

A meeting of the Board of Directors will be held on Friday 28 October 2016 at 8.30am in the Conference Room, Education Centre, The Royal Bournemouth Hospital.

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

Karen Flaherty
Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8:30-8:35	1. APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
	Derek Dundas,		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 30 September 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>Paula Shobbrook</i>
	b) Feedback from Staff Governors (verbal)	Information	<i>Jane Stichbury</i>
	c) Complaints Report (paper)	Information	<i>Paula Shobbrook</i>
	d) Feedback from CQC – Engagement Meeting (verbal)	Information	<i>Paula Shobbrook</i>
9.15-10.10	5. PERFORMANCE		
	a) Performance Exception Report (paper)	Information	<i>Richard Renaut</i>
	b) Quality Report (paper)	Discussion	<i>Paula Shobbrook</i>
	c) Finance Report (paper)	Discussion	<i>Stuart Hunter</i>
	d) Workforce Report (paper)	Discussion	<i>Karen Allman</i>
10.10-10.55	6. STRATEGY AND RISK		
	a) Clinical Services Review (paper)	Information	<i>Tony Spotswood</i>
	b) Vanguard: One NHS in Dorset update (paper)	Information	<i>Tony Spotswood</i>
	c) Planning Guidance 2017/18 and 2018/19 (paper)	Information	<i>Tony Spotswood</i>
	d) Trust Vision Update: Most Improved Hospital (presentation)	Information	<i>Tony Spotswood</i>
	e) Winter Plan and Trust-wide Escalation (paper)	Discussion	<i>Richard Renaut</i>

7. GOVERNANCE

- a) No items

8. NEXT MEETING

Friday **25 November 2016** at 8.30am in the Conference Room, Education Centre,
The Royal Bournemouth Hospital

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 30 September** in the Hilary Christy Room, Greyfriars Community Centre, Ringwood, Hants

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</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>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Stuart Hunter	(SH)	<i>Director of Finance</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	Steven Peacock	(SP)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Karen Allman	(KA)	<i>Director of HR</i>
	Nicola Hartley	(NH)	<i>Director of OD and Leadership</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>
	Lynn Davidson	(LD)	<i>PA to Medical Director (minutes)</i>
	Dily Ruffer	(DR)	<i>Governor Co-Ordinator</i>
Public/ Governors:	David Brown		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Carole Deas		<i>Public Governor</i>
	Keith Mitchell		<i>Public Governor</i>
	Roger Parsons		<i>Public Governor</i>
	David Bellamy		<i>Public Governor</i>
	Bob Gee		<i>Public Governor</i>
	Doreen Holford		<i>Public Governor</i>
	Sue Parsons		<i>Public Governor</i>
Staff:	Lisa Brinkman		
	Marie Miller		
	Alison Pressage		
	James Donald		
	Noel Tadman		
Public:	Mark Hill		

Apologies
69/16

WELCOME

Action

The chairperson welcomed those attending. The Board Charter was emphasised in particular transparency and consistency in decision making. The Board Charter will be covered at the start of each Board Meeting; the venue today supports transparency, as a Board and Hospital Trust by making us more accessible to our Hampshire patients.

Minutes of the meeting held on 29 July 2016 (Item 2a)

The minutes of the meeting held on 29 July were **approved** as an accurate record.

To provide updates to the action log (Item 3a)

- 62/16 (c) CQC Inpatient Survey Results –Work is on-going to develop a proposal to measure progress against the Trust's vision. A draft will be circulated for comment prior to the October Board. **Action** Agenda item Part I October Board.
- 62/16 (e) Finance Report – Private Patient Business case and return on investment of the new unit along with an update on the Regents Park partnership will be provided firstly to the Finance Committee and then to the October Board.
- 68/16 (5) Call bell technology – There are two main call bell systems in Trust; one can be digitally upgraded to pager alerts with pc popups. Training for staff to fully use system in particular the turn down at night functions. A Group has been set up Looking at successes for wards and areas for improvement.

To approve 2017 meeting dates (Item 3b)

Discussion to be taken outside of meeting for confirmation, 15th December 2017, being preferable. Location to be determined and confirmed.

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

The patient story focused on the patient experience survey for Cancer Care. The results provided in July 2016 are for previous patients in July 2015.

Themes from the survey included communication, privacy and dignity and information giving. These were scored and the Trust came out well and there has been further improvement in a number of areas.

Cancer Care moved into the new Jigsaw building which opened officially in March 2016. The new unit has enabled more services to be provided which were unavailable previously, including a purpose built chemotherapy day unit.

The specialist cancer nurses in haematology and oncology work together to ensure that the patient journey is as positive as it can be, providing a positive environment. Positive feedback has been received from patients and family.

There is a wealth of information available throughout the unit; such as national Macmillan cancer support packs, booklets about the hospital's ward 11, the day unit, explanation about chemotherapy and treatment, who to contact, wallet sized emergency cards and the Macmillan bus. The information is accessible to both patients

and family.

Working with the Dorset network to look at patient information and how patients receive information. There are information hubs supported by Macmillan Cancer in different areas such as Kinson library and Blandford. These are advertised in the Unit in order for our patients to obtain as much information as possible.

Discharge from treatment can be daunting, in order to ensure patients do not feel alone after treatment support projects and contacts have been put in place. Specialist nurses are available, which are funded by charities to ensure there is contact if needed.

A social worker is based in the day unit and a Macmillan funded social worker in the hospital. There is also a student social worker who has joined the team; some of the support provided to patients goes above and beyond what is required. The social workers can educate patients and staff about all the different benefits available to ensure that all patients receive the appropriate benefits.

The Jigsaw building has provided more space and has private booths for patient privacy.

Recruited Macmillan Acute Oncology & Cancer of Unknown Primary (CUP) nurse specialist, to support patients who arrive having not been diagnosed, into ED, AMU or wards. Most CUP patients will have palliative prognosis and normally go to the palliative team.

There is a cancer specialist nurse based in the Jigsaw building who provides 1:1 to patients prior to chemotherapy along with group sessions and she set up the HOPE course which is due to commence end of 2016. The HOPE course is sponsored by Macmillan and is a 6 weeks survivorship programme for patients finishing treatment.

Working with Wessex cancer looking at an alternative therapy service to offer a 1 day a week service at the Jigsaw building for our patients. Wessex Cancer Trust have opened a day centre service in Bournemouth and is open 3 days a week and will be extending to 5 due to popularity.

It was queried whether there was an appetite amongst partners to have an online service. Although this is an up and coming theme especially for the younger generation, the majority of patients prefer the personal contact to discuss concerns.

The Board discussed the paper communication available and the importance of support for personal contact, enabling patients to talk about concerns. It was highlighted the hospital is thinking beyond the direct patient interaction with the holistic personal approach which complements the other services available.

The HOPE course and previous work in relation to exercise and dietary input was queried. It was confirmed patients are referred although it was unclear how this was funded. **Action** to clarify funding

PS

It was queried whether it might be possible for mobile devices to be brought into sessions to record patient discussions in order that they may listen through again and review at a later stage. Although there is a website which is visited frequently it would be useful for this to include the information group sessions. **Action** Recording discussions to be shared as an idea.

PS

The Board were advised that the RBCH Charity is always very supportive; they fund the social worker, the live support nurse and are funding the alternative therapy. The Unit is continuing to work closely with Wessex and within the Dorset Network. Learning is shared with partner agencies.

The Chair commended the work carried out by the team. The facilities are of an exceptional standard, and the patient feedback has been superb since the Jigsaw Building has opened.

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

The Chairperson outlined the themes from the meeting with the Staff Governors which included:

- Reflection on staff Governor listening events and attendance
- Noted the next Junior Doctors listening event on 1st November
- Importance of continuing to push the message about raising concerns.
- Emphasised the challenges managing through change brings
- Theatres- discussion re aspects raised by staff
- Patient transport and some of the difficulties observed in respect of some patients and the reliability of the transport and the need to escalate.
- CSR
- Forthcoming staff survey
- Health Assurance Committee (HAC)
- Recent Governor Election results were noted:-
Sue Parsons, elected Governor, three year turn of office
Alan Radley, re-elected, three year turn of office
Petrina Taylor, re-elected as the Staff Governor representing nursing .
Good bye to Guy Rouquette and many thanks for his work as a Governor.

(c) Complaints Report (item 4c) (Paper)

The report was summarised with following highlighted;

- Report was reviewed in detail at HAC
- Acknowledgement times has been validated as 92% for August
- Response times, Surgical and Specialties Care Groups are managing well. Medical Care Group is finding the targets challenging, due to a new team. The Head of Nursing for Care Group has taken personal responsibility to manage in the short term.

- Good Progress seen in Care of the elderly, with increased response times. On trajectory of improvement for Medical Care Group
- 25 formal complaints, along with informal contact which are managed at point of contact by the PALS team
- Detail of Parliamentary Health Service Ombudsman (PHSO) - 7 enquiries closed. 1 was upheld, a full action plan has been sent to PHSO and complainant.

The positive effect of telephone communication with the complainant and how this may help to deflect some of the formal complaints was highlighted.

It was queried whether an impressionistic analysis in terms of quality of the main areas of complaints was available. Although the report is at high level, these themes are discussed at HAC; nationally one of the key themes has been communication. A lot has been done and there has been improvement. A communication course has been introduced with significant improvement. Other themes are quality of treatment and cared for with compassion, however, the majority of feedback is positive.

It was highlighted that within the last 12 months there has been an increase in the number of complaints coming through questioning the care that was given, an increase in the number of claims and a significant rise in the request for notes. It is unclear whether this is driven by legal routes.

Assurance was queried in relation to the Medical Care Group as to whether the issues were administrative, and there was the correct level of clinical engagement. The administrative first response has been looked at and resolved and a process implemented for sickness pressures. A proactive approach to complaints is required, ensuring face to face discussions with the consultant or senior person. Surgery has made excellent progress, they reviewed their structure and they have a person responsible to deal with complaints. There is good engagement from all the Care Groups.

The Chair confirmed there had been a detailed discussion at HAC, this is an interim position for the Medical Care Group and assurance was provided that processes are in place. The message from the Board which is to be fed back; the Board is not being complacent about complaints and support will be provided as required to ensure those addressing complaints can hold people to account in order to get the information they require.

(d) Adult Safeguarding and Child Protection and Safeguarding Report (Item 4d) (Paper)

The key themes of the report were highlighted

- Statutory report for Board
- Robust processes are in place for adults and children; the report includes data in terms of the number of patients that have come through.
- Deprivation of Liberty safeguards (DoLs)

- Learning disabilities
- Good links in place with safeguarding adults and safeguarding children's Boards.
- The report includes some highlights on investigations.
- Focus for coming year; sharing of learning, as per the internal audit. Introducing newsletters and conversations with Matron Groups. There is a lot of engagement throughout the organisation with Medical leads, Champions in departments for safeguarding, along with Medical engagement through name Doctor and local lead.
- CQC outcome 7 safeguarding – positive feedback in relation to safeguarding processes. The report aims to bring together the information for Board and to re-emphasise that strong processes are in place.

It was confirmed that the Deprivation of Liberty applications made during 2015/16 were made by the Trust and were accurate.

FGM reporting was discussed and it was confirmed the Trust is reporting any such cases.

It was confirmed that training and engagement has significantly increased, training is being reviewed to ensure it is applicable for Doctors and there have been conversations through Trust Management Board (TMB) and this is the focus for the coming year. It was highlighted that someone cannot have their appraisal if they have not completed their mandatory training. New medical starters are chased and it is ensured that they have time to complete their mandatory training.

The Chair emphasised that the DoLs issue is sensitive, mandatory training continues to be of interest and importance, and would like this brought back to Board at a later date to ensure mandatory training is improving. **Action**

PS

72/16

PERFORMANCE

(a) Performance Exception Report (Item 5a)

The report was taken as read with following highlighted

- Trust performance in August secured the STF with all KPIs achieving national target and trajectory submission excepting RTT.
- Significant risk for second half of the year particularly on RTT, there are similar positions across the South of England where RTT appears to be the largest risk of non-compliance.
- Strong performance in A&E 4 hour, this may be difficult to maintain with winter pressures.

It was confirmed that the quarter would be achieved and YTD would be approximately 95%.

The Chair queried the Risk in terms of the routine elective. It was advised patients are on an elective pathway, ophthalmology are known to risk, with an approximate 8% growth in referrals and staffing pressures. Southampton and Dorchester have the same

pressures. There is generally increasing trend of demand vs capacity. Although comfortably avoiding very long waits, nationally missing RTT target.

The Chair asked if there was anything the Board could do to support. The Board was advised there are 20-25 weeks for completion of referral pathway; there is a role for commissioners in terms of opening up additional capacity. Outside of this we should look at what can be done to control flow.

Assurance was provided that there is a plan of action which could be provided at the next Board.

It was queried whether there could be meetings with the CCG to discuss the issues. It was reported there was Joint Board meeting with CCG 2nd November, and that a B2B had been held during the year. The value of a further B2B should be considered.

A Meeting with the GP locality Leads to be arranged **Action**

RR

The Board warmly thanked the Performance Team.

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

HAC will be on a two monthly cycle; this new schedule is in transition. The idea being there is an interim operational focused meeting with HAC focusing on underlying issues.

The general consensus from HAC was there was nothing urgent to report to the Board.

One of the themes HAC will start to look at will be interrelationships, it was identified performance is measured in individual areas and those areas are not static due to changing pressures, the process will look at those underlying issues. How issues relating to workforce and capacity feeds into the aspects of quality.

(c) Quality Report (Item 5c) (paper)

The key themes of the report were highlighted

- Three Serious Incidents (SIs) reported. Two relate to information governance, both of these have been closed by the Information Governor. The third SI is in terms of treatment delay, duty of Candour has been paramount in the process. The Trust remains in top quartile for Family and Friends tests.
- Continued improvement on Harm Free Care score. This is the highest score obtained in 2016. This is due to campaigns and focus on pressure damage and a reduction in falls with harm.
- Good correlation in terms of performance and quality.

The Chair reflected on the work in relation to pressure damage and falls, and the sustained effort to achieve results.

It was advised that Friends and Family ED results remains

challenging in terms of the difficulties in obtaining the feedback. A process to obtain feedback from patients after they have left ED is being investigated. Outpatients is work in progress.

It was highlighted there are 3330 check- (circa 30,000?) outpatients attendances each year, with a minimal number of complaints, it is about customer care. This data can be used with customer information training which is envisaged to start in this financial year, the timetable will be brought back to a future Board.

(d) Report from Chair of Finance and Performance Committee (Item 5d) (Paper)

A brief summary was provided by the Chair of the Finance and Performance Committee with the following highlighted;

- Focused on CIP, areas to make future savings and efficiency initiatives.
- 2017/18 will be challenging with October being an important meeting.

(e) Finance Report (Item 5f) (paper)

The report was summarised and the following themes were noted:

- The Trust has achieved its year to date control total, however contingency was released in month to achieve. Contingency set at the start of the financial year for unforeseen issues. The main elements being income coding and an excess bed day reduction.
- Private Patient Income has continued to decline and remains behind plan. This will be discussed further during the November Board.
- The Sustainability & Transformation Fund (STF) achieved in month.
- Cost Improvement Plan – There remains a gap between the CIP target for the year and the value of schemes currently identified. Closing this gap remains a key focus.
- Good solid position on savings delivered year to date, savings are delivered every year at the level required however in the current year the Trust remains behind plan. This risk was highlighted at beginning of year. This will be an agenda item at the October Finance Committee. A paper will be brought back to the Board in November for this year and 2017/18
- Capital expenditure behind plan, both of these are timing delays rather than avoidance of expenditure.
- The Trust has returned to a level 3 financial risk rating which is in line with the annual plan forecast.
- Junior Doctors – pleased that the junior doctors' strikes were called off, not only because of the impact to our patients but from a financial point of view.
- Remain below agency cap set by Monitor, this now features in the new Monitor metrics.

A query was raised in relation to the shortfall in clinical income, in particular the NHS England Wessex. It was advised the variance was in relation to HEPC drug income, the rules have since been changed after the budgets were set, however this does not affect the bottom line as income and expenditure.

The maintenance of position and achieving targets with the use of contingency was queried. It was reported that the forecast predicts the Trust will achieve the control total for the year. However it is very tight and the October Finance Committee will be dedicated to the recovery plans.

It was confirmed that income coding work is on-going.

The Chair requested assurance in relation to the last NHSI investigation and the overall grip on finances within the Trust. Assurance was provided on Directorate Cost Control, a lot of work will continue to deliver savings although challenging, along with CSR.

It was emphasised the pace at which CSR can be executed is dictated by the national bodies and regulators, there will be a difficult period which will hinder the delivery of savings because of the slowness of executing some of the CSR strategies. Need to ensure from a Carter perspective, that priority actions are completed. The Board needs to consider a perceptible change in terms of the approach at which local authorities are taking in the slowdown in patients being able access packages of care.

Discussions have started in relation to expanding bed base in winter in order to ensure sufficient beds for emergency patients. This must be positioned carefully and will create some significant issues as a Board in terms of how to manage conflicting pressures.

The Board was advised that the Control total for the next two years would be received today, the Dorset footprint will also receive a control total, and this brings CCGs and the providers together.

The Chair thanked the Finance Committee and Finance Team for the work which is being undertaken.

Action: Performance to be moved behind Finance report on agenda.

(f) Report from Chair Workforce and Strategy Committee (Item 5f) (verbal)

A brief summary was provided by the Chair of the Workforce and Strategy Committee with the following highlighted:

- Significant risk in trajectory and agency usage apart from Medical.
- 90% values based appraisals should be completed.
- Status from Directors of Operations received about consultant job planning completion.
- Discussions re sickness in particular about when to initiate

processes.

- Main focus for next meeting will be OD

(g) Workforce Report (Item 5g) (paper)

The report was summarised and the following themes were noted:

- Report reflects activity and good news stories
- Updated appraisal figure reports 77%, every area has been following up to ensure these have been booked, it is anticipated this will have improved further by the next meeting. Noted
- Essential core skills compliance has increased to 91% thereby continuing overall trajectory.
- Concern remains with sickness absence. There is some correlation between areas.
- Turnover and joiner - The joining rate continues at a higher level than turnover. Work is on-going to understand retention.
- Change in vacancy and establishing rotas. This has not made a significant difference however confident that the figures in financial budget and information figures align.
- Sickness audit – All recommendations highlighted have been implemented and reviewed. The Bradford score is to be reviewed again. Advice to Workforce Committee is to continue to review.
- Supporting overseas staff - Two Philippines staff, who took a long time to recruit, joined in April and pleased to advise that there are another 4 who will start in December.
- The programme developed by the Trust's Senior Clinical Educator has been recognised by the NHS Employers and has been publicised on their internet site as was sent out on the National Workforce bulletin to all Trusts.

The join, turnover and vacancy rate of the Medical Care Group was queried along with the significant turnover rate in Specialties. It was agreed and explanation would be provided. **Action page 62 of pack.**

KA

It was queried whether Post BREXIT would cause future issues for Overseas staff. It was confirmed Overseas staff are being supported, there are a number of workshops, however inevitably this will cause change and problems for staff. Much will depend on the final outcome of Brexit, and any changes in approach.

The Bradford Score next stages and early intervention rate was queried. It was advised the Trusts who have an early intervention rate did not necessarily have a lower sickness absence, there is no

direct correlation. The Trust's sickness absence rate is below the NHS average. This relies on local management and there have been various discussions. It was confirmed the Trust uses the Bradford Score in ward staffing reviews, and there has been a significant improvement.

The Chair (of Workforce) highlighted there is scepticism about the Bradford score and its uses, the workforce Committee are looking into whether this is continued or changed.

The Board were advised to note there are Appraisal Champions, with further workshops in November. Feedback to be supplied to the Workforce Committee.

(h) Medical Director's Report - Mortality (Item 5h) (paper)

The Board was advised the detail is recorded in the report.

The Board is reminded Mortality surveillance remains unfinished and the Board is required to keep challenging in terms of monitoring mortality.

The issue is having courage to identify when there is sub optimal care, time to record and being able to say whether an avoidable death either category 2 possible or 3 probable. This triggers the SI process with RCAs and Panels which provides the key points of learning and actions. This must be supported going forward.

The Chair commended the work, highlighting the improvements since 2013 are tangible and outstanding. Progress can be seen and should be encouraging to the public at large.

(i) NHSI Single Oversight Framework (Item 5i) (paper)

The Chair advised the paper is to be treated as information.

The following was information from the paper was highlighted:

- The document is very important, and sets out the framework and measures by which the Trust will be judged. What success looks like from the main regulator's point of view, integrates with CQC and Commissioner Contracts.
- There may be a significant number of issues which would cause concerns to the regulator.
- The Trust will be tightly regulated, some are very subjective
- Objective Setting for 2017/18 must include this framework and form part of integrated reporting

The Chair would welcome this being represented at a later stage confirming it sits within the Board Development session in November, and further time is required to work through.

The extent this would be used for internal uses was queried as double banking of data is a waste of resources, would this be used as the primary dashboard.

The Chair confirmed this should be a primary dashboard advising integrated reporting would be helpful in terms of reporting to Board and the Council of Governors.

Action NHSI seminar presentation November

As per the recommendations all the national reporting data should start flowing from this, and the question remains as to whether all current systems are rebuilt or whether advice is sought from the regulators. Some of this may be centrally covered through the Model Hospital which will be using the same data. As regulator they are very clear and appreciate duplicate reporting criteria.

It was confirmed assessments will begin 1st October, although it was unclear as to how quickly this would be formally raised.

The Chair requested further clarification. **Action**

RR

73/16

STRATEGY AND RISK

(a) Clinical Services Review (Item 6a) (Paper)

Very positive discussions with the National Investment Committee, CCG are awaiting the official letter from NHS England confirming the outcome. There is strong support for the STP proposals and in particular the CSR proposals. We are anticipating the CCG will receive formal sanction to launch public consultation in approximately six weeks.

The decision to consult does not represent confirmation that the capital is being made available. There have been detailed discussions around how much capital is required and is subject to a separate detailed business case.

There are Four tests; NHS England need to be satisfied on in terms of moving forward with consultation, one relates to enhancing patient choice, the concern that still exists is how this will be interpreted by the Competition and Markets Authority.

In order for the CSR to proceed the CMA will need to lift the existing 55 undertakings in order to implement the CSR.

One of the issues to consider is whether to parallel paths at same time; development of benefits case to support the lifting of the undertakings linked to the implementation of the CSR, along with pursuing the same arguments in order to allow the two organisations to merge. There are significant questions around the level of investment required at both sites.

On the whole this very encouraging, particularly the level of support which is available for the Dorset proposals.

There has been rapid progress made by Dorset County Hospital and Yeovil who are coming together to develop a plan for future provisions of maternity and paediatric services. There are wider questions as to whether this is sustainable.

The Chair advised discussions would continue later however the Board is open to urgent questions.

There were no urgent questions raised.

(b) Local Authority Reorganisation (Item 6b) (Paper)

This is welcomed by the Local Authorities to consider reorganisation; there have been internal discussions with the favoured option from a health perspective being option 2a.

Option 2a would bring together, particularly from the Trust's perspective the Dorset County Council and Bournemouth Local Authority services departments to work as a single function covering Christchurch, Bournemouth and Poole conurbation. This ideally matches where health is going. There is a lot of public interest and particular councillor interest surrounding this.

The recommendation to the Board is to support option 2a.

The Chair advised although there may be different views as a Board we have to do what is best for the Trust and for patients who we serve. Observations are welcome.

There were concerns around any financial position within the County. This is a good point, this does leave a residual issue in terms of Dorset, and it is thought this is a staging point on journey.

The Trust's position would align with the local authority position. The largest area of concern is within the Dorset County Council and the impact on Christchurch. From a health and patient perspective it does not make sense to differentiate between Bournemouth and Christchurch.

The Chair asked whether the Board was agreeable to support the recommendation, option 2a.

The Board Agreed to Support option 2a.

(c) Sustainability and Transformation Plan Update (Item 6c) (Paper)

The Board was advised there has been review county wide of all 44 sustainability and Transformation Plans. The feedback received

from NHS Improvement and NHS England reports the Dorset plan is one of the strongest.

All have been asked to revise their plans, on the basis of initial assessments. The paper has been redrafted to include suggested improvements to the plan in the following area:

- Primary Care
- Mental Health
- Further detail around public engagement.

There were some issues as to whether these plans are made visible across the NHS, and there is a plan to formally launch them towards the end of 2016. The Trust's initial document was made public and the revised document published in the reading room. This is particularly important with the consultation around CSR that the Trust is as open as they can be.

The Chair advised there has been very positive feedback for Dorset as a whole in terms of joint working.

(d) Junior Doctors' Strikes (Item 6d) (Verbal)

The Trust was advised the Junior Doctors' strikes have been called off, which is clearly good news for patients and the Trust.

There is a large workforce who is disengaged on a national level. The Trust should be mindful that particularly over the next two years there could be a significant rise in vacant Junior Doctors. The Trust is making progress on the agency bill. The longer term implications remain, however in the shorter term it is obviously very good news.

The chair advised there is a lot of support within Trust for Junior Doctors, and everything possible is being done to show support.

74/16

GOVERNANCE

(a) Updated Board Skills Matrix (Item 7a) (paper)

The Board was advised some discussions have taken place although some individuals were absent; the paper is for additional comments.

The Chair reported this was discussed at Blue skies 11th August

A timetable of planned sequence changes of events would be helpful when thinking about skill sets. The Chair confirmed this was prepared and discussed. ACTION- to circulate to Board the timetable that accompanies the Skills matrix- KA/Trust Sec

(b) Chair Recruitment update and NED Recruitment (Item 7b) (Verbal)

A brief summary was provided with the following highlighted:

- Working with an external national leadership academy.

- Advertised nationally
- 4 candidates have been shortlisted
- Carousel event scheduled 11th October, interviews scheduled 12th October.
- An external assessor will be present
- Recruitment process will be starting shortly to replace Derek Dundas who leaves at the end of March.

(c) Progress Update on Board Objectives Q1 (Item 7c)(paper)

The Board was advised this is the first report as a Board of the performance against the Trust objectives for 2016/17. It is evident that there is further progress in relation to appraisal. The paper is for information and questions are welcome.

The Chair reported it would be helpful to have adequate time subsequently when looking at objectives for next year. **Action**

(d) Standing Financial Instructions Revision (Item 7d)(paper)

The Board was advised the regulations have changed; therefore a request was made to the Board for agreement to update SFIs next week.

The Board Agreed.

(e) EPRR Assurance Declaration (Item 7e) (paper)

As part of the national EPRR assurance process for 2016/17, the Trust has been required to assess itself against these core standards by October 2016.

The Board was asked to note the self-assessment, subsequent CCG review and rating as partially assured and the appropriate action plan to address these.

The Chair requested an update of the action plan and a timeframe. **Action** report back on actions in January.

RR

75/16

DATE OF NEXT MEETING

28 October 2016 at 8.30am in the **Conference Room, Education Centre, Royal Bournemouth Hospital**

76/16

Key Points for Communication:

1. Performance issues
2. Patient Story
3. Agreed line with CCG on the Trust communications of the outcome of the Investment Committee,
4. Progress in relation to Mortality, particularly the progresses and continuing to Challenge. There is a significant difference between the

Trust's mortality rates and neighbouring hospitals.

The Chair gave thanks to The Trust Secretary who was appointed on an interim basis for all the help and support provided.

The Chair thanked David Bennett, Non-Executive Director for all the support provided during his term. Most notably his work with supporting the Finance Committee and HAC and the changes in HAC.

The Chair thanked Basil Fozard for support as Medical Director and as a clinician for the Trust. The Mortality work has been a wonderful legacy for Trust, along with the QI work and the championing of so many campaigns for improved clinical support, such as Sepsis and the QI Conference. Basil leaves the Trust with a fantastic legacy.

Basil Fozard advised things can only be achieved as an individual if you are working in a team and so in turn passed his thanks to the Executive colleagues NEDs, Chairperson and the Governors for their support and involvement through some turbulent times over the years.

77/16

QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC

1. During the walkabout (in ED), there were concerns in relation to the loss of 10 staff in recent months. Is the Trust managing to recruit more staff? Furthermore it was highlighted that staff were able to complete mandatory training however unable complete non-compulsory training due to staff shortages, such as the HOPE training.
It was confirmed there have been new staff and some leavers. The ED template has been signed off which has been positive. There are some very skilled nurses in ED, they have been up skilled to Nurse Practitioners. Mandatory training is important to ensure all nurses have key skills before looking at other things. Those that can go on additional training come back and share their learning.
The Chair reported an action list is produced during the walk around and would imagine this action would be on the list. **Action** Walk around action list update.
2. It was questioned whether discreet blue tooth headsets would solve the call bell issue. There has been some interesting dialogue around this, lots of Trusts are trying different things. The key discussion is how the Trust manages the various different ways in which members of nursing staff should be alerted and how to differentiate one from another. Technology is converging however how to make it useful is being considered.
3. The 2a preference was questioned in relation to the Local Authority Reorganisation and whether the Trust are engaging with a wider audience, as there appears to be a complete disconnect between the clinical services review issues, the organisation and the savings. It was confirmed that the Trust is a stakeholder and therefore needs to feedback the Trust views not necessarily the views of the public. It is for the local authority to share with the public. Issue of savings are relative not the Trust's responsibility to consult with the public it is the

PS

Local Authorities, in terms of the connection with the CSR. The Trust sees 2a being a natural way of better serving the population. The issue of savings are relevant however the Trust is keen in getting to a point where we have a standardised approach to how patients are considered and cared for across both health and social care. The view generally is in health and indeed the views of some of the Social care colleagues that 2a represents the best thing for local residents as patients.

The Chair advised the CSR consultation process will start hopefully within a number of weeks.

DRAFT

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
30.09.16	71/16	QUALITY			
	(a)	<u>Patient Story</u>			
		Clarification of funding for patients referred – HOPE course	PS		BACSUP is now being run by BH Live with funding from Wessex Cancer Trust to continue the programme
		Recording of patient discussions to be shared as an idea. This enables patients to review at a later stage	PS	In progress	To be followed up by QARC and Association Medical Director
	(d)	<u>Adult Safeguarding and Child Protection Safeguarding Report</u>			
		DoLS mandatory training. Report to be brought back at a later date to ensure improvement.	PS	Report to Workforce Committee December 16	<p>Adult safeguarding (includes Learning Disability) Overall compliance is 94.3% Medical and Dental compliance has improved at 86% All other groups are 90% or over</p> <p>MCA & DoLS Overall compliance is 55.9%. To be monitored at the TPSC and report to be taken to the Workforce Committee in December.</p> <p>Safeguarding Children compliance for medical and dental staff L2 = 82% L3 = 79% September compliance has been checked and is being followed up. There are 9 medical and dental staff showing as non-compliant with L3 training and they will be compliant within the timescale of end of November 2017.</p>
	72/16	PERFORMANCE			
	(a)	<u>Performance Exception Report</u>			
		Meeting with the GP locality Leads to be arranged.	RR		Meeting with 2 of the 4 main GP locality leads. Agreement the “rightcare” workstream of STP

RBCH Board of Directors Part 1 Actions September 2016 & previous

					most profictive route to focus effordts on demand management. CCG to arrange initial workshop. Work to be overseen via TMB. Action Closed
	(g)	Workforce Report			
		Explanation of joint turnover and vacancy rate of the Medical Care Group and significant turnover rate within Specialties.	KA	In progress	The workforce analyst in the information department is reviewing the data to identify it they are background issues.
	(i)	NHSI Single Oversight Framework			
		NHSI Seminar Presentation.	RR	November	To form part of blue skies discussion on board objectives for 17/18+, then to review best reporting format following that.
		Clarification of NHSI assessments.	RR	Completed	Completed. Rank of 2
	74/16	GOVERNANCE			
	(c)	Progress update on Board Objectives			
		Adequate time within agenda when looking at objectives for 2017	TS	November	Draft objectives to come to Board in November 2016
	(e)	EPRR Assurance Declaration			
		Update of the action plan and timeframe.	RR	January	EPRR action due January Board. Place in Forward plan
	77/16	QUESTIONS FROM GOVERNORS AND MEMBERS OF PUBLIC			
	1.	Walk round action list update.	PS		Action list from walk round includes action relating to training to be completed by 30 November
29.07.16	62/16	QUALITY			
	(c)	CQC Inpatient Survey Results			
		Develop a proposal to measure progress against the Trust's vision to be the 'most improved' by 2017.	DM/TS		A paper is being developed for submission to the Board in October
	63/16	PERFORMANCE			
	(e)	Finance Report			
		Submit the Private Patient Strategy to the Board for	SH	In Progress	A paper will be provided firstly to the Finance

RBCH Board of Directors Part 1 Actions September 2016 & previous

		review.		October	Committee and then to the Board in October.
	68/16	QUESTIONS FROM GOVERNORS AND PUBLIC			
	5.	Explore call bell technology and innovation to support resolving on going issues with delays in answering call bells.	PG/RR	Completed	Call bell nursing group in place, with estates team input. Action to be monitored via senior nurses group. Action closed
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 and submitted to independent assessor.

Key:

	Outstanding
	In Progress
	Complete
	Not yet required

BOARD OF DIRECTORS

Meeting Date:	28 th October 2016: Part 1
Subject:	Complaints Performance Report September 2016
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing and Midwifery Grace Maughan, Information Analyst
Details of previous discussion and/or dissemination:	Healthcare Assurance Group 27 th October 2016
Action required:	The paper is provided for information

Executive Summary:

The Complaints report includes aggregate and Care Group 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.

Key messages:

The corporate team operational processes have been explored in detail in month. This includes formal complaints, PALS and Clinical Claims. Over the past three months, the claims and complaints function has been temporarily separated (at a cost pressure but within the budget envelope) to enable a review of case load, service need, resource required and job roles. Progression is now being made to appoint to a Complaints post and a Clinical Claim post.

Some complaints received in July, August and September were not acknowledged on time, which will further impact on response delivery. Data anomalies are being reviewed and checked. This has been previously reported. Mitigating actions were put in place and have been sustained.

1. Current Trust aggregate response time in month (September 2016) is 67% against a standard of 75%
2. The response time improvement focus continues and has reached the required trajectory for month 6 (quarter 2 YTD) above 65%. This **has** been achieved by two out of the three care groups with only Care Group B now requiring improvement;

Care Group A = 100%
Care Group B = 33%
Care Group C = 80%

Improvement trajectories for formal responses are:

Q1 above 60%
 Q2 above 65%
 Q3 above 70%
 Q4 to maintain 75% from the start of quarter 4.

3. 26 formal complaints were received in September 2016.
4. Acknowledgement times for September are 73% in the data set. Manual checking is underway to validate this position.
5. Concerns, written and verbal, (informal issues) in month have been reported. The volume is much higher than formal complaints, however the response times are reported by care group in section 5.1.

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 Performance Report September 2016

1.0 Introduction

This summary paper includes information on formal complaints, informal concerns and written concerns received, acknowledged and responded to times in month (September 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 Group and Committee.

2.0 Number of complaints

26 formal complaints were received in September 2016

73 verbal concerns were presented to PALS in September 2016

38 written informal concerns were presented to PALS in September 2016

3.0 Acknowledgement and response times

- 3.1 Of the 26 formal complaints received for September 2016, 73% were acknowledged within three days. A manual check against the data set has commenced to validate this position which will be updated next month. This was predicted to be lower than we would usually expect due to resource issues in the team, which are being rectified. Revalidated data updates the August position to 92%. Following a structure review, secondment and substantive positions are being advertised to move forward with a restructure to appropriately resource the team. Medicine received the most complaints (n = 11) in month with the rest being equally scattered amongst other directorates.
- 3.2 First responses to complaints should be within 25 working days (quality strategy standard of 75%), which is monitored at the Healthcare Assurance Committee. For August on aggregate the first response times have been validated as 63% from the previously reported 64%, a drop from the previous month which was expected due to reasons previously reported. For September, the first response time on aggregate is 67%. 18 of the 27 complaints responses were sent on time.
- 3.3 In terms of Care Group response times, the performance of two out of the three care groups has sustained in month and meets the expected trajectory target for September of in excess of 65%. Care Group B still requires further support to deliver a recovery plan. The directorate with the most late responses is medicine and older people's medicine.
- Care Group A = 100%
 - Care Group B = 33%
 - Care Group C = 80%

4.0 Themes and trends - Complaints received

- 4.1 The highest theme again in month was implementation of care. Implementation of care has sub categories, of the highest theme (n = 12 with 5 in medicine) was quality, suitability of care / treatment. Incorrect diagnosis and staff attitude categories both had 3 respectively.

5.0 Informal Concerns

5.1 Informal concerns are raised by patients, carers, relatives or others about a wide variety of subjects. These are managed at the point of contact by the PALS team at the front entrance of the hospital. Informal concerns can be verbal or written but the decision to make them formal remains with the person raising the concern. The quality strategy response time remains 25 days. The volume of the informal concerns is larger than formal complaints and the opportunity to close and resolve arising concerns is very responsive and less formal in terms of style. The current acknowledgement and response time which is recorded against a 25 working day deadline for both written and verbal by Care Group is as follows

5.2 Informal concern acknowledgement times:

- **Written** – (n = 38 in month) 95% acknowledged in the timeframe
Care Group A - 100%
Care Group B - 100%
Care Group C - 71%
- **Verbal concerns** (n = 73 in month) 99% acknowledged within the timeframe
Care Group A - 95%
Care Group B - 100%
Care Group C - 100%

5.2 Informal concerns first response performance:

- **Written concerns**
Care Group A - 83%
Care Group B - 55%
Care Group C - 57%
- **Verbal Concerns**
Care Group A - 93%
Care Group B - 89%
Care Group C - 100%

In conclusion, the overall picture is one of improvement, in terms of response times and acknowledgments. Care Group B requires the most support, with the medical directorate needing the most focus, in terms of numbers of complaints received and the response times. The Head of Nursing and Quality is leading this work.

5.2 Parliamentary Health Service Ombudsman Referrals (PHSO) year to date

The PHSO received referrals from the Trust and direct from complainants. They assess each case for investigation and then again produce a verdict on upheld, partially upheld or not upheld.

The current status 1 April to 20 September 2016 is summarised in the table below:

Enquiries received	18
Enquiries closed	10
Upheld	1
Partly upheld	4
Not upheld	4
Withdrawn	1
Open and on time	8
Referred back for local resolution	1
Paused by PHSO	3
Awaiting records and files	3

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. Actions against this are in progress, driven in the Complaints Performance meeting and presented at the Healthcare Assurance Committee. The Dorset and West Hampshire CCGs are performing a quality review of our complaint responses to facilitate our improvement. This will take place in November and be presented back to the Complaints Performance Group.

7.0 Recommendations

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

BOARD OF DIRECTORS

Meeting Date and Part:	28 th October 2016 – Part 1
Subject:	Performance Report to the end of September 2016
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Performance Matrix Trust Balanced Dashboard
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>This includes full compliance with STF tolerance, but noting the diminishing margin for RTT 18 week pathways, and pressures in both Radiology and Endoscopy services.</p> <p>Finally, the Board is also requested to note the detailed report on RTT performance and recovery plans.</p>
<p>Summary:</p> <p>The full Performance Report for September is attached and accompanies the Performance Indicator Matrix which is 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.</p> <p>The Single Oversight Framework which will take effect from 1 October. Reporting will be reviewed in line with this.</p> <p>An Executive Summary and Key Risks page has also been provided.</p>	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	<p>The following risk assessments are currently being reviewed in light of the latest performance and STF rules of engagement:</p> <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. RTT due to reduced performance.

1. Executive Summary

Trust performance in September (*August for Cancer*) secured the Sustainability and Transformation Fund (STF) with two KPIs fully achieving both national target and trajectory. This was excepting RTT which was below trajectory but within the 1% STF tolerance to secure funds. This was, as previously highlighted, due to the impact of unplanned additional medical staff absence on top of existing and/or growing demand pressures. A&E 4 hour was just below national target but well above our required trajectory for the funds.

RTT 18 Weeks Incomplete Pathways (*12.5% of funds*) –

91.2%, just below the 92% target and trajectory but within the 1% tolerance for STF. 22,963 patients on an RTT pathway currently remain within 18 weeks from referral.

A&E 4 hour (*12.5% of funds*) –

achieved 94.6% well above our trajectory requirement of 91% in September. October is currently at 95.6% and close management of increasing pressures is in place.

Cancer 62 Day from Referral to Treatment (*5% of funds*) –

achieved compliance with the 85% national target in August (88.2%). This is in line with our trajectory and the Urology recovery programme. Compliance is anticipated for the Quarter though there is some risk due to the expected September position.

Diagnostics 6 Week Wait (*0% of funds*) –

achieved compliance and above trajectory, at 99.96%.

All other Monitor Risk Assessment Framework (RAF) and key contractual targets were met for September except C Difficile where we now stand at 9 cases against our stretching full year objective of 14. Also we had one cancelled operation which was unable to be rebooked within 28 days due to its specialist nature. The finalised

Single Oversight Framework will be implemented from 1 October 2016 signalling a different approach to key financial, quality and risk targets and replacing the Monitor RAF. The Board reporting is being reviewed in response to this new Framework.

2. Key Risks

From a performance perspective the key risks are:

RTT 18 Weeks Incomplete Pathways – the backdrop of an increased overall waiting list and higher proportion of patients over 18 weeks means a reduced tolerance to mitigate speciality risks. Therefore, sudden/unplanned medical staff absence and demand pressures remain a risk to our ability to manage this. In particular Ophthalmology, Gastroenterology, Dermatology and the visiting specialities are key areas of demand and capacity pressure which are requiring close management; including additional sessions, out/insourcing, demand management and recruitment of medical staff. In addition the pressure of non elective activity levels and our need to remain within the financial control total remain challenges. However, we continue to see good progress in some areas across Surgery and a number of additional medical posts are now coming on line. The actions are being closely managed, and we are working with our CCG colleagues, to remain within STF tolerance thresholds to secure funds.

A&E 4 hour – our QI work, incorporating the national 'A&E Improvement initiatives, and the launch of the new Frailty Unit is continuing to help our overall flow of patients. This is supporting our 4 hour performance. Although we dipped slightly in September, alongside an increase in delayed transfers of care, the position is currently positive for October so far. This, together with our winter plan, puts us in a good position to for the national requirement of 93.6% in March 2017, though increased activity (c10% YTD) and system-wide pressures remain a significant risk.

Cancer 62 Day from Referral to Treatment – as highlighted previously, the most significant risk going forward relates to the potential impact of the new NICE fast track referral forms in January. We continue to work across the trust and with our commissioners to develop pathways and capacity towards meeting this demand.

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. Additional activity and the potential for outsourcing continues. However, payment is not expected to be withheld.

Performance Report



For the period to end September 2016

Richard Renaut
Chief Operating Officer

Performance Report

As at 17/10/2016

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 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', which replaces the RAF, commences from 1 October 2016. The Board reporting is being reviewed in response to this new Framework.

This report covering performance for September 2016 includes a focus on the Month 3 Indicators – RTT and Diagnostics - as per attached quarterly cycle (*Table 1*).

The Trust's full Balanced Dashboard for September 2016 (end Q2) 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	RTT speciality level Admit/non admit total list and >18wks 52 week wait breaches 28 day cancelled ops 2 nd urgent cancelled ops Learning Disabilities

Table 1 – Quarterly Cycle for Focus on Performance Indicators

Performance Report

As at 17/10/2016

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

2.1 Sustainability and Transformation Fund 16/17

The Trust was at national threshold or in line with trajectories or tolerance for the 4 KPIs for Quarter 2. This means that payment is expected to be secured. The Quarter generally saw positive performance, though RTT did fall below the 92% in August and September (91.2%). However, this remained within the 1% tolerance to secure the funds. A&E 4 hour did dip just below the 95% at 94.6% in September, but remained well above our agreed trajectory and we achieved above 95% (95.9%) for Q2.

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

			Q1 16/17		Q2 16/17	
Target or Indicator (per Risk Assessment Framework)	National Target	STF Trajectory Target*	Performance Against National Target	Performance Against STF Trajectory	Performance Against National Target	Performance Against STF Trajectory
Referral to treatment time, in aggregate, incomplete pathways	92%	92%				Within STF 1% threshold
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	91.7%				
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	80%			est. only**	est. only**
Diagnostic 6 week wait	99%	99%				

*NHS Improvement Q1 STF payment based on agreeing trajectories only.

**Validated final position awaited - upload is early November

RTT Incomplete Pathways (18 week) and 52 Week Breaches

As expected in August, performance against the RTT Incomplete Pathways indicator has continued to be below the 92% in September

(91.2%). Although just below the national target and our STF submitted trajectory, we remained within the tolerance to secure the Sustainability and Transformation funds for the month. 22,963 patients continue to wait less than 18 weeks.

Good progress has been seen in Urology and in some General Surgery sub specialities, with recent recruitment in the latter expected to assist with maintaining and further improving their position. Plans are currently underway to respond to actual/pending vacancies in Urology (e.g. due to retirement), as this is a potential risk going forward. Recruitment in the Vascular Service is expected to improve their performance as well as provide a more robust network-wide service, in line with national standards for specialist services.

Securing capacity to deal with demand and capacity pressures both in elective and non-elective, alongside the need to remain with the national agency cap and our financial control limit, has sometimes proven challenging. This is usually able to be balanced to ensure RTT performance is sustained through close management.

Unfortunately, the culmination of the pressures in recent months including sudden or unplanned medical staff absence and demand growth, has meant a few key specialities were unable to reduce their 18 week patients as much as planned. This was seen in Ophthalmology, Orthopaedics and Dermatology. Furthermore, some specialities have also seen increases in their 18 week patients, such as Gastroenterology, ENT, Oral Surgery, Neurology and Allergy. Following a peak in August and September, however, Ophthalmology's backlog is now beginning to reduce as a result of the action plan.

This target remains challenging going forward and key risks indicated above will continue to require further action to sustain an STF compliant position, particularly going into Q4 when the overall impact of winter pressures will also be evident.

Performance Report

As at 17/10/2016

Further detail is included in section 4 but in summary, plans include:

- Recruitment of locums and substantive posts in Ophthalmology together with outsourcing;
- Demand and capacity work in Gastroenterology, again along with outsourcing;
- Optimising productivity and capacity in Orthopaedics through Q3
- Joint work with Poole to reduce long waiters in 'hub & spoke' services (ENT, Vascular, Oral, Neuro).

Positively, substantive appointments and embedding of existing plans mean that sustainability of improvement plans in Urology, General Surgical sub specialities (including Vascular) and Gynaecology are expected to continue in Q3 and Q4.

There were no 52 week wait breaches in September.

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

The Trust was well above the STF trajectory of 91% achieving 94.6%, though just below the 95%. However the 4 hour target is above 95% at 95.9% for Q2. There were no 12 hour breaches.

This is an extremely positive position given the continued high level of ED attendances and non-elective admissions (9.4% YTD up on last year).

The Trust's urgent care improvement work has sustained the reduction in length of stay compared to last year which has meant better flow of patients through the hospital and out of the Emergency Department. However, increasing pressure has been seen in September with Delayed Transfers of Care now above last year's levels and outliers increasing.

The Frailty Unit opened in September as a culmination of work to improve frailty pathways over a number of months and is already moving towards the reduced length of stay target set. Staff have so far expressed positive feedback and are committed to the model, and all of this work is already demonstrating improvements in patient experience with the Family and Friends test results consistently above last year in Older Persons' Medicine. The daily focus on long stay patients overall has also now seen levels reduce below last year's.

To support next steps in improvement, as well as the winter plan, we are now fully developing the internal professional standards and escalation triggers across all areas of the hospital. This will be pulled together into a revised flow escalation plan

September has seen an increase of 4.4% in total ambulance handovers (conveyances) compared to September '15, and an increase of 1.9% compared to August 2016. We are working jointly with the local ambulance services to implement improved systems for handovers. This has included a review of the joint handover process in the rapid assessment area (BREATH) which has already demonstrated a reduction in handover times. The department are also implementing a new safety checklist to support quality and safety of care to patients.

62 Day from Referral for Suspected Cancer to Treatment

Performance was 88.2% in August with a sustained improvement in Urology. Lung, Colorectal and Haematology had a small number of breaches (4.5). It is expected that there will be an increase in breaches reported for September, though confirmation of validations is awaited. This is due to various factors but patient choice, medical deferral, complex pathways, surgical capacity and capacity at other trusts have all been key factor in the breaches. However, compliance with the national target and STF trajectory is still anticipated for Q2 though there is some risk. The risk indicated above in relation to

Performance Report

As at 17/10/2016

Urology medical staff, along with the introduction of the new fast track referral forms in January, remains a risk from Q4 onwards.

Diagnostic 6 Week Wait (*end of month*)

Our improved position was sustained in September with a pleasing 99.96% 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 and in Endoscopy, supported by additional insourcing. 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).

Following a number of compliant months in Endoscopy our Joint Advisory Group reaccreditation inspection is taking place in November 2016. This will allow 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 2 performance. Full compliance is expected excepting against the C Difficile national objective target.

NHS Improvement has now released the final Single Oversight Framework which commences from 1 October 2016. 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. Board reporting is being reviewed to reflect the new Framework.

Table 3 - Monitor Risk Assessment Framework

		16/17					
		Q1	Q2	Q3	Q4	Q1	Q2
Target or Indicator (per Risk Assessment Framework) not included within STF	%	Pred	Pred	Pred	Pred	Actual	Actual
Cancer 62 day Waits for first treatment (from Cancer Screening Service)	90						*
Cancer 31 Day Wait for second or subsequent treatment - surgery	94						*
Cancer 31 Day Wait for second or subsequent treatment - drugs	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 Nov 16.

Cancer

62 Days from Screening to Treatment

Full compliance was achieved in August (100%), and compliance overall is currently anticipated for Q2 through there is some risk due to expected September performance.

31 Days Subsequent Treatment

The 31 day subsequent surgical treatment performance was compliant for August at 94.6%.

31 Days from Diagnosis for First Treatment

Performance was compliant for August at 99.5%, with only 1 breach reported (Urology). Our agreed CCG recovery trajectory requires full sustainable recovery by end Q2 which is currently expected.

2 Week Wait

Performance was compliant for August, at 95.3% with breaches predominantly due to patient choice. September and Q2 are expected

Performance Report

As at 17/10/2016

to be compliant. A significant risk for Q4 though is changing the referral thresholds for GP fast track referrals. Despite joint work with the commissioners and additional funding, we remain concerned about the impact, particularly on diagnostic services which will require close monitoring.

Breast Two Week Wait

Performance was compliant at 100%.

Infection Control – C Diff and MRSA

15 cases of C Diff have been reported up to the end of September 2016. Of these, lapse in care is deemed to have contributed to 9, being above the 7 YTD threshold. As highlighted previously, we have been set a challenging stretch objective for the year, with a target for lower levels of breaches per occupied bed day than other trusts. We continue to strive to minimise breaches with a launch of lecture theatre based education sessions and ‘screensaver’ awareness raising being implemented in October.

There have been no reported cases of hospital acquired MRSA.

Access to Healthcare for People with a Learning Disability

Compliance has been confirmed for Q2.

3. Contractual and Other Targets Exception Reporting

Compliance was maintained on all other key targets in September excepting one on-the-day cancelled operation which was not rebooked within 28 days. Unfortunately this was as a result of consultant sickness and the operation required a senior specialist and longer surgical slot that couldn't be arranged immediately.

The Stroke Sentinel National Audit results will shortly be published and are expected to demonstrate a positive position for our service. A paper will be provided separately.

Table 4 – Contractual and Other Targets

Indicator	Measure	Target 16/17	Jul-16	Aug-16	Sep-16
Mixed Sex Accommodation	Minimise no. of patients breaching the mixed sex accommodation requirement	0	1	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%	100.0%	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%	93.2%	92.7%
Admission via A&E	No. of waits from decision to admit to admission over 12 hours	0	0	0	0
Ambulance Handovers	No. of breaches of the 30 minute handover standard	0	58	67	59
Ambulance Handovers	No. of breaches of the 60 minute handover standard	0	1	4	8
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%		
NHS Number Compliance	Completion of NHS Numbers in SUS A&E Submissions	95%	97.7%		
SSNAP indicator	% of Stroke patients are treated on a dedicated stroke ward for 90% of spell		94.5%	92.3%	84.8%
SSNAP indicator	Direct admission to Stroke Unit within 4 hours of admission		78.9%	70.4%	43.1%
SSNAP indicator	Patients receive CT Scan within 24 hours of admission		100.0%	95.8%	96.6%
SSNAP indicator	Patients with acute stroke receive brain imaging within 1 hr		36.8%	38.9%	43.1%
SSNAP indicator	Thrombolysis Rate		5.3%	12.5%	15.5%
SSNAP indicator	% appropriate patients receiving thrombolysis (within 1 hour of clock start)		100.0%	55.6%	44.4%
TIA indicator	High risk TIA cases investigated and treated within 24hrs		46.0%	71.0%	44.0%
TIA indicator	Low risk TIA cases, seen within 7 days		90.0%	88.0%	82.0%
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	tbc	6397	6397	6306
Clocks still running - admitted	Number of patients with an admitted incomplete pathway over 18 weeks	tbc	1099	1135	1118
Clocks still running - non admitted	Total number of patients with a non admitted incomplete pathway	tbc	18600	18471	18868
Clocks still running - non admitted	Number of patients with a non admitted incomplete pathway over 18 weeks	tbc	856	888	1093

Performance Report

As at 17/10/2016

4. Performance Focus - RTT, Diagnostics and Cancelled Operations

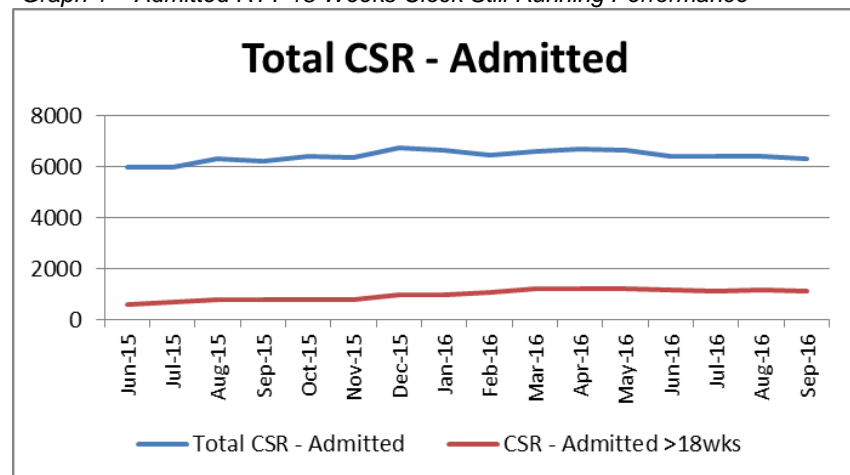
4.1 RTT 18 Weeks – Clocks Still Running

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
CLOCK STILL RUNNING (CSR) PERFORMANCE	92.3%	92.4%	92.4%	92.2%	91.8%	91.2%
Total CSR (Patients)	23,237	23,938	24,072	24,997	24,868	25,174
Total CSR > 18wks (Patients)	1,797	1,817	1,842	1,955	2,033	2,211

Table 5 – RTT 18 Weeks Clock Still Running Performance

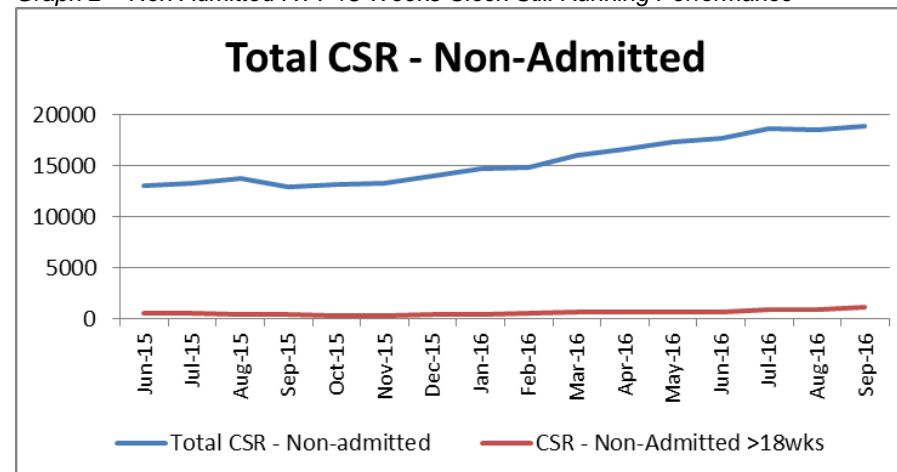
The above table and below graphs show the growing overall waiting list (clocks still running/incomplete pathways), up 2700 since April. This increase reflects a number of factors including: increased referrals over time; bed capacity limitations due to non-elective activity increases; unplanned capacity shortages, particularly in medical staff, 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 – 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.

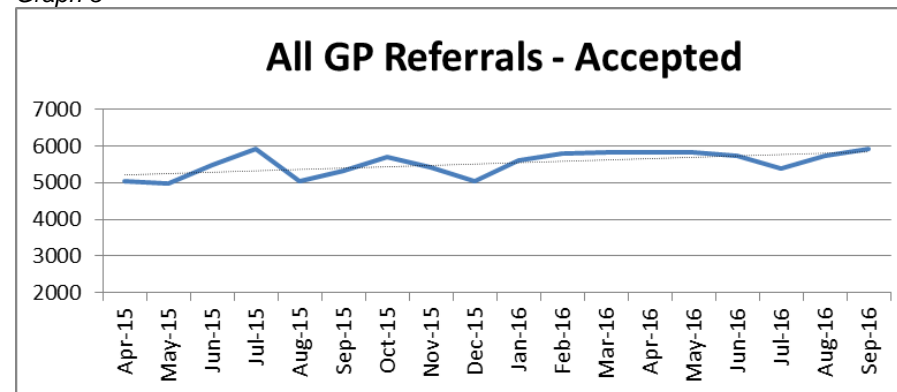
Graph 2 – Non Admitted RTT 18 Weeks Clock Still Running Performance



4.2 Referrals

GP referrals have increased in 2016 with a growth of >5% in overall accepted referrals.

Graph 3



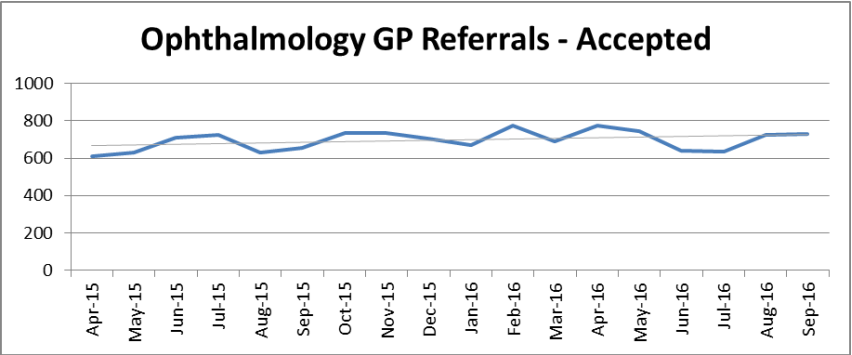
Performance Report

As at 17/10/2016

Particular growth has been seen in:

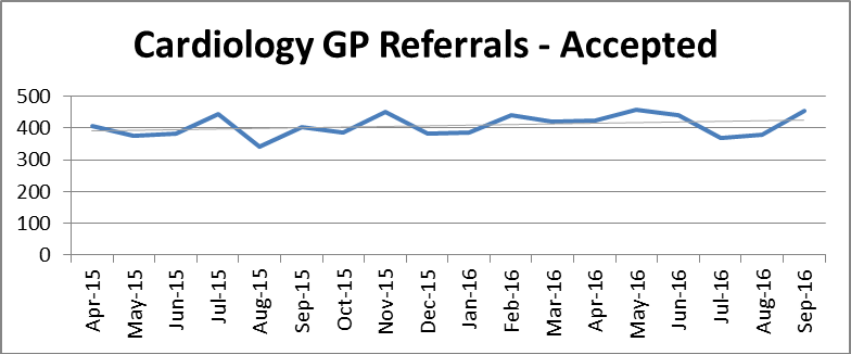
Ophthalmology +7.3% YTD on last year. Demand management work may have contributed to a reduction being seen over the summer, though the underlying trend has remained upward.

Graph 4



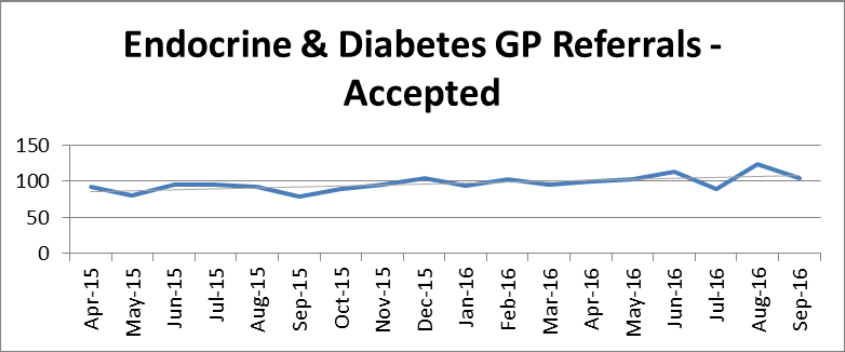
Cardiology +7% YTD compared to last year.

Graph 5



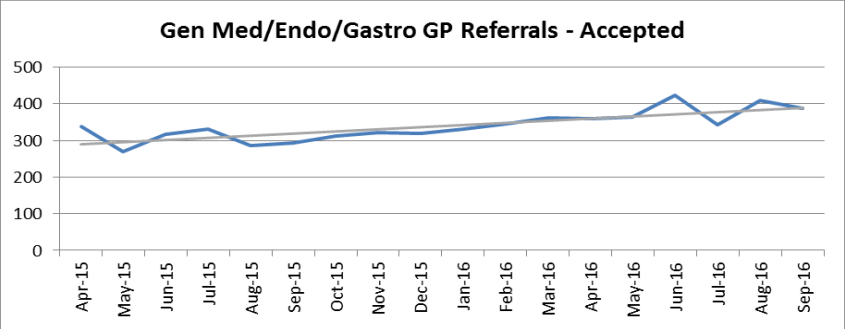
Endocrine & Diabetes +18.3% YTD compared to last, though a relatively small number of patients overall.

Graph 6



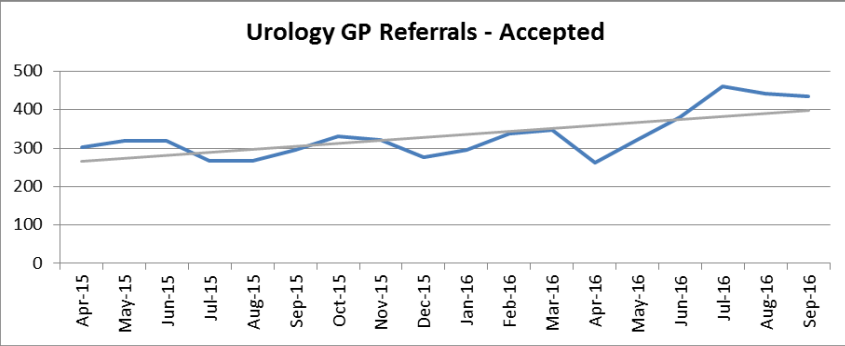
Gen Med / Endo / Gastro +24.3% YTD compared to last.

Graph 8



Urology +29.9%YTD compared to last year.

Graph 9

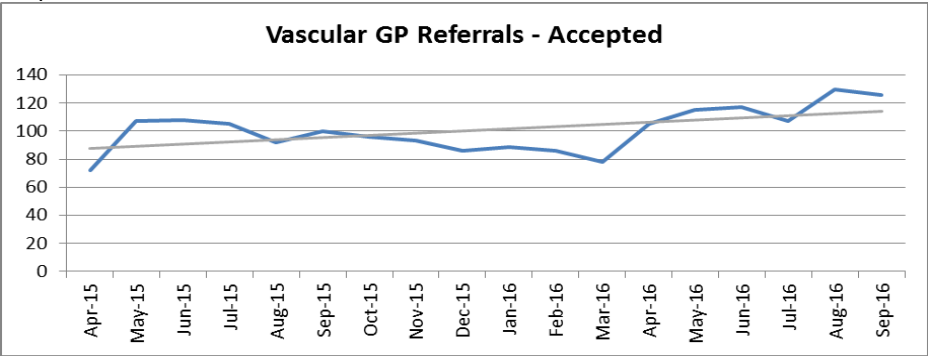


Performance Report

As at 17/10/2016

Vascular +20% YTD compared to last year. This may also be related to our development as the Vascular Network hub.

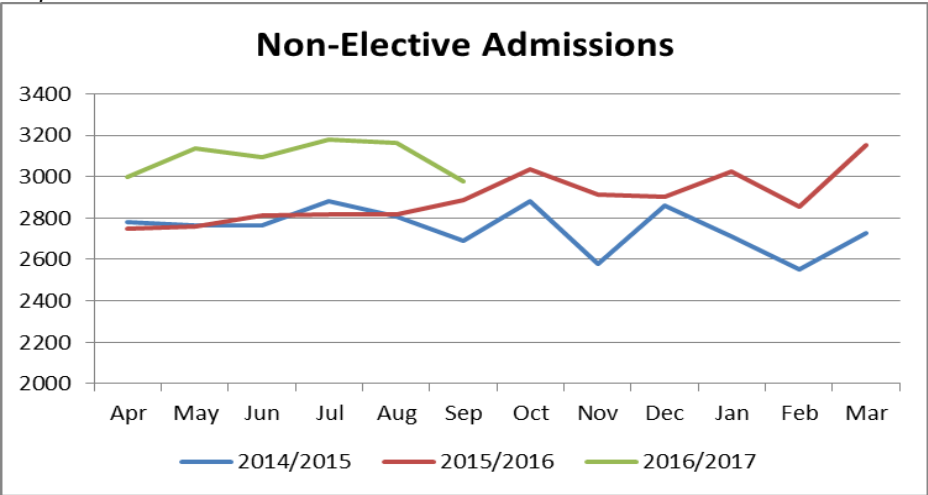
Graph 10



4.3 Emergency & Elective Admissions and Outpatient Activity

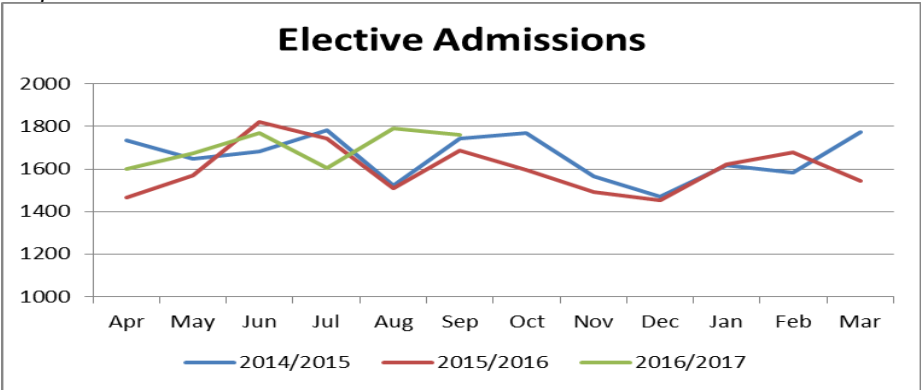
2015/16 saw a reduction in elective activity through the year as non-elective activity increased, contributing to the growing pressure on RTT incomplete pathways (waiting lists).

Graph 11



Inpatient elective activity has, however, increased by 5% since April 2016 compared to the same period last year. This is despite a corresponding increase of c10% 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 shorter stay and theatre backfilling capacity to increase its activity, together with ringfencing of the Derwent Orthopaedic Unit.

Graph 12

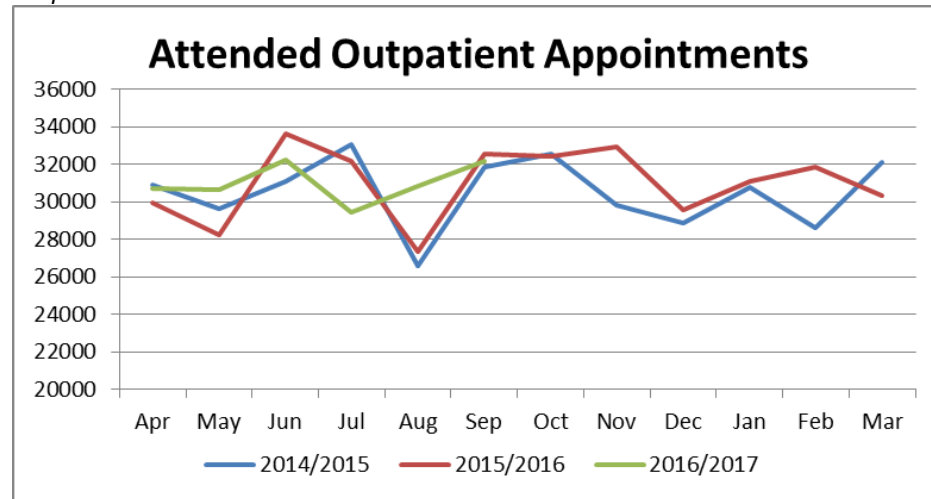


Overall outpatient activity for new patients has increased on last year (3%) though a slight reduction in follow ups. The latter can contribute to increasing patients on the RTT pathway as longer follow up waits increase the time to final treatment. Outpatient waits continue to be monitored alongside the increasing referral rate, 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.

Performance Report

As at 17/10/2016

Graph 13



4.4 Overall Clocks Still Running by Specialty and Recovery Plans (National Target = 92%; STF Trajectory + Tolerance = 91%)

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16		
						<18 wks	Total	%
100 - GENERAL SURGERY	91.0%	90.7%	91.0%	92.1%	91.5%	3152	3461	91.07%
101 - UROLOGY	81.7%	84.9%	85.5%	85.1%	88.9%	1273	1441	88.34%
110 - TRAUMA AND ORTHOPAEDICS	90.0%	90.7%	91.5%	91.6%	91.7%	4247	4694	90.48%
120 - EAR NOSE AND THROAT	93.6%	90.8%	90.9%	90.5%	91.2%	593	657	90.26%
130 - OPHTHALMOLOGY	90.4%	90.1%	89.0%	89.5%	87.4%	3933	4478	87.83%
140 - ORAL SURGERY	100.0%	99.6%	98.3%	97.0%	92.0%	574	648	88.58%
170 - CARDIOTHORACIC SURGERY	100.0%	100.0%	100.0%	97.5%	100.0%	0	0	-
300 - GENERAL MEDICINE	97.8%	97.4%	96.4%	96.4%	95.3%	1682	1799	93.50%
320 - CARDIOLOGY	94.9%	95.3%	96.1%	94.4%	95.7%	1922	2022	95.05%
330 - DERMATOLOGY	97.9%	97.4%	96.6%	95.2%	94.3%	916	991	92.43%
340 - THORACIC MEDICINE	98.4%	98.2%	99.1%	98.6%	98.5%	740	742	99.73%
400 - NEUROLOGY	99.0%	97.1%	94.5%	96.2%	94.3%	318	345	92.17%
410 - RHEUMATOLOGY	98.2%	97.2%	97.0%	95.0%	94.7%	982	1020	96.27%
430 - GERIATRIC MED	100.0%	100.0%	98.9%	97.4%	96.4%	180	182	98.90%
502 - GYNAECOLOGY	91.2%	90.6%	89.5%	87.7%	88.4%	961	1082	88.82%
Other	94.2%	95.4%	96.6%	95.5%	95.4%	1490	1612	92.43%
Total	92.3%	92.4%	92.4%	92.2%	91.8%	65577	25174	91.22%

Table 6 – Clocks Still Running Speciality Performance

A number of specialities remain below 92% at speciality performance level and Oral Surgery (visiting speciality) has also now fallen below 92%. Positively Urology has been improving its position over recent months and Ophthalmology saw a slight improvement in October, which has assisted with the overall Trust position. Positive and/or improving positions in Cardiology, Rheumatology, Thoracic and Older Persons' Medicine are also supporting this.

The following indicates the actions being taken across these specialities to support continued compliance with the STF trajectory tolerance and return to national target.

Speciality	RTT Key Issues	Recovery Plans Underway
Ophthalmology	GP referral demand growth - 7.3% (graph 4) Medical staff vacancies and lack of recruitment up-take System-wide pressures on this service	- Work with CCGs to support community/primary care based services including transfer of follow-up activity - Guidance to GPs and criteria management - Redesign of e-referral outpatient booking processes - Additional sessions - Locum/substantive posts - Outsourcing
ENT	Unplanned medical staff shortages at provider Trust impacting on capacity available at RBH 17% increase in GP referrals	- Working with visiting provider trust to secure additional capacity and manage long waiters
Oral Surgery	Unplanned medical staff shortages at provider Trust impacting on capacity available at RBH 14+% increase in GP referrals	- Working with visiting provider trust to secure additional capacity and manage long waiters
General Surgery	Unplanned medical staff capacity shortages particularly in Colorectal and Vascular Capacity for routine procedures in Upper GI	- 2 substantive consultant posts commenced in Colorectal and a post in Upper GI - 2 consultant posts appointed in Vascular commencing Nov/Dec. - Additional sessions and outsourcing in interim
Gynaecology	Unplanned medical staff capacity shortages	- Medical recruitment now in place - Additional sessions - Outsourcing
Urology	Good progress with backlog reduction to date Risk re two impending medical staff vacancies and 30% referral increase	- Locum in place to backfill one vacancy (but no longer additional) - Further recruitment underway - Additional sessions - Outsourcing

Performance Report

As at 17/10/2016

Finally, risks relating to a number of specialities that are seeing a deteriorating performance is also flagged: General Medicine (Gastroenterology), Dermatology, Allergy and Neurology.

Increased referrals in Gastroenterology, plus endoscopy and inpatient non elective demand, have triggered a demand and capacity QI project. In the interim, additional sessions are being provided, partially released by insourcing to release medical staff time to outpatients.

An additional consultant has been recruited to Dermatology who will commence in January, though a fixed term speciality post will also be ending at this time. A meeting is being held with surrounding providers in November to review further joint work that could support improvement to the overall system demand and capacity pressures.

Finally, we continue to work with the visiting provider trust to jointly manage the Neurology demand and have commenced discussions with commissioners in relation to the ongoing provision of Allergy services. Furthermore, in light of our increasing long waiting patients we have piloted a methodology to review a sample of clinical pathways and RTT data quality in Ophthalmology.

Improvement Case Study	
RTT – Review of long waiting patients	
Aim:	<ul style="list-style-type: none">To check that delays did not result in clinical harm to patientsTo review patient pathway recording for data quality
Methodology:	<ul style="list-style-type: none">A random sample of Ophthalmology long waiting patients (both on admitted and non-admitted pathways) was selectedEach patient’s referral origins checkedRTT Start date was accuracy checkedRTT pathway record checked to ensure this reflects Hospital PAS system

- timeline of dates and noting any cancellations by the Hospital and Patients.
- 18 week rules have been applied correctly checked
 - Accuracy of clock stop checked
 - Review of correspondence and clinical notes on Clinical viewer to ascertain if any clinical harm has occurred due to waiting over 18 weeks.

Results:

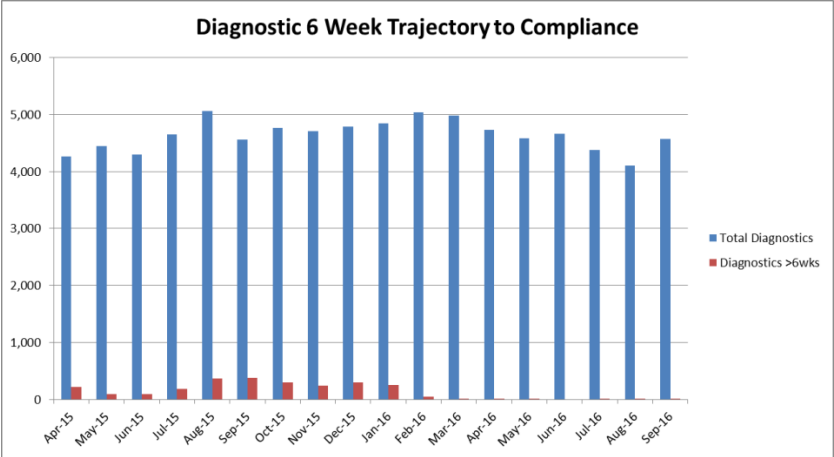
- No evidence of any clinical harm being caused to any of the patients during their RTT period was found
- No data quality issues identified.

Next Steps:

- Review to be undertaken quarterly focusing on specialities with increased or waits longer than usual expected pathway.

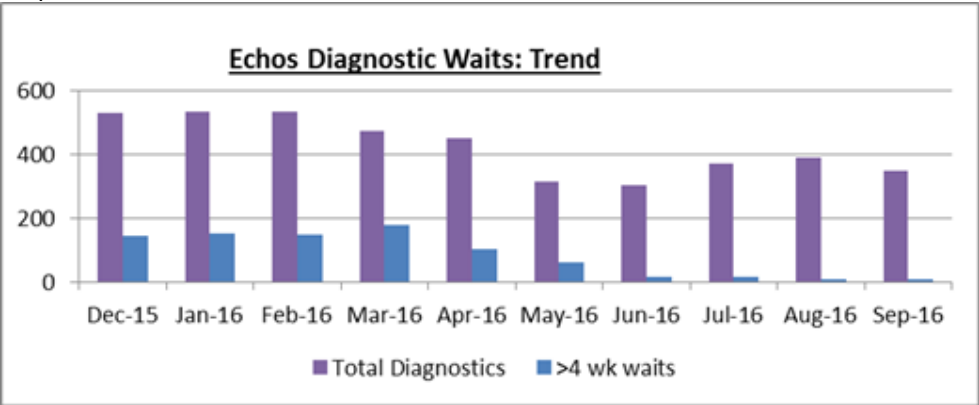
4.5 Diagnostic 6 Week Wait Trends

Graph 14



Overall the diagnostic waiting list has remained relatively stable and the numbers waiting over 6 weeks have been largely eliminated. Ongoing additional capacity is being provided in Endoscopy and Radiology. Of particular note the improvements in the Echo waiting times as a result of the Cardiology improvement project, reported in July, have been sustained. (See graph 15).

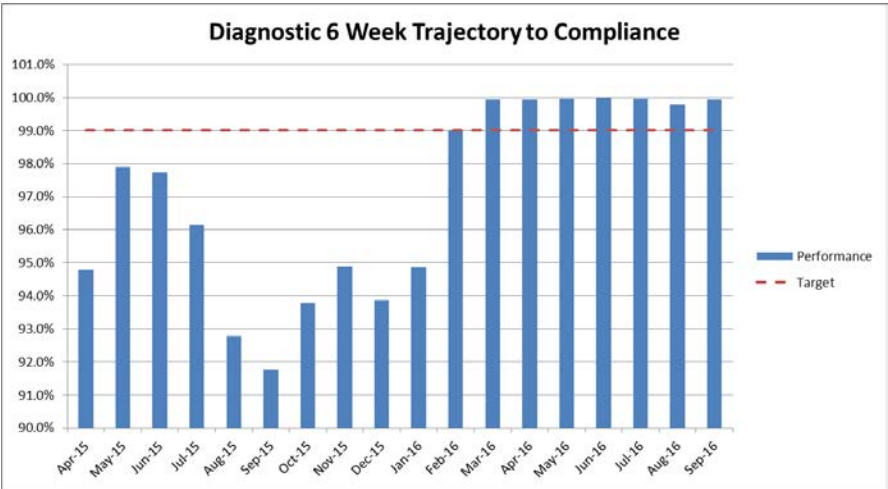
Graph 15



As highlighted earlier, the biggest risk to diagnostics currently is the new fast track referral forms due to be launched in January. We are working jointly with our commissioners and some additional funding has been provided, however, the demand and our ability to respond should demand be above expected levels will be closely monitored. This will also be supported by our participation in the national 28 day diagnosis project which will be reviewing pathways to diagnosis for suspected cancer referrals.

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.



This position has been sustained, however, further insourcing capacity is being commissioned on an ad hoc basis to balance all waiting time pressures: cancer pathways, diagnostics 6ww, planned patients and RTT. A further review of demand and capacity is being implemented, and will also incorporate Gastroenterology outpatients.

4.6 Cancelled Operations

The Trust generally performs well in terms of minimising cancelled operations and on rebooking within 28 days. YTD we currently remain well within our contractual 0.7% target, at 0.55% of total elective admissions and we have had a very small number of 28-day breaches (3) YTD. These are usually in very specific circumstances where a senior and/or specialist procedure is required.

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 continued strong performance.

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.

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would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 th October 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:	Ellen Bull, Deputy Director of Nursing and Midwifery Jo Sims, Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Healthcare Assurance Group 27 th October 2016
Action required:	The paper is provided for information and assurance
Executive Summary <p>The Quality report is a summary of the key quality indicators in Month.</p> <ul style="list-style-type: none"> • Four serious incidents have been reported. • Safety Thermometer has remained in a good position in month • Top quartile performance is sustained for the In-Patient FFT • Care Audit chronic performers have established groups to drive forward further improvement actions. 	
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

Quality Report



For the period to end
September 2016

Paula Shobbrook
Director of Nursing and Midwifery

1.0 Introduction

This report accompanies the Trust Quality Dashboard and outlines the Trust's actual performance against key patient safety and patient experience indicators. In particular it highlights progress against the trajectories for the priority targets set out in the Board objectives for 2016/17.

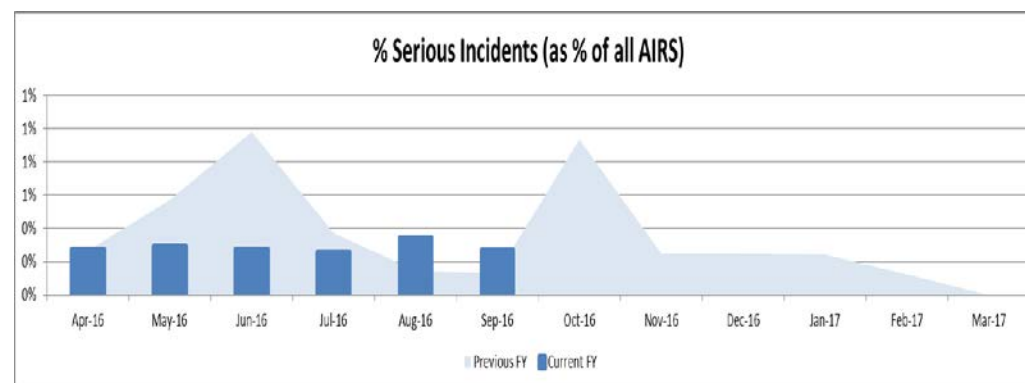
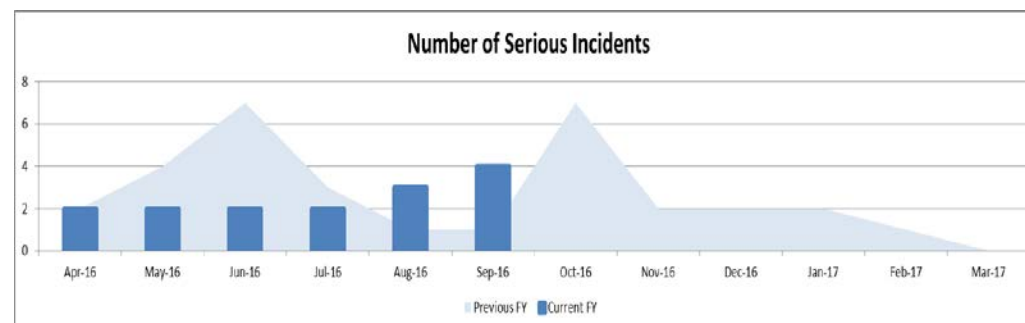
2.0 Serious Incidents

2.1 There were fewer serious incidents April-Sept 16 (n= 15) compared with the same period last year (n=18)

2.2 Four Serious Incidents were reported in September 16:

- 1) 2016/23626: Delay in diagnosis.
- 2) 2016/23627: Delay in reporting, diagnosis. However surgical outcome was good.
- 3) 2016/25159: potential delay in recognition of deteriorating patient.
- 4) 2016/27073: Patient sepsis

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



3.0 Safety Thermometer

3.1 The Trust New Harm Free Care score has remained the same in month with continuing good performance on reducing new (hospital acquired) pressure ulcers (5 in month) and falls with harm.

The overall harm free care score has decreased slightly in month as a result of a higher number of patients being admitted with existing (community acquired) pressure ulcers.

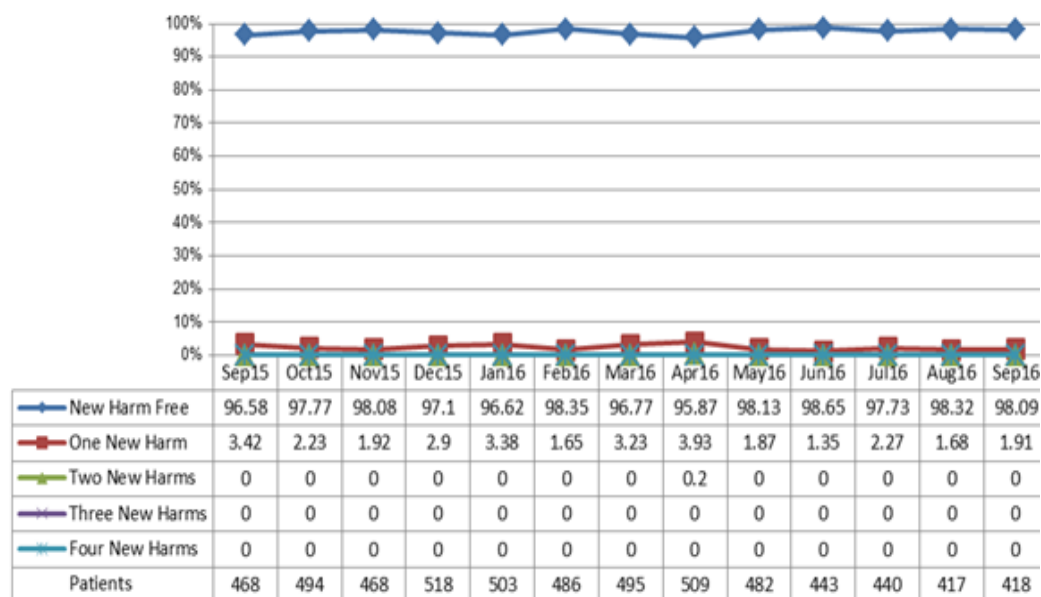
Quality Report

As at 21/09/2016

	15/16 Trust Average	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Safety Thermometer % Harm Free Care	89.79%	88.02%	87.34%	88.49%	91.36%	93.29%	87.32%
Safety Thermometer % New Harm Free Care	97.53%	95.87%	98.13%	98.60%	97.73%	98.32%	98.09%

New Harm Free: patients with New-Harm Free

ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITAL'S NHS FOUNDATION TRUST, All Care



4.0 Patient Experience Report – October 2016 (containing August/September 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 **August 2016** data.

- Inpatient and day case Friends and Family Test (FFT) national performance in August 2016 ranked RBCH Trust 3rd with 27 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 21.9%.
- The Emergency Department FFT performance in August 2016 ranked RBCH Trust 4th with 7 other hospitals out of 141 placing RBCH ED department in the top quartile. The response rate was 6.4% against the 15% national standard.
- Outpatients FFT performance in August 2016 ranked RBCH Trust 4th with 32 other Trusts out of 234 Trusts, placing the departments in the second quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

Quality Report

As at 21/09/2016

In-Patient Quartile	March	April	May	June	July	August
Top	98.259%	98.068%	98.086%	98.704%	98.703%	98.318%
2						
3						
Bottom						

ED Quartile	March	April	May	June	July	August
Top			95.103%	94.186%		94.570%
2	86.857%	92.086%			92.470%	
3						
Bottom						

OPD Quartile	March	April	May	June	July	August
Top						
2		95.705%		96.734%	96.734%	96.716%
3	95.069%		95.497%			
Bottom						

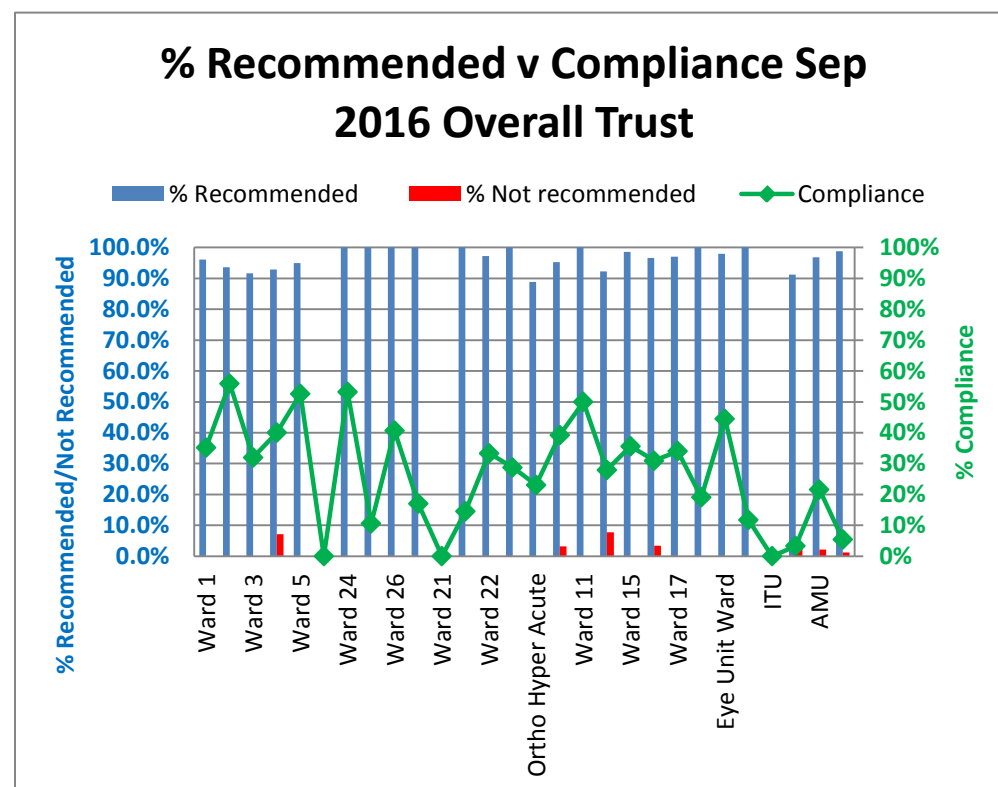
4.2 The following **September 2016** data is taken from internal data sources:

Table 1 below represents Trust, ward and department performance for FFT percentage to recommend, percentage to not recommend and the response compliance rate. The majority of inpatient areas are above the 15% compliance rate providing further assurance of the top quartile FFT outcome performance.

The emergency department areas still require an improvement on data compliance with actions in place to increase the numbers of cards handed out to patients.

Unlikely to recommend remain minimal, and although comments are rarely left, those that are reviewed by the area for any improvement action to take.

Table 1



4.3 Family and Friends Test: Corporate Outpatient areas

Corporate	Total eligible to respond	No. PEC's completed	No. of FFT Responses	% Recommended
Corporate				
Derwent OPD	N/A	40	37	94.6%
Main OPD Christchurch	N/A	31	29	100.0%
Oral and Maxillofacial	N/A	27	27	96.3%
Outpatients General	N/A	374	360	96.9%
Jigsaw OPD	N/A	20	20	95.0%
Corporate Total	N/A	492	473	96.8%

4.4 Patient Opinion and NHS Choices: August 2016 Data

4 patient feedback comments were posted in September, 2 express satisfaction with the service they received. 2 negative responses relating to a lack of nursing staff/care, and a reported misdiagnosis of injury. All information is shared with clinical teams and relevant staff, with Senior Nurses responses included in replies following complaints.

5.0 Recommendations

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

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would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 th October 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 and Performance Committee
Action required: Approve/Discuss/Information/Note	The Board of Directors is asked to note the financial performance for the month ending 30 September 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 risk 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 September 2016

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £0.2 million as at 30 September. This is £5,000 better than plan meaning that the Trust has achieved its year to date financial control total thereby securing access to the Sustainability and Transformation Fund each month to date. Through also achieving all performance trajectories, the Trust has accrued the associated Fund income in full.

However, there remains considerable risk within the Trusts financial position, and action is required to mitigate these risks to ensure the Trust continues to achieve against its budget in the remaining months of the year.

Within this position, savings of £3.9 million have been achieved, which is £0.3 million behind the year to date target. The full year savings forecast increased by £0.3 million in month, and the current forecast is for total savings of £8.7 million against the full year target of £9.5 million.

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 September £3.5 million of capital spend has been committed, which is £3 million less than planned at this point in the year. The Trust is currently reforecasting its capital programme due to some slippage against key schemes. As a result, the Trust is expecting to under spend against the full year programme.

The Trust continues to report a favourable cash position against its plan, with a current cash balance of £34.1 million. The forecast end of year cash balance is £20 million meaning that no Department of Health support is required.

The Trust's Financial Sustainability Risk Rating has remained consistent with a rating of 3 (1 being worst and 4 being best). The new Single Oversight Framework will come into effect from 1 October, and the Trust expects to score 2 under this new framework (1 being best and 4 being worst).

Key Financial Risks

The key financial uncertainties and risks remain unchanged. 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 enacted to mitigate this risk, 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 £0.8 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. ***Private Patient Income***

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

4. ***Increasing Emergency Demand and Winter Pressures***

The sustained increase in emergency demand is having a detrimental impact on the Trusts financial position. If this continues into winter, additional beds may be required to ensure patients remain safe. This would result in a potentially significant unbudgeted cost.

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 £0.2 million, almost exactly in line with its budget profile. Within this however, there are material variances against both income and expenditure budgets as set out below in the table below.

£'000	Budget	Actual	Variance
NHS Clinical Income	132,724	129,599	(3,124)
Non NHS Clinical Income	3,398	2,735	(661)
Non Clinical Income	11,894	11,695	(199)
TOTAL INCOME	148,015	144,030	(3,985)
Employee Expenses	88,054	86,356	1,698
Drugs	17,911	16,124	1,787
Clinical Supplies	18,898	18,686	212
Misc. other expenditure	23,365	23,072	293
TOTAL EXPENDITURE	148,229	144,238	3,990
SURPLUS/ (DEFICIT)	(213)	(209)	5

Income

NHS clinical income was £1 million below budget during September, further adding to the year to date adverse variance. Key drivers for this included a reduction in income through the Hepatitis C network (£315,000); a reduction in other high cost drugs (£197,000) and a reduction in cardiac devices (£181,000). Each of these items have a corresponding expenditure under spend and therefore do not affect the Trusts overall financial performance. The remainder reflects the level of activity during September as set out in the Care Group Performance section below.

Private patient income continued its trend during September, with an adverse variance in month of £136,000.

Further detail at contract level is set out below.

£'000	Budget	Actual	Variance
NHS Dorset CCG	88,225	87,871	(354)
NHS England (Wessex LAT)	25,478	22,519	(2,959)
NHS West Hampshire CCG	12,498	12,494	(4)
Non Contracted Activity	1,436	1,656	220
Public Health Bodies	1,551	1,433	(117)
NHS England (Other LATs)	898	797	(101)
NHS Wiltshire CCG	389	450	61
Other NHS Patient Income	0	12	12
Private Patient Income	1,549	991	(558)
Other Non NHS Patient Income	298	311	13
Non Patient Related Income	11,894	11,695	(198)
Sustainability and Transformation Fund	3,800	3,800	0
TOTAL INCOME	148,015	144,030	(3,985)

Expenditure

Pay reported an in month under spend of £283,000 due to a number of on-going vacancies together with a reduction in anticipated agency costs. It is pleasing to see a continued increase in staff working through the Trusts internal resource pool.

Drug expenditure was £356,000 below plan during September, mainly reflecting the reduction in drugs approved through the Hepatitis C network (£315,000), a reduction in high cost drugs (£197,000) and off-set in part by additional spend in relation to general drugs.

Clinical supplies budgets reported a favourable variance of £263,000 in month, mainly reflecting the reduction in cardiac device expenditure (£181,000).

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	22,213	20,223	1,990	911	510	216	353
Medical Care Group	31,999	28,142	3,856	1,207	2,181	156	312
Specialties Care Group	18,719	17,330	1,389	298	438	65	589
Corporate Directorates	15,044	14,053	991	212	244	90	445
Centrally Managed Budgets	80	80	0	0	0	0	0
TOTAL	88,054	79,829	8,225	2,627	3,373	527	1,698

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 £3.134 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 September can be summarised as follows:

£'000	Block Booked	Off-Framework	Other	TOTAL
Nursing	6	0	27	32
Medical	0	59	200	260
Non Clinical	51	3	0	54
TOTAL	57	62	227	346

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 September were as follows:

	Medical	Nursing	Other
Shifts covered (Number)	238	0	43
Approximate Cost above Cap (£)	79,883	0	2,987

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 £3.9 million to date, being £326,000 behind plan.

The current forecast is for full year savings amounting to £8.7 million against the target of £9.5 million. This represents a £0.3 million improvement as a result of new schemes being identified during September. It should be noted however, that at present, £2 million (23%) of the forecast £8.7 million is reported as non recurrent. If this position continues, there is a significant financial risk when moving into the 2017/18 financial year which will put considerable pressure on the Trusts overall budget.

The Surgical Care Group position improved by £50,000 during September; however there remains considerable risk within this forecast as a result of the significant increase in emergency surgery activity above planned levels. This continues to be monitored closely.

The Medical Care Group forecast remained consistent in month, and remains a cause for concern given the current forecast under achievement. Further schemes have been identified and are currently being assessed for feasibility through the Quality Impact Assessment process; however it is unlikely that these will close the gap fully and thus further work is required to identify new opportunities to deliver the savings requirement in full.

The Specialties Care Group forecast remained consistent, and further opportunities continue to be worked up to close the remaining gap.

Corporate savings have increased by £0.2 million in month with a number of new schemes being identified. Unfortunately these are opportunistic and non-recurrent in nature rather than being the result of new and sustainable ways of working.

DIRECTORATE	YEAR TO DATE			FULL YEAR		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000	TARGET £'000	FORECAST £'000	VARIANCE £'000
ANAESTHETICS AND THEATRES	(168)	183	15	(389)	399	10
MATERNITY	(53)	50	(3)	(104)	62	(42)
ORTHOPAEDICS	(339)	323	(16)	(986)	1,028	42
SURGERY	(167)	207	40	(712)	745	33
CARE GROUP A	(727)	762	36	(2,191)	2,235	44
CARDIOLOGY	(306)	339	33	(607)	643	36
ED AND AMU	(84)	28	(56)	(181)	117	(64)
OLDER PEOPLES MEDICINE	(492)	488	(4)	(1,150)	1,125	(24)
MEDICINE	(148)	73	(75)	(672)	148	(524)
CARE GROUP B	(1,030)	929	(101)	(2,610)	2,033	(577)
CANCER CARE	(295)	171	(123)	(428)	360	(68)
OPHTHALMOLOGY	(99)	67	(32)	(291)	152	(139)
PATHOLOGY	(133)	108	(25)	(239)	273	34
RADIOLOGY	(229)	228	(1)	(327)	322	(5)
SPECIALIST SERVICES	(365)	350	(15)	(826)	783	(43)
CARE GROUP C	(1,121)	924	(196)	(2,111)	1,890	(221)
NURSING, QUALITY & RISK	(65)	62	(3)	(116)	102	(14)
ESTATES	(296)	285	(11)	(726)	726	(0)
FACILITIES MANAGEMENT	(209)	180	(29)	(486)	486	0
FINANCE AND BUSINESS INTELLIGENCE	(85)	87	2	(162)	174	12
HR, TRAINING AND POST GRAD	(76)	50	(26)	(159)	126	(32)
INFORMATICS	(448)	447	(1)	(656)	666	10
OPERATIONAL SERVICES	(84)	87	2	(180)	154	(26)
OUTPATIENTS	(35)	38	3	(57)	67	10
TRUST BOARD & GOVERNORS	(23)	23	0	(23)	23	0
CORPORATE	(1,322)	1,257	(65)	(2,565)	2,525	(39)
GRAND TOTAL	(4,199)	3,873	(326)	(9,477)	8,683	(793)

Care Group Performance

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

£'000	Budget	Actual	Variance
Surgical Care Group	8,639	8,714	76
Medical Care Group	5,262	4,775	(487)
Specialties Care Group	2,978	2,769	(209)
Corporate Directorates	(17,111)	(16,810)	300
Centrally Managed Budgets	19	344	325
SURPLUS/ (DEFICIT)	(213)	(209)	5

September saw a continuation of the activity profile reported previously, whereby emergency activity is significantly above plan resulting in capacity issues and a corresponding reduction in planned care.

Non-elective activity was 7.9% above budgeted levels, and emergency department attendances, which were 9.4% above budgeted levels. Correspondingly, elective activity was below budget in month by 8.8%, and outpatient activity was 6.6% below budget.

The Care Group financial performance reflects the change in activity profile against the agreed budget, together with the under achievement against the cost improvement programme target to date. The latter is being proactively managed through the Trusts CIP Governance arrangements, and in particular, the weekly CIP Delivery Group.

Sustainability and Transformation Fund

Members will recall 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 Trust has achieved the financial control total to date, and has forecast the achievement of each of the agreed performance improvement metrics. As such, the Trust has therefore met all conditions associated with the Fund to date and has accrued the associated income in full.

The current financial position against the Fund is set out below.

CRITERIA	FUND		YEAR TO DATE		
	WEIGHTING %	VALUE £	BUDGET £	ACTUAL	VARIANCE £
Revenue Control Total	70.0%	5,320,000	2,660,000	2,660,000	0
RTT Performance Trajectory	12.5%	950,000	475,000	475,000	0
A&E Performance Trajectory	12.5%	950,000	475,000	475,000	0
Cancer 62 Day Performance Trajectory	5.0%	380,000	190,000	190,000	0
Diagnostics Performance Trajectory	0.0%	0	0	0	0
TOTAL	100.0%	7,600,000	3,800,000	3,800,000	0

It should be noted however, that the significant and sustained 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 RTT performance trajectory, and thus the achievement of the full STF funding. Plans continue to be progressed to mitigate this risk, which to date, have included the engagement of additional locum consultants in tandem with the outsourcing of elective activity to the private sector.

Statement of Financial Position

Overall the Trusts Consolidated 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 £3 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 totalling £2.9 million. In addition, the delay in the Christchurch development has resulted in the Trust delaying its investment contribution into the Christchurch Fairmile Village LLP, explaining the adverse variance against the investments heading.
- **Trade and other receivables:** The receivables balance is now broadly in line with the plan. This follows the agreement with Dorset Clinical Commissioning Group to refresh monthly cash payments to align more closely with the level of activity being undertaken.
- **Cash and cash equivalents:** The Trusts cash balance reflects the under spend against the capital programme, the increase in trade and other payables together with the timing of the investment into the Christchurch Joint Venture.
- **Trade and other payables:** The material payables variance to date is made up of a small number of discrete items. The variance reflects the timing of cash payments as compared to the original plan. These are being actively monitored and are expected to be paid over the coming months.

This Consolidated Statement of Financial Position excludes the Trusts Charitable Fund, to align with the monthly reporting to NHS Improvement.

£'000	Plan	Actual	Variance
Property, plant and equipment	179,038	176,495	(2,543)
Intangible assets	3,850	3,504	(346)
Investments (Christchurch LLP)	6,203	3,944	(2,259)
Non-Current Assets	189,091	183,943	(5,148)
Inventories	5,763	5,611	(152)
Trade and other receivables	14,569	14,790	221
Cash and cash equivalents	23,156	36,012	12,856
Current Assets	43,488	56,413	12,925
Trade and other payables	(26,628)	(33,853)	(7,225)
Borrowings	(307)	(307)	0
Provisions	(222)	(222)	0
Other Financial Liabilities	(1,102)	(1,102)	0
Current Liabilities	(28,259)	(35,484)	(7,225)
Trade and other payables	(997)	(999)	(2)
Borrowings	(18,712)	(18,772)	(60)
Provisions	(519)	(587)	(68)
Other Financial Liabilities	0	0	0
Non-Current Liabilities	(20,228)	(20,358)	(130)
TOTAL ASSETS EMPLOYED	184,092	184,514	422
Public dividend capital	79,681	79,681	0
Revaluation reserve	72,570	72,570	0
Income and expenditure reserve	31,841	32,263	422
TOTAL TAXPAYERS EQUITY	184,092	184,514	422

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 is focussed around three key strategic projects, being the finalisation of the Christchurch development (£3.4 million), the refurbishment of the cardiology laboratories (£2.4 million), and the Trusts approved five year IT Strategy (£3.4 million).

Expenditure to date totals £3.5 million, representing a year to date under spend of £3 million. This is attributable mainly to further slippage against the Christchurch development. Whilst the scheme will be completed within the current year, it is pleasing to report that an overall under spend is now being forecast against this key development. In addition, a number of the other schemes have not commenced as quickly as anticipated and as a result, the Trust is expecting to under spend against its full year capital programme. The detailed scheme level forecast is currently being finalised and will be reported in future months.

Full detail at scheme level is set out below.

£'000	Annual	IN MONTH			YEAR TO DATE		
	Budget	Budget	Actual	Variance	Budget	Actual	Variance
Christchurch Development	3,425	335	(105)	440	3,275	1,064	2,211
Cardiac Laboratories	2,400	0	0	0	30	0	30
CT3 Building Alterations	450	150	2	148	330	10	320
Estates Maintenance	400	70	42	28	290	139	151
Sterile Services Department	300	90	1	89	220	18	202
QI Projects (Frailty unit, AEC, Cardiac)	300	38	12	26	270	273	(3)
Miscellaneous Schemes	300	100	0	100	100	46	54
Capital Management	265	22	31	(9)	133	125	8
Catering Equipment	100	0	2	(2)	100	77	23
Medical Equipment	1,000	100	(6)	106	400	292	108
IT Strategy	3,409	363	256	107	1,406	1,467	(61)
TOTAL	12,349	1,268	235	1,033	6,554	3,511	3,043

Cash

The Trust (excluding grouped entities) is currently holding £34.1 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 £28 million.

The forecast closing cash balance for the current financial year is £20.06 million, and thus there is no requirement for Department of Health financial support at present.

The Trusts 24 month rolling cash flow 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 predicated 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 and secure the Sustainability and Transformation Fund payment in full to protect its medium term cash balance.

Financial Sustainability Risk Rating

The Trusts Financial Sustainability Risk Rating as at 30 September 2016 is set out below.

	Plan Metric	Actual Metric	Risk Rating	Weighted Rating
Capital Service Cover	1.56x	1.64x	2	0.50
Liquidity	9.9	20.0	4	1.00
I&E Margin	(0.33%)	(0.25%)	2	0.50
I&E Variance to Plan	0.96%	0.08%	4	1.00
Trust FSRR				3
Mandatory Override				No
Final FSRR				3

As reported previously, NHS Improvement's new Single Oversight Framework will be introduced with effect from 1 October 2016, replacing this current rating. Had this new framework been in place during September, the Trust would have achieved the following ratings:

	Risk Rating	Weighted Rating
Capital Service Cover	3	0.60
Liquidity	1	0.20
I&E Margin	3	0.60
I&E Variance to Plan	1	0.20
Agency Spend	1	0.20
Trust UOR	2	
Mandatory Override	No	
Final UOR	2	

Members will recall that scores are between 1 (best) and 4 (worst), and that a score of either 3 or 4 against this overall financial assessment will trigger a potential concern, as will scoring a 4 (i.e. significant underperformance) against any of the individual metrics.

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

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 th October 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; plus safe staffing data. The report also includes an update on violence and aggression, and summary details of prosecution outcomes.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? 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? 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 – OCTOBER 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 September			Rolling 12 months to 30 September				At 30 September
Surgical	59.2%	65.2%	89.1%	4.64%	15209	12.8%	10.6%	1.6%
Medical	88.9%	73.3%	87.9%	4.08%	20473	16.3%	11.9%	7.9%
Specialities	84.0%	80.0%	91.8%	3.22%	9174	8.7%	11.2%	6.6%
Corporate	83.3%	0.0%	93.5%	3.85%	12399	7.1%	10.8%	3.4%
Trustwide	80.1%	72.1%	89.9%	3.99%	57255	11.8%	11.2%	5.3%

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 September			Rolling 12 months to 30 September				At 30 September
Add Prof Scientific and Technical	89.6%		93.2%	3.13%	1401	10.8%	14.4%	9.4%
Additional Clinical Services	77.5%		90.4%	6.01%	15512	17.6%	13.9%	10.1%
Administrative and Clerical	80.7%		94.6%	3.57%	10811	7.6%	9.7%	4.2%
Allied Health Professionals	96.2%		90.9%	2.21%	2002	16.1%	15.1%	2.7%
Estates and Ancillary	74.9%		89.8%	4.82%	6066	9.3%	10.6%	4.2%
Healthcare Scientists	77.6%		90.8%	3.14%	930	14.5%	14.5%	2.4%
Medical and Dental		72.1%	80.5%	1.41%	2239	4.3%	6.4%	5.8%
Nursing and Midwifery Registered	78.5%		90.3%	4.30%	18294	12.4%	10.2%	3.5%
Trustwide	80.1%	72.1%	89.9%	3.99%	57255	11.8%	11.2%	5.3%

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 was set through to the 6-month period end date of 30th September, reflecting the cascade nature of the process.

This timeline has now been passed and as can be seen from the above, compliance has fallen short of the 95% target, However, there are some strong performances and work continues to ensure that all staff have meaningful and appropriate appraisals.











2. Essential Core Skills Compliance

After 18 months of upward trend, overall compliance has slipped back slightly to 89.9% from 91% last month. However this still represents a 10.8% increase over the position at the same point last year (79.1%).

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

Directorate	Organisation	Headcount	Compliance	Trend
Surgery Directorate	153 Obs/Gynae Medical Staff 10100	20	65.38%	
Cancer Care Directorate	153 Haematology Snr.Medical 11346	19	71.43%	
ED Directorate	153 ED Admin Clerical/Receptionist 10456	30	72.00%	
Elderly Care Services Directorate	153 MFE Medical Staff 10077	51	72.88%	
Medicine Directorate	153 Medical General Staff 10075	67	75.17%	
ED Directorate	153 ED Medical Staff 10015	34	76.41%	
Anaesthetics/Theatres Directorate	153 Ccssd 55400	34	77.35%	
Anaesthetics/Theatres Directorate	153 ICU/HDU 10315	56	79.98%	
Surgery Directorate	153 Surgery - General 10085	30	81.60%	
Cardiac Directorate	153 Cardiac Medical Staff 10076	35	81.75%	

Areas with highest compliance:

Directorate	Organisation	Headcount	Compliance	Trend
Human Resources Directorate	153 Blended Education and Training 18100	13	100.00%	
Informatics Directorate	153 Telecoms 13585	22	100.00%	
Finance and Business Intelligence	153 Information 13541	17	100.00%	
Pathology Directorate	153 Histology 11310	37	99.73%	
Finance and Business Intelligence	153 Supply Chain Management 14915	20	99.50%	
Cardiac Directorate	153 Cardiac Administration 11523	38	99.49%	
Informatics Directorate	153 Information Technology 13584	32	99.05%	
Facilities Directorate	153 XCH I/H Dom Contract 14350	15	98.89%	
Informatics Directorate	153 Health Records 13540	40	98.75%	
Operational Services Directorate	153 Cancer Information Team 13495	16	98.75%	

Whilst it is disappointing to see a dip in compliance, there are however a number of reasons for this downturn, which included all subjects. This is the time of year where there are the largest cohorts of clinical staff starting within the organisation. Although the new starters in the main are engaging with the Virtual Learning Environment and Trust induction, once they have been in the organisation for a period of time this is when their competencies will be expiring. There is continuous supportive work from within BEAT with the managers of the departments where there is lower compliance. A promotional campaign working with all forms of communication as well as targeted interventions is in train.

3. Sickness Absence

The Trust-wide sickness rate shows a small increase to 3.99% (3.94% last month), but continues its amber rating.

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

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Anaesthetics/Theatres Director	153 Day Surgery Services 10385	32	9.17%	
153 Elderly Care Services Directorat	153 MFE Ward 24 10594	40	8.58%	
153 Elderly Care Services Directorat	153 MFE Ward 5 10378	41	8.53%	
153 Surgery Directorate	153 Ward 17 10428	31	8.26%	
153 Clinical Governance Directorate	153 Risk Management 14115	15	8.03%	
153 Elderly Care Services Directorat	153 MFE Ward 4 10382	34	7.96%	
153 Surgery Directorate	153 Surgical Admissions Unit 10535	26	7.81%	
153 Elderly Care Services Directorat	153 XCH Nurs Day Hospital 10576	37	7.49%	
153 Cancer Care Directorate	153 Macmillan Unit 10565	39	7.34%	
153 Ophthalmology Directorate	153 BEU Outpatients 10480	25	7.09%	

Areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Pathology Directorate	153 Medical Staff - Histology 11300	11	0.12%	
153 Other Directorate	153 Postgraduate Centre 13531	13	0.16%	
153 Surgery Directorate	153 Surgery - Urology 10084	20	0.27%	
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	42	0.46%	
153 Surgery Directorate	153 Surgery - General 10085	32	0.52%	
153 Medicine Directorate	153 Medical General Staff 10075	95	0.69%	
153 Other Directorate	153 Chief Executive 13535	26	0.78%	
153 Elderly Care Services Directorat	153 MFE Medical Staff 10077	53	0.85%	
153 Elderly Care Services Directorat	153 Dietitians 13315	15	0.88%	
153 Orthopaedics Directorate	153 Ortho Medical Staff 10160	36	1.05%	

4. Turnover and Joiner Rate

Joining and turnover rates of 11.8% and 11.2% respectively have both reduced slightly over the previous month (12.8% and 11.5%). 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 13.4% at this point in 2015.

5. Vacancy Rate

The vacancy rate at 5.3% overall shows the progress that we have made as trust to recruit to our vacancies. Of particular note is the nursing and midwifery vacancy rate of 3.5% which is a 2% reduction from August.

6. Safe Staffing

The Trust overall actual against planned fill rates on aggregate are the following in month:

Registered nurse days	89.4%
Healthcare assistant days	98.8%
Registered nurse nights	95.6%
Healthcare assistant nights	119.2%

The overall picture is one of tight control and appropriate mitigation on nurse staffing as the local nursing teams manage sickness absence, other absences and fluctuations in capacity with local review and mitigation with directorate moves. There has not been any use of Tier 3 agencies for registered nurses in month again, sustaining the good performance adherence to NHSI (Monitor) guidance. As we head into winter with the expected increase in internal capacity requirements, and potential seasonal illness risks in staff sickness, this will need to be closely monitored against the quality metrics with appropriate exceptions made.

Over plan for RNs in terms of actual against planned hours

Three areas are over plan for their actual against planned nursing hours: Bournemouth Eye Unit (BEU), Macmillan Unit and Ward 11. This is due to increased capacity of medical outliers, meeting specific care needs and managing short term sickness.

One area was over plan for their healthcare assistants: Ward 16. This was due to meeting needs of patients with mental health needs.

Under plan RNs or RMs

Four directorates had areas under plan for their staffing. The main reasons were vacancies and then supporting sickness, increased capacity in some areas, meeting specific needs of patients with escalating conditions, roster anomalies which have been identified and are in the process of being reviewed or updated, or short term redeployment to manage peak ward times; and in midwifery, this was due to clinic requirements.

One red flag was raised, relating to a ward with only two RNs on duty for a 4 hour period.

Care Hours Per Patient Day (CHPPD)

The information continues to be produced for CHPPD which is then reported as part of the Unify return. This reflects what we would expect to see in that the higher care areas with higher nurse to patient ratios have the higher CHPPD. There is more variation at the general ward level, which is aligned with the actual nurse hours within the body of the Unify report. This is still in an early stage as we observe the patterns and trends in this data.

7. Violence & Aggression Audit

The Board will be aware of previous concerns relating to incidents of violence and aggression experienced by staff as reported by staff.. A recent audit was commissioned on Violence & Aggression and some significant changes have been made. As part of this, and in response to comments from frontline staff in higher risk areas, we are reviewing a one day "Breakaway Training" course for staff working in areas such as ED, AMU & some MFE wards. The idea is to have an additional course beyond the Conflict Resolution training that is for the majority of staff,. We hope this course will provide staff with the skills to manage some of our more difficult patients or relatives.

The Trust is keen to take action against patients who assault our staff. Health & Safety Committee in October received details and outcomes of 5 recent appearances in court – the information below has been pulled from newspaper reports; all had come through ED. Communications are being developed to share this information across the Trust to show our staff that we do take action in such circumstances. The Trust also uses a “critical patient information flag” to alert staff when past offenders visit the hospital. 21 first warnings have been issued since the start of the year.

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BOARD OF DIRECTORS

Meeting Date and Part:	28 October 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)	None
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	Previous Board meetings
Action required:	To note
Executive Summary: A brief presentation will be given at the Board meeting on the approach to be taken to engaging with the general public, staff and local Staakeholders responding to the consultation proposals	
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?	

Clinical Service Review

At the time of preparing papers for the October Board meeting, Dorset CCG are still awaiting formal confirmation from NHS England on when they can launch their public consultation.

In Part 1 of the meeting I will take Board through our proposed approach to the consultation process focused on ensuring that as many staff and local residents as possible are able to give the CCG their views.

Tony Spotswood
Chief Executive

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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 October 2016 Part 1
Reason for Part 2:	n/a
Subject:	One NHS in Dorset: Vanguard Update
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	One Dorset Stroke : Strategic Outline Case
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:	For information
Executive Summary: This report provides an update on the Vanguard work	
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?	

Progressing Work within the Dorset Acute Vanguard

The purpose of this paper is to apprise the Board of on-going progress with regard to each of the Vanguard workstreams. The attached report highlights progress in each clinical area. Of note, excellent progress is being made to develop a joint Cardiology on call rota which will strengthen out of hours provision at Poole Hospital. Detailed work has also been undertaken by the 3 Stroke teams to develop options for the future provision of the Stroke service centred on, strengthening hyper acute stroke care developed around a vision of 'One Dorset Stroke'. The Executive Vanguard Group agreed the outline plan for advancing this work, the full proposal is contained in the Reading Pack.

Work is also underway in the East of Dorset to develop a single Gynaecology emergency service from 1 April 2017. Further work to integrate Gynaecology and Maternity services in the east is prohibited under the terms of the CMA undertakings. Investment has now been agreed to support the clinical workstreams and £291,500 will be available to support backfill.

Various options are under consideration to bring together the IT and associated functions of the four foundation trust in Dorset. Work is also progressing to develop joint consortia arrangements for back office functions.

This paper is presented to the Board as an update for information.

Tony Spotswood
Chief Executive

Dorset Vanguard Programme Update

17 October 2016

Annex A



Highlights this period

- Engagement with NCMT
 - Attended inaugural meeting Acute Care Collaborative
 - Met team at Health and Care Innovation Conference
 - Participation in development of ACC framework
 - Interviews as part of evaluation of national support to vanguards and future design needs
 - Participant in several Community of Practice teleconferences
 - Participation in Communication Leads teleconference and Dorset have offered to pilot Future NHS Collaboration Platform which will aid information sharing across Trusts
- Currently advertising for joint Ophthalmology paediatric consultant post
- Agreement from all 3 Trusts to progress Pathology Services to Outline Business Case, additional support secured and currently internal advert for Pathology Clinical Director role
- First teleconference held with Medical Directors and COOs

Programme element		RAG
Overall status		A
Clinical	Cardiology	A
	Non-surgical cancer	A
	Ophthalmology	A
	Paediatrics	A
	Stroke	A
	Women's health	A
Clinical support	Radiology	A
	Pathology	A
Other	Healthcare Informatics	A
	Business Support Services	A

Decisions required

- Endorse recommendations from MD & COOs Oversight Group in relation to
 - Women's Health
 - Ophthalmology
 - Paediatrics
- Review of Risk Register

Vanguard Programme Update

17 October 2016



Patient & Public Engagement

- Process agreed with PPEG for engagement in clinical pathway redesign
- Presentation at CCG Clinical Working Group 21 September 2016
 - General overview of progress
 - Stroke update
 - Workshop on what the future of Pathology should look like

Key issues

- Consolidation of back office and pathology service template for completion to be returned shortly.

Key risks

- Raised profile of potential merger could distract from Vanguard workstreams. Workstream project managers to maintain focus and escalate as required.

Expected in next period

- Development of Dorset Vanguard Evaluation plan
- Submission of business case templates to NHSI for Pathology & Back Office Services
- Progress development of Joint Venture
- Kings Fund: Leadership Development Event with Professor Don Berwick

Cardiology workstream			Current RAG	A
			Previous RAG	A
Report date:	17 October 2016	Exec sponsor:	Julie Pearce (DCH)	
Clinical lead:	Mark Sopher (RBCH)	Management lead:	TBC	
Medical Director:	Ruth Williamson (RBCH)	Project Manager:	Peter Davis	
Outputs achieved this period:-		Outputs planned next period:-		
<ul style="list-style-type: none">• Capture of cardiology service information• Development of proposed change methodology for sub-groups to identify and effect required changes• Agreement to prioritise Chest Pain and Heart Failure workstreams initially• Preliminary discussions around future of Acute service in the East, including 7-day cover as soon as possible		<ul style="list-style-type: none">• Further capture of current service information: e.g. organisational structures, workforce numbers, activity breakdowns, key processes, issues and opportunities• Review current procurement by Trusts (categories, spend)• Setup of Chest Pain, Heart Failure sub-groups• Develop a proposed model for the East’s Acute service, and initial planning to achieve 7-day cover		
Risks & issues:-		Mitigating actions:-		
<ul style="list-style-type: none">• Lack of availability of funding for backfill• Lack of availability of key stakeholders		<ul style="list-style-type: none">• Backfill funding included in budget (to be agreed by ESG)• Plan workstream activities around existing commitments wherever possible; review if ongoing capacity issues		

Non-Surgical Cancer workstream			Current RAG	A
			Previous RAG	A
Report date:	17 October 2016	Exec sponsor:	Julie Pearce (DCH)	
Clinical lead:	Overall lead Tracy Nutter Saskie Dorman (PH) – EoL Care	Management lead:	Cincy Shaw-Fletcher	
Medical Director:	TBC	Project Manager:	Sarah Woods	
Outputs achieved this period:-		Outputs planned next period:-		
<ul style="list-style-type: none">Confirmed all deliverables within original scope for Vanguard workstream will be delivered through Dorset Cancer Partnership.EoL Programme to report through Dorset Cancer Partnership. Delivery group has now met and chair agreed.		<ul style="list-style-type: none">Discussion with CCG regarding EoL programmeOngoing Vanguard reporting requirements agreed with CCG		
Risks & issues:-		Mitigating actions:-		
<ul style="list-style-type: none">The detailed work is underway to understand the risks and issues plus any mitigating action.				

Ophthalmology workstream			Current RAG
			Previous RAG
Report date:	17 October 2016	Exec sponsor:	Richard Renaut (RBCH)
Clinical lead:	Non Matthews (RBCH)	Management lead:	Louise Neville (RBCH)
Medical Director:	Paul Lear (DCH)	Project Manager	Sue Varley
Outputs achieved this period:-		Outputs planned next period:-	
<ul style="list-style-type: none"> Joint paediatric ophthalmology post agreed and advertised – interview panel arranged for Nov 2016 		<ul style="list-style-type: none"> Explore benefits of joint Corneal surgery consultant post East Dorset pilot of sub-contacting directly with community optometrists to undertake work on behalf of acute team Paper for ESG to agree future direction of Ophthalmology Vanguard 	
Risks & issues:-		Mitigating actions:-	
<ul style="list-style-type: none"> Work traditionally undertaken in acute setting not transferred to community setting due to lack of agreement over transfer of funding,- capacity at acute sites unable to meet increased demand 		<ul style="list-style-type: none"> DCH Pilot - direct subcontracting of cataract reviews from DCH to community optometrists 	

Paediatrics workstream			Current RAG
			Previous RAG
Report date:	17 October 2016	Exec sponsor:	Julie Pearce (DCH)
Clinical lead:	Medical Consultant Lead: TBC (DCH) and Mark Tigne (PH) Nursing leads: Alison Ryder (RBCH) and Sian Jenkins (PH)	Management lead:	Catherine Aberly-Williams (DCH)
Medical Director:	Robert Talbot (PH)	Project Manager:	Sue Varley
Outputs achieved this period:-		Outputs planned next period:-	
<ul style="list-style-type: none"> Links made with Integrated Community Children's Programme and presentation from Dorset Care Record Final visits to community nursing services to develop model for future CCN services in Dorset Consultant Leads, RBCH (ED) and GP link secured Gap analysis of current position at all 3 sites against Facing the Future standards undertaken and shared 		<ul style="list-style-type: none"> Review workstream PID with new medical leads in place Outline for proposed new CCN service developed and out to steering group for discussion Identification of quick wins for implementing Together for Health Standards following baseline self-assessment Attendance of key stakeholders at Together for Health RCPCH Learning event, London (3rd Nov) 	
Risks & issues:-		Mitigating actions:-	
<ul style="list-style-type: none"> Teams feel unable to adopt Facing the Future - Together for Child Health Standards alongside business as usual 		<ul style="list-style-type: none"> GP engagement, Gap analysis to identify quick wins Attendance national event to learn from earlier implementers 	

Stroke workstream			Current RAG
			Previous RAG
Report date:	17 October 2016	Exec sponsor:	Mark Mould (Poole)
Clinical lead:	Dr Suzanne Ragab (Poole)	Management lead:	Claire Stalley (RBCH)
Medical Director:	Paul Lear (DCH)	Project Manager:	Sarah Woods
Outputs achieved this period:-		Outputs planned next period:-	
<ul style="list-style-type: none"> Currently working on draft Strategic Outline Case to go to ESG 17 October Terms of Reference agreed for workstream and sub streams Work on current pathways Presentation of progress made to CCG CDW 21 September 2016 		<ul style="list-style-type: none"> Finalise SSNAP Dorset Guide to Completion Work plan workshop for leads to agree priorities and timescales for delivery To undertake work on benefits and plans for realisation 	
Risks & issues:-		Mitigating actions:-	
<ul style="list-style-type: none"> To review at work plan workshop 		<ul style="list-style-type: none"> Meeting to consider 21 October. 	

Radiology workstream			Current RAG
			Previous RAG
			A
			A
Report date:	17 October 2016	Exec sponsor:	Richard Renaut (RBCH)
Clinical lead:	Robert Ward (DCH)	Management lead:	Mandy Tanner (Poole)
Medical Director:	Angus Wood (PH)	Project Manager:	Sue Varley
Outputs achieved this period:-		Outputs planned next period:-	
<ul style="list-style-type: none"> Agreement to undertake Imaging Services Accreditation Scheme (ISAS) “traffic light ready” bench marking tool at all 3 sites. 42 Honorary contracts issued to enable key staff to work across RBCH and PH sites according to service need Clinical Lead appointed from DCH team CCG/GP representation secured on steering group 		<ul style="list-style-type: none"> Gap analysis of current services against ISAS standards Business case for shared ISAS manager to be developed once benefits of accreditation locally clearly identified Procurement led meeting of potential suppliers for IT fix to enable cross site reporting linking RBCH/PH with DCH scheduled end Oct. Pan-Dorset baseline metrics piloted 	
Risks & issues:-		Mitigating actions:-	
<ul style="list-style-type: none"> Teams may be unable to find resources for shared ISAS manager role (0.2wte band 7 at each site) 		<ul style="list-style-type: none"> Benefits of ISAS accreditation to be clearly defined and business case for investment to be developed 	

Women's Health workstream			Current RAG
			Previous RAG
			A
			A
Report date:	7 October 2016	Exec sponsor:	Mark Mould (Poole)
Clinical lead:	Audrey Ryan (DCH) – Maternity James Balmforth (RBCH) – Gynae	Management lead:	Sue Whitney (Poole)
Medical Director:	Robert Talbot (Poole)	Project Manager:	Carolyn Brooke
Outputs achieved this period:-		Outputs planned next period:-	
<ul style="list-style-type: none"> Gynaecology sub working group meeting fortnightly CCG data around mapping of GP codes to understand presentations and referrals activity now received and distributed. CCG resubmitted application for early adopter - Better Births Agreement to develop service specification for single gynae service 		<ul style="list-style-type: none"> Review current patient information and clinical guidance in each Trust to inform pathway mapping. Prioritise activity and workstream for single service Identify and analyse planned and unplanned data Further enquiries about whether referral data from CCG can show presenting condition. Service vision to be articulated to facilitate more detailed work on demand and resource required 	
Risks & issues:-		Mitigating actions:-	
<ul style="list-style-type: none"> Risk of April 2017 deadline not being met due to multiple activities identified by subgroup 		<ul style="list-style-type: none"> Prioritise to meet April 17 deadline for single service 	

Pathology workstream			Current RAG
			Previous RAG
Report date:	17 October 2016	Exec sponsor:	Mark Mould (Poole)
Clinical lead:	[TBA – out to advert]	Management lead:	John Wood (Interim Service Lead)
Medical Director:	Ruth Williamson (RBCH)	Project Manager:	Peter Davis
Outputs achieved this period:-		Outputs planned next period:-	
<ul style="list-style-type: none"> Strategic Outline Case (SOC) now approved by all three Trust boards; proceeding to Outline Business Case (OBC). External support secured to lead on OBC (John Wood). Advert for clinical lead approved and issued internally. Progress towards some 'quick win' actions (e.g. identifying out-of-area tests) and requirements definition for the common IT system using an existing template 		<ul style="list-style-type: none"> Content development for the OBC, which will be through a series of papers to be reviewed and approved through the Pathology Board, escalating to ESG as required. Engagement of a new clinical lead (will go to external advert if this cannot be filled internally). Development of the sub-groups structure to support OBC. Continue early stages of common IT system procurement. Development of stakeholder and engagement strategy 	
Risks & issues:-		Mitigating actions:-	
<ul style="list-style-type: none"> Elements of the Outline Business Case (e.g. lab configuration) could prove contentious. 		<ul style="list-style-type: none"> Agree the information needed, stakeholders involved and process by which agreement can be reached in advance, as well as noting and addressing concerns along the way. 	

Health Informatics workstream			Current RAG	A
			Previous RAG	A
Report date:	17 October 2016	Exec sponsor:	Libby Walters (DCH)	
Clinical lead:	TBC	Management lead:	Mike Sinclair / Peter Gill	
Medical Director:	n/a	Project Manager:	Peter Davis	
Outputs achieved this period:-		Outputs planned next period:-		
<ul style="list-style-type: none">Updated draft of the Apira IT delivery strategy deliveredReview of alternatives for the high-speed link, which could not be provided at the cost & specification agreed with the supplier. Proposal now to work with 1Gb (not 10Gb), upgraded next year as part of BT enhancements.Work to finalise costs and options for video conferencing.		<ul style="list-style-type: none">Further strategic planning as part of the Dorset-wide ‘Digital Discussion’ being led by the CCG.Beginning of video conferencing pilot, subject to agreement of requirements and preferred options.Progress on commissioning of high-speed link (if agreed).Review of other Vanguard workstream ICT requirements.		
Risks & issues:-		Mitigating actions:-		
<ul style="list-style-type: none">The high-speed link will now be slower than originally specified.		<ul style="list-style-type: none">Speed should not affect commissioning of the radiology bunker in Dorchester, and will ultimately be upgraded.		

Business Support Services workstream		Current RAG	Previous RAG
			A N/A
Report Date:	17 October 2016	Exec sponsors:	Nick Johnson (DCH)
Project Manager:	Sarah Woods		
Outputs achieved this period:-		Outputs planned next period:-	
<ul style="list-style-type: none"> Initial sub-group workshops held Identification of scope for shared service Quick wins identified Risks and issues identified Baseline data collation and high level analysis Guidance provided by NHSI and leading practice examples Vision and design principles agreed by Steering Group 		<ul style="list-style-type: none"> One day sub-group workshops scheduled to look at service vision, high-level target operating model, transformation requirements, delivery vehicle options, next steps and actions Delivery plan quick wins Confirm and challenge presentations with steering group Complete and submit NHSI Case for Change (14 October) 	
Risks & issues:-		Mitigating actions:-	
<ul style="list-style-type: none"> Lack of programme resource to deliver at pace 		<ul style="list-style-type: none"> Allocated funding in financial forecast and organisations to identify dedicated resource 	

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BOARD OF DIRECTORS

Meeting Date and Part:	28 October 2016 Part 1
Subject:	Planning Guidance - Update
Section on agenda:	Strategy
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	
Action required: Approve / Discuss / Information/Note	Note
Executive Summary: The guidance for the development of Trust plans has been received and is described in this paper.	
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?	

Team/Group/Committee/Board Date
Name of item

Planning Guidance - Update

Introduction

The planning guidance for the NHS was released on the 22nd September and contains a number of features of significance to the Trust, summarised in this paper. The guidance indicates:

- Structure for the document – 16 pages (Activity Planning [2 pages], Quality Planning [4], Workforce Planning [2], Financial Planning [6], Membership [1])
- Provider contracts to be signed by Christmas
- Uses draft tariff prices
- Incorporate specialised commissioning intentions

A key item alongside the above is the 30th September publication of the Trust and system (STP) financial control totals and these reflect the extremely difficult funding position for the NHS over the next two years.

Timetable

One of the main features, is that the whole timetable is 3 months earlier in the year than previously, which makes some of the assumptions about activity, finance etc. even more difficult to predict. The timetable highlights are:

- **21 October:** final STP submissions including an updated finance template
- **End October:** Better Care Fund guidance 2017-2019
- **24th November:** CCGs and NHS providers to share first drafts of operational plans for 2017/18 & 2018/19 with NHS Improvement
- **23rd December:** CCGs and NHS providers to submit finalised two-year operational plans

Key Features

In terms of content, the development of the STP has moved us toward a more system based approach, but while the “system” has no statutory basis, the statutory organisations such as the Trust and the CCG will continue to have to plan and deliver their obligations. Our own plan will need to be seen to be drawn from and relating to, the overall system STP, triangulating our activity finance and manpower assumptions with the rest of the system and reconcile these internally for the purposes of our own plan. Our plan will also need to include:

- Deliver Carter productivity esp back office and pathology
- Abide by agency spend rules
- Alignment with local adoption of RightCare

- Better use of NHS estate
- Management of the gap between Control Total and reality
- Recognition of the new Single Oversight Framework
- Evidence of our constructive participation in the health system
- Demonstrably robust understanding of chronology of the plans and their deliverables
- A strong sense that this is a plan that will be delivered
- A coherent approach to the realities of the engagement and communication support that will be required

Tariffs and Control Totals

The planning guidance has been issued with a complete revision of the tariff structure. The new tariffs have a significant impact on specialities such as orthopaedics, where the income for elective services could be reduced via lower tariffs by the order of £5m. Consequently NHS Improvement are also revising Trust control totals. The Trust will receive Sustainability and Transformation Fund (STF) funding, subject to the terms and conditions, of approximately £6.4m, which is less than in the current year, but in return for a deficit of £6.6m in 17/18, with the deficit reducing to £3.8m in 18/19.

Implication of the Annual Planning Guidance for the Trust

It is clear that the future planning periods (2 years for Annual Plan, 5 years for STP) are likely to be some of the most difficult seen historically in the NHS and this is further complicated by a very complex local juxtaposition of plans and programmes, including the Clinical Service Review, Vanguard, merger and many others. Conversely, the Dorset health system is seen as an exemplar, primarily because of the level of planning and clinical engagement that already had taken place under the CSR banner. This therefore creates an opportunity for our health system to capitalise on this early work and receive the financial and political support required to reconfigure the local health system in the interest of our patients.

There is also a sense in the conversation surrounding the publication of the guidance that there is recognition of the difficult position the NHS is in and therefore will entertain approaches that hitherto have been untenable. This may of course help with some of the public realities of CSR and merger, but may also allow the introduction of other approaches that previously would have been unacceptable.

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BOARD OF DIRECTORS

Meeting Date and Part:	28 th October 2016 – Part 1
Subject:	Winter Plan 2016/17 – Working Draft
Section on agenda:	Strategy & Risk
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Richard Renaut / Donna Parker
Details of previous discussion and/or dissemination:	Execs, PMG and TMB
Action required: Approve / Discuss / Information/Note	Discuss
Executive Summary: This is a working draft of the plans for the forthcoming winter. The Board of Directors are asked to comment.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Yes Yes Yes Yes Yes
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	

Winter Plan 2016/17 – Working Draft

1. Introduction

Improvement requires learning. Learning from mistakes, is often the best learning. Therefore the Winter Plan has looked at the root causes of previous year's successes and failures, as well as best practice, to develop this draft plan.

It is worth stressing the Quality Improvement work over the last year has significantly improved emergency services, using a bottom up, PDSA learn and improve approach. These changes still need time to bed in and deliver what the teams have set themselves as their objectives.

Throughout this plan it is important to distinguish between the two types of capacity – **“storage” capacity**, and **“processing” capacity**. In national improvement jargon, these are ‘green’ and ‘red’ times. The processing capacity is diagnosis, treatment and active engagement in progressing care. “Storage” capacity is more about a bed being occupied by a patient whilst waiting for something to happen, such as waiting for a package of care to go home. This does not take away from that time needing care and compassion.

However the key learning is that previous year's plans have often focused too much on getting extra “storage”, such as opening a new ward, and not enough on extra diagnostics and decision making time.

Where we have increased processing this has had a major impact e.g. work to increase weekend ward rounds and diagnostics have helped hugely. Thus a winter plan should be focused on ensuring all our processes and services are working optimally to process against what QI teams have agreed themselves. This can then be improved further by being nimble and flexible to variations in demand, so less resource goes into “storage” and more into progressing along the pathway.

This plan is therefore based around three core areas:

- i) Making what we have work to best effect, based on what teams say is possible.
- ii) Having department and Trust wide escalation to respond to peaks in demand, (much of which is predictable), to best meet processing (or storage) shortfalls, internally and with partners.
- iii) Effective communication and engagement with staff and partners to create the right culture and QI approach, celebrating the achievements already made, and what is to come.

The majority of work fits in the first category as this will have the greatest impact on patient care. It is all about ensuring the hard work of the past 18 months is embedded and refined to achieve optimal patient benefit e.g. from Acute Frailty Unit (AFU), Cardiac pathways, Surgical AEC etc.

2. Background – scale of opportunity

2.1 Learning and myth busting

Learning from preparing four previous winter plans, plus detailed modelling and review of best practice has informed this plan. It also includes “busting some myths”

- 1) *Opening a winter ward helps* – experience shows 1-2 days benefit then bed occupancy normalises again, as occupied bed days increases.
- 2) *Cancelling elective helps* – again 1-2 days benefit only. All our inpatient elective work goes through a handful of beds and most of this is major cancer. Mixed use of the Derwent is not safe for medical outliers of any complexity, and therefore, cancelling Orthopaedics has little benefit.
- 3) *Volume increases are the main problem* – most of the rise in emergency work has been 0-1 day stays. Approaching 50% of emergency work is now 0-2 day stays. This is partly through our improved processes (ambulatory etc.). Our processing capacity is crucial; however it is the complex frailest 3.5% who are taking up 35% of our bed days which most affects flow; whereas 50% of our emergency workload is through 10% of our beds. So bed numbers is not the crucial factor for a successful winter plan, but rather the ability to avoid patients becoming ‘stranded’.
- 4) *Emergency demand is unpredictable* – in fact it is predictable and it is system factors, like weekend and work patterns which have the greatest impact on our services.
- 5) *Hospital is a safe place for long stays* – 10% muscle loss after 10 days for our typical patient means the longer they are in a bed, the greater and more complex the discharge package needed. This can become a vicious circle leading to longer and longer stays. Avoiding non-medical reasons for being in hospital must be our top priority.

2.2 Staff and funds

Important context is that virtually all available funding has already been deployed to get best value. By directly employing staff this avoids agency rates, reduces quality risks and allows services to be well established before winter. This is more effective, but puts the onus on existing services to continue to improve and flex to meet demand.

Likewise whilst the staffing levels on wards have largely improved, and agency reduced, there is insufficient staffing to open more beds for ‘storage’. Therefore, even if it were desirable it is not really an option at any scale. Tactical flexing of bed capacity can be achieved, as set out later in the paper.

However, more beds, as a blanket solution, are not desirable when the Trust’s 577 beds have on a typical day:

- 10 patients wanting to die at home but staying for an average of 10 days extra in hospital

- Patients with 30 to 220 day stays are still accounting for 59 beds tied up (snapshot 03/10/16). A further 100 beds are 14-29 days length of stays.
- Ambulatory care rates below possible levels
- 75% of discharges occurring after lunch requiring c10 more beds to cope with midday peaks and backlogs in ED
- A Sunday / Monday effect, needing 30+ beds to cope with the drop in discharges over those days
- Lack of clarity on Estimated Date of Discharge (EDD) and other aspects of 'SAFER' care bundles which make it harder for well-coordinated discharges.

In conclusion the winter plan needs to focus on improvements to processes first, then flexible capacity and escalation, rather than fixate on bed numbers.

3. Modelling

The Trust's capacity and demand model has been built to reflect the fluctuations in demand during the week and day, using October 2015 to April 2016 data (i.e. busiest inpatient time of the year). It is designed to operate well at 90% of the time with minimal outliers. It does require some flexing of capacity when demand for beds goes above this, predictably on Sunday / Monday and the first two weeks of January.

The flex capacity is either 'storage' until such time as processing capacity is available i.e. after morning ward round or after a weekend. Any shortfall in capacity is met either by outlying, opening flex beds, or queues in ED or other wait areas.

These peaks can also be met with greater processing capacity, such as staff in ambulatory care, more frequent senior reviews, quicker diagnostics or discharge to assess.

The fact the Trust has performed relatively well to the rest of the UK, despite rising demand of 10% and 50 fewer beds in recent months, is largely due to the increase in processing capacity throughout the Trust. Examples include greater consultant weekend presence and ambulatory areas e.g. surgery, cardiac etc. Ensuring these new approaches fully deliver what is possible is crucial to keep within the model's criteria of no outlying from Medical Care Group. Outlying produces greater pressures on processing capacity, as outlier teams travel the hospital and ward staff get up to speed with the patient's discharge planning, usually resulting in a longer length of stay and greater risk of harm.

When the model's demand peaks above 90% then outlying may be required short term, before the outliers are discharged or repatriated back. The ability to predict these peaks and rapidly mobilise processing capacity, means less resources are diverted for 'storage' i.e. beds. Better patient care and outcomes can thus be delivered, more cost effectively if we can optimise our current services, combined with "predict and flex" to meet demand profiles.

This is a different approach to previous years. Having 'busted' the myths and modelled and analysed the key issues to ensure safe and effective emergency care, the key lessons are:

- Focus on processing capacity to make decisions.
- Be clear on what the 'next step' is on a care pathway and escalate if there is delay (e.g. EDDs fully used and shared by MDT).
- For the known periods of demand exceeding processing capacity, have pre-planned responses, e.g. for first two weeks of January, Sunday / Mondays, and key school / holiday periods, more processing and storage.
- Have a clear set of predictor tools, combined with triggers to escalate in the same day / next day, (or accept the build-up in ED / AMU / SAU and outliers) and plan for this.

We will also be aiming to achieve a minimum of 20% spare bed capacity prior to Christmas as per the national drive in 2015, to start the New Year with as much headroom as possible.

4. Making what we have work optimally

The QI work in emergency flow has achieved great success in allowing us to cope with 10% growth, on a bed base of 50 fewer beds, by improving our processes. These fit well with the three nationally mandated actions for acute hospitals to deliver.

- i) Streaming in ED
- ii) Improved flow and adoption of SAFER care bundles
- iii) Improved discharge processes and Discharge to Assess

In addition the Ambulance services and 111 services both have a series of actions and metrics for improvement, based on "intelligent" conveying, and 111 capacity and response times. We also have a role to play in releasing Ambulances from ED in a timely way.

See Annex for one page description of each action.

5. Key risks – Headlines

The Trust risk register's highest entry is 20 out of 25 for emergency care flows. Under this the greatest risks to delivering a safe service are:

RISK	MITIGATION	RATING likelihood x severity	IMPACT
Staff sickness internally and across partner organisations	<ul style="list-style-type: none"> • Flu campaign • Sickness policy compliance • OH support • Early identification of rota gaps 		<ul style="list-style-type: none"> • Greatest impact ED and 4 hour breaches • Increase bank and agency costs
Infection Control (Norovirus and Influenza) outbreak	<ul style="list-style-type: none"> • IC management • Deep cleans • Closing bays / wards 		<ul style="list-style-type: none"> • Increase outlying and delays • Pressure to open unstaffed areas
Significant pressures in a neighbouring Trust leading to a divert	<ul style="list-style-type: none"> • Limited, can take some cohorts e.g. cardiac, trauma, rehab 		<ul style="list-style-type: none"> • Reduction in community capacity as diverted • Increase in emergency admits leads to greater pressures
Loss of community provision via CQC blocks and cautions on care homes and domiciliary care	<ul style="list-style-type: none"> • Brokerage tries to bring on alternative providers • Accept slower placements and longer acute LoS • Support to remove CQC blocks? 		<ul style="list-style-type: none"> • Increase LoS, slower moves off reablement and interim packages leads to more outliers and 4 hour breaches
Ambulance demand outside of planning assumptions, for a prolonged period	<ul style="list-style-type: none"> • Ambulance and 111 recovery plans • Divert to Poole, or flex borders 		<ul style="list-style-type: none"> • Increased ambulance handovers and 4 hour breaches • Slower ambulance response times to 999 calls
Severe weather conditions	<ul style="list-style-type: none"> • Sudden temperature changes affect cardiac, respiratory and stroke increasing pressure • Potential for staff travel to work delays 		<ul style="list-style-type: none"> • Short spikes tend to create delays, outlying and bed pressures • Business continuity plans
Insufficient social and community capacity particularly in holiday / peak periods	<ul style="list-style-type: none"> • Work with Councils to incentivise providers to maintain capacity • Ensure RBH at full capacity 		<ul style="list-style-type: none"> • Increase LoS, outlying and 'stranded' patients

The risk register is being updated to reflect these sub risks and mitigations. The scoring will also be updated. Increased LoS, outlying, exit blocks from ED and ambulance handovers are associated with increased risk of harm.

In support of the national Cold Weather Plan, we continue to contribute to the Dorset system-wide planning for cold weather. The role of primary, community, pharmacy and voluntary services will be key to prevention of harm and support for vulnerable people and their neighbours and relatives in the community. We are reviewing our internal policies (e.g. flu plan, arrangements for severe weather including staff getting to work and related business continuity plans) as well as services and guidance provided to patients with long term conditions, to ensure alignment with 2016/17 national and local requirements. Dorset-wide and national public messaging will also be key in protecting the population from cold related harm and we will provide support to the communication plan as required.

6. Funding

CCG resilience funding of £2.5m has continued in 2016/17, included within our commissioner contracts. As in 2015/16 at the beginning of the financial year all funds were committed, to allow time for planning and recruitment of staff or to facilitate continued development of the improvement journey which commenced in 2015/16. In a number of areas, services have been allowed to “bed in” and develop staff and consistency. It has also significantly reduced the use of agency staff and therefore made the funds go further, though financial pressure from agency costs do remain. Some of the projects that were funded included:

- Ambulatory emergency care across the Trust
- Interim care beds and packages of care project (making up for shortfalls in low capacity)
- Frailty pathway development supported by nurse practitioners for older persons medicine
- B.R.E.A.T.H in ED made substantive, for rapid assessment and treatment
- Additional medical staffing in ED and AMU
- Pharmacist support to key areas
- Additional HCAs for ‘specials’ across elderly care wards.

In addition there has been significant re-profiling of resources to support ‘processing’ such as Acute Frailty Unit, Cardiac Pathway etc.

Following the commitment of a further £100k to continue to expand interim capacity for winter, a contingency of £100 - £150k remains within the medical care group from their ‘Resilience Funds’ for winter pressure. This will be used flexibly predominantly for the January – March period when demand is greatest. Therefore there are no central or CCG funds left to deploy, and anything extra for the winter period needs to come from existing budgets.

7. Key areas of 2016/17 plan

The thrust of the Trust's approach to urgent care and patient flow through the hospital has been a move towards 'front loading' of pathways. This means early streaming to the right speciality, early diagnostics, senior review and decision making, as well as discharge planning from the outset. All inpatient specialities dealing with emergency and urgent patients have been developing their services to support this, e.g. through doctor/specialist nurse in-reach to the front door assessment areas; establishing speciality based ambulatory and assessment services; and short stay areas supported by MDTs to support timely care and flow of patients.

A further element has been the move towards '**discharge to assess**' (D2A) pathways which support community based, on-going care needs assessments out of the hospital when patients are medically fit. Development of the interim care team model and MDT reviews, with progress chasing supported by local authority staff, for patients whose stay in hospital is greater than 7 days, have been key to this. Furthermore, the **Christchurch locality hub** pilot is testing a primary, community, secondary and social care vertically integrated approach to supporting patients at risk of or being admitted to hospital. The aim being that their acute care is optimised with their stay in hospital no longer than needed. Support services to facilitate discharge then collaborate to ensure that wherever possible, personalise care and rapidly tailor it from current services.

The third key aspect in 2016/17 is the further development of the Trust's **predictor and trigger tools and supporting escalation process**. This will also be supported by the possible implementation of an e-bed management system in the latter half of the year. This will support real-time, transparency of available capacity, avoiding duplication and allowing staff to focus on action required to support flow and clinical support across the trust, rather than laborious reporting. E-White Boards are part of this, and UHS is piloting in October. This will support key aspects of the SAFER care bundle.

Thus, internally the Trust's winter plan focuses on the three key acute provider-led national interventions. Many of these areas are already being progressed in 2016/17 and have already started to support the positive performance seen in the early part of the year, despite the significant increase in activity. A few of the significant projects will commence or be expanded as we go into winter. Below outlines the key aspects and improvements so far this year or planned which will support our approach to winter pressures:

DRAFT ACTION	National A&E Improvement Requirement		
	<i>Streaming at Front Door</i>	<i>Improved Flow & SAFER</i>	<i>Improved Discharge & Discharge to Assess</i>
CARE GROUP A – SURGERY			
Surgery			
Surgical AEC 7 day service - single point of access for Surgical emergencies. Calls streamed via central bleep. Consultant of the day named, Surgical Registrar relieved of general duties to focus on emergency surgical care. All day CEPOD list in place. Vascular calls taken by Vascular Consultant in hours. Gynae and Vascular hot clinics in place.	x		
Vascular: New 1:7 Consultant Vascular Hub rota and additional hub activity from January 2017. Additional bay (6 beds) on Ward 14 to support this to run concurrently.		x	
General Surgery: New 7 Day a week Consultant rota (1:9) from January 2017. Additional bay (6 beds) opening on Ward 16 to support evidenced 18% increase in demand for emergency surgery, and in particular, Colorectal.		x	
Surgical rotas above to support timely medical review and discharge planning.		x	
Discharge Coordinator trial on Ward 15 (Urology) from November (using medical ward model) to support discharge planning, links to outlier teams and EDD implementation. Review at 3/12 with potential to expand.			x
Orthopaedics			
Orthopaedic urgent/emergency care – reviewed and agreed pathways (e.g. Fractured NoF, Back Pain) with PHT. Streaming from ED is via the Orthopaedic Registrar at PHT.	x		
Ring-fenced Derwent beds to maintain major elective work and RTT compliance.		x	
Derwent not operating 24/12/16-02/01/17. Beds on Derwent to be used for WD7 decant or medical patients. Derwent will recommence operating from 03/01/17 and taper in TCIs based on bed pressures, but will plan to operate on six patients each of the four working days of that week.		x	

Focused elective pathway timings to reduce LoS and facilitate flow from Ward 7			x
Anaesthetics			
ITU transfer prioritisation PDSA to support transfers out of ITU and timely support for ED Resus and other appropriate patients	x		
Optimise use of Ward 12 Short Stay Unit and day case. Ward 12 – extended weekend opening to support continuity of care for Breast patients and maintain surgical capacity through Sun-Tues peaks in demand		x	
New theatre template from 10 th October. Alignment of anaesthetic, surgical and theatre rotas to improve efficiency.		x	
Continue to run CEPOD list 24/7, 365. When required use of Vascular list for additional emergency activity. If required through ELF or formal surgical escalation, use of second CEPOD list through standing down of EL activity.		x	
Sterile services to run flexibly to support demand.		x	
CARE GROUP B – MEDICINE			
Medicine			
ED - Continuation of rapid assessment and 'see and treat' models, supported by Assisting Practitioners and consultant (8) rota.	x		
ED implementation of SHINE. Improvement methodology to support quality and timeliness of care in ED from November.	x		
Consider benefit of additional ED based SpR or Consultant at weekends?	x		
24/7 Crisis support to ED for mental health patients.	x		
Escalation process developed to facilitate timely transfer from ED of mental health patients to appropriate facility, linked to expanded DHUFT capacity at St Anne's and step down beds.	x		
Primary care stream weekends 8am-12pm and 4- 8pm. Review of SWAST 12-4pm service. On site out of hours services. Review pathways for primary care out of hours to ensure best use of current resources including AEC, ED Minors (ENP's) and SWAST Out of Hours provision. Consider benefits of extending GP evening input to AEC	x		

In-reach to ED and 'pull' model from AEC, Cardiology and OPM.	x		
GP Streaming – Single point of contact (Bed Bureau) available 24/7, 7 days a week for all GP's accessing Acute Services for either advice or admission or streaming to AEC/AFU. New telephone system with additional telephone lines introduced to ensure calls answered quickly. Call activity and performance actively managed by Reception manager. Contact to downstream specialities via bleep and telephone. Process in place to ensure swift response from appropriate clinician.	x		
Ambulatory Emergency Care (AEC) – available 5 days per week 0800-1800 with specialist nurse support, consultant lead weekdays and GP led ad hoc flex weekend service 0900-1600 hours (reviewing additionality over Winter)	x		
Reviewing pathways of GP admitted patients in relation to AEC to optimise ambulatory care for appropriate patients.	x		
Model of speciality consultant of the day in place in hours for all medical specialities – available to GPs and ED Consultants. Out of hours, any calls will be to the on-call consultant (Medicine, Cardiology, Gastro – GI bleed).	x		
Continued high acuity bay model in AMU to facilitate streaming and care for very unwell patients.	x		
2 nd consultant on weekends – second AMU review.		x	
'Early bloods' PDSA (6-8am).		x	
Provision of 'pleural room' adjacent to Ward 2 to support LoS reduction for respiratory patients.		x	
Respiratory Team actions (key focus early January): <ul style="list-style-type: none"> • Increase input to wards on Wednesdays <ul style="list-style-type: none"> ○ Cancel education session so ward round can start earlier ○ 2 consultants to do outliers/referrals • All outliers seen <ul style="list-style-type: none"> ○ Prompter input for referrals ○ If required, reduce clinic on post take days to allow fuller post take ward round • Extra full blue ward round post bank holiday • Consultant on ward 2/3 every day and outliers seen daily. For the general "on take" • Extra SpR/senior decision maker at weekends (e.g. approach ex-trainees now in research) • WLI: reconsider evening ward rounds or extending consultant on call at weekend to work until 5 	x	x	

<p>Gastro Christmas/January plan:</p> <ul style="list-style-type: none"> • Consultant on site on each of the weekend/bank holidays. • Provide additional ward/endoscopy time by either extending the working day of the on call consultant or having another consultant deliver an extra 1 or 2 sessions across the long bank holiday • To consider additional junior support for this • Weekdays - backfill all emergency endoscopy and inpatient roles to ensure GI presence on AMU/ Ward 1 every morning. • Review clinic and OP capacity and consider requirement/impact of redirecting routine/annual follow up capacity to emergency capacity. 	x	x	
Cardiology			
Acute Cardiac Clinic opened and works alongside the Cardiac ANPs in-reaching into ED and AMU. The ambulatory service is currently open 5 days a week taking referrals from ED and AMU, moving towards direct referral from GPs. This will compliment some of the urgent access clinics already in place (rapid access AF, Heart function clinic and the rapid access chest pain clinic).	x		
Joint working with other local acute providers to develop timely advice and guidance for GPs.	x		
Cardiac LoS improvements also supported by 'step up'/'step down' area allowing reduced time to lab and day case approaches, additional inpatient focused capacity will be supported around peak periods. (e.g. Christmas and New Year)		x	
Admission avoidance and discharge of patients facilitated through planned clinics which support the on-going pathway whilst allowing patients to remain at home.			x
Older Persons' Medicine (including Discharge Team)			
Older Person Ambulatory Care Clinic (OPAC) runs Monday – Friday supported by Geriatricians and Nurse Practitioners. Function of avoiding admission or supporting early discharge from the frailty unit.	x		x

<p>Older Persons Admission Unit (Frailty Unit) operating from September 2016 which includes Ambulatory Care and short stay beds for up to 5 days LOS.</p> <p>Comprehensive Geriatric Assessment (CGA) commences within 2 hours of admission to support triage of patients identified with frailty to access the appropriate acute or community service from ED. This will include either transfer to:</p> <ul style="list-style-type: none"> • OPAU (Older Persons Frailty Unit) • OPAC (Older Persons Ambulatory Care) • Discharge to Locality Community Hub Services (Intermediate care, Day Hospital, Step down beds or reablement). <p>To consider dedicated Porter.</p>	x	x	x
OPM Clinical Nurse Specialist roles developed to support frailty pathways.	x	x	x
Response from DHUFT (Bmth & Dorset) Intermediate Care service within 2 hours of referrals to avoid admission.	x		
Pan-Dorset 'Leaving Hospital Policy' (replaced Patient Choice Policy) updated in June 2016 and in operational use across the Trust supporting training and compliance.			x
MDT Outlier reviews			x
'Funding out of hospital' in place for patients admitted from Bournemouth and Dorset. West Hampshire pilot from October 2016.			x
Trusted Assessor for Intermediate Care discharges in place. Trusted Assessor for discharge with Social Care Reablement services commencing from November 2016 (to include patients requiring a new package of care or increase in care over 7 days). This applies to Bournemouth & Dorset local authorities.			x

Discharge to Assess Service currently in development with Bournemouth & Dorset Local Authorities and Dorset Healthcare Community Services. Includes the following services / initiatives: Trusted Assessors (as above) Interim Care Service providing two functions: <ul style="list-style-type: none"> • Transfer to an interim care home for a further period of social care assessment • Transfer home with an interim package of care whilst awaiting long term domiciliary or Reablement services to commence. • To work with commissioners to consider extension to West Hants. • To consider cohorting dementia/complex patients in ring-fenced interim care capacity. • To extend Nurse Practitioner support to interim care. 			X
Implementation of the Christchurch Locality Hub service providing integrated health and social care community services to avoid admissions to and support discharge from RBCH.	X	X	X
Developing domiciliary care provider market to support packages of care, including End of Life			X
Proactive therapy/MDT review of patients awaiting long term packages of care to seek alternative approaches to managing activities of daily living			X
Work with Dorset Healthcare to support development of the Canford Ward & Community Hospital pathways to support rehab philosophy and potentially include step up admission avoidance and interim care.			X
Development of BCHA model and social care support for early discharge of Self Funders with low level and complex care needs			X
Review domiciliary care pathways with a view to reducing delays for patients awaiting care			X
Medical Care Group Wide			
Flow Matrons being established (end Sept) in all Medicine areas will support EDD and discharge before midday approaches which are key areas for further improvement. They will also support review of patients 7+ days, escalating through internal Care Group flow management approach.		X	
Weekend consultant cover continues.		X	

Optimise in-week utilisation of TIU.		x	
MFFD database being implemented from Nov 16 to support review of 7+ day patients.		x	
Nurse facilitated criteria based discharge in place in some areas. Increased out of hours/weekend consultant presence and MDT review supports discharge. Clinician's inpatient work list also indicates criteria for individual discharge.			x
<p>To consider:</p> <ul style="list-style-type: none"> • Rejigging of SPA or non-essential clinics to divert consultants to extra ward rounds/ front door at peak times • WLI 12-4pm weekend Ward Rounds • Evening Ward Rounds until 10pm • Extra SpR to triage in evening to reduce flow issues overnight 		x	
CARE GROUP C – SPECIALITIES			
Specialist Services			
Reviewing options presented at Urgent Care Steering Group to increase senior pharmacist presence on AMU consultant ward rounds.		x	
Ward based pharmacy teams and work stations to dispense medication and prepare discharge letters.			x
Reviewing potential and resource for fixed term locum pharmacist to support discharges and flow.			x
Cancer Care and Pathology			
On-going review and flexible management of phlebotomy provision across the trust to support wards.		x	
Reviewing potential for Macmillan flex capacity to be provided, linked to escalation approval processes, including trigger for fast track CHC		x	
Considering option to improve timeliness of ED sample delivery to pathology.			
Radiology			
The out of hours on call service provides a 7 day and extended day service in CT and a 7 day ultrasound service. This ensures acutely unwell patients receive timely diagnostics, support discharges and assist the hospital with patient 'flow'.			

Ophthalmology			
Eye Unit flex capacity provision to continue to be provided to support outliers during peak occupancy and flow.		x	
Maintenance of RTT through winter - plans to include: <ul style="list-style-type: none"> • continuation of demand management and referral process review • additional activity (to include spread into weekends) • focus on outpatient waits to reduce late 'additions to list' requiring surgical capacity • additional locum/substantive posts • outsourcing 		x	
TRUSTWIDE			
Five Daily Actions (SAFER) – additional to actions above			
Agreed definition for Estimated Date of Discharge (EDD) and Confirmed Date of Discharge (CDD) and roll out across the Trust supported by new Discharge Database and e-bed system.		x	
'Stranded patient' report with regular MDT review of 7+ days stay (significant improvement already achieved in 14+ day stays).		x	
Review and selection of e-bed management system and implementation.		x	
Development and implementation of bed predictor and trigger tools		x	
Development of escalation processes and actions, signed off by TMB, linked to predictors/triggers to support flow, task and finish group to be established.		x	
Reduction in consultant outpatient activity Xmas/New Year (other peak times) to redirect medical input into early senior reviews, outlying patients, ambulatory, in reach and frailty models		x	
Cancer capacity and RTT recovery plans, including additional activity and outsourcing during Q3 to support STF attainment over the winter.		x	

8. Escalation

The Trust's trigger and escalation process is currently being reviewed and developed for full implementation from the end of Q3. This will be linked to our recently revised bed predictors and trigger tools as well as the system-wide policy. It will also incorporate a daily, real time 'action card' approach to support timely response to

increasing pressures. A senior Task and Finish Group will be reviewing and approving these in readiness for the winter and this will form the basis of our daily flow, escalation and response. The aim is that this will also be supported by the introduction of an e-bed management system which is currently planned for implementation in the second half of the year.

The Trust's Escalation Policy will also outline the process for calling an Executive-led Escalation Meeting and/or extraordinary 'Breaking the Cycle' event, together with the Dorset-wide Surge & Escalation Policy which will be applied in the event of key safety, demand, capacity and performance triggers.

At a system-wide level, in addition to the weekly teleconference, the established process for calling an extraordinary teleconference via Single Point of Access (SPoA). The requirement for more regular calls at peak times will be reviewed regularly and supported by national sitrep reporting.

9. Flex Capacity

Full realisation of the benefits of the above approaches will be absolutely imperative to managing our winter flow, given the very limited opportunities to create flex capacity for either 'processing' or 'storage'. The enthusiastic engagement and commitment of all staff to these has been clearly evident and this continued positivity and drive through the winter is key to the safe, quality of care to our patients

In the event that the Trust does reach significant triggers (e.g. 'red' / 'black'), recognition and support of the escalation and flex process that would be required is best established in advance. It is therefore, only prudent that these plans, in response to predicted pressure periods and/or as contingencies are worked up in readiness, to be in the best position that we can to protect flow and patient care in these circumstances. The following therefore, outlines the escalation and flex approach planned which would be instigated through the system-wide and internal escalation actions (as per Dorset-wide and internal escalation policies/SOPs):

- 1) Fully optimise and extend existing urgent care work outlined above. Opening additional beds, +6 Broadwaters Jan – March; +6 Ward 16 December; +6 Ward 14 January
- 2) Communication with external partners to seek support through escalation and system-wide resilience alert processes
- 3) Use of normal agreed flex areas (e.g. Eye Unit)
- 4) Increased outlying within normal bed capacity (e.g. Surgery/Ward 7) – dependent upon case by case review of impact on major/urgent elective treatments and diagnostics

5) Pre-planned additional capacity

- Discharge lounge function to TIU / extra or move existing.
- Christmas/New Year – Derwent/Ward 7 no operating, ward to take selected outliers with a plan to clear over the first week of January 2017.
- Ward 12 – day and overnight surgery, weekend opting for electives, failed day cases and surgery 'expected home by Monday'.

6) Contingency based on Trust escalation triggers

- Ward 7 extension - additional 9 beds for Medicine requires extra staffing and leadership. First step Sunday – Wednesday AM opening.
If Ward 7 extension fails to empty by Wed (i.e. cannot de-escalate), then move to Ward 9 and open additional beds in steps: 18, 24, 35 (all capacity open). Need staffing and budgeting options for all these bed numbers.
- Other staff resources required: Night time queue management ED; facilitator and portering for extra wards. Extra Phlebotomy and site as previous years.
- Mac Unit +2 bed numbers and transfer CHC fast track patients
- Increase interim care home beds beyond agreed funding envelope

7) Contingency based on triggers (pre black – Phase 3 flex) into unstaffed areas or major elective disruption.

- Derwent outlying, cancellation of electives.
- Ward 21 – now reconfigured to offices; convert back.
- Day Surgery Unit (convert to inpatients needing 24/7 staff and cancellations)
- Endoscopy (as per DSU)

Consideration will be given at all levels to the benefit/impact of cancelling electives though note section 2.1 above. Electives to be considered:

- Day case
- Endoscopy
- Inpatient Surgery and Orthopaedics
- Day case and inpatient Cardiac

10. Dorset-Wide Actions

The Dorset-wide A&E and Urgent Care Delivery Board is leading the review and assurance against the 5 nationally mandated interventions. Action will be shared across partner organisations, supported by a Winter Workshop in October 2016 where each partner presents their plans.

The national interventions include requirements from NHS 111 and ambulance services, which will be supported by a Dorset-wide concordat to minimise ambulance handover delays in EDs

Partner organisations are also required to support Discharge to Assess and Trusted Assessor models being in place before the winter, so as to reduce delays in hospital.

The system-wide Delayed Transfers of Care (DTC) group continues with a focus on growing the domiciliary care workforce for general and End of Life care.

Canford Ward (St Leonards Hospital), will continue over the winter to support community hospital based capacity in the East of the County and work is underway to speed up transfer and discharge from the ward, to support flow.

Mental health services are also moving forward with programmes of work to provide additional support to patients and avoid admission or secure timely assessment and transfer for those patients admitted to an acute trust. Additional bed capacity will be available at St Anne's Hospital from November, plus step down community accommodation.

In addition, the CCG is supporting a pilot of pre-crisis "retreats" to allow drop ins and earlier interventions, avoiding the need to use ED to access mental health care.

Primary Care opening, especially over the Christmas and New Year will also be supported, along with the Boscombe walk-in service. Greater use of this can be made by ED.

11. Governance and monitoring

Progress against action plans will be reviewed at the Urgent Care Steering Board, Care Group Review Meetings and Performance Management Group (PMG). Twice daily bed meetings will ensure day to day oversight.

Metrics include:

- Ward dashboards and quality framework metrics
- AIRS, mortality and/or other quality alert flags
- Urgent care metrics (e.g. ambulatory and frailty unit admissions/transfers; LoS)
- 5 Daily Actions metrics (e.g. Use of EDDs and discharge lounge; discharges before midday)
- Cancelled operations
- Patients with extended LoS (e.g. 7/10/14+ days)
- Numbers of outliers
- Delayed discharges (DTC)
- CHC (especially fast track) delays
- 4hr breaches in ED for decision to admit or discharge
- Ambulance handover delays
- Ambulance conveyances and ED attenders

- Admission levels and activity (non-elective and elective)

Regular reporting to the Trust Management Board and Trust Board of Directors will also include relevant metrics, highlights and issues to support Board assurance.

Dorset-wide oversight will be via the A&E Delivery and Urgent Care Board.

12. Communication

As stated at the beginning of the paper, the three priorities are:

- i) Making what we have work to best effect.
- ii) Having department and Trust wide escalation to respond to peaks in demand, much of which is predictable, to best meet processing (or storage) shortfalls, internally and with partners.
- iii) Effective communication and engagement with staff and partners to create the right culture and QI approach.

Our staff and partners need to know what actions are underway, not least to maintain morale. Knowing how much effort there is going into improving emergency care, and how to access new or improved services is critical to the success of the system overall.

Board member views as to how much effort, and the most effective ways of communicating with our staff, would be welcome.

The objectives of any communications campaign would be:

- Staff up-to-date and feeling supported to know what is happening for emergency care within RBCH and with partner organisations.
- Sharing learning and successes from QI and other change initiatives, as part of developing the wider improvement culture.
- Have public facing messages, such as “choose well for winter” and “no place like home” through using our own media channels to promote local and national campaigns, and provide public confidence in service delivery.

Communication mediums include:

- Face to face briefings through team and Directorate structures
- Corporate communications (Core Brief, Bulletin, Screen Savers, Payslips, posters etc.) as well as targeted emails.
- Social media (Twitter, Facebook)
- Local print and broadcast media, via press releases and story generation.

Feedback on this approach is encouraged.

Creating a “social movement” of staff (and partners) providing feedback, and celebrating successes would help create the well led, staff engaged services required for outstanding care.

13. Conclusion

There is no doubt the winter period will once again be challenging. With staffing levels, financial control totals and agency cap locked down, and rapidly deteriorating domiciliary care provision, there are significant additional risks.

Positively the Trust has taken a new, QI based approach to focusing on the most effective ways of managing demand, which is bedding in. There also remains significant potential for improvement in SAFER care / 5 daily actions which will improve flow, and thus patient safety. In addition we need to improve our predictor tools and triggers for escalation, so we have well-rehearsed and effective responses for inevitable periods of demand outstripping capacity.

In addition this requires greater effective communication and coordination, strong clinical leadership at all levels, within a positive learning culture.

By pulling these key workstreams together and harnessing the skills and drive of our staff and partners, we need to ensure as safe as possible care for the population we serve.

Mandated initiative 1 - Front Door – Primary and Ambulatory Care streaming

Larger urban A&Es, particularly those with chronic staff shortages, should consider developing primary care streams to manage patients presenting with minor illnesses and/or chronic conditions during peak demand periods. Patients should not be redirected away from the service without treatment (which may include advice). Non-registered patients should be helped to register with a practice close to their home. Such services should not include GPs where in or out of hours general practice has staffing shortages.

Issues

Literature suggests that between 10-30% of attendances to A&E could be cared for by Primary Care

Creates a demand that for a service that A&E services are not intended to deliver

How these issues should be addressed

Streaming patients to Primary Care at presentation to A&E

Patients assessed on arrival at A&E to have a condition within the competence of a primary care practitioner, should be streamed to the service.

Governance

The service should be fully integrated with the A&E and under its direct management. The service may be staffed by established local GPs or other professionals with suitable competencies.

Funding

Develop local tariffs, that incentivise all partners to work in the patients' best interests

When designing primary care provision in conjunction in A&E, consideration needs to be given to:

- Patient involvement
- Leadership
- Change management
- Capacity & demand
- Access to patient information and diagnostics
- Metrics
- Ongoing care needs

Results

Reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.

Redirect people to the 'right' care.

Develop a more integrated, whole system approach to urgent and emergency care.

Provide expert care for patients presenting to emergency departments with primary care presentations or minor illnesses.

***Key metric: Potentially avoidable attendance metric**

What will be different?

Accountability

Delivery

Mobilisation – local, regional and national actions

Governance

Timetable

Mandated initiative 2 - Ambulance Response Programme

The proposals put forward in the current Ambulance Response Programme (ARP) are ultimately about creating the best model to enhance patient outcomes, improve user experience and reduce mortality by prioritising those with the greatest need whilst ensuring that all those who contact the ambulance service receive an appropriate and timely clinician and transport response.

Issues

Ambulance services are facing unprecedented demand; the number of Category A (Red 1 & Red 2) ambulances arriving at scene averaged 6,900 per day in 2011-12; 7,400 in 2012-13; 7,900 in 2013-14; and 8,600 in 2014-15. This demonstrates an increase of almost 25% between 2011-12 and 2014-15.

To deal with this level of demand whilst achieving the constitutional standard of an 8 minute response time for all Red calls ambulance services dispatch more than one vehicle (around 1.7 vehicles per call) and engage in a range of other behaviours, including fleet changes, that are designed to meet response standards, but are not always in the best interests of the patient.

There is increasing awareness that ambulance services are not measured on components that reflect a patient-centred organisation, user experience and clinical outcomes.

How we are addressing these issues

Dispatch on Disposition

We have a pilot project in the evaluation stage that allows ambulance call handlers additional time to assess 999 calls to ensure appropriate and safe triage for all but the most life threatening calls; this is called Dispatch on Disposition

Clinical Coding

We have also conducted a clinically led and evidence-based review of the current 999 call coding systems. We explored whether changes could be made to improve performance whilst maintaining patient safety, based on the analysis of outcomes from previous 999 calls.

As we pilot and trial the interventions required to make improvements for patients it is becoming increasingly difficult to compare the performance of English ambulance services with each other and over time. For Dispatch on Disposition (DoD) the six pilot sites have data that are not comparable to the four control sites. At the same time, for the new code set trials the three pilot sites are working to a different set of clinical codes and AQIs.

To avoid confusion, and pave the way for future improvements we therefore propose :

- The reporting of Red2 is suspended nationally from April 2016 - date TBC (National statistician advises that having collected April data we should publish and suspension should be underpinned by some form of user consultation), with a continuation of Red1 and A19 as a backstop to ensure ongoing patient safety (Red and Red19 will be reported by the coding trial sites).
- New metrics, with headline clinical outcomes, are developed and consulted on.
- New performance thresholds are agreed, for implementation in 2017-18.
- The current system of associated financial incentives (e.g. the CCG Quality Premium and ambulance performance penalties) are reviewed as part of this process.

***Key metric: CAT A Red 1, Red 2 and CAT A 19 performance**

Results

The independent evaluation of this intervention is due at the beginning of June 2016.

The independent evaluation of this intervention is due in September 2016.

Risks

- Buy in and engagement of key stakeholders.
- Availability of resource (time, people, systems) to develop new metrics.
- Reputational impacts due to any adverse media coverage.
- Perceived patient safety risk due to 'lesser' scrutiny over transitional period.
- Possible business interruption as new protocols are developed, agreed and embedded.
- Compliance with statutory guidance and the NHS constitution.
- Financial impacts resulting from the above process and changes

What will be different?

Accountability

Delivery

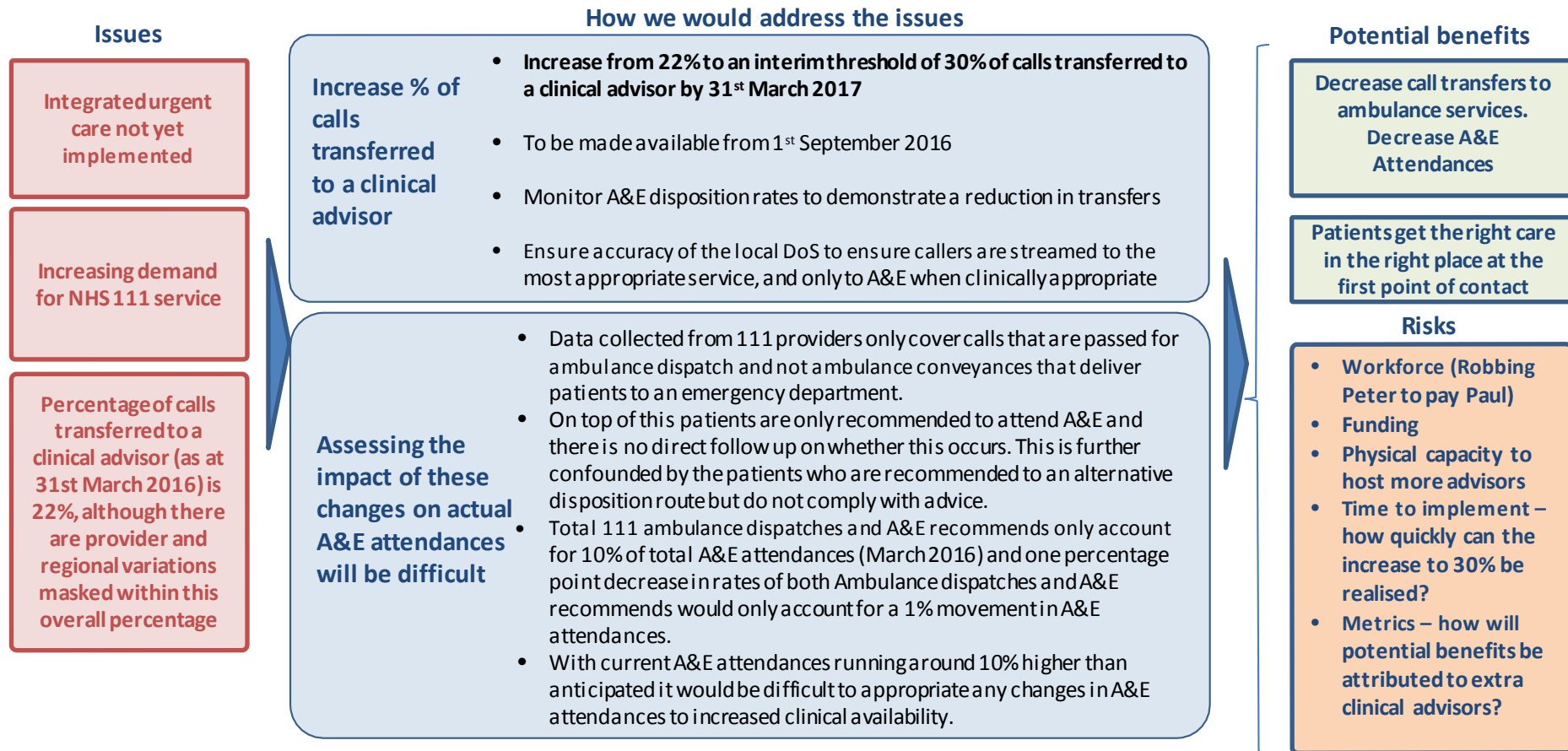
Mobilisation – local, regional and national actions

Governance

Timetable

Mandated initiative 3 - NHS 111

All CCGs to work as a whole system and consider how to increase levels of clinical input into current 111 providers.



***Key metric: Number/proportion of calls handled by a clinician - Of answered calls, % transferred to clinical advisor**



Mandated initiative4 - Flow

Priorities to enhance patient flow and reduce hospital bed occupancy – individual action and timeline - *Must*’ refer to essential priorities that all local health communities will resource and plan to deliver as part of their 2016/17 STPs. *Should*’ refer to important priorities that are complex and of a longer term nature and included in STPs for resourcing and delivery during 2017/18.

Issues

Implement ambulatory emergency care

Implement frailty pathways

Implement SAFER patient flow bundle

Focus on simple discharge

Implement “Internal Professional Standards”

Priorities for making it happen

How we would address the issues

All acute hospitals must have a consultant led AEC service operating at least 10 hours each weekday before the end of **N ov’1 6** . A 7 day service should be looked to be introduced this year and be fully established during 2017/18.

All trusts should have consultant led, multidisciplinary frailty teams working at front of the pathway by **Se pt ‘1 6** . Trusts should have processes systematically to identify people with frailty syndromes and provide them with comprehensive geriatric assessment within 24 hours of admission. Phased implementation should be completed **before end of O ct ‘1 7** .

All trusts must implement SAFER.
By **N ov’1 6** hospitals must demonstrate progress towards every patient being reviewed every day by a senior clinician (normally a consultant) as set out in ‘7 day services Clinical Standards’ Section 8. Twice daily consultant ward rounds must be mandatory on all assessments units. All patients must have a written care plan that includes clinical criteria for discharge and an expected date of discharge so that multidisciplinary teams have clear goals for each patient. The care plan must be determined and signed off by the consultant within 14 hours of a patient’s admission. The use of ward round check lists is essential to patient safety and should be mandatory.

All hospitals must establish a systematic process to review the reasons for any inpatient stay that exceeds six days. This standard must be met by **N ov’1 6** .

All providers must develop an adequately resourced, supernumerary team experienced in improvement methodologies to support delivery of the priorities . Systems must assess their capacity and capability to deliver and sustain change using a recognised [evaluation tool](#) by the end of **A ug’1 6** .

Potential benefits

Reduces inpatient bed occupancy

Reduces harm and inappropriate LoS

Promotes continuity and consistency – reduces unnecessary variation

Avoid focus on short delays

Means clinicians working collaboratively in best interests of patients

***Number of patients spending >4 hours and >12 hours from decision to admit to admission, Bed occupancy**
Stranded patient metric

What will be different?

Accountability

Delivery

Mobilisation – local, regional and national actions

Governance

Timetable

Mandated initiative 5 - Improving discharge from hospital Part 1 – what can be done now:

Issues		How we would address the issues		Potential benefits
Discharge programme board priority work areas	“Implement discharge to assess” (home first)	Local systems should implement a ‘discharge to assess’ model so health and social care assessments of care are carried out in patients’ places of residence rather than in acute hospitals. This standard should be met by <u>No v’ 17</u> . “Respond rapidly to requests for home visits” - GPs should have processes in place to respond to and prioritise requests for urgent home visits, usually through early telephone assessment and a duty doctor rota. This standard should be incentivised by commissioners through a LES by no later than <u>1 June ’17</u> . Commissioners of ambulance services should ensure ambulance services respond rapidly to general practice requests relating to patients who need urgent conveyance to hospital. This standard must be met at the time the response standard LES becomes operational.		Greatly reduces delays in discharging and points to home as the first port of call if clinically appropriate
	Data and metrics	Fill ‘gap’ in current work programmes by improving current dataset and driving development of alternative metrics	Improve the utility and consistency of the current DTOC SitRep	
	Acute flow	Coordinate action to and help develop winter 2016/17 support offer on patient flow; develop suite of products to spread learnings from local successes and ECIP	Improve local understanding of best practice around patient flow and discharge pathway (i.e. model pathway)	
	Senior decision-making in the system	Fill ‘gap’ in current work programmes by raising profile of timely discharge, highlighting quality and safety arguments through multiple channels	Fill ‘gap’ in current work programmes by raising profile of timely discharge with senior clinical and managerial decision-makers in local systems	
	Better use of step-down / intermediate care	Use programme team and other resource to drive development of models and identify opportunities to embed discharge in key frameworks (e.g. BCF)	Collate experience of using step-down / intermediate care (financial models, business cases and key success factors)	
	Local leadership/ accountability	Define core, effective leadership and accountability structures that support good patient flow and promote these through system levers (e.g. BCF)	Define small number of key 'ingredients' of successful local leadership on discharge issues	
	Assessment and regulation	Ensure that relevant assessment and regulatory frameworks support better patient flow and smoother discharge processes	Address nationally-controlled barriers / incentives that lead to slow and duplicate assessments. Identify further opportunities to improve CHC process and feed into existing work (e.g. refresh of Simple Guide, review of Care and Support regulations, updated National Framework for NHS CHC)	

***Key metric: DToC rate**



Mandated initiative 5 - Improving discharge from hospital Part 2 – what can be done longer term:

We are proposing a set of 15-20 pilots to test new metrics and models on hospital discharge, including discharge to assess and step down care, with proper evaluation to provide an evidence base and identify potential national changes.

Issues

How we would address these issues with pilots

Potential benefits

We have not done enough to provide robust evidence of clinical benefits of step-down

Costs, risks and savings fall to different actors across a local system which means agreeing shared funding for schemes is difficult

Market is highly immature, without an established understanding of expected outcomes

Current metrics and targets for delayed discharge are not fit for purpose

Commercial providers looking for stronger signals from the NHS that there is sustainable demand for these services

New payment and service models

- **15-20 step-down pilot projects** (bed- or home- based). Guiding principle of 'home is best'; and should save money. Need **strong case that step-down models would tackle issues and local buy in**. Work on the selection criteria and mobilisation plan for regional pilot sites underway. Systems would also need to demonstrate that step-down would **facilitate a reduction in acute capacity; and good practice embedded**.
- **A sustainable funding model agreed locally** – likely to include a risk-share mechanism or other form of pooled funding. Potential adopting a local 'step down' tariff which could be tested for national adoption
- Matching local areas to a menu of independent providers with models to meet their need inc. technology; capacity; services.

Trialling new data

- **Trialling of another metric, or suite of metrics** from an agreed menu e.g. stranded patient; medically fit for discharge; admission to discharge ratio, % patients discharged home, and others – e.g. from ECIP suite)
- Agreement to collect and share data on a regular basis throughout the pilot and participate in NHSE/NHSI funded **full evaluation** of costs, benefits and savings
- This could include collecting better data on community services to help inform creation of a national dataset

Best-practice on discharge

- **Embedding of best practice**, based on ECIP models, including NHSE discharge to assess guidance; 7 day discharge

National Support for pilot sites

- **Embedded in A&E plan governance**, including national oversight, support from intensive support team, regional teams driving pilots. Might need additional support e.g. LGA; commercial teams.
- Work to **remove of any national barriers to success of new models** e.g. agreement with CQC on their inspection of step-down schemes
- **Potentially, national financial support on a loan basis (to be agreed)**, which systems could access whilst they agree a local funding model (e.g. for the first 3 months) to allow them to start set-up and contracting. Based on modelling, this fund would need to be **in the region of £5-8m to fund 15 local systems for the first 3 months of a 30 step-down bed trial**

Reduction in delayed discharge in pilot areas (20% - 40%)

Best practice embedded in pilot sites; and evidence on what works.

Improved metrics and incentives for measuring delayed discharge

V indicative savings for cost of c.£1.2-1.6m

Provider:
Reduced bed base (o/head)
£134k - £201k

CCG:
Excess bed day
£626k - 939k

CCG:
Continuing Healthcare reduction
£693k - £1m

Local authority:
Social care savings
£120k - £190k

***Key metric: DTc rate**

What will be different?

Accountability

Delivery

Mobilisation – local, regional and national actions

Governance

Timetable