

A meeting of the Board of Directors will be held on Friday 27 May 2016 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital

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

Sarah Anderson
Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8:30-8:35	1. APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 29 April 2016		<i>All</i>
	b) To provide updates to the Actions Log		<i>All</i>
8.40-8.45	3. MATTERS ARISING		
	a) None		
8.45-9.25	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>
9.25-10.25	5. PERFORMANCE		
	a) Performance Exception Report (paper)	Information	<i>Richard Renaut</i>
	b) Report from Chair of HAC (verbal)	Information	<i>Dave Bennett</i>
	c) Quality Report (paper)	Discussion	<i>Paula Shobbrook</i>
	d) Report from Chair Finance Committee (verbal)	Information	<i>Ian Metcalfe</i>
	e) Finance Report (paper)	Discussion	<i>Stuart Hunter</i>
	f) Workforce Report (paper)	Discussion	<i>Karen Allman</i>
	g) Medical Director's Report (paper)	Information	<i>Basil Fozard</i>
	i. Mortality		
10.25-10.35	6. STRATEGY AND RISK		
	a) Clinical Services Review (paper)	Information	<i>Tony Spotswood</i>
	7. NEXT MEETING		
	Friday 24 June 2016 at 8.30am in the Oasis Restaurant, Royal Bournemouth Hospital		
	8. ANY OTHER BUSINESS		

Key Points for Communication to Staff

9. 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.

10. 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 29 April 2016** in the Conference Room, Education Centre, The Royal Bournemouth Hospital.

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of HR</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>
	Ian Metcalfe	(IM)	<i>Non-Executive Director</i>
	Steve Peacock	(SP)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Sarah Anderson	(SA)	<i>Trust Secretary</i>
Staff	James Donald	(JD)	<i>Head of Communications</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NH)	<i>Director of Organisational Development</i>
	Dr Helen Holt	(HH)	<i>Consultant, Diabetes & Endocrine</i>
	Dily Ruffer	(DR)	<i>Governor Coordinator</i>
	Melanie Weis	(MW)	<i>Nurse Specialist, Diabetes & Endocrine</i>
Public/ Governors	Rob Bowers		<i>Snr Wessex Cardiology Trainee (observer)</i>
	Derek Chaffey		<i>Public Governor</i>
	Eric Fisher		<i>Public Governor</i>
	Bob Gee		<i>Public Governor</i>
	Paul McMillan		<i>Public Governor</i>
	Margaret Neville		<i>Representative of the Friends of the Eye Unit</i>
	Roger Parsons		<i>Public Governor</i>
	Gordon Stollard		<i>Member of Public</i>
	Rae Stollard		<i>Appointed Governor</i>
	David Triplow		<i>Public Governor</i>
Apologies	Bill Yardley		<i>Non-Executive Director</i>

- 31/16 **DECLARATIONS OF INTEREST** Action
- None.
- 32/16 **Minutes of the meeting held on 1 April 2016 (Item 2a)**
- The minutes were **approved** as an accurate record subject to amending reference JMP to JM at 24/16.

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

- 25/16 (a) - hand hygiene will be highlighted to TMB and remitted to the IPCC.
- 25/16 (b) the stroke team have been included on the schedule.
- 25/16 (h) - the Workforce Committee recently reviewed compliance targets for mandatory training and appraisals. It was agreed that the target will remain at 95%. Compliance increased by 11% over the last year.
- 26/16 (b) - recommendations were presented to Executives and will be provided at the May Board.
- 20/16 (3) - videos are being developed with front line staff to promote understanding of the Trust Objectives. Governors will receive a briefing at the next governor meeting.
- 07/16 (a) - the terms of reference for the Equality and Diversity Committee have been re launched and attendance has improved. Work is on-going to ensure that appropriate adjustments are being made to reflect the wider population and demographics.

MATTERS ARISING

- (a) None.

33/16

QUALITY

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

HH and MW presented the patient story arising from the Bournemouth Diabetes and Endocrine Centre (BDEC) and Obstetric services. The story concerned a patient who had a longstanding history of poorly managed type 1 diabetes, eye disease and a number of 'did not attend' (DNA) appointments. The team offered support and education during their first pregnancy however the patient did not want to engage with the control of their diabetes.

The department lost contact with the patient who was not reviewed again until they were referred during their second pregnancy. The patient was more aware of her diabetes and as such it was better controlled. The team sought to develop a relationship of trust with the patient and following intensive input from the team they delivered a healthy baby in March 2016. The patient commented that, *"I liked coming to clinic, I felt supported and so did my family."*

As a result of the patient's pathway the team sought to address follow up care by ensuring that patients attended their 6 week post natal check-up. Communication was also improved between departments and primary care partners to highlight when appointments were cancelled. The department is involved in educating the community and with developing services with GPs to promote awareness of the wider implications of diabetes. Board members queried how the medical teams were brought together to address complex needs. Allotting time for face to face

discussions with regular meetings to discuss the service with partners had supported the provision of quality of care. The story was praised as being a good example of teamwork across pathways and that it embodied the Trust's core values.

The Board questioned whether further support could be provided to track patients across departments and services. Difficulties with patient engagement and communication between IT systems were recognised as the main challenges. Developments with the Dorset Care Record will support improvements going forwards and clinical involvement in the process will be key.

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

Staff Governors met with the Chairperson on 26 April. Feedback on issues previously raised had been positive, including improvements to the provision of food for staff in the west wing. The request for annual leave arrangements from nurses for the year had been raised as a burden for some staff to provide. The request is aimed to support staffing arrangements over the year.

Staff pressures were referenced and further publicity of the support available to staff was requested, including Care First and occupational health services. Staff are also interested in receiving feedback on the impact of the junior doctor strikes. The first 'listening session' for staff will be held on 26 May.

(c) Complaints Report (Item 4c)

The report was presented and discussed at the Healthcare Assurance Committee (HAC). The areas with the highest volume of complaints and overdue responses are surgery and medicine. Some complaints are complex and teams are working to urgently address the back log. There is increased engagement and it is a standardised agenda item at performance meetings for each care group.

The Board were advised that the number of complaints was reducing and being sustained in an environment where activity is increasing. It was noted that more frequently issues were being dealt with as they arise before they translate into a complaint.

(d) Picker Inpatient Survey results (Item 4d)

The Trust performed well with significant improvements in 18 questions when compared with other trusts. Themes included patient feedback about doctors, communication and discharge arrangements for patients. Generally the Trust performs well above average.

Although the Trust has made a significant improvement in 2014, performance was below expectation, in relation to patients using a bath or shower which could also be used by a member of the

opposite sex. Due to the layout of the wards the Trust is unable to provide extra single- sex facilities in central areas without reducing the number of beds and significant expenditure. This is mitigated where possible to provide same sex bays and highlighted to patients to ensure that privacy and dignity is respected. If successful, under the Clinical Services Review (CSR), more ward refurbishments will be possible.

The data will be reviewed and triangulated against all Trust feedback, including the staff survey, and specific actions will be developed within care groups and directorates. The results will be provided to the CQC who will aggregate the data and publish their inpatient survey in May. The Board **noted** the report and the significant shift in performance this year.

34/16

PERFORMANCE

(a) Performance Exception Report (Item 5a)

The Board were informed that the strike action had not impacted upon patient safety. This was due to staff flexibility and proactive planning with the involvement of Junior Doctors. 700 appointments were to be rescheduled with a financial impact of at least £200k per day.

It is understood that the new contract will be imposed from August and further planning will be required over a potentially longer period of time. The contract will affect the recruitment of new starters, rotas and financial costs will be incurred if the fill rate is not met. Additional funds for protection against these risks will need to be identified. The Board noted the risks going forwards and thanked staff and partner agencies for their support.

RR outlined the Trust's performance against the key performance indicators:

- Cancer 2 week wait – performance is at risk for the first quarter however mitigation is in place. Ring fenced cancer fast track referral clinics have been impacted upon by the strike action;
- Emergency pressures- activity dipped within the last week although this will continue to be monitored;
- Cancer 62 days- robotic surgery waiting times have been reduced. One screening case breached the screening target however the issue was outside of the control of the Trust.

An update on the progress with delayed transfers of care will be provided next month. RR thanked the teams for coordinating the work during the challenging periods.

**Agenda
item/RR**

Board members raised concern for potential strike action exceeding beyond day care and maintaining safety in the acute sector. It was noted that Medical Directors in the South were aware of the concerns in terms of escalation. The new contract will create

significant issues in filling training grade posts as increasingly doctors are opting to take a year out or pursue options abroad. The issue has been flagged nationally and will accelerate some of the issues highlighted within the CSR.

An analysis was requested of both the impact and risks going forwards for both patients and the Trust to emphasise what needs to be done nationally. It was proposed that the information was then shared with NHS England and NHS improvement.

**Agenda
item
BF/RR**

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

The Chair highlighted the key themes discussed by the Committee:

- There had been a slight deterioration with Electronic Nursing Assessment (ENA) compliance highlighted through the care audit. Issues related to the significant number of patient moves and the outliers. Data issues are also being addressed;
- Internal Audit report on risk assessment maturity – the report has been discussed with the Heads of Nursing and specifically the appropriate management and assessment of risks. It was recommended that the Board should consider its appetite for internal risk;
- Information governance- appropriate discussions and actions are in place following the discovery of printed ribbons in an alleyway by a member of the public;
- Ward 3- a formal improvement plan has been put in place following consistent poor performance in a number of data areas. Patient experience, friends and family test (FFT) data and complaints are not reflective of any serious issues and quality care is being provided. The plan will address compliance with processes.

(c) Quality Report (Item 5c)

The report was taken by exception and the following points were highlighted:

- New pressure ulcers had been reported in month resulting from community acquired pressure ulcer damage;
- The Trust is performing within the top quartile for FFT data although the volume of feedback within ED remains challenging. IT solutions and additional support options are being considered;
- FFT- themes identified included waiting times in Pathology which have been prolonged due to vacancies in the department and a 20% increase in attendances. This is being managed with additional training and the appointment of a new manager. Wider strategic work is underway to review the model of pathology provision. The department incurs additional pressures from the drop in service in comparison to Poole Hospital where there is an appointment service. Internal and external actions being considered to improve

efficiencies.

It was emphasised that the Trust was an acute hospital providing a service that other trusts did not provide.

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

The Chair summarised the Committee discussions:

- The draft year end position indicated an improvement upon the original budget and the amended target submitted to Monitor resulting from an increase in the cost improvement plan (CIP);
- The Trust achieved a £9.5 million CIP for 2015/16 in challenging circumstances;
- The Trust is fully integrating quality improvement into the financial CIP programme;
- Management staff are engaged in the financial processes and the controls have been endorsed by the Trust's internal auditors who remarked specifically on staff engagement. This is reflected in the figures;
- Lord Carter of Coles recommendations will be integrated with the QI programme to avoid additional metrics for the organisation;
- Budget management has significantly improved and particularly within the medical care group;
- Monitor is yet to provide the outcome of their investigation.

(e) Finance Report (Item 5e)

SH highlighted the key themes from the report which included:

- The Trust ended the year with an unaudited position cumulative deficit of £11.566 million, £1.4 million better than the initial budget plan of £12.9 million and £0.4 million better than the revised plan of £11.9 million;
- Aggregate savings totalled £9.5 million. The level of non-recurrent savings is significant at £3.7 million, and this has placed significant pressure on the 2016/17 budgets;
- The accounts will be concluded over the next few weeks. The costs pressures incurred as a result of the strikes have not yet been identified and will be worked through;
- The three main contracts have been agreed on a PBR basis and arbitration has been avoided;
- Lord Carter of Coles report recommendations- the Trust response has been developed and will be presented to the Board for ratification in May.

Board members requested assurance that controls were in place for next year to manage drug expenditure. The nature of the contract last year provided a risk share, the 2016/17 contracts will be on a full PBR basis and as such insurance will be recovered in full. Improvements in productivity will also be required to manage costs.

The decline in private patient income over the last three years was acknowledged. It was emphasised that plans have been agreed to develop a private facility at the Trust and a process to recover cardiology private patient income has been agreed with Regents Park.

Board members reflected upon the initial forecasting for the year and the significantly improved position to date noting the difficult discussions and decisions made contributing to the positive outcome.

(f) Feedback from the Chair of Workforce Committee (verbal)

- Discussions around Consultant succession planning have been useful although there are concerns around the position within Histopathology;
- Sickness Internal Audit Report- the report identified that improvements were required with compliance with management and policies;
- Health and wellbeing initiatives have been promoted amongst staff through the communication department. Staff are frequently utilising the ZEST portal;
- Attendance of care groups at the Equality and Diversity Committee has much improved with greater involvement in work streams.

(g) Workforce Report (Item 5h)

KA summarised the key areas of the report:

- Trajectories over the last year demonstrate improvements including essential core skills training which has increased by 11%;
- Medical Appraisals- there has been a reduction in medical appraisal compliance however this is due to reporting issues;
- Appraisals- there have been detailed discussions at the Workforce Committee. Strong performance areas have been identified and positive feedback will be provided. It has been recognised that areas linked with high sickness levels relate to management action;
- Staff retention- projects are underway and the Trust is working with individual areas to develop solutions;
- Work experience- the programme has received encouraging feedback. This are will be fundamental to working with the demographics and through developments with the CSR;
- The Filipino nurse appointments have commenced work at the Trust. 40 European nurse appointments have also been made;
- Unify Safe Staffing Return- the reported red flags were reviewed at HAC. One red flag arose in surgery overnight and related to issues with the provision of temporary staff and sickness. Mitigation was in place and no significant issues arose.

Board members commented on the internal audit sickness report. It was supported that a more interventionist approach was required and further training to provide managers with more confidence to enforce Trust policies. It was emphasised that the policy needed to identify when managers should intervene.

(h) Medical Director's Report: Mortality (Item g(i))

The recent changes to mortality reporting requirements from NHS England were outlined. Board members discussed the presentation of the data. The Board were advised that the volume of deaths exceeding 30 would trigger a review to identify any examples of sub optimal care and clinicians will be provided with support to understand the concept. The significant improvement in the mortality figures over the last two years was commended.

Medical Director's Report: Medical Staffing Transformation (Item g (ii))

The Board were advised that 62/180 consultants had completed the job planning process by the deadline of 31 March. It was noted that implementing the process had been difficult as it is a new concept to the Trust. The Trust will be adopting a targeted approach to assist the completion of the fundamental process.

(i) Update from Audit Committee (Item 5h) (Verbal)

The update was provided in the part 2 meeting.

35/16

STRATEGY AND RISK

(a) Vanguard Progress Report (Item 6a) (Verbal)

TS provided an update on the Vanguard project:

- There is apprehension about the funding for the project following receipt of an offer of £175,000 for the first quarter. Growth money allocated to the NHS nationally is being used to underpin underlying deficits. There are concerns that the Department of Health may exceed its financing with the Treasury. The national care team have suggested that trusts should consider a loan and the Sustainability Transformation Fund (STF) offer to partners has been rescinded. The delivery of the Vanguard Project should be recognised as the delivery of the Sustainability Transformation Plan (STP) in Dorset as a whole. Additional funding may be acquired through developments with the CSR however further clarity will be provided in August;
- Appointments have been made for an independent Chairman and Programme Director. The scheme of delegation is being developed with partner trusts to clarify the relationship between the Boards. There have also been discussions about the model for the joint venture vehicle;

- Improvement work is underway to strengthen relationships with the partner organisations led by NH.

(b) Clinical Services Review (Item 6b) (Verbal)

TS updated the Board on the recent developments:

- The CCG's Governing Body attended both Poole Hospital and RBCH on 20 April and received presentations and tours of the sites led by the clinical workforce at RBCH;
- The Governing Body will meet to identify the preferred option for consultation for the emergency care and planned care sites.
- Due to the purdah period for local elections no public announcements will be made before the 6 May. Arrangements will be made for briefings to both staff and governors once the decision has been released.

(c) Royal College of Paediatrics and Child Health (RCPCH) reviews (Item 6c)

The independent Royal Colleges reviewed the provision of Paediatrics across the whole of Dorset. The recommendations included within the report concerned developing the womens health service provision between Bournemouth and Poole and providing a new maternity/obstetrics unit with rapid changes to providing neo natal care at Dorset County Hospital. The potential collaboration of services between Dorset County and Yeovil is being considered. If the service is not provided in the West it will be essential to link more closely with the East.

36/16

GOVERNANCE

(a) Annual Plan (Item 7a)

Comments to be provided to TS outside of the meeting.

ALL

(b) Amendments to the Trust Constitution (Item 7b)

The amendments to the constitution were approved by the Constitution Joint Working Group and agreed by the Council of Governors at their meeting in April. Attention was drawn to amendments including the renaming of the public constituency, the definition of a significant transaction providing the Trust more discretion on issues to consult with the Council of Governors and promoting transparency and the definition of non- NHS income.

The Board **approved** the amendments to the constitution.

37/16

INFRASTRUCTURE

(a) Staff Car Parking Charges (Item 8)

The recommendations to build upon the successful work which has reduced congestion and increased access to the site were outlined to the Board. It was noted that, despite the increase car parking charges would align with Poole Hospital and should not impact upon recruitment or retention. Lower paid staff will pay a lower rate and the Trust will be investing in additional security, storage, alternative travel incentives and increasing links with partners to provide travel options to staff.

Board members acknowledged the importance of supporting the new road junction and that the initiative prevented funds being taken from patient care. It was requested that the staff charges data table was made clearer for those paying a lower rate. **RR**

The Board **approved** the recommendation.

38/16 **DATE OF NEXT MEETING**
27 May 2016 at 8.30am in the **Conference Room, Education Centre, Royal Bournemouth Hospital**

39/16 **Key Points for Communication:**

1. Staff car parking charges
2. Inpatient Picker survey results
3. Patient story
4. End of year financial position
5. Positive response to the Junior Doctor strikes

40/16 **QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC**

1. The impact of the Junior Doctor contract upon the STF funding was raised. Clarification was provided that if the Trust chose not to implement the new contract this would impact upon the funding. The criteria linked to the STF funding will be provided to governors once available.
2. The number of hospital acquired C. Difficile cases due to lapses in care was queried. PS advised that the generic term related to compliance with processes and documentation. The themes linked to lapses in care concerned the lack of documentation and timeliness of isolating patients.

SH

There being no further business the meeting closed at 10:56 AH 29.04.2016

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
29.04.16	34/16	PERFORMANCE			
	(a)	<u>Performance Exception Report</u>			
		Provide an analysis of the impact and risks for patients/Trust and emphasise what needs to be done nationally in relation to the Junior Doctor's contract. The information is to be shared with NHS England and NHS improvement.	RR	Complete	An update will be provided by TS during the Part 2 meeting.
		Provide feedback on the progress with delayed transfers of care.	RR	Complete	Included within the Performance Report.
	36/16	GOVERNANCE			
	(a)	<u>Annual Plan</u>			
		Comments on the plan are to be provided to TS outside of the meeting.	Execs	Complete	
	37/16	INFRASTRUCTURE			
	(a)	<u>Staff Car Parking Charges</u>			
		It was requested that the staff charges data table was made clearer for those paying a lower rate.	RR	Complete	Communication circulated highlighting lower charges for lower paid staff.
	40/16	QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC			
	1.	Provide a summary of the criteria linked to the STF funding to governors once available.	SH	Complete	Presented to the Finance Sub Group for governors on 4 May.
01.04.16	24/16	QUALITY			
	(d)	<u>Complaints Report</u>			

RBCH Board of Directors Part 1 Actions April 2016 & previous

		Ensure that additional focus is paid to complaint response times and report on improvements within the next two months.	PS	June	Work is in progress and will be reported to HAC
	26/16	STRATEGY AND RISK			
	(b)	<u>Annual IG Briefing</u>			
		Review the incentives and accountability for IG compliance. Provide support to address compliance with the IG toolkit requirements and FOI responses to improve the position by next year. Also 108/15 (b): Ensure that the actions on the IG plan are prioritised to drive forward to achieve compliance.	PG/Execs	Complete	29.04.16 Executives met and recommended that as much information should be proactively published on the trust website to reduce the burden of responding to each FOI. A paper outlining the recommendations will be presented to the May BoD. For the IGT compliance Execs agreed to continue the performance management of the required tasks through the Performance Management Group. 20.05.16 Part 2 paper provided.
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	June HAC	Not yet due – pre-self assessment being prepared and self assessment to be refined over the summer.
	17/16	PERFORMANCE			
	(d)	<u>Staff Survey</u>			
		Incorporate the themes identified, such as harassment and bullying, within the staff survey into the cultural audit along with the CQC assessment. Provide a timeline for completion.	NHa/KA	June	Results of the 2015 staff survey have been shared with care groups and directorates who have been developing their action plans; also discussed at Workforce Committee. Existing themes will be reviewed as part of the cultural audit.

RBCH Board of Directors Part 1 Actions April 2016 & previous

29.01.16	07/16	GOVERNANCE			
	(a)	<u>Workforce Race Equality Scheme</u>			
		Provide Executive support to the areas identified within the plan and increase further development of diversity. Provide a timeline for completion.	KA/Execs	June	The WRES is due back to Workforce Committee in June. Care Group attendance at Equality & Diversity Committee improved for April, with care groups A & C represented and a plan in place for care group B.
18.12.15	108/15	PERFORMANCE			
	(g)	<u>Workforce Report</u>			
		Develop and agree a retention plan. Provide a timescale for the outline retention plan.	Execs/KA	June	This will form part of the cultural review. Summary information from the recent Exit Interview exercise is included in the Workforce report and has been shared with relevant areas.

Key:

	Outstanding
	In Progress
	Complete
	Not yet required

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

BOARD OF DIRECTORS

Meeting Date and Part:	27 th May 2016 Part 1
Subject:	Complaints report
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Ellen Bull Deputy Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing and Midwifery Anton Parker, Information Manager
Details of previous discussion and/or dissemination:	HAC 26 th May 2016
Action required:	The paper is provided for information
<p>Executive Summary:</p> <p>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.</p> <p>Key messages:</p> <ol style="list-style-type: none"> 1. Current Trust response time in month (April 2016) is 69% against a standard of 75% (9 out of 13 complaints were closed within the 25 working day time). 2. 31 formal complaints were received in month. 3. The response time improvement focus continues and is positively demonstrated in the in month performance. The current position is also presented to provide further information and assurance that focus is sustained and improvements actions continue. 4. The reporting style is being developed to provide increased transparency and assurance against complaint volume and themes and the hospital activity, 5. The acknowledgement time for April is unvalidated. During March and April team sickness and vacancies resulted in data entry omissions and this is currently being recovered. From May the position is stronger with recovery actions taking effect. The interim team is in place and the substantive 	

<p>postholder is commencing on 23rd May. The Clinical Claims caseload is being reviewed and discussions have commenced between the medical director and deputy director of nursing in terms of clinical claims reporting structure.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>All domains</p>
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	<p>N/A</p>

Complaints Report May 2016

1. Introduction

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

2. Number of complaints and concerns

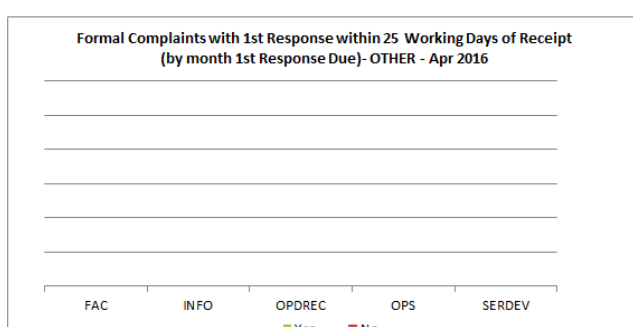
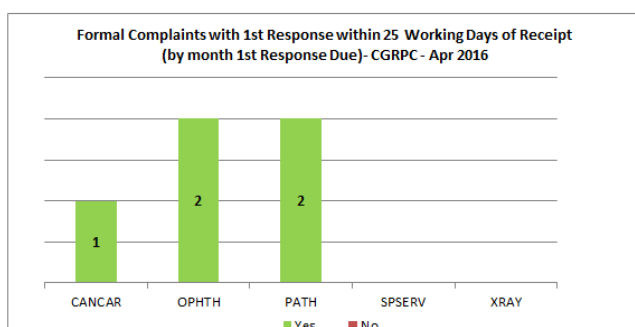
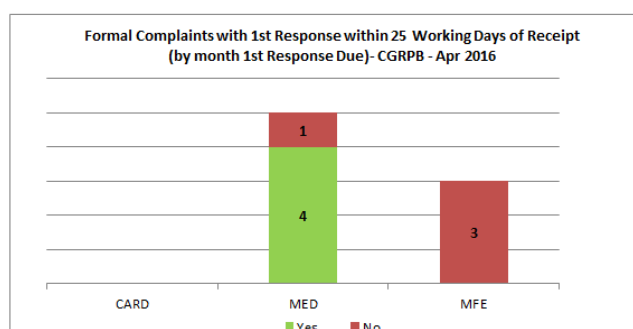
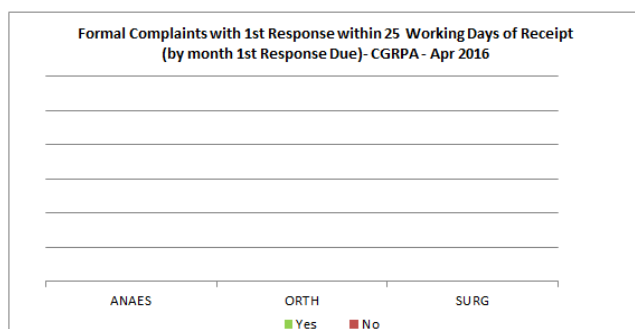
31 formal complaints were received in April 2016.

3. Acknowledgement and response times

3.1 Acknowledgements to the patient/carer/relative may be by telephone/letter and email within the timeframes to acknowledge the complaint. The acknowledgement time for April for the 31 complaints received is unvalidated. Due to staffing sickness, workload this information is being retrospectively reviewed and validated.

3.2 Responses to complaints should be within 25 working days (quality strategy standard of 75%), which is monitored monthly at the Healthcare Assurance Committee. For April on aggregate the first time response times were 69% (9 out of 13 complaint responses due were within 25 working days).

The graphs below show the performance for first responses due in April 2016 by Care Group and directorate. All Care Groups need to improve consistency in response times with Care Group B needing significant improvement within two directorates.



- 3.3** The overall average aggregate response time for 15/16 was 54%. The table below shows all in month figures on aggregate. Actions are underway to provide a sustained improvement in response times including, monthly performance meeting, supportive regular in month feedback, directorate engagement with outstanding responses, and a focus on working to resolve the in date responses. There is an overall improvement in engagement, focus on resolution, and the in month April position is much clearer and improved.

Table illustrating the 15/16 position for formal complaint response times.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	2015/16
1st Responses Due in Month	22	29	29	31	35	25	31	24	26	20	27	27	326
Number where 1st Response Completed within 25 working days	12	19	18	20	18	11	14	13	16	10	13	12	176
Percent with 1st Response within 25 working days	55%	66%	62%	65%	51%	44%	45%	54%	62%	50%	48%	44%	54%

3.4 Current position as of 19th May 2016

The table below illustrates the position in detail of care groups and directorates for complaints

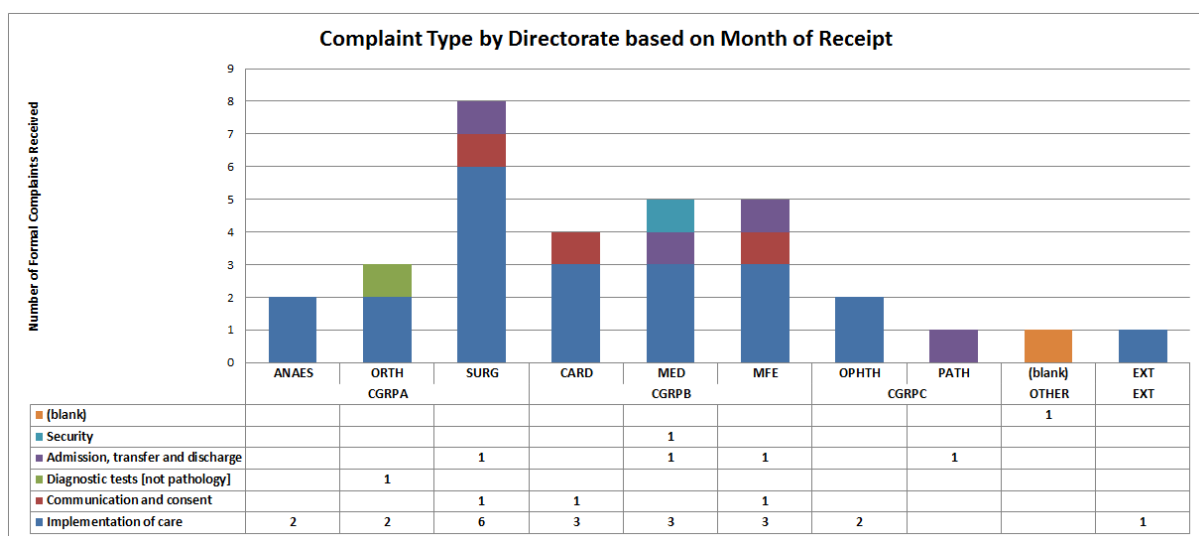
	Open Complaints Including Late/paused and PHSO	Late Complaints	Reasons for late	Paused Complaints	PHSO referrals and (upheld)
Care Group A	19 Aneas 2 Orth 6 Surg 11	9	Awaiting meeting dates N=2, awaiting final responses.	1 = ?external review.	1 (PHSO investigation is upheld)
Care Group B	23 Card 3 Med 10 MFE 10	7	Taking accountability for leading response, Consent clarity, initial meeting cancelled and being rearranged, 1= joint directorate response, awaiting final response	3 (1=RCA and panel meeting/1+ SI panel review/1=external review)	4 (2= investigation and 2= awaiting final report from PHSO.
Care Group C	1 Path 1	0	N/A	N/A	N/A
Other	3 Info 1 Null 1 Corporate 1	0	N/A	N/A	N/A
Total	46	16	N/A	N/A	N/A

Directorates requiring the most focus and support to close complaints within the 25 working day deadline are Surgery, Medicine, Older Peoples medicine and orthopaedics. Responses are being followed up by the corporate complaints team. Response time improvement remains a strong focus. Directorate leads are requested to monitor and support closing their overdue and pending complaints to improve the overall position. This is being supported by providing up to date positions from the central team and close liaison with the information team.

4. Themes and trends – Complaints received

The highest recurring theme for complaints (n=31) in April 2016 was implementation of care.

Actions are being taken through care group and directorate leadership teams.



5.0 Recommendation

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

providing the excellent care we
would expect for our own families

BOARD OF DIRECTORS

Meeting Date and Part:	27th May 2016 – Part 1
Subject:	Performance Report May 2016
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Performance Matrix
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Donna Parker / David Mills
Details of previous discussion and/or dissemination:	PMG
Action required: Approve / Discuss / Information / Note	<p>The Board is requested to note the performance exceptions to the Trust's compliance with the 2016/17 STF, Monitor Framework and contractual requirements..</p> <p>Finally, the Board is also requested to consider and comment on the new report format.</p>
<p>Executive Summary:</p> <p>This report accompanies the Performance Indicator Matrix (<i>available in the Reading Room</i>) and outlines the Trust's actual and predicted performance against key access and performance targets. In particular it highlights progress against the likely trajectories for the priority targets set out in the Sustainability and Transformation Fund. These are: ED 4 hour, RTT, Cancer 62 day, Diagnostic 6ww, ED 12 hour, RTT 52ww and ambulance handover delays.</p> <p>For April we are meeting or exceeding the STF proposed trajectories. The baseline for ambulance handover delay metric is yet to be confirmed.</p> <p>The detailed performance levels against the remaining key targets, which 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.</p> <p>Throughout 16/17 the Performance Report will provide a focus on the key STF areas on a quarterly cycle to allow 'deep dives' into the key areas. This month's report incorporates the Month 1 cycle, focusing on ED 4 hour, flow, infection control and single sex accommodation.</p> <p>Going forward the report will also include the Trust's integrated reporting Balanced Dashboard as an annex on a quarterly basis. This will be included next month.</p>	
Relevant CQC domain:	
Are they safe?	Yes
Are they effective?	Yes
Are they caring?	
Are they responsive to people's needs?	Yes
Are they well-led?	Yes

<p>Risk Profile:</p> <p>i) Impact on existing risk?</p> <p>ii) Identification of a new risk?</p>	<p>The following risk assessments remain on the risk register:</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. Endoscopy wait times – under review now recovery programme completed. iv. RTT due to reduced performance. <p>The urgent care impact risk assessment remains on the Trust Risk Register given the continued activity pressures, 4 hour performance and other indicators such as the increase in outliers.</p> <p>The Cancer Two Week Wait risk assessment is also under review.</p>
---	---

Performance Report May 2015/16 For April 2016

1. Introduction

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

The detailed performance levels against the remaining key targets, which 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.

Throughout 16/17 the Performance Report will provide a focus on the key STF areas on a quarterly cycle to allow 'deep dives' as follows:

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

The Trust's Balanced Dashboard which integrates Quality, Clinical Outcomes, Performance, Finance and Workforce will also be included on a quarterly basis (following the end of each quarter). The Q4 dashboard will be included next month once finalised for 16/17 reporting and then in the Month 1 cycle going forward.

This report covering performance for April 2016 therefore, includes a focus on the Month 1 Indicators above.

2. Sustainability and Transformation Plan (STF) and Monitor Risk Assessment Framework (RAF) Indicators – April 2016 Performance

2.1 Sustainability and Transformation Fund 16/17

In response to the national STF requirements the Trust has submitted proposed trajectories. Final sign off from NHS Improvement is awaited. The below shows our current position against our submitted STF trajectory for April 2016.

Sustainability and Transformation Fund 2016/17 Key Indicators

		Q1 16/17 April	
Target or Indicator (per Risk Assessment Framework)	RAF Threshold	Trajectory (<i>projected performance against target</i>)*	Actual Performance
Referral to treatment time, in aggregate, incomplete pathways	92%		
A&E Clinical Quality - Total Time in A&E under 4 hours	95%		
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%		est. only**
Diagnostic 6 week wait	99%		
12 hr A&E breaches	Zero or report as SUI		
52ww breaches	Zero 100%		
Ambulance handovers	Below 15/16 levels		baseline tbc

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

**Validated final position awaited - upload is early June

RTT Incomplete Pathways (18 Weeks) and 52 Week Breaches

2015/16 saw an increase in our 18 week backlogs due to a number of factors including: winter bed pressures, junior doctor strikes, unplanned medical staff absence and the need to release capacity for additional cancer pathway demand.

A cautious approach was therefore, indicated in relation to our submitted trajectory which projected a potential below threshold performance through Q1. Pleasingly, actual performance for April was 92.3%, slightly higher than March and just above the 92% threshold. 21,440 patients continue to wait less than 18 weeks. Good progress has been made in reducing 18 week backlogs in a number of specialities through April. Demand and securing capacity continues to be managed closely as it presents some ongoing risk. A key area of concern currently is Dermatology with demand levels and unplanned reduced capacity across Dorset. Discussions with the CCG and other providers have commenced to explore short and medium term actions.

There were no 52 week wait breaches in April.

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

The complex challenges experienced in achieving the 4 hour target in 15/16 are evidenced across the country. Many Trusts have signalled further deterioration in 4 hour performance due to evidence of ongoing increases in demand and ongoing limited social and community care capacity. Our own assessment indicates a similar position and we have therefore, indicated a below 95% trajectory for the year in our STF submission.

April has continued to see pressures with a significant increase in non elective admissions compared to last year (9.1%). This, along with a rise ED attendances (4.4% compared to last year) and continued delayed discharges, resulted in a reduction in patient flow through the hospital. This meant that the Trust missed compliance in March with the ED 4 hour target, at 91.2% (though a slight increase compared to March 2016 – 90.2%). There were no 12 hour breaches.

Clearly significant work will continue in order to strive towards the optimum pathways for our patients, but this position recognises the extent of the challenge.

April has seen an increase of 2.8% of ambulance handovers compared to April '15. Due to the extra pressure, handovers occurring over the 30 minute standard was 4.1% compared to 1.4% in April 15, however this has decreased from 7.4% in March. Joint work is underway with SWAST on handover processes and moving towards electronic handover. A visit to Bath Hospital as an exemplar site has also recently occurred and learning will be disseminated.

62 Day from Referral for Suspected Cancer to Treatment

Improvement work, particularly in Urology where additional robot prostatectomy capacity together with improved pathways, has meant some patients were able to be treated within target. As a result we were able to exceed the 62 day target of 85% in both March (88%) and for Q4 (87.2%). However, due to the remaining prostatectomy backlog together with some additional demand and capacity pressures in Colorectal, Lung and Upper GI, our indicated trajectory was non compliance through Q1 to support clearance of breach backlog and recovery. April data is not yet available (national upload early June), however, current projections for the month look more positive with us moving closer to the 85% threshold.

Diagnostic 6 Week Wait

Pleasingly our improved, compliant performance was sustained in April, ahead of trajectory and 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 with the need for additional capacity on an ad hoc basis to respond to peaks in demand.

2.2 Other Monitor Risk Assessment Framework Indicators

Below are projections for 16/17 against the remaining Monitor RAF indicators, together with April confirmed or expected performance.

Monitor Risk Assessment Framework

		16/17				
		Q1	Q2	Q3	Q4	April
Target or Indicator (per Risk Assessment Framework)	%	Pred	Pred	Pred	Pred	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 June 16.

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

Cancer

62 Days from Screening to Treatment – performance was not compliant for Q4 due to a small number of breaches in Colorectal. However, compliance is currently indicated for April and Q1.

31 Days to Subsequent Treatment - The 31 day subsequent treatment performance was compliant for Q4 at 94.6%, and 97.9% for March. There remains some risk going forward linked to treating the Urology backlog patients.

31 Days from Diagnosis for First Treatment – performance was non compliant as projected for March (95.4%) and Q4 (95.3%) due to clearing the Urology backlog. 28 breaches out of 597 (18 in Urology) were reported in Q4. Our agreed CCG recovery trajectory requires full recovery by end Q2 though we continue to strive for an earlier recovery programme. April data is awaited though there are some indications of improved performance.

2 Week Wait – compliance was maintained in March and Q4 (95.7%). However, due to demand and capacity pressures in Colorectal and Gynaecology (the latter due to some sudden unplanned absence) we have seen a number of breaches that will

mean non compliance for April performance. Additional sessions have been arranged and performance is expected to improve for the Quarter

Breast Two Week Wait – performance was compliant at 98.7%.

Infection Control – C Diff and MRSA

Our trajectory projects some risk in the second half of the year based on the current target of 14. For April 2016, one case of C Diff due to lapse in care has been reported and a further case remains under review but is not expected to reflect a lapse in care.

There have been no reported cases of hospital acquired MRSA.

Access to Healthcare for People with a Learning Disability

Whilst reported quarterly, we were compliant for April.

3. Contractual and Other Targets Exception Reporting

Compliance was maintained on all other key targets excepting Single Sex Accommodation where we incurred two breaches, and Consultant Upgrades to a Cancer Pathway where we incurred 2 breaches.

The two SSA breaches were due to unavailability of ward beds to move patients out of HDU where there remained capacity and appropriate clinical cover. The bed position in Medicine was in a 'minus' position with increased levels of admissions and a resilience alert being triggered.

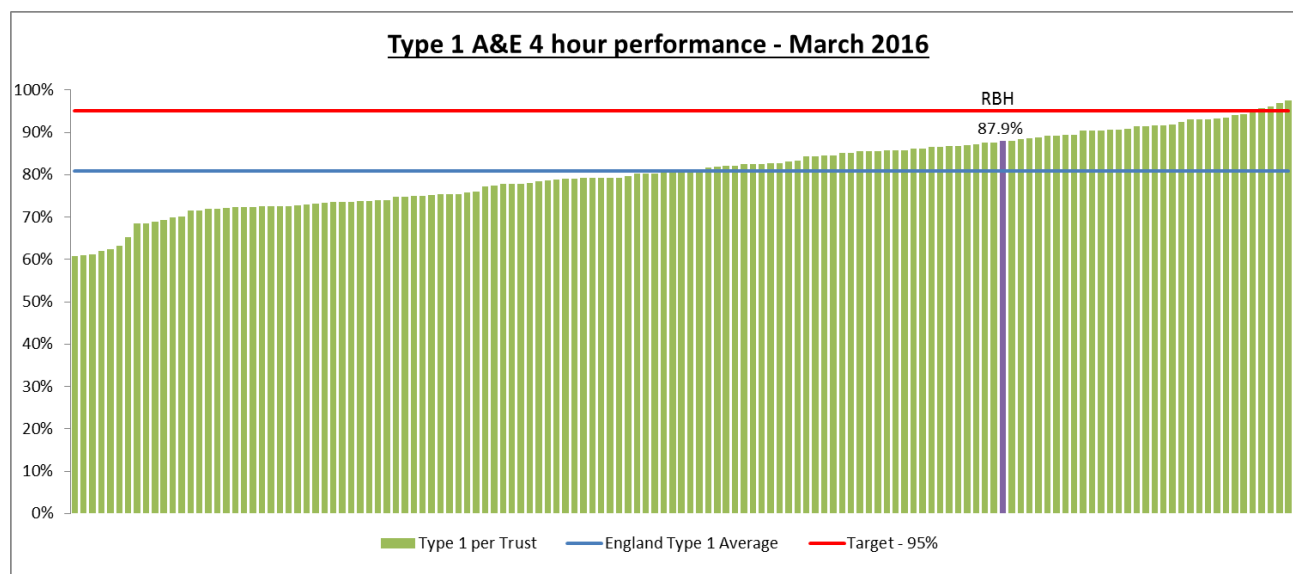
Both consultant upgrade patients had complex pathways with a number of diagnostic tests and MDT reviews, with one of the patients being transferred to an out of area provider to be considered for a clinical trial.

The Stroke Service maintained or improved performance against the following indicators: 90% stay on the Unit, 24 hour scan, thrombolysis within 1 hour, TIA high and TIA low risk. A dip in performance was seen in 4hr direct access, 1 hour scan and thrombolysis rate, however, this is not expected to affect maintenance of our SSNAP performance. A separate quarterly report will be provided to the Board on publication of the next Quarter SSNAP

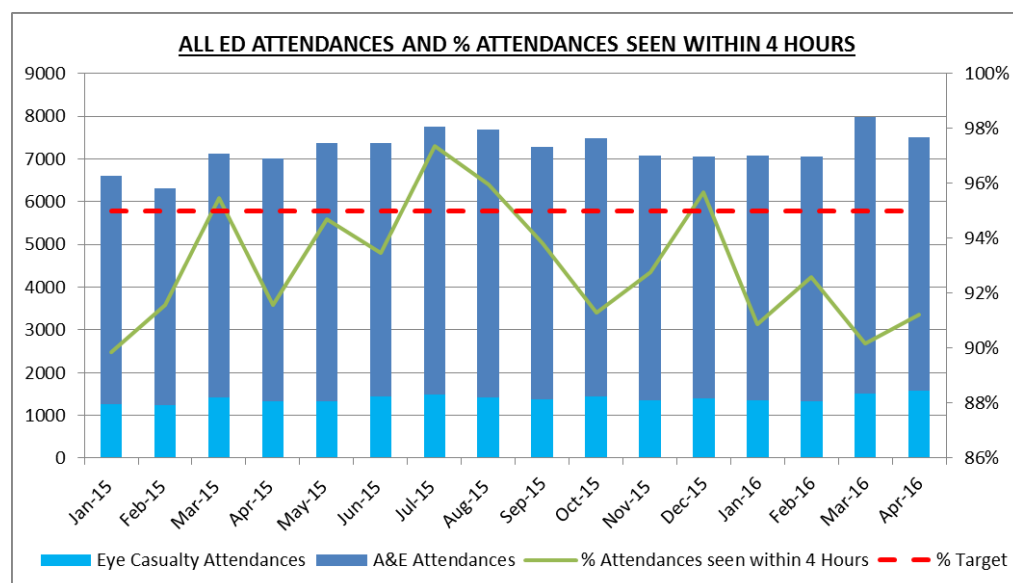
4. Performance Focus - A&E 4 Hour, Single Sex Accommodation and Infection Control

4.1 Performance and Activity

Whilst the Trust failed to achieve compliance against the ED 4 Hour target in April, the below graph shows how our March Type 1 performance benchmarked against other trusts in March.



April has continued to see pressures with a significant increase in non elective admissions compared to last year (9.1%). This, along with a rise ED attendances (4.4% compared to last year) and continued delayed discharges, resulted in a reduction in patient flow through the hospital. This meant that the Trust missed compliance in April with the ED 4 hour target, at 91.2% (a slight increase compared to March 2016 – 90.2%). This increase in demand has continued into May with, for example, a 12.7% increase in attendances on the same period last year being seen 1-12th May.



Non-Elective Activity - % variance against previous year

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Variance against 14/15	-1.2%	-0.3%	1.7%	-2.3%	0.3%	7.4%	5.6%	13.2%	1.6%	11.6%	11.8%	15.5%	9.1%

4.2 Progress Against ED and Trust-wide Actions and High Level Metrics

Actions and improvement work through 15/16 included the following areas:

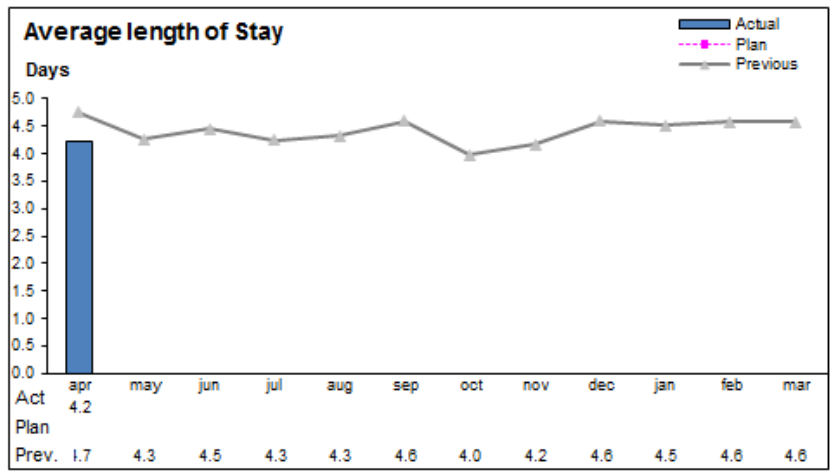
- Ongoing embedding of Acute Medicine, Acute Surgical and Older Persons' Medicine (OPM) ambulatory care models
- 2 additional ED consultants and embedding Majors Assisting Practitioners
- Substantive establishment of the BREATH (rapid assessment and treatment) model in ED
- Substantive establishment of additional consultant cover out of hours, particularly in Acute Medicine, ED and OPM
- New approach to the management of outliers with dedicated outlier leads and daily cross organisational MDT meetings
- Further development of the interim care team and movement towards 'Discharge to Assess'

ED 4 Hour

Despite an overall increase in ED attendances of 1.3%, and urgent care admissions of 5.2%, through the full financial year (15/16), we maintained 93.37% performance against the ED 4 hour target, compared to 93.32% in 14/15.

Average Length of Stay

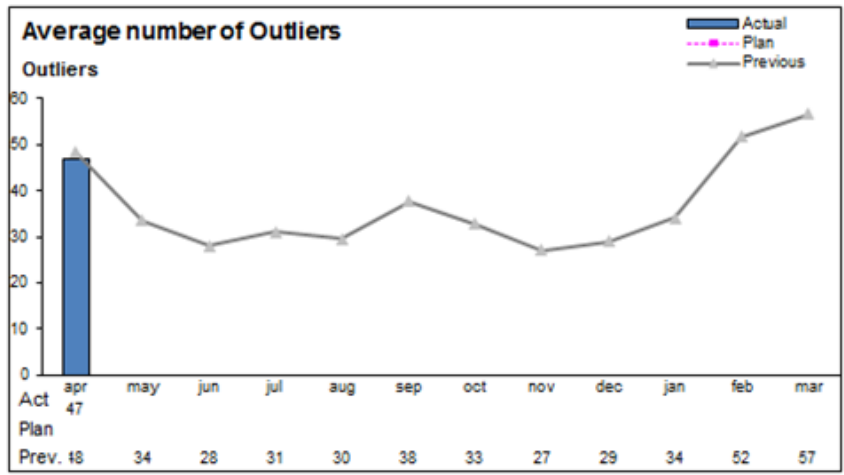
Positively average length of stay remained below last year's levels since October reflecting the focus on ambulatory care and short stay models.



Outliers

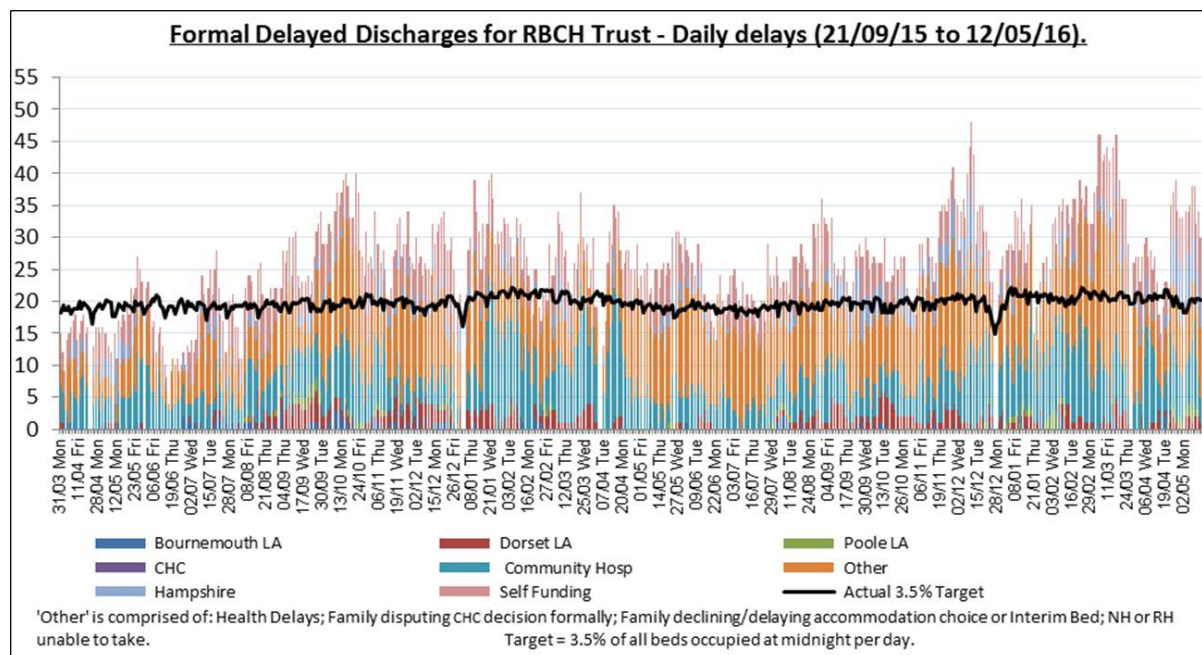
Lower level of outliers were seen during 15/16 up to and including the early part of the winter due to the new approach to the management of outliers. As the additional pressures over winter progressed outliers increased in February and March. Whilst reduced, this remained at high levels in April though a similar position to the previous April. However, a significant reduction has been seen since the end of April with medical outliers in surgical areas down to just 4 across the Trust as at 17 May. This is largely as a result further dedicated focus by the OPM Directorate as part of the preparatory work towards establishing the Frailty Unit.

This is a significant achievement to be celebrated as having the right patients in the right beds is known to lead to improved outcomes and shorter hospital stays.



Delayed Transfers of Care

Delayed Transfers of Care together with patients ‘medically fit for discharge’ who are still in hospital, have remained a pressure, though a slight reduction has been seen in April to date.



Following the Dorset wide external review of DTOCs by Ian Wilson, the detailed action plan of 42 recommendations is being progressed. This includes the following developments:

- Frailty Pathway and Frailty Unit development
- Review of DTOC reporting to improve clarity and identification of areas for improvement
- Further development, agreement and implementation of the Choice Policy
- 'Issue log' and staff engagement approach
- Working jointly with partners incl Hants LA to: develop integrated discharge team and 'discharge hub', shared approach to whiteboard rounds, implement Funding Out of Hospital, setting up KPIs (e.g. time to brokerage)
- Review of the Leaving Hospital Support Service
- A specific focus on End of Life Care

The Reading Room has the full action plan and NHSE Summary Report.

4.3 ED, Urgent Care and Flow – QI for 16/17

The QI and performance management structures established through 15/16 will continue and be strengthened in 16/17 to oversee the Urgent Care improvement agenda. A monthly internal Urgent Care Steering Board continues, chaired by the Director of Improvement, with weekly workstream groups progressing the focused work in:

- Ambulatory care
- Frailty Pathways and the Frailty Unit
- 5 Daily Actions/Ward pathways
- Cardiology
- General Medicine, including Thoracic, Gastro and AMU.

The ED Weekly CoO/DoO Review Group supported by the weekly ED Team Meeting continues to steer progress against the revised ED action plan. The DTOC action plan (see 5.2 above) is overseen by the SRG East Health and Social Care Accountable Care Partnership. This is attended by Dorset and West Hampshire CCGs, DHUFT, GP Leads and Bournemouth and Dorset Social Services.

Ambulatory Care

This workstream has been relaunched to progress Phase 2 of the development of ambulatory services. This will focus on further opportunity for the existing Acute Medical and Acute Surgical AECs as well as development of new models in Cardiology and Stroke.

Frailty Pathways and the Frailty Unit

‘Plan, Do, Study, Act’ (PDSA) cycles are being implemented in Older Persons’ Medicine to develop the pathways and service models for patients from GP referral/ED presentation through to discharge. This will support the implementation of the new Frailty model which will ‘pull’ appropriate patients into the Frailty Unit (short stay) and/or OPAC (ambulatory service), with flow through to longer stay inpatient wards and onto interim team home/community based supported discharge.

This is being complemented by the DTOC action plan and pilot work with primary and community care integrated locality teams, together with the ‘discharge hub’.

5 Daily Actions and Ward Pathways

5 Daily Actions principles continues, supported by dedicated ward focused work which commenced on Wards 4 and 5 and will be further rolled out through 16/17. The Director of Nursing has agreed to become the Exec Lead for this work.

ED and Flow

The revised ED action plan for 16/17 includes:

- Development of an escalation trigger tool and action cards in ED and AMU
- Revision of our daily bed predictor linked to review of our Escalation protocols and bed flows
- Review of ED staff rotas and lead roles
- Development of pathways to the ambulatory care and frailty models.

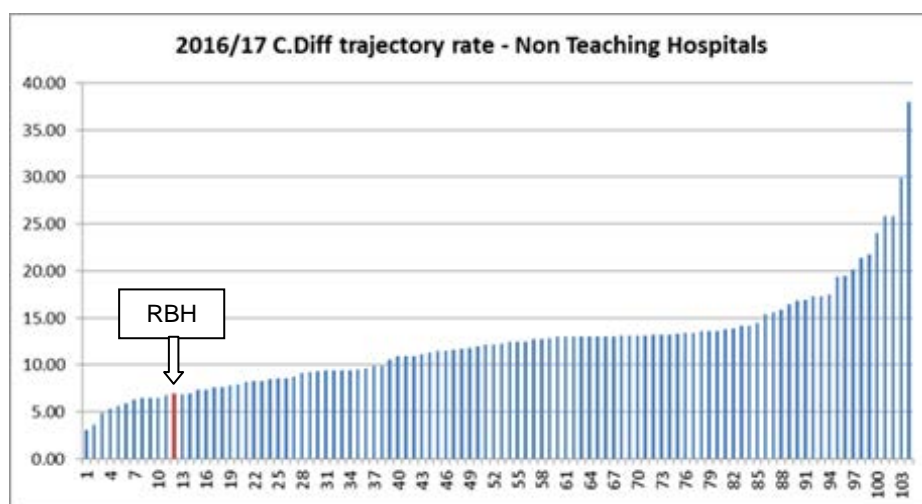
4.4 Single Sex Accommodation

Under the revised MSA policy, in line with contractual agreements with Dorset CCG, two MSA breach occasions occurred during April, affecting 2 patients. Reviews of each potential breach continues to be undertaken via root cause analysis (RCA). As indicated above, the two breaches related to flow out of HDU at times of extreme bed/non elective admission pressures. The work indicated above to improve flow together with learning from RCAs is aimed at avoiding SSA breaches. A clinical group

is also reviewing critical care flows and is focussed on 3 priority areas: ED Resus, thoracic and surgical patients.

4.5 Infection Control

A separate report has recently been submitted to the Board in relation to C Difficile outlining the work across the Trust to avoid breaches due to lapses in care. Performance for April is outlined in section 2.2 above. The Trust's target of 14 remains extremely challenging with a rate per 1,000 bed days amongst the lowest for non teaching hospitals. However, with the ongoing improvement work we continue to strive to achieve this target.



5. Recommendation

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

Finally, the Board is also requested to consider and comment on the new report format.

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

BOARD OF DIRECTORS

Meeting Date and Part:	27 th May 2016 Part 1
Subject:	Quality report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack):	Quality Dashboard
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Joanne Sims, Associate Director Quality & Risk Ellen Bull, Deputy Director of Nursing
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee (HAC) 26 th May
Action required: Discuss/Information	The Board is invited to discuss the Trust's quality performance; to note the improvements which have been made and areas for focus which are reviewed in detail at the HAC and will be reported by the Chair.

Executive Summary:

This report provides a summary of information and analysis on the key quality performance indicators, linked to the Board objectives for 15/16, for April 2016.

- Serious Incidents:** Two SIs were reported
- Safety Thermometer:** Harm Free Care is below the average for 2015-16. This is a result of an increase in new pressure ulcers in month from 13 in March to 16 in April and falls increasing from 1 to 4
- 2015/16 Quality Objectives:** progress against quality objectives will be reported quarterly
- Patient experience:**
 - Inpatient Friends and Family Test performance was in the national top quartile in Month
 - Emergency department FFT was in the second quartile and response rates still require improvement
 - Care Audit trends largely consistent, focussed work has been agreed for understanding more about how we can improve noise at night. This will be reported via the HAC.

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

Quality and Patient Safety Performance Exception Report: April 2016

1. Purpose of the report

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

2. Serious incidents

Two Serious Incidents were reported in April 16:

- 1 Category 4 pressure ulcer (deterioration from an external Category2). Gaps in documentation noted on initial review.
- 1 Deterioration patient. Gaps in monitoring noted on initial review.

Root cause analysis (RCA) investigations are in progress and SI panel meetings have been arranged. Duty of Candour has been undertaken in both cases.

3. Safety Thermometer

NHS Safety Thermometer	15/16 Trust Average	April 16
Safety Thermometer % Harm Free Care	89.79%	88.02%
Safety Thermometer % Harm Free Care (New Harms only)	97.53%	95.87%

4. Patient Experience Report – Report April 2016 (March 2016 data)

4.1 Friends & Family Test: National Comparison using NHS England data

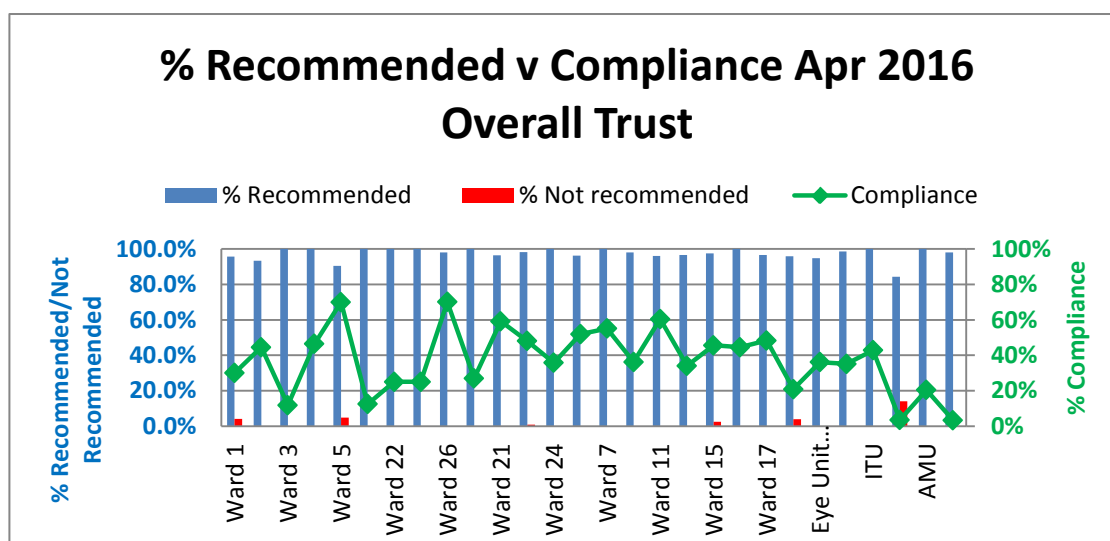
The national performance benchmarking data bullet pointed below is taken from the national data provided by NHS England which is retrospectively available and therefore, represents March 2016 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in March 2016 ranked RBCH Trust 3rd with 14 other hospitals out of 172 placing RBCH in the top quartile for patient satisfaction. The response rate was sustained above the 15% national standard at 17.2%. This is a reduction on the previous compliance rates, however, will be rectified by an increase in April with 3359 FFT returns (March 3123 FFT returns)
- The Emergency Department FFT performance in March 2016 ranked RBCH Trust 13th with 4 other hospitals out of 141 placing RBCH ED department in the second quartile for patient satisfaction. For comparison in February the Trust was ranked 7th. The response rate 2.9% against the 15% national standard is a reduction from February when the compliance rate was 4.6%.
- Outpatients FFT performance in March 2016 ranked RBCH Trust 6th with 19

other Trusts out of 234 Trusts, placing the departments in the third quartile for the first time. Response rates are variable between individual outpatient departments; there is no national standard.

4.2 The following 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.



This month has seen an increase in FFT responses from 3123 in March to 3359 April. There is minimal change in “unlikely or extremely unlikely to recommend” from 66 in March to 63 in April. 11 areas attained FFT 100% scores. AMU experienced 100% of those patients who completed the FFT as “would recommend”.

4.3 Care Campaign Audit (CCA) Trend Data

Overall	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Red	49	51	51	45	60	91	85	101
Amber	43	69	73	61	58	92	99	73
Green	203	178	199	163	229	194	191	223
N/A	55	52	27	81	28	28	30	8

A total of 336 patients answered the CCA audits which were administered across 21 clinical areas. In month, there is an increase in green responses, a reduction in amber and increase in red responses. Analysis of the red responses illustrates the themes of support at mealtimes; food, call bells and noise at night are not yet addressed. Actions to address this includes review of noise at night and Protected night-times, governor audit, introduction of food and drink volunteers, corporate dignity review and audit, and the care groups will update on specific local actions.

Both surveys have a section now for patients to reflect their appreciation of specific staff that deserve recognition and leave a compliment to the ward team. Following the implementation of a compliments section to the survey there have been a total of 182 excellent responses and 74 good with 11 satisfactory and 1 poor. Comments remain overwhelmingly positive especially in regard to staff being caring and compassionate.

4.5 Patient Opinion and NHS Choices: April 2016 Data

10 patient feedback comments were posted in April, 7 express satisfaction with the service they received. 3 negative responses relate to waiting times, noise at night and staff attitude. All information is shared with clinical teams and relevant staff, with Senior Nurses responses included in replies following complaints.

5. Recommendation

<p>The Board of Directors is asked to note the report which is provided for information.</p>
--

*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:	27 th May – Part I
Subject:	Financial Performance
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Yes
Officer with overall responsibility:	Stuart Hunter, Director of Finance
Author(s) of papers:	Pete Papworth, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance Committee
Action required: Approve/Discuss/Information/Note	The Board of Directors is asked to note the financial performance for the month ending 30 April 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?	Two current financial risks exist on the risk register related to the next year's financial planning and Cardiology procurement. 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 April 2016

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £393,000 as at 30 April. Although this is £115,000 better than plan, it has only been achieved through the release of a considerable proportion of the Trusts annual contingency budget. This was required to off-set the significant financial pressures that were experienced as a result of the Junior Doctors strike action, and associated loss of both elective and outpatient income.

Activity

April reported a loss of activity, with total activity being 3% below planned levels. This was mainly driven by reduced planned activity due to the Junior Doctors strike action together with significant increases in unplanned activity. Specifically; elective activity was below budgeted levels by 3%, with outpatient activity 7% below budget. This was partially off-set by a significant increase in non-elective activity which was 10% above budget, and Emergency Department attendances which were 9% above budgeted levels in month.

Income

Income reported an adverse variance of £501,000 during April mainly due to the loss of NHS clinical income through a reduction in planned activity. This was compounded by a further reduction in private patient income, which was far lower than anticipated. Some issues were encountered within clinical coding, however these have been resolved and the estimated impact accounted for within the April accounts. Some further corrections may be required during May.

Expenditure

Expenditure reported an under spend of £617,000 during April due to an under spend against pay budgets together with the release of contingency to off-set the loss of income noted above.

Whilst the Trust remains reliant upon agency staff, the premium cost has reduced considerably, and was considerably less than budgeted during April.

Cost Improvement Programme

The Trust recorded savings of £527,000 during April, and is currently forecasting total savings of £7.5 million. Whilst this is £1.9 million below the full year savings requirement, it is anticipated that this gap will be closed during the year with additional schemes that are currently being worked up.

Capital Programme

During April the Trust committed £1 million in capital spend, consistent with the plan. The total capital programme for 2016/17 amounts to £12.3 million and includes the finalisation of the Christchurch Development, the replacement of the Trusts Cardiology Labs, and the agreed IT Strategy.

Statement of Financial Position

Overall the Trust's Statement of Financial Position is on plan; however some variances are apparent against individual balances. Both receivables and payables balances reduced during the financial year end NHS balance agreement process; however some key invoices remain outstanding as at 30 April. The Trust has received assurances that these will be paid during May.

Cash

The Trusts current cash balance is £36.4 million and includes a timing benefit as a result of the delay in the Christchurch Development. The current forecast is that the Trust will end the year with a cash balance of £18.7 million.

Financial Sustainability Risk Rating

Under Monitor's new risk assessment framework the Trust achieves a Financial Sustainability Risk Rating of 2 meaning that it is within the 'Material Risk and Potential Investigation' category. Monitor has concluded its investigation, and the outcome is expected during May following review of the Trusts 2015/16 outturn position and 2016/17 plan.

Income and Expenditure

At the end of Month One, the Trust is reporting a net deficit of £393,000 against a budgeted deficit of £509,000. This is a favourable variance of £115,000.

However, significant financial pressures were experienced during April as a result of the Junior Doctors strike action. This resulted in a significant loss of both elective and outpatient income, which the Trust has mitigated through the release of a significant proportion of its annual contingency budget.

The Trusts overall income and expenditure position is summarised below.

£'000	Budget	Actual	Variance
NHS Clinical Income	21,813	21,504	(309)
Non NHS Clinical Income	514	363	(151)
Non Clinical Income	1,934	1,893	(41)
TOTAL INCOME	24,261	23,760	(501)
Employee Expenses	14,688	14,493	195
Drugs	3,116	3,022	93
Clinical Supplies	3,069	3,006	63
Other expenditure	3,897	3,632	266
TOTAL EXPENDITURE	24,770	24,153	617
SURPLUS/ (DEFICIT)	(509)	(393)	115

Income

NHS clinical income was significant below budget during April as a result of the Junior Doctors strike action. The most significant impact was felt within Orthopaedics, and was only partially off-set by reduced expenditure.

Non NHS clinical income remains significantly below budget due to a continued reduction in private patient activity, specifically within cardiology, radiology and cancer care. This was the lowest month on record for cardiology private income, and the Trust continues to finalise its plan to recover this through an external partner during 2016/17.

Expenditure

Pay reported an overall under spend in month, reflecting the timing of appointments to newly established posts together with the continued effort to reduce premium cost agency expenditure. Whilst this is a positive position overall, pressures were experienced within the Medical Care Group, which reported an over spend against pay budgets.

Drugs and clinical supplies expenditure was below budget in month, reflecting the reduction in planned activity, particularly within Orthopaedics.

Cost Improvement Programme

The Trust has achieved financial savings of £527,000 during April, and is currently forecasting total savings of £7.5 million.

This exceeds the 2016/17 target of £6.4 million, however represents a shortfall of £1.9 million against the total savings requirement for the year when factoring in the recurrent shortfall from the previous financial year.

The Trust remains confident that further savings will be identified to close this gap.

Forecast Outturn

Despite the financial pressures experienced during April, the Trust continues to forecast the achievement of its annual financial plan.

Employee Expenses

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

£'000	Substantive Budget	Substantive Cost	Substantive Variance	Agency Cost	Bank Cost	Overtime Cost	Workforce Variance
Surgical Care Group	3,675	3,334	341	125	102	35	78
Medical Care Group	5,336	4,644	692	298	466	37	(108)
Specialties Care Group	3,123	2,856	267	48	84	13	122
Corporate Directorates	2,543	2,350	193	33	42	17	102
Centrally Managed Budgets	11	10	1	0	0	0	1
TOTAL	14,688	13,194	1,494	504	694	102	195

The Trust has agreed to the agency 'ceiling' cost requested by NHS Improvement, which amounts to £5.9 million. Whilst this will be very challenging given the total agency spend during 2015/16 of £8.6 million, it is pleasing to report that agency expenditure during April was lower than anticipated.

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 April can be summarised as follows:

£'000	Block Booked	Off-Framework	Other	TOTAL
Nursing	94	71	144	309
Medical	0	29	139	167
Non Clinical	23	5	0	28
TOTAL	117	105	283	504

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 April were as follows:

	Medical	Nursing	Other
Shifts covered (Number)	169	113	68
Approximate Cost above Cap (£)	46,980	42,239	6,010

Statement of Financial Position

Overall the Trusts Statement of Financial Position is in line with the agreed plan, as set out below. Some key receivables balances were outstanding at 30 April, however the Trust has received confirmation that these will be paid during May.

£'000	Plan	Actual	Variance
Non-Current Assets	182,932	183,047	115
Current Assets	52,129	52,632	503
Current Liabilities	(32,302)	(32,684)	(382)
Non-Current Liabilities	(20,959)	(21,037)	(78)
TOTAL ASSETS EMPLOYED	181,800	181,958	158
Public dividend capital	79,681	79,681	0
Revaluation reserve	71,402	72,570	1,168
Income and expenditure reserve	30,717	29,707	(1,010)
TOTAL TAXPAYERS EQUITY	181,800	181,958	158

Capital Programme

Following a rigorous clinical prioritisation process, the Trust approved a capital programme amounting to £12.3 million. This includes £3.4 million to finalise the Christchurch development; £2.4 million to replace the Cardiology Laboratories; and £3.4 million in relation to the Trusts IT Strategy.

As at 30 April, the Trust had committed capital expenditure of £1 million, being £26,000 behind plan overall.

Cash

The Trust is currently holding £34.6 million in cash reserves. However, the delay in the Christchurch development has resulted in a cash timing benefit when compared to the agreed phasing of the ITFF loan drawdown. As such, the underlying cash position is lower.

The forecast closing cash balance for the current financial year is £18.7 million.

Financial Sustainability Risk Rating

The Trusts Financial Sustainability Risk Rating as at 29 February 2016 is set out below.

	Plan Metric	Actual Metric	Risk Rating	Weighted Rating
Capital Service Cover	0.24x	0.35x	1	0.25
Liquidity	19.7	28.7	4	1.00
I&E Margin	(4.45)	(4.88)	1	0.25
I&E Variance to Plan	(1.17)%	(0.43)%	3	0.75
Trust FSRR				2
Mandatory Override				Yes
Final FSRR				2

This rating of 2 places the Trust in the 'Material Risk' and 'Potential Investigation' category. Monitor's investigation has been completed, and the Trust is awaiting final confirmation of the outcome. This is expected imminently.

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

*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:	27 th May 2016 – Part 1
Reason for Part 2:	n/a
Subject:	Workforce Report
Section on agenda:	7. Performance
Supplementary Reading (included in the Reading Pack)	Safe staffing
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, Mandatory Training, Turnover and Joiner rates, Sickness and Vacancies.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>Well Led.</p> <p>Providing appropriate staffing to deliver effective and safe care.</p>
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	<p>Recruitment, Appraisal Compliance, Essential Core Skills (mandatory training) compliance, and workforce planning are all existing risks on the risk register.</p>

WORKFORCE REPORT – MAY 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.

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 April			Rolling 12 months to 30 April				At 30 April
Surgical	3.0%	80.5%	87.6%	4.50%	14799	13.7%	12.6%	
Medical	3.9%	79.1%	86.1%	4.03%	19797	19.1%	11.5%	
Specialities	5.2%	82.2%	89.1%	3.14%	8899	11.0%	11.8%	
Corporate	2.9%	0.0%	93.1%	3.82%	12290	8.2%	11.6%	
Trustwide	3.7%	80.0%	88.2%	3.91%	55785	13.7%	11.9%	

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 April			Rolling 12 months to 30 April				At 30 April
Add Prof Scientific & Technical	12.4%		92.8%	2.70%	1202	20.1%	11.2%	
Additional Clinical Services	3.8%		87.2%	6.34%	16569	18.5%	13.1%	
Administrative and Clerical	2.6%		93.5%	3.36%	10275	8.3%	12.3%	
Allied Health Professionals	1.9%		90.4%	2.11%	1919	14.7%	14.3%	
Estates and Ancillary	0.7%		91.5%	4.73%	5795	13.0%	12.0%	
Healthcare Scientists	2.1%		94.2%	3.40%	819	11.2%	11.2%	
Medical and Dental		80.0%	79.6%	1.35%	2156	4.8%	6.5%	
Nursing & Midwifery Registered	5.1%		87.8%	4.09%	17050	15.7%	11.3%	
Trustwide	3.7%	80.0%	88.2%	3.91%	55785	13.7%	11.9%	

1. Appraisal

From 1st April 2016, with the commencement of year 2 of the values based appraisal process, compliance was reset to zero apart from medical and dental staff. Therefore this is the first month's reporting for this new period, whereby Executive appraisals have been undertaken to commence the cascade process. The proposed trajectory for this year has been planned accordingly, to reflect the cascade nature of this process and we will expect to see momentum gather as it spreads throughout the organisation, through to the 6-month period end date of 30th September.

Appraisal champions have been nominated for each directorate to receive additional training in order to enable them to provide assistance to their team colleagues as and when required. Communications have been issued regarding the correct process for recording on ESR and a reminder to upload the completed document to the BEAT VLE.

2. Essential Core Skills Compliance

Overall compliance has increased to 88.2% from 86.6% last month.

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

Directorate	Organisation	Headcount	Compliance	Trend
Surgery Directorate	153 Obs/Gynae Medical Staff 10100	17	62.21%	
Elderly Care Services Directorate	153 MFE Management 13510	16	70.89%	
Medicine Directorate	153 Medical General Staff 10075	71	72.71%	
Elderly Care Services Directorate	153 MFE Medical Staff 10077	51	73.37%	
Orthopaedics Directorate	153 Orthopaedic Outpatients 10587	16	74.83%	
Cancer Care Directorate	153 Haematology Snr.Medical 11346	19	75.34%	
Medicine Directorate	153 Ward 2 10369	34	75.70%	
Anaesthetics/Theatres Directorate	153 Anaesthetic 10025	49	75.88%	
Cancer Care Directorate	153 Macmillan Unit 10565	38	76.48%	
Elderly Care Services Directorate	153 MFE Ward 4 10382	27	77.50%	

Areas with highest compliance:

Directorate	Organisation	Headcount	Compliance	Trend
Informatics Directorate	153 Telecoms 13585	23	100.00%	
Cardiac Directorate	153 Cardiac Administration 11523	36	100.00%	
Pathology Directorate	153 Haematology 11340	22	99.55%	
Estates and Support Directorate	153 Works Department 17000	50	99.44%	
Orthopaedics Directorate	153 Orthopaedic Med Secs 13560	13	99.24%	
Informatics Directorate	153 Clinical Coders 13211	14	98.54%	
Informatics Directorate	153 Information Technology 13584	33	98.47%	
Specialist Services Directorate	153 Orthodontics 10210	21	98.41%	
Finance & Business Intelligence Directorate	153 Information 13541	19	97.89%	
Pathology Directorate	153 Histology 11310	36	97.78%	

Trend data has been added to highlight the improvement in those areas with highest compliance and demonstrate what has happened in the individual cost centres.

3. Sickness Absence

The Trust-wide sickness rate shows a small improvement to 3.91% from the previous month's 3.92%, continuing its amber rating.

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

Directorate	Organisation	Headcount	Absence Rate
153 Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	14	11.13%
153 Outpatients Directorate	153 Outpatients 10370	46	10.40%
153 Clinical Governance Directorate	153 Risk Management 14115	14	9.39%
153 Elderly Care Services Directorate	153 MFE IP Therapy 10581	20	9.08%
153 Elderly Care Services Directorate	153 MFE Ward 4 10382	32	8.23%
153 Elderly Care Services Directorate	153 MFE Ward 22 10594	32	8.19%
153 Informatics Directorate	153 IT Development Recurrent 13588	13	7.91%
153 Surgery Directorate	153 Colorectal Ward 16 10427	37	7.82%
153 Surgery Directorate	153 Surgical Admissions Unit 10535	27	7.76%
153 Elderly Care Services Directorate	153 OPAL ESD & Outreach 10593	28	7.68%

Areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rate
153 Surgery Directorate	153 Surgery - Urology 10084	21	0.21%
153 Other Directorate	153 Chief Executive 13535	28	0.29%
153 Elderly Care Services Directorate	153 MFE Management 13510	16	0.36%
153 Surgery Directorate	153 Surgery - General 10085	33	0.65%
153 Cancer Care Directorate	153 Haematology Snr.Medical 11346	26	0.66%
153 Elderly Care Services Directorate	153 Dietitians 13315	14	0.70%
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	43	0.70%
153 Elderly Care Services Directorate	153 MFE Medical Staff 10077	59	0.86%
153 ED Directorate	153 ED Medical Staff 10015	68	0.87%
153 Other Directorate	153 Postgraduate Centre 13531	11	0.92%

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

4. Turnover and Joiner Rate

Joining and turnover rates of 13.7% and 11.9% show a slight change over the previous month (14.4% and 12.1%).

5. Vacancy Rate

Details regarding the vacancy rate were not yet available when the board paper was completed and will be communicated at the meeting.

Recruitment activity remains strong. A successful event was held on the 14 May for nurses due to qualify this year and offers have been made to 42 applicants to work across the Trust. We continue to highlight opportunities at the Trust through social media, marketing and external communications.

6. Safe Staffing

For the month of April the Safe Staffing Unify return on aggregate is as below;

- Day RN Fill rate 87.2%
- Day HCA Fill rate 99.8%
- Night RN Fill rate 101%
- Night HCA Fill rate 119.1%

There are five areas across both surgery and older people's medicine which fell below 80% for registered nurses during the day. Local review and mitigation of risk remains in place as a continuous process.

ITU - RN Fill rate 84.3% for April. Current vacancies affecting month, 4 Band 5's, 1 long term sick and 2 on maternity in April. Backfill was via 3 bank/agency shifts and internal overtime. Unit has been safely staffed throughout though tight at times and much good will by staff moving around to cover at short notice for sickness.

SAU - low on RN on days due to vacancies/bank unfilled, night over use due to escalation beds being used.

Ward 14 under fill as template not yet changed for reduced beds.

Ward 15 under fill trained during the day due to vacancies/bank unfilled therefore mitigated with HCA hence over fill, night HCA overfill due to specials.

Ward 16 under fill on trained mitigated with use of HCA, overfill nights HCA due to significant specials.

Ward 17 under fill on trained, mitigated slight over fill on HCA overfill in HCA night due to specials.

Day Surgery - Over fill rates as a result of additional staffing for waiting list initiatives.

There were no red flags in surgery. Red flags in Medicine and older people's medicine were being validated at the time of the report and will be verbally presented at the meeting.

In terms of the Agency cap, the threshold for approving Agency Tier threes has been maintained with the implementation of an internal incentive scheme. In addition a date has been agreed to cease the approval of Tier threes. In planning this, rosters have been reviewed and all areas have been included in the decision.

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

BOARD OF DIRECTORS	
Meeting Date and Part:	27 th May 2016, Part 1
Subject:	Mortality Report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Mr Basil Fozard, Medical Director
Author(s) of papers:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	
Action required: Approve / Discuss / Information/Note	Information/Note
Executive Summary: This paper updates the Board on the current Trust position and activities to reduce mortality.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Safety
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	

Trust Mortality Report

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

Sepsis

The Trust has had groups looking at sepsis over many years and most recently this has developed as part of the QI programme. The primary metric for measuring improvement in sepsis, is the time it takes from patient admission ("door") to the time the patient is given antibiotics ("needle"). We have made progress on this in the past, but recently this has deteriorated (to December 2015, 70% within 1 hour; to March 2016, 40%).

David Martin (ED consultant & sepsis lead) indicated that there were a number of confounding issues, in particular the lack of agreement nationally or internationally about how sepsis is defined. Recently there has been a substantial amount of effort on sepsis, for example including significant Communications Department support, but despite this we do not seem to have been able to "mainstream" this. A number of avenues are being pursued:

- To avoid the lack of clarity associated with the diagnostic definition and to focus on the patients particularly requiring fast treatment, the group have decided to focus on "serious sepsis".
- Undertake a PDSA cycle using pre-filled antibiotics to expedite drug administration
- Discuss with Critical Care the use of their IT system as a means for escalation of sick patients
- Utilise a cultural summit within the ED Department to explore the sepsis difficulties
- Ensure full use of the electronic prescribing system (scheduled for autumn 2017) to ensure that medicines are prescribed and administered in a timely fashion

Review of Endoscopic Retrograde CholangioPancreatography (ERCP)

A recent review was undertaken of the above category of patients, with the following recommendations:

- Patients with cardiovascular conditions (heart failure, pulmonary oedema) may not tolerate this procedure very well. It was therefore agreed that the gastroenterology teams would:
 - Review their selection criteria

- Arrange an anaesthetic opinion in advance of the procedure where appropriate.

The frailty score under development as part of the QI programme may also offer some help with these decisions.

- A further audit will be required, focussing on elderly care patients who are transferred in (eg from Poole) and the decision making processes within this. This would be a joint review across gastroenterology and interventional radiology.

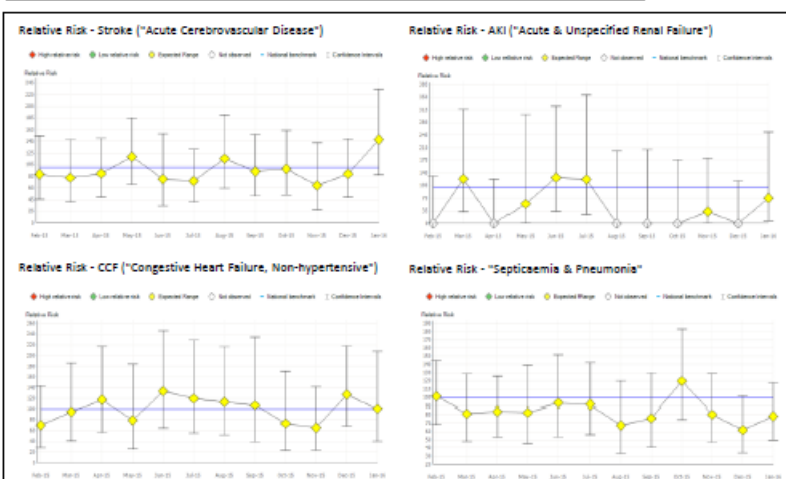
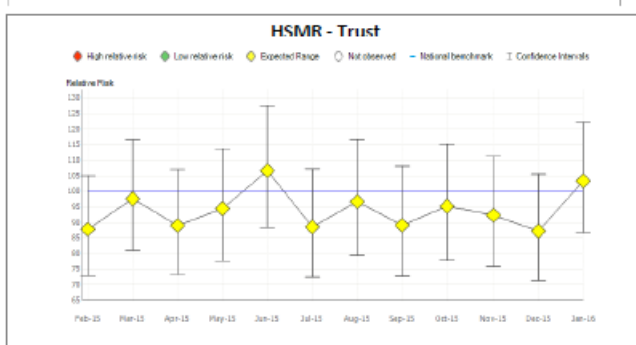
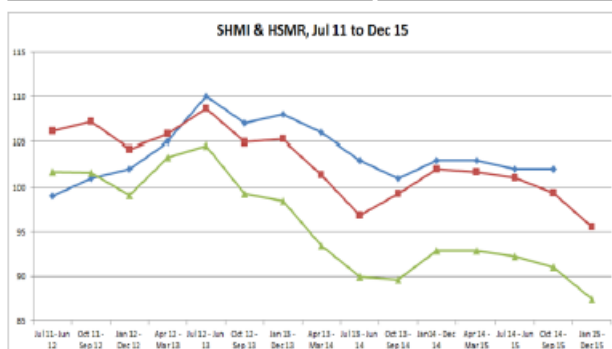
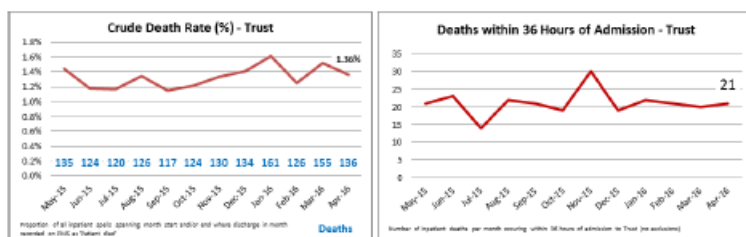
Deaths within 36 Hours of Admission

The MSG considered a deeper analysis of the above patient group. A proportion of these patients are admitted from nursing homes, but there was no obvious evidence of particular nursing homes being problematic. This information will be cross referenced against the eMortality review question (Was this an Appropriate Place to Die?) to establish any possible correlation.

The Board is asked to note this report.

Annexe A

Data Review (Annexe A) - Mortality Surveillance Group



*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:	27 May 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:	On-going strategy work
Action required:	For Information
<p>Executive Summary:</p> <p>This paper summarises the key decisions made by Dorset CCG at its meeting on 18 May including to progress the consultation on its favoured option to develop RBH as a major emergency site, Poole Hospital as a major planned care site and DCH as a planned and emergency hospital.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	All
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	

Clinical Services Review

I am pleased to confirm to the Board that the Dorset CCG formally agreed at its Governing Body meeting on 18 May to:

- a. Approve the updated acute hospital model of care and the CCG preferred site-specific option
- b. Approve the proposal to proceed to consultation
- c. Approve the proposed Integrated Community Services model of care and further development of the site specific options
- d. Approve the proposal to proceed through NHS England assurance
- e. Approve the delegation of authority to the Chair and Chief Officer to make reasonable amendments to the public consultation proposal to address the external assurance feedback
- f. Approve the delegation of authority to the Chair and Chief Officer to sign off the public consultation document

Full details are included in the attached paper provided to the Board for Information

Tony Spotswood
Chief Executive

1. Executive Summary

- 1.1 This report sets out the progress of the Clinical Services Review. It describes how we are seeking to transform services across Dorset to meet the challenges faced by an increasingly elderly population with more complex health needs in an environment of restricted funding.
- 1.2 Delivering the recommendations in this report will start us on the journey towards meeting these challenges over the next 5-10 years and beyond. We are aiming to deliver a high quality, responsive, accessible, integrated health and care service across Dorset that is sustainable for the current and future generations.
- 1.3 There are 2 overarching objectives contained in this paper:
 - 1) Reconfigure acute services to create an acute network of services across Dorset to allow sharing of experience and expertise and to meet the future challenges of delivering increasingly complex healthcare
 - 2) Design an integrated community services model to deliver care closer to home which will reduce travel times and improve the number and quality of services available locally
- 1.4 If, following public consultation, we can achieve these objectives, this will allow us to:
 - Establish a dedicated specialist role for Poole Hospital as a Major Planned Hospital and Royal Bournemouth Hospital as a Major Emergency Hospital with access to these services from the whole of Dorset. This will give better outcomes for patients and save lives by creating centres of excellence
 - Continue to support Dorset County Hospital as a pivotal provider for Planned and Emergency Services in West Dorset so we can better support the rural communities whilst providing high quality of care through our clinical networks
 - Improve the acute hospital estate in East Dorset which could include a new maternity unit and allow over £100 million investment in our hospitals which will deliver better outcomes and improved patient experience
 - Improve maternity and paediatric services by making decisions on development of community services and a single Dorset service approach that addresses national guidance and local patient needs
 - Develop and support the mental health acute pathway review that is running concurrently to the Clinical Services Review to ensure mental health and wellbeing for patients is an integral part of local services

1.5 These should then enable Dorset to have:

- A more sustainable workforce across our hospitals to allow better care to be provided more reliably over the whole of Dorset in future years
- An integrated IT system to improve access to information for health and care staff and to enable more informed clinical decisions on patient care
- A financially sustainable NHS that allows for future investment in services for patients

2. Introduction

2.1 The Governing Body recognised the scale of the future challenges facing the healthcare of Dorset in 2013 and approved the initiation of the Clinical Services Review (CSR) programme in March 2014. The CSR remit was to develop a transformation plan for Dorset that would meet the changing need of our population, best practice standards and deliver a financially sustainable system.

2.2 The CSR concluded its review, analysis and design stage in May 2015. The review recommendations were in line with national guidance, the NHS Five Year Forward View and are supported by NHS England and the Clinical Senate. During May 2015, the CCG Governing Body approved recommendations to agree the model of care for acute hospital services, the site specific options for acute hospital services, the out of hospital approach (now termed the Integrated Community Services programme) and to proceed to public consultation (pending NHS England assurance).

2.3 Based on feedback from patients, public, clinicians and NHS England, a decision was taken following this approval to reschedule the public consultation to 2016 pending further work on the detailed review of acute and Integrated Community Services models.

2.4 This report sets out the progress of the CSR since May 2015 and seeks approval from the Governing Body to proceed to the formal public consultation to consult on whole system change in Dorset encompassing:

- approve the updated acute hospital model of care and the CCG preferred site-specific option
- approve the proposal to proceed to public consultation
- approve further development of the proposed Integrated Community Services model of care and further development of the site specific options
- approve the proposal to proceed through NHS England assurance
- approve the delegation of authority to the Chair and Chief Officer to make reasonable amendments to the public consultation proposal to address the external assurance feedback
- approve the delegation of authority to the Chair and Chief Officer to sign off the public consultation document

3. Background

3.1 The model of care for acute hospital services, the site specific options for acute hospital services and the Integrated Community Services (ICS) approach that were approved in May 2015 were all based on the requirement to meet the changing need of our population, best practice standards and to deliver a clinically and financially sustainable system.

3.2 The Governing body preferred ICS approach was to:

- Transform primary and community care towards consistent quality seven day services delivered in an integrated way
- Develop a rapid response to urgent care needs with a single point of access
- Integrate care for people with long term conditions and frailty by integrated locality based teams
- Improve care closer to home by delivering more outpatient and other planned care in the community
- Support people to recover independence quickly by improving home based support and use of technology
- Develop plans for a workforce that was fit for the future
- To develop proposals for community hubs to support the delivery of services at scale

3.3 The preferred acute hospital model of care and site specific options were to:

- Develop a Major Planned Care Hospital with an Urgent Care Centre
- Develop a Planned Care and Emergency Hospital
- Develop a Major Emergency Hospital
- Evaluate and consult on site specific options for the locations of the acute models of care

3.4 A Pre-Consultation Business Case was developed providing the technical evidence and rationale for the CSR, a detailed explanation of the model of care, options and processes by which recommendations were derived and engagement and assurance activities undertaken.

4. The Need for Change

4.1 The need for change has remained stronger than ever and we have published an updated 'Need for Change' (first published January 2015) in March 2016 which sets out the compelling story describing why Dorset's health services need to change. We have identified the changes for both physical and mental health. The headlines are:

- A growing elderly population with changing health needs e.g. a 60% increase in registered diabetes patients expected by 2020
- More people in Dorset living with long term conditions

- Variable quality of community care, with patients reporting difficulty accessing care at weekends and out of usual weekly hours
- Variable quality of hospital based care, such as Dorset failing to meet some of the national access standards for suspected cancer
- Further work required for parity of esteem between physical and mental health services
- Difficulty sustaining staffing of services (under the current models of care) with high numbers of staff approaching retirement age and difficulty in recruiting staff such as GP's, mental health nurses, paramedics and emergency medical consultants
- A growing financial challenge with a projected gap between costs and available funding of £158 million per year by 2020/21 if we continue to provide healthcare in the way that we do now

4.2 Some of the initial forecasts made during the early stages of the CSR, such as the growing financial challenges, have since been shown to hold true. For instance the four Dorset acute and community providers have reported a combined deficit of over £27 million for the 2015-16 financial year. We have revised the original estimated funding gap of over £200 million in 2020/21 to £158 million to take into account the additional funding that has been allocated to the NHS in 2016-17.. Despite the positive changes in NHS financial allocations in 2016-17 there remains a clear message that doing more of the same will not deliver safe and sustainable services in the future.

5. Progress since May 2015

5.1 We have progressed the depth and detail within our plans in a range of areas over the past year, these are outlined in the following section of this report.

5.2 The CCG initiated a series of Clinical Delivery Groups to provide a focus for more detailed planning and review of the CSR clinical models. These clinically led groups were constituted along themes similar to those of the working groups of the CSR with membership drawn from clinical and public stakeholder groups:

- Maternity and Family Health
- Urgent and Emergency Care
- Planned and Specialist Care (including Cancer services)
- Long Term conditions, frailty and end of life care
- A new group of Mental Health and Learning Disability (previously included as part of other working groups)

5.3 To help provide more details on the acute reconfiguration, an estates review was commissioned from Capita to provide financial cost information and outline estate plans for the acute reconfiguration options outlined in May 2015. This report had a remit to examine the site specific options to check that facilities for the site specific services were viable and affordable. Options to reduce capital costs were also explored with providers and assumptions in the clinical model were tested in order to make the options more cost-effective.

8.1

- 5.4 In order to address specific concerns raised by stakeholders with the proposed options for maternity and paediatric services, the CCG commissioned an independent specialist review of services led by the Royal College of Paediatrics and supported by the Royal Colleges of Obstetrics, Midwifery and Anaesthetics care (termed the Royal College review) to provide an expert peer review of the proposed models of care.
- 5.5 The three Dorset acute hospitals successfully bid to become a national vanguard site as part of the acute care collaboration programme launching Developing One NHS in Dorset. Based on the principles of the CSR this programme is seeking to accelerate the delivery of the CSR by establishing networked clinical services across Dorset starting with the following areas:
- Women's health
 - Paediatrics
 - Cardiology
 - Stroke
 - Ophthalmology
 - Non-surgical cancer services
 - Radiology and Pathology
 - Back office and IT functions
- 5.6 In addition to the acute hospital options, a programme was initiated to provide further detailed service planning for ICS. The focus on this programme is to work with Local Authorities and GPs, community and acute sectors to co-design services covering health and care, wellbeing and prevention that are either co-located in community hubs, delivered locally from public sector estate or delivered in patient's homes by community based teams. In all cases the design principle of extensive engagement with public, patients and carers of Dorset remains central to these plans.
- 5.7 The acute and ICS programmes have engaged a wide range of stakeholders to provide views and input into the future design of Dorset's healthcare services (see Appendix 1), including:
- The public, patients and carers of Dorset at a range of public events and meetings (Including The public and patient (carer) engagement group established specifically for CSR)
 - The GP members who work in the 98 GP practices across Dorset
 - Leading clinical views of the staff who work in Dorset's NHS providers
 - Other groups of people who have an interest in the planning and delivery of Dorset's health system including carers, providers, local authorities, NHS England, Health and Wellbeing Boards, MPs, councillors and elected members, local Healthwatch, West Hampshire CCG, neighbouring trusts in Somerset, Wiltshire and Hampshire, Dorset Race Equality Council, Dorset Young People's Forum and a wide range of community voluntary organisations
 - Information has been made available on www.dorsetsvision.nhs.uk website at every stage of the programme

- Local authorities and Dorset Association of Parish and Town Councils have become much closer partners in the programme
- 5.8 Further details of the engagement and stakeholder groups are referenced in the Pre-Consultation Business Case along with the comprehensive programme of engagement undertaken.

6. Acute hospital care for Dorset

- 6.1 In this section of the report the further developments of the acute model of care are described and how these were used to develop the site specific options. Evidence is presented for each site specific option, based on evaluation criteria, and a recommendation is made for the CCG preferred site specific option.
- 6.2 This work aims to improve care and quality to deliver better outcomes by defining a more specialist role for each of our hospitals. The efficiencies generated under the new model of care would allow for investment in the hospital estate (e.g. A new maternity unit for East Dorset), less disruption to services from unplanned care, better recruitment and retention of staff and a more financially sustainable future for all of our acute hospitals.

Acute Model of Care-how the models were developed

- 6.3 One of the underpinning principles of the CSR is to be clinically led. Much of the development and design has taken place at large Clinical Working Group (CWG) meetings where Dorset's healthcare providers are represented.
- 6.4 Clinical Working Groups 1 to 5 took place in 2014-15 and designed the model of care subsequently approved by the Governing Body in May 2015. The design is based on national best practice, advice and guidance from Wessex clinical networks and patient and public feedback. Specialist work was undertaken in each of the CWG clinical areas and submitted to the Wessex Clinical Senate for assurance purposes.
- 6.5 Subsequent CWG's took place in 2015 and 2016 to further develop the options for acute services and to seek wider views from NHS and local authority stakeholders on the emerging models and associated developing options. The topic areas for each CWG are shown below:
- CWG 6 – Clinical network development and Integrated Community Services design
 - CWG 7 – Management of acute medical patients in the Major Planned hospital, theatre utilisation between the Major Planned and Major Emergency Hospitals and review of maternity and paediatric services: progress so far
 - CWG 8 – Mental health acute care pathway update, community service development and emerging models of care
 - CWG 9– Integrated Community Services community model and options for delivery

- CWG 10 (May 2016) – Summary of clinical models and options for telling the Dorset story

- 6.6 The Royal College review of Maternity and Paediatric Services was commissioned in Summer 2015, started work in Autumn 2015 and completed in March 2016. The report was published by the CCG in April 2016.
- 6.7 In considering the development of potential future acute hospital models, consideration has been given to the interdependencies between clinical services that may need to be co-located. For example the interdependencies between emergency surgery, critical care and high risk obstetrics were considered in the model for the Major Emergency Hospital.

Acute Model of Care-the results of our work

- 6.8 The Clinical Delivery Groups carried out work to outline the current service, future vision for the service and benefits to patients of the proposed new service. The service and pathway work has drawn on external expertise where available (such as the Wessex wide Operational Delivery Networks and Specialised Commissioners) and was reviewed by the Clinical Senate in April 2016. The patient pathways have been described for:

- Urgent and Emergency Care
- A&E and Trauma Services
- Cancer Services
- Long Term Conditions - Stroke
- Transient Ischaemic Attack
- Preventative Care after a Stroke
- Cardiology Services
- Diabetes
- Frailty
- Paediatrics and Neonatal services
- Maternity Services
- Dementia Services
- Child and Adolescent Mental Health Services (CAMHS)
- Adult mental health services and the Acute Psychosis pathway

- 6.9 The Royal College review found that Maternity and Paediatric services across Dorset are highly valued by local people and provided by caring, dedicated staff. However, some aspects of care could be improved and updated. In particular, offering better services in the community across Dorset was seen as essential. The review confirmed that Dorset's maternity and paediatric services needed to change to remain safe and sustainable clinically and financially over the next 5-10 years. The recommendations were:

- Offer better services in the community and develop a Dorset-wide children's community nursing service
- Create a Dorset-wide team of midwives, health visitors and nurses
- Provide easier access to home births

- Increase midwife-led care across the county
 - Reorganise hospital care
- 6.10 For the West of the county, the recommendation was that there should be an urgent decision (within 6 months) to explore the integration of services between Dorset County Hospital (DCH) and Yeovil District Hospital resulting in one site delivering consultant led obstetric care and one site with a midwifery led unit. One site would then deliver an inpatient paediatric service and one site a paediatric assessment unit.
- 6.11 If the feasibility of this was not agreed within 6 months, the review recommended that there should be a Dorset wide network with a move to midwifery led unit and paediatric assessment unit at DCH with a high risk obstetric unit and consultant delivered paediatric inpatient site at the East Dorset Major Emergency Hospital. In addition, the DCH neonatal unit should be re-designated as a Special Care Baby Unit (for babies >32 week gestation). These changes would ensure safe and sustainable Maternity and Paediatric services that are fit for the future.
- 6.12 The detailed planning by the Clinical Delivery Groups, output from the CWG's, recommendations from the Royal College's review and the recommendations of the Clinical Reference Group were combined into a more detailed clinical model. The revised clinical model was then used in the further development of the site specific options for acute hospital care across Dorset, taking into consideration that aspects of the Royal College review are still in progress.

Site specific options for acute hospitals – how the options were developed

- 6.13 Site specific options were developed with the Clinical Working Groups 1-5 and the options for consultation were detailed at the Governing Body in May 2015:
- A Planned and Emergency Hospital should be located at Dorset County Hospital
 - A Major Emergency Hospital should be located at the Poole or Bournemouth Hospital sites
 - A Major Planned Hospital with an urgent care centre should be located at the Poole or Bournemouth Hospital sites
- 6.14 The models of care within these options meet the Keogh Review of Emergency Services¹ vision by proposing:
- A highly responsive community based service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families for those people with urgent care needs (see ICS section below)

¹ NHS England's *Transforming urgent and emergency care services in England End of Phase 1 report* (November 2013)

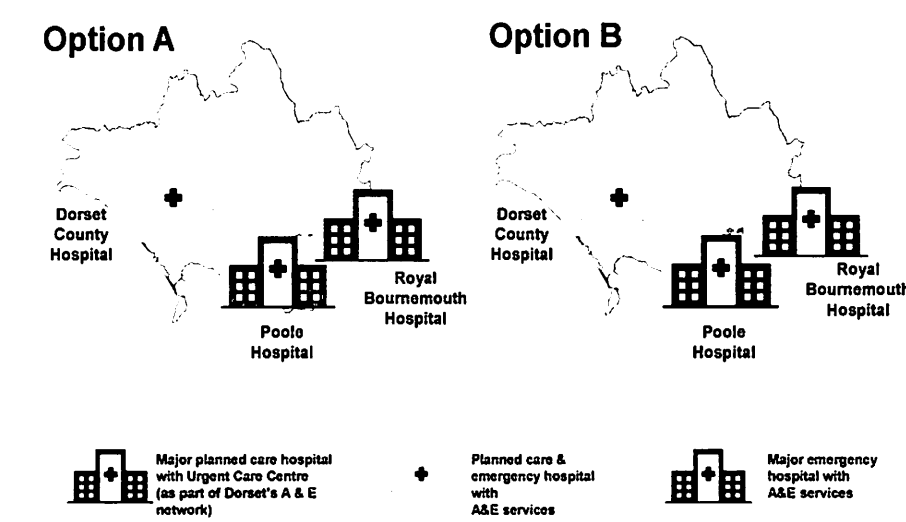
8.1

- An acute care model for those people with more serious or life threatening emergency care needs, to ensure that they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery

- 6.15 Clinicians also took account of services offered outside of the county of Dorset such as specialist tertiary services delivered from Southampton and patient flows into Dorset from other counties such as Hampshire. Dorset patients receiving services from surrounding hospitals such as Yeovil and Salisbury were also taken into account.
- 6.16 Workshops were carried out between CWG 6 and CWG 7 with clinicians and managers to determine if the potential site capital costs could be reduced whilst maintaining the integrity of the clinical model for both options.
- 6.17 The deliberations from these workshops and the estates and financial calculations were taken to CWG 7. In summary, two principal variations to the original concept of the Major Emergency and Major Planned hospitals were discussed, both of which are believed to maintain the integrity of the clinical models of care as conceived in the CSR whilst reducing capital costs:
- Firstly to increase the proportion of medical patients who could be cared for safely on the Major Planned site from 10% of the medical take to 30%
 - Secondly, if option B (see site specific options below) was to be implemented, to retain the 'Derwent' Suite as a dedicated elective orthopaedic theatre complex to reduce the requirement for new theatre construction on the Poole Hospital site

Site specific options for acute hospitals – the results of our work

- 6.18 The two site specific options that were identified by clinicians for delivering the model of care for acute hospital based services are shown in the diagram and table below:



	Dorchester	Poole	Bournemouth
OPTION A	Planned and Emergency Hospital	Major Emergency Hospital	Major Planned Care Hospital with an Urgent Care Centre
OPTION B	Planned and Emergency Hospital	Major Planned Care Hospital with an Urgent Care Centre	Major Emergency Hospital

- 6.19 Both options A and B are underpinned by Dorset's hospitals working together as part of 'One NHS' in Dorset as outlined in the Dorset Hospitals Acute Care Vanguard proposal, to ensure all hospitals provide services in a networked way. This will improve workforce issues and deliver more responsive services to patients across Dorset. A summary of the services at each hospital is provided in Appendix 2.
- 6.20 In both options, Dorset County Hospital will continue to provide a planned and emergency service to support access to services in West Dorset. It is expected that between 1%-3% of people attending A&E at Dorset County Hospital may have their travel time impacted as a result of the proposals.
- 6.21 Services will develop into networked models under the acute care vanguard programme and the more complex and specialist services will be supported by the Major Emergency Hospital or by specialist tertiary providers (in much the same way as major trauma services are currently provided by Southampton University Hospital for West Dorset residents). The Major Emergency Hospital will provide some highly specialised services for the whole of Dorset, with tertiary specialist services continuing to be provided by Southampton. It is expected that between 5%-6% patients currently treated at a hospital in Dorset may transfer to the Major Emergency Hospital site in future.
- 6.22 The two proposals that were developed during the testing of the assumptions in the clinical models were evaluated at CWG 7 against the same evaluation criteria established during the CSR design phase. The CWG supported the proposals and they were referred on to the Clinical Reference Group for assurance.
- 6.23 In February 2016 the Clinical Reference Group received the proposals and the CWG7 views on both options. The Clinical Reference Group agreed with the evidence presented and the evaluation criteria rating for each proposal.

8.1

- 6.24 The Clinical Reference Group supported the medical patients proposal which would result in fewer 'new build' beds on the Major Emergency site thus requiring £25 million less capital under option A and £12 million less capital under option B. This proposal would also deliver a benefit of improved access times for residents close to the Major Planned Hospital.
- 6.25 The CRG did not support the theatre proposals at this time since the potential capital cost savings were relatively low and it was not felt that this justified changing the clinical model design of all routine elective surgery centred on the Major Planned Hospital site.
- 6.26 Having looked at the acute model of care and considered the site specific options, the evidence for each option has been evaluated in order to come to a recommendation.

Evaluation of the acute hospital options

- 6.27 The evaluation criteria developed by clinicians, the Patient and Public Engagement Group and the Finance Reference Group were used to evaluate both options (Appendix 3). The evaluation criteria are:
- Quality of care for all
 - Access to care for all
 - Affordability and value for money
 - Workforce
 - Deliverability
 - Other (e.g. research and education)
- 6.28 Scrutiny of evidence against each criterion was based on data and information provided directly by local providers, publicly available published data or information supplied via reference groups and working groups and the knowledge, expertise and judgement of the professionals involved. In addition to the factual evidence provided, site visits were undertaken by the Governing Body in April 2016. At each visit the Governing Body received a brief tour of a section of the hospital site and a presentation by the hospital leadership team. The feedback from the visits was incorporated into a 2 day Governing Body workshop in April to further consider the site specific options and impact of the future site specific configuration across Dorset.
- 6.29 Quality of care for all was evaluated by assessing in terms of its impact on quality of care in 2019/20. The impact on patient safety, outcomes/clinical effectiveness and patient experience were all examined from clinical audit data or nationally published clinical standards data.
- 6.30 Access to care for all was evaluated by extensive and detailed travel time analysis undertaken by external experts and based on satellite navigation system data from hundreds of thousands of real time journeys. This was used to assess the impact on the population of possible changes from the current location of services to those contained within the CSR proposals. Impact on journey times to elective services, specialist services (recognising that only a

8.1

small proportion of patients would access specialist services) and emergency services were analysed. Service operating hours and impact on patient choice were also assessed under this criterion.

- 6.31 For the purpose of considering access to the Major Emergency Hospital in East Dorset two aspects were considered.
- Firstly the expected volumes of patients in Dorset requiring access to more specialised emergency services, such as those which are proposed to be centralised on the Major Emergency Hospital site. For a number of residents nearer the borders of Dorset, and for some in West Hampshire, the nearest hospitals providing such services will be outside Dorset, e.g. Royal Devon and Exeter Hospital or Southampton Hospital
 - Secondly, the expected volumes and travel time impact of the options to patients in the East requiring access to low complexity urgent care services typically provided by District General Hospitals and similar to those proposed by the Planned and Emergency Hospital
- 6.32 Affordability and value for money was assessed with input from the Finance Reference Group by modelling the financial impact of the proposed clinical models and site specific options on capital costs, expected transition costs, income and expenditure, resulting number of organisations in financial deficit and the impact on net present value.
- 6.33 The Workforce criteria was assessed in conjunction with the Workforce Reference Group by the scale of impact of changes on the workforce, sustainability of the workforce and overall numbers of people moving to work outside of Dorset as a result of the changes.
- 6.34 Deliverability was assessed by examining the expected time to deliver and the impact on other policy areas/proposed changes to health and care services. This included movement of services, beds, facilities and staff.
- 6.35 Other (e.g. research and education) was assessed in line with national and local policies for research and development (R&D) and education and training.

Results of the evaluation

- 6.36 In many cases the evaluation highlighted benefits of each option that were not of a significant enough magnitude in each criterion alone to include in this paper. These benefits were taken into account in the final recommendation as supporting evidence. The results below are therefore a high level summary of each option for the criteria where the major benefits of each option are outlined. The detailed results of the evaluation are available in the Pre-Consultation Business Case (summarised in Appendix 4).

Quality of care for all

- 6.37 For quality of care for all, under all options being considered, it is expected that there will be significant improvements to quality of care through:

8.1

- Increased investment in integrated community services to reduce the rate of hospital admissions and provide care closer to home
- Increased volumes of care in the Major Emergency Hospital, resulting in improved quality of care for patients and less disruption to planned care in the Major Planned Hospital
- More differentiated services across Dorset meaning patients receive the right care in the right place

6.38 Analysis of hundreds of clinical audit measures, published clinical quality data, patient and carer experience data and clinical safety information highlighted the current variations in quality under the existing models and that the proposals would improve quality equally under both option A and option B. **Each option scored the same against this criteria.**

Access to care for all

- 6.39 For access to care for all, both options will result in an improvement in travel times for patients accessing hyper-acute services alongside an improvement in travel to local services that is expected with the ICS proposals.
- 6.40 The majority of the current A&E activity will remain on the Poole and Bournemouth sites under both options, with over 95% remaining on the Dorset County Hospital site. Under the ICS proposals, outpatients will move closer to people's homes as clinicians recognised the majority of these did not need to be delivered in hospital. Inpatient activity is affected the most under both options due to the proposed changes for high volume elective surgery that would be carried out at the Major Planned Hospital and emergency admissions that would be carried out at the Major Emergency Hospital. Whilst the Major Planned Hospital will continue to treat patients in its Urgent Care Centre and accept 30% of the medical take, the majority of emergency patients requiring bed based care would receive treatment at the Major Emergency Hospital site given the improved clinical services available.
- 6.41 The overwhelming majority of patients require access to low complexity urgent care services typically provided by District General Hospitals, the majority of which would be provided at two centres in Dorset, the Planned and Emergency Hospital and the Major Emergency Hospital. The population of West Dorset and those in central Dorset would be closest to the Planned and Emergency Hospital in Dorchester. For the population living in the East of the county and West Hampshire, the population density is higher around the Bournemouth conurbation and West Hampshire than it is around Poole, thus option B is the more easily accessible site for these services.
- 6.42 Taking account of guidance relating to emergency travel and transfer times the CWGs and the Clinical Reference Group rated option A and B equally on quality, covering clinical effectiveness, patient and carer experience and safety.
- 6.43 For patients needing access to the low volume high complexity services provided on the Major Emergency Hospital site, option A offers the better access for the Dorset and West Hampshire population. The numbers of

8.1

patients requiring these type of services is relatively low when compared to those requiring access to less complex high volume emergency care.

- 6.44 Both options have differing effects on surrounding hospitals, with a greater proportion of patients expected to attend Southampton under option A (due to increased travel times to the Major Emergency Hospital from West Hampshire) and a greater proportion expected to attend Salisbury under option B.
- 6.45 Patient choice and service operating hours are scored equally for both options. Service operating hours will improve under the proposed clinical model moving towards a 24/7 service and all three sites will remain and support patient choice with significant patient benefits from the proposed model.
- 6.46 Overall, the analysis shows that option B is better for access as the proportion of the population needing highly specialised services is small and option B is more easily accessed by a greater proportion of the population in the East of Dorset. When the population of West Hampshire is taken into account, option B is also better.**

Affordability and value for money

- 6.47 Both options were shown to provide value for money by generating savings in future revenues.
- 6.48 The table below shows the comparative costs of options A and B following the review commissioned from Capita of the estates implications for both sites. The cost figures are compiled using the nationally prescribed methodology. Actual local costs could be 20%-30% less than this based on real experience of commissioning similar construction work. These costs take into account the changes recommended by Clinical Reference Group on medical admissions.

National Methodology	Cost for Major Planned Hospital (£m)	Cost for Major Emergency Hospital (£m)	Total Cost (£m)
Option A	£33	£156	£189
Option B	£62	£85	£147

- 6.49 When examining potential future estate development on Bournemouth and Poole hospital sites, in either option the intention is that all clinical activity would be consolidated onto the main Poole hospital site with the St Mary's maternity site being vacated. There is a £42m (28%) price difference between option A and option B, based on the Capita calculations, although the actual cost could be around 20%-30% lower.
- 6.50 Both options will deliver an expected saving of around £30 million per year once operational. This means that the investment in option A will have a

8.1

payback time of 6.3 years and option B a payback time of 4.9 years, when considered using the national cost methodology. If local costs are considered the capital costs could reduce to between £100m-£150m. It is the efficiency saving generated by implementing the options that allow for the development and improvement of the estate on both Poole and Bournemouth sites.

- 6.51 Both options are similar for financial impact on income and expenditure, option A is less expensive (£6m) when considering transition costs and option B has a higher Net Present Value than option A (£12m).
- 6.52 When all financial criteria are evaluated together, option B is significantly better than option A based on the lower capital requirement.**

Workforce

- 6.53 Both options are considered to have a similar impact on the workforce in terms of overall numbers of staff changing place of work when travel from home is considered. When assessing workforce in relation to service transfer, option A would retain more of the existing workforce on their current place of work than option B, due to fewer services requiring transfer.
- 6.54 Both options are considered to result in improved sustainability of the workforce as they result in fewer sites needing to provide 24 hours, seven days a week delivered care for the same service. The duplication of services between sites in East Dorset is also reduced. Both options result in increased volumes of work in their services which will maintain staff specialist expertise – this is especially true if more specialist staff move to working in a clinical network approach where they provide care across all three of Dorset's acute hospitals, rotating through different types of hospital/unit or community facility. **Each option scored the same against this criteria.**

Deliverability

- 6.55 In considering deliverability, fewer clinical service moves are required under option A than option B with potentially less disruption to services under option A. This impact is taken into account in the evaluation of transition costs and workforce criteria as outlined above.
- 6.56 Estates guidance suggested that Option B (with expansion of the Royal Bournemouth site) could be less disruptive to ongoing service delivery during the construction phase than option A (with expansion of the Poole Hospital site) due to the more modern construction of the Royal Bournemouth site and greater availability of space for planned and future development. **Each option scored the same against the deliverability criteria.**

Research and education

- 6.57 All options will need to be taken forward in line with national and local policies for research and development (R&D) and education and training so there is not considered to be any difference between the options considered. **Each option scored the same against this criteria.**

8.1

- 6.58 All the evidence provided to assess against the evaluation criteria is included in an updated Pre-Consultation Business Case and was used to inform views on which option would deliver the best services for the people of Dorset.

The CCG recommended Acute Hospital preference

- 6.59 In considering the evidence local stakeholders requested that the CCG determine a preference for one option, noting that this is a preference. A final decision will be reached by the CCG once the public consultation has completed and the results taken into account.
- 6.60 A summary of the evaluation of both options, noting this is the summary of the major benefits highlighted above, is outlined below:

Criteria	Option A	Option B
Quality of Care for all	↔	↔
Access to care for all		✓
Affordability		✓
Workforce	↔	↔
Deliverability	↔	↔
Other (R&D)	↔	↔

↔ = Equal Evaluation

✓ = Better Evaluation

- 6.61 Based on the evidence and results of the evaluation, it is recommended that Option B is the CCG preferred site specific option for the future delivery of the acute hospital model of care in Dorset.

7. Integrated Community Services

- 7.1 In this section we describe the previous work undertaken in developing the ICS approach, the further development of the ICS model of care and how we used this to start to develop the site specific options. This work aims to deliver better services to patients by delivering them closer to home in a more integrated way with more personalised care based on the needs of patients.

Integrated Community Services - how the community model was developed

- 7.2 During early 2015, Clinicians across Dorset from primary and community care attended 13 locality events to consider out of acute hospital models of care and the way in which the system could be organised to deliver the model. They considered:

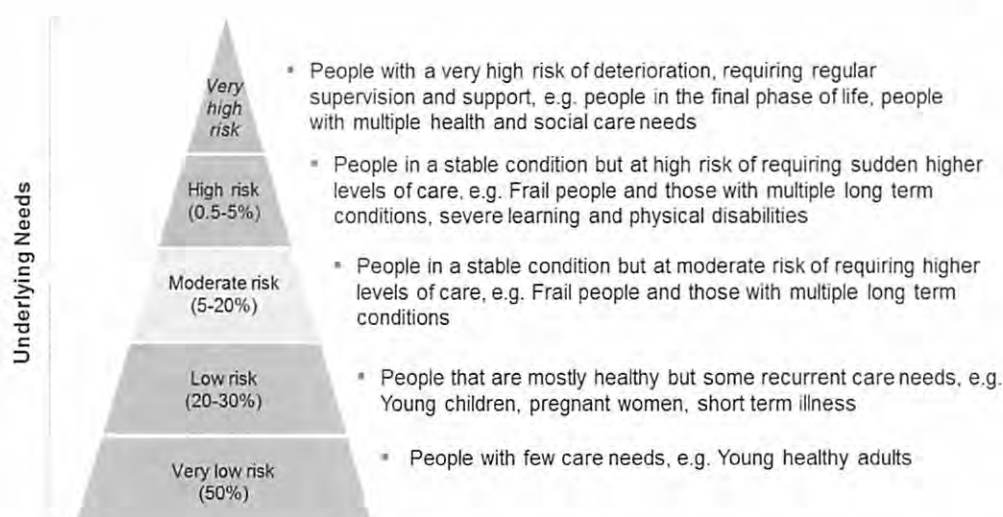
- The current service model
- Potential challenges
- Potential opportunities
- Potential ways to organise delivery in the future

8.1

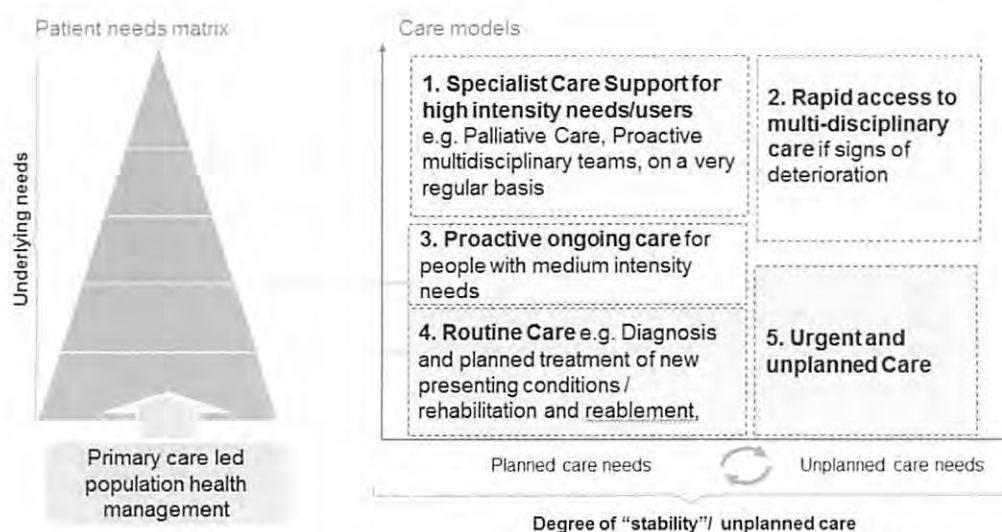
- 7.3 The detailed output from this work formed the basis for the ICS approach and led to a more detailed workplan to progress the model of care and to develop site specific options.
- 7.4 Following the Governing Body approval to proceed with the ICS approach, a programme was developed to explore future models of care and configuration of community services across Dorset.
- 7.5 The programme has been overseen by an ICS steering group consisting of GP, local authority, acute and community provider service representation. In exploring future models, current best practice and published evidence were used to explore ways in which the challenges outlined in the need for change could be met by community based services. This work has been undertaken in parallel to the acute reconfiguration activity recognising the interdependencies that exists between these two programmes.
- 7.6 The community modelling started with the results of the CSR and built on these to develop the model for community services. In doing this the programme considered the workforce profiles, high level financial forecasts, estates information, current and future activity projections, population growth and travel times data. The modelling considered the acute hospital options A and B as both these can affect community service configuration in their localities. Assumptions on which community models were based were tested and amended with Clinicians and managers at two events in March and April 2016 and continue to be refined.
- 7.7 The early results of the programme on the community models were presented at Clinical Working Group 8, further modelling at CWG 9 and a summary provided to the Clinical Reference Group in March 2016 and April 2016. A draft of the community model and potential service configuration was presented to the System Leadership Team, CCG Governing Body and the ICS Steering and Reference Groups in April 2016. Nine public engagement events with over 300 attendees were held in March and April 2016 along with input from the Patient and Public Engagement Group and the Stronger Voices forum (Appendix 1). Views from all attendees have been fed into the future model design.
- 7.8 In addition to the ICS programme, a local Dorset Vanguard was initiated and funded by the CCG in September 2015. The remit of this programme was to design integrated community services at scale along with other local service provider stakeholders and patients.

Integrated Community Services - the results of our work

- 7.9 The community model is based on stratifying the local population needs. This then allows us to look to configure service delivery around these needs in the most appropriate way. The five broad groupings of population need are outlined below.



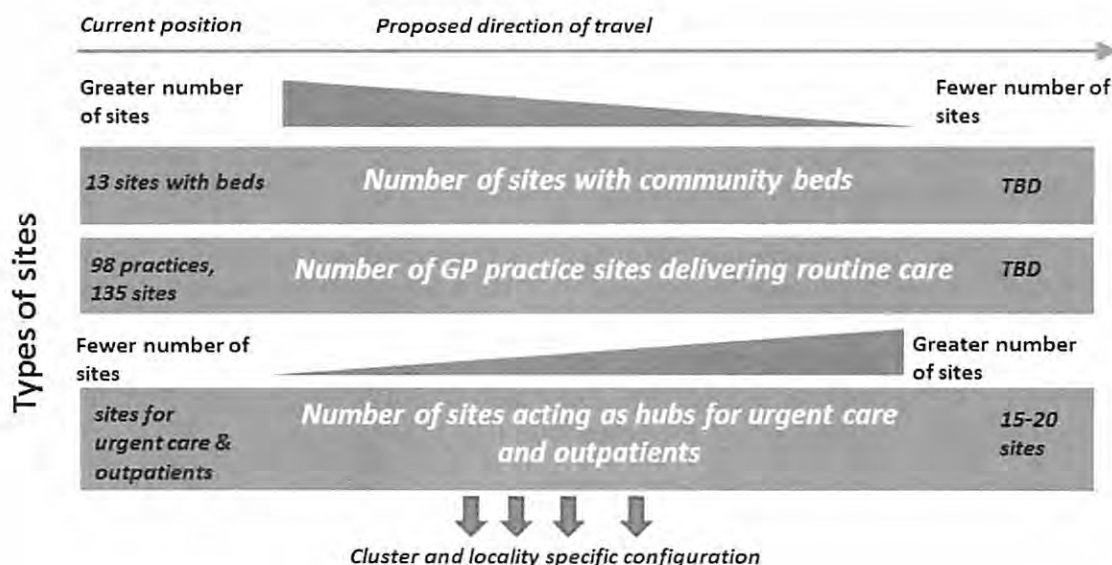
- 7.10 When the categories of need are then used to examine the services that could be designed to meet that need, a range of care models have emerged. These care models are in place in other parts of the country and have been shown to be highly effective in the delivery of community based care. A summary of the five care models and how they map to the population need is outlined below:



- 7.11 Initial workforce analysis has indicated that if care is delivered in new community care models, the majority of the workforce is in place across the system to meet the future service demands. This would require some recruitment, changes in skill-mix across staff groups and amended ways of working, including the development of nursing and allied health professional roles across community and primary care services.
- 7.12 Modelling of the impact of the new models of care has shown that the required 25% reduction in non-elective medical admissions and the 20% reduction in non-elective surgical admissions that underpin the acute model of

care can be met. This will require improved community based support and better access to step up beds for short term rehabilitation, with acute, community, primary care and the local authority working together in a more co-ordinated way.

- 7.13 The proposed service configuration model is evolving with stakeholders and initial results have shown that there is potential to deliver better care closer to people's home in a series of community hubs and primary care sites. Currently Dorset has 13 community hospital sites with beds and 98 GP practices delivering care in 135 sites. The community model of ICS would potentially allow for development of expanded integrated teams delivering more services and working from fewer community hubs and primary care sites.
- 7.14 In examining the public sector estate across Dorset there are a range of options for service delivery. The options could involve a range of consolidation of services on some sites, such as those with community hospital beds, to allow us to use our estate more effectively and invest in re-purposing or developing of other sites. The modelling has shown that this is also possible to develop new community hubs and expanded routine care sites within the existing estate. It has become clear that to meet the future need of our population we should make better use of the resources that are invested in Dorset's healthcare buildings.
- 7.15 The options for the site specific configuration depend on the level of consolidation of sites and will need to be co-designed with local stakeholders to suit the local geography and need of the population. A range of options will apply to the different localities across Dorset with a varying range of consolidation and development in the categories outlined below.



- 7.16 As an example, an option may be to consolidate community hospital beds currently provided over two sites onto one, re-purpose the site that no longer provide bed based care and develop expanded routine and urgent care services from larger primary care sites in the locality.
- 7.17 We have used our developing modelling programme and information as a starting point for site specific options for the new community model. This has taken into account our criteria for quality of care, access to care, affordability and value for money, workforce, deliverability and other (e.g. R&D).
- 7.18 In order to assess the impact of site specific options on travel times, we have carried out travel time analysis and modelling. The analysis has demonstrated that, 95% of people would be able to access community bedded sites within 20 minutes by private car and 90% within an hour by public transport with potentially as few as 6 strategically located sites with community beds compared to the current 13. Whilst the review is not currently proposing only 6 sites with community beds, the results question the use of resources and future sustainability of the current configuration.
- 7.19 Similarly, access to primary care and community services in a scenario of fewer community sites with beds and establishment of primary care hubs without beds, would be possible by car within 8 minutes for 90% of the population and 25 minutes by public transport with just 25 well placed primary care locations. Again, this is not currently being proposed, but it does point to the current 135 sites as over-stretching our resources, both workforce and financial. As mentioned above, a single solution will not suit all areas and we will seek to explore what would be right for the different needs of the local population with stakeholders. Further travel analysis is currently underway.
- 7.20 We have also considered the interdependency of the two site specific acute options, option A and option B in our community modelling and this is reflected in the analysis undertaken. The development of site specific options for the community model are subject to further engagement and consultation with stakeholders, including joint work on understanding the implications for adult social care services across the three councils and will be presented to the Governing Body in the coming months.
- 7.21 The local Dorset Vanguard attracted 6 GP federations successfully bidding to design integrated community services. The 6 federations presented initial thoughts at public engagement events in March and April 2016 and are due to provide their plans for integrated services towards the end of April when they will be considered along with the Integrated Community Services programme outputs in development of a Dorset wide ICS Strategy.
- 7.22 The proposed community clinical model was supported by the Clinical Reference Group on 21st April 2016 and the next steps are to further engage with NHS and Local Authority staff, patients, public and carers in Dorset to refine the community model and site specific options. These will be evaluated using the evaluation criteria used for the acute configuration options and presented to the Governing Body for further consideration prior to public consultation.

8. Mental Health

- 8.1 Dorset CCG's mental health team have been working extensively for the past two years to bring about significant change to the mental health services and to develop parity of esteem. This work has been closely linked to other elements of the CSR and in particular with elements of the ICS programme.
- 8.2 Parity of esteem is being embedded within every aspect of the work the CCG is taking forward in order to ensure mental health is valued equally with physical health. This means we will be tackling mental health issues with the same energy and priority as we have tackled physical illness.
- 8.3 The CCG is leading the Mental Health Acute Care Pathway (MHACP) Service Review a specific pan-Dorset review including services such as inpatient assessment and treatment, psychiatric liaison, crisis response and home treatment, street triage and community mental health teams. The MHACP design is being co-produced by service users, carers, the voluntary sector, NHS providers and Dorset Police, all of whom bring different insights into the system
- 8.4 During the view seeking phase, the CCG received 3,355 comments in total and Bournemouth University's Market Research Group independently analysed these with findings used to inform future service model design.
- 8.5 The project is currently in the modelling phase which is aiming to produce a Strategic Outline Business Case by the end July. We expect this to include up to three options for the potential new model of care that will be taken to public consultation.

9. Enablers for change

- 9.1 To enable service transformation the enabling workstreams set up during the CSR process have continued to develop plans and programmes to support the overarching transformation plan.
- 9.2 Digital Dorset has continued to advance the procurement of the Dorset Care Record (now at tendering stage) and record integration is a key strategic priority of the pan Dorset Informatics Reference Group.
- 9.3 The Finance Reference Group is providing specialist input on future costs of the service models and on financial sustainability of local providers.
- 9.4 We have developed a workforce plan for Dorset which includes health, social care and primary care. The plan brings together national and local data and information in a consistent format across the five Clinical Delivery Groups . It includes the aligned programmes of work where relevant, as well as sections on Primary Care and Social care.

10. Patient Benefits of the models of care and site specific options

- 10.1 Delivering our two overarching objectives of the acute care reconfiguration and development of ICS models of care will go a long way towards meeting the challenges set out in the need for change. There will be significant benefits in delivering a high quality, responsive and accessible integrated health and care service across Dorset that is sustainable for the current and future generations.
- 10.2 If, following public consultation, we can achieve these objectives, this will allow us to:
 - Establish a dedicated specialist role for Poole Hospital as a Major Planned Hospital and Royal Bournemouth Hospital as a Major Emergency Hospital with access to these services from the whole of Dorset to give better outcomes for patients and save lives by creating centres of excellence
 - Continue to support Dorset County Hospital as a pivotal provider for Planned and Emergency Services in West Dorset so we can better support the rural communities whilst providing high quality of care through our clinical networks
 - Improve the acute hospital estate in East Dorset which could include a new maternity unit and allow over £100m investment in our hospitals which will deliver better outcomes and improved patient experience
 - Improve maternity and paediatric services by making decisions on development of community services and a single Dorset service approach that addresses national guidance and local patient needs
 - Develop and support the mental health acute pathway review that is running concurrently to the Clinical Services Review to ensure mental health and wellbeing for patients is an integral part of local services
- 10.3 These should then enable Dorset to have:
 - A more sustainable workforce across our hospitals to allow better care to be provided more reliably over the whole of Dorset in future years
 - An integrated care record to improve access to information for health and care staff and to enable more informed clinical decisions on patient care
 - A financially sustainable acute and community sector that allows for future investment in services for patients
- 10.4 These benefits can be considered against the evaluation criteria to demonstrate how we intend to meet requirements asked of us by our patients and public in the initial consultation and engagement phase of our programme (Appendix 6)

11. Next Steps

- 11.1 The next steps of the CSR transformation programme are to seek the views of stakeholders via a formal public consultation and to seek further assurance on the programme by external stakeholders to allow the programme to progress to a commissioning decision in 2017 (Appendix 5).

Public Consultation

- 11.2 The main objectives of the public consultation on the acute model of care and site specific options are:

- to enable and help people in and around Dorset to be aware of the critical challenges facing local health and social care services and understand that things need to change and what the possible options are
- to hear peoples' views on the possible changes to the way health care is organised in Dorset
- to find out if there is any additional information we need to be aware of to help us make our decisions

- 11.3 The CCG has worked with the Patient and Public Engagement Group to develop consultation objectives and principles resulting in a consultation pledge. The pledge states that we will:

- Share what we have been told
- Involve a wide range of people
- Use clear and simple language
- Ensure sufficient time to be involved
- Work in partnership to reach out to Dorset's diverse population
- Ensure good value for money
- Use the feedback to inform decision-making

- 11.4 A number of proposed consultation themes and linked objectives have been developed on which we will determine public views and levels of support. These are shown in the table below:

Thematic area	Public views about and levels of support around
The need to change	Why change is required and acceptance that the status quo is neither sustainable or desirable
Our vision for healthcare in Dorset	Agreement with the CCG's overarching vision
Transforming our out of acute hospitals to provide high quality,	Changing model of Integrated Community Services care focused on bringing more care closer to people's homes, offering a greater

Thematic area	Public views about and levels of support around
safe and sustainable care	range of services locally (based on a scale model), and making best use of estates.
Transforming our acute hospitals to provide high quality, safe and sustainable care	Changing model of acute hospital care with centres of excellence that can offer specialist and day-to-day acute emergency, urgent and planned care . Consulting on site specific options (Option A and B) for new ways to organise care
Implementation of the agreed solution	Any specific issues of note or to be aware of during implementation (e.g. public transport routes, sequencing of new and old services)

- 11.5 The specific questions that will be asked during the public consultation stage have yet to be determined and will be developed in the consultation planning between now and September 2016.
- 11.6 The recommendations in this report will be subject to the Stage 2 assurance (stage 1 assurance was successfully completed in 2015) carried out by NHS England and subsequently submitted to NHS England's national Investment Committee. Investment Committee approval is required before the CCG can commence public consultation. The stage 2 assurance is timetabled for June 2016 and the Investment Committee for August 2016.

Assurance

- 11.7 In early June 2016 NHS England will consider the external assurance from the Health Gateway review team and the clinical Senate Council advice following their independent review as well as a more in-depth assessment of how the CCG is meeting the four key tests:
- Strong public and patient engagement
 - Consistency with current and prospective need for patient choice
 - A clear clinical evidence base
 - Support for proposals from clinical commissioners
- 11.8 Providing NHS England is satisfied with this information, and the programme passes the stage 2 assurance process, a submission is made to the NHS England national Investment Committee.
- 11.9 NHS Dorset CCG recognises the decision that was made by the Competition Commission (now the Competition and Markets Authority (CMA)) in relation to a proposed statutory merger between Royal Bournemouth and Christchurch NHS Foundation Trust and Poole Hospital NHS Foundation Trust. NHS

8.1

Dorset CCG will engage fully with competition regulators (NHS Improvement and the CMA) to ensure any competition law concerns are fully addressed.

11.10 NHS Dorset CCG has and will continue to take into account its duties under the NHS Act and other relevant legislation including the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013.

11.11 NHS Dorset CCG has ensured that its Public Sector Equality duties have been met in the proposed clinical models with Equality Impact Assessments being developed for the new service models to identify and address any equality issues arising.

12. Conclusion

12.1 The Governing Body is asked **approve** the recommendations contained within the frontis.

APPENDICES	
Appendix 1	Engagement Activity
Appendix 2	Acute Hospital Service Summary
Appendix 3	Evaluation Criteria
Appendix 4	Options Evaluation Summary
Appendix 5	Programme Timelines
Appendix 6	Patient Benefits

Appendices

Appendix 1: engagement activity

A high level summary of engagement activity undertaken to date is outlined below and is ongoing:

- **29,000 pieces of feedback themed and used to inform the “Need to Change”.**
 In November 2014, at the start of the CSR consideration was given to what local people had already been saying. Bournemouth University was commissioned to analyse 29,000 qualitative pieces of feedback collected through 4 Dorset-wide surveys. They reviewed themes around access to services (time and location), integrated working and communication. The outcomes were shared with all working groups and used to inform the need to change.
- **12 Patient (Carer) and Public Engagement Group (PPEG) meetings – providing feedback at all stages of the CSR.**
 In December 2014 the PPEG was formed. The group comprises about 20 local people with a wealth of life-experience across Dorset's geography, demography and diversity. It is chaired by a National Patient Leader and meets regularly, providing feedback at all stages of the CSR. Views fed directly into assurance, reference and clinical working groups. Key outputs include:

 - Requesting a public facing “Need to change” document (produced Jan 2015).
 - Directly informing the development of the CSR Evaluation Criteria (Feb 2015).
 - Designing consultation principles for the CSR (March 2015).
 - Producing a “Guide to person-centred discussions” – shared widely with clinical working group, clinical delivery groups and community vanguards (December 2015).
- **Pan Dorset Engagement Leads Forum set up – representatives from 18 partner organisations.**
 In December 2014 the pan Dorset Engagement Leads Forum was set up. This forum is attended by engagement leads from health and social care providers, the local authorities, the voluntary sector, public health Dorset, Healthwatch Dorset, NHS England (South) and South West Ambulance and Dorset Fire and Rescue. The forum was set up to share information, intelligence and approach to engagement, to align work, to reduce duplication and act as a professional group for developing, critiquing and enhancing participation across the county. This approach was applied collectively to the CSR.
- **Public Meetings hosted across the initial CSR design phase – attended by 525 local people and filmed to reach out to a wider audience, including the working well, seldom heard etc.**
 During the initial design phase of the CSR the same information that was shared with clinicians and other working groups was shared with the PPEG and through a series of public meetings. A trio of public meetings were held in December 2014, January 2015 and February 2015. One of each trio was filmed to enable

the messages to be shared more widely, providing opportunity for information and involvement via the website, Facebook and twitter to a wider audience, including the working well, seldom heard, etc.

- **Information and opportunity for involvement provided at 84 forums, meetings and events.**

Across the CSR information and opportunity for involvement has also been provided to thousands of people at numerous forums, meetings, and public shows. These included voluntary sector health and care forums, learning disability groups, equality and diversity forums, Dorset Youth Council, etc.

- **3,900 Health Involvement Network (HIN) and 150 Supporting Stronger Voices members - regularly informed and involved.**

Information and opportunities for involvement around the CSR regularly sent to HIN members via the CCG "Feedback" bulletin. 150 CCG patient, carer, lay and public representatives invited to 6 monthly forums with CSR as a standing agenda item.

- **Engagement with NHS West Hampshire CCG**

CSR presentations given to Involvement Steering Group, New Forest Locality and Patient Public Engagement Group. Information communicated regularly. CSR patient/carers survey in New Forest area - 277 survey responses received and shared with NHS Dorset CCG.

- **CSR and Young People**

CSR poster co-designed with young people. 2 x CSR young people's conferences co-designed and co-hosted with young people in October and November 2015.

- **Views collected across the CSR.**

Across the CSR comments and questions have been collated for further consideration as appropriate. Recently, the strongest themes were presented in an information walk through at 9 public engagement events around community services.

- **Simple animation of the "Need to Change" produced and shared with over 4,100 people. 95% understand the need to change.**

In response to suggestions from PPEG, the public and Healthwatch Dorset a simple 3 minute animation illustrating a) the need to change b) what is being done about it and c) how people can get involved was produced in October 2015 – to reach out more widely to the working well, the seldom heard, the hard to reach etc. This has been viewed by over 4,100 people and those who completed a simple feedback survey 95% said that having watched the animation they understand why local health and care services need to change.

- **9 locality based Integrated Community Services (ICS) public engagement events were hosted in March and April 2016. 339 local people attended providing 2,162 pieces of feedback.**

In response to the need to co-design integrated community services with local people a series of 9 public engagement locality based events were held across

8.1

Dorset in March and early April 2016. This is an important stage in on-going engagement or participation work in Dorset – with a vital local community focus. The focus of each event was to listen and learn from local people, with lived-experience and knowledge of each area, exploring what they felt we need to consider when developing health and care services in their particular area of Dorset. Their views were also sought on emerging models of care. A high-level overview was shared at Clinical Working Group 9. The 2,162 pieces of feedback have been collated and themed and 9 individual reports and a master report produced. Feedback is being shared to inform emerging models and local people will then be updated.

- **Engagement “roadshow” being planned for June and July 2016.**
Local people have asked us to come to where they are and to provide engagement opportunities across a wider geographical area. During June and July 2016 we will be covering a wide area of Dorset’s geography in a mobile vehicle – providing information and an opportunity for people to provide us with their feedback, views, concerns and questions. As with all previous engagement work - all views will be used to inform emerging models and options that will be taken back out to public consultation.

Appendix 2: acute hospital service summary

Planned Care and Emergency Hospital summary of services

Urgent and emergency care	<ul style="list-style-type: none"> 24/7 Consultant led A&E with 14/7 consultant presence Trauma unit Hyper-acute cardiac* Non-interventional cardiac * Hyper-acute stroke service * Stroke unit and stroke rehabilitation Emergency surgery 24/7 Acute medical admissions Acute oncology
Planned and specialist	<ul style="list-style-type: none"> Level 3 Critical Care High volume lower risk planned and day case surgery including cancer Planned medical interventions/admissions e.g. chemotherapy Networked single Dorset cancer service Interventional radiology Outreach radiotherapy Outpatients and diagnostics
Maternity and Paediatrics	<ul style="list-style-type: none"> Urgent decision (within 6 months) to integrate services between DCH and Yeovil District Hospital resulting in one site delivering consultant led obstetric care and one site with midwifery led unit; one site delivering inpatient paediatric service and one site with paediatric assessment unit. If no integration with YDH then Dorset wide network with move to Midwifery Led Unit and Paediatric Assessment Unit (as per RC recommendation) Special Care Baby Unit (>32 week)
Long term conditions, frailty and End of Life care	<ul style="list-style-type: none"> Integrated frailty service Primary and community care services on site Step up, step down beds Mental health care services (not inpatient beds)

*Services provided 24/7 across Dorset on a networked basis Indicative no. of beds: ~320 - 360

Major Emergency Hospital Summary of services

Urgent and emergency care	<ul style="list-style-type: none"> 24/7 consultant delivered A&E with major trauma 24/7 hyper-acute cardiac, stroke 24/7 consultant delivered emergency surgery in line with NCEPOD* recommendations Acute medical admissions 24/7 Gastrointestinal bleed rota Acute oncology
Planned and specialist	<ul style="list-style-type: none"> Level 3 Critical Care Higher risk low volume planned care including cancer 24/7 interventional radiology Outpatients and diagnostics Networked single Dorset cancer service
Maternity and paediatrics	<ul style="list-style-type: none"> 24/7 High risk obstetrics unit for maternity Alongside midwifery led unit 24/7 Inpatient consultant delivered paediatrics Local Neonatal unit level 2
Long term conditions, frailty and End of Life care	<ul style="list-style-type: none"> Integrated frailty service Primary and community care services on site Mental health care services (not inpatient beds)

*National Confidential Enquiry into Patient Outcome and Death
Indicative no. of beds: ~900 - 1,100

Major Planned Care Hospital summary of services

**Urgent and
emergency
care**

- 24/7 Urgent Care Centre (as part of Dorset's Urgent Care Services) – GP led with consultant input in networked arrangement with integrated GP out of hours services.
- Sub-acute medical admissions (up to 30%)
- Rehabilitation beds

**Planned
and
specialist**

- High volume lower risk planned and day case surgery including cancer
- Enhanced planned recovery unit
- Planned medical interventions/admissions e.g. chemotherapy
- Outpatients and diagnostics
- Networked single Dorset cancer service

**Maternity
and
paediatrics**

- Antenatal and postnatal care
- Children's therapies and outpatients

**Long term
conditions,
frailty and
End of Life
care**

- Integrated frailty service
- Primary and community care services on site
- Step up, step down beds
- Mental health care services (not inpatient beds)

Indicative no. of beds: ~180 to 300

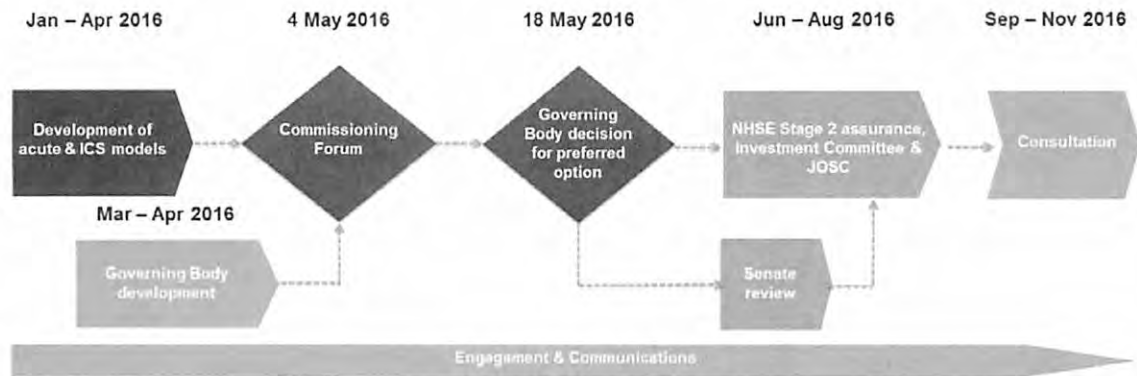
Appendix 3: evaluation criteria

Criteria ¹	Sub-criteria	Description
1	Quality of care for all	
	▪ Clinical effectiveness	▪ Improved delivery against clinical and constitutional standards, access to skilled staff and specialist equipment, comparison of current clinical quality of sites
	▪ Patient and carer experience	▪ Improved patient and carer experience (overall holistic/personalised care, respect and involvement in decisions and consistency) with excellent communication and improved estate
2	Access to care for all	
	▪ Safety	▪ Expected impact on excess mortality, serious untoward incidents
	▪ Distance and time to access services	▪ Impact on population weighted average travel times (blue light, off-peak car, peak car, public transport) to reflect average impact for emergency and elective treatment and total impact for more isolated and/or rural populations
3	Affordability and value for money	
	▪ Service operating hours	▪ Ability of model to facilitate 7 day working and improved access to care out of hours
	▪ Patient choice	▪ No. of sites delivering emergency, obstetrics, elective, outpatients, diagnostics; no. of Trusts with major hospital sites
4	Workforce	
	▪ Capital cost to the system	▪ Capital requirement to achieve required capacity & quality
	▪ Transition costs	▪ One off costs (excl. capital & receipts) to implement changes
5	Deliverability	
	▪ Net present value	▪ Total value of each potential option incorporating future capital and revenue/cost implications and compared on like-for-like basis
	▪ Meet license conditions	▪ Meets regulatory requirements e.g. surpluses generated by each Foundation Trust
6	Other (e.g., research and education)	
	▪ Scale of impact	▪ Potential impact on current staff and retraining required
	▪ Sustainability	▪ Likelihood to be sustainable from a workforce perspective, facilitating 7 day working and taking into account recruitment challenges and change in what work force does i.e. ability to ensure sufficient people with the right skills in the right places?
7	Loss of Dorset workforce	▪ Potential impact on staff attrition due to change
	Expected time to deliver	▪ Ease of delivering change within 3-5 years
	Co-dependencies with other strategies	▪ Alignment with other strategic changes (e.g. Better Together, national and local NHS strategies) and provides a flexible platform for the future
8	Disruption to education & research	▪ Disruption to Research and Education
	Support current & future education & research delivery	▪ Support for current and developing research and education delivery e.g. meeting college standards of training individuals and service specifications

Appendix 4: options evaluation summary

	Quality of Care			Access to care for all							Affordability & Value for Money					Workforce			Deliverability		Research & Education
	Clinical effectiveness	Patient & carer experience	Safety	Time to access green services	Time to access yellow services	Time to access elective services	Service operating hours	Patient choice	Capital cost to the system	Transition costs	I&E	Net Present Value 20yr (£m)	Scale of impact	Sustainability	Loss of Dorset workforce	Expected time to deliver	Co-dependencies				
<div><ul style="list-style-type: none">- NCH/elective- LCH/elective centre- LCHV/elective centre</div>	++	++	++	+	-	+	++	+	+	+	-	+	++	++	+	+	++	+			
<div><ul style="list-style-type: none">- NCH/elective- LCH/elective centre- LCHV/elective centre</div>	++	++	++	+	+	+	++	+	++	+	-	+	++	++	+	+	++	+			

Appendix 5: Programme timelines



Appendix 6: Patient Benefits

High level criteria	Benefit
Quality of care for all	<ul style="list-style-type: none"> • Care centred around the patient • Meeting patients' physical and mental health needs • Improved outcomes: morbidity and mortality • Saving more lives by having 24/7 consultant on site led care • Provide centres of excellence • Right care in the right place at the right time • Improved communication between clinicians across the health community • Ensuring people have a positive experience of care • Provide seamless integrated care • Meeting national quality standards for key specialist services • Reduced hospital admissions • Reduced length of stay • Increased focus on prevention and wellbeing
Access to care for all	<ul style="list-style-type: none"> • Care delivered closer to home for more people • More services available 7 days a week • More services available for 24 hours a day • Easier access to hyper-acute and specialist services • More services delivered in the community
Sustainability and value for money	<ul style="list-style-type: none"> • Closing predicted financial gap of £158 million per year by 2021 using: <ul style="list-style-type: none"> ➢ new models of care ➢ cost avoidance ➢ in-house productivity improvements • Increased efficiency and reducing variation • Further savings beyond 2021 through prevention
Workforce	<ul style="list-style-type: none"> • Sustainable workforce with availability 24/7 where appropriate • Attract and retain high calibre staff to Dorset • Greater focus on multidisciplinary working • Improved efficiency of working practices and reduced pressures on workforce • Sufficient volumes of care per consultant to maintain skills and expertise
Deliverability	<ul style="list-style-type: none"> • A solution that can be largely implemented within 5 years • Service models supported by national

8.1

High level criteria	Benefit
	guidance and best practice <ul style="list-style-type: none"> • Support from national bodies
Other (e.g. research and education)	<ul style="list-style-type: none"> • Improved opportunities for training and education of clinicians in Dorset with networked working • Enhanced ability to attract research and development work and funding • More able to adopt new technologies, techniques and treatments

BOARD OF DIRECTORS MEETING – 27 MAY 2016

PART 2 AGENDA - **CONFIDENTIAL**

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

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

Timings		Purpose	Presenter
11.00	1. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 29 April 2016		All
11.05	2. MATTERS ARISING		
	a) To provide updates to the Actions Log		All
	- Update on junior doctor risks and impact – <i>Tony Spotswood</i>		
	- Non-Executive Directors – <i>Jane Stichbury</i>		
	- Well led review self assessment Draft 1 – <i>Sarah Anderson</i>		
	- Update on STF Performance Trajectories – <i>Richard Renaut</i>		
11.30	3. STRATEGY AND RISK		
	a) Workforce Strategy (paper)	Information	<i>Karen Allman</i>
	b) Clinical Services Review (paper)	Information	<i>Tony Spotswood</i> To Follow
	c) Vanguard Update	Discussion/ Decision	<i>Tony Spotswood</i>
	d) Sustainability and Transformation Plan (paper)	Information	<i>Tony Spotswood</i>
	e) Facilities Business Case (paper)	Decision	<i>Richard Renaut</i> To Follow
	f) EPMA Recommendation Report	Decision	<i>Stuart Hunter</i>
12.30	4. GOVERNANCE		
	a) SBAR Report – FOI Compliance	Discussion	<i>Peter Gill</i>
12.45	5. QUALITY		
	a) <i>Issues not dealt with in Part 1</i>		
	6. PERFORMANCE		
	a) <i>Issues not dealt with in Part 1</i>		
12.50	7. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff		
	b) Reflective Review		

2.00pm Blue Skies Session: Automation opportunities (PG)