

A meeting of the Board of Directors will be held on Friday 18 December 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

*** Denotes supplementary documents in reading pack*

TIMINGS	1. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST		
8.30-8.35	2. MINUTES OF THE PREVIOUS MEETING		
	(a) To approve the minutes of the meeting held on 27 November 2015		
8.35-8.40	3. MATTERS ARISING		
	(a) To provide updates to the Actions Log		<i>All</i>
	(b) NHS Preparedness for a Major Incident (verbal)		<i>Richard Renaut</i>
8.40-9.30	4. QUALITY IMPROVEMENT		
	(a) Feedback from Staff Governors (Verbal)	Information	<i>Jane Stichbury</i>
	(b) Patient Story (Verbal)	Information	<i>Paula Shobbrook</i>
	(c) Quality Improvement: Update on Urgent Care in Medicine Project (presentation)	Information	<i>Richard Renaut Deb Matthews/ Andrew Williams</i>
9.30-10.20	5. PERFORMANCE		
	(a) Performance Exception Report (presentation)	Discussion	<i>Richard Renaut</i>
	(b) Report from Chair of HAC (verbal)	Information	<i>Dave Bennett</i>
	(c) Quality Performance (verbal)	Discussion	<i>Paula Shobbrook</i>
	(d) Report from Chair of Charity Committee (verbal)	Discussion	<i>Bill Yardley</i>
	(e) Financial Performance (paper to be tabled)	Discussion	<i>Stuart Hunter</i>
	(f) Report from Chair of Finance Committee (verbal)	Information	<i>Ian Metcalfe</i>
	(g) Workforce Report (paper)	Discussion	<i>Karen Allman</i>
	(h) Stroke Services Quarterly Update (paper)	Information	<i>Richard Renaut</i>
10.20-10.35	6. STRATEGY AND RISK		
	(a) Acute Care Vanguard Project (paper) **	Information	<i>Tony Spotswood</i>
	(b) Clinical Services Review update (verbal)	Information	<i>Tony Spotswood</i>
10.35-10.40	7. GOVERNANCE		
	(a) Workforce Committee Terms of Reference (paper)	Decision	<i>Derek Dundas</i>

8. NEXT MEETING

Friday 29 January 2016 at 8.30am in the **Conference Room, Education Centre Royal Bournemouth Hospital**

10.40-10.45

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.45-11.00

10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

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

11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

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 27 November 2015** in the Conference Room, Education Centre, Royal Bournemouth Hospital.

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Derek Dundas	(DD)	<i>Non-Executive Director</i>
	Basil Fozard	(BF)	<i>Medical Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</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>
	Richard Renaut	(RR)	<i>Chief Operations Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
	Bill Yardley	(BY)	<i>Non-Executive Director</i>
In attendance:	Sarah Anderson	(SA)	<i>Trust Secretary</i>
	Matthew Benbow	(MB)	<i>Senior Radiographer</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NHa)	<i>Director of Organisational Development</i>
	Catherine Paton	(CP)	<i>Human Resources</i>
	Dily Ruffer	(DR)	<i>Governor Coordinator</i>
	Derek Chaffey	(DC)	<i>Public Governor</i>
	Eric Fisher	(EF)	<i>Public Governor</i>
	Bob Gee	(BG)	<i>Public Governor</i>
	Paul Higgs	(PH)	<i>Public Governor</i>
	Doreen Holford	(DH)	<i>Public Governor</i>
	Paul McMillan	(PM)	<i>Public Governor</i>
	Margaret Neville	(MN)	<i>Chair of the Friends of the Eye Unit</i>
	Roger Parsons	(RP)	<i>Public Governor</i>
	Graham Swetman	(GS)	<i>Public Governor</i>
	David Triplow	(DT)	<i>Public Governor</i>
	Brian Young	(BY)	<i>Public Governor</i>
Apologies:	<i>None.</i>		

96/15 **DECLARATIONS OF INTEREST**

BY declared his appointment as a Non- executive Director at the Houses of Parliament.

97/15 **MINUTES OF THE MEETING HELD ON 25 SEPTEMBER 2015 (Appendix A)**

The minutes of the meeting on 30 October were confirmed as an accurate record subject to an amendment at 91/15 (f) from “ *There was an issue that some staff needed to be aware of their eligibility for an appraisal,*” to

"Staff needed to be aware of 100% appraisal compliance target for all eligible staff."

98/15

MATTERS ARISING (ACTIONS LOG) (Appendix B)

- (a)
- 89/15 (d) the latest figures for appraisal performance were 58.7% following a drive amongst staff to achieve the compliance target. Quality of appraisals is being maintained and good feedback has been received. The values based approach is being considered for clinical appraisals and feedback on progress will be provided. **BF**
 - 80/15 (d) themes raised are being addressed through the cultural audit work and the Board will be sighted on the actions. **BoD Dev Agenda**
 - 90/15 (c) it has been agreed that the QIA process will be incorporated into the internal audit programme.
 - 91/15 (a) a letter and a plan will be developed in order to gain greater support from local authorities to improve social care provisions within Dorset. **TS/RR**
 - 91/15 (b) the Trust's cash position will be reviewed through the Finance Committee.
 - 91/15 (b) communications have been circulated to staff about the Trust's financial position including FAQ's.
 - 91/15 (g) a root cause analysis review has been proposed to identify solutions to address sickness levels.
 - 95/15 EDM will be considered as a governor training topic.
 - 68/15 (c) Race Equality scheme- this will be discussed at the Workforce Committee in December. Further information will be provided to the Board once the consultation has concluded. **KA/Jan**

(b) **Whistleblowing (Freedom to Speak Out)**

The action plan had been updated and there has been an increased focus to embed the process within the culture of the organisation through a communication campaign. Policies are in place and overall education has improved. Monitor are consulting on the guidance. The approach to the appointment of the Freedom to Speak out Guardian will be considered at the Workforce Committee.

99/15

QUALITY IMPROVEMENT

(a) **Feedback from Staff Governors (Verbal)**

JS outlined the themes raised during the meeting with Staff Governors:

- An update on nursing recruitment was requested. It was suggested that a route map of the recruitment process was provided; **KA**
- Services remain busy despite staffing templates and increased recruitment;
- Discussions about the impact of the Vanguard application upon the Trust strategy;

- Some training issues with the Electronic Nursing Assessment;
- Car parking and leaving the site. TS noted that the Deansleigh Road roundabout is being adapted to ease congestion;
- Provide staff with more feedback following the CQC visit when it is available;
- Staff appreciated the extension of the appraisal compliance target as wards are busy;
- Mandatory training can be difficult to access. KA advised that feedback about access to the system had been positive and some areas now realise the need to plan training;
- The cost of the Christmas lunch available to staff was raised;
- Staff Governors have proposed walk around sessions or stands in clinical areas to obtain staff views/concerns.

The Board acknowledged the importance of hearing staff views. TS advised that from January all Executives would be spending time each month to work within various areas of the Trust. This will provide the Board with the opportunity to gain greater understanding about staff views and the delivery of services from a staff point of view across a significant number of areas.

(b) Patient Story (Verbal)

MB presented the patient story arising from the CT and MRI department whereby a patient had been inconvenienced due to delays with their scan arising from a blood test not being completed to assess renal functions for the use of IV contrast media.

The existing process involved checking blood results were available two days prior to a scan appointment to ensure information is available on the required day. It is part of national guidelines to ensure patients have received this blood test prior to being scanned to ensure the patient is not put at risk.

The process was reviewed and a new system put in place whereby blood tests are considered and ordered by the referrer. It was highlighted that the order comms system would provide greater electronic assistance. PG advised that the system would be live soon and would provide greater facilities than those suggested in the story.

BF suggested that the CT/MRI booking form was amended to indicate when an 'EGFR' test was required. MB noted that this had been included on in-patient forms.

The Board commended the story as a good example of genuine transformation for the Trust in which patient care was improved and savings were also made.

(c) Serious Incidents and Complaints Report

The complaints report was to be presented and discussed at the Healthcare Assurance Committee (HAC) meeting in December. It was

highlighted that fewer complaints had been received in comparison to last year and this was due to the proactive approach with patients to ensure they can raise concerns at appropriate times to receive the best experience. There is still work to improve complaint response times and further detail will be provided by the Heads of Nursing at HAC.

Board members queried what support could be provided to areas where response times were an issue. DB advised that progress was being made and there is increased engagement from departments. There are some difficult areas that fail to achieve response times but these often relate to complex complaints.

It was queried when the target would be achieved. PS emphasised that the issue would be debated at HAC and a plan would be provided to the Board. PS highlighted that the Emergency Department (ED) was one area the CQC had recognised as being responsive to complaints. The complaints process involves having discussions with patients which may take longer. **PS**

SP queried the Trust Management Board's perception of the issue. PS advised that the report is also presented to TMB and that the corporate complaints team meets with Clinical Directors, Directors of Operations and Heads of Nursing to address specific areas. The Trust is also creating a database for the run rate of complaints by consultant to increase transparency. It was emphasised that the issue was also discussed at individual directorate meetings.

100/15

PERFORMANCE

(a) Performance Exception Report (Appendix G)

RR summarised the key themes from the report:

- Infection control- CDiff performance is above trajectory. PS noted this related to delays in receiving specimen results and assured that robust processes are in place to review each case. There has been no evidence to suggest spread of infection;
- Cancer 2 week waits – significant improvements in Endoscopy and routine waits are dropping rapidly. Work is in progress but the actions in place are gaining purchase;
- Urology- there has been progress against the backlog but remains an area of focus;
- ED- is the main area for Board awareness as compliance has been challenging. The Trust was compliant for the Q2 as a result of the actions put in place to support patient flow. This will be important to maintain during the winter period. There has been an increase in delayed transfers of care as a result of increases in activity;
- Stroke- the Trust has received formal confirmation that performance is level B compliant. The Board thanked all concerned for this improvement;
- Referral to Treatment Times (RTT) - due to the planned Junior

Doctor strikes and other various operational issues service level risks will be monitored. Sustainability of performance against RTT target will be supported by focused improvement projects;

- There have been exceptionally low levels of cancellation of elective operations in light of the increases in activity and pressures. RR commended the resilience of staff at the Trust.

The Board supported that an increase in proactive media releases to promote successes in the Trust's performance including the level of consistency of the stroke service.

The Board queried the comparison in CDiff performance to last year. PS advised that performance was at the same level compared to last year however that Monitor had reduced the target so it appeared more challenging.

RR advised the Board that the Trust that planning was in place for the Junior Doctor strikes including with external partners. It is anticipated by the Ambulance Trust that activity levels will be greater than the previous year. Work is on-going to prioritise patient flow as capacity will be challenging. TS emphasised that the Board needed to be aware of the reasons behind the activity levels in order to address pressures.

(b) Report from Chair of HAC (Verbal)

DB advised that the meeting had been postponed as the data provided in the papers would not allow for sufficient discussion. Following an extensive conversation with the Deputy Director of Nursing and Associate Director of Clinical Governance it was identified that the timing of the committee impacted upon the collection of current data.

The structure and timings of the HAC meetings are to be reviewed as part of the whole Board governance structure review.

SA

(c) Quality Performance Report (Appendix H)

PS advised that the report was yet to be discussed by the HAC but highlighted the key themes:

- 7 SIs were reported. This was higher than previous months due to increases in falls and pressure ulcers. Following assessment it was identified that a lack of documentation to evidence the care and use of agency staff in some areas contributed to the outcomes. 2 SIs are awaiting panel review;
- Safety thermometer- new harm performance has improved compared to last year;
- The Trust is performing within the top quartile for in patients;
- Carer's audit- the Trust recognises the importance of feedback from carers and relatives about the services.

PS noted that the feedback from the governor listening event would be circulated and highlighted positive comments about the quality of care at the Trust had been obtained. The comments will form a 'you said,

SA

we did' campaign for the website following the engagement event.

SP queried whether the format of the quality performance report would be reviewed following the use of an integrated report at the Bod/Cog away day. It was agreed that this would be considered outside of the meeting.

**SA/
Execs**

IM queried the care audit data trend, whether any underlying issues had been identified and requested an action plan to address performance. The report will be submitted to the Board following discussions at HAC.

PS

(d) Report from Chair of Finance Committee (Verbal)

The Finance Committee focused on planning for 2016/17. There has been an increase in CIP traction and more individuals are identifying new schemes however the Trust must ensure that support is in place to implement the schemes and make the savings.

The committee discussed the 2016/17 forecast and will address the revised forecast with actions for the remainder of the year. IM emphasised that the Trust needed to ensure achieves the £11.9 million as there is no alternative.

(e) Financial Performance (Appendix I)

SH outlined the report noting the following:

- The Trust had performed against the plan and at the end of October had made improvements on the forecast deficit by £39k in month;
- CIP has improved and the Trust is performing ahead of the revised plan;
- Financial sustainability risk rating will remain at 2 until the Trust reaches a budgetary breakeven point;
- Concerns were raised about care group forecasts due to slippage against the plans.
- The care groups will attend the Finance Committee and TMB to present their recovery plans and implementation. SH emphasised that difficult decisions and measures will need to be supported;
- The Trust has been looking ahead to next year and planning the 2016/17 budget ;
- Monitor has confirmed they will be investigating the Trust and will visit the Trust in January to conduct interviews with the Board and care groups. The focus will be financial governance but also performance and following requests, additional information has been provided. It is anticipated a decision will be reached in late January;
- The Lord Carter of Coles adjusted treatment index report has identified areas where improvements could be made, including within Cardiology. The Trust is required to respond to the report by 4 December.

It was suggested that the findings within the report from Lord Carter would aid the work with care groups, cost structures and identify what the Trust can influence and address. There will be challenging discussions around the 2015/16 forecast as the Trust must achieve the budget set for this year.

Board members queried what the consequences were for those accountable for the care group forecasts. It was noted that some factors could have been anticipated although some issues were outside of the Trust's control. Whilst acknowledging the difficulties of many Trusts throughout the country in achieving deficit plans, it was emphasised that the Trust must deliver the revised plan.

(f) Workforce Report

KA summarised the key information from the workforce report:

- Vacancy rate has decreased to 4.6%. This demonstrates significant progress within recruitment. Occupational group vacancies remain although successful events for HCAs have been held. Recruitment overall is still challenging but is in focus;
- Recruitment stickers for staff cars are being introduced to promote working at the Trust. Further ideas are welcomed;
- Sickness absence- the top 10 areas were summarised within the report. This information and an action plan will be discussed at the Workforce Committee;
- Initiatives are in place to reinforce staff health and wellbeing offers and provide support;
- There will be a fresh fruit and vegetable stall to promote healthy eating and staff wellbeing;
- Flu campaign- 1700 staff have received the vaccine and the drive will continue.

DD as Chair of the Workforce Committee added:

The terms of reference of the committee were to be reviewed and amended to include more financial input. The audit into sickness absence would be welcomed to help the Trust identify ways to address high sickness levels and provide support to staff.

The Unify safe staffing return information was provided, noting a reduction in agency spends. There were higher than template HCS fill rates at night as special nursing staff were required to care for the complex needs of some patients.

The Board were advised that the independent workforce review and the transformation project would be provided in January. The report will also be discussed by Executives. It is anticipated that there will be a CIP for workforce next year but clarification around the data will be necessary.

**Agenda
item Jan**

(g) Monitoring Board Objectives

The report was presented to the Board for information. Board members observed the red areas and emphasised the need for additional support in some areas. RR advised that management processes are in place and the Board should gain assurance from this.

It was agreed that the objectives should be actively managed and analysed on a more regular basis. Further, Board members queried the method by which the objectives would be achieved. TS advised that timescales were reflective of completion by the end of year and that aggregated reporting was important to both drive and gain an overview. The management and review of Board objectives was remitted for consideration of the Trust Strategy Group. Further information was requested on the outstanding red objectives for next the Board meeting.

RR

RR

101/15

STRATEGY AND RISK

(a) Acute Vanguard Project (Verbal)

TS updated the Board on the recent developments:

- The intention is to provide county wide services with new and improved pathways for patients through a standardised approach;
- It will address 3 key challenges highlighted as a result of the Clinical Services Review (CSR)- the variability within the current clinical services being delivered, the mortality rate across Dorset and the sustainability of the workforce noting the predicted £200 million deficit for Dorset by 2021;
- The Trust is not sustainable in its current form along with many other Trusts in the area;
- There will be a uniform approach to IT services across Dorset;
- Create common back office functions across Dorset;
- Work is underway to develop a joint venture vehicle to deliver the services identified;
- Legal advice is being obtained and also from Monitor, with regards to the anticipated impact of the Competition and Markets Authority;
- Governance Board will be developed to oversee and manage the joint venture. The key task will be to establish a relationship with the three Boards and ensure governance arrangements are secure;
- Funding will be allocated for this year to help create the capacity to complete the work and to backfill/ develop single services across Dorset. This will create a template for resources next year;
- In return for the investment the Trust will need to demonstrate a return on investment for the Department of Health.

Concerns were raised about the pressures from the involvement in this

work and the capacity of individuals to service developments. The Board emphasised the importance of maintaining services currently.

(b) Clinical Services Review (CSR) (Verbal)

TS highlighted the following developments with the CSR process:

- Revised costs have been received for the development of Poole as the green/purple site and RBCH as the purple/green;
- There are contrasting views about the need for a further intensive care unit on the purple site which would allow for a larger medical take which may not be sustainable;
- The Trust has not received a response to the letter sent to the CCG regarding concerns for the methodology used;
- The estimated costs for Poole Hospital as the purple site must be addressed. Designs for some services will need to be worked up as these will unlock changes to the proposals.

102/15

DATE OF NEXT MEETING

Friday 18 December 2015 at 8.30am, Conference Room, Education Centre, Royal Bournemouth Hospital

103/15

ANY OTHER BUSINESS

Key Points for Communication to Staff

1. Patient story
2. Stroke
3. Monitor Investigation and work in support
4. Appreciation of how busy staff are and the resilience demonstrated
5. CSR/Vanguard

104/15

QUESTIONS FROM GOVERNORS AND PUBLIC

1. Governors requested a briefing sheet on Vanguard and CSR to discuss with patients at future listening events. The Board agreed that the public needed to be aware of developments and the move towards county-wide services and pathways. **RR/SA**
2. It was proposed that the appointed governors for local Councils were utilised to gain local authority support on some issues raised. **JS/SA**
3. The fill rate was queried and whether it included bank staff cover. PS advised that shifts were covered during the day however temporary staff was being used to support wards at night. PS noted the importance of the visibility of the data.
4. Further explanation for governors was requested around the issues with local authority support for social care provision. It was proposed that this would form a governor training topic. **SA**

There being no further business the meeting closed at 10:40
AH 27.11.2015

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
27.11.15	104/15	<u>QUESTIONS FROM GOVERNORS AND PUBLIC</u>			
	1	Develop a briefing sheet on the Vanguard and CSR for governors to use at public events.	TS/SA	Complete	Completed
	2	Utilise appointed governors for local Councils to gain local authority support on current social care issues.	JS/SA	Complete	A meeting to be arranged with Appointed Governors, Chairperson and Trust Secretary.
	3	Local Authority issues to be considered as a governor training topic.	SA	Complete	Agreed as a suggested topic for future training sessions at the December GTC meeting.
	100/15	<u>PERFORMANCE</u>			
	(b)	<u>Report from Chair of HAC</u>			
		Review the structure and timings of the HAC meetings as part of the whole Board governance structure review.	SA	February	PS/EB meeting with DB in January re HAC. Incorporate into review.
	(c)	<u>Quality Performance Report</u>			
		Consider the use of an integrated quality and performance report in the future.	Execs	BoD Dev March	To be discussed at the next Board development session.
		Provide an action plan to address the performance within the care audit data.	PS	January	Will be discussed at the HAC on 17 th December and an update provided at the January Board.
	(f)	<u>Workforce Report</u>			
		Provide the Board with the strategic workforce plan once available.	KA	December	To be provided to the Board at the December meeting.
	(g)	<u>Monitoring Board Objectives</u>			
		Remit the management and review of Board objectives to the Trust Strategy Group.	RR		The Board will be updated quarterly. Added to the Forward Programme.
		Provide additional information on the outstanding red objectives for the next Board meeting.	RR	Agenda item – December	Added to the December agenda under matters arising
	99/15	<u>QUALITY IMPROVEMENT</u>			
	(a)	<u>Feedback from Staff Governors</u>			
		Provide a route map of the nursing recruitment process for staff governors.	KA	February	The methodology for feedback is being discussed.

RBCH Board of Directors Part 1 Actions November & previous

	(c)	<u>Serious Incidents and Complaints Report</u>			
		Sight the Board on the action plan to address complaint response times.	PS	January	Include in the January report to Board
	98/15	MATTERS ARISING			
	(a)	Provide the Board with an update on the progress with incorporating the values into clinical appraisals.	BF	10 Dec BF revised Date Jan	In progress. RW advised that progress has been made and further detail can be provided at the January meeting.
30.10.15	91/15	<u>PERFORMANCE</u>			
	(a)	<u>Performance Exception Report (Appendix G)</u>			
		Develop a plan to mobilise local authority parties to address community care provision issues	TS/RR	Complete	Briefing note on plan and update to be circulated outside of Board.
25.9.15	80/15	<u>PERFORMANCE</u>			
	(d)	Sight the Board on the actions to address themes from the time to lead presentations.	NHa/ BoD Dev Agenda item	Complete	Issues raised through the Time to Lead programme are being addressed as part of the OD Discovery Phase work.
31.07.15	68/15	<u>QUALITY IMPROVEMENT</u>			
	(c)	<u>Workforce Race Equality Scheme</u>			
		Timescales and actions to be provided to the Board when available.	KA	January Agenda Item	Added to the Board agenda in January.

Key:

	Outstanding
	In Progress
	Complete
	Not yet required

BOARD OF DIRECTORS	
Meeting Date and Part:	18 th December 2015 – Part I
Subject:	Performance Report December 2015
Section:	Performance
Executive Director with overall responsibility	Richard Renaut, Chief Operating Officer
Author(s):	Donna Parker/David Mills
Previous discussion and/or dissemination:	PMG
Action required: The Board of Directors is asked to consider the information provided in the Performance Indicator Matrix.	
Summary: The attached Performance Indicator Matrix shows performance exceptions against key access and performance targets for the month of November 2015 where these have been finalised. Due to the December Board falling earlier in the month, the following metrics have not yet been finalised and will be included where available, along with further narrative on key indicators, within a slide presentation to the Board on 18 December: <ul style="list-style-type: none"> • 18 Weeks RTT and related metrics • Learning Disabilities – requirements regarding access to healthcare • Mixed Sex Accommodation • Diagnostics 6 Week Wait • Stroke 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.	
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: The following risk assessments remain on the risk register: <ol style="list-style-type: none"> Cancer 62 day wait non-compliance and national guidance on 'high impact' changes. 4 hour target due to the continued high level of ambulance conveyances, attendances and admissions. Risks for endoscopy wait times. The urgent care impact risk assessment remains on the Trust Risk Register given the continued activity pressures, 4 hour performance and other indicators such as the increase in outliers.	
Reason paper is in Part 2	N/A

2015/16 PROPOSED PERFORMANCE INDICATOR MATRIX FOR BOARD OF DIRECTORS



Area	Indicator	Measure	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-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	9			6			3			3	5	n/a	n/a			
	Clostridium difficile	C. Difficile cases due to lapses in Care	-			1			6			2	1				>1	≤1
Referral to Treatment	RTT Admitted	18 weeks from GP referral to 1 st treatment – aggregate	90.2%			90.1%			90.5%			82.9%					<90%	≥90%
	RTT Non Admitted	18 weeks from GP referral to 1st treatment – aggregate	91.9%			93.0%			93.8%			95.4%					<95%	≥95%
	RTT Incomplete pathway	Patients on an 18 week pathway awaiting treatment – aggregate	92.6%			92.6%			94.2%			94.5%					<92%	≥92%
Cancer	2 week wait	From referral to date first seen - all urgent referrals	91.6%			96.4%			95.1%			95.3%					<93%	≥93%
	2 week wait	From referral to date first seen - for symptomatic breast patients	98.1%			98.6%			100.0%			100.0%					<93%	≥93%
	31 day wait	From diagnosis to first treatment	96.2%			96.5%			96.2%			94.1%					<96%	≥96%
	31 day wait	For second or subsequent treatment - Surgery	86.1%			94.8%			92.2%			96.7%					<94%	≥94%
	31 day wait	For second or subsequent treatment - anti cancer drug treatments	100.0%			100.0%			100.0%			100.0%					<98%	≥98%
	62 day wait	For first treatment from urgent GP referral for suspected cancer	81.9%			85.5%			82.6%			83.7%					<85%	≥85%
	62 day wait	For first treatment from NHS cancer screening service referral	89.6%			91.3%			87.2%			100.0%					<90%	≥90%
A&E	4 hr maximum waiting time	From arrival to admission / transfer / discharge (Type 1 & 2)	92.39%			93.3%			95.75%			91.31%	92.76%				<95%	≥95%
LD	Patients with a learning disability	Compliance with requirements regarding access to healthcare															No	Yes
TOTAL	CURRENT QUARTERLY MONITOR (PREDICTION) / SCORE		5			1			2			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	29	4	6				> 0		0
Infection Control	MRSA Bacteraemias	Number of hospital acquired MRSA cases	0	0	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 *	100.0%	100.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	85.70%	0.0%				< 90%		≥90%
VTE	Venous Thromboembolism	Risk assessment of hospital-related venous thromboembolism	95.5%	95.8%	96.1%	95.4%			96.1%							<95%		≥95%
Diagnostics	Six week diagnostic tests	More than 99% of patients to wait less than 6 wks for a diagnostic test	94.2%	94.8%	98.4%	94.8%	97.9%	97.7%	96.2%	92.8%	91.8%	93.8%				<99%		≥99%
A&E	Admission via A&E	No. of waits from decision to admit to admission over 12 hours	2	5	0	0	0	0	0	0	0	0	0			≥1		0
	Ambulance Handovers	No. of breaches of the 30 minute handover standard	66	55	49	20	20	22	43	56	85	106	87	n/a	n/a	tbc		
	Ambulance Handovers	No. of breaches of the 60 minute handover standard	31	31	6	5	2	2	4	9	10	38	12	n/a	n/a	tbc		
Cancelled Operations	28 day standard	No. of patients not offered a binding date within 28 days of cancellation	0	2	0	0	0	1	0	1	0	1	1			≥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	0	0			≥1		0
Stroke & TIA	SSNAP indicator	% of Stroke patients are treated on a dedicated stroke ward for 90% of spell	66.7%	83.7%	72.7%	51.1%	69.4%	84.3%	88.9%	89.6%	81.7%	67.5%		tbc	tbc	tbc		
	SSNAP indicator	Direct admission to Stroke Unit within 4 hours of admission	64.9%	68.1%	70.0%	53.3%	75.0%	62.9%	86.8%	69.1%	73.0%	66.0%		tbc	tbc	tbc		
	SSNAP indicator	Patients receive CT Scan within 24 hours of admission	98.2%	97.9%	98.1%	96.7%	100.0%	92.0%	100.0%	n/a	n/a	n/a		tbc	tbc	tbc		
	SSNAP indicator	Patients with acute stroke receive brain imaging within 1 hr	35.1%	42.6%	55.8%	46.7%	41.1%	40.0%	56.6%	35.1%	40.6%	31.5%		tbc	tbc	tbc		
	SSNAP indicator	Thrombolysis Rate	14.0%	19.1%	17.3%	13.3%	12.5%	12.3%	17.0%	10.5%	7.8%	11.1%		tbc	tbc	tbc		
	SSNAP indicator	% appropriate patients receiving thrombolysis (within 1 hour of clock start)	37.5%	33.3%	11.0%	50.0%	14.3%	62.5%	33.3%	33.3%	60.0%	0.0%		tbc	tbc	tbc		
	TIA indicator	High risk TIA cases investigated and treated within 24hrs	75.0%	70.0%	71.0%	67.2%	63.0%	60.0%	60.0%	39.0%	53.0%	65.0%		tbc	tbc	tbc		
	TIA indicator	Low risk TIA cases, seen within 7 days	76.0%	86.0%	91.0%	89.2%	92.0%	91.0%	86.0%	90.0%	90.0%	94.0%		tbc	tbc	tbc		
Referral to Treatment	Clocks still running - 52 weeks	Zero tolerance of over 52 week waiters (Incomplete Pathways)	0	0	0	0	0	0	0	0	0	0				≥1		0
	Clocks still running - admitted	Total number of patients with an admitted incomplete pathway	n/a	n/a	n/a	5976	6097	5967	5967	6306	6222	6430		n/a	n/a	tbc		
	Clocks still running - admitted	Number of patients with an admitted incomplete pathway over 18 weeks	n/a	n/a	n/a	656	600	568	669	753	790	787		n/a	n/a	tbc		
	Clocks still running - non admitted	Total number of patients with a non admitted incomplete pathway	n/a	n/a	n/a	14169	13434	13054	13265	13717	12951	13166		n/a	n/a	tbc		
	Clocks still running - non admitted	Number of patients with a non admitted incomplete pathway over 18 weeks	n/a	n/a	n/a	826	581	499	448	425	349	286		n/a	n/a	tbc		
	RTT Clocks still running - Combined	100 - GENERAL SURGERY	92.4%	94.0%	92.8%	91.1%	93.0%	92.3%	91.6%	91.3%	90.5%	91.9%				<92%		≥92%
	RTT Clocks still running - Combined	101 - UROLOGY	92.1%	91.9%	91.0%	89.9%	90.1%	90.0%	89.0%	88.4%	87.2%	89.8%				<92%		≥92%
	RTT Clocks still running - Combined	110 - TRAUMA AND ORTHOPAEDICS	87.3%	84.8%	86.3%	89.2%	92.9%	94.2%	94.5%	93.9%	93.7%	94.8%				<92%		≥92%
	RTT Clocks still running - Combined	120 - EAR NOSE AND THROAT	85.1%	87.2%	85.3%	87.8%	87.4%	90.3%	95.0%	98.4%	98.9%	98.9%				<92%		≥92%
	RTT Clocks still running - Combined	130 - OPHTHALMOLOGY	94.9%	95.7%	96.3%	97.4%	97.3%	97.5%	96.6%	95.4%	94.8%	93.4%				<92%		≥92%
	RTT Clocks still running - Combined	140 - ORAL SURGERY	90.4%	87.5%	86.5%	80.5%	73.3%	65.8%	59.5%	84.9%	98.0%	100.0%				<92%		≥92%
	RTT Clocks still running - Combined	170 - CARDIOTHORACIC SURGERY	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				<92%		≥92%
	RTT Clocks still running - Combined	300 - GENERAL MEDICINE	94.0%	98.2%	96.0%	93.0%	94.6%	97.6%	97.5%	96.9%	96.4%	96.9%				<92%		≥92%
	RTT Clocks still running - Combined	320 - CARDIOLOGY	94.0%	94.7%	94.5%	94.6%	94.9%	95.8%	95.8%	94.2%	93.5%	95.2%				<92%		≥92%
	RTT Clocks still running - Combined	330 - DERMATOLOGY	77.6%	72.1%	79.4%	84.6%	89.3%	89.1%	92.1%	91.7%	93.8%					<92%		≥92%
	RTT Clocks still running - Combined	340 - THORACIC MEDICINE	95.8%	100.0%	99.5%	97.9%	99.4%	97.9%	98.6%	99.4%	100.0%	99.2%				<92%		≥92%
	RTT Clocks still running - Combined	400 - NEUROLOGY	98.5%	94.1%	91.8%	86.7%	85.6%	81.7%	87.7%	96.8%	97.5%	97.0%				<92%		≥92%
	RTT Clocks still running - Combined	410 - RHEUMATOLOGY	99.5%	99.1%	99.5%	97.1%	96.1%	94.5%	96.9%	98.2%	98.6%	98.7%				<92%		≥92%
	RTT Clocks still running - Combined	430 - GERIATRIC MED	98.0%	98.9%	100.0%	97.8%	97.0%	98.1%	97.0%	99.2%	98.5%	100.0%				<92%		≥92%
	RTT Clocks still running - Combined	502 - GYNAECOLOGY	96.5%	95.8%	93.3%	91.8%	95.1%	92.5%	92.1%	92.3%	93.7%	94.6%				<92%		≥92%
	RTT Clocks still running - Combined	Other	99.8%	99.3%	98.6%	97.3%	97.7%	97.6%	95.6%	95.9%	97.7%	96.4%				<92%		≥92%
Planned waits	Planned waiting list	% of patients less than 6 weeks past their due date	n/a	n/a	n/a	96.9%	95.2%	95.6%	98.1%	95.8%	96.3%	96.5%				tbc		
Cancer	Cancer 62 day by Tumor Site	Haematology	76.9%			100.0%			100.0%	100.0%	50.0%	80.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Lung	75.0%			79.4%			71.4%	65.0%	80.0%	58.3%				<85%		≥85%
	Cancer 62 day by Tumor Site	Colorectal	73.8%			82.6%			82.2%	83.3%	60.0%					<85%		≥85%
	Cancer 62 day by Tumor Site	Gynae	92.6%			85.7%			100.0%	80.0%	100.0%	100.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Skin	94.2%			95.8%			100.0%	100.0%	93.4%	100.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	UGI	77.1%			90.5%			88.9%	100.0%	100.0%					<85%		≥85%
	Cancer 62 day by Tumor Site	Urology	73.8%			72.1%			70.1%	53.4%	65.2%	70.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Breast	97.1%			93.7%			92.3%	95.2%	88.9%	88.9%				<85%		≥85%
	Cancer 62 day by Tumor Site	Head & Neck	69.2%			80.0%			100.0%	100.0%	100.0%	n/a				<85%		≥85%
	Cancer 62 day by Tumor Site	Brain/central nervous system	n/a			n/a			n/a	n/a	n/a	n/a		n/a	n/a	<85%		≥85%
	Cancer 62 day by Tumor Site	Children's cancer	n/a			n/a			n/a	n/a	n/a	n/a		n/a	n/a	<85%		≥85%
	Cancer 62 day by Tumor Site	Other cancer	55.6%			100.0%			n/a	n/a	n/a	n/a				<85%		≥85%
	Cancer 62 day by Tumor Site	Sarcoma	75.0%			0.0%			n/a	n/a	100.0%	100.0%				<85%		≥85%
SUS Submissions	NHS Number Compliance	Completion of NHS Numbers in SUS Submission (IPS/OPS)	99.8%	99.9%	100%	99.9%	99.9%	100%	99.9%	tbc	tbc	tbc				<99%		≥99%
	NHS Number Compliance	Completion of NHS Numbers in SUS A&E Submissions	97.5%	97.6%	98%	97.9%	97.9%	98%	97.5%	tbc	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

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Finance Report



For the period to 30 November 2015

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £7.8 million as at 30 November. This is £302,000 better than plan. However, further financial pressures are forecast in the latter part of the year due to winter resilience requirements and a reduction in the agency premium budget trajectory. As such, whilst the Trust has been able to reduce its forecast deficit from £12.9 million to £11.9 million, further careful management is required to ensure that this financial improvement is realised in full.

Activity

November reported a continued reduction in elective activity (mainly in relation to elective Orthopaedic procedures), together with a small reduction in emergency department attendances. Outpatient attendances were 6% above budgeted levels during November, and non elective activity saw a further increase with a 3% variance to plan in month placing considerable operational and financial pressure on the Trust. Total activity to date remains broadly in line planned levels overall.

Income

Due to the nature of the Trusts contracts with its three key commissioners, income remains broadly on plan at the end of month eight with a moderate adverse variance of £262,000 (0.1%). Increases in non contracted activity and non patient related income are more than off-set by the significant under achievement against planned private patient income.

Expenditure

Expenditure reports a modest under spend of £564,000 to date equating to a variance of 0.3%. This is mainly driven by a significant pay under spend, off-set by over spends against drugs and clinical supplies budgets.

Whilst the Trust remains heavily reliant agency staff, the premium cost has been less than expected during the first seven months of the year resulting in an overall pay under spend of £1.5 million. It should be noted however, that the agency budget trajectory reduces significantly in the latter half of the financial year which represents a continued financial risk if agency usage remains at current levels.

Cost Improvement Programme

The Trust has identified further savings in year which has contributed to its reduced deficit forecast. To date the Trust has recorded savings of £5.4 million which is in line with the target. The full year savings forecast improved in month to £9.2million which is £207,000 more than the target. However, the level of non recurrent savings within this forecast remains a cause for concern.

Capital Programme

As at 30 November the Trust has committed £11.2 million in capital spend representing an under spend to date of £2 million. Key areas of spend include the Christchurch development (£3 million), the Jigsaw new build (£3 million), and the approved IT Strategy (£1.6 million). The full year forecast is being considered in light of a Department of Health request.

Statement of Financial Position

The trust continues to report high levels of outstanding payables and receivables. The main balances are with local NHS organisations and work to resolve a number of outstanding issues has continued. This is expected to conclude during December, for payment during January.

Cash

The Trusts current cash balance includes two one-off timing benefits. After adjusting for these, the Trust currently holds £32.5 million of cash. The current forecast is that the Trust will end the year with £24.4 million of cash, representing approximately one months operating expenditure. The Trust must continue to reduce its deficit forecast in future years to avoid the need for external financing.

Financial Sustainability Risk Rating

Under Monitor's new risk assessment framework the Trust achieves a Financial Sustainability Rating of 2 meaning that it is within the 'Material Risk and Potential Investigation' category. Monitor has now launched its investigation, and is currently reviewing further information provided by the Trust. The investigation team plan to visit the Trust during January.

Income and Expenditure

To date the Trust has delivered a deficit of £7.8 million. Within this, income is below budget (adverse) by £262,000 and expenditure is below budget (favourable) by £564,000. This results in a net favourable variance of £302,000.

The Trusts overall income and expenditure position is summarised below.

£'000	Budget	Actual	Variance
NHS Clinical Income	162,741	163,160	419
Non NHS Clinical Income	5,132	4,136	(996)
Non Clinical Income	13,901	14,216	315
TOTAL INCOME	181,774	181,512	(262)
Employee Expenses	113,848	112,302	1,546
Drugs	20,655	21,472	(817)
Clinical Supplies	24,258	24,599	(340)
Misc. other expenditure	24,855	24,661	194
Depreciation	6,277	6,295	(19)
TOTAL EXPENDITURE	189,893	189,329	564
SURPLUS/ (DEFICIT)	(8,119)	(7,817)	302

Income

NHS clinical income is above budget, mainly due to increases in the level of out of area, non contracted activity.

November saw a correction to the previously reported genitourinary medicine (GUM) income commissioned via Public Health bodies, which moves this into a favourable position against the budget. However, non NHS clinical income remains significantly below budget due to a significant reduction in private patient activity, specifically within cardiology, cancer care and radiology. Non patient related activity is marginally ahead of plan.

Further detail at contract level is set out below.

£'000	Budget	Actual	Variance
NHS Dorset CCG	111,860	111,860	0
NHS England (Wessex LAT)	30,441	30,508	67
NHS West Hampshire CCG	16,625	16,636	11
Non Contracted Activity	1,800	2,129	329
Public Health Bodies	1,763	1,799	37
NHS England (Other LATs)	1,131	1,091	(40)
NHS Wiltshire CCG	497	510	13
Other NHS Patient Income	388	426	39
Private Patient Income	2,971	1,973	(997)
Other Non NHS Patient Income	398	363	(35)
Non Patient Related Income	13,901	14,216	315
TOTAL INCOME	181,774	181,512	(262)

Expenditure

Pay reports a significant under spend to date. This is due to agency expenditure being below expected levels following considerable efforts in relation to both substantive and bank recruitment across the Trust, together with a number of more tactical workforce initiatives. Further detail is included overleaf.

The Trust continues to report additional drugs expenditure, resulting in a significant year to date over spend. Particular increases are apparent in relation to Anti TNF; Hepatitis C; and Somastin drug costs.

Clinical supplies expenditure is above budget to date, mainly due to a significant increase in non-elective cardiac activity, off-set in part by a reduction in the level of planned orthopaedic activity undertaken to date.

Other non pay budget lines continue to report a favourable position to date.

Employee Expenses

The Trust continues to rely heavily upon agency staff to cover substantive vacancies. The year to date under spend against substantive staffing budgets is £9.9 million. Agency expenditure to date totals £7.4 million, with a further £4.5 million spent on bank and overtime. This results in a total 'premium' workforce cost of £2.1 million to date.

£'000	Substantive Budget	Substantive Cost	Substantive Variance	Agency Cost	Bank Cost	Overtime Cost	Workforce Variance	Premium Funding	Residual Variance
Surgical Care Group	27,445	25,420	2,026	1,564	676	220	(434)	779	345
Medical Care Group	39,014	34,548	4,466	4,558	1,968	277	(2,337)	2,096	(241)
Specialties Care Group	24,064	22,433	1,631	910	484	67	171	208	379
Corporate Directorates	19,717	17,960	1,757	394	680	139	545	0	545
Centrally Managed Budgets	8	5	3	0	0	0	3	515	518
TOTAL	110,249	100,366	9,883	7,425	3,807	703	(2,053)	3,599	1,546

The Trust welcomes the national support in reducing agency costs, and has pro-actively embraced the new governance measures. However, by exception the Trust has been required to utilise off-framework or tier three agency suppliers and engage staff above the capped rates to ensure services are delivered safely. The exceptions recorded since the introduction of the cap on 23 November were as follows:

	Medical	Nursing	Other
Shifts covered	25	55	20
Approximate Cost	23,309	6,677	3,276

The Trust recognises that the current level of premium workforce cost is unsustainable and is actively working to reduce this. As such, three key work streams have been established to support the management of the workforce in a clinically safe and appropriate manner. These cover medical job planning, premium cost avoidance, and strategic workforce management. Each work stream operates through a Transformational Steering Group chaired by the appropriate executive sponsor.

Cost Improvement Programme

The Trust has delivered financial savings amounting to £5.4 million to date, being exactly on target. The forecast is for total savings of £9.2 million against the full year target of £9 million. This represents a further improvement on the previously reported forecast.

Whilst this is a positive position, it should be noted that a large proportion of the forecast savings are still to commence, which presents a financial risk if schemes start to slip.

In addition, total savings currently classified as being non recurrent amount to £3 million. This represents a significant financial pressure moving into 2016/17, albeit a small improvement on the previously reported figure..

The Surgical Care Group is forecasting full delivery of the full year target. Whilst currently the majority of this achievement is reported as non recurrent, the Care Group are confident that these savings can be achieved on a recurrent basis. This continues to be validated.

The Medical Care Group position has improved considerably during November due to one new scheme being confirmed and an enhanced savings forecast against an existing scheme. The Care Group are now forecasting a small over achievement against the full year target.

The Specialties Care Group continues to forecast an over achievement against the full year target, with an improvement during November due to an increased savings expectation in relation to existing Pharmacy schemes.

Corporate directorates continue to forecast full delivery against their targets. Some risks remain (particularly within Estates and facilities), and these are being followed up as appropriate.

DIRECTORATE	YEAR TO DATE			FULL YEAR		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000	TARGET £'000	ACTUAL £'000	VARIANCE £'000
ANAESTHETICS AND THEATRES	73	0	(73)	164	164	0
MATERNITY	26	27	1	84	85	1
ORTHOPAEDICS	210	209	(1)	346	344	(2)
SURGERY	134	54	(81)	310	309	0
CARE GROUP A	443	289	(154)	903	902	(1)
CARDIOLOGY	123	95	(29)	254	221	(33)
ED AND AMU	39	14	(25)	78	19	(59)
OLDER PEOPLES MEDICINE	115	139	24	243	180	(63)
MEDICINE	244	324	80	249	473	224
CARE GROUP B	521	571	50	824	893	69
CANCER CARE	146	181	34	265	321	56
OPHTHALMOLOGY	157	131	(26)	258	206	(52)
PATHOLOGY	173	137	(37)	268	223	(46)
RADIOLOGY	71	98	27	131	199	68
SPECIALIST SERVICES	776	891	114	1,139	1,207	68
CARE GROUP C	1,324	1,437	113	2,061	2,156	94
ESTATES	340	335	(5)	586	580	(6)
FACILITIES MANAGEMENT	148	131	(17)	354	354	0
FINANCE AND BUSINESS INTELLIGENCE	320	314	(7)	544	528	(16)
HR, TRAINING AND POST GRAD	129	117	(12)	185	157	(28)
INFORMATICS	415	363	(52)	777	777	(0)
NURSING, QUALITY & RISK	78	78	0	92	94	3
OPERATIONAL SERVICES	88	88	0	122	121	(1)
OUTPATIENTS	9	3	(6)	19	14	(4)
TRUST BOARD & GOVERNORS	87	178	91	154	251	97
CORPORATE	1,614	1,606	(8)	2,832	2,877	44
PRODUCTIVITY	1,538	1,538	0	2,307	2,307	0
DIRECT ENGAGEMENT	0	0	0	115	115	0
CROSS DIRECTORATE	1,538	1,538	0	2,422	2,422	0
GRAND TOTAL	5,441	5,442	1	9,042	9,249	207

Care Group Performance

The Trusts year to date net surplus/ (deficit) is shown by Care Group below.

£'000	Budget	Actual	Variance
Surgical Care Group	11,234	11,031	(203)
Medical Care Group	5,158	4,821	(337)
Specialties Care Group	3,959	3,855	(104)
Corporate Directorates	(23,971)	(23,510)	461
Centrally Managed Budgets	(4,498)	(4,013)	485
SURPLUS/ (DEFICIT)	(8,119)	(7,817)	302

Surgical Care Group

The Care Group reported a favourable position during November and continue to forecast achievement against their full year budget.

Income reported a marginal adverse variance driven mainly by a modest under performance in orthopaedic activity being balanced off by an increase in both day case and elective surgical activity.

Maternity pathway recharges remain higher than anticipated and continue to be reviewed to understand the appropriateness of these increased charges given the recent services changes and in comparison to the pathway tariff income received. Any residual pressure following this detailed review will need to be mitigated within the agreed full year forecast.

Medical Care Group

The Medical Care group recorded an adverse variance to budget during November; however the full year forecast improved as a result of a number of recovery actions that were being developed.

However, despite forecast improvements across the majority of income and expenditure lines, cardiology private patient income remains a significant financial risk. November saw a further deterioration, reporting a historical low value of just £29k in month against a budgeted income target of £198k.

Cardiology activity remained above budgeted levels, particularly within Cardiac Resynchronisation Therapy (CRT-D) and Percutaneous coronary intervention (PCI) activity.

Specialties Care Group

Overall the Care Group reported a favourable position in month, driven primarily by staffing under spends together with reduced diagnostic outsourcing costs.

However, pressures were apparent within Ophthalmology, particularly in relation to drugs for age related macular degeneration and an increase in cataract referrals; and within Pathology due to increased agency costs within histology and microbiology.

Unfortunately recruitment into the consultant histologist vacancies has been unsuccessful, resulting in the extension of additional sessions and agency cover. These posts will be re-advertised during December.

Corporate Directorates

Corporate directorates continue to perform well financially, delivering a significant favourable variance to date. The Informatics directorate saw an improved position during November, however pressures continue within the Facilities directorate.

Statement of Financial Position

Overall the Trusts Statement of Financial Position is in line with the agreed plan, however the Trust is reporting a number of variances against individual balances. The key drivers for this are set out below:

- **Non-current assets:** The Trusts capital programme is currently behind plan by £2 million, as set out overleaf. This, together with the timing impact of capital schemes on the associated depreciation and amortisation charges account for the overall non-current assets variance to date.
- **Inventories:** Stock is currently higher than anticipated, mainly due to an increase within the pharmacy store in relation to the new Hepatitis C network. The Trust is currently undertaking a detailed review of its policies and procedures with a view to enhancing stock management across the Trust with the support of internal audit.
- **Trade and other receivables:** Delays in the payment of invoices, mainly by local NHS organisations, account for a significant proportion of the receivables variance to plan. These outstanding balances are being actively pursued and have been escalated where appropriate. In addition, the new Hepatitis C network has resulted in additional invoices above the level initially planned.
- **Cash and cash equivalents:** Cash is currently greater than planned, driven mainly by the capital under spend. Further detail is included below.
- **Trade and other payables:** The Trust is carefully managing cash payments, pending resolution of the outstanding receivables balance, which has resulted in a variance to plan. This is exacerbated by the Hepatitis C network and the timing of capital related payments.

The Trust is currently working through a detailed re-valuation of its estate, which once complete, will be reflected within the Statement of Financial Position.

£'000	Plan	Actual	Variance
Property, plant and equipment	177,277	175,128	(2,599)
Intangible assets	1,975	2,297	322
Investments (Christchurch LLP)	1,980	1,849	(131)
Non-Current Assets	181,682	179,274	(2,408)
Inventories	5,690	6,015	325
Trade and other receivables	7,723	12,620	4,897
Cash and cash equivalents	54,829	57,991	3,162
Current Assets	68,242	76,626	8,384
Trade and other payables	(39,790)	(45,447)	(5,657)
Borrowings	(389)	(389)	0
Provisions	(155)	(180)	(25)
Other Financial Liabilities	(551)	(551)	0
Current Liabilities	(40,885)	(46,567)	(5,682)
Trade and other payables	(1,026)	(1,026)	0
Borrowings	(20,615)	(20,650)	(35)
Provisions	(519)	(519)	0
Other Financial Liabilities	0	0	0
Non-Current Liabilities	(22,160)	(22,195)	(35)
TOTAL ASSETS EMPLOYED	186,879	187,138	259
Public dividend capital	79,665	79,665	0
Revaluation reserve	74,609	74,609	0
Income and expenditure reserve	32,605	32,864	259
TOTAL TAXPAYERS EQUITY	186,879	187,138	259

Capital Programme

The Trust approved a significant capital programme during 2015-16 amounting to £19.8 million. This includes £10.6 million in relation to the continuation of the Christchurch development and the final year of the JIGSAW new build for Haematology/ Oncology and Women's Health.

Expenditure to date totals £11.2 million, representing an under spend of £2 million against the year to date budget of £13.2 million. Progress can be summarised as follows:

- The Christchurch development continues to progress behind the initial plan due to delays with steel works together with environmental issues.
- The new JIGSAW building is complete and services have transferred and are now operating within their new setting.
- The refurbishment of Ward 4 has been completed ahead of the initial plan, and the ward has returned to use. Works across other wards are progressing as planned.
- An upgrade to the Trusts electronic roster system has been approved in year and has now been purchased.
- The IT Strategy comprises 27 individual projects. Whilst many are progressing as planned, some key schemes are currently behind plan.

£'000	Annual	IN MONTH			YEAR TO DATE		
	Budget	Budget	Actual	Variance	Budget	Actual	Variance
Christchurch Development	7,565	628	132	496	4,300	2,995	1,305
JIGSAW New Build	3,050	84	148	(64)	3,050	3,050	0
Relocate and Expand AEC	900	50	0	50	120	0	120
Atrium Project	1,200	75	5	70	1,165	1,065	100
CT3 Build	500	0	0	0	35	5	30
Ward Refurbishment	400	100	32	68	400	310	90
Estates Maintenance	400	50	46	4	210	303	(93)
Aseptic Unit	510	0	2	(2)	510	545	(35)
Miscellaneous Schemes	100	0	8	(8)	50	242	(192)
Traffic Congestion Works	100	25	0	25	85	0	85
Residences Refurbishment	50	0	15	(15)	50	56	(6)
Catering Equipment	150	0	(1)	1	75	34	41
Macmillan Development	0	0	0	0	0	15	(15)
Capital Management	300	25	9	16	200	131	69
Medical Equipment	1,500	125	50	75	1,000	820	180
IT Strategy	3,062	454	304	150	1,924	1,583	341
TOTAL	19,787	1,616	750	866	13,174	11,154	2,020

Cash

The Trust is currently holding £57.9 million in cash reserves. However, there are two significant cash timing benefits within this figure meaning that the underlying cash position is significantly lower at £32.5 million.

The first relates to the delays in the Christchurch development, which has resulted in a cash timing benefit when compared to the agreed phasing of the ITFF loan drawdown. The second relates to the contract payment schedule agreed with Dorset Clinical Commissioning Group for the year, as set against the activity and associated expenditure profile for the year.

The forecast closing cash balance for the current financial year is £31 million. After adjusting for the residual cash timing benefits, the Trust is forecasting to end the year with £24.4 million of cash.

The summarised cash forecast for the current financial year is shown below.

£ million	Dec-15	Jan-16	Feb-16	Mar-16
OPENING CASH	57.99	55.50	53.84	52.19
NHS Clinical Income	19.75	19.75	19.75	19.77
Non NHS Clinical Income	0.60	0.59	0.59	0.89
Non Patient Related Income	1.46	1.38	1.46	1.46
Working Capital	(0.10)	(0.10)	(0.10)	(14.03)
CASH INFLOWS	21.71	21.62	21.70	8.09
Revenue Account	(21.82)	(21.61)	(21.74)	(24.55)
Capital Account	(1.45)	(1.06)	(1.54)	(1.60)
Christchurch Investment	0.00	(1.80)	(0.26)	(0.58)
ITFF Loan Repayment	0.00	0.00	0.00	(0.54)
Working Capital	(0.94)	1.20	0.19	(2.02)
CASH OUTFLOWS	(24.21)	(23.27)	(23.35)	(29.29)
CLOSING CASH	55.50	53.84	52.19	30.99

Financial Sustainability Risk Rating

Monitor's revised Risk Assessment Framework came into effect from 1 August 2015. This included a change from the previous Continuity of Services Risk Rating to the new Financial Sustainability Risk Rating.

The Trusts Financial Sustainability Risk Rating as at 30 November 2015 is set out below.

	Plan Metric	Actual Metric	Risk Rating	Weighted Rating
Capital Service Cover	0.35x	0.48x	1	0.25
Liquidity	29.0	32.2	4	1.00
I&E Margin	(4.47)	(4.31)	1	0.25
I&E Variance to Plan	(1.17)%	0.16%	4	1.00
Trust FSRR				3
Mandatory Override				Yes
Final FSRR				2

This rating (after the application of mandatory overrides) of 2 places the Trust in the 'Material Risk' and 'Potential Investigation' category.

Monitor has now opened their investigation and the Trust has responded to the initial data request. Monitor will review this information during December and plan to spend three days on site during January, including observing the January Board of Directors meeting.

The Trusts medium term financial strategy focuses on reducing the deficit in each and every year, together with the careful management of its cash reserves through detailed working capital management. The financial modelling for 2016/17 and beyond is currently being refreshed following the Comprehensive Spending Review announcement and subsequent information received.

BOARD OF DIRECTORS	
Meeting Date and Part:	18 th December 2015 - Part 1
Subject:	Workforce report
Section:	5: Performance
Executive Director with overall responsibility	Karen Allman
Author(s):	Karen Allman
Previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC. Education and Training Committee
Action required: For discussion and noting areas highlighted below.	
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 staff sickness, recruitment initiatives and staff survey and the progress with the organisational development programme.	
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 – DECEMBER 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 30 November			Rolling 12 months to 30 November				At 30 November
Surgical	53.8%	69.3%	79.0%	4.44%	14477	14.1%	12.8%	
Medical	53.4%	52.4%	80.0%	4.01%	19009	19.0%	12.0%	
Specialities	72.3%	65.6%	82.4%	3.37%	9413	11.3%	12.2%	
Corporate	69.5%	50.0%	85.3%	3.66%	11640	12.2%	12.6%	
Trustwide	61.3%	62.5%	81.1%	3.90%	54540	14.7%	12.4%	

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 November			Rolling 12 months to 30 November				At 30 November
Add Prof Scientific and Technical	90.6%		81.6%	2.70%	1175	21.0%	11.2%	
Additional Clinical Services	52.0%		82.1%	6.23%	15814	21.0%	12.5%	
Administrative and Clerical	63.6%		85.7%	3.40%	10459	9.5%	13.5%	
Allied Health Professionals	72.9%		87.1%	1.98%	1786	13.5%	13.1%	
Estates and Ancillary	70.4%		82.0%	4.98%	5822	21.7%	15.1%	
Healthcare Scientists	67.7%		90.7%	2.76%	586	17.5%	15.9%	
Medical and Dental		62.5%	64.8%	1.00%	1572	7.0%	7.0%	
Nursing and Midwifery Registered	56.7%		82.0%	4.26%	17326	13.4%	11.4%	
Trustwide	61.3%	62.5%	81.1%	3.90%	54540	14.7%	12.4%	

1. Appraisal

As previously advised, appraisal compliance was reset to zero with the introduction of the new values based appraisal. The appraisal rate has increased to 61.3% for values based appraisal (47.3% last month) but this continues to be below trajectory.

2. Essential Core Skills Compliance

Overall compliance has increased slightly to 81.1% from 80.4% last month. The table below shows the 10 areas with the lowest compliance as at 30th November:

Directorate	Organisation	Headcount	Compliance
Surgery Directorate	153 Obs/Gynae Medical Staff 10100	15	42.32%
Elderly Care Services Directorate	153 MFE Medical Staff 10077	48	44.97%
Surgery Directorate	153 Surgery - General 10085	33	49.71%
Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	13	54.05%
Surgery Directorate	153 Surgery - Urology 10084	17	57.36%
Pathology Directorate	153 Phlebotomy 11330	38	57.38%
Cancer Care Directorate	153 Haematology Snr.Medical 11346	21	57.63%
ED Directorate	153 ED Medical Staff 10015	35	64.91%
Ophthalmology Directorate	153 BEU Ophthalmic 10110	22	65.37%
Medicine Directorate	153 Medical General Staff 10075	73	67.05%

3. Sickness Absence

The Trust-wide sickness rate remains at 3.9% as per last month, which represents an amber rating. The table below shows the 10 areas with the highest 12-month rolling sickness absence as at 30th November.

Directorate	Organisation	Headcount	Absence Rate
153 Outpatients Directorate	153 Outpatients 10370	37	11.96%
153 Elderly Care Services Directorate	153 MFE IP Therapy 10581	18	10.07%
153 Medicine Directorate	153 Medical R.E.D.S. 11536	14	9.90%
153 Surgery Directorate	153 Colorectal Ward 16 10427	33	9.89%
153 Elderly Care Services Directorate	153 MFE Ward 4 10382	29	8.93%
153 Maternity Directorate	153 Community Midwives 10515	28	8.58%
153 Surgery Directorate	153 Surgical Admissions Unit 10535	24	8.50%
153 Surgery Directorate	153 Urology Ward 15 10426	36	7.49%
153 Elderly Care Services Directorate	153 MFE Ward 22 10594	35	7.38%
153 Elderly Care Services Directorate	153 MFE Ward 5 10378	34	7.33%

It is continually emphasised with the care groups that there needs to be close local management of sickness, with support available from HR and OH where needed.

The Trust auditors will be carrying out some work to investigate the issues behind the significant variance in the percentage of absence across the Trust. The scope and terms of reference are being finalised currently but the audit is due to commence early in the New Year. The audit will focus on departments showing good performance as well as those areas requiring improvement so that we can share good practice and identify areas for improvement.

Health and wellbeing and support for staff remain important and will be a focus for the organisation into next year.

4. Turnover and Joiner Rate

Joining and turnover rates of 14.7% and 12.4% respectively show small changes from last month (15.0% and 12.6%).

5. Vacancy Rate

Figures not available at time of writing and will be reported at the meeting.

6. Recruitment

Strong focus on recruitment continues. We are proceeding with 15 EU nurses who have all received recent offers and are likely to start with the Trust end January - February.

Interviews are scheduled with 36 nurses from the Philippines on the 10th and 11th December. We continue to plan our attendance at relevant recruitment and careers fairs, and a HCA recruitment day is taking place on Saturday 14th December.

7. Organisational Development Programme

Fifteen Change Champions have now been appointed to support the Discovery Phase of the RBCH culture change programme and the first OD workshop took place on 5th November. This event was opened by Tony Spotswood and closed by Peter Gill and the team were energetic and enthusiastic about the programme and their role. Much of the focus at the inaugural workshop was on developing the group as a high performing team, using MBTI personality profiling to help team members to understand and celebrate the different styles and preferences in the team and to think about how they would use this knowledge to work effectively together. The first phase of the desk top analysis was also designed and an action plan developed and the findings will be fed back and collated at the second workshop which is to be held on 10th December. This will be opened by Derek Dundas.

Nicola Hartley has now presented the plans for the OD Discovery Phase to twelve directorate team meetings and these have received positive feedback. Interest is also being generated in neighbouring Trusts who are keen to understand our approach and methodology. The model of collective leadership underpins the OD proposals for the Vanguard value proposition which have been developed in collaboration with OD Leads at Poole and Dorset County Hospitals NHS Trusts.

BOARD OF DIRECTORS	
Meeting Date and Part:	18 th December 2015 – Part I
Subject:	Stroke Services Update
Section:	Information
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: <ul style="list-style-type: none"> ▪ Most recent published stroke performance using SSNAP (July to September 2015) ▪ Our internal assessment of performance for October and November (Quarter to date) ▪ Details actions the service is taking to improve performance with no domain area below C, and the majority moving to B or better and to sustain performance in the upper quartile 	
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: <ul style="list-style-type: none"> 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 (July to September 2015)
- Our internal assessment of performance for October and November (Quarter to date)
- Detailed actions the service is taking to improve performance with no domain area below C, and the majority moving to B or better and to sustain performance in the upper quartile.

The quality of stroke services is measured via the quarterly SSNAP results. To achieve a SSNAP Level B, a score of 70+ is required and for a SSNAP Level A, a score of 80+ is required. The more recent SSNAP results cover July to September 2015, in which RBCH achieved SSNAP level B and a score of 78. Nationally for Q2, 17% of Trusts achieved a SSNAP level A and 21% of Trusts achieved SSNAP level B. Our Q2 results will be within the upper quartile. National results will be available in January to confirm our actual position.

To put this result into local context with the rest of Wessex, for the last regional SSNAP report (Q1) we were the only Trust to achieve a SSNAP Level B. The next highest score was The Royal Hampshire County Hospital who achieved a score of 62 which is a Level C; all other Trusts achieved a SSNAP Level D. It is pertinent to note that no other routinely admitting Stroke Service in Wessex or the South West of England regions achieved a SSNAP Level B. For Q1, Dorset County Hospital achieved a SSNAP score of 53.2 and Poole Hospital a score of 46.8. Regional results for Q2 will be available in January.

Ensuring sustainability of improvements over the next 12 months relies upon expansion of the radiology service out of hours and management of risks. By delivering the overall plan our trajectory is sustain SSNAP Level B+ for Q3 with no domain lower than level C.

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 recent performance is below.

Quarter	Oct-Dec 2014	Jan-March 2015	Apr-June 2015	July-Sept 2015	National Average
SSNAP level	D	C	B	B	
SSNAP score	57.8	66.7	70.3	78	
Case ascertainment band	A	B	A	A	A
Audit compliance band	D	C	B	A	B
1) Scanning	D	C	C	B	B
2) Stroke unit	D	C	C	C	C
3) Thrombolysis	D	C	C	C	C
4) Specialist Assessments	D	D	D	C	C
5) Occupational therapy	A	A	A	A	B
6) Physiotherapy	B	A	B	B	B
7) Speech and Language therapy	A	A	B	B	D
8) MDT working	B	B	B	B	C
9) Standards by discharge	B	B	B	B	B
10) Discharge processes	B	A	A	A	B

We have sustained or improved performance in all domains. This is the first quarter we have achieved our goal of all Domains being a Level C or above. Notably Audit Compliance has improved to a Level A and Case Ascertainment has remained a Level A, this is the first quarter we have achieved this and therefore have had no detrimental score adjustment. We are extremely pleased to have achieved a Level B for scanning and this is due to the considerable hard work and dedication of both our Stroke Outreach Team and the Radiology Department.

3. Other stroke actions

Dr Michelle Dharmasiri will start in January 2016 as a 1.0 wte Stroke Consultant. We have a short-term Locum Stroke Consultant in post until early January 2016 at which point we will be at template for Stroke Consultants.

Mel Young will commence as Advanced Specialist Stroke Nurse in January 2016 which is a very exciting development for the service and in particularly the stroke nursing team. Mel will have a key role in working together with the Nurses on the Stroke Unit to support delivery of high quality stroke specialist nursing care, key to this will be provision of stroke specialist training and her initial focus will be on hyper-acute care.

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 the last 3 Quarters 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 5.

The Stroke Service was delighted when their recent poster submission to the SSNAP national poster competition was awarded first place; the poster was displayed by SSNAP at the UK National Stroke Forum and will be displayed on the SSNAP website. We were also extremely pleased to have 2 posters selected to be presented at the UK National Stroke Forum.

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 sustained SSNAP Level B (score of 70+) is certainly achievable and we hope to continue to achieve no domain being lower than a Level C.

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 the Locum Stroke Consultant staying in post until January and further vacancies in both Nursing and Therapy teams being filled. It is relevant to note that the Therapy teams (particularly SALT) have a number of unfilled posts (due to vacancy and maternity leave) which may detrimentally impact Q3 performance. The recruitment process is ongoing for these vacancies.

The new Stroke Outreach Service is delivering considerable improvements with our front door performance and ensuring all acute assessments are completed in a timely manner. It is proving considerably challenging for the team (only 4 wte) to provide such an extended service of 7am to midnight 7 days a week; there is not enough capacity to adequately cover sickness and we have had shifts in Q3 to date that we have been unable to cover. The new Stroke Specialist Nurse post which commences in January will provide some additional support to the team and we currently have 0.36 wte vacancy that we're hoping to combine with Stroke Unit Nurse vacancy to create a viable post.

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 stroke unit. 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 Q2, significant improvement is still needed.

Ensuring sustainability of improvements over the next 12 months also relies upon expansion of the radiology service out of hours; this is particularly relevant for achieving thrombolysis within 1 hour out of hours, as delays occur with waiting for a Radiographer to come in and further delays waiting for the scan to be reported.

6. Recommendation

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

ANNEX: STROKE PERFORMANCE & DELIVERY PLAN – DECEMBER 2015 – ONE PAGE SUMMARY

(Q3 to date results **have not been fully validated**. Where there are gaps the data is not available internally)

DOMAIN	SSNAP Q1 (Apr to June)	SSNAP Q2 (July to Sept)	Q3 to date	Plans	Comments/Risks
1 Scanning	C	B	D (borderline C)	<ul style="list-style-type: none"> CT3 in ED On-site Radiographer overnight 	<ul style="list-style-type: none"> Delayed identification of stroke patients due to unusual presentation
2 Stroke Unit	C	C	D (borderline C)	<ul style="list-style-type: none"> GP Referral pathway review with ACM Stroke QI Project to address pt flow 	<ul style="list-style-type: none"> GP Referral breaches, delayed diagnosis pts & delayed D/C pts
3 Thrombolysis	C	C	D	<ul style="list-style-type: none"> SIM training Aim to reduce OOH reporting times 	<ul style="list-style-type: none"> OOH delays due to radiographer being off-site and waiting for radiologist review
4 Specialist Assessments	D	C	C	<ul style="list-style-type: none"> New twice daily MDT rounds for new pt assessments 	<ul style="list-style-type: none"> Stroke Consultant - 7 day provision
5 Occupational Therapy	A	A	A	<ul style="list-style-type: none"> New timetabling process New therapy teams 	<ul style="list-style-type: none"> To closely monitor changes to Therapy provision OT Band 5 & 6 maternity leave
6 Physiotherapy	B	B	B	<ul style="list-style-type: none"> New timetabling process New therapy teams 	<ul style="list-style-type: none"> To closely monitor changes to Therapy provision PT Band 6 maternity leave -
7 Speech and Language Therapy	B	B	B (borderline A)	<ul style="list-style-type: none"> New timetabling process New therapy teams 	<ul style="list-style-type: none"> To closely monitor changes to Therapy provision Band 7 Vacancy/Maternity Leave – 1.2 wte
8 MDT Working	B	B	B (borderline A)	<ul style="list-style-type: none"> New twice daily MDT rounds for new pt assessments 	<ul style="list-style-type: none"> New MDT Ax rounds will reduce time to initial therapy assessment
9 Standards by discharge	B	B	A	<ul style="list-style-type: none"> Induction for new staff 	<ul style="list-style-type: none"> On track
10 Discharge Processes	A	A	A	<ul style="list-style-type: none"> Validation for AF breaches in place 	<ul style="list-style-type: none"> On track
Audit compliance	B (-5%)	A	A	<ul style="list-style-type: none"> Continue NIHSS training of all staff 	<ul style="list-style-type: none"> New Stroke Specialist Nurse to commence in January which will greatly help nurse training
Case ascertainment	A	A	A	<ul style="list-style-type: none"> Monthly lockdown checks will be performed 	<ul style="list-style-type: none"> On track
SSNAP Level	B	B	B		
SSNAP Score	70.3	78	72	Note if borderline scores improve to higher domains then overall score would be 80 (A)	

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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (B)	Q3 (to date)	Key Improvement Actions
1.1 Proportion of patients scanned within 1 hour of clock start (A = 48%)	43% (B)	43.7% (B)	31.8% (C)	<ul style="list-style-type: none"> Undertake monthly breach analysis for any 12 hour scan breaches – Q3 breaches primarily patients with late diagnosis stroke. Stroke recognition training throughout Trust to reduce numbers of late diagnosis strokes & awareness to contact Stroke Outreach Team Promote greater understanding of the stroke targets throughout Trust to improve urgency of referral to Stroke Outreach CT3 in ED and on-site Radiographer 24/7
1.2 Proportion of patients scanned within 12 hours of clock start (A = 95%)	90% (B)	92.0% (B)	87.3% (C)	
1.3 Median time between clock start and scan (A = < 60mins)	< 60mins (A)	67 mins (B)	108 mins (D)	

Domain 1: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Monthly breach analysis for 12 hour scan breaches	Ongoing	<ul style="list-style-type: none"> KC to lead on this in conjunction with Stroke Outreach Team
2. To review options to ensure all patients have their scan within 12 hours of arrival	Ongoing	<ul style="list-style-type: none"> Potential for Radiology to extending scanning hours until 10pm – linked to radiographer staying on-site. MB to keep us updated
3. Stroke recognition training to reduce delays to stroke diagnosis including for unusual presentation stroke patients	Ongoing	<ul style="list-style-type: none"> Update in Grand Round, presentation at OPM Audit Symposium and Stroke Outreach on-going training programmes Comms Team to promote Stroke Outreach Team information
4. Promote updated protocol so that all are aware including the fact that scans should be done within 1 hour or 12 hours	Ongoing	<ul style="list-style-type: none"> Update in Grand Round, presentation at OPM Audit Symposium and Stroke Outreach on-going training programmes Comms Team to promote Stroke Outreach Team information
5. Staff to have training on IRMER, NIHSS and completing request form correctly	Ongoing	<ul style="list-style-type: none"> Rolling programme for new staff and to ensure staff have timely updates
6. Audit CT request form completion and timeliness (monthly)	Ongoing	<ul style="list-style-type: none"> CT to collate all CT request forms and SH/KC to review and provide feedback to individuals incorrectly completing form
7. To work with Radiology as required to support development of electronic CT request form submission	As needed	<ul style="list-style-type: none"> MB to update as required
8. Implementation of CT3 in ED and plan that X-ray Radiographers will be able to undertake CT Brain Scans	Long-term	<ul style="list-style-type: none"> The intention would be that with CT 3 in ED that someone would be on-site 24/7 to be able to undertake CT Brain scans

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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	Q3 (to date)	Key Improvement Actions
2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (A = 90%)	90% (A)	76.0% (B)	67.6% (C)	<ul style="list-style-type: none"> Establish a pre-alert for all stroke patients coming to RBH by SWAST Review GP referral pathway for Stroke as large percentage of breaches come through this pathway – 35% of direct access breaches in October Continue to raise awareness to contact Stroke Outreach if patient ? stroke or stroke part of differential diagnosis as 35% of direct access breaches were due to delayed diagnosis of stroke Immediate re-triage of any non-stroke patients on the SU to facilitate transfer off SU Stroke Quality Improvement projects – stroke ambulatory care, redesign of pathway for frail with severe stroke, review of MDT working and Complex Nutrition Project.
2.2 Median time between clock start and arrival on stroke unit (hours:mins) (A = Median < 2 hrs)	Median < 3 hrs (B)	03:11 (C)	03:30 (C)	
2.3 Proportion of patients who spent at least 90% of their stay on stroke unit (A = 90%)	85% (B)	84.3% (C)	69.1% (E)	

Domain 2: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To implement hospital pre-alert for all stroke patients	April 2015	<ul style="list-style-type: none"> KC in liaison with ED/SWAST re implementation of pre-alert for all stroke patients – meeting 7th December.
2. To complete a breach analysis of every patient not achieving direct transfer to SU and not achieving 90% stay	ongoing	<ul style="list-style-type: none"> Act immediately on any breach themes – key themes identified are GP referral pathway and delayed diagnosis stroke
3. To trial stroke screening process for GP Referral patients (in conjunction with ACM)	underway	<ul style="list-style-type: none"> To trial screening process and if high success rate then look to alter admission pathway for identified stroke patients (SU and ACM collaboration)
4. Ensure all non-stroke patients on the SU have appropriate re-triage in place to facilitate transfer off the SU	ongoing	<ul style="list-style-type: none"> To proactively move non-stroke patients off the stroke unit rather than waiting until SU full
5. Stroke recognition/awareness training to reduce delays to stroke diagnosis including for unusual presentation stroke patients	Ongoing	<ul style="list-style-type: none"> Update in Grand Round, presentation at OPM Audit Symposium and Stroke Outreach on-going training programmes Comms Team to promote Stroke Outreach Team information
6. To undertake QI project with QI Team to address patient flow on/off the stroke unit	Ongoing	<ul style="list-style-type: none"> Commenced in October with fortnightly Stroke QI meetings Aim to reduce LOS on the SU and reduce stroke outliers
7. To implement changes to MDT working/organisation as per Stroke Leads Away Day on 7 th October	complete	<ul style="list-style-type: none"> To implement changes i.e. new twice daily HASU MDT Ax, therapy/nursing teams etc

Domain 3: Thrombolysis - Domain Leads: Becky Jupp & Katherine Chambers

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	Q3 (to date)	Key Improvement Actions
3.1 Proportion of all stroke patients given thrombolysis (A=20%)	15% (B)	11.5% (D)	8.2% (E)*	<ul style="list-style-type: none"> To maintain good standards of awareness of acute stroke identification and management, including thrombolysis eligibility across the Trust. To reduce door to needle times for thrombolysis treatment through engagement with those involved in the pathway. To review all breaches to achieving thrombolysis within 1 hour of clock start to determine whether clinically appropriate delay or a process delay To use stakeholder engagement to identify training needs and areas for service improvement to optimise prompt and effective care and decision making. Review of Q2 indicates that our Door to Needle time is significantly less in hours than OOH due to delays OOH waiting for radiographer to come in and for Radiologist to report
3.2 Proportion of eligible patients given thrombolysis (A=90%)	90% (A)	100% (A)	100% (A)*	
3.3 Proportion of patients who were thrombolysed within 1 hour of clock start (A=55%)	50% (B)	40% (C)	22.2% (E)*	
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)	76.0% (A)	67.6% (A)*	
3.5 Median time between clock start and thrombolysis (A=< 40mins)	< 60 mins (C)	75 mins (D)	70 mins (D)*	

*note: 2 further patients were thrombolysed early December however not included in this dataset as hadn’t reached their 72 hour SSNAP lock-down

Breakdown of Thrombolysis Patients and their Door to Needle Time (DTN) for October & November

No. of pts	Outcome
1	Achieved within 1 hour
2	Clinically appropriate delays: <ul style="list-style-type: none"> 1 pt: DTN of 65 mins –pt initially improving therefore not for thrombolysis and then symptoms deteriorated 1 pt: DTN of 70 mins – delay in family/pt consenting to thrombolysis
2	OOH patients: <ul style="list-style-type: none"> 1 pt: DTN of 95 mins – Radiographer already on-site and delay due to monitoring INR levels as pt on warfarin 1 pt: DTN of 168 mins – 61 mins was awaiting scan to be reported – this is being investigated by Radiology
2	In-hours delays: <ul style="list-style-type: none"> 1 pt: DTN of 61 mins 1 pt: DTN of 68 mins – some delay due to initial unclear diagnosis
7	Total Number of patients

Domain 3: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To complete a breach analysis of all thrombolysis cases taking more than 1 hour and identify themes to be addressed	ongoing	<ul style="list-style-type: none"> To develop action plan to address any contributing factors/themes i.e. out-of-hour radiology reporting
2. Radiology to negotiate with OOH scan reporting provider to reduce OOH thrombolysis patient scan reporting time to 15 mins	Jan 2016	<ul style="list-style-type: none"> Radiology feedback at November Stroke Board meeting
3. Stroke outreach to collate information re door to needle for all cases and also discuss this at weekly Thrombolysis/Imaging meeting to support identification of areas to improve.	Ongoing	<ul style="list-style-type: none"> New meeting format commenced in September 2015
4. Stroke Consultants and Stroke Outreach Lead to co-ordinate a walk-through of thrombolysis process with relevant staff to establish how Door to Needle time can be reduced	January 2016	<ul style="list-style-type: none"> Review all current processes to minimise process delays for all thrombolysis calls
5. To support developing stroke outreach service and other staff delivering thrombolysis with skills to support thrombolysis pathway to help speed to stroke specific assessment and reduce door to needle time.	Ongoing	<ul style="list-style-type: none"> Arrange SIM training for all involved in thrombolysis pathway re. thrombolysis situations and leadership/organisation of the team at each thrombolysis call On-going supervision and competency sign-off with each member of the Stroke Outreach Team
6. Implement new Thrombolysis workbook/documentation	complete	<ul style="list-style-type: none"> To be implemented by end of November
7. Liaise with Radiology re. timescales for CT3 and/or extending current CT hours	February 2015	<ul style="list-style-type: none"> Update received at December Stroke Board meeting, for further update in February
8. Complete Risk Assessment and develop action plan regarding consistent delivery of thrombolysis on the SU rather than in ED and also confirm the pathway for thrombolysis for patients having stroke as in-patient	March/April 2016	<ul style="list-style-type: none"> Competency training plan for all Nursing staff supporting the Hyper-Acute Stroke Unit – to commence from January when new Stroke Advanced Specialist nurse starts in post
9. To develop action plan to reconfigure stroke unit beds/staffing to enable provision of Hyper-Acute Stroke Unit care to meet National Stroke Strategy and National Clinical Guidelines for Stroke	TBC	<ul style="list-style-type: none"> To be worked up as part of Stroke Vanguard

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

DOMAIN KEY INDICATORS	Plan (C)	Last SSNAP (C)	Q3 (to date)	Key Improvement Actions
4.1 Proportion of patients assessed by a stroke consultant within 24hrs of clock start (A=95%)	80% (C)	70.7% (D)	64.5% (E)	<ul style="list-style-type: none"> Breaches relate to weekend/BH admissions, late diagnosis pts New twice daily MDT Assessment rounds to improve time to assessment Monday to Friday Explore options to deliver Stroke Consultant cover at the weekend – network approach/additional Stroke Consultant (Vanguard)
4.2 Median time between clock start and being seen by stroke consultant (hrs:mins) (A=<6hrs)	<15hrs (D)	18:54 (E)	18:14 (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)	94.8% (B)	91.8% (B)	<ul style="list-style-type: none"> 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)	< 60 mins (A)	64 mins (B)	74 mins (B)	
4.5 Proportion of applicable patients who were given a water swallow screen within 4hrs of clock start (A=85%)	85% (A)	78.2% (B)	78.3% (B)	<ul style="list-style-type: none"> 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 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)	97.8% (A)	98.1% (A)	<ul style="list-style-type: none"> Understand any risks to sustaining this level of performance i.e. SALT recruitment challenges SALT continue 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. Options to introduce 7-day Consultant ward-rounds when Stroke Consultant wte fully established	January 2016	<ul style="list-style-type: none"> • BJ/AW to review feasibility of implementing 7-day Stroke Consultant ward-rounds • Vanguard stroke
2. Review patients for Q1 who breached being assessed by Stroke Consultant within 24 hours of clock start	Complete	<ul style="list-style-type: none"> • Majority of breaches are patients admitted on Fri/Sat/Sun and those with delayed diagnosis of stroke indicating need for 7-day Stroke Consultant ward-rounds to improve performance
3. WSS – to complete breach analysis for Q2 to date and identify themes and action plan accordingly	Complete	<ul style="list-style-type: none"> • Complete – primarily delayed diagnosis stroke patients
4. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in WSS	Complete Ongoing with new staff	<ul style="list-style-type: none"> • 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
5. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in NIHSS	Ongoing as staffing allows	<ul style="list-style-type: none"> • New Stroke Specialist Nurse commences in January 2016 which will significantly help nurse training • 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. To implement changes to MDT working/organisation as per Stroke Leads Away Day on 7 th October	complete	<ul style="list-style-type: none"> • To implement changes i.e. new twice daily HASU MDT Ax, therapy/nursing teams etc

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q3 (to date)	Key Improvement Actions
5.1 Proportion of patients reported as requiring occupational therapy (A=80%)	80% (A)	81% (A)	85% (A)	<ul style="list-style-type: none"> 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)	40.6 (A)	45 (A)	<ul style="list-style-type: none"> Ensure end dates for OT are being inputted; B7 mentors for each therapy team to support this Implement new timetabling process to increase efficiency of therapy planning and release time for therapy – to closely monitor impact of changes upon performance Maintain consistent therapy groups on the unit
5.3 Median % of days as an inpatient on which occupational therapy is received (A=>70%)	>70% (A)	78.2% (A)	81% (A)	
5.4 Compliance (%) against the therapy target of an average of 25.7 minutes of occupational therapy across all patients (A=80%)	80% (A)	100% (A)		

Domain 5: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To implement therapy non clinical working practices/organisation to maximise time released for direct patient care (from away day in October).	complete	<ul style="list-style-type: none"> To review whole process (timetabling, whiteboard rounds, MDT meetings, Ax pathway, discharge summaries etc) at away day in October.
2. Review breaches for 6.1 to understand rationale for patients being deemed not appropriate	ongoing	<ul style="list-style-type: none"> Validation processes in place and to be completed on an ongoing basis
3. Establish twice weekly OT groups (gardening and tell your story)	ongoing	<ul style="list-style-type: none"> Completed in March – to monitor
4. To implement group cancellation protocol	complete	<ul style="list-style-type: none"> To ensure groups are only cancelled by Band 7+ staff Implemented.
5. Recruit to Band 6 vacancies	Jan 2016	<ul style="list-style-type: none"> Vacancies filled and staff to commence in January 2016

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (B)	Q3 (to date)	Key Improvement Actions
6.1 Proportion of patients reported as requiring physiotherapy (A=85%)	80% (B)	76.5% (C)	72% (D)	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)	31.1(B)	36.7(A)	<ul style="list-style-type: none"> Ensure end dates for PT are being inputted; B7 mentors for each therapy team to support this Implement new timetabling process to increase efficiency of therapy planning and release time for therapy – to closely monitor impact of changes upon performance Establish consistent therapy groups on the unit
6.3 Median % of days as an inpatient on which physiotherapy is received (A=>75%)	>75% (A)	78.1% (A)	80.5% (A)	
6.4 Compliance (%) against the therapy target of an average of 25.7 minutes of physiotherapy across all patients (A=90%)	80% (B)	68% (D)		

Domain 6: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To implement therapy non clinical working practices/organisation to maximise time released for direct patient care (from away day in October).	complete	<ul style="list-style-type: none"> To review whole process (timetabling, whiteboard rounds, MDT meetings, Ax pathway, discharge summaries etc) at away day in October.
2. Review breaches for 6.1 to understand rationale for patients being deemed not appropriate	ongoing	<ul style="list-style-type: none">
3. Re-establish regular/sustained twice weekly exercise group (seated exercise group/sit to stand group/Wii).	ongoing	<ul style="list-style-type: none"> 1 x per week exercise group established. Need to 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. To implement group cancellation protocol	complete	<ul style="list-style-type: none"> To ensure groups are only cancelled by Band 7+ staff

Domain 7: Speech and Language Therapy - Domain Leads: Louise Johnson and Morwenna Gower

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (B)	Q3 (to date)	Key Improvement Actions
7.1 Proportion of patients reported as requiring speech and language therapy (A=50%)	50% (A)	59.2% (A)	56% (A)	<ul style="list-style-type: none"> 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)	36.1 (A)	44(A)	<ul style="list-style-type: none"> 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)
7.3 Median % of days as an inpatient on which speech and language therapy is received (A=>70%)	>70% (A)	64.1% (B)	65.3% (B)	
7.4 Compliance (%) against the therapy target of an average of 25.7 minutes of speech and language therapy across all patients (A=90%)	75% (B)	85.3% (B)		
				Main risk to Q3 performance is SALT vacancy

Domain 7: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Communication Group now running twice weekly – to monitor	ongoing	<ul style="list-style-type: none"> Band 3 Therapy Assistant being trained to run group. Review progress and potentially increase to 3 x per week thereafter.
2. Therapy Assistants now supporting dysphagia patients at breakfast on a daily basis	Ongoing	<ul style="list-style-type: none"> To monitor compliance with this SALT to support TA's with providing this 3x days a week
5. To implement group cancellation protocol	complete	<ul style="list-style-type: none"> To ensure groups are only cancelled by Band 7+ staff
6. To recruit to SALT vacancy ASAP	In progress	<ul style="list-style-type: none"> VRP to be submitted on 7th December

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (B)	Q3 (to date)	Key Improvement Actions
8.1 Proportion of applicable patients who were assessed by an occupational therapist within 72hrs (A=90%)	90% (A)	99.4% (A)	100% (A)	
8.2 Median time between clock start and being assessed by Occupational therapist (A=<12hrs)	<18hrs (C)	19:42hrs (D) (N.A is 22:11 hrs)	20:17 (D)	<ul style="list-style-type: none"> Implement new twice daily MDT Assessment rounds
8.3 Proportion of applicable patients who were assessed by an physiotherapist within 72hrs (A=90%)	90% (A)	99.4% (A)	100% (A)	
8.4 Median time between clock start and being assessed by physiotherapist (A=<12hrs)	<18hrs (D)	19:42hrs (E) (N.A. is 21:15hrs)	20:17 (E)	<ul style="list-style-type: none"> Implement new twice daily MDT Assessment rounds
8.5 Proportion of applicable patients who were assessed by speech and language therapist within 72hrs (A=90%)	90% (A)	97.7% (A)	96.3%(A)	
8.6 Median time between clock start and being assessed by speech and language therapist (A=<12hrs)	<18hrs (C)	21:45hrs (D) (N.A. is 23:45hrs)	22:25 (D)	<ul style="list-style-type: none"> Implement new twice daily MDT Assessment rounds
8.7 Proportion of applicable patients who have rehabilitation goals agreed within 5 days of clock start (A=80%)	80% (A)	N/A	96.5% (A)	<ul style="list-style-type: none"> 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	70.9% (A)	

Domain 8: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Implementation of GAS Goal setting on the SU including staff training	Complete	
2. Therapy to support the new Integrated MDT Ax for all new patients via daily 8:30am and 3pm HASU rounds	Complete	<ul style="list-style-type: none"> To be introduced on 2nd November
3. To implement therapy non clinical working practices/organisation to maximise time released for direct patient care (from away day in October).	Complete	<ul style="list-style-type: none"> To review whole process (timetabling, whiteboard rounds, MDT meetings, Ax pathway, discharge summaries etc) at away day in October. To closely monitor impact upon performance
4. To undertake a review of all Q3 to date patients who have had initial assessment from OT/PT/SALT at > 12 hours to determine where gains can/should be made	Jan 2016	<ul style="list-style-type: none"> To closely monitor and determine whether new processes will improve performance for time to therapy assessment

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (B)	Q3 (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)	83.9% (B)	100% (A)	<ul style="list-style-type: none"> To review breaches quarter to date to understand reasons for breach – complete and system in place to validate
9.2 Proportion of applicable patients who have a continence plan drawn up within 3 weeks of clock start (A=95%)	95% (A)	92.5% (B)	97.6% (A)	<ul style="list-style-type: none"> 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%	99.3% (A)	98.8% (A)	<ul style="list-style-type: none"> 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	ongoing	<ul style="list-style-type: none"> Complete for new Medical Juniors – to review benefits/impact of this
2. To ensure all breaches are reviewed and validated	ongoing	<ul style="list-style-type: none"> 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	ongoing	<ul style="list-style-type: none"> Working party being formed to review quality and content of continence assessments and management to ensure meeting national guidance and also ensuring continence plans are in place for all patients to support patient discharge from hospital

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q3 (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)	<ul style="list-style-type: none"> 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)	41.1% (A)	48.8% (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)	100% (A)	100% (A)	
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	<ul style="list-style-type: none"> System in place for ongoing validation of any breaches

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q3 (to date)	Key Improvement Actions
Overall	90%	93.3%		
NIHSS at arrival (30% of score)		94.8% (N.A. 85.9%)	98.2%	<ul style="list-style-type: none"> 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)		100% (N.A. 89.9%)	100%	
Transfers (10% of score)		100%		<ul style="list-style-type: none"> Ensure all patients discharged to ESD/CRT are transferred on the webtool
Data Entry (10% of score)		100%		
72hr Measures (15% of score)		95.9%		<ul style="list-style-type: none"> Ensure reason is documented for all patients not having a swallow screen within 72hrs
Post 72hr Measures (15% of score)		99.1%		

Note: for NIHSS 24 hours post thrombolysis, there was one breach for Q1 and this was due to the patient self-discharging before 24 hours. We have advised SSNAP accordingly and therefore our performance without this breach would have been 100%.

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	Ongoing as staffing allows	<ul style="list-style-type: none"> Aim for 85% Nurses on SU competent with NIHSS New Stroke Specialist Nurse commences in January 2016 which will significantly help nurse training
2. NIHSS – ensure system in place to train all new starters	ongoing	<ul style="list-style-type: none"> Need an induction in place for all new starters
3. Review patients recorded as discharged to ESD/CRT are transferred to ESD/CRT on webtool	complete	
4. Ensure reason is documented for all patients not having a swallow screen within 72hrs	Complete	

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

DOMAIN KEY INDICATORS	Plan	Last SSNAP (A)		Key Improvement Actions
Average patient centred case ascertainment	90+%	90+%		<ul style="list-style-type: none"> 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	Ongoing	
2. All requests for record unlocks and data changes to go through SSNAP administrator	Ongoing	<ul style="list-style-type: none"> Ensure all relevant staff are made aware
3. To review case ascertainment figure with SSNAP	Nov 2015	<ul style="list-style-type: none"> SSNAP have lowered our case ascertainment numbers for stroke following updated review of our coding

BOARD OF DIRECTORS	
Meeting Date and Part:	18 December 2015 - Part 1
Subject:	Progress on Vanguard Project – One NHS for Dorset
Section:	Strategy
Executive Director with overall responsibility	Tony Spotswood
Author(s):	Tony Spotswood
Previous discussion and/or dissemination:	TMB, Board of Directors
Action required: The Board is asked to note the report and to authorise the CEO to sign off the January 8 th Value Proposition Submission	
Summary: To provide an update on the progress of the Vanguard Project	
Related Strategic Goals/Objectives:	All
Relevant CQC Outcome:	All
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

Dorset Vanguard – One NHS in Dorset

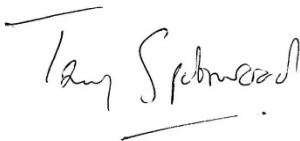
The formal launch of the Vanguard, One NHS in Dorset is scheduled to take place on Thursday 17 December in Poole. The first Steering Board meeting will take place earlier in the week on 15 December and I intend to report back to the Board on the key outcomes from that meeting. The Board is constituted to ensure the Chairman, CEO and Director colleagues are able to shape on-going work.

I enclose for information the final submission made to NHS England of the Value Proposition setting out the case for additional support and resource to help facilitate the development of a single range of hospital IT and back office services in Dorset. The submission has been well received and we are likely to hear before Christmas on the level of resource agreed for 2015/16.

A further revised submission is required by 8 January. I would be grateful for the Board's agreement for me to sign this off on behalf of the Trust. It is important that the collaboration will require a further £8.7m in 2016/17, an element of which will be used to create sufficient capacity to take this work forward.

Discussions will take place following the Board with Legal advisors aimed at ensuring there are clear options to allow this work to progress under the confines of the competition regulations. A meeting will be held with Monitor in early January to ensure that the Trusts can prepare fully for discussions with the Competition and Markets Authority.

This paper, whilst provided for information, asks the Board to delegate authority to the CEO to authorise the sign off of the Value Proposition to be submitted for resources in 2016/17 on 8 January.



Tony Spotswood
Chief Executive

BOARD OF DIRECTORS	
Meeting Date and Part:	18 th December 2015 - Part 1
Subject:	Workforce Committee – Terms of Reference
Section:	7. Governance
Executive Director with overall responsibility	Derek Dundas, Non Executive Director
Author(s):	Derek Dundas/Karen Allman
Previous discussion and/or dissemination:	Executive Meeting 1/12/15
Action required: For Decision	
Summary: The Terms of Reference for Workforce Committee have been updated and the revised document is tabled for agreement by the Board. Changes include updated membership; meetings now bi-monthly rather than quarterly; Organisational Development.	
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

COMMITTEE FOR WORKFORCE STRATEGY AND DEVELOPMENT

TERMS OF REFERENCE

The Committee for Workforce Strategy and Development (the “Committee”) is a sub-committee of the Board which is responsible for the consideration of matters relating to workforce planning and development, and Human Resources Policy and Strategy. This includes workforce modernisation; recruitment and retention; training and development; talent management; leadership development; equality and diversity; and workforce productivity and utilisation.

The Committee also acts as a means of internal assurance for compliance against the Care Quality Commission’s essential standards of quality and safety: Outcome 12 - Requirements relating to workers; Outcome 13 – Staffing; Outcome 14 - Supporting Workers; and the strategic goal of maintaining financial stability, enabling the Trust to invest in and develop services for patients.

1. Membership

- 1.1 The Committee Chairman (the “Chairman”) shall be a Non-Executive Director. In the absence of the Chairman the deputy Chair shall be the Director of Human Resources.
- 1.2 Standing members of the Committee shall include the Non-Executive Director x2, Director of Human Resources, Medical Director, Director of Nursing and Midwifery, Director of OD & Leadership, Director of Medical Education, Head of the Postgraduate Medical Centre, Leadership & Corporate Education Manager, Clinical Skills & Professional Education Manager, Organisational Development Manager, and Director of Operations for Care Groups A, B and C.
- 1.3 Only members of the Committee have the right to attend Committee meetings but if a standing member is unable to attend it is expected that he/she will ensure their nominated deputy is invited and can attend in his/her place, notifying the Chairman.

There will be one governor attending each meeting as an observer. Observers are not technically members of the Committee. This governor has been elected to undertake this duty by the Council of Governors by means of a ballot organised by the Trust Secretary in accordance with the process agreed by the Council of Governors.
- 1.4 It is expected that members attend a minimum of 3 meetings per year.
- 1.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.

2. Secretary

The Secretary to the Director Human Resources (the “Secretary”) or their nominee shall act as the secretary of the Committee.

3. Quorum

The quorum necessary for the transaction of business shall be three members, including a NED. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4. Frequency of Meetings

The Committee shall meet every two months.

5. Notice of Meetings

5.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend at least 4 working days prior to the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of Meetings

6.1 The Secretary to the Director of HR shall minute the proceedings and resolutions of all meetings of the Committee, including recording the names of those present and in attendance.

6.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

7. Duties

The duties of the Committee can be categorised as follows:

7.1 Workforce Modernisation & Planning

7.1.1 To ensure that workforce planning and development is considered and appropriate actions are taken to address workforce requirements. The planning process in the NHS is affected by a range of broader political, regulatory and professional policy decisions which are related to workforce modernization. The Committee aims to pre-empt these changes and anticipate associated workforce requirements.

7.1.2 To review the productivity of health services the Workforce Committee will review plans for the development of new working patterns and new skill mixes and include the utilisation of resources and financial/workforce balance.

7.2 Recruitment and Retention

7.2.1 To effect the balance of demand for staff with its supply - to ensure that sufficient numbers of appropriate qualified personnel are available, in the right place and at the right time, with the right skills, to match the demand for their services.

7.2.2 To monitor attrition rates in order to anticipate deficits in numbers of personnel.

7.3 Training and Development

7.3.1 To anticipate changes in Professional Education and Essential Core Skills training to ensure compliance and the continued provision of high quality care. Formal reporting against the LDA and HEW.

- 7.3.2 To monitor the provision of Training and Development and implement solutions which deliver a skilled, flexible and modernised workforce improving productivity, performance and reducing health inequalities

7.4 Organisational Development and Leadership

- 7.4.1 To provide governance and oversight for the Trust-wide culture change programme and development of the Leadership Strategy.

7.5 Equality and Diversity

- 7.5.1 The Equality and Diversity Committee will report to the Workforce Committee and will report on progress against action plans.

8. Reporting Responsibilities

- 8.1 The Committee shall report bi-monthly on its activities to the Board of Directors by way of Minutes and any report by the Chairman.
- 8.2 The Committee shall provide annual assurance to the Board of Directors that the Care Quality Commission's essential standards for quality and safety (Outcomes 12, 13, 14) are monitored and shall highlight any gaps in compliance, controls or assurance.

9. Other

The Committee shall:

- 9.1 have access to sufficient resources in order to carry out its duties;
- 9.2 give due consideration to laws and regulations;
- 9.3 oversee any investigation of activities which are within its terms of reference;
- 9.4 at least once a year review its own performance and terms of reference to ensure it is operating at maximum effectiveness and discuss any changes it considers necessary.

10. Authority

The Committee is authorised:

- 10.1 to seek any information it requires from any employee of the Trust in order to perform its duties;
- 10.2 to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its Terms of Reference.

11. Supported Strategic Goals

The Committee aims to support the Trust fulfil the following strategic objectives:

- 11.1 To strive towards excellence in the services and care we provide;
- 11.2 To listen to, support, motivate and develop staff.