

A meeting of the Board of Directors will be held on Friday 29 July 2016 at 8.30am in the Committee Room, Royal Bournemouth Hospital

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

Alison Buttery
Interim Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8:30-8:35	1. APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
	Paula Shobbrook, Nicola Hartley, Karen Allman,		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 24 June 2016		<i>All</i>
8.40-8.45	3. MATTERS ARISING		
	a) To provide updates to the Actions Log		<i>All</i>
8.45-9.15	4. QUALITY		
	a) Patient Story (verbal)	Information	<i>Ellen Bull</i>
	b) Feedback from Staff Governors (verbal)	Information	<i>Jane Stichbury</i>
	c) CQC Inpatient Survey results (paper)	Information	<i>Ellen Bull</i>
	d) Complaints Report (paper)	Information	<i>Ellen Bull</i>
9.15-10.10	5. PERFORMANCE		
	a) Performance Exception Report (paper)	Information	<i>Richard Renaut</i>
	b) Outcome of Monitor Investigation (verbal)	Information	<i>Tony Spotswood</i>
	c) Report from Chair of HAC (verbal)	Information	<i>Dave Bennett</i>
	d) Quality Report (paper)	Discussion	<i>Ellen Bull</i>
	e) Report from Chair Finance Committee (verbal)	Information	<i>John Lelliott</i>
	f) Finance Report (paper)	Discussion	<i>Stuart Hunter</i>
	g) Workforce Report (paper)	Discussion	<i>Derek Dundas</i>
	h) Medical Director's Report – Mortality (paper)	Information	<i>Basil Fozard</i>
10.10-10.45	6. STRATEGY AND RISK		
	a) Clinical Services Review (paper)	Information	<i>Tony Spotswood</i>
	b) Cultural Audit Next Steps (paper)	Discussion	<i>Tony Spotswood</i>
	c) Dorset CCG Community Site Specific	Discussion	<i>Tony Spotswood</i>

Consultation Options (paper)

- | | | |
|--|-------------|-----------------------|
| d) Vanguard Progress Report (paper) | Information | <i>Tony Spotswood</i> |
| e) Dorset Sustainability and Transformation Plan (paper) | Information | <i>Tony Spotswood</i> |

10.45-10.55

7. GOVERNANCE

- | | | |
|---|-------------|-----------------------|
| a) Medical Director Role (verbal) | Information | <i>Tony Spotswood</i> |
| b) Feedback from the Council of Governors meeting on 21 July (verbal) | Information | <i>Jane Stichbury</i> |

8. NEXT MEETING

Friday **30 September 2016** at 8.30am in the Hilary Christy Room, Greyfriars Community Centre, Ringwood

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.55-11.00

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.

*providing the excellent care we
would expect for our own families*

Part I Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Board of Directors** held on **Friday 24 June 2016** in the Oasis Cafe, The 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>
	Dave Bennett	(DB)	<i>Non-Executive Director</i>
	Derek Dundas	(DD)	<i>Non-Executive Director</i>
	Basil Fozard	(BF)	<i>Medical Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Nicola Hartley	(NH)	<i>Director of OD and Leadership</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Stuart Hunter	(SH)	<i>Director of Finance</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	John Lelliott	(JL)	<i>Non-Executive Director</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Alison Buttery	(AB)	<i>Interim Trust Secretary</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Louise Johnson	(LJ)	<i>Trainee Consultant Practitioner, OPM</i>
	Becky Jupp	(BJ)	<i>Consultant, OPM</i>
	Vanessa Mason	(VM)	<i>Directorate Manager, OPM</i>
	Sue Mellor	(SM)	<i>Head of Patient Engagement</i>
	Donna Parker	(DP)	<i>Deputy Chief Operating Officer</i>
	Dily Ruffer	(DR)	<i>Governor & Membership Manager</i>
	Clare Stalley	(CS)	<i>Stroke Services Manager</i>
	Andrew Williams	(AW)	<i>Clinical Director, OPM</i>
Members of Staff:	Jo Blackwell		<i>Directorate Manager, Cardiology</i>
	Paul Bolton		<i>Senior Infection Prevention & Control Nurse</i>
	Ellen Bull		<i>Deputy Director of Nursing & Midwifery</i>
	Lis Corkell		<i>Friends of the Eye Unit, Acting Chairman</i>
	Sue Davies		<i>Directorate Matron, Surgery</i>
	Debbie Dethridge		<i>Improvement Facilitator</i>
	Lucy Hart		<i>Pathway & Innovation Manager, Orthopaedics</i>
	Kate Horsefield		<i>Head of Nursing & Quality</i>
	Jenny House		<i>Nurse Manager</i>
	Faye Jordan		<i>Deputy Clinical Leader</i>
	Sue Langlois		<i>Directorate Matron, Anaesthetics</i>
	Miriam Lester		<i>Corporate Education Training</i>
	Maria Loulaki		<i>Phlebotomy Manager</i>
	Tracey Mack-Nava		<i>Organisational Development</i>
	Jo Maple- Roberts		<i>Sister, Endoscopy</i>
	Marie Miller		<i>Senior Staff Nurse, Pathology</i>
	David Mills		<i>Associate Director Performance, Information & Contracting</i>

	Anton Parker	<i>Information Specialist</i>
	Catherine Paton	<i>HR Recruitment Officer</i>
	Diane Potter	<i>Clinical Lead, Outpatients & 18 wks</i>
	Alison Pressage	<i>Matron, Specialist Services</i>
	Duncan Ridgeon	<i>Chaplain</i>
	James Rowden	<i>Patient Engagement Volunteer Coordinator</i>
	Mark Sopher	<i>Clinical Director, Cardiology</i>
	Noel Tadman	<i>Communications Assistant</i>
	BJ Waltho	<i>Head of Service Delivery</i>
	Vicki West	<i>Facilitator for Adult Safeguarding & Learning Disabilities</i>
Public/ Governors:	David Brown	<i>Public Governor</i>
	Derek Chaffey	<i>Public Governor</i>
	Carole Deas	<i>Public Governor</i>
	Eric Fisher	<i>Public Governor</i>
	Paul Higgs	<i>Public Governor</i>
	Paul McMillan	<i>Public Governor</i>
	Keith Mitchell	<i>Public Governor</i>
	Margaret Neville	<i>Representative of the Friends of the Eye Unit</i>
	Roger Parsons	<i>Public Governor</i>
	Alan Radley	<i>Public Governor</i>
	Maureen Todd	<i>Public Governor</i>
	Graham Swetman	<i>Public Governor</i>
Apologies	Steven Peacock	<i>Non-Executive Director</i>
	Richard Renaut	<i>Chief Operating Officer (Donna Parker attending)</i>

51/16 **WELCOME** Action

The Chairperson, in light of the European Referendum result, reinforced that the Trust was grateful for the dedicated work from all EU staff and would continue to provide support to all staff.

The newly appointed Non- Executive Directors, John Lelliott with effect from 1 June and Alex Jablonowski with effect from 20 June were welcomed to the Board. In addition, Peter Gill was welcomed as Director of Informatics, with effect from 1 June, following an interim position over the last 18 months.

52/16 **Minutes of the meeting held on 27 May 2016 (Item 2a)**

The amendments highlighted were agreed and the minutes were **approved** as an accurate record.

To provide updates to the action log (Item 2b)

- 46/16 STF Funding- trajectories had been resubmitted to NHS Improvement (NHSI) and were supported by the Clinical Commissioning Group (CCG). The rules governing the control total were still outstanding together with the penalties if the associated targets were breached. The 4hr ED trajectory would be confirmed at the end of March.
- Junior Doctors contract- it was noted that the financial consequences

would be built into the assumptions.

- 108/15 (g) Workforce Retention plan- the plan was being developed across the wider system including through the Clinical Services Review (CSR) and Vanguard project. Discussions were also taking place with Care Groups and the plan is being influenced by the Cultural Audit. Further feedback would be provided in September.

53/16

QUALITY

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

The patient story focused on the work to improve engagement with hard to reach groups at the Trust. Numerous focus groups were held to obtain feedback and identify improvement ideas to implement within the Trust to improve patient experience.

The Trust facilitated a co- designed young person stakeholder event which focused on what the Trust could offer young people and how to engage with young volunteers. Future engagement events were being planned to increase feedback on services from young people.

It was emphasised that the Trust was committed to ensuring that all minority groups had their needs heard throughout the organisation. The Trust worked alongside the Dorset LGBT network to identify areas for improvement and co- designed videos for staff on the intranet to place an emphasis on how staff and patients wanted to be treated. The Trust had since been contacted by other organisations including the Clinical Commissioning Group (CCG) for advice.

The Trust had implemented a number of changes to support patient needs including multi faith gowns which had been initiated by one of the governors. The Board were advised that the Trust would continue to improve relationships with a variety of different minority groups. It was queried whether the current mandatory core skills training could be upgraded to reflect the work underway at the Trust. The Board thanked SM, who was retiring from the Trust after 34 years, noting her role in facilitating the Friends and Family Test feedback.

KA

(b) Feedback from Staff Governors (Item 4b) (Verbal)

The Chairperson outlined the themes from the meeting which included:

- An issue was raised about the impact of a number of Staff leaving a particular area within the Trust. Assurance was provided that vacancies had been addressed;

- Concerns about the recent problems with the IT system;
- Mandatory training capacity- staff highlighted that they had been unable to book onto courses;
- Staff consultation exercises would prove useful in the future with regard to any plans for restructuring;
- Positive feedback about the success of the Quality Improvement work and training;
- Staff were aware of the Trust's Cultural Audit work and anticipated the feedback together with information about how they could be involved.

(c) Stroke Reflections (Item 4c) (presentation)

The team from the Stroke Unit reported on the significant improvement within the Sentinel Stroke National Audit Programme results which had been improved from a category D to an A over the last 12 months. It was highlighted that, previously, the multi-disciplinary team (MDT) had been fractured and this impacted upon staff morale, retention and the service provided. The service had been perceived poorly both internally and externally.

The team outlined the 'Blocks of Change' which involved improving leadership and ensuring that members of the team were in the right roles, listening to staff and working together to make staff feel empowered whilst challenging negative behaviours. The attendance, quality and efficiency of MDT meetings and ward rounds were improved to ensure they were focused on patient's needs. This enabled the department to release 12hrs of clinical time. In addition the team worked closely with other departments including the Ambulatory Care Unit and developed a 6wk stroke MDT follow up clinic to provide support.

It was emphasised that the changes implemented within the Stroke Unit underpinned the service today; which was being led by a strong team who had achieved a Category A rating. The team expressed that they were proud of the service and that positive feedback had been received from patients.

The Board commended the improvements which had been made in a short period of time and recognised that this was as a result of having the suitable leadership in place. Further, the impact of empowering staff was discussed noting the benefits which had been generated for patients.

It was requested that the learning was identified from the 'Blocks of Change' implemented by the team and for them to work with

NHa

Organisational Development to apply across the organisation.

(d) Nursing Midwifery and Allied Health Professional (AHP) Strategies

It was highlighted that the strategies had been developed over the last year and in conjunction with staff, the Senior Nursing team and Matrons, with a bottom up approach to identify what was important to the organisation. It was emphasised that the document was driven by staff and had received positive feedback with ideas already being embedded. The strategies also reflected the Trust's plans, national priorities and objectives.

The strategies were launched on International Nurses Day 12 May and a range of national speakers attended. The key themes focused on safe and effective care delivered through effective leadership. It is anticipated that the conference become an annual event at the Trust and a date had been confirmed for next year.

Board members commended the team collaboration and emphasised that this was fundamental to staff retention. It was noted that staff were empowered to work together to make changes. The Board thanked those involved.

(e) Complaints Report (Item 4c)

The Board was advised that the Trust had made progress against the 25 day target for responses to complaints. The Trust was receiving fewer complaints and teams were focused on response times. The process had also been made clearer to both patients and staff.

The vacancy within the corporate team had previously impacted upon progress however assurance was provided that, following comprehensive discussions at the Healthcare Assurance Committee (HAC), progress would be made and clear plans were in place. The key themes from complaints, the Care Audit and from the 'Noise at night' survey would be triangulated and the chronic themes considered at HAC. The improvement trajectories for complaints response times were noted, which will be monitored by the Healthcare Assurance Committee.

54/16

PERFORMANCE

(a) Performance Exception Report (Item 5a)

Performance against the key national priorities were highlighted to

the Board:

- The priority targets set out in the Sustainability and Transformation Fund would be ED 4 hours, 62 day cancer, 18 wks Referral to Treatment (RTT) and 6 wks diagnostics;
- During May performance against the submitted STF trajectories were on track. Whilst the ED 4 hour target remained below 95%, significant improvements had been noted and this was reflective of the dedicated staff, cultural work and actions to improve patient flow and bed availability;
- 62 day Cancer- the work to address pressures within Urology had improved performance. It was anticipated that going forwards the national trajectory would be met;
- There had been an increase in non-elective activity and pressures were being managed;
- 18 wks RTT- achieving the target was challenging with increased demand across the system including areas such as Ophthalmology and Dermatology nationally. The Trust was working with the CCG to address pressures;
- Performance against the national trajectories for both C-difficile and Cancer 2 wk wait was non-compliant. The position with Cancer 2 wk would be recovered with additional sessions being allocated;
- Ambulance times- the Trust was working with partners across Dorset to improve the data captured and improve reporting.

The importance of identifying the issues within colorectal to ensure patients had access to treatment within the 62 day standard was emphasised. It was noted that additional resources and the appointment of new posts would provide the support required. Lung pathways were complex and required improved joint working with Southampton Hospital. Attention was drawn to a national bid to move diagnostic times forward which would support compliance with the 62 day pathway. The detail and actions to address compliance with the 62 day target were requested for assurance.

RR

(b) SSNAP Results (Item 5b)

The item was discussed at 53/16 (c).

(c) Outcome of Monitor Investigation (Item 5c) (verbal)

The announcement had been delayed until the 27 June but would be communicated internally and externally.

(d) Report from Chair of HAC (Item 5d) (Verbal)

Due to the restructuring of the Committee meetings to bi-monthly an update was not due. The executive led Healthcare Assurance Group met and it was emphasised that the new model would be beneficial going forwards. **Amend planner**

(e) Quality Report (Item 5e)

By exception the Board was informed of two serious incidents which related to breaches in information governance. Data had been located in a public area which highlighted a lack of awareness amongst staff about the destruction of confidential information. The Trust would be contacting those patients concerned however no clinical data had been identified. In addition it was identified that data had been sent using an unsecure email address. The policies and processes were reviewed and made clearer to staff.

The Trust remained within the top quartile for FFT feedback although actions were being put in place to increase the volume of feedback within ED and to improve compliance. Care Audit actions were considered at Healthcare Assurance Group (HAG) and included promoting the availability of snack boxes and increasing hydration in the evening with the assistance of volunteers. The Board encouraged the plans to address the themes raised within the audit.

(f) Report from Chair Finance Committee (Item 5d) (Verbal)

The Chair paid tribute to his predecessor Ian Metcalfe. It was reported that income had been recovered in May following the Junior Doctor strikes and that Care Groups remained broadly on plan. The gap within the Cost Improvement Plan (CIP) was yet to be addressed although schemes were being developed.

The terms of reference for the Committee had been extended to include the review performance against the national targets. In addition, the Trust had revised the action plan in response to the Lord Carter of Coles recommendations.

(g) Finance Report (Item 5e)

The themes within the report were highlighted and included:

- Income had returned to planned levels in May noting that activity levels had increased by 13% within Emergency Department (ED) and this was being managed within the infrastructure available;
- £1.4 million gap remained within the CIP however schemes

were being developed;

- The cash position remained stable and within the forecast for the end of the year;
- The Sustainability and Transformation Fund (STF) conditions were included in the report;
- The position with the Junior Doctor Contract remained a risk and funding was not available in the system. Income levels would continue to fall if the contract was not agreed and strike action continued. Assumptions were being incorporated within the budget;
- The trajectories for the STF had been submitted and the Trust was broadly in line with the financial plan for Q1.

Concern was raised about the lack of certainty around the impact of the risks if the Trust breached an STF condition. It was emphasised that the Trust was doing everything within its power to achieve the control total and assurance had been provided that it would be difficult to penalise the organisation as a result.

(h) Report from the Chair of the Workforce Committee

**Amend
planner**

The Chair summarised the main themes discussed at the meeting:

- Workforce Race and Equality Scheme (WRES)- a number of indicators highlighted a gap which the Trust needed to address;
- Bullying- the figures had improved however further work was required and an action plan would be developed;
- Appraisal compliance had reached 95% at the end of September. Appraisal Champions had been appointed to drive improvements further;
- Sickness Audit- the Trust would be considering the effectiveness of redeployment in some areas;
- Essential Core Skills (ECS)- compliance had improved and the Trust had achieved 95% excluding the medical and dental staff group. It was anticipated that the target identified would be attainable.

(i) Workforce Report (Item 5h)

The report was summarised and the Board noted the following information:

- Appraisal compliance had increased by 13% as a result of additional support and a more assertive approach;
- Changes had been announced to the Junior Doctor contract and it was anticipated that these would be implemented by October. The fill rates provided by the Deanery placed the Trust in a better position than originally perceived;
- Sickness absence remained an area of focus and there were

good examples of management in some areas.

It was raised that the expenditure on security had not impacted upon staff experiences of violence and it was queried whether this was the appropriate response. It was emphasised that a number of actions were in place which aligned with the national guidance which would be communicated to staff. The escalation pathway and alternative options were being considered to ensure that the right approach and care was being provided to certain patients. It was noted that the issue was complex and had been considered in detail by the HAG. It was requested that the action plan and detail was provided to the Board.

(PS)

(j) Update from Charity Committee (5.5.2016) (Item 5i) (verbal)

It was emphasised that the Board acted as Trustees for the Hospital Charity. The Board were advised that the quarterly report had been received, the strategy had been refreshed and that the team were positive about the aims for the future. It was noted that the Committee had considered the future of the staff Pride Awards and that this would be reviewed in line with the feedback from the Cultural Audit.

The Board thanked the charitable contributors to patient hospital equipment and noted that the Hospital Charity had funded the work to provide guest Wi-Fi for visitors at the Trust.

55/16

STRATEGY AND RISK

(a) Clinical Services Review (Item 6a)

The Board received the update and noted the key themes which included:

- The Wessex Clinical Senate had been requested by NHS England to review the CSR proposals. The draft report would be finalised and shared with the Board;
- The proposals for the provision of Cancer and Acute Oncology services would be considered by the Senate following a request for the Radiotherapy service to be located on the main emergency site. The estimated outline costs for providing the consolidated service on the RBH site was £12.4 million and this would not fundamentally effect the development cost difference between RBCH and Poole Hospital;
- There were concerns about the position of Poole Hospital, who did not wish to advocate RBH as the main emergency site, and the impact this would have upon the progress of the CSR;
- The Trust was developing a Communication Strategy to

engage stakeholders during the CSR consultation. The rationale for the CSR and the benefits to patients needed to be reinforced and this would be emphasised at the Trust Open day. A programme of external events with governors would be developed and to widen stakeholder engagement including CCGs, GPs and other representatives.

(b) Performance against Trust Objectives (Item 6b)

The Board noted the challenging areas however were encouraged that, despite delays, the QI work had released 100 beds to aid the flow of patients by ensuring that patients were in the right clinical area. The Board commented that the progress with patient flow and the SNNAP should be used as a marker to measure progress towards the Trust's ambition to be the most improved in 2017.

56/16

GOVERNANCE

(a) IPCC Annual Report and board Statement of Commitment to Prevention of Healthcare Associated Infection (Item 7a)

The Board considered the statement noting that good practices were in place for infection control however that the Trust would continue to drive improvements. Areas of focus included tracing patients within the system and C- Difficile. It was reinforced that the CQC had positively recognised the consistency of practice across the organisation. The impact of the reduction of side rooms would be provided to the Board for awareness once available.

PS

The Board **approved** the statement of compliance and commitment.

57/16

DATE OF NEXT MEETING

29 July 2016 at 8.30am in the Committee Room, Management offices, Royal Bournemouth Hospital

58/16

Key Points for Communication:

1. Celebrate the examples of staff team working
2. Key performance trajectories
3. Achievements over the last year against the Trust Objectives.

59/16

QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC

1. The Trust's work with young carers was raised. It was outlined that events were incorporated within the work programme including a focus group had been planned together with engagement at local schools to identify how to involve young carers. It was noted that links with schools had improved and this would be maintained.
2. Further to the EU referendum result it was emphasised that the Trust

needed to reinforce to staff that they were valued members of staff. Feedback from patients obtained from the Care Campaign Audit praised many of the nurses and doctors from EU countries and the excellent care they provided.

3. The next phase of the Cultural Audit was queried and how staff could be involved. It was confirmed that the feedback would be presented to the Board and Trust Management Board before the report would be provided to staff together with the responses from the Trust and action plan. The feedback would also be shared with governors at the Board and Council of Governors away day on 29 June to form a collaborative approach to the next steps in the process.
4. It was recognised that the Trust processes had improved and patients were being listened to and communicated with before a complaint arose.

There being no further business the meeting closed at 10:40
AH 24.06.16

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
24.06.16	53/16	QUALITY			
	(a)	<u>Patient Story</u>			
		Consider upgrading the mandatory core skills training to reflect the work at the Trust to improve equality and diversity.	KA		Modules are currently under review and are being updated.
	(c)	<u>Stroke Reflections</u>			
		To work with the stroke team and identify lessons to apply across the organisation.	NHa		The OD team will be contacting the Stroke department to identify the elements of good practice to cascade throughout the organisation.
	54/16	PERFORMANCE			
	(a)	<u>Performance Exception Report</u>			
		Provide further detail and the actions to address compliance with the 62 day target.	RR		Included within the performance report.
	(i)	Workforce Report			
		Provide the action plan and further detail to address security and staff experiences of violence.	PS		Update requested from Rowena Green, BJ Waltho.
	56/16	GOVERNANCE			
	(a)	<u>IPCC Annual Report and board Statement of Commitment to Prevention of Healthcare Associated Infection</u>			
		A summary of the impact of the reduction of side rooms would be provided to the Board for awareness once available.	PS	September	Review is underway and will be reported in September.
27.05.16	44/16	PERFORMANCE			
	(a)	<u>Performance Exception Report</u>			
		Discuss the challenges to achieving the ED 4hr target with NHSI in light of the STF requirement and provide feedback to the Board.	RR	In progress	Discussions on going with CCG but anticipated to be agreed local trajectory for Months 1-11 M12 to be agreed with NHSI.

RBCH Board of Directors Part 1 Actions June 2016 & previous

		Provide clarification around the reporting of C-difficile within the performance report.	PS		Complete.
	(f)	<u>Workforce Report</u>			
		Include the rationale behind the HCA night fill rate within the performance report.	PS		June: Being reviewed at premium Cost Avoidance meeting on 21.6.16 July: Included within the Complaints report narrative.
01.04.16	24/16	QUALITY			
	(d)	<u>Complaints Report</u>			
		Ensure that additional focus is paid to complaint response times and report on improvements within the next two months.	PS	In progress	Work is in progress and will be reported to HAC and incorporated within the complaints report to Board.
26.02.16	13/16	MATTERS ARISING			
	(a)	<u>CQC Report Update</u>			
		Utilise the Monitor well- led self-assessment to measure Trust improvements ahead of the next CQC inspection together with the peer review programme. Remit the overarching assessment to the Healthcare Assurance Committee.	PS		Not yet due – pre-self assessment being prepared and self assessment to be refined over the summer.
18.12.15	108/15	PERFORMANCE			
	(g)	<u>Workforce Report</u>			
		Develop and agree a retention plan. Provide a timescale for the outline retention plan.	Execs/KA	Sept	June: Retention issues are being incorporated within plans under the CSR, Vanguard and Trust processes.

Key:

	Outstanding
	In Progress
	Complete
	Not yet required

BOARD OF DIRECTORS

Meeting Date:	29 th July 2016 Part 1
Subject:	Report on CQC Inpatient Survey published 2016 sample date July 2015
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	None
Officer with overall responsibility:	Paula Shobbrook Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing and Midwifery
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee 28th July 2016
Action required:	The paper is provided for information

Executive Summary:

The CQC in patient report was published in May 2016. This is for a data sample that was taken in July 2015. Overall the results demonstrate a sustained position against a backdrop of increased activity and at the time of the sample being taken, a challenged workforce vacancy position which is now improved.

The key messages are;

1. Same Sex accommodation question is different to previous survey so cannot be directly compared, however the results from this score are demonstrative of improvement.
2. Overall there is
 - improvement in 28 questions (42 questions in 2014)
 - 2 questions show statistical improvement (8 in 2014)
 - 14 questions have remained the same (6 the same in 2014)
 - Minimal deterioration (not statistically relevant) in 18 questions (10 in 2014)
 - statistical decrease in 1 question
3. Questions 59 (printed information leaving hospital) and question 64 (danger signals to watch for after discharge) both evidence better than most when compared with other Trusts placing the Trust in the top 20%.

Relevant CQC domain:	All domains
Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	
Risk Profile:	N/A
i. Impact on existing risk? ii. Identification of a new risk?	

National Care Quality Commission Inpatient Survey results from July 2015

The annual Care Quality Commission (CQC) national inpatient survey is a public determinant of patient experience; a regulatory measure performance analysed by the CQC and a local performance measure monitored by our local Clinical Commissioning Groups.

The 13th annual CQC in-patient survey includes responses from in excess of 83,000 patients from 149 acute Trusts with a national response rate of 47%. RBCH had an increased response rate of 57% from a sample of 1250 (increased from 830 in July 2104) eligible patients who were in the Trust overnight during July 2015. There were 687 responses completed.

The data analysis is based on an “expected range” when compared to other Trusts and is standardised by age, gender and method of admission to ensure the results are fair regardless of demographic. The numerical score is 0 (worst) - 10 (best).

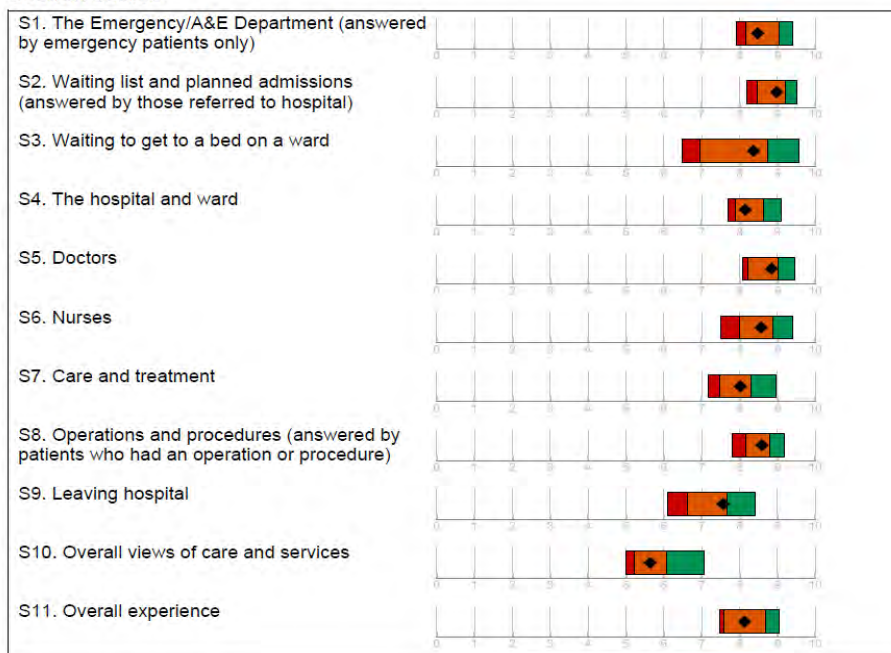
1.0 National comparison results

Results are displayed when compared with other trusts as:

- **better than most** other trusts (coloured green)
- **about the same** as most other trusts (coloured amber)
- **worse than** most other trusts (coloured red)

Survey questions are segmented into 11 sections to reflect key aspects of the patient journey or quality of care by professional disciplines. There are a total of 63 questions in total. Overall performance results for the 2015 survey by section are displayed in the table below;

Section scores



The Section score for internal comparison based on 2014 are as follows:

1. 'ED' has improved from 8.3 (2014) to 8.5
2. 'Waiting list' is down by 0.1 point to 9
3. 'Waiting to get a bed' is improved from 8.2 (2014) to 8.4
4. 'Hospital ward and ward' is reduced by 0.1
5. 'Doctors' has improved to 8.8
6. 'Nurses' remains sustained at 8.6
7. 'Care and treatment' has improved to 8
8. 'Operations and procedures' is reduced by 0.1
9. 'Leaving hospital' remains static at 7.6
10. Overall views of care and service has decreased by 0.2
11. Overall experience remains sustained at 8.1

Overall, performance when compared to last year is largely sustained with some improvement variations in specific categories; ED, waiting to get a bed, Doctors and care and treatment.

Last year's question regarding sharing same sex sleeping areas when moved has been amended to reflect the whole journey in one question and now also excludes patients in critical care areas. This has provided increased question validity to represent the trust performance which has shown improvement in both questions 11 and 14 (re same sex bathrooms and sleeping areas).

- Q11 Sleeping areas 9.0 (8.8 in 2014)
- Q14 (same sex bathrooms) 8.1 (7.5 in 2014)

2.0 Comparison with 2014 results

Internal comparison with 2014 performance demonstrates:

- improvement in 28 questions (42 questions in 2014)
- 2 questions show statistical improvement (8 in 2014)
- 14 questions have remained the same (6 the same in 2014)
- Minimal deterioration (not statistically relevant) in 18 questions (10 in 2014)
- statistical decrease in 1 question

Please note there are 3 additional questions in 2015 survey relating to:

- Did staff work well together (Q31)
- Support from health and social care to recover (Q57)
- Was there a plan in place for your transfer to other clinical care facilities (Q58);
The Trust has no result for this question due to a low number of respondents (33)

3.0 National performance comparison

Questions 59 (printed information leaving hospital) and question 64 (danger signals to watch for after discharge) both evidence **better than most** when compared with other Trusts placing the Trust in the top 20%.

The Trust has no results in the worse than categories.

4.0 Summary

In summary, performance against the Trust's 2014 performance demonstrates minimal variation in results and sustained performance with two questions in the top 20% when compared to other Trusts.

5.0 Recommendation

The results have been requested by directorate so they can be reviewed at directorate level for the management responses and improvements as part of the overall improvements from all the feedback. This will be reviewed at the Healthcare Assurance Committee.

BOARD OF DIRECTORS

Meeting Date:	29 th July 2016 Part 1
Subject:	Report on Formal Complaints Performance against the Trust Policy
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	None
Officer with overall responsibility:	Ellen Bull Deputy Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing and Midwifery Anton Parker, Information Manager
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee 28th July 2016
Action required:	The paper is provided for information
<p>Executive Summary: The Complaints report includes aggregate and Care Group and directorate complaint acknowledgement and response performance. This is a key focus of the Board of Directors and this has been reported through the Healthcare Assurance Committee and Trust Management Board.</p> <p>Key messages:</p> <ol style="list-style-type: none"> 1. Current Trust aggregate response time in month (June 2016) is 50% against a standard of 75% (10 out of 20 complaints were closed within the 25 working day time that were due in month). 2. 24 formal complaints were received in June 2016. Acknowledgement times are currently being validated. 3. The response time improvement focus continues and has not sustained the required above 60% trajectory for month 3 YTD on aggregate. This has been achieved by two out of the three care groups with only Care Group B now requiring improvement. 4. Improvement trajectories for all Care Groups are to sustain responses above 60% for Q1. Improvement trajectories for formal responses are: <ul style="list-style-type: none"> • Q1 above 60% • Q2 above 65% • Q3 above 70% • Q4 to maintain 75% from the start of quarter 4. 5. Implementation of care was the commonest theme of the in month formal complaints received. 6. Concerns (informal issues) in month have been reported. The volume is much higher than formal complaints, however the response times are 81% in month for a written response to a verbal concern, and for verbal concerns addressed this was 96% in month. 	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All domains
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	N/A

Complaints Report July 2016

1.0 Introduction

This summary paper includes information on formal complaints received, acknowledged and responded to times in month (June 2016). Complaints are presented in terms of incidence, response times and themes. This is measured against our own Trust Policy and reviewed in detail at the Healthcare Assurance Committee.

2.0 Number of complaints

24 formal complaints were received in June 2016. Surgery as a directorate received the most complaints in month with 6 complaints across four themed domains, with Medicine the next with 4 in month complaints all scattered themes, and then Cancer care, older peoples medicine, orthopaedics and medicine each with three. Orthopaedics and older peoples medicine have the most complaints (n=3) in one domain, implementation of care. Currently there are 47 open formal complaints.

3.0 Acknowledgement and response times

- 3.1 Of the 24 complaints received for June, 82% (N = 18 out of 22) were acknowledged within three days. 1 was customised to be more appropriate for the complaint. 3 were beyond the time due to staff resource. A review of the resource contingency has been performed and action taken to mitigate this for the future. Acknowledgements have traditionally been a formal letter however this can also be a phone call, email or meeting alongside a formal letter to support an increased customised approach appropriate to the complaint context. This is being reviewed in terms of data capture.
- 3.2 Responses to complaints should be within 25 working days (quality strategy standard of 75%), which is monitored at the Healthcare Assurance Committee. For June on aggregate the first response times were 50% (complaint responses due were within 25 working days).
- 3.3 In terms of Care Group response times, the performance of two out of the three care groups is improved in month and meets the expected trajectory target for June of 60%. Care Group B required immediate support to deliver a recovery plan, and discussions for delivery for this are underway with the leadership team of Care Group B at the Complaints Performance Group. In terms of actual volume, there are 10 complaints which are late. These are attributed to older peoples medicine (n=5), medicine (n=1), orthopaedics (n=1), cardiology (n=2) and other (N=1).
 - a) Care Group A 75%
 - b) Care Group B 33%
 - c) Care group C 100%

4.0 Themes and trends – Complaints received

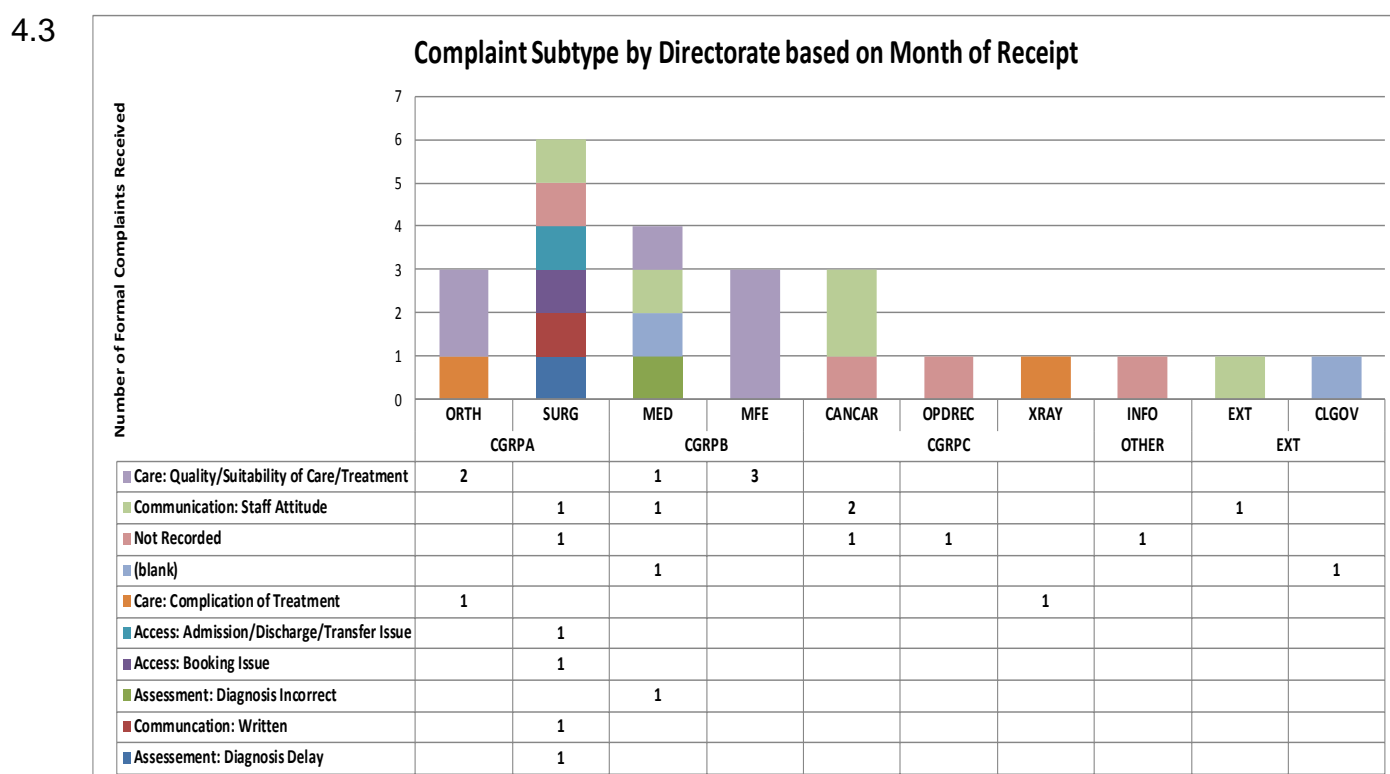
The total received in June by directorate with themes is in table 4.3. The highest theme again in month was implementation of care.

- 4.1 Implementation of care is broken down into subcategories and directorates for complaints received in June 2016. The largest of the subcategories is quality, suitability of care and treatment. A detailed review of this sub type of complaints will be examined through the

Complaints Performance meeting to determine overall improvements or actions taken and required. Actions being taken forward include;

- Consent and recording of consent taken
- A review of skills of required and education provided for frontline staff to support early resolution
- A review of expectations and messaging and language to use and what to do for reception staff, ward clerks and clinical staff in terms of how to manage an arising concern. This will be considered against the wider cultural work in the Trust.

4.2 Table 4.3 depicts in month (June 2016) complaints by category Implementation of Care sub types.



5.0 Informal Concerns Response rates

5.1 Informal concerns are raised by patient's, carers, relatives or others about a wide variety of subjects. The volume of the informal concerns is larger than formal complaints and the opportunity to close and resolve arising concerns is responsive and less formal in terms of style. The concerns are resolved in two ways; written response and verbal response. The current response time which is recorded against a 25 working day deadline for both is as follows

Written response to verbal concern 81% in month and 72% for the 12 month rolling average
 Verbal concerns were addressed for 96% in month and 90% for the 12 month rolling average

6.0 Healthwatch report

6.1 In January 2016, the Trust was approached by Healthwatch to work in partnership to facilitate completion of an independent survey of individuals who had submitted a formal complaint to this Trust. As a Trust we agreed and we partook in this alongside two other local Trusts. Our internal Complaints team facilitated the identification of past complainants within the

information governance structure, the sending of the surveys which were then returned directly to Healthwatch. The results are depicted as percentages in the report, which is attached for information.

- 6.2 The response rate for returned surveys was 27% (n=86), the best response of the three Trusts. Healthwatch provided a summary analysis containing 6 points. The results have been helpfully depicted per Trust. Reviewing the summary analysis and the results in detail, this report is being reviewed within directorates and compared to actions in place against the CQC actions for a gap analysis. Additional actions will be added to directorate reports, and brought back to the Complaints Performance group, which will then be provided to the Healthcare Assurance Committee for monitoring and oversight. Corporate actions are being taken forward.

7.0 Recommendation

The Board of Directors is requested to note this report which is provided for information.

Fobbed Off

Experiences of making a
complaint about
NHS Foundation Trust services
in Dorset

What we did



We sent a survey to people who had brought a complaint against an NHS Foundation Trust in Dorset in 2015. We invited them to share with us their experiences of the complaints system and process.



The survey was sent to complainants who had received services from either Dorset County Hospital NHS Foundation Trust, The Royal Bournemouth and Christchurch NHS Foundation Trust or Dorset Healthcare University NHS Foundation Trust. (Poole Hospital NHS Foundation Trust was not able to take part on this occasion, but would like to take part if and when we repeat the exercise.)



The survey went to 764 people in total. 158 of them responded to it (a response rate of 21%).



We wrote a report on our findings, called "Fobbed Off".

We sent the report to the people responsible for the services and asked them to respond to it and to our recommendations for action. Their responses are printed in the full version of our report.

We've also been back in contact with the people who took part in our survey, to thank them and to let them know about our findings.

Some of the things people told us, in their own words

As well as asking people to answer our survey questions, we gave them the opportunity to tell us in their own words about their experiences of various aspects of making a complaint. We received 176 such comments, the majority of which were wholly or partly negative. A sample of the comments received are below.

Quite honestly I felt it was a fob off.

It was a fob off and I am complaining to the Ombudsman.

They were rallying around and protecting their negligent colleague instead of addressing the view point of my Dr. and myself.

I felt...that the process was more interested in protecting the NHS and its staff from recognising the very real danger that my relative was left in and the distress caused to the family. We had no interest in playing the blame game, only in ensuring that vulnerable people were better cared for.

How about having a really novel idea of having independent community adjudicators, who have no bias, one way or the other looking at complaints! Makes sense to me!

I was certainly listened to. Only one staff member (not from the complaints team), was rude and dismissive.

The focus is on the process, not on the outcomes. The complaints are judged against policy and procedure, not against the specific needs of the patient.

The whole process needs to be taken out of hospital control.

I was incredibly impressed with the matron and other staff member present at our fault finding meeting. Everything was very thorough and dignified.

I was cross with the response but did not feel I had the energy to take it any further, plus it caused emotional distress in the family.

An answer to my complaint would be good. Here we are 1 year later and I have not had any response to my complaint, apart from the acknowledging letter. My relative has since died.

Do not dismiss problems because the patient is elderly.

Management should not ignore patient concerns and try to whitewash and cover up complaints - especially when patients are only trying to help the NHS make improvements - those making complaints should not be victimised.

I was dealing with 2 parts of the NHS. In the end they blamed one another and I was left in the middle.

I was informed at the time I could make a complaint, but not how to do so. In fact, I was adamant that I did not blame the overstretched staff, but the system which treated the patient.

The process was fine. Hopefully action has been taken to ensure that similar oversights and mistakes do not happen in future.

Staff were very unhelpful at the hospital, no empathy, blaming each other.

At no stage did I receive a personal apology for what happened. I was brushed aside several times and the response was unsatisfactory.

The reply didn't take into account my true feelings.

Almost all of my concerns were minimised and I felt that no changes for the better would be put in place.

The letter had a usual standard response feel to it. There was no sympathy for my problem expressed.

Fobbed off - wasted our time on the day and again with response.

Trust offered no reassurances or practical actions that would be undertaken to avoid repetition.

Wasn't taken seriously, complaint was barely addressed. I was just given a series of excuses.

Still fearful as to how I will be treated next time.

My concerns were not answered properly and I felt dismissed.

Basically provided with a whitewash.

The whole process was a 'cover our arse' exercise.

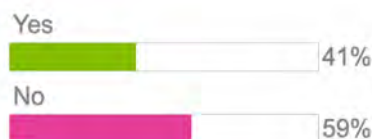
No one accepted responsibility for the poor service.

I felt that my complaint was the only thing they were interested in and not any mention of support. They simply washed their hands of me.

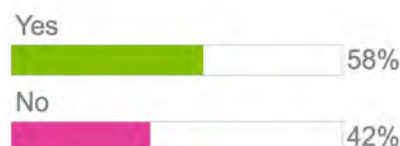
We were placated rather than being listened to.

The people who deal with complaints are probably the first line of defence, therefore their job is to put people off but patients have the right to see justice. X was uncaring, defensive and downright rude and I worry they could put people off as they'll worry that everyone is like that.

Did you feel your complaint was handled fairly?



Were you satisfied with the actual process of making the complaint?



Did you feel confident that making the complaint would have no adverse effect on any current or future care you may require?



Did anyone make you aware that you could be supported to make the complaint by an independent advocate?



Our Recommendations

- 1 We recommend that Trusts review the information available to patients, families and carers about PALS, to ensure that from the perspective of patients and families the information is readily available and accessible throughout all services provided by the Trust. We also recommend that all staff receive training so that they fully understand the role of PALS. In many circumstances, staff are likely to be already aware that a patient or their relative/carer is unhappy with aspects of their care and they should be empowered to work with patients and families to resolve issues, wherever possible, “in real-time”.
- 2 We recommend that Trusts consider how they could be more proactive both in giving patients and families the opportunity to meet with staff at the very beginning of the complaints procedure and in supporting and encouraging them to do so. (Trusts should be aware that sometimes the complaints process comes across to people as being process-driven rather than person-centred. Some people feel that Trusts “hide behind” procedure. Most people simply want an acknowledgement that something went wrong and an apology for what has happened, and to know that the Trust has learned from it and taken action to ensure that it doesn’t happen to someone else.)
If this happened more often, we believe that many complaints could be dealt with more quickly, be less stressful for all concerned and would ensure a higher level of satisfaction.
- 3 We recommend that Trusts not only provide all complainants with information about available independent advocacy services, but also actively ensure that complainants have seen and read that information and have confirmed that they are aware of the support available, should they choose to use it.
We also recommend that Trusts meet with Dorset Advocacy (the provider of the “Help with NHS Complaints” service in Dorset) to develop an effective process of referral and to discuss how awareness of the advocacy service can be raised.
- 4 We understand that investigating a complaint can sometimes be complicated, with many staff and professionals involved and timescales can slip due to various factors.
However, we recommend that Trusts take steps to ensure that people are always kept informed as to the progress of their complaint, by their chosen method of communication. If timescales are not going to be met, there should be further communication with the complainant with full and frank reasons for delays made clear.
- 5 We recommend that Trusts review their procedures to ensure that all complainants are provided with information about what options are open to them if they are not satisfied with the result of their complaint (specifically, information about the Parliamentary & Health Service Ombudsman).
- 6 We recommend that staff with any responsibility for handling complaints should be provided with additional/ongoing/updated training in interpersonal and communication skills, to ensure that patients and families receive effective and appropriate support and communication. People will then be more likely to feel that their complaint was fairly handled. Effective ongoing communication at every stage of the process will also go a long way to ensuring that people feel that they are dealing with staff who really care and that their complaint is taken seriously.

Responses from the NHS

Before its release, we shared our report with the Trusts concerned and invited them to respond to it. Here are some extracts from their responses. The full text of their responses is contained in our full report, available on our website.

Dorset County Hospital (extracts)

We appreciate receiving feedback about our services so that we can continually make improvements. We have carefully read the report and would like to assure Healthwatch and our patients, staff, carers and public of our processes and use of the recommendations in the report to make service improvements.

... we have designed stickers with contact details of PALS which are being distributed throughout the Trust, particularly to highly visible areas like patient lockers.

... we...make people aware of Dorset Advocacy who offer independent support to help people raise concerns, but...we will make this more explicit.

(We) recognise that further assurances need to be given that their concerns are being taken seriously. With this in mind we have developed complaints standards, in which all people raising a formal concern are contacted by telephone by senior staff to keep people informed, mutually agree timeframes, the chosen method of response, and what aspects of their concern they would like addressed. We think that this will provide a more person-centred, compassionate and kind service and over time this will improve satisfaction with the process being fair, the outcome of the complaint and the timeliness of our responses.

We appreciate that this report has given us greater insight into the experience of people raising concerns at DCH, and think that the service improvements we have identified and implemented as a result will ensure that everyone has a similar experience to one of our respondents who commented that:

"I was incredibly impressed with the matron and other staff member present at our fault finding meeting. Everything was very thorough and dignified. Thank you!"

Royal Bournemouth Hospital (extracts)

(We are concerned) that people were not being given apologies. Quality assurance is now strengthened for response to ensure style and responses are appropriate.

We are aware that timescales require improving and are working on this currently.

This may have been due to team structure and vacancies for which we sincerely apologise. There is a robust system now in place to ensure responses are of higher quality, and demonstrate appropriate personalisation and empathy.

The complaints leaflet is currently being updated with the correct advocacy information on it and advocacy information is being added to the website, also currently being updated.

(We) are aware that timescales need improving and we have a plan in place which is being reviewed... While 51% of responders felt that their complaint had not been handled fairly a high percentage of these complainants will not have had the outcome they wished for therefore may be unhappy with the process.

Dorset Healthcare (whole response)

This report serves as an important opportunity for us to learn from the experiences of our patients and as a reminder of the importance of responding effectively and compassionately to the complaints we receive. From the feedback within the report we can identify a larger proportion of complaints from our prison services and we have worked really hard to make the complaints process easier to use and more responsive, however acknowledge that further improvements need to be made. Our own review of our complaints process - involving feedback from patients - suggests a more positive picture but we can always improve how we work. We have already been doing this and recently made a series of changes to align our complaints process to the best practice principles outlined by the Parliamentary and Health Service Ombudsman. We would like to thank Healthwatch Dorset for undertaking this important piece of work on behalf of local people and patients.

Thank you - and how to find out more

Thank you to everyone who shared their experiences and insights with us, and to the NHS Foundation Trusts for their cooperation.

You can download the full report (which contains a lot more detail, including the full responses from the NHS Foundation Trusts to our findings) from our website: <http://www.healthwatchdorset.co.uk/resources/reports>

Hard copies of both this summary and the full report are available on request.
0300 111 0102. enquiries@healthwatchdorset.co.uk.

*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	29 th July 2016 – Part 1
Subject:	Performance Report to End June 2016
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Performance Matrix
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Donna Parker / David Mills
Details of previous discussion and/or dissemination:	PMG
Action required: Approve / Discuss / Information / Note	<p>The Board is requested to note the performance exceptions to the Trust's compliance with the 2016/17 STF, Monitor Framework and contractual requirements.</p> <p>The Board is also asked to consider the NHSI Single Oversight consultation document.</p> <p>Finally, the Board is also requested to note the detailed report on RTT, Diagnostics and Cancelled Operations performance and support the ongoing actions for recovery, where this is required.</p>
<p>Summary:</p> <p>The full Performance Report for June is attached and accompanies the Performance Indicator Matrix and Balanced Dashboard which are both available in the Reading Room. The report outlines the Trust's actual and predicted performance against key access and performance targets and this month, provides a detailed focus on RTT, Diagnostics and Cancelled Operations.</p> <p>NHS Improvement have also published their proposed Single Oversight Framework for consultation which will replace the Monitor Risk Assessment Framework. This is attached as an Annex. Board member views are welcome to inform our response.</p> <p>An Executive Summary and Key Risks page has also been provided.</p>	
Relevant CQC domain:	
Are they safe?	Yes
Are they effective?	Yes
Are they caring?	
Are they responsive to people's needs?	Yes
Are they well-led?	Yes
Risk Profile:	
i) Impact on existing risk?	The following risk assessments remain on the risk register and are currently being reviewed in light of latest performance and STF rules of engagement:
ii) Identification of a new risk?	<ul style="list-style-type: none"> i. Cancer 62 day wait non-compliance and national guidance on 'high impact' changes. ii. 4 hour target. iii. Endoscopy wait times – under review now recovery programme completed and sustained for 3 months. iv. RTT due to reduced performance.

1. Executive Summary

The Trust is currently fully achieving the submitted trajectories in relation to the Sustainability and Transformation Fund (STF) performance targets. We estimate this puts us in top 10% of Trusts.



RTT 18 Weeks Incomplete Pathways (12.5% of funds) – above 92% performance national target (92.3%) and in line with monthly and quarterly trajectory.

A&E 4 hour (12.5% of funds) – achieved above the 95% national target in June (95.99%), with 94.12% for Q1. Both above the submitted trajectory - set at 91% for June.

Cancer 62 Day from Referral to Treatment (5% of funds) – achieved compliance above the 85% national target in May (85.6%). This is above the submitted trajectory which was agreed at below national target in Q1 to support the Urology recovery programme.

Diagnostics 6 Week Wait (0% of funds) – achieved compliance and above trajectory, at 100%.

All other Monitor Risk Assessment Framework (RAF) and key contractual targets were met for June. One cancelled operation was rebooked at 31 days rather than the target of 28 days.

2. Key Risks

The STF rules of engagement have now been published and we are undertaking a risk assessment against securing the funds. **Workforce** remains the most significant risk, and one of the hardest to mitigate. From a performance perspective the key risks are:

RTT 18 Weeks Incomplete Pathways – the backdrop of an increased overall waiting list with a higher proportion of patients waiting greater than 18 weeks means a reduced tolerance to mitigate speciality risks. Ophthalmology demand and capacity pressures are a particular risk and a focus on managing demand, re-designing referral and booking processes, together with securing additional capacity which may require outsourcing, is a priority. Smaller issues across other specialities are being managed on a case by case basis. It is anticipated that this action together with STF tolerance thresholds will secure the national funds.

A&E 4 hour – the national requirement is that RBH must achieve 93.6% for March 2017. If progress in May and June 2016 is maintained, together with a robust winter plan, this should be achievable, though increased activity (11% YTD) and system-wide pressures remain a significant risk with factors outside our control.

Cancer 62 Day from Referral to Treatment – the most significant risk to achieving the agreed trajectory is the potential impact of the new fast track referral forms in September reflecting the new NICE guidance. For some tumours sites estimates include up to 15% increase in referrals. Detailed work is underway to review referral pathways and capacity.

Diagnostics 6 Week Wait – the impact of the above potential increase in cancer referrals, together with scanner down time and some staff shortages in Radiology and Endoscopy present risks to performance. However, payment is not expected to be withheld.

Performance Report



For the period to end June 2016

Richard Renaut
Chief Operating Officer

Performance Report

As at 18/07/2016

1. Introduction

This report accompanies the Performance Indicator Matrix (*available in the Reading Room*) and outlines the Trust's actual and predicted performance against key access and performance targets. In particular it highlights progress against the likely trajectories for the priority targets set out in the Sustainability and Transformation Fund (STF).

The detailed performance levels against the remaining key targets, which currently form part of the Monitor Risk Assessment Framework (RAF) or national/contractual obligations, are included in the Performance Indicator Matrix. Narrative is included in this report on an exception basis.

The NHS Improvement 'Single Oversight Framework' consultation document is also attached at Annex A along with some initial comments. This replaces the RAF. Board member views are welcome to inform our response.

This report covering performance for June 2016 includes a focus on the Month 3 Indicators – RTT and Diagnostics - as per attached quarterly cycle (*Table 1*). The final validated performance for Learning Disabilities (Q1) is awaited and will be included in the August report.

The Trust's full Balanced Dashboard for July 2016 (end Q1) is also included in the *Reading Room*, integrating Quality, Clinical Outcomes, Performance, Finance and Workforce.

Quarter Cycle	NHS Improvement (STF) Indicators	RAF and Contractual Indicators
Report Month 1 (Apr, Jul, Oct, Jan)	ED 4 hours (incl flow)	Infection Control (C Diff) Mixed sex accommodation Ambulance handovers DToCs MRSA VTE
Month 2 (May, Aug, Nov, Feb)	Cancer 62 days	Cancer 2 weeks, 31 days Tumour site performance 62 day upgrade and screening 104 day 'backstop' breaches
Month 3 (Jun, Sept, Dec, Mar)	RTT and Diagnostics	Learning Disabilities RTT speciality level Admit/non admit total list and >18wks 52 week wait breaches 28 day cancelled ops 2 nd urgent cancelled ops,

Table 1 – Quarterly Cycle for Focus on Performance Indicators

Performance Report

As at 18/07/2016

2. Sustainability and Transformation Fund and Monitor Risk Assessment Framework Indicators – June 2016 Performance

2.1 Sustainability and Transformation Fund 16/17

In response to the national STF requirements the Trust has submitted revised proposed trajectories. The rules of engagement for the STF have now been released outlining the obligations under which the payments will be released and the tolerances. Final sign off from NHS Improvement is expected following the end of Q1. The below shows our current position against our submitted STF trajectory for June 2016 and Q1 which in summary, reflects achievement of trajectory.

Table 2 - Sustainability and Transformation Fund 2016/17 Key Indicators

Target or Indicator (per Risk Assessment Framework)	RAF Threshold	April		Q1 16/17 May		June	
		Trajectory (projected performance against target)*	Actual Performance	Trajectory (projected performance against target)*	Actual Performance	Trajectory (projected performance against target)*	Actual Performance
Referral to treatment time, in aggregate, incomplete pathways	92%						
A&E Clinical Quality - Total Time in A&E under 4 hours	95%						
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%						est. only**
Diagnostic 6 week wait	99%						

*Final sign off by NHS Improvement is awaited following submission.

**Validated final position awaited - upload is early August

RTT Incomplete Pathways (18 week) and 52 Week Breaches

In line with our submitted trajectory we met the RTT Incomplete Pathways 92% performance target in June and for Quarter 1. Performance for June was maintained at 92.4% with 22,230 patients continuing to wait less than 18 weeks.

The good progress made through April and May in stabilising 18 week admitted backlogs in a number of specialities supported the Q1 position. However, a general increase in total patients on RTT pathways, as well as deterioration in Ophthalmology and pressures

across some surgical specialities, has meant an increase in overall patients waiting over 18 weeks. Further detail is included in section 4 below.

There were no 52 week wait breaches in May.

A&E 4 Hour Target, 12 Hour Breaches and Ambulance Handovers

The Trust achieved compliance in June with the national ED 4 hour target, where we saw a significant improvement at 96.1%. There were no 12 hour breaches.

June has continued to see pressures with a significant increase in non-elective admissions compared to last year (10.1%) and ED attendances (7%). Despite this and the continued level of social and community care delayed discharges, the outputs of the Trust's improvement work (*including in ambulatory care, Frailty, Cardiology and Respiratory Medicine*) have contributed to good levels of hospital discharges overall and reduced bed occupancy. The ED team have also commenced a period of focused team work on improving processes within ED and across the trust, including the development of inter-professional standards and escalation action cards.

June has seen an increase of 3.8% in total ambulance handovers (conveyances) compared to June '15, but a decrease of -3.8% compared to May 2016. The drop in June handovers from May follows historical trends. We are working jointly with the local ambulance services to implement improved systems for handovers and the ongoing metrics and trajectories for the year are being agreed, including the process of data validation.

62 Day from Referral for Suspected Cancer to Treatment

With lower numbers of Urology breaches continuing in May, supported by the reduced waits for robot prostatectomies for all Dorset patients,

Performance Report

As at 18/06/2016

we were able to achieve the 62 day target in May at 85.6%. Earlier in the Quarter we saw some pressure from fast track demand and capacity pressures in both Colorectal and Gynae, both of which are improved now, through locum or permanent staff in post. There were also a number of complex pathways affecting patients in Lung and other tumour site services. Our projection for June therefore, continues to reflect this impact with an expected below threshold performance. This remains in line with our submitted trajectory. Overall for Q1, it is possible that performance will just meet the national threshold of 85% as we have been moving towards a more sustainable position overall.

Diagnostic 6 Week Wait (*end of month*)

Our improved position was sustained in June with a pleasing 100% performance in line with our STF submission. Currently performance remains on track in the key areas (Endoscopy, Radiology, Cardiology and Urology) though this continues to be closely managed. In Radiology there is a continuing need for additional capacity on an ad hoc basis to respond to peaks in demand or reductions in capacity (e.g. scanner breakdown). We are also seeing some reduced endoscopy capacity over the summer due to four medical staff leaving for a variety of career reasons. Recruitment is underway, but is proving challenging.

Following 3 compliant months (now 4) in Endoscopy we have applied to the Joint Advisory Group for reaccreditation and expect our inspection to take place in November 2016. This allows us to do more screening and earn best practice tariffs.

2.2 Other Monitor Risk Assessment Framework Indicators

Below indicates our earlier projections for 16/17 against the remaining Monitor RAF indicators, together with Quarter 1 to date confirmed or expected performance.

NHS Improvement has released the Single Oversight Framework document for consultation, closing on 4/8/16 (Annex A). This replaces the Monitor Risk Assessment Framework and proposes that the four STF metrics (as above) become the key operational performance indicators for 16/17. The remaining RAF metrics are excluded. We are currently reviewing the consultation document and will respond to NHSI. Comments from Board members on the response is very welcome.

Table 3 - Monitor Risk Assessment Framework

Target or Indicator (per Risk Assessment Framework) not included within STF	%	16/17						
		Q1	Q2	Q3	Q4	April	May	June
		Pred	Pred	Pred	Pred	Actual	Actual	Actual
Cancer 62 day Waits for first treatment (from Cancer Screening Service)	90							*
Cancer 31 Day Wait for second or subsequent treatment -	94							*
Cancer 31 Day Wait for second or subsequent treatment -	98							*
Cancer 31 Day Wait from diagnosis to first treatment	96							*
Cancer 2 week (all cancers)	93							*
Cancer 2 week (breast symptoms)	93							*
C.Diff objective								
MRSA								
Access to healthcare for people with a learning disability							**	**

Note:

*Cancer reflects our predicted position to date. Final upload early July 16.

**Learning Disabilities reflects our predicted position to date. Compliance is confirmed quarterly.

Cancer

62 Days from Screening to Treatment

Full compliance was achieved in May (100%), and compliance overall is currently indicated for Q1.

31 Days Subsequent Treatment

The 31 day subsequent surgical treatment performance was compliant for May at 97.8%. There remains some risk going forward linked to treating the Urology backlog patients, though June predictions are above threshold.

31 Days from Diagnosis for First Treatment

Performance was compliant for May with 98.9%, with only 2 breaches reported (Urology). Our agreed CCG recovery trajectory requires full

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sustainable recovery by end Q2 though we continue to strive for an earlier recovery date.

2 Week Wait

Performance was compliant for May, with 93.6% and we expect 97.7% for June. Some capacity pressures in Colorectal and Gynaecology (the latter due to some sudden unplanned absence) resulted in a number of breaches early in the quarter. Additional sessions have been arranged and performance has improved in the second half of the Quarter, however, this is unlikely to recover full compliance for the Quarter. Q2 though is expected to be compliant. A significant risk for Q3 though is changing the referral thresholds for GP fast track referrals. We are currently modelling the potential impact on clinics and diagnostics.

Breast Two Week Wait

Performance was compliant at 100%.

Infection Control – C Diff and MRSA

3 cases of C Difficile, where lapse in care is deemed to have contributed, have been reported up to the end of June 2016. We were above the 1.2 monthly threshold in May but compliant for the Quarter with 0 in April and 1 in June. There are 2 cases under review to see if there is evidence of a lapse in care.

There have been no reported cases of hospital acquired MRSA.

Access to Healthcare for People with a Learning Disability

Whilst reported quarterly, we expect compliance to be confirmed.

3. Contractual and Other Targets Exception Reporting

Compliance was maintained on all other key targets in June excepting one on-the-day cancelled operation which was not rebooked within 28 days (see section 4.9 for detail).

Table 4 – Contractual and Other Targets

Indicator	Measure	Target 16/17	Apr-16	May-16	Jun-16
Mixed Sex Accommodation	Minimise no. of patients breaching the mixed sex accommodation requirement	0	2	0	0
MRSA Bacteraemias	Number of hospital acquired MRSA cases	0	0	0	0
62 day – Consultant upgrade	Following a consultant's decision to upgrade the patient priority *	90%	42.9%	100.0%	
Venous Thromboembolism	Risk assessment of hospital-related venous thromboembolism	95%			
Planned waiting list	% of patients less than 6 weeks past their due date	0	95.5%	96.0%	95.6%
Admission via A&E	No. of waits from decision to admit to admission over 12 hours	0	0	0	0
Ambulance	No. of breaches of the 30 minute handover standard	0	66	67	67
Ambulance	No. of breaches of the 60 minute handover standard	0	7	2	10
28 day standard	No. of patients not offered a binding date within 28 days of cancellation	0	0	0	1
Urgent ops Cancelled for 2nd time	No. of urgent operations cancelled for a second time	0	0	0	0
NHS Number Compliance	Completion of NHS Numbers in SUS Submission (IPS/OPS)	99%	99.7%	99.7%	
NHS Number Compliance	Completion of NHS Numbers in SUS A&E Submissions	95%	98.3%	98.4%	
SSNAP indicator	% of Stroke patients are treated on a dedicated stroke ward for 90% of spell		81.6%	86.7%	89.1%
SSNAP indicator	Direct admission to Stroke Unit within 4 hours of admission		66.7%	76.4%	66.0%
SSNAP indicator	Patients receive CT Scan within 24 hours of admission		100.0%	91.8%	96.2%
SSNAP indicator	Patients with acute stroke receive brain imaging within 1 hr		46.3%	37.0%	35.8%
SSNAP indicator	Thrombolysis Rate		7.4%	12.3%	5.7%
SSNAP indicator	% appropriate patients receiving thrombolysis (within 1 hour of clock start)		50.0%	44.4%	66.7%
TIA indicator	High risk TIA cases investigated and treated within 24hrs		72.0%	61.0%	79.0%
TIA indicator	Low risk TIA cases, seen within 7 days		87.0%	89.0%	89.0%
Clocks still running - 52 weeks	Zero tolerance of over 52 week waiters (Incomplete Pathways)	0	0	0	0
Clocks still running - admitted	Total number of patients with an admitted incomplete pathway	n/a	6679	6634	6421
Clocks still running - admitted	Number of patients with an admitted incomplete pathway over 18 weeks	n/a	1227	1191	1177
Clocks still running - non admitted	Total number of patients with a non admitted incomplete pathway	n/a	16558	17304	17651
Clocks still running - non admitted	Number of patients with a non admitted incomplete pathway over 18 weeks	n/a	570	626	665

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4. Performance Focus - RTT, Diagnostics and Cancelled Operations

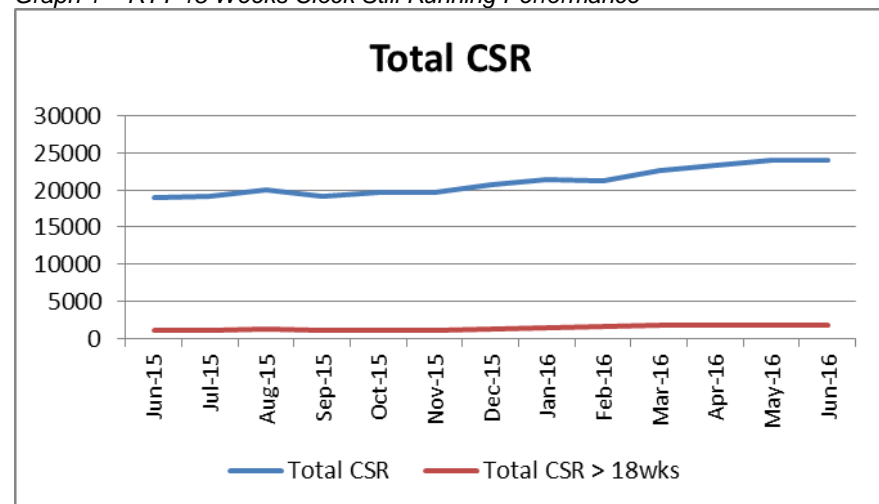
4.1 RTT 18 Weeks – Clocks Still Running

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
CLOCK STILL RUNNING (CSR) PERFORMANCE	93.7%	92.8%	92.1%	92.3%	92.4%	92.4%
Total CSR (Patients)	21,377	21,259	22,592	23,237	23,938	24,072
Total CSR > 18wks (Patients)	1,344	1,527	1,796	1,797	1,817	1,842

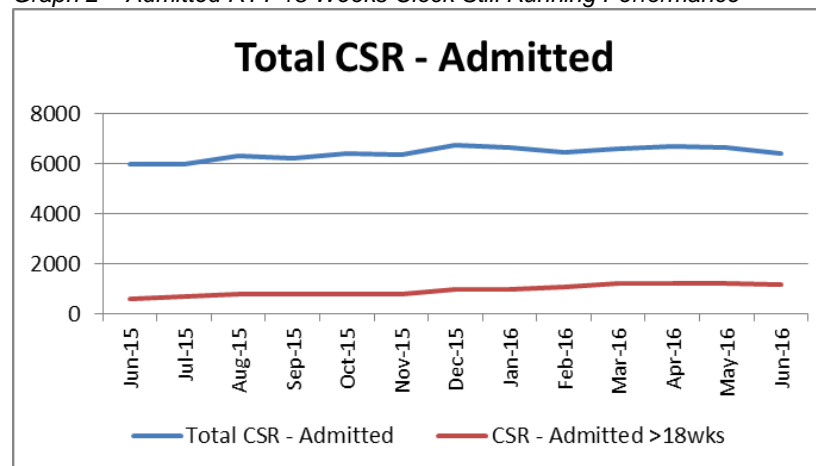
Table 5 – RTT 18 Weeks Clock Still Running Performance

The above table and below graphs show the growing overall waiting list (clocks still running/incomplete pathways), up 2700 since January. This increase reflects a number of factors including: increased referrals over time; bed capacity limitations due to non-elective activity increases; unplanned capacity shortages that cause a step up in the waiting list which then are not recovered (though stabilised); lost capacity from junior doctor strikes, reduced premium cost waiting list initiatives; better patient tracking ensuring all patients are correctly on an RTT pathway that should be; and additional consultant vacancies in some specialities.

Graph 1 – RTT 18 Weeks Clock Still Running Performance

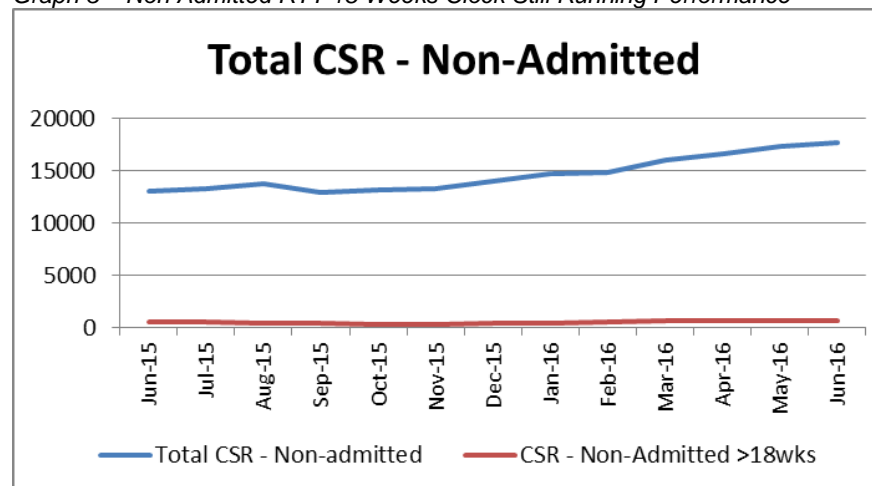


Graph 2 – Admitted RTT 18 Weeks Clock Still Running Performance



A large part of the growth is in non admitted i.e. clinic based pathways, although a considerable subset are Ophthalmology patients awaiting a procedure, e.g. cataracts.

Graph 3 – Non Admitted RTT 18 Weeks Clock Still Running Performance



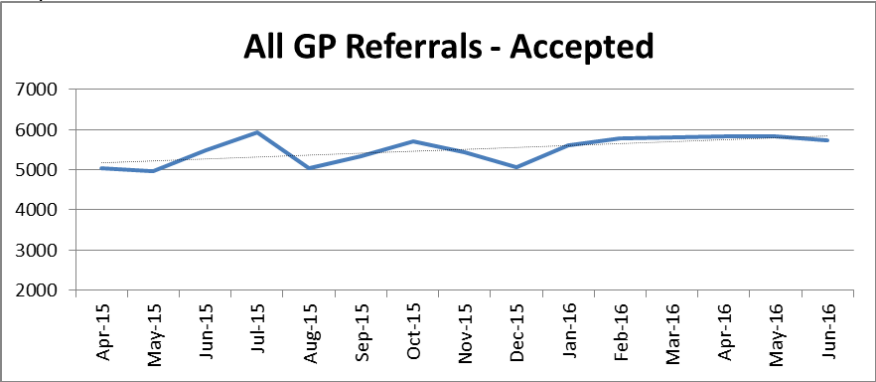
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4.2 Referrals

GP referrals have increased in 2016 with a growth of >2% in overall accepted referrals, but a sustained higher level since February which is feeding the overall list size.

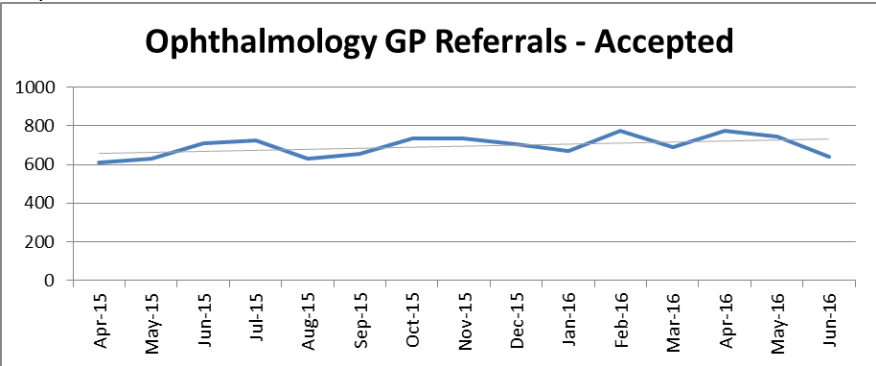
Graph 4



Particular growth has been seen in:

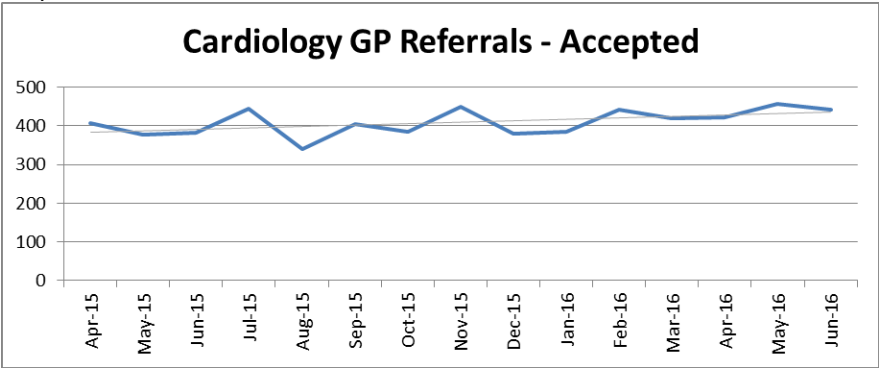
Ophthalmology +15%, though accepted referrals have reduced in June as a result of rigorous demand management, use of community alternatives and ongoing development of alternative pathways.

Graph 5



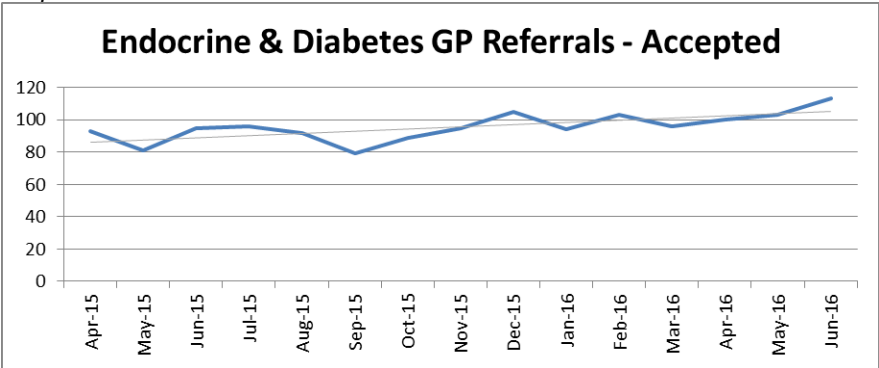
Cardiology +13%

Graph 6



Endocrine & Diabetes +10%

Graph 7

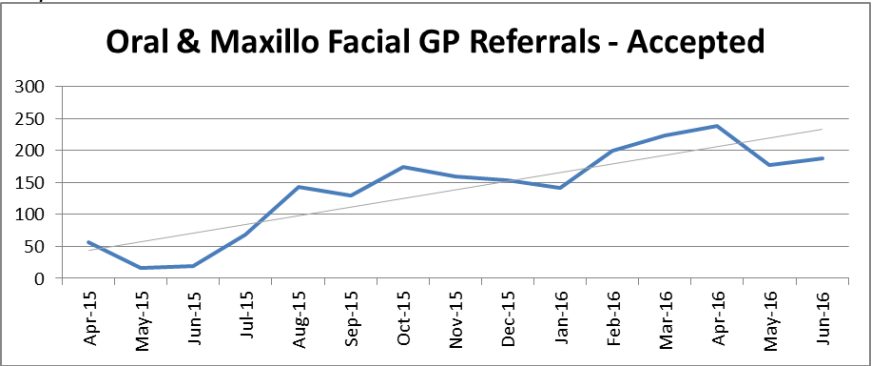


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Oral and Maxillo Facial +12%

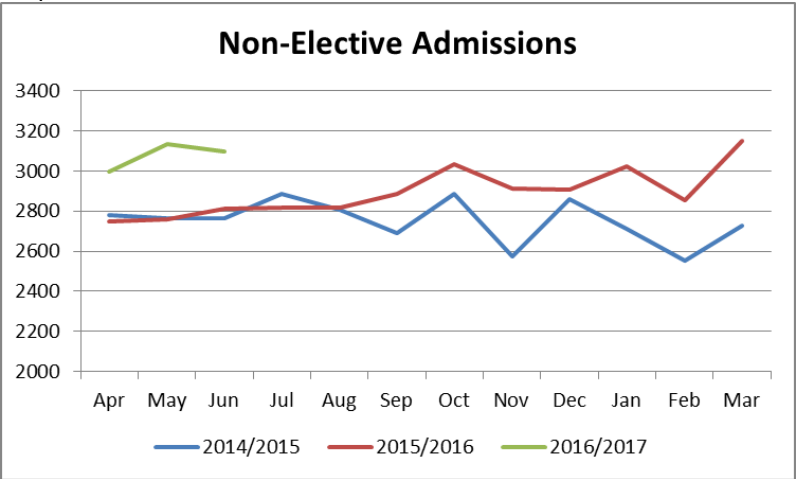
Graph 8



4.5 Emergency & Elective Admissions and Outpatient Activity

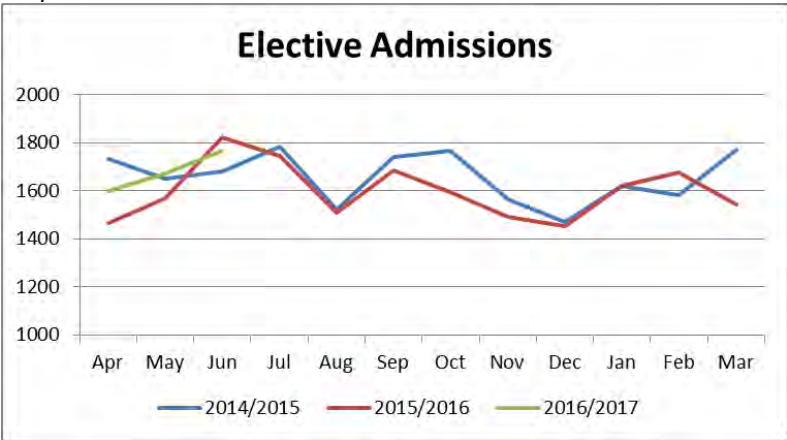
2015/16 saw a reduction in elective activity through the year as non-elective activity increased, contributing to the growing pressure on RTT incomplete pathways (waiting lists).

Graph 9



Inpatient elective activity has, however, increased by 5% since April 2016. This is despite an increase of 11% in non-elective which has been supported by a strong focus on ambulatory care to reduce overnight and length of stay, as well as the improvements in Frailty, other services and outliers. Equally Surgery has continued to develop day case, overnight and backfilling capacity to increase its activity.

Graph 10

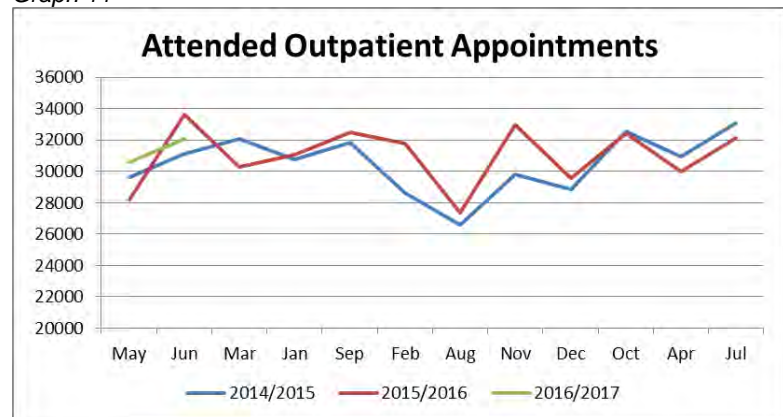


Overall outpatient activity has increased on last year however, this continues to be monitored alongside the increasing referral rate, outpatient waiting times, non-admit waiting list and contract activity plans. Referrals and outpatient waits are reviewed regularly at speciality level with directorates with targeted action as required. Such action includes: additional sessions; notes review clinics; demand management approaches, for example, through GP advice and guidance and clinic template reviews. The flexibility, resilience and goodwill of all the staff to sustain the higher levels of elective and emergency workloads is crucial to our ongoing success.

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Graph 11



4.6 Overall Clocks Still Running by Specialty and Recovery Plans (Compliance = 92%)

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16		
									<18 wks	Total	%
100 - GENERAL SURGERY	91.9%	92.2%	92.0%	92.0%	91.9%	90.9%	90.9%	90.7%	2797	3075	91.0%
101 - UROLOGY	89.8%	90.5%	86.5%	83.6%	82.2%	81.8%	81.8%	84.9%	1207	1412	85.5%
110 - TRAUMA AND ORTHOPAEDICS	94.8%	94.2%	92.5%	92.3%	91.0%	90.8%	90.8%	90.7%	3978	4349	91.5%
120 - EAR NOSE AND THROAT	98.9%	98.2%	96.3%	98.0%	94.2%	92.7%	92.7%	90.8%	602	662	90.9%
130 - OPHTHALMOLOGY	93.4%	93.4%	93.2%	93.9%	92.6%	91.4%	91.4%	90.1%	4230	4753	89.0%
140 - ORAL SURGERY	100.0%	100.0%	100.0%	100.0%	100.0%	99.3%	99.3%	99.6%	577	587	98.3%
170 - CARDIOTHORACIC SURGERY	100%	100%	100%	100%	100%	100%	100%	100%	7	7	100%
300 - GENERAL MEDICINE	96.9%	95.8%	96.9%	99.1%	96.5%	96.9%	96.9%	97.4%	1630	1691	96.4%
301 - GASTROENTEROLOGY				94.2%	-	-	-	-	0	0	-
320 - CARDIOLOGY	95.2%	95.1%	93.8%	94.9%	94.9%	91.5%	91.5%	95.3%	1888	1965	96.1%
330 - DERMATOLOGY	93.8%	93.8%	96.4%	96.9%	97.6%	97.8%	97.8%	97.4%	772	799	96.6%
340 - THORACIC MEDICINE	99.2%	99.5%	98.6%	97.7%	97.2%	96.4%	96.4%	98.2%	634	640	99.1%
400 - NEUROLOGY	97.0%	98.8%	96.5%	99.5%	99.1%	98.8%	98.8%	97.1%	324	343	94.5%
410 - RHEUMATOLOGY	98.7%	98.4%	98.0%	97.2%	97.9%	97.8%	97.8%	97.2%	1021	1053	97.0%
430 - GERIATRIC MED	100.0%	98.9%	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	186	188	98.9%
502 - GYNAECOLOGY	94.6%	94.0%	94.1%	93.0%	91.2%	90.5%	90.5%	90.6%	1052	1176	89.5%
Other	96.4%	97.9%	96.8%	97.0%	95.3%	94.5%	94.5%	95.4%	1325	1372	96.6%
TOTAL	94.5%	94.5%	93.7%	93.7%	92.8%	92.1%	92.3%	92.4%	22230	24072	92.3%

Table 5 – Clocks Still Running Specialty Performance

A deteriorating position has been seen across some specialities due to a number of factors and the following actions are being taken:

Speciality	RTT Key Issues	Recovery Plans
Ophthalmology	GP referral demand growth - 15% (graph 5), alongside medical staff vacancies	<ul style="list-style-type: none"> - Work with CCGs to support community/primary care based services - Guidance to GPs - Redesign of e-referral outpatient booking processes - Additional sessions - Seeking locum/substantive posts - Exploring outsourcing options
General Surgery	Unplanned medical staff capacity shortages particularly in Colorectal and Vascular	<ul style="list-style-type: none"> - 2 substantive consultant posts appointed in Colorectal - Interviews in August for Vascular consultant - Additional sessions and outsourcing
ENT	Unplanned medical staff shortages at provider Trust impacting on capacity available at RBH plus 10% increase in GP referrals	<ul style="list-style-type: none"> - Working with visiting provider trust to secure additional capacity - West Hants community ENT service
Orthopaedics	Medical staff capacity shortages due to doctor turnover leading to peaks and troughs in capacity, as well as impact of non elective activity on bed capacity (graphs 9 & 10)	<ul style="list-style-type: none"> - LoS reduction project and ringfencing of Derwent Unit for Ortho - Additional sessions - Backfill of medical vacancies
Gynaecology	Unplanned medical staff capacity shortages	<ul style="list-style-type: none"> - Locum recruitment - Additional sessions - Outsourcing

The impact of the recovery plan in Urology can be seen to have impacted with May and June showing an improved position. This follows the impact of growing demand and the need to focus existing capacity on priority cancer pathways, which has affected the routine work. Improvement work related to booking and scheduling processes as well as increased capacity through outsourcing, securing theatre capacity at a community provider and locum sessions have all assisted.

Referral growth in other specialities (see section 4.2) is also being closely monitored in order to manage impending impact on RTT. A further risk area is Dermatology where outpatient waits are now known to over 18 weeks following increased demand since December, which will have a knock on impact in the coming months. Ad hoc additional capacity is being provided currently with more substantive additional capacity from August and October, together with redesigned clinic and surgical templates from September.

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Improvement Case Study

RTT - Reducing Delays in Diagnostic Results to Patients and GPs

Issue:

18 week Trackers highlighted significant delays in patients/GPs being informed of diagnostic results following outpatient appointment. This also affected patients on a 'non admit' RTT pathway. Patients/GP's should be notified either in writing or at a follow up outpatient appointment. Delays at this stage also affect subsequent listing for patients going onto surgery.

Aim:

- To achieve earlier communication of results to patients and GPs
- To reduce unnecessary delays in the patient's clinical and 18 weeks RTT pathway
- To ensure timely clinical intervention

Previous Process:

- Diagnostic results are printed out within 48 hours and sent to consultant's secretary in the internal mail
- On receipt results are filed waiting for consultant's admin day to review
 - **Delays of between 4 to 12 days**
- After results review, patient/GP letters are written to discharge patient or follow-up is arranged
- For follow up, secretaries check available appointments and notify Health Records

Process Redesign:

- Updateable report developed enabling Trackers to identify verified reports on a daily basis
- Secretaries now being trained as part of a PDSA cycle to use this report and access the Radiology reporting system to identify the status of the diagnostic request
- Reports ready are flagged to consultants quickly for review
- Report also highlights future appointments to simplify follow-up booking processes

Improvements:

- Clinical Pathways being reduced by 4 to 12 days (min)
- Clinical decision made earlier and communicated to both patient and GP

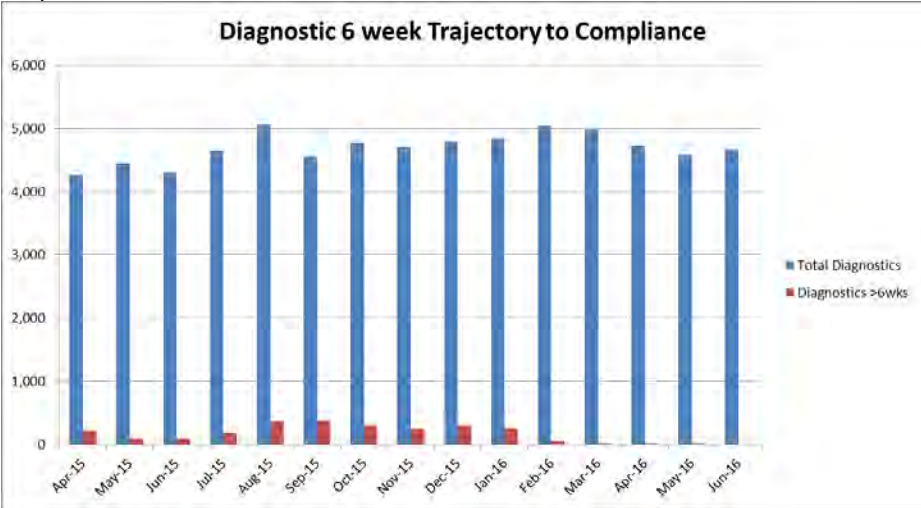
- Supports timely 18 week 'clock stops' where patients are discharged
- Secretaries having all the information on one report to support streamlined patient pathways

Next Steps:

- Continue training and rollout of process
- Extend process to link to follow up database

4.7 Diagnostic 6 Week Wait Trends

Graph 13



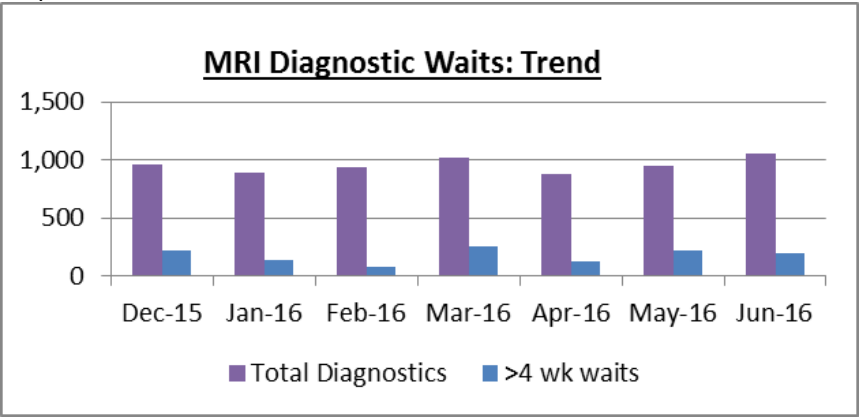
Overall the diagnostic waiting list last year but the numbers waiting over 6 weeks has been eliminated. Ongoing additional capacity is being provided in Endoscopy and Radiology. A recent increasing trend has been seen in the MRI waiting list. Of particular note is the improvement project in Cardiology to improve processes and support appropriate demand management. There has been a reduction in the Echocardiography waiting list and also a significant reduction in agency staffing costs. This is a positive example of taking a holistic approach to an area that is a national, perennial problem service, applying the Trust

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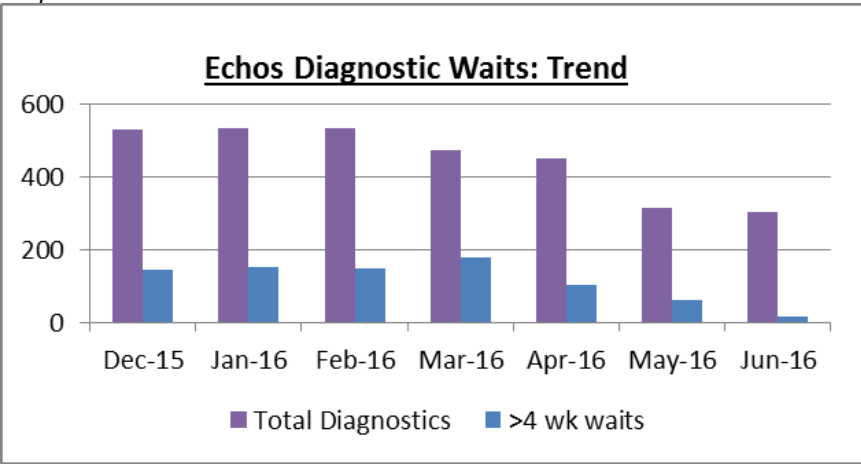
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values and dedicated focus by Paula Rayson, to significantly improve a service. (See graph 15).

Graph 14



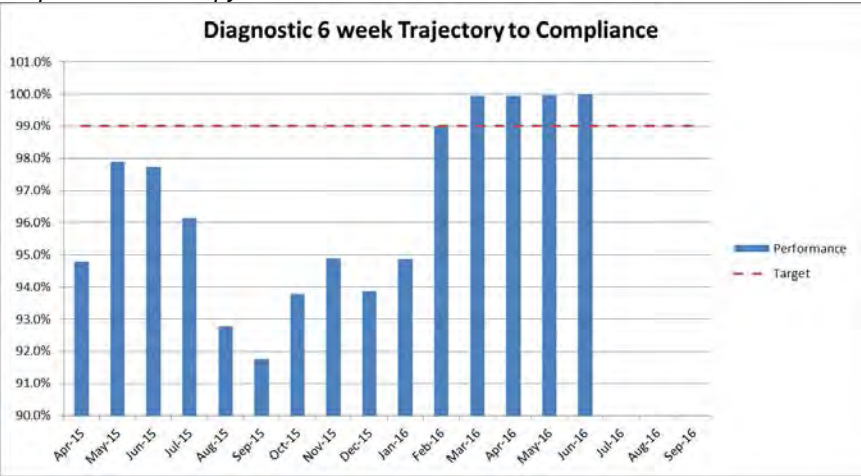
Graph 15



Endoscopy

The work in Endoscopy during late 2015 which incorporated significant improvements to booking and scheduling processes, as well as additional internal and insourced capacity, resulted in a return to compliance against the Diagnostics 6ww (end of month) target.

Graph 12 - Endoscopy 6 Week Performance



The Endoscopy demand and capacity tool is currently being reviewed, particularly in light of medical staff turnover in the coming months. Weekly team meetings attended by lead clinicians continue in order to keep close management of the waiting list. Actions include arranging additional capacity as well as reviewing cases and list utilisation. We are also participating in the Wessex SCN Diagnostics demand and capacity project to allow benchmarking and learning.

4.8 Diagnostics New Weekly PTL

From 20 July, Trusts have been requested to submit weekly Patient Tracking List (PTL) reports (waiting list summaries) to NHS Improvement. This is to support the national focus on reducing diagnostic waits to support cancer, RTT and GP direct access pathways. Further information will be provided in the Board report as this process develops. However, weekly reporting requires more data checking and validation than monthly, so we expect locally and nationally this will take some time for the data robustness to develop.

4.9 Cancelled Operations

The Trust generally performs well in terms of minimising cancelled operations and on rebooking within 28 days. In Q4 we were amongst the best in the country for 28 day rebooking with no breaches. YTD we currently remain well within our contractual 0.7% target, at 0.45% of total elective admissions.

One 28-day breach was reported in June. As a result a process improvement has been made in theatres to ensure list outcomes are recorded on the system within 24 hours to ensure timely reporting of patients cancelled on the day. This will facilitate early action to rebook.

5. Recommendation

The Board is requested to note the performance and exceptions to the Trust's compliance with the 2016/17 STF, Monitor Framework and contractual requirements, and the overall strong performance.

The Board is also asked to consider the NHSI Single Oversight consultation document.

The Board is also requested to note the detailed report on RTT and Diagnostics performance and support the ongoing actions for recovery, where this is required in certain specialities.

Overall the Trust is one of a handful nationally which met all 4 of the key STF metrics, as well as performing strongly on all other indicators. The dedication of the staff to achieving such excellent care for our patients should be noted.

Single Oversight Framework Consultation

June 2016



About NHS Improvement

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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1. Context

In recent years, the NHS has achieved improvements in care and delivered efficiencies during a time of increasing financial pressure caused by slowing growth in the NHS budget and rising demand. The need to respond effectively to this continuing increase in demand during a period of limited funding growth was the key impetus for the [NHS Five Year Forward View](#) (5YFV).

Part of the national response to the ambitious and stretching tasks highlighted in the 5YFV was to create NHS Improvement, reflecting that NHS trusts and foundation trusts face similar challenges. On 1 April 2016, NHS Improvement became the operational name that brings together Monitor, the NHS Trust Development Authority (TDA), Patient Safety, the Advancing Change Team and Intensive Support Teams. The specific legal duties and powers of Monitor and TDA persist.¹ We will build on the best of what these organisations did but with a change of emphasis to one primarily focused on helping NHS trusts and foundation trusts to improve. We will provide strategic leadership, oversight and practical support for the trust sector.

We will support NHS trusts and foundation trusts² to give patients consistently safe, effective, compassionate care within local health systems that are financially and clinically sustainable. We will work alongside providers, building deep and lasting relationships, harnessing and spreading good practice, connecting people, and enabling sector-led improvement and innovation. We will stimulate an improvement movement in the provider sector, helping providers build improvement capability, so they are equipped and empowered to help themselves and, crucially, each other. Our aim is to help providers attain, and maintain, Care Quality Commission (CQC) ratings of 'Good' or 'Outstanding'.

The challenges facing the system require a joined-up approach and increased partnership between national bodies. We are committed to working more closely with the CQC, NHS England and other partners, at national, regional and local levels.

2. This consultation

This document sets out the approach NHS Improvement proposes to take in overseeing providers using a Single Oversight Framework for both NHS trusts and

¹ NHS Improvement will be clear on which duties and powers of Monitor and the TDA it is exercising at both Board and executive level. Non executive positions are joint and the executive decision-making structure accommodates appropriately constituted committees to enable the exercise of respective functions.

² For the purposes of this document and our framework, we will use the term 'providers' to mean NHS trusts and NHS foundation trusts. This document does not apply to Independent Sector Providers: *The Risk Assessment Framework for Independent Providers* (available at <https://www.gov.uk/government/publications/risk-assessment-framework-independent-sector-providers-of-nhs-services>) covers our statutory duty to assess financial risk at those organisations where they provide Commissioner Requested Services (CRS).

foundation trusts and shaping the support we provide. It describes our proposed approach to:

- the main areas of focus of our oversight
- how we will collect the information we require from providers
- how we will identify potential concerns with a provider's performance
- how we will segment the provider sector according to the level of challenge each provider faces.

The purpose of this framework is to identify where providers may benefit from, or require, improvement support across a range of areas (see below). This will inform the way we work with each provider. This framework does not detail the improvement support we will provide as in each case this will be individually tailored to address what a provider needs help with. We ask a number of specific questions on our proposed approach through the document, and these are collected together in Section 8 and at the survey website (see below for link).

We are still considering our approach to oversight in a number of areas, including how well a provider is managing strategic change, and we are using this exercise to invite views on how we should proceed.

The Single Oversight Framework will replace Monitor's risk assessment framework and TDA's Accountability Framework. It is a 'Single' Oversight Framework because it applies to both NHS trusts and foundation trusts. As far as possible, we will combine and build on the previous approaches of Monitor and TDA, but adapt them to reflect and enable our primary improvement role. Any changes from these frameworks are intended to be as much as possible incremental in nature. The changes we are making are intended to reflect the challenges providers face and initiatives to support them. All other related policies and statements, unless indicated, remain unchanged.

The Single Oversight Framework set out in this document reflects the continuing statutory duties and powers of Monitor with respect to NHS foundation trusts and of TDA with respect to NHS trusts (whereby the TDA exercised functions via directions from the Secretary of State).

Alignment with CQC

CQC sets out what good and outstanding care looks like, asking five key questions of all care services: Are they safe, are they effective, are they caring, are they responsive to people's needs, and are they well-led? These questions will be supplemented by a forthcoming assessment of the use of resources being jointly developed by CQC and NHS Improvement.

NHS Improvement will support providers in attaining and/or maintaining a CQC 'good' or 'outstanding' rating, covering the areas listed above. We will do this by focusing on five themes. As set out in the next section, these five themes are linked to CQC's key questions, but are not identical to those questions. This is because: CQC's questions do not yet incorporate use of resources; we have a particular role in supporting improvement in performance against the NHS Constitution standards for patients; and because our approach to improvement incorporates the strategic changes within local health economies that will be needed to assure high-quality services in the longer term.

We will continue to work with CQC to align our approaches more fully as we move towards a single combined assessment of quality and use of resources. We welcome views on this as part of the consultation.

Lord Carter's report, *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*³, recommended the development of an integrated performance framework to ensure there is a single set of metrics and approach to reporting, reducing the reporting burden in order to allow providers to focus on improving quality and efficiency. In line with this recommendation, we are working with the CQC and with the provider sector to ensure that we draw on a single, shared set of metrics both to review performance and to decide where to target support or oversight.

Responding to the consultation

We are looking forward to collecting the views of providers and stakeholders on our proposals. We ask all interested parties and stakeholders to respond to the consultation by **5pm on 4 August 2016**. To do so please use the survey link: <https://www.surveymonkey.co.uk/r/JBCFCMY>. If you have trouble accessing this please email us at NHSI.singleoversightframework@nhs.net. During the consultation period we will run engagement events to (i) get views, answer queries and clarify points; and (ii) get more detailed input from the sector on certain areas.

Confidentiality

Please let us know if your response is in confidence. Your name and/or that of your organisation will then not be given in our published summary of responses.

If you would like just part of your response (instead of or as well as your identity) to be confidential, please make this obvious by marking those parts we should keep confidential.

³ Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

We will do our best to meet all requests for confidentiality, but because we are a public body subject to freedom of information legislation we cannot guarantee that we will not be obliged to release your response (including potentially your identity) or part of it even if you say it is confidential.

3. Summary of our proposed approach to overseeing providers

NHS Improvement will use the new oversight framework to identify where providers need support in any of five areas (which we will refer to as themes):

- **Quality of care:** we will use CQC's most recent assessments of whether a provider's care is **Safe, Caring, Effective** and **Responsive**, in combination with in-year information where available. We will also include delivery of the four priority standards for 7 day hospital services.
- **Finance and use of resources:** we will oversee a provider's financial efficiency and progress in meeting its financial control total. We are co-developing this approach with CQC.
- **Operational performance:** we will support providers in improving and sustaining performance against NHS Constitution and other standards. These will include A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, and access to mental health services.
- **Strategic change:** working with system partners we will consider how well providers are delivering the strategic changes set out in the 5YFV, with a particular focus on their contribution to Sustainability and Transformation Plans (STPs), new care models, and, where relevant, implementation of devolution.
- **Leadership and improvement capability:** building on the joint CQC and NHSI well-led framework, we will develop a shared system view with CQC on what good governance and leadership looks like, including organisations' ability to learn and improve.

By focusing on these five themes we will support providers to improve to attain and/or maintain a CQC 'good' or 'outstanding' rating. Quality of care, finance and use of resources, and operational performance relate directly to sector outcomes. Leadership and improvement capability is crucial in ensuring that providers can deliver sustainable improvement. Strategic change recognises that organisational accountability and system-wide collaboration are mutually supportive.

We welcome the sector's views on how we can most effectively align NHS Improvement's approach to support and oversight with CQC's framework for assessing providers.

Consultation question 1: What should we consider in seeking to ensure NHS Improvement and CQC's frameworks are as aligned as possible?

The Single Oversight Framework

NHS Improvement's Single Oversight Framework is intended to:

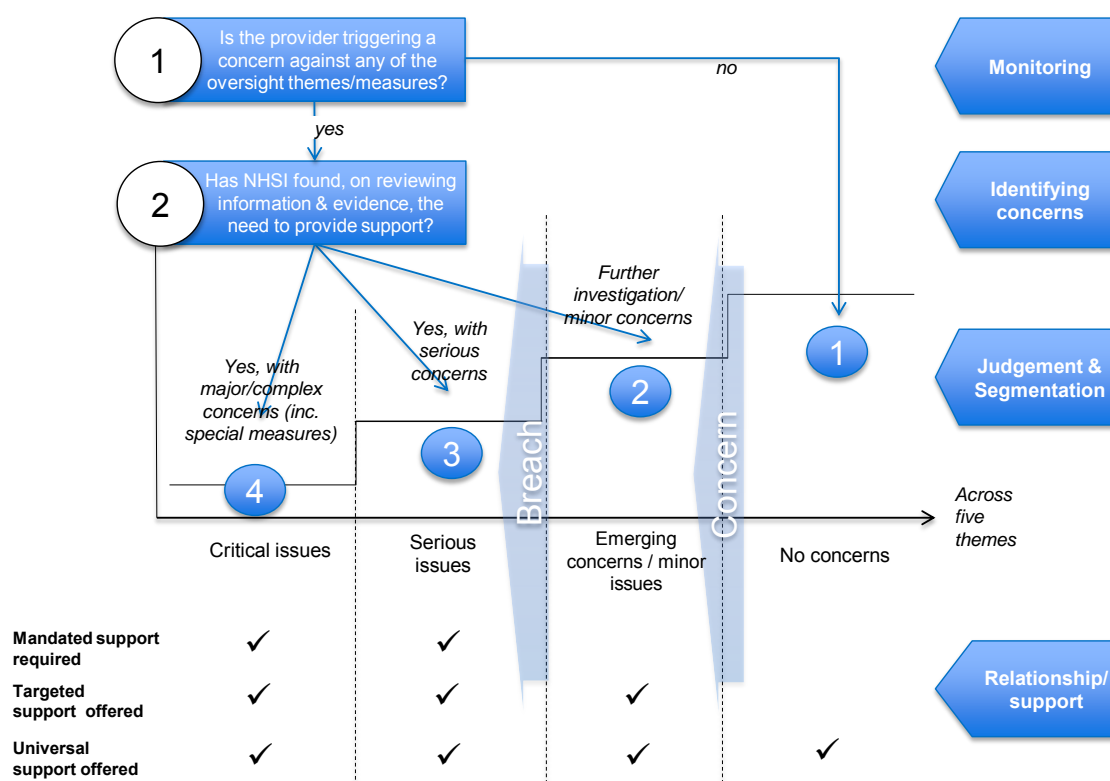
- provide one framework to oversee providers, irrespective of their legal form
- help us identify problems, and risks of problems, as they emerge
- pinpoint the source of the problem, allowing us to tailor our support packages to the specific needs of providers and local health systems. These packages will draw on expertise from across the sector as well as within NHS Improvement.

NHS Improvement will need to be flexible in how it carries out its role. For example, we may need to respond quickly and proactively to unexpected issues in individual providers or sets of providers, or to policy changes at a national level. We may, therefore, from time to time, adjust our approach, for example:

- add/remove some metrics from our oversight of providers
- increase the frequency of our data collection
- act sooner than the general threshold set in the framework.

We propose to segment the provider sector according to the scale of issues faced by individual providers. This will be informed by data monitoring and, importantly, judgement based on an understanding of providers' circumstances. Figure 1 sets out

Figure 1: Summary of our approach



The segment a provider is in will determine the nature of the support we provide. While this will be tailored to the circumstances of providers, we have identified three broad categories of support for providers – universal offers, targeted offers and mandated – which will link to the segment they are in – see section 7.

Segmentation does not in itself constitute an assessment of provider performance. NHS Improvement teams will work with providers to determine the appropriate, tailored, support package for each, including directly provided support and support facilitated by, for example, other parts of the sector.

The legal basis for actions in respect of NHS trusts and NHS foundation trusts remains unchanged. This means that, for example, a foundation trust will only be in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence. Mandated support for foundation trusts⁴ continues to follow existing policy set out in the Enforcement Guidance.⁵

3.1. Other considerations

The NHS Provider Licence

The statutory obligations of Monitor and TDA continue within NHS Improvement. Therefore, NHS Improvement must ensure the operation of a licensing regime over all eligible NHS providers. The [NHS provider licence](#)⁶ forms the legal basis for Monitor's oversight of foundation trusts and can be found [here](#). While NHS trusts are exempt from the requirement to apply for and hold the Monitor provider licence itself, Directions from the Secretary of State require TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

The Single Oversight Framework applies equally to NHS foundation trusts and NHS trusts, and we aim to treat all providers in comparable circumstances similarly unless there is sound reason not to. Consequently NHS Improvement will base our oversight of all providers – NHS trusts and foundation trusts – on the conditions of the NHS provider licence.⁷

⁴ Based on s.105, s.106 or s.111 of the Health and Social Care Act 2012

⁵ We will look to update the Enforcement Guidance in due course and consult as appropriate

⁶ <https://www.gov.uk/government/publications/the-nhs-provider-licence>

⁷ For the most part, this is likely to entail holding providers to account against the standards in condition FT4 – the NHS foundation trust governance condition, but our scope extends to the entire NHS provider licence (see www.gov.uk/government/publications/the-nhs-provider-licence). For completeness it should be noted that NHSI has functions and powers in addition to those stemming from the Monitor provider licence in relation to both NHS Trusts and Foundation Trusts and the Single Oversight Framework does not cover these additional matters.

4. Monitoring providers

We will use information from our data monitoring processes to identify where providers are triggering a potential concern in one or more of the five themes (which indicates they are not in segment 1 and may benefit from support) and judgement, based on consistent principles, to determine whether or not they are in breach of licence – or the equivalent for NHS trusts – and, if so, whether the issues are serious or very serious/complex.

We will collect information on providers (see Figure 2) – either directly or from third parties. We will seek to ensure that the collection burden is proportionate and, where possible we will use nationally available information.⁸ We will collect, for example:

- regular financial and operational information
- annual plans
- third-party information
- any ad-hoc or exceptional information that can be used to oversee providers according to the five themes.

Figure 2: Summary of information requirements for monitoring

	In-year	Annual/ less frequently	Ad hoc
Quality of care	In-year quality information to identify any areas for improvement (see Appendix 2)	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters
Finance & Use of Resources	Monthly returns	Annual plans	One-off financial events (eg sudden drops in income/ increases in costs) Transactions/mergers
Operational performance	Monthly/quarterly(in some cases weekly) operational performance information (see Appendix 3)		Any sudden & unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of Sustainability and Transformation Plans (STPs) Progress of any new care models, devolution plans	Sustainability and Transformation Plans (STPs)	Any sudden & unforeseen factors driving a significant failure to deliver
Leadership & improvement capability	Third-party information with governance implications ¹ Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff & patient surveys Third-party information with governance implications ¹	Findings of well-led reviews Third-party information with governance implications ¹

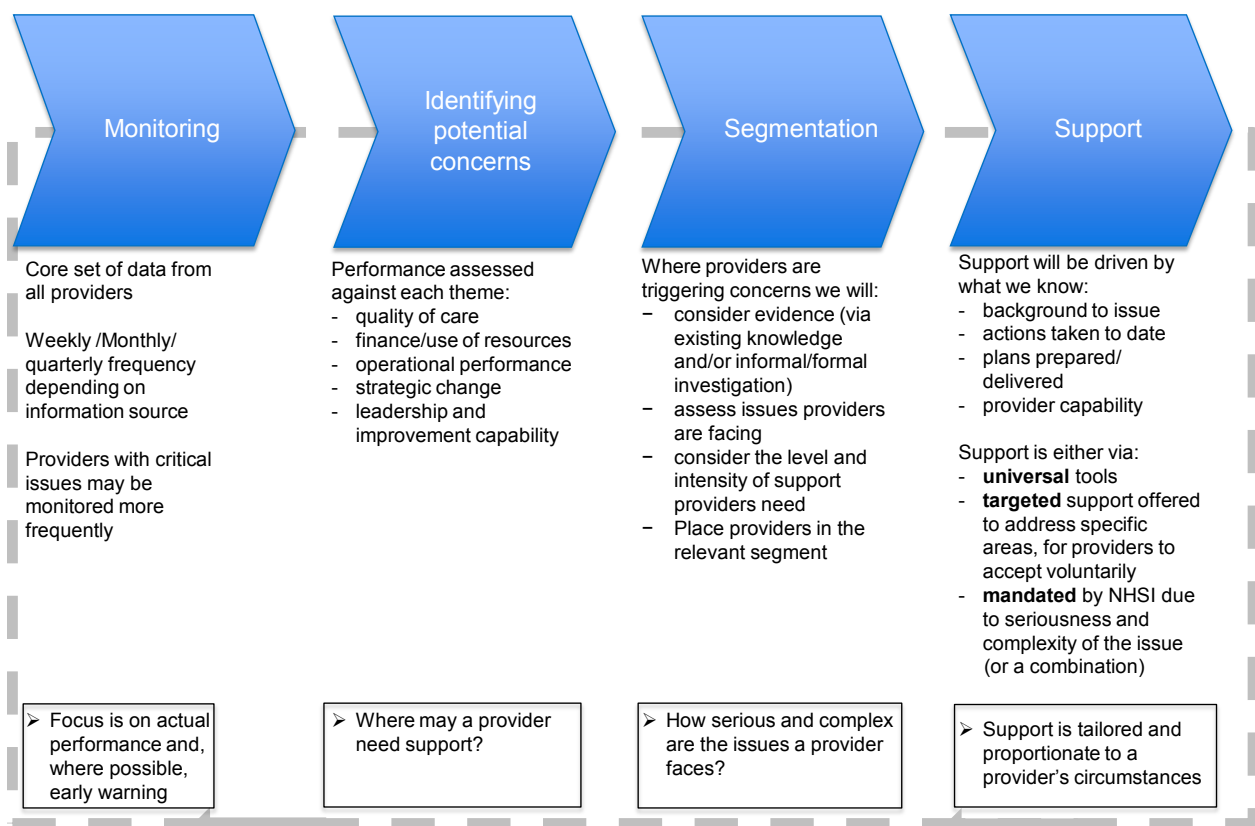
¹ eg reports from Quality Surveillance Groups (QSGs), GMC, Ombudsman, CCGs, Healthwatch England, auditors, Health & Safety Executive, Patient groups, complaints, whistleblowers, Medical Royal Colleges

Collection will be:

⁸ Eg in reviewing performance against national targets and standards.

- **in-year:** following a regular in-year monitoring cycle (see Figure 3), using weekly/monthly/quarterly/six-monthly collections as appropriate
- **annual:** using annual provider submissions (eg Annual Plans, Annual Statements on Quality) or other annually published data (eg staff surveys)
- **ad-hoc/by exception:** NHS Improvement will be as agile as possible in responding to issues identified at providers. Where material events occur, or we receive information that triggers our concerns outside the regular monitoring cycle, we will consider these in our view as to whether there are potential concerns at the provider and the steps we need to take

Figure 3: NHS Improvement's oversight cycle



During 2016/17, we will use the existing Monitor and TDA oversight templates to collect information. We will give notice of changes to the collection as we develop our processes to gather information from providers.

Consultation question 2:

- (i) Do you agree with our proposed approach to the oversight of providers?
- (ii) Do you consider that regular reporting should be on a weekly/ monthly or quarterly basis? Are there circumstances where oversight should be more or less frequent than these intervals?
- (iii) Do you have any further comments on our overall approach?

5. Identifying potential concerns

We will use the information we collect on provider performance to identify where providers need support. Our oversight focuses on identifying ‘triggers’ of potential concern in each theme.

Our approach in each theme is set out below and summarised in Appendix 1. Where providers are triggering any of these potential concerns, we will consider the circumstances surrounding the triggers to determine the nature of any support required. Practically, we are likely to consider:

- the **extent** to which the provider is triggering a potential concern
- any **associated circumstances** the provider is facing
- the degree to which the provider **understands what is driving the issue**
- the provider’s **capability** and the **credibility of plans it has developed** to address the issue
- the extent to which the provider **is delivering against a recovery** trajectory.

We will engage with providers on an ongoing basis. When providers trigger potential concern, we will consider whether the level of interaction needs to change to monitor the issue and the provider’s response to it. How we propose to identify potential concerns against each theme is set out below.

5.1. Quality of care

Where CQC’s assessment identifies a provider as ‘inadequate’ or ‘requires improvement’ against any of the **Safe, Caring, Effective or Responsive** key questions, this will represent a potential concern and we will consider what support is appropriate for the provider.

We will supplement CQC’s inspection findings with warning notices, any civil or criminal actions or changes to registration conditions to ensure that we use the most up to date CQC views of quality and also that their views on quality at providers yet to be inspected can be incorporated.

In a continuation of TDA’s approach, we will use a number of additional in-year quality-related metrics to identify emerging issues and/or scope for improvement at providers – see Appendix 2. If necessary, we will use this information to identify any improvement needs and support needed.

In addition we will oversee delivery of 7 day hospital services across providers in order to identify where organisations need support. This will include assessing whether providers are delivering against an agreed trajectory to meet the four priority standards for 7 day hospital services. We may, in time, extend this to monitoring other 7 day services standards and metrics where appropriate.

Consultation question 3:

- (i) Do you agree with our proposed approach to overseeing quality of care?
- (ii) Given our and CQC's respective roles in the NHS, are there other approaches we could consider?
- (iii) Are there other ways in which we could use this framework to identify where providers may need support to meet 7 day services requirements?
- (iv) Do you have any further comments on our proposed approach to overseeing quality of care?

5.2. Finance and use of resources

We will oversee and support providers in improving financial sustainability, efficiency and controls relating to high profile policy imperatives such as agency staffing, capital expenditure and the overall financial performance of the sector. We are, with CQC, co-developing the approach to overseeing providers' use of resources. This builds on the approaches taken by Monitor and TDA, which aimed to identify financial distress rapidly, while introducing a greater focus on efficiency as recommended by the Carter Review. As the Model Hospital develops, we may include further efficiency metrics in the Single Oversight Framework.

We propose to use financial metrics to oversee financial performance (see Table 1) by:

- scoring providers 4 (poorest) to 1 (best) against each metric (see Figure 4)
- using provider performance average across all the metrics to arrive at an overall view of the provider.⁹

Identifying potential financial concerns

Providers scoring 4 or 3 against this overall financial assessment will trigger a potential concern, as will providers scoring a 4 (ie significant underperformance) against **any** of the individual metrics.¹⁰

⁹ Scores are rounded to the nearest whole number. Where a provider's score is exactly in between two whole numbers, it is rounded to the lowest whole number (eg both 2.2' and 2.5 are rounded down to 2). This follows Monitor's prior approach where financial scores were rounded positively, ie towards the 'best' score for providers, which in the Single Oversight Framework is lower.

¹⁰ The best overall score a provider scoring '4' for any of the individual metrics can obtain is a '3'

Table 1: Finance and Use of Resources Metrics

Metric	Rationale/considerations
Capital Service Capacity	Assess how much financial headroom providers have over interest or other capital charges (eg PFI payments).
Liquidity	Assess providers' short-term financial position, ie their ability to pay staff and suppliers in the immediate term.
Distance from control total or financial plan	As part of our role in providing sector-wide financial oversight, we are working with providers to agree control totals that will help the sector achieve financial balance. We will track providers' positions against these through the year.
EBITDA ¹¹ margin	Assess providers' operating efficiency independent of capital structure or other factors.
Cost/Weighted Activity Unit - efficiency metrics (to be run in shadow form in 2016/17 – we will track but not incorporate in the financial rating)	<p>We are introducing a proposed efficiency metric, cost per weighted activity unit (WAU), developed as part of the Carter Review. This estimates provider efficiency by measuring the average cost of an average episode of care, taking into account different types of treatments (HRGs) and modes of delivery (eg elective, outpatient).</p> <p>The metric relates to a provider's efficiency improvement and will exclude factors that affect costs but are outside its control. Because reference costs are reported annually, we will use different, more frequently reported, activity and cost datasets to calculate in-year costs per WAU¹²</p>
Capital Controls (as above, to be run in shadow form in 2016/17)	NHS Improvement has a responsibility to ensure that capital expenditure remains within the system's means and we will track providers' positions against their set capital limits over the year.
Agency spend (as above, to be run in shadow form in 2016/17)	Monitor and TDA introduced controls on agency spend in 2015 in response to the sharp increases in agency costs seen since 2012. We will continue to track agency spending at providers. Where we have potential concerns, we will consider how best to support the provider in addressing them.

Broader value for money considerations

In addition to using the metrics above, we may investigate whether there is, more broadly, sufficient evidence to suggest inefficient and/or uneconomical spending at a provider. Such spending may indicate that a provider is failing to operate effectively

¹¹ Earnings Before Interest, Tax, Depreciation and Amortisation

¹² The data in these datasets are already provided by providers. There is therefore no new additional reporting burden associated with the calculations.

systems and/or processes for financial management and control, and not operating economically, efficiently and effectively.

Such evidence would come from, for example, published national benchmarking. We will notify the sector when appropriate benchmarks become available nationally. We may also look at whether a provider is delivering good practice with respect to value for money, for instance regarding management consultancy spend. In the absence of appropriate benchmarks we may still consider investigating a provider if there is material evidence to suggest it is delivering poor value for money.

Figure 4: Financial rating metrics

Area	Metric	Definition	Score			
			1	2	3	4 ¹
Financial sustainability	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	EBITDA margin	EBITDA/total revenue	≥5%	3-5%	0-3%	≤0%
	Change in Cost per Weighted Activity Unit²	Assessing provider efficiency by measuring its average cost increase for an average episode of care (smaller is better)	≤1.1%	1.1%-2.1%	2.1%-3.1%	>3.1%
Financial controls	Capital controls²	Distance above capital control total	<5%	0-5%	5-15%	≥15%
	Distance from Control Total or financial plan	Providers with control totals: Ytd actual surplus/deficit vs. Ytd trajectory Providers without control totals: Ytd actual I&E surplus in comparison to the Ytd plan I&E surplus ²	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	Agency spend²	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Note: brackets indicate negative numbers

¹ Scoring a '4' on any metric will cap the overall rating to at most 3, triggering a concern.

² To be used on a shadow basis - ie monitored not evaluated - in 2016/17.

Phasing in the new metrics

We propose to use three of these metrics – change in cost/weighted activity unit, capital controls and agency spend – in 'shadow' form during 2016/17. As a result, we will not use those in calculating providers' average financial score during 2016/17, nor will scoring a 4 against the thresholds for these metrics lead to an override. This will allow us to assess the quality of data underpinning them and calibrate them across providers. We can then consider how best to introduce them formally in 2017/18. For 2016/17 our oversight for the purpose of identifying a potential financial concern will be based on the remaining four metrics in Figure 4.

Consultation question 4:

- (i) Do you agree with our proposed approach to overseeing finance and use of resources?
- (ii) Do you agree with the chosen metrics?
- (iii) Do you agree with the proposal to weight the metrics equally, or should some, eg distance from control totals and change in cost/WAU receive a higher weighting?
- (iv) Are there any other metrics you consider we should use?
- (v) Do you agree with our proposed approach to phasing in three of the metrics (change in cost/weighted activity unit, agency controls, capital expenditure controls) above?
- (vi) Do you have any further comments on overseeing finance and use of resources?

5.3. Operational performance

We will track providers' performance against, and support improvements in, a number of NHS Constitution standards and other metrics. Rather than require providers to make bespoke data submissions, wherever possible we will use nationally collected and evaluated datasets. Appendix 3 lists the metrics we propose to use and their collection frequency across acute, mental health, ambulance and community providers. We may revise this list – introducing new metrics or varying the collection frequency – as necessary and appropriate, particularly as the Model Hospital work develops. We will consider whether a potential concern has been triggered if:

- for a provider with one or more agreed Sustainability and Transformation Fund trajectories against any of the metrics in Appendix 3: it fails to meet any trajectory for at least **two consecutive months**
- for a provider with no agreed Sustainability and Transformation Fund trajectory against any metrics: it fails to meet a relevant target or standard in Appendix 3 for at least **two consecutive months**
- where other factors (eg a significant deterioration in a single month, or multiple potential concerns across other standards and/or other themes) indicate we need to get involved **before two months have elapsed**.

We will then consider the nature of the issues and use this to identify the appropriate segment for the provider (see below) and develop the support offer.

Consultation question 5 :

- (i) Do you agree with our proposed approach to overseeing operational performance?**
- (ii) Do you agree with the metrics proposed in Appendix 3?**
- (iii) Are there other metrics or approaches we should also consider?**
- (iv) Do you have any further comments on overseeing operational performance?**

5.4. Strategic change

The 5YFV sets out the agenda for the change necessary to support a sustainable NHS. We will consider the extent to which providers are working with local partners to address local challenges and improve services for patients. This will include their contribution to developing, agreeing and delivering Sustainability and Transformation Plans (STPs) as well as in some cases the implementation of new care models and implementation of devolution.

To begin with we will use our forthcoming STP assurance process and associated reviews of STPs as our principal approach to oversight of this theme across providers. We are working with NHS England to develop a consistent approach and are likely to consider:

- providers' relationships with local partners
- their plans (including STPs they are involved in)
- how far these plans have been implemented.

We have published draft guidance on how we expect well-led providers to work with partners and collaborate locally to improve the quality and sustainability of services for patients.¹³ In this guidance we set out the expectation that providers should be engaging constructively with local partners to

- build a shared understanding of local challenges and patient needs
- design and agree solutions
- implement improvements.

It will be important in our oversight and our support offer to acknowledge the interplay between individual provider outcomes and delivery of aggregate outcomes

¹³ Available at www.improvement.nhs.uk/uploads/documents/Guidance_on_good_governance_in_a_LHE_context_final.pdf

across a local health economy. As we are still developing our approach under this theme, we invite input from the service on what other information we should collect and how we could identify where a provider may need support in this area. We will look to hold engagement events on this theme during the consultation period.

Consultation question 6: What should we consider to identify potential issues and/or potential support needs in the area of Strategic change?

5.5. Leadership and improvement capability

Shared standards of governance were set out in the NHS foundation trust governance condition (FT4), TDA Accountability Framework as well as TDA general objective (which covers much of the same ground as FT4). We expect providers to demonstrate three main characteristics as part of this theme:

1. **Effective boards and governance:** We will use a number of information sources to oversee provider leadership as used previously by Monitor and TDA, including:
 - information from third parties
 - staff/patient surveys
 - organisational metrics
 - information on agency spend
 - CQC 'well-led' assessments.

We will also draw on the existing well-led framework and associated tools to identify any potential concerns with the governance and leadership of a provider. Many providers have already used this framework to assess their governance.

2. **Continuous improvement capability:** We are working with CQC to consider how the current shared well-led framework needs to evolve to better reflect the theme of improvement.
3. **Use of data:** Effective use of information is an important element of good governance. Well-led providers should collect, use and, where required, submit robust data. Where we have reason to believe this is not the case, we will consider the degree to which providers need support to do so in this area.

Our approach in 2016/17

We will review our approach to leadership and well-led, working with the CQC. In the meantime, we propose using the same information previously collected by Monitor and TDA, augmented by other information where available, to identify potential leadership concerns at individual providers. These can provide early warnings of issues that have yet to manifest themselves in, for example, quality issues or financial underperformance, as well as evidence of serious governance failings.

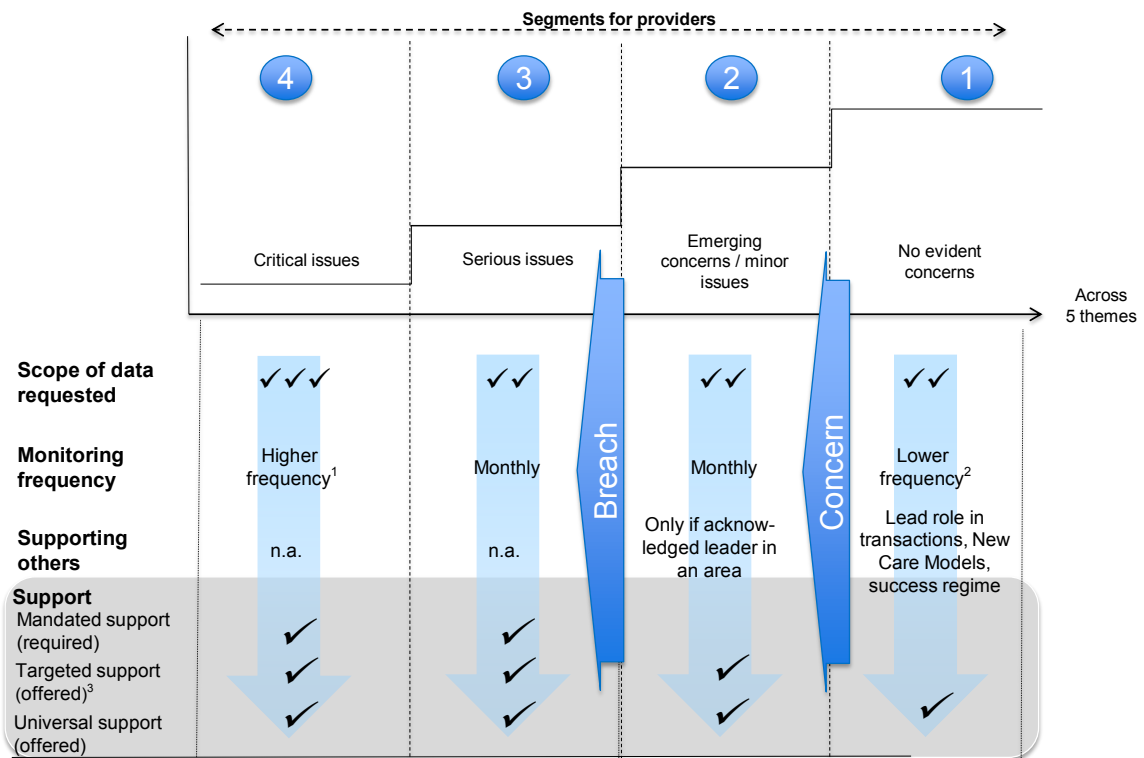
Consultation question 7:

- (i) Do you agree with our proposed approach to overseeing providers' leadership and improvement capability?**
- (ii) Are there other factors we should incorporate to identify where providers may require support?**
- (iii) Do you have any further comments on overseeing leadership and Improvement capability?**

6. Segmentation and the segmentation process

Segmentation helps NHS Improvement determine the nature of the appropriate support relationship with a provider (see Section 7). It does not give an overall assessment of a provider's performance, for which the CQC's rating is the benchmark; nor does it determine the specifics of the support package needed, which is tailored by teams working with the provider in question. We propose segmenting the sector into four, depending on the extent of any issues identified in the oversight process.

Figure 5: Segmenting the provider sector



¹ Where necessary

² Where appropriate

³ Or requested by providers

Segment	Description
1	No potential concerns identified across our five themes – lowest level of oversight
2	Triggering criteria of concern in one or more of the five themes – but not in breach of licence (or equivalent for NHS trusts) and/or formal licence action not needed
3	Serious issues – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	Critical issues - the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues (eg including providers requiring major intervention on multiple issues to return to sustainable performance).

6.1. Segmentation process

The segment a provider is placed in will reflect, in our judgement, the seriousness and complexity of the issues it faces. We will base our decision on the appropriate segment for a provider by:

- considering all available information on providers – both obtained directly and from third parties
- identifying those providers with one or more triggers of potential concern
- using our judgement, based on relationship knowledge and/or the findings of formal or informal investigations, consideration of the scale of the issues faced by a provider and whether it is in breach or suspected breach of licence conditions.

Providers will then be segmented as follows:

- no potential concerns identified (per section 5 of this document): **segment 1**
- provider in licence breach (or equivalent for NHS trusts): **segment 3 or 4** depending on the seriousness and/or complexity of the issues faced
- provider not in breach but still triggering a potential concern: **segment 2**.

Segmentation needs to be as timely and rigorous as possible, without becoming a bureaucratic or complex process. We plan to carry out a segmentation exercise before going live with this new framework, identifying which segment a provider is in at the time the framework goes live. Subsequently, where our in-year, annual or ad-hoc monitoring of a provider flags a potential concern, we will review the provider's situation and consider whether we need to change its allocated segment.

In parallel with the development of the framework, we will consider providers' incentives to be in segment 1. While some conditions are fixed across the sector (eg control totals) others could vary from segment to segment in accordance with the principle of earned autonomy.

Consultation question 8:

- (i) Do you agree with our proposed approach to segmentation?
- (ii) Do you have any further comments on segmentation?

7. Our support of providers

While outside the scope of the Single Oversight Framework itself, our teams will co-ordinate and oversee tailored support for providers, to support sustainable improvement. Segmentation informs the oversight and support relationship we have with each provider, but does not determine the support package, which will be tailored to a provider's particular situation.

The support offered will be provider specific but we envisage that it will fall into three categories:

- **universal support offer** – tools that providers can draw on if they wish to improve specific aspects of performance. Optional for providers to draw on.
- **targeted support offer** – support to help providers with specific areas – eg intensive support teams to help in emergency care or agency spend. Programmes of targeted support will be agreed with providers. This support is offered to providers – its use is voluntary.
- **mandated support** – where a provider has complex issues, we may prepare a directed series of improvement actions to help it, eg appoint an improvement director, or agree a recovery trajectory and support providers to deliver this. In these serious and critical cases, providers are required to comply with NHS Improvement's actions/expectations.

Table 2 below outlines how these types of support link to the segment a trust is in.

Table 2: Support offer by segment

Segment	Relationship with provider
1 No concerns	Universal support <ul style="list-style-type: none"> • eg tools, guidance, benchmark information • made available for providers to access
2 Emerging issues/ minor concerns	Universal support (as for segment 1) Targeted support as agreed with the provider <ul style="list-style-type: none"> • to address issues and move the provider to segment 1 • either offered to provider (and accepted voluntarily) or requested by provider
3 Serious issues	Universal support (as for segment 1) Targeted support as agreed with the provider (as for segment 2) Mandated support as determined by NHS Improvement <ul style="list-style-type: none"> • to address specific issues, move the provider to segment 2 or 1 • compliance required
4 Critical issues	Universal support (as for segment 1) Targeted support as agreed with the provider (as for segment 2) Mandated support as determined by NHS Improvement <ul style="list-style-type: none"> • to minimise the time the provider is in segment 4 • compliance required

Consultation question 9 : Do you agree with our proposed approach to supporting providers?

8. Summary of consultation questions

Consultation question 1:

What should we consider in seeking to ensure NHS Improvement and CQC's frameworks are as aligned as possible?

Consultation question 2:

- (i) Do you agree with our proposed approach to the oversight of providers?
- (ii) Do you consider that regular reporting should be on a weekly/ monthly or quarterly basis? Are there circumstances where oversight should be more or less frequent than these intervals?
- (iii) Do you have any further comments on our overall approach?

Consultation question 3:

- (i) Do you agree with our proposed approach to overseeing quality of care?
- (ii) Given our and CQC's respective roles in the NHS, are there other approaches we could consider?
- (iii) Are there other ways in which we could use this framework to identify where providers may need support to meet 7 day services requirements?
- (iv) Do you have any further comments on our proposed approach to overseeing quality of care?

Consultation question 4:

- (i) Do you agree with our proposed approach to overseeing finance and use of resources?
- (ii) Do you agree with the chosen metrics?
- (iii) Do you agree with the proposal to weight the metrics equally, or should some, eg distance from control totals and change in cost/WAU receive a higher weighting?
- (iv) Are there any other metrics you consider we should use?
- (v) Do you agree with our proposed approach to phasing in three of the metrics (change in cost/weighted activity unit, agency controls, capital expenditure controls) above?
- (vi) Do you have any further comments on overseeing finance and use of resources?

Consultation question 5 :

- (i) Do you agree with our proposed approach to overseeing operational performance?
- (ii) Do you agree with the metrics proposed in Appendix 3?
- (iii) Are there other metrics or approaches we should also consider?
- (iv) Do you have any further comments on overseeing operational performance?

Consultation question 6: What should we consider to identify potential issues and/or potential support needs in the area of Strategic change?

Consultation question 7:

- (i) Do you agree with our proposed approach to overseeing providers' leadership and improvement capability?
- (ii) Are there other factors we should incorporate to identify where providers may require support?
- (iii) Do you have any further comments on overseeing leadership and Improvement capability?

Consultation question 8:

- (i) Do you agree with our proposed approach to segmentation?
- (ii) Do you have any further comments on segmentation?

Consultation question 9 :

Do you agree with our proposed approach to supporting providers?

Appendix 1: Summary of triggers of potential concern

Theme	Information used	Triggers
Quality of care	<ul style="list-style-type: none"> • CQC information • Other quality information to inform our view of a provider (see Appendix 2) • 7 day services 	<ul style="list-style-type: none"> • CQC 'inadequate' or 'requires improvement' assessment versus one or more of: <ul style="list-style-type: none"> - 'Safe' - 'Caring' - 'Effective' - 'Responsive' • CQC warning notices • Any other material concerns identified through CQC's monitoring process, eg civil or criminal cases raised • Concerns arising from trends in our Quality Indicators (Appendix 2) • Delivering against an agreed trajectory for the 4 priority standards for 7 day hospital services
Finance	<ul style="list-style-type: none"> • Sustainability <ul style="list-style-type: none"> o Capital Service Cover o Liquidity • Efficiency <ul style="list-style-type: none"> o EBITDA¹⁴ margin o Efficiency metrics • Controls <ul style="list-style-type: none"> o Delivery of control totals or against plan o Capital expenditure controls o Agency spend • Value for money information 	<p>Poor levels of overall financial performance (average score of 3 or 4)</p> <p>Very poor performance (score of 4) in any individual metric</p> <p>Potential value for money concerns</p>

¹⁴ Earnings Before Interest, Tax, Depreciation and Amortisation

Operational performance	<p>NHS Constitution standards</p> <p>Other national targets and standards</p>	<p>For providers with STF trajectories in any metric: failure to meet the trajectory for this metric in more than two consecutive months</p> <p>For providers without STF trajectories: Failure to meet any standard in more than two consecutive months</p>
Strategic Change	Review of Sustainability and Transformation Plans (STPs) and other relevant matters	Material concerns with a provider's delivery against the transformation agenda, including New Care Models and devolution
Leadership and Improvement capability	<p>Findings of governance or well-led review undertaken against the current well-led framework</p> <p>Third party information, eg Healthwatch, MPs, whistleblowers, Coroners' reports</p> <p>Organisational Health Indicators</p> <p>Operational efficiency metrics</p> <p>CQC well-led assessments</p>	<p>Material concerns</p> <p>CQC 'inadequate' or 'requires improvement' assessment against 'Well-led'.</p>

Appendix 2: Proposed quality of care monitoring metrics

Quality indicators for quality surveillance and oversight

The 42 proposed indicators below are those previously used in either TDA's Assurance Framework, Monitor's Risk Assessment Framework or NHS England's quality dashboard. The latter mirrors the CQC Intelligent Monitoring Tool. The primary focus and CQC domain for these indicators are shown.

Proposed indicators

Measure	Type	Frequency	Source
Organisational Health Indicators – all providers			
Staff sickness(2)	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
Staff turnover(2)	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
Executive team turnover (3)	Organisational Health	Monthly	FT return/O&E
NHS Staff Survey	Organisational Health	Annual	CQC (publicly available)
Proportion of Temporary Staff (4)	Organisational Health	Quarterly	FT return
Aggressive Cost Reduction Plans (4)	Organisational Health	Quarterly	FT return
Written Complaints - rate	Caring	Quarterly	HSCIC (publicly available)
Staff Friends and Family Test Percentage Recommended - Care	Caring	Quarterly	NHSE (publicly available)
Never events	Safe	Monthly	NHSE (publicly available)
Never events - incidence rate	Safe	Monthly	NHSE (publicly available)
Serious Incidents rate	Safe	Monthly	StEIS
National Reporting and Learning System (NRLS) medication errors: Percentage of harmful events	Safe	Monthly ⁽¹⁾	NRLS (publicly available)
Proportion of reported patient safety incidents that are harmful	Safe	Monthly	NRLS (publicly available)
Potential under-reporting of patient safety incidents	Safe	Monthly	NRLS (publicly available)
Central Alerting System (CAS) alerts outstanding	Safe	Monthly	NRLS (publicly available)
Acute providers			
Mixed Sex Accommodation Breaches	Caring	Monthly	NHSE (publicly available)
Inpatient Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
A&E Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)

Measure	Type	Frequency	Source
Emergency c-section rate	Safe	Monthly	HES
CQC Inpatient / MH and Community Survey	Organisational Health	Annual	CQC (publicly available)
Maternity Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
Percentage of new Harms	Safe	Monthly	NHSE (publicly available)
VTE Risk Assessment	Safe	Quarterly	NHSE (publicly available)
<i>Clostridium Difficile</i> - variance from plan	Safe	Monthly	PHE (publicly available)
<i>Clostridium Difficile</i> - infection rate	Safe	Monthly	PHE (publicly available)
MRSA bacteraemias	Safe	Monthly	PHE (publicly available)
Hospital Standardised Mortality Ratio (DFI)	Effective	Quarterly	DFI
Hospital Standardised Mortality Ratio - Weekend (DFI)	Effective	Quarterly	DFI
Summary Hospital Mortality Indicator	Effective	Quarterly	HSCIC (publicly available)
Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	Effective	Monthly	HES
Community providers			
CQC Inpatient / MH and Community Survey	Organisational Health	Annual	CQC (publicly available)
Community Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
Percentage of new Harms	Safe	Monthly	NHSE (publicly available)
Mental health providers			
CQC Inpatient / MH and Community Survey	Organisational Health	Annual	CQC (publicly available)
Mental Health Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Admissions to adult facilities of patients who are under 16 years of age	Safe	Monthly	HSCIC (publicly available)
Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
Percentage of new Harms	Safe	Monthly	NHSE (publicly available)

Measure	Type	Frequency	Source
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	Effective	Monthly	HSCIC (publicly available)
% clients in settled accommodation	Effective	Monthly	HSCIC (publicly available)
% clients in employment	Effective	Monthly	HSCIC (publicly available)
Ambulance providers			
Ambulance see and treat from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
Return of Spontaneous Circulation (ROSC) in Utstein group	Effective	Monthly	NHSE (publicly available)
Stroke 60 mins	Effective	Monthly	NHSE (publicly available)
Stroke Care	Effective	Monthly	NHSE (publicly available)
ST Segment Elevation Myocardial Infarction (STeMI) 150 Mins	Effective	Monthly	NHSE (publicly available)

Notes

1. If we use published data NRLS data would be six monthly and publicly available.
2. Historically TDA used ESR and Monitor used HSCIC for these data, hence the difference in frequency in 2016-17
3. These data are readily available for NHS providers.
4. The data for NHS trusts has to be confirmed.

Appendix 3: Proposed operational performance metrics

Standard	Frequency	Standard ¹⁵
Acute and specialist providers¹⁶		
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	Monthly	95%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	92%
All cancers – maximum 62-day wait for first treatment from: <ul style="list-style-type: none"> - Urgent GP referral for suspected cancer - NHS cancer screening service referral 	Monthly	85% 90%
Maximum 6-week wait for diagnostic procedures	Monthly	99%
Ambulance providers¹⁷		
Maximum 8-minute response for Red 1 calls	Monthly	75%
Maximum 8-minute response for Red 2 calls	Monthly	75%
Maximum 19-minute response for all Category A calls	Monthly	95%
Mental health providers¹⁸		
Patients admitted to inpatient services who are given access to crisis resolution / home treatment teams in line with best practice standards (UNIFY2 and MHSDS)	Quarterly	95%

¹⁵ Minimum % of patients for whom standard must be met

¹⁶ NHS Improvement is following the development of indicators to assess the expansion and oversight of liaison mental health services in acute hospitals, including routine analysis of (i) numbers of emergency admissions of people with a diagnosis of dementia; and (ii) length of stay for people admitted with a diagnosis of dementia. These may be incorporated in future iterations of this framework.

¹⁷ We will balance this oversight with the impact of dispatch on disposition and other pilots affecting performance reporting currently underway across ambulance providers

¹⁸ In addition to the Mental Health indicators here, NHS Improvement is following the development of indicators to assess: (i) Access and waiting times for children and young people eating disorder services; (ii) Providers' collection of data on waiting times (decision to admit to time of admission, decision to home-treat to time of home-treatment commencement), Delayed Transfers of Care and Out of area placements(OATS); and (iii) Systems to measure, analyse and improve response times for urgent and emergency mental health care for people of all ages. These may be incorporated in future iterations of this framework.

Standard	Frequency	Standard ¹⁵
People with a first episode of psychosis should commence treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)	Quarterly	50%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas ¹⁹ :	Quarterly	
a) Inpatient wards		90%
b) Early intervention in psychosis services		90%
c) Community mental health services (people on Care Programme Approach)		60%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to the HSCIC:		
• identifier metrics ²⁰	Monthly	95%
• priority metrics ²¹	Monthly	85%
IAPT / Talking Therapies		
Proportion of people completing treatment who move to recovery (from IAPT MDS)	Quarterly	50%
Waiting time to begin treatment (from IAPT MDS)		
- within 6 weeks	Quarterly	75%
- within 18 weeks	Quarterly	95%
Community providers		
Any relevant mental health or acute metrics above		

¹⁹ Board declaration

²⁰ Comprising: NHS number, Date of birth, Postcode, Current gender, Registered GP org code, Commissioner org Code

²¹ Comprising: Ethnicity, Employment status (for adults), School attendance (for CYP), Accommodation status, ICD10 coding. By 2016/17 year-end



Improvement

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NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request.

NHS Improvement – Single Oversight Framework Consultation June 2016

Consultation ends 4 August. Note request from NHS Providers -

As the consultation period is short, closing on **4 August at 5pm**, please send any comments you have to Miriam.deakin@nhsproviders.org by **2 August**. Either Miriam, or our governance advisor, John (john.coutts@nhsproviders.org), or our finance advisor (edward.cornick@nhsproviders.org) would also be equally happy to discuss.

Suggested responses to Operational Performance related questions:

Q2(ii) Do you consider that regular reporting should be on a weekly/monthly or quarterly basis? Are there circumstances where oversight should be more or less frequent than these intervals?

Operational performance metrics – monthly reporting where there are no significant concerns is supported as a principle. However, see response to Q5(i) re clarity required in relation to current quarterly compliance approach for some targets.

Q5 (i) Do you agree with our proposed approach to overseeing operational performance?

Clarity is required on whether ‘a potential concern has been triggered’ if the submitted trajectory is missed for 2 consecutive months but the trust remains within the tolerance (Q2 – 1% and Q3 - 0.5%)

Historically A&E 4 hour and Cancer 62 Day have been required to meet 95% across a quarter, **allowing for variation or exceptional issues that are resolved relatively quickly**. With monthly monitoring, are we moving away from this approach?

Q5 (ii) Do you agree with the metrics proposed in appendix 3?

Due to the target applying to a relatively small proportion of patients, we would recommend that 62 day screening to treatment is excluded from the 62 day target, with all patients included within the overall 62 day metric.

Q5 (iii) Are there other metrics or approaches we should also consider?

We support the metrics as an overview of the existing key areas of operational and access performance affecting the majority of patients receiving care from an acute trust and welcome any reduction in reporting burden to release resource to operational improvement and Carter model hospital review.

Q5 (iv) Do you have any further comments on overseeing operational performance?

Going forward for the future, a review of the targets to better reflect system-wide and pathway changes (e.g. in urgent care networks) should be considered.

Q6.1 (ii) Do you have any further comments on segmentation?

Triggers of 'potential concern' are relatively clear in relation to operational performance metrics and Quality – CQC, however, it is less clear in relation to the broad range of Quality metrics (appendix 2) if/how these will 'trigger' (e.g. will it be a matrix approach).

The 7 Day Services priority standards metrics remain 'untested' and unclear in terms of ongoing development of the national 7DS audits.

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Board of Directors

Meeting Date and Part:	29 th July 2016 Part 1
Subject:	Quality report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Joanne Sims, Associate Director Quality Governance & Risk Ellen Bull, Deputy Director of Nursing and Midwifery
Details of previous discussion and/or dissemination:	Board of Directors 29 July 2016
Action required: Discuss/Information	The Healthcare Assurance Committee is invited to discuss the Trust's quality performance; to note the improvements which have been made and areas for focus which will be presented to the Board of Directors for information.

Executive Summary:

This report provides a summary of information and analysis on the key quality performance indicators, linked to the Board objectives for 16/17, for June 2016.

- 1. Serious Incidents:** Two SIs were reported
- 2. Safety Thermometer:** Harm Free Care is better (above) the average for 2015-16. This is a result of a significant decrease in new pressure ulcers in month from 16 in April, 8 in May and only 3 in June 2016.
- 3. 2015/16 Quality Objectives:** The Trust remains on trajectory in Q1 to achieve in year improvement against quality objectives agreed for patient safety.
- 4. Patient experience:**

Relevant CQC domain:	Safe, Caring, Effective, Responsive & Well Led
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	No

Quality and Patient Safety Performance Exception Report: June 2016

1. Purpose of the report

This report accompanies the Quality/Patient Performance Dashboard and outlines the Trust's performance exceptions against key quality indicators for patient safety and patient experience for the month of June 2016

2. Serious incidents

Two Serious Incidents were reported in June 16:

- Patient Fall. OPM. Ward 9. Patient mobilising to toilet with zimmer frame. Tripped and fell sustaining #NOF
- Patient Fall. Ophthalmology Outpatients. Patient slipped sitting down on chair in clinic room, sustaining a # NOF

Root cause analysis (RCA) investigations and panel meetings are in progress for both incidents.

The Trust is currently on trajectory to achieve quality objectives for reducing serious incidents in year.

METRIC	2015/2016 Total	2016/2017 Plan	16/17 YTD Total	Avg Per Month (2016/2017)	Apr-16	May-16	Jun-16
PATIENT SAFETY							
Total AIRS reported	9243		1932	644	756	571	605
% No Harm	61%	≥70%	62%		60%	65%	63%
% Moderate and Severe Harm	2.7%	<0.50%	5.5%		2.8%	8.1%	6.6%
Number of Serious Incidents	36	≤36	6	2	2	2	2
% Serious Incidents (as % of all AIRS)	0.39%	≤0.39%			0.26%	0.35%	0.33%
Number of Internal Cat 3 & 4 Pressure Ulcers (reported as SIs)	6	≤6	1	0	1	0	0
Number of Patient Falls (reported as SIs)	14	≤14	2	1	0	0	2

3. Safety Thermometer

NHS Safety Thermometer	15/16 Trust Average	April 16	May 16	June 16
Safety Thermometer % Harm Free Care	89.79%	88.02%	87.34%	88.49%
Safety Thermometer % Harm Free Care (New Harms only)	97.53%	95.87%	98.13%	98.6%

4. Patient Experience Report July 2016 (containing June data)

4.1

Friends and Family Test: National Comparison using NHS England data

The national performance benchmarking data bullet pointed below is taken from the national data provided by NHS England which is retrospectively available and therefore, represents May 2016 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in May 2016 ranked RBCH Trust 3rd with 26 other hospitals out of 172 placing RBCH in the top quartile based on patient satisfaction. The response rate was sustained above the 15% national standard at 24.6%.
- The Emergency Department FFT performance in May 2016 ranked RBCH Trust 6th with 6 other hospitals out of 141 placing RBCH ED department in the top quartile. The response rate 6.0% against the 15% national standard. Actions continue to improve the data response.
- Outpatients FFT performance in May 2016 ranked RBCH Trust 6th with 16 other Trusts out of 234 Trusts, placing the departments in the third quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

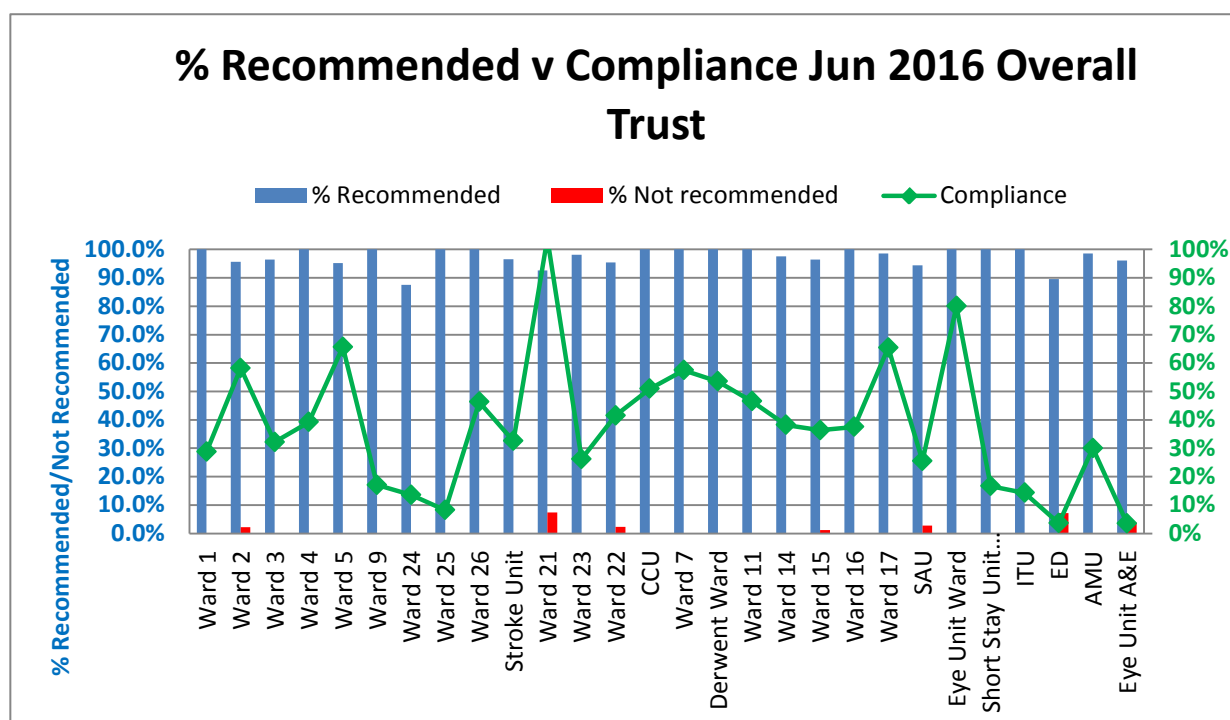
In-Patient Quartile 2016	Dec	Jan	Feb	Mar	Apr	May
Top	98.520%		98.202%	98.259%	98.068%	98.086%
2		97.771%				
3						
Bottom						

ED Quartile						
Top		94.022%	92.636%			95.103%
2	91.398%			86.857%	92.086%	
3						
Bottom						

OPD Quartile						
Top						
2	97.085%	96.730%	96.522%		95.705%	
3				95.069%		95.497%
Bottom						

4.2

Table 1 below represents Trust ward and department performance for FFT percentage to recommend, percentage to not recommend and the response compliance rate. The following data is taken from internal data sources



Family and Friends Test: Corporate Outpatient areas

4.3

Care Audit Trend Data

CCA administrations remain consistent with 247 collected with volunteer support. Overall the improvement in the number of greens is consistent.

Overall	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May16	Jun16
Red	51	45	60	91	85	101	83	90
Amber	73	61	58	92	99	73	80	38
Green	199	163	229	194	191	223	210	253
N/A	52	27	81	28	28	30	8	51

Patient Opinion and NHS Choices: June 2016 Data

4.4

10 patient feedback comments were posted in June, 8 express satisfaction with the service they received. 1 negative response relating to waiting times. 1 comment was mixed highlighting poor services and waiting time then countered with praise for responsive follow up. All information is shared with clinical teams and relevant staff, with Senior Nurses responses included in replies following complaints. A data anomaly has been found with the website, with opinions being placed under two hospital addresses. NHS Choices have been requested to amalgamate this.

Recommendation

The Board of Directors are requested to note the report provided for information.

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th July 2016 – Part I
Subject:	Financial Performance
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Yes
Officer with overall responsibility:	Stuart Hunter, Director of Finance
Author(s) of papers:	Pete Papworth, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance Committee
Action required: Approve/Discuss/Information/Note	The Board of Directors is asked to note the financial performance for the month ending 30 June 2016
Executive Summary:	The financial reports are detailed in the attached papers.
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Goal 7 – Financial Stability Outcome 26 – Financial Position
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	One current financial risks exist on the risk register related to the next year's financial planning. The actions are being monitored through the Finance Committee.

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Finance Report



For the period to 30 June 2016

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £0.8 million as at 30 June. This is £0.2 million better than the budget plan. As reported previously, this has been achieved through the release of a considerable proportion of the Trusts annual contingency budget to off-set the significant loss of both elective and outpatient income as a result of the Junior Doctors strike action.

Within this position, the Trust has delivered savings of £1.7 million which is £0.3 million behind the year to date target. The full year savings forecast increased in month, and the Trust is now forecasting total savings of £8.2 million against the full year target of £9.5 million. The Trust remains confident however, that additional savings will be identified during the year to close this gap.

The Trust has significantly reduced its reliance upon agency staff, and this together with the national price controls has reduced the overall premium cost. As a result, the Trust is operating within the agency ceiling put forward by NHS Improvement.

As at 30 June the Trust has committed £2.3 million in capital spend. This is £1 million less than planned at this point in the year, however this is due to the timing of individual projects and the Trust continues to forecast total capital spend of £12.3 million.

The Trust reports a favourable cash position against its plan, with a cash balance of £32 million. The Trust continues to forecast an end of year cash balance of £18.7 million.

The Trust continues to report a Financial Sustainability Risk Rating of 2 meaning that it is within the 'Material Risk and Potential Investigation' category.

NHS Improvement concluded their investigation some time ago, and the Trust has now been advised of the outcome. It is pleasing to report that the investigation has been closed with enforcement action not deemed necessary. Specifically, NHS Improvement concluded that there was no evidence of significant weaknesses in the trust's financial or performance governance.

Key Financial Risks

Whilst the Trusts current financial position is favourable, a number of key financial uncertainties and risks remain. Key risks can be summarised as follows:

1. Sustainability and Transformation Fund

The significant increase in non-elective activity and emergency department attendances is placing pressure on the Trusts elective and outpatient capacity. This puts at risk the Trusts ability to achieve the agreed performance improvement trajectories, and thus the achievement of the full STF funding. Plans are currently being developed to mitigate this risk, and these need to be implemented as a priority, to ensure the Trust continues to achieve its 2016/17 budget and planned cash balance.

2. Cost Improvement Programme

There remains a gap between the CIP target for the year and the value of schemes currently identified. This amounts to £1.2 million and poses a significant risk to the Trusts 2016/17 budget and cash forecast. Closing this gap remains a key focus for the weekly CIP delivery group.

3. Junior Doctors Contract

The recent ballot resulted in a rejection of the new contract, therefore increasing the risk of further strike action. This could result in a material loss in revenue unless there is a national intervention to manage this pressure across the commissioner provider sector.

4. Private Patient Income

Private patient income has continued to decline. Plans are in place to improve this position; however this may not recover the full in year loss.

The overall financial risk within the Board Assurance Framework, risk register entry 169, resulting from these specific risk items remains unchanged. This continues to be considered a high risk and is being managed as such.

Income and Expenditure

To date the Trust is reporting a deficit of £0.8 million. Within this, income is below budget (adverse) by £1.2 million and expenditure is below budget (favourable) by £1.4 million. This results in a net favourable variance of £199,000.

The Trusts overall income and expenditure position is summarised below.

£'000	Budget	Actual	Variance
NHS Clinical Income	65,582	64,785	(797)
Non NHS Clinical Income	1,629	1,289	(339)
Non Clinical Income	6,291	6,192	(99)
TOTAL INCOME	73,502	72,267	(1,235)
Employee Expenses	44,380	43,688	692
Drugs	9,062	8,278	784
Clinical Supplies	9,321	9,624	(303)
Misc. other expenditure	11,748	11,486	262
TOTAL EXPENDITURE	74,511	73,077	1,434
SURPLUS/ (DEFICIT)	(1,009)	(810)	199

Income

NHS clinical income continues to report an adverse variance, driven by the Junior Doctors strike action during April together with a significant reduction in pass-through drug income via the new Hepatitis C network.

Private patient income remains below plan year to date, however this is expected to partially recover in the coming months. In addition, the Trust is progressing the implementation of a dedicated Private Patient Unit, and is continuing with the contracting process to secure an external partner for private cardiology activity. This is expected to significantly increase private patient income from February onwards.

Further detail at contract level is set out below.

£'000	Budget	Actual	Variance
NHS Dorset CCG	43,549	43,723	174
NHS England (Wessex LAT)	12,615	11,614	(1,001)
NHS West Hampshire CCG	6,179	6,173	(6)
Non Contracted Activity	709	748	39
Public Health Bodies	763	643	(120)
NHS England (Other LATs)	438	412	(27)
NHS Wiltshire CCG	191	211	19
Other NHS Patient Income	0	5	5
Private Patient Income	718	496	(222)
Other Non NHS Patient Income	147	150	3
Non Patient Related Income	6,291	6,192	(99)
Sustainability and Transformation Fund	1,900	1,900	0
TOTAL INCOME	73,502	72,267	(1,235)

Expenditure

Pay reports an under spend to date, reflecting the considerable efforts made in relation to both substantive and bank recruitment across the Trust.

Drug related expenditure is below plan, mainly in relation to a reduction in the estimated cost of Hepatitis C drugs through the recently created network.

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

The favourable variance against other expenditure reflects the release of contingency, off-set by additional non pay costs.

Employee Expenses

The Trust continues to rely heavily upon agency and bank staff to cover substantive vacancies, as set out by Care Group below.

£'000	Substantive Budget	Substantive Cost	Substantive Variance	Agency Cost	Bank Cost	Overtime Cost	Workforce Variance
Surgical Care Group	11,143	10,158	985	445	247	109	184
Medical Care Group	16,131	14,086	2,045	772	1,152	98	23
Specialties Care Group	9,333	8,674	659	147	209	32	271
Corporate Directorates	7,734	7,267	467	101	108	44	214
Centrally Managed Budgets	38	39	0	0	0	0	0
TOTAL	44,380	40,225	4,155	1,465	1,716	283	692

The Trust has agreed to the agency 'ceiling' cost requested by NHS Improvement, which amounts to £5.9 million for the year and represents a significant reduction against the 2015/16 outturn of £8.6 million. It is pleasing to report that agency expenditure to date is below the agency ceiling value of £1.645 million.

Where possible, block bookings are placed for specific agency staff to secure a reduced rate and provide consistency of cover within ward areas. Agency expenditure during June can be summarised as follows:

£'000	Block Booked	Off-Framework	Other	TOTAL
Nursing	31	17	111	159
Medical	0	50	227	277
Non Clinical	19	2	0	21
TOTAL	50	69	338	457

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 engage staff above the capped rates to ensure services are delivered safely. This 'break glass' procedure is subject to a rigorous executive approval process, and the exceptions recorded during June were as follows:

	Medical	Nursing	Other
Shifts covered (Number)	259	0	25
Approximate Cost above Cap (£)	67,060	0	2,329

Whilst a significant number of medical shifts were approved through this 'break glass' procedure, this relates to only a small number of individuals who provide vital sessions.

Cost Improvement Programme

The Trust has delivered financial savings amounting to £1.7 million to date, being £271,000 behind plan.

This year to date under achievement reflects the fact that at present, the Trust has identified full year savings of £8.2 million against the full year target of £9.5 million.

Despite this adverse forecast variance, the Trust continues to have confidence that the target will be achieved, with numerous additional schemes being worked up in addition to the current programme. This is being driven through the weekly CIP delivery group, to ensure the appropriate level of focus and momentum is maintained.

The key schemes making up this year's programme include improving patients Length of Stay, further procurement savings across non pay budgets, significant reductions in drugs expenditure resulting from new procurement, dispensing and delivery models, and workforce savings including significant reductions in premium cost agency expenditure.

It should be noted that at present, £1.7 million of the forecast £8.2 million is reported as non-recurrent. If this position continues, there is a significant financial risk when moving into the 2017/18 financial year.

DIRECTORATE	YEAR TO DATE			FULL YEAR		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000	TARGET £'000	FORECAST £'000	VARIANCE £'000
ANAESTHETICS AND THEATRES	(106)	99	(6)	(726)	349	(377)
MATERNITY	(27)	26	(1)	(158)	62	(96)
ORTHOPAEDICS	(39)	77	39	(520)	1,028	508
SURGERY	(63)	58	(5)	(787)	710	(76)
CARE GROUP A	(234)	261	27	(2,191)	2,150	(41)
CARDIOLOGY	(141)	124	(17)	(607)	509	(98)
ED AND AMU	(47)	31	(17)	(181)	156	(26)
OLDER PEOPLES MEDICINE	(199)	186	(13)	(1,150)	1,020	(130)
MEDICINE	(126)	104	(22)	(672)	453	(219)
CARE GROUP B	(514)	445	(69)	(2,610)	2,137	(472)
CANCER CARE	(197)	84	(113)	(428)	402	(26)
OPHTHALMOLOGY	(58)	29	(29)	(291)	134	(157)
PATHOLOGY	(66)	44	(22)	(244)	283	39
RADIOLOGY	(104)	95	(9)	(327)	240	(87)
SPECIALIST SERVICES	(170)	143	(27)	(826)	580	(246)
CARE GROUP C	(595)	395	(200)	(2,116)	1,639	(477)
NURSING, QUALITY & RISK	(24)	20	(4)	(116)	74	(42)
ESTATES	(105)	98	(6)	(726)	657	(69)
FACILITIES MANAGEMENT	(94)	82	(12)	(486)	363	(122)
FINANCE AND BUSINESS INTELLIGENCE	(42)	44	1	(162)	174	12
HR, TRAINING AND POST GRAD	(32)	19	(13)	(159)	130	(28)
INFORMATICS	(244)	244	0	(656)	668	12
OPERATIONAL SERVICES	(45)	50	5	(180)	146	(34)
OUTPATIENTS	(26)	26	0	(57)	57	0
TRUST BOARD & GOVERNORS	(19)	19	0	(22)	23	1
CORPORATE	(632)	603	(29)	(2,564)	2,295	(269)
GRAND TOTAL	(1,974)	1,703	(271)	(9,481)	8,221	(1,260)

Care Group Performance

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

£'000	Budget	Actual	Variance
Surgical Care Group	3,914	3,894	(21)
Medical Care Group	2,084	2,074	(10)
Specialties Care Group	1,320	1,379	60
Corporate Directorates	(8,561)	(8,436)	125
Centrally Managed Budgets	233	279	45
SURPLUS/ (DEFICIT)	(1,009)	(810)	199

June continued to see high levels of activity, particularly in relation to non-elective activity which was 11.4% above budgeted levels, and emergency department attendances, which were 13.3% above budgeted levels. This has placed significant pressure on the Trust, particularly when coupled with elective activity also being above budget by 3.3%. Outpatient activity however, was below budget in month by 2.9%.

Year to date, elective activity has recovered and is in line with budgeted levels, however outpatient activity remains significantly lower than planned, being 3.6% below budget. Non elective activity and emergency department attendances end the quarter 11.5% and 10% above budget respectively.

In light of the activity pressures noted above, it is pleasing to report that at the end of quarter one all Care Groups are performing broadly in line with their agreed budgets. However, a considerable level of risk remains given the forecast CIP shortfall, particularly within the Medical and Specialties Care Groups and Corporate directorates. This is being proactively managed through the Trusts CIP Governance arrangements, and in particular, the weekly CIP Delivery Group.

Sustainability and Transformation Fund

The Trust has accepted the offer of payment from the Sustainability and Transformation Fund, which totals £7.6 million. In doing so, the Trust has signed up to the conditions of the offer.

Further clarity has now been received in relation to how the fund will operate and how the Trusts achievement will be assessed. Full detail is available in a separate report to the Board, however the key conditions and weightings can be summarised as follows:

CRITERIA	WEIGHTING %	ANNUAL £	MONTHLY £
Revenue Control Total	70.0%	5,320,000	443,333
RTT Performance Trajectory	12.5%	950,000	79,167
A&E Performance Trajectory	12.5%	950,000	79,167
Cancer 62 Day Performance Trajectory	5.0%	380,000	31,667
Diagnostics Performance Trajectory	0.0%	-	-
TOTAL	100.0%	7,600,000	633,333

It should be noted that the financial control total is a binary on/off switch to secure STF Funding. Only if the Trust achieves its control total in a quarter, does it become eligible for STF Funding. The amount of funding achieved is then determined by the level of success with the other criteria.

The significant increase in non-elective activity and ED attendances is placing pressure on the Trusts elective and outpatient capacity. This puts at risk the Trusts ability to achieve the RTT performance trajectory, and thus the achievement of the full STF funding. Plans are currently being developed to mitigate this risk.

This funding has also been confirmed as non-recurrent, and we understand that to secure this funding in future years, there will be new conditions attached which are currently unclear. This places the Trust in a difficult position when forecasting its financial position forwards over the medium term.

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 £1 million, as set out overleaf. This, together with the timing impact of capital schemes on the associated depreciation and amortisation charges account for the variances shown against property, plant and equipment and intangible assets. In addition, the delay in the Christchurch development has resulted in the Trust delaying its investment contribution into the Christchurch Fairmile Village LLP.
- **Trade and other receivables:** This variance results from the level of activity undertaken and accrued being higher than the cash payment received from the Trusts commissioners, based on the agreed contract value.
- **Cash and cash equivalents:** The Trusts cash balance is currently £3 million above plan. This reflects the under spend against the capital programme, an increase in the level of capital creditors, together with the timing of the investment into the Christchurch Joint Venture.
- **Trade and other payables:** A significant proportion of this variance relates to an increase in capital creditors. In addition, a small number of invoice payables remain unpaid, and these are being actively pursued.

£'000	Plan	Actual	Variance
Property, plant and equipment	177,180	176,419	(761)
Intangible assets	3,524	3,407	(117)
Investments (Christchurch LLP)	4,358	3,331	(1,027)
Non-Current Assets	185,062	183,157	(1,905)
Inventories	6,078	5,644	(434)
Trade and other receivables	14,188	15,638	1,450
Cash and cash equivalents	29,070	32,084	3,014
Current Assets	49,336	53,366	4,030
Trade and other payables	(30,625)	(32,396)	(1,771)
Borrowings	(307)	(307)	0
Provisions	(222)	(192)	30
Other Financial Liabilities	(1,102)	(1,102)	0
Current Liabilities	(32,256)	(33,997)	(1,741)
Trade and other payables	(1,006)	(1,007)	(1)
Borrowings	(19,362)	(19,391)	(29)
Provisions	(519)	(587)	(68)
Other Financial Liabilities	0	0	0
Non-Current Liabilities	(20,887)	(20,985)	(98)
TOTAL ASSETS EMPLOYED	181,255	181,541	286
Public dividend capital	79,681	79,681	0
Revaluation reserve	72,570	72,570	0
Income and expenditure reserve	29,004	29,290	286
TOTAL TAXPAYERS EQUITY	181,255	181,541	286

Capital Programme

The Trust undertook a detailed clinical prioritisation process to inform the capital programme for 2016/17. As a result of this process, the Trust has approved a capital programme amounting to £12.3 million, and comprising only the existing contractually committed schemes, schemes that relate to clinical priorities, and a small number of quality improvement/ invest to save schemes.

The programme for 2016/17 includes £3.4 million in relation to the finalisation of the Christchurch development, £2.4 million to refurbish the cardiology laboratories, and £3.4 million in relation to the Trusts approved five year IT Strategy.

Expenditure to date totals £2.3 million, representing a year to date under spend of £1 million. This is attributable to further slippage against the Christchurch development, and will be corrected in the coming months.

Full detail at scheme level is set out below.

£'000	Annual	IN MONTH			YEAR TO DATE			FORECAST	
	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance
Christchurch Development	3,425	620	327	293	1,740	749	991	3,425	0
Cardiac Laboratories	2,400	0	0	0	0	0	0	2,400	0
CT3 Building Alterations	450	5	4	1	20	4	16	450	0
Estates Maintenance	400	60	28	32	80	51	29	400	0
Sterile Services Department	300	20	5	15	20	11	9	300	0
QI Projects (Frailty unit, AEC, Cardiac)	300	0	3	(3)	202	199	3	300	0
Miscellaneous Schemes	300	0	47	(47)	0	46	(46)	300	0
Capital Management	265	22	15	7	66	52	14	265	0
Catering Equipment	100	50	29	22	100	68	32	100	0
Medical Equipment	1,000	100	0	100	100	33	67	1,000	0
IT Strategy	3,409	39	112	(73)	967	1,051	(84)	3,409	0
TOTAL	12,349	916	570	347	3,295	2,264	1,031	12,349	0

Cash

The Trust is currently holding £32.1 million in cash reserves. However, delays in the Christchurch development to date have resulted in a cash timing benefit when compared to the agreed phasing of the ITFF loan drawdown. As a result, the underlying cash position is significantly lower at £25.0 million.

The forecast closing cash balance for the current financial year is £18.7 million, and thus there is no requirement for Department of Health financial support at present.

The Trusts 24 month rolling cashflow forecast indicates that at the end of the next financial year, 31 March 2018, the Trusts cash balance will be reduced to £16.3 million. However, this is predicted on a range of assumptions within which there is material risk.

The Trust must ensure that it achieves its financial plan in the current year to protect the medium term cash balance.

Financial Sustainability Risk Rating

The Trusts Financial Sustainability Risk Rating as at 31 May 2016 is set out below.

	Plan Metric	Actual Metric	Risk Rating	Weighted Rating
Capital Service Cover	1.39x	1.48x	2	0.50
Liquidity	14.1	20.0	4	1.00
I&E Margin	(1.30%)	(1.22%)	1	0.25
I&E Variance to Plan	0.96%	0.08%	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.

The Trusts operational plan for 2016/17 confirms a Financial Sustainability Risk Rating of 3 from August 2016.

NHS Improvement Investigation

NHS Improvement (formerly Monitor) concluded their investigation into the Trust some time ago, and the Trust has been awaiting the outcome.

Following a meeting of their Provider Regulation Directorate on 27 June 2016, NHS Improvement concluded that the formal investigation into the trust's compliance with its licence should be closed and that enforcement action was not required. Specifically, NHS Improvement concluded that there was no evidence of significant weaknesses in either the Trust's financial or performance governance.

As a result, the Trusts governance rating has been updated to 'Green', with 'No evident concerns'.


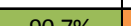


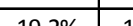













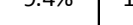



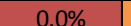


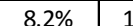









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BOARD OF DIRECTORS

Meeting Date and Part:	29 th July 2016 – Part 1
Reason for Part 2:	n/a
Subject:	Workforce Report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Karen Allman
Author(s) of papers:	Karen Allman & Ellen Bull
Details of previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC, Education & Training Committee
Action required: Approve/Discuss/Information/Note	For discussion and noting areas highlighted.
<p>Executive Summary:</p> <p>The report shows the performance of the Trust by care groups across a range of workforce metrics: Appraisal, Essential Core Skills, Turnover and Joiner rates, Sickness and Vacancies.</p> <p>The safe staffing section includes detail regarding the HCA cover for night shifts as requested by the Board.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>Well Led.</p> <p>Providing appropriate staffing to deliver effective and safe care.</p>
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	<p>Recruitment, Appraisal Compliance, Essential Core Skills (mandatory training) compliance, and workforce planning are all existing risks on the risk register.</p>

WORKFORCE REPORT – JULY 2016

The monthly workforce data is shown below, both by care group and category of staff. A Trust target for appraisal compliance has been set at 90% of eligible employees to be appraised by 30/9/16; mandatory training (essential core skills) compliance target is 95%; sickness absence target is 3%. Performance has been RAG rated against these targets. The trend line is a twelve month rolling picture and the values based appraisal reflects the zeroing of compliance from April 16.

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 June			Rolling 12 months to 30 June			At 30 June	
Surgical	9.2%	79.1%	89.1%	4.51%	14862	13.9%	12.3%	
								
Medical	15.8%	90.7%	87.2%	4.06%	20149	19.2%	12.0%	
								
Specialities	22.6%	85.7%	90.9%	3.22%	9167	9.4%	11.2%	
								
Corporate	16.9%	0.0%	93.0%	3.80%	12233	8.2%	11.2%	
								
Trustwide	16.0%	84.4%	89.4%	3.94%	56410	13.5%	11.7%	
								

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 June			Rolling 12 months to 30 June			At 30 June	
Add Prof Scientific and Technical	35.4%		95.4%	2.97%	1329	18.2%	10.6%	
Additional Clinical Services	12.1%		88.4%	6.24%	16256	19.6%	13.5%	
Administrative and Clerical	19.2%		94.0%	3.38%	10267	7.9%	12.0%	
Allied Health Professionals	8.9%		90.8%	2.23%	2025	14.9%	15.6%	
Estates and Ancillary	5.8%		90.5%	4.70%	5836	13.3%	11.2%	
Healthcare Scientists	12.5%		86.1%	3.97%	1045	9.6%	8.4%	
Medical and Dental		84.4%	82.1%	1.42%	2273	4.8%	5.2%	
Nursing and Midwifery Registered	19.1%		89.6%	4.12%	17378	14.6%	11.2%	
Trustwide	16.0%	84.4%	89.4%	3.94%	56410	13.5%	11.7%	

1. Appraisal

Year 2 of the values based appraisal process commenced 1st April 2016 and compliance was reset to zero (apart from medical and dental staff). A trajectory is set through to the 6-month period end date of 30th September, which reflects the cascade nature of the process which will see momentum gather as it spreads throughout the organisation.

Performance against the key workforce KPIs is reviewed at monthly care group meetings and at the Strategic Workforce Committee.

Stronger performance against the trajectory is shown for Specialties showing amber, but with the surgical directorates performance well below trajectory.

2. Essential Core Skills Compliance

Overall compliance continues its upward trend, increasing to 89.4% from 88.9% last month. This represents an 11.9% increase over the position at the same point last year (77.5%), a reflection of the hard work put in by all concerned.

The table below shows the 10 areas with the lowest compliance as at 30th June:

Directorate	Organisation	Headcount	Compliance	Trend
Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	13	55.05%	
Surgery Directorate	153 Obs/Gynae Medical Staff 10100	16	65.65%	
Cancer Care Directorate	153 Haematology Snr.Medical 11346	19	73.63%	
Elderly Care Services Directorate	153 MFE Medical Staff 10077	49	73.70%	
Cardiac Directorate	153 Cardiac Techs 11525	38	74.00%	
Clinical Governance Directorate	153 Patient Services Dept 10550	14	74.21%	
Medicine Directorate	153 Ward 2 10369	30	75.42%	
Medicine Directorate	153 Medical General Staff 10075	70	76.17%	
Anaesthetics/Theatres Directorate	153 Anaesthetic 10025	50	79.82%	
Cancer Care Directorate	153 Macmillan Unit 10565	34	79.94%	

Areas with highest compliance:

Directorate	Organisation	Headcount	Compliance	Trend
Informatics Directorate	153 Telecoms 13585	23	100.00%	
Cardiac Directorate	153 Cardiac Administration 11523	37	100.00%	
Informatics Directorate	153 Poole IT Services 13586	28	99.29%	
Other Directorate	153 Transformation Prog. Management 14150	11	99.09%	
Ophthalmology Directorate	153 BEU Admin 13520	18	98.88%	
Finance and Business Intelligence Directorate	153 Information 13541	17	98.82%	
Specialist Services Directorate	153 Orthodontics 10210	21	98.44%	
Medicine Directorate	153 Medical Respiratory 11535	22	98.28%	
Specialist Services Directorate	153 Pharmacy 10815	97	98.22%	
Human Resources Directorate	153 Blended Education and Training 18100	13	98.14%	

We have again reviewed the capacity and demand model for the individual elements required for clinical and non- clinical staff. Areas of concern are the clinical manual handling and fire training- both departments have experienced turnover or absence. Additional resource to support the continued delivery of essential core skills training are being identified and a plan put in place.

3. Sickness Absence

The Trust-wide sickness rate has slipped back very slightly to 3.94% from the previous month's 3.93%, continuing its amber rating. However, this compares favourably with the red-rated 4.05% at this point last year.

The table below shows the 10 areas with the highest 12-month rolling sickness absence as at 30th June:

Directorate	Organisation	Headcount	Absence Rate	Trend
153 Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	13	11.90%	
153 Clinical Governance Directorate	153 Risk Management 14115	14	9.52%	
153 Outpatients Directorate	153 Outpatients 10370	45	8.90%	
153 Elderly Care Services Directorate	153 MFE Ward 5 10378	39	8.50%	
153 Cardiac Directorate	153 MFE Ward 24 10594	33	8.49%	
153 Informatics Directorate	153 IT Development Recurrent 13588	12	8.41%	
153 Anaesthetics/Theatres Directorate	153 Day Surgery Services 10385	32	8.30%	
153 Elderly Care Services Directorate	153 MFE Ward 4 10382	32	8.29%	
153 Cancer Care Directorate	153 Macmillan Unit 10565	39	7.96%	
153 Surgery Directorate	153 Surgical Admissions Unit 10535	25	7.77%	

Areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rate	Trend
153 Pathology Directorate	153 Medical Staff - Histology 11300	11	0.12%	
153 Other Directorate	153 Postgraduate Centre 13531	11	0.12%	
153 Surgery Directorate	153 Surgery - Urology 10084	21	0.19%	
153 Other Directorate	153 Chief Executive 13535	27	0.29%	
153 Elderly Care Services Directorate	153 MFE Management 13510	18	0.29%	
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	42	0.53%	
153 Cancer Care Directorate	153 Haematology Snr.Medical 11346	26	0.65%	
153 Surgery Directorate	153 Surgery - General 10085	33	0.67%	
153 Elderly Care Services Directorate	153 MFE Medical Staff 10077	54	0.75%	
153 Elderly Care Services Directorate	153 Dietitians 13315	15	0.80%	

HR have been holding sickness absence surgeries to encourage managers to discuss concerns and identify action plans to address areas of concern.

4. Turnover and Joiner Rate

Joining and turnover rates of 13.5% and 11.7% little changed over the previous month (13.6% and 11.8%). The joining rate continues at a higher level than the turnover rate; and encouragingly the turnover rate has fallen over the past year, down from 12.8% at this point in 2015.

5. Vacancy Rate

Due to Information/Establishment issues, details regarding the vacancy rate were not available when the board paper was completed. Work to resolve the issue.

6. Safe Staffing

RN Day actual fill rate 87.2%
 HCA Day actual fill rate 94.7%
 RN Night actual fill rate 95.7%
 HCA Night actual fill rate 116.9%

Overall the safe staffing is reflective of a consistent position compared to previous months. This is testament to the ongoing work of local mitigation, increased efficiency in rostering practice, and recruitment and retention actions as this is against the backdrop position of the agency cap introduced by Monitor. During the in-month position, there has not been any requirement to use Tier 3 agency, and fill rates of actual staff remain consistent. There is much more acceptance of the need to locally mitigate with the workforce resource as care needs dictate.

The slight increase in HCA actual fill rates against planned is mainly for meeting enhanced care needs especially at night when actual resource is much lower, substituting short term for qualified staff to mitigate a shortage and this is assessed as appropriate. The list below depicts a detailed view of the in-month position on some ward areas where the mitigations have occurred and contributed to the overall position.

- Ward 1: Shortages of RNs safely mitigated with HCA's during the day.
- Ward 2: Local movement within the directorate has mitigated the shifts. RN trained slightly higher as supported ward 3 via movement. Outstanding trained shifts at night mitigated with a HCA which has increased the actual over planned of HCAs.
- Ward 3: These figures do not truly reflect as ward 3 often had help from ward 2 hence why ward 2 fill rate is high for RNs. The template for ward 3 is under review.
- Ward 14: Reduced fill rate due to reduction in capacity/beds template now correct from 6th June; however an ad hoc basis increase in capacity has brought the HCA night fill rate up over the planned.
- Ward 15: Under on trained during the day due to some sickness mitigated within the directorate; night over actual over planned fill rates due to specials required to meet patients enhanced care needs.
- Ward 16: Under fill during the day due to sickness again mitigated within the directorate; over planned fill rates at night due to acuity.
- Ward 17: Over fill of HCA day and night due to acuity and specials to meet specific care needs of patients.
- SAU: Over fill at night due to formal escalation and therefore increased bed capacity requiring staff resource to meet care needs of the extra patients.
- Discrepancies in fill rates for orthopaedics due to ward reconfiguration and additional activity with low fill rates as a result of Mat leave and long term sickness.
- The very low fill rate shown for ward 7 is the result of the amalgamation of two rosters (Ward 7 and Derwent) at the beginning of June with the primary roster being the Derwent going forward.
- The under fill on Treatment Centre (DTC) and the Day Surgery Unit (DSU) has been due to short term sickness which is not backfilled but locally mitigated with a Band 7 from other area.
- The under fill rate for ITU is as a result of vacancies and some sickness. Shifts mitigated according to activity at the time.
- Eye Unit vacant trained shifts on days have been mitigated appropriately with HCA once dependency and acuity has been reviewed.
- Eye Unit increase on HCA fill rate at night was to meet care needs of outlying patients.
- Mac unit HCA usage has mitigated the RN requirements and to meet enhanced care needs of patients.
- Ward 11 have had a number of short and long term sickness issues on top of vacancies; staffing has not been compromised due to lower capacity through lower occupancy in June.

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th July 2016 – Part I
Subject:	Mortality Report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	No
Officer with overall responsibility:	Basil Fozard, Medical Director
Author(s) of papers:	Divya Tiwari, Consultant Physician
Details of previous discussion and/or dissemination:	Mortality Surveillance Group Directorate Governance
Action required: Approve/Discuss/Information/Note	Information / Note
Executive Summary:	This paper updates the Board on the current Trust position and activities to reduce mortality.
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Safety
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	No

Trust Mortality Report

The metrics for the Trust mortality position are at Annexe A. Overall they show the Trust to be in a good position overall and 'high risk group' mortality, but the areas of further work discussed at the most recent Mortality Surveillance Group (MSG) are described below.

Review of Coma, Stupor and Brain Damage Deaths (Nov2014-Oct 2015)

Mortality chair for cardiology Jahangir Din reviewed deaths in this category following an outlier alert in Dr Foster.

Discussion points were as follows:

1. On review of cardiology cases, no preventable deaths. All seemed to have appropriate management.
2. Effect of coding anoxic brain damage on Dr Foster data
3. Consider PM where cause of death uncertain
4. For sudden arrhythmic death, consider underlying cardiomyopathy and need for family screening.

Action plan

Identify MI as cause of death in death certificates and mention genetic screening in Mortality Newsletter for wider dissemination. :

Type Two Respiratory Failure (June 2014-May 2015)

A recent review was undertaken by Respiratory chair Dawn Edward of the above category of patients following Dr Foster alert, with the following recommendations:

1. Failure to always prescribe oxygen
2. Failure to act on prescriptions / instructions for oxygen delivery
3. Failure to repeat ABGs / reassess / act on results for patients in hypercapnic respiratory failure
4. Failure to up-titrate BIPAP settings adequately
5. Possible difficulty accessing level 2 beds to deliver care.
6. The use of the term 'respiratory failure' on death certificates which should be avoided.

Action Plan:

1. If an electronic solution to prescribing / monitoring / recording oxygen use could be identified this could transform this area of practice.
2. On-going education about oxygen prescription and management within the trust is aimed to address the issues in this area and our thoracic practice educator continues to focus on this issue and is liaising with AMU staff to improve education there.
4. Education regarding death certification may reduce the influence of this (and indeed there has been some focus on this within the trust recently). Perhaps the next mortality / governance newsletter could be used to remind clinicians to avoid using modes of death.
5. Modify Prescription chart in ED to allow oxygen prescription

Stroke Pathway Walk (June 2016)

Stroke is identified as 'high risk' condition for the mortality and therefore national recommendation for annual Mortality review. Stroke Mortality chair Kamy Thavanasen discussed findings.

Standards of Care

- MDT goals agreed within 5 day of hospital arrival – 100%
- UTI within 7 days of admission – 6% (n.a.4.8%)
- Newly acquired pneumonia – 19% (n.a.8.8%)
- Continence plan agreed within 3 weeks of admission – 100%
- Patients who are identified as high risk of malnutrition seen by a dietician
- Mood screen performed – 100%
- Cognitive screen performed – 100%
- Intermittent pneumatic compression applied – 31% (n.a.16%)

Action Plan:

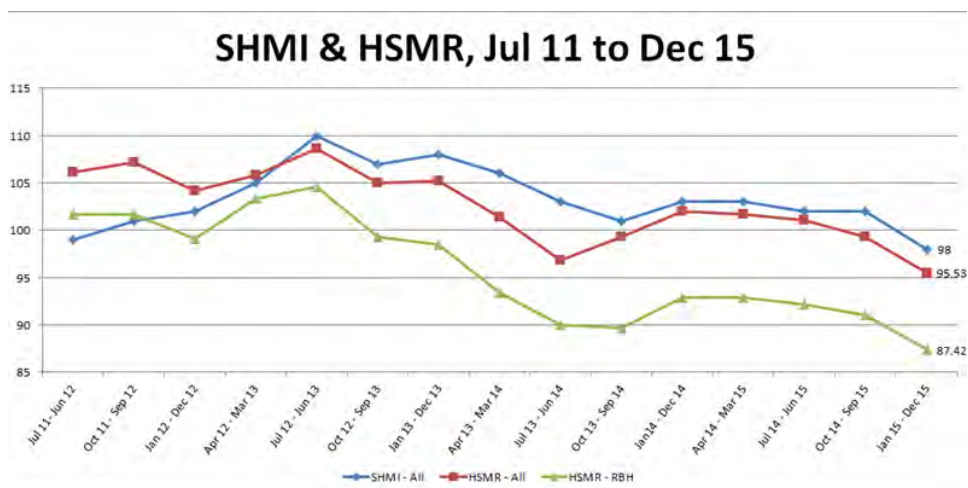
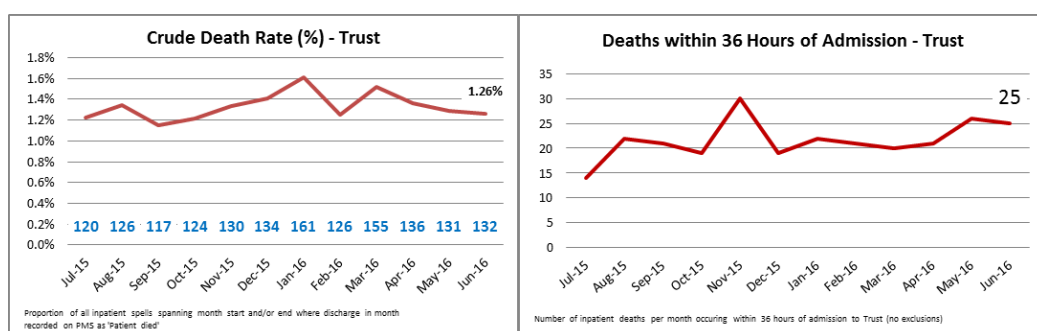
- Targeted education to improve stroke recognition particularly for non-FAST presenting stroke. This will include the development of a stroke brand and campaign, with the aim to increase awareness of stroke outreach and recognition of less common stroke symptoms.
- Implementation of ambulatory care, to facilitate early discharge from hospital, to include investigations and stroke consultant review.
- To continue to work proactively with the Trust discharge team, social services and other agencies to facilitate discharge at the earliest point.

Deaths within 36 Hours of Admission

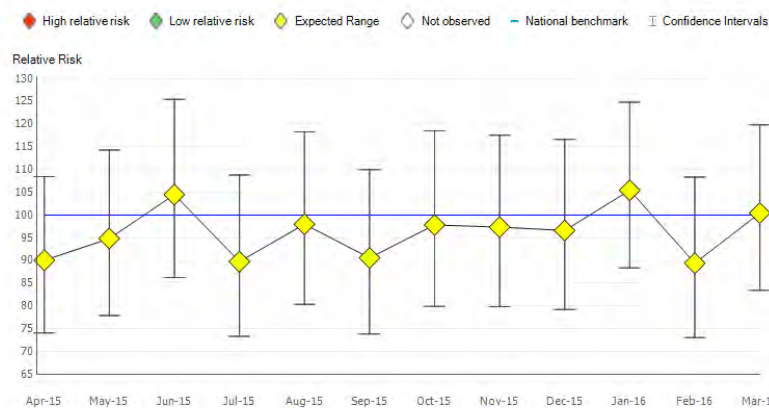
The MSG considered a deeper analysis of the above patient group. A significant proportion of mortality is within 36 hours of admission (23-25% of overall mortality). Detail study is required to quantify avoidable admissions from nursing homes.

The Board is asked to note this report.

Annexe A



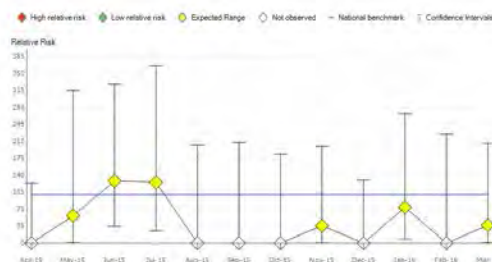
HSMR Trust



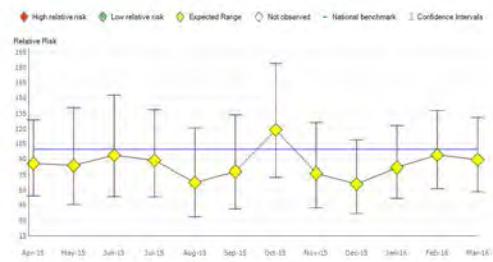
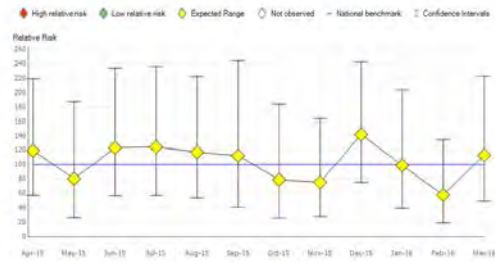
Relative Risk 'Stroke'



Relative Risk 'Acute Kidney Injury'



Relative Risk CCF-Non hypertensive Relative Risk 'Septicaemia &Pneumonia



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BOARD OF DIRECTORS

Meeting Date and Part:	29 July 2016 Part 1
Reason for Part 2:	n/a
Subject:	Clinical Services Review
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	Copy letter to Chair of Dorset CCG Copy briefing for staff at Poole Hospital
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	Trust Management and Board of Directors
Action required:	The Board is asked to note the progress reported within the paper
<p>Executive Summary:</p> <p>The paper briefly explains the commitment of Poole Hospital's Board to support work to further develop the CCG's preferred option to develop Poole Hospital as the Planned Care site and RBH as the main Emergency site subject to consultation and a final decision.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	All
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	

Clinical Service Review

1. INTRODUCTION

The purpose of this paper is to apprise the Board of on-going progress to take forward the Clinical Service Review proposals.

2. RESPONSE FROM POOLE HOSPITAL FOUNDATION TRUST

A very positive response has been made to Dorset CCG from colleagues at Poole Hospital who have confirmed their commitment to working with partners to develop plans to implement (subject to consultation and the final CCG decision) the changes which would see Poole Hospital develop as the main planned care site and RBH as the main emergency site within Dorset. Within the Reading Pack are copies of the letter Debbie Flemming has sent to Forbes Watson, Chairman of Dorset CCG and the briefing shared with staff at Poole Hospital. You will also note within the letter, reference to the need to step up work to integrate hospital and community services. The Board will welcome warmly this development recognising that it enables a more consistent message to be given to staff and members of the public about the benefits to be gained from reconfiguration of hospital services as we move into the consultation phase.

A similarly positive meeting was held with Simon Stevens, Chief Executive of NHS England and colleagues from NHS Improvement at an event on 15 July to consider proposals for the wider sustainability and transformation of services within Dorset. This provided a forum for all partners within Dorset to express their support for the proposals outlined within the STP.

3. LOCATION OF CANCER SERVICES

As the Board is aware part of the assurance process for NHS England of reviewing these proposals is to seek the views of the Wessex Clinical Senate. A copy of the Senate's draft response is included with the Reading Pack. Broadly the Senate have been supportive of the Clinical Service Review proposals including the designation of RBH as the preferred site for the provision of emergency services. The Senate did, however, raise the issue of whether Radiotherapy services would be better located in concert with acute Oncology on the emergency site. As a consequence the Trust has submitted proposals for accommodating the relocation of Radiotherapy services. This recommendation from the Senate has, however, been challenged by NHS England's own independent oversight group who have requested that the CCG consider again with the Senate the need to transfer Radiotherapy services leading to the potential for these service to remain located at Poole Hospital. Whilst the Trust has been open to the potential to absorb Radiotherapy services we remain equally supportive of the possibility that these service sill remain located at Poole Hospital for the foreseeable future. This is an issue that will need to be addressed prior to consultation formally beginning.

4. NEXT STEPS

The next steps are for NHS England (Wessex) to set out the proposals in detail and develop the Benefits Case for consideration by NHS England's National Investment Committee which will meet on 19 August. Subject to support from the National Investment Committee, authorisation will be granted for consultation to begin in mid-October 2016. A 12 week consultation period will then follow.

Further work is still required to secure agreement to and sourcing of the capital to facilitate the proposed investment at both the Poole Hospital and Royal Bournemouth Hospital sites. This is discussed further within the Part 2 papers.

This paper is provided for information.

Tony Spotswood
Chief Executive

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BOARD OF DIRECTORS

Meeting Date and Part:	29 July 2016 Part 1
Reason for Part 2:	N/A
Subject:	Action Plan Response to address the Cultural Audit Survey findings
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	The full audit is available within the Reading Room
Officer with overall responsibility:	Nicola Hartley, Director of OD and Leadership
Author(s) of papers:	Nicola Hartley, Director of OD and Leadership Bridie Moore, OD and Leadership Manager
Details of previous discussion and/or dissemination:	Full Cultural Audit Report
Action required:	To consider and approve the action plan response
Executive Summary: This paper summarises the actions delivered following consideration of the Cultural Audit by the Board, TRMB and the joint COG/Board planning event. The Board is asked to consider and agree the actions contained within the plan.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

	A	B	C	D	E	F	G	H	I
1		Priority	ACTION	Category	Sponsor	How	Lead	Outcome	Notes
2	1	*	Share cultural audit findings and senior leadership response with all staff	A	TS	Cultural Audit Communication plan Schedule of events - open sessions, care group based and dept based. Standardised comms pack	OD working with Comms	All staff aware of work Visible senior leadership team Staff know how to contribute	Led by OD for open sessions, DOOs and senior managers in own areas Will require Comms resource
3	2		Become a more visible and accessible leadership team, role modelling the behaviours and values	A	TS	Develop our approach to being more accessible Change Champions to share ideas at workshop with senior leaders.	TS with support from OD	Staff surveys report increased visibility and accessibility of senior leadership. Positive staff feedback against Board team charter	
4	3		Expand Change Champion model	A	NH	Invite expressions of interest Recruit additional Change Champions Create development programme to support Design Phase	OD	Enthusiastic and committed staff identified and supported to lead culture change	
5	4	*	Improve Meeting Effectiveness	A B	TS	Agree principles of effective meetings Role model a different approach to behaviour in meetings. Reflect after each meeting Use cultural audit data to inform existing Governance Committee review	Exec Team AB	Transparent decision making People find all meetings useful Less time in meetings	Developing skills in running and attending meetings
6	5		Communicate a clear message about it is okay to use your initiative, offer solutions and take calculated risks and learn from mistakes	A B	TS	Communicate the message to staff Role model "Just do it" Promote the Improvement Ideas Develop reward & recognition scheme	TS working with Comms, QI and team leaders	Staff generate ideas Staff see positive improvements for patients and staff Get feedback on ideas and we learn from each other	
7	6		Help team leaders to develop SMART team and individual objectives that link to the vision as part of the appraisal process in 2017/8	B	NH	Appraisal Champion training Implement Aston OD Effective Team Tool Early publication of corporate objectives	OD	Clear line of sight from vision to individual objectives for all staff Team leaders confident and competent in setting SMART objectives	
8	7	*	Introduce customer service training across the trust	B	NH	Commission Customer Service Skills training Agree priorities for roll out	OD	All patients feel welcomed and experience positive, helpful interactions with our staff.	Funding not currently available Look to Frimley for example/options for delivery - external provider v internal
9	8	*	Support staff to manage poor behaviour, performance and variation	B	KA NH	Develop policy and practice Review policy, explain policy and communicate Supporting team leaders (through leadership development) Clarify expectations and permission, develop skills and confidence and link to Values based appraisals and job planning Role modelling by senior leadership team	HR OD	Everyone knows poor behaviour and performance will be addressed effectively. Staff are confident and competent to deal with poor behaviour and performance.	Use of external provider or OD team Emphasis on resolution through dialogue. Funding to support Vital Conversations training in year. Beyond this it will be included in the leadership development strategy.

	A	B	C	D	E	F	G	H	I
1		Priority	ACTION	Category	Sponsor	How	Lead	Outcome	Notes
10	9	*	Prioritise development of team and inter-team working, relationship building and supporting each other	B	NH	Promote importance and develop skills and mindset Commission AstonOD Team Coach programme Recruit internal team coaches for training Explore potential to develop Arbing Institute practitioners within the trust (mindset change)	OD	Improved team effectiveness (with effectiveness measurement tool in place) Internal team coaching skills and capacity Internal mindset change skills and capacity	Priority call on 2016/17 OD investment plan Linking mindset of teamwork to achieving vision
11	10	*	Engage with staff to define the culture we want to create and role model it.	B	TS	Use staff briefing sessions to engage and involve staff	OD working with leadership teams	Staff feel genuinely involved in creating our new culture All staff feel inspired to role model the new culture	
12	11		Develop role of Medical Leaders	B	BF	Use cultural audit data to : -Develop role of medical leaders to deliver the Trust strategy -Consider extending CD term of office, time allocated to role, clinical chair, introduction of Deputy CD	BF with support from OD and DOOs	Clarity of medical leadership roles and responsibilities in supporting delivery of trust vision and strategy. Enthusiasm for role Pipeline of medical leaders	
13	12		Making QI business as usual	B	DM	Consider next phase of roll out QI training and include a core content for all staff training and development. Relaunch Improvement Ideas scheme with mechanism for feedback Role model improvement as a collective leadership responsibility	QI, with support from OD, PS & BF	All staff trained in basic QI and report an understanding of how it helps achieve our vision. Recognising and rewarding QI initiatives Staff generate ideas Staff see positive improvements for patients and staff Get feedback on ideas and we learn from each other	
14	13		Develop a feedback culture	B	NH	Give feedback from the cultural audit Introduce 360 feedback through pilot Include as core skill in leadership development programmes Role model giving feedback Recognise and reward good practice	OD, Pilot sites to be determined	Staff feel comfortable and confident to give and receive feedback. Improved performance and direct impact on patient care.	In discussion with Kings Fund re pilot.
15	14		To create a technical solution for capturing and analysing appraisal conversations including development needs	C	PG	Scope work Develop specification	IT, BEAT, OD	We only have one process for training & development conversations. Relevant and timely management information to support: -Financial planning -Staff management -leadership development, -talent management and succession planning	Currently no resources identified Needs to link to talent management plans

	A	B	C	D	E	F	G	H	I
1		Priority	ACTION	Category	Sponsor	How	Lead	Outcome	Notes
16	15		Restate our position with regards to Equality & Inclusion and name our Executive Lead	C	KA	DESIGN PHASE Establish a design team Scope the work	DM, KA, NH	Our commitment to E &I is reflected in everything we do: engage with patients, recruit staff, manage talent and address poor performance Compliant with WRES standard Reduced bullying & harassment by BME staff	
17	16		Test appetite and level of ambition for research, innovation and becoming a learning organisation and develop a proposition	C	PS	DESIGN PHASE Workshop to explore Establish a design team Scope the work Recruit E&I Champions	Clinical QI lead, with support from Execs, Medical Director, Clinical Director for Research and Innovation, QI Lead, OD, Director of Medical Education, Research Lead, BEAT lead Clinical Governance	Clear ambition statement Role model learning from mistakes Greater alignment, patient safety, OD and research Reputation as a centre of excellence. Strengthened relationships with Bournemouth Uni.	
18	17	*	Taking Trust Vision beyond 2016/17	C	TS	DESIGN PHASE Exec team to work with Change Champions in a workshop Establish a design team Scope the work	OD working with Senior Leadership team, Change Champions, Comms	Staff surveys report that: Staff understand Trust vision and their role in helping to deliver it. Staff feel inspired and committed to supporting the vision.	Not a re-write. A reinforcement
19	18	*	Taking Trust Strategy beyond 2016/17	C	TS	DESIGN PHASE What vanguard/CSR mean for our staff - the compelling strategic narrative. Engage wider leadership team to develop strategy and problem solve. Introduce quarterly Senior Leadership team(Exec, DOOs, HONQs, CDs, DMs & Matrons, Heads of Service) workshops to engage wider leadership team in developing strategy.	TS working with Senior Leadership team, Comms	Clear direction of travel for the trust for the next 5 years. Staff feel committed and inspired to contribute to the success of the organisation and understand their role in achieving it.	

	A	B	C	D	E	F	G	H	I
1		Priority	ACTION	Category	Sponsor	How	Lead	Outcome	Notes
20	19	*	Care Group Development	C	RR	DESIGN PHASE DOOs with OD review current arrangements and make recommendations to include: -Leadership/manager job descriptions, -scheme of delegation, -Levels of hierarchy and accountabilities from Board to Ward, -Develop authority and autonomy to act. -Care Group support teams as enablers Care Group development programme	OD with support from DOOs	Care Group model fit for purpose to deliver strategy and vision.	
21	20	*	Develop a cohesive staff engagement strategy with our staff and name our Executive Lead	C	TS	DESIGN PHASE Establish a design team Scope the work Use cultural audit data to develop SES Continue to listen and involve staff through focus groups	HR with OD, Change Champions, Staff Governors.	Clear statement that Staff matter with a plan for: -Attraction and retention -Staff Wellbeing -Recognition, Reward & celebrating success -Induction -Medical Engagement -Develop relationships and connectedness with our staff.	Connecting the elements of the SES Exit interviews Values based recruitment Probationary periods Recognition and reward - emphasis on team working, innovation and ideas into action.
22	21	*	Develop Management & Leadership Development investment plan	C	NH	DESIGN PHASE Establish a design team Scope the work	OD, Change Champions, leadership programme alumni	Investment plan to deliver Leadership Strategy Leadership Development programmes Menu based management skills training and development	Leadership defines culture. Support staff to develop skills and competencies to manage and lead well - building local capacity and capability.
23	22	*	Develop a Trust Communications & Marketing Strategy to support staff and patient engagement	C	KA	DESIGN PHASE Establish a design team Scope the work	Comms, Change Champions, OD, Governors, NED, CD	Comprehensive joined up, connected messages relevant to the specific audience, with consistent branding linked to values Modernise website & intranet Social media unblocked and used to connect with staff	
24	23		Develop a Leadership Strategy (Appendix D from Cultural Audit Report)	C	NH	DESIGN PHASE Establish a design team Scope the work	OD working with Change Champions, MD/DMD, DOOs, Leadership programme alumni	Competent, capable, confident managers and creating the desired culture. Succession plans Talent pipeline	
25	24		Strengthen our approach to patient engagement and involvement	C	PS	DESIGN PHASE Establish a design team Scope the work Learn from Day Hospital approach Include patients	PS working with Change Champions, patients, OD, RR, CCG, Governors, QI	A planned and effective approach to genuine patient involvement in the design of our services	Design around the CSR and Vanguard opportunities

	A	B	C	D	E	F	G	H	I
1		Priority	ACTION	Category	Sponsor	How	Lead	Outcome	Notes
26	25	*	Support staff to speak out (against poor practice, unsafe practice, poor behaviour)	C	PS	DESIGN PHASE Establish a design team Scope the work Develop local policy Develop support package Identify Guardian	PS working with OD, Change Champions, HR, Comms, Clinical Governance, Clinical QI lead	Local version of national integrated whistleblowing policy shared with staff Guardian identified All staff feel safe to speak out and raise concerns	Funding available to support Vital Conversations training in year. Beyond this it will be included in the leadership development strategy and investment plan. Link to Speak Out Safely Campaign.
27	26		Build internal OD and LD capacity to deliver the Leadership Strategy and reduce dependency on external providers	C	NH	DESIGN PHASE Establish a design team Scope the work Identify staff for training and development Create skills development programme	OD	An internal team of skilled and competent OD and LD practitioners Reduced reliance on external providers An opportunity to provide support to other organisations	

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th July 2016 – Part I
Subject:	CSR - Community Site Specific Consultation Options
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	No
Officer with overall responsibility:	Tony Spotswood, Chief Operating Officer
Author(s) of papers:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	CSR Proposal
Action required: Approve/Discuss/Information/Note	For discussion
Executive Summary: <p>The CCG is proposing a new strategy for community and primary care provision. This paper outlines possible options (subject to consultation) to change and develop the focus of community hospitals. The Board's views are sought on the proposals including correlation of how they affect services provided by this Trust.</p>	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All of these
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	

Dorset CCG – Governing Body Meeting

CSR – Community Site Specific Consultation Options

Introduction

The Dorset Clinical Service Review (CSR) has laid out options for the reorganisation of the acute services across Dorset and Dorset CCG has expressed their preference for RBH as the major emergency hospital for Dorset. In parallel with this has been a review of a community model of care, which sees the development of a series of “community hubs” intended to further the aim of admissions avoidance and support for patients at or close to home. The attached paper (Annex A) is to be considered by the CCGs Governing Body on the 20th July.

Implicit in the CSR was a reduction of 25% in non-elective medical admissions and a reduction of 20% in the surgical equivalent and these figures are affirmed in this paper. In addition to this there are several key discussion points and recommendations, including the use of Christchurch Hospital as part of the network of community hubs.

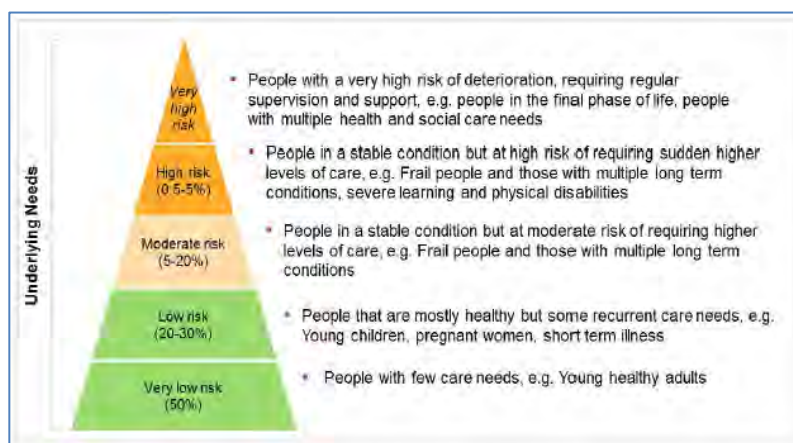
Process

The paper asks the CCG Governing Body to:

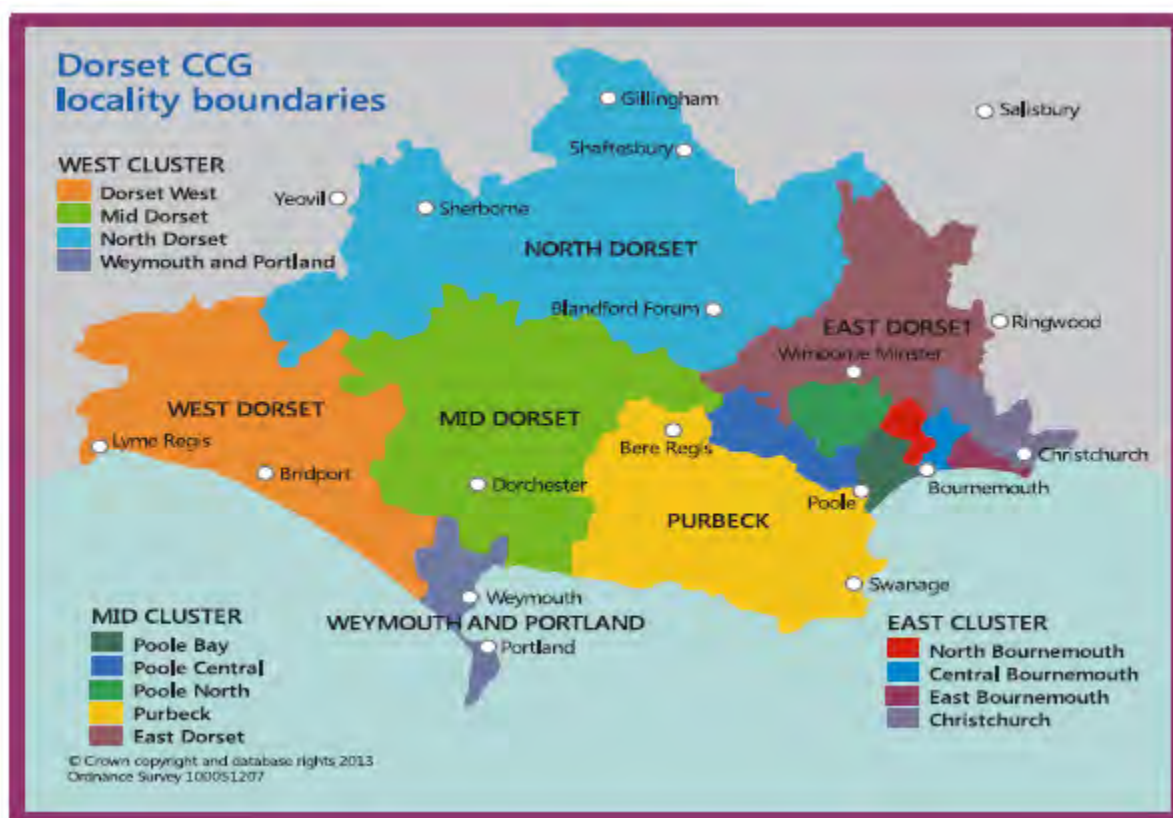
- approve the CCG integrated community services preferred community site-specific options for community hubs with and without beds;
- approve the proposal to proceed to consultation;
- approve the delegation of authority to the Chair and Chief Officer to make reasonable amendments to the public consultation proposal to address the external assurance feedback;

The document includes the following sections:

- A stratification of the population and an understanding of the relevant models of care (see model alongside)
- A series of evaluation criteria, including access, affordability, workforce, deliverability
- A consultation process, including questions to and responses from the public
- A series of recommendations



Service Model



The nature of the model of community care and its successful operation are key to ensuring the successfully running of our Trust and are described as follows:

In each locality the following services will be delivered;

- A rapid response team to assess and support people with complex and high level needs
- A multidisciplinary team of Doctors, Nurses, Therapists, Pharmacists, Social Care and community and voluntary sector staff to treat and care for people and to support self- management and independence

At least one community hub using existing facilities;

- Urgent Care Centres (UCC) (if Primary Care urgent care is managed through UCC, and provides the scale required, and not near an existing emergency department)
- Outpatient consultations for diabetes, geriatrics, dermatology and therapies (Physiotherapy, Occupational Therapy, Podiatry and Audiology) could be run from 13 or more sites (subject to further detailed analysis by speciality).
- Scale, efficiency, sub specialism and diagnostic need/scale allows for 7 to 13 sites for the all other specialties (subject to further detailed analysis by speciality);
- For example orthopaedics delivered from 13 sites but not all sub-specialisms in all 13 sites e.g. ankle clinic;
- Base for Integrated Health and Social Care Teams.

The following services will be also available at locality level;

- Mental Health teams and Integrated Learning Disability teams;
- Potential for a wider range of early help and community resources;
- Pharmacy.

In each cluster area (West, Mid and East Dorset) the following services will be delivered;

- A large community bedded hub or network of beds:
 - Step up beds from people's homes;
 - Step down beds from acute hospital;
 - A wide range of outpatient facilities;
 - Daycase facilities;
 - X-ray/other diagnostic facilities;
 - Urgent Care Centre for minor injuries and ailments, (if not co-located with a major hospital) supporting people who historically go to the emergency department.

Results / Recommendations

Based on a set of criteria (quality, access, affordability, workforce, and deliverability) the paper makes a series of recommendations regarding which community facilities should be developed into community hubs.

A key factor in the report is recognition that East Dorset and in particular our conurbation, has a dearth of community beds when compared with the west of the county. *“The results of the bed modelling indicate that over the next five years we require an additional 69 community beds and redistribution across the County to reflect local needs, with a decrease of community beds in the West of the County, and an increase in the East.”*

The report makes reference to the fact that the selection of the major emergency / elective has not been concluded and confirms that whichever site ends up being the planned site, it will incorporate some community beds and services and be a key part of the community health infrastructure.

The CCG has also sought some pre-consultation views and the principal ones relating to our geography are at Annex B.

The site specific recommendations of the report are as follows:

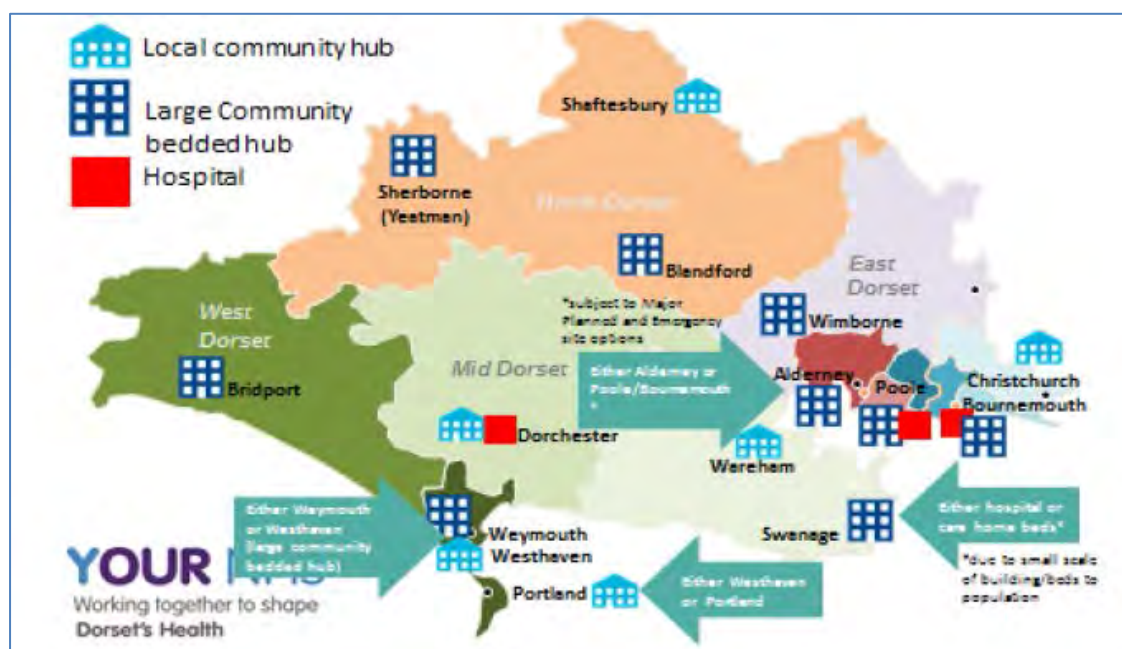
- 2.24 It is recommended that the following are the CCG preferred site specific options for the future delivery of community hubs with and without beds:

Community hospital hubs with beds	Community hubs without beds
<ul style="list-style-type: none"> • Poole or Bournemouth hospitals (subject to public consultation on the preferred major planned hospital) • Wimborne Hospital • Bridport Hospital • Blandford Hospital • Sherborne Hospital • Swanage Hospital • Weymouth Hospital 	<ul style="list-style-type: none"> • Shaftesbury (with care home beds) • Christchurch (with care home beds for the Christchurch and Bournemouth areas) • Dorset County Hospital* • Portland • Wareham (with care home beds)

*Dorset County Hospital is also an acute hospital

- 2.25 It is recommended that Alderney, Westhaven and St Leonards would no longer be community hospital hubs, and the services re-provided within the recommend sites. In addition, it is recommended that alternative sites for the local hubs without beds, in Portland, Shaftesbury and Wareham are pursued.

The geography of the recommendation across Dorset is shown below:



Although there is no suggestion in the report that any of the sites that are no longer community hubs would close, the fact that they are not being developed as part of this plan might suggest that their future might be in question. This may therefore give rise to another series of communication issues associated with the development of the Dorset health system.

The specific statements relating to the East Dorset, Poole and Bournemouth / Christchurch localities are shown below.

Impact on RBCH

One of the principal factors affecting the operational performance of RBCH is the high level of delayed Transfers of Care (DTOC). These are principally associated with the lack of domiciliary care packages and residential care and it is not clear if any of the changes envisaged here will necessarily improve this position.

It is critical to the success of the reorganisation of the acute services that the community services provide a coherent and complementary service, in particular responding to the challenges offered by demography and manpower and financial constraints. There are intentions and assumptions in both the overall Sustainability and Transformation Plan and the Clinical Services Review that will only deliver the intended outcomes if community services operate in an integrated and collaborative fashion. The fact that many of these services sit within different organisations has meant in the past that it has been difficult to ensure seamless and efficient services when individual organisational priorities are very different.

This CCG paper is only about the model of care and the implications for the health estate across the County – it does not address the organisational form, or the workforce development, both of which will be key in future.

Summary of Site Specific Preferred Options – East Dorset, Poole & Bournemouth

East Dorset

To have a community hub with a wide range of facilities including outpatients, diagnostics and community beds at Wimborne. In addition access to community hubs in neighbouring Christchurch, Poole and Blandford hospitals. Initial discussions have commenced with West Hampshire CCG regarding the potential for collaboration in commissioning future provision for the population around the Hampshire/Dorset border in the Ferndown area.

Poole Localities

To have access to 1 community hub with a wide range of facilities including outpatients, diagnostics and community beds at Poole hospital or Bournemouth hospital (subject to the outcome of public consultation on the location of the major planned hospital). In addition access to the community hub in neighbouring Wimborne hospital.

Bournemouth and Christchurch Localities

To have a hub without community hospital beds (there is palliative care beds) at Christchurch hospital, and community beds in a range of sites across the area, using short term care home beds with enhanced support, and access to 1 large community hub with a wide range of facilities including outpatients, diagnostics and community beds at Poole hospital or Bournemouth hospital (subject to the outcome of public consultation on the location of the major planned site).

Recommendations

The Board is invited to comment on the proposals and highlight any specific issues or requirements it wishes to see discussed further with the CCG.

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BOARD OF DIRECTORS

Meeting Date and Part:	29 July 2016 Part 1
Reason for Part 2:	n/a
Subject:	Update on work of the Dorset Vanguard
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	No
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	Trust Management and Board of Directors
Action required:	The Board is invited to comment on the key workstream deliverables.
<p>Executive Summary:</p> <p>This paper briefly summarises the outcome of the work undertaken by the Vanguard Board to agree deliverables for each of the key workstreams. The paper is presented for information and comment.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	All
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	

Dorset Vanguard Update

Attached is a summary of the prioritised deliverables for each of the Vanguard work streams which the Board is invited to consider and comment on.

NHSI have now requested that all STP footprints in England develop proposals for the consolidation of Pathology and Back Office services as a minimum within the strategic footprint. With specific regard to Pathology services a strategic outline case is currently being developed and will recommend a single integrated service introduced across Dorset. The case is likely to identify savings across the three Trusts in the order of £2-2.5m. Integral to a single integrated service is the development of a unified local information management system which enables common approach to the requesting and reporting of tests across all three hospitals and primary care within Dorset. The intention is to bring back a detailed Business Case for consideration by the Board in the autumn and work continues with colleagues in all Trusts to consider which elements of the Pathology service need to be located on an emergency site, an acute hospital site, and a planned care site. Further discussions will then take place concerning where other less site specific or automated services are best located within the confines of the need to best use the estate within Dorset.

This paper is provided for information. I would welcome comments or questions from Board members on the key deliverables as described in the attached diagram.

Tony Spotswood
Chief Executive

One acute network – prioritised deliverables

11th July 2016

Improving consistency of care and removing unwarranted variation in **clinical outcomes**

Improving the **safety and quality** of services and improving **access to services** – which in turn improve **patient experience**

Creating **resource sustainability** and delivering value for money



*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	29 th July 2016 – Part I
Subject:	Dorset Sustainability and Transformation Plan
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	Our Dorset STP Final Our Dorset Appendix Final
Officer with overall responsibility:	Tony Spotswood, Chief Operating Officer
Author(s) of papers:	Sandy Edington, Associate Director Service Development
Details of previous discussion and/or dissemination:	The Board has received early drafts of this document
Action required: Approve/Discuss/Information/Note	For information
Executive Summary: <p>This paper briefly introduces and summarises the content of the Dorset Sustainability and Transformation Plan. A full copy of the plan and associated Appendices is available within the Reading Pack</p>	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	

Dorset Sustainability and Transformation Plan

1. Introduction

This paper briefly introduces and summarises the content of the Dorset Sustainability and Transformation Plan (STP).

The STP for the Dorset “footprint” has been under development over the last few months and the final document was submitted to NHS Improvement (NHSI) - previously Monitor- at the end of June. This has been led by the CCG with participation from all Dorset health organisations and local authorities and is thus designated as a health system plan rather than an individual organisation’s plan.

Much of the intention of the plan is described in its title – one fundamental was to describe the Dorset health system’s route back to financial balance, but it also signals a move toward a planning model that is health system based and thus wider than either individual health organisations such as Trusts, or the NHS itself.

This is part of a national exercise and therefore the translation of this into a local plan and structure is important; in essence the STP can be seen as the umbrella plan for all the various programmes already underway including, for example, the acute and community Vanguard initiatives. Importantly, the Clinical Service Review (CSR) can be seen as one part of this overall STP strategy.

2. The Dorset STP

“Our Dorset”, the Dorset health system STP, is set out based on the guidance offered from NHSI and describes the challenges facing health the local system in terms of three gaps – health and wellbeing; care and quality; and finance and efficiency. By way of response to these challenges, three broad programmes of work are outlined – Prevention at Scale; Integrated Community; and One Acute Network and supporting these are two enabling programmes – Leading and Working Differently and Digitally-Enabled Dorset. The CSR and its implementation is the major part of the One Acute Network programme.



A key feature locally has been the parallel development of a System Leadership Team (SLT) with senior representation from all of the statutory health and local authority organisations within Dorset.

2.1 “Our Local Challenges”

The narrative on this covers the following;

Health & Wellbeing – demographics; obesity; mental health; gap between poorest and richest; rise in heart disease in Bournemouth.

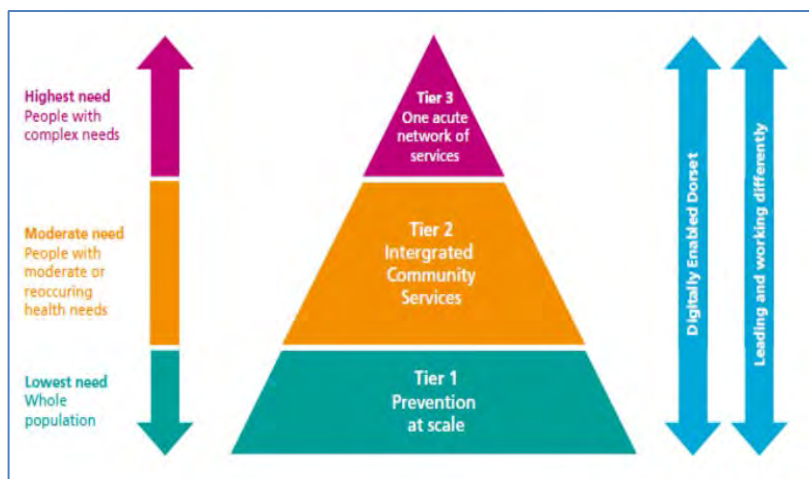
Care & Quality – Quality standards (high and rising); discharge delays; variations in quality eg diabetes; immunisation rates; dental care.

Finance & Efficiency – in 5 years a shortfall of £158m per annum; increase efficiency; gaps in staffing eg domiciliary care, nursing, GPs; organising and delivering differently; invest more in prevention.

2.2 “Our Plans”

Prevention at Scale

These plans include primary prevention (staying healthy), secondary prevention (staying well) and tertiary prevention (staying independent). This section also covers the wider determinants of health such as a focus on children and families, job creation, housing availability/quality and supporting the development of communities.



Integrated Community Services

This section has its emphasis on the seamlessness of patients' care as they move through NHS and non-NHS services, recognises the increasing numbers of patients with chronic conditions and the need for a multidisciplinary approach to supporting them. The intention is to support patients to manage their own health, including the use of new technologies and a review of the existing NHS estate.

One Acute Network

Much of this section is about the CSR, including the selection of RBCH as the CCG's preferred option as the Major Emergency Hospital, but it also includes the work going on to deliver the Acute Vanguard programme (One NHS in Dorset).

Enabling Programmes - Leading and Working Differently

The workforce affected by this plan numbers around 30,000 and the STP recognises the need to deploy these differently and to develop different roles and skills. The section also highlights the potential for new and different organisations (Accountable Care Organisations) to take this forward and for the potential for one of these to cover the east of the County.

Enabling Programmes - Digitally-Enabled Dorset.

This describes the alignment of the various digital strategies of the local providers and includes the implementation of the Dorset Care Record - intended to facilitate the sharing of patient information across both health and social care organisations, to improve safety and efficiency.

3. Conclusion

The conclusion of the STP is essentially a request for national financial support for the wide range of programmes across the Dorset health system, supporting the principal of sustainability and transformation and this incorporate the funding associated with the CSR.

4. Recommendation

This paper is provided to the Board for information
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BOARD OF DIRECTORS MEETING – 29 July 2016

PART 2 AGENDA - **CONFIDENTIAL**

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

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

Timings		Purpose	Presenter
11.00	1. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 24 June 2016		<i>All</i>
11.05	2. MATTERS ARISING		
	a) To provide updates to the Actions Log		<i>All</i>
	b) Update on Christchurch Issues (paper)	Information	<i>Richard Renaut</i>
11.15	3. STRATEGY AND RISK		
	a) Significant Risk and Assurance Framework (paper)	Information	<i>Ellen Bull</i>
	b) CSR (paper)	Information	<i>Tony Spotswood</i>
	c) Wessex Fields Land use (paper)	Discussion	<i>Richard Renaut</i>
11.35	4. GOVERNANCE		
	a) Terms of Reference Review Finance Committee (paper)	Decision	<i>John Lelliott/ Stuart Hunter</i>
	b) Well-led Self-Assessment (paper)	Discussion	<i>Anneliese Harrison</i>
	c) Appraisal and Revalidation Annual Report including Annual Organisation Audit Report (paper)	Decision	<i>Basil Fozard</i>
	d) NICE Appraisal and Compliance (paper)	Approval	<i>Basil Fozard</i>
	e) Update from the Chair of the Audit Committee (verbal)	Discussion	<i>Steven Peacock</i>
12.10	5. QUALITY		
	a) Maternity external review and actions taken (paper)	Discussion	<i>Basil Fozard</i>
	b) CQC Action Plan (paper)	Discussion	<i>Ellen Bull To Follow</i>
12.30	6. PERFORMANCE		
	a) Sustainability and Transformation Fund (paper)	Information	<i>Stuart Hunter</i>
	b) Facilities Business Case (paper)	Decision	<i>Richard Renaut To Follow</i>
13.00	7. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff		
	b) Reflective Review		