

A meeting of the Board of Directors will be held on Friday 24 June 2016 at 8.30am in the Oasis Restaurant, Royal Bournemouth Hospital

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

Alison Buttery
Interim Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8:30-8:35	1. APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 27 May 2016		<i>All</i>
	b) To provide updates to the Actions Log		<i>All</i>
8.40-8.45	3. MATTERS ARISING		
	a) None		
8.45-9.45	4. QUALITY		
	a) Patient Story (verbal)	Information	<i>Paula Shobbrook</i>
	b) Feedback from Staff Governors (verbal)	Information	<i>Jane Stichbury</i>
	c) Stroke Reflections (presentation)	Discussion	<i>Claire Stalley/ Becky Jupp/ Andrew Williams</i>
	d) Nursing Midwifery and AHP Strategy and Conference feedback (paper/video)	Information	<i>Paula Shobbrook</i>
	e) Complaints Report (paper)	Information	<i>Paula Shobbrook</i>
9.45-10.05	5. PERFORMANCE		
	a) Performance Exception Report (paper)	Information	<i>Richard Renaut</i>
	b) SSNAP Results (paper)	Information	<i>Richard Renaut</i>
	c) Outcome of Monitor Investigation (verbal)	Information	<i>Stuart Hunter</i>
	d) Report from Chair of HAC (verbal)	Information	<i>Dave Bennett</i>
	e) Quality Report (paper)	Discussion	<i>Paula Shobbrook</i>
	f) Report from Chair Finance Committee (verbal)	Information	<i>John Lelliott</i>
	g) Finance Report (paper)	Discussion	<i>Stuart Hunter</i>
	h) Workforce Report (paper)	Discussion	<i>Karen Allman</i>

	i)	Update from Charity Committee held on 5.5.2016 (verbal)	Information	<i>Stuart Hunter</i>
10.05-10.15	6.	STRATEGY AND RISK		
	a)	Clinical Services Review (paper)	Information	<i>Tony Spotswood</i>
	b)	Performance against Trust Objectives (paper)	Information	<i>Tony Spotswood</i>
10.15-10.25	7.	GOVERNANCE		
	a)	IPCC Annual Report and Board Statement of Commitment to Prevention of Healthcare Associated Infection (paper)	Approval	<i>Paula Shobbrook</i>
	8.	NEXT MEETING		
		Friday 29 July 2016 at 8.30am in the Committee Room, Management suite, Royal Bournemouth Hospital		
	9.	ANY OTHER BUSINESS		
		Key Points for Communication to Staff		
10.25-10.45	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.		

Part I Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Board of Directors** held on **Friday 27 May 2016** in the Conference Room, Education Centre, The Royal Bournemouth Hospital.

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Derek Dundas	(DD)	<i>Non-Executive Director</i>
	Basil Fozard	(BF)	<i>Medical Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Stuart Hunter	(SH)	<i>Director of Finance</i>
	Ian Metcalfe	(IM)	<i>Non-Executive Director</i>
	Steve Peacock	(SP)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Sarah Anderson	(SA)	<i>Trust Secretary</i>
Staff	Kate Bond	(KB)	<i>Acting Matron, Specialist Services & Ophthalmology</i>
	Alison Buttery	(AB)	<i>Interim Trust Secretary (with effect 31 May 16)</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	John Lelliott	(JL)	<i>Non- Executive Director (with effect 1 June 16)</i>
	Alison Pressage	(AP)	<i>Matron, Specialist Services</i>
	Emma Whittingham	(EW)	<i>Staff Nurse, Ophthalmology</i>
Public/ Governors	David Brown		<i>Public Governor</i>
	Carole Deas		<i>Public Governor</i>
	Eric Fisher		<i>Public Governor</i>
	Bob Gee		<i>Public Governor</i>
	Paul Higgs		<i>Public Governor</i>
	Margaret Neville		<i>Representative of the Friends of the Eye Unit</i>
	Roger Parsons		<i>Public Governor</i>
	Alan Radley		<i>Public Governor</i>
	Maureen Todd		<i>Public Governor</i>
	Graham Swetman		<i>Public Governor</i>
Apologies	Dave Bennett		<i>Non- Executive Director</i>
	Nicola Hartley		<i>Director of Organisational Development</i>
	Bill Yardley		<i>Non- Executive Director</i>

41/16 DECLARATIONS OF INTEREST

Action

The Chairperson welcomed John Lelliott, Non-Executive Director effective from 1 June 2016 and Alison Buttery, interim Trust Secretary effective from 31 May 2016, who were present as observers at the meeting.

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

The minutes were **approved** as an accurate record subject to the amendment at 34/16 (i) *“The Board were advised that the volume of deaths exceeding 30 would trigger a review to identify any examples of sub optimal care and clinicians will be provided with support to understand the concept,”* to *“The Board were advised that any death graded at ‘3’ (suboptimal care-probable avoidable death) would trigger a serious incident review and panel.”*

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

- 34/16 (a) British Medical Association is yet to reach an agreement with the Government. The new contract will be implemented from August. It is anticipated that 10 additional posts will be required to ensure rotas are compliant together with additional cost pressures. The impact will be summarised together with the additional costs. Communication will be considered both internally and externally.
- 07/16 (a) Workforce Race Equality Scheme- feedback will be provided in June and will incorporate the findings from the Cultural Audit work.

RR/
JD**MATTERS ARISING**

- (a) The Monitor Well Led Self - Assessment, once complete, will be reviewed by Executives and updated on a regular basis before being provided to the Independent External Assessor. The evidence identified by the Board must support the Board reflections. Key areas will be identified with actions to address during the interim and this will enable the Board to influence the focus of the assessment with the external body.

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

KB, EW and AP presented the patient story arising from the Ophthalmology Department following feedback about the privacy of the consultation environment. The Friends and Family Test (FFT) feedback highlighted that patients felt they were being overheard by members of the public in the waiting area as consultations were not taking place in a sealed and private room. Due to the nature of some conditions patients may have also not been aware that the consultation rooms were not completely private. The issue was also highlighted in the Privacy and Dignity Audit in 2013.

The team sought to address the issue as a priority and worked together to identify a solution. Due to the restricted space available within the department it took some time to identify and implement changes. The Hospital Charity provided funding to create private consultation rooms with closing doors and improved wheelchair access. The improvements received a positive response from patients and this is reflected in the positive FFT feedback.

Board members commended the changes implemented and

emphasised the positive impact upon privacy and dignity for patients which is paramount for the Trust. The presentation prompted the Board to learn more about the challenges delaying the execution of smaller projects. It was agreed that the process should be improved with clear guidance and support. RR

The Board were informed that the Trust was focused on completing smaller projects internally, with the Estates team, and that these are normally prioritised. The importance of charitable funding was recognised and the support it provides to services for the benefit of patients. Further the broader theme of involving clinicians and patients in the design of facilities in the future was emphasised.

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

The following themes were highlighted at the recent Staff Governor meeting:

- Communicating changes to working structures to staff particularly in Orthopaedics. This has been raised with Executives and is being addressed;
- Premium shifts- Staff Governors reported that there were issues regarding premium shifts. Further communication for staff would be helpful;
- Clinical Services Review- concerns about issues raised within the media. Reassurance was provided that the changes would not impact upon staff pay and staff would not be forced to relocate;
- Personal development opportunities and training;
- The Staff Governor Listening event that took place on 26 May.

The feedback highlighted the importance of ensuring clear communication and escalating issues to appropriate levels.

Staff Governor Listening Event – Thursday 26 May:

The session provided an excellent platform for staff to express views contributing to valued conversations in an informal setting. A range of topics were raised and included:

- The impact upon staff following changes to the bed base in the Derwent. The Director of Operations (DOO) and Matron for the care group are providing support to staff where required;
- Staff rest rooms facilities;
- Transferring patients through the Pathology corridor from theatres;
- Clinical Services Review (CSR) - whether the changes would impact staff pay/contracts and concerns about relocation. There was no debate about the rationale for the changes and staff were supportive. Further clarification will be provided including the member leaflet and Q&A document;
- Medicines Governance Committee- appropriate attendance at to promote learning about medicines governance;
- BEAT- whilst aspects of the system are positive staff would

- prefer face to face training for some modules including diabetes training;
- Concerns about national pay for nursing staff were raised. The Trust will ensure that it works with the health system to influence greater pay opportunities;
- Request to make the external signage to the hospital clearer.

RR

Clarity was provided where possible and further work is on-going to address any issues identified. The importance of communication with staff was emphasised.

Nursing, Midwifery and Allied Health Professionals Conference- Thursday 12 May:

The conference launched the strategies for Nursing, Midwifery and AHPs which were developed in conjunction with staff and aligned with the Trust objectives.

The Chief AHP Officer presented & Professor Jane Reid alongside teams from the Trust to the 150 attendees. There were a series of presentations showcasing the outstanding work at the Trust to develop and improve patient experience and it has been intimated that this will form international best practice as a result of the conference. A detailed report on the event will be presented at the next Board meeting including a video from the team involved.

PS

(c) Complaints Report (Item 4c)

The report was reviewed in detail by the Healthcare Assurance Committee (HAC). Compliance for the acknowledgement of complaints reached 98% in April. The substantive post within the complaints team has been appointed to and assurance was provided that this would support progress going forwards.

Overall complaint response times were improving and changes to internal processes had supported the reduction in the backlog. In June HAC will identify a trajectory for the closure of complaints and a full report will be provided to the Board.

Workshops are being held within directorates to focus on response times and developing compassionate and appropriate responses. It is anticipated that further improvements will be seen next month following embedding of the changes outlined. It was emphasised that complaints had been included as a standardised agenda item at Care Group meetings. The Board requested a more detailed report at the next meeting.

PS

44/16

PERFORMANCE

(a) Performance Exception Report (Item 5a)

The expected priority targets linked with the Sustainability and Transformation Fund included ED 4 hour, RTT, Cancer 62 day, Diagnostic 6 weeks, ED 12 hour, RTT 52 weeks and ambulance

handover delays. During April the Trust met or exceeded the STF proposed trajectories. It was confirmed that the Trust would agree 3/4 of the national targets which included maintaining RTT, 6 week diagnostic waits and Cancer 62 days.

Pressures have been addressed for Cancer 2 week and 62 day performance with additional capacity and support. The Trust is one of a small minority of Trusts who are compliant with the remaining trajectories linked to the STF funding.

Compliance with the ED 4 hour trajectory remains challenging and the Trust achieved 95% against the trajectory for the year in relation to the STF submission. Further deterioration in performance is being evidenced across the country. It was requested that the issue was discussed with NHS Improvement (NHSI) to review and provide feedback.

RR

The criteria linked to the funding remains unclear and whether the impact will be proportional is yet to be determined. It was acknowledged that, further to the announcement of the final position of the provider sector, NHSI would be considering the impact and provision for the control total. It was reinforced that the majority of providers have raised concern about the ED 4 hour trajectory. Board members emphasised the need for the Board to be sighted on the effect of losing part of funding.

The Board were advised that the Infection Control summary report would be provided next month. Performance is ahead of the C-difficile trajectory. Historically good practice has been in place and whilst the target remains challenging the Trust will continue to strive to achieve the target of 14. Clarification around the reporting of C-difficile was requested within the report.

PS

The progress with the Quality Improvement projects was queried. Periods of challenge were recognised within the nature of the projects, however, progress was noted. It was requested that the factual content of the QI summary report was revised and to identify any factors impacting upon progress including resources.

RR

The Board were informed that performance against the national Stroke indicator 'SSNAP' had increased to 87 and graded within the 'A' category.

The impact of the average length of stay graph within the report was raised. It was suggested that areas should be owned individually with specific with targets. It was agreed that the Lord Carter of Cole's recommendations would support reporting.

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

The key themes were outlined and included:

- The CQC action plan was assessed in detail before being presented to the CQC and CCG, who were content with the

- Trust's determination to address issues;
- The Board Assurance Framework was reviewed and recommendations put in place to provide assurance of the work to tackle areas of challenge;
- FFT results were positive with quality care being delivered, however, completion of records required improvement;
- The Committee commended the positive work on AMU and requested it was promoted around the Trust;
- There is a lack of mental health beds and this needed to be escalated with partners;
- Recurring themes identified within complaints included noise at night, food and communication.

Board members questioned the root cause of issues with incomplete documentation. Progress had been made with more robust methods of assurance including the Electronic Nursing Assessment. It was emphasised that factors included leadership, training and culture and the Trust was holding staff to account by providing support to ensure processes are embedded. The Board noted that the Cultural Audit feedback would provide further insight into the issues raised.

(c) Quality Report (Item 5c)

- Two serious incidents are awaiting panel review. The issues identified included the appropriate completion of the documentation. It was emphasised that staff must ensure that all steps within the pathway are evidenced and that they are compliant with standard operating procedures;
- The Trust rated within the top quartile for patient experience within inpatient areas. The actions put in place are being reflected within the scoring;
- It was noted that themes within complaints were aligned with the Care Campaign audit and considered by HAC.

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

The Chair noted that April had been a difficult financial month as a result of the Junior Doctors strikes which had impacted upon the Trust's activity based contract. Cancelled elective activity was estimated to be £350-400,000k and contingency had been used to supporting the reporting position.

The recent and significant reduction in the number of medical outliers supported both improvements in quality of care and the financial position. The inventory management system is due to be piloted in theatres and it is anticipated that this will also have financial benefits.

The Chair reflected upon their term of office as Non-Executive Director and emphasised that the Trust had improved and the Board was working as a team.

(e) Finance Report (Item 5e)

The report was summarised noting the following themes:

- The Junior Doctor strikes had impacted upon the financial position. Further decreases in Cardiology private patient income had also been a factor. An agreement is now in place with Regents Park and income is expected to be recovered;
- There was an underspend in light of the reduction in activity. The Trust will need to meet activity levels going forwards;
- Cost Improvement Programme (CIP)- there is confidence that schemes will be identified to generate the income required to address the gap in the plan;
- The agency cap must be maintained or this will impact upon the STF funding.

Board members voiced their frustration that the full conditions for the STF funding had not been identified by the Department of Health. The Board were assured that the Q1 trajectories were in the process of being had been agreed and noted the risk that if the Trust failed to achieve the £1.45 million control total that the funding could be reduced. This will also impact upon the cash position for 2017/18.

The impact of the Junior Doctors strikes was queried. Throughout the strikes senior clinical engagement increased and intervention earlier within pathways was known to improve outcomes, efficiencies and cost. The Trust would be working to support and encourage the working practices of the consultant body amongst Junior Doctors with increased consultant presence.

It was requested that an acknowledgment of the risks and the challenging position was reflected in the report with future planning of likely scenarios.

RR/SH

(f) Workforce Report (Item 5h)

The report was summarised and the key information outlined:

- Strong performance against the trajectory for Values Based Appraisals with positive feedback on the process;
- Essential Core Skills- improvements in compliance are being made. Communication is being addressed and support for staff is being reviewed. A developer has been appointed to review the training modules and support further progress;
- Sickness absence- the recommendations from the report will be discussed at the next Workforce Committee. Performance Management Group (PMG) will be addressing areas with high levels of sickness;
- Recruitment continues to be a key area of focus for the Trust and new initiatives are being developed;
- The Communication report reflects the recent positive media attention and this is expected to continue;
- Safe staffing- staff are being managed and vacancies mitigated across the organisation to ensure that quality care

is being provided. This has been challenging in light of increased activity and vacancies. It is expected that the implementation of the Lord Carter recommendations will have a positive impact;

- The use of Thornbury tier 3 nurses has been terminated. One red flag was noted last month and discussed in detail at HAC. Robust processes are in place and red flags are reviewed with rigour.
- The high levels of HCA fill rate at night links to security and patients with high needs. The rationale behind the fill rate is to be included within the report.

PS

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

The report was noted for information. The Board emphasised that focus will be maintained on progressing the strong position which has developed over the last two years.

45/16

STRATEGY AND RISK

(a) Clinical Services Review (Item 6a)

The following updates were provided to the Board:

- The CCG have engaged with the Clinical Senate who will review the proposal and provide a view and assurance to NHS England. NHS England and NHS Improvement will need to provide their support;
- There were concerns about the configuration of the cancer services within the model with inpatient haematology and acute oncology services developing on the emergency site and radiotherapy remaining at Poole Hospital. The Clinical Senate would take an interest in this aspect;
- Poole Hospital was not supportive of the proposal for the emergency site. The CCG would work with the Poole Board and the responses from NHSI and NHSE would be influential and essential to progress;
- The CSR formed the basis of the Dorset Sustainability and Transformation Plan and was the most advanced in the South of England however limited capital would be available;
- The National Investment Committee would be likely to consult on the proposal in September. If there was a view that the Trusts were not aligned across Dorset it may prevent the consultation from proceeding and impact upon financial support;
- Work was on-going with the communication strategy and a detailed plan was being developed aligning with the CCG.
- Clinicians needed to keep in mind the broader purpose of the CSR, to improve the spectrum of care for patients in Dorset;
- Critical to the success of the CSR would be whether the clinical body was aligned with the proposal before September;
- It would be vital to demonstrate and promote the benefits to

patients and the public including how services will look in the future and this needed to be led by the CCG and clinical body.

48/16

DATE OF NEXT MEETING

24 June 2016 at 8.30am in the Oasis Café, Royal Bournemouth Hospital

49/16

Key Points for Communication:

1. The venue of the next Board Meeting- Oasis Café Area 24 June
2. CSR
3. Thank you to Staff Governors for the Listening Event
4. Patient Story

In addition the Chairperson thanked BY who was stepping down as Non-Executive Director, effective from 14 June, and SA, as Trust Secretary effective from 31 May, for their contributions to the Trust. Further the Chairperson thanked IM, whose term of office expired on 27 May, for his contribution and leadership on the Finance Committee during challenging circumstances.

50/16

QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC

1. The new format for reporting progress with delayed transfers of care (DTC) scheme was welcomed. The key risk to the delivery of the scheme was queried together with the trajectory for improvements going forwards. RR outlined that the trajectory was formed by the Better Care Fund and that the main risk related to funding from the CCG. The bed state within the Trust had improved however DTC had increased slightly. The Trust would focus on the underlying internal actions together with influencing improvements with external provisions of domiciliary care. It was anticipated that there will be an improvement against the trajectory over the next two months once the actions had been embedded.
2. It was suggested that RBCH should form a joint statement of support for the green model with Poole Hospital to emphasise the need for a solution for Dorset as a whole. It was discussed that the Trust was working with Poole Hospital colleagues to improve relationships. Opportunities to develop relationships will also be supported through areas of the Vanguard Project. Within the next phase of work the Trust will release an announcement to promote to staff the importance of working together to design the future of services jointly and that this will not impact upon staff loyalty.

There being no further business the meeting closed at 10:50am.
AH 27.05.2016

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
27.05.16	44/16	PERFORMANCE			
	(a)	<u>Performance Exception Report</u>			
		Discuss the challenges to achieving the ED 4hr target with NHSI in light of the STF requirement and provide feedback to the Board.	RR	In progress	Discussions on going with NHSE and CCG. Local trajectory for Months 1-11 likely to be agreed with CCG. M12 to be agreed with NHSI.
		Provide clarification around the reporting of C-difficile within the performance report.	PS		
		Revise the factual content of the QI summary report and ensure that factors impacting upon progress are identified.	RR	Complete	Feedback given to various report authors, to consider language and content .
	(e)	<u>Finance Report</u>			
		Include an acknowledgement of the risks to the STF funding and the challenging position the Trust has been placed in within the report with future planning of likely scenarios.	RR/SH	Complete	The finance section of the board report now reflects the risks associated with the STF funding and future reports will detail the assumptions behind the allocation of the fund
	(f)	<u>Workforce Report</u>			
		Include the rationale behind the HCA night fill rate within the performance report.	PS		
	43/16	QUALITY			
	(a)	<u>Patient Story</u>			
		Identify the challenges delaying the execution of the project within Ophthalmology.	RR	Complete	No blame- lessons learnt exercise undertaken, and action points agreed to improve small works processes.
	(b)	<u>Feedback from Staff Governors</u>			
		Address issues obstructing the signage to the Hospital.	RR	Complete	Foliage being cut back in June

RBCH Board of Directors Part 1 Actions May 2016 & previous

		Provide a detailed report and presentation to the Board on the success of the Nursing, Midwifery and AHP conference.	PS	Complete	Agenda item June with video presentation.
	(c)	<u>Complaints Report</u>			
		Provide a more detailed report for the next Board meeting.	PS		
29.04.16	34/16	PERFORMANCE			
	(a)	<u>Performance Exception Report</u>			
		27.05.16 (42/16) Summarise the impact and the additional cost to the Trust. Consider external/internal communication.	RR/JD	Complete	Effect of strikes has been factored into the Month 1 budget position, with c£250K cost allocated.
01.04.16	24/16	QUALITY			
	(d)	<u>Complaints Report</u>			
		Ensure that additional focus is paid to complaint response times and report on improvements within the next two months.	PS	June	Work is in progress and will be reported to HAC
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	15 June HAC	Not yet due – pre-self assessment being prepared and self assessment to be refined over the summer.
	17/16	PERFORMANCE			
	(d)	<u>Staff Survey</u>			
		Incorporate the themes identified, such as harassment and bullying, within the staff survey into the cultural audit along with the CQC assessment. Provide a timeline for completion.	NHa/KA	June	Included within the Cultural Audit work and action plans reviewed at the workforce committee in June.

RBCH Board of Directors Part 1 Actions May 2016 & previous

29.01.16	07/16	GOVERNANCE			
	(a)	<u>Workforce Race Equality Scheme</u>			
		Provide Executive support to the areas identified within the plan and increase further development of diversity. Provide a timeline for completion	KA/Execs		The WRES was discussed at the Workforce Committee. An update will be provided at the meeting.
18.12.15	108/15	PERFORMANCE			
	(g)	<u>Workforce Report</u>			
		Develop and agree a retention plan. Provide a timescale for the outline retention plan.	Execs/KA		Retention issues are being incorporated within plans under the CSR, Vanguard and Trust processes.

Key:

	Outstanding
	In Progress
	Complete
	Not yet required

RBCH Board of Directors Part 1 Actions May 2016 & previous

		Incorporate the themes identified, such as harassment and bullying, within the staff survey into the cultural audit along with the CQC assessment. Provide a timeline for completion.	NHa/KA	June	March: Results of the 2015 staff survey have been shared with care groups and directorates who have been developing their action plans; also discussed at Workforce Committee. Existing themes will be reviewed as part of the cultural audit. June:
29.01.16	07/16	GOVERNANCE			
	(a)	<u>Workforce Race Equality Scheme</u>			
		Provide Executive support to the areas identified within the plan and increase further development of diversity. Provide a timeline for completion	KA/Execs		The WRES was discussed at the Workforce Committee. An update will be provided at the meeting.
18.12.15	108/15	PERFORMANCE			
	(g)	<u>Workforce Report</u>			
		Develop and agree a retention plan. Provide a timescale for the outline retention plan.	Execs/KA	June	

Key:

	Outstanding
	In Progress
	Complete
	Not yet required

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

BOARD OF DIRECTORS

Meeting Date and Part:	24 th June 2016 Part 1
Subject:	A briefing on the development of the Nursing, Midwifery and Allied Health Professional Strategies, and the collaborative Nursing, Midwifery and Allied Health Professional Conference
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	Nursing and Midwifery Strategy Allied Health Professional and Scientific Staff Strategy Conference Agenda
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing and Midwifery
Details of previous discussion and/or dissemination:	N/A
Action required: Discuss/Information	The Board is invited to note the engagement and development process undertaken, the publication of the Nursing & Midwifery and Allied Health Professional & Scientific Staff Strategies
Executive Summary: The Board is invited to note the process for designing the Nursing and Midwifery Strategy and the Allied Health Professional, Scientific and Technical Staff Strategy together with the content of the final documents which are available in the Reading Room. They align with the board objectives, vision and values and the Quality Strategy. The Nursing, Midwifery and Allied Health Professional Conference held on the 12 th May, was attended by 123 nurses, midwives and allied health professionals. The Strategies were formally launched at the Conference. With notable national and local speakers, this was concluded to be a success. The final agenda is available in the Reading Room and a short video depicting the day from the voice of the attendees will be screened at the board meeting.	
Relevant CQC domain:	Safe, Caring, Effective, Responsive & Well Led
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	No

RBCH Nursing, Midwifery and Allied Health Professional Strategies

1 The Nursing and Midwifery Strategy Development

- 1.1** The design and development of the Nursing and Midwifery Strategy, launched on May 12th 2016 began in May 2015 with an open invitation to the nursing and midwifery workforce to attend a workshop. The workshop event, facilitated by Sue Mellor Head of Patient Experience and Ellen Bull Deputy Director of Nursing was structured into group work following an introduction by Paula Shobbrook. Materials utilised to initiate and stimulate thought on both content and style were provided. This included review of the Trust's Strategic Plan, objectives and Quality Strategy, Nursing and Midwifery strategies from other acute Trusts, research on current topics, and quotes from professional experts or famous dignitaries on the definition of caring.
- 1.2** Fifty people attended the initial workshop with registered nurses, midwives and care staff present. Working in five groups, the attendees were asked to review the materials, and then determine what they wanted from a Nursing and Midwifery strategy within this Trust. The information was collated under the CQC five themes with additional themes emerging. At a further meeting in the Autumn of 2015 headings were revised and rationalised into four. The four key themes were then allocated to working groups, with a senior nurse lead for each, which included a wider representation with all levels of staff to further develop the components. This enabled each member team to get feedback from the workforce with the opportunity to contribute and comment in the design and style of the strategy. During this phase, through discussion and review of the outputs the four themes were merged into:
 1. Getting staffing right
 2. Delivering Safe Effective Care; a Safe and Effective workforce
 3. Guiding and embedding compassionate care through Values Based Leadership
- 1.3** This was then collated into one style, with aims and measurable outcomes added. Quotes from patient and staff were included throughout the design. The Communications team were hugely supportive in terms of the delivery of the final layout and styling.

2. The Allied Health Professional Strategy Development

- 2.1** The Allied Health Professional Forum, supported by the Director of Nursing and Midwifery, worked in a similar facilitated manner to develop an Allied Health Professional, Scientific and Technical Staff Strategy. Following discussion at the forum, it was decided a separate strategy would be most appropriate at this point. To support the overarching vision of 'collaborative care', it was agreed this would be aligned with the work of nursing and midwifery colleagues. The Strategies offer identifiable and quantifiable actions for optimum professional practice to deliver the best in patient care, under the same key themes.

Members of the Allied Health Professional Forum were key in gaining feedback from their AHP, technical and scientific staff teams, reviewing the content and incorporating this into their strategy development. There was an identified lead from the forum, Ian Knox, who met regularly with the lead of the nursing and midwifery strategy so that there was coordination in the approach and messaging.

3. The Collaborative Conference 12th May 2016

- 3.1** Simultaneously, a Conference Planning Group was convened to plan the first professional Nursing, Midwifery and AHP Conference in the Trust. The date was chosen to mark the occasions of:
- International Midwifery Day on 5th May
 - International Nurses Day on the 12th May
 - Allied Health Professionals Hear Our Voice National Campaign launch
- 3.2** The Conference was planned to:
- Celebrate professional practice and innovation within the Trust.
 - Hear about the future national and local landscape, with national, regional and local key note speakers including: Suzanne Rastrick Chief Allied Health Professionals Officer NHS England, Sally Shead Director of Quality Dorset Clinical Commissioning Group, Professor Jane Reid, Nicola Hartley
 - Through presentations and discussions led by our staff, share practice which is happening across the Trust.
 - Celebrate the launch of our collaborative strategies.
 - Celebrate the international days afforded to the nursing and midwifery professions
 - Formally Launch the Nursing and Midwifery and Allied Health Professional Strategies.
- 3.2** Invitations to share practice innovation were requested across the workforce. Four individuals or teams presented their practice innovation from nursing and midwifery and the allied health professionals presented in the afternoon in a breakout session. This included a question and answer session which was attended by the Chief AHP Officer from NHS England, Chief Executive and Director of Nursing and Midwifery.
- 3.3** In total there were 123 attendees with many more able to join in the networking in the refreshment breaks. The communications team filmed the event and have produced a short film to capture the ambience and atmosphere of the day.
- 3.4** The evaluation of the event has been formally reviewed by the conference planning group. As it was such a success, we are planning the next conference at the same next year, and this is likely to be an annual event.

4. Next steps

- 4.1** Following the launch on 12th May, the strategies are being publicised through the Trust's professional groups and formal communications are planned.
- 4.2** The Nursing and Midwifery strategies have been hand delivered by the Director or Deputy Director of Nursing to all wards and departments. As the strategies provide the detail support delivery of the Trust's vision, this will be incorporated into the team and personal objectives for nursing and midwifery staff. The matron's meeting and strategic senior nurse meeting will sponsor and support the continued engagement and monitor progress.
- 4.3** The AHP forum will continue to lead the implementation of their strategy, and further plans for this will be discussed at the next meeting in July.

BOARD OF DIRECTORS

Meeting Date:	24 th June 2016 Part 1
Subject:	Report on Formal Complaints Performance against the Trust Policy
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	None
Officer with overall responsibility:	Ellen Bull Deputy Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing and Midwifery Anton Parker, Information Manager
Details of previous discussion and/or dissemination:	Healthcare Assurance Group 23 rd June 2016
Action required:	The paper is provided for information

Executive Summary:

The Complaints report includes aggregate and Care Group and directorate complaint acknowledgement and **response performance**. This is a key focus of the Board of Directors and this has been reported through the Healthcare Assurance Committee and Trust Management Board.

Key messages:

1. Current Trust response time in month (May 2016) is 62% against a standard of 75% (18 out of 29 complaints were closed within the 25 working day time that were due in month).
2. 17 formal complaints were received in May with 9 validated as being acknowledged within the three day timescale, and 8 awaiting validation.
3. Response time in April has been validated at 64% (9 out of 14 complaints were closed within the 25 working day time that were due in month).
4. The response time improvement focus continues and is sustained above 60% for month 2 YTD.
5. Improvement trajectories for all are to sustain responses above 60% for Q1.
Improvement trajectories for formal responses are:
 - Q1 above 60%
 - Q2 above 65%
 - Q3 above 70%
 - Q4 to maintain 75% from the start of quarter 4.
6. Implementation of care was the commonest theme of the in month formal complaints received.
7. During March and April 2016 team sickness and vacancies resulted in data entry backlog and this is currently being recovered. The substantive post holder commenced on 23rd May and is being orientated into the Trust.

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

Complaints Report June 2016

1. Introduction

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

2. Number of complaints

17 formal complaints were received in May 2016.

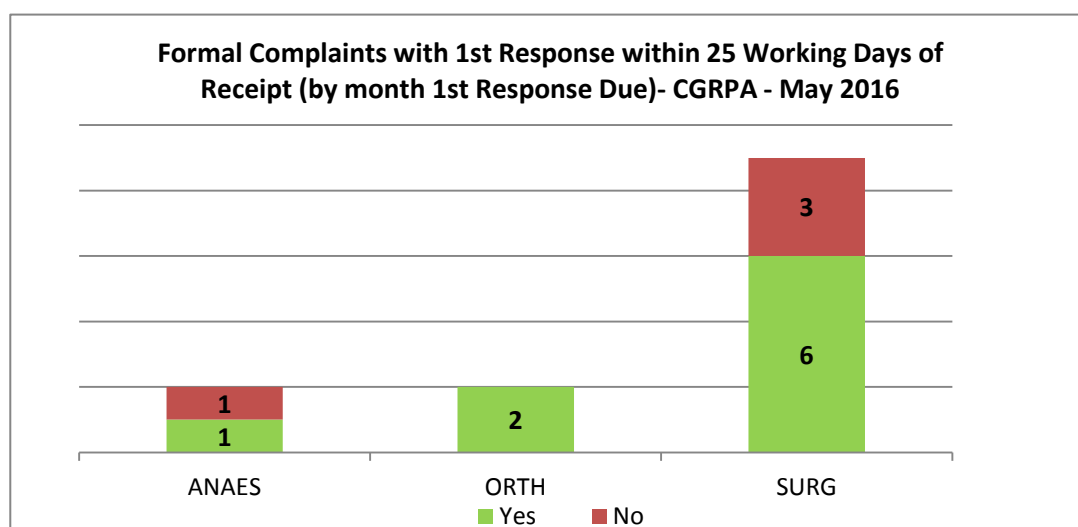
3. Acknowledgement and response times

3.1 Of the 17 complaints received for May, 9 have been validated as acknowledged. The remaining 8 are to be validated. Acknowledgements have traditionally been a formal letter however this can also be a phone call, email or meeting alongside a formal letter to support an increased customised approach appropriate to the complaint context.

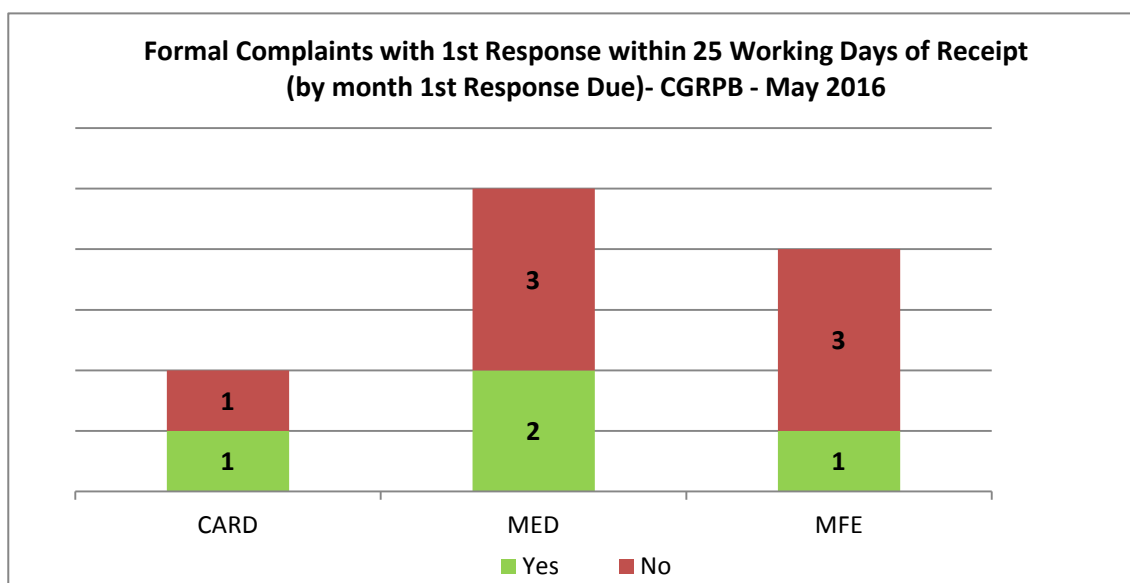
3.2 Responses to complaints should be within 25 working days (quality strategy standard of 75%), which is monitored at the Healthcare Assurance Committee. For May on aggregate the first response times were 62% (18 out of 29 complaint responses due were within 25 working days).

The bar chart 3.3, 3.4 and 3.5 show the in month performance for first responses due in May 2016 by Care Group and directorate respectively. All Care Groups need to improve consistency in response times with Care Group B needing significant improvement within two directorates. In May, the number of total complaint responses which were late were 11 including previous months accrual. However of these, some are paused due to PHSO investigations, external reviews or awaiting a meeting. Refined reporting is being discussed and built to enable this to be accurately depicted. Overall, the focus on closure is having a positive effect and the mid-month position provides an improving picture.

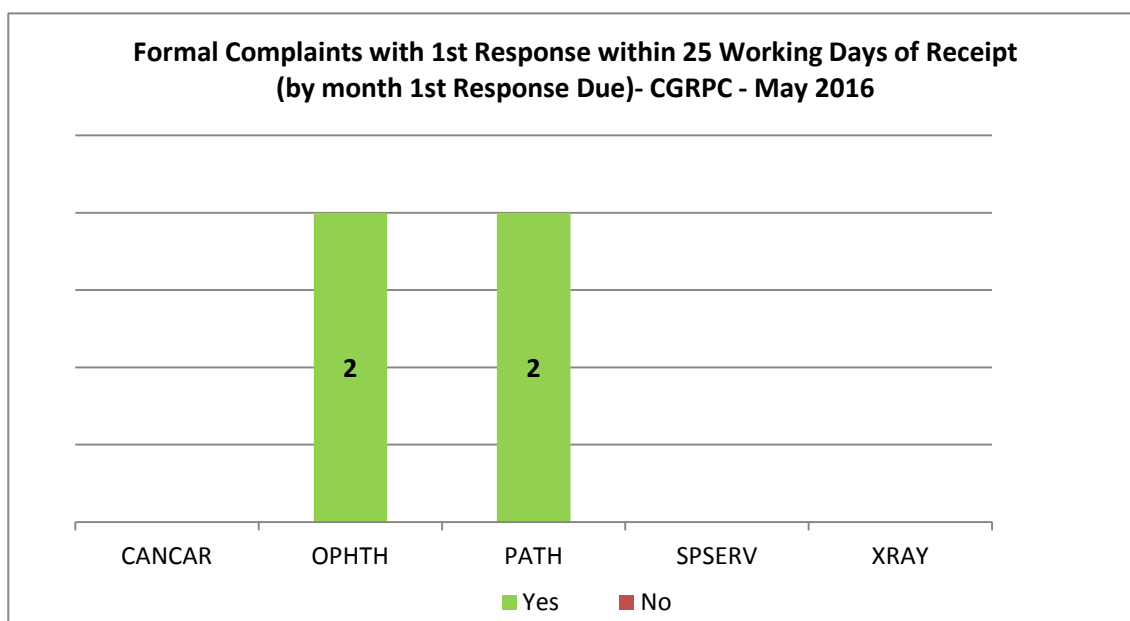
3.3 Table 3.3 depicting Care Group A first response complaint performance May 2016.



3.4 Table 3.4 depicting Care Group B first response complaint performance May 2016.



3.5 Table 3.5 depicting Care Group C first response complaint performance May 2016.



3.5 Current position as of 16th June 2016

There is an improving mid-month position for care groups and directorates for complaint response closures and late cases. This will be reviewed at the Healthcare Assurance Group on 23rd June

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

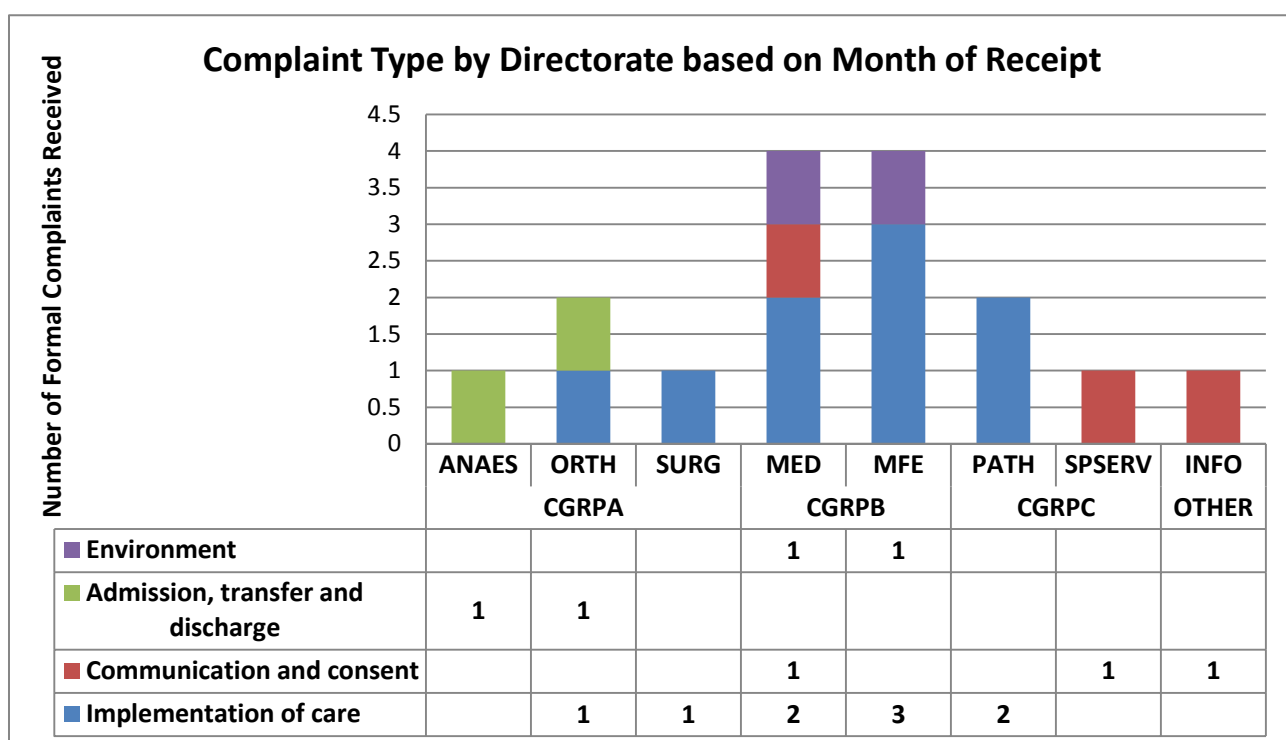
3.7 The Complaints Performance meeting has strong attendance and actions agreed this month are:

1. Focus on closure of in date complaints
2. Agree escalation process to central team before due time if a response is going to be late to identify support required
3. Add an agenda item for shared learning by directorate
4. Scope out the needs of specific staff groups to support resolving arising issues and concerns before they get to formal complaint stage.
5. To ensure transparency of PALS work
6. To identify the learning from Complaints from the group to propose to HAC to place on the website.

4. Themes and trends – Complaints received

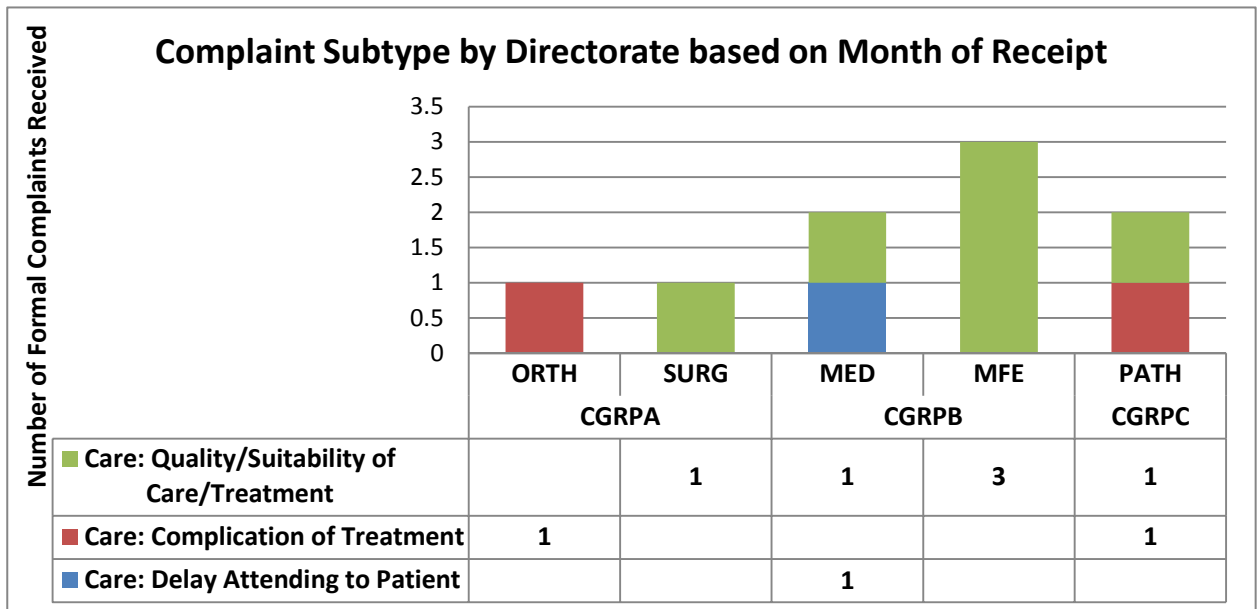
The total received in May by directorate with themes is below. The highest theme again in month was implementation of care.

4.1 Complaints received in Month (May 2016) by type:



4.2 Implementation of care is broken down into subcategories and directorates for complaints received in May 2016. The largest of the subcategories is quality, suitability of care and treatment. A detailed review of this sub type of complaints will be examined through the Complaints group to determine overall improvements or actions taken and required.

4.3 Table 4.3 depicts in month (May 2016) complaints by category Implementation of Care sub types (three subtypes exist for implementation of care).



5.0 Recommendation

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

providing the excellent care we
would expect for our own families

BOARD OF DIRECTORS

Meeting Date and Part:	24 th June 2016 – Part 1
Subject:	Performance Report to End May 2016
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Performance Matrix
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Donna Parker / David Mills
Details of previous discussion and/or dissemination:	PMG
Action required: Approve / Discuss / Information / Note	<p>The Board is requested to note the performance exceptions to the Trust's compliance with the 2016/17 STF, Monitor Framework and contractual requirements..</p> <p>Finally, the Board is also requested to note the detailed report on cancer performance and support the ongoing actions for recovery, where this is required.</p>
<p>Executive Summary:</p> <p>This report accompanies the Performance Indicator Matrix (<i>available in the Reading Room</i>) and outlines the Trust's actual and predicted performance against key access and performance targets. In particular it highlights progress against the likely trajectories for the priority targets set out in the Sustainability and Transformation Fund. These are: ED 4 hour, RTT, Cancer 62 day, Diagnostic 6ww, ED 12 hour, RTT 52ww and ambulance handover delays.</p> <p>For May we are meeting the STF proposed trajectories. The baseline for ambulance handover delay metric is yet to be confirmed.</p> <p>The remaining Monitor Risk Assessment Framework (RAF) indicators were compliant for May excepting the C Difficile target. The Cancer Two Week Wait target is also expected to be below threshold when the final validated upload is completed in July. Improvement is expected across the Quarter but the metric overall is predicted to be non compliant for Q1.</p> <p>The detailed performance levels against the remaining key targets, which form part of the national/contractual obligations, are included in the Performance Indicator Matrix. Narrative is included in this report on an exception basis.</p> <p>Throughout 16/17 the Performance Report will provide a focus on the key STF areas on a quarterly cycle to allow 'deep dives' into the key areas. This month's report incorporates the Month 2 cycle, focusing on Cancer Waiting Times.</p> <p>The Trust's Balanced Dashboard for April 2016 is submitted at Annex A to the Board of Directors, integrating Quality, Clinical Outcomes, Performance, Finance and Workforce. The full report is available in the Reading Room.</p>	
Relevant CQC domain:	
Are they safe?	Yes
Are they effective?	Yes
Are they caring?	
Are they responsive to people's needs?	Yes
Are they well-led?	Yes

<p>Risk Profile:</p> <p>i) Impact on existing risk?</p> <p>ii) Identification of a new risk?</p>	<p>The following risk assessments remain on the risk register:</p> <ul style="list-style-type: none"> i. Cancer 62 day wait non-compliance and national guidance on 'high impact' changes. ii. 4 hour target. iii. Endoscopy wait times – under review now recovery programme completed and sustained for 3 months. iv. RTT due to reduced performance. <p>The urgent care impact risk assessment remains on the Trust Risk Register given the continued activity pressures, 4 hour performance and other indicators such as the increase in outliers.</p>
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Performance Report



For the period to end May 2016

Richard Renaut
Chief Operating Officer

Performance Report

As at 15/06/2016

1. Introduction

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

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

This report covering performance for May 2016 includes a focus on the Month 2 Indicators – Cancer Waiting Times - as per attached quarterly cycle (*Table 1*).

The Trust's Balanced Dashboard for April 2016 is submitted to the Board of Directors, integrating Quality, Clinical Outcomes, Performance, Finance and Workforce. The Trustwide dashboard will be provided quarterly on an ongoing basis following the end of the quarter and is attached at Annex A. (*The full report is available in the Reading Room*).

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

Table 1 – Quarterly Cycle for Focus on Performance Indicators

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

2.1 Sustainability and Transformation Fund 16/17

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

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

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

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

**Validated final position awaited - upload is early July

RTT Incomplete Pathways (18 week) and 52 Week Breaches

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

A cautious approach was therefore, indicated in relation to our submitted trajectory which projected a potential below threshold performance through Q1. Pleasingly, actual performance for May was 92.4%, slightly higher than April and just above the 92% threshold. 21,121 patients continue to wait less than 18 weeks.

Good progress was made through April and May in reducing 18 week admitted backlogs in a number of specialities. These included Orthopaedics, Urology and Cardiology. However, a general increase in total patients on RTT pathways, as well as deterioration in Ophthalmology and pressures across surgical specialities, has meant an increase in overall patients waiting over 18 weeks. Demand and securing capacity therefore, continues to be managed closely as it presents some ongoing risk. Dermatology continues to be a concern across Dorset and we are continuing to work with the CCG and other providers to review actions to manage demand and create capacity. We are also seeing some growing pressure from visiting services and will be working with the provider trusts such as Poole and UHS to review capacity and other options to manage these.

There were no 52 week wait breaches in May.

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

The ongoing increases in demand and limited social/community care capacity has meant that Trusts nationally are continuing to signal further deterioration in 4 hour performance. Our own assessment indicates a similar position and we have therefore, continued to indicate a below 95% trajectory for the year in our revised STF submission. We are committed to striving for an improved position and have supported a national trajectory for improvement by the end of the financial year.

May has continued to see pressures with a significant increase in non-elective admissions compared to last year (13.7%) and ED attendances (12.2%). Despite this and the continued level of social and community care delayed discharges, the outputs of the Trust's improvement work are considered to have contributed to good levels of hospital discharges overall. This meant that although the Trust missed compliance in May with the ED 4 hour target, we saw a significant improvement at 94.9%. There were no 12 hour breaches.

Performance Report

As at 15/06/2016

The challenge to ourselves is to create sustainability and go even further, driven by our QI commitment. This work is pushing forward with further developments in the Cardiology and Orthopaedic pathways this month and a number of 'tests of change' in readiness for the opening of the Frailty Unit in September.

May has seen an increase of 3.8% in total ambulance handovers compared to May '15, and a 3.5% increase compared to April 2016. We are working jointly with the local ambulance services to implement improved systems for handovers and the ongoing metrics and trajectories for the year are being agreed.

62 Day from Referral for Suspected Cancer to Treatment

With lower numbers of Urology breaches in April, supported by the reduced waits for robot prostatectomies for all Dorset patients, we were able to achieve the 62 day target in April at 88.5%. Fast track referrals for Urology, particularly in March as a result of the Blood in Pee campaign, are placing additional demand pressures on the Urology pathways through this quarter. We are also anticipating some impact from some fast track demand and capacity pressures early in the quarter in both Colorectal and Gynae, together with a number of complex pathways affecting patients in Lung and other tumour site services. We therefore, continue to anticipate a below threshold compliance overall, in line with our submitted trajectory for Q1, but to continue the move towards a sustainable position.

Diagnostic 6 Week Wait

Pleasingly our improved, compliant performance was sustained in May with 99.98%, ahead of trajectory and in line with our STF submission.

This also means that we have achieved the Endoscopy national accreditation (JAG) requirement of 3 compliant months and we will be seeking urgent review of our current accreditation status. Currently performance remains on track in the key areas (Endoscopy,

Radiology, Cardiology and Urology) though this continues to be closely managed with the need for additional capacity on an ad hoc basis to respond to peaks in demand. In particular, we are seeing additional demands for Urology cancer diagnostics (e.g. MRI, TRUS) as a result of the increased fast track demand.

2.2 Other Monitor Risk Assessment Framework Indicators

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

Table 3 - Monitor Risk Assessment Framework

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

Note:

*Cancer reflects our predicted position to date. Final upload early June16.

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

Cancer

62 Days from Screening to Treatment

Full compliance was achieved in April (100%), and although there is some risk to threshold achievement in the individual months of May and June, compliance overall is currently indicated for Q1.

31 Days Subsequent Treatment

The 31 day subsequent surgical treatment performance was compliant for April at 97.6%. There remains some risk going forward linked to

Performance Report

As at 15/06/2016

treating the Urology backlog patients, though May predictions are above threshold.

31 Days from Diagnosis for First Treatment

Performance was non-compliant for April as projected (94.3%), due to clearing the Urology backlog. 11 breaches out of 194 (10 of which were Urology) were reported in April. Our agreed CCG recovery trajectory requires full recovery by end Q2 though we continue to strive for an earlier recovery date.

2 Week Wait

Performance was non-compliant for April as expected (84.3%), due to demand and capacity pressures in Colorectal and Gynaecology (the latter due to some sudden unplanned absence) resulting in a number of breaches. Additional sessions have been arranged and performance has improved in the second half of the Quarter, however, this is unlikely to recover full compliance for the Quarter.

Breast Two Week Wait

Performance was compliant at 100%.

Infection Control – C Diff and MRSA

Our trajectory already highlighted some risk in the second half of the year based on the current target of 14. This requires a much lower incident per 1,000 bed days than surrounding providers. This is before the expected increases in incidence over the winter period. 5 cases of C Diff have been reported up to the end of May 2016. Of these, lapse in care is deemed to have contributed to 2, being just above the 1.2 monthly threshold.

There have been no reported cases of hospital acquired MRSA.

Access to Healthcare for People with a Learning Disability

Whilst reported quarterly, we expect compliance to be confirmed for April and May.

3. Contractual and Other Targets Exception Reporting

Compliance was maintained on all other key targets in May. Consultant Upgrades to a Cancer Pathway was below threshold in April (last reported month) with 2 breaches. One patient was delayed for medical reasons as they were unfit for a diagnostic test and the other patient had a complex pathway with multiple diagnostic tests required.

Publication of the Q4 (15/16) Sentinel Stroke National Audit Programme (SSNAP) report will be reported separately to the Board. This shows a high level of performance and above the previous quarter. Monthly un-validated monitoring suggests improvements in the 4 Hour Direct Access and Stay on a Stroke Unit standards in May compared to April.

Performance Report

As at 15/06/2016

Indicator	Measure	Target 16/17	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Mixed Sex Accommodation	Minimise no. of patients breaching the mixed sex accommodation requirement	0	1	1	0	2	0
MRSA Bacteraemias	Number of hospital acquired MRSA cases	0	0	0	0	0	0
62 day – Consultant upgrade	Following a consultant's decision to upgrade the patient priority *	90%	0.0%	33.3%	75.0%	42.9%	
Venous Thromboembolism	Risk assessment of hospital-related venous thromboembolism	95%	96.6%				
Planned waiting list	% of patients less than 6 weeks past their due date	0	93.5%	94.5%	95.5%	95.5%	96.0%
Admission via A&E	No. of waits from decision to admit to admission over 12 hours	0	0	0	0	0	0
Ambulance Handovers	No. of breaches of the 30 minute handover standard	0	96	68	123	66	67
Ambulance Handovers	No. of breaches of the 60 minute handover standard	0	12	12	21	7	2
28 day standard	No. of patients not offered a binding date within 28 days of cancellation	0	0	0	0	0	0
Urgent ops Cancelled for 2nd time	No. of urgent operations cancelled for a second time	0	0	0	0	0	0
NHS Number Compliance	Completion of NHS Numbers in SUS Submission (IPS/OPS)	99%	99.8%				
NHS Number Compliance	Completion of NHS Numbers in SUS A&E Submissions	95%	97.7%				
SSNAP indicator	% of Stroke patients are treated on a dedicated stroke ward for 90% of spell	tbc	82.5%	81.8%	80.0%	81.6%	86.7%
SSNAP indicator	Direct admission to Stroke Unit within 4 hours of admission	tbc	72.7%	69.1%	74.2%	66.7%	76.4%
SSNAP indicator	Patients receive CT Scan within 24 hours of admission	tbc	98.2%	100.0%	100.0%	100.0%	91.8%
SSNAP indicator	Patients with acute stroke receive brain imaging within 1 hr	tbc	40.0%	47.3%	56.5%	46.3%	37.0%
SSNAP indicator	Thrombolysis Rate	tbc	9.1%	16.4%	12.9%	7.4%	12.3%
SSNAP indicator	% appropriate patients receiving thrombolysis (within 1 hour of clock start)	tbc	60.0%	88.9%	37.5%	50.0%	44.4%
TIA indicator	High risk TIA cases investigated and treated within 24hrs	tbc	64.0%	51.0%	64.0%	72.0%	61.0%
TIA indicator	Low risk TIA cases, seen within 7 days	tbc	91.0%	89.0%	82.0%	87.0%	89.0%
Clocks still running - 52 weeks	Zero tolerance of over 52 week waiters (Incomplete Pathways)	0	0	0	0	0	0
Clocks still running - admitted	Total number of patients with an admitted incomplete pathway	tbc	6634	6443	6589	6679	6634
Clocks still running - admitted	Number of patients with an admitted incomplete pathway over 18 weeks	tbc	942	1058	1203	1227	1191
Clocks still running - non admitted	Total number of patients with a non admitted incomplete pathway	tbc	14743	14816	16003	16558	17304
Clocks still running - non admitted	Number of patients with a non admitted incomplete pathway over 18 weeks	tbc	402	469	593	570	626

4. Performance Focus - Cancer

4.1 Performance and Activity

Table 4 – Cancer Performance Q4 and April Q1

Key Performance Indicators	Threshold	2015-2016 Qtr 4	Mar-16	Apr-16
2 weeks - Maximum wait from GP	93.0%	95.7%	93.0%	84.3%
2 week wait for symptomatic breast patients	93.0%	98.7%	96.8%	100.0%
31 Day – 1st treatment	96.0%	95.3%	95.4%	94.3%
31 Day – subsequent treatment - Surgery	94.0%	94.6%	97.9%	97.6%
31 Day – subsequent treatment - Drugs	98.0%	100.0%	100.0%	100.0%
62 Day – 1st treatment	85.0%	87.2%	88.0%	88.5%
62 day – screening patients	90.0%	84.4%	80.0%	100.0%
62 day – Consultant upgrade (local target)	90.0%	69.2%	75.0%	42.9%

Note: Final validated May data will be uploaded early July.

In line with national guidance we will be working with CCGs in 16/17 to move towards monitoring further cancer metrics, including 104 day 'backstop' breaches.

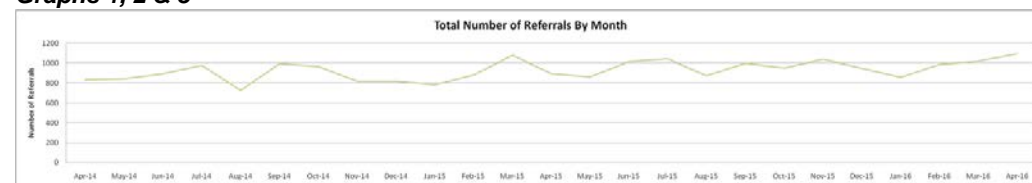
4.2 Two Week Wait

Demand and capacity pressures particularly affected Colorectal (39 more patients than Apr 15) and Gynaecology (43 more patients) in April; both also exacerbated by some medical staff shortages. As previously highlighted, this affected April performance (84.3%). Additional sessions were arranged and performance has improved in the second half of the Quarter, however, this is unlikely to recover full compliance for the Quarter.

Overall referrals continue to increase and the impact of the Blood in Pee campaign was particularly seen in March. The Trust was able to respond with first appointment fast track capacity for the Urology patients referred. We are now tracking these through for 62 day pathways and expect that the Urology recovery programme through Q1 will support resulting treatments.

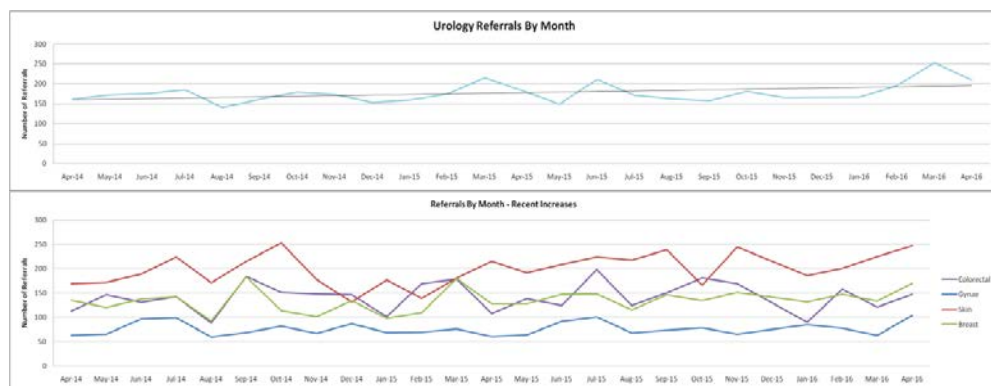
Overall fast track referrals continue to increase (Graphs 1-3). April 2016 referrals were 22% above April 2015 with increases of between 14-70% against all tumour sites except Haematology, Upper GI, Children and Other. Care Groups are reviewing these trends against their planning assumptions for fast track capacity for 16/17.

Graphs 1, 2 & 3



Performance Report

As at 15/06/2016



4.3 Overall 31 day performance by specialty

Table 5

31 Day First Treatment (Tumour) (96%)

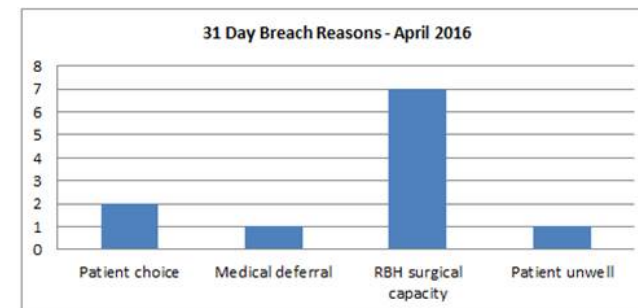
Site	Quarter 4 2015/16			Mar-16			Apr-16		
	Total	Within Target	Performance	Total	Within Target	Performance	Total	Within Target	Performance
Haematology	40	40	100.0%	16	16	100.0%	9	9	100.0%
Lung	38	38	100.0%	8	8	100.0%	18	18	100.0%
Colorectal	57	57	100.0%	20	20	100.0%	12	12	100.0%
Gynae	16	16	100.0%	7	7	100.0%	4	4	100.0%
Skin	112	109	97.3%	43	41	95.3%	47	47	100.0%
UGI	44	42	95.5%	12	10	83.3%	13	13	100.0%
Urology	193	175	90.7%	58	53	91.4%	62	52	83.9%
Breast	81	76	93.8%	28	28	100.0%	26	25	96.2%
Others									
Head & Neck	3	3	100.0%	1	1	100.0%			
Brain/central nervous system	1	1	100.0%						
Children's cancer	0	0							
Other cancer	7	7	100.0%	2	2	100.0%	2	2	100.0%
Sarcoma	5	5	100.0%	1	1	100.0%	1	1	100.0%
Total	597	569	95.3%	196	187	95.4%	194	183	94.3%

There were a total of 11 breaches out of 194 treatments in April, breaking down as follows: Urology (10), and Breast (1). The below graph breaks down the key reasons for the breaches. As outlined in our CCG joint recovery plan, continued clearance of Urology surgical backlog such as RARPs and the need to achieve a consistent max 1-2 week wait from decision to treat, means that breaches will continue through the quarter as we work towards this clearance.

Graph 4

31 Days - Breach Reasons

Apr-16	
Delay Reasons	Value
Patient choice	2
Medical deferral	1
RBH surgical capacity	7
Patient unwell	1
Grand Total	11

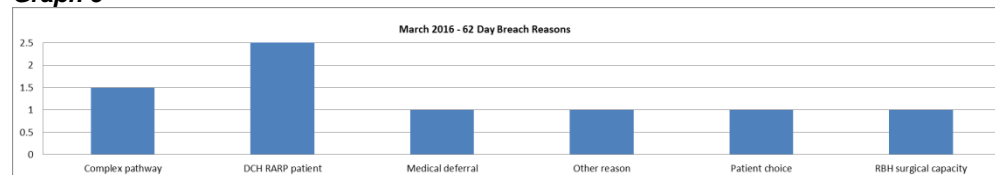


One Breast patient breached as the patient cancelled their operation date and this could not be reorganised within the remaining 4 days.

4.4 62 Day Referral/Screening to Treatment by Speciality

Pooling the waiting lists for robotic prostatectomy patients across East and West Dorset together with additional capacity is progressing well and backlog clearance continues through the Quarter as per our recovery plan. The below breach analysis reflects the backlog clearance as a number of surgical breaches have been treated and as the RARP waiting times are evened out across Dorset through pooling. The improvement in the RARP waiting times for the Dorchester patients is also noted.

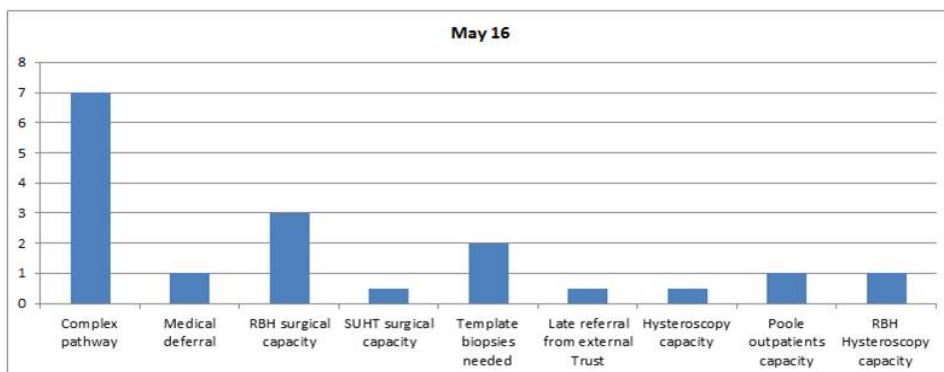
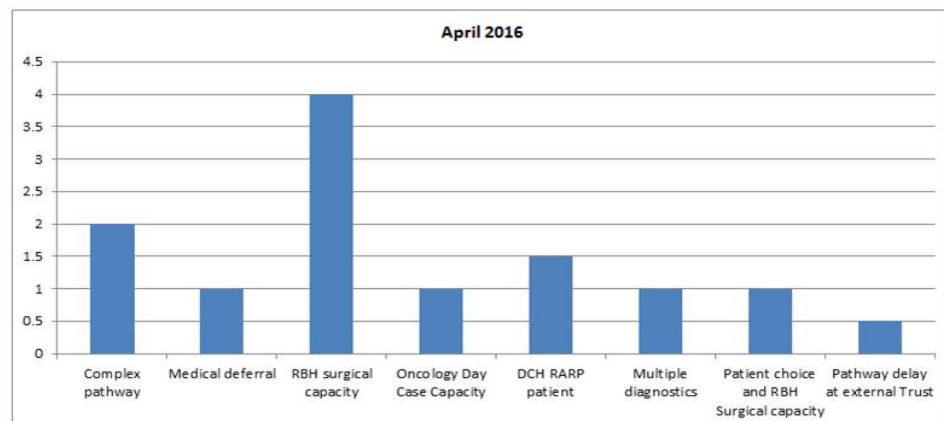
Graph 5



Performance Report

As at 15/06/2016

Graph 6 & Graph 7 (unvalidated)



The analysis also reflects the increases in breaches across a small number of other tumour sites, particularly as a result of complex pathways in April and May (*latter currently being validated*). This is most noticeable in the Lung, Breast and Upper GI potential/breaches.

Colorectal fast track capacity was unable to immediately flex to meet fast track referrals earlier in the Quarter. This has now been resolved but has had a knock on impact on endoscopy and on surgical treatment capacity due to the subsequent 'surges' in onward 62 day pathways. Gynae also had limited fast track capacity for a short while early in the Quarter due to unplanned medical staff absence

combined with a peak in referrals. Again this has now been resolved but with an impact on the full pathways.

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

Site	Quarter 4 2015/16			Mar-16			Apr-16		
	Total	Within Target	Performance	Total	Within Target	Performance	Total	Within Target	Performance
Haematology	9.5	8.5	89.5%	1	1	100.0%	2	2	100.0%
Lung	19	14	73.7%	5.5	4.5	81.8%	5	3	60.0%
Colorectal	20	17.5	87.5%	2	2	100.0%	5	4	80.0%
Gynae	9.5	8	84.2%	5.5	4.5	81.8%	1.5	1.5	100.0%
Skin	65.5	63.5	96.9%	26	24.5	94.2%	28.5	28.5	100.0%
UGI	20.5	19.5	95.1%	4.5	3.5	77.8%	5	4.5	90.0%
Urology	106.5	83.5	78.4%	31.5	25.5	81.0%	41	34	82.9%
Breast	42	40	95.2%	10	10	100.0%	14	13	92.9%
Others									
Head & Neck	2	1.5	75.0%				0.5	0	0.0%
Brain/central nervous system									
Children's cancer									
Other cancer	2	2	100.0%	1	1	100.0%	1	1	100.0%
Sarcoma	4.5	4.5	100.0%	0.5	0.5	100.0%	1	1	100.0%
Total	301.0	262.5	87.2%	87.5	77.0	88.0%	104.5	92.5	88.5%

There were a total of 12 breaches out of 104 treatments in April, breaking down as follows: Lung (2), Colorectal (1) UGI (0.5), Urology (7), Breast (1) and Head & Neck (0.5).

We continue to progress the actions included in our Urology based Remedial Action Plan jointly with our commissioners and Dorset County Hospital and have an agreed recovery trajectory which anticipates full recovery in Q2. The plan to also increase capacity for Urology non prostatectomy cancer cases (e.g. bladder and kidney operations) commenced in April supported by outsourcing, sessions at Wimborne Hospital and some locum sessions. A continuous QI approach to the pathway is in place with further pathway/process improvements implemented – see *Case Study*.

Compliance for April against the 62 day from screening target was fully achieved at 100%.

Improvement Case Study:

Urology Flow Rate Testing

Aim : To increase capacity and meet cancer fast track targets for patients requiring flow rate testing and residual volume bladder scanning prior to clinical decision regarding treatment

Previous Process:

- daily capacity for tests, separate from outpatient appointment = 8 slots (Mon – Thurs) (Fri am – LUTS clinic only)
- 21 day wait for fast track cancer patients on a 62 day pathway due to lack of capacity, causing a backlog of patients requiring intervention.

This created delays on the pathway affecting clinical decision making for treatment.

- Prior to change - 32 slots per week were available
- Prior to the change - in 40 working days, 256 patients were seen for flow rate and bladder scanning (25 Jan – 18 Mar)

Process Redesign

- Flow rate clinic moved to OPD
- Daily capacity for tests = 14 slots (Mon-Thurs) (Fri am – LUTS clinic only + 7 slots available Fri pm)
- Patients can now be seen on the same day as their outpatient appointment (or within two days if patient prefers), reducing hospital visits for the patients and ensuring timely treatment

Since the change

- 63 slots per week are available
- in 37 working days, 371 patients were seen for flow rate and bladder scanning (21 Mar – 13 May)
- There is no back-log of FT patients – the next available slot is today (15 June)
- A further 154 patients have been seen in the last 21 working days (16 May – 14 June)

104 days. This monitoring and review seeks to ensure the avoidance of harm to the patient as well as highlighting and cascading any learning for improvement. This is also in line with national guidance that would require any harm to be reported under the Serious Incident procedure.

Reviews to date have demonstrated longer pathways for patients with:

- multiple/clinically iterative diagnostic pathways, and/or
- a need for an urgent procedure for another condition which was a higher priority, and/or
- waiting times at other providers.

However, our tracking, escalation and clinical reviews in relation to these have confirmed no harm to the patient. This process will continue with further detail provided to the Board in our cancer ‘deep dives’

5. Recommendation

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

Finally, the Board is also requested to note the detailed report on cancer performance and support the ongoing actions for recovery, where this is required.

4.5 104 day ‘backstop’ breaches

The Cancer Team closely track all patients on a 62 day pathway. This includes an escalation process for patients not meeting timed pathway points. Full clinical and pathway monitoring, together with root cause analysis, is in place for all patients passing 62 days and by extension,

Trust Balanced Dashboard

Quality, Performance, Clinical Outcomes, Productivity and Efficiency

Reporting Month: Apr 2016

Trust Performance Dashboard: Apr 2016

Report produced: 14/06/2016 10:48:00

Quality							Clinical Indicators							Productivity & Workforce						
KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend	KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend	KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend
HSMR - RBH - January 2016	Ratio	96.4	100.0	83.3			Medication administration incidents	No.	26		17	22		Average number of Outliers	No.	46.8		56.6	48.4	
HSMR - MAC - January 2016	Ratio	190.8	100.0	146.8			IP cardiac arrest calls / 1,000 bed days	Ratio	2.4		2.9	3.13		Average length of Stay	Days	4.2		4.6	4.7	
% Harm Free Care (Patient Safety Thermometer)	%	88.0%	95.0%	89.3%	92.6%		Acute Kidney Injuries / 1,000 bed days	Ratio	10.1		7.3	11.9		Theatre session utilisation	%	83.3%	85.0%	84.3%	85.3%	
Serious incidents	No.	2	4	0	2		Returns to theatre / 1,000 bed days	Ratio	1.8		0.3	2.8		Average follow-ups per new attendance	Ratio	0.64		0.64	0.66	
Emergency Department Friends & Family Test	%	93%		88%	94%		Unplanned IP admissions to ITU or HDU / 1,000 bed days	Ratio	TBC	TBC	TBC			Sickness absence	%	4.1%	3.0%	4.1%	4.1%	
Inpatient Friends & Family Test	%	98%		98%	98%		Dementia CQUIN (step 1 compliance)	%	100%	90%	100%	52%		Vacancy	%	6.4%		7.4%	9.4%	
Delayed Transfers of Care	No.	33	10	23	24		% of CHC fasttrack patients that die on a ward	%	TBC		27%	21%		Appraisal- Non-medical Staff **	%	3.7%	4%	82.9%		
30 day readmissions	No.	608		647	527		Time to antibiotics for patients with severe sepsis	hh:mm	TBC	TBC	TBC	TBC		Appraisal- Medical Staff	%	80.0%	85%	71.9%		
Performance							Activity & Finance							Activity & Finance						
KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend	KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend	KPI	Units	Actual	Plan	Last Month	Last Year	Rolling 12 Month Trend
MRSA Bacteraemias	No.	0	0	0	0		Hospital at Night Average Response Time - Amber Calls	hh:mm	NA	NA	NA	NA		ED Attendances	No.	7,505	6,906		-	
Clostridium difficile	No.	0	1	2	0		Hospital at Night Average Response Time - Red Calls	hh:mm	00:34	00:15	00:35	00:33		Elective admissions	No.	5,619	5,762		-	
RTT - Incomplete Pathway below plan	Y/N	N	N	N			Stroke mortality rate (SSNAP)	%	24%		11%	12%		Non-elective admissions	No.	3,023	2,743		-	
Cancer metrics (below plan) (1)	No.	2	0	2	1									GP OP Referrals	No.	5,648	4,718	5,694	5,053	
A&E 4 hr maximum waiting time	%	91.2%	95%	90%	92%									Risk ratings	Rating	2		2		
Patients with a learning disability (Monitor compliance)	Y/N	100.0%	100.0%	100.0%	100.0%									Surplus	£000s	£ 393	£ 509	£ 516	£ 1,958	
														Transformational plans	£000s	£ 546	£ 740	£ 1,070	£ 236	

** Appraisal- Non-medical Staff; compliance is zero based at the start of each financial year

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

BOARD OF DIRECTORS

Meeting Date and Part:	24 th June 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 receive this report and to note the progress made against the measures of an effective stroke service, and the risks being mitigated.
Executive Summary: This report covers: <ul style="list-style-type: none"> • Most recent published stroke performance using Sentinel Stroke National Audit Programme (SSNAP) (January to March 2016) • Our internal assessment of performance for April and May (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) (Q4: January to March 2016)
- Our internal assessment of performance for April and May (Quarter to date)
- Detailed actions the service is taking to sustain 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 A, a score of 80.1 or more is required. The more recent SSNAP results cover Q4, January to March 2016, in which RBCH achieved SSNAP Level A and a score of 87. This is an improvement on our score for Q3 which was 80 and we estimate may put us in the top 5% of Stroke Units nationally.

Ensuring sustainability of improvements over the next 12 months relies upon expansion of the radiology service out of hours and management of risks specifically relating to staffing. By delivering the overall plan our trajectory is to sustain SSNAP Level A with no domain lower than level C. For our estimated performance to date for Q1, we are achieving a SSNAP score of 84 which is a SSNAP Level A (see Annex).

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	Apr-June 2015	July-Sept 2015	Oct-Dec 2015	Jan-March 2015	National Average
SSNAP level	B	B	B	A	
SSNAP score (team-centred)	70.3	78	80	88	
Case ascertainment band	A	A	A	A	A
Audit compliance band	B	A	A	A	B
1) Scanning	C	B	C	B	B
2) Stroke unit	C	C	C	C	C
3) Thrombolysis	C	C	C	B	C
4) Specialist Assessments	D	C	C	B	C
5) Occupational therapy	A	A	A	A	B
6) Physiotherapy	B	B	B	B	B
7) Speech and Language therapy	B	B	A	A	D
8) MDT working	B	B	B	A	C
9) Standards by discharge	B	B	A	A	B
10) Discharge processes	A	A	A	A	B

Our overall SSNAP score is 87 however as detailed in the table above our team-centred SSNAP score was actually 88. The overall SSNAP score is calculated as an average of our Team-centred SSNAP score (88) and Patient-centred SSNAP score (86). The Team-centred score is solely based on key indicator outcomes completed at RBCH whereas the Patient-centred results will reflect key indicator outcomes for patients completed at more than one hospital. To date our Team-centred and Patient-centred results have always been exactly the same due to the small number of patients that are repatriated to RBCH. For Q4 there was a very small outcome difference for Domain 4 (Specialist Assessments) which resulted in a Level B for Team-centred and a Level C for Patient-centred resulting in a slightly lower overall score.

The Stroke Service is delighted to have achieved a SSNAP Level A; this is the accumulation of a significant amount of hard work by the entire Stroke MDT and work undertaken in close collaboration with our colleagues in the Emergency Department, Radiology Department, Clinical Site Team and the Information Department. We continue to be proactive with sharing our good practice and presenting at various forums both regionally and nationally.

For Q4 we have sustained or improved performance in all domains. We achieved a SSNAP Level B for the first time for Thrombolysis, Specialist Assessment and MDT Working domains which reflects the focused quality improvement work being undertaken in each of these areas.

For Thrombolysis we achieved a median door to needle time of 55 minutes which is the lowest we have ever achieved. Our Stroke Consultants and Stroke Outreach Team have undertaken a full review of the thrombolysis pathway; implemented a number of measures to reduce/minimise process delays; updated and streamlined the thrombolysis handbook; and introduced regular thrombolysis training for all involved. As detailed in section 5 (risk mitigation), achieving the required door to needle time of less than 60 minutes for all patients is of significant challenge out of hours due to delays waiting for a Radiographer to come in and subsequent wait for the CT to be reported. For Q4 we only had a small cohort of thrombolysis patients out of hours which will have positively contributed to our improved results.

The improvement with Specialist Assessments is largely due to the effectiveness of our Stroke Outreach team some examples include: the median time between arrival and assessment by a Stroke Nurse of 1 hour (national average is 1 hour 30 minutes) though for Q1 to date this has improved further to 37 minutes; and 83.8% of stroke patients having a swallow screen within 4 hours of arrival (national average is 71.2%).

With the MDT Working domain, we are now seeing the positive results from our Stroke MDT Quality Improvement project. Focused MDT review of working practices led to 12 hours per week of clinical time being released. This enabled the implementation of twice daily MDT Hyper Acute Stroke Unit ward rounds and a median reduction in time to initial Physiotherapy and Occupational Therapy assessments of 4 hours, and median reduction in time to initial Speech and Language Therapy assessment of 3 hours. These improvements are excellent for patient care, have resulted in higher levels of staff satisfaction as well as having a positive impact upon our SSNAP results.

SSNAP released details in May of changes to their reporting schedule for 2016/17. To date SSNAP have provided a quarterly assessment and report. Due to a reduction in their funding, from 1st April 2016 they will be reporting on a 4-monthly basis. A review of potential impact of this upon our SSNAP results has been undertaken and it is likely we may see a slight reduction in SSNAP score with triannual reporting however we do not anticipate this will detrimentally affect our overall SSNAP Level.

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 has included the following:

- Development of a Dorset 'document of principle' stroke service specification detailing standards for future stroke service provision in Dorset that we all collaboratively agree to (currently in draft status);
- A very well attended Stroke Vanguard Launch event (50+ attendees from each of the Acute Trusts, DHUFT, Dorset CCG, Social Services and the Stroke Association);
- The development of sub-streams for TIA, Pre-hospital and Hyper-acute, Acute and Stroke ESD which will develop options appraisals and implementation plans to deliver the Dorset Stroke Specification;
- A SSNAP Task and Finish Group to develop consensus on SSNAP monitoring and reporting for Dorset;
- Workforce plan and shared stroke specialist competencies across Dorset.

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 sustainable and our ambition is to achieve no domain being lower than a Level B. It is likely however that with the release on the updated RCP Guideline for Stroke (2016) later this year that the parameters for success for a number of the key indicators are set to increase.

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;
- the quarter to date performance.

5. Risk Mitigation

The 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 Q4 and Q1 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.

Dr Loganathan, our full-time Associate Specialist Doctor will be leaving the service in July. This is likely to have a significant impact upon our service provision, specifically time to initial Stroke Consultant review and supporting the MDT on the Stroke Unit. We currently have some part-time Consultant Locum to backfill a number of clinical sessions and will work with Medical staffing to recruit into the vacancy as soon as possible.

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, 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. Radiology's plans for the third CT scanner from late summer will significantly help the service.

6. Recommendation

The Board is asked to receive this report, and to note the progress made against the measures of an effective stroke service, and the risks being mitigated.

ANNEX: STROKE PERFORMANCE & DELIVERY PLAN – JUNE 2016 – ONE PAGE SUMMARY

(Q1 to date results **have not been fully validated**. Where there are gaps the data is not available internally)

DOMAIN	SSNAP Q4 (Jan-March)	Q1 (Apr-June)	Plans	Comments/Risks
1 Scanning	B	C	<ul style="list-style-type: none"> Clear categorisation of breaches 	<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. breaches 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	B	C	<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	B	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"> Upcoming 1.0 wte Band 5 & 1.0 wte Band 6 vacancy and 1.0 wte Band 6 mat leave
6 Physiotherapy	B	A	<ul style="list-style-type: none"> Exercise group 	<ul style="list-style-type: none"> Upcoming 1.0 wte Band 6 vacancy
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 6 and 7 Vacancy/Maternity Leave (though staff due to commence in post soon)
8 MDT Working	A	A	<ul style="list-style-type: none"> New twice daily MDT rounds for new pt assessments 	<ul style="list-style-type: none"> Upcoming OT and PT vacancy/mat leave
9 Standards by discharge	A	B (borderline 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 	
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	A	A		
SSNAP Score	88	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 (B)	Q1 (to date)	Key Improvement Actions
1.1 Proportion of patients scanned within 1 hour of clock start (A = 48%)	43% (B)	48.6% (A)	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. These patients broadly fall into 2 main categories – 1) atypical/complex presentations without clear stroke symptoms and being treated appropriately for something else i.e. sepsis and likely would not have been diagnosed as a stroke even by a Stroke Consultant and 2) process delays – patients whom stroke should have been diagnosed on admission and it wasn't, stroke outreach not made aware etc which are organisational reasons. Going forwards from Q1 we are going to clearly categorise patients who have breached to help us monitor numbers/proportions, focus actions to address and monitor our progress. 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 and on-site Radiographer 24/7 <p>For Q1 to date * the increase in median time to scan is primarily due to a recent high number of atypical presenting stroke patients that resulted in a delayed stroke diagnosis and delayed time to scan. As detailed above this is a primary focus of the service to raise awareness throughout the Trust of atypical presenting strokes to help try and address this – see point 3 below.</p>
1.2 Proportion of patients scanned within 12 hours of clock start (A = 95%)	90% (B)	92.6% (B)	91.5% (B)	
1.3 Median time between clock start and scan (A = < 60mins)	< 75 mins (B)	64 mins (B)	92mins (D)*	

Domain 1: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To continue to undertake a breach analysis of all patients who do not get their scan in the required timescales	ongoing	<ul style="list-style-type: none"> Primary breach group is atypical presenting stroke patients.
2. To implement a clear categorisation for all breaches so we can clearly understand which are due to atypical/complex clinical presentations and which are due to process/organisational misses	ongoing	<ul style="list-style-type: none"> This is now in place from April.
3. Targeted education to improve stroke recognition, particularly for non-FAST presenting stroke.	July 2016	<ul style="list-style-type: none"> To develop a Stroke Brand (similar to Sepsis campaign) to be able to undertake a stroke campaign within the hospital over the summer. Main aims to ensure all are aware to contact Stroke Outreach if patient ? stroke and to raise awareness of less common stroke symptoms
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. 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
7. Implementation of CT3 and plan that X-ray Radiographers will be able to undertake CT Brain Scans	? Autumn 2016	<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
8. Stroke Outreach to receive a 'pre-alert' for all FAST positive patients not just those who may be for thrombolysis.	? Autumn 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. This has been put on hold as SWAST and SCAST need it to be a pre-alert for all Wessex-wide stroke service providers and the other Acute Stroke Services are currently not in a position to be able to respond

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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	Q1 (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)	71.7% (C)	72.7% (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, extended LOS, review of MDT working and Complex Nutrition Project. Main impacting two impacting factors on performance are: <ol style="list-style-type: none"> Late diagnosis stroke <ul style="list-style-type: none"> i.e. missed on admission and so are not scanned within the required timescales. These patients broadly fall into 2 main categories – 1) atypical/complex presentations without clear stroke symptoms and being treated appropriately for something else i.e. sepsis and likely would not have been diagnosed as a stroke even by a Stroke Consultant and 2) process delays – patients whom stroke should have been diagnosed on admission and it wasn't, stroke outreach not made aware etc which are organisational reasons. Going forwards from Q1 we are going to clearly categorise patients who have breached to help us monitor numbers/proportions, focus actions to address and monitor our progress. 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)	03:12 (C)	03:10 (C)	
2.3 Proportion of patients who spent at least 90% of their stay on stroke unit (A = 90%)	85% (B)	83.2% (C)	84.5% (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	? Autumn 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. This has been put on hold as SWAST and SCAS need it to be a pre-alert for all Wessex-wide stroke service providers and the other Acute Stroke Services are currently not in a position to be able to respond
2. To implement a clear categorisation for all breaches so we can clearly understand which are due to atypical/complex clinical presentations and due to process misses	ongoing	<ul style="list-style-type: none"> This is now in place from April
3. To trial stroke screening process for GP Referral patients (in conjunction with ACM)	complete	<ul style="list-style-type: none"> This proved to have a low success-rate however the number of breaches due to GP pathway are currently less. Plan to monitor GP admission breaches and liaise with ACM as appropriate
4. Targeted education to improve stroke recognition, particularly for non-FAST presenting stroke.	July 2016	<ul style="list-style-type: none"> To develop a Stroke Brand (similar to Sepsis campaign) to be able to undertake a stroke campaign within the hospital over the summer. Main aims to ensure all are aware to contact Stroke Outreach if patient ? stroke and to raise awareness of less common stroke symptoms
5. 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"> Ambulatory Care clinics are now happening on a daily weekday basis on the Stroke Unit with 74 patients being supported since starting in April. Further work is being undertaken to develop FAST MRI in collaboration with Radiology
6. Stroke QI: MDT Review – to write up impact of MDT working changes and their impact	June 2016	<ul style="list-style-type: none"> On track and abstract submitted to the UK Stroke Forum
7. 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"> Notes audit currently being carried out Action plan will be developed further to completion of audit
8. 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 for likely new admissions Where possible outreach team to attend 10am bed meetings CST to be informed of pts arrival time to assist in prioritising pts transfers Stroke unit co-ordinator to hold a bleep solely for new admissions
9. To continue to work proactively with the Trust Discharge Team, Social Services and other agencies to facilitate discharge at earliest possible time	ongoing	<ul style="list-style-type: none"> Meetings underway with Dorset and Bournemouth SS Need to establish links with Hampshire SS

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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (B)	Q1 (to date)	Key Improvement Actions
3.1 Proportion of all stroke patients given thrombolysis (A=20%)	12% (C)	12.7% (C)	10.9% (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 breaches 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)	100% (A)	100% (A)	
3.3 Proportion of patients who were thrombolysed within 1 hour of clock start (A=55%)	55% (A)	63.6% (A)	50% (B)	
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)	71.7% (A)	72.7% (A)	
3.5 Median time between clock start and thrombolysis (A=< 40mins)	< 50 mins (B)	55 mins (C)	01:01 mins (D)	

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 Q1 to date, 10.9% 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. 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"> Regular teaching sessions established for all Medical registrars to improve knowledge and skill re thrombolysis to support prompt service delivery – MD and KC/KH On-going supervision and competency sign-off with Stroke Outreach Team.
3. Deliver a robust pathway for thrombolysis for patients having stroke as in-patient to improve efficiency in these cases	July 2016	<ul style="list-style-type: none"> Updating protocol for the in-patient management of Thrombolysis in acute stroke pathway. Laminated print out of pathway in thrombolysis bag.
4. 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"> Patient and relative thrombolysis information completed and approved by PIG. Further investigation following UKSF re tools being devised to share following a research project in Scotland.
5. 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 agreed and programme for regular checking confirmed Decision to be made re medication and suitability in bag in line with pathway work. Agreed for medication to not be included in the bag.
6. Liaising with ambulance teams to optimise pre-hospital care	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. Issue re windows 10 and running relevant software. This has been reviewed and not currently a viable option. Continue to explore options for pre-alert.
7. 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.	June 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 Audit in progress to check accuracy of weight predictions for thrombolysis patients.
8. To implement bedside Coag check to reduce wait for INR	June 2016	<ul style="list-style-type: none"> Coag checked and purchased currently being PAT tested. SOP Audit accuracy ongoing and to be completed before instigating clinical use.

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

DOMAIN KEY INDICATORS	Plan (C)	Last SSNAP (B)	Q1 (to date)	Key Improvement Actions
4.1 Proportion of patients assessed by a stroke consultant within 24hrs of clock start (A=95%)	80% (C)	71.7% (D)	72.9% (D)	<ul style="list-style-type: none"> To undertake an ongoing breach analysis for this as 4.1 and 4.2 continue 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)	16:43 (E)	15:49 (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)	97.7% (A)	96.1% (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)	60 mins (A)	00:37 mins (A)	
4.5 Proportion of applicable patients who were given a water swallow screen within 4hrs of clock start (A=85%)	85% (A)	83.8% (B)	85.4% (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)	98.1% (A)	<ul style="list-style-type: none"> Understand any risks to sustaining this level of performance i.e. SALT recruitment challenges SALT continue to prioritise formal swallow assessment within existing service; impact of reduced staffing should be minimal.

Domain 4: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Options to introduce 7-day Consultant ward-rounds when Stroke Consultant wte fully established	Ongoing as part of Vanguard	<ul style="list-style-type: none"> • BJ/AW to review feasibility of implementing 7-day Stroke Consultant ward-rounds • Vanguard stroke
2. Review all patients for Q4 who breached being assessed by Stroke Consultant within 24 hours of clock start	June 2016	<ul style="list-style-type: none"> • Complete analysis and identify themes and appropriate action plan
3. Amend thrombolysis and stroke outreach initial assessment documentation to include whether Stroke Consultant was present for patient assessment	Complete	<ul style="list-style-type: none"> • Complete and in-place
4. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in WSS	Complete Ongoing with new staff	<ul style="list-style-type: none"> • Put in place a training plan to achieve 85% compliance with Band 5 and 6 Nurses • All new staff to complete training and be signed off as competent within 3 months of starting on unit
5. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in NIHSS	Ongoing as staffing allows	<ul style="list-style-type: none"> • New Stroke Specialist Nurse commences in January 2016 which will significantly help nurse training • Put in place a training plan to achieve 85% compliance with Band 5 and 6 Nurses • All new staff to complete training and be signed off as competent within 3 months of starting on unit

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q1 (to date)	Key Improvement Actions
5.1 Proportion of patients reported as requiring occupational therapy (A=80%)	80% (A)	77.8% (B)	78.6% (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)	43.8 (A)	40 (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 Upcoming band 6, 1.0 wte OT vacancy Upcoming rehab assistant vacancies - band 3, 2.0 wte and band 2, 1.0 wte from September
5.3 Median % of days as an inpatient on which occupational therapy is received (A=>70%)	>70% (A)	69.5% (B)	76.6% (A)	
5.4 Compliance (%) against the therapy target of an average of 25.7 minutes of occupational therapy across all patients (A=80%)	80% (A)	92% (A)	93.7% (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. Review breaches for 6.1 to understand rationale for patients being deemed not appropriate	ongoing	<ul style="list-style-type: none"> Validation processes in place and to be completed on an ongoing basis
3. Establish twice weekly OT groups (gardening and tell your story)	ongoing	<ul style="list-style-type: none"> 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
4. Establish breakfast group (joint with SALT)	Complete	
5. Recruit to all vacancies and establish/implement mitigation plans whilst we have vacancies	Ongoing	<ul style="list-style-type: none"> To increase group activity and decrease non-clinical activities whilst recruiting Explore options to effectively utilise volunteer time to support non-clinical activities.

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (B)	Q1 (to date)	Key Improvement Actions
6.1 Proportion of patients reported as requiring physiotherapy (A=85%)	80% (B)	75% (C)	82.9% (B)	<ul style="list-style-type: none"> 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??) 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 Upcoming band 6, 1.0 wte PT vacancy Upcoming rehab assistant vacancies - band 3, 2.0 wte and band 2, 1.0 wte from September
6.2 Median number of minutes per day on which physiotherapy is received (A=>32 mins)	>32 mins (A)	35(A)	36.9 (A)	
6.3 Median % of days as an inpatient on which physiotherapy is received (A=>75%)	>75% (A)	79.5% (A)	86.4% (A)	
6.4 Compliance (%) against the therapy target of an average of 25.7 minutes of physiotherapy across all patients (A=90%)	80% (B)	76.4% (C)	96.7% (A)	

Domain 6: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To implement therapy non clinical working practices/organisation to maximise time released for direct patient care (from away day in October).	complete	<ul style="list-style-type: none"> To review whole process (timetabling, whiteboard rounds, MDT meetings, Ax pathway, discharge summaries etc) at away day in October.
2. Review breaches for 6.1 to understand rationale for patients being deemed not appropriate	ongoing	<ul style="list-style-type: none"> 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"> 3 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
5. Recruit to all vacancies and establish/implement mitigation plans whilst we have vacancies	Ongoing	<ul style="list-style-type: none"> To increase group activity and decrease non-clinical activities whilst recruiting Explore options to effectively utilise volunteer time to support non-clinical activities.

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q1 (to date)	Key Improvement Actions
7.1 Proportion of patients reported as requiring speech and language therapy (A=50%)	50% (A)	62.8% (A)	65.81% (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)	40 (A)	35.8(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) Upcoming rehab assistant vacancies - band 3, 2.0 wte and band 2, 1.0 wte from September
7.3 Median % of days as an inpatient on which speech and language therapy is received (A=>70%)	>70% (A)	68.5% (B)	74.6% (A)	
7.4 Compliance (%) against the therapy target of an average of 25.7 minutes of speech and language therapy across all patients (A=90%)	90% (A)	100% (A)	100% (A)	

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	complete	<ul style="list-style-type: none"> SLT to support TAs by ensuring effective goal setting
4. To implement group cancellation protocol	complete	<ul style="list-style-type: none"> To ensure groups are only cancelled by Band 7+ staff
5. Recruit to all vacancies and establish/implement mitigation plans whilst we have vacancies	Ongoing	<ul style="list-style-type: none"> To increase group activity and decrease non-clinical activities whilst recruiting Explore options to effectively utilise volunteer time to support non-clinical activities.
6. To implement a twice weekly smoothie group	June 2016	<ul style="list-style-type: none"> Group specifically for patients on modified diet and fluids to make their own smoothie.
7. To implement joint OT/SALT "tell your story group"	Complete	

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q1 (to date)	Key Improvement Actions
8.1 Proportion of applicable patients who were assessed by an occupational therapist within 72hrs (A=90%)	90% (A)	99.4% (A)	97.6% (A)	
8.2 Median time between clock start and being assessed by Occupational therapist (A=<12hrs)	<12hrs (B)	16:45hrs (C) (N.A is 22:08 hrs)	16:24 (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)	99.4% (A)	97.6% (A)	
8.4 Median time between clock start and being assessed by physiotherapist (A=<12hrs)	<12hrs (B)	16:45hrs (C) (N.A. is 21:11hrs)	16:24 (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)	98.5% (A)	95.9%(A)	
8.6 Median time between clock start and being assessed by speech and language therapist (A=<12hrs)	<18hrs (C)	20:19hrs (D) (N.A. is 24:01hrs)	18:47 (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	95.9% (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	84.5% (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	Complete	<ul style="list-style-type: none"> New twice daily HASU MDT rounds in place Initial results indicate significant improvement for time to OT and time to PT initial assessment (median reduction of 4 hours) and SALT (median reduction 2 hours)

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q1 (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)	92.9% (B)	92.9% (B)	<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)	90.2% (B)	<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. On-going education and training for staff on continence management.
9.3 Proportion of applicable patients who have mood and cognition screening by discharge (A=95%)	95% (A)	99.3% (A)	98.8% (A)	<ul style="list-style-type: none"> To maintain this we need to ensure all new starters to team have induction for SSNAP and understand cognitive and mood screens we use and how to complete them. Recording also needs to stay consistent – continue with green forms (and ensure induction completed). Also taught band 3 to complete basic cognitive screen. confirmation of no screen required ‘medically unwell’ option for patients who are globally significantly impaired confirmation within team of basic cognitive screens acceptable ie AMTS for low level patients

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 July 2016	<ul style="list-style-type: none"> Audit complete Working party developed new continence pathway assessment and documentation – commenced in use in practice in March 2016 To undertake evaluation and re-audit

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q1 (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)	98.2% (A)	100% (A)	
10.2 Proportion of patients treated by a stroke skilled ESD team (A=40%)	40% (A)	36.7% (B)	35.9% (C)	<ul style="list-style-type: none"> Note a reduction in achievement with this target, likely due to an increased number of more complex patients being supported including those with non-stroke diagnosis requiring neurorehabilitation. Issue also highlighted re. a number of patients who have been supported by ESD who should have had stroke diagnosis and been on SSNAP but were incorrectly diagnosed as TIA and therefore not put on SSNAP and therefore missed on SSNAP reporting. This issue is now being addressed to ensure correct diagnosis on discharge summaries
10.3 Proportion of applicable patients in AF on discharge who are discharged on anticoagulants or with a plan to start anticoagulation (A=95%)	95% (A)	100% (A)	100% (A)	
10.4 Proportion of those patients who are discharged alive who are given a named person to contact after discharge (A=95%)	95% (A)	100% (A)	100% (A)	

Domain 10: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. ESD to immediately escalate to Stroke Consultants any patient being referred to ESD with diagnosis of TIA to ensure correct diagnosis and correct reporting	ongoing	<ul style="list-style-type: none"> System in place to address and monitor impact

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	Q1 (to date)	Key Improvement Actions
Overall	90%	93.3%	100%	
NIHSS at arrival (30% of score)		98.8% (N.A. 85.9%)	99.2%	<ul style="list-style-type: none"> Stroke Outreach Training to achieve 85% of SU Nursing staff are competent to undertake NIHSS Ensure all are aware of need of 24 hour post-thrombolysis NIHSS
NIHSS 24hrs post thrombolysis (20% of score)		90.9% (N.A. 89.9%)	100%	
Transfers (10% of score)		100%		<ul style="list-style-type: none"> Ensure all patients discharged to ESD/CRT are transferred on the webtool 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)		100%	100%	<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%	98%	

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	On-going 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)	Q1 to date	Key Improvement Actions
Average patient centred case ascertainment	90+%	90+%		<ul style="list-style-type: none"> Monthly lockdown checks will be performed on both 72hr and discharge lists All requests for record unlocks and data changes to go through SSNAP administrator. 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:	24 th June 2016 Part 1
Subject:	Quality report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Joanne Sims, Associate Director Quality & Risk Ellen Bull, Deputy Director of Nursing
Details of previous discussion and/or dissemination:	Healthcare Assurance Group 23 rd June
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 May 2016. <ol style="list-style-type: none"> Serious Incidents: Two SIs were reported Safety Thermometer: Harm Free Care is better (above) the average for 2015-16. This is a result of a significant decrease in new pressure ulcers in month from 16 in April to only 8 in May 16. 2015/16 Quality Objectives: progress against quality objectives will be reported quarterly Patient experience: Inpatient FFT was in the top quartile for May with ED and outpatients in the 2nd quartile. Care Audit trend data is largely consistent with previous months and focus continues at HAC on the chronic performing indicators. 	
Relevant CQC domain:	Safe, Caring, Effective, Responsive & Well Led
Risk Profile:	No
i. Impact on existing risk? ii. Identification of a new risk?	

Quality and Patient Safety Performance Exception Report: May 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 May 2016

2. Serious incidents

Two Serious Incidents were reported in May 16:

- Information Governance (IG) Breach. Label printer ribbon with patient details found in alley in Boscombe. Reported as Grade 2 IG incident to Information Commissioners Office. RCA completed and action plan agreed.
- Information Governance Breach. Spread sheet containing patient details e-mailed from an RBCH email to the member of staff's ISP email account. RCA in progress.

Root cause analysis (RCA) investigation reports and action plans will be approved and monitored by the Information Governance Committee.

3. Safety Thermometer

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

4. Patient Experience Report - June 2016 (Containing May data)

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

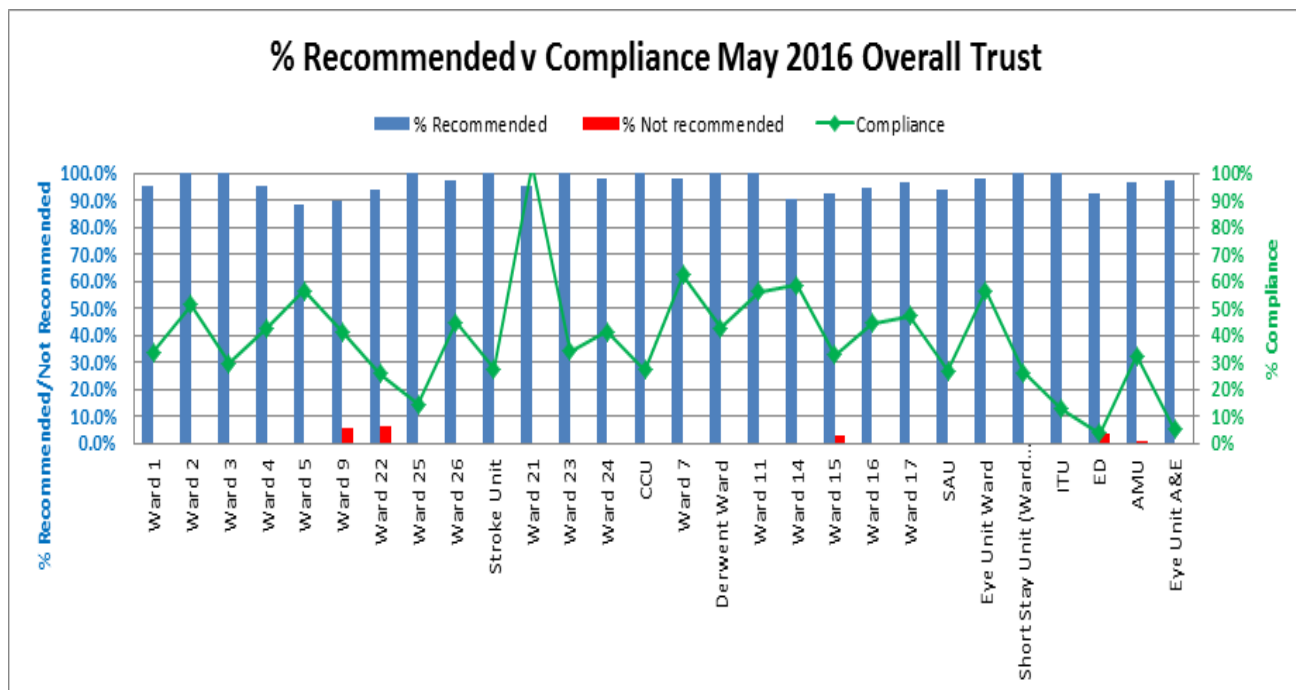
The national performance benchmarking data below is taken from the national data provided by NHS England which is retrospectively available and therefore, represents April 2016 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in April 2016 ranked RBCH Trust 3rd with 23 other hospitals out of 172 placing RBCH in the top quartile. The response rate was sustained above the 15% national standard at 21.6%.
- The Emergency Department FFT performance in April 2016 ranked RBCH Trust 8th with 11 other hospitals out of 141 placing RBCH ED department in the second quartile. The response rate was 4.7% against the 15% national standard.

- Outpatients FFT performance in April 2016 ranked RBCH Trust 6th with 27 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 The following data is taken from internal data sources

Table 1 below represents Trust ward and department performance for FFT percentage to recommend, percentage to not recommend and the response compliance rate.



The percentage of patients who recommend the Trust and the aggregate in month performance of data compliance remains strong; although variable between wards and departments, most areas are well above the 15% compliance threshold offering increased FFT result validity. The 'do not recommends' responses are reviewed at local level and appropriate action taken; although in some instances there is no commentary so it is challenging to determine the action to take.

4.3 Care Audit Trend Data

Overall	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May16
Red	51	51	45	60	91	85	101	83
Amber	69	73	61	58	92	99	73	80
Green	178	199	163	229	194	191	223	210
N/A	52	27	81	28	28	30	8	32

There is an in month reduction on the number of reds in the care audit, and actions are being progressed with the chronic areas requiring improvement; noise at night, food, answering call bells in some areas. This is monitored at HAC.

4.4 Patient Opinion and NHS Choices: May 2016 Data

Nine patient feedback comments were posted in May, five express satisfaction with the service they received. Three negative responses relate to waiting times, support and staff attitude. One comment was seeking advice following an unsuccessful visit to her GP. All information is shared with clinical teams and relevant staff, with Senior Nurses responses included in replies following complaints.

5. Recommendation

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

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The Royal Bournemouth and
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BOARD OF DIRECTORS

Meeting Date and Part:	24 th June – Part I
Subject:	Financial Performance
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Yes
Officer with overall responsibility:	Stuart Hunter, Director of Finance
Author(s) of papers:	Pete Papworth, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance Committee
Action required: Approve/Discuss/Information/Note	The Board of Directors is asked to note the financial performance for the month ending 31 May 2016
Executive Summary:	The financial reports are detailed in the attached papers.
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Goal 7 – Financial Stability Outcome 26 – Financial Position
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	Two current financial risks exist on the risk register related to the next year's financial planning and Cardiology procurement. The actions are being monitored through the Finance Committee.

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Finance Report



For the period to 31 May 2016

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £1.1 million as at 31 May. This is £0.2 million better than the budget plan. As reported previously, this has been achieved through the release of a considerable proportion of the Trusts annual contingency budget to off-set the significant loss of both elective and outpatient income as a result of the Junior Doctors strike action.

Activity

May reported an increase in activity, being 1.5% above planned levels overall. Particular pressures were seen in relation to non-elective activity which was 11% above budget, and Emergency Department attendances which were 13% above budget. Elective activity was also above planned levels in month by 3%; whilst Outpatients activity was 3% below plan overall. Whilst this has partially recovered the reduction seen during April as a result of the Junior Doctors strike action, overall activity remains below budgeted levels to date.

Income

Income reported an adverse variance of £121,000 during May. This was due to reductions in Private Patient income and pass through income in relation to drugs, particularly from the Hepatitis C network. This was off-set in part by increases in tariff income as a result of the increased activity noted above, however this has not corrected the loss reported in April.

Expenditure

Expenditure reported an under spend of £216,000 during May, mainly reflecting the reduction in pass through drug costs noted above.

Whilst the Trust remains heavily reliant upon agency staff, this position has stabilised and overall the Trust is reporting an under spend against pay budgets to date.

Cost Improvement Programme

To date the Trust has recorded savings of £1 million which is £215,000 behind the year to date target. The full year savings forecast increased in month, and the Trust is now forecasting total savings of £8 million against the full year target of £9.5 million. The Trust remains confident however, that additional savings will be identified during the year to close this gap.

Capital Programme

As at 31 May the Trust has committed £1.7 million in capital spend. Key areas of spend include the Christchurch development (£0.4 million), and the Trusts IT Strategy (£0.9 million). The Trust continues to forecast total capital spend of £12.3 million, and is awaiting confirmation of its capital control total from NHS Improvement.

Statement of Financial Position

Overall the Trust's Statement of Financial Position is on plan; however some key variances are apparent against individual balances. Specifically; later than anticipated maintenance contract payments, slippage against the capital programme, and the timing of the investment into the Christchurch Joint Venture have increased the Trusts cash balance and resulted in variances against the receivables and payables balances.

Cash

The Trusts current cash balance includes a timing benefit as a result of the Christchurch development slippage as compared to the ITFF loan drawdown. After adjusting for this, the Trust has an underlying cash balance of £26 million. The current forecast is that the Trust will end the year with a cash balance of £18.7 million.

Financial Sustainability Risk Rating

Under Monitor's 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 following their Regulatory Committee meeting on Monday 20 June.

Income and Expenditure

To date the Trust is reporting a deficit of £1.1 million. Within this, income is below budget (adverse) by £623,000 and expenditure is below budget (favourable) by £834,000. This results in a net favourable variance of £211,000.

The Trusts overall income and expenditure position is summarised below.

£'000	Budget	Actual	Variance
NHS Clinical Income	43,073	42,738	(336)
Non NHS Clinical Income	1,022	769	(253)
Non Clinical Income	3,907	3,874	(33)
TOTAL INCOME	48,003	47,381	(622)
Employee Expenses	29,384	29,034	350
Drugs	6,076	5,755	321
Clinical Supplies	6,080	6,198	(118)
Misc. other expenditure	7,731	7,451	280
TOTAL EXPENDITURE	49,271	48,438	833
SURPLUS/ (DEFICIT)	(1,268)	(1,057)	211

Income

NHS clinical income was significant below budget during April as a result of the Junior Doctors strike action. Whilst activity increased in May, this has not corrected the loss made in April.

Private patient income picked up in May, but remains below plan year to date. The Trust is progressing the implementation of a dedicated Private Patient Unit, and is continuing with the contracting process to secure an external partner for private cardiology activity.

Further detail at contract level is set out below.

£'000	Budget	Actual	Variance
NHS Dorset CCG	28,598	28,792	194
NHS England (Wessex LAT)	8,270	7,772	(498)
NHS West Hampshire CCG	4,061	4,060	(1)
Non Contracted Activity	466	437	(29)
Public Health Bodies	497	428	(69)
NHS England (Other LATs)	287	279	(8)
NHS Wiltshire CCG	126	127	1
Other NHS Patient Income	0	4	4
Private Patient Income	430	259	(171)
Other Non NHS Patient Income	96	82	(14)
Non Patient Related Income	3,905	3,874	(31)
Sustainability and Transformation Fund	1,267	1,267	0
TOTAL INCOME	48,003	47,381	(622)

Expenditure

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

Drug related expenditure is below plan, mainly in relation to cost and volume drugs and drugs through the Hepatitis C network.

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

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

Employee Expenses

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

£'000	Substantive Budget	Substantive Cost	Substantive Variance	Agency Cost	Bank Cost	Overtime Cost	Workforce Variance
Surgical Care Group	7,385	6,766	619	274	169	78	97
Medical Care Group	10,713	9,355	1,358	564	811	67	(84)
Specialties Care Group	6,232	5,754	478	94	144	22	219
Corporate Directorates	5,029	4,734	296	76	74	29	118
Centrally Managed Budgets	25	25	0	0	0	0	0
TOTAL	29,012	26,260	2,752	1,008	1,197	195	350

The Trust has agreed to the agency 'ceiling' cost requested by NHS Improvement, which amounts to £5.9 million for the year and represents a significant reduction against the 2015/16 outturn of £8.6 million. It is pleasing to report that agency expenditure to date is within the agency ceiling value of £1.096 million.

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

£'000	Block Booked	Off-Framework	Other	TOTAL
Nursing	42	32	185	258
Medical	0	47	156	204
Non Clinical	40	2	0	42
TOTAL	82	81	341	504

The Trust welcomes the national support in reducing agency costs, and has pro-actively embraced the new governance measures. However, by exception the Trust has been required to engage staff above the capped rates to ensure services are delivered safely. This 'break glass' procedure is subject to a rigorous executive approval process, and the exceptions recorded during May were as follows:

	Medical	Nursing	Other
Shifts covered (Number)	269	29	57
Approximate Cost above Cap (£)	80,789	11,629	3,799

Finance Report

As at 31 May 2016

Cost Improvement Programme

The Trust has delivered financial savings amounting to £1 million to date, being £215,000 behind plan.

This year to date under achievement reflects the fact that at present, the Trust has identified full year savings of £8 million against the full year target of £9.5 million.

Despite this adverse forecast variance, the Trust remains confident that the target will be achieved in full, with numerous additional schemes being worked up in addition to the current programme.

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

It should be noted that at present, £1.6 million of the forecast £8 million is reported as non recurrent. If this position continues, there is a significant financial risk when moving into the 2017/18 financial year.

DIRECTORATE	YEAR TO DATE			FULL YEAR		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000	TARGET £'000	FORECAST £'000	VARIANCE £'000
ANAESTHETICS AND THEATRES	(65)	72	7	(726)	399	(327)
MATERNITY	(18)	8	(10)	(158)	52	(106)
ORTHOPAEDICS	(20)	24	4	(520)	1,027	507
SURGERY	(42)	37	(5)	(787)	710	(76)
CARE GROUP A	(144)	141	(4)	(2,191)	2,189	(3)
CARDIOLOGY	(102)	81	(21)	(607)	496	(111)
ED AND AMU	(35)	19	(17)	(181)	156	(26)
OLDER PEOPLES MEDICINE	(161)	139	(22)	(1,150)	1,020	(130)
MEDICINE	(36)	8	(28)	(672)	363	(309)
CARE GROUP B	(334)	246	(88)	(2,610)	2,034	(576)
CANCER CARE	(64)	58	(6)	(428)	416	(12)
OPHTHALMOLOGY	(47)	25	(22)	(291)	128	(163)
PATHOLOGY	(46)	27	(19)	(244)	304	60
RADIOLOGY	(78)	70	(9)	(327)	232	(95)
SPECIALIST SERVICES	(127)	102	(25)	(826)	580	(246)
CARE GROUP C	(362)	282	(81)	(2,116)	1,660	(456)
NURSING, QUALITY & RISK	(16)	12	(4)	(116)	74	(42)
ESTATES	(62)	52	(10)	(726)	621	(105)
FACILITIES MANAGEMENT	(62)	51	(11)	(486)	363	(122)
FINANCE AND BUSINESS INTELLIGENCE	(28)	29	1	(162)	174	12
HR, TRAINING AND POST GRAD	(22)	13	(9)	(159)	131	(27)
INFORMATICS	(163)	155	(8)	(656)	613	(42)
OPERATIONAL SERVICES	(35)	34	(1)	(180)	140	(40)
OUTPATIENTS	(3)	1	(2)	(57)	32	(25)
TRUST BOARD & GOVERNORS	(13)	13	0	(22)	23	1
CORPORATE	(404)	361	(44)	(2,564)	2,173	(392)
GRAND TOTAL	(1,245)	1,029	(215)	(9,481)	8,055	(1,426)

Care Group Performance

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

£'000	Budget	Actual	Variance
Surgical Care Group	2,364	2,362	(2)
Medical Care Group	1,370	1,383	12
Specialties Care Group	643	642	(1)
Corporate Directorates	(5,722)	(5,660)	62
Centrally Managed Budgets	77	217	140
SURPLUS/ (DEFICIT)	(1,268)	(1,057)	211

As reported in April, the Trust released a significant proportion of its uncommitted contingency to off-set the loss of income resulting from the Junior Doctors strike action. This has been released into Care Group budgets to mitigate the impact at directorate level.

It is pleasing to report that following this adjustment, all Care Groups are performing in line with their agreed budget.

However, a considerable level of risk remains given the forecast CIP shortfall, particularly within the Medical and Specialties Care Groups and Corporate directorates. This is being proactively managed through the Trusts CIP Governance arrangements, and in particular, the weekly CIP Delivery Group.

Sustainability and Transformation Fund

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

- Agreeing to operate within a revenue 'control total' (i.e. agreeing to a maximum deficit for the year of £1.473 million);
- Agreeing to operate within a capital 'control total' (i.e. agreeing to a maximum capital spend at a value yet to be agreed);
- Agreeing performance improvement trajectories for key national access standards, and achieving this trajectory;
- Working with commissioners to develop an integrated five year sustainability and transformation plan;
- Realising financial efficiency savings as a result of the implementation of the Lord Carter of Coles Recommendations;
- Ensuring full compliance with the national spending controls on locum and agency staff; and
- Fully implementing the new junior doctor's contract.

Unfortunately, to date, there is insufficient clarity surrounding the full list of conditions associated with the fund. In addition, NHS Improvement has confirmed that the process to assess delivery against the criteria of the fund is still being finalised.

This places significant financial risk on the Trust, given that it has set a financial operating plan for the year without a comprehensive understanding of everything it is being asked to achieve in order to secure this funding. In addition, it has not yet agreed its performance improvement trajectories or its capital control total.

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

Statement of Financial Position

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

- **Non-current assets:** The Trusts capital programme is currently behind plan by £0.7 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 of £0.5 million.
- **Trade and other receivables:** A significant proportion of this variance relates to a reduction in pre-payments as compared to the initial plan. This mainly reflects the timing of payments in relation to IT maintenance contracts. This variance is expected to reduce in June once payments are made.
- **Cash and cash equivalents:** The Trusts cash balance is currently £4 million above plan. This reflects the delay in cash payment for IT maintenance contracts, the slippage against the capital programme, together with the timing of the investment into the Christchurch Joint Venture.
- **Trade and other payables:** £0.5 million of the payables variance to date reflects the timing of the cash payment into the Christchurch Joint Venture. In addition, a small number of invoice payables remain unpaid, and these are being actively pursued.

£'000	Plan	Actual	Variance
Property, plant and equipment	176,825	176,469	(356)
Intangible assets	3,523	3,347	(176)
Investments (Christchurch LLP)	3,881	3,916	35
Non-Current Assets	184,229	183,732	(497)
Inventories	6,183	6,059	(124)
Trade and other receivables	14,586	12,517	(2,069)
Cash and cash equivalents	29,478	33,410	3,932
Current Assets	50,247	51,986	1,739
Trade and other payables	(30,801)	(31,813)	(1,012)
Borrowings	(307)	(307)	0
Provisions	(222)	(189)	33
Other Financial Liabilities	(1,102)	(1,102)	0
Current Liabilities	(32,432)	(33,411)	(979)
Trade and other payables	(1,009)	(1,010)	(1)
Borrowings	(19,395)	(19,415)	(20)
Provisions	(519)	(587)	(68)
Other Financial Liabilities	0	0	0
Non-Current Liabilities	(20,923)	(21,012)	(89)
TOTAL ASSETS EMPLOYED	181,121	181,295	174
Public dividend capital	79,681	79,681	0
Revaluation reserve	72,570	72,570	0
Income and expenditure reserve	28,870	29,044	174
TOTAL TAXPAYERS EQUITY	181,121	181,295	174

Capital Programme

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

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

Expenditure to date totals £1.7 million, representing a year to date under spend of £0.7 million. This is attributable to further slippage against the Christchurch development, and will be corrected in the coming months.

Full detail at scheme level is set out below.

£'000	Annual	IN MONTH			YEAR TO DATE			FORECAST	
	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance
Christchurch Development	3,425	1,100	385	715	1,120	422	698	3,425	0
Cardiac Laboratories	2,400	0	0	0	0	0	0	2,400	0
CT3 Building Alterations	450	10	0	10	15	0	15	450	0
Estates Maintenance	400	20	0	20	20	25	(5)	400	0
Sterile Services Department	300	0	5	(5)	0	5	(5)	300	0
QI Projects (Frailty unit, AEC, Cardiac)	300	112	115	(3)	202	196	6	300	0
Miscellaneous Schemes	300	0	(1)	1	0	(1)	1	300	0
Capital Management	265	22	20	2	44	37	7	265	0
Catering Equipment	100	50	41	9	50	41	9	100	0
Medical Equipment	1,000	0	11	(11)	0	33	(33)	1,000	0
IT Strategy	3,409	39	117	(78)	927	936	(9)	3,409	0
TOTAL	12,349	1,353	693	660	2,378	1,694	684	12,349	0

Cash

The Trust is currently holding £33.4 million in cash reserves. However, delays in the Christchurch development to date have resulted in a cash timing benefit when compared to the agreed phasing of the ITFF loan drawdown. As a result, the underlying cash position is significantly lower at £26.0 million.

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

Financial Sustainability Risk Rating

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

	Plan Metric	Actual Metric	Risk Rating	Weighted Rating
Capital Service Cover	0.98x	1.03x	1	0.25
Liquidity	15.0	18.8	4	1.00
I&E Margin	(2.27)	(2.28)	1	0.25
I&E Variance to Plan	0.96%	0.96%	4	1.00
Trust FSRR				3
Mandatory Override				Yes
Final FSRR				2

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

Monitor's investigation into the Trust has been completed and the consequent recommendation report will be presented to its regulatory committee on Monday 20 June. The Trust will be advised of the outcome shortly after this date.

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

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would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	24 th June 2016 – Part 1
Reason for Part 2:	n/a
Subject:	Workforce Report
Section on agenda:	7. Performance
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Karen Allman
Author(s) of papers:	Karen Allman & Ellen Bull
Details of previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC, Education & Training Committee
Action required: Approve/Discuss/Information/Note	For discussion and noting areas highlighted.
<p>Executive Summary:</p> <p>The report shows the performance of the Trust by care groups across a range of workforce metrics: Appraisal, Mandatory Training, Turnover and Joiner rates, Sickness and Vacancies.</p> <p>This month's report also includes details of Care Hours per patient day (CHPPD), an additional metric introduced by NHS Improvement to produce an outcome measurement re. patient care hours in registered nurse and care worker hours for each ward or department area.</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 – JUNE 2016

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

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 May			Rolling 12 months to 31 May				At 31 May
Surgical	5.6%	79.8%	88.4%	4.52%	14874	14.0%	12.1%	
Medical	9.2%	90.9%	87.0%	4.06%	20059	18.7%	12.4%	
Specialities	12.9%	86.8%	90.0%	3.19%	9065	10.6%	11.3%	
Corporate	6.5%	0.0%	93.0%	3.80%	12231	8.3%	11.0%	
Trustwide	8.5%	85.2%	88.9%	3.93%	56228	13.6%	11.8%	4.6%

**Vacancy Rate is Draft Figure*

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 May			Rolling 12 months to 31 May				At 31 May
Add Prof Scientific and Technical	19.4%		92.7%	2.86%	1280	17.8%	11.9%	
Additional Clinical Services	8.9%		88.6%	6.30%	16437	19.2%	13.7%	
Administrative and Clerical	7.8%		93.7%	3.36%	10229	7.7%	12.3%	
Allied Health Professionals	4.2%		91.2%	2.17%	1979	15.7%	15.0%	
Estates and Ancillary	2.8%		91.2%	4.72%	5823	13.2%	11.3%	
Healthcare Scientists	4.2%		82.7%	3.68%	927	9.6%	10.8%	
Medical and Dental		85.2%	80.8%	1.41%	2250	4.8%	5.2%	
Nursing and Midwifery Registered	10.7%		89.0%	4.13%	17304	15.4%	11.0%	
Trustwide	8.5%	85.2%	88.9%	3.93%	56228	13.6%	11.8%	4.6%

1. Appraisal

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

Some useful progress has been made against the trajectory in particular across Specialities/Care group C. Performance against the key workforce KPIs is reviewed at monthly care group meetings and at the Strategic Workforce Committee.

2. Essential Core Skills Compliance

Overall compliance has increased slightly to 88.9% from 88.2% last month.

The table below shows the 10 areas with the lowest compliance as at 31st May:

Directorate	Organisation	Headcount	Compliance	Trend
Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	12	60.33%	
Surgery Directorate	153 Obs/Gynae Medical Staff 10100	15	63.41%	
Cardiac Directorate	153 Cardiac Techs 11525	39	66.71%	
Elderly Care Services Directorate	153 MFE Medical Staff 10077	50	73.82%	
Cancer Care Directorate	153 Haematology Snr.Medical 11346	19	74.32%	
Elderly Care Services Directorate	153 MFE Management 13510	18	74.60%	
Anaesthetics/Theatres Directorate	153 Anaesthetic 10025	50	75.47%	
Medicine Directorate	153 Medical General Staff 10075	71	76.27%	
Medicine Directorate	153 Ward 2 10369	31	77.90%	
Cancer Care Directorate	153 Macmillan Unit 10565	37	78.28%	

Areas with highest compliance:

Directorate	Organisation	Headcount	Compliance	Trend
Human Resources Directorate	153 Blended Education and Training 18100	13	100.00%	
Informatics Directorate	153 Telecoms 13585	23	100.00%	
Cardiac Directorate	153 Cardiac Administration 11523	37	99.74%	
Orthopaedics Directorate	153 Orthopaedic Med Secs 13560	13	99.24%	
Pathology Directorate	153 Haematology 11340	24	99.17%	
Operational Services Directorate	153 Cancer Information Team 13495	17	98.82%	
Estates and Support Directorate	153 Works Department 17000	51	98.55%	
Specialist Services Directorate	153 Orthodontics 10210	21	98.41%	
Finance and Business Intelligence Directorate	153 Information 13541	17	98.24%	
Ophthalmology Directorate	153 BEU Admin 13520	22	98.06%	

3. Sickness Absence

The Trust-wide sickness rate has slipped back very slightly to 3.93% from the previous month's 3.91%, continuing its amber rating.

The table below shows the 10 areas with the highest 12-month rolling sickness absence as at 31st May:

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	13	12.08%	
153 Outpatients Directorate	153 Outpatients 10370	45	10.11%	
153 Clinical Governance Directorate	153 Risk Management 14115	14	9.60%	
153 Informatics Directorate	153 IT Development Recurrent 13588	13	9.05%	
153 Elderly Care Services Directorate	153 MFE Ward 22 10594	31	8.54%	
153 Elderly Care Services Directorate	153 MFE IP Therapy 10581	19	8.51%	
153 Elderly Care Services Directorate	153 MFE Ward 5 10378	39	8.44%	
153 Elderly Care Services Directorate	153 MFE Ward 4 10382	32	8.15%	
153 Anaesthetics/Theatres Directorate	153 Day Surgery Services 10385	33	7.97%	
153 Surgery Directorate	153 Surgical Admissions Unit 10535	25	7.73%	

Areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Pathology Directorate	153 Medical Staff - Histology 11300	11	0.11%	
153 Other Directorate	153 Postgraduate Centre 13531	11	0.15%	
153 Surgery Directorate	153 Surgery - Urology 10084	21	0.19%	
153 Other Directorate	153 Chief Executive 13535	29	0.29%	
153 Elderly Care Services Directorate	153 MFE Management 13510	18	0.35%	
153 Cancer Care Directorate	153 Haematology Snr.Medical 11346	26	0.64%	
153 Surgery Directorate	153 Surgery - General 10085	33	0.69%	
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	42	0.70%	
153 Elderly Care Services Directorate	153 Dietitians 13315	15	0.71%	
153 ED Directorate	153 ED Medical Staff 10015	65	0.87%	

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

4. Turnover and Joiner Rate

Joining and turnover rates of 13.6% and 11.8% show a slight change over the previous month (13.7% and 11.9%).

5. Vacancy Rate

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

6. Safe Staffing

The Unify Safe staffing data is provided in the table below, depicting the actual (not planned) percentage fill rate on aggregate of registered nurses and health care assistants respectively on day and night templates

Unify Data on Aggregate:

Day RN: 87.8%	Day HCA: 99.5%
Night RN: 100.2%	Night HCA: 117.6%

The in-month data is largely consistent with previous months, whilst important to note this is set against implementation of the backdrop of the Monitor 'agency rules' guidance and also the Carter recommendations on rostering efficiency. Following considerable scrutiny and review, roster efficiency has improved and work continues to sustain this, and tolerance and expectations for staff movement within directorates and outside of directorates has improved, although this is an area of continued focus. Red flags, the formal report made by the nursing team against a criteria for when staffing concerns exist, are monitored and assessed and reviewed by the Matron and Head of Nursing teams. This is reported verbally to the board.

Where areas had higher usage of HCAs, this was to mitigate the registered nurse activities. Ward 9 have a planned lower qualified to HCA ratios. The maternity data is not a true reflection as the template requires refinement.

Care Hours per patient day (CHPPD)

In May 2016 NHS Improvement published 'Care Hours per patient day (CHPPD) An implementation Guide', an additional metric to produce an outcome measurement on the number of patient care hours in registered nurse and care worker hours in each ward or department area.

One of the obstacles to eliminating unwarranted variation in nursing and care staff deployment across the NHS provider sector has been the absence of a single means of recording and reporting deployment. Conventional units of measurement that have been developed previously have informed the evidence base for staffing models, such as reporting staff complements using WTEs, skill-mix or patient to staff ratios at a point in time, but it is recognised by Nurse leaders may not reflect varying staff allocation across the day or include the wider multidisciplinary team. Also, because of the different ways of recording this data, no consistent way of interpreting productivity and efficiency is straightforward nor comparable between organisations.

To provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units, NHS Improvement developed, tested and adopted Care Hours per Patient Day (CHPPD).

- CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight)
- CHPPD reports split out registered nurses and healthcare support workers to ensure skill mix and care needs are met.

It is important to note that the data is pulled from the systems at 23:59.

This is the first month the data has been reported to NHS Improvement and NHS England. It is largely consistent with expectations, in that areas with:

- day case activity have a higher proportion of care hours due to the report being taken at 2359, when usual activity is much lower than the day;
- high acuity areas such as Coronary care unit, high dependency unit and intensive care have a higher CHPPD as the nurse to patient ratio is planned to be higher to meet patient care needs;
- at ward level, the CHPPD is largely rationalised to be within consistent parameters.

Variations to this are:

- day cases areas such as the eye unit and day case surgery, and also ward areas that have day cases, such as cardiology. The data run is taken at the time when day cases are not present;
- ward 9 is our GP unit and has a planned lower ratio of RNs to HCAs so this is what we expect to see;
- the higher acuity care areas such as HDU/ITU and CCU have much higher care hours due to their higher ratios which is to be expected.

In terms of CHPPD, on aggregate this demonstrates that of the areas collectively averaged in the Unify data, on average patients receive 4.5 hours of Registered nurse time and 2.8 of care staff time according to the calculation made. The variations to this match the variations in the original Unify data. It is concluded that this is the initial data run so in the first instance we are setting the baseline and examining the data to examine for unexpected variation.

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would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	24 June 2016 Part 1
Reason for Part 2:	N/A
Subject:	Clinical Services Review
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	Letter to Chairman of Dorset CCG 2.6.16
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	
Action required:	The Board is asked to note the update and comment on the communications plan
Executive Summary: This paper provides an update on progress to advance the CSR proposals and sets out for the Board a communications plan to aid understanding and engagement in the Consultation process	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

Clinical Services Review

This paper provides an update on the progress made to take forward the Clinical Services Review. Discussions have now taken place with the respective Health and Wellbeing Boards (covering Dorset County Council and a joint board covering both Bournemouth and Poole Borough Councils) where the proposals were well received. In particular emphasis has been placed on the rationale for change and the importance of reconfiguring and consolidating services in order to save lives and improve patient outcomes. Discussions have now commenced on a specialty basis to consider what changes to existing services and patterns of provision need to be made in order to facilitate implementation of the CSR proposals. The full design costs associated with major capital developments normally equate to 10% of the total spend. In advance of a final decision it is proposed that the Trust focuses on developing an outline design and a clear site development plan but that detailed work is not yet commissioned until the CCG have made their final decision on how the sites are to be used.

I have had the opportunity over the past fortnight to talk further with colleague Chief Executives both to better understand their perspective and to share the views of the Board (summarised in the recent letter sent to the Chairman of the CCG and contained in the Reading Pack). There is an explicit recognition on the part of partners of the importance of “falling in behind” the final CCG decision in order that the necessary changes can be enacted. It is likely, however, that Poole Hospital will continue to promote arguments for it to be the main emergency site during the consultation period. Further work is also planned to better articulate the benefit to patients of developing a planned care centre.

It is anticipated that the Clinical Senate will ask the CCG to consider further the implications of their proposals with regard to the configuration of Cancer services. The preferred proposal brings together Cancer services, and in particular Cancer surgery, in a more integrated way providing a single surgical site for the most complex treatment undertaken within Dorset. The proposals also allow for the integration of inpatient Haematology services and co-locate acute Oncology with Haematology and surgical Cancer services. The relationship between the siting of Radiotherapy services and other Cancer services is one that we will be explored further.

Discussions are also underway between Dorset County Hospital and Yeovil Hospital to consider the potential for joint working in order to enable more localised inpatient paediatric and obstetric care within the locality of Dorchester/Yeovil. I will update the Board on these early discussions when we meet on 24 June.

The Sustainability and Transformation Plan will be submitted to NHS England at the end of June. The acute hospital configuration is a centre-piece of this plan. Notwithstanding this the CCG will include specific reference to its preferred option within the Plan. Informal soundings from NHS England continue to be supportive of the new model of care and subject to the CCG responding to further questions the Senate may have as part of NHS England’s Assurance Framework, the timescale remains that agreement is sought from NHS England on 2 August to go out to consultation on the options including the preferred option from September 2016.

In light of this I have appended the proposed Trust Communications Plan (Annex A) to underpin our work in preparation for the consultation process with outline proposals for how we will also manage and engage with the consultation process in a way that both supports the CCG's consultation and actively seeks to convey key points the Trust views as critical to the reconfiguration of services.

The Board is asked to note this report and to comment on the Communications Plan.

Tony Spotswood
Chief Executive

Clinical Services Review – Communications Strategy

Annex A

Overview

The Clinical Services Review (CSR) is being run by the Dorset Clinical Commissioning Group (CCG). The CCG is responsible for commissioning health services across our county and the CSR is their project to look at the way that services are provided across our acute hospitals in Dorset.

The CCG has announced that they intend to go to public consultation on proposals that would see the Royal Bournemouth Hospital (RBH) develop as the Major Emergency Site within Dorset and West Hampshire. This means that some of our existing services will be expanded, including Accident and Emergency services, medical services for both elderly and acutely ill as well as those inpatients requiring haematology, emergency surgical services and critical care.

The CCG is also proposing that at Poole Hospital planned/elective care will be expanded as Poole will act as the location for the vast majority of Planned Care. Outpatient and diagnostic services will also be enhanced.

We need a communications strategy to ensure that we work with the CCG to outline why we are the preferred choice and to help ensure that our voice is heard through the consultation process.

CSR so far

When the CCG's decision was announced, there was an immediate outcry from people in support of Poole Hospital, with many concerned about the loss of their A&E department.

There was a lot of negative comment from people in the local media about the process; about losing A&E and about having to travel from Poole to the Royal Bournemouth Hospital and the traffic problems around Royal Bournemouth Hospital.

The negative comment was mostly from people living in the Poole area – people from other areas of Dorset did not appear to be commenting at this stage.

There was a petition set up calling to "Save Poole A&E" which gained a lot of support in a very short space of time.

Since then the CCG has worked hard to correct some of the misunderstandings particularly over what Poole Hospital's urgent care centre will provide.

The level of public interest as displayed in news coverage has also fallen, but it is anticipated that this will rise again in August in the run up to the start of the public consultation which the CCG plan to start in September 2016.

Targets/Aims of this Communications Strategy

We want to outline that:

- We support the CCG with their model, their proposals and their consultation
- We agree that RBCH should be the preferred option
- We will continue to work with colleagues across the health service and beyond with the Clinical Services Review
- We want to work with the CCG to ensure that their CSR process and public consultation goes as smoothly as possible so that they are able to make their final decision based on their findings so far and the findings from the public consultation.

Audience

1. Our staff
2. Our governors
3. Our local population
4. Our Trust Members
5. Population of Poole
6. Population of rest of Dorset
7. Our stakeholders/partners

Communication partners

- Our governors
- CCG
- Our Trust Members
- Our staff

Channels of communication

Local press	<ul style="list-style-type: none">• Bournemouth Echo• BBC Radio Solent• BBC South Today• Blackmore Vale Magazine• Stour and Avon Magazine• New Milton Advertiser and Lymington Times
Our social media and online channels	<ul style="list-style-type: none">• Twitter• Facebook• Our internet and intranet
Events	Further list below, but to include: <ul style="list-style-type: none">• Understanding Health Talks• Governor engagement events• Trust Open Day – 10 September

CSR key messages

- This is a CCG led proposal
- We support the CCG with their proposal
- We believe we are the best placed to become the Major Emergency site
- We believe the CSR will help save lives
- There is a need for change as outlined by Dorset Clinical Commissioning Group
- We have been involved with the process and will continue to do so
- We support the models of care that the CCG are proposing
- There is a need to change – the way we provide health services in Dorset is not sustainable
- By concentrating services, we can provide better outcomes for patients. This has already been proved locally and is a model that works. The CSR is an extension of this progression

We believe the future health needs of Dorset and West Hampshire residents are best served through the development of the Royal Bournemouth Hospital (RBH) as the main emergency hospital for Dorset. Reasons for this include:

- The conurbation we serve is the largest in Dorset.
- The fact RBH already provides a number of emergency services including vascular surgery, interventional radiology and interventional cardiology, which serve, out-of-hours, the whole of Dorset
- The RBH site naturally lends itself to development through its modern design and will be more cost effective to redevelop as an emergency centre than Poole Hospital.
- It will be the cheaper option – the CCG's analysis shows that the level of investment in new facilities is some £50m less expensive than the alternative of developing Poole Hospital as the main emergency site.

Christchurch Hospital will also have an important role to play focusing on outpatient and diagnostic provision, and provision of ongoing specialist palliative care. The site will also be a base for GP and community based services.

If Poole was to develop as the emergency site, this would mean a wide range of services having to transfer which would impact on the care of 50,000 patients and could lead to 2,500 staff relocating.

New highway infrastructure for which Bournemouth Borough Council already has funding linking the hospital directly to the Wessex Way. This would include a fly-over which would be funded by us.

The design of the RBH site means that the redevelopment work can take place with minimum disruption to existing services. We are confident that the construction of the new facilities can take place quickly.

We also need to ensure we are promoting positive messages in our general communications – see section below.

Events – opportunities to promote key messages

Month	Event	Output	Audience (see grid above)
May	CCG announcement of RBH being preferred option	Tony Spotswood interview with the BBC on South Today	3;
		Tony Spotswood interview with Bournemouth Echo	3;
		Member's newsletter – electronic	4;
		Member's newsletter – printed	4;
		Staff briefings	1;
		Governor briefings	2;
		Details of the CSR and link to the CCG website.	All
June	CCG announcement	Core Brief Q&A for staff and further details	1;
	End of A338 Roadworks	Much negative publicity for the CCG's decision came about because of the perception that RBCH was hard to reach. The end of the Dorset County Council's improvements to the A338 was something to celebrate.	1;
FUTURE EVENTS			
	Understanding Health Talk – 27 June	Understanding Heart Failure with Dr Chris Critoph. Opportunity to promote interventional cardiology and also to hand out Members' newsletter to audience.	2; 4
July	Stakeholder feedback/engagement	We have commissioned a report by GainMomentum to find out more on public opinion of the Trust. This includes questions for our Members; the local population and young people locally. Findings from this will be fed into this communications strategy.	1; 3; 4
	Possibility that the Trust may be awarded Green Flag	If this were to happen, we would be the first Trust in the UK to be given this award. It is based on the quality of our estate. This would be a good accolade to promote to showcase the quality of our environment.	3
August	CCG/NHSI/NHS Meeting	Press release after event and offer Tony Spotswood for interviews with media. Also offer a range of clinicians so we can showcase the range of services we already provide. Boilerplate with some of the key messages above.	3

	Governor Listening Events – TBC	Opportunity for our governors to meet with members of the public to talk about some of the issues around the CSR. We would provide our governors with a pack to take with them to these meetings – details below in Collateral. These should be in a range of locations across West Hampshire and Dorset. Work with local press and our social media channels to promote. We could also have a member of the board and some of our clinicians attend as well to help outline why we agree with the CCG's preferred option. We should also ensure we go to north Dorset; west Dorset and Poole.	3; 4; 5; 6
Sept	Understanding Health Talk – 9 September		3
	Trust Open Day and Annual Members' Meeting – 10 September	Our Open Day will be a great opportunity to showcase RBCH to the wider public. We shall ensure that our publicity leading up the event also is an opportunity to share our key messages. With the Annual Members' Meeting, this is a chance to remind our Member's about why we agree with the CCG's preference that we should be the Major Emergency Site.	3
Sept	FT Focus		

Positive messages for general communications

This is conjunction with any PR and internal communications about the CSR. We need to be continuing the showcase the best of the Trust and the best of the care we provide. We need to be focussing on our centres of excellence. We also need to be focussing on the quality of our staff.

Our focus for **external PR** over the next few months must include:

Areas of expertise – for instance our SSNAP data

Quality of our staff – awards

Quality of our care – our Dr Foster mortality data

The areas where we already specialise – and how we are doing in these areas, for instance interventional cardiology

Our focus for **internal communications** must be on:

Reassuring staff about the proposed changes and what the changes could mean to staff.

Building on a sense of pride of working for RBCH – we want staff to be our best ambassadors for the CSR in the lead up to the public consultation starting later on this year. This ties in with the findings from the recent Cultural Audit.

We also want to ensure that we emphasise our vision and our values to all staff. Our staff need to have a good understanding of the organisation they work for so that they can feel confident in their roles, and also that they can be confident when explaining to friends and family why RBH should be the preferred option.

Our focus on **social media** (mixed audience of staff and public) must be on:

Positive stories about Trust staff and the care we provide

Positive stories about our expertise

Promotion of any awards given to us

Focus on our estate – for instance if we are awarded a Green Flag

We want to focus on our staff – much of the negative coverage about RBCH has been centred on us being an uncaring organisation. We need to show the faces behind our care and share these stories wider. Not just with our doctors and our nurses – but all our staff, from AHPST, to porters, to admin.

Future plans: Attend the Performance Management Group to ask for help in highlighting any areas we should be promoting.

Collateral

We need to produce a range of collateral to help our staff and our governors know more about the process and answer any questions. These will include:

Collateral	Audience	Contents	Produced when
Members' Newsletter on the CSR	Our Members	Further details on the process and why we think we agree with the CSR that we should be the preferred option	June 2016 (Done)
Q&A for staff	Our staff	Answering any questions we think staff may have, including on possibility of redundancies and relocation for staff to Poole	June 2016 in Core Brief (Done)
Online Q&A for staff	Our staff	Put the Q&A on our intranet and invite our staff to send any further questions	June 2016
Governors event pack	Our governors	This will support governors for any events where they will come in contact with the public to help answer any questions they receive. It will contain background details from the Members' newsletter and their own Q&A. This will be updated as the process evolves.	July 2016
Clinical Services Review microsite	All – on our external website	This site will contain details of the process, a Q&A for members of the public and links to our	September 2016

Measurement

Ultimately the greatest measure of success will be that the consultation process proceeds and the CCG is able to make their final decision based on their research so far and the results of this consultation process.

No matter what the outcome of this, the fact we are doing a survey this month and July into public perceptions of RBCH, means that in a year's time we can redo the survey and measure whether or not there has been any shift in perceptions over our key messages locally. The survey is therefore vital to measuring success.

Next steps

Agree communications plan

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BOARD OF DIRECTORS	
Meeting Date and Part:	24 th June 2016, Part 1
Subject:	Performance Against Trust Objectives
Section on agenda:	Strategy
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Sandy Edington
Details of previous discussion and/or dissemination:	
Action required: Approve / Discuss / Information/Note	To note for information.
Executive Summary: This is the internal assessment of the performance against the Trust objectives for Quarter 4, 2015/16	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All CQC Standards
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	N/A

Team/Group/Committee/Board Date
Name of item

2015/16 Monitoring of Performance against Board Objectives

Success Criteria / Milestone	Lead Exec	Monitored By	Information Provided By	RAG / Achieve d Q1	RAG / Achieve d Q2	RAG / Achieve d Q3	RAG / Achieve d Q4	Commentary
1. To continue to improve the quality of care we provide to our patients ensuring that it is safe, compassionate and effective, driving down reductions in the variation of care whilst ensuring that it is informed by, and adheres to best practice and national guidelines. Our specific priorities are:								
Achieving consistency in quality of care by a year on year improvement in providing harm free care, measured by a reduction in Serious Incidents	PS	HAC	Governance					Plan for 15/16 is no more than 35 SIs – number of SIs at end of Q4 was 32 - objective achieved
Ensuring patients are cared for in the correct care setting on Wards by improving the flow of patients admitted non electively and reducing the average number of outlying patients and non clinical patient moves by at least 10%	RR							Out of hours ward moves - 10% target reduction achieved Q1, Q2 & Q3. Outliers > than in 14/15 in Q1, but < in Q2 & Q3.
To reduce the number of avoidable category 3 and 4 pressure ulcers acquired in our hospital in 2015/16 by 25%, measured through Serious Incidents	PS	HAC	Governance					Plan for 15/16 is no more than 14 PU SIs - number of Cat 3 & 4 pressure ulcers reported as SIs was 6 - objective achieved
To ensure that there are no MRSA bacteraemia cases and that the Trust achieves its target of no more than 17 Clostridium Difficile	PS	IPCC	Information					We did not have an MRSA case in 15/16. We achieved the target for c.diff cases at end of 15/16 (17 cases against a trajectory of 17).
To be within the top quartile of hospitals reporting patient satisfaction via the Family and Friends Test	PS	HAC	Governance					Top quartile for in-patients. 2nd quartile for ED.
2. To drive continued improvements in patient experience, outcome and care across the whole Trust. The Trust will use a QI methodology to support this work. Key priorities are:								
Improving the management of sepsis, ensuring we implement the six key interventions (high-flow oxygen, fluid bolus, blood cultures, IV antibiotics, monitoring urine output, and measuring lactate) within one hour of patients being identified as having sepsis or being in septic shock.	DM	Improvement Board	PMO					Improved from March 2015 baseline measurement of 26% to 62% at end of December 2015. Challenge is to maintain momentum. Comms video now in final draft version and the poster campaign has been refreshed and new education packages launched. There is a revised version of stickers and screening tool. Successfully completed participation of Wessex Patient Safety Collaborative Sepsis Project. Successful submission of poster to European safety forum in Gothenburg. Next steps include continuing work to improve on Sepsis 6 supported by membership of Wessex Sepsis Network. Presentation to the Wessex Quality Improvement conference planned for June 2016.
Implementing the Department of Health's best practice guidance for effective discharge and transfer of patients from hospital and intermediate care. These including developing a clinical management plan for every patient within 24 hours of admission; all patients having an estimated date of discharge within 24-48 hours of admission; use of a discharge checklist, daily discharge board rounds and the involvement of patients and carers to make informed decisions about their on-going care and discharge. The full list is shown as Annex 1.	DM		PMO					Learning from SDA PDSA in Quarter 3 has informed a new approach to tackling challenges of hospital flow. Focused work on Ward 4 board round and resulting changes in process have shown improvement in length of stay and number of discharges before midday. Approach is now being tested on Ward 5. The challenge remains around the ability to spread and sustain improvement.
Using a standard operating procedure for all patients undergoing emergency laparotomy with the aim of reducing mortality from 11.4% to 9% during 2015.	DM		PMO					New pathway designed and implemented. Challenge is to embed and making it easier to use by incorporating in current inpatient record. MFE fellow joined team to focus on frailty. Successful submission of poster to European safety forum in Gothenburg. Next steps in project include plans to record and incorporate the frailty score in the e-lap pathway and trial an education/awareness programme for new intake of trainee doctors.
Uniform use of surgical checklists across the whole organisation with the intention that there are no Never Events associated with failure to use checklist.	DM		PMO					Results of compliance review showing improvement in all areas. IT solution developed to make it easier to complete the checklist and to carry out the audits. System in testing phase and will be available Q1 2016/17. Next steps include plans to fully implement National Standards for Invasive Procedures (NatSSIP) and extend human factors training beyond theatres to underpin improvements in quality of checklist completion
Implementing the NICE guidelines for patients referred with suspected GI cancer ensuring a minimum of 93% of patients receiving an appointment within two weeks.	DM		PMO					Challenge is around the capacity constraints. Work being done to develop a 'straight to test' model for fast track colorectal PDSA. First trial starts November 2015 for 6 weeks. Second PDSA February 2016 using clinician and Nurse Practitioner(NP) to run clinic. The initial results have been positive including feedbacks from patients on the clinic arrangements. Next step is to move to trial NP clinics and then develop a plan to resource an expanded number of clinics.
3. To support and develop our staff so they are able to realise their potential and give of their best, within a culture that encourages engagement, welcomes feedback, and is open and transparent in its communication with staff, public and service users. Key priorities include:								
Introducing a new staff appraisal system, using a value based behavioural framework which will launched in April 2015, with all staff appraisals completed by November 2015*	KA	workforce and BOD	ESR/Workforce/OD					New staff appraisal system was introduced across the Trust with an end of year 83% completion rate. There has been a refresh for 16/17 and a trajectory agreed this year.
Ensuring all staff have agreed personal development plans, which reflect both the needs of the service and their own development requirements	KA	Care Group/Directorate	Workforce					Personal Development Plans form part of a values based appraisal. TNA completed and agreed following consultation in November. The process will be reviewed for 16/17.
The development and implementation of a comprehensive leadership and organisational development strategy to ensure delivery and develop an open, transparent culture where staff are readily able to take responsibility and have authority for the provision of their services. The strategy will be finalised by September 2017.	NH		Workforce					Discovery Phase commenced, Change Champions appointed and Discovery Phase underway. Report of findings and recommendations will be made to the Board meeting on 6 th June 2016.
The strengthening of engagement within the Trust, facilitating opportunities for staff to contribute to the design and delivery of services (this will be measured through the Trust improving its staff survey results to the upper quartile).	KA	Workforce	Picker					Staff Survey results showed a significant improvement and action plans have been developed to address corporate and local priorities
Promoting greater autonomy within a clear framework of responsibility and accountability for staff to manage their services.	TS							The cultural audit and leadership strategy will drive this work with proposals being considered by the Board, presented by the change leaders at the June 16 meeting.

Success Criteria / Milestone	Lead Exec	Monitored By	Information Provided By	RAG / Achieved Q1	RAG / Achieved Q2	RAG / Achieved Q3	RAG / Achieved Q4	Commentary
4. To develop and refine the Trust's strategy to give effect to the agreed outcomes following the CCG led Dorset Clinical Service Review. Key priorities include:								
The development of clear proposals to maintain the provision of resilient, high quality, viable services in the lead up to full implementation of the Clinical Service Review. Proposals developed by December 2015	TS	BOD						The Vanguard proposal has been completed and submitted. The Trust has accepted the offer from NHS Improvement for Sustainability and Transformation Fund (STF) funding, to underpin the overall financial position.
The continued development of Christchurch Hospital, offering a community hub for provision of healthcare services	RR	BOD						Project on track.
The provision of new facilities for patients with blood disorders and those requiring women's health services, through the completion of building work by September 2016	RR	BOD						Project on track.
Launch of the Trust's Vision in April 2015 providing clarity to staff and members of the public about our core purpose and values	TS	BOD						Completed
Electronic Document Management: To implement the necessary process changes within clinical and administrative practices within all care groups and corporate departments to seize the full benefits of the new EDM service which enables patient's Health Records to be available 24/7, instantly in a searchable format. To achieve the EDM business case expectations of cost improvements of £759k within 2015/16 and £1.1M in 2016/17.	PG							Records are now scanned for all patients that present electively and approximately 75% of all patients that present have been scanned from a previous event. There are still clinical risks associated with the effective use of the system which are being worked on in collaboration between clinical leads, IT and operations. 522k saved in 2015/16 (to be confirmed by Helen R); an additional 397k target savings in 2016/17 which provides a total saving in 2016/17 against the 2014/15 baseline cost of 919k (to be confirmed by Helen R)
5. To ensure the Trust is able to meet the standards and targets necessary to provide timely access to high quality responsive elective diagnostic and emergency services. The key targets are:								
95% of patients waiting no more than 4 hours from arrival in ED to their admission discharge or transfer	RR	TMB & PMG	Information					As per monthly BOD report
93% of patients referred using the fast-track cancer pathway being seen within 14 days of referral	RR	TMB & PMG	Information					As per monthly BOD report - achieved Q3
93% of patients referred to the symptomatic breast clinic seen within 14 days of referral	RR	TMB & PMG	Information					As per monthly BOD report - achieved Q3
96% of patients diagnosed with cancer receiving treatment within 31 days	RR	TMB & PMG	Information					As per monthly BOD report - achieved Q3
85% of patients receiving their first treatment within 62 days of urgent GP referral with suspected cancer.	RR	TMB & PMG	Information					As per monthly BOD report - achieved Q3
92% on incomplete pathways within 18 weeks	RR	TMB & PMG	Information					As per monthly BOD report - achieved Q3
6. The Trust achieves its financial plan with emphasis on reducing agency spend, cutting waste and securing improvements in efficiency and productivity without detriment to patient care.								
	SH	FC & BOD	FINANCE					The Trust reported an actual deficit of £11.6m for the financial year 2015/16. This deficit was an improvement over the original plan of £12.9m and was achieved through reducing agency expenditure and delivering £9.5m of cost improvement during the year..

Table:

G - Delivered, or on track and on time
 A - Risk of delay or partial completion
 R - Risk of non-delivery or delay
 - not yet done

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would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	24 th June 2016 Part 1
Subject:	IPCC Annual Report and Board Statement of Commitment to Prevention of Healthcare Associated Infection
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Paul Bolton, Lead Infection Prevention Control
Details of previous discussion and/or dissemination:	Infection Prevention and Control Committee. Healthcare Assurance committee
Action required: Discuss/Information	The Board of Directors is asked to note the summary report and approve the statement of commitment with infection prevention and control.
Executive Summary: <p>The enclosed summary report outlines the Trust's work and progress with the prevention, control and management of infection. This work programme is overseen by the Infection Prevention and Control Committee, which reports to the Healthcare Assurance Committee.</p> <p>The Board of Directors is required to sign and publish an annual statement which reaffirms its commitment to infection prevention and control. The statement details the processes which are in place to meet the duties under The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2011). This has been updated to include reference to the CQC essential standards and the Trust's Quality Strategy.</p> <p>Once approved, the IPCC annual report and the statement will be published on the Trust's website to reaffirm to the public the Board's commitment to Infection Prevention and Control.</p>	
Relevant CQC domain:	All
Risk Profile:	
i. Have any risks been reduced?	No
ii. Have any risks been created?	No

ROYAL BOURNEMOUTH & CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

Board of Directors' Statement of commitment to the principles of the Code of Practice for the Prevention and Control of Health Care Associated Infections

The successful management, prevention and control of infection is recognised by the Trust as a key factor in the quality and safety of the care of our patients and of those in the local health community, and in the safety and wellbeing of our staff and visitors.

The Board is aware of its duties under the The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2011). The Board has collective responsibility for infection prevention and control including minimising the risks of infection.

The Board receives assurance that the Trust has mechanisms in place for minimising the risks of infection by means of the Infection Control Committee and the Director of Infection Prevention and Control (DIPC). Assurance is provided by performance reports, audit reports, root cause analysis reports and verbal presentations from the DIPC.

The Infection Control Committee is chaired by the DIPC. It is a sub-committee of the Healthcare Assurance Committee (HAC) and the Board receives the annual report and exception reports. It has terms of reference and produces an annual plan, both of which are approved by the HAC and reported to Board.

The DIPC is appointed by the Board and reports directly to the Chief Executive and the Board. The post holder is a member of the Trust Management Board and Healthcare Assurance Committees, and produces an annual report. The DIPC role is incorporated in the Director of Nursing and Midwifery's portfolio and the post holder is assisted in discharging the relevant responsibilities by the Hospital Infection Control Doctor the Lead Infection Control Nurse and the Infection Control Team.

The Board is committed to the exemplary application of infection control practice within all areas of the Trust. To this end the Board will ensure that all staff are provided with access to infection control advice with a fully resourced infection control and occupational health service, access to personal protective equipment and training and policies that provide up-to-date infection control knowledge and care practices. Individual and corporate responsibility for infection control will be stipulated as appropriate in all job descriptions with individual compliance monitored annually through the appraisal systems and personal development plans.

The policies in place in the Trust and the arrangements set out above are to encourage, support and foster a culture of trust wide responsibility for the prevention and control of infection in practice, with the aim of continually improving the quality and safety of patient care. This extends to all relevant departments; clinical directorates, clinical support services, estates and ancillary services.

The Trust's policies and practices in respect of infection prevention and control accord with the aims and objectives in national policy and strategy and, in addition, the Trust participates fully in all national mandatory reporting requirements. This is aimed at ensuring the full confidence of the local population in the quality of care the Trust delivers.

Summary of IPCC Annual Report: April 2015 to March 2016

Working together to break the chain of infection

Introduction

The last 12 months have seen continued positive results with progress in infection prevention and control, with no cases of MRSA bacteraemia and low clostridium difficile rates when compared nationally. There have been a range of challenges and a key goal this last year has been to ensure that all the learning from each individual case is used to reduce the likelihood of further cases. This theme drives the report with a focus on the impact our Infection Control policies have on the patient journey and how each challenge facing the Trust is helping to shape the delivery of care.

The purpose of this report is to provide assurance to the Board of Directors and the public on compliance with the Health and Social Care Act 2010: Code of Practice for the NHS on Prevention and Control of Healthcare Associated Infections and related recommendations (the hygiene code) including NICE guidance.

IPC and Information Technology

In order to address current gaps in the ability to carry out epidemiological analysis of our Hospital/ follow up of our patients the infection control team have been looking at IT developments to help meet NICE guidance. After a failed bid to the Nursing Technology fund for ICNet we are now working closely with the IT department to create our own system within RBCH. This is in the development stage.

Currently the team are unable to track and trace patients and their contacts as they move throughout the Trust receiving care in the various departments. We have a good understanding of where a patient is and can use current systems in the Trust to ascertain locations at given points in time but a system does not currently exist that can link this to infectious diseases. In order to truly understand the impact on the Trust of C diff, MRSA or other Multi Antibiotic Resistant Organisms this facility is key.

Clostridium Difficile Infection (CDI) trajectories.

The total number of CDI cases testing positive at RBCH has fallen over the past 6 years, however the number of those that are inpatients has increased. The percentage of those cases deemed as late has fluctuated in that time period but over the last 3 years has remained around 20% with a slight upwards trend in line with the increase in cases tested positive at RBCH.

For 2015/ 16 we were over trajectory of 14 by 3 cases. Gaps in practice that may have contributed to these cases, 'lapses in care', have been used to create key learning points for the Trust. In addition to teaching sessions and awareness raising

posters the IPC team have worked with Wards and departments to help identify any changes that could reduce the likelihood of reoccurrence. Changes to improve practice have included;

- One stool chart throughout the Trust and to have it incorporated into the care plan.
- Updating the risk assessment tool

Norovirus

This year 6 wards and 7 bays were closed due to Norovirus. The number of patients reported to have this virus was 88, 20 members of staff reported in unwell with symptoms. In total there were 154 empty bed days (beds unoccupied in closed wards or bays).

At the time of writing this report the Trust had 550 beds and 95 side rooms including 5 wards with an ICEpod (temporary side room) each. Current evidence indicates that on an average day 60% of the side rooms within the Trust are used for patients carrying infectious bacteria. With the rising threat from resistant bacteria and new and emerging infections on top of the current plan to reduce bed spaces (including side rooms) it is essential that we continue to look at new areas to isolate patients and novel methods to decontaminate areas after the patient leaves the hospital. These methods are coming to market and will be investigated in due course. A future wish for the Trust would be for an increase in the number of side rooms to improve our ability to promptly isolate patients.

Care Quality Commission (CQC)

The CQC inspection carried out in 2015 did not have any compliance actions related to infection prevention and control. However, the inspectors cited examples where staff did not fully comply with the Infection Prevention and Control principles. The summary report stated that staff generally adhered to Infection control procedures, but there were “some lapses in hand hygiene and some practices that did not fully support effective infection control and prevention”.

An action plan has been developed to address these concerns led by the Heads of Nursing and Quality in each Care Group. These actions include but are not limited to:

- An audit of equipment cleaning records to ensure that all equipment is cleaned after each use and that this is documented.
- Hand hygiene awareness will occur throughout this year with events timed to coincide with World Hand Hygiene Day (May 5th) and to line up with the Infection Prevention Society Hand Hygiene Torch Tour that starts on the 5th May and ends on the 29th September.

- Ensure that all patients are offered the opportunity to wash their hands before meal times.
- Ensure that more staff access and complete the mandatory infection control training with a focus on improving uptake of this within the medical professionals.

The Infection Control Team will support these actions, which will be monitored through the Trust's Infection Prevention and Control Committee.

BOARD OF DIRECTORS MEETING – 24 June 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 meetings held on 25 and 27 May 2016		All
11.05	2. MATTERS ARISING		
	a) To provide updates to the Actions Log - Update on STF Performance Trajectories Richard Renaut (verbal)		All
11.30	3. STRATEGY AND RISK		
	a) Significant Risk and Assurance Framework (paper)	Information	Paula Shobbrook
	b) Clinical Services Review (paper)	Information	Tony Spotswood
	c) Vanguard Update (paper)	Information	Tony Spotswood
	d) Medical Director Role going forward (paper)	Discussion/ Decision	Tony Spotswood To Follow
	e) Dorset Care Record (paper)	Decision	Peter Gill
12.30	4. GOVERNANCE		
	a) Terms of Reference Review – Audit Committee (paper)	Decision	Alison Buttery
	b) Terms of Reference Review – Healthcare Assurance Committee (paper)	Decision	Paula Shobbrook
	c) Terms of Reference Review Workforce Strategy and Development Committee (paper)	Decision	Karen Allman
	d) Follow up from Board Development Session and Review and Agree the revised Board Charter (presentation)	Discussion/ Decision	Nicola Hartley
12.45	5. QUALITY		
	a) Issues not dealt with in Part 1		
	6. PERFORMANCE		
	a) Issues not dealt with in Part 1		
	b) Carter Review Recommendations (paper)	Discussion	Stuart Hunter
	c) Facilities Business Case (paper)	Decision	Richard Renaut To Follow

12.50

7. ANY OTHER BUSINESS

- a) Key Points for Communication to Staff
- b) Reflective Review