

**A meeting of the Board of Directors will be held on Friday 25 November 2016 at 8.30am in the Conference Room, Education Centre, the Royal Bournemouth Hospital.**

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

Karen Flaherty  
Trust Secretary

## A G E N D A

Timings		Purpose	Presenter
8:30-8:35	<b>1. APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST</b>		
	Karen Allman		
8.35-8.40	<b>2. MINUTES OF PREVIOUS MEETING</b>		
	a) To approve the minutes of the meeting held on <b>28 October 2016</b>		<i>All</i>
8.40-8.45	<b>3. MATTERS ARISING</b>		
	a) To provide updates to the Actions Log		<i>All</i>
8.45-9.15	<b>4. QUALITY</b>		
	a) Patient Story (verbal)	Information	<i>Paula Shobbrook</i>
	b) Feedback from Staff Governors (verbal)	Information	<i>Jane Stichbury</i>
	c) Complaints Report (paper)	Information	<i>Paula Shobbrook</i>
	d) Medical Director's Report - Mortality (verbal)	Information	<i>Alyson O'Donnell</i>
9.15-9.55	<b>5. PERFORMANCE</b>		
	a) Performance Exception Report (paper)	Information	<i>Richard Renaut</i>
	b) Quality Report (paper)	Information	<i>Paula Shobbrook</i>
	c) Finance Report (paper)	Information	<i>Stuart Hunter</i>
	d) Workforce Report (paper)	Information	<i>Karen Allman</i>
	e) Stroke Services Update (paper)	Information	<i>Richard Renaut</i>
9.55-10.15	<b>6. STRATEGY AND RISK</b>		
	a) Clinical Services Review (verbal)	Information	<i>Tony Spotswood</i>
	b) Vanguard: One NHS in Dorset update (verbal)	Information	<i>Tony Spotswood</i>
	c) Update on OD Strategy and Leadership (presentation)	Information	<i>Nicola Hartley</i>
	<b>7. GOVERNANCE</b>		
	a) <i>No items</i>		
	<b>8. NEXT MEETING</b>		
	Friday <b>16 December 2016</b> at 8.30am in the Conference Room, Education Centre,		

**9. ANY OTHER BUSINESS**

Key Points for Communication to Staff

10.15-10.30

**10. COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC**

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

**11. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS**

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

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

Part I Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Board of Directors** held on **Friday 28 October** in the Conference Room, Education Centre, The Royal Bournemouth Hospital.

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of HR</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(NH)	<i>Non-Executive Director</i>
	Stuart Hunter	(CH)	<i>Director of Finance</i>
	Alex Jablonowski	(SH)	<i>Non-Executive Director</i>
	John Lelliott	(AJ)	<i>Non-Executive Director</i>
	Richard Renaut	(JL)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(RR)	<i>Director of Nursing and Midwifery</i>
		(PS)	
In attendance:	Ellen Bull	(EB)	<i>Deputy Director of Nursing &amp; Midwifery</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	Rachel Francis	(RF)	<i>Theatre Sister</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary(minutes)</i>
	Nicola Hartley	(NH)	<i>Director of OD and Leadership</i>
	Kate Horsefield	(KH)	<i>Head of Nursing &amp; Quality, Care Group A (Surgical) (item 4a only)</i>
	Rebecca Jones	(RJ)	<i>Communications Officer</i>
	Sue Langlois	(SL)	<i>Directorate Matron, Anaesthetics (item 4a only)</i>
	Deb Matthews	(DM)	<i>Director of Improvement</i>
	Alyson O'Donnell	(AOD)	<i>Medical Director designate</i>
	Eddie Rathbone	(KW)	<i>Associate Director, Commercial Services</i>
	Dily Ruffer	(ER)	<i>Governor and Membership Manager</i>
	Kate Whiteside	(DR)	<i>Manager, Discharge Services (item 4a only)</i>
Public/ Governors:	David Brown		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Carole Deas		<i>Public Governor</i>
	Eric Fisher		<i>Public Governor</i>
	Margaret Neville		<i>Representative of the Friends of the Eye Unit</i>
	Roger Parsons		<i>Public Governor</i>
	Sue Parsons		<i>Public Governor</i>
	Rae Stollard		<i>Public Governor</i>
	David Triplow		<i>Public Governor</i>
	Brian Young		<i>Public Governor</i>
Apologies	Derek Dundas		<i>Non-Executive Director</i>
	Steven Peacock		<i>Non-Executive Director</i>

78/16 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Action

The Chair reflected upon the September meeting trialling an offsite venue in Ringwood to promote the accessibility and transparency of the Board to the public. In addition the Chair referenced the need to promote and celebrate

staff successes in the Board Charter.

The new Medical Director Alyson O'Donnell, who would commence in post from 7 November 2016, was welcomed together with Karen Flaherty who had returned as Trust Secretary.

79/16 **MINUTES OF PREVIOUS MEETING (Item 2a)**

The minutes of the meeting held on 30 September 2016 were **approved** as an accurate record subject to the clarification of the number of outpatient appointments at 71/16(c).

80/16 **MATTERS ARISING (Item 3a)**

The following updates were made to the actions log:

- 72/16(g) - the higher workforce joint turnover and vacancy rate in the Medical Directorate was due to a specific number of staff who join and then go on to work in other areas of the Trust. The Trust benchmarked better than the average and well across other trusts in Dorset;
- 63/16(e) - private patient strategy was due to be submitted to the Finance Committee in November before being presented to the Board.

81/16 **QUALITY**

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

The patient story focused on the learning points from four patient pathways within theatres and the Emergency Department (ED). The departments had experienced a peak of activity late on a Friday afternoon with a number of acute cases already in theatres. External team support was required to staff the theatres in addition to the CEPOD theatre.

The issues highlighted concerned the ability of theatres to be self-sufficient in unusually busy circumstances supported by the goodwill of staff but also a lack of communication between departments which potentially delayed the transfusion of blood for one patient. This had been reported through the Trust's Adverse Incident Reporting System to promote learning and improvement.

The team had sought to improve patient pathways out of hours by increasing collaborative working with ED which would be taken forward through a theatres summit in November. In addition, the department would continue to develop the practice educator team and support development for theatre staff.

The Board questioned how often the department was required to open additional theatres and what additional support could be provided. It was highlighted that a retention strategy was required together with further investment in staff development to increase the number of highly skilled theatres staff available. A rota coordinator was being appointed to support staffing out of hours and a new staff template had been agreed. It was proposed that the new IT system for requesting tests and communicating results could be used to

support the processes around blood transfusions in the future.

The Board reflected upon the outcomes of the patient story noting that increased demand had been managed because of the goodwill and commitment of the team. The patient story had portrayed the Trust at its best in unusual circumstances and four emergency patients had received excellent care with a positive outcome in a pressured situation. The Board thanked the team.

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

The Chair summarised the key themes raised:

- Patient transport was sometimes unreliable. It was recognised that this issue was frequently raised and staff were encouraged to report all delays and other issues so that the managers responsible could address these with the supplier of the patient transport service;
- The response to the Leadership Summit had been very positive;
- Encouraging staff to speak up;
- A separate session with Staff Governors had been arranged to identify potential solutions to concerns following changes in theatres;
- Staff listening events were being held on 1 November and for Junior Doctors on 23 November;
- Access to mandatory training;
- The importance of providing information and a timeline to staff for the Clinical Services Review (CSR);
- An email about pharmacy and recruitment would be followed up.

The value of discussions with Staff Governors was emphasised and responses on the themes raised would be provided.

**(c) Complaints Report (item 4c)**

Changes within the corporate complaints team had impacted upon acknowledgment and response times however overall progress was being made within care groups. A team was in place to manage informal concerns responsively, who met with patients to address issues as they arose.

The Board were notified that one complaint had been upheld by the Parliamentary and Health Service Ombudsman and four complaints had been partially upheld. Trust was working with the Ombudsman service to develop an action plan.

The Trust had invited the local clinical commissioning groups to conduct a peer review of Trust's complaints process in November.

**(d) Feedback from CQC – Engagement Meeting (Item 4d) (Verbal)**

Executives had attended a constructive meeting with Care Quality Commission (CQC) inspectors on 7 October 2016 in which they

discussed progress against the action plan. The majority of actions had been completed and were being embedded.

The maternity department were focused on implementing the actions identified and senior staff appointments had been made. Actions within the gynaecology department were taking longer to embed and an independent governance advisor had been invited to review governance.

Executives had also updated the CQC on the work relating to the well-led domain and culture change and the CQC had responded positively on the progress made.

In accordance with the new CQC inspection format using smaller teams the Trust would be batched into a group for the next assessment process which would commence from 1 April. Stakeholder events with the CQC would be arranged around the next engagement meeting in March.

Board members queried when the Trust would be assessed as having improved. The Trust remained positive about the outcome of the next inspection and the target date to assess and showcase its progress would be within Q1 2017, preferably April.

The Chair emphasised that improvements were being made for the benefit of patients and reflected the Trust's aim to provide excellent services for patients. This was supported by the work on culture change to ensure that the focus remained on ensuring the quality of services for the long term.

82/16

## **PERFORMANCE**

### **(a) Performance Exception Report (Item 5a)**

The key themes from the report were highlighted:

- The overall position on performance was positive as a result of the dedicated work of the staff;
- At the end of October the Trust would have secured the Sustainability and Transformation Fund (STF) meeting performance targets/trajectories in all areas with the exception of Referral to Treatment (RTT) which was below trajectory but within the 1% tolerance allowable;
- ED performance year to date placed the Trust within the top 10% in the country;
- Key risks to the 18 week RTT performance related to the Trust's ability to manage increased waiting lists and demand pressures. Work was underway to mitigate the risk with additional sessions, out/insourcing, demand management and recruitment of medical staff;
- Diagnostic 6 week wait performance may be impacted upon by the increase in cancer referrals, staff shortages and scanner downtime;
- The endoscopy department achieved JAG accreditation on

- the new, higher quality standards;
- Stroke performance remained strong and it was anticipated the Trust's service would retain its 'A' score.

Growth in activity had increased in many key areas however a range of different teams had risen to the challenge and staff effort needed to be recognised. The Trust's focus would remain on timely discharge from hospital and engaging with social services colleagues to ensure performance was consistent, however current performance reflected how the organisation as a whole was operating as a team. The Board supported the ongoing actions to support patient flow through the hospital.

It was emphasised that over the next six months the Trust would need to take radical steps with commissioners and engage in positive work with GPs and community services to reduce waits on referrals under the 'Right Care' programme. Patient expectation needed to be managed and addressed on a specialty by specialty basis through local hospitals and GPs with clear communication to assuage patients' concerns as changes were made.

#### **(b) Quality Report (Item 5b)**

The report was summarised, noting strong performance with fewer serious incidents (SIs) reported in comparison to the previous year. Four SIs had been reported in September and investigations were in progress. Safety thermometer data reflected that the Trust was consistently performing at a positive level for harm-free care.

Friends and Family Test data indicated that the Trust remained in the top quartile for patient feedback and work continued in ED to increase the volume of responses.

Performance against the C-Difficile trajectory was non-compliant (with nine cases currently and a full year objective of 14 cases), however it was emphasised that the Trust was not the cause of any cases C-Difficile but needed to improve the documentation of care. The Trust had been set a challenging trajectory compared with other trusts as a result of its strong performance in previous years. The Infection Control team were working with Quality Improvement to improve the processes.

The chronic performance areas identified within the care campaign audit included noise at night, call bells and food. Over the past year the Trust had worked with groups and matron leads to establish improvement plans. The detail would be discussed at the Healthcare Assurance Group (HAG) and presented to the Healthcare Assurance Committee (HAC).

#### **(c) Finance Report (Item 5c)**

The report highlighted that the Trust had delivered a cumulative deficit of £0.2 million and therefore had achieved the financial control total year to date, securing access to the STF each month to

date.

There were considerable risks linked to the Trust's financial position which needed to be mitigated. The Board were advised that the Trust was £0.3 million behind the savings plan year to date and £3.5 million of the capital plan had been committed which was £3 million less than planned. The capital plan was due to be reforecast due to slippage against key streams of the programme.

Challenges to the Medical and Specialties care group budgets had been further compounded by the need for additional beds and pressure. Recovery plans for care groups were being developed to improve the position and release contingency but the issues were primarily due to cost improvement plans and income rather than cost pressures.

The Finance Committee would be considering the significant additional costs anticipated in the latter part of the year and identify what was required in order to achieve the performance and STF targets.

The Board considered the potential consequences if the Trust failed to manage contingency and deliver performance trajectories. The recovery plans would be presented to the Board in December, following review by the Finance Committee but actions identified would be implemented immediately rather than waiting for approval.

SH

**(d) Workforce Report (Item 5d)**

The key themes from the report were summarised:

- Appraisal performance remained strong although the target of 90% had not been achieved. Difficulties within one care group were noted however plans were in place to address these. The quality of appraisals had also improved. Appraisal Champions would be involved in discussions to develop the Trust's objectives;
- Staff survey response rates were behind the levels last year and staff were encouraged to complete the online survey;
- The flu vaccination programme performance had increased with more front line staff were being vaccinated;
- The vacancy rate was low and compared well against other local trusts. Collectively work was underway throughout the Trust to identify ways to retain staff;
- The Trust commissioned audit on staff experiences of violence and aggression highlighted that staff needed to be made more aware of the action taken following reporting. Five successful prosecutions had been made and staff had been alerted. Additional training was being developed to provide support.

The position on sickness absence was queried following the internal audit. There was a consistent problem within elderly care due to a number of reasons, however action plans were in place to mitigate pressures. Overall sickness absence was being managed actively



across the Trust with an increased level of scrutiny at a high level. Support from Human Resources had been provided and all recommendations from the internal audit report had been completed.

The Board commended the reduction in the use of agency nursing staff and requested a similar reduction in the use of agency medical staff. It was noted that there was a potential to consider alternatives for appointments in older people's medicine and general medicine to address long-term vacancies. The action was remitted to the Workforce Strategy and Development Committee.

KA

83/16

## **STRATEGY AND RISK**

### **(a) Clinical Services Review (Item 6a)**

The recent developments with the CSR were outlined:

- There was some frustration with the lack of pace awaiting formal confirmation of NHS England's agreement to move forward with the public consultation;
- The public consultation period would run from 1 December to the end of February 2017. Responses would be considered over a period of three months before the final decision on the model of care and use of sites was released;
- Final implementation of the selected model would be during 2022 so the Board would need to consider how to sustain and deliver services during the implementation period;
- The CCG were responsible for and would be leading the consultation and would produce the consultation document and questions to obtain public feedback;
- The key reasons for the reconfiguration of services within Dorset needed to be reinforced as it would deliver a better quality of care with fewer patient deaths;
- A communication strategy incorporating a range of activities had been developed to address public concerns, promote the reasons why the Trust supported the CCG's preferred option of the Royal Bournemouth Hospital as the major emergency hospital for Dorset and encourage the public to respond;
- Staff drop-in sessions would be held to discuss the CSR and the practical implications of the reconfiguration of services for staff;
- Public events held by the Trust would be complementary to the CCG's own events and would coordinate attendance by governors and clinicians as well as the executive team;
- Meetings with local Members of Parliament (MPs) and councillors would be held to address their concerns and increase engagement;
- Trade unions would also be informed about the consultation process through the joint partnership forum.

The Board highlighted the need to emphasise to Poole residents that the major planned care hospital would have a 24-hour urgent care centre. It would also be important for GPs and clinicians that

this centre would be the appropriate place to attend for specific conditions which do not require admission. In addition the public needed to be aware that the services would not be viable if they continued in their current format.

**(b) Vanguard: One NHS in Dorset (Item 6b) (Paper)**

Progress was being made within the five workstreams of activity identified:

- Stroke teams had developed detailed plans for the service with one or two hyper acute units being situated in the area. It had not been confirmed whether the plans would be implemented prior to the CSR.
- It had been identified that Poole Hospital had an insufficient number of cardiologists to provide a full service out of hours. It was proposed to develop a single on call rota to cover both hospitals and strengthen the service across east Dorset;
- Within gynaecology plans were in place to centralise emergency services at Poole from April 2017;
- IT services were developing options for an integrated pathology service;
- Financial support for backfill would be identified and the Trust would continue to support the key workstreams.

**(c) Planning Guidance 2017/18 and 2018/19 (Item 6c)**

Planning guidance for the NHS was released in September and outlined that the timetable had been brought forward by three months. The Board noted the challenging timeframe and were advised that activity would be brought forward and presented to Board over the next two months.

**(d) Trust Vision Update: Most Improved Hospital (Item 6d)**

The Trust vision, 'to become the most improved hospital by 2017' was launched in April 2015. The Board reflected on some of the metrics used to measure progress against the Trust's vision and its focus on improving services, patient experience and providing a safer hospital environment:

- Following investment in building a QI culture the Trust had been shortlisted for an award;
- Duty of candour - staff were able to talk more openly with increased learning leading to improvements in the reduction of SIs through the use of checklists;
- Friends and Family Test - performance was within the top 25% of trusts and was improving year on year. The cancer experience survey also reflected positive performance which had been higher than the expected range;
- Staff engagement - improvement since 2012 onwards and compared nationally the Trust was within the top 20%. Staff recommendations as a place to work were above average;
- CQC - in 2013 the Trust received a critical report and the outcome of the most recent inspection in October 2015

highlighted that 80% of services individually were rated as good or improved;

- Cost and efficiency savings - the alignment of quality and effective financial management had culminated in a reduction of the deficit although the Trust remained under pressure. Under the latest NHS Improvement (NHSI) regulatory framework it was anticipated that the Trust would be rated 2. The Trust remained confident that it would be possible to deliver the control total;
- Stroke service - performance of the stroke service had increased from a D to an A rating, which was being maintained. The service was rated in the top 5% in the country;
- Hospital flow - the Trust opened the frailty unit which introduced new pathways of care and reduced length of stay;
- Checklists - the use of and implementation of checklists in various areas has significantly decreased the number of never events reported over the last 12 months. The mortality rate from emergency laparotomy also reduced and surgical productivity improved;
- Appraisal performance had increased to 80% compared to previous years.

The adoption of the QI methodology, which had positively supported the Trust to make the improvements outlined, was commended. The potential further collaboration with Poole Hospital was discussed noting that it presented a number of risks and complexities but that it would also provide additional opportunities to work differently.

Board members expressed their pride in the Trust and encouraged that the wider dissemination of the improvement journey in publications and patient stories. The Chair reflected that the presentation embodied the spirit of accepting challenges and a commitment to continue to improve.

**(e) Draft Winter Plan and Trust-wide Escalation (Item 6e)**

The content of the report was noted for information. The reduction of funding for social services was highlighted as a significant risk. Staffing for the additional beds in care group B had been identified for January through to March to increase the bed base. A significant number of actions had been implemented to improve processes with escalation in place for peaks in demand. Critical to the implementation of the plan was the Trust working as a whole to respond to pressures and continuing to improve patient flow.

The full plan for the winter period would be submitted to the Trust Management Board (TMB) to review the escalation process and the final costs would be confirmed by the Finance and Performance Committee. The Board was asked to approve the plan in principle subject to further consideration by the Finance and Performance Committee and TMB. There was confidence that the plans were in place to staff the beds identified. The plan would be promoted throughout the organisation and identify when departments were

required to act as part of any escalation. Emphasis was placed on the need for business continuity during the winter period and ensuring teams that teams were aware of requirements. The Board **supported** the plan in principle.

84/16

**DATE OF NEXT MEETING**

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

85/16

**Key Points for Communication:**

1. Metrics to support the Trust's Vision
2. Positive performance against key targets
2. Learning from Patient Story and the importance of candour
3. Improvements identified in the Workforce Report
4. Update on the CSR
5. Reminder of the financial challenges.

86/16

**QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC**

1. The Trust needed to emphasise to the public that under the CSR proposals there would still be access to an urgent care centre at Poole Hospital.
2. The Private Patient strategy would be presented to the Board at the next meeting and submitted to the Council of Governors in January. It was noted that the partnership between cardiology and Regent's Park Healthcare would be submitted for approval at the next Finance and Performance Committee meeting and this would help support the Trust's income. The Private Patient unit would be completed by February 2017 and the Trust would not realise the benefit until the next financial year.
3. Roadshows were not always effective and it was suggested to use schools as potential venues for the public meetings for the CSR.

**CoG  
Agenda**

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
28.10.16	81/16	<b>PERFORMANCE</b>			
	(c)	<u>Financial Report</u>			
		Present the care group recovery plans to the Board	SH	December	The new forecasts for care groups are included within the finance pack in the reading room and will be highlighted at the November meeting. Detailed plans will be discussed at the Finance Committee on Tuesday 22 November.
	(d)	<u>Workforce Report</u>			
		Identify proposals to reduce the use of medical agency staff.	Workforce Committee	December	In progress. Workforce Committee meeting scheduled 15 December.
	85/16	<b>QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC</b>			
	1.	Private Patient strategy would be presented to the Board in November and provided to the Council of Governors at their next meeting.	SH	Complete /January CoG	Part 2 Agenda item. Next CoG meeting in January 2017.
30.09.16	71/16	<b>QUALITY</b>			
	(a)	<u>Patient Story</u>			
		Recording of patient discussions to be shared as an idea. This enables patients to review at a later stage	PS	In progress	To be followed up by QARC and Associate Medical Director
	(d)	<u>Adult Safeguarding and Child Protection Safeguarding Report</u>			
		DoLs mandatory training. Report to be brought back at a later date to ensure improvement.	PS	Report to Workforce Committee December 16	November: A report will be taken for discussion at the TPSC and Workforce Committee in early December.
	72/16	<b>PERFORMANCE</b>			
	(g)	<u>Workforce Report</u>			
		Explanation of joint turnover and vacancy rate of the Medical Care Group and significant turnover rate within Specialties.	KA	Complete	Having been reviewed consistent with turnover and vacancy rate within care groups. Care group B related to the number of internal moves.

	(i)	<u>NHSI Single Oversight Framework</u>			
		NHSI Seminar Presentation.	RR	In progress	To form part of blue skies discussion on board objectives for 2017/18+, then to review best reporting format following that.
	74/16	<b>GOVERNANCE</b>			
	(c)	<u>Progress update on Board Objectives</u>			
		Adequate time within agenda when looking at objectives for 2017	TS	In progress	Draft objectives would be considered at the Blue Skies session following the November Board.
	(e)	<u>EPRR Assurance Declaration</u>			
		Update of the action plan and timeframe.	RR	January	EPRR action due January Board. Place in Forward plan
26.02.16	13/16	<b>MATTERS ARISING</b>			
	(a)	<u>CQC Report Update</u>			
		Utilise the Monitor well- led self-assessment to measure Trust improvements ahead of the next CQC inspection together with the peer review programme. Remit the overarching assessment to the Healthcare Assurance Committee.	PS	In progress	Not yet due – self assessment to be refined and submitted to independent assessor in December.

Key:	Outstanding
	In Progress
	Complete
	Not yet required

## BOARD OF DIRECTORS

Meeting Date and Part:	25 <sup>th</sup> November 2016: Part 1
Subject:	Complaints Performance Report October 2016
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing and Midwifery Grace Maughan, Senior Information Analyst
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee 24 <sup>th</sup> November 2016
Action required:	The paper is provided for information

### Executive Summary:

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

### Key messages:

1. Current Trust aggregate response time in month (October 2016) is **82%** against a standard of 75% (18 of 22 responses due were on time).
2. The response time improvement focus continues and has reached the required trajectory for month 6 (quarter 3 YTD) above 70%. This **has** been achieved on aggregate by all three care groups.  
  
 Care Group A = 86%  
 Care Group B = 70%  
 Care Group C = 100%  
  
 Improvement trajectories for formal responses are:  
 Q1 above 60%  
 Q2 above 65%  
 Q3 above 70%  
 Q4 to maintain 75% from the start of quarter 4.
3. 27 formal complaints were received in October 2016.
4. Acknowledgement times for October are 89% in the data set.

5. Written and verbal Concerns (informal issues) in month have been reported. The volume is much higher than formal complaints. The response times are reported by care group in section 5.1.

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



# Complaints Performance Report October 2016

## 1.0 Introduction

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

## 2.0 Number of complaints

27 formal complaints were received in October 2016  
63 verbal concerns were presented to PALS in October 2016  
42 written informal concerns were presented to PALS in October 2016

## 3.0 Acknowledgement and response times

3.1 Of the 27 formal complaints received for October 2016, 89% were acknowledged within three days. Revalidated data confirms the September position to 92%. Medicine received the most complaints (n = 8), verbal (n= 15) and written concerns (n=14) in month.

3.2 First responses to complaints should be within 25 working days (quality strategy standard of 75%), which is monitored at the Healthcare Assurance Committee. For August on aggregate the first response times have been re-validated as 61% from previously reported 63% a drop from the previous month which was expected due to reasons previously reported. For September, the first response time has been revalidated as 72%, an improvement on the previously reported 70%.

For **October, first response time is at 82%** on aggregate 18 of the 22 complaints responses due were sent on time.

3.3 In terms of Care Group response times, the performance of all three care groups meets the expected trajectory target for October (Q3) of at least 70%.

Care Group A = 86%  
Care Group B = 70%  
Care Group C = 100%

## 4.0 Themes and trends - Complaints received

4.1 The highest theme again in month was implementation of care (n = 10). This detail is reviewed at the complaints performance meeting and HAC.

## 5.0 Informal Concerns

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

terms of style. The current acknowledgement and response time which is recorded against a 25 working day deadline for both written and verbal concerns by Care Group is as follows.

## 5.2 Informal concern acknowledgement times

- **Written** (n = 42 in month)  
Care Group A - 75%  
Care Group B - 80%  
Care Group C - 89%
- **Verbal concerns** (n = 63 in month)  
Care Group A - 92%  
Care Group B - 100%  
Care Group C - 90%

## 5.3 Informal concerns first response performance

- **Written concerns**  
Care Group A - 100%  
Care Group B - 71%  
Care Group C - 100%
- **Verbal concerns**  
Care Group A - 100%  
Care Group B - 94%  
Care Group C - 100%

In conclusion, the overall picture is one of sustaining improvement, in terms of response times and acknowledgments. The medical directorate needs the most focus, in terms of numbers of complaints received and the response times, but this is a significant improvement on last month.

## 6.0 Healthwatch report

- 6.1 In January 2016, the Trust was approached by Healthwatch to work in partnership to facilitate completion of an independent survey of individuals who had submitted a formal complaint to this Trust. As a Trust we agreed and we partook in this alongside two other local Trusts. Actions against this are in progress, driven in the Complaints Performance meeting and presented at the Healthcare Assurance Committee. The Dorset and West Hampshire CCGs performed a quality review of our complaint responses to facilitate our improvement in November. This will be fed back to the Deputy Director of Nursing and then the Complaints Performance Group and Healthcare Assurance Committee respectively.

## 7.0 Recommendations

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

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

## BOARD OF DIRECTORS

<b>Meeting Date and Part:</b>	25 <sup>th</sup> November 2016 – Part 1
<b>Subject:</b>	Performance Report to the end of October 2016
<b>Section on agenda:</b>	Performance
<b>Supplementary Reading (included in the Reading Pack)</b>	Performance Matrix
<b>Officer with overall responsibility:</b>	Richard Renaut, Chief Operating Officer
<b>Author(s) of papers:</b>	Donna Parker / David Mills
<b>Details of previous discussion and/or dissemination:</b>	PMG
<b>Action required:</b> <b>Approve / Discuss / Information / Note</b>  <p>The Board is requested to note the performance exceptions to the Trust's compliance with the 2016/17 STF, Single Oversight Framework and other key national/contractual requirements.</p> <p>This includes compliance with STF tolerance against the three indicators: A&amp;E 4 hour, Diagnostics 6ww and Cancer 62 day. RTT is expected to be below monthly tolerance threshold in October. STF confirmation is awaited in relation to 'clawback' and YTD performance rules.</p> <p>Finally, the Committee is also requested to note the detailed report on A&amp;E, Flow and related indicators.</p>	
<b>Summary:</b>  <p>The full Performance Report for October is attached and accompanies the Performance Indicator Matrix. The report outlines the Trust's actual and predicted performance against key access and performance targets and this month, provides a detailed focus on A&amp;E, Flow and related indicators.</p> <p><b>An Executive Summary and Key Risks page has also been provided.</b></p>	
<b>Relevant CQC domain:</b>  <b>Are they safe?</b>  <b>Are they effective?</b>  <b>Are they caring?</b>  <b>Are they responsive to people's needs?</b>  <b>Are they well-led?</b>	  Yes  Yes  Yes  Yes
<b>Risk Profile:</b>  i) <b>Impact on existing risk?</b>  ii) <b>Identification of a new risk?</b>	<p>The following risk assessments are currently being reviewed in light of the latest performance and STF rules of engagement:</p> <p>Cancer 62 day wait non-compliance and national guidance on 'high impact' changes.</p> <p>4 hour target due to improved performance.</p> <p>RTT due to reduced performance.</p> <p>The Trust's Urgent Care Risk Assessment is also under full review based on the 4 key elements: Flow/frontdoor; Stranded Patients; Deteriorating Patient and Sepsis.</p>

## 1. Executive Summary

The Sustainability and Transformation Fund is expected to be achieved for the A&E 4 Hour, Diagnostics and 62 Day Cancer targets. For these, we met the national threshold and/or remained within tolerance trajectory. Although an improvement on last month, RTT October performance is expected to be below the monthly tolerance trajectory which has moved to a 0.5% tolerance in Q3. The YTD position may be sufficient to secure funds but we await clarification.

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

91.36% expected for October, below the 92% target/trajectory and the 0.5% monthly tolerance for STF. Over 23,300 patients on an RTT pathway remain within 18 weeks from referral.

### **A&E 4 hour** (12.5% of funds) –

achieved 95.5% well above our trajectory requirement of 91% in October. November is currently at 95.98% though close management of increasing pressures is in place.

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

79.8% in September and 84.7% for Q2. This meant we were just below the national threshold/our trajectory (85%) but within the 1% tolerance for STF. Compliance is anticipated for Q3.

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

achieved compliance and above trajectory, at 100%.

All other Single Oversight Framework, NHS Constitution and key contractual targets were met for October except C Difficile where we stand at 11 cases against our stretching full year objective of 14. Also we had one cancelled operation which was rebooked at 29 days due to its specialist nature and unplanned clinician absence. In Q2 we were below the target for consultant cancer referral upgrades with 1 breach, resulting in performance of 85.7%

## 2. Key Risks to Performance

**RTT 18 Weeks Incomplete Pathways** – the increased overall waiting list and higher proportion of patients over 18 weeks continues to mean a reduced tolerance to mitigate speciality risks. Therefore, sudden/unplanned medical staff absence and demand pressures remain a risk to our ability to manage this. In particular Ophthalmology, Gastroenterology, Dermatology and visiting specialities are key areas of demand and capacity pressure requiring close management; including additional sessions, out/insourcing, demand management and recruitment of medical staff. In addition, the pressure of non elective activity levels and our need to remain within the financial control total remain challenges, particularly to specialities such as Orthopaedics. To mitigate some further risk in these areas additional plans are being developed jointly with our commissioners, including outsourcing work, to achieve a backlog reduction to offset the current position and known risks to Q4 performance. We do continue to see good progress in some areas across Surgery and have seen some improvement in the Ophthalmology position.

**A&E 4 hour** – our QI work and winter planning to date continues to support our strong position, though increased activity (c9% YTD) and the inability for Social Services to ‘step up’ winter capacity across Bournemouth and Dorset is a significant concern and risk.

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

**Diagnostics 6 Week Wait** – the impact of the above potential increase in cancer referrals, together with scanner down time and some staff shortages in Radiology and Endoscopy present risks to performance. Additional activity and the potential for outsourcing continues.

# Performance Report



For the period to end October 2016

Richard Renaut  
Chief Operating Officer

## 1. Introduction

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

The detailed performance levels against remaining key targets, which currently form part Single Oversight Framework assessment or national/contractual obligations, are included in the Performance Indicator Matrix. Narrative is included in this report on an exception basis.

This report covering performance for October 2016 includes a focus on the Month 1 Indicators – ED 4 hours and associated targets - as per attached quarterly cycle (*Table 1*).

Table 1 – Quarterly Cycle for Focus on Performance Indicators

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



## 2. Sustainability and Transformation Fund and Single Oversight Framework Indicators – Q2 and October 2016 Performance

### 2.1 Sustainability and Transformation Fund 16/17

STF payment is expected in Q2. Full compliance was achieved against both national target for the quarter and our trajectory in relation to the A&E 4 Hour target and Diagnostic 6 Week Wait. This position has meant increased interest from the NHSI team and other trusts to facilitate shared learning in relation to our strong A&E position.

Compliance was below national target and trajectory for RTT and Cancer 62 day but within the 1% tolerance threshold to secure the funds. Exception reporting to our commissioners and NHSI has commenced for RTT, Cancer and Delayed Transfers of Care, recognising that we remained within the STF tolerances.

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

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

\*Validated final position to be presented at meeting - upload is 17/11/16

\*\*Validated final position awaited - upload is early December

Going forward, performance has been sustained above the national target and trajectory for A&E 4 Hour and Diagnostics for October. However, Q3 (Oct-Dec) RTT is at high level of risk of going beyond the 0.5% tolerance (91.5%). Therefore, we may not receive the monthly funding allocation, depending upon the impact on the YTD performance. There also remains some risk to the cancer 62 day target in October. Actions to address these are well in hand, but the impact of emergency pressures and staffing remain present.

### RTT Incomplete Pathways (18 week) and 52 Week Breaches

Performance against the RTT Incomplete Pathways indicator was below the 92% in September (91.2%) and is expected to remain at a similar level for October. (*An update will be provided at the meeting following the final validated upload on 17/11/16*). Although just below the national target and our STF submitted trajectory, we remained within the tolerance to secure the Sustainability and Transformation funds in September. However, due to the reduced tolerance (from 1% to 0.5% in Q3) we anticipate a significant risk to not achieving the October funding of £79k. This may be offset by the YTD position but confirmation is awaited.

Positively, improvement in 18 week backlogs across some admit and non-admit pathways was seen in line with our plans, for example in some surgical specialities (i.e. Gynaecology, Colorectal and Vascular where medical staff recruitment and some sub speciality pathway improvements took effect) and in Cardiology. Also, Ophthalmology saw its recovery trajectory commence with a drop in both admitted and non-admitted backlogs as a result of the impact of demand management, additional and locum sessions, as well as some outsourcing. However, we were unable to outsource as much as planned due to patient choice to stay on our waiting lists and we also saw deterioration in some speciality backlogs (e.g. Urology, Orthopaedics, ENT, Dermatology, Allergy and Gastroenterology)

which offset the improved areas in October. This reflected risks highlighted in last month's report.

Currently there remains significant risk to securing full recovery to the required national threshold of 92% by Q4. As outlined in detail in last month's report, plans are in place that are expected to see improvements implemented or sustained in some specialities e.g. general surgical specialities and Gynaecology. The detailed plans also outlined those areas where recovery times are likely to be longer (e.g. in Gastroenterology where further detailed work on demand and capacity is underway). However, our current assessment is that the plans to date will be insufficient to achieve an upward trajectory overall and in key challenged specialities such as Ophthalmology; as well as offset further risks we are aware of in Gastroenterology, Urology, ENT, Allergy and Oral Surgery, in readiness for Q4. Furthermore, there will be the heightened risk to elective activity over the winter period. Therefore, additional plans are currently being developed jointly with our commissioners, including outsourcing work, to achieve a backlog reduction to offset the current position and known risks to Q4 performance.

Despite the performance pressures, there were no 52 week wait breaches in September or October.

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

The Trust was well above the STF trajectory of 91% achieving 95.5%, in October. Although we are beginning to experience additional bed pressures through November, to date, in month performance is at 95.98%. The Trust continues to benchmark extremely well nationally, being within the top 20% in the national September reports and indications that this has been sustained for October and potentially exceeded.

There were no 12 hour breaches.

This is an extremely positive position given the continued high level of ED attendances and non-elective admissions (over 9% YTD up on last year).

This position has undoubtedly been supported by the urgent care Quality Improvement programme work – further detail is provided in section 3. Our challenge will now be to take this even further over the winter period to offset the increased pressures highlighted in our bed predictor. In addition, full implementation of our winter plans and flow escalation processes, both of which have been discussed in detail at our Trust Management Board, will be key.

Of concern remains the strong messages from Local Authorities that social care capacity is expected to be even further challenged. Bournemouth and Poole Borough Councils do not expect to provide any additional capacity over the winter and Dorset are currently anticipating less capacity. This is unprecedented as each year Social Services have always 'stepped up' for winter. A meeting is being arranged with the CCG and Dorset County Council to assess the expected impact and explore any further options to mitigate this. We are already actively looking at how we can increase support and capacity for self-funding patients as well as care home and domiciliary capacity. Furthermore, we are having active sessions with West Hampshire partners to secure plans to support Hampshire patients delayed in the hospital.

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



A slight increase in non-elective admissions in October compared to October 2015 was seen. The lower level of increase was supported by a decrease of 3% in total ambulance handovers (conveyances) compared to October 2015, and a decrease of 1.1% compared to September 2016. We are working jointly with the local ambulance services to implement improved systems for handovers and the on-going metrics and trajectories for the year are being agreed, including the process of data validation. A pilot of an electronic, dual handover system is due to be implemented with South Central Ambulance Service in November.

## **62 Day from Referral for Suspected Cancer to Treatment**

For the month of September the breach numbers were significantly higher than in the preceeding months at 20.5. Patient choice accounted for 4.5; complex pathways resulted in 4.5 and medical deferral caused 3 breaches. Of the remaining 8.5 - 1.5 was due to external Trust capacity with the rest being due to capacity in theatres and other Trust departments within the Trust. This was primarily due to lack of Medical staff locum appointments which we expect to be resolved in the next quarter. Performance was therefore, 79.8% in September. This did mean we were just below the quarterly national target (85%) at 84.7%, though remained within the 1% tolerance to secure the STF.

Whilst some continued pressures meansome risk to Q3, our current projections indicate compliance for the quarter. Going forward to Q4 the introduction of the new fast track referral forms in January, expected to increase demand, remain the key risk from Q4 onwards.

## **Diagnostic 6 Week Wait (*end of month*)**

Our positive position was sustained in October with a pleasing 100% performance, exceeding our STF trajectory. Currently performance remains on track in the key areas (Endoscopy, Radiology, Cardiology

and Urology) though this continues to be closely managed and in Endoscopy, supported by additional insourcing. In Radiology there is a continuing need for additional capacity on an ad hoc basis to respond to peaks in demand or reductions in capacity (e.g. scanner down time). All areas do remain on-going risks due to continued growth from inpatient demand and suspected cancer referrals and related pathways. In addition to close and proactive management this year, these services will need to be fully reviewed in relation to our planning for 17/18 and expected demand increases.

## **2.2 Other Single Oversight Framework, NHS Constitution and Contractual Indicators**

We will continue to develop our reporting to reflect the Single Oversight Framework and as the NHSI approach becomes clearer in relation to the non STF indicators.

## **Cancer and Infection Control**

Below indicates our earlier projections for 16/17 against the other cancer and infection control indicators, together with performance to date. Full compliance was achieved in Q2 and is expected for final October reporting, excepting against the C Difficile national objective target.

# Performance Report

As at 15/11/2016

Table 3 - Cancer and Infection Control Indicators

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

Note:  
\*Cancer reflects our predicted position to date. Final upload early Dec 16.

Detailed performance (%/no.) is included in the Performance Matrix. The key risk to the cancer indicators is the changing referral thresholds for GP fast track referrals from January. Despite joint work with the commissioners and limited additional funding, we remain concerned about the impact, particularly on diagnostic services which will require close monitoring.

In relation to the C Difficile performance, this remains a challenging target. Further detail is provided in section 3.

## Other Indicators

Compliance was maintained on all other key targets in October excepting one breach against the 28 day rebooking standard for patients whose operation is cancelled. Unfortunately, due to unplanned absence of our corneal surgeon, one patient who was cancelled was only able to be rebooked at 29 days. We have now secured locum cover for this service.

In the final September upload of cancer performance, consultant upgrade was below threshold due to one breach in September which also meant non-compliance for the Quarter at 85.7%.

Table 4 – Other Indicators

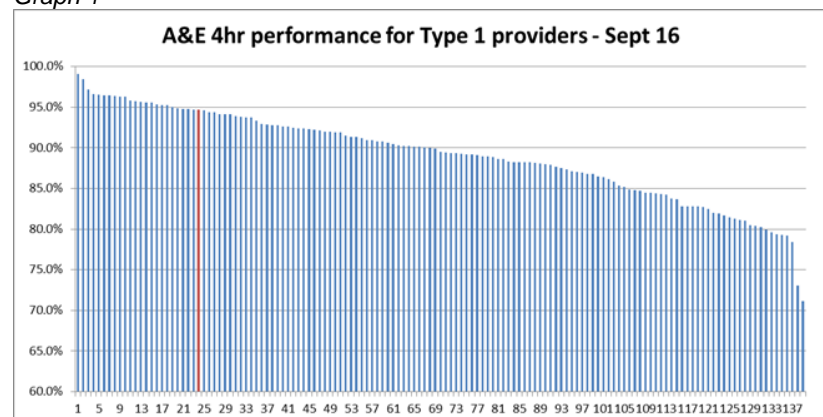
Indicator	Measure	Target 16/17	Jul-16	Aug-16	Sep-16	Oct-16
Mixed Sex Accommodation	Minimise no. of patients breaching the mixed sex accommodation requirement	0	1	0	0	0
MRSA Bacteraemias	Number of hospital acquired MRSA cases	0	0	0	0	0
62 day – Consultant upgrade	Following a consultant's decision to upgrade the patient priority *	90%	100.0%	100.0%	86.7%	
Venous Thromboembolism	Risk assessment of hospital-related venous thromboembolism	95%	96.0%			
Planned waiting list	% of patients less than 6 weeks past their due date	0	95.5%	93.2%	92.7%	91.0%
Admission via A&E	No. of waits from decision to admit to admission over 12 hours	0	0	0	0	0
Ambulance Handovers	No. of breaches of the 30 minute handover standard	0	58	67	59	50
Ambulance Handovers	No. of breaches of the 60 minute handover standard	0	1	4	8	11
28 day standard	No. of patients not offered a binding date within 28 days of cancellation	0	0	0	1	1
Urgent ops Cancelled for 2nd time	No. of urgent operations cancelled for a second time	0	0	0	0	0
NHS Number Compliance	Completion of NHS Numbers in SUS Submission (IPS/OPS)	99%	99.7%	99.7%	99.7%	
NHS Number Compliance	Completion of NHS Numbers in SUS A&E Submissions	95%	97.7%	97.4%	97.5%	
SSNAP indicator	% of Stroke patients are treated on a dedicated stroke ward for 90% of spell		94.5%	92.3%	84.8%	87.5%
SSNAP indicator	Direct admission to Stroke Unit within 4 hours of admission		78.9%	70.4%	43.1%	71.7%
SSNAP indicator	Patients receive CT Scan within 24 hours of admission		100.0%	95.8%	96.6%	96.2%
SSNAP indicator	Patients with acute stroke receive brain imaging within 1 hr		36.8%	38.9%	43.1%	32.1%
SSNAP indicator	Thrombolysis Rate		5.3%	12.5%	15.5%	13.2%
SSNAP indicator	% appropriate patients receiving thrombolysis (within 1 hour of clock start)		100.0%	55.6%	44.4%	57.1%
TIA indicator	High risk TIA cases investigated and treated within 24hrs		46.0%	71.0%	44.0%	76.0%
TIA indicator	Low risk TIA cases, seen within 7 days		90.0%	88.0%	82.0%	93.0%
Clocks still running - 52 weeks	Zero tolerance of over 52 week waiters (Incomplete Pathways)	0	0	0	0	
Clocks still running - admitted	Total number of patients with an admitted incomplete pathway	tbc	6397	6397	6306	
Clocks still running - admitted	Number of patients with an admitted incomplete pathway over 18 weeks	tbc	1099	1135	1118	
Clocks still running - non admitted	Total number of patients with a non admitted incomplete pathway	tbc	18600	18471	18868	
Clocks still running - non admitted	Number of patients with a non admitted incomplete pathway over 18 weeks	tbc	856	898	1093	

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

### 3.1 Performance and Activity

The Trust is currently performing well against the A&E 4 Hour target (October 95.5%), a position that has now largely been maintained since June and is putting us amongst the best in the country. %

Graph 1



As at 14 November 2016 our monthly and quarterly position is:

Table 5 – ED Monthly and Quarterly Performance

Month	Month Attendances	Month Performance	Quarter	Quarter Attendances	Quarter Performance
Apr-16	7,506	91.22%	Quarter 1	23,725	94.12%
May-16	8,335	94.95%			
Jun-16	7,884	95.99%			
Jul-16	8,588	95.84%			
Aug-16	8,613	97.24%	Quarter 2	25,117	95.93%
Sep-16	7,916	94.61%			
Oct-16	7,953	95.47%	Quarter 3	11,507	95.63%
Nov-16	3,554	95.98%			
Dec-16					

This is despite a significant increase in non-elective admissions compared to last year (9.4%) and ED attendances (9.4% type 1&2).

Table 6 – Non Elective Activity Variance on Same Month 15/16

Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
5.2%	13.0%	1.6%	11.6%	11.8%	15.5%	9.1%	13.7%	10.1%	12.9%	12.3%	3.3%	5.3%

### 3.2 Progress Against ED and Trust-wide Actions

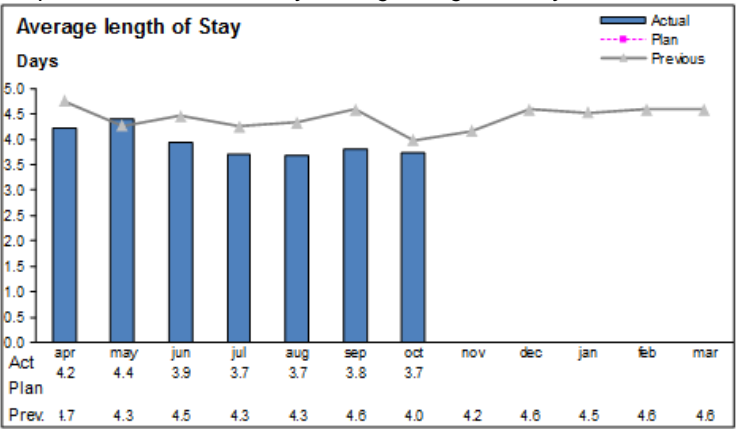
The 16/17 plans under the Trusts' Urgent Care Programme are now well progressed and are supporting the overall improvements we are seeing in bed capacity and flow across the Trust. Below outlines a number of key metrics showing improvements in length of stay, outliers and ambulatory care. However, the next phase to fully deliver the 'ask' we set ourselves in relation to Frailty, direct admission, ambulatory pathways and length of stay, will be absolutely key in sustaining this improvement. It will also be a necessity to deal with the increased challenges expected over winter given the higher than anticipated urgent care activity we are experiencing this year.

Table 7 – Improving Urgent Care Aims

Improving Urgent Care Project 'ask'		AIM No. per day	Daily Ave. Last 4 Weeks	Comments
Ambulatory Care	Medicine	8	5.1	Total AEC activity is now shown on graph e.g. all patients seen in AEC irrespective of whether they are subsequently admitted or not. This demonstrates AECs full workload.
	Cardiology	6	4.3	Chart shows the Direct admissions as % of all Cardiology admissions in addition to number of direct admissions to provide context.
Direct Admissions	OPM (btw 09:00 & 15:00)	6	4.8	
Outliers	Max 4 to surgery/Ophthal	4	13.0	Reduced LoS - Reduced Occupied Bed Days - Reduced Outliers

## Length of Stay and Ambulatory Care

Graph 2 – Trustwide Monthly Average Length of Stay 2016 vs 2015

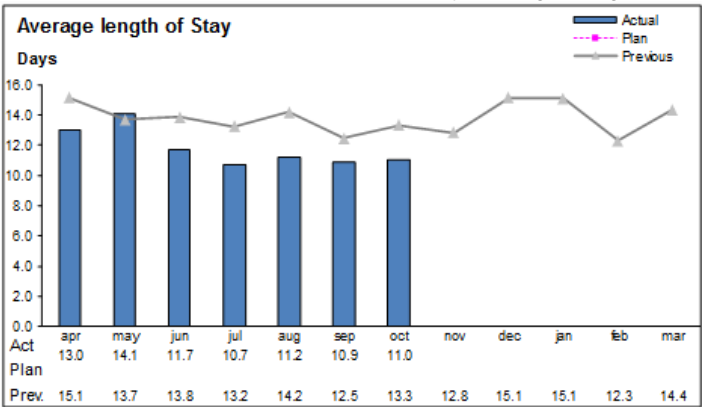


The model for the ambulatory clinic and step up/down capacity in Cardiology has continued to be refined and we are seeing a number of urgent care patients streamed more quickly to Cardiology.

Our data now shows that in Q1 we increased the percentage of patients with under 24 hour stays by 3% compared to last year. It also shows that we perform well in relation to the national benchmarking provided by the AEC network, reaching the national thresholds against many of the identified conditions. We are now reviewing those conditions where this data suggests we are below threshold. This, together with a clinical review of patients with a '0 day' length of stay which has been undertaken, will identify further opportunities for ambulatory care service development.

Older Person's Medicine continues to reduce length of stay as the short stay and ambulatory pathways have developed, supported by the opening of the Frailty Unit in September.

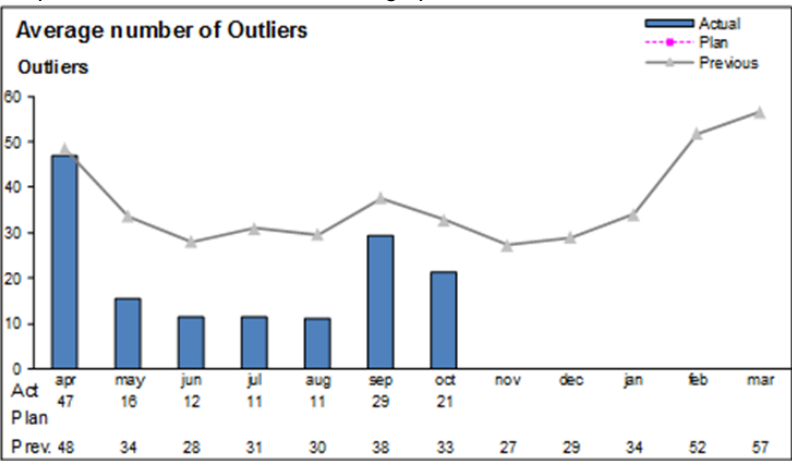
Graph 3 – Older Persons' Medicine Monthly Average Length of Stay 2016 vs. 2015



## Outliers

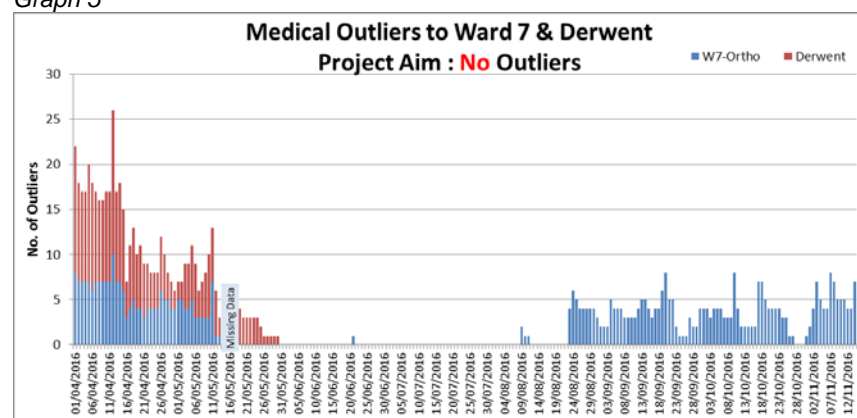
An increased focus on Older Person's Medicine remaining in hospital for over 14 days saw significant benefits in reducing the number of delayed patients. In line with national guidance, we have now increased the focus across the Trust to all patients over 7 days.

Graph 4 - Overall Trustwide outliers graph 2016 vs. 2015



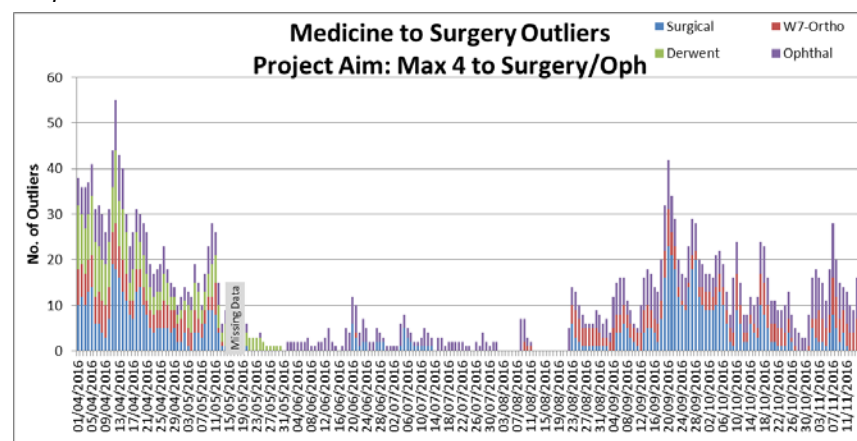
Alongside this, the focused MDT approach taken to outlying patients has improved our outlying position this year and has supported the aim to eradicate outliers in the Derwent (Orthopaedic) Unit excepting when the trust is implementing full bed escalation protocols at times of high pressure.

Graph 5



However, it is recognised that there is further work to do to achieve the full target of a maximum of 4 medical outliers into surgical beds, particularly as the pressures increased post summer and into winter.

Graph 6



## Delayed Transfers of Care

Following the Ian Wilson external review of Delayed Transfers of Care (DToC) the RBH action plan is progressing well with regular review supported by local Chief Executives and NHS England. We are working closely with Social Services across both Dorset and Hampshire and have developed the competency training to implement the Trusted Assessor model. The development of the 'Christchurch discharge hub' pilot has commenced, with further development related to the Trusted Assessor and Social care input underway. An 'issues log' approach is utilised actively to identify areas for process improvement both inside and outside of the hospital and our discharge tracker tool is in development.

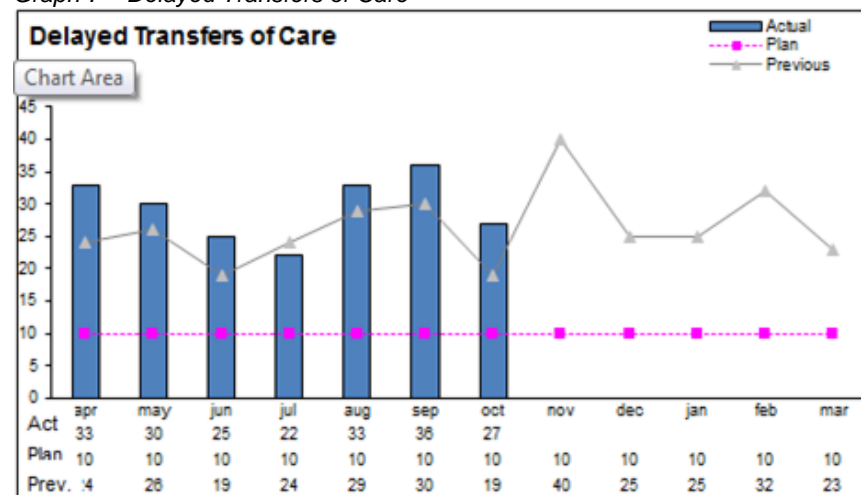
We are also continuing to develop our interim care provision to further progress the 'Discharge to Assess' model. The service sees a reduction in care needs of between 20-30%. This is as a result of supporting patients in their own homes or in interim beds out of hospital, to recover, improve their rehabilitation and independence and complete their longer term care needs assessment.

However, as highlighted in Section 2 concern remains in relation to the strong messages from Local Authorities that social care capacity is expected to be even further challenged over winter. Bournemouth and Poole Borough Councils do not expect to provide any additional capacity over the winter and Dorset are currently anticipating less capacity. A meeting is being arranged with the CCG and Dorset County Council to assess the expected impact and explore any further options to mitigate this. This means that the next phase of our discharge model which is looking at how to better support patients with severe dementia and moderate to severe frailty, patients with on-going rehabilitation who also have nursing needs, End of Life Care and self-funding patients, will all need to be accelerated.



Although a reducing DToC trend was seen earlier in the year, this has not been sustained and DToC have remained above last year's levels every month.

Graph 7 – Delayed Transfers of Care



## Capacity Modelling and Monitoring

Detailed modelling of activity, bed capacity and flow to reflect the impact of the multiple Urgent Care QI workstreams was undertaken which informed 'The Ask'; the key set of requirements that our pathways need to achieve to maintain flow within capacity. As shown above, our weekly reporting against these set of metrics is now in place to support on-going monitoring.

This modelling and all of the improvement work to date has resulted in reduced occupancy and length of stay which has supported our reconfiguration of areas in the hospital in Cardiology, OPM and Orthopaedics to further support their new pathways for direct admission, ambulatory and shorter stay care.

The weekly monitoring is also enhanced by our winter bed capacity and our real-time activity predictor tools which indicate likely admissions and discharges. These are supporting our winter planning and further development of our QI programme, as well as enabling us to respond quickly to areas of pressure and manage our pathways and bed capacity. To inform this response, we are working with our clinical and senior management teams to review and further develop the trust-wide response to the need to escalate actions in relation to levels of flow pressures.

## Emergency Department

The ED continues to develop its teamwork and processes and in November, are planning to introduce the new 'SHINE' tool to support quality and safety of care in the department. The department are also working closely with the ambulance services to refine handover processes and support timely, safe handover of patients and release crews back to 999 calls.

Specialities such as Older Persons' Medicine, Cardiology and Respiratory also continue to refine their in-reach and 'pull' pathways to support our aim to get patients quickly to the right place.

## 3.3 National 2016/17 A&E Improvement Plan

The national A&E Improvement Plan, to support improved 4 hour performance across the country, indicated the requirement for A&E delivery systems to implement the following key interventions:

1. **Streaming at the front door to ambulatory and primary care**
2. NHS 111 – Increasing the calls transferred for clinical advice
3. Ambulances – Appropriate and timely response including increases in 'hear and treat'
4. **Improved Flow – 'must do's' for acute trusts**
5. **Discharge to Assess and Trusted Assessor models.**

Our regular self-assessments against these and our on-going work described in this overall section continues to support our well placed position against interventions 1, 4 and 5.

### **3.4 Single Sex Accommodation**

Under the revised MSA policy, in line with contractual agreements with Dorset CCG, we have maintained a fully compliant position for the last three months (Aug to Sept).

### **3.5 Infection Control**

We continue to strive to eliminate lapses in care contributing to incidence of C Difficile in the hospital. Our stretch target, where lower incidence is required compared to surrounding trusts, continues to be a challenge; with 11 cases against our target of 7 YTD. The following focused work continues:

- Education and awareness raising (e.g. lecture theatre sessions and 'screensavers');
- Heightened surveillance and audit in areas of increased incidence;
- Ward level and case reviews;
- QI project planning.

## **4. Recommendation**

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

**The Board is also requested to note the detailed report on A&E 4 hour, single sex accommodation and infection control performance and support the on-going actions.**

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would expect for our own families*

## BOARD OF DIRECTORS

Meeting Date and Part:	25 <sup>th</sup> November 2016: Part 1
Subject:	Quality report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery
Author(s) of papers:	Ellen Bull, Deputy Director of Nursing and Midwifery Jo Sims, Associate Director of Quality and Risk
Details of previous discussion and/or dissemination:	Healthcare Assurance Committee 24 <sup>th</sup> November 2016
Action required:	The paper is provided for information and assurance

### Executive Summary

The Quality report is a summary of the key quality indicators in Month.

- 1 serious incident has been reported.
- Safety Thermometer has remained in a good position in month
- Top quartile performance is sustained for the In-Patient and Emergency Department Family and Friends Test
- In response to the findings of the Care Audit matron led groups are established to drive forward further improvement actions.

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



# Quality Report



**For the period to end October  
2016**

Paula Shobbrook  
Director of Nursing and Midwifery

# Quality Report

As at 16/11/2016

## 1.0 Introduction

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

## 2.0 Serious Incidents

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

2.2 One Serious Incident was reported in October 16:

1 Clinical Incident – patient monitoring.

Root cause analysis (RCA) investigations and panel meetings are in progress for current Serious Incidents.

## 3.0 Safety Thermometer

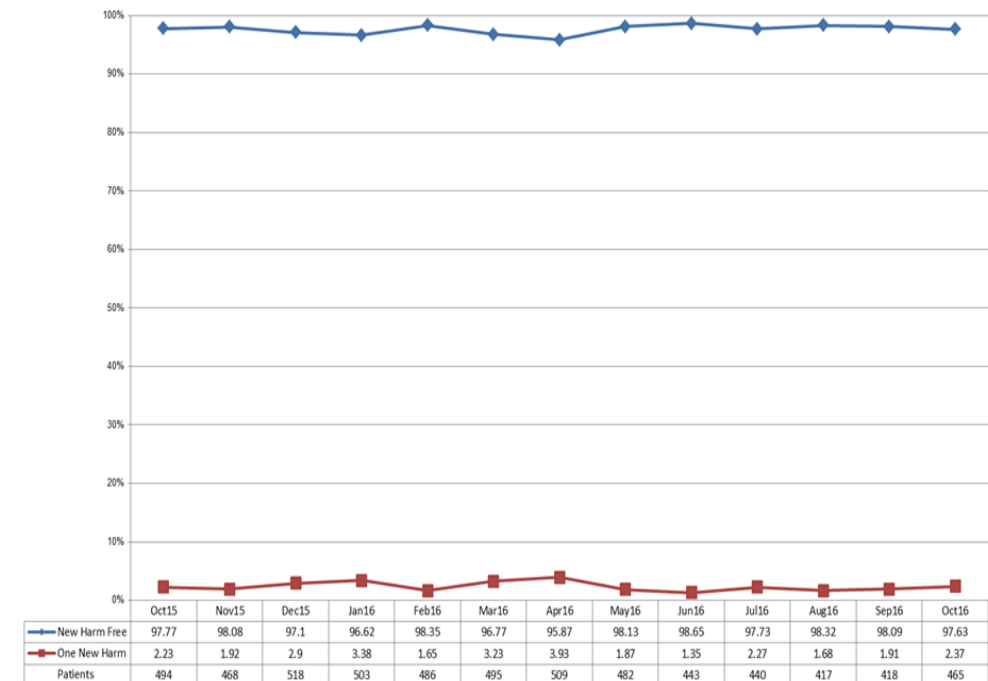
3.1 The Trust New Harm Free Care score has remained almost the same in month with continuing good performance on reducing new (hospital acquired) pressure ulcers (7 in month) and falls with harm (0 in month).

The overall harm free care score has also remained the same in month.

	15/16 Trust average	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Safety Thermometer % Harm Free Care	89.79%	88.02%	87.34%	88.49%	91.36%	93.29%	87.32%	87.31%
Safety Thermometer % New Harm Free Care	97.53%	95.87%	98.13%	98.60%	97.73%	98.32%	98.09%	97.63%

### New Harm Free: patients with New-Harm Free Care

ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITAL'S NHS FOUNDATION TRUST, All Wards, All Settings, All Services, All Ages, All Sexes



## 4.0 Patient Experience Report – October 2016 (containing September data)

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

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

- Inpatient and day case Friends and Family Test (FFT) national performance in August 2016 ranked RBCH Trust 3<sup>rd</sup> with 27 other hospitals out of 172 placing RBCH in the top quartile based on patient satisfaction. The response rate was sustained above the 15% national standard at 21.9%.
- The Emergency Department FFT performance in August 2016 ranked RBCH Trust 4<sup>th</sup> with 7 other hospitals out of 141 placing RBCH ED department in the top quartile. The response rate 6.4% against the 15% national standard.
- Outpatients FFT performance in August 2016 ranked RBCH Trust 4<sup>th</sup> with 32 other Trusts out of 234 Trusts, placing the departments in the second quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

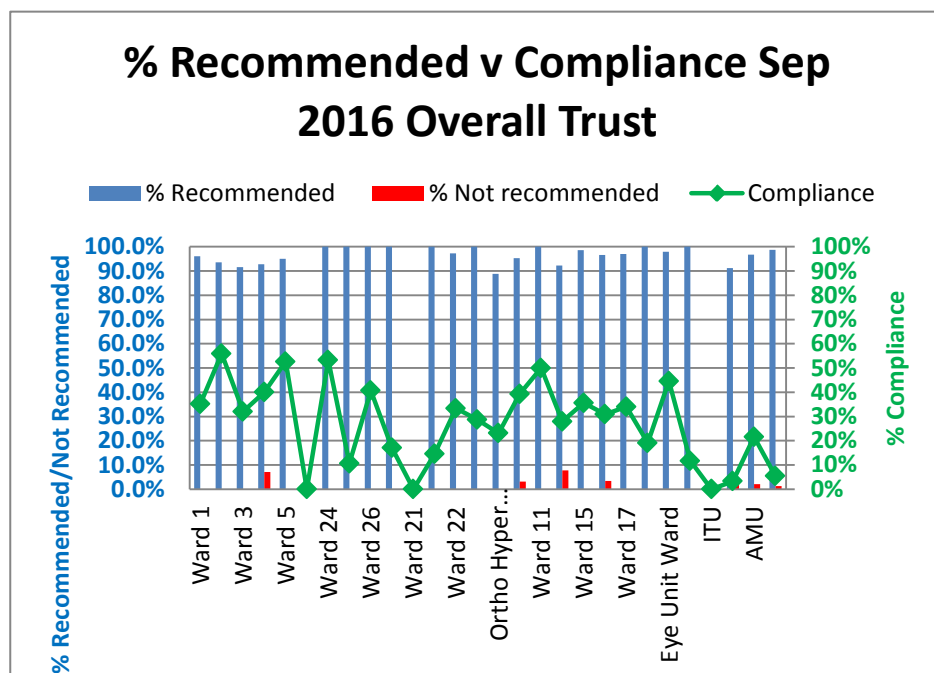
In-Patient Quartile	March	April	May	June	July	August
Top	98.259%	98.068%	98.086%	98.704%	98.703%	98.318%
2						
3						
Bottom						

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

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

## 4.2 The following data is taken from internal data sources

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



## 4.3 Family and Friends Test: Corporate Outpatient areas

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

## 4.4 Care Audit Trend Data

Actions to improve chronic performers continue with the Matron led groups. Pain, noise at night, call bells and food and drink have all established matron led groups and are being monitored through the Healthcare Assurance Group and Committee.

## 4.5 Patient Opinion and NHS Choices: August 2016 Data

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

## **5.0 Recommendation**

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

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would expect for our own families*

The Royal Bournemouth and  
Christchurch Hospitals  
NHS Foundation Trust



## BOARD OF DIRECTORS

Meeting Date and Part:	25 <sup>th</sup> November 2016 – Part I
Subject:	Financial Performance
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Yes
Officer with overall responsibility:	Stuart Hunter, Director of Finance
Author(s) of papers:	Pete Papworth, Deputy Director of Finance
Details of previous discussion and/or dissemination:	Finance and Performance Committee
Action required: Approve/Discuss/Information/Note	The Board of Directors is asked to note the financial performance for the month ending 31 October 2016.
Executive Summary:	The financial reports are detailed in the attached papers.
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Goal 7 – Financial Stability  Outcome 26 – Financial Position
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	One current financial risk exist on the risk register related to the next year's financial planning. The actions are being monitored through the Finance Committee.

The Royal Bournemouth and Christchurch Hospitals  
NHS Foundation Trust

# Finance Report



**For the period to 31 October 2016**

Pete Papworth  
Deputy Director of Finance



## Executive Summary

The Trust has delivered a cumulative deficit of £0.5 million as at 31 October. This is £9,000 better than plan meaning that the Trust has achieved its year to date financial control total thereby securing access to the Sustainability and Transformation Fund each month to date. Through also achieving all performance trajectories, the Trust has accrued the associated Fund income in full.

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

Within this position, savings of £4.6 million have been achieved, which is £0.3 million behind the year to date target. The full year savings forecast reduced by £0.2 million in month, and the current forecast is for total savings of £8.5 million against the full year target of £9.5 million.

The Trust has significantly reduced its reliance upon agency staff, and this together with the national price controls has reduced the overall premium cost. As a result, the Trust is operating within the agency ceiling put forward by NHS Improvement.

As at 31 October £3.9 million of capital spend has been committed, which is £3.8 million less than planned at this point in the year. Following a detailed mid-year review and reforecast, the Trust is currently forecasting to under spend against the full year programme by £3.3 million.

The Trust continues to report a favourable cash position against its plan, with a current cash balance of £35.8 million. The forecast end of year cash balance is £23 million meaning that no Department of Health support is required.

The new Single Oversight Framework came into effect from 1 October, and the Trust has achieved a Use of Resources score of 2 under this new framework (1 being best and 4 being worst).

## Key Financial Risks

The key financial uncertainties and risks remain unchanged. Key risks can be summarised as follows:

### **1. Sustainability and Transformation Fund**

The significant increase in non-elective activity and emergency department attendances is placing pressure on the Trusts elective and outpatient capacity. This puts at risk the Trusts ability to achieve the agreed performance improvement trajectories, and thus the achievement of the full STF funding. Plans are currently being enacted to mitigate this risk, to ensure the Trust continues to achieve its 2016/17 budget and planned cash balance.

### **2. Cost Improvement Programme**

There remains a gap between the CIP target for the year and the value of schemes currently identified. This amounts to £0.9 million and poses a significant risk to the Trusts 2016/17 budget and cash forecast. Closing this gap remains a key focus for the weekly CIP delivery group.

### **3. Private Patient Income**

Private patient income improved in month, although remains significantly below plan year to date. Plans are in place to improve this position more sustainably; however this will not recover the full in year loss.

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

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

The overall financial risk within the Board Assurance Framework, risk register entry 169, resulting from these specific risk items remains unchanged. This continues to be considered a high risk and is being managed as such.



# Finance Report

As at 31 October 2016

## Income and Expenditure

To date the Trust is reporting a deficit of £0.5 million, almost exactly in line with its budget profile. Within this however, there are material variances against both income and expenditure budgets as set out below in the table below.

£'000	Budget	Actual	Variance
NHS Clinical Income	154,879	151,664	(3,215)
Non NHS Clinical Income	3,710	3,144	(566)
Non Clinical Income	14,134	13,710	(423)
<b>TOTAL INCOME</b>	<b>172,723</b>	<b>168,519</b>	<b>(4,204)</b>
Employee Expenses	103,097	101,041	2,057
Drugs	20,989	18,888	2,102
Clinical Supplies	22,031	21,890	141
Misc. other expenditure	27,083	27,170	(87)
<b>TOTAL EXPENDITURE</b>	<b>173,200</b>	<b>168,988</b>	<b>4,213</b>
<b>SURPLUS/ (DEFICIT)</b>	<b>(477)</b>	<b>(469)</b>	<b>9</b>

### Income

NHS clinical income was £0.1 million below budget during October, further adding to the year to date adverse variance. Key drivers for this included a reduction in income through the Hepatitis C network (£283,000) and a reduction in cardiac devices (£183,000), with other high costs drugs also contributing to the year to date under performance. Each of these items have a corresponding expenditure under spend and therefore do not affect the Trusts overall financial performance. The remainder reflects the level of activity during October as set out in the Care Group Performance section below.

Private patient income reversed its trend during October, over performing in month by £50,000.

Further detail at contract level is set out below.

£'000	Budget	Actual	Variance
NHS Dorset CCG	102,843	102,489	(354)
NHS England (Wessex LAT)	29,976	26,886	(3,090)
NHS West Hampshire CCG	14,569	14,577	8
Non Contracted Activity	1,558	1,770	212
Public Health Bodies	1,507	1,489	(18)
NHS England (Other LATs)	1,045	946	(99)
NHS Wiltshire CCG	454	530	76
Other NHS Patient Income	0	32	32
Private Patient Income	1,856	1,299	(557)
Other Non NHS Patient Income	347	356	9
Non Patient Related Income	14,134	13,710	(423)
Sustainability and Transformation Fund	4,433	4,433	0
<b>TOTAL INCOME</b>	<b>172,723</b>	<b>168,519</b>	<b>(4,204)</b>

### Expenditure

Pay reported an in month under spend of £359,000 due to a number of on-going vacancies together with a reduction in anticipated agency costs. It is pleasing to see a continued increase in staff working through the Trusts internal resource pool.

Drug expenditure was £315,000 below plan during October, mainly reflecting the reduction in drugs approved through the Hepatitis C network (£283,000) off-set in part by additional spend in relation to general drugs.

Clinical supplies budgets reported a favourable variance of £71,000 in month, reflecting the reduction in cardiac device expenditure (£183,000), off-set by overspends in the Medical and Surgical directorates.

## Employee Expenses

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

£'000	Substantive Budget	Substantive Cost	Substantive Variance	Agency Cost	Bank Cost	Overtime Cost	Workforce Variance
Surgical Care Group	26,091	23,610	2,482	1,126	632	259	465
Medical Care Group	37,435	32,962	4,473	1,388	2,558	175	352
Specialties Care Group	21,974	20,315	1,660	355	515	75	715
Corporate Directorates	17,559	16,373	1,186	234	324	102	526
Centrally Managed Budgets	38	38	0	0	0	0	0
<b>TOTAL</b>	<b>103,097</b>	<b>93,298</b>	<b>9,800</b>	<b>3,103</b>	<b>4,029</b>	<b>611</b>	<b>2,057</b>

The Trust has agreed to the agency 'ceiling' cost requested by NHS Improvement, which amounts to £5.9 million for the year and represents a significant reduction against the 2015/16 outturn of £8.6 million. It is pleasing to report that agency expenditure to date is below the year to date agency ceiling value of £3.597 million.

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

£'000	Block Booked	Off-Framework	Other	TOTAL
Nursing	80	13	49	142
Medical	0	47	247	294
Non Clinical	35	4	0	39
<b>TOTAL</b>	<b>115</b>	<b>64</b>	<b>297</b>	<b>475</b>

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

	Medical	Nursing	Other
Shifts covered (Number)	260	0	73
Approximate Cost above Cap (£)	66,080	0	40,882

Whilst a significant number of medical shifts were approved through this 'break glass' procedure, this relates to only a small number of individuals who provide vital sessions.

## Cost Improvement Programme

The Trust has delivered financial savings amounting to £4.6 million to date, being £316,000 behind plan.

The current forecast is for full year savings amounting to £8.5 million against the target of £9.5 million. This is a worsening in the forecast of £0.2 million due mainly to the impact of demand pressures as noted below. In addition to the financial gap to target, it should be noted that at present, £2.7 million (31%) of the forecast savings are reported as non-recurrent. This represents a significant financial risk when moving into the 2017/18 financial year and is a focus as the Trust develops its annual plan for next year.

It has been reported previously there was significant risk within the Surgical Care Group forecast due to the major increase in emergency surgery activity above planned levels. This has come to fruition, and the forecast has reduced by £147,000 following the removal of a key bed reduction scheme.

The Medical Care Group forecast declined by £40,000 during October, with small reductions seen across a number of schemes. Further schemes have been identified and are currently being assessed for feasibility through the Quality Impact Assessment process; however it is unlikely that these will close the gap fully and thus further work is required to identify new opportunities to deliver the savings requirement in full through the financial recovery plans.

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

Corporate savings have increased by £40,000 in month with a number of new schemes being identified. Unfortunately these are non-recurrent in nature rather than being the result of new and sustainable ways of working.

DIRECTORATE	YEAR TO DATE			FULL YEAR		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000	TARGET £'000	FORECAST £'000	VARIANCE £'000
ANAESTHETICS AND THEATRES	(190)	210	20	(389)	349	(40)
MATERNITY	(88)	96	8	(104)	104	0
ORTHOPAEDICS	(423)	365	(59)	(986)	902	(84)
SURGERY	(277)	311	35	(712)	745	33
<b>CARE GROUP A</b>	<b>(978)</b>	<b>982</b>	<b>5</b>	<b>(2,191)</b>	<b>2,100</b>	<b>(91)</b>
CARDIOLOGY	(367)	405	39	(607)	654	47
ED AND AMU	(100)	31	(70)	(181)	103	(78)
OLDER PEOPLES MEDICINE	(567)	560	(8)	(1,150)	1,104	(46)
MEDICINE	(163)	73	(90)	(672)	134	(538)
<b>CARE GROUP B</b>	<b>(1,197)</b>	<b>1,069</b>	<b>(128)</b>	<b>(2,610)</b>	<b>1,995</b>	<b>(615)</b>
CANCER CARE	(322)	257	(66)	(428)	360	(68)
OPHTHALMOLOGY	(114)	82	(33)	(291)	152	(139)
PATHOLOGY	(150)	134	(16)	(244)	273	29
RADIOLOGY	(244)	243	(1)	(327)	322	(5)
SPECIALIST SERVICES	(440)	430	(9)	(826)	790	(36)
<b>CARE GROUP C</b>	<b>(1,270)</b>	<b>1,146</b>	<b>(125)</b>	<b>(2,116)</b>	<b>1,897</b>	<b>(219)</b>
NURSING, QUALITY & RISK	(74)	69	(5)	(116)	100	(16)
ESTATES	(361)	347	(14)	(726)	726	(0)
FACILITIES MANAGEMENT	(247)	213	(34)	(486)	486	0
FINANCE AND BUSINESS INTELLIGENCE	(100)	102	2	(162)	174	12
HR, TRAINING AND POST GRAD	(117)	91	(25)	(159)	155	(4)
INFORMATICS	(478)	477	(1)	(656)	666	10
OPERATIONAL SERVICES	(90)	101	11	(180)	159	(21)
OUTPATIENTS	(41)	39	(2)	(57)	67	10
TRUST BOARD & GOVERNORS	(23)	23	0	(22)	23	1
<b>CORPORATE</b>	<b>(1,530)</b>	<b>1,462</b>	<b>(68)</b>	<b>(2,564)</b>	<b>2,556</b>	<b>(8)</b>
<b>GRAND TOTAL</b>	<b>(4,975)</b>	<b>4,659</b>	<b>(316)</b>	<b>(9,481)</b>	<b>8,548</b>	<b>(933)</b>

## Care Group Performance

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

£'000	Budget	Actual	Variance
Surgical Care Group	9,990	9,888	(102)
Medical Care Group	6,110	5,531	(579)
Specialties Care Group	3,316	3,237	(79)
Corporate Directorates	(20,127)	(19,768)	359
Centrally Managed Budgets	234	643	410
<b>SURPLUS/ (DEFICIT)</b>	<b>(477)</b>	<b>(469)</b>	<b>9</b>

October saw further increases in unplanned activity resulting in further capacity challenges and a corresponding reduction in planned care.

Non-elective activity was 12.2% above budgeted levels, and emergency department attendances, which were 7.7% above budgeted levels. Correspondingly, elective activity was below budget in month by 3.2%, and outpatient activity was 14.7% below budget.

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

## Sustainability and Transformation Fund

Members will recall that the financial control total is a binary on/off switch to secure STF Funding. Only if the Trust achieves its control total in a quarter, does it become eligible for STF Funding. The amount of funding achieved is then determined by the level of success with the other criteria.

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

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

CRITERIA	FUND		YEAR TO DATE		
	WEIGHTING %	VALUE £	BUDGET £	ACTUAL	VARIANCE £
Revenue Control Total	70.0%	5,320,000	3,103,333	3,103,333	0
RTT Performance Trajectory	12.5%	950,000	554,167	554,167	0
A&E Performance Trajectory	12.5%	950,000	554,167	554,167	0
Cancer 62 Day Performance Trajectory	5.0%	380,000	221,667	221,667	0
Diagnostics Performance Trajectory	0.0%	0	0	0	0
<b>TOTAL</b>	<b>100.0%</b>	<b>7,600,000</b>	<b>4,433,333</b>	<b>4,433,333</b>	<b>0</b>

It should be noted however, that the significant and sustained increase in non-elective activity and Emergency Department attendances is placing pressure on the Trusts elective and outpatient capacity. This puts at risk the Trusts ability to achieve the RTT performance trajectory, and thus the achievement of the full STF funding. Plans continue to be progressed to mitigate this risk, which to date, have included the engagement of additional locum consultants in tandem with the outsourcing of elective activity to the private sector.

## Statement of Financial Position

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

- **Non-current assets:** The Trusts capital programme is currently behind plan by £3.8 million, as set out overleaf. This, together with the timing impact of capital schemes on the associated depreciation and amortisation charges account for the variances shown against property, plant and equipment and intangible assets totalling £3.6 million. In addition, the delay in the Christchurch development has resulted in the Trust delaying its investment contribution into the Christchurch Fairmile Village LLP, explaining the adverse variance against the investments heading.
- **Trade and other receivables:** The receivables balance has crept up during October as a result of a small number of outstanding payments due from local partner organisations. These are being actively pursued.
- **Cash and cash equivalents:** The Trusts cash balance reflects the under spend against the capital programme, the increase in trade and other payables together with the timing of the investment into the Christchurch Joint Venture.
- **Trade and other payables:** The material payables variance to date is made up of a small number of discrete items. The variance reflects the timing of cash payments as compared to the original plan. These are being actively monitored and are expected to be paid over the coming months.

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

£'000	Plan	Actual	Variance
Property, plant and equipment	179,427	176,227	(3,200)
Intangible assets	4,006	3,590	(416)
Investments (Christchurch LLP)	6,151	3,921	(2,230)
<b>Non-Current Assets</b>	<b>189,584</b>	<b>183,738</b>	<b>(5,846)</b>
Inventories	5,688	5,479	(209)
Trade and other receivables	14,186	15,159	973
Cash and cash equivalents	22,736	37,651	14,915
<b>Current Assets</b>	<b>42,610</b>	<b>58,289</b>	<b>15,679</b>
Trade and other payables	(26,484)	(35,822)	(9,338)
Borrowings	(307)	(307)	0
Provisions	(222)	(228)	(6)
Other Financial Liabilities	(1,102)	(1,102)	0
<b>Current Liabilities</b>	<b>(28,115)</b>	<b>(37,459)</b>	<b>(9,344)</b>
Trade and other payables	(994)	(996)	(2)
Borrowings	(18,679)	(18,749)	(70)
Provisions	(519)	(587)	(68)
Other Financial Liabilities	0	0	0
<b>Non-Current Liabilities</b>	<b>(20,192)</b>	<b>(20,332)</b>	<b>(140)</b>
<b>TOTAL ASSETS EMPLOYED</b>	<b>183,887</b>	<b>184,236</b>	<b>349</b>
Public dividend capital	79,681	79,681	0
Revaluation reserve	72,570	72,570	0
Income and expenditure reserve	31,636	31,985	349
<b>TOTAL TAXPAYERS EQUITY</b>	<b>183,887</b>	<b>184,236</b>	<b>349</b>

## Capital Programme

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

The programme for 2016/17 is focussed around three key strategic projects, being the finalisation of the Christchurch development (£3.4 million), the refurbishment of the cardiology laboratories (£2.4 million), and the Trusts approved five year IT Strategy (£3.4 million).

Expenditure to date totals £3.9 million, representing a year to date under spend of £3.8 million. This is attributable mainly to further slippage against the Christchurch development, slippage against the cardiology laboratory refurbishments, and a delay in the CT3 building alterations.

A detailed re-forecast has been undertaken as a result of this slippage, and as reported previously, this confirms an anticipated under spend against the full year programme. This amounts to £3.3 million and reflects the slippage in the Christchurch Development together with an anticipated under spend against the total scheme costs; together with the delay in the refurbishment of the cardiology laboratories due to a more complex procurement process that originally anticipated.

Full detail at scheme level is set out below.

£'000	Annual	IN MONTH			YEAR TO DATE			FORECAST	
	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Actual	Variance
Christchurch Development	3,425	0	(19)	19	3,275	1,044	2,231	2,305	1,120
Cardiac Laboratories	2,400	395	0	395	425	0	425	50	2,350
CT3 Building Alterations	450	120	2	118	450	11	439	350	100
Estates Maintenance	400	80	7	73	370	145	225	865	(465)
Sterile Services Department	300	70	0	70	290	18	272	300	0
QI Projects (Frailty unit, AEC, Cardiac)	300	30	0	30	300	273	27	300	0
Miscellaneous Schemes	300	0	0	0	100	46	54	830	(530)
Capital Management	265	22	17	5	155	142	13	272	(7)
Catering Equipment	100	0	36	(36)	100	113	(13)	100	0
Medical Equipment	1,000	100	36	64	500	329	171	1,000	0
IT Strategy	3,409	304	317	(13)	1,710	1,785	(75)	2,685	724
<b>TOTAL</b>	<b>12,349</b>	<b>1,121</b>	<b>396</b>	<b>725</b>	<b>7,675</b>	<b>3,906</b>	<b>3,769</b>	<b>9,057</b>	<b>3,292</b>

## Cash

The Trust (excluding grouped entities) is currently holding £35.8 million in cash reserves. However, delays in the Christchurch development to date have resulted in a cash timing benefit when compared to the agreed phasing of the ITFF loan drawdown. As a result, the underlying cash position is significantly lower at £29.8 million.

After factoring in the anticipated capital under spend, the forecast closing cash balance for the current financial year is £23.06 million, and thus there is no requirement for Department of Health financial support at present.

The Trusts 24 month rolling cash flow forecast indicates that at the end of the next financial year, 31 March 2018, the Trusts cash balance will be reduced to £14.4 million. However, this is predicated on a range of assumptions within which there is material risk.

The Trust must ensure that it achieves its financial plan in the current year and secure the Sustainability and Transformation Fund payment in full to protect its medium term cash balance.

## Use of Resource Metric

As reported previously, NHS Improvement's new Single Oversight Framework was introduced with effect from 1 October 2016, replacing the previous Financial Sustainability Risk Rating.

The Trusts Use of Resources Metric as at 31 October 2016 is set out below.

	Plan Metric	Actual Metric	Risk Rating	Weighted Rating
Capital Service Cover	1.569x	1.625x	3	0.60
Liquidity	9.025	19.973	1	0.20
I&E Margin	(0.31%)	(0.30%)	3	0.60
I&E Variance to Plan	0%	0.01%	1	0.20
Agency Spend	0%	13.73%	1	0.20
<b>Trust UoR</b>				<b>2</b>
Mandatory Override				No
<b>Final UoR</b>				<b>2</b>

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



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The Royal Bournemouth and  
Christchurch Hospitals  
NHS Foundation Trust



## BOARD OF DIRECTORS

Meeting Date and Part:	25 <sup>th</sup> November 2016 – Part 1
Subject:	Workforce Report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	
Officer with overall responsibility:	Karen Allman
Author(s) of papers:	Karen Allman & Ellen Bull
Details of previous discussion and/or dissemination:	Specific issues are reviewed at Workforce Committee, HAC, Education & Training Committee
Action required: Approve/Discuss/Information/Note	For discussion and noting areas highlighted.
<p>Executive Summary:</p> <p>The report shows the performance of the Trust by care groups across a range of workforce metrics: Appraisal, Essential Core Skills, Turnover and Joiner rates, Sickness and Vacancies; plus safe staffing data. The report also includes an update on flu and workforce productivity.</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 – NOVEMBER 2016

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

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 October			Rolling 12 months to 31 October				At 31 October
Surgical	67.8%	85.4%	88.3%	4.69%	15429	13.1%	9.8%	
Medical	89.0%	80.5%	87.7%	4.09%	20545	15.1%	12.0%	
Specialities	87.0%	95.2%	91.4%	3.27%	9318	9.2%	11.1%	
Corporate	90.5%	0.0%	93.9%	3.92%	12603	6.6%	10.3%	
Trustwide	84.3%	86.2%	89.6%	4.03%	57895	11.5%	10.9%	

Staff Group	Appraisal Compliance		Mandatory	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental	Training Compliance	Absence	FTE Days			
	At 31 October			Rolling 12 months to 31 October				At 31 October
Add Prof Scientific and Technical	91.9%		91.8%	3.31%	1466	11.4%	15.2%	
Additional Clinical Services	80.5%		90.0%	6.01%	15435	17.4%	13.9%	
Administrative and Clerical	89.5%		93.6%	3.56%	10771	8.0%	9.2%	
Allied Health Professionals	95.0%		90.4%	2.18%	1977	15.5%	15.5%	
Estates and Ancillary	84.8%		91.1%	4.94%	6240	7.2%	10.0%	
Healthcare Scientists	81.4%		93.1%	3.09%	952	15.9%	17.1%	
Medical and Dental		86.2%	81.7%	1.43%	2274	4.3%	6.0%	
Nursing and Midwifery Registered	79.7%		89.4%	4.41%	18779	11.8%	9.7%	
Trustwide	84.3%	86.2%	89.6%	4.03%	57895	11.5%	10.9%	

## 1. Appraisal











Year 2 of the values based appraisal process commenced 1<sup>st</sup> April 2016 and compliance was reset to zero (apart from medical and dental staff). A trajectory was set through to the 6-month period end date of 30<sup>th</sup> September, reflecting the cascade nature of the process.

Compliance remains short of the 95% target but has increased this month to 84.3% for values-based appraisal overall. The situation is monitored at Workforce Committee and care groups confirm that dates have been set for all outstanding appraisal meetings.











## 2. Essential Core Skills Compliance

Following last month's slight dip in overall compliance at 89.9%, this month sees a further very small (0.3%) drop to 89.6%; however this still represents a 9.2% increase over the position at the same point last year (80.4%).

The table below shows the 10 areas with the lowest compliance as at 31<sup>st</sup> October:

Directorate	Organisation	Headcount	Compliance	Trend
Cancer Care Directorate	153 Haematology Snr.Medical 11346	20	68.44%	
Surgery Directorate	153 Obs/Gynae Medical Staff 10100	15	72.99%	
ED Directorate	153 ED Admin Clerical/Receptionist 10456	32	75.50%	
Medicine Directorate	153 Medical General Staff 10075	70	75.76%	
Anaesthetics/Theatres Directorate	153 ICU/HDU 10315	61	76.74%	
Anaesthetics/Theatres Directorate	153 Csd 55400	34	77.06%	
ED Directorate	153 ED Medical Staff 10015	36	77.40%	
Elderly Care Services Directorate	153 MFE Medical Staff 10077	52	77.56%	
Orthopaedics Directorate	153 Ortho Medical Staff 10160	29	80.00%	
ED Directorate	153 ED Nursing and Income 10455	91	81.97%	

Areas with highest compliance:

Directorate	Organisation	Headcount	Compliance	Trend
Finance and Business Intelligence	153 Supply Chain Management 14915	19	100.00%	
Informatics Directorate	153 Telecoms 13585	22	100.00%	
Finance and Business Intelligence	153 Information 13541	17	100.00%	
Specialist Services Directorate	153 Prosthetic/Orthotic Centre 12650	12	99.32%	
Cardiac Directorate	153 Cardiac Administration 11523	38	99.25%	
Pathology Directorate	153 Histology 11310	37	99.19%	
Informatics Directorate	153 Health Records 13540	40	98.75%	
Human Resources Directorate	153 Blended Education and Training 18100	12	98.68%	
Pathology Directorate	153 Haematology 11340	23	98.26%	
Human Resources Directorate	153 Human Resources 13570	26	98.08%	

## 3. Sickness Absence

The Trust-wide sickness rate shows a small increase to 4.03% (3.99% last month). Sickness rates are reviewed at Workforce Committee and hotspots are being actively managed within the care groups.

The table below shows the 10 areas with the highest 12-month rolling sickness absence as at 31<sup>st</sup> October:

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Anaesthetics/Theatres Directorate	153 Day Surgery Services 10385	33	9.82%	
153 Clinical Governance Directorate	153 Risk Management 14115	15	9.60%	
153 Elderly Care Services Directorate	153 MFE Ward 5 10378	41	9.23%	
153 Surgery Directorate	153 Ward 17 10428	31	8.58%	
153 Elderly Care Services Directorate	153 MFE Ward 24 10594	40	8.30%	
153 Elderly Care Services Directorate	153 MFE IP Therapy 10581	17	7.43%	
153 Elderly Care Services Directorate	153 MFE Ward 4 10382	34	7.40%	
153 Elderly Care Services Directorate	153 XCH Nurs Day Hospital 10576	37	7.32%	
153 Ophthalmology Directorate	153 BEU Outpatients 10480	25	7.29%	
153 Orthopaedics Directorate	153 Derwent Ward 10586	64	7.20%	

Several of these areas have been on this list for a significant period of time and have deteriorated rather than improved. I have been assured that action plans are in place and that all appropriate interventions are being done. There has been another discussion at the Operational Performance Management Group where it has been agreed that whilst the formal trigger for sickness absence review will remain at 350, there will be more focus on levels between 250 and 350 to identify other patterns or issues for resolution. To support the management of sickness absence an electronic version of the return to work form has been produced and is being trialled in several areas with a view to rolling out across the organisation.

Areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Pathology Directorate	153 Medical Staff - Histology 11300	11	0.12%	
153 Other Directorate	153 Postgraduate Centre 13531	13	0.16%	
153 Surgery Directorate	153 Surgery - Urology 10084	19	0.27%	
153 Surgery Directorate	153 Surgery - General 10085	37	0.50%	
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	42	0.62%	
153 Medicine Directorate	153 Medical General Staff 10075	99	0.70%	
153 Elderly Care Services Directorate	153 MFE Medical Staff 10077	53	0.80%	
153 Other Directorate	153 Chief Executive 13535	25	0.86%	
153 Elderly Care Services Directorate	153 Dietitians 13315	16	0.96%	
153 Orthopaedics Directorate	153 Ortho Medical Staff 10160	37	0.97%	

#### 4. Turnover and Joiner Rate

Joining and turnover rates of 11.5% and 10.9% respectively have both reduced slightly over the previous month (11.8% and 11.2%). The joining rate continues at a higher level than the turnover rate; and encouragingly the turnover rate has fallen over the past year, down from 12.6% at this point in 2015.

#### 5. Vacancy Rate

The vacancy rate is not available at the time of submitting this report and will be advised at the meeting.

#### 6. Safe Staffing

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

Registered nurse days	92%
Healthcare assistant days	99.5%
Registered nurse nights	97.2%
Healthcare assistant nights	114.6%

The fill rate of registered nurses has improved in month compared to the previous month. This is now at 92%, demonstrating improvement. The slight overfill rate for nights HCAs are due to enhanced care needs.

There are no red flags in month for care groups A, B or C.

Tier 3 use of Agency remains nil in month, recognising the improvement work in rosters. As we head into the usual challenging months of December and January, we will be examining how to minimise use of Tier 3 for extra capacity against other staffing options.

## **7. Health and Wellbeing**

We are now several months into the flu campaign for the Trust. At the time of submitting this paper nearly 2500 staff had already received the vaccine through the Trust service - this compares favourably to previous years. We are particularly keen that front-line staff receive the vaccine and will continue to publicise the importance and availability of the programme to try and increase these numbers.

As part of the campaign we have produced posters, short voxpops for social media and screen savers and provided other incentives for staff to take up the vaccine.

## **8. Workforce Productivity**

As part of our workforce transformation we have secured an additional module of the rostering service that we have from Allocate.

This “Insight” Service was recently referenced at the Healthcare Assurance Committee and will provide us with more detailed information regarding the rostering performance across the Trust and allow benchmarking with other Trusts.

The service that has been designed will help Trusts get the most value from their HealthRoster implementation and is closely aligned with the Carter program to improve productivity, interrogate and compare CHPPD metrics.

The service has been designed to focus on several key areas including Trust progress and systems, maximising the workforce productivity, and comparative benchmarking both internally and externally.

Data and benchmarking will be reviewed in detail at the E-rostering steering board and disseminated across the Trust. This system will allow us to consider areas of strong performance and identify key interventions for improvement.

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## BOARD OF DIRECTORS

<b>Meeting Date and Part:</b>	25 <sup>th</sup> November 2016 – Part I
<b>Subject:</b>	Stroke Services Update
<b>Section on agenda:</b>	Performance
<b>Supplementary Reading (included in the Reading Pack)</b>	None
<b>Officer with overall responsibility:</b>	Richard Renaut, Chief Operating Officer
<b>Author(s) of papers:</b>	Claire Stalley, Stroke Services, Neurotherapy & Stroke Manager
<b>Details of previous discussion and/or dissemination:</b>	Monthly Performance Reports
<b>Action required: Approve / Discuss / Information / Note</b>	The Board of Directors is asked to receive this report and to note the progress made against the measures of an effective stroke service, and the risks being mitigated.
<b>Executive Summary:</b> This report covers: <ul style="list-style-type: none"> <li>• Most recent published stroke performance using Sentinel Stroke National Audit Programme (SSNAP) (Tri-annual report 1: April to July 2016)</li> <li>• Our internal assessment of performance for August, September and October (Tri-annual report 2 to date)</li> <li>• Detailed actions the service is taking to sustain performance to SSNAP Level A with no domain area below C, and the majority moving to B or better and to sustain performance in the upper quartile (Annex)</li> <li>• Key Indicators Summary for SSNAP Acute Organisational Audit 2016</li> </ul>	
<b>Relevant CQC domain:</b> <b>Are they safe?</b> <b>Are they effective?</b> <b>Are they caring?</b> <b>Are they responsive to people's needs?</b> <b>Are they well-led?</b>	1. to offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care 2. to promote and improve the quality of life of our patients 3. to strive towards excellence in the services and care we provide 4. to be the provider of choice for local patients and GPs 5. to listen to, support, motivate and develop our staff
<b>Risk Profile:</b> i) <b>Impact on existing risk?</b> ii) <b>Identification of a new risk?</b>	Compliance with Stroke Standards on Assurance Framework. No new risk

# Stroke Services Update

## 1. Introduction

This paper covers:

- Most recent published stroke performance using Sentinel Stroke National Audit Programme (SSNAP) (Triannual report 1: April to July 2016)
- Our internal assessment of performance for August, September and October (Tri-annual report 2 to date)
- Detailed actions the service is taking to sustain performance to SSNAP Level A with no domain area below C, and the majority moving to B or better and to sustain performance in the upper quartile (Annex)
- Key Indicators Summary for SSNAP Acute Organisational Audit 2016

The quality of stroke services is measured via tri-annual (four-monthly) SSNAP results. To achieve a SSNAP Level A, a score of 80.1 or more is required. The more recent SSNAP results cover T1, April to July 2016, in which RBCH achieved SSNAP Level A and a score of 86. Nationally for T1, 18% of Trusts achieved a SSNAP level A which is 42 out of 228 Trusts. Only 12 Trusts achieved a score of 86 or higher placing us in the top 5%. To put this result into local context with the rest of Wessex; we were the only team within Wessex to achieve a SSNAP Level A. The Royal Hampshire County Hospital and Southampton General Hospital both achieved a Level B; and the remainder a Level C or Level D. Within Dorset; Dorset County Hospital achieved SSNAP Level D with a score of 52.3; and Poole Hospital a Level C with a score of 62.7.

Ensuring sustainability of improvements over the next 12 months relies upon expansion of the radiology service out of hours, management of risks specifically relating to staffing and establishing required psychology provision. By delivering the overall plan our trajectory is to sustain SSNAP Level A with no domain lower than level C.

## 2. Summary of SSNAP

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

Quarter	July-Sept 2015	Oct-Dec 2015	Jan-March 2016	Apr-July 2016	National Average
SSNAP level	B	B	A	A	
SSNAP score (team-centred)	78	80	88	86	
Case ascertainment band	A	A	A	A	A
Audit compliance band	A	A	A	A	B
1) Scanning	B	C	B	C	B
2) Stroke unit	C	C	C	C	C
3) Thrombolysis	C	C	B	C	C
4) Specialist Assessments	C	C	B	B	C
5) Occupational therapy	A	A	A	A	B
6) Physiotherapy	B	B	B	A	B
7) Speech and Language therapy	B	A	A	A	D
8) MDT working	B	B	A	A	C
9) Standards by discharge	B	A	A	A	B
10) Discharge processes	A	A	A	A	B

The Stroke Service is delighted to have sustained a SSNAP Level A; this is the accumulation of a significant amount of hard work by the entire Stroke MDT and work undertaken in close collaboration with our colleagues in the Emergency Department, the Radiology Department, the Clinical Site Team and the Information Department..

For T1, Scanning and Thrombolysis reduced from a Level B to a Level C;  
Physiotherapy improved from a Level B to a Level A:

### Scanning Domain

- Detailed analysis of breaches for 12 hour scans has confirmed that the majority were patients presenting with atypical stroke presentations and therefore a late diagnosis of stroke.
- The Stroke Service is working in collaboration with the Trust Communications Team on a Trust-wide Stroke Awareness/Recognition Campaign of which one of the key aims is to raise awareness of atypical/less common stroke symptoms.

### Thrombolysis Domain

- Whilst our performance with Thrombolysis domain has reduced from a Level B to a Level C, we continue to perform strongly with the proportion of patients thrombolysed within 1 hour of clock start – 57.9% (note to achieve an A for this key indicator, a score > 55% is required).
- There has been a reduction in our thrombolysis rate however 94% of patients SSNAP deemed eligible for Thrombolysis were thrombolysed.
- The majority of breaches with door to needle time of < 1 hour were due to clinical decisions to delay as patient symptoms were improving or patients initially presenting with atypical symptoms leading to a delay to starting thrombolysis pathway.

- A further aim of Stroke Awareness/Recognition Campaign is to improve early referral of suspected stroke patients to our Stroke Outreach team to enable greater opportunity for early thrombolysis if indicated.

### **Physiotherapy Domain**

- The improvement of Physiotherapy from Level B to Level A is a significant achievement (only 33% of teams nationally achieving a Level A), considerable work has been undertaken to implement group therapy sessions which has likely contributed to this improvement.

Whilst Stroke Unit domain continues to be a Level C, it is notable that we are continuing to sustain an improved performance with the percentage of patients spending at least 90% of their stay on a stroke unit. For T1 we achieved a score of 86% which is the highest we have ever achieved and for T2 to date this is at 88.6% (note to achieve an A for this key indicator a score of 90% is required). Quality improvement projects re. Stroke MDT working and Stroke Ambulatory Care have been significant in achieving and sustaining these improvements. We continue to be proactive with sharing our good practice and presenting at various forums both regionally and nationally.

### **3. SSNAP Organisational Audit 2016**

SSNAP completed an Organisational Audit for all Stroke Units in England, Wales and Northern Ireland assessing compliance of services against 10 key indicators. RBCH was deemed to be compliant with 7 out of 10 indicators (31% of Trusts achieved  $\geq 7$  key indicators).

Key indicators were not achieved for the following:

- Presence of a clinical psychologist (qualified) at least 1 wte per 30 SU beds – note we currently have 0.2 wte per 36 beds (non-substantive post and non-recurrent funding);
- Nurses on duty at 10am weekends at least 3 or more nurses per 10 type 1 and type 3 beds – note we currently have 2.8;
- Patients can access intra-arterial (thrombectomy) treatment – note we have an ad hoc arrangement with Wessex Neuro for certain patient groups (in-hours Monday to Friday).

### **4. Other stroke actions**

We are pleased to have the opportunity to work together with our Stroke Service colleagues at Poole Hospital and Dorset County Hospital for the Stroke Vanguard work stream as part of the Acute Care Collaboration Vanguard for 'Developing One NHS in Dorset'. We have made considerable progress with excellent engagement from clinicians and managers from each of the three organisations. Work to date includes the following:



- Development of a Dorset ‘document of principle’ stroke service specification detailing standards for future stroke service provision in Dorset. The framework which we developed for this has been adopted by Dorset CCG to be used as a Framework for Future Commissioning.
- Well established Stroke Workstream and Sub-streams for TIA; Pre-hospital and Hyper-acute; Acute; and Stroke ESD which will develop options appraisals and implementation plans to deliver the Dorset Stroke Specification. Membership includes representation from the Stroke Association, SWAST/SCAST, Social Services and DHUFT.
- A Dorset Guide to SSNAP and plans to align processes and practices.
- Workforce plan and shared stroke specialist competencies across Dorset.
- Development of a Strategic Outline Case which was presented to Vanguard Executive Steering Group in October.

## **5. Stroke Performance and Delivery Plan: impact of new National Clinical Guideline.**

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

A SSNAP Level A (score of 80.1+) is sustainable and our ambition is to achieve no domain being lower than a Level B. It is likely however that with the recent release of new RCP Guideline for Stroke (2016) that the parameters for success for a number of the key indicators are set to increase and need to be addressed to ensure we are able to maintain a high level performance in the future. The headline changes to National Clinical Guideline for Stroke is as follows:

- TIA: removal of risk stratification for TIA requiring all suspected TIA patients to be seen, assessed and treatment commenced within 24 hours of first presenting to a health care professional;
- Scanning: for all stroke patients to be scanned within 1 hour of arrival to hospital (or stroke if this occurs as an in-patient);
- Psychology: recommendation for 0.2 wte Psychology provision per 5 Stroke Unit beds – therefore RBCH should have 1.4 wte (currently 0.2 wte non-substantive post).

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

## 6. Risk Mitigation

The Stroke Outreach Service continues to deliver considerable improvement with our front door performance and ensuring all acute assessments are completed in a timely manner. It is proving considerably challenging for the team (only 4 wte) to provide such an extended service of 7am to midnight 7 days a week. Due to vacancy and staff sickness we will be unable to sustain provision of these hours in November and December and will be reducing the availability of this service to 8am to 10pm 7-days a week. We have mitigation actions in place as much as feasible given the available staffing resource and will closely monitor associated performance.

We have advertised for a 1.0 wte Stroke Consultant to replace Dr Loganathan, our full-time Associate Specialist Doctor, who left the service in July. To date we have had no response to advert. We will have a further 0.9 wte Stroke Consultant post to cover from March 2016 due to maternity leave.

Risks remain in achieving the targets; these include access to stroke beds due to timely discharges and the surge in Trust admissions leading to non-stroke patients outlying on the stroke unit. This will be mitigated through the wider urgent care work and the specific actions on discharge.

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

## 7. Recommendation

<b>The Board is asked to receive this report, and to note the sustained progress made against the measures of an effective stroke service.</b>
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**ANNEX: STROKE PERFORMANCE & DELIVERY PLAN – NOVEMBER 2016 (up to 11<sup>th</sup> November) – ONE PAGE SUMMARY**

<b>DOMAIN</b>	<b>SSNAP T1 (Apr-July)</b>	<b>T2 to date (Aug-Nov)</b>	<b>Plans</b>	<b>Comments/Risks</b>
<b>1 Scanning</b>	C	C	<ul style="list-style-type: none"> <li>Trust Stroke Awareness campaign planned early 17</li> <li>On-site Radiographer OOH Jan 17 and CT3 April 17</li> </ul>	<ul style="list-style-type: none"> <li>Delayed identification of atypical stroke patients</li> <li>Reduced Stroke Outreach cover</li> </ul>
<b>2 Stroke Unit</b>	C	C	<ul style="list-style-type: none"> <li>Stroke QI Project to address pt flow – currently ambulatory care and Extended LOS Project</li> </ul>	<ul style="list-style-type: none"> <li>As above and also &amp; delays with MFFD patients awaiting care/placement</li> <li>Reduced Stroke Outreach cover</li> </ul>
<b>3 Thrombolysis</b>	C	C	<ul style="list-style-type: none"> <li>SIM training - ongoing</li> <li>Stroke Awareness Campaign may increase calls for thrombolysis</li> </ul>	<ul style="list-style-type: none"> <li>OOH delays due to radiographer being off-site and off-site radiologist review</li> <li>Reduced Stroke outreach cover</li> </ul>
<b>4 Specialist Assessments</b>	B	B	<ul style="list-style-type: none"> <li>Ongoing twice daily MDT rounds for new pt assessments</li> </ul>	<ul style="list-style-type: none"> <li>Stroke Consultant - 7 day provision</li> <li>Reduced Stroke Outreach cover</li> </ul>
<b>5 Occupational Therapy</b>	A	A	<ul style="list-style-type: none"> <li>Breakfast group</li> <li>'Tell your Story' Group</li> </ul>	<ul style="list-style-type: none"> <li>Upcoming 1.0 wte Band 6 mat leave</li> <li>Therapy Assistant vacancy</li> </ul>
<b>6 Physiotherapy</b>	A	A	<ul style="list-style-type: none"> <li>Exercise group</li> </ul>	<ul style="list-style-type: none"> <li>Upcoming 1.47 wte Band 6 mat leave</li> <li>Therapy Assistant vacancy</li> </ul>
<b>7 Speech and Language Therapy</b>	A	A	<ul style="list-style-type: none"> <li>Breakfast group</li> <li>Lunch Group</li> </ul>	<ul style="list-style-type: none"> <li>Therapy Assistant vacancy</li> <li>Band 6 SALT vacancy</li> </ul>
<b>8 MDT Working</b>	A	A	<ul style="list-style-type: none"> <li>Ongoing twice daily MDT rounds for new pt assessments</li> </ul>	<ul style="list-style-type: none"> <li>Upcoming OT and PT mat leave</li> <li>SALT vacancy</li> </ul>
<b>9 Standards by discharge</b>	A	A	<ul style="list-style-type: none"> <li>Induction for new staff</li> </ul>	<ul style="list-style-type: none"> <li>On track</li> </ul>
<b>10 Discharge Processes</b>	A	A		<ul style="list-style-type: none"> <li>On track</li> </ul>
<b>Audit compliance</b>	A	A	<ul style="list-style-type: none"> <li>Continue NIHSS training of all staff</li> </ul>	
<b>Case ascertainment</b>	A	A	<ul style="list-style-type: none"> <li>Monthly lockdown checks will be performed</li> </ul>	<ul style="list-style-type: none"> <li>On track</li> </ul>
<b>SSNAP Level</b>	A	A		
<b>SSNAP Score</b>	86	86	Note: 80.1 is an A!	

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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	T2 (to date)	Key Improvement Actions
1.1 Proportion of patients scanned within 1 hour of clock start (A = 48%)	43% (B)	39%(C)	38%(C)	<ul style="list-style-type: none"> <li>Main impacting factor on performance is those patients who are late diagnosis stroke (atypical presentation) i.e. missed on admission and so are not scanned within the required timescales.</li> <li>Going forwards from T1 we are going to clearly categorise patients who have breached to help us monitor numbers/proportions, focus actions to address and monitor our progress.</li> <li>Continue monthly breach analysis for any 12 hour scan breaches and review 1 hour patients to ensure those who are eligible are receiving urgent scanning in order to see where further improvements can be made</li> <li>Promote greater understanding of the stroke targets throughout Trust to improve urgency of referral to Stroke Outreach – this will be a key aim of upcoming Stroke Awareness Campaign which will ensure all are clear on actions to take if suspect stroke and raise awareness of atypical stroke symptoms.</li> <li>CT3 and on-site Radiographer 24/7</li> </ul> <p>For T1 &amp;T2 to date * the increase in median time to scan is primarily due to a recent high number of atypical presenting stroke patients (as detailed above) that resulted in a delayed stroke diagnosis and delayed time to scan. As detailed above this is a primary focus of the service to raise awareness throughout the Trust of atypical presenting strokes to help try and address this – see point 3 below.</p>
1.2 Proportion of patients scanned within 12 hours of clock start (A = 95%)	90% (B)	91.3% (B)	91.1% (B)	
1.3 Median time between clock start and scan (A = < 60mins)	< 75 mins (B)	94mins (D)*	98 mins (D)	

**Domain 1: Delivery Plan**

<b>Delivery Plan</b>	<b>Timescale for completion</b>	<b>Comment</b>
1. To continue to undertake a breach analysis of all patients who do not get their scan in the required timescales	ongoing	<ul style="list-style-type: none"> <li>Primary breach group is atypical presenting stroke patients.</li> </ul>
2. To implement a clear categorisation for all breaches so we can clearly understand which are due to atypical/complex clinical presentations and which are due to process/organisational misses	ongoing	<ul style="list-style-type: none"> <li>This is now in place from April 2016</li> </ul>
3. Targeted education to improve stroke recognition, particularly for non-FAST presenting stroke.	Early 2017	<ul style="list-style-type: none"> <li>To develop a Stroke Brand (similar to Sepsis campaign) to be able to undertake a stroke campaign within the hospital.</li> <li>Main aims to ensure all are aware to contact Stroke Outreach if patient ? stroke and to raise awareness of less common stroke symptoms</li> </ul>
4. Monthly breach analysis for 12 hour scan breaches to be extended to 1 hour scanning to review patients scanned against those who fit criteria.	Ongoing	<ul style="list-style-type: none"> <li>Audit underway to review whether patients deemed as requiring a 1 hour scan have one in required timescales (as this isn't assessed by SSNAP).</li> <li>To develop action plan as required re. any emerging themes - ? to confirm whether any breaches for in-patient stroke cohort.</li> </ul>
5. To review options to ensure all patients have their scan within 12 hours of arrival	Ongoing	<ul style="list-style-type: none"> <li>Potential for Radiology to extending scanning hours until 10pm – linked to radiographer staying on-site. MB to keep us updated.</li> </ul>
6. To work with Radiology as required to support development of electronic CT request form submission	As Needed	<ul style="list-style-type: none"> <li>MB to update as required</li> </ul>
7. Implementation of CT3 and plan that X-ray Radiographers will be able to undertake CT Brain Scans	? April 2017	<ul style="list-style-type: none"> <li>The intention would be that with CT 3 in ED that someone would be on-site 24/7 to be able to undertake CT Brain scans</li> </ul>
8. Stroke Outreach to receive a 'pre-alert' for all FAST positive patients not just those who may be for thrombolysis.	On hold – to review re. Vanguard	<ul style="list-style-type: none"> <li>This has been put on hold as SWAST and SCAST need it to be a pre-alert for all Wessex-wide stroke service providers and the other Acute Stroke Services are currently not in a position to be able to respond. Review as part of Vanguard.</li> </ul>
9. To closely monitor in the impact of reduced Stroke Outreach service (sickness and vacancy) and mitigate wherever possible. Aim to re-establish full service ASAP from early 2017	January 2017	<ul style="list-style-type: none"> <li></li> </ul>

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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	T2 (to date)	Key Improvement Actions
2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (A = 90%)	75% (B)	72.1% (C)	69.5% (C)	<ul style="list-style-type: none"> <li>Establish a pre-alert for all stroke patients coming to RBH</li> <li>Continue to raise awareness to contact Stroke Outreach if patient ? stroke and of less common stroke symptoms.</li> <li>Immediate re-triage of any non-stroke patients on the SU to facilitate transfer off SU</li> <li>Stroke Quality Improvement projects – stroke ambulatory care, extended LOS, review of MDT working and Complex Nutrition Project.</li> <li>Main impacting two impacting factors on performance are:               <ol style="list-style-type: none"> <li>Atypical presenting stroke                   <ul style="list-style-type: none"> <li>Patients presenting without clear stroke symptoms and being treated appropriately for something else i.e. sepsis and likely would not have been diagnosed as a stroke even by a Stroke Consultant and often not diagnosed until CT scan indicates stroke.</li> </ul> </li> <li>Delays with discharge for patients who are MFFD particularly from Hampshire SS who will not allocate/see patients until they are MFFD. Patients waiting for POC, NH, CHC etc</li> </ol> </li> </ul>
2.2 Median time between clock start and arrival on stroke unit (hours:mins) (A = Median < 2 hrs)	Median < 3 hrs (B)	03:10 (C)	03:14 (C)	
2.3 Proportion of patients who spent at least 90% of their stay on stroke unit (A = 90%)	85% (B)	86% (B)	88.6% (A)	

## Domain 2: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Collaboration with ED/SWAST/SCAS regarding pre-alert and pre-hospital information provision for stroke patients	On hold – review with Vanguard	<ul style="list-style-type: none"> <li>This has been put on hold as SWAST and SCAS need it to be a pre-alert for all Wessex-wide stroke service providers and the other Acute Stroke Services are currently not in a position to be able to respond – review with Vanguard</li> </ul>
2. To implement a clear categorisation for all breaches so we can clearly understand which are due to atypical/complex clinical presentations and due to process misses	ongoing	<ul style="list-style-type: none"> <li>This is now in place from April</li> </ul>
3. Targeted education to improve stroke recognition, particularly for non-FAST presenting stroke.	Early 2017	<ul style="list-style-type: none"> <li>To develop a Stroke Brand (similar to Sepsis campaign) to be able to undertake a stroke campaign within the hospital.</li> <li>Main aims to ensure all are aware to contact Stroke Outreach if patient ? stroke and to raise awareness of less common stroke symptoms</li> </ul>
4. Stroke QI: Ambulatory Care – to review impact of ambulatory care for stroke	complete	<ul style="list-style-type: none"> <li>Ambulatory Care clinics are now happening on a daily weekday basis on the Stroke Further work is being undertaken to develop FAST MRI in collaboration with Radiology</li> </ul>
5. Stroke QI: MDT Review – to write up impact of MDT working changes and their impact	complete	<ul style="list-style-type: none"> <li>On track and abstract selected for platform presentation at UK stroke forum</li> </ul>
6. Stroke QI: Extended LOS – to undertake a case notes review/audit of patients with a LOS $\geq$ 30 days to determine key themes contributing to extended LOS and actions to address	On hold	<ul style="list-style-type: none"> <li>Notes audit complete and identified 5 key factors contributing to extended LoS (independent prior to admission, Mod stroke 5-15, cognitive impairment, continence issues, communication impairment). Plan to undertake focused research project with Research Fellow.</li> </ul>
7. To improve collaborative working with CST re. full appreciation of Stroke metrics	ongoing	<ul style="list-style-type: none"> <li>'Link person' now arranged from CST and initial meetings planned.</li> <li>Review bed use overnight and keeping empty beds for likely new admissions</li> <li>Where possible outreach team to attend 10am bed meetings</li> <li>CST to be informed of pts arrival time to assist in prioritising pts transfers</li> <li>Stroke unit co-ordinator to hold a bleep solely for new admissions</li> </ul>
8. To continue to work proactively with the Trust Discharge Team, Social Services and other agencies to facilitate discharge at earliest possible time	ongoing	<ul style="list-style-type: none"> <li>Meetings underway with Dorset and Bournemouth SS</li> <li>Need to establish links with Hampshire SS</li> </ul>
9. To closely monitor in the impact of reduced Stroke Outreach service (sickness and vacancy) and mitigate wherever possible. Aim to re-establish full service ASAP from early 2017	January 2017	<ul style="list-style-type: none"> <li></li> </ul>



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

DOMAIN KEY INDICATORS	Plan (B)	Last SSNAP (C)	T2 (to date)	Key Improvement Actions
3.1 Proportion of all stroke patients given thrombolysis (A=20%)	12% (C)	7.9% (E)	13% (C)	<ul style="list-style-type: none"> <li>To maintain good standards of awareness of acute stroke identification and management, including thrombolysis eligibility across the Trust.</li> <li>To reduce door to needle times for thrombolysis treatment through engagement with all those involved in the pathway.</li> <li>To review all breaches to achieving thrombolysis within 1 hour of clock start to determine whether clinically appropriate delay or a process delay</li> <li>To use stakeholder engagement to identify training needs and areas for service improvement to optimise prompt and effective care and decision making.</li> <li>Review of breaches indicates that our Door to Needle time is significantly less in hours than OOH due to delays OOH waiting for radiographer to come in and for Radiologist to report</li> </ul>
3.2 Proportion of eligible patients given thrombolysis (A=90%)	100% (A)	94% (A)	100% (A)	
3.3 Proportion of patients who were thrombolysed within 1 hour of clock start (A=55%)	55% (A)	57.9% (A)	48% (C)	
3.4 Proportion of applicable patients directly admitted to a stroke unit within 4 hours of clock start and received thrombolysis or have a pre-specified justifiable reason (“no but”) for why it couldn’t be given (A = 65%)	65% (A)	72.1% (A)	69.5% (A)	
3.5 Median time between clock start and thrombolysis (A=< 40mins)	< 50 mins (B)	01:00 mins (D)	01:02 mins (D)	

Note\*: for key indicator 3.1, patients can only be given thrombolysis if they meet the required eligibility criteria as per key indicator 3.2. For Q1 to date, 10.9% of patients were given thrombolysis which is 100% of patients who were eligible for thrombolysis, we could not have achieved higher than 10.5% for key indicator 3.1.

**Domain 3: Delivery Plan**

<b>Delivery Plan</b>	<b>Timescale for completion</b>	<b>Comment</b>
1. To complete a breach analysis of all thrombolysis cases taking more than 1 hour and identify themes to be addressed	ongoing	<ul style="list-style-type: none"> <li>To work through action plan to address any contributing factors/themes i.e. out-of-hour radiology reporting, bedside coag check to reduce waits for INR.</li> </ul>
2. To support developing stroke outreach service and other staff delivering thrombolysis with skills to support thrombolysis pathway to help speed to stroke specific assessment and reduce door to needle time.	Ongoing	<ul style="list-style-type: none"> <li>Regular teaching sessions established for all Medical registrars to improve knowledge and skill re thrombolysis to support prompt service delivery – MD and KC/KH</li> <li>On-going supervision and competency sign-off with Stroke Outreach Team.</li> </ul>
3. Deliver a robust pathway for thrombolysis for patients having stroke as in-patient to improve efficiency in these cases	complete	<ul style="list-style-type: none"> <li>Updating protocol for the in-patient management of Thrombolysis in acute stroke pathway.</li> <li>Laminated print out of pathway in thrombolysis bag.</li> </ul>
4. To improve documentation for families re. thrombolysis and tools to support explanation of risk/benefit to support patient and relative understanding and decisions.	complete	<ul style="list-style-type: none"> <li>Patient and relative thrombolysis information completed and approved by PIG.</li> <li>Further investigation following UKSF re tools being devised to share following a research project in Scotland.</li> </ul>
5. To ensure thrombolysis bag always has necessary items always available and a robust regular checks are in place. Ensure safety of contents too (i.e. clarify if meds should be locked)	Ongoing	<ul style="list-style-type: none"> <li>Contents checklist agreed and programme for regular checking confirmed</li> <li>Decision to be made re medication and suitability in bag in line with pathway work. Agreed for medication to not be included in the bag.</li> </ul>
6. Liaising with ambulance teams to optimise pre-hospital care	Review with Vanguard	<ul style="list-style-type: none"> <li>KC to work with Keith Childs re suitable tablet device for team and train Stroke Outreach in using the new system. Issue re windows 10 and running relevant software. This has been reviewed and not currently a viable option.</li> <li>Continue to explore options for pre-alert.</li> </ul>
7. Consider use of tools for quick body measurements to more accurately estimate patients' weight and ensure delivering accurate dose of medication to optimise their outcome.	complete	<ul style="list-style-type: none"> <li>Investigation on-going and to liaise with local trusts where this is regular practice i.e. PHT</li> <li>Review of potentially suitable tools</li> <li>Audit in progress to check accuracy of weight predictions for thrombolysis patients.</li> </ul>
8. To implement bedside Coag check to reduce wait for INR	complete	<ul style="list-style-type: none"> <li>Coag checked and purchased currently being PAT tested.</li> <li>SOP</li> <li>Audit accuracy ongoing and to be completed before instigating clinical use.</li> </ul>
9. To closely monitor in the impact of reduced Stroke Outreach service (sickness and vacancy) and mitigate wherever possible. Aim to re-establish full service ASAP from early 2017	January 2017	<ul style="list-style-type: none"> <li></li> </ul>

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

DOMAIN KEY INDICATORS	Plan (C)	Last SSNAP (B)	T2 (to date)	Key Improvement Actions
4.1 Proportion of patients assessed by a stroke consultant within 24hrs of clock start (A=95%)	80% (C)	76.8% (D)	80.7% (C)	<ul style="list-style-type: none"> <li>To undertake an ongoing breach analysis for this as 4.1 and 4.2 continue to be low performing scores.</li> <li>Previous analysis of breaches indicated breaches were for weekend/BH admissions, late diagnosis pts</li> <li>New twice daily MDT Assessment rounds to improve time to assessment Monday to Friday</li> <li>Explore options to deliver Stroke Consultant cover at the weekend – network approach/additional Stroke Consultant (Vanguard)</li> </ul>
4.2 Median time between clock start and being seen by stroke consultant (hrs:mins) (A=<6hrs)	<15hrs (D)	15:27 (E)	16:39 (E)	
4.3 Proportion of patients who were assessed by a nurse trained in stroke management within 24hrs of clock start (A=95%)	95% (A)	96.3% (A)	95.3% (A)	<ul style="list-style-type: none"> <li>Ensure 85% of Stroke Nurses are competent in NIHSS, WSS and complete these as a priority with patients on arrival to SU if they have not already been completed.</li> <li>Stroke Outreach to try to use 'Mobimed/ECS' to identify and review potential strokes from paramedics earlier in pathway (reduce time to stroke nurse).</li> <li>Review of SSNAP data collection to ensure time to stroke nurse is accurate esp for thrombolysed patients (completed Jan 16)</li> <li>Continue stroke awareness work via many channels to improve referrals/awareness of Outreach team.</li> </ul>
4.4 Median time between clock start and being assessed by stroke nurse (A=< 60mins)	< 60 mins (A)	00:39 mins (A)	00:29 mins (A)	
4.5 Proportion of applicable patients who were given a water swallow screen within 4hrs of clock start (A=85%)	85% (A)	84.5% (A)	83.4% (B)	<ul style="list-style-type: none"> <li>Sub-analysis of patients who fail WSS target to further understand the limitations and gaps in current provision</li> <li>Stroke Outreach; all trained to do WSS - complete</li> <li>Stroke Unit; all B5 and B6 nurses to be trained and competent in WSS</li> <li>Organise rolling programme of training in ED/SU</li> <li>Try to link with AMU to call Stroke Outreach and put NBM if stroke considered....</li> <li>Ensure consistent/accurate documentation for patients who immediately fail WSS (i.e. too drowsy) and that this is inputted accurately into SSNAP</li> </ul>
4.6 Proportion of applicable patients who were given a formal swallow assessment within 72hrs of clock start (A=85%)	85% (A)	98.1% (A)	96.6% (A)	<ul style="list-style-type: none"> <li>Understand any risks to sustaining this level of performance i.e. SALT recruitment challenges</li> <li>SALT continue to prioritise formal swallow assessment within existing service; impact of reduced staffing should be minimal.</li> </ul>

## Domain 4: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Options to introduce 7-day Consultant ward-rounds when Stroke Consultant wte fully established	Ongoing as part of Vanguard	<ul style="list-style-type: none"> <li>• BJ/AW to review feasibility of implementing 7-day Stroke Consultant ward-rounds</li> <li>• Vanguard stroke</li> </ul>
2. Review all patients for Q4 who breached being assessed by Stroke Consultant within 24 hours of clock start	complete	<ul style="list-style-type: none"> <li>• Breaches continue to be weekend/BH admissions and those with atypically presenting stroke</li> </ul>
3. Amend thrombolysis and stroke outreach initial assessment documentation to include whether Stroke Consultant was present for patient assessment	Complete	<ul style="list-style-type: none"> <li>• Complete and in-place</li> </ul>
4. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in WSS	Complete Ongoing with new staff	<ul style="list-style-type: none"> <li>• Put in place a training plan to achieve 85% compliance with Band 5 and 6 Nurses</li> <li>• All new staff to complete training and be signed off as competent within 3 months of starting on unit</li> </ul>
5. Ensure 85% Band 5 and Band 6 nurses on the SU are trained and assessed as competent in NIHSS	Ongoing as staffing allows	<ul style="list-style-type: none"> <li>• New Stroke Specialist Nurse commences in January 2016 which will significantly help nurse training</li> <li>• Put in place a training plan to achieve 85% compliance with Band 5 and 6 Nurses</li> <li>• All new staff to complete training and be signed off as competent within 3 months of starting on unit</li> </ul>
6. To closely monitor in the impact of reduced Stroke Outreach service (sickness and vacancy) and mitigate wherever possible. Aim to re-establish full service ASAP from early 2017	January 2017	<ul style="list-style-type: none"> <li>•</li> </ul>

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	T2 (to date)	Key Improvement Actions
5.1 Proportion of patients reported as requiring occupational therapy (A=80%)	80% (A)	78.9% (B)	88.7% (A)	<ul style="list-style-type: none"> <li>On-going monitoring / validation of data collection to maintain “A”</li> </ul>
5.2 Median number of minutes per day on which occupational therapy is received (A= >32 mins)	>32 mins (A)	41.7 (A)	35 (A)	<ul style="list-style-type: none"> <li>Continue to ensure end dates for OT are being inputted and progress maintained via senior support and validation</li> <li>Build on new timetabling process introduced, to further increase efficiency of therapy planning and release time for rehab sessions via additional group work &amp; more coordinated use of TAs</li> <li>Maintain consistent therapy groups on the unit</li> <li>Upcoming band 6, 1.0 wte OT mat leave</li> <li>Upcoming rehab assistant vacancies - band 3, 2.0 wte and band 2, 1.0 wte from September</li> </ul>
5.3 Median % of days as an inpatient on which occupational therapy is received (A=>70%)	>70% (A)	76.8% (A)	86.2% (A)	
5.4 Compliance (%) against the therapy target of an average of 25.7 minutes of occupational therapy across all patients (A=80%)	80% (A)	98.2% (A)	100% (A)	

## Domain 5: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. To implement therapy non clinical working practices/organisation to maximise time released for direct patient care (from away day in October).	complete	<ul style="list-style-type: none"> <li>To review / evaluate increases in efficiency following introduction of new assessment &amp; planning practices and continue further possible improvements (i.e. possibly linked to BETTER project work)</li> </ul>
2. Review breaches for 6.1 to understand rationale for patients being deemed not appropriate	ongoing	<ul style="list-style-type: none"> <li>Validation processes in place and to be completed on an ongoing basis</li> </ul>
3. Establish twice weekly OT groups (gardening and tell your story)	ongoing	<ul style="list-style-type: none"> <li>Continue to implement lunch group daily (OT /SALT) trialling use of TAs only 3 days per week and qualified staff only 2 days per week to free up time for higher priority activities.</li> <li>Reintroduce 'tell your story group' weekly – OT led - ? SALT supported?</li> <li>With the return of spring to reintroduce gardening group, supported by TA</li> <li>Senior OT &amp; SALT to plan for introduction of breakfast group as a joint venture, supported by TAs following training</li> </ul>
4. Establish breakfast group (joint with SALT)	Complete	
5. Recruit to all vacancies and establish/implement mitigation plans whilst we have vacancies	Ongoing	<ul style="list-style-type: none"> <li>To increase group activity and decrease non-clinical activities whilst recruiting</li> <li>Explore options to effectively utilise volunteer time to support non-clinical activities.</li> </ul>

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	T2 (to date)	Key Improvement Actions
6.1 Proportion of patients reported as requiring physiotherapy (A=85%)	80% (B)	80.6% (B)	89.8% (A)	<ul style="list-style-type: none"> <li>Ensuring consistent data entry for SSNAP regarding eligibility for PT; training with teams around this to ensure accuracy.</li> <li>Continue to validate all breaches; sub analyse according to person doing initial assessment (are OT less likely to report person as needing PT??)</li> <li>Continue to ensure end dates for PT are being inputted and progress maintained via senior support and validation</li> <li>Build on new timetabling process introduced, to further increase efficiency of therapy planning and release time for rehab sessions via additional group work &amp; more coordinated use of TAs</li> <li>Maintain consistent therapy groups on the unit</li> <li>Upcoming band 6, 1.47 wte PT mat leave</li> <li>Upcoming rehab assistant vacancies - band 3, 2.0 wte and band 2, 1.0 wte from September</li> </ul>
6.2 Median number of minutes per day on which physiotherapy is received (A=>32 mins)	>32 mins (A)	35 (A)	34.3 (A)	
6.3 Median % of days as an inpatient on which physiotherapy is received (A=>75%)	>75% (A)	86.7% (A)	94.9% (A)	
6.4 Compliance (%) against the therapy target of an average of 25.7 minutes of physiotherapy across all patients (A=90%)	80% (B)	89.6% (B)	100% (A)	



## Domain 6: Delivery Plan

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

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	T2 (to date)	Key Improvement Actions
7.1 Proportion of patients reported as requiring speech and language therapy (A=50%)	50% (A)	65% (A)	65.05% (A)	<ul style="list-style-type: none"> <li>Improve accuracy of documentation on the data collection form for SSNAP (complete)</li> <li>Implement changes to screening processes and referral pathway for both speech &amp; language impairments</li> <li>Update competencies for WSS practitioners to maintain robust and effective process</li> <li>Extend the skill set of the therapy assistants to increase their role in delivering SALT rehabilitation.</li> <li>Lunch group consistently happening 5 x per week</li> <li>Communication group consistently happening 2 x per week</li> <li>Breakfast Group re-introduced on 11<sup>th</sup> February 2016 – currently 3x per week. (Aiming 4 x per week)</li> <li>Development of a flexible approach to delivering therapy intensity (i.e. 2 x 20 minute sessions if cannot tolerate a 40 minute session)</li> <li>Upcoming rehab assistant vacancies - band 3, 2.0 wte and band 2, 1.0 wte from September</li> </ul>
7.2 Median number of minutes per day on which speech and language therapy is received (A=>32 mins)	>32 mins (A)	35.8(A)	31.7(A)	
7.3 Median % of days as an inpatient on which speech and language therapy is received (A=>70%)	>70% (A)	83.3% (A)	77% (A)	
7.4 Compliance (%) against the therapy target of an average of 25.7 minutes of speech and language therapy across all patients (A=90%)	90% (A)	120.7% (A)	98.5% (A)	

## Domain 7: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Communication Group now running twice weekly – to monitor	ongoing	<ul style="list-style-type: none"> <li>Band 3 Therapy Assistant being trained to run group.</li> <li>Review progress and potentially increase to 3 x per week thereafter.</li> </ul>
2. Therapy Assistants now supporting dysphagia patients at breakfast on a daily basis via breakfast group	Ongoing	<ul style="list-style-type: none"> <li>To monitor compliance with this</li> <li>SALT to support TA's with providing this 3x days a week via breakfast group</li> </ul>
3. Therapy Assistants to lead on carrying out Lunch Group with reduced qualified support	complete	<ul style="list-style-type: none"> <li>SLT to support TAs by ensuring effective goal setting</li> </ul>
4. To implement group cancellation protocol	complete	<ul style="list-style-type: none"> <li>To ensure groups are only cancelled by Band 7+ staff</li> </ul>
5. Recruit to all vacancies and establish/implement mitigation plans whilst we have vacancies	Ongoing	<ul style="list-style-type: none"> <li>To increase group activity and decrease non-clinical activities whilst recruiting</li> <li>Explore options to effectively utilise volunteer time to support non-clinical activities.</li> </ul>
6. To implement a twice weekly smoothie group	In place	<ul style="list-style-type: none"> <li>Group specifically for patients on modified diet and fluids to make their own smoothie.</li> </ul>
7. To implement joint OT/SALT “tell your story group”	Complete	

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	T2 (to date)	Key Improvement Actions
8.1 Proportion of applicable patients who were assessed by an occupational therapist within 72hrs (A=90%)	90% (A)	98.3% (A)	98.4% (A)	
8.2 Median time between clock start and being assessed by Occupational therapist (A=<12hrs)	<12hrs (B)	15:56 (C)	16:55(C)	<ul style="list-style-type: none"> <li>Monitor impact of new twice daily MDT Assessment rounds</li> </ul>
8.3 Proportion of applicable patients who were assessed by an physiotherapist within 72hrs (A=90%)	90% (A)	98.3% (A)	98.4% (A)	
8.4 Median time between clock start and being assessed by physiotherapist (A=<12hrs)	<12hrs (B)	15:56 (C)	16:55 (C)	<ul style="list-style-type: none"> <li>Monitor impact of new twice daily MDT Assessment rounds</li> </ul>
8.5 Proportion of applicable patients who were assessed by speech and language therapist within 72hrs (A=90%)	90% (A)	95.8%(A)	97.1%(A)	
8.6 Median time between clock start and being assessed by speech and language therapist (A=<12hrs)	<18hrs (C)	17:54 (C)	19:12 (D)	<ul style="list-style-type: none"> <li>Monitor impact of new twice daily MDT Assessment rounds</li> <li>Monitor impact of changes to language screening process</li> <li>Impact of SALT vacancy</li> </ul>
8.7 Proportion of applicable patients who have rehabilitation goals agreed within 5 days of clock start (A=80%)	80% (A)	n/a	94.4% (A)	<ul style="list-style-type: none"> <li>Implement robust system for recording goal setting after MDT Assessment rounds</li> </ul>
8.8 Proportion of applicable patients who are assessed by a nurse within 24hrs and at least one therapist within 24hrs and all relevant therapists within 72hrs and have rehab goals agreed within 5 days (A=60%)	60% (A)	n/a	78.9% (A)	

## Domain 8: Delivery Plan

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

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	T2 (to date)	Key Improvement Actions
9.1 Proportion of applicable patients screened for nutrition and seen by a dietician by discharge (A=95%)	95% (A)	94.4% (B)	96.4% (A)	<ul style="list-style-type: none"> <li>To review breaches quarter to date to understand reasons for breach – complete and system in place to validate</li> </ul>
9.2 Proportion of applicable patients who have a continence plan drawn up within 3 weeks of clock start (A=95%)	95% (A)	96.1% (A)	98.8% (A)	<ul style="list-style-type: none"> <li>To review as part of Stroke Nurses action plan to ensure all stroke patients who have persistent incontinence at 2 weeks post stroke have a full continence assessment and management plan.</li> <li>To implement stroke continence assessment pathway.</li> <li>On-going education and training for staff on continence management.</li> </ul>
9.3 Proportion of applicable patients who have mood and cognition screening by discharge (A=95%)	95% (A)	98.9% (A)	98.6% (A)	<ul style="list-style-type: none"> <li>To maintain this we need to ensure all new starters to team have induction for SSNAP and understand cognitive and mood screens we use and how to complete them.</li> <li>Recording also needs to stay consistent – continue with green forms (and ensure induction completed).</li> <li>Also taught band 3 to complete basic cognitive screen.</li> <li>confirmation of no screen required ‘medically unwell’ option for patients who are globally significantly impaired</li> <li>confirmation within team of basic cognitive screens acceptable ie AMTS for low level patients</li> </ul>

### Domain 9: Delivery Plan

Delivery Plan	Timescale for completion	Comment
1. Ensure an induction plan is put in place for all new starters	ongoing	<ul style="list-style-type: none"> <li>Complete for new Medical Juniors – to review benefits/impact of this</li> </ul>
2. To ensure all breaches are reviewed and validated	ongoing	<ul style="list-style-type: none"> <li>System in place</li> </ul>
3. To ensure all stroke patients have a comprehensive continence assessment completed and appropriate management plan in place – undertake audit of current practice against national guidance recommendations	Ongoing -aim to complete Jan 2017	<ul style="list-style-type: none"> <li>Audit complete</li> <li>Working party developed new continence pathway assessment and documentation – commenced in use in practice in March 2016</li> <li>To undertake evaluation and re-audit 1 year post implementation to ensure systems and protocols are embedded within clinical practice</li> </ul>

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	T2 (to date)	Key Improvement Actions
10.1 Proportion of applicable patients receiving a joint health and social care plan on discharge (A=90%)	90% (A)	100% (A)	99.2% (A)	
10.2 Proportion of patients treated by a stroke skilled ESD team (A=40%)	40% (A)	38.9% (B)	48% (A)	<ul style="list-style-type: none"> <li>Issue also highlighted re. a number of patients who have been supported by ESD who should have had stroke diagnosis and been on SSNAP but were incorrectly as TIA and therefore not put on SSNAP and therefore missed on SSNAP reporting. This issue is now being addressed to ensure correct diagnosis on discharge summaries</li> </ul>
10.3 Proportion of applicable patients in AF on discharge who are discharged on anticoagulants or with a plan to start anticoagulation (A=95%)	95% (A)	100% (A)	100% (A)	
10.4 Proportion of those patients who are discharged alive who are given a named person to contact after discharge (A=95%)	95% (A)	100% (A)	100% (A)	

**Domain 10: Delivery Plan**

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

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

DOMAIN KEY INDICATORS	Plan (A)	Last SSNAP (A)	T2 (to date)	Key Improvement Actions
Overall	90%	95.3%	96.5%	
NIHSS at arrival (30% of score)		99.5%	98.44%	<ul style="list-style-type: none"> <li>Stroke Outreach</li> <li>Training to achieve 85% of SU Nursing staff are competent to undertake NIHSS</li> <li>Ensure all are aware of need of 24 hour post-thrombolysis NIHSS</li> </ul>
NIHSS 24hrs post thrombolysis (20% of score)		100%	100%	
Transfers (10% of score)		95.7%		<ul style="list-style-type: none"> <li>Ensure all patients discharged to ESD/CRT are transferred on the webtool</li> <li>To ensure therapy validations are completed in a timely manner to prevent delays between discharge date and case lockdowns</li> </ul>
Data Entry (10% of score)				
72hr Measures (15% of score)		100%	100%	<ul style="list-style-type: none"> <li>Ensure reason is documented for all patients not having a swallow screen within 72hrs</li> </ul>
Post 72hr Measures (15% of score)		98%	98.44%	

**Domain: Audit compliance: Delivery Plan**

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



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

DOMAIN KEY INDICATORS	Plan	Last SSNAP (A)	T2 to date	Key Improvement Actions
Average patient centred case ascertainment	90+%	90+%	90+%	<ul style="list-style-type: none"> <li>Monthly lockdown checks will be performed on both 72hr and discharge lists</li> <li>All requests for record unlocks and data changes to go through SSNAP administrator. Tracking system created on administrators database</li> <li>To review case ascertainment figure with SSNAP as/when appropriate</li> </ul>

**Domain Case Ascertainment: Delivery Plan**

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

## BOARD OF DIRECTORS MEETING – 25 November 2016

### PART 2 AGENDA - **CONFIDENTIAL**

The following will be taken in closed session i.e. 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
10.40	<b>1. MINUTES OF PREVIOUS MEETING</b>		
	a) To approve the minutes of the meeting held on <b>28 October 2016</b>		<i>All</i>
10.45	<b>2. MATTERS ARISING</b>		
	a) To provide updates to the Actions Log		<i>All</i>
10.55	<b>3. STRATEGY AND RISK</b>		
	a) Significant Risk and Assurance Framework (paper)	Information	<i>Paula Shobbrook</i>
	b) Risk Appetite (paper)	Information	<i>Paula Shobbrook</i>
	c) Private Patient Strategy (paper)	Discussion	<i>Stuart Hunter/ Michelle Burden</i>
	d) Draft Annual Plan 2017-19 and Assurance Statement (paper)	Discussion	<i>Tony Spotswood To Follow</i>
11.40	<b>4. GOVERNANCE</b>		
	a) Well-Led Self-Assessment Review (paper)	Information	<i>Karen Flaherty</i>
	b) Charitable Funds Annual Report and Account (paper)	Approval	<i>Stuart Hunter</i>
	c) CSR and Management Activity	Discussion	<i>Tony Spotswood To Follow</i>
	<b>5. QUALITY</b>		
	a) <i>No items</i>		
	<b>6. PERFORMANCE</b>		
12.20	a) Compliance with NHS Improvement's Rules on Agency Staffing (paper)	Information	<i>Karen Allman</i>
12.30	<b>7. ANY OTHER BUSINESS</b>		
	a) Key Points for Communication to Staff		
	b) Reflective Review		

The meeting will be following by a separate Board session on the Trust objectives and leadership behaviours led by the OD team with the Change Champions and Appraisal Champions, ending by 2.30pm. A draft of the Trust objectives has been included in the background reading pack for the meeting.