

A meeting of the Board of Directors will be held on Friday 29 January 2016 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

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

Sarah Anderson
Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8:30-8:35	1. APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
8:35-8:45	2. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 18 December 2015		All
	b) To provide updates to the Actions Log		All
	3. MATTERS ARISING		
	a) None		
8:45-9:25	4. QUALITY IMPROVEMENT		
	a) Feedback from Staff Governors (Verbal)	Information	Jane Stichbury
	b) Patient Story (Verbal)	Information	Paula Shobbrook
	c) Complaints Report (paper)	Information	Paula Shobbrook
	d) Internal Quality Review (paper)	Information	Paula Shobbrook
	e) Safe Staffing (paper)	Discussion	Paula Shobbrook
	f) Quality Improvement Update (paper)	Information	Tony Spotswood
9:25- 10:05	5. PERFORMANCE		
	a) Performance Exception Report (paper)	Information	Richard Renaut
	b) Report from Chair of HAC (verbal)	Information	Dave Bennett
	c) Quality Report (paper)	Discussion	Paula Shobbrook
	d) Finance Report (paper)	Discussion	Stuart Hunter
	e) Report from Chair Finance Committee (verbal)	Information	Ian Metcalfe
	f) Workforce Report (paper)	Discussion	Karen Allman
	g) Mortality (paper)	Information	Basil Fozard
10:05-10:30	6. STRATEGY AND RISK		
	a) Vanguard Progress Report (paper)	Decision	Tony Spotswood

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|---|-------------|-----------------------|
| b) CSR Update (verbal) | Information | <i>Tony Spotswood</i> |
| c) Draft Trust Objectives 2016/17 (paper) | Discussion | <i>Tony Spotswood</i> |
| d) Forward Planning Guidance and Implications (paper) | Information | <i>Richard Renaut</i> |
| e) Information Governance Strategy (paper) | Decision | <i>Peter Gill</i> |

10:30-10:45

7. GOVERNANCE

- | | | |
|---|-------------|-----------------------|
| a) Race Equality Scheme Progress Report (paper) | Information | <i>Karen Allman</i> |
| b) Monitor Quarter 2 Report (paper) | Information | <i>Sarah Anderson</i> |

8. NEXT MEETING

Friday 26 February 2016 at 8.30am. It is hoped to hold this meeting at Christchurch Hospital, but the exact venue is yet to be confirmed.

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC

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

11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

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

Part I Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Board of Directors** held on **Friday 18 December 2015** in the Conference Room, Education Centre, Royal Bournemouth Hospital.

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Dave Bennett	(DB)	<i>Non-Executive Director</i>
	Derek Dundas	(DD)	<i>Medical Director</i>
	Basil Fozard	(BF)	<i>Director of Informatics</i>
	Peter Gill	(PG)	<i>Non-Executive Director</i>
	Christine Hallett	(CH)	<i>Director of Finance</i>
	Stuart Hunter	(SH)	<i>Non-Executive Director</i>
	Ian Metcalfe	(IM)	<i>Non-Executive Director</i>
	Steven Peacock	(SP)	<i>Chief Operations Officer</i>
	Richard Renaut	(RR)	<i>Director of Nursing and Midwifery</i>
	Paula Shobbrook	(PS)	<i>Non-Executive Director</i>
	Bill Yardley	(BY)	<i>Non-Executive Director</i>
In attendance:	Sarah Anderson	(SA)	<i>Trust Secretary</i>
	Kathy Bluston	(KB)	<i>Rehab Lead, Christchurch Day Hospital</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NHa)	<i>Director of Organisational Development</i>
	Alex Lister	(AL)	<i>General Manager, Medicine</i>
	Vanessa Mason	(VM)	<i>Directorate Manager, Elderly and Therapies</i>
	Deb Matthews	(DM)	<i>Director of Improvement</i>
	Sharon McAndrew	(SM)	<i>Radiographer Improvement Facilitator</i>
	Heather Olive	(HO)	<i>Senior Occupational Therapist, Christchurch Day Hospital</i>
	Lisa Piggott	(LP)	<i>Sister, Christchurch Day Hospital</i>
	Paul Ritchie	(PR)	<i>Communications Lead</i>
	Dily Ruffer	(DR)	<i>Governor Coordinator</i>
	Geraldine Sweeney	(GS)	<i>Head of Programme Management</i>
	Andrew Williams	(AW)	<i>Clinical Director, Elderly Care</i>
	David Bellamy	(DB)	<i>Public Governor</i>
	Derek Chaffey	(DC)	<i>Public Governor</i>
	Eric Fisher	(EF)	<i>Public Governor</i>
	Bob Gee	(BG)	<i>Public Governor</i>
	Paul McMillan	(PM)	<i>Public Governor</i>
	Keith Mitchell	(KM)	<i>Public Governor</i>
	Margaret Neville	(MN)	<i>Member of Public</i>
	Roger Parsons	(RP)	<i>Public Governor</i>
	David Triplow	(DT)	<i>Public Governor</i>
Apologies	None.		

105/15

MINUTES OF THE MEETING HELD ON 27 NOVEMBER 2015 (Item 2a)

Action

SP declared that his wife had been appointed as a member of the Board for Tricura. The minutes of the meeting on 27 November were approved as an accurate record.

106/15

MATTERS ARISING (Item 3a)

(a) **To provide updates to the action log**

The action log was noted. Clarification was provided for action 100/15 (f) which related to the timeframes for the recruitment of nurses.

(b) **NHS Preparedness for a Major Incident (Verbal)**

The Board was advised that the Trust had recently undertaken an annual Emergency Preparedness Resilience assurance process. The level attained was deemed to be substantially compliant by the Clinical Commissioning Group (CCG). In response to the request from NHS England the following areas were reviewed: the cascade systems as part of the wider notification system support by the CCG and South West Ambulance and internal systems, major disruption to the local road network, the ability to increase the critical care capacity and the management of patients with traumatic blast and ballistic injuries. In light of recent events staff have been reminded to be aware and report suspicious behaviour.

107/15

QUALITY IMPROVEMENT

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

Staff Governors identified the following themes:

- Recognition of progress made on issues raised during feedback sessions, including actions to address improvements in the completion of risk assessments on Wards;
- Appraisal and sickness levels;
- Staff Governor listening events will be arranged and it has been suggested that staff could use the website to raise questions;
- Wearing governor lanyards has helped to identify staff governors and more staff have approached;
- Availability of staff rooms in the west wing. Information will be circulated to promote the various staff resting areas;
- Feedback has been reflective of how busy the Trust is and staff are aware of the current financial constraints.

(b) **Patient Story (Verbal)**

LP, HO and KB presented the patient story which focused on the transformation of the services provided at the Christchurch Day Hospital. The team explained that the services are led by a highly motivated multi-professional team who have expertise in older person's rehabilitation. The Day Hospital provides support to older

people and helps to maintain their independence. Recent increases in the demand for services has placed additional pressure on the Day Hospital and the team have noted a rise in the number of younger people with complex needs who also require support.

To address the increases in demand the team worked together to identify solutions throughout the patient journey. An example of the changes made included training staff in a variety of assessor competencies to improve efficiency when completing assessments upon admission. This has also improved patient experience as they are able to develop a rapport with an individual member of staff.

In order to prevent admissions the Day Hospital have developed a strong link with the CCG, and through the virtual ward collaboration with GPs, to identify and target patients with high needs before they need to be admitted. Staff are reactive to patients' needs and the virtual wards allow faster access to community resources. The team noted that the voluntary sector had also played an important role.

The team aspire for the Day Hospital to become a practice development unit with Bournemouth University and gain accreditation. It was highlighted that this process did not solely concern the accreditation but the overall journey in improving services. The improvement journey itself received full engagement from the Trust and the improvements link with the Trust values and strategic objectives. By restructuring and focusing on the services the Day Hospital has made improvements without the need for additional resources. The CQC supported that the Day Hospital model should be replicated elsewhere.

The Board were advised that the Day Hospital has increased its capacity by 30% however this has not impacted upon referral times and this will remain challenging. The fast track process and development of the virtual wards is making an impact and this is also as a result of strengthening communication between wards. It was proposed that the Board should visit the Day Hospital and experience the changes made.

The Board commended the Team's passion and dedication to the services they provide. Further Board members acknowledged that staff had felt empowered to make change at pace. The Board thanked the team and highlighted that it was a phenomenal achievement and a great example of proactive thinking for the whole Trust. RR outlined that there had been a 75% reduction in admissions and the services at Christchurch had contributed to this success.

(c) Quality Improvement: Update on Urgent Care in Medicine Project (presentation)

DM presented the progress made following the launch of the Quality Improvement programme 18 months ago in support of the Trust's vision; 'To become the most improved Hospital by 2017'.

- The Trust is facilitating and supporting the changing culture through the QI projects with coaching and training support for staff involved. In 2016 a new two day improvement skills training course will be launched;
- The anticipated savings from the QI projects is £2 million;
- The focus has been on improving quality and driving down cost as both are of equal importance;
- Hospital flow- improving patient experience through the 5 daily actions campaign;
- Sepsis- focus on improving the time for TTAs. Currently the Trust has achieved 52% within an hour and 72% within 90 minutes;
- Safety Checklists- standardising and embedding safety checklists across areas undertaking interventional treatments and surgery. The Trust are ahead of the curve in implementing a process like this;
- Endoscopy- administrative processes were redesigned to create a paperless environment and increase efficiency. The number of complaints have reduced and team morale has increased;
- Emergency laparotomy- a new pathway was created and mortality for the procedure has decreased from 11.9 to 4%;
- There has been national recognition for the Unscheduled Care Team and QI programmes;
- Feedback received following the Safety and Quality Conference was positive and the Trust will be holding the event again to promote learning amongst staff;

AW presented the improvements within urgent and emergency care:

- Following investment in resources improvements have been made to reduce the waiting time for clerking;
- The Trust has also expanded the ambulatory care service;
- The work has helped reduce length of stay by 4.9 days within Medicine and 6.4 days within Medicine for the Elderly;
- Focus remains on addressing patient flow to improve patient experience;
- The Trust is working to ensure that all admissions are appropriate by assessing patients early and increasing senior decision making;
- Kings fund silver book. The Trust have supported the proposal for MFE to join the Acute Frailty network;
- The QI improvements made to simplify the model of care and ensure patients are provided with the most appropriate time efficiently should amount to £5 million in savings for the Trust
- The estates team are working with the department to implement the QI work however increased support from external stakeholders will be necessary. Collective ownership and clinical leadership will be essential it making the work successful.

Board members emphasised that the outlook for social care within the UK was poor and queried how this could be improved. AW responded

that occupational therapists had a key role together with trusted assessors. He advised that there would be a pilot on the stroke unit for social workers to assess both Dorset and Bournemouth patients. It was agreed that the messaging needed to be consistent about the need for further support.

The Board queried what further support could be provided to the department. AW advised that capital decisions would be difficult but that staff needed to be allocated time to identify QI solutions. Board members commended the QI work and the traction gained from the original investment to address backlog. The Board agreed to provide further support to the areas identified by AW.

RR

108/15

PERFORMANCE

(a) Performance Exception Report (Item 5a)

RR outlined the key information from the report:

- Cancer 62 day standard- the Trust's performance remains non-compliant reflecting a high volume of West Dorset referrals and this is a challenge nationally. The Board noted the national guidance on high impact changes which the Trust is implementing;
- Cancer 2 week wait- performance has been sustained;
- ED 4 hour- compliance remains challenging and the standard is not being achieved across the UK. The Board agreed that following discussion at TMB a seminar should be considered for January to address performance issues;
- Attendances and admissions are being tracked. Within the last two months there has been an increase in the number of admissions (nationally);
- Medinet investment- this has improved the diagnostic 6 week wait performance;
- There is likely to be a national announcement concerning the fines for not achieving core performance indicators. An improvement plan is in place for diagnostic waiting times and the model has been developed. It was highlighted that this needed to be addressed together with capacity before April;
- Staff are engaged and the Trust will continue to challenge the processes behind the numbers.

RR

The Board discussed the importance of being able to consider available options and solutions in order to provide support. It was also acknowledged that empowering teams to deliver achievements was key and members recognised staff engagement and support for doing the right thing.

(b) Report from Chair of HAC (Verbal)

DB provided an update and outlined the key themes from discussions:

- It was a positive meeting as it was clear that performance was moving in the right direction;

- Movement in response rates to complaints handling. Complaints are reducing overall as a result of increased engagement with local teams;
- The IG assessment compliance was raised as a risk as the Trust may be fined for non-compliance. An action plan is in place however the Trust will be required to prioritise and this should be driven by Executives. The Board supported that IG compliance needed to be addressed;
- EDM risk discussions- the risk has been downgraded to level 16 however this was not reflective of the Cardiology department's perception of the issues concerned. The Trust will need to support the department to drive progress with EDM forward whilst acknowledging fundamental issues in some areas. PG advised that the Trust would be refocusing some IT programs and resources to support EDM.

Execs

(c) Quality Performance (Item 5c)

Two serious incidents were noted. The safety thermometer trend data supported that improvements were being made monthly in different areas of the Trust.

(d) Report from Chair Charity Committee (Verbal)

The independence of the Hospital Charity had previously been considered by the Committee however it was apparent that fewer charities had become independent following changes in legislation. It was agreed by the Board that the position should be reviewed in late 2015. Advice was sought and discussed in detail however the Committee considered that it was not the appropriate time to seek independence. The Board supported the recommendation not to seek independence at this time.

(e) Financial Performance (Item 5e)

SH summarised the key information from the report noting:

- Care group plans to address the risks to the forecast plan were considered at TMB;
- Financial performance within month 8 has remained steady. The Trust has achieved £302,000 in favourable variance to the plan although careful management is required to ensure that this financial improvement is realised in full;
- Emergency activity is above plan, however the overall total activity to date remains broadly in line with planned levels overall;
- Improvements have been made against agency expenditure and the Trust is reporting to Monitor on a weekly basis;
- CIP plans exceeded the target set as a result of granular examination of opportunities, the structured approach to realising savings and increased engagement with more staff identifying and presenting CIP plans;
- Lord Carter Report on Productivity benefits will be considered.

The Board **noted** the encouraging work around the CIP performance.

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

IM emphasised that there had been a genuine shift within the organisation with an increase in the development and progress with CIP schemes. It was highlighted that further support for investment in the IT infrastructure was necessary to ensure the resilience of the organisation. The Board noted the positive developments with the Christchurch project which was on budget and on time.

(g) Workforce Report (Item 5g)

KA outlined the key themes from the report:

- The vacancy rate was at 5.2% against 5.6% last month;
- New appointment within the Communications Department who will also support HR and encourage recruitment to attract staff to the organisation;
- New recruitment advertisement include radio adverts and stickers for cars;
- Two confirmed Filipino nurse appointments for January;
- 34 prospective appointments including EU interviews;

NHa advised that the Organisational Development programme was up and running. The culture at the Christchurch Hospital will be promoted as a basis. 15 change champions have been recruited to drive developments and work has already been undertaken under their own initiative and is progressing well.

Board members queried the plans in place to address and improve retention and turnover. KA advised that further exit questionnaire interviews were due in spring. Challenges remain around the retention of rotational staff. The Heads of Nursing are engaged and HR are working together with radiographers to redesign suitable work patterns. This will need to be incorporated into the workforce plans for each care group.

The Board is to agree a retention plan in the new year.

Execs

(h) Stroke Services Quarterly Update (Item 5h)

The update was noted for information.

109/15

STRATEGY AND RISK

(a) Acute Care Vanguard Project (Item 6a)

TS updated the Board on the recent developments:

- The Vanguard project was officially launched on 17 December;
- Clinical input will be vital to the project's success;
- It has received a positive response from NHS England and funding will be provided.

- The value proposition will require sanction from the Board. Funding will be provided to invest in capacity and to shift services;
- Changes to the governance structure have been made and agreed. Delegated decision making powers were discussed. The Sovereignty of the existing Boards will remain. Appointing an independent Chairperson is favoured in order to unlock some of the organisation's positions;
- The revised submission will be circulated including governance amendments.

The Board **noted** the update and **delegated** authority to TS to submit the value proposition by 8 January 2016. The Board are to be kept informed.

(b) Clinical Services Review Update (CSR) (Verbal)

TS updated the Board on the progress with the CSR:

- An agreement has been made between intensivists regarding the purple service site that it will not have a critical care service;
- A meeting has been arranged to discuss the provisions for older persons with GPs;
- It is anticipated that the level of medical take could increase by up to 20% and there are some assumptions about the transfer back from the green site to the purple site;
- Up to 4 wards have been outlined for the inpatient base for medicine and older persons medicine;
- Theatre discussions are on-going;
- By the end of January /early February it is likely that the RCP report for obstetric provision will be received;
- There are concerns to address within the capital costs provided as this will impact upon the nature of the proposal identified for consultation.

The Board **supported** that it was vital to follow up the letter sent to the CCG as the response will be key to moving forward.

TS/JS

110/15

GOVERNANCE

(a) Workforce Committee Terms of Reference (Item 7a)

KA outlined the amendments to the terms of reference which included introducing a financial element to the Committee to support the strategic goal of financial sustainability. Attendance at meetings from the Heads of Nursing has been beneficial and it was proposed that the Directors of Operations attend to provide an overview at the care group level. The reporting of the organisational development programme will be developed through committee. The Board **approved** the amendments to the terms of reference.

111/15 **DATE OF NEXT MEETING**

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

112/15 **ANY OTHER BUSINESS**

- (a) Christchurch Day Hospital
- (b) QI Improvement presentation
- (c) IG assessment compliance
- (d) Performance

113/15 **QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC**

1. Governors requested that the presentation slides be circulated.
2. RR advised that the next stage of visible construction at the Christchurch site was the senior living accommodation.

There being no further business the meeting closed at **10:40**
AH 18.12.15

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
18.12.15	109/15	STRATEGY AND RISK			
	(b)	<u>Clinical Services Review Update</u>			
		Follow up on the response to the letter sent to the CCG.	TS/JS	Complete	Letter seeking response to original letter sent 23/12/15. Response received and further response being drafted.
	108/15	PERFORMANCE			
	(a)	<u>Performance Exception Report</u>			
		ED 4 Hour performance should be discussed at TMB and feedback provided at a Board seminar in January in order to address performance issues.	RR/SA	Complete	Blue Skies arranged in January to cover the topic.
	(b)	<u>Report from Chair of HAC</u>			
		Ensure that the actions on the IG plan are prioritised to drive forward to achieve compliance.	Execs/PG	In progress	Compliance to the action plan is being performance managed by the PMG under the chairmanship of the COO and with the active support of the SIRO and IG manager. All staff (c.1100) that have not completed their IG annual training have been personally written to in December and this will now be a weekly process that will escalate further than a reminder letter as necessary
	(g)	<u>Workforce Report</u>			
		Develop and agree a retention plan.	KA/Execs	In progress	An outline of the plan will be developed and discussed at Executive Directors and reviewed at the workforce committee.
	107/15	QUALITY IMPROVEMENT			
	(c)	<u>Update on Urgent Care in Medicine Project</u>			
		Provide further support to the areas identified by AW.	RR	Complete	Support from QI team prioritised, with Deb Matthews as SRO. Project plan tracked through Improvement Board.
27.11.15	100/15	PERFORMANCE			
	(b)	<u>Report from Chair of HAC</u>			
		Review the structure and timings of the HAC meetings as part of the whole Board governance structure review.	SA	Complete	PS/EB meeting with DB in January re HAC. This will be incorporated into the review.

RBCH Board of Directors Part 1 Actions December & previous

	(c)	<u>Quality Performance Report</u>			
		Consider the use of an integrated quality and performance report in the future.	Execs	BoD Dev March	To be discussed at the next Board development session.
		Provide an action plan to address the performance within the care audit data.	PS	Complete	Action plan provided to the Board within the reading room papers.
	99/15	<u>QUALITY IMPROVEMENT</u>			
	(a)	<u>Feedback from Staff Governors</u>			
		December clarification: Provide an outlined of the time frames and issues with registration.	KA/PS	February	New methodology to be provided in February.
	(c)	<u>Serious Incidents and Complaints Report</u>			
		Sight the Board on the action plan to address complaint response times.	PS	February	To be discussed at the January HAC and provided to the Board in February.
	98/15	<u>MATTERS ARISING</u>			
	(a)	Provide the Board with an update on the progress with incorporating the values into clinical appraisals.	BF	In progress	Mark Goodwin (AMD) will test values based appraisal in his own appraisal and general roll out March 2016.
31.07.15	68/15	<u>QUALITY IMPROVEMENT</u>			
	(c)	<u>Workforce Race Equality Scheme</u>			
		Timescales and actions to be provided to the Board when available.	KA	Complete	Agenda item January.

Key:

	Outstanding
	In Progress
	Complete
	Not yet required

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016 Part 1
Subject:	Complaints report
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Jennie Moffat (Complaints and Claims Manager)
Author(s) of papers:	Jennie Moffat, Complaints and Claims Manager Ellen Bull, Deputy Director of Nursing Anton Parker, Information Manager
Details of previous discussion and/or dissemination:	HAC 28 th January 2016
Action required:	The paper is provided for information
<p>Executive Summary:</p> <p>The Complaints scorecard with commentary and related metrics summarises the variety of concerns about services provided by the Trust. The report includes aggregate 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. There is an improving trend in closure times and numbers of open complaints are reducing as directorates recover the position. Directorate engagement remains strong.</p> <p>Key messages:</p> <ol style="list-style-type: none"> 1. Current acknowledgment time in month is 100% 2. Current Trust response time in month (December 15) is 56% against a standard of 75% 3. PHSO YTD confirmed investigations is 6 4. Number of open complaints has reduced in the last month from 75 to 44, testament to the engagement and work in the directorates and the Complaints Team. 	

5. Current Open Complaints by Care Group as at 31st December 2015;
A = 13 (2 are late), B = 28 (7 late), C = 4 (1 late), OTHER = 1
6. The number of complaints received in month (21) which was 4 more than the same point last year

Information about PALs and claims is also included.

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 and clinical negligence claims

1. Summary

This is a report for the Board of Directors on Formal Complaints received, acknowledged and subsequent response times performance in month (December 15). Complaints and clinical claims data are presented by directorate in terms of incidences, response times and themes. This is measured against our own Trust Policy.

2. Number of complaints and concerns

- 21 formal complaints were received in December 2015
- PALS had 77 (38 written) concerns raised in December 2015.

3. Acknowledgement and response times

Acknowledgements to the patient/carer/relative may be by telephone/letter and email within the timeframes to acknowledge the complaint. Performance in December against the 95% standard was 100%.

Responses to complaints should be within 25 working days (quality strategy standard of 75%). Trust wide the overall response times datasets in the rich client Datix complaints module have been reviewed and clarified in terms of reporting against set definitions. Reports have been rebuilt and reviewed with full engagement of directorate teams. This will enable closer management of timeframes and a transparent position on current status of responding to Complaints. For December 2015; responded to figures for formal complaints are below:

December 2015	= 56%
November 2015	= 54%
October 2015	= 47%

Response times are below the standard of 75% and designated actions have been taken to recover this position. Excellent progress has been made in reducing the number of open complaints (complaints requiring a response within 25 working days) from 75 in October to 45 as at the end of December. Out of the 45 open complaints, 9 are late. Of the 9 which are late, 7 are in medicine/emergency department (ED)/acute medical unit (AMU), 1 is in orthopaedics, and 1 is in older people's medicine. Response time improvement remains a strong focus and action continues to be taken with excellent engagement from directorate managers and matrons.

4. Themes and trends – Complaints received

In December the directorates with the highest number of new complaints were;

- Surgery (7),
- ED/AMU (4)
- Anaesthetics and OPM (3).

The themes were:

- Quality/Complication of care (7)
- Clinical Assessment (6)
- Communication - staff attitude (4)
- Discharge (2)
- Medication (1)

5. Outcomes

Actions resulting from complaints are documented on the complaint outcome form and reported via the care group governance structure. Where actions are not clear or absent, this is kept as an open complaint and sent back to the directorate to complete.

Twenty seven complaints were closed in December 2015. Of those 19 forms were received and managers have been asked to complete the outstanding forms.

6. Clinical negligence claims

There were 4 new requests for copies of medical records during December and two new claims.

7. Inquests

No inquests were held in December 2015.

8. Recommendation

The Board of Directors are requested to note the information in this paper.

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BOARD OF DIRECTORS

Meeting Date and Part :	29 th January 2016 Part 1
Subject:	Internal Quality Review
Section on agenda:	Quality Improvement
Supplementary Reading (included in the Reading Pack)	none
Officer with overall responsibility:	Paula Shobbrook; Director of Nursing and Midwifery
Author(s) of papers:	Jo Sims; Associate Director of Quality governance and risk
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee December 2015
Action required:	For information
Executive Summary: The paper summarises the results of the internal inspection programme July 2015 – October 2015.	
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?	

Internal quality peer review update

1. Introduction

This paper provides a report on the findings from the internal clinical peer review programme for July 2015 – October 2015

2. Methodology

The Internal clinical quality peer review process involves two/three reviewers visiting a ward/department for approximately two hours. The review team follow the patient journey and viewing this from a patient perspective against the CQC fundamental standards. Observations and interviews with patients and staff are triangulated by the reviewers and a summary sheet is completed to record observations against the CQC standards.

Reviewers use the following CQC inspection rating scale to identify specific areas for action or shared learning against each of the CQC outcomes and domain:-

Outstanding	Blue
Good	Green
Requires Improvement	Amber
Inadequate	Red
Not assessed	White

Part of the review includes undertaking a mini documentation audit, looking at a range of paper work including the 14 day care plan, fluid management charts, allow a natural death forms, drug charts, consent forms and other risk assessments. Feedback is given to the ward staff by the inspection team at the time of the inspection and wherever possible immediate action is then taken by ward sister to rectify issues raised.

A copy of the report template is sent to the Ward Sister/Charge Nurse, Directorate Manager, Matron and Clinical Director. Where a red (inadequate) issue is noted the report is escalated to the Head of Nursing & Quality and the directorate are required to provide an assurance report confirming actions taken to resolve issues within 3 working days.

3. Programme

In October the peer review checklist was amended to include some extra questions:

- Are staff aware of the Duty of Candour requirements and can they give examples of where it had been used in their areas?
- Do staff know how to escalate a deteriorating patient or a clinical / medical concern and is the escalation process effective 24/7?
- Are patients offered a chaperone where necessary i.e. personal hygiene, intimate care etc.?
- Is there a named consultant and nurse displayed above each bed?
- Are policies and procedures up to date and regularly reviewed?
- Does the ward use the HAN system effectively?
- Do staff understand the Trust and department's vision, values and quality strategy objectives?
- Are staff aware of their local risk register, do they know what is on it and what is being done to mitigate the risks?
- What achievement is the ward / department proud of?

Sixteen Clinical Quality reviews were undertaken July 2015 – October 2015:

- | | | | |
|----------|-----------|----------------|---------|
| • ITU | CCU | TIU | Ward 15 |
| • Ward 2 | Ward 17 | Ward 22 | Ward 24 |
| • Ward 7 | Endoscopy | Macmillan Unit | AMU |
| • Stroke | Ward 18 | Ward 23 | ED |

In October there was also an early evening peer review session where 10 reviewers went round nearly every ward looking at 5 or 6 key things from the checklist. This was very successful and was also carried out by the Quality and Risk Committee.

4. Overview of findings from reviews

Outstanding

- Staff knowledge about local risk register
- Safeguarding
- Competence/mandatory training and support to do courses to further career
- Emergency response
- Medicine Management
- Privacy and Dignity

Good

- Safeguarding
- Infection Control
- Medicines Management
- Staffing levels
- Privacy and dignity
- Support
- Complaints management
- Records including nursing assessments

Required Improvement

- Policies and procedures
- Knowledge of Duty of Candour
- MCA / DOLS awareness
- Local risk register in some areas
- Test dates on equipment
- Staff support for patients who do not speak English
- Awareness of Trust Vision and Values
- Infection Control
- Named consultant above bed
- Records including nursing assessments

5. Conclusion

There is excellent clinical engagement with the internal peer review programme and this is a process which has positive feedback from the wards and departments. Improvement is noted and there is still variation in standards and practice which are highlighted at the time of the visit. This peer feedback enables teams to make improvements in a timely way, which is followed up in subsequent reviews. The process is being reviewed for 16/17 and will take into account the findings from the CQC inspection.

6. Recommendation

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

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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	29 January 2016 Part 1
Subject:	Safe Staffing Report
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	Premium Cost Avoidance; bank and agency usage
Officer with overall responsibility:	Paula Shobbrook. Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull. Deputy Director of Nursing Paula Shobbrook. Director of Nursing and Midwifery
Details of previous discussion and/or dissemination:	n/a
Action required: Discuss/Information	The Board of Directors is requested to note this report, which is provided for information, and to discuss any further workforce initiatives to support safe staffing.
Executive Summary: The 'Hard Truths' (2014) publication from the Care Quality Commission (CQC) and NHS England requires Trusts to provide a 6 monthly report on nurse staffing to the Board of Directors. This is the first report of 2016 which details ward staffing reviews and management of ward staffing. This also provides information when staff levels were escalated as red flags, vacancies and agency usage.	
Relevant CQC domain:	All domains
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	No new risk raised

Board of Directors: Safe staffing report January 2016

1.0 Introduction

The 'Hard Truths' (2014) publication from the Care Quality Commission (CQC) and NHS England detailed requirements for Trusts to:

1. Report and publish a monthly return via Unify indicating 'planned' and 'actual' nurse staffing by ward. This is returned each month to NHS England, the CQC and published on NHS Choices website. This information is included in the Board of Director's workforce report.
2. Publish information with the planned and actual nurse staffing for each shift. This is displayed on an electronic board at the entrance of each ward, including who is in charge of the shift. The role of each team member is also displayed.
3. Provide a 6 monthly report on nurse staffing to the Board of Directors. This is the first report of 2016.

2.0 Ward staffing reviews

Ward staffing reviews have been performed six monthly since 2012 and nurse staffing has been reported to the Board of Directors since October 2013. The ward staffing methodology is based on published best practice and includes a review of the funded establishment and alignment of budget, review of current staffing templates against service provision, review of the quality metrics in safety, outcomes and experience, and any service changes or projected developments. Data from VitalPac is reviewed and bespoke acuity audits are undertaken as determined by the director of nursing (or deputy), in areas where acuity requires further clarity or the case mix of patients has changed. The leadership team of the Care Group, directorate manager and matron, ward sister/charge nurse and financial accountant attend. The whole procedure is reviewed from e-rostering data and aligned with the financial management information. Outcomes and actions are noted.

- Areas reviewed in December 2015 were; ward 22; AMU; ED; Macmillan Unit; ward 10; ward 11 and the eye ward.
- Areas reviewed in January 2016 were ITU; HDU; orthopedics; Derwent ward; ward 7; maternity and the Surgical Assessment Unit.
- The emergency department is pending review. The older people's medicine wards require a review of the budgeted establishment against all templates which is in progress.
- A full review of all wards is planned from March 2016.

3.0 Management of nurse staffing

Daily review of staffing is a routine part of the 'nurse in charge' role and is included in the safety brief process. Matrons oversee staffing for their directorates to mitigate vacancies or high acuity and ensure patient safety, supported by Heads of Nursing and Quality. Out of core hours staff escalate

staffing issues to the senior nurse within the directorate who holds the bleep as the designated individual to review staffing and source a solution. At night this is the responsibility of the clinical site team. When necessary, professional judgment on supporting, swapping or moving staff will be taken as detailed in the E-Roster Policy (section 5.6.4).

E roster clinics were recently introduced, led by the Deputy Director of Nursing to review individual areas and their adherence to the e-roster policy. Individual areas received feedback on areas for action, and items of good practice. Outcome themes from this review included the following; all areas requiring to complete off duties with the eight weeks' notice advance as per the e-roster policy; areas to ensure net hours were managed closely, with a proposal to go to the e-roster steering board that net hours are to be within ten for each roster period; that flexibility in the roster meets individual requirements as far as possible as well as service need. The roster clinics have been established for the second review and devolved to the Heads of Nursing and Quality for managing in their Care Group structure. Outcomes will be reported into the E-rostering Steering Board.

4.0 Red Flags

On a daily basis, the management of safe staffing is discussed at ward sister/charge nurse and matron level with an escalation to the Heads of Nursing and Quality. The recommendations from NICE were that staff and patients could raise a nursing 'red flag' should NICE safe staffing or local agreed criteria not be met. The following criteria were agreed with Senior Nursing staff and a Standard Operating Procedure was implemented.

- Staffing depletion – less than 2 registered nurse on any shift
- Patient vital signs not recorded/assessed in a timely manner
- Delay/omission in care needs
- Unresolved pain for a significant period of time
- Inappropriate patient moves between 23:00 – 06:00hrs

Once a red flag is raised, it elicits an immediate response to review and support that ward appropriately. The initiative was launched on the 13th April 2015 at the Royal Bournemouth and Christchurch Hospitals, with the Matrons and Heads of Nursing and Quality being part of the escalation process should a nursing red flag occur. Outcome data is reported in the table below:

Reported Red Flags against RBCH criteria

Month	Number reported	Mitigated	Actual
April	5	4	1
May	10	6	4
June	14	11	3
July	8	4	4
Aug	7	4	3
Sept	3	3	0
Oct	16	11	5
Nov	10	7	3
Dec	14	13	1
Total	87	63	24

There has been variation in the interpretation of the red flag in some areas as the initiative was launched. However, correlating the above results with vacancies indicated that there was a higher vacancy factor within the Medical and Surgical care groups where staff were appointed but waiting to start employment within the Trust. The Specialties care group had the highest vacancy rate within cancer services nursing staff (wards 10 and 11), which correlated with a high use of agency trained staff.

In looking at the triangulation between raising a red flag it is clear this impacts negatively on the staff that were on duty. However, when reviewing qualitative patient experience and safety data, the current evidence does not suggest there is a correlation in red flags being reported and patient safety/experience incidences, which is a testament to the ward teams.

5.0 Exception report for vacancies

The Acute Medical Unit, Older Persons Medicine (OPM) directorate and the Emergency Department have been the areas with the most consistent vacancies. This has been managed by block booked agency, continued recruitment efforts and incentives such as the lead payment in OPM. The latter is currently being reviewed. The Anaesthetics Directorate has made excellent progress with recruitment and has reduced agency expenditure in theatres for non-medical staffing.

The removal of the restriction to recruit from outside Europe has enabled recruitment from the Philippines. A case to fund qualified nurses from the Philippines and the European Union has been proposed based on the 15/16 performance and success, which is being reviewed against care Group workforce plans and current vacancy data.

6.0 Agency provision

The Trust's focus on reducing reliance on agency staffing, overseen by the Premium Cost Avoidance group, has been further supported by Monitor publishing the guidance on Agency frameworks in October 2015. RBCH has made good progress reducing nursing agency usage, and off framework (Tier three agencies which charge rates above the Monitor guidance) has significantly reduced. Clear guidance is in place and off framework requires executive approval in extenuating circumstances after local assessment, and all other mitigations with existing resources have been examined. Judgments used include assessment of patient care needs and patient acuity and safety needs being met. Detail on bank and agency usage is available in the reading room.

Further direction from Monitor has been received (January 2016) with respect to temporary staffing and short term non-medical sickness cover; in these circumstances, acting down is to be implemented as a mitigation option. Implementing this in the Trust is currently under discussion with the formulation of appropriate guidance.

7.0 Conclusion

Appointing substantive staff, reviewing and aligning the workforce against care needs and managing these within the financial envelope remains both high profile and a constant challenge. The implementation of the agency caps, review of Lord Carter recommendations and safe staffing initiatives such as care contact time and red flags are in place. This supports workforce efficiency and productivity whilst proving a framework for providing appropriate staffing to deliver performance and quality care.

The reviews of nurse staffing against patient needs continues as a routine methodology. The review of the use of temporary staffing both in terms of efficiency and productivity and implementing national mandates continues.

The most significant implicating factor is the nationally recognized registered nurse shortage affecting vacancy factors in all sectors. The Trust has developed a strong recruitment plan which is reported in detail at the Workforce Committee to mitigate these risks.

8.0 Recommendation

<p>The Board of Directors is requested to note this report which is provided for information and to discuss the workforce initiatives which support safe staffing.</p>
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BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016 Part 1
Subject:	Quality Improvement Programme
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Deborah Matthews, Director of Improvement
Details of previous discussion and/or dissemination:	Improvement Board
Action required: Approve / Discuss / Information/Note	Information
<p>Executive Summary:</p> <p>This workbook summaries the monthly progress of our priority quality improvement (QI) projects using the standard model of improvement methodology:</p> <ul style="list-style-type: none"> • sepsis • hospital flow • GI cancer referrals (2 week wait) • emergency laparotomy • safety checklists • patient escalation • improving urgent care • urology • general theatres • emergency surgery • orthopaedics • outpatients 	
<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>	Well Led domain
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	N/A

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Quality Improvement Projects Workbook

Improvement Board January 2016

Aim : To deliver sepsis 6 to all patients with severe sepsis and / or septic shock within 1 hour by December 2015

Executive Sponsor: Dr Sean Weaver

Clinical Lead: Dr David Martin

Activity in previous period

- preparation for PDSA cycle 3 continues- storage and accessibility of antibiotics. After further review by the microbiology team, the use of pre drawn up antibiotics have been excluded
- presentation of project at Quality and Risk Committee
- new version of stickers introduced.

Does your patient have any two of the following?

Temperature > 38°C or < 36°C ☐
 Respiratory rate > 20 per minute ☐
 Heart rate > 90 per minute ☐
 Acute confusion / reduced conscious level ☐
 Glucose > 7.7 mmol/l (unless DM) ☐

Could your patient have an infection?
If yes, use the red flag screening tool.

Complete the Sepsis 6 within 1 hour

Not Sepsis ☐ Signature: _____ Date: _____

Think Sepsis, Save Lives

Sepsis Six	Time/Sign
Take blood cultures	
Give IV antibiotics	
Give a fluid challenge	
Consider oxygen	
Measure lactate	
Measure urine output	

- AMU sepsis Awareness day held.



- working alongside the emergency laparotomy team to review times of administration of IV antibiotics.
- note review of patients who received their IV antibiotics 2 hours and over from being admitted to ED/SAU/AMU

Activity in next period

- undertake PDSA cycle 3
- completion of sepsis video – awaiting for final clips to be filmed.
- poster campaign launch
- further data analysis to review Intravenous antibiotic performance against ambulance handover times, numbers of patients attending emergency admitting areas, ED breach data and Daily bed status at 3pm.
- look at use of eNA application to provide an electronic sepsis screening tool solution

Issues

- identification of all patients arriving with septic shock and /or red flag sepsis in emergency admission areas
- delivery of complete sepsis six bundle within one hour for patients who present with red flag sepsis and / or septic shock
- loss of data collection sheets at ward level, incomplete data set for analysis.
- change of international sepsis definitions and sepsis 6 bundle components. To be introduced at international sepsis forum in Agra, India in February 2016.
- management of sepsis CQUIN submission going forward.

Sepsis

Hospital Flow

GI Cancer (2
week waits)Safe
ChecklistsEmergency
LaparotomyPatient
Escalation

Aim : To implement internal professional standards '5 daily actions' by 31 March 2016

Executive Sponsors: Richard Renaut

Clinical Lead: Sue Reed

Activity in previous period

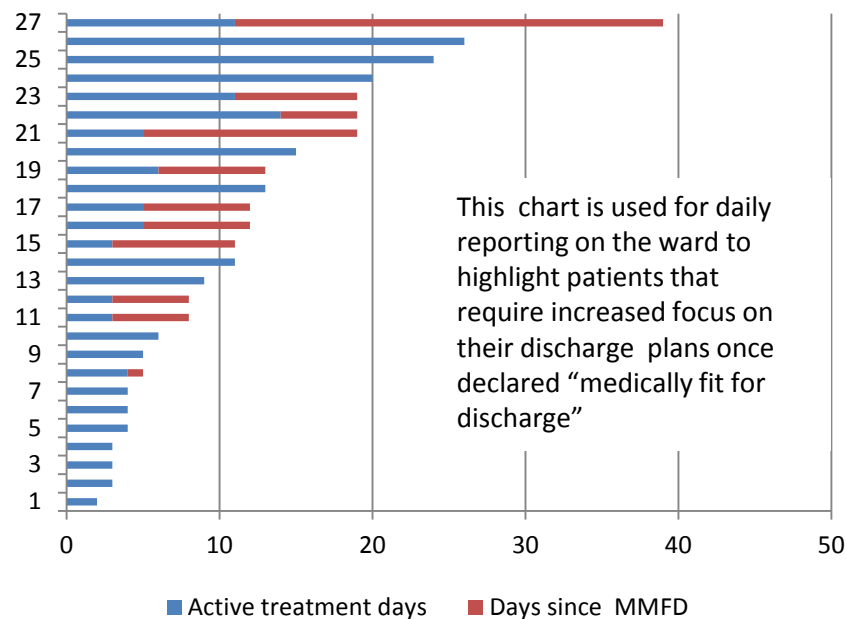
- continued progress on ward 4 focussing on;
 - effective use of the morning board round to agree what needs to be completed to facilitate the patient towards their discharge.
 - identify who will take responsibility for identified tasks
- installation of new white board to focus attention of the MDT with daily to do tasks.
- continued reminder of the need to implement five daily actions as appropriate.

Activity in next period

- baseline data to be compiled in preparation for working group on ward 5,
 - commence ward 5 & ward 3 working group
 - collection of data to quantify improvements
 - gathering of qualitative data in form of patient and staff experience.
 - features to appear within the Quality bulletin celebrating success stories at ward/dept level
- Issues**
- interdependency with Electronic Bed Management (EBM) project, non compliance with EBM
 - reduced therapy capacity secondary to recruitment.

Key Metrics

Ward 4 Length of stay



Sepsis

Hospital Flow

GI Cancer (2
week waits)Safe
ChecklistsEmergency
LaparotomyPatient
Escalation

Aim : To establish safe systems to deliver at least 93% compliance on 2 week waits for GI patients by June 2015, without detriment to other GI patients

Executive Sponsor: Basil Fozard

Clinical Lead: Robert Howell

Activity in previous period

- results of first straight to test PDSA showed some changes required to template
- 16 patients seen
- electronic endoscopy clinic trial went well

Activity in next period

- draft new template for straight to test clinic questions
- review feedback from patients
- analyse time to diagnostics appointment following telephone clinic
- review how easy to book test appointment when patient in telephone clinic
- continue scanning backlog of referrals document (93% complete)
- agree role out plan for further electronic clinics

Key Metrics

2 WEEK WAIT FIGURES - Current

Cancer Site	Rolling Q2	Oct	Nov	Dec	Rolling Q3
OUTPATIENTS					
Colorectal	416	144	160	23	327
Upper GI	54	12	25	12	49
INPATIENTS					
OGD	183	73	79	21	91
Total	653	229	264	56	467
	92.23%	95.02%	97.06%	94.92%	96.69%

2 WEEK WAIT BREACHES - Current

Cancer Site	Rolling Q2	Oct	Nov	Dec	Rolling Q3
OUTPATIENTS					
Colorectal	2	3	4	2	6
Upper GI	2	2	0	0	2
INPATIENTS					
OGD	51	7	4	1	8
Total	55	12	8	3	16

Sepsis

Hospital Flow

GI Cancer (2
week waits)

Safe Checklists

Emergency
Laparotomy

Aim : To standardise and embed safe checklist practice and culture across all areas undertaking interventional and / or surgical procedures by September 2015

Executive Sponsor: Basil Fozard

Activity in previous period	Activity in next period
<ul style="list-style-type: none"> meeting with IT to progress electronic solution for capturing compliance beyond Theatres agreed checklist to be included in the eNA application being further developed by IT sub-project lead agreed and next steps agreed for delivery - within 6 months 	<ul style="list-style-type: none"> agree way forward with human factors training review main theatres compliance data for discussion at next meeting continue to draft the SOPs for remaining areas – target to complete April 2016 <p>Issues</p>

Key Metrics			
Department	Checklist Status	Compliance Data available (Y/N)	SOP Complete (Y/N)
ITU	Complete	N	N
Emergency Department	N	N	N
AMU	N	N	N
Theatres	Complete	Y	Y
Radiology LA	Complete	N	Y
Radiology GA	Complete	Y	Y
Maternity	Complete	Y	Y
Endoscopy	Complete	N	Y
Oncology	Complete	N	N
Dermatology	Version control	Y	Y
Ophthalmology	Version control	Y	?
Cardiology	Complete	N	Draft
Outpatients	Complete	N	Y

Sepsis

Hospital Flow

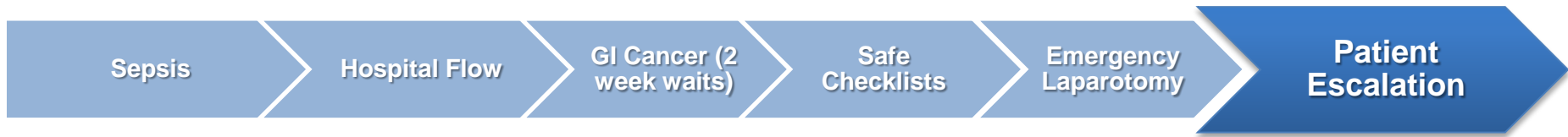
GI Cancer (2
week waits)Safe
ChecklistsEmergency
LaparotomyPatient
Escalation

Aim : To reduce mortality rate from emergency laparotomy surgery from 11.4% to 9% by March 2016

Executive Sponsor: Basil Fozard

Clinical Lead: Guy Titley

Activity in previous period	Activity in next period	Key Metrics																																																																					
<ul style="list-style-type: none"> frailty score to be used for the sub project agreed data analysis requirement for geriatric study agreed and being provided by Information funding acquired from collaborative and Wessex AHSN 	<ul style="list-style-type: none"> draft new pathway document layout finalise work up the approach to improving patient to theatre in 6 hours and surgical consultant review in 12 hours work with sepsis team to focus on antibiotics within 1 hour in SAU agree details of frailty sub project with the collaborative – some areas around 3 and 7 day followups on the ward require a flexibility in approach to the study 	<p>In-hospital mortality (crude)</p> <table border="1"> <thead> <tr> <th>Admission Month</th> <th>In Hospital Crude Mortality (%)</th> <th>In Hospital Crude Mortality Median (%)</th> </tr> </thead> <tbody> <tr><td>Jan-14</td><td>15</td><td>7.5</td></tr> <tr><td>Feb-14</td><td>18</td><td>7.5</td></tr> <tr><td>Mar-14</td><td>14</td><td>7.5</td></tr> <tr><td>Apr-14</td><td>14</td><td>7.5</td></tr> <tr><td>May-14</td><td>22</td><td>7.5</td></tr> <tr><td>Jun-14</td><td>5</td><td>7.5</td></tr> <tr><td>Jul-14</td><td>8</td><td>7.5</td></tr> <tr><td>Aug-14</td><td>10</td><td>7.5</td></tr> <tr><td>Sep-14</td><td>6</td><td>7.5</td></tr> <tr><td>Oct-14</td><td>8</td><td>7.5</td></tr> <tr><td>Nov-14</td><td>6</td><td>7.5</td></tr> <tr><td>Dec-14</td><td>0</td><td>7.5</td></tr> <tr><td>Jan-15</td><td>8</td><td>7.5</td></tr> <tr><td>Feb-15</td><td>0</td><td>7.5</td></tr> <tr><td>Mar-15</td><td>9</td><td>7.5</td></tr> <tr><td>Apr-15</td><td>0</td><td>7.5</td></tr> <tr><td>May-15</td><td>0</td><td>7.5</td></tr> <tr><td>Jun-15</td><td>6</td><td>7.5</td></tr> <tr><td>Jul-15</td><td>8</td><td>7.5</td></tr> <tr><td>Aug-15</td><td>5</td><td>7.5</td></tr> <tr><td>Sep-15</td><td>0</td><td>7.5</td></tr> <tr><td>Oct-15</td><td>0</td><td>7.5</td></tr> </tbody> </table>	Admission Month	In Hospital Crude Mortality (%)	In Hospital Crude Mortality Median (%)	Jan-14	15	7.5	Feb-14	18	7.5	Mar-14	14	7.5	Apr-14	14	7.5	May-14	22	7.5	Jun-14	5	7.5	Jul-14	8	7.5	Aug-14	10	7.5	Sep-14	6	7.5	Oct-14	8	7.5	Nov-14	6	7.5	Dec-14	0	7.5	Jan-15	8	7.5	Feb-15	0	7.5	Mar-15	9	7.5	Apr-15	0	7.5	May-15	0	7.5	Jun-15	6	7.5	Jul-15	8	7.5	Aug-15	5	7.5	Sep-15	0	7.5	Oct-15	0	7.5
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Aim : To ensure that every patient with a news score of 9 or above out of hours, is escalated for prompt review by an appropriate clinician within 30 minutes from their initial trigger by the end of February 2016.

Executive Sponsor: Basil Fozard

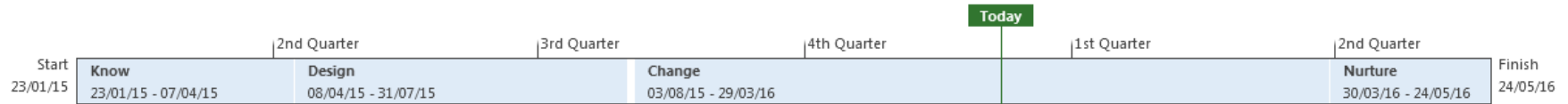
Clinical Lead: Dr Nigel White

Activity in previous period	Activity in next period
<ul style="list-style-type: none"> • inaugural project meeting held 6/1/16. Next meeting 20/1/16 • agreed project group membership • engaged with communications department to start to think about publicising project • agreement of baseline data collection 	<ul style="list-style-type: none"> • commence data collection • update VitalPac policies to match revised trust policy on escalation of patients and NEWS score. • devised method of giving feedback to wards and clinicians on response performance • present baseline data in next update <p>Issues</p> <ul style="list-style-type: none"> • None to report

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graph LR
    A[Urology] --> B[General Theatres]
    B --> C[Emergency Surgery]
    C --> D[Orthopaedics]
  
```

Orthopaedics



Executive Sponsor: Deb Matthews

Clinical Lead: Tristan Richardson

Activity in previous period	Activity in next period
<ul style="list-style-type: none"> • Branch lists to be used for pleural service: no estates work now required • bed modelling for acute medicine take in progress • options for Estates specification being reviewed 	<ul style="list-style-type: none"> • resolution of ambulatory chest drains for pleural service • completion of bed modelling bed base for AMU • strategic review and sign off of management of Acute take • Respiratory & ED job planning • review of AEC
<h3>Issues</h3> <ul style="list-style-type: none"> • bed management developing as a key issue/enabler to improving urgent care • resources – nursing input for Respiratory AEC 	

Improving Urgent Care - OPM

Urology

General Theatres

Emergency Surgery

Orthopaedics



Aim : To implement a frailty pathway with direct admissions to OPM by April 2016

Executive Sponsor: Deb Matthews

Clinical Lead: Andrew Williams

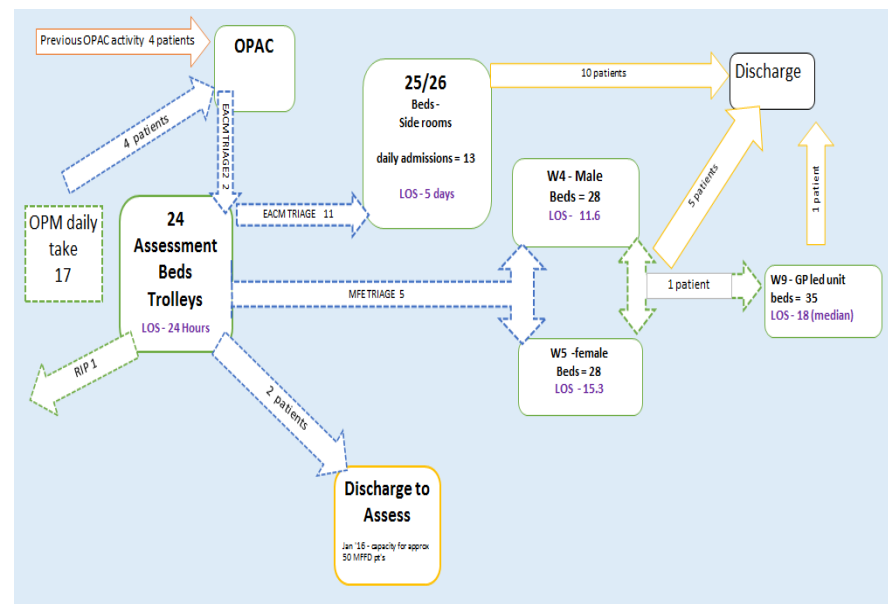
Activity in previous period

- Initial planning assumptions for bed modelling agreed.
- clinical pathways development initiated.
- ward 22/24 swap agreed.
- ward 4 length of stay project continues to make progress, with plans to commence projects on wards 3 and 5.

Activity in next period

- Testing of bed model assumptions.
- estates implementation plan to be submitted for ward 24.
- Stakeholder session to be held on 28/01/16 to launch and discuss vision for frailty unit.
- nursing model to be developed in accordance with bed model.
- confirm key milestones and CIP delivery.
- Sign off of bed plan and schedule of bed closures.
- Attendance at Acute frailty network launch event.

Key Metrics – Baseline LOS



Improving Urgent Care - Cardiology

Urology

General Theatres

Emergency Surgery

Orthopaedics

Aim : To provide rapid access Cardiology input for admissions and admission avoidance, to develop an ambulatory clinic, to provide early access to Rapid Access Chest Pain Clinic (RACPC) for chest pain of recent onset & to ensure early access to investigations

Executive Sponsor: Deb Matthews

Clinical Lead: Rosie Swallow

Activity in previous period

- project Plan developed
- 2.0wte Nurse Practitioners appointed
- Side rooms audit
- post-PCI dispensing pilot on Fridays
- process mapping initiated
- design brief for ACC
- prospective net saving of £120k (FYE) identified in respect of planned closure of 9 beds on ward 21 (subject to various other measures)

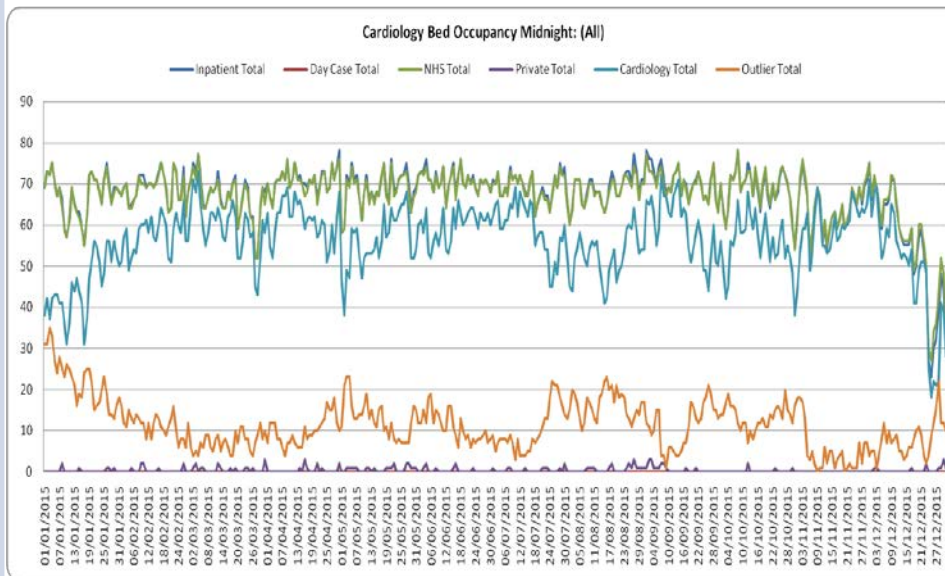
Activity in next period

- introduce rapid access angio slots (Jan)
- B/C for BNP testing at front door to support heart failure pathway (Jan)
- Yellow Forms audit to assess scope for ambulatory care conversion (Jan/Feb)
- pilot ACC service model (Jan-Mar)
- limited ED in-reach pilot by nurse practitioners (Jan-Mar)
- Poole patient pathway workshop (Feb)

Issues:

- workforce – Cons cover & middle grades
- medical outliers
- funding for ANP training
- funding to extend dispensing scheme
- access to IT systems support for process improvement

Key Metrics – Baseline Occupancy



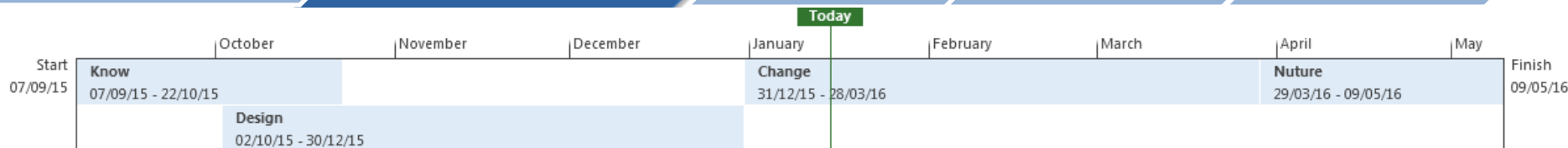
Improving Urgent
Care

Urology

General Theatres

Emergency
Surgery

Orthopaedics



Aim : To provide excellent, timely care with no clinically fit patient waiting more than 62 days for cancer treatment and with a minimum of 94% of patients on an 18 week pathway having a clock stopped; by maximising existing resources, by March 2016.

Executive Sponsor: Richard Renaut

Clinical Lead: James Manners

Activity in previous period	Activity in next period
<ul style="list-style-type: none"> Admissions office project aims agreed Admissions office project scope agreed project hub established 	<ul style="list-style-type: none"> plan PDSA to test 'patient at 8:20' in theatres for Urology develop baseline metrics for sub groups agree metrics and schedule for admissions project <p>Issues</p> <ul style="list-style-type: none"> capacity within the team to drive wide range of sub projects forward

Key Metrics		
<ul style="list-style-type: none"> procedures undertaken in procedure room – being developed as part of theatre scorecard team are discussing appropriate metrics to add 		
	Oct 2015	Nov 2015
Urology 62 days referral to treatment	70%	81.3%
All cancers 62 days referral to treatment	85.3%	89.6%
Target 85%		

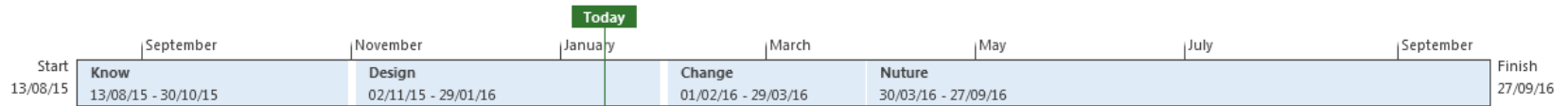
Improving Urgent
Care

Urology

General Theatres

Emergency
Surgery

Orthopaedics



Aim : To provide a reduction in 'lost' theatre time and annually release 311 patient slots (part of 1145 total opportunity) by March 2016.

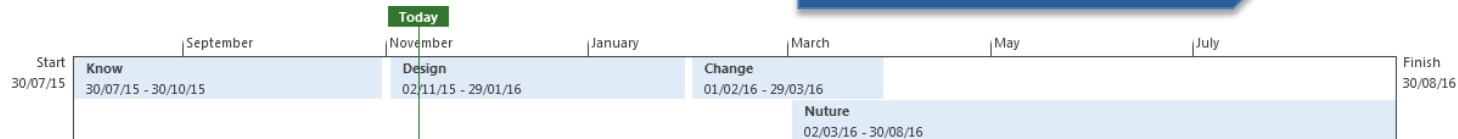
Executive Sponsor: Richard Renaut

Clinical Lead: Martin Schuster-Bruce

Activity in previous period	Activity in next period
<ul style="list-style-type: none"> theatre dashboard completed Anaesthetists clinical leadership role within project agreed band 7 project facilitator role in place to support 	<ul style="list-style-type: none"> identify any potential bottlenecks and their resolution establish full project team and plan remaining phases refresh project aim and re-launch project review opportunities identified by NHS Elect (Chris Bryant) <p>Issues Analysis of theatre activity - data found to have duplicate entries .</p>

Key Metrics						
Sum of %	Session N	Session N				
Specialty	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16		
				Jul-15	Aug-15	Sep-15
BREAST	1%	6%	3%	3%	4%	12%
COLORECTAL SURG	14%	1%	4%	7%	19%	18%
GYNAECOLOGY	15%	12%	7%	6%	22%	9%
OTHOPEAEDICS	13%	9%	16%	18%	20%	14%
UPPER GASTRO SURG	2%	1%	2%	0%	0%	4%
UROLOGY	13%	14%	13%	32%	17%	2%
VASCULAR	31%	23%	35%	11%	29%	76%
Grand Total	13%	10%	13%	17%	18%	14%

- lost patient treatment opportunity by specialty is shown above (aim is to reduce)
- number of procedures provided through existing resources (increase) is being developed
- scorecard / metrics are being developed by the team



Aim : To reduce the median length of stay by 12% for the emergency surgery patients through a co-ordinated approach across wards, theatres and medical teams by April 2016

Executive Sponsor: Basil Fozard

Clinical Lead: Emma Willett

Activity in previous period	Activity in next period
<ul style="list-style-type: none"> Sepsis audit of patients admitted to SAU over a one week period completed. in “Fishbowl” in Main Theatres the identified “Golden Patient” is entered onto a large yellow sign. meeting with IT to discuss CEPOD list has taken place 06/01/16 – promising. metrics on CEPOD have finally arrived to allow measurement of metrics currently reviewing over 500 patients who have been booked onto CEPOD from September to November to look closer at delays into theatre. 	<ul style="list-style-type: none"> 2nd PDSA on track to run in early February. Looking at improved efficiency/communication with a dedicated CEPOD coordinator. One week duration. procurement of dedicated mobile phones to improve surgeon/anaesthetist communication. <p>Issues</p> <ul style="list-style-type: none"> IT system to support CEPOD – challenges/delays with amending existing system remain though slight progress made. surgical engagement with SpRs continues to be problematic.

Key Metrics

- 90% of “Golden Patients” to be in the anaesthetic room by 08:30 by April 2016 remains a key metric. Continually reviewing what small changes could be introduced to achieve this aim.
- to improve the flow of patients through the Surgical AEC through redefining processes and promote utilisation of service.

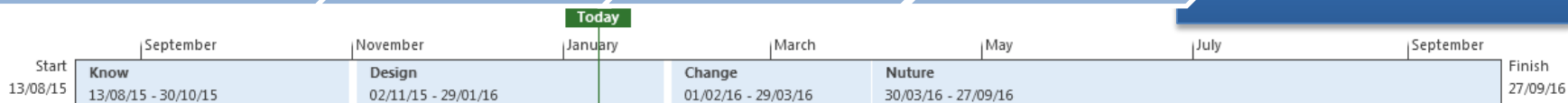
Improving Urgent
Care

Urology

General Theatres

Emergency
Surgery

Orthopaedics



Aim : To provide excellent, timely care with no clinically fit patient waiting more than 16 weeks for surgery, unless through choice, by March 2016 with all activity delivered through timetabled sessions.

Executive Sponsor: Richard Renaut

Clinical Lead: Richard Hartley

Activity in previous period

- 1) POA
 - New clinics in place
 - New phone clinics in place
 - New LA pathway agreed
 - Prior to surgery calls in place
- 2) Demand/Capacity
 - Model approved in phase I budget setting. £2.2M income. £1.6M HRG. £0.6M Outpatients, latter is 10 clinics a week (3 OPFA, 7 OPFU)
- 3) Job Planning
 - LOH job plan complete
 - 1st dual list delivered 6/1/16
 - New LOH POA clinic 19/1/16
 - New SPR Friday list agreed
- 4) Patient Pathways
 - Derwent 30 weekly baseline from 4/1/16
 - Derwent lead meeting held, criteria refreshed and shared, to hold 30/week in near term

Activity in next period

- 1) POA
 - 2) Implement new LA pathway
 - 3) Retain additional capacity
 - 4) Capture all income due
 - 2) Demand/Capacity
 - Seek agreement at phase II budget setting (21/1/15) for implementation
 - 3) Job planning
 - Continue , focus on those from old to new contract
 - 4) Patient pathways
 - Constant vigilance to retain 30 cases per week as the plan
- Issues for escalation**
- To note Directorates thanks to BJ and clinical site team, and on-going support required to ensure Orthopaedic patients continue to attain allocated bed stock on Derwent and Ward 7

Key Metrics

	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
Appt Class <input type="text"/>				
First Appt	2547	2475	2338	2342
Follow Up	6496	6726	6853	6344
Grand Total	9043	9201	9191	8686

Metric to be developed to show movements; increase 1st, reduce follow up; overall increase

Month	Attended	DNA	Attended	DNA
Jun-15	3247	158	95.36%	4.64%
Jul-15	2935	129	95.79%	4.21%
Aug-15	2406	146	94.28%	5.72%
Oct-15	2954	116	96.22%	3.78%
Sep-15	2931	139	95.47%	4.53%
Nov-15	3213	160	95.26%	4.74%
Dec-15	2772	124	95.72%	4.28%
	20458	972	95.46%	4.54%

Outpatients

Aim: To reduce by 50% last minute cancellations by March 2017

In 12 months with less than 6/52 notice Trust has cancelled (exc sick)

- 4905 New appts
- 9502 F-up appts

With < 2/52 notice

- 31 New appts
- 87 F-up appts

cancelled for study leave

With >2 but < 6/52

- 323 New appts
- 552 F-up appts

cancelled for study leave

Should study leave
be approved at
<2/52 notice?

Should Trust be
stricter with
adherence to A/L
policy?

With < 2/52 notice

- 229 New appts
- 385 F-up appts

cancelled for annual leave

With >2 but < 6/52

- 1373 New appts
- 2450 F-up appts

cancelled for annual leave

50% productivity gain over a year

2452 new appts (based on £120) = £294K

4751 F-up (based on £60) = £285K

TOTAL £579K

Less pressure on RTT waits, currently wait for many patients is now >13 weeks

Less pressure on Ca 62 day compliance

Outpatients

Aim: To reduce DNA rates to average 4% by March 2017

Over 12 months ave. 6.2%
Range 4.2% - 14.7%

Since 2013
appointment reminder service in 100
Clinics resulted in a 1% reduction in
DNA for clinics

Due to 'roll out' to
all clinics by end Jan
2016

Benefit of pilot

550 slots over last 6/12
were used as patient no
longer wanted appt or
wanted a different date

£54K p.a. net income gain
(based on £120 per appt)

Reducing DNA's across all
clinics from 6.2% to 4%
would result in 5337 appts
gain
£640K p.a

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

BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016 – Part 1
Subject:	Performance Report January 2016
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	18 Week/Diagnostic/Cancer Waiting Times Guidance
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Donna Parker / David Mills
Details of previous discussion and/or dissemination:	PMG
Action required: Approve / Discuss / Information / Note	The Board of Directors is asked to consider the information provided in the Performance Indicator Matrix.
<p>Executive Summary:</p> <p>The attached Performance Indicator Matrix shows performance exceptions against key access and performance targets for the month of December 2015 where these have been finalised.</p> <p>In summary, Q3 compliance against the Monitor KPIs is expected for the 62 day and 31 day subsequent surgery targets, evidencing improvement to date, particularly in Urology. Non-compliance is expected against the ED 4 hour target, though December was positively, above 95%. The 31 day first treatment for cancer and C Difficile targets are likely to be non-compliant, resulting in a score of 3 (below the trigger score of 4).</p> <p>The report provides detailed information on the significant actions underway to improve our performance against the Monitor and other key indicators. The Board are asked to further note the Sustainability and Transformation Fund for 2016/17 which requires compliance with all key targets, especially 4 hours and 62 day cancer wait.</p> <p>The report also provides the positive update on the Internal Audit Performance Management Report and recommendations.</p> <p>The Matrix incorporates an indicative RAG rating for expected performance in the following month based on internal monitoring to date, as well as an indication of Trust level risk in relation to the metrics in the next reporting quarter for each metric.</p> <p>Finally, we have included our internal operating guidance in the reading pack in response to the updated national RTT guidance and local Dorset Framework for Scheduled Care which were provided to the Board in November 2015.</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. <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 January 2015/16 For December 2015

1. Introduction

This report accompanies the Performance Indicator Matrix and outlines the Trust's actual and predicted performance exceptions against key access and performance targets. These targets are set out in *Forward View into Action – Planning for 15-16*, the *Monitor Risk Assessment Framework (RAF)* and in our contracts.

The report also includes some key updates on progress against additional measures, such as for diagnostics, planned patients and stroke care.

The Board should also note that as part of the Trust's annual internal audit programme, a review of the performance management and reporting process commenced was completed in December. A summary of the output and recommendations is provided.

2. Risk assessment for 2015/16 – Q3 Summary

The below shows current predictions for Q3 against the key Monitor indicators.

Monitor Risk Assessment Framework: 2015-16 Q1 Actual & Q2 Predicted	Q4 14/15 Actual	Q1 15/16 Actual	Q2 15/16 Actual	Q3 15/16 Actual
Referral to treatment time, 18 weeks in aggregate, incomplete pathways				
A&E Clinical Quality- Total Time in A&E under 4 hours				
Cancer 62 Day Waits for first treatment (from urgent GP referral)				
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)				
Cancer 31 day wait for second or subsequent treatment - surgery				
Cancer 31 day wait for second or subsequent treatment - drug treatments				
Cancer 31 day wait for second or subsequent treatment - radiotherapy				
Cancer 31 day wait from diagnosis to first treatment				
Cancer 2 week (all cancers)				
Cancer 2 week (breast symptoms)				
Clostridium Difficile -meeting the C.Diff objective				
Compliance with requirements regarding access to healthcare for people with a learning disability				

In Q3 the profile of non elective admissions did increase our bed pressures resulting in non compliance of the 4 hour target. Postively, despite this, the Trust delivered 95.7% against the target in December.

We are also pleased to report that whilst the final validated data upload has not yet been completed, we do anticipate that the continued work on the cancer 62 day recovery plans will mean that the target is achieved in Q3. There remains some risk to the 31 day first treatment target, particularly given the capacity and patient choice impact over December, therefore, this is predicted as non compliant.

For the C Difficile indicator where there was evidence of lapses in care, we have exceeded the "stretch" trajectory for CDiff YTD (maximum of 10 for end Q3). Though it should be noted that our numbers are similar to last year and we continue to benchmark low to comparable Trusts.

3. Sustainability and Transformation Fund 2016/17

Nationally £1.8bn is being made available to support trusts in 16/17 to achieve sustainability and transformation. Providers will be required to demonstrate achievement of the '9 must dos' which include the following performance related obligations:

4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.

6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21. December 2015

Improvement trajectories will be required for all key performance targets and allocation of the funds will be quarterly in arrears, subject to achievement. Currently RTT remains overall in a strong position however, the Trust will be expected to provide improvement plans and delivery against trajectory for the ED 4 Hour and Cancer targets, in response to any funding allocated to the Trust.

4. Infection Control

Number of Hospital acquired C. Difficile due to lapses in care Number of Hospital acquired MRSA cases
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Whilst we were above this year's trajectory target at the end of December 2015 (13 actual vs YTD target of 10.5 and full year target of 14) this is only 1 case above the number reported for the same month in 2014. However, in recognising an increase in reported cases with no similar patterns identified in local Acute Trusts a critical friend review was requested. This was carried out in January 2016 by the lead IPC Nurse for West Hampshire CCG. At time of writing we await the full report but verbal recommendations made at the visit are being followed up by the IPC team.

During the last quarter an increased incidence was noted on two wards within the Trust. Ribotyping of the symptomatic patients did not identify any patient to patient spread.

Learning from cases associated with "lapses in care" are assessed as part of the Post Infection Review process. These are then discussed at ward meetings with medical and nursing staff. Teaching sessions are delivered to wards and departments in conjunction with an awareness raising campaign through the use of multimedia messages. These cases are discussed openly with CCG and local NHS colleagues.

No areas of concern have been noted during these discussions but we continue to look for areas of improvement.

There have been no reported cases of hospital acquired MRSA.

5. Cancer

Performance against Cancer Targets

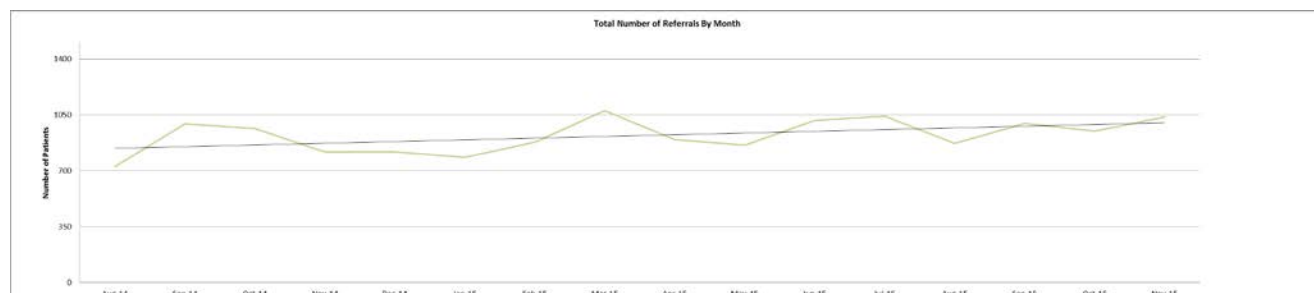
Key Performance Indicators	Threshold	2015-2016 Qtr 2	Oct-15	Nov-15
2 weeks - Maximum wait from GP	93.0%	95.1%	95.3%	97.7%
2 week wait for symptomatic breast patients	93.0%	100.0%	100.0%	100.0%
31 Day – 1st treatment	96.0%	96.2%	94.1%	95.8%
31 Day – subsequent treatment - Surgery	94.0%	92.2%	96.7%	96.7%
31 Day – subsequent treatment - Drugs	98.0%	100.0%	100.0%	100.0%
62 Day – 1st treatment	85.0%	82.6%	83.7%	89.6%
62 day – screening patients	90.0%	87.2%	100.0%	100.0%
62 day – Consultant upgrade (<i>local target</i>)	90.0%	88.9%	0.0%	80.0%

5.1 Two Week Wait

The overall improvement against the Two Week Wait target has now been sustained for three full quarters, despite a near 25% increase in volume over this period (see table below). Compliance is expected for Q3. This reflects the significant work undertaken to: review demand and capacity for fast track appointment slots; implement robust and timely escalation protocols where a patient or capacity is unavailable; and to provide dedicated support for patients where patient choice is an issue.

Endoscopy capacity remains the main risk however. Scheduling templates have been adapted and are reviewed on a weekly basis to provide dedicated capacity for fast tracks. Demand and capacity modelling now suggests that with the implementation of our significant action plan we have reached a sustainable demand and capacity match (based on current demand) and we have moved into a backlog clearance position. In addition, further insourcing capacity is being planned jointly with our commissioners for February and March to reduce the backlog more quickly. Planning the correct level of demand and capacity to meet this in a timely way is a key part of contract and budget setting that is now underway.

We continue to monitor fast track referral demand following the publication of the new NICE guidance last summer. A review of increased and expected demand and capacity for 16/17 is being incorporated in budget and contract setting. The table below shows the trend line growing from c800 referrals per month, to c1000, over a 16 month period.



5.2 62 Day Referral/Screening to Treatment - Urology

As a result of the focused improvement work to date, we were able to expedite earlier treatments for some potential breach patients. As a result performance is expected to be compliant overall for Q3. Positively, the remaining backlog of >62 day patients without a decision to treat has now reduced from 55 in October to 36 in January. Those with a decision to treat has reduced from 5 to 3. We continue to work to reduce this further. All patients from a screening pathway were screened within 62 days as per target.

Due to the continued challenges both locally and nationally in relation to the 62 day cancer target, as highlighted above, this has been included within the national '9 must dos' for the Sustainability and Transformation Plan fund for 16/17. In light of this and the requirements this year in relation to constitutional standards, we have now received a Contract Penalty Notice from our Lead CCG. In response, the Trust has developed a detailed joint action plan with a proposed recovery trajectory, and is working with commissioners to agree this.

Our indicative recovery trajectory milestones are based on our proposed plan: compliance for Q3, achievement of a backlog clearance plan (and therefore, non compliance likely) during Q4 and Q1, with performance achieved from Q2. The cornerstone of our proposed action plan (*see table below*) is joint work with Dorset County Hospital (DCH) to:

- pool demand and capacity
- provide additional capacity (initially at weekends) to reduce the backlog of patients awaiting Robotic Prostatectomies
- to reach a maximum wait from decision to treat of 2 weeks.

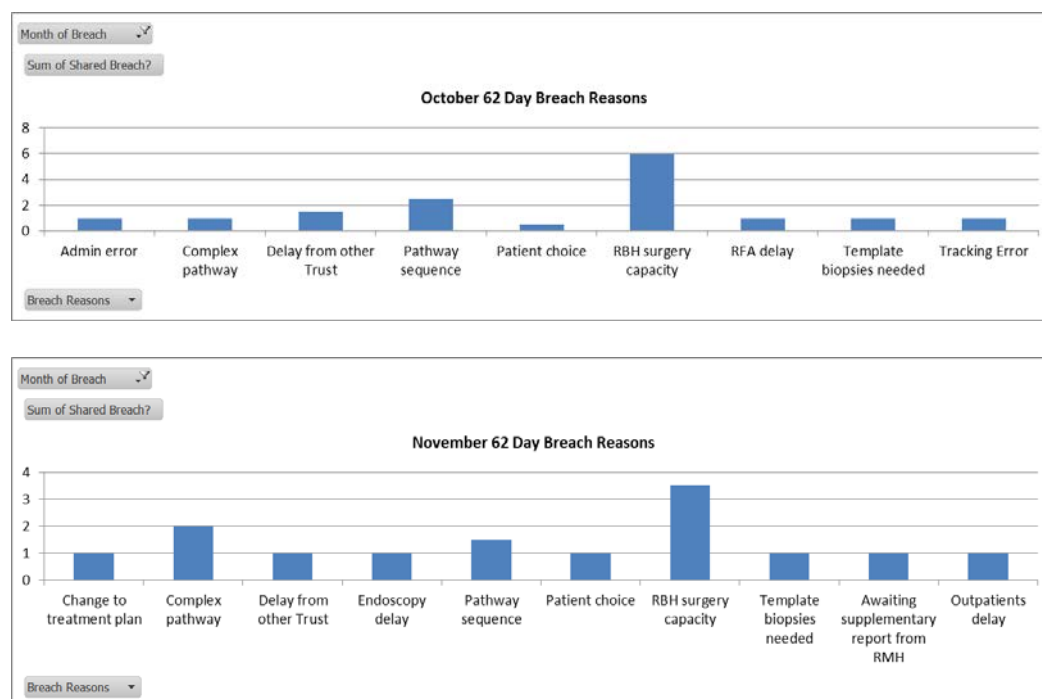
In addition, we will be working with DCH, PHT and Dorset CCG to develop a full action plan in response to the Royal College of Surgeons' review of Urology pathways.

Proposed RBCHFT 62 Day Cancer Target Remedial Action Plan

No.	Key Area of Action	Exec and Dept Senior Lead
		Timescale
1.	Develop RCS Urology Report (Nov 2015) Action Plan to include delivering pan Dorset prostate service pathway and reducing RARP backlog and waiting times	RR / LH / DCCG Lead / DCH Lead
a.	Pan-Dorset meeting to review RCS report and develop	Jan-16

No.	Key Area of Action	Exec and Dept Senior Lead	Timescale
	action plan		
b.	Align RBCH and DCH RARP pathway		Feb-16
	Commence straight to MRI pilot		Jan-16
	Implement GP referral pathway to include 2 x PSA & DRE		Mar-16
c.	All DCH RARP referrals to reach RBCH within agreed timescale		Mar-16
d.	Commence increased RARP capacity by min of 2 cases per month		Feb-16
e.	Agree pan-Dorset referral criteria for RARP		Mar-16
f.	1 year review of RBCH template biopsy service		Feb-16
g.	Implement pathway for differentiated waits for fast track patients for template biopsy		Feb-16
h.	Review referral criteria for template biopsy		Feb-16
i.	Review flow rate testing pathway and capacity		Feb 16
j.	Appoint locum and confirm long term plans		Mar-16
k.	Explore options and develop plan for providing additional capacity (e.g. outsourcing routine cases, use of procedure room 1, additional Sat capacity for routines/?RARPs)		Jan-16
l.	Pool RBH and DCH lists		Feb- 16
2.	Optimise Urology demand and capacity match	RR / LH / DCCG Lead	
a.	Review and optimise demand and capacity plan for contract and budget setting	Mar-16	
3.	Tracking and pathway improvement	RR / AA / DCCG Lead	
a.	Review 31 day pathways with teams		Mar-16
	Meeting with Sally Rickard (Wessex SCN)		Feb 16
b.	Continue RCA approach with clinical teams		Apr-16
c.	Review timeline tracking processes and review options for increasing/optimising tracking and expeditor role		Mar-16
d.	Work with CCGs and partner organisations to review pathways across organisations		Apr-16
e.	Achieve Endoscopy backlog reduction to reduce impact of delays on Colorectal/Upper GI pathways		See separate action plan
f.	Implement revised Dorset-wide referral form		TBC once form approved

The above plan has also been developed in response to our root cause analysis (RCA) of breaches. These show that the key reasons for breaches are: surgical capacity and pathway sequence, with a smaller number due to other reasons such as patient choice and transfers between trusts. Detailed breach RCA is now undertaken regularly and shared with clinicians and all relevant staff to identify further areas for improvement. These have led to positive pathway improvements for patients.



Work is also well underway in relation to demand and capacity planning. This is assisted by improvement/utilisation dashboards at speciality level to assist managers and clinicians with identifying opportunities to create efficiencies to meet demand and capacity gaps. These are being rolled out through the Surgical Care Group Theatres Quality Improvement Programme groups. The programme has a heavy current focus on driving further efficiency in Urology, GI and enabling theatre activities. It is expected that this will also support capacity in relation to cancer and RTT targets.

This work will be included within the wider Urology specific Quality Improvement programme. This is reviewing Urology admissions processes, diagnostic timelines and Urology specific theatre practices. This work also includes a development programme for robotic 'first assistants' to add additional capacity in late 2016/early 2017 following an extensive training schedule.

5.3 Overall 62 day performance by specialty

62 day performance

Site	Quarter 2 2015/16			Oct-15			Nov-15		
	Total	Within Target	Performance	Total	Within Target	Performance	Total	Within Target	Performance
Haematology	13	12	92.3%	5	4	80.0%	4	4	100.0%
Lung	27	19	68.5%	6	3.5	58.3%	4.5	3.5	77.8%
Colorectal	26	22	84.6%	5	3	60.0%	9	9	100.0%
Gynae	7	6	92.3%	2.5	2.5	100.0%	4.5	4.5	100.0%
Skin	83	80	97.0%	24.5	24.5	100.0%	35	34	97.1%
UGI	30	28	93.2%	9	9	100.0%	7	5	71.4%
Urology	100	64	64.0%	30	21	70.0%	45.5	37	81.3%
Breast	43	40	93.0%	18	16	88.9%	20	20	100.0%
Others									
Head & Neck	4	4	100.0%				0.5	0.5	100.0%
Brain/central nervous system	0	0							
Children's cancer	0	0							
Other cancer	0	0					1	1	100.0%
Sarcoma	2	2	75.0%	1.5	1.5	100.0%	3	1.5	50.0%
Total	333.0	275.0	82.6%	101.5	85.0	83.7%	134.0	120.0	89.6%

The other areas of 62 day breaches are mainly Upper GI and Lung. The demand and capacity pressures in our Upper GI and Colorectal services are mainly as a result of

longer waits for Endoscopy. These are improving, see 5.1 above. Work on Lung pathways across Dorset, and especially into UHS for treatment are being led by the CCG.

5.4 31 First Treatment and Subsequent Surgery

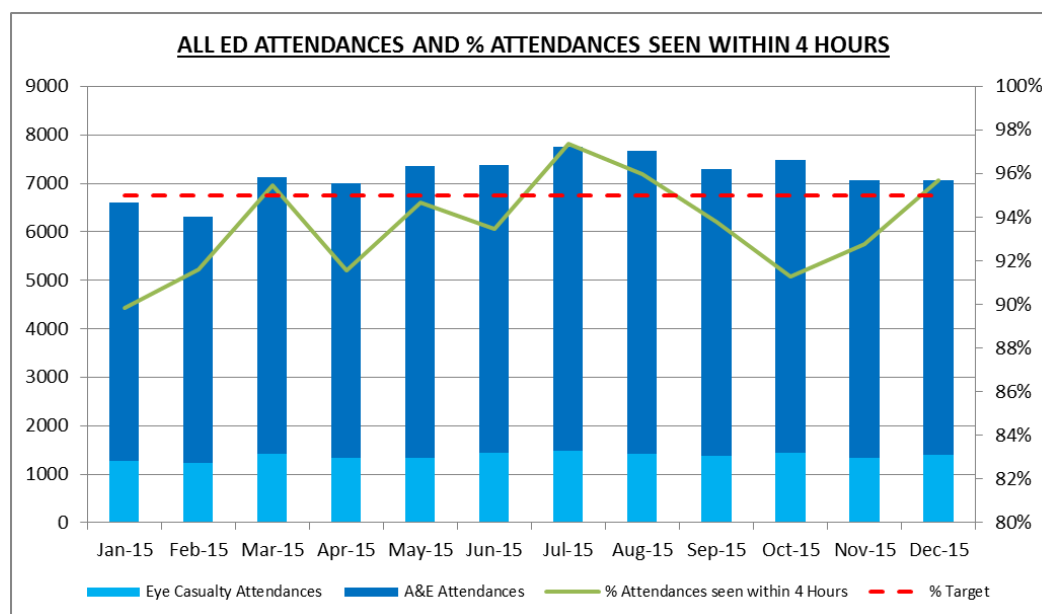
Due to the focus on the Urology backlog, we saw a number of breaches against the 31 day first treatment target in Q3 which is impacting on our overall compliance. The 31 day subsequent treatment target returned to compliance in Q3. By implementing the Trust policy and RARP recovery work, plus supporting clinicians with forward planning their work, these targets should be complaint going forward.

6. A&E

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

6.1 Performance and Activity

Given the higher consultant staffing levels in both ED and AMU, the senior decision maker/gatekeeper roles are reducing inappropriate admissions. The Ambulance service is also managing more patients without conveying them to hospital. Furthermore, the improved processes in ED together with the detailed winter and Christmas planning including the planned opening of Ward 3 in November, has helped reduce the ongoing bed pressures. Positively, the Trust delivered 95.7% against the target in December. Compliance for Q3 against the ED 4 hour target was narrowly missed, with a return of 93.2%



A&E Attendances were up 1.1% compared to December last year. We expect the lower than expected level of attendances, specifically 'walk in' patients, to be a result of the National Winter NHS campaign, signposting patients to alternative sources such as NHS 111 and use of pharmacies, as well as improved cover this year in the NHS 111, Out of Hours and 999 services. Total non-elective admissions were

however, 1.6% above December 2014 following three months of significantly higher non elective admissions than 2014.

Non Elective activity - % variance against 14/15							
	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Non-Elective	1.8%	-2.3%	0.3%	7.2%	5.2%	13.0%	1.6%

Monitoring of ED related breaches (i.e. not bed related) since October does suggest that Q3 performance has been more affected by bed availability related breaches than earlier quarters. This reflects the increase in non elective admissions, together with increasing acuity as we moved into Autumn and Winter, but also demonstrates there is more to do in terms of bed capacity and flow, whilst also continuing to create a more sustained performance in ED itself.

		BREACHES			
DATE	TRUST PERFORMANCE	TOTAL > 4 HOURS	ED Attends (excl eye unit)	ED Breaches (all not reported as bed breach)	ED Performance (exc bed breaches)
WE 4/10	94.87%	88	1382	67	95.15
WE 11/10	89.43%	181	1398	77	94.49
WE 18/10	94.54%	92	1362	68	95.01
WE 25/10	88.12%	205	1379	140	89.85
WE 1/11	91.39%	144	1328	68	94.88
WE 8/11	92.21%	126	1320	74	94.39
WE 15/11	95.47%	74	1299	48	96.30
WE 22/11	91.53%	137	1308	62	95.26
WE 29/11	90.22%	161	1327	111	91.64
WE 6/12	94.33%	97	1370	61	95.55
WE 13/12	96.28%	42	1275	34	97.33
WE 20/12	93.88%	81	1295	31	97.61
WE 27/12	98.11%	28	1204	25	97.92
WE 3/1/16	93.75%	103	1390	78	94.39
04/01/2016	92.80%	17	189	3	98.41
05/01/2016	77.73%	47	159	14	91.19
06/01/2016	86.16%	31	166	5	96.99
07/01/2016	96.07%	9	184	4	97.83
08/01/2016	90.64%	22	174	7	95.98
09/01/2016	83.41%	35	189	15	92.06
10/01/2016	98.00%	4	185	0	100.00
WE 10/1/16	89.33%	165	1246	48	96.15
11/01/2016	90.21%	23	186	2	98.92
12/01/2016	95.52%	9	150	1	99.33
13/01/2016	99.53%	1	158	1	99.37
14/01/2016	93.94%	14	173	6	96.53
15/01/2016	95.58%	10	162	1	99.38
16/01/2016	99.04%	2	183	2	98.91
17/01/2016	94.74%	12	211	8	96.21
WE 17/1/16	95.40%	71	1223	21	98.28
18/01/2016	84.86%	38	196	7	96.43

Analysis of the December performance shows 43.1% of the breaches were attributed to the inability to move patients to downstream beds, and 9.5% were due to clinical reasons. 39.14% of delays were within the ED itself, of which, 79.0% of the breaches are being attributed primarily to clinician assessment delay, and 10.9% due to patients requiring a side room. These two factors are though, significantly correlated to lack of flow in the department due to downstream bed pressures. 4.2% of the ED attributed breaches were due to seniority/skill mix of staff.

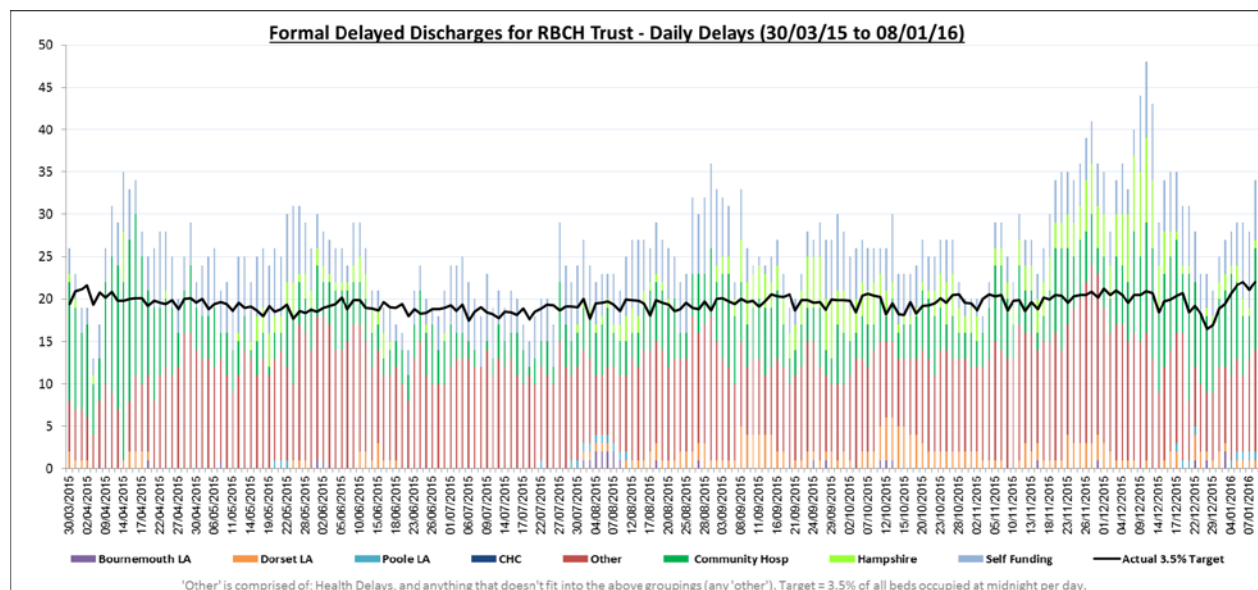
6.2 Action for Q4

The Trust's continues to strive for full monthly and quarter performance and the following is being implemented in Q4 to further the ongoing programme of work:

- Continued implementation of the winter plan, including flex capacity (as at 19/1/16 additional capacity opened = 57 plus additional interim care team beds/packages)
- 8th ED consultant commenced in Jan 16 together with separation from the PHT rota
- Pilot of consultant 6pm-12am shift
- Pilot of 4hr/hospital coordinator role
- Review of ED 4hr, flow and bed management model and implementation of PDSAs following visits to/learning from other trusts
- Reviewed structure for daily hospital bed meetings
- Revised daily admission predictor and ED trigger tools
- Continue cultural change process following detailed presentation to TMB in January 2016 to support trust-wide commitment to four hour front door standard
- Review by Monitor Improvement Team of 4 hr and flow processes and pathways
- 24/7 psychiatric liaison (commenced December 2015)
- Additional funding over and above planned resilience funds have been made available for Mental Health services and primary care, the latter supporting increased GP opening, OoH GP response vehicle and Pharmacy First.
- Review orthopaedic emergency pathways to PHT from ED
- Work with commissioners and ambulance services to identify potential for hospital liaison officer to reduce impact of delays on ambulance services and support front door flow.

This, together with continued implementation of our full Winter Plan will be key as we go through Q4 where non elective/emergency admissions and acuity, as well as increased delayed transfers of care and incidence of infection, are already increasing challenges.

Delayed Transfers of Care together with patients 'medically fit for discharge' who are still in hospital, continue to be an increased pressure on the hospital with 32 (including community hospital delays) plus 25 in interim care beds/packages as at 19 January.



Further DCCG slippage funds have been provided to Social Services to increase support over the winter period and schemes include provider incentives to maintain current levels of provision. Other initiatives include: the 'Proud to Care' brand to support recruitment, hospital social workers following up discharges rather the community social workers, further support to self funders and protecting domiciliary care packages for admitted patients. Dorset HealthCare continue to maintain the additional beds provided this year at Canford Ward (St Leonards) and the Trust is discussing in year improvement in flow across East Dorset's few community beds to cope with the rising demand.

Taken together, there is considerable activity and implementation of plans underway to cope with rising demand, within the same funding as last year for the NHS, and lower funding for social care. The net effect is there remains significant risk of emergency care pressures stopping 4 hour compliance, despite significant innovation and improvement, and strong partnership working.

Expected ongoing higher levels of demand, infections such as norivirus, junior doctor strikes and continuing reduction of care homes and packages of care do present increasing risk to Q4 and the year.

7. Learning Disability

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

We were compliant with the requirement to healthcare access for Q3 15-16 and December '15 against the target.

8. Mixed Sex Accommodation

Minimise no. of patients breaching the mixed sex accommodation requirement

December is the fifth month of reporting under the revised MSA policy, in line with contractual agreements with Dorset CCG. 1 episode of MSA breach occasion occurred during December, affecting a total of 2 patients in critical care:

	Breach Occasions	Patients Affected
ITU/HDU	1	2

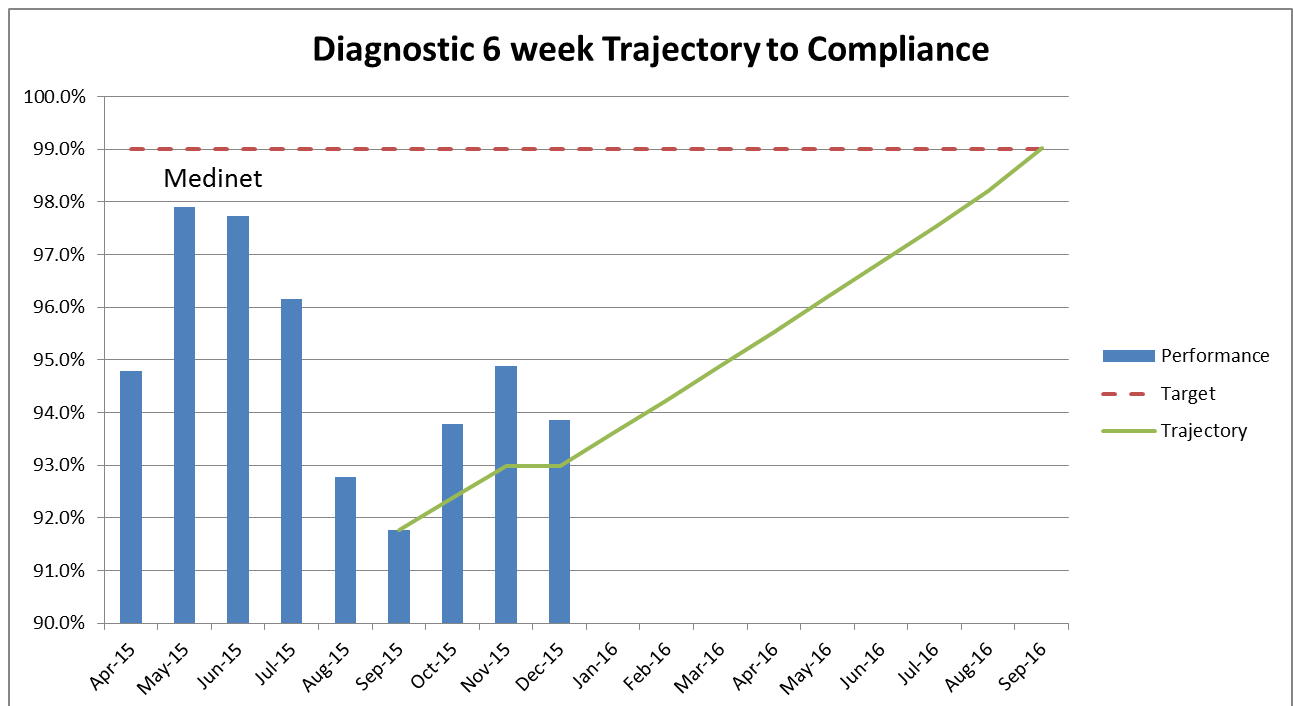
For Q3, there were 8 patients being affected during 5 MSA breach occasions.

Reviews of each potential breach is undertaken via root cause analysis. This is against the new CCG led policy. Based upon CCG advice we are also looking at each potential case to ensure the full clinical decision matrix is applied, so as to ensure safe care always remains the priority.

9. Diagnostics

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

As expected, Decembers' diagnostic result was 93.0% (against the 99% threshold) just slightly ahead of our original improvement trajectory linked to the significant improvement work and backlog reduction plan in Endoscopy. The planned December junior doctor strikes, which although called off at short notice, did mean that a number of patients were cancelled and could not be reinstated due to the bowel preparation requirements. In addition, we did have a small number of Radiology breaches due to demand and capacity pressures, including for fast tracks, over the period.



Although we have seen significant progress against our own action plan to date and resulting improvement, a Contract Penalty Notice for Endoscopy has been received

from our commissioners. The following Remedial Action Plan, of which a number of the items have already been completed or well progressed, has been agreed which includes some additional capacity through insourcing to deliver a quicker recovery trajectory.

Endoscopy – Summary Remedical Action Plan

No.	Key Area of Action	Exec and Dept Senior Lead
1.	Implement improvements to Endoscopy admin & scheduling to ensure all patients on electronic systems and clear protocols for booking in line with Dorset Framework	RR / AL
2.	Implement Demand and Capacity tool to support operational management of scheduling and performance, and establish a recovery trajectory	RR / AL
3.	Ensure optimum capacity utilisation in Endoscopy	RR / AL
4.	Increase RBH based Endoscopy capacity to achieve 6/7 day timetable, within available financial envelope	RR / AL / PV (DCCG)
5.	Increase Endoscopist capacity	RR / AL
6.	Secure additional capacity from independent sector funded as per the e-mail agreement of 11 January 2016	RR/DP
7.	Implement Direct Access Faecal Calprotectin for GPs to reduce demand for Endoscopy once the pathway is agreed and as part of the contractual process for 2016/17.	RR

Our recovery trajectory is also being revised to reflect the following milestones.

KPI	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Sep-16
Percentage waiting > 6 weeks	6%	5%	4%	3%	2%	1%	1%

Milestone dates are 30/04/16, 30/06/16 and 30/09/16

9.1 Planned Patients

In addition to our patients who have been newly referred for a diagnostic procedure, we also have patients who are on a 'planned' or 'surveillance' waiting list. These are patients that have repeated procedures on a planned basis (e.g. annually or three/five yearly). Currently we have 394 patients out of 6,128 (6.4%) who have been waiting greater than 6 weeks past their indicative due date. This is predominantly due to the pressures referred to above in Endoscopy (5.1%); the other 1.3% with much smaller numbers are mainly in Urology, Cardiology and Ophthalmology. The work being undertaken in Endoscopy will support our forward plans for reducing this. Planned patients continue to be monitored on a weekly basis, with clinical reviews of longer waiting patients being undertaken.

10. Cancelled Operations

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

Whilst during December we were compliant with this indicator, as indicated previously reported we have had two incidents in Q3 of not offered a binding date within 28 days. Both patients operations were cancelled on the day due to equipment failure. However, the Trust does benchmark well on this target and on the number of elective cancellations. Due to the proportion of cancer pathway diagnostic and treatment interventions and other major surgery undertaken by the Trust, decisions on cancelling any cases is taken very seriously.

11. Stroke

We are pleased that Q2 SSNAP results report that we have retained a level B for a second quarter with considerable improvement on our Q1 results and a score of 78 overall (Level A score is 80+). Nationally for Q2, 17% of Trusts achieved a SSNAP level A and 21% of Trusts achieved SSNAP level B. Our Q2 results will be within the upper quartile. National results will be available in January to confirm our actual position.

Quarter	Oct-Dec 2014	Jan-March 2015	Apr-June 2015	July-Sept 2015	National Average
SSNAP level	D	C	B	B	
SSNAP score	57.8	66.7	70.3	78	
Case ascertainment band	A	B	A	A	A
Audit compliance band	D	C	B	A	B
1) Scanning	D	C	C	B	B
2) Stroke unit	D	C	C	C	C
3) Thrombolysis	D	C	C	C	C
4) Specialist Assessments	D	D	D	C	C
5) Occupational therapy	A	A	A	A	B
6) Physiotherapy	B	A	B	B	B
7) Speech and Language therapy	A	A	B	B	D
8) MDT working	B	B	B	B	C
9) Standards by discharge	B	B	B	B	B
10) Discharge processes	B	A	A	A	B

We have sustained or improved performance in all domains. This is the first quarter we have achieved our goal of all Domains being a Level C or above. Notably Audit Compliance has improved to a Level A and Case Ascertainment has remained a Level A. We are extremely pleased to have achieved a Level B for scanning and this is due to the considerable hard work and dedication of both our Stroke Outreach Team and the Radiology Department.

Q3 has seen challenges to the targets especially related to bed pressures, however December has seen some improvement, e.g. in the 90% stay on the Stroke Unit indicator.

Ensuring sustainability of improvements over the next 12 months relies upon expansion of the radiology service out of hours, CT3 development and management of other risks including maintaining staffing levels. By delivering the overall plan our trajectory is to sustain SSNAP Level B+ for Q3 with no domain lower than level C. A more detailed report is provided to the Board on a quarterly basis.

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

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

90% of patients on an admitted pathway treated within 18 weeks

95% of patients on a non-admitted pathway treated within 18 weeks

12.1 Incomplete Pathways

The Trust continues to perform well against the Incomplete Pathways target, achieving 93.7% in December with 19,486 patients waiting less than 18 weeks. This is a slight reduction on November reflecting some general impact from demand, capacity availability and patient choice over the holiday period, but also some specific areas of current pressure.

Urology continues to be below threshold as a result of the balance between securing timely capacity for cancer pathway interventions and treatments, as well as routine cases. Options are currently being explored to prevent further deterioration of the backlog whilst we undertake our cancer backlog recovery plan referred to above.

Orthopaedics has seen an increase in admitted backlog however, this is expected to improve with some additional theatre capacity for consultant specific cases and additional outpatient capacity to reduce pathway delays. However, pressures in Radiology due to unplanned consultant absence is presenting some risk to timeliness of pathways. This is currently being managed through additional sessions and outsourcing.

In addition, Ophthalmology has experienced an increase in referrals, which together with some capacity reduction, has led to an increase in backlog. Additional sessions are underway to prevent further deterioration.

Some smaller individual sub speciality pressures in General Surgery have resulted in some increase in non admitted and admitted backlogs. These are currently being monitored and/or managed through some additional capacity.

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

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15		
												<18 wks	Total	Performance
100 - GENERAL SURGERY	92.4%	94.0%	92.8%	91.1%	93.0%	92.1%	91.6%	91.2%	90.5%	91.9%	92.2%	2235	2429	92.0%
101 - UROLOGY	92.1%	91.9%	91.0%	89.9%	90.1%	90.0%	89.0%	88.4%	87.2%	89.8%	90.5%	1255	1451	86.5%
110 - TRAUMA AND ORTHOPAEDICS	87.3%	84.8%	86.3%	89.2%	92.9%	94.2%	94.5%	93.9%	93.7%	94.8%	94.2%	3732	4034	92.5%
120 - EAR NOSE AND THROAT	85.1%	87.2%	85.3%	87.8%	87.4%	90.3%	95.0%	98.4%	98.9%	98.9%	98.2%	261	271	96.3%
130 - OPHTHALMOLOGY	94.9%	95.7%	96.1%	97.4%	97.3%	97.5%	96.6%	95.4%	94.8%	93.4%	93.4%	4053	4348	91.2%
140 - ORAL SURGERY	90.4%	87.5%	86.5%	80.5%	73.3%	65.8%	59.5%	84.8%	98.0%	100.0%	100.0%	208	208	100.0%
170 - CARDIOTHORACIC SURGERY	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	10	10	100.0%
300 - GENERAL MEDICINE	94.0%	98.2%	96.0%	93.0%	94.6%	97.6%	97.5%	96.9%	96.4%	96.9%	95.8%	1613	1664	96.9%
320 - CARDIOLOGY	94.0%	94.7%	94.5%	94.6%	94.9%	95.8%	95.8%	94.2%	93.5%	95.2%	95.1%	1753	1869	93.8%
330 - DERMATOLOGY	77.6%	72.1%	79.4%	84.6%	89.3%	89.1%	92.1%	92.1%	91.7%	93.8%	93.8%	428	444	96.4%
340 - THORACIC MEDICINE	95.8%	100.0%	99.5%	97.9%	99.4%	97.9%	98.6%	99.4%	100.0%	99.2%	99.5%	410	416	98.6%
400 - NEUROLOGY	98.5%	94.1%	91.8%	86.7%	85.6%	81.7%	87.7%	96.7%	97.5%	97.0%	98.8%	166	172	96.5%
410 - RHEUMATOLOGY	99.5%	99.1%	99.5%	97.1%	96.1%	94.5%	96.9%	98.1%	98.6%	98.7%	98.4%	924	943	98.0%
430 - GERIATRIC MED	98.0%	98.9%	100.0%	97.8%	97.0%	98.1%	97.0%	99.2%	98.5%	100.0%	98.9%	119	119	100.0%
502 - GYNAECOLOGY	96.5%	95.8%	93.3%	91.8%	95.1%	92.5%	92.1%	92.3%	93.7%	94.6%	94.0%	909	966	94.1%
Other	99.8%	99.3%	98.6%	97.3%	97.7%	97.6%	95.6%	95.9%	97.7%	96.4%	97.9%	1410	1457	96.8%
TOTAL	92.4%	92.7%	92.7%	92.6%	94.0%	94.4%	94.3%	94.1%	94.1%	94.5%	94.5%	19486	20801	93.7%

12.2 Admitted and Non Admitted RTT

Internally we are continuing to monitor patient treatment on the admitted and non admitted pathways. From 1st October 2015, we are reporting admitted pathways using unadjusted waits, and this is in line with national guidelines. Performance for December 2015 improved to 83.4% for admitted and remained at 95.0% for non admitted, with 6528 patients being treated within 18 weeks

13. Internal Audit Report – Performance Management

In line with the Trust's internal audit programme, an audit of performance management and reporting was undertaken in November and December. The final report was submitted to the Audit Committee in January. Overall assurance was rated at Moderate (second highest level of assurance out of four levels) stating,

'.. we identified that the Trust's performance reporting framework was robust allowing us to provide moderate assurance there are sufficient controls operating in practice to monitor the Trust's operational objectives, specifically Monitor's Key Performance Indicators (KPIs), and moderate assurance that these controls are operating effectively in practice. Our analysis of the performance reporting showed there to be an effective process of communicating key messages and performance metrics'.

A number of areas of Good Practice were cited including: clear ownership and prioritisation of KPIs, robust performance tracking tools and regular performance review meetings at all levels.

Key recommendations included the following and actions have been agreed to ensure improvement, notably:

- The Trust should formally document the performance management strategy and framework
- Ensure clear timescales and leads are documented for weekly actions at directorate level
- The Trust should optimise the effectiveness of the operational performance meetings, e.g. through advance agendas and sharing of root cause analysis and best practice.

14. Recommendation

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

The Board is asked to further note the Sustainability and Transformation Fund for 2016/17 requires compliance with all key targets, especially 4 hours and 62 day cancer waits. Improvement work plans in these two areas are highlighted in the paper, and feature in both contract and budget setting planning.

2015/16 PERFORMANCE INDICATOR MATRIX FOR BOARD OF DIRECTORS

Area	Indicator	Measure	Target 15/16	Monitor	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Forecast - Next Month	Forecast - Quarter	RAG Thresholds				
Monitor Governance Targets & Indicators															> trajectory				<= trajectory	
Infection Control	Clostridium difficile	Total number of hospital acquired C. Difficile cases under review	n/a	1.0	6		3		3		5		1		n/a					
	Clostridium difficile	C. Difficile cases due to lapses in Care	14 (1 pcm)		1		6		2		1		3							
Referral to Treatment	RTT Admitted	18 weeks from GP referral to 1 st treatment – aggregate	90%	1.0	90.1%		90.5%		82.9%		82.1%		83.4%				<90%		≥90%	
	RTT Non Admitted	18 weeks from GP referral to 1st treatment – aggregate	95%	1.0	93.0%		93.8%		95.4%		95.0%		95.0%				<95%		≥95%	
	RTT Incomplete pathway	Patients on an 18 week pathway awaiting treatment – aggregate	92%	1.0	92.6%		94.2%		94.5%		94.5%		93.7%				<92%		≥92%	
Cancer	2 week wait	From referral to to date first seen - all urgent referrals	93%	1.0	96.4%		95.1%		95.3%		97.7%						<93%		≥93%	
	2 week wait	From referral to date first seen - for symptomatic breast patients	93%		98.6%		100.0%		100.0%		100.0%						<93%		≥93%	
	31 day wait	From diagnosis to first treatment	96%	1.0	96.5%		96.2%		94.1%		95.8%						<96%		≥96%	
	31 day wait	For second or subsequent treatment - Surgery	94%	1.0	94.8%		92.2%		96.7%		96.7%						<94%		≥94%	
	31 day wait	For second or subsequent treatment - anti cancer drug treatments	98%		100.0%		100.0%		100.0%		100.0%						<98%		≥98%	
	62 day wait	For first treatment from urgent GP referral for suspected cancer	85%	1.0	85.5%		83.7%		83.7%		89.6%						<85%		≥85%	
	62 day wait	For first treatment from NHS cancer screening service referral	90%		91.3%		87.2%		100.0%		100.0%						<90%		≥90%	
	A&E	4 hr maximum waiting time	From arrival to admission / transfer / discharge (Type 1 & 2)	95%	1.0	93.3%		95.75%		91.31%		92.76%		95.68%				<95%		≥95%
LD	Patients with a learning disability	Compliance with requirements regarding access to healthcare	n/a	1.0													No		Yes	
TOTAL	CURRENT QUARTERLY MONITOR (PREDICTION) / SCORE		0.0	0.0	1		2		3						n/a		n/a		n/a	

Indicators within The Forward View into Action: Planning for 2015/16.

MSA	Mixed Sex Accommodation	Minimise no. of patients breaching the mixed sex accommodation requirement	0		0	0	0	0	29	4	6	2	2			> 0		0
Infection Control	MRSA Bacteraemias	Number of hospital acquired MRSA cases	0		0	0	0	0	0	0	0	0	0			>0		0
Cancer	62 day – Consultant upgrade	Following a consultant's decision to upgrade the patient priority *	90%		66.7%	66.7%	100.0%	100.0%	100.0%	85.70%	0.0%	80.0%				< 90%		≥90%
VTE	Venous Thromboembolism	Risk assessment of hospital-related venous thromboembolism	95%		95.4%			96.1%								<95%		≥95%
Diagnostics	Six week diagnostic tests	More than 99% of patients to wait less than 6 wks for a diagnostic test	>99%		94.8%	97.9%	97.7%	96.2%	92.8%	91.8%	93.8%	94.9%	93.9%			<99%		≥99%
A&E	Admission via A&E	No. of waits from decision to admit to admission over 12 hours	0		0	0	0	0	0	0	0	0	0			≥1		0
	Ambulance Handovers	No. of breaches of the 30 minute handover standard	0		20	20	22	43	56	85	106	87	31	n/a	n/a	tbc		
	Ambulance Handovers	No. of breaches of the 60 minute handover standard	0		5	2	2	4	9	10	38	12	3	n/a	n/a	tbc		
Cancelled Operations	28 day standard	No. of patients not offered a binding date within 28 days of cancellation	0		0	0	1	0	1	0	1	1	0			≥1		0
	Urgent ops Cancelled for 2nd time	No. of urgent operations cancelled for a second time	0		0	0	0	0	0	0	0	0	0			≥1		0
Stroke & TIA	SSNAP indicator	% of Stroke patients are treated on a dedicated stroke ward for 90% of spell	SSNAP threshold tbc		51.1%	69.4%	84.3%	88.9%	89.6%	81.7%	67.5%	69.8%	83.3%	tbc	tbc	tbc		
	SSNAP indicator	Direct admission to Stroke Unit within 4 hours of admission	SSNAP threshold tbc		53.3%	75.0%	62.9%	86.8%	69.1%	73.0%	66.0%	73.1%	70.8%	tbc	tbc	tbc		
	SSNAP indicator	Patients receive CT Scan within 24 hours of admission	SSNAP threshold tbc		96.7%	100.0%	92.0%	100.0%	n/a	n/a	n/a	n/a	n/a	tbc	tbc	tbc		
	SSNAP indicator	Patients with acute stroke receive brain imaging within 1 hr	SSNAP threshold tbc		46.7%	41.1%	40.0%	56.6%	35.1%	40.6%	31.5%	34.0%	46.3%	tbc	tbc	tbc		
	SSNAP indicator	Thrombolysis Rate	SSNAP threshold tbc		13.3%	12.5%	12.3%	17.0%	10.5%	7.8%	11.1%	7.5%	9.0%	tbc	tbc	tbc		
	SSNAP indicator	% appropriate patients receiving thrombolysis (within 1 hour of clock start)	SSNAP threshold tbc		50.0%	14.3%	62.5%	33.3%	33.3%	60.0%	0.0%	50.0%	50.0%	tbc	tbc	tbc		
	TIA indicator	High risk TIA cases investigated and treated within 24hrs	SSNAP threshold tbc		67.2%	63.0%	60.0%	60.0%	39.0%	53.0%	65.0%	47.5%	44.0%	tbc	tbc	tbc		
	TIA indicator	Low risk TIA cases, seen within 7 days	SSNAP threshold tbc		89.2%	92.0%	91.0%	86.0%	90.0%	90.0%	94.0%	91.4%	88.0%	tbc	tbc	tbc		
Referral to Treatment	Clocks still running - 52 weeks	Zero tolerance of over 52 week waiters (Incomplete Pathways)	0		0	0	0	0	0	0	0	0	0			≥1		0
	Clocks still running - admitted	Total number of patients with an admitted incomplete pathway	tbc		5976	6097	5967	5967	6306	6222	6430	6372	6766	n/a	n/a	tbc		
	Clocks still running - admitted	Number of patients with an admitted incomplete pathway over 18 weeks	tbc		656	600	568	669	753	790	787	787	967	n/a	n/a	tbc		
	Clocks still running - non admitted	Total number of patients with a non admitted incomplete pathway	tbc		14169	13434	13054	13265	13717	12951	13166	13324	14035	n/a	n/a	tbc		
	Clocks still running - non admitted	Number of patients with a non admitted incomplete pathway over 18 weeks	tbc		826	581	499	448	425	349	286	299	348	n/a	n/a	tbc		
	RTT Clocks still running - Combined	100 - GENERAL SURGERY	92%		91.1%	93.0%	92.3%	91.6%	91.3%	90.5%	91.9%	92%	92.0%			<92%		≥92%
	RTT Clocks still running - Combined	101 - UROLOGY	92%		89.9%	90.1%	90.0%	89.0%	88.4%	87.2%	89.8%	91%	86.5%			<92%		≥92%
	RTT Clocks still running - Combined	110 - TRAUMA AND ORTHOPAEDICS	92%		89.2%	92.9%	94.2%	94.5%	93.9%	93.7%	94.8%	94%	92.5%			<92%		≥92%
	RTT Clocks still running - Combined	120 - EAR NOSE AND THROAT	92%		87.8%	87.4%	90.3%	95.0%	98.4%	98.9%	98.9%	98%	96.3%			<92%		≥92%
	RTT Clocks still running - Combined	130 - OPHTHALMOLOGY	92%		97.4%	97.3%	97.5%	96.6%	95.4%	94.8%	93.4%	93%	93.2%			<92%		≥92%
	RTT Clocks still running - Combined	140 - ORAL SURGERY	92%		80.5%	73.3%	65.8%	59.5%	84.9%	98.0%	100.0%	100%	100.0%			<92%		≥92%
	RTT Clocks still running - Combined	170 - CARDIOTHORACIC SURGERY	92%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%			<92%		≥92%
	RTT Clocks still running - Combined	300 - GENERAL MEDICINE	92%		93.0%	94.6%	97.6%	97.5%	96.9%	96.4%	96.9%	96%	96.9%			<92%		≥92%
	RTT Clocks still running - Combined	320 - CARDIOLOGY	92%		94.6%	94.9%	95.8%	95.8%	94.2%	93.5%	95.2%	95%	93.8%			<92%		≥92%
	RTT Clocks still running - Combined	330 - DERMATOLOGY	92%		84.6%	89.3%	89.1%	92.1%	92.1%	91.7%	93.8%	94%	96.4%			<92%		≥92%
	RTT Clocks still running - Combined	340 - THORACIC MEDICINE	92%		97.9%	99.4%	97.9%	98.6%	99.4%	100.0%	99.2%	99%	98.6%			<92%		≥92%
	RTT Clocks still running - Combined	400 - NEUROLOGY	92%		86.7%	85.6%	81.7%	87.7%	96.8%	97.5%	97.0%	99%	96.5%			<92%		≥92%
	RTT Clocks still running - Combined	410 - RHEUMATOLOGY	92%		97.1%	96.1%	94.5%	96.9%	98.2%	98.6%	98.7%	98%	98.0%			<92%		≥92%
	RTT Clocks still running - Combined	430 - GERIATRIC MED	92%		97.8%	97.0%	98.1%	97.0%	99.2%	98.5%	100.0%	99%	100.0%			<92%		≥92%
	RTT Clocks still running - Combined	502 - GYNAECOLOGY	92%		91.8%	95.1%	92.5%	92.1%	92.3%	93.7%	94.6%	94%	94.1%			<92%		≥92%
	RTT Clocks still running - Combined	Other	92%		97.3%	97.7%	97.6%	95.6%	95.9%	97.7%	96.4%	98%	96.8%			<92%		≥92%
Planned waits	Planned waiting list	% of patients less than 6 weeks past their due date	0		96.9%	95.2%	95.6%	98.1%	95.8%	96.3%	96.5%	96.9%	96.3%			tbc		
Cancer	Cancer 62 day by Tumor Site	Haematology	85%		100.0%			100.0%	100.0%	50.0%	80.0%	100.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Lung	85%		79.4%			71.4%	65.0%	80.0%	58.3%	77.8%				<85%		≥85%
	Cancer 62 day by Tumor Site	Colorectal	85%		84.2%			82.6%	88.2%	83.3%	60.0%	100.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Gynae	85%		85.7%			100.0%	80.0%	100.0%	100.0%	100.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Skin	85%		95.8%			100.0%	100.0%	93.4%	100.0%	97.1%				<85%		≥85%
	Cancer 62 day by Tumor Site	UGI	85%		90.5%			90.5%	88.9%	100.0%	100.0%	71.4%				<85%		≥85%
	Cancer 62 day by Tumor Site	Urology	85%		72.1%			70.1%	53.4%	65.2%	70.0%	81.3%				<85%		≥85%
	Cancer 62 day by Tumor Site	Breast	85%		93.7%			92.3%	95.2%	88.9%	88.9%	100.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Head & Neck	85%		80.0%			100.0%	100.0%	100.0%	n/a	100.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Brain/central nervous system	85%		n/a			n/a	n/a	n/a	n/a	n/a		n/a	n/a	<85%		≥85%
	Cancer 62 day by Tumor Site	Children's cancer	85%		n/a			n/a	n/a	n/a	n/a	n/a		n/a	n/a	<85%		≥85%
	Cancer 62 day by Tumor Site	Other cancer	85%		100.0%			n/a	n/a	n/a	n/a	100.0%				<85%		≥85%
	Cancer 62 day by Tumor Site	Sarcoma	85%		0.0%			n/a	n/a	100.0%	100.0%	50.0%				<85%		≥85%
					99.9%	99.9%	100%	99.9%	99.8%	100%	99.8%					<99%		≥99%
SUS Submissions	NHS Number Compliance	Completion of NHS Numbers in SUS Submission (IPS/OPS)	99%		97.9%	97.9%	98%	97.5%	97.2%	97%	97.5%					<95%		≥95%

* Local standard of 90% with a de minimis of 2 breaches per month or 6 per quarter
NHS Number Compliance is YTD

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016 Part 1
Subject:	Quality report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Patient Experience information – care audit action plan
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Joanne Sims, Associate Director Quality & Risk Ellen Bull, Deputy Director of Nursing
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee (HAC)
Action required: Discuss/Information	The Board is invited to discuss the Trust's quality performance; to note the improvements which have been made and areas for focus which are reviewed in detail at the HAC and will be reported by the Chair.

Executive Summary:

This report provides a summary of information and analysis on the key quality performance indicators, linked to the Board objectives for 15/16, for December 2015.

1. Serious Incidents: 2 reported

2. Safety Thermometer: Harm Free Care remains consistent. 10 new pressure ulcers.

3. 2015/16 Quality Objectives:

- Meeting quality objectives for: reducing severe harm events, SIs, serious pressure damage, staff incidents.
- Not meeting quality improvement aim for: falls, medication incidents and never events.

4. Patient experience:

- Friends and Family Test data in month remains strong with the majority of areas attaining high percentage FFT feedback scores and is broadly stable as in previous months.
- Corporate outpatient areas have a higher percentage of not recommended as compared to previous month, however number of FFT cards were lower.
- Care Campaign Audits (CCA) remain consistent with care groups developing focussed action plans on lower performing areas.

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

Quality and Patient Safety Performance Exception Report: January 2016

1.0 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 December 2015

2.0 Serious incidents

Two Serious Incidents (SI) were confirmed and reported on STEIS in December 2015:

- 1 patient fall (OPM / Medicine)
- 1 cluster of category 3 pressure ulcers on one ward, which were a deterioration from category 2 external pressure damage (OPM / Medicine).

3.0 Safety Thermometer

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

NHS SAFETY THERMOMETER	14/15 Trust Average	14/15 National Average	Aug	Sept	Oct 15	Nov 15	Dec 15
Safety Thermometer % Harm Free Care	90.68%	93.80%	92.4%	88.9%	90.3%	86.97%	90.9%
Safety Thermometer % Harm Free Care (New Harms only)	97.18%	97.59%	97.9%	96.6%	97.6%	97.7%	97.1%

	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15
New Pressure Ulcers	8	14	6	6	10
New falls (Harm)	2	0	3	3	3
New VTE	0	1	1	0	0
New Catheter UTI	0	1	1	0	2

4.0 Quality Objectives

The following details performance against the Trust quality objectives for 2015/16.

Quality Metric	2014/15 Total	15/16 Aim	15/16 YTD	Position
Maintain high level of incident reporting and low rate of severe harm events	% no harm incidents reported = 69%	Achieve a rate of 70% or above	Average 64%	Slightly lower than 14/15 position but within acceptable range.
	% severe harm incidents reported = 0.33%	Maintain a rate of below 0.5%	Average 0.1%	Lower rate than 14/15 (positive)

Reduce the number of patient falls resulting in moderate or severe harm by 25%	25 Falls reported as SIs = 14	19	30 Falls reported as SIs = 12	Above 14/15 total and above trajectory. Increase number of moderate and severe falls reported in year.
Reduce the number of medication incidents resulting in moderate or severe harm by 10%	9	8	15	Above 14/15 total and above trajectory.
Reduce the number of Serious Incidents reported by 25%	46	35	29	On trajectory to achieve
Reduce the number of Never Events reported in year	4	0	3	Above target
Reduce the number of internal Category 3 and 4 pressure ulcers (as reported as Serious Incident) by 25%	19	14	6	On trajectory to achieve
Reduce staff accidents reportable to the Health and Safety Executive by 20%	18	16	6	On trajectory to achieve

5.0 Patient Experience

5.1 Family and Friends Test

The national performance benchmarking data bullet pointed below is taken from the national data provided by NHS England which is retrospectively available and therefore, represents November 2015 data.

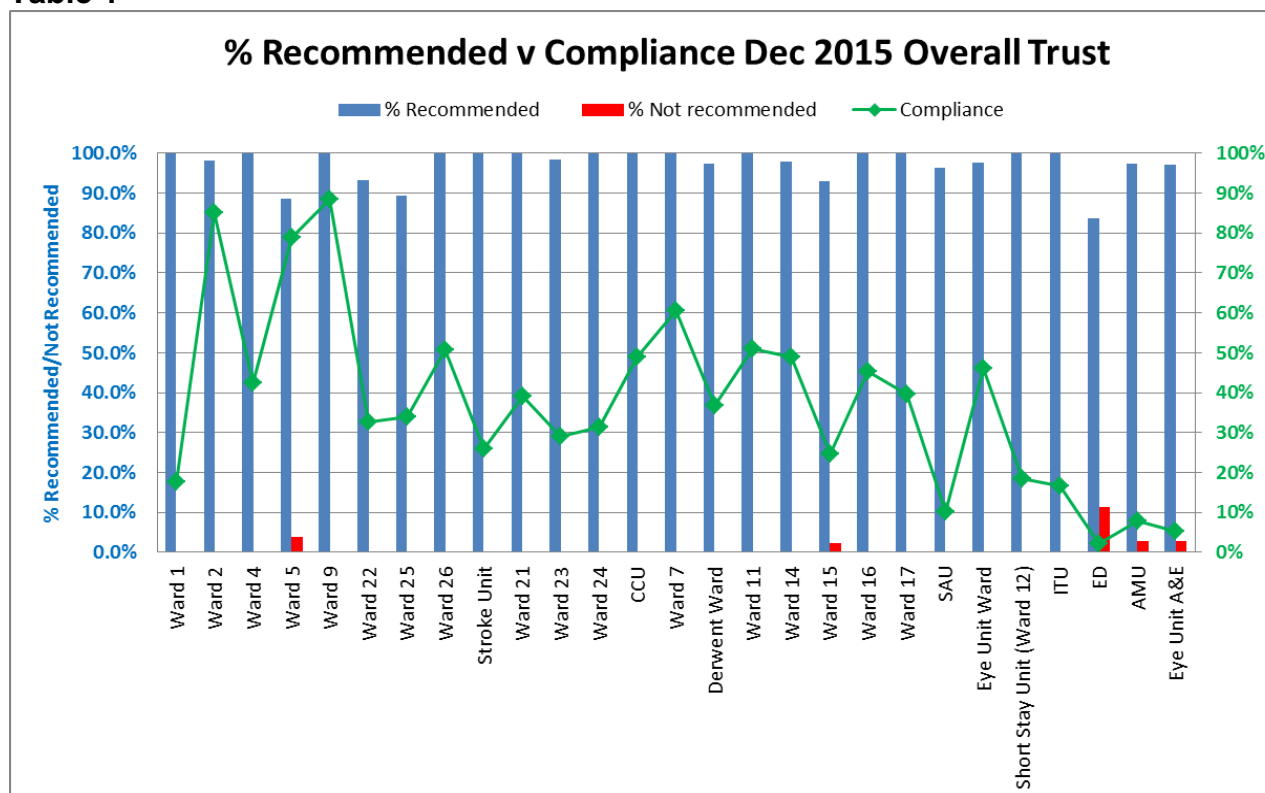
- Inpatient and day case Friends and Family Test (FFT) national performance in November 2015 ranked RBCH Trust 4th with 30 other hospitals out of 172 placing RBCH in the second quartile. The response rate was sustained above the 15% national standard at 18.6%.
- The Emergency Department (ED) FFT performance in November 2015 ranked RBCH Trust 5th with 8 other hospitals out of 141 placing RBCH ED department in the top quartile. The response rate 6.3% against the 15% national standard.
- Outpatients FFT performance in November 2015 ranked RBCH Trust 4th with 19 other Trusts out of 234 Trusts, placing the departments in the second quartile. Response rates are variable between individual outpatient departments; there is not a national response standard.

Table 1 below represents Trust ward and department performance for FFT percentage

to recommend, percentage to not recommend and the response compliance rate. A significant amount of areas attained FFT 100% scores although some of these areas have very small FFT returns.

Areas with an FFT score below 95% are ED, Ward 5, 22, 15, 25, AEC Medical, Chest Clinic (Thoracic), Jigsaw OPD, Ct/MRI, Ortho OPD, Path lab RBH, Pharmacy (RBH), X-ray and ultrasound. Areas not meeting the 15% national response compliance rate are Main ED, Eye ED, AMU, Ward 14 and SAU. Matrons are leading improvement actions.

Table 1



5.2 Patient Experience Cards

There were 3256 patient experience cards completed in total and administered. The majority of comments are very positive. Themes for negative comments include:

- waiting times, discharge
- lack of communication, re waiting times – particularly ED and OPD
- attitudes of staff

Improvement actions are being led by Heads of Nursing and reported through HAC.

5.3 Care Audit Trend Data

Overall	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Red	61	52	68	33	49	51	51	45
Amber	47	44	81	45	43	69	73	61
Green	214	172	175	243	203	178	199	163
N/A	3	7	26	29	55	52	27	81

Due to a reduction in volunteers over the festive season, the number of completed care audits dropped, which resulted in an increased number of N/A's in the table above. The full Care Campaign outcomes and Care Group action plans reviewed through HAC and can be viewed in the Reading Room.

Care Campaign questions have been reviewed and refined to reflect the need for detail on chronic performers. A shorter template has been developed for surgery and remains planned to commence in Q4.

5.4 Carer's audit

The carer's audit refinements have been completed, reviewed and agreed. They will commence use from 1st February to ensure a full month's data is available. These will be administered by Volunteers.

6.0 Recommendation

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

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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016 – Part I
Subject:	Financial Performance
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	No
Officer with overall responsibility:	Stuart Hunter, Director of Finance
Author(s) of papers:	Pete Papworth, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance Committee
Action required: Approve/Discuss/Information/Note	The Board of Directors is asked to note the financial performance for the period ending 31 December 2015
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 current year's delivery of cost improvements and next year's financial planning and are being monitored through the Finance Committee.

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Finance Report



For the period to 31 December 2015

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £8.7 million as at 31 December. This is £396,000 better than plan. Whilst some financial pressures are expected through the remainder of the winter period, the monthly expenditure run rate has improved and has stabilised in recent months. As a result, the Trust is expecting to achieve a year end deficit marginally below the revised plan of £11.9 million.

Activity

December reported a continued reduction in elective activity, again reflecting the reduced level of planned orthopaedic procedures. This was off-set by a significant increase in non-elective care, which was 4% above budget in month. Emergency department attendances and outpatient attendances were both below budgeted levels during December. Total activity to date remains broadly in line planned levels with an overall variance of just 0.9%, however the operational and financial impact of the movement between planned and emergency care is considerable.

Income

Due to the nature of the Trusts contracts with its three key commissioners, income remains broadly on plan at the end of month nine with a moderate adverse variance of £485,000 (0.2%). Increases in non contracted activity and non patient related income are more than off-set by the significant under achievement against planned private patient income.

Expenditure

Expenditure reports a modest under spend of £881,000 to date equating to a variance of 0.4%. This is mainly driven by a significant pay under spend, off-set by over spends against drugs and clinical supplies budgets.

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

Cost Improvement Programme

The Trust has identified further savings in year which has contributed to its reduced deficit forecast. To date the Trust has recorded savings of £6.6 million which is £348,000 ahead of the year to date target. The full year savings forecast improved again in month to £9.5 million which is £495,000 more than the target. However, the level of non-recurrent savings within this forecast remains a cause for concern.

Capital Programme

As at 31 December the Trust has committed £12 million in capital spend representing an under spend to date of £2.8 million. Key areas of spend include the Christchurch development (£3.3 million), the Jigsaw new build (£3.1 million), and the approved IT Strategy (£1.9 million). The full year forecast is being considered in light of a recent Department of Health request.

Statement of Financial Position

The trust continues to report high levels of outstanding payables and receivables. The main balances are with local NHS organisations and work to resolve a number of outstanding issues has continued. This is expected to conclude during January, for payment during February.

Cash

The Trusts current cash balance includes two one-off timing benefits. After adjusting for these, the Trust currently holds £31.7 million of cash. The current forecast is that the Trust will end the year with an underlying cash balance of £24.4 million. The Trust must continue to reduce its deficit forecast in future years to avoid the need for external financing.

Financial Sustainability Risk Rating

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

Income and Expenditure

To date the Trust has delivered a deficit of £8.7 million. Within this, income is below budget (adverse) by £485,000 and expenditure is below budget (favourable) by £881,000. This results in a net favourable variance of £396,000.

The Trusts overall income and expenditure position is summarised below.

£'000	Budget	Actual	Variance
NHS Clinical Income	183,511	183,993	483
Non NHS Clinical Income	5,772	4,580	(1,192)
Non Clinical Income	15,692	15,916	224
TOTAL INCOME	204,975	204,490	(485)
Employee Expenses	128,007	126,163	1,844
Drugs	23,664	24,647	(982)
Clinical Supplies	27,255	27,395	(140)
Misc. other expenditure	28,119	27,959	159
Depreciation	7,061	7,061	0
TOTAL EXPENDITURE	214,106	213,225	881
SURPLUS/ (DEFICIT)	(9,131)	(8,735)	396

Income

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

Non NHS clinical income remains significantly below budget due to a material reduction in private patient activity, specifically within cardiology, cancer care and radiology. The Trust is working up proposals to recover this position.

Non patient related activity is marginally ahead of plan.

Further detail at contract level is set out below.

£'000	Budget	Actual	Variance
NHS Dorset CCG	125,860	125,860	0
NHS England (Wessex LAT)	34,649	34,702	53
NHS West Hampshire CCG	18,708	18,726	17
Non Contracted Activity	2,027	2,386	359
Public Health Bodies	1,982	2,000	18
NHS England (Other LATs)	1,271	1,224	(47)
NHS Wiltshire CCG	559	571	12
Other NHS Patient Income	436	525	89
Private Patient Income	3,343	2,183	(1,160)
Other Non NHS Patient Income	448	398	(50)
Non Patient Related Income	15,692	15,916	224
TOTAL INCOME	204,975	204,490	(485)

Expenditure

Pay reports a significant under spend to date. This is due to agency expenditure being below expected levels following considerable efforts in relation to both substantive and bank recruitment across the Trust, together with a number of more tactical workforce initiatives. Further detail is included overleaf.

The Trust continues to report additional drugs expenditure, resulting in a significant year to date over spend. Particular increases are apparent in relation to Anti TNF; Hepatitis C; and Somastin drug costs.

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

Other non pay budget lines continue to report a favourable position to date.

Employee Expenses

The Trust continues to rely heavily upon agency staff to cover substantive vacancies. The year to date under spend against substantive staffing budgets is £10.9 million. Agency expenditure to date totals £7.9 million, with a further £5.1 million spent on bank and overtime. This results in a total 'premium' workforce cost of £2.1 million to date.

£'000	Substantive Budget	Substantive Cost	Substantive Variance	Agency Cost	Bank Cost	Overtime Cost	Workforce Variance	Premium Funding	Residual Variance
Surgical Care Group	30,881	28,581	2,300	1,700	753	249	(402)	801	399
Medical Care Group	43,933	38,984	4,949	4,855	2,258	318	(2,481)	2,274	(207)
Specialties Care Group	27,104	25,262	1,842	966	544	77	254	226	480
Corporate Directorates	22,154	20,284	1,870	433	741	152	544	0	544
Centrally Managed Budgets	9	6	3	0	0	0	3	624	627
TOTAL	124,082	113,118	10,964	7,954	4,296	796	(2,081)	3,925	1,844

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 utilise off-framework or tier three agency suppliers and engage staff above the capped rates to ensure services are delivered safely. The exceptions recorded during December were as follows:

	Medical	Nursing	Other
Shifts covered	100	50	95
Approximate Cost above Cap	£104,547	£4,827	£4,113

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

Cost Improvement Programme

The Trust has delivered financial savings amounting to £6.6 million to date, being £348,000 ahead of plan. The forecast is for total savings of £9.5 million against the full year target of £9 million. This represents a further improvement on the previously reported forecast.

However, it should be noted that a significant element of this delivery has been achieved non recurrently, representing a recurrent financial pressure moving into 2016/17. Whilst further validation and challenge is taking place as to how much of this could be secured on a recurrent basis, the current value stands at £3.4m.

The Surgical Care Group is forecasting full delivery of the full year target. Whilst currently the majority of this achievement is reported as non recurrent, this continues to be challenged and the Care Group are confident that a significant proportion can be achieved on a recurrent basis. This continues to be validated.

The Medical Care Group position has improved further during December, due to additional savings in relation to drugs expenditure. The Care Group are forecasting a small over achievement against the full year target, which is positive.

The Specialties Care Group continues to forecast an over achievement against the full year target, with a further improvement during December due to an increased savings expectation in relation to existing Pharmacy schemes.

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

DIRECTORATE	YEAR TO DATE			FULL YEAR		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000	TARGET £'000	FORECAST £'000	VARIANCE £'000
ANAESTHETICS AND THEATRES	82	0	(82)	164	164	0
MATERNITY	27	28	1	84	85	1
ORTHOPAEDICS	237	236	(1)	346	344	(2)
SURGERY	147	57	(90)	310	309	0
CARE GROUP A	494	321	(173)	903	902	(1)
CARDIOLOGY	156	128	(28)	254	229	(25)
ED AND AMU	49	15	(33)	78	19	(59)
OLDER PEOPLES MEDICINE	147	164	17	243	195	(48)
MEDICINE	245	370	125	249	473	224
CARE GROUP B	597	677	80	824	916	92
CANCER CARE	176	227	51	265	335	70
OPHTHALMOLOGY	182	148	(35)	258	199	(59)
PATHOLOGY	199	156	(43)	268	219	(50)
RADIOLOGY	86	133	47	131	219	88
SPECIALIST SERVICES	863	1,029	166	1,139	1,265	126
CARE GROUP C	1,505	1,692	187	2,061	2,237	176
NURSING, QUALITY & RISK	81	81	0	92	94	3
ESTATES	386	381	(5)	586	580	(6)
FACILITIES MANAGEMENT	210	182	(29)	354	319	(35)
FINANCE AND BUSINESS INTELLIGENCE	376	367	(9)	544	528	(16)
HR, TRAINING AND POST GRAD	148	148	0	185	185	0
INFORMATICS	492	691	200	777	959	182
OPERATIONAL SERVICES	97	97	0	122	121	(1)
OUTPATIENTS	12	6	(6)	19	14	(4)
TRUST BOARD & GOVERNORS	104	207	103	154	259	105
CORPORATE	1,906	2,160	254	2,832	3,060	227
PRODUCTIVITY	1,730	1,730	0	2,307	2,307	0
DIRECT ENGAGEMENT	0	0	0	115	115	0
CROSS DIRECTORATE	1,730	1,730	0	2,422	2,422	0
GRAND TOTAL	6,233	6,580	348	9,042	9,537	495

Care Group Performance

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

£'000	Budget	Actual	Variance
Surgical Care Group	12,707	12,260	(447)
Medical Care Group	5,886	5,528	(358)
Specialties Care Group	4,371	4,188	(183)
Corporate Directorates	(26,884)	(26,489)	395
Centrally Managed Budgets	(5,211)	(4,223)	988
SURPLUS/ (DEFICIT)	(9,131)	(8,735)	396

Surgical Care Group

Overall the Care Group reported an adverse position during December; with a significant reduction in income being only partially off-set by an under spend against the in month expenditure budget.

The income under achievement during December reflects a continued and significant reduction in orthopaedic income against plan, off-set in part by additional day case and elective surgery despite a planned reduction in activity during the Christmas period.

The Care Group expenditure position in month has been adversely affected by a further increase in maternity pathway charges, which continue to be challenged. In addition, the Care Group supported the Trusts winter resilience plans during December through provision within the surgical and orthopaedic bed base.

Despite the financial pressures reported during December, the Care Group continue to forecast a balanced position against the full year budget.

Medical Care Group

The Medical Care group reported a minor adverse variance to budget during December; however this represented a favourable position against the forecast position for December.

The main driver for the adverse in month position to budget was a further reduction in private Cardiology activity. This reduced level is forecast to continue for the remainder of the financial year, however recovery plans are being worked up to protect and recover private income in the short to medium term.

Activity pressures have continued within medicine, most notably within endoscopy, and action plans are in place to appropriately manage this additional demand.

A further reduction in agency staff costs has been reported within Older Peoples Medicine which is positive; however this has been off-set by additional agency costs within Cardiology together with additional security costs within ED.

Specialties Care Group

Overall the Care Group reported an adverse position in month, with particular financial pressures apparent within Cancer Care, Ophthalmology, and Pathology.

Medical agency spend together with increased drugs for age related macular degeneration were the key drivers for the Ophthalmology variance; emergency activity pressures together with a significant increase in immunomodulating drugs accounted for the adverse Cancer Care position; and increased agency costs within histopathology and microbiology drove the Pathology over spend .

Corporate Directorates

Corporate directorates continue to perform well financially, delivering a significant favourable variance to date. Some pressures continue in a small number of directorates, most notably, Estates and facilities.

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 £2.8 million, as set out overleaf. This, together with the timing impact of capital schemes on the associated depreciation and amortisation charges account for the overall non-current assets variance to date.
- **Inventories:** Stock is currently higher than anticipated, mainly due to an increase within the pharmacy store in relation to the new Hepatitis C network. The Trust is currently undertaking a detailed review of its policies and procedures with a view to enhancing stock management across the Trust with the support of internal audit.
- **Trade and other receivables:** Delays in the payment of invoices, mainly by local NHS organisations, account for a significant proportion of the receivables variance to plan. These outstanding balances are being actively pursued and have been escalated where appropriate. In addition, the new Hepatitis C network has resulted in additional invoices above the level initially planned.
- **Cash and cash equivalents:** Cash is currently greater than planned, driven mainly by the capital under spend. Further detail is included below.
- **Trade and other payables:** The Trust is carefully managing cash payments, pending resolution of the outstanding receivables balance, which has resulted in a variance to plan. This is exacerbated by the Hepatitis C network and the timing of capital related payments.

The Trust is currently working through a detailed re-valuation of its estate, which once complete, will be reflected within the Statement of Financial Position.

£'000	Plan	Actual	Variance
Property, plant and equipment	178,902	175,057	(3,845)
Intangible assets	1,942	2,470	528
Investments (Christchurch LLP)	2,481	2,361	(120)
Non-Current Assets	183,325	179,888	(2,408)
Inventories	5,590	7,008	1,418
Trade and other receivables	7,708	13,317	5,609
Cash and cash equivalents	52,077	56,319	4,242
Current Assets	65,375	76,644	11,269
Trade and other payables	(39,697)	(47,068)	(7,371)
Borrowings	(389)	(328)	61
Provisions	(141)	(194)	(53)
Other Financial Liabilities	(551)	(551)	0
Current Liabilities	(40,778)	(48,141)	(7,363)
Trade and other payables	(1,023)	(1,023)	0
Borrowings	(20,585)	(20,640)	(55)
Provisions	(519)	(519)	0
Other Financial Liabilities	0	0	0
Non-Current Liabilities	(22,127)	(22,182)	(55)
TOTAL ASSETS EMPLOYED	185,795	186,209	414
Public dividend capital	79,665	79,665	0
Revaluation reserve	74,609	74,609	0
Income and expenditure reserve	31,521	31,935	414
TOTAL TAXPAYERS EQUITY	185,795	186,209	414

Capital Programme

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

Expenditure to date totals £12 million, representing an under spend of £2.8 million against the year to date budget of £14.8 million. The current underspend is mainly attributable to the Christchurch development, driven by delays with steel works together with environmental issues.

Full detail at scheme level is set out below.

£'000	Annual	IN MONTH			YEAR TO DATE		
	Budget	Budget	Actual	Variance	Budget	Actual	Variance
Christchurch Development	7,565	988	319	669	5,288	3,314	1,974
JIGSAW New Build	3,050	0	(0)	0	3,050	3,050	0
Relocate and Expand AEC	900	200	0	200	320	0	320
Atrium Project	1,200	30	15	15	1,195	1,080	115
CT3 Build	500	0	0	0	35	5	30
Ward Refurbishment	400	0	17	(17)	400	327	73
Estates Maintenance	400	50	88	(38)	260	391	(131)
Aseptic Unit	510	0	0	0	510	545	(35)
Miscellaneous Schemes	100	25	6	19	75	248	(173)
Traffic Congestion Works	100	15	0	15	100	0	100
Residences Refurbishment	50	0	5	(5)	50	61	(11)
Catering Equipment	150	0	0	0	75	34	41
Macmillan Development	0	0	0	0	0	15	(15)
Capital Management	300	25	13	12	225	144	81
Medical Equipment	1,500	125	48	77	1,125	868	257
IT Strategy	3,062	176	318	(141)	2,102	1,898	203
TOTAL	19,787	1,634	828	806	14,810	11,980	2,830

The Trust is currently assessing the potential full year under spend for the year in light of a recent Department of Health request.

Cash

The Trust is currently holding £56.3 million in cash reserves. However, there are two significant cash timing benefits within this figure meaning that the underlying cash position is significantly lower at £31.7 million.

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

The forecast closing cash balance for the current financial year is £31 million. After adjusting for the residual cash timing benefits, the Trust is forecasting to end the year with £24.4 million of cash.

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

£ million	Jan-16	Feb-16	Mar-16
OPENING CASH	56.32	53.84	52.19
NHS Clinical Income	19.75	19.75	19.77
Non NHS Clinical Income	0.59	0.59	0.89
Non Patient Related Income	1.38	1.46	1.46
Working Capital	(0.10)	(0.10)	(14.03)
CASH INFLOWS	21.62	21.70	8.09
Revenue Account	(21.61)	(21.74)	(24.55)
Capital Account	(1.06)	(1.54)	(1.60)
Christchurch Investment	(1.80)	(0.26)	(0.58)
ITFF Loan Repayment	0.00	0.00	(0.54)
Working Capital	0.38	0.19	(2.02)
CASH OUTFLOWS	(24.10)	(23.35)	(29.29)
CLOSING CASH	53.84	52.19	30.99

Financial Sustainability Risk Rating

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

The Trusts Financial Sustainability Risk Rating as at 31 December 2015 is set out below.

	Plan Metric	Actual Metric	Risk Rating	Weighted Rating
Capital Service Cover	0.28x	0.47x	1	0.25
Liquidity	25.5	28.7	4	1.00
I&E Margin	(4.51)	(4.28)	1	0.25
I&E Variance to Plan	(1.17)%	0.23%	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 is currently undertaking its investigation, and will be on-site for three days during January. It is understood that whilst initial observations will be feedback immediately, Monitor will review the Trusts draft annual plan submission together with the CQC report before confirming the formal outcome. Final confirmation of the outcome is therefore expected during March.

The Trusts medium term financial plan has been refreshed following the release of the draft tariff package for 2016/17, the CCG allocations, together with confirmation of the Sustainability and Transformation Fund. This is covered in a separate report to the Board, and will continue to be updated as the Trust continues through the 2016/17 planning cycle.

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016 – Part 1
Reason for Part 2:	n/a
Subject:	Workforce Report
Section on agenda:	5. Performance
Supplementary Reading (included in the Reading Pack)	Safe Staffing: mitigations by wards/departments
Officer with overall responsibility:	Karen Allman
Author(s) of papers:	Karen Allman
Details of previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC, Education and 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>In addition to reporting the 10 areas with lowest compliance for ECS, this month and going forward, reports will also include details of the areas with highest compliance. Similarly, for sickness absence, reports will now include details of both the highest and lowest areas.</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 – JANUARY 2016

The Workforce Strategy and Development and Committee meet on the 22nd February 2016 and, as such, this paper is an interim update.

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

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 December			Rolling 12 months to 31 December				At 31 Dec
Surgical	62.5%	83.1%	81.2%	4.56%	14900	13.9%	13.2%	3.2%
Medical	61.5%	90.6%	81.1%	3.95%	18981	19.3%	12.2%	7.6%
Specialities	77.6%	85.6%	84.1%	3.19%	8954	11.6%	11.8%	5.1%
Corporate	83.4%	0.0%	87.0%	3.81%	12194	11.7%	12.6%	1.6%
Trustwide	70.4%	85.7%	82.7%	3.91%	55029	14.7%	12.4%	4.9%

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 December			Rolling 12 months to 31 December				At 31 Dec
Add Prof Scientific and Technical	91.2%		85.0%	2.82%	1230	21.3%	12.2%	13.5%
Additional Clinical Services	62.9%		83.0%	6.38%	16496	21.3%	13.1%	5.6%
Administrative and Clerical	71.8%		87.3%	3.40%	10445	9.2%	13.4%	5.2%
Allied Health Professionals	72.1%		88.9%	2.19%	1985	13.9%	13.5%	0.9%
Estates and Ancillary	91.1%		84.2%	4.84%	5715	21.2%	15.2%	2.1%
Healthcare Scientists	75.0%		93.2%	2.70%	578	16.1%	12.9%	7.8%
Medical and Dental		85.7%	68.0%	1.00%	1578	6.6%	6.6%	0.3%
Nursing and Midwifery Registered	64.9%		83.3%	4.15%	17002	13.5%	11.5%	6.4%
Trustwide	70.4%	85.7%	82.7%	3.91%	55029	14.7%	12.4%	4.9%

1. Appraisal

As previously advised, appraisal compliance was reset to zero with the introduction of the new values based appraisal. The appraisal rate has increased to 70.4% for values based appraisal (61.3% last month). Of particular note, excellent progress has been made in Estates & Ancillary up to 91.1% from 70.4% last month.

Medical & Dental have also shown a good improvement, up to 85.7% from 62.5% the previous month. Overall, performance does, however, remain below trajectory.

2. Essential Core Skills Compliance

Overall compliance has increased to 82.7% from 81.1% last month. The table below shows the 10 areas with the lowest compliance as at 31st December:

Directorate	Organisation	Headcount	Compliance
Surgery Directorate	153 Obs/Gynae Medical Staff 10100	15	47.72%
Surgery Directorate	153 Surgery - General 10085	34	54.10%
Pathology Directorate	153 Phlebotomy 11330	39	55.09%
Elderly Care Services Directorate	153 MFE Medical Staff 10077	48	60.94%
Medicine Directorate	153 Medical General Staff 10075	73	61.38%
Cancer Care Directorate	153 Haematology Snr.Medical 11346	20	62.32%
Elderly Care Services Directorate	153 Discharge Co-Ordination 15001	12	63.31%
Anaesthetics/Theatres Directorate	153 Anaesthetic 10025	49	67.09%
Surgery Directorate	153 Surgery - Urology 10084	17	68.68%
Medicine Directorate	153 Ward 2 10369	37	68.75%

Going forward this report will also show the areas with highest compliance, so their good performance is recognised, and this information is given below:

Directorate	Organisation	Headcount	Compliance
Pathology Directorate	153 Haematology 11340	27	100.00%
Finance & Commercial Services	153 Information 13541	19	100.00%
Informatics Directorate	153 Poole IT Services 13586	28	98.57%
Cardiac Directorate	153 Cardiac Pre Assessment 11522	16	98.18%
Elderly Care Services Directorate	153 Dietitians 13315	14	98.02%
Cardiac Directorate	153 Cardiac Rehab 11527	17	95.83%
Ophthalmology Directorate	153 Eye Acute Referral Unit 10485	21	95.18%
Pathology Directorate	153 Microbiology 11380	22	94.76%
Outpatients Directorate	153 Outpatients Booking Staff 10603	56	94.39%
Finance & Commercial Services	153 Finance 13575	19	94.21%

Information Governance is a current area of focus, with all non-compliant staff receiving individually addressed emails from the Director of Informatics stressing the importance of completing this training and urging them to undertake the e-learning as soon as possible.

It has also been identified that there is a delay in reporting from ESR. Informatics are aware and are developing an appropriate fix but this can affect the absolute veracity of the data. The Essential Core Skills committee is meeting shortly and will review the planned programme for 16/17, including

3. Sickness Absence

The Trust-wide sickness rate shows a very small increase at 3.91% (3.9% last month), which represents an amber rating.

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

Directorate	Organisation	Headcount	Absence Rate
-------------	--------------	-----------	--------------

153 Outpatients Directorate	153 Outpatients 10370	37	12.51%
153 Elderly Care Services Directorate	153 MFE IP Therapy 10581	18	10.34%
153 Medicine Directorate	153 Medical R.E.D.S. 11536	13	9.30%
153 Surgery Directorate	153 Colorectal Ward 16 10427	34	9.14%
153 Elderly Care Services Directorate	153 MFE Ward 4 10382	29	9.02%
153 Surgery Directorate	153 Surgical Admissions Unit 10535	24	8.60%
153 Maternity Directorate	153 Community Midwives 10515	38	8.22%
153 Surgery Directorate	153 Urology Ward 15 10426	36	7.63%
153 Elderly Care Services Directorate	153 MFE Ward 5 10378	36	7.43%
153 Orthopaedics Directorate	153 Ward 7 10590	38	7.16%

Reports to Board will also now include those areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rate
153 Pathology Directorate	153 Medical Staff - Histology 11300	11	0.00%
153 Surgery Directorate	153 Surgery - Urology 10084	20	0.03%
153 Surgery Directorate	153 Obs/Gynae Medical Staff 10100	16	0.18%
153 ED Directorate	153 ED Medical Staff 10015	71	0.35%
153 Ophthalmology Directorate	153 BEU Ophthalmic 10110	29	0.37%
153 Elderly Care Services Directorate	153 Dietitians 13315	16	0.49%
153 Surgery Directorate	153 Surgery - General 10085	39	0.52%
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	45	0.57%
153 Surgery Directorate	153 Cancer Nurse Specialist 10425	11	0.58%
153 Specialist Services Directorate	153 XCH Derm. Med Staff 10030	18	0.60%

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.

The audit of sickness absence highlighted last month has now commenced and outputs from this will be shared with the Board when available.

4. Turnover and Joiner Rate

Joining and turnover rates of 14.7% and 12.4% respectively remain unchanged from last month.

5. Vacancy Rate

The vacancy rate of 4.9% is down from 5.2% at the previous month end.

6. Safe Staffing

Safe Staffing Unify data for December 2015:

RN Day fill rate	81.3%
HCA Day fill rate	95.7%
RN Night fill rate	98.3%
HCA Night fill rate	117%

Overall the Safe Staffing actual against planned remains above 80% on aggregate. A process for review and mitigation is in place with the senior nursing team. Where mitigation is not immediately managed a “red flag” can be raised (against a locally agreed criteria) and the situation further appraised with the escalation to the senior nursing team in and executive on call out of hours. This is supported with the operational teams in terms of patient placement and clinical site team support.

Local mitigation by wards and departments are reviewed and the main themes for the planned against actual variance are provided in the reading room. December is the first month where all the Monitor Agency cap was introduced and the ward RN actual % are lower than previous months. Most have been mitigated by redeployment of staff after local review and judgements have been made across directorates.

7. Recruitment

Strong focus on recruitment continues. 18 EU nurses are currently undertaking their IELTS (English Language) tests with a view to starting with the Trust end January - February.

We continue to plan our attendance at relevant recruitment and careers fairs, and HCA recruitment days were held on the Saturday 12th December and 16th January which produced 18, and 12 successful candidates to join the temporary staff bank.

There is a wide variety of events being developed and we are planning the timetable of recruitment activity for 2016-17 at the moment and will be reviewing these plans through the workforce committee and executive director meetings.

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BOARD OF DIRECTORS	
Meeting Date:	29 th January 2016, Part 1
Subject:	Mortality Report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Yes
Officer with overall responsibility:	Basil Fozard, Medical Director
Author(s) of papers:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	
Action required: Approve/Discuss/Information/Note	Information/Note
Executive Summary: The Trust received a recent NHS England letter regarding potentially avoidable deaths and Trust mortality processes. This paper describes the Trust position on these and the actions arising.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Safety
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	No No

MORTALITY REPORT

Introduction

NHS Trusts received correspondence prior to Christmas, from Professor Sir Bruce Keogh and Dr Mike Durkin (Annexe A), commencing a process of self-assessment of avoidable mortality and providing guidance for the processes that trusts should undertake with respect to mortality governance.

The document asks trusts to undertake a basic analysis using a provided template to determine if there are opportunities beyond the existing to learn from potentially avoidable deaths.

In addition to the above the Trust Medical Director has discussed this document with the Trust Consultant Lead for Mortality (Dr Tiwari) has assessed our compliance with the specific guidance attached to the letter (Annexe B) This has resulted in a series of actions (below) where we deem ourselves to be non-compliant or where we believe further improvements could be made.

Avoidable Mortality

The purpose of this calculator is to challenge trusts to identify opportunities to learn from potentially avoidable deaths, using findings of the recent Hogan et al. study (<http://www.bmj.com/content/351/bmj.h3239>) to identify the typical number of deaths with more than a 50/50 chance that the death was attributable to problems in healthcare.

The calculations take into account the following:

- A calculation of the likely no of deaths that might have a greater than 50% chance of being avoided (77)
- Our expectations about whether we would be typical re quality of care/expectations of deaths (Typical)
- No of potentially preventable deaths based on mortality reviews (12) incorporating the proportion of deaths that are reviewed (46%)
- No of deaths attributable to a patient safety incident (4)
- No of serious incidents relating to potentially avoidable deaths (reported to STEIS) (0) – this is not a figure we have reported to STEIS

The spreadsheet calculates that we could potentially have a further 65 opportunities for investigation and learning each year, from 2,525 deaths.

Actions Arising from the Guidance

Governance

- All deaths will have a consultant review

- The Medical Director will report annually to Part One of the Board of Directors meeting and monthly to the Healthcare Assurance Committee (HAC), a subcommittee of the Board of Directors
- Junior medical staff must discuss death certification of individual patients with the relevant consultant(s)

Terms of Reference for Mortality Group

- Change title of Mortality Committee to Mortality Surveillance Group (MSG)
- Change reference to “notes review” to “mortality review”
- Extend invitations to the MSG to CCG and to HealthWatch

Amendments to eMortality Form

- The mortality form will be adjusted to include:
 - venous thromboembolism and nutrition issues
 - whether the death was expected at the time of admission (yes / no)
 - source of admission
 - adoption of the Confidential Enquiry into Stillbirths in Infancy (CESDI) mortality classification bandings:

Grade 0- Unavoidable Death, No Suboptimal Care,
Grade 1- Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).

Audits

- MD to contact Dr Cranshaw to establish the full list of relevant national audits
- Actions arising from these audits need to come to the MSG on a calendarised basis

Other

- Dr Tiwari up will establish a system for the review of patients that die within 24 to 36 hours of admission, including source of admission
- The Complaints Manager will alert MSG to any complaints relating to a death and the resulting action plan. We will look for clusters, for example, wards / procedures / clinicians

- Undertake an annual notes review, or pathway walk through on high risk patient groups including pneumonia, congestive cardiac failure, sepsis, stroke and acute kidney injury

The following individuals will lead these reviews:

Pneumonia – Dr Dawn Edwards

Sepsis – Dr David Martin

Heart failure – Dr Chris Critoph

Stroke – Dr Becky Jupp

Acute Kidney Injury – Dr Helen Partridge

Conclusion

The first part of this self-assessment process for this Trust would suggest that there are significant further learning opportunities available in our further pursuit of reduction in avoidable deaths. These opportunities will be exploited by a fuller use of the eMortality system and by delivery of the other actions indicated in this report.

Most of the recommendations in the text guidance (Annexe B) have been in place in the Trust for some time, but we need to ensure their complete adoption and consistent application. This will constitute a further workstream in early 2016 for the re-named Mortality Surveillance Group.

The Board is asked to Note this Report:

Pages 1-3 of the report and reference Annexe A,B and C in reading room.

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BOARD OF DIRECTORS

Meeting Date and Part:	29 January 2016 Part 1
Reason for Part 2:	N/A
Subject:	One NHS in Dorset - Vanguard
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	Draft Value Proposition Draft Terms of Reference for various groups Workstreams Update
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	Previous Board meeting, Trust Management Board meetings
Action required: Approve/Discuss/Information/Note	For decision
<p>Executive Summary:</p> <p>The paper provides a summary of ongoing work to establish the Vanguard. It asks for a specific decision to delegate authority for the CEO to sign off submission of the Value Proposition.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	All
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	<p>i. Provider sustainability and taking forward the CSR</p> <p>ii. No</p>

One NHS In Dorset - Vanguard

The purpose of this paper is to apprise the Board of on-going work to establish and advance the Vanguard One NHS in Dorset. I have placed a number of items within the Reading Pack including an updated draft of the Value Proposition and a draft of the proposed Terms of Reference for the various governance and activity groups including:

- The Chair and CEO Oversight Group
- Executive Steering Group
- Stakeholder Engagement Group
- Oversight Group of Medical Directors and Chief Operating Officers
- Project Team membership
- Supporting work stream activity groups

I would welcome comment on the draft Value Proposition which requires submission to the New Care Model team on 8 February and on the Governance framework. I am also asking for the Board's agreement for me to sanction, on behalf of the Board, submission of the final Value Proposition in concert with the Chief Executives of Poole Hospital FT and Dorset County Hospital FT.

With regard to the Value Proposition itself, this will be evaluated by a combination of members of the New Care Model Programme team and representatives of the Five Year Forward View arms-length bodies as well as patient and Vanguard representatives during the first week in March. From this recommendations are made to the National Investment Committee which will meet on 14 March to consider and approve proposals. We will, therefore, hear the outcome of the consideration of our proposal, and the associated funding around about the 16/17 March.

Supporting Infrastructure for the Vanguard Work

Three phases of appointments are proposed to support and underpin the Vanguard work. The first series of appointments relate to securing a Programme Director and a Project Management Team. That recruitment is underway. The three Chief Executives have agreed that Debbie Fleming will initially act as the Senior Responsible Officer for the Vanguard and that this role will rotate with either myself or Patricia Miller taking on the role in November 2016. It is anticipated that we will have a Programme Director in post by March 2016.

The second phase of appointments focuses on the establishment of the infrastructure necessary to allow work to progress with regard to the organisational development support for individual Boards and the Vanguard Board and to help advance a joint approach to IT across the whole of Dorset, as well as programme management support to the various clinical work streams. The sequencing of these

appointments will be agreed by the Chief Executives, a number of which will need to await confirmation of the funding for 16/17 and 17/18.

A third tranche of appointments is specifically designed to create headroom amongst clinical directors, lead clinicians and executive directors to support this activity. Each executive director has been asked to identify what support is necessary to allow them or a nominated colleague to contribute to the Vanguard work in line with the Value Proposition that has been developed.

Subject to the agreement of the Chairman, it is proposed that the Chairs and Chief Executives oversight group is chaired by an independent Chair.

Progress of the Clinical Work streams

Highlighted within the Reading Pack is a brief synopsis of the progress made to date by each of the clinical work streams. The Board should note that all three Trusts have received an approach from the Diabetologists asking if Diabetes can join the Vanguard work stream and this is a proposal I would wholeheartedly endorse. It is also likely that we will shortly establish a Pathology work stream.

There are a range of issues affecting the pace at which work can progress with each of the clinical work streams, these include:

- The need for clinical backfill in order to allow sufficient time for the detailed work required to drive forward a standardised approach to providing each clinical service on a more consistent basis across Dorset
- Each work group has been asked to identify a clinical lead, where this may prove problematic Medical Directors and Chief Operating Officers have been asked to oversee the appointment of a lead
- The development of high-speed IT links is an essential feature of the work of some work streams, particularly imaging, and it will take time and the agreement of a clear unified strategy in order to establish links between the east and the west.
- Refining the composition of the clinical working groups to ensure the right people are engaged in work both from a secondary and primary care perspective.

Although initially identified as an obstetric work stream the clinical teams across the three Trusts have extended the work to cover **Women's Health services** including Maternity. The Women's Health Work stream will focus on integrated and uniform care pathways covering pregnancy, pre-conception care, gynaecological cancer, pelvic floor medicine, ambulatory gynaecology, and pelvic pain services. Future topic is likely to include peri-natal mental health services. **The paediatric work stream** is less well advanced and will need to include representatives from third sector organisations and the community trust in order to advance and develop a range of integrated services across Dorset. There is also an appetite on behalf of the Dorset County Hospital clinicians to combine services with Yeovil.

In contrast, the **Ophthalmic group** is well advanced and in particular there is focus on working more closely together in order to strengthen the provision of services in the west as well as developing a more integrated approach between primary, community and secondary care services.

The **non-surgical cancer work stream** is currently considering whether to utilise a Capita horizon tool in order to model projected changes in demand and configuration as a means to developing a forward strategy for provision of these services. This work group is less advanced than some.

The **imaging work stream** has made progress and the primary focus is on enabling Dorset-wide image sharing and a combined reporting capability. Much of the activity within imaging is underpinned by enabling IT. This requires, in turn, an agreement between the Trusts in the east who have the same PACS system and Dorset County Hospital with regard to the likely changes that need to be made at Dorset County in order to establish a more collective approach to the provision of information across the three sites.

The **cardiology work stream** has been focusing on enhancing preventative and pro-active care management ensuring timely access to the right expertise transforming the acute episode of care and improving discharge and re-ablement. There is some overlap between this and the **Stroke work stream** which is considering effective discharge outside of the acute system. It is anticipated that this work group will advance proposals for a high acuity stroke unit within Dorset and changes to the TIA service.

The other two work streams focus on **IT** with Peter Gill representing both RBCH and Poole Hospital, Peter is making good progress with his counterpart Mike Sinclair reviewing options to create a single informatics strategy for the three acute trusts. It has been agreed that the Directors of Finance will lead work to consider the wider defining of the **back office services**, including transactional activities which will be developed on an integrated single point of access, going forwards. At this stage the progress of all of these groups is governed by the need for further support and therefore early confirmation from the New Care Model team of the resources allotted to support the Vanguard activity.

Competition Implications in the Development of the Joint Venture Model

Discussion took place last week with Catherine Davies from Monitor who helpfully advised on a suggested approach to the Competition and Markets Authority. It is anticipated that by the end of March the three Trusts will be in a position to initiate an initial discussion with the CMA which will be focused on an explanation of the Vanguard work and in particular the patient benefits to be secured by the Vanguard itself. These benefits will need to be granular and focused on each of the key clinical working groups. The CMA will want to consider whether the changes proposed in service provision present a relevant merger situation in which case they may wish to launch a formal investigation.

Alongside this discussion the Trusts will also share their thinking regarding the Joint Venture Vehicle to provide a basis for taking this work forward. It is proposed that Sharon Lamb, a partner with Capsticks, attends either the February or March Board meetings of each of the three Trusts in order to run a seminar for Board members focused on understanding the wider implications of establishing a Joint Venture Vehicle. As a consequence of these seminars and the discussions which take place a paper will be developed setting out a range of proposals and a preferred option, initially for consideration by the Chairs and Chief Executives and subject to their agreement, this paper would then be presented to each Board for consideration in order to allow the development of a Joint Venture Vehicle (JVV). The advice received to date suggests that a contractual JVV is best likely to meet the needs of the three organisations. Within this each Trust would have a 33% joint and equal share ensuring collective decision making on all points. Such an arrangement would allow clinical staff to continue to be employed within their current organisations; it would require one of the parties contracting directly with the CCG without any advantage conferred upon that party such a JVV would allow the three Trusts to work through the arrangements for sharing risks and benefits as a consequence of work proposed to reshape clinical and non-clinical services.

Board Decision

The Board is asked:

- i. To delegate to the CEO authority to sign off and agree the Value Proposition due to be submitted on 8 February.
- ii. To offer comment or ask questions in relation to the progress detailed in this paper.
- iii. Consider any other relevant issues it wishes to highlight.

Tony Spotswood
Chief Executive

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016, Part 1
Subject:	Trust Objectives 2016/17
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	
Action required: Approve/Discuss/Information/Note	To comment on the draft objectives
Executive Summary: The Board is asked to consider this set of draft objectives for 2016/17 and, offer comments on them.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All of these
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

Trust Objectives 2016/17

Background

I have set out below a first draft of the proposed objectives the Board is asked to consider and comment on for the organisation for 2016/17. There is a natural correlation between the Board objectives we set for 2015/16 and those proposed for the coming year. Traditionally the Board has tracked the performance of the organisation against these objectives through a series of key metrics which we report on a quarterly basis. Generally, our performance against our corporate objectives has been strong, often demonstrating achievement or significant progress towards quantified outcomes. It is proposed that the objectives agreed by the Board provide a central framework and become the basis for individual objective setting across the whole organisation. Specifically it is expected that every member of staff will agree objectives which reflect the following themes:

- **The Quality of Care** ensuring it is safe compassionate and effective.
- Creating a **culture of transparency and learning**; demonstrating the Trust vision, mission and values in everything we do
- **Improvement.** All staff will have an improvement objective, it will either focus on one of the five priority areas for the Trust or be localised to their area if it does not directly contribute to one of the priorities identified without corporate objectives. All staff should, however, focus on how their services can be improved.
- A focus on their **personal and professional development and team work.**
- **Performance.** Their personal contribution towards ensuring that the Trust meets the standards and targets which govern the delivery of our services.
- **Value for Money.** The responsibility all members of staff have to ensure the Trust operates within an agreed budget using resources wisely and cutting waste to allow as much resource as possible to go to front line patient care.

There is an important balance to be struck when considering the objectives we set for the Trust between, on the one hand, the need for these to be clear and measurable and on the other, the importance of not over-specifying to the point that they fail to be relevant to the broader church of staff or lack ownership and connectivity due to their relevance to small defined areas of the Trust. I have sought to establish the balance necessary between the two positions.

Draft Objectives 2016/17

I have detailed below the draft Trust objectives, including the proposed metrics that will underpin our monitoring of the progress we have made. The final section of this paper provides a simple summary explanation. I have, however, set them out below in their full form.

1. To continue to improve the **quality of care** we provide to our patients ensuring that it is safe, compassionate and effective, driving down variations in care whilst ensuring that it is informed by, and adheres to, best practice and national guidelines. Our specific priorities are:
 - Creating a **fair and just culture**; being transparent when things go wrong and **embedding learning**, measured by a reduction in Serious Incidents and avoidance of Never Events
 - Promoting the **recognition of avoidable mortality** and potential links to deficiencies in care by **improved and comprehensive eMortality review**. Monitor eMortality review compliance and ensure lessons are disseminated and actions completed.
 - Ensuring patients are cared for in the most appropriate place for their needs by:
 - **Improving the flow** of patients and reducing the average number of outlying patients and non-clinical patient moves by at least 10%.
 - Supporting more patients who want to die at home to achieve this.
 - To deliver consistent standards in quality care for our patients demonstrated by further improvements in **reducing the number of avoidable pressure ulcers and falls** which happen in our hospital in 2016/17 by a further 10%, measured through Serious Incident Reports
 - To ensure that there are **no MRSA cases** and that the Trust achieves its target of **no more than xx Clostridium Difficile cases** due to lapses in care
 - To be within the **top quartile of hospital reported patient satisfaction** via the Family and Friends Test
 - To address all issues highlighted within the **CQC Report** during 2016/17
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:
 - **Improve the management of sepsis**, ensuring we implement 'sepsis 6' within one hour of patients being identified as having severe sepsis or being in septic shock
 - 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.
 - Implement internal professional standards - '**5 Daily Actions**' and a new frailty pathway to improve hospital flow and ensure every patient has the right care, in the right place, at the right time

- Improve **surgical productivity and operating theatre efficiency** to reduce 'lost' theatre time and release patient slots. This will include a reduction in variation, removing waste and improving flow across elective pathways in orthopaedics and urology
 - **Reduce last minute clinic cancellations** by 50% and **DNA rates** to an average of 4% in outpatients through more effective utilisation of current resource and standardisation of clinic templates
 - Applying standards of care for all patients undergoing **emergency laparotomy** with the aim of maintaining mortality below 5%
 - Uniform use of **surgical checklists** across the whole organisation with the intention that there are no Never Events associated with failure to use checklist. Monitor compliance, response and better education.
 - Implementing the **NICE guidelines for patients referred with suspected GI cancer** ensuring a minimum of 93% of patients receiving an appointment within two weeks.
 - To **embed the use of VitalPac** within the Trust and its application as a trigger tool for escalation. Development of a **clear escalation protocol** and the accompanying education. Measurable reduction in SIs related to lack of escalation.
 - **Exploit the opportunities for automation** using advanced IT systems where possible, to reduce human error.
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:
- To ensure **all staff have a values based appraisal and agreed personal development objectives** which reflect both the needs of the service and their own development requirements
 - Providing support and interventions for the **health and wellbeing of our staff**.
 - Providing appropriate **education, training and development opportunities and support** for staff, and demonstrate the return on investment for the organisation.
 - To develop and implement a **comprehensive leadership and organisational development strategy** which reflects the organisation's values and views of staff and focuses on good organisational health and a positive development and learning culture.
 - To build the management and leadership capability of the Trust through the development of a **comprehensive leadership development programme** that reflects the needs of the Trust and individuals at all levels who are managing and leading services.

- To **strengthen levels of staff engagement** within the Trust, creating opportunities for staff to contribute to the design and delivery of services and improvement ideas. This engagement will be measured by an improvement in the national Staff Survey (2016) engagement scores and by an increase in the quarterly Staff Impressions measure of engagement.
 - To **promote collective responsibility for the success of the Trust** and greater autonomy for staff to manage and deliver their services, within a clear framework of responsibility and accountability.
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:
- To implement the **Trust's strategy** within the context of the *emerging Clinical Service Review* being led by Dorset CCG
 - To establish the **Vanguard "One NHS in Dorset"** and implement proposals to unify and standardise patient pathways, thereby strengthening the quality of service for patients across Dorset in the following areas of maternity, paediatrics, stroke, cardiology, imaging, ophthalmology, non-surgical cover and diabetes. This will be taken forward throughout 2016.
 - To develop proposals to evaluate the introduction of an **integrated pathology service** for Dorset. Proposal developed for the conurbation by 2017.
 - To establish a **joint venture vehicle** by November 2017 to facilitate provision of a range of Dorset wide hospital services
 - Work with the Dorset Community Trust, primary care and local authority partners to extend the range of services available to **support patients discharged from hospital** and to help local people maintain their independence and health without recourse to admission to hospital.
 - To shape and develop proposals to support and agree a **new model of care** for hospital and out of hospital services, promoting the **Royal Bournemouth Hospital as a future major emergency site for Dorset and West Hampshire residents**
 - To establish a **dedicated private patients facility** by April 2017
 - To complete work to create an **integrated community hub** offering a range of services and facilities at Christchurch including radiology, outpatients, a GP practice, and a community pharmacy
 - Implement the **resilient Data Network**, telephone system and refreshed computer room.
 - **Embed Electronic Document Management (EDM)** so that it no longer appears on the Trust's risk register.
 - Undertake all the necessary preparatory work to enable RBCH to move to Graphnet **Electronic Patient Record (EPR)** by April 2017.
 - Implement **Order Communications** in the four diagnostic areas

- Achieve **full compliance with the IG Toolkit**.
 - Participate in the development of a **joint informatics strategy** for the three acute trusts in Dorset
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
 - 93% of patients referred using the **fast-track cancer pathway** being seen within 14 days of referral
 - 93% of patients referred to the **symptomatic breast clinic** seen within 14 days of referral
 - 96% of patients **diagnosed with cancer** receiving treatment within 31 days
 - 85% of patients **receiving their first treatment** within 62 days of urgent GP referral with suspected cancer.
 - 95% of patients admitted within 18 weeks of referral and requiring **elective treatment**
 - 95% of patients seen within **18 weeks of referral** when no admission is required
- A key deliverable linking the above will be the need to deliver the performance targets associated with the 16/17 Sustainability and Transformation fund.
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. The Trust will fully engage with the Lord Carter of Coles work to assist with the objective to improve the productivity and efficiency including reporting and sharing data in line with the national timetable and compliance with the NHS Improvement agency controls guidance

Summary

The objectives outlined above are naturally detailed when including the metrics that underpin attainment of the objectives. However, it is important that the Trust objectives are widely understood and owned within the Trust. I am therefore proposing the following summary to capture our work and focus.

- **Quality** - providing safe, effective and compassionate care
- a **culture of transparency and openness** demonstrating our vision, mission and values in everything we do.

- **Improvement** - using the QI methodology to support achievement of the Trust priorities
- **Strategy and Partnerships** - to have a clear strategy that responds to the Clinical Service Review and provides a basis for maintaining viable high quality services through until its implementation
- **Staff** - focusing on good organisational health with a positive development and learning culture, strong leadership and team work
- **Performance** - delivering the performance required to maintain access to elective diagnostic and emergency services
- **Value for Money** - staying within budget using resources wisely and cutting waste to allow the maximum funding to go to front line patient care

Decision

The Board is asked to consider this set of draft objectives for 2016/17 and, offer comments on them.

Tony Spotswood
Chief Executive

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BOARD OF DIRECTORS

Meeting Date and Part:	29 th January, Part 1
Subject:	Trust Annual Planning Guidance and Timetable
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	
Action required: Approve / Discuss / Information/Note	For Information
Executive Summary: <p>This paper lists the national priorities that need to be reflected in plans, describes the content expected in the Annual Plan for 2016/17 and notes the Trust timetable in responding to the annual planning guidance issued by Monitor</p>	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All of these
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	

Trust Annual Planning Guidance and Timetable

1. Introduction

The annual planning guidance has been issued recently by Monitor and requires the production of a one year annual plan by April 11th (draft by February 8th) and a Sustainability and Resilience Plan (STP) for all health economies (i.e. multi-organisational) by end June 2016.

The footprint for the latter has been agreed as the count of Dorset and it is likely that this will be largely drawn from Vanguard and Clinical Services Review plans.

The primary guidance (Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21) was issued before Christmas, indicates that the Annual Plan will have two principal components – a series of spreadsheets outlining the expected financial position for 2016/17 and a 25 page narrative to go alongside this. The development of these (has been recently supplemented by a series of annexes, describing expected content and priorities.

In addition to the normal planning round there is a large funding top up available (£7.6m) for completion of an agreed STP, and delivery of financial control limit and savings plan, plus all the key national standards such as waiting times, plus a range of other issues in the “must do list.” Further details are emerging and the Board will be updated at the meeting.

This paper lists the national priorities that need to be reflected in plans, describes the content expected in the Annual Plan for 2016/17 and notes the Trust timetable in responding to the annual planning guidance issued by Monitor.

2. National Priorities

The various guidance documents for this year's planning round have indicated the 9 “must do’s”, with the specific components of these that are particularly relevant to us in bold:

The guidance indicates

1. Develop a high quality and agreed STP
2. Return the system to aggregate financial balance.
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
4. Get back on track with access standards for A&E and ambulance waits
 - **ensuring more than 95 percent of patients wait no more than four hours in A&E**
 - **making progress in implementing the urgent and emergency care review and associated ambulance standard pilots**

5 & 6. Improvement against and maintenance of the NHS Constitution standards

- **that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice**
- **62 day cancer waiting standard, including by securing adequate diagnostic capacity**
- **continue to deliver the constitutional two week and 31 day cancer standards**
- **make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two**
- **reducing the proportion of cancers diagnosed following an emergency admission**

7. Achieve and maintain the two new mental health access standards

- **Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia**

8. Deliver actions set out in local plans to transform care for people with learning disabilities

9. Develop and implement an affordable plan to make improvements in quality. In addition providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

There is no further guidance in relation to 9, other than a separate letter and explanation of an approach to “avoidable mortality” which is being followed up separately by the Medical Director.

In addition to the above there are three further strategic imperatives, which have longer time frames (2020):-

- 7 day services
- Paperless NHS
- New Care Models

Finally, the Carter Report is being discussed across the Trust with a view to addressing the issues raised that specifically relate to RBCH. This was the subject of an earlier Board paper.

3. Trust Priorities and Planning Process

In addition to accommodating national priorities we also need to recognise and reflect our local priorities in our objectives for 2016/17. Specifically, it is suggested that we need to include:

- Greater focus on emergency flows, to help address the root cause of many issues and thus improve quality, finances, and workforce, as well as deliver the 4 hour target
- Our desire to become the major emergency hospital for Dorset

- The national policy intention to deliver a 7 day NHS
- Address all performance targets, recognising the risks for elective, diagnostics and cancer waits, as well as particular difficulties we have with 4 hour waits in ED
- Address the difficulties associated with manpower deficits in a variety of professions

The clinical and non-clinical directorates have been tasked with producing a half to one page narrative describing the major issues (clinical, operational and financial) they are facing, incorporating any relevant carry over from the current 15/16 year.

Alongside this they are completing a set of “Major Actions” for 16/17, cross-reference against the headline Trust objectives from 15/16. These will be monitored in-year via the quarterly Care Group performance management process.

An overall timetable showing the Trust processes in delivering the draft and substantive annual plan documents to the Monitor target is at Annexe A.

4. Annual Plan Document

The guidance provides more detail on the expected constituents of the annual plan for 2016/17 and the chapters and length of these is indicated as follows:

- Approach to activity planning (max 2 pages)
- Approach to quality planning (max 4 pages)
- Approach to workforce planning (max 4 pages)
- Approach to financial planning (max 6 pages)
- Link to the emerging ‘Sustainability and Transformation Plan’ (STP) (max 2 pages)
- Membership and elections (NHS foundation trusts only) (max 1 page)

The principal guidance supporting each of these sections is at Annexe B. Each of the above sections have been assigned to Trust Executive Directors and a draft plan will be submitted to Monitor by the February 8th deadline.

5. Conclusion

At both macro and micro levels we are in a good position to develop and execute annual and strategic plans in line with NHS priorities and Monitor expectations. As a result of our extensive efforts in developing our long-term strategy last summer, participation in the Dorset Clinical Services Review and the agreement to a Dorset Vanguard development in which we are a partner, we are well placed as a Trust and health economy to develop a coherent, agreed and deliverable Sustainability and Transformation Plan for Dorset. The specific priorities set for the NHS for 2016/17 and the process for developing the Annual Plan, are benefiting from a self-assessment we did some years ago as part of a Monitor strategy development process, which recognised the need to strengthen our planning and strategy capability including developing our proficiency in understanding demand and capacity. As well as this we have invested heavily in recent years in improving our staffing overall, our evening and weekend services, developing a Quality

Improvement programme and more recently a strong focus on budgetary control and cost improvement delivery. The combination of these factors puts us in a good position to plan and deliver excellent services, in line with national priorities, for our patients in 16/17 and beyond.

6. Recommendation

The Board is asked to note this report

Appendix A

<u>Planning Timetable Dec 15-Apr 2016 incorporating dates from Monitor</u>	Date of Meeting / Milestone [papers by]
Trust Strategy 2015-20 refresh, including speciality / directorate specific versions	√ Completed – Summer 2015
Governor Strategy / Plan Event	√ 16 th Dec
Formal Monitor Guidance published (Require 16/17 operational plan & 3 year system wide plan (CCGs and providers))	√ 22th Dec
<u>January 2015</u>	
Initial directorate / speciality headlines, incorporating Monitor requirements	22 nd January
<u>February 2015</u>	
Council of Governors	3 rd Feb
TMB (Final version of draft)	5th Feb [26th Jan]
Submission of draft 16/17 plan to Monitor	8th Feb 15
Finance Committee	24 th Feb
Board Strategy Group	25 th Feb
Board of Directors	26 th Feb [16 th Feb]
<u>March 2015</u>	
TMB	4 th Mar [23 rd Feb]
Governors Training Session	18 th Mar
Finance Committee	23 rd Mar
Board Strategy Group	24 th Mar
<u>April 2015</u>	
Board of Directors (Final Version)	1 st April [21 st Mar]
TMB (Final Version)	8th Apr [24th Mar]
Submission of final 16/17 plan to Monitor	11th April 15
Council of Governors	13 th Apr
Q1 Care Group Review against strategy & plan	
Q2 Care Group Review against strategy & plan	
Q3 Care Group Review against strategy & plan	
Q4 Care Group Review against strategy & plan	
3 year system wide Sustainability and Transformation Plan (STP) plan (CCGs and providers)	End June 2016

Appendix B

- **Provider plans must do the following:**
 - plan for a reasonable and realistic level of activity & demonstrate the capacity to meet this
 - provide adequate assurance on the robustness of workforce plans and the provider's approach to quality
 - be stretching from a financial perspective, taking full advantage of efficiency opportunities (including those identified by Lord Carter and the new rules around agency)
 - demonstrate improvement in the delivery of core access and NHS Constitution standards
 - contain affordable, value-for-money capital plans that are consistent with the provider's clinical strategy and clearly demonstrate the delivery of safe, productive services
 - be aligned with commissioner plans, and underpinned by contracts that balance risk appropriately
 - link to the local health and care system's emerging STP, the requirements for which are set out in Delivering the Forward View: NHS planning guidance 2016/17 to 2020/21
 - be internally consistent between activity, workforce and finance plans.
- **Structure of Annual Plan for 2016/17**
 - Approach to activity planning (max 2 pages)
 - Approach to quality planning (max 4 pages)
 - Approach to workforce planning (max 4 pages)
 - Approach to financial planning (max 6 pages)
 - Link to the emerging 'Sustainability and Transformation Plan' (STP) (max 2 pages)
 - Membership and elections (NHS foundation trusts only) (max 1 page)
- **Approach to activity planning (max 2 pages)**
 - its activity plans for 2016/17 are based on outputs from:
 - the demand and capacity approach for 2016/17
 - demand and capacity modelling tools that have been jointly prepared and agreed with commissioners
 - its activity returns are underpinned by agreed planning assumptions, with explanation provided as to how these assumptions compare with expected growth rates in 2015/16
 - it has sufficient capacity to deliver the level of activity that has been agreed with commissioners. It would be helpful for providers to indicate their plans for using the independent sector to deliver activity, highlighting volumes and type of activity if possible
 - its activity plans are sufficient to deliver, or achieve recovery milestones for, all key operational standards, and in particular Accident and Emergency (A&E), Referral to Treatment (RTT) Incomplete, Cancer and Diagnostics waiting times. Reference should also be made to any explicit plans agreed with commissioners around:
 - extra capacity as part of winter resilience plans, for instance extra escalation beds
 - arrangements for managing unplanned changes in demand.
- **Approach to quality planning (max 4 pages)**
 - Approach to quality improvement
 - Seven Day Services
 - Quality impact assessment process
 - Triangulation of indicators

- **Approach to workforce planning (max 4 pages)**
 - articulation of a robust approach to workforce planning with clinical engagement
 - the governance process for board approval of workforce plans
 - a clear link to clinical strategy and local health and care system commissioning strategies
 - specific reference to local workforce transformation programmes and productivity schemes, including impact on workforce by staff group
 - the effective use of e-rostering and reduction in reliance on agency staffing
 - alignment with Local Education and Training Board plans to ensure workforce supply needs are met
 - triangulation of quality and safety metrics with workforce indicators to identify areas of risk
 - the application and monitoring of quality impact assessments for all workforce CIPs
 - plans for any new workforce initiatives agreed with partners and funded specifically for 2016/17 as part of the Five Year Forward View
 - balancing of agency rules with the achievement of appropriate staffing levels
 - systems in place to regularly review and address workforce risk areas.
- **Approach to financial planning (max 6 pages)**
 - Financial forecasts and modelling
 - Efficiency savings for 2016/17
 - Lord Carter's provider productivity work programme
 - Agency rules
 - Procurement
 - Capital planning
- **Link to the emerging 'Sustainability and Transformation Plan' (STP) (max 2 pages)**
 - briefly articulate the following in their 2016/17 operational plan narratives:
 - an early view of what the vision for the local health and care system's STP might include, including the provider's own role in this
 - any elements of the local health and care system's early strategic thinking that might affect the provider's individual, organisational operational plan for 2016/17: for instance setting out the most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.
- **Membership and elections (NHS foundation trusts only) (max 1 page)**
 - high-level narrative on membership and elections, including:
 - governor elections in previous years and plans for the coming 12 months
 - examples of governor recruitment, training and development, and activities to facilitate engagement between governors, members and the public
 - membership strategy and efforts to engage a diverse range of members from across the constituency over past years, and plans for the next 12 months.

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BOARD OF DIRECTORS

Meeting Date and Part:	29 January 2016 – Part 1
Subject:	Information Governance (IG) Strategy
Section:	Decision
Supplementary Reading (inc in Reading Pack)	
Executive with Overall Responsibility	Peter Gill, Director of Informatics
Author of Paper:	Camilla Axtell, IG Manager
Details of previous discussion and/or dissemination:	IG Strategy agreed at the IG Committee in Dec 2015.
Action required:	For approval by the Board
Executive Summary: The IG Strategy sets out the purpose, resources, policies and management framework for the IG work at the Trust. It is a stipulation of the national IG Toolkit that this strategy is approved by the Board of Directors.	
Related Strategic Goals & Objectives:	Financial performance: compliance to the IG Toolkit is contractual requirement and the CCG may impose financial penalties for non-compliance.
Relevant CQC Outcome	Quality Management, 21 Records
Risk Profile:	1. Have any risks been reduced? No 2. Have any risks been created? No

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Information Governance Strategy

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	3	January 2016	January 2017	Information Governance Manager

Table of Contents

1. Introduction.....	3
2. Purpose and Scope	3
3. Senior Roles	3
4. Key Policies	3
5. Governance	4
6. Resources	5
7. Training and Guidance	6
8. Incident Management	6

1. Introduction

Information Governance provides a framework to bring together all the legal rules, guidance and best practice that apply to the handling of information. The Trust believes that accurate, timely and relevant information, protected as required and appropriate, is essential as a component of the highest quality healthcare. As such, it is the responsibility of all clinicians and managers to promote the quality and care of information used in decision-making processes.

2. Purpose and Scope

The purpose of this document is to set out the internal management structures and responsibilities and provide an overview of the policies and procedures to ensure the safe handling of all information in the Trust in accordance with the law, regulation, best practice and national guidance and minimising information risk within the Trust. Information Governance is the responsibility of every member of staff. The Information Governance Strategy is designed to inform everyone of their responsibilities and provide the structure that ensures compliance by the Trust and members of staff.

The document should not be considered in isolation as it forms part of the Trust's Integrated Governance approach to the management and monitoring of corporate and clinical governance, risk management and clinical effectiveness.

The scope of Information Governance is wide ranging and includes electronic and paper records relating to patients and service users and employees as well as corporate information. The goal is to embed best practice in the Trust so that sensitive and safe handling of all information is considered as part of normal business.

3. Senior Roles

The lead for Information Governance within the Trust is the Director of Informatics, who is also the Senior Information Risk Owner (**SIRO**) and the Named Data Protection Officer.

The SIRO is responsible for coordinating the development and maintenance of information risk management policies, procedures and standards for the Trust in the context of the Trust's overall risk management framework, and updating the Board regularly on information risk issues. The Director of Informatics has line management responsibility for the Information Governance Manager.

The Trust's Caldicott Guardian is the Medical Director. The Caldicott Guardian is the most senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

4. Key Policies

The Trust has the following Information Governance-related policies:

- Data Protection Policy
- Freedom of Information Policy
- Confidentiality and Disclosure Policy
- Safe Haven Policy
- Information Risk Management Policy & Procedures
- Corporate Records Management and Information Lifecycle Policy
- Health Records Strategy
- Health Records Retention and Disposal Policy
- IT Security Policy
- Risk Management Policy
- Adverse Incident Reporting & Management Policy
- Essential Core Skills Training Policy

Copies of the policies are available on the Trust's intranet and separate guidance on confidentiality and data protection is provided to all staff, governors and volunteers.

Policies are ratified by the appropriate committees and groups, a full list of which is included in the Trust's Document Control Policy.

Policies relating to health records management and subject access requests will be ratified by the Health Records Management Group and reviewed by the Information Governance Committee. IT related security policies will be ratified by the IT Steering Group and reviewed by the Information Governance Committee.

The Healthcare Assurance Committee is responsible for reviewing and approving the Risk Management Strategy which is ratified by the Board of Directors.

The Quality and Risk Committee is responsible for reviewing and approving the Serious Incident Policy and the Adverse Incident Reporting Policy.

The Essential Core Skills Training Group is responsible for reviewing the Essential Core Skills Training Policy which is ratified by the Workforce Strategy Group.

The Information Governance Committee is responsible for reviewing and approving the other policies which are ratified by the Board of Directors or the Healthcare Assurance Committee as required.

5. Governance

The Information Governance Committee is the key governance body with overall responsibility for delivering the IG agenda across the Trust. The IG Committee reports to the Healthcare Assurance Committee, which in turn is a sub-committee of the Board of Directors.

The Trust is audited on the basis of compliance with the laws and standards specified in section 4. Compliance is monitored internally through clinical audit, the results of which are reported through the Quality and Risk Committee and Healthcare Assurance Committee and internal audit which is reported through the Audit Committee. In addition the Information Governance Toolkit is completed each

year and the results are forwarded to the local Clinical Commissioning Groups, Monitor and the Care Quality Commission, all of which have powers to intervene in the running of the Trust in the event of failings in its healthcare standards.

Compliance with the IG Toolkit is used as one of the measures reported in the Quality Report and Annual Governance Statement in the Annual Report and Accounts. Compliance with Outcome 21 of the Care Quality Commission's essential standards is also assessed using a provider compliance assessment which is reviewed by the Information Governance Committee.

6. Resources

The Information Governance Manager is responsible for:

- ensuring compliance with legislation and standards for Information Governance and reporting performance to the Information Governance Committee;
- keeping new legislation and standards under review and ensuring appropriate amendments to policies and procedures are introduced;
- developing and reviewing the Information Governance action plan and reporting progress, risks and outcomes to the Information Governance Committee;
- reporting issues and risks relating to confidentiality to the Information Governance Committee.
- developing and maintaining relevant policies, standards, procedures and guidance;
- reviewing operational Information Governance issues that arise;
- providing a co-ordinating role for Information Governance within the Trust;
- communicating and raising awareness of Information Governance across the Trust.

The SIRO is also supported by Information Asset Owners (**IAOs**) who have been appointed by their respective departments/directorates, and who shall ensure that information risk assessments are performed at least once each quarter on all information assets where they have been assigned 'ownership', following guidance from the SIRO on assessment method, format and content. This process should reflect the policy and procedures for risk assessment adopted by the Trust more generally. IAOs shall submit the risk assessment results and associated mitigation plans to the SIRO for review at meetings of the Information Governance Committee.

The lead for Information Security Policy development is the Assistant Director of IT Operations.

The lead for Data Quality Policy development is the Head of Information.

The lead for Health Records management and subject access policy development is the Health Records Manager.

The lead for the Trust's Registration Authority (RA) function is the Director of Informatics. Responsibilities for the management and implementation of the RA

function including documenting a local RA policy have been allocated to the Assistant Director of IT Operations, who acts as the RA Manager.

The Trust has also nominated a Clinical Safety Officer who is responsible for the control of clinical risk associated with a new IT system roll out or change to an IT system to support compliance with ISB 0160.

All staff contracts contain clauses relating to data protection and confidentiality. These clauses alert staff to how their data will be used and their data protection rights and the consequences of breaching confidentiality in terms of disciplinary action and professional registration. Breaches of confidentiality are specifically referred to in the Trust's Disciplinary Policy and Procedure as an example of gross misconduct.

There is also a Code of Conduct for Staff which acts as a guide to all members on the required behaviours, responsibilities and actions expected of employees of the Trust. This has been produced in line with guidance issued by the Department of Health.

7. Training and Guidance

All staff, volunteers and governors receive Information Governance training as part of initial induction and annually thereafter. The Information Governance training programme covers staff at all levels, both clinical and non-clinical, and is detailed in full in the Information Governance Training Plan, which is reviewed annually for its effectiveness.

In addition, IAOs are given specific training by the IG manager, SIRO and other subject matter experts (e.g. the Director of Commercial Services) to ensure that they understand their duties and can complete their IAO tasks effectively.

8. Incident Management

Information Governance incidents should be reported and managed in accordance with the Trust's Adverse Incident Reporting Policy and Serious Incident Policy. The Quality and Risk Department will inform the Information Governance Manager of all adverse incidents which relate to Information Governance so that the Information Governance Manager can provide input and support to staff dealing with these incidents and monitor these as required. The reporting process for incidents which are suspected to be serious incidents is set out in Appendix D. Serious incidents are assessed using the HSCIC IG Serious Incident Requiring Investigation (SIRI) Reporting Tool and reported in accordance with the Serious Incident Policy supported by additional guidance used by the Information Governance Manager.

APPENDIX A

Legislative and Regulatory Framework

The Information Governance Strategy brings together all the requirements, standards and best practice that apply to handling information. The areas that are covered are to be kept under review as changes are made to legislation and guidance.

Legislation and common law

This includes:

- Access to Health Records Act 1990
- Access to Medical Reports Act 1988
- Common law duty of confidentiality
- Computer Misuse Act 1990
- Data Protection Act 1998
- Environmental Information Regulations (EIR) 2004
- Freedom of Information (FOI) Act 2000
- Human Rights Act 1998 (Article 8)
- The Privacy and Electronic Communications (EC Directive) Regulations 2003
- Re-use of Public Sector Information Regulations 2005
- National Health Service Act 2006

Standards and Guidance

The standards are defined by a number of national bodies and include:

- Health Service Circular: HSC 1999/012 (requirement for NHS organisations to have a Caldicott Guardian)
- The Caldicott Principles
- The Caldicott Guardian Manual 2010
- Care Quality Commission Essential Standards Outcome 21: Records
- NHS Information Governance Toolkit
- NHSLA standards for Acute Trusts
- BS ISO/IEC 17799:2005; BS ISO/IEC 27001:2005; BS7799-2:2005 – Management Information Security compliance
- Information Security Management: NHS Code of Practice (April 2007)
- Confidentiality: NHS Code of Practice (November 2003)
- Records Management: NHS Code of Practice (April 2006)
- Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems (ISB 0160 2013)

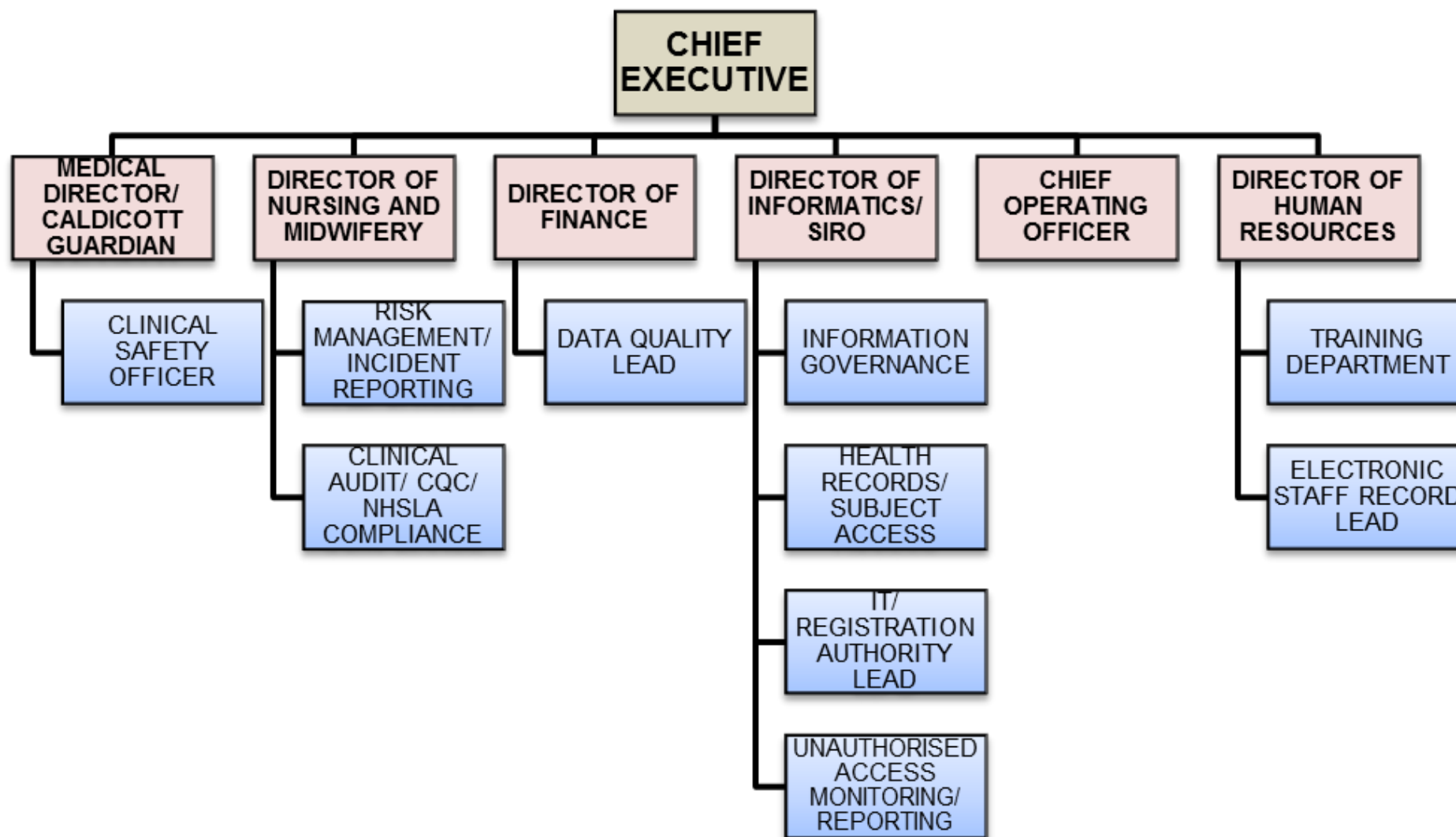
Professional Codes and Rules

Professional bodies have also set out standards for relevant professionals and associated guidance which includes:

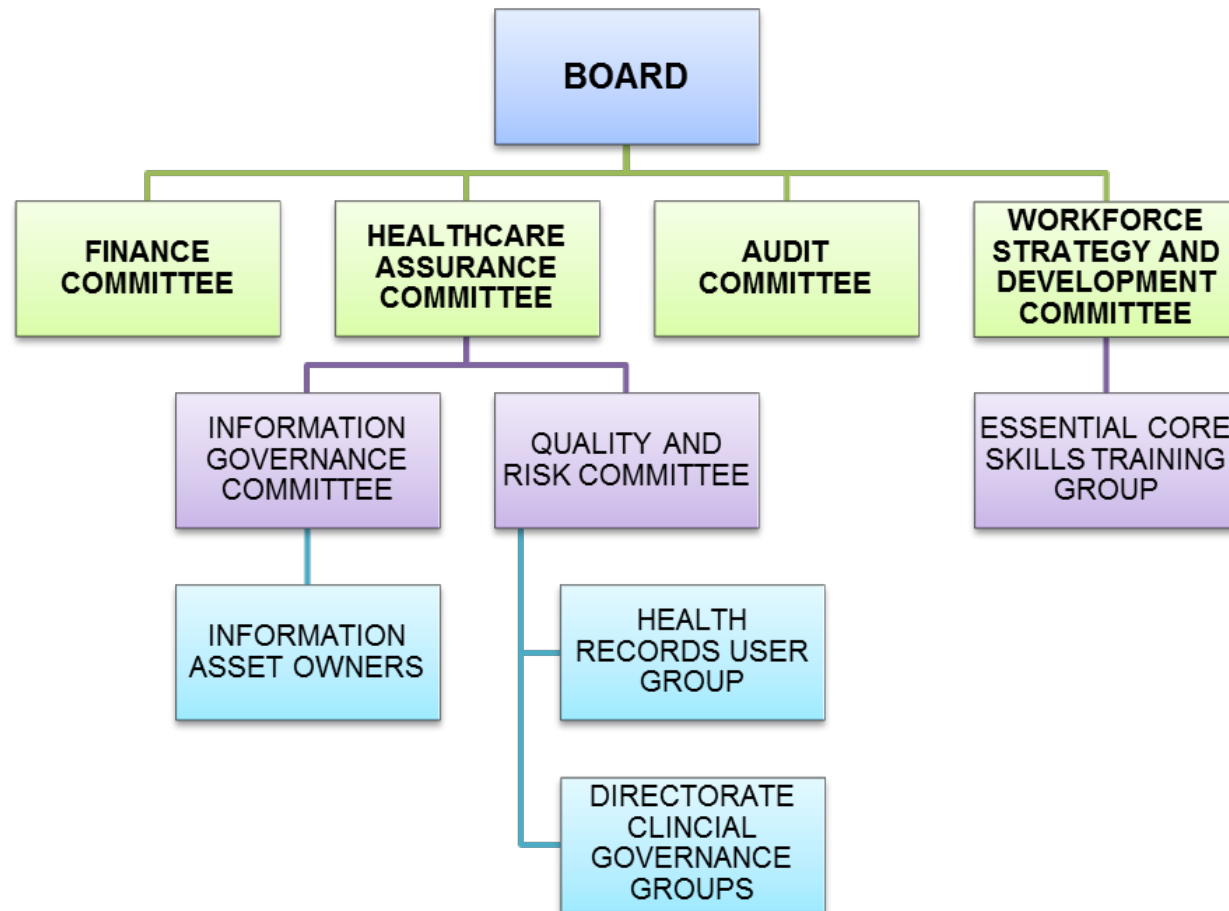
- General Medical Council, Good Medical Practice – paragraph 37 (2006)
- General Medical Council, Confidentiality for Doctors (2009)
- Nursing & Midwifery Council, The code: Standards of conduct, performance and ethics for nurses and midwives produced by the – paragraphs 42-47 (May 2008)
- Nursing & Midwifery Council, Record keeping: Guidance for nurses and midwives (July 2009)
- General Pharmaceutical Council, Standards of conduct, ethics and performance – principle 3 (July 2012)

- Health & Care Professions Council, Standards of conduct, performance and ethics – principle 2 (2012)
- Chartered Society of Physiotherapy, Rules of Professional Conduct (2nd edition) – Rule 3 (January 2002)
- British Medical Association, Confidentiality and Disclosure of Health Information Toolkit

APPENDIX B
Overarching Information Governance Structure



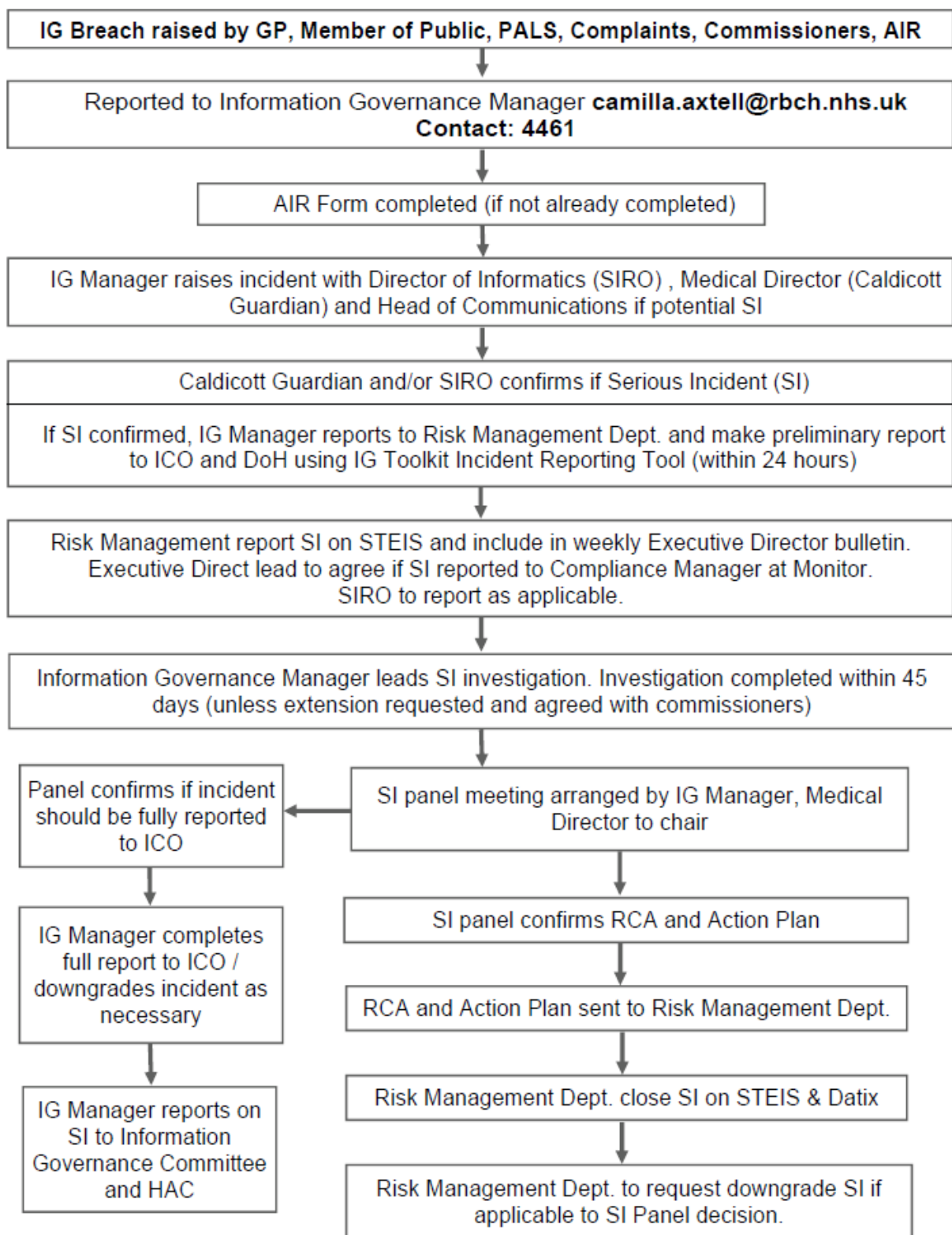
APPENDIX C
Committee Structure



APPENDIX D

Information Governance Serious Incident Reporting Flowchart

Information Governance - Serious Incident Reporting Flowchart



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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016 – Part 1
Reason for Part 2:	n/a
Subject:	Race Equality Scheme
Section on agenda:	7. Governance
Supplementary Reading (included in the Reading Pack)	--
Officer with overall responsibility:	Karen Allman
Author(s) of papers:	Wendy Holdich
Details of previous discussion and/or dissemination:	Reviewed at Diversity Committee
Action required: Approve/Discuss/Information/Note	For discussion and noting.
Executive Summary: The report is an update on the Workforce Race Equality Scheme highlighting the areas of key actions relating to race equality in 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?	Well Led. Providing appropriate staffing to deliver effective and safe care.
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	--

Workforce Race Equality Standard (WRES) Update

1 Background

The purpose of the WRES is to mandate actions in NHS organisations to ensure race equality and fair treatment for Black and Minority Ethnic (BME) staff. The reason for this is because the Kline Report¹ demonstrated BME staff were treated less favourably in terms of promotion, grading, discipline, bullying and access to non-mandatory training. The report also demonstrated evidence showing there has been little or no progress in recent years despite the growing number of BME staff employed as doctors, nurses and in other roles.

2 The WRES

- The WRES is a set of 9 metrics (indicators) selected to identify 'gaps' between the experience that White and BME staff have in the workplace.
- All NHS organisations with contracts over £200k are **mandated through the NHS Standard Contract**, to provide evidence demonstrating year on year progress against these metrics.
- WRES is included within the **CQC's 'well led domain'**
- WRES will be **published and benchmarked**. A new data base for WRES will be complete by April 2016. A report regarding the 2015 submissions is planned which will highlight some good (and bad) practice.
- RBCH is now accountable for identifying key gaps and creating interventions which close them. RBCH submitted its first WRES reporting template in June 2015 for the baseline audit on 1 July 2016. The next report is due in June 2016.

3 RBCH Data

The RBCH data submitted in June 2015 was based on the number of bank and substantive staff employed at RBCH at April 2015 and is summarised below:

RBCH Data at April 2015		
Staff	Number	Percentage
Total	5293	100%
*Ethnicity disclosed:	5052	95.5%
• BME staff	616	12.2
• White staff	4436	87.8

*Undisclosed ethnicity = 4.5% (241)


Local Population = BME 4.1% White 95.9


¹ Roger Kline: *The "snowy white peaks" of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England*











4 RBCH Workforce Race Equality Indicators – The 2015 Results

The traffic light classifications have been added to provide a simple assessment as follows:

 On Target

 Work to be done

 Area of concern

Workforce Indicator		BME %	BME #	White %	White #	
1	Staff in Band 8-9 positions	2	3	98	144	
2	Appointment following shortlisting	9.8		88		
3	Staff entering disciplinary process	13.8	8	86.2	50	
4	Relative likelihood of BME staff accessing non-mandatory training	12.2	132	87.8	947	
Staff Survey Findings 2014 In 2014 a random selection of 850 Trust employees were sent the national staff survey. Response rate was 48% (409 people) The 409 ethnicity breakdown is: White: 352 BME: 44 Undisclosed: 13						
Workforce Indicator		BME %	BME #	White %	White #	
5	Staff bullied/harassed/abused by patients/relatives/public	37	16	31	109	
6	Staff bullied/harassed/abused by staff	33	15	24	84	
7	Staff believing the Trust provides equal opportunities for career progression or promotion	65	29	91	320	
8	Staff experiencing discrimination at work from their manager, Team leader or a colleague	39	17	10	35	

Indicator 9: Hospital Board

Boards are expected to be broadly representative of the population they serve. For RBCH the population is 95% White. The Board (7 execs and 7 non-execs) there are no BME members.

5 Proposed Actions for 2016

5.1 Strengthen Diversity Committee

The Diversity Committee meets quarterly with the objective of working collaboratively to support diversity across the Trust and promote equality of opportunity for both 'Trust Users/Patients' and 'Trust Staff'. Consequently relevant committee members have been selected to represent the interests of these two groups. Attendance needs to be improved from care groups and some other operational areas. Although we have had good support from corporate areas including estates, logistics and commercial services, and HR. It is proposed that the composition of the committee is reviewed again by the executive and operations directors.

Board Action: Support is requested from the executive directors in particular to review the statistics and take positive actions to encourage members from senior staff to attend regularly and if unable to attend to nominate deputies.

5.2 Employee Survey / Network Groups / Coaching and Mentoring / Focus Groups

It is proposed that a short and specific employee survey is conducted, with the objectives of:

- Understanding how best to engage with BME employees
- Identifying individual issues
- Soliciting requests for specific actions, support and issue resolution

The survey would need to be made available to all staff because it is not possible to utilise monitoring information to communicate with specific groups. Assistance from the National WRES team would be sought to develop both the content and dissemination process for the survey. Actions would then be planned and implemented by the Diversity Committee.

Networking, Coaching and Mentoring

Areas explored by the survey would include the enthusiasm for initiating employee networking opportunities and coaching and mentoring for underrepresented groups.

Senior Staff Focus Groups

A further opportunity to gather feedback and suggestions would be to conduct focus groups with staff in bands 6 and 7. While all staff in these bands would be invited, input from BME staff might assist with identifying and addressing concerns of BME staff who would be future candidates for very senior roles (Band 8 and 9).

Board Action: Support for the development and rollout of the survey across the trust

5.3 Organisation Development Synergies

The OD team is currently conducting a review of the culture and leadership of the organisation, part of this initiative is to obtain a staff perspectives on diversity and inclusion. Consequently there will be synergies between the information gathered for this review and that needed to develop appropriate WRES actions. A meeting is scheduled to share objectives and identify opportunities.

5.4 Board Recruitment

RBCH is currently recruiting NEDS. The specification has highlighted that RBCH welcomes applications from under-represented groups. The agency involved in supporting the search and selection is fully briefed about this aspect.

5.5 Board Involvement in WRES

WRES was discussed at the July 2015 Board when Karen Allman requested the support of other executives and help with ideas.

The National WRES team have prepared a briefing document for Boards to provide a detailed understanding of the impact that less favourable treatment of BME staff has on the efficient and effective running of NHS organisations.

Board Action: Review of the briefing document and generation of ideas. The Workforce Committee will be reviewing the WRES at its meeting in February.

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The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	29 th January 2016 – Part 1
Reason for Part 2:	n/a
Subject:	Monitor Q2 Report
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	n/a
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Monitor
Details of previous discussion and/or dissemination:	None.
Action required: Approve/Discuss/Information/Note	For Information.
<p>Executive Summary:</p> <p>Monitor have responded to the Trust's Quarter 2 submission and continues to rate the Trust as level 3 for the Continuity of services risk rating and 'Under Review'. The rating will continue until such time as Monitor has concluded its investigation and determined what if any regulatory action may be appropriate.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	All.
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	--

1 December 2015

Mr Tony Spotswood
Chief Executive
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust
Royal Bournemouth Hospital
Castle Lane East
Bournemouth
Dorset
BH7 7DW



Making the health sector
work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.gov.uk/monitor

Dear Tony,

Q2 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q2 submissions is now complete. Based on this work, the trust's current ratings are:

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

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

The trust's governance rating is 'Under Review - Investigation', which reflects its financial sustainability risk rating.

As per our letter of 20 November 2015, Monitor is investigating the trust for a potential breach of its provider licence and the Trust's governance rating will remain 'Under Review' until such time as Monitor has concluded its investigation and determined what if any regulatory action may be appropriate.

Should Monitor decide not to take formal enforcement action, the Trust's governance rating will revert to 'Green'. Where Monitor decides to take formal enforcement action to address its concerns, the trust's governance rating will be 'Red'. In determining whether to take such action, Monitor will take into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance¹ and the Risk Assessment Framework².

A report on the FT sector aggregate performance from Q2 2015/16 is now available on our website³ which I hope you will find of interest.

We have also issued a press release¹ setting out a summary of the key findings across the FT sector from the Q2 monitoring cycle.

¹ www.monitor-nhsft.gov.uk/node/2622

² www.monitor.gov.uk/raf

³ <https://www.gov.uk/government/publications/nhs-providers-quarterly-performance-report-quarter-2-201516>

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

Yours sincerely

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

Sabir Mughal
Senior Regional Manager

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

¹ <https://www.gov.uk/government/news/challenging-environment-for-nhs-providers>

BOARD OF DIRECTORS MEETING – 29 JANUARY 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
11:00-11:05	1. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 18 December 2015		All
11:05-11:15	2. MATTERS ARISING		
	a) To provide updates to the Actions Log - Project Brief		All
11:15-11:45	3. QUALITY IMPROVEMENT		
	a) Transformation Options Update for Facilities (paper)	Decision	Richard Renaut
	b) Congestion/Car Parking (paper)	Decision/ Discussion	Richard Renaut
11:45-12:15	4. PERFORMANCE		
	a) Lord Carter of Coles – Review of opportunities (paper)	Discussion	Stuart Hunter
12:15-12:50	5. STRATEGY AND RISK		
	a) CSR Update (paper)	Discussion	Tony Spotswood
	b) Strategic Workforce Action Plan (paper)	Discussion	Karen Allman
	c) Significant Risk and Assurance Framework (paper)	Information	Paula Shobbrook
	d) Response to Draft CQC Report (verbal)	Decision	Paula Shobbrook
12:50-13:05	6. GOVERNANCE		
	a) Monitor Quarter 3 Submission (paper)	Decision	Stuart Hunter
	b) Outline Financial Plan to Monitor (paper)	Discussion / Decision	Stuart Hunter
	c) NED Recruitment Plan (paper)	Information	Sarah Anderson
13:05-13:15	7. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff		
	b) Reflective Review:		
	- What has gone well?		
	- What do we need more of?		

- What do we need less of?

2.30pm Blue Skies Session: ED 4 hour performance