new therapy assistants have achieved their competencies § Note B6 Physiotherapy rotations end of March; B5 OT's/PT's rotate beginning of May – ensure SSNAP is clearly covered in induction |
| 6.3 Median % of days as an inpatient on which physiotherapy is received (A=>75%) | >75% (A) | 80.1% (A) | 72.8% (B) | |
| 6.4 Compliance (%) against the therapy target of an average of 25.7 minutes of physiotherapy across all patients (A=90%) | 90% (A) | 90.8% (A) | | |

Domain 6: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|--|--------------------------|--|
| 1. Review breaches for 6.1 to understand rationale for patients being deemed not appropriate | May 2015 | § Validate Q4 breaches and put in place systems/actions as required |
| 2. More efficient process for timetabling therapy input now in place - formal timetabling to take place twice weekly | ongoing | § Completed in March – to monitor |
| 3. Re-establish regular/sustained twice weekly exercise group (seated exercise group/sit to stand group/Wii). | May 2015 | § Review criteria and guidelines for groups, review competencies for staff leading groups and Review processes for referring to/organising groups § Audit non-compliance to understand any reasons for groups not occurring |
| 4. Ensure all staff know to complete Therapy SSNAP form in a timely/complete manner and implement monitoring system | June 2015 | § Ensure this is robustly implemented |
| 5. To remind all staff of the need to NFI patients in a timely manner and implement monitoring system | June 2015 | § Ensure this is robustly implemented |
| 6. To implement group cancellation protocol | June 2015 | § To ensure groups are only cancelled by Band 7+ staff |

Domain 7: Speech and Language Therapy - Domain Leads: Louise Johnson and Claire Irvine

| DOMAIN KEY INDICATORS | Plan (A) | Last SSNAP (A) | Quarter to date | Key Improvement Actions |
|--|--------------|----------------|----------------------------|---|
| 7.1 Proportion of patients reported as requiring speech and language therapy (A=50%) | 50% (A) | 69.8% (A) | 53.2% (A) | § Improve accuracy of documentation on the data collection form for SSNAP (complete) § Screening processes and referral pathway for both aphasia (FAST) and dysphagia (WSS) is robust and is working effectively. |
| 7.2 Median number of minutes per day on which speech and language therapy is received (A=>32 mins) | >32 mins (A) | 35 (A) | 29.2 (B) Not validated | § Extend the skill set of the therapy assistants to increase their role in delivering SALT rehabilitation. § Lunch group consistently happening 5 x per week § Communication group currently 1 x per week § Assistants supporting dysphagia patients at breakfast time (scope to increase to daily) § Development of a flexible approach to delivering therapy intensity (i.e. 2 x 20 minute sessions if cannot tolerate a 40 minute session) § Weekend service Saturday and Sunday since May 2014 |
| 7.3 Median % of days as an inpatient on which speech and language therapy is received (A=>70%) | >70% (A) | 74.9% (A) | 57.3% (C) Not validated | |
| 7.4 Compliance (%) against the therapy target of an average of 25.7 minutes of speech and language therapy across all patients (A=90%) | 90% (A) | Not given | | |

Domain 7: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|---|--------------------------|---|
| 1. Communication Group now running twice weekly – to monitor | ongoing | § Band 3 Therapy Assistant being trained to run group. § Review progress and potentially increase to 3 x per week thereafter. |
| 2. All B2 and B3 Therapy Assistants to be trained and assessed as competent in the delivery of oral trials, prescribed communication exercises and completion of the informal language assessment (B3). | April 2015 | § All TA competent except recent new starter who is working through them |
| 3. Therapy Assistants now supporting dysphagia patients at breakfast on a daily basis | Ongoing | § To monitor compliance with this § SALT to support TA's with providing this 3x days a week |
| 4. To ensure that "no further input" dates are entered consistently onto SSNAP for patients who no longer benefit from regular SALT input (i.e. priority 4) | Ongoing | § Need to monitor compliance with this; accuracy of data entry. |
| 5. Recruit to SALT vacancies and maintain weekend service | May 2015 | § Band 7 post recruited into to start in July. Locum cover booked for May and June. § To re-advertise Band 6 vacancy (again!) § Band 5's joining weekend rota in April and June when appropriate level of competence and experience is achieved § Full weekend rota to re-start in April |
| 6. Ensure all staff know to complete Therapy SSNAP form in a timely/complete manner and implement monitoring system | June 2015 | § Ensure this is robustly implemented |
| 7. To remind all staff of the need to NFI patients in a timely manner and implement monitoring system | June 2015 | § Ensure this is robustly implemented |
| 7. To implement group cancellation protocol | June 2015 | § To ensure groups are only cancelled by Band 7+ staff |

Domain 8: Multidisciplinary Team - Domain Leads: Louise Johnson, Tracey Legg and Nikki Manns

| DOMAIN KEY INDICATORS | Plan (A) | Last SSNAP (B) | Quarter to date | Key Improvement Actions |
|---|------------|-------------------------------------|-----------------|--|
| 8.1 Proportion of applicable patients who were assessed by an occupational therapist within 72hrs (A=90%) | 90% (A) | 99.3% (A) | 96.9% (A) | |
| 8.2 Median time between clock start and being assessed by Occupational therapist (A=<12hrs) | <18hrs (C) | 20:21hrs (D) (N.A. is 23:10 hrs) | | § Review system for same day assessments for patients admitted throughout the day § Consider relative benefits of extending therapy cover to include a twilight service |
| 8.3 Proportion of applicable patients who were assessed by an physiotherapist within 72hrs (A=90%) | 90% (A) | 99.3% (A) | 96.9% (A) | |
| 8.4 Median time between clock start and being assessed by physiotherapist (A=<12hrs) | <18hrs (D) | 20:21hrs (E) (N.A. is 22:03hrs) | | § Review system for same day assessments for patients admitted throughout the day § Consider relative benefits of extending therapy cover to include a twilight service |
| 8.5 Proportion of applicable patients who were assessed by speech and language therapist within 72hrs (A=90%) | 90% (A) | 96.9% (A) | 96.2%(A) | |
| 8.6 Median time between clock start and being assessed by speech and language therapist (A=<12hrs) | <18hrs (C) | 23:16hrs (D) (N.A. is 24:55hrs) | | § Performance threatened by current recruitment challenges; aim to maintain weekend service from April onwards. |
| 8.7 Proportion of applicable patients who have rehabilitation goals agreed within 5 days of clock start (A=80%) | 80% (A) | N/A | | § Quality improvement action – introduction of GAS goal setting on the SU to be discussed at March SQIIF meeting |
| 8.8 Proportion of applicable patients who are assessed by a nurse within 24hrs and at least one therapist within 24hrs and all relevant therapists within 72hrs and have rehab goals agreed within 5 days (A=60%) | 60% (A) | N/A | | |

Domain 8: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|---|--------------------------|---|
| 1. Review potential benefits, challenges and impact of extending therapy service delivery to include twilight hours | June 2015 | § Update required |
| 2. Implementation of GAS Goal setting on the SU including staff training | June 2015 | § On-track |
| 3. Undertake a “Time to Therapy Assessment” project | Sept 2015 | § ? to undertake mapping exercise to review current provision of therapy to develop options appraisal to improve time to therapy assessment |

Domain 9: Standards by discharge - Domain Leads: Nikki Manns and Tracey Legg

| DOMAIN KEY INDICATORS | Plan (A) | Last SSNAP (B) | Quarter to date | Key Improvement Actions |
|---|----------|----------------|--------------------------|--|
| 9.1 Proportion of applicable patients screened for nutrition and seen by a dietician by discharge (A=95%) | 95% (A) | 93.1% (B) | 60% (C) Not validated | § To review breaches quarter to date to understand reasons for breach i.e. documentation, timeliness of referral to Dietetics, Dietetics provision - develop action plan as required. |
| 9.2 Proportion of applicable patients who have a continence plan drawn up within 3 weeks of clock start (A=95%) | 95% (A) | 88.1% (B) | 92.3% (B) | § To review as part of Stroke Nurses action plan to ensure all stroke patients who have persistent incontinence at 2 weeks post stroke have a full continence assessment and management plan. § To implement stroke continence assessment pathway. |
| 9.3 Proportion of applicable patients who have mood and cognition screening by discharge (A=95%) | 95% | 99.1% (A) | | § To maintain this we need to ensure all new starters to team have induction for SSNAP and understand cognitive and mood screens we use and how to complete them. § Recording also needs to stay consistent – continue with green forms (and ensure induction completed). § Also taught band 3 to complete basic cognitive screen. |

Domain 9: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|--|--------------------------|---|
| 1. Ensure an induction plan is put in place for all new starters | April 2015 | § Complete for new Medical Juniors – to review benefits/impact of this |
| 2. To ensure all breaches are reviewed and validated | ongoing | § System in place |
| 3. To ensure all stroke patients have a comprehensive continence assessment completed and appropriate management plan in place – undertake audit of current practice against national guidance recommendations | June 2015 | § To organise audit of current practice and then determine appropriate action plan if required. |

Domain 10: Discharge processes - Domain Leads: Louise Johnson and Nikki Manns

| DOMAIN KEY INDICATORS | Plan (A) | Last SSNAP (A) | Quarter to date | Key Improvement Actions |
|--|----------|----------------|-----------------|---|
| 10.1 Proportion of applicable patients receiving a joint health and social care plan on discharge (A=90%) | 90% (A) | 100% (A) | 100% (A) | § Implement Dorset CCG Joint Health and Social Care Plan template |
| 10.2 Proportion of patients treated by a stroke skilled ESD team (A=40%) | 40% (A) | 47% (A) | 49.5% (A) | |
| 10.3 Proportion of applicable patients in AF on discharge who are discharged on anticoagulants or with a plan to start anticoagulation (A=95%) | 90% (B) | 89.3% (C) | 88% (C) | § Scrutinise retrospective data to understand reasons for poor performance – assumed to be a documentation/data entry issue § SSNAP Administrator to liaise with member of the medical team before entering “no” for 7.10.1. § Audit facilitator to validate before locking down. |
| 10.4 Proportion of those patients who are discharged alive who are given a named person to contact after discharge (A=95%) | 95% (A) | 100% (A) | 100% (A) | |

Domain 10: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|---|--------------------------|--|
| 1. Audit facilitator to specifically validate 10.3 for non-compliant records before locking down. | ongoing | § System in place for ongoing validation of any breaches |

Domain: Audit compliance - Domain Leads: Tanya Davies and Claire Stalley

| DOMAIN KEY INDICATORS | Plan (B) | Last SSNAP (C) | Quarter to date | Key Improvement Actions |
|--|----------|-----------------------|-----------------|--|
| Overall | 80% | 71.9% | | |
| NIHSS at arrival (30% of score) | | 37.1% (N.A. 83.1%) | 61.9% | § Stroke Outreach § Training to achieve 85% of SU Nursing staff are competent to undertake NIHSS § Ensure all are aware of need of 24 hour post-thrombolysis NIHSS |
| NIHSS 24hrs post thrombolysis (20% of score) | | 69.2% (N.A. 85.4%) | 100% | |
| Transfers (10% of score) | | 87.9% | | § Ensure all patients discharged to ESD/CRT are transferred on the webtool |
| Data Entry (10% of score) | | 87.5% | | |
| 72hr Measures (15% of score) | | 97.2% | | § Ensure reason is documented for all patients not having a swallow screen within 72hrs |
| Post 72hr Measures (15% of score) | | 99.1% | | |

Domain: Audit compliance: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|---|--------------------------|--|
| 1. NIHSS on arrival – ensure that all nursing staff on the SU are trained and competent to complete NIHSS on patients | June 2015 | § Aim for 85% Nurses on SU competent with NIHSS by end of June |
| 2. NIHSS – ensure system in place to train all new starters | ongoing | § Need an induction in place for all new starters |
| 3. NIHSS Register – to ensure there is a register on the shared drive of all staff who are competent with NIHSS | complete | |
| 4. Review patients recorded as discharged to ESD/CRT are transferred to ESD/CRT on webtool | June 2015 | § CS to liaise with TD |
| 5. Ensure reason is documented for all patients not having a swallow screen within 72hrs | June 2015 | § CS to liaise with TD |

Domain: Case Ascertainment - Domain Leads: Tanya Davies & Claire Stalley

| DOMAIN KEY INDICATORS | Plan | Last SSNAP (B) | | Key Improvement Actions |
|--|------|----------------|--|--|
| Average patient centred case ascertainment | 90+% | 80-89% | | § Monthly lockdown checks will be performed on both 72hr and discharge lists § All requests for record unlocks and data changes to go through SSNAP administrator § To review case ascertainment figure with SSNAP |

Domain Case Ascertainment: Delivery Plan

| Delivery Plan | Timescale for completion | Comment |
|---|--------------------------|--|
| 1. Monthly lockdown checks will be performed on both 72hr and discharge lists | June 2015 | |
| 2. All requests for record unlocks and data changes to go through SSNAP administrator | June 2015 | § Ensure all relevant staff are made aware |
| 3. To review case ascertainment figure with SSNAP | June 2015 | |

| BOARD OF DIRECTORS | |
|---|---|
| Meeting Date and Part: | 26 June 2015 - Part 1 |
| Subject: | Communications Report (including media KPIs and Core Brief) |
| Section: | Information |
| Executive Director with overall responsibility | Karen Allman, Director of Human Resources |
| Author(s): | James Donald, Head of Communications, and Jane Bruccoleri-Aitchison, Communications Manager |
| Previous discussion and/or dissemination: | |
| Action required: The Board of Directors is asked to: To note the report | |
| Summary: The Communications Report provides a summary of key communication activities over the past month as well as upcoming activities and media KPIs | |
| Related Strategic Goals/ Objectives: | Access to care Provider of choice |
| Relevant CQC Outcome: | Section 1, Outcome 1, Section 4, Outcome 13 and 14 |
| Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? ii. Have any risks been created? | |
| Reason paper is in Part 2 | N/A |

Communications activities June 2015

1. Introduction

The following paper includes:

- recent and future communication activities
- media coverage summary key performance indicators
- June Core Brief

2. Recent activities

- Buzzword – publication celebrating staff achievement
- Sexual Health Dorset marketing plan for tender
- Clinical Services Review – update in Core Brief
- Website updates
- Working with fundraising on developing local networks
- Film celebrating 10 years of Cardiology shown at their celebration event
- Bournemouth Echo interview with Tony Spotswood re CSR – further interviews to follow
- Promotion of CQC Intelligent Monitoring report
- Promotion of Staff Friends and Family Test

3. Upcoming activities

- BBC South Today coverage for CCG Clinical Services Review
- Promote start date of public consultation for CSR
- Planning the 2015 Pride Awards
- Raising sponsorship for 2015 Pride Awards
- Raise awareness of CQC full inspection in October
- Do you have a concern? Communications flow chart being produced with HR
- Workforce transformation communications
- Communicate RBCH's financial situation to staff
- NMC Nurse revalidation communications support
- Quality improvement communications
- Communications for planned works on A338 from September
- Annual Report – summary document for members
- Promote range of Health & Wellbeing services

4. Recommendation

| |
|--|
| The Board is asked to note the report. |
|--|

Media relations - Key Performance Measures

May saw a very good level of positive articles both online and in the print media. Articles included events to mark International Nurses' Day - which was featured in the Nursing Times as well as local media - the positive results of our latest inpatient survey and a television interview with Chief Executive Tony Spotswood on the Clinical Services Review.

May also saw a series of articles about the work of our Bournemouth Hospital Charity, including stories that celebrated the success of March for Men and articles promoting the Twilight Walk for Women, which saw record numbers of people register to take part.

Both our Twitter and Facebook followers continue to grow by approximately 100 every month. Posts about International Nurses' Day reached over 5,500 people while pictures of hand hygiene day reached 2,525.

Relationships with the Daily Echo go from strength to strength and the newspaper is sponsoring our Unsung Hero Award in this year's Pride Awards.

For more information, or to access any of the media coverage the Trust has received, contact communications@rbch.nhs.uk or call 01202 726172.

| 2015 | Number of proactive news releases distributed | % that received media coverage in <u>that month</u> | Total PRINT coverage (includes adverts) | Total OTHER coverage (online, radio, TV) | Positive media coverage | Neutral media coverage | Negative media coverage | Media enquiries |
|--------------|--|---|--|---|-------------------------|------------------------|-------------------------|--|
| May | 11 (including International Nurses' Day, the CSR, patient survey and charity news) | 100% | 24 | 24 | 46 | 2 | 0 | 13 (including the Clinical Services Review, babies born on the same day as Princess Charlotte and stroke statistics) |
| April | 8 (including health talks, charity news releases and physio in £1m study) | 100% | 32 | 15 | 35 | 12 | 0 | 8 (including high attendances in ED, referral to treatment costs and traffic issues) |

excellent care for every patient,
every day, everywhere

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



Core Brief

From: Tony Spotswood, Chief Executive

June 2015

Survey shows our patients have confidence in clinical staff

A recent national survey of adult inpatients carried out by the Care Quality Commission shows increasing numbers of our patients have confidence in the doctors and nurses treating them.

The 12th annual survey was completed by 447 patients who had spent at least one night in RBH last summer. They were asked to rate their experience in a number of areas, including care and treatment, and advice given to them when leaving hospital.

There were four areas where our results placed us in the best performing trusts in the country, including patients feeling their hospital specialist had the right information about their condition/illness, those who felt they were given good information from their anaesthetist about pain management and the number of patients who said they were given written advice when leaving hospital.

The results also showed year on year improvements in 42 areas, for example the number of patients feeling there were enough nurses on duty to care for them, the level of emotional support offered to them in hospital, and the level of privacy they had when discussing their condition or treatment.



Director of Nursing, Paula Shobbbrook, said:

"These results are really encouraging and it is pleasing to see we are making improvements in a number of areas."

"One question in the survey put us in the lowest 20% of trusts; patients reporting they used the same bathroom or shower area as patients of the opposite sex. We are working hard with our teams to address this by improving signage and re-designating bathrooms as male and female depending on how many patients of each sex are on a ward each day."

Remember!

Even more patients will be sent the survey this year, including those who are inpatients with us now, so let's continue to improve and ensure we deliver excellent care to our patients reflecting the care we expect for our family.

CQC Intelligent Monitoring Report and inspection

The CQC Intelligent Monitoring report was published on 29 May 2015. The report includes an analysis of a suite of over 150 indicators which are used to calculate an overall "Priority Band for Inspection". The banding is rated band 1 (worst: high risk) to band 6 (best: low risk). We were given a rating of 6.

Please note! The CQC will be conducting a full inspection of the Trust in October 2015, from which we shall receive a rating. We will hear of the exact date of the inspection 12 weeks in advance, but in the meantime work is going on around the Trust in preparation.

Dorset's Clinical Services Review

Over the past six months the Dorset Clinical Commissioning Group (CCG) has led work involving both primary and secondary care clinicians to review and redesign how hospital and out-of-hospital care needs to change and develop.

The centrepiece of the proposals for in-hospital provision are:

- the creation of a major emergency hospital for Dorset offering a range of 24/7 consultant-delivered care
- the development of a planned care site focusing on the provision of planned, diagnostic and outpatient care to the population of east Dorset
- the enhancement of district general hospital services for west Dorset residents

Following careful consideration, including discussions with a broad range of clinicians and consideration by the Board, we believe the future health needs of Dorset and West Hampshire residents are best served through the development of the Royal Bournemouth Hospital as the main emergency hospital for Dorset.

We outlined the reasons in a message sent to all staff on Tuesday 2 June and also in a letter sent to the CCG by Tony Spotswood and Basil Fozard. Please contact the Communications Team - **communications@rbch.nhs.uk** - if you would like copies of these sent to you.

Formal consultation on the proposals to change the role of existing hospital sites will not commence until 17 August. The CCG will not make a decision on the future roles of Dorset hospitals until March 2016.

Given that we do not anticipate these changes being implemented until 2018/19 at the earliest, we want to continue our focus within the Trust on continuing to provide high standards of care to our patients and to improve quality in all areas.



shaping your local NHS

Revalidation workshops for nurses and midwives

The revised Code of Conduct for nurses and midwives has been launched by the Nursing and Midwifery Council. It is integral to the revalidation process of all registered nurses and midwives.

All nurses and midwives are currently required to renew their registration every three years. Revalidation will strengthen the renewal process by introducing new requirements that focus on:

- up-to-date practice and professional development
- reflection on the professional standards of practice and behaviour as set out in the Code

- engagement in professional discussions with other registered nurses or midwives

We will be running a series of drop in sessions to assist you through the revalidation process. Please see below for dates and times, or talk to your heads of nursing for more information. For more background or to find out your renewal date, please visit: **www.nmc.org.uk**

| Date | Time | Venue |
|----------------------|---------|--------------------|
| Thursday 11 June | 1pm | Committee Room |
| Wednesday 8 July | 2pm | Committee Room |
| Tuesday 11 August | 12.30pm | Committee Room |
| Tuesday 8 September | 10.30am | Committee Room |
| Tuesday 6 October | 10.30am | Consultants Lounge |
| Tuesday 3 November | 10.30am | Consultants Lounge |
| Thursday 10 December | 2pm | Committee Room |



Pride Awards 2015

- *keep nominating!*

You have been busy filling in and submitting your nomination forms for this year's Pride Awards, which will take place on **Thursday 12 November** at Poole Lighthouse.

Making a nomination is an ideal opportunity for you to represent your department and get the recognition you deserve. Ideally we would like a nomination from every department so that we can celebrate the hard work of everyone.

This year there are eight award categories in which you can nominate your colleagues and staff, an award where you can nominate one of our dedicated community or charity champions, and our Unsung Hero Award. This award is sponsored by the Daily Echo and is a chance for the public to nominate you.

Making a nomination couldn't be easier. Simply use one of our 2015 Pride Awards Nomination Packs available on the intranet, or log on to www.rbch.nhs.uk/pride_awards and complete the form online.

Please ensure that your nominations are **at least 200 words long**, as we want to hear exactly why you are highlighting someone for an award. We will be asking anyone who submits a nomination that doesn't meet the word count to re-submit.



Don't forget if you require any assistance filling in your nomination form, the Communications Team is more than happy to help. Simply contact us on ext. **4271** or via email at communications@rbch.nhs.uk

The deadline for nominations is any time before **12noon on Friday 10 July**.

A big thank you to everyone who has signed up to become judges for the awards. We now have a full panel for both stages of judging.



The categories are:

Award for Patient Experience

Award for Teamwork

Learning and Development Award

Award for Improving Quality

Inspirational Leadership Award

Community and Charity Award

Award for Improving Patient Safety

Behind the Scenes Award

Unsung Hero Award

Chairman's Award for Living our Values



Theatre recruitment and retention

A stable and motivated theatre workforce is crucial to the delivery of timely and appropriate care to our patients.

Our Theatres Directorate is working hard to recruit and retain theatre staff to ensure the highest quality of care can be delivered to our patients now and in the future. They are focusing on:

- retaining the current workforce by engaging, communicating and addressing issues of concern
- attracting qualified staff by identifying where potential sources of staff are and targeting these specifically with a tailored plan
- increasing the number of applicants for this type of role using social media and developing our networks
- developing the competencies, setting goals and carrying out more frequent reviews for staff already working in the department

What have we been doing?

Recruitment

To date, we have placed targeted adverts in medical publications, attended successful recruitment fairs in London and Glasgow and supporting the overseas recruitment campaign.

Interviews for healthcare assistants

have taken place, with applicants being offered positions on the day subject to reference checks. Early interviews of newly qualified nurses and operational department practitioners have also been completed with a follow-up evening arranged to help reduce the drop-out rate.

Retention

We have worked closely with HR to gather and analyse information from the Staff Survey, Staff Impressions Survey and a Surgical Listening Event held last October. This has highlighted a number of areas to concentrate on, such as staff appraisals and a perceived lack of training and support.

Education and development

All of our band 7 clinical leaders/sisters will be taking part in a new leadership programme which offers them the opportunity to improve their skills and enhance their team's developments.

A review of our local induction paperwork has been undertaken which is now more tailored to the needs of staff and includes dates when training must be completed by. This is currently being trialled with new recruits. We are also ensuring that our mentors have sufficient training to support



learners.

The plan going forward

Several new appointments have already been made, and this includes 12 new nurses from the Philippines who will start imminently.

Work is underway to increase the number of mentors in theatres to ensure they have the skills to support and develop new staff. There is also a focus on ensuring communication within the department improves with regular notice board updates and team meetings.

There are a number of new initiatives in the pipeline, from creating an 'ideas box' where staff can submit written ideas and resolutions to improve the department and introducing a 'bright idea of the month' award.

To support improved communication we are ensuring all staff has access to an internal email address.

Complete our latest Staff Friends and Family Test

Please take five minutes to complete the Staff Friends and Family Test (FFT) for June 2015. It is open until Tuesday 30 June and can be accessed via the homepage of the intranet.

The questions we ask are similar to those we ask our patients, including whether you would recommend the Trust to your family and friends for treatment and as a place of work.

Remember this is a chance for you to tell us what you think and share any ideas you have for change. We use the information you give us to work to identify themes and make changes.

Your responses help us to better understand how it feels to work here.

The FFT results are reported and published nationally, so this has an impact on how our Trust is viewed as a provider of care, and as an employer.

Any feedback you give us is anonymous. If you have any questions please contact **organisational.development** @rbch.nhs.uk or call us on ext. 4932.



Happy Birthday to #ThankYou!

It has been a year since the #ThankYou! recognition website was launched and since then we have received over 360 'thank yous' from grateful patients and colleagues.

The aim of #ThankYou! is to provide prompt, informal feedback to those individuals and teams who have gone the extra mile and who are living our values.

These are some of the words that have been used in the nominations:



When a nomination is made, the nominee and their manager are both notified and permission is requested to publish the #ThankYou! on the website as well as on our Twitter page.

#ThankYou! is proving extremely successful among staff. Here are just a few comments we have received about the campaign:

"It would be an absolute honour for you to publish on the #ThankYou and Trust twitter, I am ecstatic - the smile isn't going anywhere today that's for sure!"

"I have no words to express my gratitude and happiness reading these kind words. I do my best to work as a team within the Trust so it's a pleasure when our hard work is valued. Really appreciate your email."

"It was such a lovely surprise that a patient had taken the time to write this."



To celebrate the landmark one year anniversary, a special event will be held on **Monday 15 June** in the Discharge Lounge at RBH and **Thursday 18 June** at Christchurch.

Royal College of Nursing (RCN) Congress

Bournemouth will host this year's Royal College of Nursing (RCN) Congress between **Sunday 21 June - Thursday 25 June**.

The event, taking place at the Bournemouth International Centre, is a chance for those attending to learn, develop and share nursing practice. It is also where members inform the RCN agenda and influence nursing and health policy through debate.

There are three parts to the congress:

- **The Business Agenda**

This provides members with the opportunity to share their opinions and concerns with RCN Council and influence future work of the RCN.

- **The events programme**

This includes professional and personal development sessions, educational seminars, as well as social and networking events.

- **The congress exhibition**

The largest nursing exhibition in the UK where you can discover practice innovations and opportunities before they reach your workplace.

The RCN South West is currently recruiting ambassadors to represent our region at the event. Shifts will be around two hours long and your travel expenses will be paid, even if you can only make one day. Roles of an ambassador include greeting delegates, distributing information packs and stewarding doors.



BJ Waltho, Associate Director of Operations and Vice Chair of Congress, said: *"The RCN Congress is a free event which brings together nurses, HCAs, APs and students from across the UK to participate in professional development opportunities and much more. I would really encourage RCN members to take this chance to visit congress while it is on our doorstep."*

If you are interested please contact BJ Waltho via email at bj.waltho@rbch.nhs.uk

Let's talk about IT

eDM update: Evolve training

Evolve is the electronic document management (eDM) system we use to store our patient's clinical records.

We run weekly training sessions to explain how to use the new software in the most efficient way. We strongly recommend that all staff attend a training session to ensure you can find the information you require.

Each training session lasts for an hour and includes plenty of practice on the following topics:

- finding patients
- navigating through the electronic documents
- using keyword searches and bookmarks
- creating summary/research notes and annotating them

You can book training dates via ESR Manager Self Service or email IT.TrainersTeam@rbch.nhs.uk



Friday 12 June:
Training Room 1, 2pm

Monday 15 June:
Training Room 1, 10am

Wednesday 24 June:
Training Room 2, 2pm

Monday 29 June:
Training Room 1, 2pm

Friday 10 July:
Training Room 2, 2pm

Wednesday 15 July:
Training Room 1, 1pm

Friday 24 July:
Training Room 1, 9.30am

Wednesday 29 July:
Training Room 1, 1pm

Patient Demographic Data Quality:

Please note that our Data Quality Team no longer has a fax machine.

If you wish to contact them with regards to duplicate registrations, please email them at data.quality@rbch.nhs.uk

Spacelabs Sentinel Analysers

Our Cardiac Department has received two new state-of-the-art analysis systems which will enable cardiac physiologists to report ambulatory recordings on patients.

It means they can also look at the heart rhythms of patients over a period of 24 hours to see whether there have been any arrhythmias such as fast ventricular rhythms (ventricular tachycardia), or atrial arrhythmias (atrial fibrillation / atrial flutter). It can also be used to see slower heart rates (bradycardia) and pauses in a patient's heart rate.

Other benefits include speedier analysis of recordings with lots of added diagnostic detail which consultants will find helpful in their clinical treatment of patients.

The system is an upgrade of our older analysis system Pathfinder.

Please use this form to cascade key messages from Core Brief to your staff – please return to the Communications Department, ppB43, RBH

Core Brief

Date of Core Brief cascade briefing: 10 June 2015

Name:
Department/Ward:

Date delivered:

Who to:
How many:

Please use the *Core Brief* that has been circulated to all staff via global email to support you in cascading the following messages:

Inpatient Survey results: A national survey of adult inpatients carried out by the Care Quality Commission has shown increasing numbers of our patients have confidence in our doctors and nurses providing their treatment and care. A total of 447 patients who had spent at least one night in RBH last summer responded to the survey. The results showed year on year improvements in 42 areas.

Action: Please could all managers ensure the positive results are cascaded to staff and that staff are aware that patients currently staying with us will likely be sent a survey about their stay.

CQC Intelligent Monitoring Report and inspection: The CQC Intelligent Monitoring report was published at the end of May which banded us as '6' – the lowest priority band for inspection. The CQC will be conducting a full inspection of the Trust in October from which we will receive an overall rating. The exact date of the inspection is expected to be announced 12 weeks in advance, and work is currently ongoing around the Trust in preparation.

Action: Please ensure your teams are aware of the inspection date once it is announced. We will provide regular updates in the coming months.

Dorset's Clinical Services Review: Over the past six months the CCG has led work to review and redesign how hospital and out-of-hospital care needs to change and develop. We believe the future health needs of Dorset and West Hampshire residents are best served through the development of RBH as the main hospital for Dorset. Formal consultation on the proposals will start in August with a decision expected next March.

Action: We outlined our reasons on why we think RBH should be the main emergency hospital for Dorset in a letter to staff on Tuesday 2 June. If you would like a copy of the letter, please contact the Communications Team on ext. 6172. Please can managers ensure copies of Core Brief are disseminated to staff, as regular updates on the CSR will be included over the coming months.

Pride Awards 2015: Nominations for this year's Pride Awards continue to come in, although we have yet to see any nominations from some areas so please make a nomination and ensure your department is represented.

Action: To make a nomination you can use one of our 2015 Pride Awards Nomination Packs available on the intranet or visit www.rbch.nhs.uk/pride_awards. Please ensure that your nominations are **at least 200 words long**. If you require assistance filling in your nominations contact the Communications Team on ext. 4271 or via email at communications@rbch.nhs.uk. The deadline for nominations is 12 noon on **Friday 10 July**.

Revalidation workshops for nurses and midwives: The revised Code of Conduct for nurses and midwives has been launched by the Nursing and Midwifery Council. It is vital to the revalidation process of all registered nurses and midwives. All nurses and midwives are currently required to renew their registration every three years.

Action: See Core Brief for a list of drop-in sessions to assist you through the revalidation process.

Staff questions: (please list any questions your staff have following the briefing)

Signed:

Date:

CORPORATE EVENTS CALENDAR 2015

| Date and Time | Event Description | Venue | Contact Details |
|--------------------------------|-----------------------------------|---|-----------------|
| Thursday 25 June | Simply Health | Between the RBCH restaurants | 01202 726159 |
| Friday 26 June | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |
| Monday 29 June – Friday 3 July | 5 Daily Actions | Between restaurants | 01202 704229 |
| Tuesday 30 June | Estates | Atrium | 01202 704394 |
| Tuesday 14 July | Blood Pressure machine evaluation | Atrium | 01202 704394 |
| Wednesday 15 July | Council of Governors' Meeting | Conference Room, Education Centre, Royal Bournemouth Hospital | 01202 704246 |
| Saturday 18 July | Sky Dive | Bournemouth Hospital Charity | 01202 704060 |
| Friday 31 July | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |
| Saturday 12 September | Volunteer's Tea Party | Invitation Only- Volunteer's Office | 01202 704253 |
| Monday 21 September | Understanding Diabetes | The Village Hotel | 01202 704271 |
| Wednesday 23 September | Annual Members' Meeting | The Village Hotel | 01202 704246 |
| Friday 25 September | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |
| Sunday 27 September | Pedal Power | 10am New Forest | 01202 704060 |
| Saturday 3 & Sunday 4 October | Bournemouth Marathon | Bournemouth Hospital Charity | 01202 704060 |
| Friday 30 October | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |

| | | | |
|-------------------------|---|---|--------------|
| Friday 16 October | Light up the Prom- for Oncology & Haematology | 8pm Bournemouth Pier | 01202 704060 |
| Thursday 5 November | Council of Governors' Meeting | Conference Room, Education Centre, Royal Bournemouth Hospital | 01202 704246 |
| Friday 27 November | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |
| Friday 4 December (TBC) | Understanding Knee Pain | The Village Hotel | 01202 704271 |
| Friday 18 December | Board of Directors' Meeting | Committee Room, Trust Management Office, Royal Bournemouth Hospital | 01202 704777 |

Key

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|--|---------------------------------------|
| | Surveys and audits |
| | Meetings |
| | Volunteer events |
| | Health and other talks |
| | Stakeholder groups, events and forums |
| | Stands at local/community events |
| | Bournemouth Hospital Charity events |
| | Staff Events |
| | Other activities/events |

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| Declaration of interests | SA | Trust Secretary | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Trust Secretary |
| Register of Interests | SA | Trust Secretary | | | Part 1 | | | | | | | | | | Trust Secretary |
| Code of Governance Disclosure Statement | SA | Trust Secretary | | | | | part 2 | | | | | | | | Monitor |
| Meeting Dates for Next Year | SA | Trust Secretary | | | | | | | | Part 1 | | | | | N/A |
| Forward Programme | SA | Trust Secretary | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | Part 1 | N/A |
| Annual IG Briefing | PG | HAC | | | | | | | | | | | | | IG Toolkit |
| IG Toolkit | PG | HAC | | | | | | | | | | | | | HSCIC |
| Results of Governor Elections | SA | External | | | | | | | | | | | | | AMM |
| Annual Members' Meeting | CoG | N/A | | | | | | | | | 24th | | | | N/A |
| Seasonal Plan | RR | N/A | | | | | | | | | | Part 1 | | | CCG/NHS England |
| Board Performance | JS | N/A | | | | | | | | | | | | | CoG |
| Transformation Update and report on milestones | MF | n/a | | | | | | | | | | | | | N/A |
| Standing Financial Instructions (SFIs) | SH | Finance Cttee | | | | | Part 2 | | | | | Part 2 | | | Trust Secretary |

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