

A meeting of the Board of Directors will be held on Friday 1 April 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		
	Tony Spotswood, Karen Allman, Nicola Hartley, Christine Hallett, Steve Peacock		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 26 February 2016		<i>All</i>
	b) To provide updates to the Actions Log		<i>All</i>
8.40-8.45	3. MATTERS ARISING		
	a)		
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) CQC Inspection: Trust Action Plan (paper)	Approval	<i>Paula Shobbrook To follow</i>
	d) 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) Stroke Services Quarterly Update (paper)	Information	<i>Richard Renaut</i>
	c) Report from Chair of HAC (verbal)	Information	<i>Dave Bennett</i>
	d) Quality Report (paper)	Discussion	<i>Paula Shobbrook</i>
	e) Report from Chair Finance Committee (verbal)	Information	<i>Ian Metcalfe</i>
	f) Finance Report (paper)	Discussion	<i>Stuart Hunter</i>
	g) Report from Chair Workforce Committee (verbal)	Information	<i>Derek Dundas</i>
	h) Workforce Report (paper)	Discussion	<i>Derek Dundas</i>
	i) Medical Director's Report (verbal)	Information	<i>Basil Fozard</i>
10.25-10.40	6. STRATEGY AND RISK		

a) Vanguard Progress Report (verbal) Information *Paula Shobbrook*

b) Annual IG Briefing (paper) Information *Peter Gill*

10.40-10.45

7. GOVERNANCE

a) Monitor Quarter 3 Report (paper) Information *Sarah Anderson*

8. NEXT MEETING

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

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

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

11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

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

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



Part I Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Board of Directors** held on **Friday 26 February 2016** in the Macmillan Seminar Room, Christchurch Hospital.

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Dave Bennett	(DB)	<i>Non-Executive Director</i>
	Basil Fozard	(BF)	<i>Medical Director</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Stuart Hunter	(SH)	<i>Director of Finance</i>
	Ian Metcalfe	(IM)	<i>Non-Executive Director</i>
	Steven Peacock	(SP)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
	Bill Yardley	(BY)	<i>Non-Executive Director</i>
In attendance:	Sarah Anderson	(SA)	<i>Trust Secretary</i>
Staff	Nicola Bowers	(NB)	<i>Directorate Matron, Elderly Care</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Vicky Douglas	(VD)	<i>Human Resources Manager</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NHa)	<i>Director of Organisational Development</i>
	Nicky Manns	(NM)	<i>Ward Sister, Stroke Unit</i>
	Alison Murguia	(AM)	<i>Clinical Leader, Dermatology</i>
	Catherine Ovington	(CO)	<i>Stroke Research Nurse</i>
	Dr Carole Pound	(CP)	<i>Bournemouth University</i>
	Lisa Pigott	(LP)	<i>Sister, Christchurch Day Hospital</i>
	Abby Radley	(ARa)	<i>SALT, Stoke Unit</i>
	Dily Ruffer	(DR)	<i>Governor Coordinator</i>
	Dorothy Shire	(DS)	<i>Admissions Clerk, Dermatology</i>
	Jackie Thomas	(JT)	<i>Healthcare Assistant, Stroke Unit</i>
Public/ Governors	Derek Chaffey	(DC)	<i>Public Governor</i>
	Carole Deas	(CD)	<i>Public Governor</i>
	Bob Gee	(BG)	<i>Public Governor</i>
	Paul Higgs	(PH)	<i>Public Governor</i>
	Doreen Holford	(DH)	<i>Public Governor</i>
	Paul McMillan	(PM)	<i>Public Governor</i>
	Don McQueen	(DM)	<i>Member of Public</i>
	Keith Mitchell	(KM)	<i>Public Governor</i>
	Margaret Neville	(MN)	<i>Representative of the Friends of the Eye Unit</i>
	Roger Parsons	(RP)	<i>Public Governor</i>
	Rashad Paracha	(PR)	<i>Member of Public</i>
	Alan Radley	(AR)	<i>Public Governor</i>
	Hank Rogers	(HR)	<i>Member of Public</i>
	Guy Rouquette	(GR)	<i>Public Governor</i>

Apologies	Caroline Troy	(CT)	<i>Member of Public</i>
	Brian Young	(BY)	<i>Public Governor</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Derek Dundas	(DD)	<i>Non-Executive Director</i>

11/16 **DECLARATIONS OF INTEREST**

Action

BY declared his interest as a Non- Executive Director (NED) for 'Platinum Skies Living Limited', part of the Quantum Group, and his subsequent resignation as Chair and designated member of Christchurch Fairmile Village LLP Steering Board with immediate effect. JS advised the Board that a meeting would take place with BY to consider the interest and any potential conflicts with his role as a NED at the Trust. The Board will be kept up to date with developments.

12/16 **Minutes of the meeting held on 29 January 2016 (Item 2a)**

The minutes were **approved** as an accurate record.

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

- 05/16 (a) mixed sex breaches occurred in January due to emergency bed pressures. Further information was provided in the performance report.
- 06/16 (a) TS outlined the Executive resource provisions for the Vanguard Project noting that some additional posts had been agreed and remaining posts were being considered. The establishment of the programme management team and for key posts will be finalised once resources are approved. The level of detail of support for the roles was queried. TS advised that individual directors should voice any concerns.
- 07/16 (a) the Race Equality Scheme was considered in further detail at the Workforce Committee meeting. The staff survey results will be incorporated and more detail will be brought back to the Board.
- 108/15 (b) the IAO action plan is progressing and the Trust is in dialogue with the Clinical Commissioning Group (CCG). The Board recognised the tight deadlines and the risk if the Trust is not compliant.
- 108/15 (g) Work is in progress and the plan will be brought back in April.
- 98/15 (a) the values based appraisal for the medical workforce will be implemented from 1 April 2016. It will be actively monitored through the revalidation process.

13/16 **MATTERS ARISING**

(a) CQC Report Update (Item 3a)

The Trust received 3 reports overall. Christchurch Hospital was rated 'good' for all services in all domains. The report for Royal Bournemouth Hospital recognised the significant improvements made since the last inspection however was rated as 'requires improvement.'

The Board highlighted their disappointment with the overall rating but emphasised that the Trust was on an improvement journey. The positive themes identified included that staff were engaged and that the clinical leadership model had taken grip. The quality summit, on 4 March, will provide an opportunity to meet with local authorities, Poole Hospital and the CCG to discuss and address external factors.

The Trust will focus on addressing the issues identified within the report including the consistency of compliance, the completion of risk assessments, checks for emergency equipment and medicines management. Tackling the flow of patients will also ease pressures within the Emergency Department (ED). The Board supported that the consistency of compliance with Trust policies and procedures would be addressed through the Organisational Development work.

The positive result in the improvement journey was acknowledged and that the Trust is taking responsibility to address issues identified. The inspection experience had been positive and the Trust was able to address some inaccuracies within the ratings; although some remained the Trust is committed to moving forward. The Board were advised that to achieve a 'good' rating, three indicators needed to be changed. Going forwards the 'use of resources' and 'well led' domains will require preparation.

The Trust's ambition to be recognised as 'good' working to 'outstanding' with no complacency was emphasised. It was proposed that the Monitor well- led governance self-assessment was utilised to measure improvements ahead of the next inspection to ensure it is embedded within the organisation. The peer review programme will also support the process providing transparency. It was agreed that the overarching assessment would be remitted to the Healthcare Assurance Committee.

PS

The Board expressed thanks to all staff and to PS for coordinating the process. The positive media coverage and wider appreciation of the positive report was also noted.

14/16

STRATEGY AND RISK

(a) Draft Trust Objectives 2016/17 (Item 4a)

The draft Trust Objectives had been reviewed to incorporate comments provided by Board members. Further additions were to include that the estate was to remain safe at all times and to ensure financial sustainability for 2017/18. It was noted that the targets for the quality objectives were yet to be finalised by HAC and that section 5 needed to be aligned with the 18 week Referral to treatment (RTT) target, to reflect the national requirement. The recommendation for the appraisal timetable will be difficult and will require executive support.

Subject to the incorporation of the additional references the Board **agreed** the Trust Objectives for 2016/17, as a marker for all staff within

the organisation. It was confirmed that the annual plan and objectives would be integrated into and monitored through the board assurance framework, reviewed by the HAC.

(b) Monitoring of Performance against Trust Objectives (Item 4b)

The Trust Objectives had been reviewed against the third quarter and provided to the Board for information. The key challenge to address patient flow through the hospital to support achieving the ED 4hr target was emphasised. Board members were asked to be cognisant of the Trust's comparative performance as the 10th best performing Trust.

The item was **noted** for information.

(c) Final Workforce Plan (Item 4c)

The granularity for work streams was provided within the paper and it was noted that this would take time to address within the organisation.

The recent staff survey results were positive and staff felt supported noting greater access to resources. A series of work streams are being developed through the Workforce Transformation Steering Group and there is focus on affording a workforce for the future. The exit process data is yet to be reviewed however it will support the retention plan. The nursing themes identified from the data included a lack of flexibility and these are being addressed by Matrons.

The plan will be incorporated with the Vanguard project to improve the work across boundaries and with key providers. A formal linkage between the programs will be required in order to achieve some of the significant savings. Further work will be completed on the structures and benchmarking to provide scope and clarity in early spring. The vacancy review has been put in place during the interim and the benefits of the overseas recruitment are being reviewed.

The workforce scheme will provide significant savings and sustainability and will be monitored heavily from April. The structure and resources are being worked through to ensure that individual areas are being supported with workforce planning. An update will be provided at the end of April to ensure progress is being made. The Board requested that any resource concerns were flagged and support would be provided to support the scheme. The plan was **noted** for information.

KA

(d) Draft Annual Plan (Item 4d)

It was agreed that the aspect of financial sustainability was to be included within the plan and seven day services. The Trust will focus on achieving the four standards identified with a view to be compliant by 2017/18.

Board members discussed the lack of clarity of definitions from

regulators and NHS England. The detail for the next submission and base line will need to be reviewed and the outcome standards are also being pushed to balance the context.

The plan was **noted** for information and comments were welcomed before submission.

ALL

(e) Vanguard Progress Report (Verbal)

The update was summarised for the Board:

- The 7 clinical groups are concluding their work to identify leads to take the project forwards;
- 8 clinical work streams have been agreed;
- There is support for developing the outline case for the integrated pathology service over the next 13 weeks across the three Trusts;
- The draft reports from the Royal Colleges have identified options for Obstetrics and Paediatric services going forwards and the development of services outside of Dorset;
- TS will be meeting with the national team in April to review progress and interviews will be taking place for the Programme Director;
- Infrastructure is being put in place but resources from NHSE are yet to be approved. The NHSE funding decision will concern a joint work programme on emergency flow across the three Trusts with dedicated resource.

(f) CSR Update (Verbal)

The developments were outlined and included:

- The draft strategic plan is being developed to support the NHS 5 year forward plan;
- The ambition of the Clinical Commissioning Group (CCG) is to submit an option in June;
- There is significant concern about the out of hospital strategy which needs to be addressed and developed. Neither organisation feels engaged in the work however it will influence the rate of patients being admitted to the green site;
- If all organisations are not sufficiently developed it will be difficult to take a preferred option forward;
- The draft Royal College reports have been published for Paediatrics and Obstetrics but are subject to factual accuracy;
- The cost of the Poole purple site has increased to £62 million. The proposal to reduce the cost of the Poole Hospital purple site with orthopaedic work at the RBH Green site has been rejected;
- Concerns about the assessment process are on-going.

Non- Executives raised concern about the process and that the original purpose of the review was being overlooked. The Board **noted** the update.

GOVERNANCE**(a) Council of Governors Overview of meeting 3 February 2016) (Item 5a)**

JS outlined that three new governors were welcomed to the Council of Governors. The key theme from the meeting included was that governors identified patient moves as the quality indicator for this year, that the strategy committee would support CQC and there was to be a higher profile for the engagement programme and further developments around listening events.

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

The themes identified within the meeting included:

- Clarity needs to be provided about the links between mandatory training and the link to increments;
- Issues with electronic handover sheets to be addressed;
- Food provision for staff and patients in the west wing was raised;
- Staff Governor listening events will be taking place from May 18 and were welcomed by the Board;
- Staff have welcomed Executives working in departments and request that this is extended;
- Sensitivities around pay and emphasis on a robust management for sickness;
- To provide a report outlining the information about the health and wellbeing initiatives at the Trust.

KA

(b) Patient Story (Verbal)

The team from the Bournemouth University Stroke team and members of the Stroke Unit presented the patient story which focused on humanising care for stroke patients. The principles are grounded in EU philosophy and concern the environment and the way we interact with each other.

The team emphasised the importance of building relationships and provided examples of everyday occurrences and objects that help to make patients feel more comfortable to open up about the care they need. Examples included providing a patient with a cup of tea during a busy night shift.

The department have designed a humanising tree with examples of good humanising care where it has made a difference to patient experience. Staff are encouraged to give value and feedback when examples are seen on wards. It concerns giving value to what is already there by embedding values and rewarding small changes in care given. As a result staff feel more valued and this impacts upon

retention and staff contribution. Humanising care champions are being appointed to support and nurture the progress and integration. The team are also working on a transferable strategy for humanising care which can be implemented in other areas in the Trust. It was noted that a study within surgery would identify opportunities for learning.

The link to the cultural audit and the importance of cascading learning was discussed. The team were congratulated on their achievements and the powerful examples that embodied the Trust's vision. The Board supported the roll out of the process throughout the Trust.

(c) Complaints Report (Item 6c)

The criteria to pause the timescale for responses to complaints was agreed at HAC. The Board **received** the report.

17/16

PERFORMANCE

(a) Performance Exception Report (Item 7a)

The themes from the report were highlighted:

- Infection control performance was above the threshold;
- The Trust was close to achieving the 62 days cancer trajectory for the quarter and huge progress has been made;
- ED 4 hour target- struggling to achieve the 95% standard and performance was currently at 92%. The Trust is committed to achieving the standard. The QI work will improve capacity through the front door work stream;
- Older Persons Medicine – the results from the external review on delayed transfers of care have been delayed but the findings will support improvements;
- Improvement in length of stay and a reduction in the number of outliers compared to last year;
- Mixed sex breaches related to the clinical choice of specialty for patients. The Trust is working to address any issues;
- Diagnostics- the Trust is optimistic that the trajectory can be achieved by the end of March and the Trust will therefore achieve the JAG accreditation;
- Cardiac and Radiology pressures- processes are being reviewed;
- Stroke- rated as category B. The Trust is compliant with the evidence based quality standards together with humanising care and progressing towards an A grade;
- Referral to treatment - the standard is being achieved but there are significant pressures and concerns around contract setting. Performance for the next quarter will be at risk;

The Board commended the work to address performance within endoscopy, which had been achieved two months ahead of schedule, in light of increased pressures. It was requested that a summary of the themes identified within the external reviews was provided to the Board.

RR

(b) Report from Chair of HAC (Verbal)

The Chair summarised that over the last 12 months the Committee had been focused on addressing areas of variability and that this had started to improve as a result of the leadership from the Heads of Nursing and increased sharing of good practice.

It was emphasised that the Trust needed to continue to focus on the leadership model within areas of concern such as call bell response, discharge planning and risk assessment compliance.

(c) Quality Performance (Item 5c)

The Board were advised that two serious incident panels had been arranged. There had been a drop in the safety thermometer performance as a result of an increase in patients being admitted with pressure ulcer damage. A new QR code system within ED will be trialled to increase Friends and Family Test electronic feedback and staff engagement had increased.

(d) Staff Survey (presentation)

The staff survey results were presented to the Board and the following key themes highlighted:

- 1600 staff responded and the overall response rate had improved;
- Staff engagement had been benchmarked and the Trust performed well in comparison to other NHS Trusts and locally;
- Top strengths included- adequate equipment to complete work, appraisals and their value;
- Weaknesses- fewer staff had completed their appraisals at the time, physical violence from patients, harassment and bullying, level of pay, fewer staff had completed mandatory training in the last 12 months;
- Improved communication with senior management and visibility,
- The Trust scored within the top 20% of Trusts;
- Bullying and harassment had reduced however the rate of bullying and harassment not reported had increased;
- Staff are more positive about recommending the Trust as a place to work and to recommend services to family;
- Q4 Friends and Family Test data will be linked to the survey results.

The Board discussed the rise in the lack of reporting of experiences of harassment and bullying and requested further detail to understand the issues within areas. It was agreed that this would be incorporated into the cultural audit along with the CQC assessment. The presentation will be circulated to the Board and governors.

**KA/
NHa**

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

The Chair advised that the Trust was on trajectory to achieve the Cost Improvement Plan (CIP). There had been an increase in the use of tier 3 agency as a result of an increase in activity. It was emphasised that the Trust needed to be able to access staff at alternative levels.

An under spend of £4m was reported within OPM as a result of staff engagement with commercial services. Schemes are being worked up to achieve the target in 2016/17 however and resources will remain challenging. It was highlighted that the Christchurch project was within budget and on time and was an exemplary example.

(f) Finance Report (Item 7f)

The Board were advised that the Trust was on target to deliver within the plan and was ahead within month 10. The budget plans for next year have been signed off and the internal plan will be dependent upon the buying activity for next year although there are issues nationally to be addressed. The Trust will be meeting with the CCG and it is hoped that a contract will be in place by the end of the financial year or a PBR contract will need to be considered.

(g) Report from Chair Workforce Committee (Verbal)

The appraisal recommendation to impose a shorter time period for completion of appraisals from April to September was outlined. Discussions are on-going about education and training and improvements have been made within careers and work experience. The appraisal compliance target should be reviewed to 90% of eligible staff within 6 months. It was noted that the Workforce Race Equality Scheme will be reviewed together with the staff survey results and that the Freedom to Speak Out guardian arrangements were still being confirmed.

(h) Workforce Report (Item 7h)

The Board were advised that there had been no red flags which had been formalised for January although it had been a difficult month for staffing and agency had been authorised. TIU was opened to provide additional capacity and pressures were mitigated. Sickness levels had marginally improved. Further information will be provided to the Board upon receipt of the internal audit report.

(i) Report from Chair Audit Committee (Verbal)

The Chair advised that the internal sickness management report would be provided at the next Board meeting. Progress was noted with clinical audit and work is underway to incorporate this into job planning. With regards to IT processes and the implementation of EDM, lessons had been learnt however a culture of accepting non-compliance had been identified and needed to be addressed.

**Agenda
item**

(j) Medical Director's Report – Dr Foster (Item 7j)

The Board were informed that the Trust was benchmarking fifth within its peer group and performing well in comparison to neighbouring hospitals. The commissioned reviews were outlined and that mortality would be considered in detail together with the pathways. With regards to readmissions, performance was statistically lower together with length of stay and the Trust was benchmarking well. The Board **received** the positive report.

18/16 DATE OF NEXT MEETING

1 April 2016 at 8.30am in the Conference Room, Education Centre, The Royal Bournemouth Hospital

19/16 Key Points for Communication:

1. CQC
2. Staff Survey
3. Patient Story

20/16 QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC

1. The variance in the nursing skill mix for registered nurses was queried and the impact on the skill level in the nursing workforce going forwards. PS highlighted that the skill mix was reviewed every six months to assess wards and in practice. The lack of Band 5 nurses across the UK was emphasised however it was noted that the Trust was working internally to train Band 3 and 4 nurses. PS expressed that patient care was paramount.
2. The definition of being bullied was queried in comparison to an individual 'being managed'. KA confirmed that this theme would be considered when the data was reviewed in detail. Focus groups were held following the survey results last year and it was identified that staff actually felt pressured rather than bullied and areas have implemented new processes to alleviate pressure.
3. The Trust's overall objective to be the most improved trust by 2017 was raised and the methodology to link trajectories with objectives was questioned. TS advised that the objective formed an aspiration for the organisation. The Trust will chart its performance against a range of national audits, the CQC assessment, the cultural audit work, and National Patient Surveys to assess performance and benchmark improvements. A summary of the Trust objectives and the methodology to measure Trust progress against them will be provided. **TS**
4. It was queried why the plans to integrate back office staff could not be implemented during the interim to the Vanguard. TS advised that this was true of all services and not just back office. The intention will be to make progress across all areas in the near future.

There being no further business the meeting closed at 10:50am.
AH 26.02.2016

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
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.
	(c)	<u>Final Workforce Plan</u>			
		Provide an update on progress with the plan and flag any resource concerns as they arise.	KA	April/Agenda item	
	(d)	<u>Draft Annual Plan</u>			
		Board members to provide any comments before submission of the plan.	ALL	17 March	Comments received
	16/16	QUALITY IMPROVEMENT			
	(a)	<u>Feedback from Staff Governors</u>			
		Provide a consolidated initiative about the resources for staff wellbeing	KA	Complete	Information will be provided in the Workforce paper.
	17/16	PERFORMANCE			
	(a)	<u>Performance Exception Report</u>			
		Provide a summary of the themes affecting performance identified within the three external reviews to the Board.	RR	Complete	This will be included within the Performance report, covering ED, frailty pathway and Delayed transfers of care.
	(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.	NHa/KA	In progress	Work on-going.

RBCH Board of Directors Part 1 Actions February 2016 & previous

	(i)	<u>Report from Chair of Audit Committee</u>			
		Provide the sickness internal audit report to the Board once finalised.	Agenda item	April meeting	Report still being finalised
	20/16	QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC			
	3.	Provide a summary of the Trust objectives and the methodology to measure Trust progress against them.	TS	17 March	To be provided to April CoG
29.01.16	04/16	QUALITY IMPROVEMENT			
	(e)	<u>Internal Peer Review</u>			
		Review the implementation of improvements through relevant Board Committees.	Committee Chairs		On-going
	05/16	PERFORMANCE			
	(d)	<u>Financial Performance</u>			
		Present the progress on the Private Patient developments to the Board.	SH	Not yet due	On 1 April agenda
	07/16	GOVERNANCE			
	(a)	<u>Race Equality Scheme</u>			
		Provide Executive support to the areas identified within the plan and to increase further development of diversity.	KA/Execs	In progress	
18.12.15	108/15	PERFORMANCE			
	(b)	<u>Report from Chair of HAC</u>			
		Ensure that the actions on the IG plan are prioritised to drive forward to achieve compliance.	Execs/PG	In progress	The IAO action plan is progressing and the Trust is in dialogue with the Clinical Commissioning Group (CCG)
	(g)	<u>Workforce Report</u>			

RBCH Board of Directors Part 1 Actions February 2016 & previous

		Develop and agree a retention plan.	Execs/KA	In Progress	An outline of the plan will be developed and discussed at Executive Directors and reviewed at the workforce committee.
27.11.15	100/15	PERFORMANCE			
	(c)	Quality Performance Report			
		Consider the use of an integrated quality and performance report in the future.	Execs	BoD Dev March	Use of data and trend analysis covered in March Board development session.
	98/15	MATTERS ARISING			
	(a)	Provide the Board with an update on the progress with incorporating the values into clinical appraisals.	BF	In progress	Progress has been made and further detail will be provided as developments continue.

Key:

	Outstanding
	In Progress
	Complete
	Not yet required

Item 4c

CQC Inspection:
Trust Action Plan

REPORT TO FOLLOW

Board of Directors Part 1

1 April 2016

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

BOARD OF DIRECTORS

Meeting Date and Part:	1 st April 2016 – part 1
Subject:	Complaints report
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing Anton Parker, Information Manager
Details of previous discussion and/or dissemination:	HAC 29 th March 2016
Action required:	The paper is provided for information
Executive Summary: <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 (February 2016) is 44% against a standard of 75% (12 out of 27 complaints were closed within the 25 working day time). 2. Parliamentary Health Service Ombudsman (PHSO) YTD confirmed investigations remains at 8 3. 28 formal complaints were received in month. 	
Relevant CQC domain:	All domains
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	N/A

Formal Complaints

1. Introduction

This summary paper includes information on formal complaints received, acknowledged and responded to times in month (February 2016). Complaints and clinical claims are presented by directorate 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

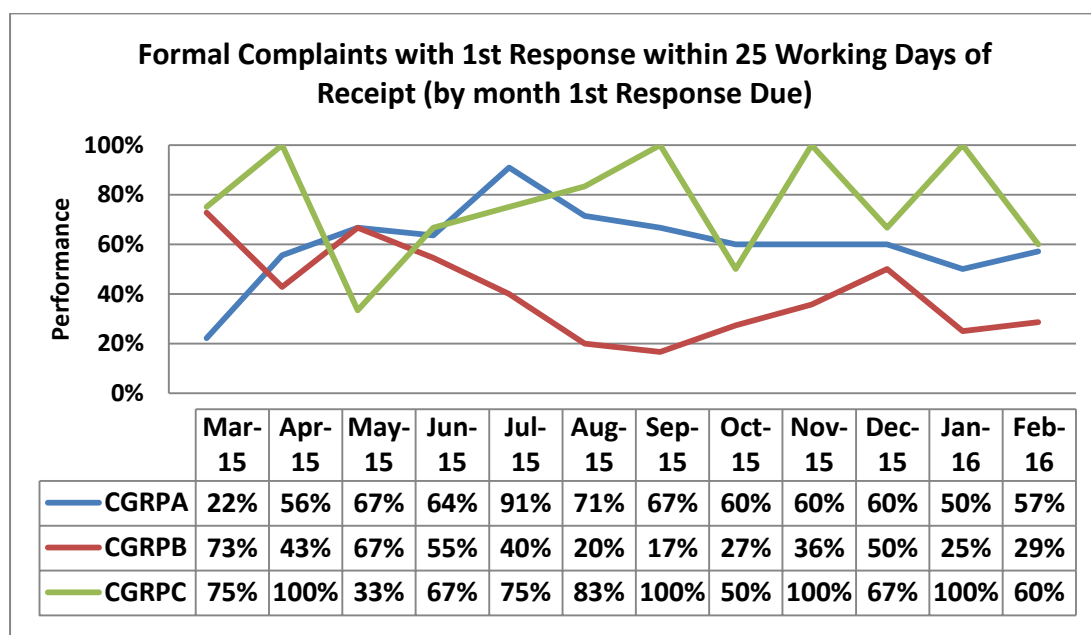
- 28 formal complaints were received in February 2016.

3. Acknowledgement and response times

Acknowledgements to the patient/carer/relative may be by telephone/letter and email within the timeframes to acknowledge the complaint. This remains largely consistent meeting the 100% Trust target.

Responses to complaints should be within 25 working days (quality strategy standard of 75%), which is monitored monthly at the Healthcare Assurance Committee. For February on aggregate the response times was 44% (12 out of 27 complaint responses due were within 25 working days)

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



Directorates requiring the most focus and support to close complaints within the 25 working day deadline are medicine and older people's medicine. Responses are being chased. Response time improvement remains a strong focus.

4. Themes and trends – Complaints received

The highest recurring theme for complaints in February 2016 was quality/suitability of care with complaints in this field in all three care groups.
Actions are being taken through care group and directorate leadership teams.

5. Recommendation

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

Meeting Date and Part:	1 st April 2016 – Part 1
Subject:	Performance Report March 2016
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Monitor: urgent care review letter and action plan 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	The Board is requested to note the performance exceptions to the Trust's compliance with the 2015/16 Monitor Framework and 'The Forward View into Action' planning guidance requirements
<p>Executive Summary:</p> <p>The attached Performance Indicator Matrix shows performance exceptions against key access and performance targets for the month of February 2016. This is at the Board as compliance against these standards is a regulatory and contractual requirement.</p> <p>The report also includes benchmark data for ED and the report and action plan relating to the Monitor Delivery Team review of urgent care is attached in the Reading Pack.</p> <p>Against the Monitor KPIs, we expect to be non-compliant against the Cancer target. The expected position for 62 days cannot yet be indicated as the outcome of a small number of treatments and diagnosis will impact on compliance.</p> <p>Non-compliance is expected against the ED 4 hour target, though benchmarking indicates strong performance compared to others. The C Difficile target will also be non-compliant.</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>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>
<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. <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>A risk assessment is also being completed for RTT due to a reduced performance.</p>

Performance Report March 2015/16 For February 2016

1. Introduction

This report accompanies the Performance Indicator Matrix (see Board Reading Pack). The focus here is the Trust's actual and predicted performance exceptions against key access and performance targets. *Forward View into Action – Planning for 15-16*, the *Monitor Risk Assessment Framework (RAF)* and our contracts, plus additional measures, such as for diagnostics and planned patients, represent our Key Performance Indicators.

Weekly performance monitoring is currently being reviewed with a view to including Statistical Process Control (SPC) methodology where this would be beneficial, predominantly where improvement work is underway or where the impact of variation may be significant (e.g. referrals). As this develops, this information will be included in the Performance Report where this would aid understanding or assurance.

2. Monitor Risk Assessment Framework for 2015/16

The below shows the final position for Q3 and current predictions for Q4 against the key Monitor indicators.

Monitor Compliance Framework

		15/16			
		Q1	Q2	Q3	Q4
Target or Indicator (per Risk Assessment Framework)	%	Actual	Actual	Actual	Pred
Referral to treatment time, 18 weeks in aggregate, admitted patients	90			NLR	NLR
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95			NLR	NLR
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				
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					

Performance for ED 4 hours for Q4 to date is currently at 91.3%¹. This is due to the continued challenge of non elective activity at over 10% and additional pressures in January resulting from norovirus, together with the increase in delayed transfers of care. RBCH benchmarks well compared to other trusts but will not meet the 95%

¹ As at 21 Mar 16

standard in Q4. These continued pressures are likely to challenge performance going into 2016/17.

The cancer 62 day target is a handful of patients either way to being compliant for Q4. Final outturn will be dependent upon exact numbers of further treatments and cancer diagnoses confirmed. The joint prostatectomy pooling and backlog recovery programme with Dorset County Hospital fully commenced in February and additional long waiting patients have been booked through the Quarter. This is agreed with our commissioners, with the understanding that this might impact negatively on overall RBCH performance. The recovery trajectory has now been agreed with commissioners and full recovery of performance is expected by Q2 2016/17.

The knock-on impact of the Urology recovery programme has been seen on the 31 day target and this is not expected to be compliant this quarter, with a commissioner agreed recovery trajectory expected by Q3 2016/17.

For the C Difficile indicator where there was evidence of lapses in care, we have now exceeded the full year “stretch” trajectory with YTD confirmed cases now at 16 (target of 14 full year). It should be noted that our numbers are similar to last year and we continue to benchmark low to comparable Trusts.

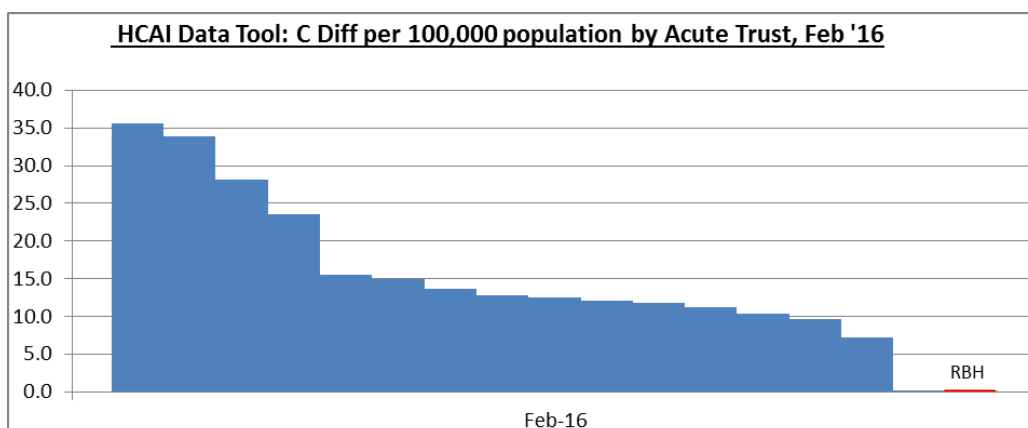
We have also for the first time this year, become compliant with 6 week diagnostic standard which is likely to be included in Monitor and Tripartite KPI monitoring in 2016/17.

3. Infection Control

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

By the end of January 2016, we reached the annual allowed target of C Diff cases due to lapses in care (14). In February, 1 more case was reported and a further in March. This has resulted in a total of 16 cases and thus non compliance for this indicator for this financial year. Our overall rate remains low (see chart).

There have been no reported cases of hospital acquired MRSA.



4. Cancer

Performance against Cancer Targets

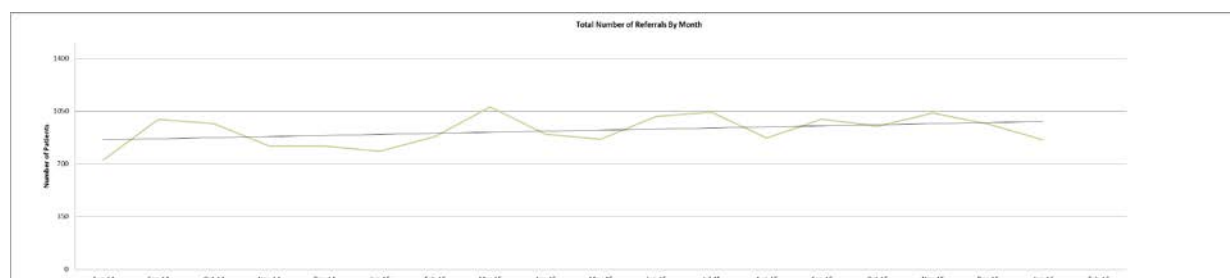
Key Performance Indicators	Threshold	2015-2016 Qtr 3	Dec-15	Jan-16
2 weeks - Maximum wait from GP	93.0%	97.0%	95.9%	98.1%
2 week wait for symptomatic breast patients	93.0%	100.0%	100.0%	100.0%
31 Day – 1st treatment	96.0%	94.9%	95.6%	94.1%
31 Day – subsequent treatment - Surgery	94.0%	94.3%	90.9%	91.7%
31 Day – subsequent treatment - Drugs	98.0%	100.0%	100.0%	100.0%
62 Day – 1st treatment	85.0%	88.6%	91.0%	84.5%
62 day – screening patients	90.0%	98.1%	95.7%	88.9%
62 day – Consultant upgrade (<i>local target</i>)	90.0%	58.3%	75.0%	0.0%

4.1 Two Week Wait

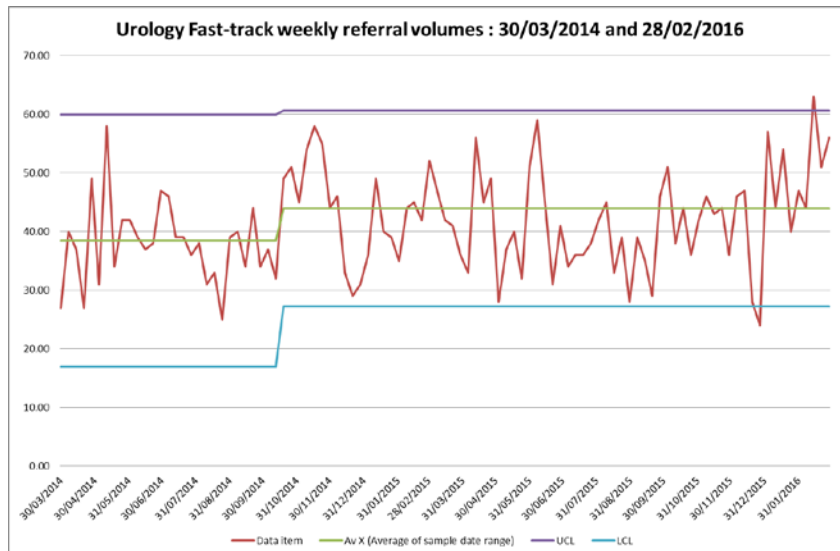
The Two Week Wait performance has been maintained. However, an increase in referrals to Urology is being seen since the commencement of the Blood in Pee campaign as well as additional demand and capacity pressures in Colorectal. These are currently being mitigated with additional capacity but do present a risk.

The release of the new Wessex Strategic Clinical Network fast track referral forms for GPs, in line with the published NICE guidance last summer, is expected to drive higher referrals in 2016/17. Referral trends are being closely monitored with additional capacity and amendment to booking schedules implemented as required. Expected growth trends are also being incorporated in our, as yet unconfirmed, contract activity negotiations.

The table below shows the trend in growing referrals. Although we saw a slight reduction in December 2015 and January 2016, the latter was 10% higher than January 2015.



The below SPC chart shows Urology fast track referrals since 2014 and the stepped increase in October 2014 when the Blood in Pee campaign was held. The next campaign commenced on 15 February and runs to 31 March and the below will continue to be closely monitored.



Note: special cause variation dates: 27/12/15 and 14/2/16

4.2 62 Day Referral/Screening to Treatment

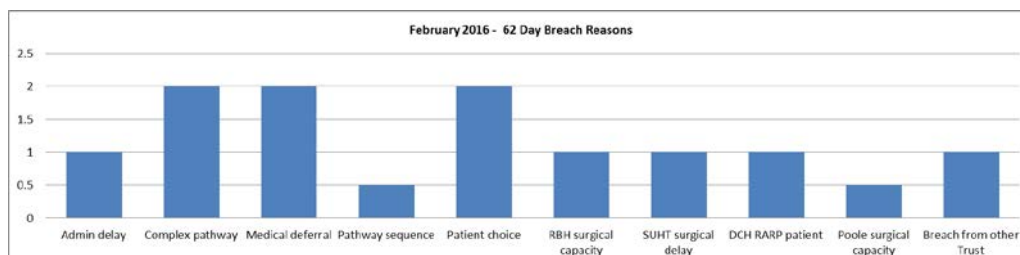
Pooling the waiting lists for robotic prostatectomy patients across East and West Dorset has now commenced along with the further additional sessions supported by Dorset County Hospital to reduce the backlog of patients waiting for this procedure. A significant reduction in waits has already been seen as a result of pooling the list. Monthly and quarterly compliance will be finalised following final scheduling of some of the additional March capacity and as some cancer diagnoses are confirmed, but this currently remains borderline on compliance.

We continue to progress the actions included in our Remedial Action Plan jointly with our commissioners and Dorset County Hospital and have an agreed recovery trajectory which anticipates full recovery in Q2. Activity and capacity to support the recovery will remain key and is being worked through in contract discussion.

Compliance for Q4 against the 62 day from screening target is also currently borderline, due to very low patient numbers. The January return of 88.9% is due to one Breast patient breaching.

The table below sets out the primary reason for 62 day breaches in February, including shared (0.5) breaches with partner trusts.

Detail of these pathways is provided to the MDTs to review whether there are opportunities for improvements to avoid future breaches. Dorset County Hospital are also reviewing their Urology diagnostic pathways prior to transfer to RBCHFT. As a result of this work, there are targeted actions such as improving flow rate service



4.3 Overall 62 day performance by specialty

Cancer Plan 62 Day Standard (Tumour) (85%)

Site	Dec-15			Quarter 3 2015/16			Jan-16		
	Total	Within Target	Performance	Total	Within Target	Performance	Total	Within Target	Performance
Haematology	4.5	4.5	100.0%	13.5	12.5	92.6%	2	1	50.0%
Lung	9	9	100.0%	20.5	18	87.8%	8	5	60.0%
Colorectal	10.5	8.5	81.0%	24.5	20.5	83.7%	7	5	76.9%
Gynae	3	3	100.0%	10	10	100.0%	3	3	100.0%
Skin	8	8	100.0%	69.5	68.5	98.6%	17	16	97.0%
UGI	6.5	6.5	100.0%	23	21	91.3%	5	5	100.0%
Urology	30.5	25.5	83.6%	106	83.5	78.8%	38	29	76.3%
Breast	12	12	100.0%	51	49	96.1%	14	14	100.0%
Others									
Head & Neck							1	1	100.0%
Brain/central nervous system									
Children's cancer									
Other cancer	2	2	100.0%	3.5	3.5	100.0%	1	1	100.0%
Sarcoma	2.5	1.5	60.0%	7	4.5	64.3%	3	3	100.0%
Total	88.5	80.5	91.0%	328.5	291.0	88.6%	97.0	82.0	84.5%

The main areas of 62 day breaches are Colorectal, Urology, Lung, Haematology and Skin. 38 patient journeys over 3 months took longer than the target, 23 of which were Urology and the next largest being colorectal.

4.4 31 First Treatment and Subsequent Surgery

Due to the focus on clearing the Urology backlog, we are continuing to see a number of breaches against the 31 day first treatment target which will impact on our overall compliance for the Quarter. The 31 day subsequent treatment performance was also non compliant at 94.1% for the same reason and remains with some risk for the quarter.

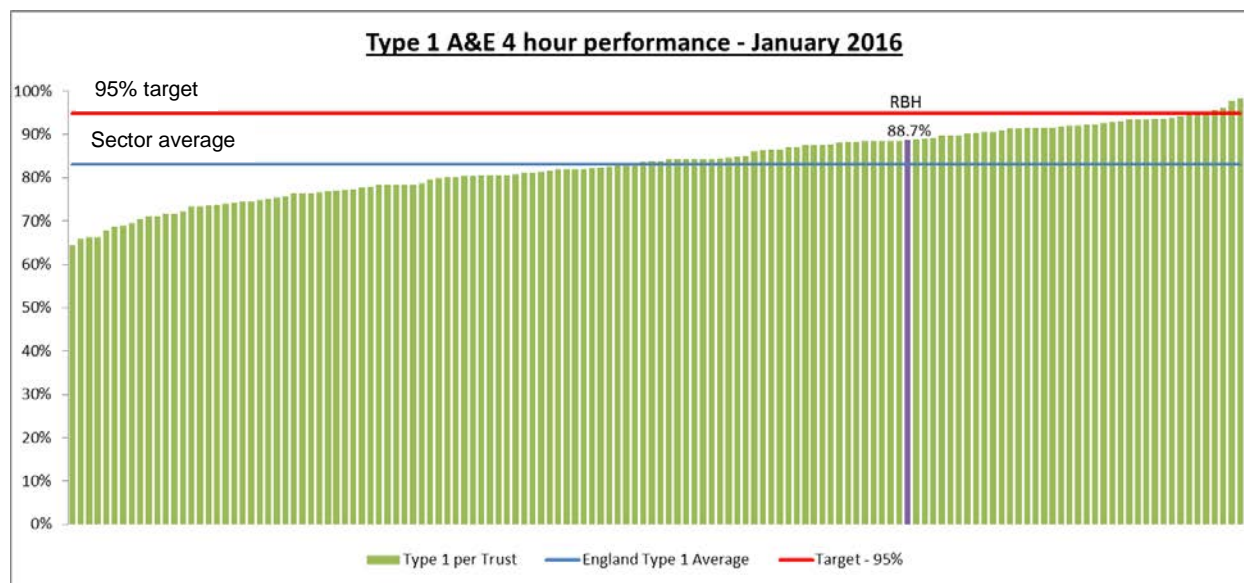
These targets are predominantly impacted when we treat the longer waiting robot prostatectomy (RARP) patients and therefore, remain at risk during the joint recovery programme with Dorset County Hospital. However, this will improve on completion of the recovery programme which is anticipated to be achieved by Q3, 2016/17 as we need to reduce the RARP wait to a 0-2 weeks.

5. A&E

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

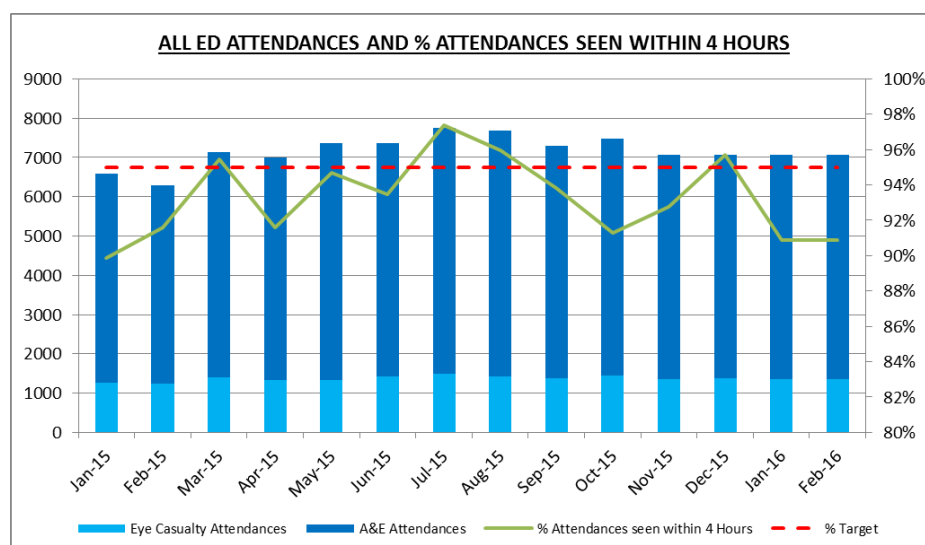
5.1 Performance and Activity

Whilst the Trust failed to achieve compliance against the ED 4 Hour target in January and February 2016, the below graph shows our January performance benchmarked against other acute trusts (for “type1” hospital ED).



Note: this data excludes Type 2 attendances, such as Eye Unit and Minor Injury Units, type 3

February and March have seen pressures with a significant increase in non elective admissions compared to last year (11.8%). This, along with a rise ED attendances (11.9% above last year) and a high level of delayed discharges, resulted in a reduction in patient flow through the hospital. This meant that the Trust missed compliance in February with the ED 4 hour target, at 92.58% (though marginally better than February 2015 – 91.59%). March though is showing a decline, both at RBH and neighbouring Trusts.



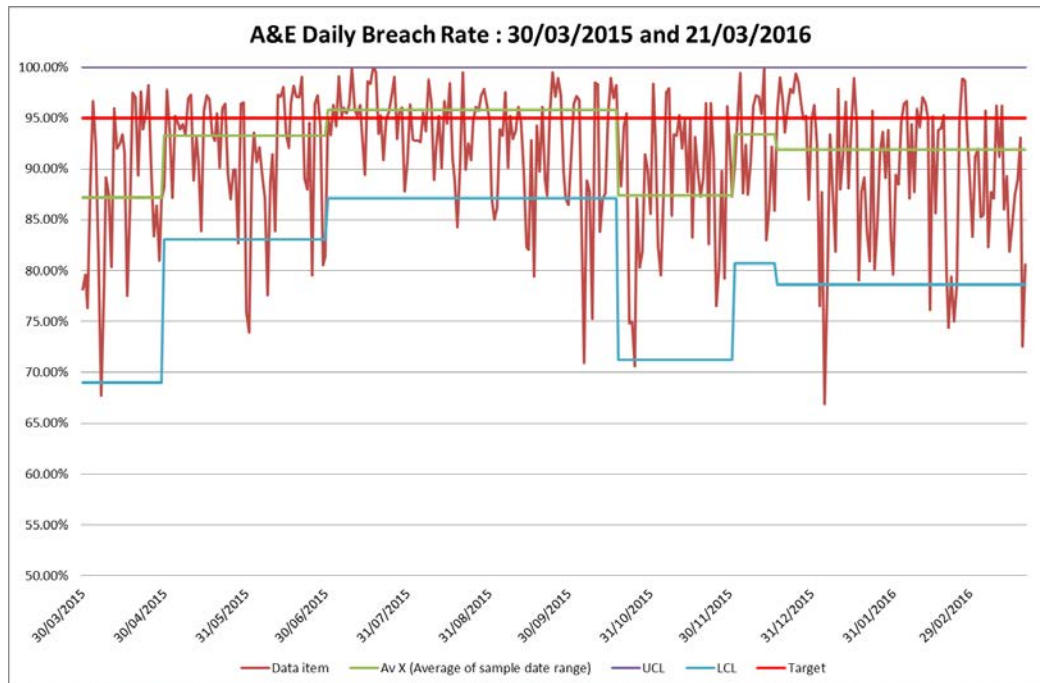
Non-Elective Activity - % variance

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Variance against 14/15	-1.2%	-0.3%	1.8%	-2.3%	0.3%	7.2%	5.2%	13.0%	1.6%	11.6%	11.8%

5.2 Progress Against ED and Trust-wide Actions

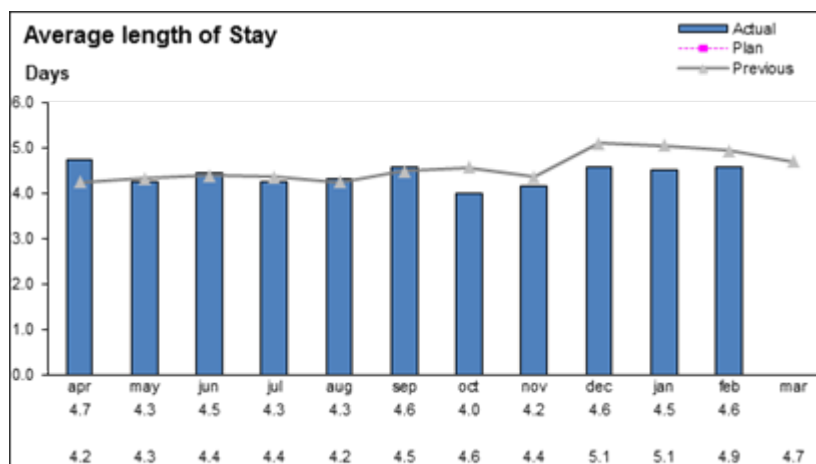
Analysis of the February performance shows 36.8% of the breaches were attributed to the inability to move patients to downstream beds, and 53.1% of delays were within the ED itself. SPC charts for performance show the positive and negative step changes in performance through the year and shows a 'normal' performance range of

between 69%-100%. Further work is underway to investigate the special cause variations (*variations outside of the normal performance limits*) and any 7-point trends (*indicating 'real' improvement or deterioration in response to a causal factor or intervention*). The team are also looking at other aspects of ED process and pathway through the assistance of SPC measurement.



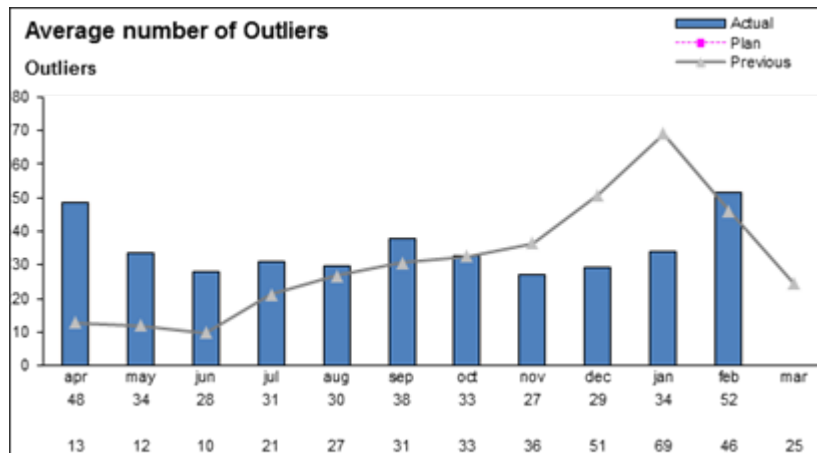
The ongoing pressures of high attendances and activity continue to be a concern and contracted activity plans alongside our significant programme of work to develop Cardiac, Older Persons' and Stroke ambulatory care models, together with the establishment of a Frailty Unit, will be key.

Positively average length of stay has remained consistently below last year's levels since October reflecting the focus on ambulatory care and short stay models which have come into their own as acuity rises from October.

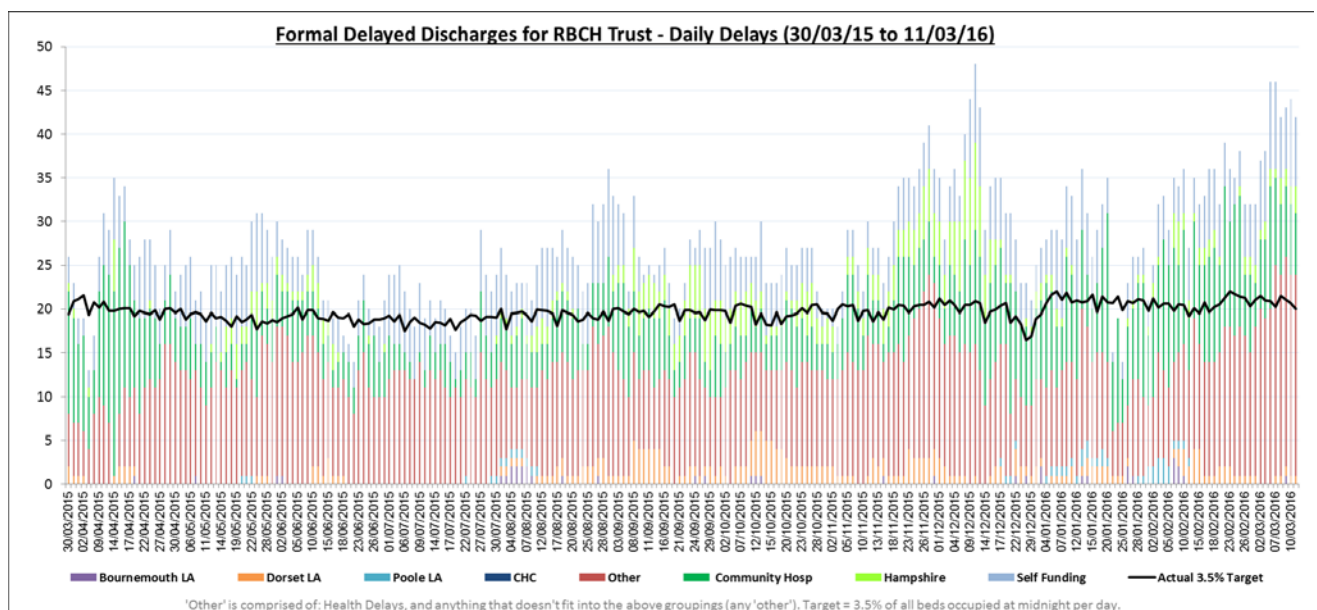


Though there are in-month peaks in outliers, especially in January, average outliers were below last year's levels from November – January. This reflects new

approaches to outlier management this year, supported by Nurse Practitioners, as well as planned winter bed opening based on better demand and capacity planning. However, the ongoing pressures have seen a continued increase in outliers, going above 2015 levels in February.



Delayed Transfers of Care together with patients 'medically fit for discharge' who are still in hospital, have remained a pressure. A peak was seen in December and the step up has predominantly remained to date. Some additional support to provide increased packages of care across health and social care was provided through January in response to the extreme pressures however, a further increase has been seen in February and March with currently no real indication of when this will reduce.



6. Learning Disability

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

We remain compliant with the requirement for healthcare access for the year to date.

7. Mixed Sex Accommodation

Minimise no. of patients breaching the mixed sex accommodation requirement

February is the seventh month of reporting under the updated MSA policy, in line with contractual agreements with Dorset CCG. 1 episode of MSA breach occasion occurred during February, affecting just 1 patient in critical care:

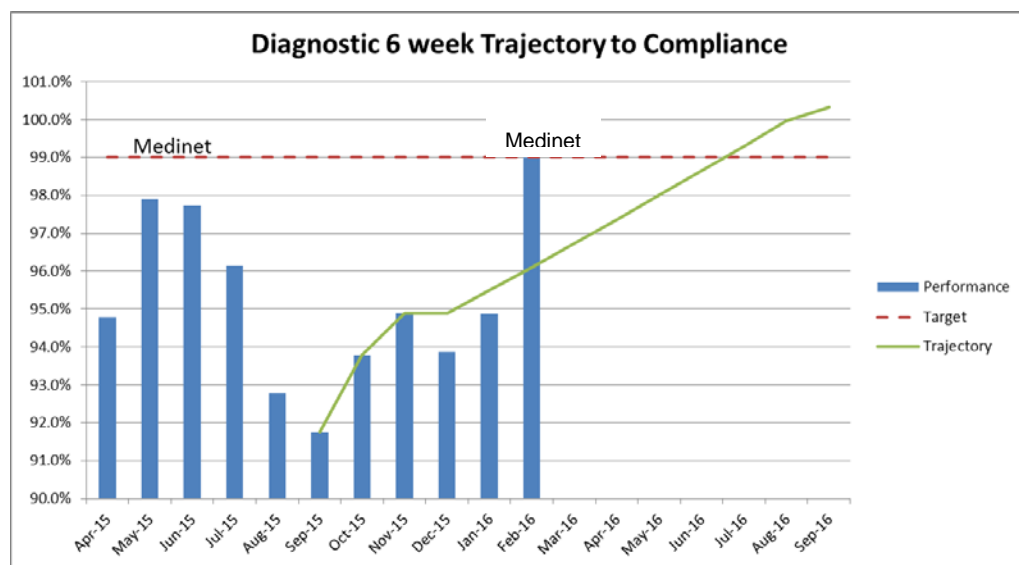
	Breach Occasions	Patients Affected
ITU/HDU	1	1

To date for Q4, there are 2 patients affected during 2 MSA breach occasions, an improvement on Q3. Reviews of each potential breach continues to be undertaken via root cause analysis (RCA).

8. Diagnostics

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

February's diagnostic result was 99.01% (against the 99% threshold). This is the first time this financial year we have hit target. This is ahead of our improvement trajectory linked to the significant improvement work and backlog reduction plan in Endoscopy. The junior doctor strikes meant a number of patients were cancelled and could not be reinstated due to the bowel preparation requirements. Joint commissioning of some additional in-sourcing capacity through February and March has supported the Trust's Endoscopy improvement trajectory which is expected to be achieved sustainably by June at the latest.



Pressures relating to medical staff shortages in Radiology and demand and capacity pressures for Urological Cystoscopies and in Cardiology, do pose growing risk to the Diagnostic 6ww target. Further work is underway on these areas going into 2016/17.

Planned Patients

In addition to our patients who have been newly referred for a diagnostic procedure, we also have patients who are on a 'planned' or 'surveillance' waiting list. These are patients that have repeated procedures on a planned basis (e.g. annually or three/five yearly). Currently we have 307 patients out of 5,940 (5.2%) who have been waiting greater than 6 weeks past their indicative due date, an improvement on January. This is predominantly due to the pressures referred to above in Endoscopy (3.3%); the other 1.8% with much smaller numbers are mainly in Urology, Ophthalmology and Cardiology. The work being undertaken in Endoscopy along with the additional insourcing will support our forward plans for reducing this. Planned patients continue to be monitored on a weekly basis, with clinical reviews of longer waiting patients being undertaken to minimise the risk of any harm.

9. Cancelled Operations

No. of patients not offered a binding date within 28 days of cancellation

We were fully compliant in February, though additional cancellations due to the Junior Doctor strikes and bed pressures will present increased challenge to the 28 day rescheduling going forward.

10. Stroke

The published Q3 SSNAP results showed we retained level B (see separate Board report). Results score was 80, just 0.1 below the threshold for a level A.

Strong team work across Radiology, ED and within the Stroke Unit continues to drive forward improvements in the service. These include ambulatory care developments and dedicated, case by case learning in relation to specific complex diagnostic patients being a key feature for sustaining success.

A full quarterly report is separately included within the Board papers.

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

92% of patients on an incomplete RTT pathway within 18 weeks
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Incomplete Pathways

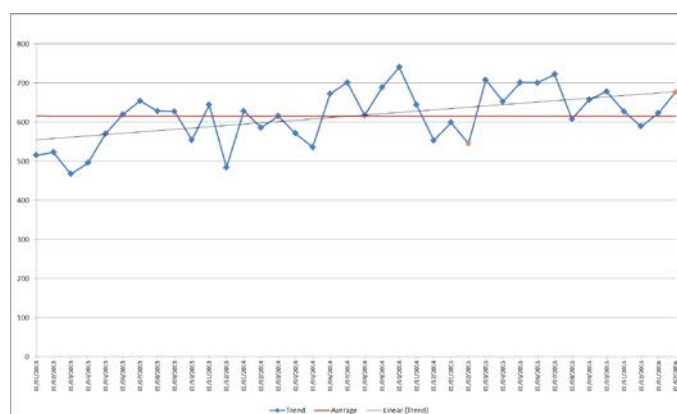
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16		
											<18 wks	Total	Performance
100 - GENERAL SURGERY	91.1%	93.0%	92.3%	91.6%	91.3%	90.5%	91.9%	92.2%	92.0%	92.0%	2395	2605	91.94%
101 - UROLOGY	89.9%	90.1%	90.0%	89.0%	88.4%	87.2%	89.8%	90.5%	86.5%	83.6%	1250	1520	82.24%
110 - TRAUMA AND ORTHOPAEDICS	89.2%	92.9%	94.2%	94.5%	93.9%	93.7%	94.8%	94.2%	92.5%	92.3%	3597	3951	91.04%
120 - EAR NOSE AND THROAT	87.8%	87.4%	90.3%	95.0%	98.4%	98.9%	98.9%	98.2%	96.3%	98.0%	387	411	94.16%
130 - OPHTHALMOLOGY	97.4%	97.3%	97.5%	96.6%	95.4%	94.8%	93.4%	93.4%	93.2%	93.9%	4020	4341	92.61%
140 - ORAL SURGERY	80.5%	73.3%	65.8%	59.5%	84.8%	98.0%	100.0%	100.0%	100.0%	100.0%	272	272	100.00%
170 - CARDIOTHORACIC SURGERY	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	4	4	100.00%
300 - GENERAL MEDICINE	93.0%	94.6%	97.6%	97.5%	96.9%	96.4%	96.9%	95.8%	96.9%	99.1%	1550	1606	96.51%
320 - CARDIOLOGY	94.6%	94.9%	95.8%	95.8%	94.2%	93.5%	95.2%	95.1%	93.8%	94.9%	1698	1789	94.91%
330 - DERMATOLOGY	84.6%	89.3%	89.1%	92.1%	92.1%	91.7%	93.8%	93.8%	96.4%	96.9%	644	660	97.58%
340 - THORACIC MEDICINE	97.9%	99.4%	97.9%	98.6%	99.4%	100.0%	99.2%	99.5%	98.6%	97.7%	377	388	97.16%
400 - NEUROLOGY	86.7%	85.6%	81.7%	87.7%	96.7%	97.5%	97.0%	98.8%	96.5%	99.5%	221	223	99.10%
410 - RHEUMATOLOGY	97.1%	96.1%	94.5%	96.9%	98.1%	98.6%	98.7%	98.4%	98.0%	97.2%	977	998	97.90%
430 - GERIATRIC MED	97.8%	97.0%	98.1%	97.0%	99.2%	98.5%	100.0%	98.9%	100.0%	98.6%	140	140	100.00%
502 - GYNAECOLOGY	91.8%	95.1%	92.5%	92.1%	92.3%	93.7%	94.6%	94.0%	94.1%	93.0%	905	992	91.23%
Other	97.3%	97.7%	97.6%	95.6%	95.9%	97.7%	96.4%	97.9%	96.8%	97.0%	1295	1359	95.29%
TOTAL	92.6%	94.0%	94.4%	94.3%	94.1%	94.1%	94.5%	94.5%	93.7%	93.7%	19732	21259	92.82%

As expected our performance against the Incomplete Pathways target remained compliant in February, however, reduced to 92.8% in February, with 19,732 patients waiting less than 18 weeks. This decline in % under 18 weeks is predominantly due to the significant increase in the waiting list for patients who require elective admission, particularly in: Urology, Orthopaedics and Ophthalmology. Some additional pressures are also being seen in Cardiology, Gynaecology, plus the visiting specialities of ENT and Allergy. To date, we have performed well on our non admitted pathways, however, overall speciality pressures together with the national requirement to reduce premium waiting list activity are increasingly presenting a risk to our RTT performance.

Urology has continued to build some backlog for patients awaiting routine procedures due to the need to secure timely capacity for cancer pathways. Additional capacity is currently being provided through outsourcing to prevent further delays to patients.

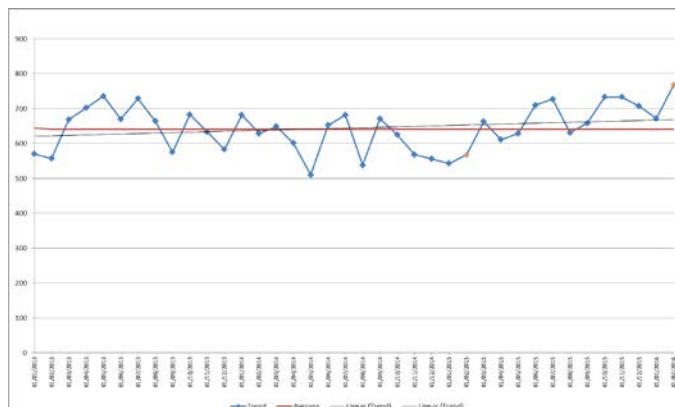
Orthopaedics has also seen an increase in admitted backlog together with an increase in referrals, however, this is expected to improve with some additional theatre capacity for consultant specific cases and additional outpatient capacity which is reducing pathway delays.

All theatre capacity is also affected by shortages in anaesthetists, junior doctors strikes and cancellations (or not backfilling gaps) due to emergency pressures.

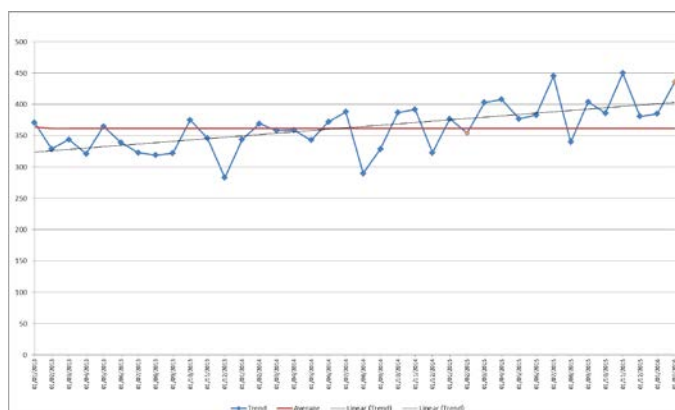


Orthopaedic GP Referral Trend – 6% increase Mar 15-Feb 16 compared to same period 14/15

In addition, Urology, Ophthalmology and Cardiology have experienced an increase in fast track and/or routine referrals, which together with some capacity reduction, has led to an increase in backlog. Additional sessions are underway to prevent further deterioration. Key work has commenced with commissioners to assist with the efficient management of Ophthalmology referral demand.



Ophthalmology GP Referral Trend -15% increase Mar 15-Feb 16 compared to same period 14/15



Cardiology GP Referral Trend- 12% increase Mar 15-Feb 16 compared to same period 14/15

Finally, we will continue to monitor the Dermatology service performance as referrals increase and to work with our commissioners to improve referral pathways to ensure appropriate referrals to the service.

12. Sustainability and Transformation Fund Update

NHS England South have released their expectations in relation to performance trajectories for 2016/17 which, in short, requires us to meet all the targets. The Trust has submitted the outline trajectories. To date these are pending ongoing contract negotiations and based on expected demand, capacity and risks for next year. The latest estimated trajectories will be updated within the verbal update for the Board Performance Report.

13. External Reviews

The Monitor Delivery Team recently undertook a review of our ED and urgent care flows in support of Monitor's review of the trust. The report has been received which overall was positive and highlighted the engagement in and transformation being progressed. An action plan has been developed to address the recommendations

within the report (both attached in the Board Reading Pack). A CCG commissioned review of delayed transfers of care and a Frailty Network review of our Older Person's and Frailty pathways (at our request) have also been recently undertaken and reports and action plans are being finalised.

14. Recommendation

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

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

BOARD OF DIRECTORS

Meeting Date and Part:	1 st April 2016 – Part I
Subject:	Stroke Services Update
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Claire Stalley, Stroke Services, Neurotherapy & Stroke Manager
Details of previous discussion and/or dissemination:	Monthly Performance Reports
Action required: Approve / Discuss / Information/Note	The Board of Directors is asked to note the progress made against the measures of an effective stroke service.
Executive Summary: This report covers: <ul style="list-style-type: none"> • Most recent published stroke performance using Sentinel Stroke National Audit Programme (SSNAP) (October to December 2015) • Our internal assessment of performance for January and February (Quarter to date) • Detailed actions the service is taking to improve performance to SSNAP Level A with no domain area below C, and the majority moving to B or better and to sustain performance in the upper quartile. 	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	1. to offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care 2. to promote and improve the quality of life of our patients 3. to strive towards excellence in the services and care we provide 4. to be the provider of choice for local patients and GPs 5. to listen to, support, motivate and develop our staff
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	Compliance with Stroke Standards on Assurance Framework. No new risk

Stroke Services Update

1. Introduction

This paper covers:

- Most recent published stroke performance using Sentinel Stroke National Audit Programme (SSNAP) (October to December 2015)
- Our internal assessment of performance for January and February (Quarter to date)
- Detailed actions the service is taking to improve performance to SSNAP Level A with no domain area below C, and the majority moving to B or better and to sustain performance in the upper quartile.

The quality of stroke services is measured via the quarterly SSNAP results. To achieve a SSNAP Level B a score of 70+ is required, and for a SSNAP Level A, a score of 80.1+ is required. The more recent SSNAP results cover October to December 2015, in which RBCH achieved SSNAP Level B and a score of 80. This is an improvement on our score for Q2 which was 78. Nationally for Q3, 12% of Trusts achieved a SSNAP level A which is 26 Trusts. Given we missed out on a SSNAP Level A by 0.1, it is likely we are the 27th or 28th Trust and therefore within the top 15%. National results will be available later in March to confirm our actual position. For our performance to date for Q4, we are achieving a SSNAP score of 84 which is a SSNAP Level A (see Annex).

To put this result into local context with the rest of Wessex; in the last regional SSNAP report (Q2) for routinely admitting teams, The Royal Hampshire County Hospital and RBCH were the only Trusts to achieve a SSNAP Level B; all other Trusts achieved a SSNAP Level D. For Q2, Dorset County Hospital achieved a SSNAP score of 47.8 and Poole Hospital a score of 46.5. Regional results for Q3 will be available later in March.

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

2. Summary of SSNAP

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

Quarter	Jan-March 2015	Apr-June 2015	July-Sept 2015	Oct-Dec 2015	National Average
SSNAP level	C	B	B	B	
SSNAP score	66.7	70.3	78	80	
Case ascertainment band	B	A	A	A	A

Quarter	Jan-March 2015	Apr-June 2015	July-Sept 2015	Oct-Dec 2015	National Average
<i>Audit compliance band</i>	C	B	A	A	B
1) Scanning	C	C	B	C	B
2) Stroke unit	C	C	C	C	C
3) Thrombolysis	C	C	C	C	C
4) Specialist Assessments	D	D	C	C	C
5) Occupational therapy	A	A	A	A	B
6) Physiotherapy	A	B	B	B	B
7) Speech and Language therapy	A	B	B	A	D
8) MDT working	B	B	B	B	C
9) Standards by discharge	B	B	B	A	B
10) Discharge processes	A	A	A	A	B

We have sustained or improved performance in all domains except for scanning which we dropped from a Level B to a C. Detailed analysis of our breaches/delays with scanning for Q2 indicate that this was due to a high number of patients who had a late diagnosis of stroke i.e. stroke was not considered as a differential diagnosis on admission, the patient was later found to have had a stroke by which point the required timescales to complete the scan had passed. It is important to note that patients being missed on admission are those primarily with atypically presenting strokes. We have now introduced a feedback process, where for any patient found to have a delayed diagnosis of stroke the Stroke Consultants will go and discuss the patient case with those involved in their care on admission to improve recognition and management of atypically presenting strokes.

The Stroke Service has been and continues to undertake a number of Quality Improvement (QI) projects, primarily to improve timeliness of all assessments and interventions and to improve flow through the stroke unit. For Q4 to date (see Annex), we are delighted that, as a direct impact of this work, 2 more domains are showing significant improvements. Thrombolysis has improved from Level C to Level B with our median door to needle time for thrombolysis reducing from 90 mins (Q4 14/15) to its current in Q4 of 52 minutes. As a result of our MDT working QI project, we have introduced twice daily MDT Hyper-acute Stroke Unit rounds. This has seen a reduction in median time to initial Occupational Therapy and Physiotherapy assessments of 3 hours, and initial Speech and Language Assessment by 2 hours, this has enabled our performance for Domain 8 to increase from Level B to Level A.

3. Other stroke actions

We are pleased to have the opportunity to work together with our Stroke Service colleagues at Poole Hospital and Dorset County Hospital for the Stroke Vanguard work stream as part of the Acute Care Collaboration Vanguard for 'Developing One NHS in Dorset'. We have had a number of productive meetings. Initial work will include developing a 'document of principle' stroke service specification detailing standards for future stroke service provision in Dorset that we all collaboratively agree to; completion of a baseline review of current service provision at each hospital (staffing resource, structures, processes and performance); an options appraisal for future models of service provision; and collaboration on SSNAP.

4. Stroke Performance and Delivery Plan

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

A SSNAP Level A (score of 80.1+) is certainly achievable and our ambition is to achieve no domain being lower than a Level B.

The Stroke Services performance and delivery plan details in the Annex the following for each of the SSNAP key indicators: the key indicator information with the performance required to achieve a SSNAP level A; the performance level plan for the key indicator; the latest SSNAP result; and the quarter to date performance.

5. Risk Mitigation

The new Stroke Outreach Service is delivering considerable improvements with our front door performance and ensuring all acute assessments are completed in a timely manner. It is proving considerably challenging for the team (only 4 wte) to provide such an extended service of 7am to midnight 7 days a week; there is not enough capacity to adequately cover sickness and we have had shifts in Q3 and Q4 to date that we have been unable to cover. We currently have 0.36 wte vacancy which is currently being utilised for bank shifts to help cover sickness wherever possible. We're hoping to combine this vacancy wte with Stroke Unit Nurse vacancy to create a viable post.

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

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

6. Recommendation

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

ANNEX: STROKE PERFORMANCE & DELIVERY PLAN – MARCH 2016 – ONE PAGE SUMMARY(Q4 to date results **have not been fully validated**. Where there are gaps the data is not available internally)

DOMAIN	SSNAP Q3 (Oct- Dec)	Q4 to date (Feb & Mar)	Plans	Comments/Risks
1 Scanning	C	C	<ul style="list-style-type: none"> Feedback process re. missed/delayed diagnosis of stroke 	<ul style="list-style-type: none"> Delayed identification of stroke patients due to unusual presentation – Non FAST stroke
2 Stroke Unit	C	C	<ul style="list-style-type: none"> As above re. feedback process GP Referral pathway review with ACM Stroke QI Project to address pt flow 	<ul style="list-style-type: none"> GP Referral breaches, delayed/missed diagnosis pts & delays with MFFD patients
3 Thrombolysis	C	B	<ul style="list-style-type: none"> SIM training Actions from pathway walk-through 	<ul style="list-style-type: none"> OOH delays due to radiographer being off-site and waiting for radiologist review
4 Specialist Assessments	C	C (borderline B)	<ul style="list-style-type: none"> New twice daily MDT rounds for new pt assessments 	<ul style="list-style-type: none"> Stroke Consultant - 7 day provision
5 Occupational Therapy	A	A	<ul style="list-style-type: none"> Breakfast group 'Tell your Story' Group 	<ul style="list-style-type: none"> Vacancy and maternity leave due to impact on ability to deliver required treatment intensity
6 Physiotherapy	B	B (Borderline C)	<ul style="list-style-type: none"> Exercise group 	<ul style="list-style-type: none"> Vacancy and maternity leave due to impact on ability to deliver required treatment intensity
7 Speech and Language Therapy	A	A	<ul style="list-style-type: none"> Breakfast group Lunch Group 	<ul style="list-style-type: none"> Current Band 7 Vacancy/Maternity Leave – 1.2 wte
8 MDT Working	B	A	<ul style="list-style-type: none"> New twice daily MDT rounds for new pt assessments 	<ul style="list-style-type: none"> New MDT Ax rounds will reduce time to initial therapy assessment
9 Standards by discharge	A	A	<ul style="list-style-type: none"> Induction for new staff 	<ul style="list-style-type: none"> On track
10 Discharge Processes	A	A		<ul style="list-style-type: none"> On track
Audit compliance	A	A	<ul style="list-style-type: none"> Continue NIHSS training of all staff 	<ul style="list-style-type: none"> New Stroke Specialist Nurse to commence in January which will greatly help nurse training
Case ascertainment	A	A	<ul style="list-style-type: none"> Monthly lockdown checks will be performed 	<ul style="list-style-type: none"> On track
SSNAP Level	B	A		
SSNAP Score	80	84	Note: 80.1 is an A!	

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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	Q4 (to date)	Key Improvement Actions
1.1 Proportion of patients scanned within 1 hour of clock start (A = 48%)	43% (B)	38.3% (C)	41.9% (C)	<ul style="list-style-type: none"> Main impacting factor on performance is those patients who are late diagnosis stroke i.e. missed on admission and so are not scanned within the required timescales – therefore need to introduce process of feedback to those not considering stroke as diagnosis on admission and targeted education to improve stroke recognition. Patients being missed are primarily those with non-FAST presenting stroke i.e. atypical presentation strokes Continue monthly breach analysis for any 12 hour scan breaches and review 1 hour patients to ensure those who are eligible are receiving urgent scanning in order to see where further improvements can be made Deliver stroke recognition training throughout Trust to reduce numbers of late diagnosis strokes & awareness to contact Stroke Outreach Team Promote greater understanding of the stroke targets throughout Trust to improve urgency of referral to Stroke Outreach - CT3 in ED and on-site Radiographer 24/7
1.2 Proportion of patients scanned within 12 hours of clock start (A = 95%)	90% (B)	87.8% (C)	89.5% (C)	
1.3 Median time between clock start and scan (A = < 60mins)	< 75 mins (B)	92 mins (D)	84 mins (C)	

Domain 1: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To undertake a full breach analysis for Q3 to determine the increase in median time to scan for Q3 patients and a reduction in performance (from SSNAP B to SSNAP C)	Complete	<ul style="list-style-type: none"> Confirms that the vast majority of breaches are for late diagnosis stroke – see above.
2. To implement a process of feedback to those involved in the initial care/management of patients with missed diagnosis of stroke	March 2016	<ul style="list-style-type: none"> This has started. Stroke Outreach email breach alert form to Stroke Consultants with details for any late identified stroke patient Need to develop a robust process for undertaking this – to discuss with Stroke Consultants
3. Targeted education to improve stroke recognition, particularly for non-FAST presenting stroke.	tbc	<ul style="list-style-type: none"> The areas requiring targeted education will be identified from the feedback process and learning from this.
4. Monthly breach analysis for 12 hour scan breaches to be extended to 1 hour scanning to review patients scanned against those who fit criteria.	Ongoing	<ul style="list-style-type: none"> KC to lead on this in conjunction with Stroke Outreach Team To develop action plan as required re. any emerging themes - ? to confirm whether any breaches for in-patient stroke cohort.
5. To review options to ensure all patients have their scan within 12 hours of arrival	Ongoing	<ul style="list-style-type: none"> Potential for Radiology to extending scanning hours until 10pm – linked to radiographer staying on-site. MB to keep us updated.
6. Stroke recognition training to reduce delays to stroke diagnosis including for unusual presentation stroke patients	Ongoing	<ul style="list-style-type: none"> Continue to take training opportunities (formal and informal) where possible to promote the team and service offered Update planned in May with Comms team
7. To work with Radiology as required to support development of electronic CT request form submission	As Needed	<ul style="list-style-type: none"> MB to update as required
8. Implementation of CT3 in ED and plan that X-ray Radiographers will be able to undertake CT Brain Scans	Long-term	<ul style="list-style-type: none"> The intention would be that with CT 3 in ED that someone would be on-site 24/7 to be able to undertake CT Brain scans
9. Stroke Outreach to receive a 'pre-alert' for all FAST positive patients not just those who may be for thrombolysis.	May 2016	<ul style="list-style-type: none"> Embed use of new 'Mobimed/ECS' system to inform us of possible stroke patients to move Stroke Outreach assessment earlier in stay and therefore CT requesting.

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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	Q4 (to date)	Key Improvement Actions
2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (A = 90%)	75% (B)	68.6% (C)	69.5% (C)	<ul style="list-style-type: none"> Establish a pre-alert for all stroke patients coming to RBH Review GP referral pathway for Stroke; 35% of direct access breaches in October Continue to raise awareness to contact Stroke Outreach if patient ? stroke or stroke part of differential diagnosis as 35% of direct access breaches in October were due to delayed diagnosis of stroke Immediate re-triage of any non-stroke patients on the SU to facilitate transfer off SU Stroke Quality Improvement projects – stroke ambulatory care, redesign of pathway for frail with severe stroke, review of MDT working and Complex Nutrition Project. Main impacting two impacting factors on performance are: <ol style="list-style-type: none"> those patients who are late diagnosis stroke i.e. missed on admission and so are not scanned within the required timescales – therefore have introduced a process of feedback to those not considering stroke as diagnosis on admission and targeted education to improve stroke recognition. Patients being missed are primarily those with non-FAST presenting stroke i.e. atypical presentation strokes. Delays with discharge for patients who are MFFD particularly from Hampshire SS who will not allocate/see patients until they are MFFD. Patients waiting for POC, NH, CHC etc
2.2 Median time between clock start and arrival on stroke unit (hours:mins) (A = Median < 2 hrs)	Median < 3 hrs (B)	03:33 (C)	03:21 (C)	
2.3 Proportion of patients who spent at least 90% of their stay on stroke unit (A = 90%)	85% (B)	76% (D)	82.2% (C)	

Domain 2: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Collaboration with ED/SWAST/SCAS regarding pre-alert and pre-hospital information provision for stroke patients	May 2016	<ul style="list-style-type: none"> KC in liaison with ED/SWAST and SCAS re implementation of pre-alert for all stroke patients and how this may fit with new 'Mobimed/ECS' systems. Initial mtgs held.
2. To implement a process of feedback to those involved in the initial care/management of patients with missed diagnosis of stroke	March 2016	<ul style="list-style-type: none"> This has started. Stroke Outreach email breach alert form to Stroke Consultants with details for any late identified stroke patient Need to develop a robust process for undertaking this – to discuss with Stroke Consultants
3. Targeted education to improve stroke recognition, particularly for non-FAST presenting stroke.	Tbc	<ul style="list-style-type: none"> The areas requiring targeted education will be identified from the feedback process and learning from this.
4. To trial stroke screening process for GP Referral patients (in conjunction with ACM)	R/V in March	<ul style="list-style-type: none"> To trial screening process and if high success rate then look to alter admission pathway for identified stroke patients (SU and ACM collaboration)
5. Stroke recognition/awareness training to reduce delays to stroke diagnosis including for unusual presentation stroke patients	Ongoing	<ul style="list-style-type: none"> Update in Grand Round, presentation at OPM Audit Symposium and Stroke Outreach on-going training programmes Comms Team to promote Stroke Outreach Team information
6. Stroke QI: Ambulatory Care – to introduce ambulatory care for stroke to facilitate earlier discharge from hospital including investigations and Consultant review as an outpatient	April 2016	<ul style="list-style-type: none"> Arrangements in place for Stroke Consultant time, Nurse/HCA support and carotid dopplers Discussions underway with Radiology re. Outpatient MRI and Cardiac re. 24 hour tapes
7. Stroke QI: MDT Review – to write up impact of MDT working changes and their impact	April 2016	<ul style="list-style-type: none"> Team meeting arranged for 16th March to confirm agreed impact and next steps
8. Stroke QI: Extended LOS – to undertake a case notes review/audit of patients with a LOS \geq 30 days to determine key themes contributing to extended LOS and actions to address	June 2016	<ul style="list-style-type: none"> To agree audit proforma Action plan will be developed further to completion of audit
9. To improve collaborative working with CST re. full appreciation of Stroke metrics	May 2016	<ul style="list-style-type: none"> 'Link person' now arranged from CST and initial meetings planned. Review bed use overnight and keeping empty beds at expense of AMU strokes ? Attendance at HAN meetings to help with issues re. OOH stroke pt clerking
10. To continue to work proactively with the Trust Discharge Team, Social Services and other agencies to facilitate discharge at earliest possible time	ongoing	

Domain 3: Thrombolysis - Domain Leads: Michelle Dharmasiri & Katherine Chambers

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	Q4 (to date)	Key Improvement Actions
3.1 Proportion of all stroke patients given thrombolysis (A=20%)	12% (C)	8.9% (E)*	10.5% (D)*	<ul style="list-style-type: none"> To maintain good standards of awareness of acute stroke identification and management, including thrombolysis eligibility across the Trust. To reduce door to needle times for thrombolysis treatment through engagement with all those involved in the pathway. To review all breaches to achieving thrombolysis within 1 hour of clock start to determine whether clinically appropriate delay or a process delay To use stakeholder engagement to identify training needs and areas for service improvement to optimise prompt and effective care and decision making. Review of Q2 indicates that our Door to Needle time is significantly less in hours than OOH due to delays OOH waiting for radiographer to come in and for Radiologist to report
3.2 Proportion of eligible patients given thrombolysis (A=90%)	100% (A)	93.3% (A)	100% (A)	
3.3 Proportion of patients who were thrombolysed within 1 hour of clock start (A=55%)	55% (A)	43.8% (C)	72.7% (A)	
3.4 Proportion of applicable patients directly admitted to a stroke unit within 4 hours of clock start and received thrombolysis or have a pre-specified justifiable reason ("no but") for why it couldn't be given (A = 65%)	65% (A)	68.6% (A)	69.5% (A)	
3.5 Median time between clock start and thrombolysis (A=< 40mins)	< 50 mins (B)	68 mins (D)	00:52 mins (C)	

Note*: for key indicator 3.1, patients can only be given thrombolysis if they meet the required eligibility criteria as per key indicator 3.2. For Q4 to date, 10.5% of patients were given thrombolysis which is 100% of patients who were eligible for thrombolysis, we could not have achieved higher than 10.5% for key indicator 3.1.

Domain 3: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To complete a breach analysis of all thrombolysis cases taking more than 1 hour and identify themes to be addressed	ongoing	<ul style="list-style-type: none"> To work through action plan to address any contributing factors/themes i.e. out-of-hour radiology reporting, bedside coag check to reduce waits for INR.
2. Radiology to negotiate with OOH scan reporting provider to reduce OOH thrombolysis patient scan reporting time to 15 mins	complete	<ul style="list-style-type: none"> Radiology feedback at February Stroke Board meeting that 4ways unlikely to be able to get report completed in less than 15 mins
3. Stroke Consultants and Stroke Outreach Lead to co-ordinate a thrombolysis walk-through with aim to reduce DTN time	complete	<ul style="list-style-type: none"> Review all current processes to minimise process delays for all thrombolysis calls. Plan in place to address/implement all key improvement actions
4. To support developing stroke outreach service and other staff delivering thrombolysis with skills to support thrombolysis pathway to help speed to stroke specific assessment and reduce door to needle time.	Ongoing	<ul style="list-style-type: none"> Set up regular teaching sessions for all Medical registrars to improve knowledge and skill re thrombolysis to support prompt service delivery – MD and KC. Consider SIM training for all involved in thrombolysis pathway re. thrombolysis situations and leadership/organisation of the team at each thrombolysis call. On-going supervision and competency sign-off with Stroke Outreach Team. ? consider process to feedback to Med Registrars after cases (esp OOH).
5. Deliver a robust pathway for thrombolysis for patients having stroke as in-patient to improve efficiency in these cases	TBC	<ul style="list-style-type: none"> Agree pathway for all to follow
6. To improve documentation for families re. thrombolysis and tools to support explanation of risk/benefit to support patient and relative understanding and decisions.	May 2016	<ul style="list-style-type: none"> Stroke Outreach team to draft a document for patients/relatives for PIG approval Further investigation following UKSF re tools being devised to share following a research project in Scotland.
7. To ensure thrombolysis bag always has necessary items always available and a robust regular checks are in place. Ensure safety of contents too (i.e. clarify if meds should be locked)	Ongoing	<ul style="list-style-type: none"> Contents checklist to be agreed and programme for regular checking to be confirmed Decision to be made re medication and suitability in bag in line with pathway work.
8. Embed the use of 'Mobimed/ECS' system to enable us to access paramedic information prior to arrival	May 2016	<ul style="list-style-type: none"> KC to work with Keith Childs re suitable tablet device for team and train Stroke Outreach in using the new system. Once in place, audit to ensure prep work is being done prior to patient arrival to reduce DTN .i.e. CT booked, PMH and contraindication check.
9. Consider use of tools for quick body measurements to more accurately estimate patients' weight and ensure delivering accurate dose of medication to optimise their outcome.	May 2016	<ul style="list-style-type: none"> Investigation on-going and to liaise with local trusts where this is regular practice i.e. PHT Review of potentially suitable tools.
10. To implement bedside Coag check to reduce wait for INR	May 2016	<ul style="list-style-type: none"> Investigate options for bedside coag check Review and update any relevant policies to enable use for thrombolysis

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

DOMAIN KEY INDICATORS	Plan (C)	Last SSNAP (C)	Q4 (to date)	Key Improvement Actions
4.1 Proportion of patients assessed by a stroke consultant within 24hrs of clock start (A=95%)	70% (D)	67.8% (E)	69.5% (E)	<ul style="list-style-type: none"> To undertake a breach analysis for this for Q3 and Q4 to date as 4.1 and 4.2 continues to be low performing scores. Previous analysis of breaches indicated breaches were for weekend/BH admissions, late diagnosis pts New twice daily MDT Assessment rounds to improve time to assessment Monday to Friday Explore options to deliver Stroke Consultant cover at the weekend – network approach/additional Stroke Consultant (Vanguard)
4.2 Median time between clock start and being seen by stroke consultant (hrs:mins) (A=<6hrs)	<15hrs (D)	16:28 (E)	17:14 (E)	
4.3 Proportion of patients who were assessed by a nurse trained in stroke management within 24hrs of clock start (A=95%)	95% (A)	92.2% (B)	96.2% (A)	<ul style="list-style-type: none"> Ensure 85% of Stroke Nurses are competent in NIHSS, WSS and complete these as a priority with patients on arrival to SU if they have not already been completed. Stroke Outreach to try to use 'Mobimed/ECS' to identify and review potential strokes from paramedics earlier in pathway (reduce time to stroke nurse). Review of SSNAP data collection to ensure time to stroke nurse is accurate esp for thrombolysed patients (completed Jan 16) Continue stroke awareness work via many channels to improve referrals/awareness of Outreach team.
4.4 Median time between clock start and being assessed by stroke nurse (A=< 60mins)	< 60 mins (A)	74 mins (B)	63 mins (B)	
4.5 Proportion of applicable patients who were given a water swallow screen within 4hrs of clock start (A=85%)	85% (A)	77.8% (B)	84.8% (B)	<ul style="list-style-type: none"> Sub-analysis of patients who fail WSS target to further understand the limitations and gaps in current provision Stroke Outreach; all trained to do WSS - complete Stroke Unit; all B5 and B6 nurses to be trained and competent in WSS Organise rolling programme of training in ED/SU Try to link with AMU to call Stroke Outreach and put NBM if stroke considered.... Ensure consistent/accurate documentation for patients who immediately fail WSS (i.e. too drowsy) and that this is inputted accurately into SSNAP
4.6 Proportion of applicable patients who were given a formal swallow assessment within 72hrs of clock start (A=85%)	85% (A)	97.8% (A)	98.2% (A)	<ul style="list-style-type: none"> Understand any risks to sustaining this level of performance i.e. SALT recruitment challenges SALT continue to prioritise formal swallow assessment within existing service; impact of reduced staffing should be minimal.

Domain 4: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Options to introduce 7-day Consultant ward-rounds when Stroke Consultant wte fully established	January 2016	<ul style="list-style-type: none"> • BJ/AW to review feasibility of implementing 7-day Stroke Consultant ward-rounds • Vanguard stroke
2. To undertake further breach analysis for this. Review all patients for Q3 and Q4 to date who breached being assessed by Stroke Consultant within 24 hours of clock start	March 2016	<ul style="list-style-type: none"> • Complete analysis and identify themes and appropriate action plan
3. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in WSS	Complete Ongoing with new staff	<ul style="list-style-type: none"> • Put in place a training plan to achieve 85% compliance with Band 5 and 6 Nurses • All new staff to complete training and be signed off as competent within 3 months of starting on unit
4. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in NIHSS	Ongoing as staffing allows	<ul style="list-style-type: none"> • New Stroke Specialist Nurse commences in January 2016 which will significantly help nurse training • Put in place a training plan to achieve 85% compliance with Band 5 and 6 Nurses • All new staff to complete training and be signed off as competent within 3 months of starting on unit
11. To implement changes to MDT working/organisation as per Stroke Leads Away Day on 7 th October	complete	<ul style="list-style-type: none"> • To implement changes i.e. new twice daily HASU MDT Ax, therapy/nursing teams etc

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q4 (to date)	Key Improvement Actions
5.1 Proportion of patients reported as requiring occupational therapy (A=80%)	80% (A)	81.9% (A)	76.2% (B)	<ul style="list-style-type: none"> On-going monitoring / validation of data collection to maintain “A”
5.2 Median number of minutes per day on which occupational therapy is received (A= >32 mins)	>32 mins (A)	43.6 (A)	43.4 (A)	<ul style="list-style-type: none"> Continue to ensure end dates for OT are being inputted and progress maintained via senior support and validation Build on new timetabling process introduced, to further increase efficiency of therapy planning and release time for rehab sessions via additional group work & more coordinated use of TAs Maintain consistent therapy groups on the unit
5.3 Median % of days as an inpatient on which occupational therapy is received (A=>70%)	>70% (A)	77.8% (A)	69.7% (B)	
5.4 Compliance (%) against the therapy target of an average of 25.7 minutes of occupational therapy across all patients (A=80%)	80% (A)	100% (A)	89.6% (A)	

Domain 5: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To implement therapy non clinical working practices/organisation to maximise time released for direct patient care (from away day in October).	complete	<ul style="list-style-type: none"> To review / evaluate increases in efficiency following introduction of new assessment & planning practices and continue further possible improvements (i.e. possibly linked to BETTER project work)
2. Change communication screening from FAST to NIHSS	complete	
3. Review breaches for 6.1 to understand rationale for patients being deemed not appropriate	ongoing	<ul style="list-style-type: none"> Validation processes in place and to be completed on an ongoing basis
4. Establish twice weekly OT groups (gardening and tell your story)	ongoing	<ul style="list-style-type: none"> Continue to implement lunch group daily (OT /SALT) trialling use of TAs only 3 days per week and qualified staff only 2 days per week to free up time for higher priority activities. Reintroduce 'tell your story group' weekly – OT led - ? SALT supported? With the return of spring to reintroduce gardening group, supported by TA Senior OT & SALT to plan for introduction of breakfast group as a joint venture, supported by TAs following training
5. Establish breakfast group (joint with SALT)	March 2015	
6. To implement group cancellation protocol	complete	<ul style="list-style-type: none"> Continue to maintain very low rate of group cancellation
7. Recruit to Band 6 vacancies	complete	<ul style="list-style-type: none"> Vacancies filled and staff to commence 18th January 2016

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (B)	Q4 (to date)	Key Improvement Actions
6.1 Proportion of patients reported as requiring physiotherapy (A=85%)	75% (C)	74.9% (D)	73.3% (D)	Ensuring consistent data entry for SSNAP regarding eligibility for PT; training with teams around this to ensure accuracy Continue to validate all breaches; sub analyse according to person doing initial assessment (are OT less likely to report person as needing PT??)
6.2 Median number of minutes per day on which physiotherapy is received (A=>32 mins)	>32 mins (A)	35.3(A)	35 (A)	<ul style="list-style-type: none"> Continue to ensure end dates for PT are being inputted and progress maintained via senior support and validation Build on new timetabling process introduced, to further increase efficiency of therapy planning and release time for rehab sessions via additional group work & more coordinated use of TAs Maintain consistent therapy groups on the unit
6.3 Median % of days as an inpatient on which physiotherapy is received (A=>75%)	>75% (A)	80.7% (A)	73.7% (B)	
6.4 Compliance (%) against the therapy target of an average of 25.7 minutes of physiotherapy across all patients (A=90%)	75% (C)	78% (C)	69.3% (D)	

Domain 6: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To implement therapy non clinical working practices/organisation to maximise time released for direct patient care (from away day in October).	complete	<ul style="list-style-type: none"> To review whole process (timetabling, whiteboard rounds, MDT meetings, Ax pathway, discharge summaries etc) at away day in October.
2. Review breaches for 6.1 to understand rationale for patients being deemed not appropriate	March 2016	<ul style="list-style-type: none"> All breaches are being reviewed and data fully validated. To collate information relating to reason for being not appropriate, and review for themes.
3. Re-establish regular/sustained twice weekly exercise group (seated exercise group/sit to stand group/Wii).	ongoing	<ul style="list-style-type: none"> 1 x per week exercise group established. Hannah Walker (B6) to lead on developing criteria and guidelines for groups, review competencies for staff leading groups and review processes for referring to/organising groups Audit non-compliance to understand any reasons for groups not occurring
4. To implement group cancellation protocol	complete	<ul style="list-style-type: none"> To ensure groups are only cancelled by Band 7+ staff

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q4 (to date)	Key Improvement Actions
7.1 Proportion of patients reported as requiring speech and language therapy (A=50%)	50% (A)	57.3% (A)	59% (A)	<ul style="list-style-type: none"> Improve accuracy of documentation on the data collection form for SSNAP (complete) Implement changes to screening processes and referral pathway for both speech & language impairments Update competencies for WSS practitioners to maintain robust and effective process
7.2 Median number of minutes per day on which speech and language therapy is received (A=>32 mins)	>32 mins (A)	42.5 (A)	37.8(A)	<ul style="list-style-type: none"> Extend the skill set of the therapy assistants to increase their role in delivering SALT rehabilitation. Lunch group consistently happening 5 x per week Communication group consistently happening 2 x per week Breakfast Group re-introduced on 11th February 2016 – currently 3x per week. (Aiming 4 x per week) Development of a flexible approach to delivering therapy intensity (i.e. 2 x 20 minute sessions if cannot tolerate a 40 minute session)
7.3 Median % of days as an inpatient on which speech and language therapy is received (A=>70%)	>70% (A)	65.4% (B)	65.7% (B)	
7.4 Compliance (%) against the therapy target of an average of 25.7 minutes of speech and language therapy across all patients (A=90%)	75% (B)	99.1% (B)	91% (A)	
				Main risk to Q3 performance is SALT vacancy – post recruited awaiting start date

Domain 7: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Communication Group now running twice weekly – to monitor	ongoing	<ul style="list-style-type: none"> Band 3 Therapy Assistant being trained to run group. Review progress and potentially increase to 3 x per week thereafter.
2. Therapy Assistants now supporting dysphagia patients at breakfast on a daily basis via breakfast group	Ongoing	<ul style="list-style-type: none"> To monitor compliance with this SALT to support TA's with providing this 3x days a week via breakfast group
3. Therapy Assistants to lead on carrying out Lunch Group with reduced qualified support	May 2016	<ul style="list-style-type: none"> SLT to support TAs by ensuring effective goal setting
5. To implement group cancellation protocol	complete	<ul style="list-style-type: none"> To ensure groups are only cancelled by Band 7+ staff
6. To recruit to SALT vacancy ASAP	In progress	Recruitment successful – vacancy to be filled from 29.3.16

Domain 8: Multidisciplinary Team - Domain Leads: Louise Johnson, Morwenna Gower and Nikki Manns

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (B)	Q4 (to date)	Key Improvement Actions
8.1 Proportion of applicable patients who were assessed by an occupational therapist within 72hrs (A=90%)	90% (A)	100% (A)	99% (A)	
8.2 Median time between clock start and being assessed by Occupational therapist (A=<12hrs)	<18hrs (C)	19:16hrs (D) (N.A is 22:08 hrs)	15:58 (C)	<ul style="list-style-type: none"> Monitor impact of new twice daily MDT Assessment rounds
8.3 Proportion of applicable patients who were assessed by an physiotherapist within 72hrs (A=90%)	90% (A)	100% (A)	99% (A)	
8.4 Median time between clock start and being assessed by physiotherapist (A=<12hrs)	<18hrs (D)	19:16hrs (E) (N.A. is 21:11hrs)	15:58 (C)	<ul style="list-style-type: none"> Monitor impact of new twice daily MDT Assessment rounds
8.5 Proportion of applicable patients who were assessed by speech and language therapist within 72hrs (A=90%)	90% (A)	97.2% (A)	98.8%(A)	
8.6 Median time between clock start and being assessed by speech and language therapist (A=<12hrs)	<18hrs (C)	22:06hrs (D) (N.A. is 24:01hrs)	20:30 (D)	<ul style="list-style-type: none"> Monitor impact of new twice daily MDT Assessment rounds Monitor impact of changes to language screening process
8.7 Proportion of applicable patients who have rehabilitation goals agreed within 5 days of clock start (A=80%)	80% (A)	N/A	96.5% (A)	<ul style="list-style-type: none"> Implement robust system for recording goal setting after MDT Assessment rounds
8.8 Proportion of applicable patients who are assessed by a nurse within 24hrs and at least one therapist within 24hrs and all relevant therapists within 72hrs and have rehab goals agreed within 5 days (A=60%)	60% (A)	N/A	80.2% (A)	

Domain 8: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Implementation of GAS Goal setting on the SU including staff training	Complete	
2. Therapy to support the new Integrated MDT Ax for all new patients via daily 8:30am and 3pm HASU rounds	Complete	<ul style="list-style-type: none"> To be introduced on 2nd November
3. To implement therapy non clinical working practices/organisation to maximise time released for direct patient care (from away day in October).	Complete	<ul style="list-style-type: none"> To review whole process (timetabling, whiteboard rounds, MDT meetings, Ax pathway, discharge summaries etc) at away day in October. To closely monitor impact upon performance
4. To undertake a review of all Q3 to date patients who have had initial assessment from OT/PT/SALT at > 12 hours to determine where gains can/should be made	March 2016	<ul style="list-style-type: none"> To closely monitor and determine whether new processes will improve performance for time to therapy assessment In progress; initial results indicate significant improvement for time to OT and time to PT initial assessment (median reduction of 5 hours)

Domain 9: Standards by discharge - Domain Leads: Nikki Manns and Morwenna Gower

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q4 (to date)	Key Improvement Actions
9.1 Proportion of applicable patients screened for nutrition and seen by a dietician by discharge (A=95%)	95% (A)	96.2% (A)	100% (A)	<ul style="list-style-type: none"> To review breaches quarter to date to understand reasons for breach – complete and system in place to validate
9.2 Proportion of applicable patients who have a continence plan drawn up within 3 weeks of clock start (A=95%)	95% (A)	100% (A)	100% (A)	<ul style="list-style-type: none"> To review as part of Stroke Nurses action plan to ensure all stroke patients who have persistent incontinence at 2 weeks post stroke have a full continence assessment and management plan. To implement stroke continence assessment pathway.
9.3 Proportion of applicable patients who have mood and cognition screening by discharge (A=95%)	95% (A)	98.6% (A)	98.7% (A)	<ul style="list-style-type: none"> To maintain this we need to ensure all new starters to team have induction for SSNAP and understand cognitive and mood screens we use and how to complete them. Recording also needs to stay consistent – continue with green forms (and ensure induction completed). Also taught band 3 to complete basic cognitive screen.

Domain 9: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Ensure an induction plan is put in place for all new starters	ongoing	<ul style="list-style-type: none"> Complete for new Medical Juniors – to review benefits/impact of this
2. To ensure all breaches are reviewed and validated	ongoing	<ul style="list-style-type: none"> System in place
3. To ensure all stroke patients have a comprehensive continence assessment completed and appropriate management plan in place – undertake audit of current practice against national guidance recommendations	Ongoing -aim to complete April 2016	<ul style="list-style-type: none"> Working party being formed to review quality and content of continence assessments and management to ensure meeting national guidance and also ensuring continence plans are in place for all patients to support patient discharge from hospital

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q4 (to date)	Key Improvement Actions
10.1 Proportion of applicable patients receiving a joint health and social care plan on discharge (A=90%)	90% (A)	99.2% (A)	98.4% (A)	<ul style="list-style-type: none"> Implement Dorset CCG Joint Health and Social Care Plan template
10.2 Proportion of patients treated by a stroke skilled ESD team (A=40%)	40% (A)	46.8% (A)	35.6% (C)	
10.3 Proportion of applicable patients in AF on discharge who are discharged on anticoagulants or with a plan to start anticoagulation (A=95%)	90% (B)	100% (A)	100% (A)	
10.4 Proportion of those patients who are discharged alive who are given a named person to contact after discharge (A=95%)	95% (A)	100% (A)	98.6% (A)	

Domain 10: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Audit facilitator to specifically validate 10.3 for non-compliant records before locking down.	ongoing	<ul style="list-style-type: none"> System in place for ongoing validation of any breaches

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q4 (to date)	Key Improvement Actions
Overall	90%	94.9%	93.6%	
NIHSS at arrival (30% of score)		98.3% (N.A. 85.9%)	98.1%	<ul style="list-style-type: none"> Stroke Outreach Training to achieve 85% of SU Nursing staff are competent to undertake NIHSS Ensure all are aware of need of 24 hour post-thrombolysis NIHSS
NIHSS 24hrs post thrombolysis (20% of score)		100% (N.A. 89.9%)	99%	
Transfers (10% of score)		100%		<ul style="list-style-type: none"> Ensure all patients discharged to ESD/CRT are transferred on the webtool To ensure therapy validations are completed in a timely manner to prevent delays between discharge date and case lockdowns
Data Entry (10% of score)		100%		
72hr Measures (15% of score)		98.8%		<ul style="list-style-type: none"> Ensure reason is documented for all patients not having a swallow screen within 72hrs
Post 72hr Measures (15% of score)		100%		

Domain: Audit compliance: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. NIHSS on arrival – ensure that all nursing staff on the SU are trained and competent to complete NIHSS on patients	Ongoing as staffing allows	<ul style="list-style-type: none"> Aim for 85% Nurses on SU competent with NIHSS New Stroke Specialist Nurse commences in January 2016 which will significantly help nurse training
2. To ensure section 4 validations are completed in timely manner and locked down using a robust database	February 2016	<ul style="list-style-type: none"> To liaise with the information dept. to ensure the current SSNAP therapy database is running efficiently To ensure administrators are aware at the earliest point that records are validated and can be locked down.

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

DOMAIN KEY INDICATORS	Plan	Last SSNAP (A)	Q4 to date	Key Improvement Actions
Average patient centred case ascertainment	90+%	90+%	90+%	<ul style="list-style-type: none"> Monthly lockdown checks will be performed on both 72hr and discharge lists All requests for record unlocks and data changes to go through SSNAP administrator. Tracking system created on administrators database To review case ascertainment figure with SSNAP as/when appropriate

Domain Case Ascertainment: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Monthly lockdown checks will be performed on both 72hr and discharge lists	Ongoing	
2. All requests for record unlocks and data changes to go through SSNAP administrator	Ongoing	<ul style="list-style-type: none"> Ensure all relevant staff are made aware Administrators to maintain tracking system for unlock requests
3. To review case ascertainment figure with SSNAP	Complete	<ul style="list-style-type: none"> SSNAP have lowered our case ascertainment numbers for stroke following updated review of our coding (i.e. not to include late return (post-72 hours) patients from Wessex or elsewhere)

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BOARD OF DIRECTORS

Meeting Date and Part:	1 st April 2016 Part 1
Subject:	Quality report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Proposed quality objectives (for approval at HAC)
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)
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 February 2016.

1. **Serious Incidents:** 1 reported
2. **Safety Thermometer:** Harm Free Care improved in month. .
3. **2015/16 Quality Objectives:**
 - Meeting quality objectives for: reducing severe harm events, SIs, serious pressure damage, staff incidents.
 - Not meeting quality improvement aim for: falls, medication incidents and never events.
4. **Patient experience:**
 - Friends and Family Test (FFT) remains strong: inpatient performance is in the second quartile. The response rate was sustained above the 15% national standard at 19.6%.
 - The Emergency Department FFT performance is in the top quartile, however. The response rate was 3.3% against the 15% national standard.
 - Outpatients FFT performance is in the second quartile. Response rates are variable between individual outpatient departments; there is no national standard.

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: February 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 February 2016

2. Serious incidents

One Serious Incident (SI) was confirmed and reported on STEIS in February 2016

- Patient fall resulting in #NOF, Ward 2, RCA in progress.

3. Safety Thermometer

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

NHS SAFETY THERMOMETER	14/15 Trust Average	14/15 National Average	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16
Safety Thermometer % Harm Free Care	90.68%	93.80%	88.9%	90.3%	86.97%	90.9%	84.10%	89.51%
Safety Thermometer % Harm Free Care (New Harms only)	97.18%	97.59%	96.6%	97.6%	97.7%	97.1%	96.62%	98.35%

	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16
New Pressure Ulcers	14	6	6	10	13	5
New falls (Harm)	0	3	3	3	4	2
New VTE	1	1	0	0	0	1
New Catheter UTI	1	1	0	2	0	0

4. Patient Experience Report – March 2016 (containing February data)

4.1 Friends and Family Test: National comparison

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

- Inpatient and day case Friends and Family Test (FFT) national performance in January 2016 ranked RBCH Trust 3rd with 25 other hospitals out of 172 placing RBCH

in the second quartile. The response rate was sustained above the 15% national standard at 19.6%.

- The Emergency Department FFT performance in January 2016 ranked RBCH Trust 6th with 9 other hospitals out of 141 placing RBCH ED department in the top quartile. The response rate was 3.3% against the 15% national standard.
- Outpatients FFT performance in January 2016 ranked RBCH Trust 4th with 26 other Trusts out of 234 Trusts, placing the departments in the second quartile. Response rates are variable between individual outpatient departments; there is no national standard.

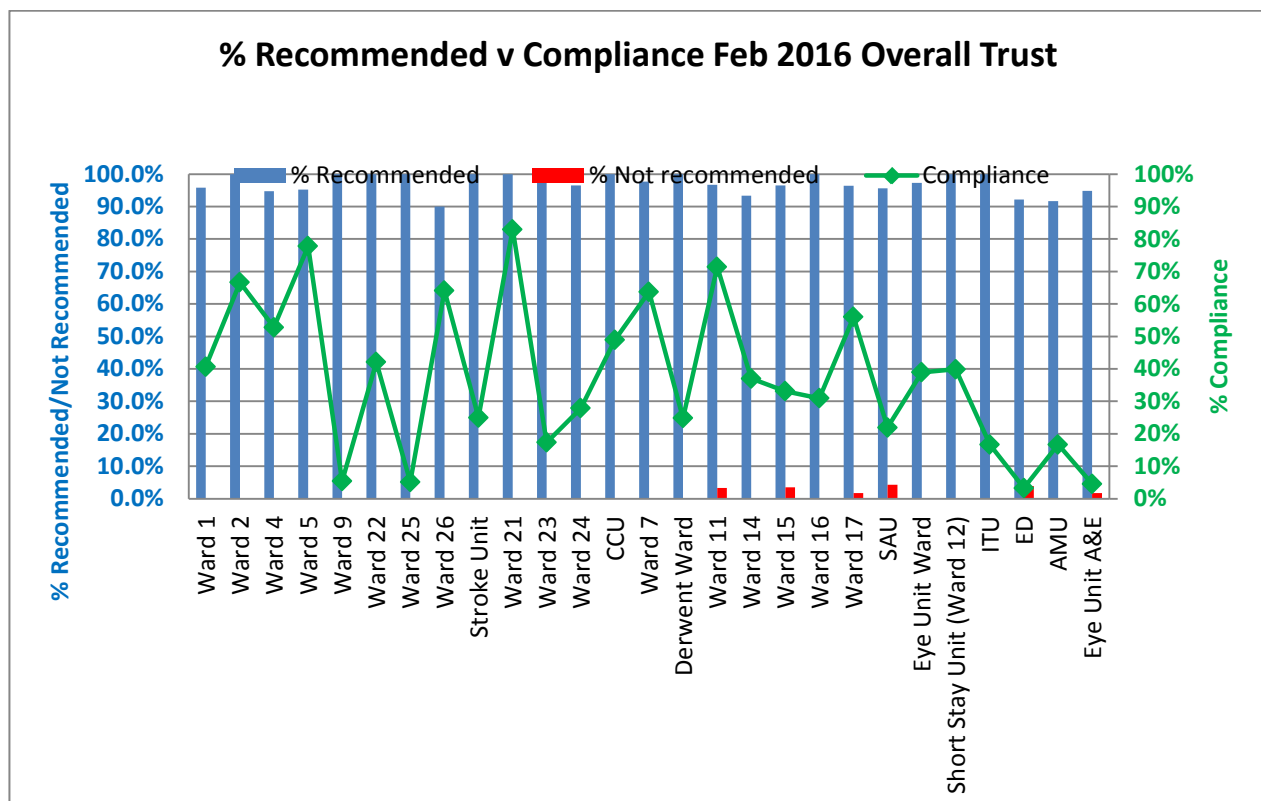
4.2 Friends and Family Test: Inpatient and ED performance

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

A significant amount of areas attained FFT 100% scores although some of these areas have very small FFT returns. Areas with an FFT score below 95% are ED, AMU, Eye ED, Wards 4, 14, 26, Ante Natal, Jigsaw OPD, Ct/MRI, Derwent OPD, Ortho OPD, pathology RBH, Pharmacy RBH, Pre-Assessment in OD, X-ray/Ultrasound, Rheumatology, Discharge Lounge.

Areas not achieving the national 15% compliance target include Main ED (3% of total activity) Eye ED (5% of total activity), wards 3, 9, and 25. Action has been requested from the clinical teams to improve this. However, some areas achieve significantly high returns over the 15% and exceeding 30%.

Table 1



This month has seen an increase in FFT responses from 3251 (Jan) to 3329 in February. This is reflected by a minimal increase in “unlikely or extremely unlikely to recommended” from 42 (Jan) to 47(Feb).

4.3 Family and Friends Test: Corporate Outpatient areas

There were 3442 cards completed in total; 85% of comments were very positive. The table below shows the main OPD areas FFT results. OPD FFT returns remain low and, although compliance rates are not nationally mandated, there is a focus on increasing this feedback.

Corporate	No FFT Cards	No FFT responses	Recommended %	Not Recommended %
Main Outpatients RBH	465	452	97.6%	0.9%
Derwent OPD	41	39	94.9%	2.6%
Oral and Maxillofacial	23	23	100.0%	0.0%
Main Outpatients Xch	73	70	95.7%	1.4%
Total	602	584	97.3%	1.0%

Themes for negative comments include:

- staff behaviours
- lack of communication, re waiting times and care
- waiting times, pathology and pharmacy
- food
- noise at night
- smell of smoke near ED and other ward areas.

4.4 Care Campaign Audit (CCA) Trend Data

Overall	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Red	68	33	49	51	51	45	60	91
Amber	81	45	43	69	73	61	58	92
Green	175	243	203	178	199	163	229	194
N/A	26	29	55	52	27	81	28	28

The Care Campaign Audit tool has been refined following a request from the Healthcare Assurance Committee. Whilst comments from patients remain predominately positive, the significant number of negative comments pertains to noise at night.

4.5 Patient Opinion and NHS Choices: January 2016 data

7 patient opinion comments were left in February, all but 1 express satisfaction with the service they received.

5. Quality objectives (proposed) – 2016/17

The metrics for measuring progress against the Trust quality objectives for 2016/17 will be reviewed for approval at the HAC on 31st March. The proposals are included in the reading room and a verbal update will be given at the board meeting.

6. Recommendation

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

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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	1 st April 2016 – Part I
Subject:	Financial Performance
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	No
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 period ending 29 February 2016
Executive Summary:	The financial reports are detailed in the attached papers.
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Goal 7 – Financial Stability Outcome 26 – Financial Position
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	One current financial risk exist on the risk register related to the next year's financial planning and is being monitored through the Finance Committee.

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Finance Report



For the period to 29 February 2016

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £11.1 million as at 29 February. This is £1.027 million better than the initial budget plan which amounts to a full year deficit of £12.9 million. As a result, the Trust is expecting to achieve a year end deficit marginally below the revised plan of £11.9 million.

Activity

February reported an increase in activity, being 1% above planned levels overall. Particular pressures were seen in relation to non-elective activity, which was 8% above budget. Outpatient activity also saw an increase during February, being 1% above budget. Elective activity, due to capacity issues resulting from additional emergency patients together with the Junior Doctors strike action, was below budgeted levels by 0.3%. Emergency Department attendances were consistent with budgeted levels in month.

Income

Due to the nature of the Trusts contracts with its three key commissioners, income remains broadly on plan with a moderate adverse variance of £464,000 (0.2%). Increases in non contracted activity and non patient related income are more than off-set by the significant under achievement against planned private patient income. Income reported a favourable variance of £36,000 during February.

Expenditure

Expenditure reported an under spend of £464,000 during February resulting in a modest under spend of £1.5 million to date and equating to a variance of 0.6%. This is mainly driven by a significant pay under spend, off-set by over spends against drugs and clinical supplies budgets.

Whilst the Trust remains heavily reliant upon agency staff, the premium cost has been considerably less than expected. This reflects the relentless internal focus supported by the introduction of national controls and support.

Cost Improvement Programme

To date the Trust has recorded savings of £8.2 million which is £244,000 ahead of the year to date target. The full year savings forecast reduced marginally in month and stands at £9.5 million which is £410,000 more than the target. However, the level of non-recurrent savings within this forecast remains a cause for concern.

Capital Programme

As at 29 February the Trust has committed £13.3 million in capital spend. Key areas of spend include the Christchurch development (£4 million), the Jigsaw new build (£2.9 million), and the Trusts IT Strategy (£2.2 million). The full year forecast is for an under spend of £3.8 million, reflecting delays in the Christchurch Development and the decision not to progress the relocation of Ambulatory and Emergency Care.

Statement of Financial Position

Overall the Trust's Statement of Financial Position is on plan; however some key variances remain against individual balances. Specifically, the trust continues to report high levels of outstanding payables and receivables. The main balances are with local NHS organisations and work to resolve a number of outstanding issues has continued. This is expected to conclude shortly, for payment before 31 March.

Cash

The Trusts current cash balance includes two one-off timing benefits. After adjusting for these, the Trust currently holds £30.4 million of cash. The current forecast is that the Trust will end the year with an underlying cash balance of £26.9 million. The Trust must continue to reduce its deficit forecast in future years and proactively manage its working capital to avoid the need for external financing.

Financial Sustainability Risk Rating

Under Monitor's new risk assessment framework the Trust achieves a Financial Sustainability Rating of 2 meaning that it is within the 'Material Risk and Potential Investigation' category. Monitor has concluded its investigation, and the outcome is expected imminently.

Income and Expenditure

To date the Trust is reporting a deficit of £11.1 million. Within this, income is below budget (adverse) by £464,000 and expenditure is below budget (favourable) by £1.491 million. This results in a net favourable variance of £1.027 million.

The Trusts overall income and expenditure position is summarised below.

£'000	Budget	Actual	Variance
NHS Clinical Income	223,382	223,953	571
Non NHS Clinical Income	7,023	5,652	(1,371)
Non Clinical Income	19,168	19,504	336
TOTAL INCOME	249,573	249,109	(464)
Employee Expenses	156,433	154,757	1,675
Drugs	28,896	30,193	(1,298)
Clinical Supplies	33,129	33,383	(254)
Misc. other expenditure	34,564	33,175	1,391
Depreciation	8,630	8,653	(23)
TOTAL EXPENDITURE	261,652	260,161	1,491
SURPLUS/ (DEFICIT)	(12,079)	(11,052)	1,027

Income

NHS clinical income is above budget, mainly due to increases in the level of out of area, non contracted activity. The Trusts main contractual income remains in line with the contracted level.

Non NHS clinical income remains significantly below budget due to a material reduction in private patient activity, specifically within cardiology, cancer care and radiology. The Trust is developing plans to recover this position during 2016/17.

Non patient related activity is marginally ahead of plan.

Further detail at contract level is set out below.

£'000	Budget	Actual	Variance
NHS Dorset CCG	153,116	153,116	0
NHS England (Wessex LAT)	42,278	42,348	70
NHS West Hampshire CCG	22,762	22,789	26
Non Contracted Activity	2,469	2,758	290
Public Health Bodies	2,409	2,442	33
NHS England (Other LATs)	1,546	1,509	(37)
NHS Wiltshire CCG	680	722	42
Other NHS Patient Income	531	712	181
Private Patient Income	4,069	2,748	(1,321)
Other Non NHS Patient Income	545	462	(83)
Non Patient Related Income	19,168	19,504	336
TOTAL INCOME	249,573	249,109	(464)

Expenditure

Pay reported an over spend in month, reflecting the operational pressures faced by the Trust during February. Despite this, the Trust continues to report a significant under spend due to agency expenditure being below expected levels. This is the result of considerable efforts in relation to both substantive and bank recruitment across the Trust, together with a number of more tactical workforce initiatives.

The Trust continues to report additional drugs expenditure, resulting in a significant year to date over spend. In addition, clinical supplies expenditure is above budget to date, mainly due to a significant increase in non-elective cardiac activity, off-set in part by a reduction in the level of planned orthopaedic activity undertaken to date.

Employee Expenses

The Trust continues to rely heavily upon agency staff to cover substantive vacancies. The year to date under spend against substantive staffing budgets is £12.8 million. Agency expenditure to date totals £9.3 million, with a further £6.3 million spent on bank and overtime. This results in a total 'premium' workforce cost of £2.8 million to date.

£'000	Substantive Budget	Substantive Cost	Substantive Variance	Agency Cost	Bank Cost	Overtime Cost	Workforce Variance	Premium Funding	Residual Variance
Surgical Care Group	38,012	35,404	2,607	2,082	892	296	(663)	949	286
Medical Care Group	53,799	47,932	5,867	5,626	2,952	389	(3,100)	2,703	(397)
Specialties Care Group	33,124	30,851	2,273	1,109	665	100	399	240	639
Corporate Directorates	26,971	24,925	2,046	497	850	176	523	0	523
Centrally Managed Budgets	11	11	0	0	0	0	0	624	624
TOTAL	151,917	139,123	12,794	9,315	5,359	960	(2,840)	4,516	1,675

Where possible, block bookings are placed for agency staff to secure a reduced rate and provide consistency. Agency spend during February can be summarised as follows:

	Block Booked	Off-Framework	Other
Nursing	109,691	51,637	158,510
Medical	0	21,375	322,517

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 is subject to a rigorous executive approval process, and the exceptions recorded during February were as follows:

	Medical	Nursing	Other
Shifts covered	133	81	128
Approximate Cost above Cap	45,743	16,075	12,137

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

Cost Improvement Programme

The Trust has delivered financial savings amounting to £8.2 million to date, being £244,000 ahead of plan. The forecast is for total savings of £9.5 million against the full year target of £9 million.

In month, the forecast has slipped overall, mainly due to a reduced forecast savings within Medical Records as part of the Electronic Document Management Project. This has been mitigated in part by improved savings forecasts within the Medical and Specialties Care Groups.

Whilst further validation and challenge is taking place, currently £3.5 million continues to be reported as non recurrent. This remains a risk moving into the new financial year.

The Surgical Care Group is forecasting full delivery of the full year target. Further validation of the non recurrent savings within this is taking place.

The Medical Care Group position has remained broadly consistent, with a small £4,000 improvement within the ED and AMU forecast.

The Specialties Care Group continues to forecast an over achievement against the full year target, with a further improvement during February. This is the result of additional drug savings.

Corporate directorates continue to forecast full delivery against their targets. Some risks remain, and these are being followed up as appropriate.

DIRECTORATE	YEAR TO DATE			FULL YEAR		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000	TARGET £'000	ACTUAL £'000	VARIANCE £'000
ANAESTHETICS AND THEATRES	124	0	(124)	164	164	0
MATERNITY	30	31	1	84	85	1
ORTHOPAEDICS	283	282	(2)	346	344	(2)
SURGERY	174	64	(110)	310	309	0
CARE GROUP A	611	377	(234)	903	902	(1)
CARDIOLOGY	221	153	(69)	254	174	(80)
ED AND AMU	66	16	(50)	76	17	(59)
OLDER PEOPLES MEDICINE	211	208	(2)	243	225	(18)
MEDICINE	250	509	259	251	558	307
CARE GROUP B	748	886	138	824	973	150
CANCER CARE	235	304	68	265	335	70
OPHTHALMOLOGY	233	182	(51)	258	199	(59)
PATHOLOGY	245	196	(49)	268	215	(54)
RADIOLOGY	116	188	72	131	219	88
SPECIALIST SERVICES	1,047	1,271	224	1,139	1,382	243
CARE GROUP C	1,877	2,140	264	2,061	2,350	289
NURSING, QUALITY & RISK	88	89	1	92	93	1
ESTATES	527	517	(10)	586	574	(12)
FACILITIES MANAGEMENT	296	272	(24)	354	316	(38)
FINANCE AND BUSINESS INTELLIGENCE	488	498	10	544	556	12
HR, TRAINING AND POST GRAD	173	173	0	185	185	0
INFORMATICS	682	778	96	777	824	47
OPERATIONAL SERVICES	113	113	0	122	121	(1)
OUTPATIENTS	16	12	(5)	19	14	(4)
TRUST BOARD & GOVERNORS	138	222	84	154	237	82
CORPORATE	2,521	2,673	153	2,832	2,920	87
PRODUCTIVITY	2,115	2,115	0	2,307	2,307	0
DIRECT ENGAGEMENT	77	0	(77)	115	0	(115)
CROSS DIRECTORATE	2,191	2,115	(77)	2,422	2,307	(115)
GRAND TOTAL	7,948	8,191	244	9,042	9,452	410

Care Group Performance

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

£'000	Budget	Actual	Variance
Surgical Care Group	15,036	14,437	(599)
Medical Care Group	6,895	6,606	(289)
Specialties Care Group	5,198	4,955	(243)
Corporate Directorates	(32,878)	(32,302)	576
Centrally Managed Budgets	(6,330)	(4,748)	1,582
SURPLUS/ (DEFICIT)	(12,079)	(11,052)	1,027

Surgical Care Group

The Care Group reported an overall deficit in month of £124,000. This was driven by reduced elective orthopaedic income due to reduced capacity resulting from a significant increase in non-elective patients together with the impact of the junior doctors strike action.

The Care Group expenditure position in month was broadly on plan, with a minor adverse variance of £6,000. The Care Group continues to forecast a balanced expenditure position overall.

Medical Care Group

The Medical Care group reported a favourable variance to budget during February of £52,000.

Income reported a favourable variance of £273,000 in month reflecting the scale of additional non-elective activity reported during February, together with a planned increase in endoscopy activity.

This was off-set in part by a continued adverse variance in relation to private Cardiology activity.

The volume of additional activity during February placed significant pressure on expenditure budgets, which reported an aggregate over spend of £221,000.

Specialties Care Group

Overall the Care Group reported an adverse variance in month of £76,000. This was the result of an under achievement against the income budgets together with a marginal expenditure over spend.

Specific pressures were reported within Cancer Care in relation to staffing pressures and increased drug costs; and Ophthalmology to ensure continued compliance with national access standards.

Corporate Directorates

Whilst some pressures remain within a small number of directorates, overall the corporate areas continue to perform well financially, delivering a significant favourable variance to date.

Statement of Financial Position

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

- **Non-current assets:** The Trusts capital programme is currently behind plan by £4.8 million, as set out overleaf. This, together with the timing impact of capital schemes on the associated depreciation and amortisation charges account for the overall non-current assets variance to date.
- **Inventories:** Stock is currently higher than anticipated, mainly due to an increase within the pharmacy store in relation to the new Hepatitis C network.
- **Trade and other receivables:** Delays in the payment of invoices, mainly by local NHS organisations, account for a significant proportion of the receivables variance to plan. These outstanding balances are being actively pursued and have been escalated where appropriate. In addition, the new Hepatitis C network has resulted in additional invoices above the level initially planned.
- **Cash and cash equivalents:** Cash is currently greater than planned, driven mainly by the capital under spend. Further detail is included below.
- **Trade and other payables:** The Trust is carefully managing cash payments, pending resolution of the outstanding receivables balance, which has resulted in a variance to plan. This is exacerbated by the Hepatitis C network and the timing of capital related payments.

The Trust continues to work through a detailed re-valuation of its estate, which will be reflected within the Statement of Financial Position as at 31 March 2016.

£'000	Plan	Actual	Variance
Property, plant and equipment	181,217	174,218	(6,999)
Intangible assets	1,875	3,081	1,206
Investments (Christchurch LLP)	2,779	2,343	(436)
Non-Current Assets	185,871	179,642	(6,229)
Inventories	5,390	6,876	1,486
Trade and other receivables	6,465	11,923	5,458
Cash and cash equivalents	48,596	54,326	5,730
Current Assets	60,451	73,125	12,674
Trade and other payables	(39,258)	(45,755)	(6,497)
Borrowings	(389)	(328)	61
Provisions	(141)	(92)	49
Other Financial Liabilities	(551)	(551)	0
Current Liabilities	(40,339)	(46,726)	(6,387)
Trade and other payables	(1,018)	(1,018)	0
Borrowings	(20,527)	(20,601)	(74)
Provisions	(519)	(519)	0
Other Financial Liabilities	0	0	0
Non-Current Liabilities	(22,064)	(22,138)	(74)
TOTAL ASSETS EMPLOYED	183,919	183,903	(16)
Public dividend capital	79,665	79,665	0
Revaluation reserve	74,609	74,609	0
Income and expenditure reserve	29,645	29,629	(16)
TOTAL TAXPAYERS EQUITY	183,919	183,903	(16)

Capital Programme

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

Expenditure to date totals £13.3 million, representing a year to date under spend of £4.8 million. Significant spend is planned for March, and thus the forecast is for a full year under spend of £3.8 million. This is attributable mainly to slippage against the Christchurch development due to delays with steel works together with environmental issues, and the decision not to progress the relocation of Ambulatory and Emergency Care.

Full detail at scheme level is set out below.

£'000	Annual	IN MONTH			YEAR TO DATE			FORECAST	
	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance
Christchurch Development	7,565	1,069	670	399	6,997	4,040	2,957	5,915	1,650
JIGSAW New Build	3,050	0	0	(0)	3,050	2,909	141	2,908	142
Relocate and Expand AEC	900	200	0	200	720	0	720	20	880
Atrium Project	1,200	0	51	(51)	1,200	1,214	(14)	1,200	0
CT3 Build	500	175	0	175	310	5	305	30	470
Ward Refurbishment	400	0	0	(0)	400	327	73	400	0
Estates Maintenance	400	50	10	40	360	428	(68)	400	0
Aseptic Unit	510	0	3	(3)	510	549	(39)	543	(33)
Miscellaneous Schemes	100	0	(30)	30	75	225	(150)	341	(241)
Traffic Congestion Works	100	0	0	0	100	0	100	0	100
Residences Refurbishment	50	0	(0)	0	50	64	(14)	64	(14)
Catering Equipment	150	0	16	(16)	75	50	25	50	100
Macmillan Development	0	0	0	(0)	0	15	(15)	15	(15)
Capital Management	300	25	33	(8)	275	192	83	192	108
Medical Equipment	1,500	125	83	42	1,375	1,029	346	1,519	(19)
IT Strategy	3,062	303	148	156	2,559	2,209	349	2,421	641
TOTAL	19,787	1,947	984	964	18,056	13,257	4,799	16,018	3,769

Cash

The Trust is currently holding £54.3 million in cash reserves. However, there are two significant cash timing benefits within this figure meaning that the underlying cash position is significantly lower at £30.4 million.

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

The forecast closing cash balance for the current financial year is £33.3 million. After adjusting for the residual cash timing benefits, the Trust is forecasting to end the year with £26.9 million of cash.

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

£ million	Mar-16
OPENING CASH	54.33
NHS Clinical Income	19.77
Non NHS Clinical Income	0.89
Non Patient Related Income	1.46
Working Capital	(14.03)
CASH INFLOWS	8.09
Revenue Account	(23.95)
Capital Account	(1.50)
Christchurch Investment	(0.55)
ITFF Loan Repayment	(0.54)
Working Capital	(2.55)
CASH OUTFLOWS	(29.09)
CLOSING CASH	33.33

Financial Sustainability Risk Rating

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

The Trusts Financial Sustainability Risk Rating as at 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 (after the application of mandatory overrides) 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 has been formally submitted to Monitor, and the medium term financial forecast has been shared as part of the investigation process. Whilst a number of key assumptions and risks remain within this plan, the Trust is forecasting a Financial Sustainability Risk Rating of 3 from August 2016. This annual plan and medium term forecast will continue to be updated as the Trust continues through the 2016/17 planning cycle.

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would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	1 st April 2016 – Part 1
Subject:	Workforce Report
Section on agenda:	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 – MARCH 2016

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

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 29 February			Rolling 12 months to 29 February				At 29 February
Surgical	80.3%	86.3%	84.4%	4.53%	14874	15.1%	13.3%	1.4%
Medical	77.2%	97.6%	82.2%	3.97%	19308	19.3%	12.1%	7.9%
Specialities	86.9%	82.6%	84.8%	3.18%	8991	11.3%	12.0%	5.1%
Corporate	90.4%	50.0%	89.1%	3.87%	12438	10.7%	12.6%	3.2%
Trustwide	83.1%	88.3%	84.5%	3.92%	55611	14.7%	12.5%	4.9%

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 29 February			Rolling 12 months to 29 February			At 29 February	
Add Prof Scientific and Technical	91.4%		86.8%	2.77%	1221	21.8%	12.0%	11.0%
Additional Clinical Services	75.1%		83.4%	6.40%	16720	21.1%	14.0%	8.8%
Administrative and Clerical	84.2%		91.0%	3.39%	10401	8.9%	13.6%	6.9%
Allied Health Professionals	89.7%		89.2%	2.18%	1983	14.3%	14.7%	3.7%
Estates and Ancillary	94.8%		85.3%	4.98%	5995	19.2%	13.7%	-0.5%
Healthcare Scientists	82.7%		93.2%	2.78%	615	8.6%	8.6%	10.0%
Medical and Dental		88.3%	76.1%	1.10%	1755	4.7%	6.9%	1.1%
Nursing and Midwifery Registered	81.0%		83.3%	4.09%	16921	15.3%	11.3%	3.2%
Trustwide	83.1%	88.3%	84.5%	3.92%	55611	14.7%	12.5%	4.9%

1. Appraisal

As previously advised, appraisal compliance was reset to zero with the introduction of the new values based appraisal. The appraisal rate has increased to 83.1% for values based appraisal (79.5% last month). Medical & Dental is 88.3% (90.5% last month).

Appraisal was discussed at Workforce Committee on 22nd February, with year 2 of the values-based process due to commence 1st April. The Committee agreed the appraisal period would run from 1st April to 30th September, with a target of 90% of eligible staff to have a completed appraisal within that 6 month period. Executive appraisals to be held as soon as possible in the timeframe to start the cascade process.

2. Essential Core Skills Compliance

Overall compliance has increased to 84.5% from 83.8% last month. The table below shows the 10 areas with the lowest compliance as at 29th February:

Directorate	Organisation	Headcount	Compliance
Pathology Directorate	153 Phlebotomy 11330	35	51.11%

Surgery Directorate	153 Obs/Gynae Medical Staff 10100	16	60.09%
Elderly Care Services Directorate	153 MFE Medical Staff 10077	51	64.86%
Cancer Care Directorate	153 Macmillan Unit 10565	39	65.57%
Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	12	66.01%
Medicine Directorate	153 Medical General Staff 10075	72	70.34%
Anaesthetics/Theatres Directorate	153 Cstd 55400	34	70.88%
Medicine Directorate	153 Ward 3 10598	32	71.06%
Elderly Care Services Directorate	153 MFE Ward 4 10382	29	71.08%
Medicine Directorate	153 Ward 2 10369	34	72.18%

Areas with highest compliance:

Directorate	Organisation	Headcount	Compliance
Finance & Business Intelligence Directorate	153 Information 13541	19	100.00%
Pathology Directorate	153 Haematology 11340	26	100.00%
Informatics Directorate	153 Poole IT Services 13586	28	99.64%
Operational Services Directorate	153 Cancer Information Team 13495	17	98.82%
Informatics Directorate	153 Clinical Coders 13211	15	98.64%
Informatics Directorate	153 Telecoms 13585	23	98.26%
Cardiac Directorate	153 Cardiac Administration 11523	34	97.44%
Human Resources Directorate	153 Human Resources 13570	26	97.31%
Outpatients Directorate	153 Outpatients Booking Staff 10603	53	97.22%
Finance & Business Intelligence Directorate	153 Finance 13575	19	96.84%

3. Sickness Absence

The Trust-wide sickness rate shows a very small increase at 3.92% (3.89% last month), continuing its amber rating.

The table below shows the 10 areas with the highest 12-month rolling sickness absence as at 29th February.

Directorate	Organisation	Headcount	Absence Rate
153 Outpatients Directorate	153 Outpatients 10370	39	11.57%
153 Elderly Care Services Directorate	153 MFE IP Therapy 10581	20	9.54%
153 Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	12	9.52%
153 Surgery Directorate	153 Colorectal Ward 16 10427	37	9.05%
153 Elderly Care Services Directorate	153 MFE Ward 4 10382	30	8.29%
153 Surgery Directorate	153 Surgical Admissions Unit 10535	28	8.22%
153 Medicine Directorate	153 Medical R.E.D.S. 11536	13	7.94%
153 Elderly Care Services Directorate	153 MFE Ward 22 10594	31	7.75%
153 Surgery Directorate	153 Urology Ward 15 10426	35	7.71%
153 Elderly Care Services Directorate	153 MFE Ward 5 10378	41	7.49%

Areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rate
153 Pathology Directorate	153 Medical Staff - Histology 11300	11	0.02%

153 Surgery Directorate	153 Surgery - Urology 10084	20	0.16%
153 Other Directorate	153 Chief Executive 13535	28	0.34%
153 Ophthalmology Directorate	153 BEU Ophthalmic 10110	29	0.41%
153 Elderly Care Services Directorate	153 Dietitians 13315	16	0.58%
153 Surgery Directorate	153 Surgery - General 10085	38	0.59%
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	44	0.60%
153 Surgery Directorate	153 Cancer Nurse Specialist 10425	11	0.61%
153 Elderly Care Services Directorate	153 MFE Medical Staff 10077	57	0.70%
153 Anaesthetics/Theatres Directorate	153 Anaesthetic 10025	53	0.75%

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 14.7% and 12.5% respectively show slight improvements from last month. (14.2% and 12.7%).

5. Vacancy Rate

The vacancy rate at 4.9% remains unchanged from the previous month.

6. Safe Staffing

Safe Staffing Unify Return - February 2016 data:

RN Fill Days	84.5%
HCA fill days	99.3%
RN fill nights	99.7%
HCA fill nights	123.2%

The Safe Staffing Unify return illustrates the total amount of registered nurse (RN) actual hours deployed in a percentage against the total planned amount. This is captured for all ward areas from E-roster off duty retrospectively.

The aggregate percentages are displayed above. This remains largely unchanged from the previous month and is mostly consistent YTD. The Registered Nurse Fill rate against the agreed template in the day in month is 84.5%. This means that on aggregate the Trust is operating with a negative variance of 15.5% against the planned templates, despite bank and agency cover. This includes the Tier three usage and expenditure.

The reasons for variances remain consistent with lower than planned actuals due to vacancies, which cannot then be filled by bank duties, or by short term sickness, when it is most challenging to cover at short notice. Other reasons are loss of the agency block bookers due to the Agency cap. For areas over the actual against planned, this is due to extra capacity areas requiring staffing, and the use of specials, patients who require 'enhanced care', which is a higher nursing ratio such as 1:1 or 2:1 for a variety of risk assessed clinical reasons.

All shifts are reviewed locally against acuity, skill mix taking into account all the managerial requirements of the area. Red Flags are raised against an agreed criteria, modelled on the national recommendations, agreed locally with the Nursing

Team. This is currently reported via the Datix system, but will be re implemented under the E-Roster system with the Safe Care module through 2016. Red Flag data is being validated currently.

Band 4's.

Formal introduction of Band 4's is being scoped as part the Nursing Workforce project as part of the wider Workforce Transformation workstream. The senior nursing team have scoped areas and identified where band 4's can be implemented taking account of the patient interventions they can perform. This is mostly complete and currently being modelled into the off duty.

The Band 4 scoping includes future needs and will inform the educational planning for places for September 2016.

A Trust wide advert is currently open to attract qualified band 4's to apply to the Trust.

7. Health & Wellbeing

At the last board there was a request to understand more about the health and wellbeing support that is offered in the organisation to staff. Since the meeting in February there has been a positive move to support initiatives nationally. NHS England has announced plans to offer financial incentives to improve the health and wellbeing of NHS staff in England, as part of its Healthy Workplaces effort.

These plans are in the form of a new Commissioning for Quality and Innovation (CQUIN), which has been influenced by the ambitions of the Five Year Forward View. New guidance to help NHS organisations reach these targets has been released. From April 2016, as part of a new health and wellbeing indicator, NHS organisations will be funded to improve the support they offer to healthcare staff to stay healthy. This new focus will be on giving staff better access to health and wellbeing initiatives and supporting them to make healthy choices and lead healthy lives.

In theory all NHS care providers will be able to earn their share of a £600m national incentive fund in 2016/17. However, we have been told that there is no new money in the system to fund initiatives - the money is already in the tariff and that those provider organisations that do not meet standards may be subject to fines.

Organisations will be expected to demonstrate a 5 per cent improvement in health and wellbeing related (including MSK and stress) staff survey questions, provide a step-change in the health of the food offered on premises and improving the uptake of flu vaccinations for frontline staff; up to 75 per cent.

Existing initiatives that we already have in the trust include:

- Counselling - accessed through the Employee Assistance Programme - the EAP also provides confidential advice and support for relationship problems, debt management, career advice and information regarding elder care and on a wide range of other subjects.

- Rapid access for staff to physiotherapy services - we would like to enhance this service further as evidence has shown that early interventions results in staff returning to work earlier
- Weight watchers - we host an on-site group at the Bournemouth site every Thursday.
- Annual flu jab
- Negotiated discounts and rates for trust staff including restaurants, beauty treatments and gym membership
- Vitality (Zest) portal - this is part of the EAP and is available to staff at work and on- line at home and offers advice re personal fitness, dietary advice, stress management and sleeping patters.
- Every fortnight we include information in the staff bulletin about health and wellbeing including events and opportunities
- Fit for work- weekly sessions for staff in the physiotherapy gyms in Christchurch and Bournemouth
- Pilates - weekly classes for staff in the physiotherapy gym in Bournemouth
- Zumba fitness sessions are also offered at Christchurch every Monday
- We hold regular health and wellbeing days where staff are able to access information from a range of organisations and in house - often these are themed

Going forward we would like to improve the support for staff regarding mental health wellbeing and we will be discussing the overall development and how to enhance the offer at the Strategic Workforce Development Committee in April.

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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	Friday 1 st April 2016, Part 1
Reason for Part 2:	
Subject:	Information Governance Annual Performance Update
Section on agenda:	4. STRATEGY AND RISK
Supplementary Reading (included in the Reading Pack)	-
Officer with overall responsibility:	Peter Gill, Director of Informatics
Author(s) of papers:	Camilla Axtell, IG Manager
Details of previous discussion and/or dissemination:	Reviewed at IG Committee and HAC
Action required: Approve/Discuss/Information/Note	For Information
Executive Summary:	
Annual report of the Information Governance work within the trust for information for the BoD	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Records Management and IG Toolkit
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	-

INFORMATION GOVERNANCE ANNUAL REPORT 2015/16

Introduction

This year has been one of great challenge in Information Governance at RBCH. Following the Trust's poor performance in the Information Governance Toolkit during 2014/15, extensive work has been carried out to improve the submission for 2015/16 and to ensure that the assurance provided is substantiated with adequate evidence of the Trust's IG practices. This work commenced early in the year however it has proved to be more demanding than expected; part of this work has required 27 IAOs and 38 IAAs to complete a total of 555 separate tasks between them across a list of 66 assets. This is in addition to improving the remainder of the Trust's IG Toolkit submission, including a full review of all policies and a rigorous drive to improve IG training compliance across the Trust. It is hoped that these endeavors will help to imbed good IG practice throughout the Trust and to provide assurance to patients and to the Board that information is managed in a legally compliant fashion.

Information Governance Toolkit

The Information Governance Toolkit is a self-assessment audit completed by every NHS Trust and submitted to the Health and Social Care Information Centre on 31st March each year. The purpose of the IG Toolkit is to assure an organisation's information governance practices through the provision of evidence around 45 individual requirements. This is the most significant single piece of work regularly undertaken by the Information Governance department.

In previous years, the Trust has needed to take a pragmatic approach to managing this work which was commensurate with the resource available – generally this meant that the audit focused on a few departments only rather than compliance across the whole Trusts. However it is widely recognised that good information governance can be built around the tenets of this audit, and this can only be achieved through a more rigid adherence to these requirements. As such, going forwards a greater focus is to be placed on attaining a robust level of compliance by providing better quality evidence for each of these requirements which will in turn give a greater level of assurance of the Trust's IG practices.

Much of this audit is underpinned by work associated with information risk assurance. This involves the identification of the Trust's key information systems (information assets), the designation of a senior person who is responsible for each system (known as an Information Asset Owner), and ensuring that each of these systems has in place such measures as appropriate contract clauses, adequate access controls, regular risk assessments and suitable business continuity plans, and to ensure that any information which is transferred into or out of the Trust through this system is risk assessed and appropriately protected. This work is essential to ensure the continuous provision of effective care and to ensure that any risks to the integrity and availability of critical information are mitigated as far as is possible.

Once this work is established and firmly embedded within the Trust, this will inform compliance with many of the requirements within the IG Toolkit. In order to succeed,

however, this requires the commitment of the appointed IAOs to ensure that the information systems under their control are compliant with the relevant IG Toolkit requirements.

During 2015/16, the Trust has implemented its Information Risk Management Policy which is the first major step towards imbedding this work. The policy sets out the work required, the responsibilities of IAOs, and provides the Trust's abstracted definition of an "information asset".

A twofold approach is now being taken to the completion of the IG Toolkit – requirements are divided into those requiring input from IAOs and those requiring completion by subject matter experts. The IAOs co-operation is key to the completion of this work, as they take responsibility for providing the required assurance within each separate area of the Trust, meaning that the level of assurance provided within the IG Toolkit submission covers the whole organisation rather than selected areas. These members of staff are managed by the Information Governance Manager under the jurisdiction of the Director of Informatics, and compliance amongst IAOs is routinely monitored through IG Committee and PMG meetings.

The consequence of the introduction of this altered approach to the IG Toolkit in 2014/15 was that initially the Trust experienced a significant decrease in its overall compliance score to 37%. A considerable amount of work has been undertaken during 2015/16 to ensure that the tasks required to be completed by IAOs is started and seen through to completion where possible, and also to provide more accurate assurance to all other IG Toolkit requirements. As a consequence, a significant improvement in score is expected for 2015/16. Please see Appendix 1 for a breakdown of the requirements and predicted scores (between 0 and 3) associated with each of these.

The nature of the IG Toolkit's scoring system is that if one of the requirements is deemed non-compliant then the whole audit is scored as "Not Satisfactory". Whilst targeting full compliance, the amount of work required to improve upon the 2014/15 position is considerable and should not be underestimated. It is unlikely that the Trust will score at least a Level 2 in all 45 requirements during 2015/16 and will therefore not be compliant with the IG Toolkit. However the overall percentage score will be significantly improved as a reflection of the work undertaken.

It is possible to submit an improvement plan to the HSCIC for any requirements which are non-compliant by the end of March – if accepted this will lead to the overall assessment being graded as "Satisfactory (with Improvement Plan)". If compliance cannot be achieved by the end of March, the Trust will submit its IG Toolkit return on this basis.

Moving into 2016/17, the Trust must work to maintain the traction that is has gathered on this work during the year in order to firmly imbed the concepts as "business as usual", and enable the submission of a compliant IG Toolkit each year – if ambivalence or apathy sets in following this submission, the hard work of 2015/16 will be negated.

As of March 2016, the HSCIC has indicated that it is developing the 'next generation IG Toolkit', currently for smaller organisations, such as general and dental practices,

and later for larger organisations such as NHS Trusts and Local Authorities. This had originally been expected during 2015 and it remains to be seen whether this will be in use for 2016/17.

Data Protection and Confidentiality Incidents

There has been a sharp increase in reported breaches of Information Governance during 2015/16. During 2014/15, 54 breaches and no Serious Incidents Requiring Investigation (SIRIs) were reported, whereas 2015/16 has seen 81 breaches and no SIRIs reported.

Whilst seemingly a negative point, this is not necessarily indicative of an increase in incidents within the Trust and could potentially be as a result of increased levels of incident reporting following the in-year introduction of DatixWeb electronic incident reporting across the Trust.

Some of the types of incidents reported are recurrent – the most common type being patients receiving correspondence relating to other patients in error. However these tend to be one-off incidents rather than incidents that all occur within one department, and can therefore generally be attributed to human error rather than lack of appropriate training or processes not being in place. There have also been a number of incidents of confidential paperwork being found outside within the hospital grounds – a review of confidential waste disposal arrangements will be carried out during April 2016 as a direct result of this.

During 2016/17, further awareness-raising will be carried out to ensure that all staff are aware of what may constitute an IG breach and therefore what they should be reporting as such. Primarily this will be done through e-learning, however various different communication methods such as screensavers and Trust-wide communications will also be considered within the year. Anecdotal evidence has established previously that some members of staff do not consider such things as accessing medical records inappropriately as an IG breach which requires formally reporting, and therefore clarity for all staff is required on this.

The national guidance with regard to the reporting of IG incidents has been updated during 2015, reflected in requirement 202 of the IG Toolkit, to include the requirement to report all activities that involve the use or sharing of confidential personal information that do not have a lawful basis as SIRIs.

Freedom of Information

During 2015/16 the Trust has seen a decrease in the number of Freedom of Information (FOI) requests received from the previous year; 502 as at 21 March 2016, an average of 42 requests per month. This is down from 524 at the same point last year. A part time member of Bank staff has assisted with dealing with requests during 2015/16 (demonstrated by the improved response performance during Quarter 3), and a full time post is being recruited to which will, in part, assist with the processing of these requests.

Compliance with the statutory time limit imposed by the FOIA remains poor overall. The number of breaches seen generally remains indicative of the increased number of requests received, and the increased complexity of these requests which can

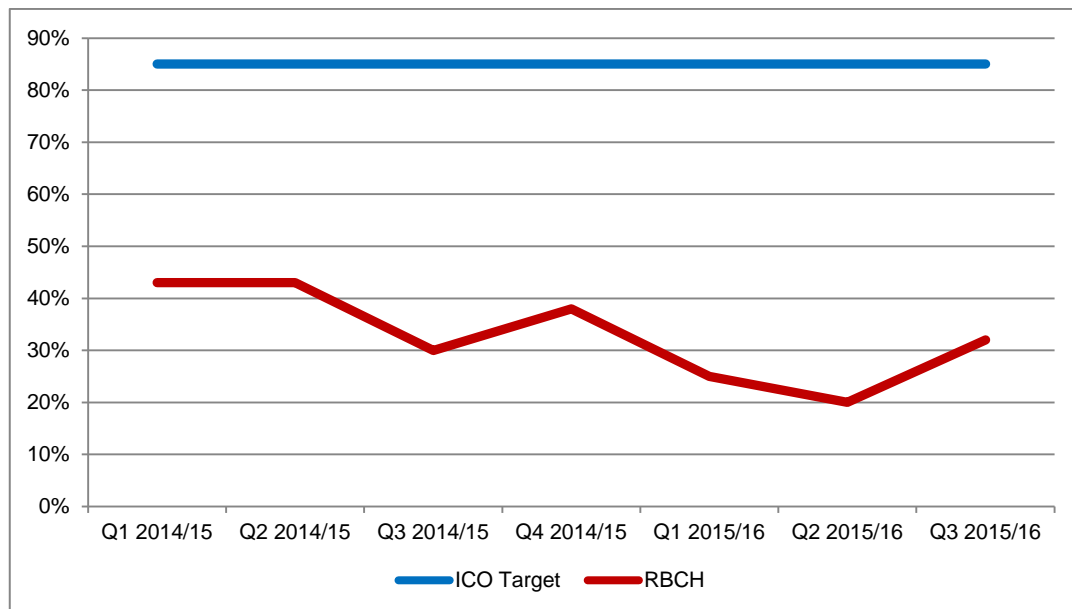
require a larger amount of work to locate the information requested. However, this can also be attributed to the difficulty of obtaining full responses from staff and the timeliness of those responses; information is very often supplied incomplete and requires further work or a request needs to be transferred to another department. Active dissent from staff has also often been observed.

It continues to be accepted by the Board that FOI compliance should not currently be a priority for the Trust set against clinical demand – this is particularly relevant to certain subjects where the information being requested is held by clinical staff, or by departments who are providing services directly to clinical staff (such as the Information department).

The Information Commissioner's Office (ICO) will monitor selected organisations to review their performance in adhering to the Freedom of Information Act, targeting those authorities which repeatedly fail to respond to at least 85% of FOI requests received within the appropriate timescales. Monitoring may be a precursor to further action if an authority is unable to demonstrate an improvement. Further action could include the Trust having to sign an undertaking to improve its practices, an enforcement notice, reports to Parliament, or prosecution.

The Trust has recorded the response times for FOI requests over the last fifteen full quarters, broken down by month. During this period there has been no month where 85% of all requests have been responded to within 20 days – on average during 2015/16 only 26% of requests have been responded to within the statutory time limit.

Fig 1 – FOI response time compliance by Quarter



Information Governance Training

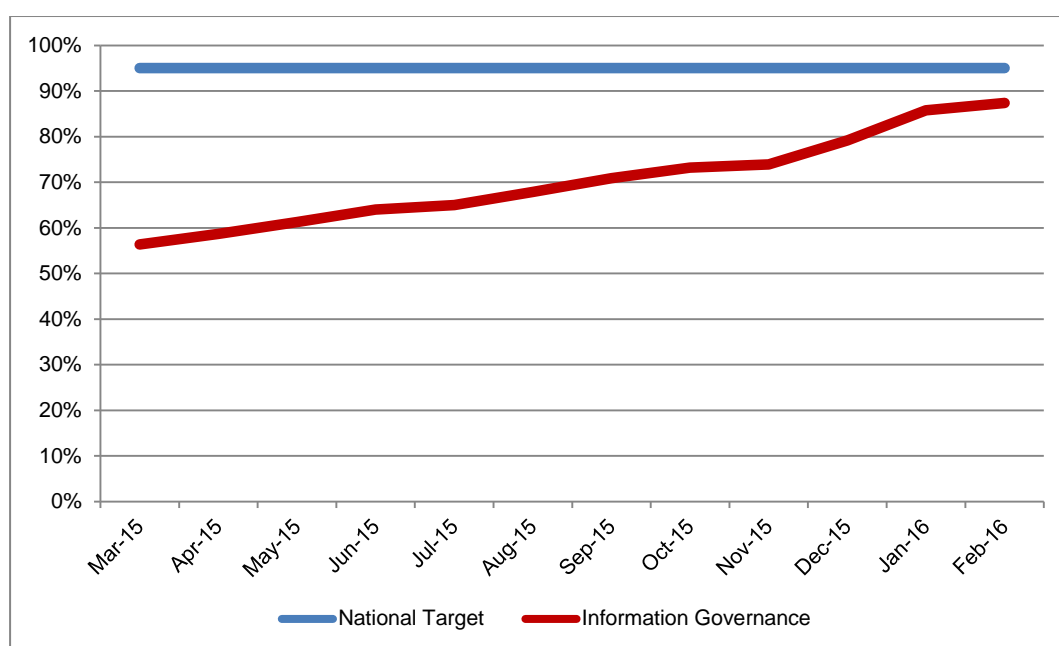
Information Governance training compliance has seen a steady increase during the year and at the end of February 2016 sits at 87.4% - the national target for compliance is 95%. This is a significant increase on the same time last year, when compliance was at 54.4%.

This increase can be attributed in the most part to two significant factors – the introduction of the Blended Education and Training Virtual Learning Environment (BEAT VLE) system in March 2015 meaning that staff can complete this training via e-learning in the own time rather than needing to book into and attend a face-to-face training course, and also a concerted campaign of chasing individual non-compliant members of staff and their line managers, led by the Director of Informatics.

Additional work is being undertaken to ensure that outlying staff groups – those for whom e-learning may not be suitable owing to language barriers or lack of access to a computer – are still able to receive the training required. Staff groups such as Catering, Sterile Services and Housekeeping are given the option to receive bespoke face-to-face training within their departments.

One of the major challenges in attaining compliance is the fact that IG training is an annual competency unlike many other subjects which only require renewing every two or three years, and so requires staff to go out of their way to obtain this competency in the “off years”.

Fig 2 – IG training compliance



Conclusion

Significant improvements have been made during 2015/16, particularly with IG training uptake and information risk assurance. However it must be recognised that this work is ongoing and requires continual update and maintenance to ensure that compliance with the national standards is sustained. While the initial drive to begin to imbed this initiative is perhaps the most difficult, it is essential that this momentum is sustained to avoid a retrograde slump, negating the achievements of this year.

Once the information risk agenda is firmly imbedded within the organisation, attentions will be turned to improving compliance in other areas, such as with the above-noted poor FOI compliance.

Appendix 1 – IG Toolkit scores

Standard	Description	Owner	Targeted Level
101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Information Governance Manager	3
105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Information Governance Manager	3
110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Associate Director Commercial Services	2
111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	HR Manager	3
112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Information Governance Manager	1
200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Information Governance Manager	3
201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	Information Governance Manager	1
202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	Information Governance Manager	1
203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	Information Governance Manager	2
205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Health Records Manager	2
206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	Information Governance Manager	2
207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Information Governance Manager	1
209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Information Governance Manager	2
210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Assistant Director IT Development	2

300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Assistant Director IT Operations	2
301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Information Governance Manager	2
302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Information Governance Manager	3
303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Assistant Director IT Operations	2
304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Assistant Director IT Operations	2
305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Assistant Director IT Operations	2
307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Information Governance Manager	3
308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Assistant Director IT Operations	2
309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Information Governance Manager	2
310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Assistant Director IT Operations	2
311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Assistant Director IT Operations	3
313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Assistant Director IT Operations	2
314	Policy and procedures ensure that mobile computing and teleworking are secure	Assistant Director IT Operations	2
323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Assistant Director IT Operations	2
324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Head of Information	2
400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Information Governance Manager	2
401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Director of Informatics	2

402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Assistant Director IT Development	2
404	A multi-professional audit of clinical records across all specialties has been undertaken	Clinical Effectiveness Manager	2
406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Health Records Manager	2
501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Assistant Director IT Operations	2
502	External data quality reports are used for monitoring and improving data quality	Head of Information	2
504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Head of Information	2
505	An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	Clinical Coding Manager	2
506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Head of Information	2
507	The Completeness and Validity check for data has been completed and passed	Head of Information	2
508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Clinical Coding Manager	2
510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	Clinical Coding Manager	2
601	Documented and implemented procedures are in place for the effective management of corporate records	Information Governance Manager	2
603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Information Governance Manager	3
604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Information Governance Manager	2
			70%

*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:	1 April 2016 – Part 1
Subject:	Monitor Q3 Report
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	n/a
Officer with overall responsibility:	Sarah Anderson, Trust Secretary
Author(s) of papers:	Monitor
Details of previous discussion and/or dissemination:	The return informing this quarterly feedback letter was submitted in January 2016 following Board approval.
Action required: Approve/Discuss/Information/Note	For Information.
<p>Executive Summary:</p> <p>Monitor have responded to the Trust's Quarter 3 submission and rates the Trust as level 2 for the Financial sustainability risk rating and 'Under Review' for the Governance rating. The latter rating will continue until such time as Monitor has concluded its investigation and determined what, if any, regulatory action may be appropriate.</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>	--

1 March 2016

Mr Tony Spotswood
Chief Executive
The Royal Bournemouth and Christchurch Hospitals
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Dear Tony

Q3 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q3 submissions is now complete. Based on this work, the trust's current ratings are:

- Financial sustainability risk rating: 2
- Governance rating: Under review - Investigation

These ratings will be published on Monitor's website later in March.

The trust's governance rating is 'Under Review - investigation', which reflects its financial sustainability risk rating. The trust has also failed to meet the A&E four-hour target which has triggered consideration for further regulatory action.

As per our letter of 20 November 2015, Monitor is investigating the trust for a potential breach of its provider licence and the Trust's governance rating will remain 'Under Review' until such time as Monitor has concluded its investigation and determined what if any regulatory action may be appropriate. Should Monitor decide not to take formal enforcement action, the Trust's governance rating will revert to 'Green'. Where Monitor decides to take formal enforcement action to address its concerns, the trust's governance rating will be 'Red'. In determining whether to take such action, Monitor will take into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance¹ and the Risk Assessment Framework².

A report on the aggregate performance of all NHS providers (Foundation and NHS trusts) from Q3 2015/16 will be available in due course on our website (in the News, events and publications section), which I hope you will find of interest.


For your information, we will be issuing a press release in due course setting out a summary of the report's key findings.

¹ www.monitor-nhsft.gov.uk/node/2622

² www.monitor.gov.uk/raf

If you have any queries relating to the above, please contact me by telephone on 02037470311 or by email (Sabir.Mughal@Monitor.gov.uk).

Yours sincerely

A handwritten signature in black ink, appearing to read 'Sabir Mughal'.

Sabir Mughal
Senior Regional Manager

cc: Ms Jane Stichbury, Chair
Mr Stuart Hunter, Finance Director

BOARD OF DIRECTORS MEETING – 1 APRIL 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 26 February 2016		All
11.05	2. MATTERS ARISING		
	a) To provide updates to the Actions Log		All
	b) Potential NED Conflict of Interest (Paper)	Discussion	Jane Stichbury To Follow
11.10-11.45	3. STRATEGY AND RISK		
	a) Vanguard Update (verbal)	Information	Paula Shobbrook/ Peter Gill
	b) Draft Capital Expenditure (Capex) Plan 16/17 (paper)	Discussion/ Decision	Richard Renaut
	c) Significant Risk and Assurance Framework (paper)	Information	Paula Shobbrook
	d) Private Patients Business Case (paper)	Decision	Stuart Hunter
11.45-12.15	4. GOVERNANCE		
	a) Board Committee Structure (paper)	Decision	Sarah Anderson
	b) Update on medical staff issues (verbal)	Information	Basil Fozard
12.15-12.20	5. QUALITY		
	a) Issues not dealt with in Part 1		
12.20-12.50	6. PERFORMANCE		
	a) Issues not dealt with in Part 1		
	b) CCG Contract (verbal)	Discussion	Stuart Hunter
	c) Operational Budgets 2016/17 (paper)	Decision	Stuart Hunter
	d) Recommendation Report: EPMA	Decision	Stuart Hunter
12.50	7. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff		
	b) Reflective Review:		
	– What has gone well?		
	– What do we need more of?		
	– What do we need less of?		

2.30pm Blue Skies Session: Monitor Well-led Review (SA)