

A meeting of the Board of Directors will be held on Friday 27 January 2017 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital.

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

Karen Flaherty
Trust Secretary

A G E N D A

Timings		Purpose	Presenter
8.30-8.35	1. WELCOME, APOLOGIES FOR ABSENCE and DECLARATIONS OF INTEREST		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 16 December 2016		<i>All</i>
8.40-8.45	3. MATTERS ARISING		
	a) To provide updates to the Actions Log		<i>All</i>
8.45-9.45	4. QUALITY		
	a) Patient Story (verbal)	Information	<i>Paula Shobbrook</i>
	b) Action/Learning Week on Discharge Process (presentation)	Information	<i>Deb Matthews/ Sean Weaver</i>
	c) Response to Winter Pressures (verbal)	Information	<i>Richard Renaut</i>
	d) Feedback from Staff Governors (verbal)	Information	<i>Jane Stichbury</i>
	e) Medical Director's Report – Mortality (paper)	Information	<i>Alyson O'Donnell</i>
	f) Complaints Report (paper)	Information	<i>Paula Shobbrook</i>
9.45-10.00	5. PERFORMANCE		
	a) Performance Exception Report (paper)	Information	<i>Richard Renaut</i>
	b) Quality Report (paper)	Information	<i>Paula Shobbrook</i>
	c) Financial Performance Report (paper)	Information	<i>Stuart Hunter</i>
	d) Workforce Report (paper)	Information	<i>Karen Allman</i>
10.00-10.30	6. STRATEGY AND RISK		
	a) Annual Plan 2017-18 and 2018-19 (paper)	Information	<i>Tony Spotswood</i>
	b) Clinical Services Review (verbal)	Information	<i>Tony Spotswood</i>
	c) Vanguard: One NHS in Dorset (paper)	Information	<i>Tony Spotswood</i>
	d) Trust Objectives (paper)	Approval	<i>Tony Spotswood</i>

- | | | | |
|----|---|-------------|-----------------------|
| e) | Information Governance Strategy (paper) | Approval | <i>Peter Gill</i> |
| f) | Emergency Preparedness, Resilience and Response (EPRR) Update (paper) | Information | <i>Richard Renaut</i> |

10.30-10.35

7. GOVERNANCE

- | | | | |
|----|---|----------|----------------------|
| a) | Charitable Funds Committee Terms of Reference | Approval | <i>Stuart Hunter</i> |
| b) | Audit Committee Terms of Reference | Approval | <i>Steve Peacock</i> |

8. NEXT MEETING

Friday **24 February 2017** at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital

9. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.35-10.50

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.

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would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



Part 1 Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Board of Directors** held on **Friday 16 December 2016** in the Conference Room, Education Centre, the Royal Bournemouth Hospital.

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Tea Colaianni	(TC)	<i>Non-Executive Director (from item 6)</i>
	Derek Dundas	(DD)	<i>Non-Executive Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Christine Hallett	(CH)	<i>Non-Executive Director</i>
	Stuart Hunter	(SH)	<i>Director of Finance</i>
	Alex Jablonowski	(AJ)	<i>Non-Executive Director</i>
	John Lelliott	(JL)	<i>Non-Executive Director</i>
	Alyson O'Donnell	(AOD)	<i>Medical Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	James Donald	(JD)	<i>Head of Communications</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	John Gault	(JG)	<i>Clinical Site Team</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NH)	<i>Director of OD and Leadership</i>
	Diane Potter	(DP)	<i>Matron, Outpatients Department</i>
	Dily Ruffer	(DR)	<i>Governor and Membership Manager</i>
	Sarah Smith	(SS)	<i>Clinical Leader, Outpatients Department</i>
	Geraldine Sweeney	(GS)	<i>Improvement Manager</i>
	Chris Trent	(CT)	<i>Clinical Site Team</i>
Public/ Governors:	David Bellamy		<i>Public Governor</i>
	David Brown		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Eric Fisher		<i>Public Governor</i>
	Paul Higgs		<i>Public Governor</i>
	Doreen Holford		<i>Public Governor</i>
	Keith Mitchell		<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>
	Guy Rouquette		<i>Public Governor</i>
	Donald Smith		<i>Member of the public</i>
	David Triplow		<i>Public Governor</i>
Apologies	Steven Peacock		<i>Non- Executive Director</i>

95/16

WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Action

The Chair reflected on the Board Charter and the ambition to provide an inspiring vision and clear direction for the Trust, particularly during times of change. The public meeting held by the Trust on 8 December 2016,

concerning the public consultation for the Clinical Services Review, had been well attended by members and others who were interested in the future of the Trust and healthcare locally.

Apologies were **received** as noted above.

96/16 **MINUTES OF PREVIOUS MEETINGS**

(a) Minutes of the meeting held on 25 November 2016 (Item 2a)

The minutes of the meeting held on 25 November 2016 were **approved** as an accurate record of the meeting.

97/16 **MATTERS ARISING**

(a) To provide updates to the action log (Item 3a)

- 89/16(e) Stroke Services - letters had been drafted to the Stroke and Endoscopy teams and the action could be closed;
- 81/16(d) Medical agency staff - the issue was considered at the Workforce Strategy and Development Committee meeting. There would be further work to analyse the data in relation to the medical workforce;
- 71/16(a) Recording of patient discussions - an update would be provided in the new year;
- 71/16(d) Deprivation of Liberty standards - the Workforce Strategy and Development Committee had received an update on the increase in training for staff and the action could be closed;

An update was also provided on the patient story at October's meeting regarding the introduction of the new IT system for requesting tests and communicating results in Theatres which would improve the visibility of the status of requests for pathology.

98/16 **QUALITY**

(a) Patient Story (Item 4a)

The patient story was presented by nursing staff from the Outpatients department. Patient feedback had highlighted some themes concerning staff introducing themselves to patients and the availability of refreshments for clinics in the afternoons.

The 'Hello my name is' campaign, introduced by Dr Kate Granger, was developed to remind healthcare staff about the importance of introductions. The campaign had been successfully introduced in the Trust but was often overlooked in the department as staff tried to get patients into clinic appointments as promptly as possible. The campaign was reintroduced to staff at team meetings and within two weeks every nurse was introducing themselves to patients. Staff recognised that this simple and common courtesy had a huge impact on patient experience and immediately built a rapport and made it easier for patients to communicate with staff. The latest feedback from patient experience cards reflected positively on the

warm and welcoming environment and the department were proud of this achievement.

Patients had also highlighted that there was a lack of refreshments near the main Outpatients department after 2.00pm when the tea bar was closed. There was a different service provided to patients in the mornings and afternoons: drinks vouchers were provided to patients in the morning when clinics were overrunning and they were having to wait longer than expected but staff could not do the same for patients in the afternoon once the tea bar closed.

The department had initially wanted to extend the opening hours for the tea bar, however there were no staff available to do this. The department now proposed to install vending machines in the main Outpatients department and also in the Derwent and Jigsaw buildings which did not currently have anywhere to purchase refreshments. This request had been declined as the location presented a fire risk.

The Board recognised that the lack of refreshments impacted upon the overall patient experience and asked that the available options were reviewed when the new fire safety officer joined the Trust in January 2017. It was noted that the RVS Café in the atrium had recently extended its opening hours and it was suggested that this should be promoted more widely to patients in the department.

RR

The 'Hello my name is' campaign would be refreshed to ensure that this happened in all areas of the Trust linked with the organisational development work.

PS/NHa

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

Staff governors were unable to meet due to other commitments. Executives would respond to the queries raised by email and it was emphasised that communication remained open with staff governors.

(c) Quality Improvement Progress (item 4c)

Two years ago, the Trust set out its vision, to 'be the most improved hospital in the UK by 2017' to address variability in the quality of services provided and to recognise the need for improvement in some areas. The Quality Improvement (QI) approach was being used to deliver transformational change within the organisation with over 150 staff at various levels having been trained in the QI methodology and more staff attending the Quality & Safety Conferences in 2015 and 2016.

QI leads within the Trust had collaborated with Health Education Wessex School of Improvement (AHSN), Patient Safety Collaborative and The Health Foundation Q Initiative, leading on this work nationally. Health Education Wessex and the Thames Valley Wessex Leadership Academy have recruited three members of staff to participate in a 12 month Quality Improvement Fellowship

programme. The ambition for the Trust in the long term was to establish a QI alumni for staff who had been involved in the QI programme and develop QI fellowships with funding for training and work and junior doctor QI to drive the QI programme and measure progress.

The QI was supporting the change in culture within the organisation and there had been a series of powerful events focused on the duty of candour and encouraging clinicians to be open and honest around their experiences.

The Board reflected on the progress made against the Trust's vision on the basis of the QI projects, acknowledging that this work was ongoing:

- Sepsis – This work had a national perspective with the NHS England campaign to help doctors and nurses recognise and treat sepsis. The Trust's own project and campaign focused on areas outside the Emergency Department such as the Acute Medical Unit. This continued to be a challenging area however the Trust was committed to reducing mortality arising from sepsis;
- Hospital flow - The five daily actions project supported improvements in patient flow by identifying actions each day which progressed a patient's treatment and discharge from hospital. This work also encompassed the Frailty Unit which looked to avoid the long-term admission of frail older patients by ensuring they were cared for by experienced, specialist staff. As a result the average length of stay for this group of patients had reduced from 10.5 to 6.2 days. The final element related to discharge planning with practical changes to ensure patients had the drugs they needed ready when being discharged and dealing with cultural change in the approach to the what was a complex discharge process;
- Improving Urgent Care - Against a backdrop of sustained growth in emergency admissions the Trust had reduced bed numbers, length of stay and the number of stranded patients. This included a multi-disciplinary approach to with social workers, the discharge team and clinical staff to address some of the difficult issues with both families and patients in a sensitive but focussed way;
- 2 Week GI Cancer Waiting times - There had been a focus within Gastroenterology on establishing safe systems to achieve 93% compliance with the 2 week trajectory. 98.8% of patients were now being seen within two weeks and the exceptions tended to be patients who had requested that their appointment be delayed. Skilled nurse specialists were being used more efficiently for assessments and the Trust had been identified as a pilot site for faster diagnosis and treatment for cancer patients;
- Safety Checklists - The Trust was one of a few trusts consistently using safety checklists outside of Theatres. Clinical staff had spoken candidly about their experiences at the Quality & Safety Conference and about the value gained from using checklists which reflected a shift in culture;

- Emergency Laparotomy - Through its participation in this collaborative, the Trust had reduced mortality rate for patients undergoing this high risk, emergency procedure to under 5%, which had been sustained over a period of 18 months. This was significantly lower than the average mortality rate of 11% of patients, increasing to 20% for those over 70 years of age. This had been achieved by focussing on the patient pathway without any additional staff required;
- Urology – There were difficulties in matching robotic capacity to demand providing this service to the whole of Dorset. An improved booking process within the admissions team had supported consistent improvements in the trajectories for 31 and 62 day cancer waits and 18 week Referral to Treatment times (non-cancer). The number of patients waiting over 18 weeks had reduced from 81 to three between April and December 2016;
- Surgical Productivity – A standard theatre day and changes in processes to improve efficiency had enabled 267 more patients to be seen in the first quarter following its introduction, as compared to the same period in the previous year. Overrunning lists had also reduced from 20% to 4% which was better for both patients and staff;
- Orthopaedics – Initiatives such as ring-fenced beds and managing the beds and other resources more effectively had contributed to 97 more joint replacements taking place year on year.
- Patient Escalation – This will be a focus for 2017 to identify these patients using a pragmatic approach.
- Outpatients - The project targeted a reduction in the 'Did Not Attend' (DNA) rate to an average of 4% for first and follow-up appointments by March 2017. The Trust currently benchmarked in the top quartile (best 25%) of similar trusts.

Cost and efficiency improvement had been embedded within all of the QI projects and this had generated a cost reduction of £551,000. The Trust's reference cost had reduced by 6% due to the reduction in length of stay from the QI work with readmission levels showing a reduction at the same time. In addition, the programme had supported the sustained performance against the Emergency Department (ED) 4 hour target from April to October.

The Board praised the volume of positive work and the improvements achieved over the past year. In response to a question it was confirmed that there was a good understanding of some of the barriers to achieving the objective of delivering antibiotics to patients with severe sepsis within one hour. The Trust had produced its own clear guidance as there were some issues around the national definition of sepsis. While the Trust's position on mortality overall had improved the rate was flat in relation to mortality from sepsis identifying that there was scope for the Trust to improve to be better than average. The Trust also now had the information on which to base further improvements.

It was emphasised that the Trust was creating a culture of learning

and improvement by placing the patient experience at the forefront when refining processes led by the clinicians. It also demonstrated that a drive to perform above the average or top quartile and to be outstanding.

The incredible achievement was commended and the Improvement team were thanked for their role enabling and acting as a catalyst for change.

(d) Medical Director's Report – Mortality and Sepsis (Item 4d)

The report reflected a downward trend across all metrics and showed that the Trust was improving faster than the national average which was reset each year.

Data was being triangulated to support the work to improve performance using the alerts from Dr Foster, which produced the mortality data, which prompted a review of cases and the identification and dissemination of any learning. This included addressing how certain deaths were coded and providing support to junior doctors on the completion of death certificates.

It was noted that the Trust had been an outlier based on the outcome data for systemic anti-cancer therapy. Work was in progress to improve the data which had given rise to the Trust's position as an outlier. Teams had been asked to record the intent of any chemotherapy treatment accurately in terms of managing symptoms or as a curative treatment. An update will be provided to the Board once the systemic anti-cancer therapy data was available in order to give some assurance on the Trust's position.

The outcome data from the national Joint Registry for the replacement joint service reflected that the service was within the better than expected range and revision rates placed the Trust within the top performing trusts.

**Agenda
item**

99/16

PERFORMANCE

Due to the date of the Board meeting in December being earlier than usual, the regular performance reports for November were not be available in time for the meeting. The following updates were provided at the meeting.

Financial Performance

The Trust remained on plan at the end of November. Two care groups had slipped against their forecast position; however assurance had been provided that this would be brought back in line for the rest of the year.

Agency spending remained below the ceiling set by NHS Improvement and the Sustainability and Transformation Fund projection enabled additional support to be provided for winter pressures. The regular report would be circulated to the Board once the information had been collated.

Performance Exception Report

The ED 4 hour performance trajectory continued to be challenged with

increased admissions however the Trust remained above the trajectory at 95.2% year to date and in the top 5% of trusts nationally.

89% of eligible staff had completed the appraisal process and the staff survey would provide additional information on the quality of appraisals.

100/16

STRATEGY AND RISK

(a) Sustainability and Transformation Plan (Item 6a)

The Dorset Clinical Commissioning Group (CCG) had indicated that they would appreciate a clinical response to the Clinical Services Review (CSR) proposals. Responses to date had focussed on pressures in primary care and community services. AOD and TS would address clinical groups to encourage responses from clinicians. Governors were requested to provide their support in responding to the CSR and the proposals.

The outcome of the consultation on reconfiguring the local authorities in Dorset had been circulated. The overwhelming view was that Bournemouth, Poole and Christchurch should be combined to form one single, combined local authority. The Board supported this view from the point of view of patients and local healthcare as it would simplify the patient journey from hospital through to community and social care. There were concerns about the proposals, notably from Christchurch residents and the local councillors there had taken a contrary view. The three local authorities would be meeting to consider the outcome of the consultation and to agree the position.

Early indications were that the Vanguard funding would be confirmed for next year. The Trust would consider how this would be utilised to support the delivery of the CSR and resourcing for personnel.

In light of pressures in primary care the Trust was considering how it might help support practices and the potential to integrate primary care services and create combined roles for staff as well as providing primary care input in care homes to reduce pressure on both GPs and the acute hospitals. It was agreed that the developments at Christchurch would support developing the strategy in the future.

101/16

DATE OF NEXT MEETING

25 January 2017 at 8.30am in the **Conference Room, Education Centre, Royal Bournemouth Hospital**

102/16

Key Points for Communication:

1. Promote the successes of the QI work and recognise the QI team;
2. Themes from the Medical Director's report
3. Patient Story

103/16

QUESTIONS FROM GOVERNORS AND MEMBERS OF THE PUBLIC

- The public perception of the CSR proposals at the recent CCG consultation meeting in Poole had been negative initially and the public were unaware how the proposals had been developed and did not fully understand what was proposed. 400 consultation responses had been received and governors were asked to engage with members and encourage responses. The Trust would work with staff in each specialty to ensure that considered responses were provided albeit that not everyone would agree with all the proposals. It was perceived that the launch of the consultation had enabled conversations and a focus on what needs to happen for the population of Dorset;
- It was suggested that the positive improvements in the QI presentation were communicated to members with a Christmas message as well as reminding members about the CSR consultation and encouraging them to respond. A 'good news' bulletin was being developed and AOD would be featuring on the Radio Solent during the morning on 19 December;
- In view of the excellent work and innovative approach on QI, it had been disappointing that a request to improve the provision of refreshments in the Outpatients department had been requested at Board level. It was emphasised that it was important that individuals felt empowered to raise these issues and the Board were certain that the request would be addressed;
- In response to a query raised about the provision of community beds at Christchurch Hospital it was explained that the Trust was involved in extensive work to identify solutions for integration which were relevant for the whole of the population including Christchurch.

The Board were encouraged by the improvements outlined in the meeting, noting that this emphasised that the Trust was striving to do what was best for patients. The Board thanked all staff, public and governors for their support and dedicated work throughout the year.

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
16.12.16	98/16	QUALITY			
	(a)	<u>Patient Story</u>			
	1.	Consider options to improve the provision of refreshments in the outpatient department with the new fire officer.	RR	In Progress	This will be addressed as a priority with the new fire officer who will commence in post from January 2017. Further update to be provided at the meeting.
	2.	Refresh the 'Hello my name is' campaign and link with the organisational development work.	PS/NHa	Complete	The element of the campaign is being incorporated within the Leadership and Organisational work.
	(d)	<u>Medical Director's Report – Mortality and Sepsis</u>			
		Provide an update on the progress with systemic anti-cancer outcome data performance.	AOD	February	Data not yet available. Update to be provided to the Board meeting in February.
28.10.16	81/16	PERFORMANCE			
	(d)	<u>Workforce Report</u>			
		Identify proposals to reduce the use of medical agency staff. 16.12.16 update: Information would be triangulated in the new year.	Workforce Committee/ AOD	March	Work is underway to triangulate the information and an update will be provided to the Board in March.
30.09.16	71/16	QUALITY			
	(a)	<u>Patient Story</u>			
		Recording of patient discussions to be shared as an idea. This enables patients to review discussions at a later stage. 16.12.16: update to be provided in the new year.	PS/AOD	Complete	This was discussed with TMB and it was agreed that consent should not be withheld however recording of conversations by either party must not be covert.
	74/16	GOVERNANCE			
	(e)	<u>EPRR Assurance Declaration</u>			
		Update of the action plan and timeframe.	RR	Complete	Agenda item.

26.02.16	13/16	MATTERS ARISING			
	(a)	<u>CQC Report Update</u>			
		Utilise the Monitor well-led self-assessment to measure Trust improvements ahead of the next CQC inspection together with the peer review programme. Remit the overarching assessment to the Healthcare Assurance Committee.	PS	Complete	Well Led Self-Assessment has been completed and external review is underway. The self-assessment has been provided as part of the evidence base for the CQC inspection.

Key:	Outstanding
	In Progress
	Complete
	Not yet required

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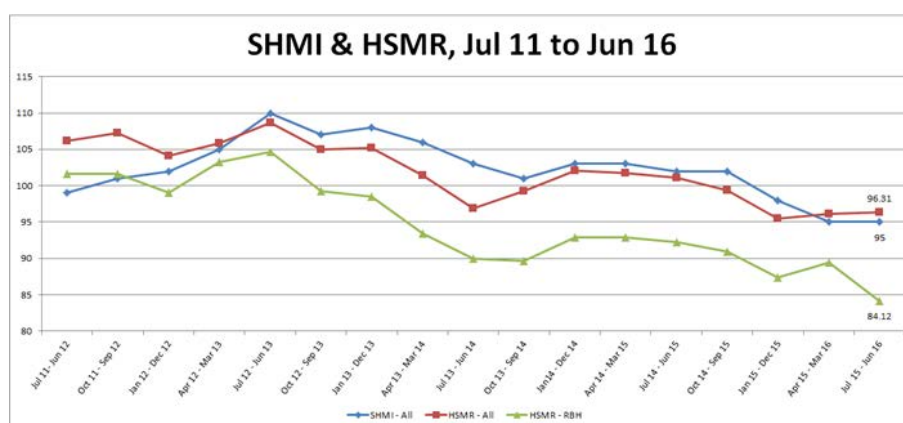
BOARD OF DIRECTORS

Meeting Date and Part:	27 th January 2017 Part 1
Subject:	Mortality Report
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	Dr Foster, Mortality Matrix, MSG Minutes
Officer with overall responsibility:	Alyson O'Donnell
Author(s) of papers:	Alyson O'Donnell
Details of previous discussion and/or dissemination:	MSG 12/1/2017
Action required: Approve/Discuss/Information/Note	For information only
Executive Summary:	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

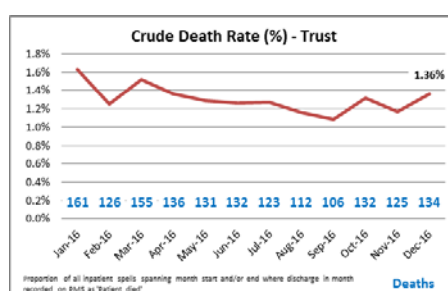
Mortality Report for Board of Directors

Mortality Metrics:

Background mortality metrics continue to show an improving trend. The Hospital Standardised Mortality Rate (HSMR) in September was 85.3 with a year to date position of 89.9 putting us in the 'better than expected' category. For the benchmarked period of October 15 to September 16 overall trust HSMR is 95.9 with a continued downward trend over the last few months. HSMR and SHMI are better than expected. Importantly there are no alerts for procedure related mortality. Continued downward trends are also seen for stroke, acute kidney injury and congestive cardiac failure.



Crude mortality rates are also continuing to fall and should provide assurance that this reflects a real improvement and not coding gains. The upward trend seen in October is likely to be a Winter effect and is expected to continue until around March. As this is an annual national trend it is unlikely to affect HSMR but will be monitored closely.



Mortality alerts:

A new alert was identified this quarter for Cancer of the ovary. Early review suggests that this is due to patients being admitted, predominantly to the Macmillan unit, for palliative care. Further work is ongoing to analyse deaths in a small number of low risk groups for trends.

The Mortality Surveillance Group has focussed discussions on deaths from sepsis/pneumonia. Although this group remains in the 'as expected' group it was felt that more work is required. A walk through of the pneumonia pathway is proposed to repeat a piece of work undertaken a number of years ago. The additional quality improvement work on sepsis and the deteriorating patient will also inform this process.

BOARD OF DIRECTORS

Meeting Date and Part:	27 th January 2017 Part 1
Subject:	Complaints Performance Report
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery / Deputy Chief Executive
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 26th January 2017
Action required: Approve/Discuss/Information/Note	The paper is provided for information and assurance

Executive Summary:

The Complaints report includes aggregate and Care Group complaint **acknowledgement** and **response performance for December 2016**. This is a key focus of the Board of Directors and this has been reported through the Healthcare Assurance Group and Healthcare Assurance Committee.

Key messages:

1. Current Trust aggregate response time in month (December 2016) is **95%** against a standard of 75% (21 of 22 responses due were on time).
2. The response time improvement focus continues and has exceeded and sustained the required improvement trajectory for month 9 (quarter 3 end YTD) above 70%. This **has** been achieved on aggregate by all three care groups. All three Care Groups have exceeded the Trust Policy for responding within 25 working days for 75% of the complaints due.

Care Group A = 100%
Care Group B = 90%
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. 19 formal complaints were received in December 2016.

4. Acknowledgement times for December 2016 are 100% in the data set.
5. Written and verbal Concerns (informal concerns) 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 December 2016

1.0 Introduction

This summary paper includes information on formal complaints, informal concerns and written concerns received, acknowledged and responded to in month (December 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

19 formal complaints were received in December 2016

52 verbal concerns were presented to PALS in November 2016

27 written informal concerns were presented to PALS in November 2016

3.0 Acknowledgement and response times

3.1 Of the 19 formal complaints received for December 2016, 95% were acknowledged within three days. Revalidated data confirms the November position to 100%.

- **Formal Complaints (n=19)** Surgery (n=5), Cancer (n=3), Xray (n=2)
- **Verbal Concerns (n=52)** Medicine (n= 12), Surgery (n=10), Older Peoples Medicine (n=7) received the most verbal concerns.
- **Written concerns (n=27)** Medicine (n=12) received the most written concerns by directorate in this category.

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 October the response time has been validated as 81% with the previously reported differences being attributed to a data anomaly. For November the validated first response time to formal complaints is 93%.

For December, **first response time is at 95%** on aggregate, 21 out of the 22 complaints responses due were sent on time.

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
1st Responses Due in Month	14	27	22	25	32	29	21	30	22
Number where 1st Response Completed within 25 working days	9	17	12	17	20	21	17	28	21
Percent with 1st Response within 25 working days	64%	63%	55%	68%	63%	72%	81%	93%	95%

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

- Care Group A = 100%
- Care Group B = 90%
- Care Group C = 100%

4.0 Themes and trends - Complaints received

- 4.1 The highest theme in month was Admission, Discharge or Transfer (n=9) with implementation of care (n=8) the next highest.

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 working 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 concerns acknowledgement times

Care Group	Concerns	Written Concerns	Total
A	100%	100%	100%
B	100%	93%	97%
C	100%	100%	96%
Other	100%	100%	100%
Total	100%	96%	98%

5.3 Informal concerns first response performance

- **Written concerns**
Care Group A (9) - 100%
Care Group B (18) - 82%
Care Group C (10) - 100%
- **Verbal concerns**
Care Group A - 100%
Care Group B - 94%
Care Group C - 100%

In conclusion, the overall picture is one of real sustaining improvement, in terms of response times and acknowledgments across all pathways of concerns and complaints.

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 in November of our complaint responses to facilitate our improvement in November. This has been fed back to the Deputy Director of Nursing and to the Complaints Performance Group and Healthcare Assurance Committee respectively in January 2017.

7.0 Recommendations

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

BOARD OF DIRECTORS

Meeting Date and Part:	27 January 2017 Part 1
Subject:	Performance Report to the end of December 2016
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Performance Matrix Trust Balanced Dashboard
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Donna Parker / David Mills
Details of previous discussion and/or dissemination:	PMG, Finance Committee
Action required: Approve / Discuss / Information / Note	<p>The Board of Directors is requested to note the performance exceptions to the Trust's compliance with the 2016/17 STF, Monitor Framework and contractual requirements.</p> <p>Finally, the Committee is also requested to note the detailed report on RTT performance and support the plans for return to national threshold.</p>
<p>Summary: The Sustainability and Transformation Fund is expected to be achieved for all of the 4 key metrics:</p> <ul style="list-style-type: none"> • RTT 18 Weeks Incomplete Pathways • A&E 4 hour • Cancer 62 Day from Referral to Treatment • Diagnostics 6 Week Wait <p>Though noting additional pressures in Q3 and risks expected in Q4 which are reducing tolerance against the thresholds.</p> <p>All other Single Oversight Framework, NHS Constitution and key contractual targets were met for December except 28 Day Rebook Following Cancellation and Cancer Consultant Upgrade.</p> <p>As per the quarterly reporting cycle, the report includes a focus this month on RTT performance. Attached in the Reading Room are the supporting Performance Matrix and Trust Balanced Dashboard.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>
<p>Risk Profile:</p> <p>i) Impact on existing risk?</p> <p>ii) Identification of a new risk?</p>	<p>The following risk assessments continue to be under regular review 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 all of the 4 key metrics.

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

90.25% for December, below the 92% target/trajectory, but remains within the 0.5% Q3 tolerance on YTD performance to secure STF. Improvement is expected in January with a return to national threshold through Q4, noting risks below. Over 21,850 patients on an RTT pathway remain within 18 weeks from referral.

A&E 4 hour (12.5% of funds) –

achieved 94.14% well above our trajectory requirement of 91.01%. We achieved 95.2% for Q3 and secured the STF, though close management of increasing pressures is in place.

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

88.7% in November (85% target/trajectory) and though we expect to be below monthly target in December, we anticipate remaining within the tolerance threshold for Q3 to secure the STF.

Diagnostics 6 Week Wait (0% of funds) –

achieved compliance and above trajectory, at 99.98%.

All other Single Oversight Framework, NHS Constitution and key contractual targets were met for December except 28 Day Rebook Following Cancellation and Cancer Consultant Upgrade. We saw one breach against each of these indicators.

2. Key Risks to Performance

RTT 18 Weeks Incomplete Pathways – the increased overall waiting list through 16/17 and higher proportion of patients over 18 weeks continues to mean a reduced tolerance to mitigate speciality risks. Positively, our reduction in admitted long waiters was maintained and we have now seen this drop by c400 since the summer. We have also seen some positive performance or upward trends in overall 18 week waits across a few specialities e.g. Gynaecology, Urology, Cardiology. However, lower performance or downward trends have continued in a few currently challenged areas: Orthopaedics, ENT, Oral Surgery, Neurology, Gastroenterology and Dermatology. An outline of our recovery plans is included within the detailed Performance Report. The pressure of non elective activity levels and our need to remain within the financial control total remain risks.

A&E 4 hour – our QI work and winter planning to date continues to support our strong position, though increased activity (c9% YTD and up to 19% over/post the Christmas/New Year period) 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 December 2016

Richard Renaut
Chief Operating Officer

1. Introduction

This report accompanies the Performance Indicator Matrix 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 for the Sustainability and Transformation Fund (STF) and in the Single Oversight Framework.

The detailed performance levels against remaining key targets, which currently form part of the 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 December 2016 includes a focus on the Month 3 Indicators – RTT and Diagnostics - 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 2nd urgent cancelled ops,

2. Sustainability and Transformation Fund and Single Oversight Framework Indicators

2.1 Sustainability and Transformation Fund 16/17

STF payment is expected for Q3, though December has been a more challenging month. Whilst this is in part, due to increased urgent care demand putting additional pressure on the Trust's bed capacity, patient choice over the festive period has also contributed.

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

Target or Indicator (per Risk Assessment Framework)	National Target	STF Trajectory Target*	Q3 16/17					
			Oct		Nov		Dec	
			Performance Against National Target	Performance Against STF Trajectory	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 YTD tolerance threshold		Within STF YTD tolerance threshold		Within STF YTD tolerance threshold
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	91.7%						Within STF YTD tolerance threshold
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	80%					est. *	Within STF YTD tolerance threshold
Diagnostic 6 week wait	99%	99%						

*Validated final position awaited - upload is early February

- 6 Week Wait Diagnostics – full compliance against national target and trajectory in December and for the Quarter.
- A&E 4 Hour – above (better than) December and quarterly trajectory which secured STF funds. We were just below the 95% national target in December at 94.14%, however, have consistently remained in the top 20 of reporting trusts.
- 18 Week RTT - below national target and monthly trajectory for RTT at 90.25% however, our year to date compliance is expected to secure the funds for Q3.
- Cancer 62 Day – compliance achieved for the last reported month (November) and currently on track to remain within tolerance threshold to receive funds for the Quarter. December final validated performance is awaited, though is expected to

be below compliance due to an increased number of breaches as well as a lower number of treatments.

Exception reporting to our commissioners and NHSI continues to be required in relation to RTT and Delayed Transfers of Care, recognising that we remained within the STF YTD tolerances.

Going forward, performance is expected to be sustained above the national target and trajectory for Diagnostics. Whilst there are additional risks to the remaining key targets in Q4, with full implementation of our ongoing recovery and sustainability plans, we expect to remain above trajectory/within tolerance thresholds to secure the STF. The additional challenges over these winter months though, remain a risk.

RTT Incomplete Pathways (18 week) and 52 Week Breaches

Performance against the RTT Incomplete Pathways indicator was below the 92% in December (90.25%). Although below the national target and our STF submitted monthly trajectory, we have remained within the tolerance to secure the Sustainability and Transformation funds YTD. 21,850 patients remain under 18 weeks.

Whilst the overall number of patients on an 18 week pathway dropped in December which will be a potential benefit in the medium term, a bigger proportion had waited over 18 weeks by the end of December. Increased impact from patient choice is experienced around the festive period. Positively, our reduction in admitted long waiters was maintained. We have also seen some positive performance or upward trends in overall 18 week waits across a few specialities e.g. Gynaecology, Urology, Cardiology. However, lower performance or downward trends have continued in a few currently challenged areas: Orthopaedics, ENT, Oral Surgery, Neurology, Gastroenterology and Dermatology.

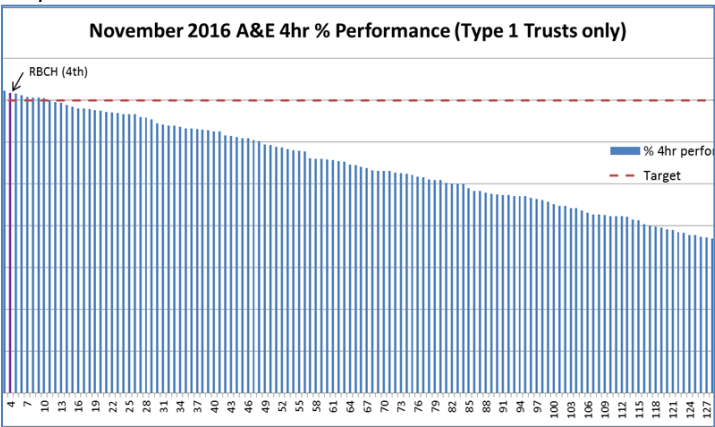
More detail is provided in section 3 below, but recovery plans include an increase in additional outpatient sessions, including ‘Super Saturdays’ in January. With Super Saturdays we aim to run a number of outpatient clinics across various specialities in one location, ideally with speciality teams (e.g. Consultant, Registrar, Junior Dr, Nurse Practitioner) to optimise outpatient staffing and activity. Winter bed pressures do however, remain a risk to elective capacity in Q4.

Despite the performance pressures, there were no 52 week wait breaches in December.

A&E 4 Hour Target and 12 Hour Breaches

The Trust was well above the STF trajectory of 91.01%, securing the STF, achieving 94.1% in December and 95.2% for Quarter 3. This meant that we remained above the national target of 95% for the Quarter and we have consistently been in the top 20 reporting Trusts. In November we were 4th in the country (Type 1).

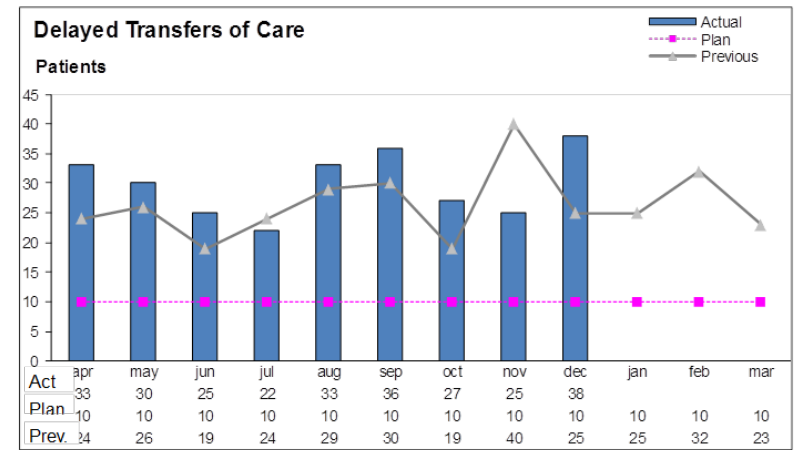
Graph 1 – Benchmarked A&E 4 Hour Performance – Nov 2016



As expected, in December we began seeing increased bed pressures within the hospital and as a result, a higher number of 4 hour breaches as a result of capacity and flow. Implementation of our winter plan

commenced with additional beds opening and elective activity being reduced to facilitate beds for urgent care patients.

Graph 2 – Formal Delayed Discharges 2016/17



Following a lower level of Delayed Transfers of Care earlier in the year and in the Autumn, levels have remained higher through December. Support from partners in early January has led to a reduction in daily reported delays which is currently assisting recovery of our bed position immediately post New Year. This continues to be closely monitored due to the continued high level of urgent care demand.

There were no 12 hour breaches.

ED performance and our benchmarked position is extremely positive given the continued high level of ED attendances (+8.6% YTD above last year) and non-elective admissions (8.0%). Over and following the festive period, we have seen levels up to 19% above the same period last year which has impacted on performance through January. Despite this, we have continued to benchmark above most trusts in the country.

This position has undoubtedly been supported by the urgent care Quality Improvement programme work. However, the significant positive teamwork seen right across the Trust in January so far, has meant we have coped extremely well with the demand pressures. We also held our Discharge Action and Learning Week w/c 9 January, where all wards focused on the use of EDDs, improving whiteboard rounds and any individual daily delays to patients' pathways. Further information on this will be provided in next month's focus report.

In addition to the levels of demand being seen, of concern remains the strong messages from Local Authorities that social care capacity is expected to be even further challenged. We have therefore, implemented our plans to increase support and capacity for self-funding patients as well as interim care capacity. We are continuing to discuss actions with Hampshire partners to support an improvement in delays to their patients.

62 Day from Referral for Suspected Cancer to Treatment

For the month of November (*last formal reported month*) there were 12.5 breaches, well within the 85% performance tolerance at 88.7% and the STF trajectory. There were 6.5 breaches across 5 specialities, with 6 breaches in Urology which was a lower number than previously. The main reason for breaches was complex diagnostic pathways.

Whilst some continued pressures mean some risk to Q3, our current projections suggest compliance for the quarter though there are some breaches in December. Whilst incidents of pathway complexity increased slightly in December, we have seen a significant increase in patient choice related breaches.

Going forward to Q4 the introduction of the new fast track referral forms in January, expected to increase demand, remains the key risk from Q4 onwards.

Diagnostic 6 Week Wait (*end of month*)

Our positive position was sustained in December with a pleasing 99.98% 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, has to date continued to be 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.

2.2 Other Single Oversight Framework, NHS Constitution and Contractual Indicators

Our new dashboard is being developed to adopt the Single Oversight Framework and as this is finalised we will adapt our reporting to reflect this. We will also review any changes resulting from contract sign off. Below indicates performance against other current key standards.

Cancer and Infection Control

The following table shows our earlier projections for 16/17 against the other cancer and infection control indicators and performance to date. Full compliance was achieved/is expected in December.

Table 3 - Cancer and Infection Control Indicators										
16/17										
		Q1	Q2	Q3	Q4	Q1	Q2	Q3		
								Oct	Nov	Dec
Target or Indicator (per Risk Assessment Framework) not included within STF	%	Pred	Pred	Pred	Pred	Actual	Actual	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 Feb 17

3. Performance Focus - RTT, Diagnostics and Cancelled Operations

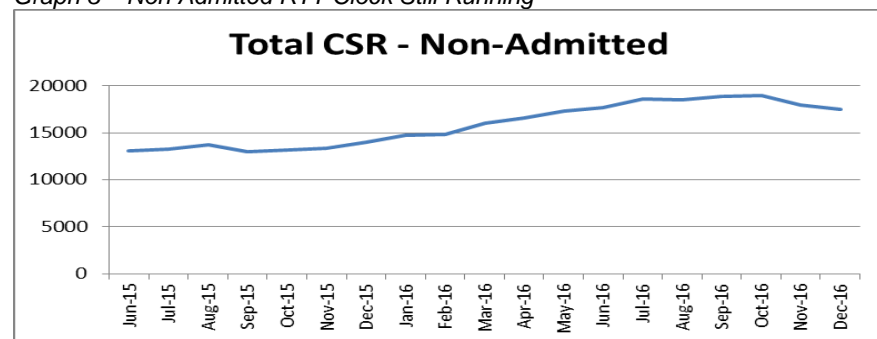
3.1 RTT 18 Weeks – Clocks Still Running

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
CLOCK STILL RUNNING (CSR) PERFORMANCE	92.3%	92.4%	92.4%	92.2%	91.8%	91.2%	91.4%	91.4%	90.3%
Total CSR (Patients)	23,237	23,938	24,072	24,997	24,868	25,174	25,526	24,456	24,210
Total CSR > 18wks (Patients)	1,797	1,817	1,842	1,955	2,033	2,211	2,204	2,101	2,360

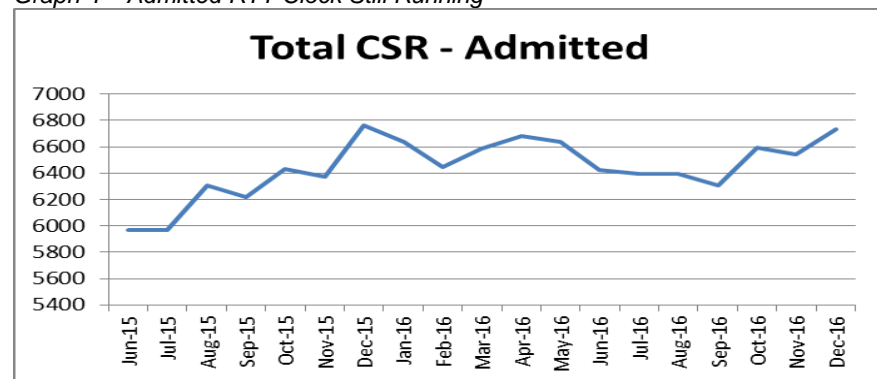
Table 4 – RTT 18 Weeks Clock Still Running Performance

The above table and below graphs show the number of patients on an 18 week pathway waiting for outpatients, diagnostics or treatment.

Graph 3 – Non Admitted RTT Clock Still Running



Graph 4 – Admitted RTT Clock Still Running



Overall the list has grown since April, though a slight reduction has been seen in December. The overall increase reflects:

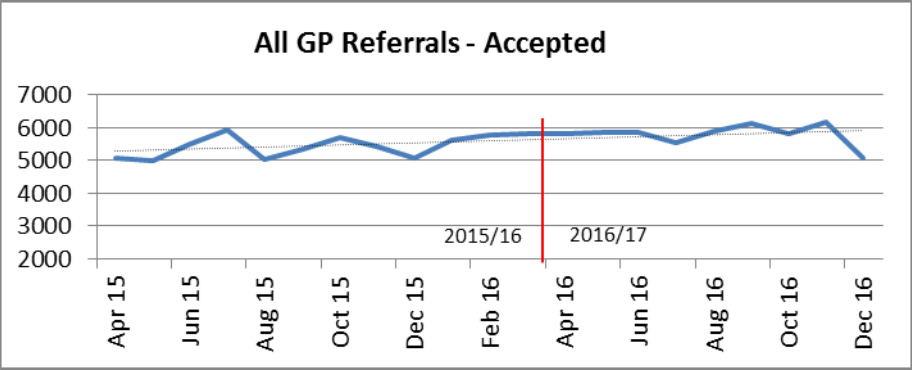
- Increased referrals over time, particularly in some specialities;
- Bed capacity limitations due to non-elective activity increases last year and this year, with clinically urgent cases being prioritised against routine cases;
- Unplanned capacity shortages, particularly in medical staff, that cause a step up in the waiting list which then are not recovered (though stabilised);
- Previously lost capacity from junior doctor strikes;
- Reduced premium cost waiting list initiatives earlier in the year.

A large part of the growth is in non admitted i.e. clinic based pathways, although a considerable subset are Ophthalmology, Orthopaedic and Gastroenterology patients, many of whom also require a procedure, e.g. cataracts, joint operations and endoscopy. This has however, been reducing since October.

3.2 Referrals

Although a reduction in referrals in line with seasonal trends was seen in December, GP referrals have increased YTD with an overall growth of >8.6% in accepted referrals. This demand has contributed to the increased challenge in maintaining RTT performance through 16/17. Management of this and ensuring we focus the skills and time of our specialist clinicians where they can add most value to patient care will be key to recovery and sustainability in 17/18. This is the focus of the Dorset-wide Programme Approach to elective care for 17/18, working with 9 key specialities (*Ophthalmology, Cardiology, Gastroenterology, Urology, ENT, Oral Surgery, Neurology, Dermatology and Orthopaedics*). Further information will be provided in subsequent reports.

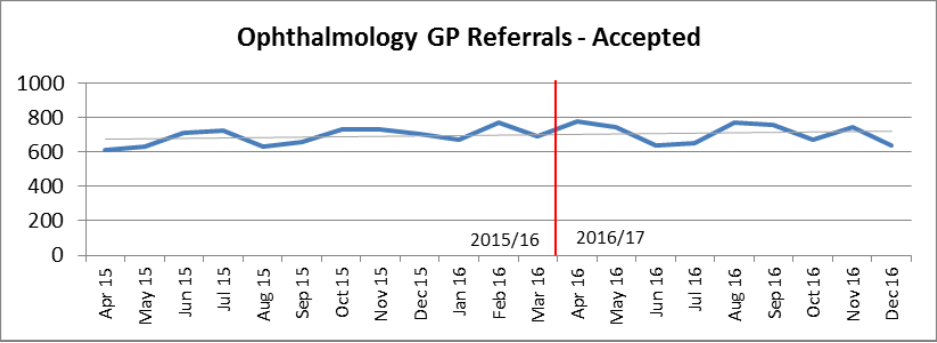
Graph 5



Particular growth has been seen in:

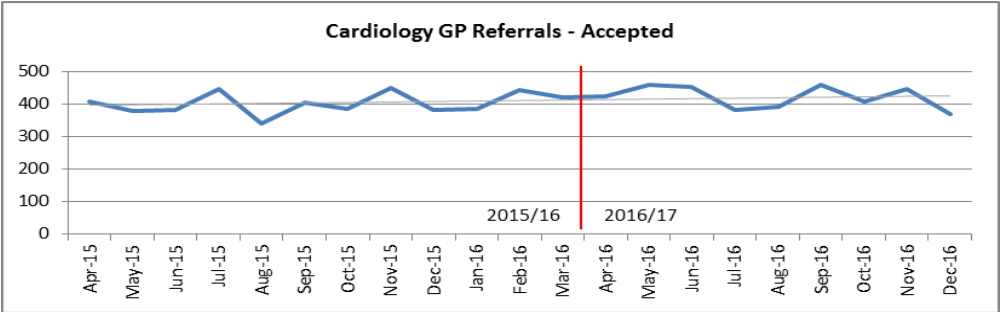
Ophthalmology +4.1% YTD on last year. Whilst the underlying trend has remained upward, growth this year is much lower than previously (+18.3% from 14/15 to 16/17). Significant referral process work has been undertaken in Ophthalmology (see *Improvement Case Study below*). Early signs indicate this is having a positive impact on ensuring our resources are focused on optimising the value of care provided to patients, as well as getting patients to the right service/clinic first time.

Graph 6



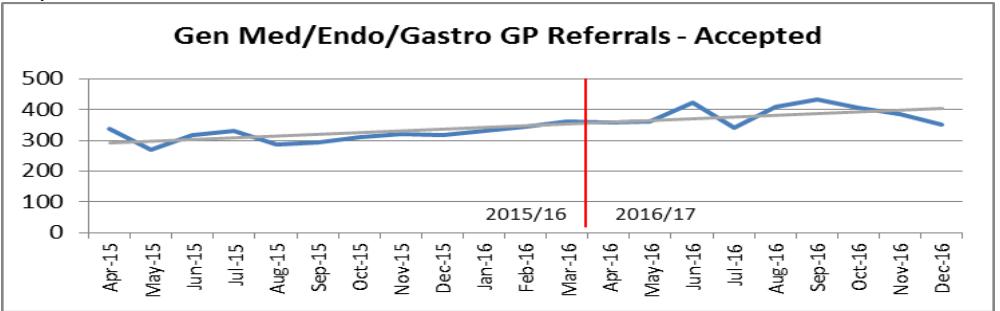
Cardiology +5.9% YTD compared to last year.

Graph 7



Gastroenterology and General Medicine +24.5% YTD compared to last year.

Graph 8

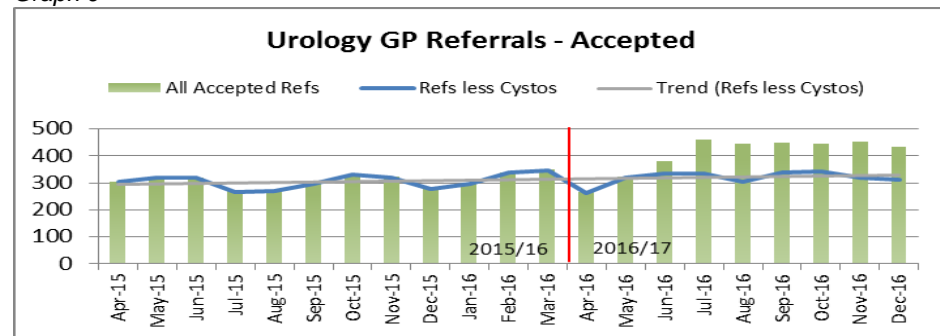


Performance Report

As at 16/01/2017

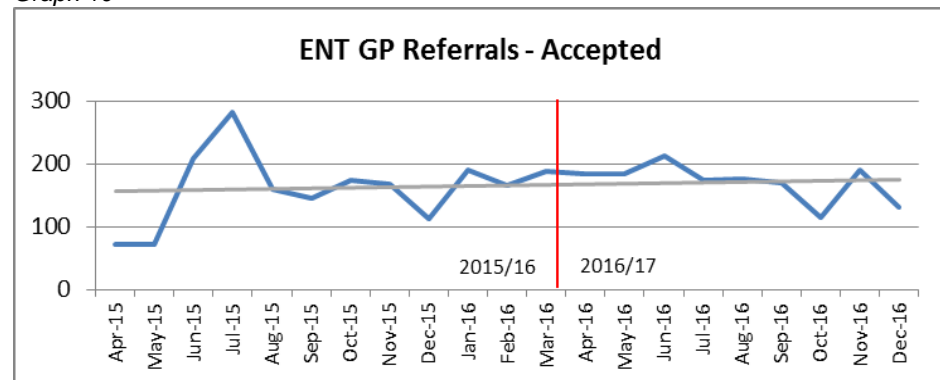
Urology +6.2% (excl pathway change relating to Cystoscopies).

Graph 9



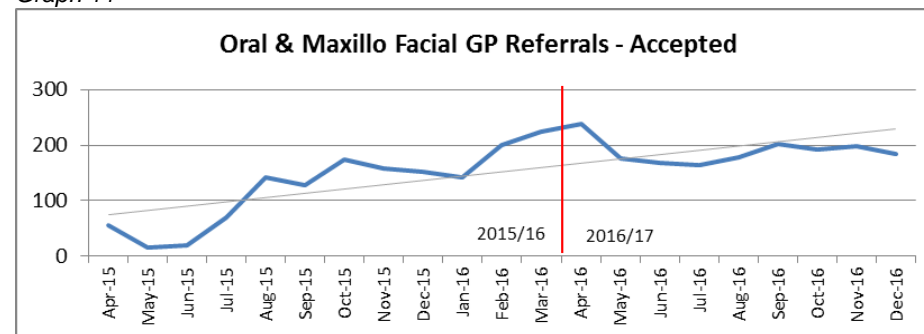
ENT +10.4% YTD compared to last year

Graph 10



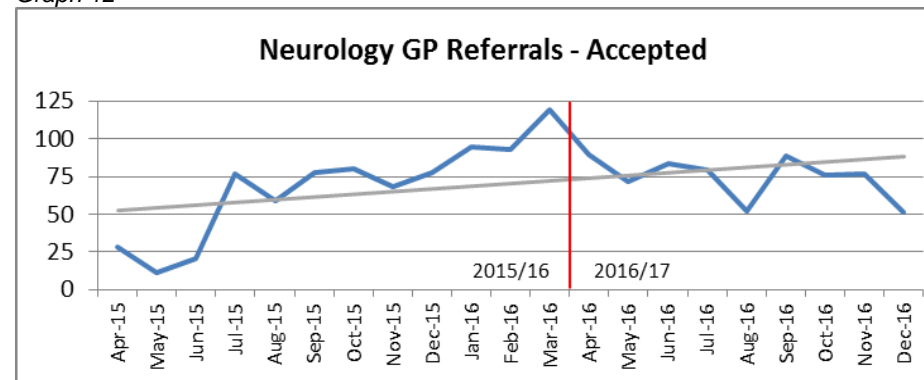
Oral Surgery & Max Fac +85.9% YTD compared to last year (though noting a pathway change during 2015). Real growth is closer to +14.6%

Graph 11



Neurology Noting a pathway change during 2015, comparing 14/15 to 16/17 there is a reduction of 20.4%, however, it is understood that demand growth at Poole has added pressure to this service.

Graph 12

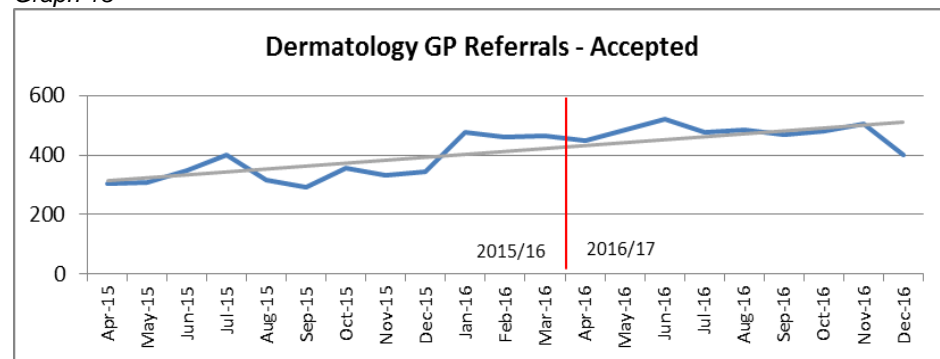


Performance Report

As at 16/01/2017

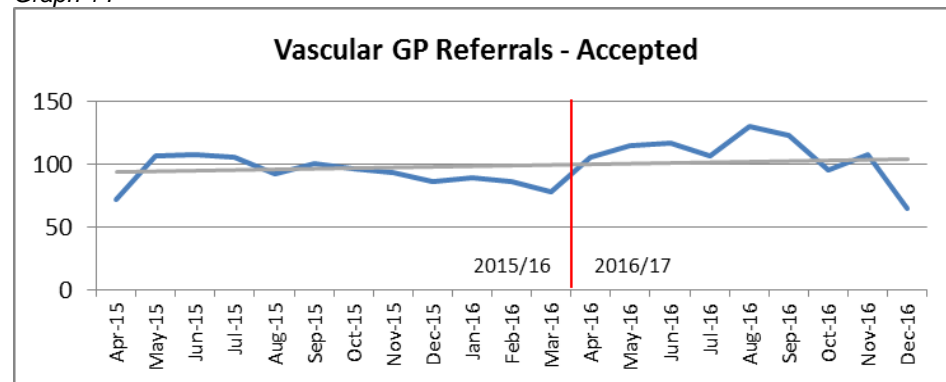
Dermatology +42.2% YTD compared to last year (though noting a pathway change last year). Real recent growth is closer to 2%.

Graph 13



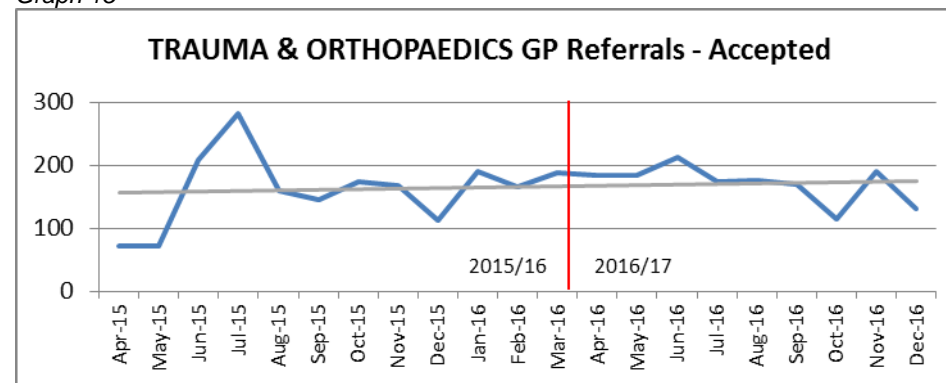
Vascular +12.3% YTD compared to last year. This is likely to be related to our development as the Vascular Network hub.

Graph 14



TRAUMA & ORTHOPAEDICS has remained relatively stable this year at -0.2% YTD compared to last year, however, maintaining these levels will be key to managing the financial challenge for 17/18.

Graph 15

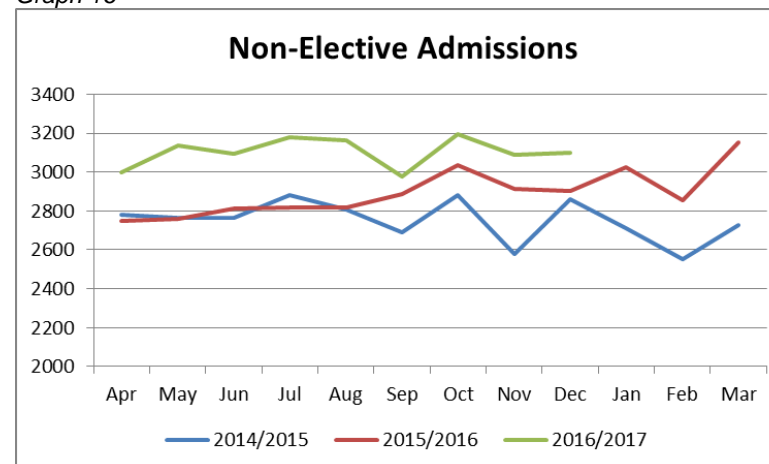


3.3 Emergency & Elective Admissions and Outpatient Activity

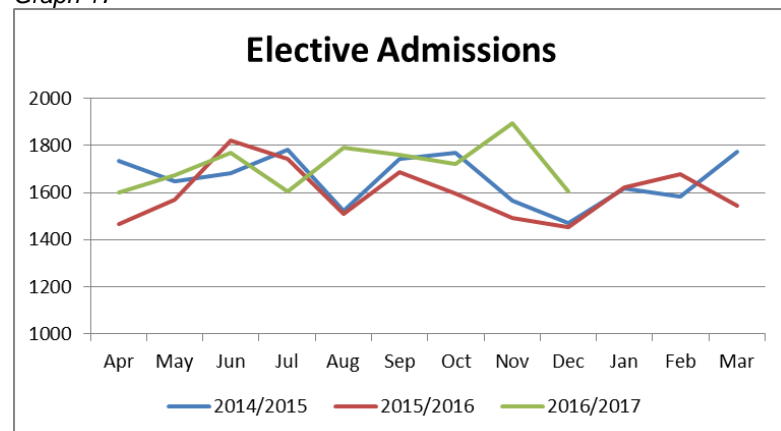
Emergency and Elective Admissions

2015/16 saw a reduction in elective activity through the year as non-elective activity increased, contributing to the growing pressure on RTT incomplete pathways (waiting lists) going into 16/17.

Graph 16



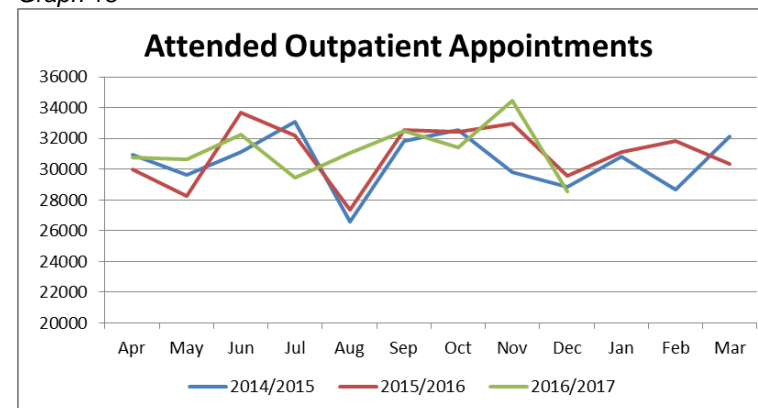
Graph 17



Inpatient elective activity has, however, increased by 7.5% from April to December 2016 compared to the same period last year. This is despite a corresponding increase of 8.8% in urgent care activity; the latter having been supported by a strong focus on ambulatory care to reduce overnight and length of stay, as well as the improvements in Frailty, other services and outliers. Equally Surgery has continued to develop shorter stay and theatre backfilling capacity. In October 2016 the Care Group also moved to standardised 4 hour theatre sessions, alongside implementation of improved processes for scheduling and matching procedure lengths, and increased focus on start/finish times, to increase its activity. This was further supported by our ability to ringfence the Derwent Orthopaedic Unit during that period and prior to winter.

Outpatient Activity

Graph 18



Overall outpatient activity for new patients has increased on last year (3.8%) though a slight reduction has been seen in follow ups -1.6%. The latter can contribute to increasing patients on the RTT pathway as longer follow up waits increase the time to final treatment. Outpatient waits continue to be monitored alongside the increasing referral rate which has to date, been above the increase in activity. It is also monitored against the non-admit waiting list and contract activity plans. Referrals and outpatient waits are reviewed regularly at speciality level with directorates with targeted action as required. Such action includes: additional sessions; notes review clinics; demand management approaches, for example, through GP advice and guidance and clinic template reviews. This will continue to be key as part of the Dorset-wide programme referenced above.

Performance Report

As at 16/01/2017

3.4 Overall Clocks Still Running by Specialty and Recovery Plans (National Target = 92%; STF Trajectory + Tolerance YTD = 91.5%)

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
100 - GENERAL SURGERY	90.9%	90.7%	91.0%	92.1%	91.5%	91.07%	90.73%	91.10%	91.61%
101 - UROLOGY	81.8%	84.9%	85.5%	85.1%	88.9%	88.34%	90.95%	93.03%	92.51%
110 - TRAUMA AND ORTHOPAEDICS	90.8%	90.7%	91.5%	91.6%	91.7%	90.48%	90.21%	88.80%	86.14%
120 - EAR NOSE AND THROAT	92.7%	90.8%	90.9%	90.5%	91.2%	90.26%	86.88%	88.14%	88.24%
130 - OPHTHALMOLOGY	91.4%	90.1%	89.0%	89.5%	87.4%	87.83%	89.07%	90.48%	88.71%
140 - ORAL SURGERY	99.3%	99.6%	98.3%	97.5%	92.0%	88.58%	88.44%	90.41%	89.07%
170 - CARDIOTHORACIC SURGERY	100%	100%	100%	100%	100%	-	100.00%	100.00%	100.00%
300 - GENERAL MEDICINE	96.9%	97.4%	96.4%	96.4%	95.3%	93.50%	91.85%	90.93%	90.17%
301 - GASTROENTEROLOGY	-	-	-	-	-	-	-	-	-
320 - CARDIOLOGY	91.5%	95.3%	96.1%	94.4%	95.7%	95.05%	94.87%	96.42%	95.28%
330 - DERMATOLOGY	97.8%	97.4%	96.6%	95.2%	94.3%	92.43%	92.84%	89.38%	87.86%
340 - THORACIC MEDICINE	96.4%	98.2%	99.1%	98.6%	98.5%	99.73%	98.91%	98.92%	98.65%
400 - NEUROLOGY	98.8%	97.1%	94.5%	96.2%	94.3%	92.17%	94.13%	93.92%	91.51%
410 - RHEUMATOLOGY	97.8%	97.2%	97.0%	95.0%	94.7%	96.27%	96.87%	97.00%	95.65%
430 - GERIATRIC MED	100.0%	100.0%	98.9%	97.4%	96.4%	98.90%	98.92%	98.84%	96.75%
502 - GYNAECOLOGY	90.5%	90.6%	89.5%	87.7%	88.4%	88.82%	91.18%	90.36%	91.72%
Other	94.5%	95.4%	96.6%	95.5%	95.4%	92.43%	91.74%	90.98%	90.29%
TOTAL	92.3%	92.4%	92.3%	92.2%	91.82%	91.22%	91.37%	91.41%	90.25%

Table 5 – Clocks Still Running Speciality Performance

As outlined in Section 2.1 above, a number of specialities were below 92% at speciality performance level in December, reflecting the challenges outlined.

The following indicates the actions being taken across these and the improving specialities, to support continued compliance with the STF trajectory tolerance and return to national target. This is in addition to increased outpatient sessions and 'Super Saturdays' planned for January and potentially February, across a number of specialities. Significant improvement is expected by the end of January with plans to further recover to the national 92% threshold through Q4, though noting the demand, capacity and winter pressure risks.

Speciality	RTT Key Issues	Recovery Plans Underway
Ophthalmology	<ul style="list-style-type: none"> - GP referral demand growth - now 4.1% reduced from 7+% earlier in the year (graph 6) - Previous medical staff vacancies and lack of recruitment up-take - System-wide pressures on this service 	<ul style="list-style-type: none"> - Work with CCGs to support community/primary care based services including transfer of follow-up activity - aim to commence by Apr 17 - Guidance to GPs and criteria management well progressed with early signs of stabilising referrals - Redesign of e-referral outpatient booking processes with outpatient waiting times now reduced - Additional sessions - Locum/substantive posts - now in post - Outsourcing of cataract pathways - 18 week admitted backlog now reduced by 200 since Sept - Key speciality in the Dorset-wide programme
Gastroenterology	<ul style="list-style-type: none"> - Demand growth (c24.5%) - Capacity for outpatients and endoscopy - Follow up backlog 	<ul style="list-style-type: none"> - QI project commenced and will be aligned with Dorset-wide programme - Additional sessions - Key speciality in the Dorset-wide programme
ENT	<ul style="list-style-type: none"> - Unplanned medical staff shortages at provider Trust impacting on capacity available at RBH - 10.4% increase in GP referrals 	<ul style="list-style-type: none"> - Working with visiting provider trust to secure additional capacity and manage long waiters - Ad hoc additional sessions - Key speciality in the Dorset-wide programme
Oral Surgery	<ul style="list-style-type: none"> - Unplanned medical staff shortages at provider Trust impacting on capacity available at RBH - 14.6% increase in GP referrals 	<ul style="list-style-type: none"> - Working with visiting provider trust to secure additional capacity and manage long waiters - Ad hoc additional sessions - Key speciality in the Dorset-wide programme
Neurology	<ul style="list-style-type: none"> - Capacity at provider Trust impacting on capacity available at RBH 	<ul style="list-style-type: none"> - Working with visiting provider trust to secure additional capacity and manage long waiters - Ad hoc additional sessions - Key speciality in the Dorset-wide programme
Allergy	<ul style="list-style-type: none"> - Capacity at provider Trust impacting on capacity available at RBH - 14% increase in GP referrals 	<ul style="list-style-type: none"> - Working with CCG to repatriate to lead provider trust, supporting local service - Additional sessions - 18 week non admit backlog just commenced reduction
General Surgery	<ul style="list-style-type: none"> - Previous unplanned medical staff capacity shortages particularly in Colorectal and Vascular - Capacity for routine procedures in UGI 	<ul style="list-style-type: none"> - Substantive consultant posts now in place in Colorectal, Upper GI and Vascular. - Additional sessions and outsourcing continues - 18 wk admitted backlog now reduced in Colorectal and Vascular
Gynaecology	<ul style="list-style-type: none"> - Previous unplanned medical staff capacity shortages 	<ul style="list-style-type: none"> - Medical recruitment now in place - Additional sessions - Outsourcing - 18 wk admitted backlog reduced and non admitted above 92%
Urology	<ul style="list-style-type: none"> - Good progress with backlog reduction to date - Risk re potential vacancies and 6.2% referral increase 	<ul style="list-style-type: none"> - Locums in place - Further recruitment underway - Additional sessions - Outsourcing - Now above 92% Nov and Dec - Key speciality in the Dorset-wide programme
Orthopaedics	<ul style="list-style-type: none"> - Previous medical staff capacity shortages due to doctor turnover leading to peaks and troughs in capacity. - Risk of impact of non elective activity on bed capacity going forward. 	<ul style="list-style-type: none"> - LoS reduction project and ringfencing of Derwent Unit for Ortho - Additional sessions and potential outsourcing - Backfill of medical vacancies - Elective activity increased YTD - admitted backlog stabilised, though not significantly reduced. - Key speciality in the Dorset-wide programme
Dermatology	<ul style="list-style-type: none"> - Previous unplanned medical staff capacity shortages - Referral increase (c2%) - Follow up backlog 	<ul style="list-style-type: none"> - Substantive consultant post and other (fixed term) posts now in place - Additional sessions - 18 week admitted backlog now reduced - Key speciality in the Dorset-wide programme

As part of our plan, we are working closely with Poole Hospital on their visiting specialties – ENT, Oral Surgery and Neurology. All of these services are extremely challenged in relation to growing demand and capacity. ENT is of specific concern due to recruitment challenges at Poole. We are currently maintaining waiting times only through ad hoc additional sessions, but this remains challenging as we are not the lead provider for these services. All three services are included within the Dorset-wide Programme to review value care and referral/outpatient pathways.

The following case study highlights the significant team improvement work undertaken to date in Ophthalmology which has contributed to their recovery plan.

Improvement Case Study

Ophthalmology - Demand and Capacity Management – December 2016

Aim:

- Ophthalmology referrals have increased by 3% over the last year, but mainly in macular and cataracts where the increase is nearer 20%.
- With no additional funding available, the Directorate were looking at ways of managing this demand, both short term and longer term.

Methodology:

By reviewing the steps of the patient pathway from referral to listing the team were able to identify opportunities for improvement, optimising value care and increasing efficiency. Improvement actions implemented:

- Reconfigured the general and specialised clinics on e-referral so that patients could be directed to the right clinic first time, incorporating assessment and Advice & Guidance where appropriate
- Implemented direct triage – consultant review of referrals to confirm information provided, referral pathway correct and urgency to support smoother processing and timeliness of the referral and appointment
- Redirection of referrals to Primary Care Ophthalmology Service (PCOS) for appropriate conditions, supporting timeliness and appropriateness of

appointment and ensuring specialist skills are focused on patients where the most value is gained – supported by training

- Reviewed and revised criteria and education for GPs and Optometrists to ensure patients are referred appropriately for cataract procedures
- Reviewed process for ensuring Dorset-wide requirements for 2nd eye cataracts are followed
- With the support of our commissioners, implemented outsourcing to support flex in capacity and provide patient choice linked to waiting times
- Recruited specialist nurses, trained to carry out injections, minor ops, pre-assessment and see follow ups also releasing medical staff capacity
- Recruited more technicians and optometrists for a broader approach to outpatient support functions, with extended roles where appropriate
- Implemented dedicated, team based, booking/clinic cancellation/patient tracker role to ensure timely cancellation and rebooking of clinics/appointments, checking and ensuring timeliness of patient pathways
- Development of a demand and capacity tool for immediate and longer term operational planning

Results:

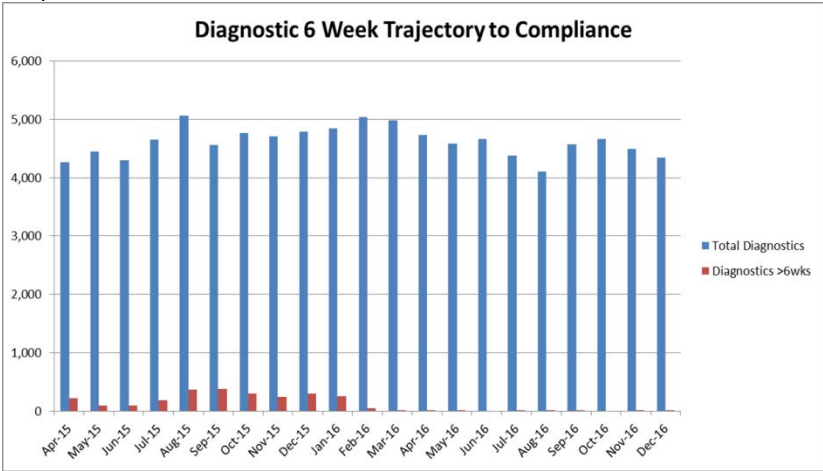
- Stabilised referrals
- Reduced 18 week backlog
- Reduced outpatient waits

Next Steps:

- Continue to monitor the outcomes of above
- Progress implementation of Optometrist cataract follow-up
- Looking at apprenticeships
- Further extended roles
- Review of outpatient capacity options and configuration
- Consider 3 session days and 9 day fortnight contracts/job plans
- Outreach provision of services e.g. at community hospitals, GP surgeries

3.5 Diagnostic 6 Week Wait Trends

Graph 19



Overall the diagnostic waiting list has remained relatively stable and the numbers waiting over 6 weeks have been largely eliminated. Ongoing additional capacity has continued to be provided on an ad hoc basis in Endoscopy and Radiology.

As highlighted earlier, the biggest risks to diagnostics currently are the new fast track referral forms due to be launched in January and age of some of the Radiology equipment. We are working jointly with our commissioners and some additional funding has been provided to support the cancer pathways. However, the demand and our ability to respond should demand be above expected levels, will be closely monitored. This will also be supported by our participation in the national 28 day diagnosis project which is reviewing pathways to diagnosis for suspected cancer referrals.

3.6 Cancelled Operations

The Trust generally performs well in terms of minimising cancelled operations and on rebooking within 28 days. YTD we currently remain

well within our contractual 0.7% target, at 0.52% of total elective admissions and we have had a very small number of 28-day breaches (5) YTD. These are usually in very specific circumstances where a senior and/or specialist procedure is required. Whilst winter bed pressures have led to a very small number of cancellations, these have generally been cancelled the day before and rearranged quickly.

4. Recommendation

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

This includes compliance with STF trajectories and tolerances to date, but noting the diminishing margin for elective 18 week pathways and additional risks across the targets associated with Q4.

Finally, the Board is also requested to note the detailed report on RTT performance and the plans for return to national threshold.

BOARD OF DIRECTORS	
Meeting Date and Part:	27 January 2017
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 / Deputy Chief Executive
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 Group
Action required: Approve/Discuss/Information/Note	The paper is provided for information and assurance
Executive Summary: <ul style="list-style-type: none"> • 2 serious incidents were reported in December 2016 • The Trust New Harm Free Care score has improved in month • The Trust remains in the top quartile for inpatient and ED Family and Friends test scores. 	
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

Quality Report



**For the period to end December
2016**

Paula Shobbrook
Director of Nursing and Midwifery

1.0 Introduction

- 1.1 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 Two Serious Incidents were reported in December 16:

1. Potential delay in diagnosis of infection.
2. Potential delay in diagnosis of metastatic cancer

Scoping meetings have been held for both incidents, RCA investigations are in progress and SI panel dates arranged. Recommendations and learning points will be shared following completion of the SI investigation process.

3.0 Safety Thermometer

- 3.1 The Trust New Harm Free Care score has improved in month as a result of a decrease in the number of reported catheter related urinary tract infections (1 in month compared to 5 in November).

The number of reported falls with harm (2) and hospital acquired pressure ulcers (10) remain consistent with previous months.

Harm Free Care		
	2015/16	2016/17
April	92.56	88.02
May	92.51	87.34
June	89.29	88.49
July	90.13	91.36
Aug	92.41	93.29
Sept	88.89	87.32
Oct	90.49	87.31
Nov	87.39	87.25
Dec	90.93	86.72
Jan	84.1	
Feb	89.51	
Mar	89.29	
Average	89.79	88.57

Trust New Harm Free Care		
	2015/16	2016/17
April	96.78	95.87
May	97.86	98.13
June	98.85	98.65
July	97.64	97.73
Aug	97.89	98.32
Sept	96.58	98.09
Oct	97.77	97.63
Nov	98.08	96.7
Dec	97.1	97.22
Jan	96.62	
Feb	98.35	
Mar	96.77	
Average	97.52	97.59

4.0 Patient Experience Report – January 2017

- 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 November 2016 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in November 2016 ranked RBCH Trust 2nd with 13 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 17.7%.

- The Emergency Department FFT performance in November 2016 ranked RBCH Trust 7th with 9 other hospitals out of 141 placing RBCH ED department in the top quartile. The response rate 7.1% against the 15% national standard.
- Outpatients FFT performance in November 2016 ranked RBCH Trust 3rd with 16 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.

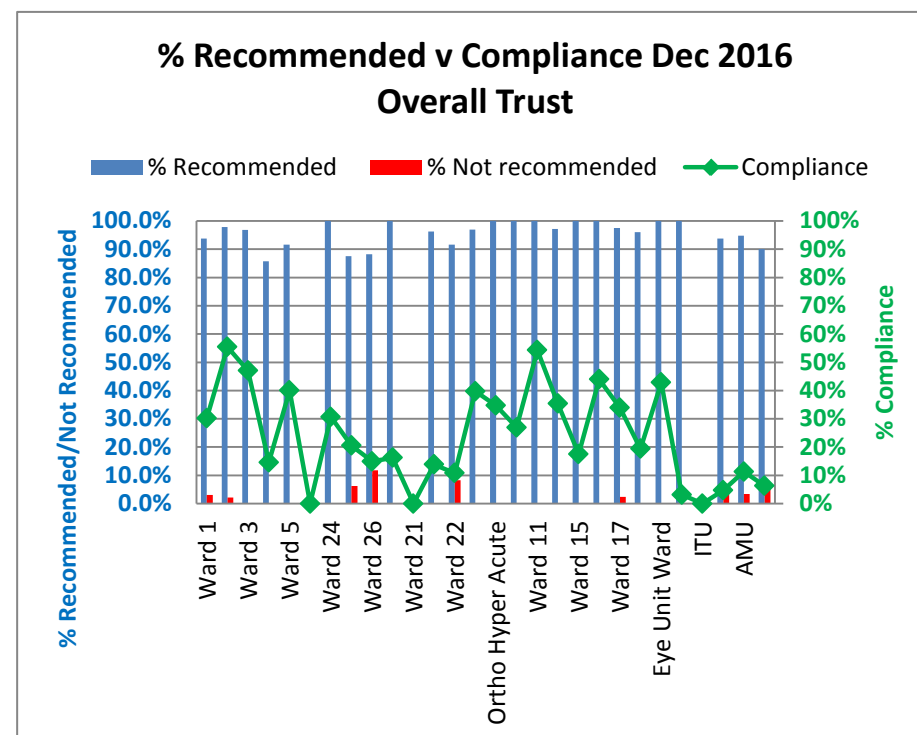
	June	July	August	September	October	November
In-Patient Quartile						
Top	98.704%	98.703%	98.318%	98.143%	98.573%	98.548%
2						
3						
Bottom						

	June	July	August	September	October	November
ED Quartile						
Top	94.186%		94.570%	94.737%	94.737%	94.131%
2		92.470%				
3						
Bottom						

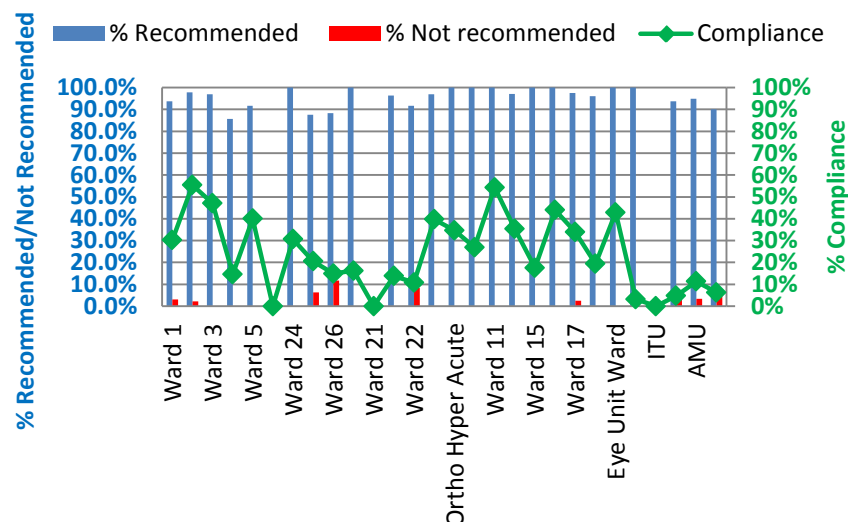
	June	July	August	September	October	November
OPD Quartile						
Top						
2	96.734%	96.734%	96.716%	97.008%	96.893%	97.549%
3						
Bottom						

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.



% Recommended v Compliance Dec 2016 Overall Trust



4.3 Family and Friends Test: Corporate Outpatient areas

Corporate	Total eligible to respond	No. PEC's completed	No. of FFT Responses	% Recommended	% Not Recommended
Corporate					
Derwent OPD	N/A	2	2	100.0%	0.0%
Main OPD Xch	N/A	30	28	100.0%	0.0%
Oral and Maxillofacial	N/A	32	32	100.0%	0.0%
Outpatients General	N/A	203	193	95.9%	1.0%
Jigsaw OPD	N/A	6	5	100.0%	0.0%
Corporate Total	N/A	273	260	96.9%	0.8%

4.4 Care Audit Trend Data

The Care Audit Campaign continues with close monitoring. Focus groups continue on call bells, noise at night, food and drink, and pain management. This is reported into the Healthcare Assurance Group and Committee.

4.5 Patient Opinion and NHS Choices: December Data

4 patient feedback comments were posted in November, 3 express satisfaction with the service they received. 1 negative response related to staff attitude and waiting time. 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.

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

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	27 th January 2017 – 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 st December 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?	Well-led
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	One current financial risk exists on the risk register related to 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 December 2016

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust has delivered a cumulative deficit of £843,000 as at 31 December. This is £67,000 worse than budget.

Sustainability and Transformation Fund

Despite the marginal over spend to date, the Trust has achieved its year to date financial control total set by NHS Improvement thereby securing access to the Sustainability and Transformation Fund. All agreed performance trajectories have also been achieved to date, and thus the Trust has accrued the associated Fund income in full.

Cost Improvement Programme

Financial savings of £6.2 million have been achieved, which is £0.4 million behind the year to date target. The full year savings forecast improved marginally during December, and the current forecast is for total savings of £8.5 million against the full year target of £9.5 million. Further schemes continue to be identified to close this gap.

Employee Expenses

The Trust has significantly reduced its reliance upon agency staff, and this together with the national price controls has reduced the associated cost considerable. The Trust is spending considerably less than the previous year and is currently operating within the agency ceiling agreed with NHS Improvement. Expenditure is expected to increase during the final quarter as a result of the requirement to open and staff an additional ward to manage the increased demand for services during the winter months.

Forecast Outturn

The Trust continues to forecast the achievement of its full year deficit control total of £1.45 million. However, there remains risk in this forecast due to anticipated winter pressures and action is being taken to mitigate the effect. Specifically, each Care Group has prepared and is implementing a detailed financial recovery plan.

Capital Expenditure

As at 31 December £4.8 million of capital spend has been committed, which is £4.9 million less than planned at this point in the year. The Trust is currently forecasting to under spend against the full year programme by £3.2 million, mainly due to slippage in relation to the refurbishment of the cardiology labs which will continue into 2017/18 following a very detailed procurement process.

Cash

The Trust continues to report a favourable cash position against its plan, with a current consolidated cash balance of £41.2 million. The forecast end of year cash balance is £23.2 million meaning that no Department of Health support is required at this stage.

Financial Risk Rating

The Trust has achieved a Use of Resources score of 2 under NHS Improvement's Single Oversight Framework (1 being best and 4 being worst).

Recommendation

Members are asked to note the Trusts financial performance to 31 December 2016.

Finance Report

As at 31 December 2016

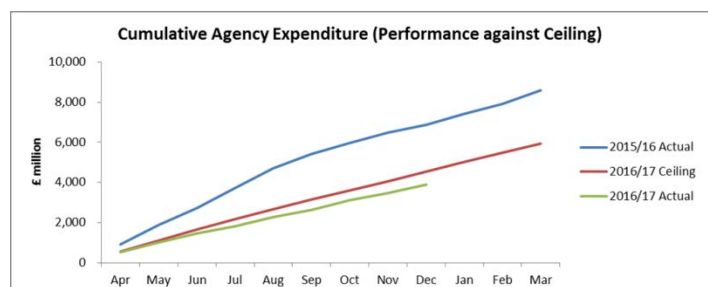
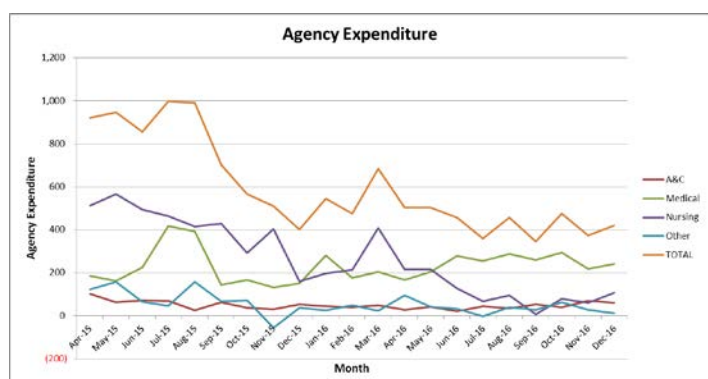
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000
NHS Clinical Income	192,943	188,433	(4,509)
Non NHS Clinical Income	4,857	4,089	(768)
Non Clinical Income	23,800	23,537	(263)
TOTAL INCOME	221,601	216,060	(5,541)
Employee Expenses	132,467	130,042	2,426
Drugs	26,987	24,171	2,817
Clinical Supplies	28,292	28,203	89
Misc. other expenditure	34,630	34,488	143
TOTAL EXPENDITURE	222,377	216,903	5,474
SURPLUS/ (DEFICIT)	(777)	(843)	(67)

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	131,889	131,682	(207)
NHS England (Wessex LAT)	38,481	34,007	(4,474)
NHS West Hampshire CCG	18,678	18,683	5
Other NHS Patient Income	5,826	5,979	153
Sustainability and Transformation Fund	5,700	5,700	0
Non NHS Patient Income	2,926	2,171	(755)
Non Patient Related Income	18,100	17,837	(263)
TOTAL INCOME	221,601	216,060	(5,541)

SUSTAINABILITY AND TRANSFORMATION FUND (STF) INCOME	YEAR TO DATE		FULL YEAR FORECAST	
	BUDGET £'000	ACTUAL £'000	BUDGET £'000	FORECAST £'000
Financial: Control Total (70%)	3,990	3,990	5,320	5,320
Performance: A&E Trajectory (12.5%)	713	713	950	950
Performance: RTT Trajectory (12.5%)	713	713	950	950
Performance: Cancer Trajectory (5%)	285	285	380	380
TOTAL	5,700	5,700	7,600	7,600

Agency Expenditure

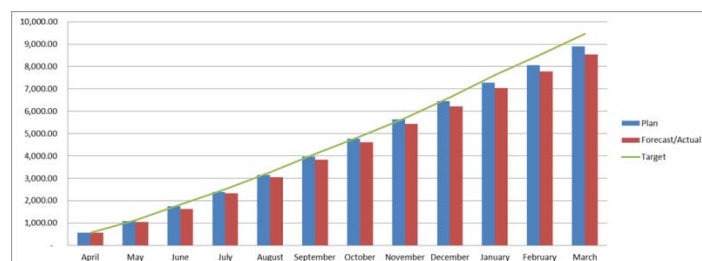


Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	12,798	12,575	(224)
Medical Care Group	7,773	6,999	(774)
Specialties Care Group	4,138	4,082	(56)
Corporate Directorates	(25,962)	(25,486)	476
Centrally Managed Budgets	476	987	511
SURPLUS/ (DEFICIT)	(777)	(843)	(67)

Cost Improvement Programme

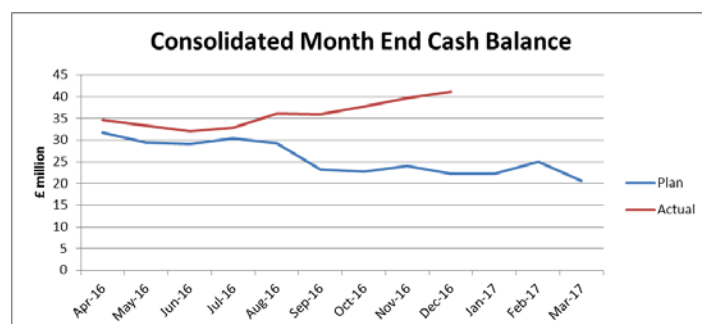
COST IMPROVEMENT PROGRAMME (CIP)	YEAR TO DATE			FULL YEAR		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000	TARGET £'000	FORECAST £'000	VARIANCE £'000
Surgical Care Group	(1,446)	1,422	(25)	(2,191)	2,100	(91)
Medical Care Group	(1,571)	1,378	(193)	(2,598)	1,908	(690)
Specialties Care Group	(1,637)	1,468	(169)	(2,116)	1,967	(149)
Corporate Directorates	(1,969)	1,937	(32)	(2,564)	2,567	3
Total	(6,623)	6,204	(419)	(9,469)	8,542	(927)



Capital Expenditure

CAPITAL PROGRAMME	YEAR TO DATE			FULL YEAR FORECAST		
	BUDGET £'000	ACTUAL £'000	VARIANCE £'000	BUDGET £'000	FORECAST £'000	VARIANCE £'000
Estates	6,589	2,237	4,352	7,940	5,466	2,474
IT Strategy	2,315	2,150	165	3,409	2,685	724
Medical Equipment	700	367	333	1,000	1,000	0
TOTAL	9,604	4,754	4,850	12,349	9,151	3,198

Cash



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would expect for our own families*

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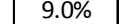
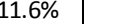






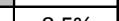
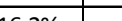




















BOARD OF DIRECTORS

Meeting Date and Part:	27 th January 2017 – Part 1
Reason for Part 2:	n/a
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.</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 – JANURY 2017

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 December			Rolling 12 months to 31 December				At 31 December
Surgical	85.4%	83.3%	88.9%	4.86%	16009	13.0%	10.8%	5.2%
								
Medical	88.9%	86.2%	88.9%	4.23%	21200	13.6%	11.9%	8.1%
								
Specialities	93.0%	86.9%	92.0%	3.60%	10258	9.0%	11.6%	7.4%
								
Corporate	93.4%	0.0%	95.5%	3.92%	12611	8.5%	16.2%	3.5%
								
Trustwide	90.1%	84.8%	90.6%	4.18%	60077	10.7%	11.8%	6.3%
								

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 December			Rolling 12 months to 31 December				At 31 December
Add Prof Scientific and Technical	94.5%		93.1%	3.48%	1535	12.3%	16.2%	5.4%
Additional Clinical Services	85.0%		89.1%	6.03%	15310	16.8%	14.6%	12.4%
Administrative and Clerical	92.0%		94.7%	3.65%	11036	8.7%	12.5%	5.1%
Allied Health Professionals	92.0%		92.8%	2.31%	2082	12.8%	15.0%	2.5%
Estates and Ancillary	94.2%		93.9%	5.35%	6785	7.4%	10.2%	5.6%
Healthcare Scientists	96.0%		95.0%	3.23%	1072	16.7%	19.0%	2.3%
Medical and Dental		84.8%	83.9%	1.49%	2367	4.3%	6.4%	4.2%
Nursing and Midwifery Registered	88.9%		90.6%	4.66%	19891	10.6%	9.6%	5.5%
Trustwide	90.1%	84.8%	90.6%	4.18%	60077	10.7%	11.8%	6.3%

1. Appraisal











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

It is pleasing to report that appraisal compliance has reached its target at the year end, being 90.1% at 31st December, up from 87.9% the previous month.











2. Essential Core Skills Compliance

Overall compliance continues above the 90% mark at 90.6%, as per the previous month. This compares favourably with the 82.7% figure at the same point last year.

The 10 areas with the lowest compliance as at 31st December:

Directorate	Organisation	Headcount	Compliance	Trend
Surgery Directorate	153 Surgery - General 10085	34	73.44%	
Cancer Care Directorate	153 Haematology Snr.Medical 11346	20	79.38%	
Anaesthetics/Theatres Directorate	153 ICU/HDU 10315	60	79.81%	
Medicine Directorate	153 Medical General Staff 10075	72	79.86%	
Elderly Care Services Directorate	153 MFE Medical Staff 10077	51	80.28%	
Facilities Directorate	153 Portering 14615	35	80.34%	
ED Directorate	153 ED Nursing and Income 10455	90	81.75%	
Cancer Care Directorate	153 Macmillan Unit 10565	33	82.96%	
Elderly Care Services Directorate	153 MFE Ward 4 10382	29	83.10%	
Elderly Care Services Directorate	153 MFE Ward 5 10378	36	83.16%	

Areas with highest compliance:

Directorate	Organisation	Headcount	Compliance	Trend
Operational Services Directorate	153 Cancer Information Team 13495	14	100.00%	
Informatics Directorate	153 Telecoms 13585	22	100.00%	
Facilities Directorate	153 XCH I/H Dom Contract 14350	14	100.00%	
Finance and Business Intelligence	153 Supply Chain Management 14915	20	100.00%	
Finance and Business Intelligence	153 Information 13541	17	100.00%	
Informatics Directorate	153 Health Records 13540	40	99.75%	
Pathology Directorate	153 Haematology 11340	25	99.60%	
Human Resources Directorate	153 Blended Education and Training 11	12	99.34%	
Specialist Services Directorate	153 Prosthetic/Orthotic Centre 12650	12	99.32%	
Informatics Directorate	153 IT Development Recurrent 13597	13	99.29%	

Fire Safety and Resus training show lowest compliance at just over 80%; additional Resuscitation training sessions have been planned, and a new Fire Officer is now in post which will enable on-ward/in-department fire training sessions to recommence, which should hopefully see compliance increase for both competencies. The BEAT (Blended Education and Training Team) continue to work on position-based competencies for individuals to ensure that people are required to complete the appropriate training, as well as the development of new modules for the VLE (Virtual Learning Environment).

3. Sickness Absence

The Trust-wide sickness rate has slipped back again to 4.18% (4.11% last month) which is up on the 3.91% figure at the same point last year, despite having seen some month-on-month improvements during the year.

The 10 areas with the highest 12-month rolling sickness absence as at 31st December:

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Anaesthetics/Theatres Directorate	153 Day Surgery Services 10385	31	10.10%	
153 Elderly Care Services Directorate	153 MFE Ward 5 10378	41	9.93%	
153 Facilities Directorate	153 Portering 14615	39	9.32%	
153 Surgery Directorate	153 Ward 17 10428	30	9.06%	
153 Specialist Services Directorate	153 XCH Dermatology 10362	25	8.62%	
153 Orthopaedics Directorate	153 Orthopaedic Outpatients 10587	25	8.56%	
153 Specialist Services Directorate	153 XCH Medical Secretaries 13556	11	8.26%	
153 Medicine Directorate	153 Ward 3 10598	43	8.16%	
153 Specialist Services Directorate	153 Department of Sexual Health 1009	39	7.93%	
153 Elderly Care Services Directorate	153 MFE Ward 24 10594	40	7.92%	

Areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Surgery Directorate	153 Surgery - Urology 10084	19	0.29%	
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	41	0.53%	
153 Medicine Directorate	153 Medical General Staff 10075	87	0.69%	
153 Orthopaedics Directorate	153 Ortho Medical Staff 10160	34	0.71%	
153 Other Directorate	153 Postgraduate Centre 13531	13	0.82%	
153 Finance and Business Intelligence	153 Information 13541	17	0.89%	
153 Finance and Business Intelligence	153 Fundraising Expenses 13576	14	0.90%	
153 Surgery Directorate	153 Surgery - General 10085	37	0.92%	
153 Elderly Care Services Directorate	153 MFE Medical Staff 10077	53	1.05%	
153 Cardiac Directorate	153 Cardiac Rehab 11527	21	1.05%	

4. Turnover and Joiner Rate

Joining rate 10.7% compared to 11.1% last month; turnover rate of 11.9% compared to 11.0% the previous month.

5. Vacancy Rate

Vacancy rate 6.3% (5.6% last month). This is a slight rise but consistent with the pattern in previous years.

6. Safe Staffing

December Unify Data -

RN Day actual against planned	91%
HCA Day actual against planned	98.3%
RN Night against planned	98.7%
HCA Night against planned	117.6%

The overall Unify data shows sustained fill rates of planned against actual although a slight drop in month when compared to the previous month for Registered nursing on day shifts.

Areas of exception or variation have substantiated their position with main themes being specials. We have an overall care hour per patient day (CHPPD) of 7.7 hours, with 4.7 hours being registered nursing and 3.0 being care staff. This is a fairly new metric, which is reported alongside the Unify data, and we are observing our internal baseline initially.

There is variance between areas, but this is largely what we would expect to see, for example areas with higher CHPPD are the intensive care or higher dependency areas where nurse to patient ratios are higher.

There were no red flags this month.

7. Other

A successful NHS careers day was held on 17 January 2017 in the education centre for year 12 students from 13 local schools and colleges. A comprehensive programme of sessions and demonstrations took place including time in the simulation suite, sessions from Bournemouth University, voluntary services, "life as a Junior Doctor", pharmacy, midwifery, as well as the role of a therapist, clinical apprenticeships, and presentations from radiology and the ambulance service, information on clinical apprenticeships and the changes in career pathways, careers in pathology and biomedical science as well as nursing..

A two day Introduction to Medicine programme will also run on 16/17 February for those students considering medicine as a career. We also continue to attend local careers fairs and events usually in partnership with other Dorset Trusts.

8. Organisational Development

There are a series of events and opportunities for staff to contribute to the development of new staff awards and recognition. This was a strong theme from the cultural audit with staff expressing a need to review our existing schemes and develop some new ways of recognising achievement and excellence and saying thank you.

There are 10 open invitation focus groups to be facilitated by the Change Champions during January. There are also several team meetings in which time has been given to our Change Champions to canvas views and we have a paper survey that the champions are circulating around the Trust. When this exercise is complete, the Change Champions and OD will review the options and make a final proposal for 2017. It is likely that the proposals will include a number of different ways to reward and recognise the efforts of Team RBCH, and some options will need to be scoped out more fully.

The Board will be aware of the development of our plans for Customer Care training. This will be a 2 hour session aimed at all staff and is due to be launched from 1st April. The course content is drafted and there will be a number of pilots in March. There is a patient focus group arranged to test the content and assumptions and we have identified a number of staff who would like to be trainers on the programme.

Some of the Board members will have been present at the Leadership summit in September and experienced some of the breakout sessions that were run on this day. The “Resilient Mind” session was well received and as a result we are running five half-day leadership development workshops in March. These will be delivered by Optimus OD and aimed at all staff. Using an overarching metaphor of a battery, delegates explore 5 pillars of resilience and they learn not only how to increase their resilience day to day, but how to build their resilience capacity.

We are also running “Difficult Conversations” - another of the breakout sessions - from March. This day-long event will be delivered by Practive with a target audience of Ward Sisters/Charge Nurses, Directorate Managers, Medical Staff and Matrons. There are 140 spaces in total. This practical and experiential session will explore the challenges of leading and influencing others through the conversations we have with them and, in particular, to explore some practical skills and techniques for having more difficult and “courageous” conversations.

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

BOARD OF DIRECTORS

Meeting Date and Part:	Friday 27 th January 2017- Part 1
Subject:	Trust Annual Plan 2017/18 and 2018/19 – Submitted Version
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	n/a
Officer with overall responsibility:	Tony Spotswood, Chief Executive Officer
Author(s) of papers:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	Drafts at November 2016 and December 2016 Boards
Action required: Approve / Discuss / Information/Note	Note
Executive Summary: The final version of the annual plan was submitted on 23 rd December and included amendments resulting from NHSI, Trust Board and governor comments on the earlier drafts. This paper describes the final changes and appends the final version.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All of these
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	

Operational Plan 2017/18 and 2018/19

Introduction

The Board received draft versions of the Trust's Operational Plan at both the November and December Board meetings. The final version of the plan was submitted on the 23rd December and this paper briefly updates the Board as to the changes that were made for the final submission. This addresses feedback we had from NHS Improvement, the Board itself and from the governors.

Changes from Draft to Submitted Final Version

The table below shows the main changes made to the Operational Plan, reflecting comments made on the draft versions.

Source of Suggested change	Suggested / Required Change	Changes Made
NHS Improvement	Requires stronger portrayal of the reconciliation between flat cash and flat activity, given historic growth trends.	Included agreed Dorset level tabulation of demand management schemes
	Expected impact of QI on CQC status	Additional text re CQC action plan. More re measurable improvements as a result of QI interventions. Mention of improvements in stroke service and patient safety conferences.
	More evidence and assurance of CIP programme	Extended section in Finance chapter re CIP programmes
	Describe quality impact assessment process, including Board oversight.	Additional paragraph re QIA, including governance.
	Evidence showing we will meet NHS Constitution standards	Paragraph re not meeting ED standard in 17/18.
	Governance arrangements to ensure we meet agency guidance	Additional paragraph in workforce section, covering weekly executive oversight.
	Workforce plan with respect to 7 day services	Commentary re additional posts in vascular and colorectal surgery enhancing on-call arrangements.
Governors	Strengthen demand management	See above
	Evidence ICS as vehicle for demand management	In demand management table
	Use stroke improvement as evidence of QI approach	Mention of improvements in stroke service and patient safety conferences.
Board	Nursing workforce changes described inaccurately – no intention to reduce templates	Table amended
	18/19 control total in text to be amended	Table amended

A final copy of the Operational Plan for 2017/18 and 2018/19 is appended. The Board is asked to note this report

Operational Plan 2017/18 & 18/19

Activity planning

The Trust is very aware of the constraints facing the NHS and as a result we have a particularly tight financial settlement for 17/18. For our contract with Dorset CCG this can be described as a “flat cash” scenario and this is reflected in our financial submission. Our initial demand and capacity modelling and planning, as indicated in our activity submission, suggests significant elective and non-elective pressure in such a scenario. However, we also recognise that the STP and the developing collaboration across the local health system offers new opportunities to address these issues utilising, for example, economies of scale and proactive demand management.

Modelling Demand and Capacity

The Trust has developed a number of demand and capacity models for a variety of its work, including outpatient referrals, elective and non-elective work, ED attendances and bed modelling. These have been developed in-house but utilised some of the methodologies featured in the Regional workshops, providing more detailed variation based models for specific areas.

To support our planning in relation to this demand, internally we have also been able to model the opportunities for further efficiencies, including ambulatory care and frailty pathways, theatre utilisation and outpatient Did Not Attend (DNA) rates. Realisation of these opportunities is being supported by our internal Quality Improvement Programme, described more in the Quality Planning section. During 16/17 our bed modelling fully supported implementation of our Urgent Care QI Programme which, combined with our daily and winter prediction tools, has allowed us to make significant change to pathways and bed configuration. This continues to inform our planning for 17/18 onwards though again, assumptions for further efficiency against a backdrop of 10% increase in urgent care activity become more difficult to predict.

Elective Care

Elective modelling of activity for 17/18 and 18/19 currently reflects an expected continuation of growth trends seen between 15/16 and 16/17, including 4.5% overall growth in referrals year on year and 6.6% growth in demand for elective procedures. Variation modelling in specialities will inform this further. Upward trends have been seen in Gastroenterology, Ophthalmology, Orthopaedics and Dermatology. Combined with this, the national challenge in relation to medical staff recruitment is reflected locally requiring the development of new approaches to these services.

It is recognised that the impact of some system-wide changes, (e.g. the full implementation of the new referral process reflecting NICE guidance on cancer referrals due to commence in January 2017) is not yet fully understood, despite some analysis. Whilst capacity to support the historical level of growth in fast track referrals (10%) is included within our planning assumptions - this will require further refinement. Commissioning of some additional diagnostic capacity is being supported by commissioners for 17/18.

16/17 has seen an increase in our RTT incomplete pathways and 18 week backlogs (over 2000). In particular we have seen an increase in the non-admit backlog and this constitutes a significant proportion of the total. Whilst work to recover these through the end of the financial year are expected to have some success, some carry over into 17/18 will be a further challenge to managing within the flat cash envelope.

Non Elective Care

Overall non elective care outturn in 16/17 is expected to have increased by 9.5% and A&E attendances by 10.5%. Current indications are that this will continue which together with the reducing capacity in Social Care to support discharge and care in the community, will require further embedding and development of our models of care and discharge support.

Managing Demand and Developing Capacity

In addition to our modelling and internal efforts to release efficiencies to create capacity, joint work with the Dorset health system will be key to managing demand and capacity within the financial envelope.

System-wide Demand Management

The first two years of STP planning is aimed at reducing demand and reversing historical growth seen in Dorset and this will allow organisations to free up capacity and reduce costs to enable transformational changes in years 3-5 as identified in the STP and as part of the Dorset Clinical Services Review (CSR). In order for the system to deliver at scale on the financial challenge and to support delivery of a reduction in the current growth of activity (flat activity), a system wide programme of demand management has been agreed:

Main programmes	Action	Stage 1 Deadline	Accountability
Stream 1			
a. Referral Management	Define work programme, with specific interventions by specialty focussing on; <ul style="list-style-type: none"> • Doing things differently e.g. best practice, In-house second opinion, Educational Interventions & structured referral guidelines • Productivity improvements e.g. follow-up review & advice & guidance • One Dorset Approach to referral process e.g. peer review, with specialist feedback 	by 31 January 2017 <ul style="list-style-type: none"> • Speciality Clinical Meetings to be established • Review Data pack • Agree opportunities and develop plans for implementing • Monthly Update to Joint COO /Medical Director Meeting by 28 Feb 2017 <ul style="list-style-type: none"> • Update Clinical Commissioning Committee 15 February 2017 • CRG February by 31 March 2017 <ul style="list-style-type: none"> • Implement changes across the speciality 	AB: <ul style="list-style-type: none"> • Dermatology • ENT • Neurology • Oral surgery CD: <ul style="list-style-type: none"> • Gastro • Ophthalmology • Orthopaedics • Urology EF: <ul style="list-style-type: none"> • Cardiology
(b) Primary Care Demand Management – referrals and triage	Mobilisation plan for Q1-4 2017/18 with specific focus on: <ul style="list-style-type: none"> • Reducing variation • Peer review of referrals • Triage of key specialties 	By 15 February 2017 Final plan to be signed-off at the Clinical Commissioning Committee, to include transparent KPIs for monitoring across all 13 localities by 31 March 2017 Implement changes across the speciality	GH supported by IJ
Stream 2			
(a) Low Priority Procedures	Review and endorse limited clinical value procedures process (e.g. Hampshire)	by 31 January 2017 <ul style="list-style-type: none"> • CRG briefing 5 January 2017 • Provider clinical executive meetings in January By 15 February 2017 <ul style="list-style-type: none"> • Clinical Commissioning Committee 	KL working with 4x Medical Directors MN (CCG)

Main programmes	Action	Stage 1 Deadline	Accountability
(b) RightCare, value care and 'realistic medicine'	Mobilisation plan for quick wins Q1-4 2017/18.	By 31 January 2017 <ul style="list-style-type: none"> Provider clinical executive meetings in January By 15 February 2017 <ul style="list-style-type: none"> Clinical Commissioning Committee 	OP to lead with IJ (CCG) & QR (RBH) link to COOs/ MDs to ensure ownership at each provider & GP ownership.
(c) Getting It Right First Time (GIRFT)	Mobilisation plan for quick wins Q1-4 2017/18.	by 31 January 2017 <ul style="list-style-type: none"> Provider clinical executive meetings in January CRG February 	Medical Directors x4 speciality leads to be specified
Stream 3			
(a) NEL Demand Management work and 5 high impact changes	Outline delivery plan for Quarter 1-4 2017/18.	By 11 January 2017 Draft plan to A&E Delivery Board, By 19 January 2017 SLT	KL , working with COOs
(b) Opportunities of integration between community, secondary and local authority care	Outline delivery plan for Quarter 1-4 2017/18.	by 31 January 2017 <ul style="list-style-type: none"> CEOs/Chief Officers to compile list of suggested service areas that need to be reviewed and evaluated prioritise the list together, so that attention is first focused on the specialties that will deliver most benefits through further integration Develop greater integration, and whole system accountability in the conurbation and across Dorset. Accountable Care Partnership models may emerge from this work programme. by 28 Feb 2017 <ul style="list-style-type: none"> Mobilisation Plan to be shared with the Senior Leadership Team 	ST working with CEOs, supported by KL and UV, GP leads to be identified WX, YZ (West) BC, DE, CD, AB (East) and KL
(c) Integrated Community Services and Primary Care Services (ICPS)	Outline quick wins for implementation in 2017/18	By 31 January 2017 <ul style="list-style-type: none"> Dorset system to agree transparent KPIs for community services to demonstrate optimal utilisation of funded capacity 	FG supported by HI
(d) Improved mental health services	Outline delivery plan for Quarter 1-4 2017/18.	By 31 January 2017 <ul style="list-style-type: none"> Plan to improve local capacity and reduce out of area placements as part of MH acute care pathway revision 	JK supported by LM OP

Main programmes	Action	Stage 1 Deadline	Accountability
		<ul style="list-style-type: none"> Plan to improve access to psychological services (IAPT) to meet new target thresholds 	
Stream 4			
(a) Avoiding delayed transfers of care	Mobilisation plan for quick wins Q1-4 2017/18.	<p>by 31 January 2017</p> <ul style="list-style-type: none"> Establish feasibility of common real-time reporting for DTOCs Establish list of hotspots by patient/ward/service Agree common protocols and service level agreements for timely discharge. Draft Plan to make better use of system bed-capacity both in community and in acute hospitals <p>by 28 Feb 2017</p> <ul style="list-style-type: none"> Mobilisation Plan to be shared with the Senior Leadership Team 	Chief Operating Officers supported by Local Authorities

We expect the programmes outlined above to be the start of delivering changes that will reduce activity in hospitals and move the system towards the strategy outlined in the STP for greater care outside of hospital delivered in a more integrated way with social care.

Developing Capacity - Elective

In addition to managing demand, as highlighted above, we will be seeking opportunities for internal efficiencies to create additional capacity in our services. Furthermore, we will be looking at opportunities for new roles and pathways - for example, working with community Optometrists to extend their roles. We will also continue to develop and enhance our specialist nursing and other roles to support speciality capacity (e.g. Gastroenterology, Uro-gynae and Dermatology nurses) as well as explore models for speciality doctors at different levels. Following on from joint work to provide capacity at community bases, we will be looking at further community and mobile options, as well as supporting improved pathway pilots (e.g. teledermatology). As the Dorset STP takes shape and through our Vanguard programme, collaborative and networked approaches to speciality pathways, demand and capacity will be progressed.

During 16/17 outsourcing has supported our activity plans and performance. Whilst we aim to secure internal substantive capacity, we will continue to review the role of outsourcing where cost effective and/or to respond to particular peaks in demand.

Developing Capacity – Non Elective

Our modelling indicates a likelihood of considerable growth in non-elective admissions. To address this we have developed comprehensive surgical and medical ambulatory services, which have increased the number of patients requiring over 24 hour admissions. Most recently we have developed a Frailty Service which provides more streamlined pathways and an ambulatory multi-disciplinary service for elderly patients. This has required increased collaboration with other partners – the community Trust (Dorset Healthcare) and social services being two examples. Although this service has only been running since September 2016 we have seen a consistent

reduction in length of stay in Older Persons Medicine. We have also continued to develop our discharge pathways, supported by interim care, trusted assessment and discharge to assess approaches. Going forward, we will continue to develop and refined these models and well as learn from our locality based Discharge Hub pilot.

Operational Performance

Overall the Trust has maintained a strong position against the key operational performance indicators: A&E, RTT, Cancer and Diagnostics. However, the particular pressures relating to demand (e.g. urgent care growth; variation and peaks in demand; increased referrals in certain specialities) and capacity (e.g. recruitment delays, exacerbated by national shortages; sudden unplanned clinician absence) create some risk to our performance. In addition to the A&E trajectory, we are investigating the detail in relation to the other performance trajectories. In light of current known risks, particularly in relation to the need to manage both emergency and elective demand, as highlighted above, it is anticipated that these trajectories may be lower than 2016/17.

RBCH has had a strong 4 hour performance achieving the national standard year to date to November 2016, based on using a Quality Improvement approach across the emergency care pathway. However the Operational Plan proposed trajectory is similar to the current year trajectory, for the following reasons:

- Reduction in social care funding, and market contraction for care home and domiciliary care provision
- NHS flat cash funding for community and hospital services, reducing ability to cope with underlying demand increases
- Vulnerable General Practices (c30% locally) that we know lead to increased referrals and emergency admissions
- Underlying drift of work linked with CSR changes

The impact of these changes mean the Trust is unable to support a plan that fully delivers the ED standard all year. However our record in 16/17 demonstrates our ambition and ability to deliver at national standard (often in the top 10 Trusts in England). Agreeing the trajectory, with ambition to sustainably deliver from 18/19, is therefore in the Annual Plan.

Quality planning

1. Approach to quality improvement

Quality standards for patient services are continually under review with the emphasis being on learning and improvement. The Quality Improvement Programme has the Chief Executive as the executive lead, supported by the Director of Improvement and the Associate Medical Director.

Key Trust wide projects are identified and supported by the Board in line with national quality priorities including Sepsis, Flow and Patient Escalation. All major QI projects have an executive sponsor and the aims and progress against plan are reported to the Board via an Improvement Steering Board which meets monthly and is chaired by the Chief Executive.

The Trust has adopted and adapted the internationally accepted model for Quality Improvement (IHI) which is designed to ensure teams can identify opportunities and deliver and sustain improvement across all specialties. This has achieved some considerable success in, for example, the significant improvement of our stroke service (from Band D to Band A in the Stroke Sentinel National Audit Programme (SSNAP)). The model is scalable to enable groups at all levels to tackle smaller schemes delivering marginal gains.

The Trust has a full action plan covering CQC recommendations with good ownership at ward and departmental level and supported by clinical peer reviews. There are regular meetings with CQC to update on progress with presentations from the clinical teams. The Trust is receiving positive feedback from CQC and Commissioners on the progress being made.

The QI model structure ensures that there is a strong emphasis on metrics to monitor progress and demonstrate returns on investment using identified and reported outcome, process and balancing measures. The measures used are directly linked to the aim statements for each project. Examples include:

- Reduction in mortality for emergency laparotomy from 11% to 9% in 12 months
- Reduction in surgical patients' length of stay by 1 day by March 2017
- Ensure that every patient with an Early Warning Score (EWS) score of 9 or above out of hours, is escalated for prompt review by an appropriate clinician within 30 minutes from their initial trigger, by the end of July 2017

In addition all projects take account of the unintended consequences which may be positive or negative and use balancing measures to monitor and address. Examples include:

- Measurement of re-admissions rates where length of stay has been reduced
- Patient satisfaction feedback where a new pathway is introduced that reduces time from referral to diagnostics

The QI model structure ensures that there is a strong emphasis on metrics to monitor progress and demonstrate returns on investment using outcome, process and balancing measures identified and reported.

The RBCH Improvement Academy has been established to provide improvement skills training to all areas and has so far trained over 120 employees including consultants, nurses, AHPs managers and support staff. The emphasis is on providing staff with the skills to enable them to contribute to the larger projects as well as implementing smaller improvements at a local level.

We have now held two annual Quality and Safety Conferences and these have both supported and exemplified a more transparent approach to patients' safety and our developing capacity to share and learn from reviews, including mortality and serious incidents.

2. Summary of quality improvement plan

Priorities for 17/18

HOSPITAL FLOW

To improve emergency hospital flow to deliver 'the right patient, at the right time, to the right place' by March 2018.

This will be delivered through:

- all inpatients having a senior review before midday;
- 90% of new patients will be given an estimated date of discharged (EDD) within 24 hours of admission;
- all inpatient wards ensuring that by 10:00 each day the first patient is transferred in from the assessment unit and their 'golden patient' is discharged or transferred by 10:00;
- 33% of patients are discharged from inpatient wards before midday;
- 100% of inpatients with a length of stay in excess of 7 days are be systematically reviewed with clear management plans in place;

ESCALATION OF THE DETERIORATING PATIENT

To ensure every patient with an early warning score of 9 or above is escalated for prompt review by an appropriate clinician within 30 minutes of their trigger by March 2018

This will be delivered through

- increased early recognition of clinical deterioration;
- improving therapeutic response and escalation using structured protocols;
- implementing more robust activation systems and tools to call for response.

SEPSIS

To treat everyone with a qSOFA positive sepsis within 1 hour and all other sepsis patients within 3 hours of admission and / or diagnosis by June 2017.

This will be delivered through

- improved early identification in all admitting areas, pre-hospital ambulance alerts and lactate measurement
- improved escalation and intervention and monitoring of intravenous antibiotic delivery times to support sustainability

7 Day Services

The results of the 7 Day Services National Audit show that from March 2016 there has been considerable improvement against three of the four key standards:

	Consultant Review within 14 hours		Consultant Review Patient/family aware of plan within 48 hours	
	Mar-16	Oct-16	Mar-16	Oct-16
Mon		75%		79%
Tues		88%		83%
Wed	70%	78%	73%	86%
Thurs		65%		80%
Fri		57%		84%
Sat	39%	89%	64%	94%
Sun	59%	70%	47%	100%

Diagnostic	Consultant Directed Diagnostics Immediate need (1hr) 7 days		Consultant Directed Diagnostics Urgent need (12hr) 7 days	
	Mar-16	Oct-16	Mar-16	Oct-16
CT	100%	Always	91%	Always
Echo	0%	Always	92%	Always
Histopathology	0%	Weekday – Always Weekend – Never	0%	Weekday – Always Weekend – Not usually
Microbiology	50%	Always	63%	Always
MRI	0%	Weekday – Always Weekend – Usually/mostly	75%	Weekday – Always Weekend – Sometimes
Ultrasound	0%	Always	85%	Always
Upper GI Endoscopy	0%	Always	25%	Always

Ongoing Review - once daily		
	Mar-16	Oct-16
Mon	Data not published	95%
Tues		98%
Wed		95%
Thurs		100%
Fri	Data not published	98%
Sat		96%
Sun		90%

and consistently high performance for the fourth – “consultant directed intervention available 7 days across all specialities”.

A new rota for vascular surgeons is being introduced in January 2017 which will provide full cover for elective and non-elective cases supporting activity in the Vascular hub. In addition there is a new emergency surgery rota planned for introduction to the Trust in December 2016. This provides dedicated consultant surgical resource to cover the emergency lists on a rota basis.

Clinical Audit

We will comply with the requirements of national clinical audits as published by HQIP. The Trust Clinical Audit and Effectiveness Group(CAEG) routinely review progress against the Trust action plan and the results of any applicable published national audits. We maintain an annual audit plan and this will be informed by the 17/18 HQIP programme, yet to be published.

The Trust has implemented a process for the standard review and investigation of all in patient deaths (e-mortality). Results are reviewed monthly by the Trust mortality surveillance group, chaired by the medical director. Learning points from mortality reviews are discussed and shared. Plans are in place to identify opportunities to further improve organisational learning and quality improvement.

Whilst the Trust established robust processes for the investigation of serious incidents, plans are in place to further improve the learning culture. A new approach to reporting all patient safety events including near misses, no harm events and excellent events will be launched and embedded during 17/18. The focus is on reporting all events as an opportunity for sharing and learning.

The Trust QI programme will support compliance with national and local CQUINS.

The Trust will continue to focus on the importance of ensuring harm free care for patients, maintaining current improvements in the reduction in patient falls and hospital acquired pressure ulcers.

Anti-microbial resistance

The Antimicrobial Management Team (AMT) will continue to write and audit the use of the Trust’s antimicrobial prescribing policies to ensure appropriate antimicrobial use within our hospitals. We will also continue our educational role to aid prescribers in the correct use of antimicrobials. The AMT will continue to provide the ‘antibiotic ward rounds’ to monitor antibiotic usage and to consult on difficult cases and be a presence on the wards to provide advice on appropriate antimicrobial prescribing.

Screening for antimicrobial resistance will continue as per our policies and where specific instances of infection with resistant organisms are identified our infection control team will continue to ensure appropriate management in accordance with our infection control procedures. Treatment of such infections will remain under the guidance of the microbiologist.

Safe Staffing

- To build on the concepts of ‘Safe Staffing’ by
- Adhering to the Carter reforms
- Optimise roster practice aligned with work life balance policy and staff survey feedback
- Implementing and embed ‘Safe Care’ as part of the holistic operational needs of the hospital to promote efficiency.

In addition to the above objectives, specific workforce objectives are incorporated into the Trust valuing staff strategy. These include improving training and development opportunities for staff, improving mandatory training compliance, improving staff satisfaction, improving recruitment and retention and reducing sickness absence. The Trust Annual plan incorporates wider corporate objectives to streamline corporate process to enable timely and effective clinical care. This includes areas such as recruitment, revalidation, business planning, procurement and informatics. Quality impact assessments and quality improvement are integral to all work streams.

Patient Experience

- To further develop a patient and public engagement plan
- To develop a comprehensive Carers plan, aligning with the CCG and the CSR plans.
- To develop the Volunteer workforce to appropriately support the outcomes of the CSR.
- To drive forward a health economy wide holistic pathway approach to end of life care.

End of Life Care

Our vision is to provide outstanding end of life care to all those who come into contact with the Royal Bournemouth and Christchurch hospitals. There is only one chance to get it right.

Plans are in place to increase the exposure of different clinical areas to specialist palliative care (SPC), the initiative is supported by the increase in SPC nurses to seven days, and the inclusion of palliative medicine consultants in multidisciplinary meetings and ward rounds.

There are also plans to extend the collection of views from patients and relatives through use of volunteers, which together with staff feedback, will evidence best practice and help identify themes for continuous improvement. The Trust will adopt the Sage & Thyme model designed to train all grades of staff how to listen and respond to patients/clients or carers who are distressed or concerned.

There will be increased collaboration with DHUFT and the CCG to develop optimum patient pathways and prevent inappropriate admission to hospital of patients who are at the end of their lives.

STP priorities

The Trust can confirm that The QI programme will support delivery of the STP Care and Quality outcomes: equal standard of care, improved health, improved access to 7 day services, more joined up care, more opportunities to be cared for closer to home and improved patient experience.

3. Summary of quality impact assessment process

All CIP schemes above £20k require a Quality Impact Assessment.

Our assessment of each CIP scheme includes identified performance measures to confirm whether the scheme is having an adverse impact upon quality. These are reviewed by the QIA group on a quarterly basis. The Trust Board uses a detailed dashboard to review quality, the key metrics reviewed are: HSMR, harm free care, serious incidents, Friends and Family, delayed transfers of care and 30 day readmissions. These identify areas of concern which are then focused on including the impact of any CIP schemes. This dashboard provides an oversight of organisational performance and enables the Board to have sense of risks as they develop. Further to this the Quality Assurance and Risk Committee regularly reviews the proposed CIP schemes to enable the appropriate design and review of metrics relating to areas of concern if they feel that this approach is insufficient.

Where in-depth clinical analysis of products or drugs is required, quality review is completed through an appropriately convened group of experts (e.g. procurement evaluation panels). All other schemes are assessed against the three core quality domains and includes a section on the mitigation plans to manage identified risk. The group is chaired by the Director of Nursing and Midwifery (Vice Chair Medical Director) and includes the

Director of Human Resources, Associate Director of Risk and Governance and rotating non-executive and finance team members.

Details of the QI process are recorded within the CIP trackers which demonstrate the progress made against individual schemes. Individual schemes can be called back for review subsequent to implementation. The Trust Improvement Board receives reports on the large scale, complex projects including specific performance metrics indicating the progress of each area and enabling challenge to areas of poor performance.

4. Summary of triangulation of quality with workforce and finance

The Board dashboard produced on a monthly basis provides 32 performance metrics presented in a format that highlights areas of particular concern. Indicators are presented to review quality, performance, productivity, workforce, activity and finance. Further to the core NHS Constitution standards around A&E waiting times, RTT and cancer treatment, other key metrics relate to HSMR, friends and family test, DTOC's, outliers, length of stay, vacancy rates, appraisals, admissions, budget position and CIP delivery. Further detailed trend-lines and performance against plan is also presented to support the analysis within the paper. This dashboard is further reviewed by the Quality Assurance and Risk Committee, chaired by the clinical lead for QI to ensure that messages are communicated to our clinical leaders.

In addition the Improvement Board for the Trust reviews performance indicators of individual improvement projects aligned with financial reports and contributions from the strategic workforce steering group to ensure that the Improvement Programme focuses on particular areas of concern for the hospital. This enables the development of future programmes and priorities for the Improvement Programme to ensure that we can focus resource to support the development of quality.

Workforce planning

It is critical that given the substantial organisational changes envisaged for the health system in Dorset that as these are enacted there is a suitably trained and available workforce to take forward these new models. This is particularly important against a back drop of financial stringency and demographic changes that make relying on the availability of a traditionally trained and developed workforce extremely risky.

System Workforce

As part of the development of the Clinical Services Review it was evident that there would be a significant requirement for a flexible staffing arrangement, both in terms of geographic location but more importantly in terms of experience and expertise. As a result of this the Dorset Workforce and Advisory Board (DWAB) was developed and they have developed a workforce strategy entitled the Living and Working Differently Strategy for Dorset and this has developed 4 components each under the leadership of an HR director, as follows:

- Development Of Our Leaders And Organisations
- Recruitment And Retention Of Our Staff
- Developing Our Staff
- Supporting Staff Through Change

The subsequent development of the Sustainability and Transformation Plan (STP) has formalised the system wide approach that was already in place and has extended that to include local authorities. This has helped cement the system wide approach and reinforced the intentions in the DWAB Strategy, to develop plans and programmes that are applicable and consistent across all partners. An example of the developments envisaged will be the introduction of a Dorset-wide recruitment portal.

Included in these plans are strong business support services shared across Dorset Trusts, maximising the opportunities for joined up services including the temporary workforce and cost effective recruitment services. As a trust we have embedded electronic working, rolling out ESR self-service across the organisation and e-rostering across clinical and non-clinical areas.

Local Workforce

As a Trust we are developing our workforce planning capacity, developing care group and corporate plans that will form part of the overarching workforce strategy.

Two issues that will have a significant impact on the Trust over the next 2 years are the introduction of the apprenticeship levy from May 2017 and the replacement of the bursaries for nursing and allied health professional students in England with student loans, from August 2017. Key actions to mitigate these risks are focused on recruitment and retention and the development and education of our staff. There are plans being developed for a Dorset wide approach to apprentices across the STP footprint.

Recruitment & Retention

- Increased student placement capacity utilising the hub and spoke model to make RBCH the placement provider of choice.
- Provision of Return to Practice Placements and recruitment on completion
- Provision of multidisciplinary educational sessions for student workforce
- Increased partnership working with the Higher Education Institutes
- Continuing to develop our employee brand to recruit and then retain our staff through effective support and positive staff engagement

Staff Development & Education

- Continuation of Preceptorship programme for newly qualified nurses and Allied Healthcare Professionals

- Allocation of funded education via the Training Needs Analysis to enhance patient care and staff development
- Standardised local information e.g. teaching sessions available, how to guides, example of a typical week (either using 'Dr Toolbox' or our own version)
- Local feedback outside of the GMC survey
- Improve Essential Core Skills Compliance across the Trust aiming for 95% by Dec 2017.
- To ensure that Healthcare Support Workers (HCSW) will be well prepared for their role, improving the quality of patient care and safety.

Part of the workforce approach is to ensure we have coherent management of agency expenditure. We have a process of reporting and discussion on this at the weekly executive meeting and this ensures we operate within expectations.

Our performance on the 7 day service agenda is excellent (as exemplified in our recent - September 2016 audit) as a result of many developments over many years, we are still instituting improvements that support this. Recent developments include further development of our role as the hub for the Dorset and South Wiltshire Vascular Network via two further consultant appointments and the release of the on-call general surgeon from fixed clinical commitments, again via substantial consultant recruitment.

ORGANISATIONAL DEVELOPMENT AND LEADERSHIP STRATEGY

The Trust has completed the first phase of the cultural change programme – Discovery – and presented the findings to the Board. The Design Phase is now underway with in excess of 20 work streams being developed to address the issues raised by staff and respond to the findings and recommendations made by the Trust Change Champions. Some of the most significant areas of work are as follows:

Leadership Strategy and Investment Plan	Staff Engagement Strategy	Customer Care training
Developing the role of medical leaders	Speak Out Safely	Recognising and rewarding staff
Restating our commitment to Inclusion, Equality and Diversity	Patient engagement	Effective Team working
Developing our Vision for 2017-2020	Communications Strategy	Building OD capacity

A key output in 2017/18 will be the Trust Leadership Strategy which will support implementation of the new Trust Leadership Model and Behaviours:

10 leadership behaviours that support collective leadership:

	Leadership Behaviour	Cultural Element
1.	Ensuring direction and alignment	<i>Vision and Values</i>
2.	Developing positivity, pride and identity	
3.	Ensuring effective performance	<i>Goals and Performance</i>
4.	Ensuring necessary resources are available and used well	
5.	Modelling support and compassion	<i>Support and Compassion</i>
6.	Valuing diversity and fairness	
7.	Enabling learning and innovation	<i>Learning and Innovation</i>
8.	Helping people to grow and lead	
9.	Building effective teams	<i>Team Work</i>
10.	Building partnerships between teams, departments and organisations	

In addition, the Trust will be working in partnership with NHS Improvement, The King's Fund and the Centre for Creative Leadership to develop a reliable and valid measurement of the ten leadership dimensions used in the NHS Improvement Culture and Leadership work. This will be open source material available on the NHS Improvement toolkit website for use by NHS organisations at national, regional and local levels as part of their Discovery phase or to support wider leadership assessment.

Financial planning

2017/18 and 2018/19 Financial Plans

Annually, the Trust undertakes a comprehensive budget setting process to ensure that challenging yet achievable budgets are agreed and owned by clinical teams. Specifically, the following key steps are undertaken:

- Detailed demand and capacity planning is completed by Care Group management teams (clinical and operational), supported by finance and information colleagues;
- Income budgets are calculated based on this activity plan, including the impact of the final tariff package;
- The expenditure (marginal cost) impact of this activity plan is calculated and included within directorate budgets;
- Directorate specific cost pressures are discussed, challenged, and budgeted where appropriate;
- Corporate cost pressures are assessed and budgeted, including nationally agreed pay inflation, increases in the Trust's Clinical Negligence Scheme for Trusts (CNST) contributions, together with cost inflation in relation to business rates and utilities;
- The Cost Improvement Target is agreed at directorate level, and removed from the budget.

This process is currently underway for 2017/18, as is the contractual negotiation process with the Trusts Commissioners. As such, the detailed operational revenue budget has not been finalised and the Trusts draft Annual Operational Plan is based on the latest available information together with a number of key planning assumptions. This is set out within the detailed finance template, and confirms a planned deficit of £6.648 million.

The draft 2017/18 financial plan has been forecast forward to 2018/19 based on a range of planning assumptions. These assumptions reflect the most up to date information available to the Trust, including but not limited to the latest tariff proposals, anticipated pay and price inflation, historic trend analysis, local demand and activity modelling, and the advised Sustainability and Transformation Fund payments. Again, this is set out fully within the detailed finance template, and confirms a planned deficit of £6.365 million.

The high level bridge from the 2016/17 forecast outturn to the 2017/18 and 2018/19 draft operating plans can be summarised as follows:

2016/17 Forecast Outturn	(1.5)
National Tariff and Activity Demand	0
Normalising Adjustment	(4.4)
Pay, Pensions, CNST, Rates, Utilities, Other	(8.8)
Cost Improvement Programme	9.3
Movement in Sustainability and Transformation Fund	(1.2)
2017/18 Draft Operating Plan	(6.6)
National Tariff and Activity Demand	0.4
Normalising Adjustment	(1.6)
Pay, Pensions, CNST, Rates, Utilities, Other	(6.8)
Cost Improvement Programme	8.2
Movement in Sustainability and Transformation Fund	0
2018/19 Draft Operating Plan	(6.4)

Through the submission of the draft Annual Plan, the Trust is signalling its intent to accept the offer of payment from the Sustainability and Transformation Fund (STF) amounting to £6.4 million in each year. In doing so, the Trust is accepting the associated conditions, most notably, a revenue control total deficit of £6.648 million in 2017/18. As a result of confirming its intent to abide by the control totals for 2016/17 and 2017/18, the Trust is requesting some flexibility within its 2018/19 control total. The Trust is therefore proposing a revenue control total deficit of £6.365 million for 2018/19. The Trust has also signalled its acceptance of an agency ceiling of £5.940 million in each year.

The Trust's sensitivity analysis has highlighted a number of risks to the 2017/18 and 2018/19 financial plan. Key risks can be summarised as follows:

1. Commissioned Activity/ Income

The Trust has experienced significant year on year activity growth. Specifically, the current year (2016/17) has seen a material increase in non-elective activity and emergency department attendances. The Trusts has concerns if this activity growth continues during 2017/18 and 2018/19.

All organisations within Dorset accept that this is simply unaffordable, and through the development of the Dorset Sustainability and Transformation Plan, have committed to progress a joined up, system wide approach to demand management. The Trust will receive no more income than it did during 2016/17. This reflects a flat-cash contract with Dorset CCG, a small reduction in the West Hampshire CCG contract, and a broadly consistent contract value in relation to specialist activity (excluding pass through drugs).

As such, there remains a material risk that the Trust will not be commissioned for the activity growth that ultimately comes through. This would result in an inability to achieve the national access standards resulting in the loss of the Sustainability and Transformation Fund income, together with a significant financial pressure due to demand continuing to increase, with the Trust required (for patient safety reasons) to undertake this activity without the corresponding payment.

2. Cost Improvement Programme

The Trust is targeting 2% in line with the proposed tariff efficiency requirement amounting to £6.7 million. However, when added to the recurrent shortfall from the current year, the CIP requirement for 2017/18 is £9.6 million. At present the Trust has a credible plan to achieve £6.7 million through risk adjusted schemes. However, this leaves a significant gap that must be found between now and the start of the year.

The Trusts financial modelling indicates an efficiency requirement of £8.5 million during 2018/19 and at present the Trust does not have worked-up schemes that will deliver against this.

3. Commissioning for Quality and Innovation (CQUIN)

Whilst the final structure of the Trusts contracts with commissioners is still being worked through, it is currently expected that the CQUIN incentive payments will still be within certain contracts. As such, this income is at risk if the Trust does not achieve the CQUIN standards.

4. Capacity

The Trust will need to increase internal capacity to manage the forecast activity levels, should these come to fruition. This will require recruitment into new clinical posts, which presents a risk given the national workforce shortages and may therefore result in an additional agency premium cost.

In addition to the above risks, the Trust has identified a small number opportunities which could mitigate, at least in part, the above risks.

1. Contingency

A small, currently uncommitted, contingency has been included within the draft annual plan.

2. Cost Improvement Programme

Consistent with the current year, additional CIP schemes could be developed in year, which exceed the target and provide mitigation to unbudgeted financial pressures.

3. *Private Patient Income*

Private patient income has reduced significantly in recent years, mainly in relation to private cardiology procedures. The Trust is currently in the process of building a new dedicated Private Patient Unit which will open in February 2017, and is also in the contractual process of partnering with a specialist private company to jointly deliver a new cardiology private practice. There is, therefore, a significant income opportunity to increase income in relation to private patients above current budgets.

Cost Improvement Programme

The Trust's focus on the overall financial position and the need to correct this has remained unrelenting. As part of this focus, the Trust developed a new governance structure during 2015/16 supporting the process of cost improvement and transformation. The resulting Transformation Steering Boards comprise multi-disciplinary teams across clinical and non-clinical, operational, non-operational and cross cutting areas and have been developed with the explicit mandate to focus on ideas generation and implementation. The transformation process includes cross-cutting workshops bringing together a wide range of attendees from across the organisation to examine areas for change and development across the organisation. These focus on systemic opportunities including the development of more radical ideas in a 'safe' environment.

The benefits of this approach have been seen throughout the current year, 2016/17, with forecast aggregate savings of £8.5 million and equating to 2.9% of gross revenue. This compares favourably to the national tariff requirement of 2%.

The planning process for 2017/18 has identified a range of schemes which are progressing either in terms of further work-up, or in terms of actual delivery. In addition, a number of schemes have been considered but not progressed due to the potentially detrimental impact they may have had.

The result is that the Trust currently has a credible, risk adjusted cost improvement programme that provides confidence that the Trust will achieve the efficiency requirement proposed within the tariff package for 2017/18. However, the Trust has carried forward a significant non-recurrent shortfall which also needs to be made up in order to achieve the 2017/18 financial control total. At present, the Trust does not have schemes identified that will make up this shortfall. In addition to this, it should be emphasised that many of the identified schemes are complex and require significant work to ensure full delivery in a timely fashion. As a result, these remain a risk to the delivery of the overall programme.

The key themes and projects that make up the 2017/18 cost improvement programme are:

Programme	Description
Workforce (Agency)	Significant reduction in agency premium costs. Introduction of incentivised bank, revised agency controls, adherence to national caps.
Workforce (Medical)	Medical job planning and reduction in Waiting List Initiative (WLI) payments. Introduction of policy for cut-off point at which regular WLI sessions should be made substantive within individual job plans. Standardise rate of payment for WLI sessions.
Workforce (Nursing)	Implementation of a skill mix review based on benchmarking against other relevant organisations. Detailed review of all existing ward nursing templates.
Workforce (Other)	Delivery of external workforce review based on comparison to the peer group average.
Prescribing	Medicines optimisation on all wards. Review of variation and prescribing thresholds.

	Expansion of home delivery service. Development and delivery of the Pharmacy Transformation Plan and review of the 'top ten' spend items to identify areas for change.
Income Generation	Development of a private patient strategy to increase delivery as a % of trust turnover. Increase staff and patient car parking. Outsourcing pharmacy. Research income.
Surgical Productivity	Improving the utilisation of our theatre capacity to reduce 'lost' theatre time, release patient slots and WLIs. Focusing on ambulatory care to reduce bed base.
Procurement	Major tenders in cardiology and orthopaedics. Driving increased value from spend through reductions in price, improved product and service output and delivery, supporting appropriate reductions in demand. Consideration of Managed Equipment Service within Radiology. The delivery of the Procurement Transformation Plan and the adoption of the NHSI Purchasing Price Index will enable further comparison and identification of areas of opportunity.
Front Door Redesign and Patient Flow	Improving patient flow, reductions in length of stay and reducing bed base by expansion of ambulatory care, 'discharge to assess,' new frailty pathway and direct admission to cardiology and Older Peoples Medicine.
Outpatients	Reduction in DNA and clinic cancellations; standardisation of clinic templates.
Estates	Benchmarking using ERIC data returns to optimise use of the Trust premises and estates function. Reviewing the asset valuation methodology and remaining asset lives.
Other	Locally developed directorate schemes

There are a number of schemes that have not yet been costed as well as number of more radical opportunities that will require Board approval following identification of the financial and quality benefits. The Transformation Steering Groups will continue with their mandate for ideas generation and translating the ideas into practice.

Embedded within these schemes is the work the Trust is undertaking in relation to the Lord Carter of Coles efficiency metrics. Lord Carter's review is based on the 2014/15 Reference Costs submission, and compares the Trust's average unit cost for each HRG (unit of activity), against the national average cost for that HRG. The fundamental premise is that where the Trust is cheaper than the national average cost, it must sustain this level; and where the Trust is more expensive than the national average it has a potential savings opportunity.

The Trust wholeheartedly supports the principle of benchmarking against similar organisations in order to identify areas for improvement. However, it is recognised that both locally and nationally there are further refinements required in the calculation methodology behind Reference Costs. Once these are implemented, any improvements will change the benchmarked figures and a more realistic savings opportunity will be identified.

However, that is not to say that the savings opportunity will be achievable in full. For example, where the Trust has higher costs than the national average as a result of a greater number of delayed discharges, this will result in a savings opportunity. However, this will not be realisable without Dorset system-wide improvements in the current level of community provision.

A detailed work programme has been established, focusing on the services which have been identified as having the highest savings opportunities (Cardiology, Geriatric Medicine and General Medicine) to rationalise the findings and identify a realistic savings opportunity in these areas. Whilst we are still in the early stages of our investigations and analysis, progress has been made in the three key areas and with further clinical input into the

costing methodology, the savings opportunity has reduced significantly through improved data capture and refined cost apportionment. The outcome of this work will feed into the overall cost improvement programme for 2017/18 and beyond.

Our current gap of £3.4m reflects the burden of non-recurrent delivery from previous years. The Transformation Steering Groups that we have implemented provide a robust process for both ideas generation and the monitoring of identified schemes. They are tasked with pursuing and implementing options as they arise and are continuing to review practice for opportunities to make further savings. The budget setting process provides further rigour by reviewing the overall activity, pressures and opportunities across the organisation and is likely to identify further savings as well reduce the risk rating of schemes as they are more fully worked up and operational decisions are made around how they are implemented.

Critical to the delivery of a sustainable transformation plan is the review and understanding of our benchmarking data provided through model hospital and NHS Benchmarking. This data is regularly reviewed for accuracy and to identify opportunities that are not immediately apparent. This work is supported by a range of cross-cutting TSG's which focus on areas such as strategic workforce, medical workforce, premium cost avoidance (agency spend), procurement and prescribing. These groups look to mobilise cross-organisational change to enable areas to deliver savings.

Fundamental to the delivery of CIP plan is the development of a robust quality improvement programme which will deliver significant productivity and efficiency benefits freeing up resource for reinvestment or savings. This programme has four areas of focus this year: Hospital flow, Sepsis, Deteriorating Patient and Planned Care.

Of the schemes already identified, 43% by value are high risk and this reflects the complexity of these schemes as well as the significant financial values. The development of project documentation and implementation of our QIA process will enable us to reduce the risk rating of these projects. Part of our on-going review and ideas generation process is to provide alternatives for those schemes that we are unable to take through to implementation.

Our current phasing is based on an assessment of how we think schemes are likely to deliver in terms of their outputs. As projects are worked up phasing's will be refined to reflect more likely delivery.

As noted above we are reviewing the Carter recommendations and metrics to identify areas of opportunity for the organisation to improve. Many of the recommendations align with the areas that sit within our Vanguard programme and its review of back office services. The STP is actively engaging in developing an understanding of the benchmarking data and how the organisations compare in terms of the service we deliver. This will enable us to identify early opportunities for savings as well as developing long term plans for a consolidation and reduction of spend. This will be one of the key areas that our Strategic Workforce Review will review.

Our diagnostics and imaging services are part of another Vanguard work-stream. Given the complexity of developing a robust service offering, we envisage that this will deliver savings in the longer term future but are cautious about how this will look given there are a range of potential options as to how the service is delivered. As such the plan does not yet contain figures related to this work-stream.

Capital Programme

The Trust has developed a draft medium term capital programme, and has placed particular focus on preparing a detailed plan for 2017/18 and 2018/19. Through a risk based approach, the Trust has reduced the long list of potential capital developments into a shortlist. Given the financial constraints, this shortlist was further prioritised into four categories.

- *Contractually committed* – contracts have been signed, which would incur significant penalties to exit, as well as potential impact on service provision.

- *Must* – this is a strict definition of (i) we cannot continue to provide a service without this investment, to the extent this would harm patients or staff, and/or (ii) there is a significant financial penalty which would impact on the Trust's ability to live within the proposed revenue control total.
- *Should* – these are schemes which are strongly supported, but there is some degree of choice, or a level of risk that will need to be managed.
- *Could* – this list has been heavily reduced. The remaining items are ones which are deemed significant, such as ward refurbishments for dementia friendly layouts, but are optional in that the Trust can still deliver a safe service without this investment.

The proposed capital programme for 2017/18 and 2018/19 includes only the *contractually committed* and *must* categories.

Financial Sustainability

Whilst the Trust has confidence in its financial planning, a great deal of uncertainty remains in a number of key areas which are outside of the Trusts direct control, namely:

- The value and timing of financial benefits associated with the Dorset Vanguard
- The value and timing of financial benefits associated with the Dorset Clinical Services Review

As a result, it is difficult to prepare detailed financial forecasts over the medium term with any degree of certainty. However, the most up to date information has been factored in to the Trusts financial projections for 2017/18 and beyond. This provides confidence that in the base case scenario, the Trust remains financially sustainably during this Comprehensive Spending Review period, supported by a strong cash balance.

Risks remain in the downside scenario, whereupon the Trust would move into a significant deficit position and require significant cash support.

The detailed operational plans for 2017/18 and 2018/19 confirm that the Trust will achieve a Use of Resources rating of 3.

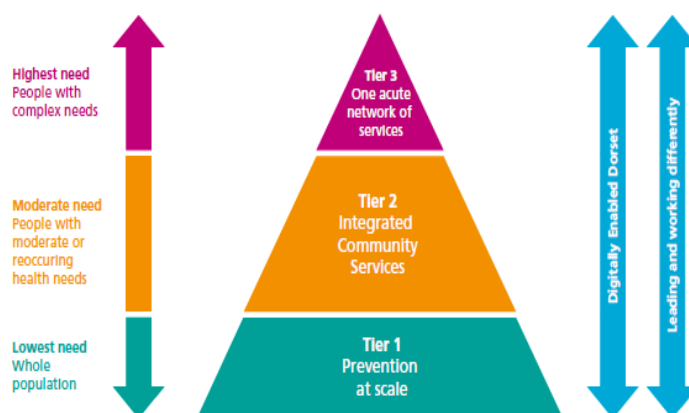
Link to the local sustainability and transformation plan

Delivering 'Our Dorset' Sustainability and Transformation Plan

During 2016/17, health and social care partners across Dorset came together to develop 'Our Dorset' STP, which sets out a clear vision: we want to *provide services which meet the needs of local people and deliver better outcomes*.

To deliver our vision we have three interconnected programmes of work to drive forward changes to our services in order that we meet the differing health and care needs of local children and adults, as illustrated alongside.

Our three programmes of:



1. **Prevention at Scale**- will help people to stay healthy and avoid getting ill;
2. **Integrated Community Services**- will support individuals who are unwell, by providing high quality care at home and in community settings;
3. **One Acute Network**- will help those who need the most specialist health and care support, through a single acute care system across the whole of Dorset.

These programmes are supported by two enabling workstreams of:

- **Leading and Working Differently**- which focusses on giving the health and care workforce the skill and expertise need to deliver new models of care in an integrated health and care system;
- **Digitally Enabled Dorset**- which will increase the use of technology to support new approaches to service delivery.

Delivery of our STP will be overseen through the System Leadership Team, with each organisation individually and collectively accountable.

The following section of our operational plan sets out our draft objectives for 2017/18 and a summary of our main work programmes and the connection they have with the overall STP.

- Providing quality care which is safe, compassionate and effective
- A continued focus on improvement to reduce avoidable harm and mortality
- Developing and delivering culture change and improved leadership capacity and capability
- Advancing our strategy for the Royal Bournemouth Hospital to develop as the main emergency site and Christchurch Hospital operating as a local community hub
- Meeting local and national performance standards
- Ensuring the Trust remains financially sustainable and meets its financial targets

Trust Plans	Fit with STP
<u>Progressing the Clinical Service Review</u> Consultation on the CSR options will commence at the beginning of December 2016 and we will actively support the CCG led communications efforts associated with this, as	The Clinical Services Review encompasses both the One Acute Network and Integrated Community Services programmes and as such is a critical component of the implementation of the STP

well as preparing the organisation for the implementation of the selected option.	
<u>Acute Vanguard Programme</u> The acute vanguard programme is a collaborative programme across clinical specialists and back office functions. Developments within this include a single pathology service for Dorset, a network approach to cardiology and stroke services and the rationalisation of back office services.	The Acute Vanguard programme is a pan-organisation precursor to the CSR implementation itself, encompassing progressive integration across clinical and non-clinical services.
<u>Merger and the Competition and Markets Authority (CMA) Undertakings</u> Undertakings given to the CMA at the time of the intended merger with Poole preclude merger within 10 years. However, there is work underway to rescind these restrictions, but in the interim Poole and RBCH are developing an aligned approach to the CSR and to the coordinated operational running of the two hospitals.	Although the STP itself does not consider changes in organisational form in any depth, it is recognised that with the significant change of services envisaged, changes in organisational structure are likely to take place in future, with the potential for the emergence of Accountable Care Organisations (ACO). There is discussion about developing STP governance structures that support East and West Dorset programmes.
<u>Vertical and Horizontal Integration</u> The CSR and Vanguard programmes above, can be seen as a form of horizontal reorganisation and in concert with this is the substantial work on a more vertically integrated approach, illustrated by the Integrated Community Services (ICS) programme. This will facilitate patients moving more seamlessly across the interfaces between health and social care and between primary and secondary care and this will deliver improvements in admissions avoidance and hospital flow.	The ICS is one of the main components of the STP developing aspects of the interface across the primary and secondary care and health and social; care boundaries reducing the requirement for hospital care and facilitating better discharge and flow. As services integrate, developing the capacity to exchange information across the health and social care system will become even more important and the development of our own Electronic Patient Record (EPR) in 2017 and its integration with the Dorset Care Record will facilitate this.
<u>Develop our QI Approach and Programmes</u> The Trust's QI programme is now in its 3rd year of operation and we anticipate in the immediate 2 years an approach that will include: <ul style="list-style-type: none"> • Integration and coordination of QI with our leadership and cultural programmes • Improve patient flow through the hospital • Develop a more consistent approach to the escalation of deteriorating patients and to the diagnosis and treatment of sepsis 	Many of the plans outlined in the quality section, require the successful collaboration with partners within the health system. The STP provides the vehicles and discussion fora for developing this more successfully than has been possible in the past. For example, patient flow through the hospital depends critically on services supporting the avoidance of unnecessary admission and the timeliness of discharge.
<u>Culture and Leadership Work</u> The Trust has embarked on a programme to develop a more consistent leadership improvement culture. We have now completed the diagnostic phase of this work and are designing a number of new leadership and development projects: <ul style="list-style-type: none"> • Partnership with NHSI, Kings Fund, Centre for Creative Leadership and RBCH • Increasing the visibility of senior leaders • Align our vision, QI and OD work – leading improvement • Progressing our Well Led assessment to the review and action stages 	A fundamental component of the STP is the leading and working differently programme and our cultural and leadership work will contribute to this by strengthening our leadership at all levels within the organisation and particularly with quality improvement in mind. We will also contribute to the development of the system leaderships as increasingly we operate on a system wide basis.

Membership and elections

Elections 2016/17

The following elections for governors were held in 2016:

- Public Governor – New Forest, Hampshire and Rest of England
- Public Governor – Bournemouth and Poole (two positions)
- Public Governor – Christchurch and Dorset County
- Staff Governor – Medical and Dental
- Staff Governor – Nursing, Midwifery and Healthcare Assistants

A vacancy which arose in the Bournemouth and Poole constituency following the election was filled by invitation to the next highest polling candidate as permitted by the Trust's constitution.

There have also been changes to the appointed governors from the following appointing organisations since September 2015:

- Bournemouth Borough Council
- Borough of Poole
- Bournemouth University
- The Royal Bournemouth and Christchurch Hospitals Volunteers Group

Elections 2017/18 and 2018/19

Elections in the following constituencies are planned for 2017/18:

- Public Governor – Bournemouth and Poole (seven positions)
- Public Governor – Christchurch and Dorset County (five positions)
- Public Governor – New Forest, Hampshire and Rest of England (three positions)
- Staff Governor - Estates and Ancillary Services
- Staff Governor - Allied Health Professions, Scientific and Technical
- Staff Governor - Administrative, Clerical and Management

There are currently no plans for any governor elections in 2018/19.

Governor Recruitment, Training and Development

In advance of governor elections an event is usually held to provide information to members and members of the public who may be interested in becoming a governor. Once elected or appointed, all governors are provided with an induction programme which includes the essential core skills training for all staff covering areas such as infection control and safeguarding.

Governors have their own ongoing training programme, consisting of six sessions each year grouped around a variety of themes, as well planned visits to different areas of the Trust. In 2016/17, the training themes included emergency care, equality and diversity and financial, quality and performance reporting.

Engagement Activities between Governors, Members and the Public

The membership strategy has been focussed on recruitment of younger members following the reduction in the minimum age for membership in 2014.

Engagement activities between governors, members and the public take place within the hospitals and in the community. We hold regular listening events and health talks and individual governors present to a variety of community organisations. The annual members' meeting in 2016 was also held in conjunction with the Trust's open day.

Governors participate in audits and patient surveys within the hospitals including specific audits in relation to noise at night and responding to call bells in 2016/17

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BOARD OF DIRECTORS

Meeting Date and Part:	27 January 2017 Part 1
Reason for Part 2:	N/a
Subject:	One NHS in Dorset (Vanguard) Update
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	Update on Dorset Vanguard January 2017
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	On-going report of Vanguard Work
Action required:	To note progress
<p>Executive Summary:</p> <p>This paper outlines progress on the various Vanguard workstreams, identifies priorities for 2017/18 and confirms national funding for the final year of this work.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	All
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	

Dorset Acute Vanguard Work

This paper provides Board members with an update on the Vanguard projects underway across Dorset as detailed in the attached report. Board members will recall that the purpose of the Acute Vanguard is to support the rapid implementation of the Clinical Service Review and STP plans – subject to consultation.

At a meeting of Vanguard Chairmen and CEOs on 4 January 2017 we agreed 4 areas will be a specific priority for 2017/18, these are:

- Development of a Joint Pathology Service for Dorset
- Establishment of shared Back Office functions
- Progressing the strengthening of Stroke provision for Dorset and west Hampshire residents
- The continuation of the Organisational Development work to underpin the changes agreed on for Dorset

Specific resource will be targeted to ensure significant progress in each of these areas. Increasingly the work of the Acute Vanguard and its various clinical work streams will link with work to advance the Clinical Service Review. This will entail a programme based approach across Bournemouth and Poole which will see each clinical service focus on:

- i. Determining how services will be provided into the future based on a model of emergency and planning hospital sites
- ii. The opportunities that present for integrating services within the community and shifting the location of provision where this is appropriate
- iii. The need to work with colleagues in the west to identify options which secure through network based solutions sustainable access to acute services for residents in the west of Dorset

The development of a more integrated approach to service provision will afford opportunities to integrate:

- Hospital and Community services
- Hospital and Primary Care
- Community and Social Care

This may, in turn, generate the scope to create two accountable care partnerships in Dorset focused in the west and the east. The potential to support this development is already reshaping the Vanguard work such that it aligns with the anticipated direction of travel.

Finally, I am pleased to confirm that there will be funding for one further year, the Dorset community has had confirmed an allocation of £1.22m for 2017/18 on top of the 2016/17 allocation of £1.09m.

The Board is asked to note the progress on Vanguard work.

Tony Spotswood
Chief Executive



Quarterly Progress Meeting Vanguard: Developing One NHS in Dorset

Our values:

clinical engagement, patient involvement,
local ownership, national support

1 Attendees

- **Karen Green:** Head of ACC Models
- **Jayne Thorpe:** Finance Manager, NCM
- **Sue Wales:** Senior Account Manager
- **Jane McVea:** Strategic Senior Account Manager, London & South
- **Bennett Low:** NHSE
- **Marcus Appleton:** NHSI
- **Steve Killen:** Dorset Vanguard Programme Director
- **Sally-Ann Webb:** Dorset Vanguard Programme Manager
- **Michelle Robinson,** Dorset Vanguard Finance Manager

2 Programme progress against delivery plan

Comments:

Overall progress to date

Stephen Killen and Sally-Ann Webb provided updates on each of the workstreams to date.

Infrastructure

- The Executive Steering Group continues to meet monthly and is being extended to include Dorset Healthcare in Part Two to discuss Business Support Services consolidation plans.
- Joint clinical leads now been identified for paediatrics workstream and medical director leads have been established for clinical workstreams.
- A communications lead is now in place
- Feedback received from PPEG on suggested engagement activities and methods and process agreed for engagement in clinical pathway redesign
- Dorset is piloting Future NHS Collaboration Platform which will aid information sharing across Trusts. They will also be developing a workspace to share information and learning with other Vanguard sites.
- Terms of reference have been agreed for
 - Executive Steering Group
 - Chairs & Chief Executive Officers Supervisory Board
 - Medical Directors & Chief Operating Officers Oversight Group (providing clinical assurance to Executive Steering Group)
- Supporting Clinical Lead for Dorset Cancer Partnership
- Supporting DCH/Yeovil paediatric work with project management support
- Discussing options for development of Vanguard Evaluation Plan

Joint Venture

- Agreement to proceed with the exploration of a 'prime contractor' joint venture.

- Work continues through the Pathology workstream and Business Support Services towards Shared Services across Dorset.

Prioritised Activities/Local Priorities

An update on progress against the prioritised activity for the first six months of the programme has been produced, showing good progress to date against key deliverables. With the appointment of both Clinical Lead and Service Lead for the development of One Dorset Pathology, this is the **first single management approach for a clinical service** as part of the Vanguard, and if successful, can be used in other parts of the programme.

As part of communication and engagement activity, Dorset Vanguard also presented an update at CCG Clinical Working Group 21 September 2016, providing a;

- General overview of progress
- Stroke update
- Workshop – What does Pathology in the future look like?

Stroke Workstream

- Standardised data collection/reporting
- Service specification developed and shared with CCG who are using as the basis for future commissioning framework
- Working with Stroke Association and Trusts to identify recent stroke survivors to co-design new models of care
- Strategic Outline Case being developed for Stroke Services which has informed CSR consultation documents. This is a good example of how clinicians can be involved in influencing and shaping future service commissioning and Dorset are developing a good news story about this replicable model to share with other vanguards.
- The Stroke team have applied through the Wessex AHSN to be part of the flow coaching programme in 2017-18, which will bring rapid change support (PDSA-style as mentioned above) to the Dorset pathway, which in turn can be shared with other pathways.
- Good news story produced to share insights and enable other areas to replicate on how clinicians can be involved in influencing and shaping future service commissioning.

Ophthalmology Workstream

- Recruitment for Joint Ophthalmology Paediatric Consultant post unsuccessful – to be re- advertised
- Space identified in community for potential surgery sessions (Swanage, Wimborne & Blandford hospitals)
- Proposals for Pan Dorset out of hours service commenced
- Similar pathways in place following NICE guidance

Women's Health Workstream

- Dorset STP agreed as an Early Adopter Better Births to test a range of new and innovative ways of working to transform maternity services
- Pathway mapping underway
- Developing service specification for single gynae emergency service for gynae services
- Analysis of data to understand presentations and referral activity

Paediatrics Workstream

- Joint clinical leads for Paediatrics now agreed
- Dependency and acuity tool for paediatric services shared for use Pan-Dorset
- Attendance of cross Dorset team at Together for Health RCPCH Learning event, London (3rd Nov)
- GP link secured to support work better linking acute and primary care parts of pathways
Project management support agreed for work on DCH and Yeovil Strategic Alliance
- Work is underway to implement the Royal College recommendations
- Outline for proposed community children's nursing service being developed

Cardiology Workstream

- Draft Cardiology strategy developed
- Agreement of four sub-specialty areas to focus on standardising and improving cardiology pathways;
 - Cardiac Rhythm management,
 - chest pain,
 - heart failure
 - Imaging

Non-Surgical Cancer Workstream

- Vanguard workstream aligned with Dorset Cancer Partnership
- One Clinical Lead for Cancer Services across Dorset funded through Vanguard programme
- Pan Dorset End of Life Care Delivery Group reformed to progress more collaborative working
- Initial workshop session held on 'Developing the Dorset Vision' and to agree next steps.
- Lead on community chemotherapy agreed and work plan being developed.

Pathology Workstream

- Agreement from all 3 Trusts to progress Pathology Services to Outline Business Case
- Additional external support secured to lead on development of this.
- Clinical Director for Pathology appointed
- Roadshow presentations held for pathology staff to give an overview of the aims of the project.
- Workshops planned to run through options in more detail for each pathology

- area – blood sciences, cellular pathology and microbiology
- Defining requirements for common IT system.
- Quick wins being progressed

Radiology Workstream

- Clinical lead for this workstream now agreed
- Firewalls removed to allow image sharing between Poole & Bournemouth
- Work on honorary contracts to enable cross site working for radiologists awaiting feedback from British Medical Association – Lead for Workforce & Leadership national group advised and Dorset intend to share the final document for use by other vanguards.
- Discussion held with potential suppliers to consider future requirements for radiology cross site reporting needs
- Engagement in ISAS process across all acutes and community provider seen as an essential indicator when assessing good quality diagnostic services in future.
- Event held for staff to raise awareness of benefits of ISAS with officer from Royal College of Radiologists and Royal College of Radiographers sharing more information about the scheme when she visited teams in November.
- Developing business case for Pan Dorset Quality Manager

Health Informatics Workstream

- Report originally produced for 3 trusts ICT strategy
- Health Informatics and Business Support Services workstreams now extended to include Dorset Healthcare & CCG
- Response on consolidation sent to NHSI mid Oct
- Finalising costs and options for videoconferencing to reduce time and travel costs in collaborative working.
- One gigabit cloud link agreed as interim solution ICT until wider health and social care network is available. (Dec16)
- Developing Strategic Outline Case
- Considering governance alongside Digital Dorset strategy being led by the CCG
- Workshop with CIOs / leaders from all Acute Trusts, CCG and Dorset HealthCare to advance plans for joint working
- Collated cost data and contract renewal dates for major systems

Business Support Services

- Sub workstreams for Finance, Estates & Facilities, Procurement and HR have been established and initial workshops held.
- Executive leads allocated to each sub group
- Baseline data collection and high level analysis undertaken
- Initial strategic enablers, quick wins, risks and issues identified.
- Vision and design principles agreed by Steering Group
- Case for Change for Business Support Services template submitted to NHSI
- Review & Guide event held for Business Support Services
- Workshops arranged to develop Strategic Outline Cases
- Developing a 'recruit once, train once, work anywhere' approach

3 Progress against metrics/hypothesis tree assertions – discussion of local metrics dashboard and national outcome measures

Note: There are no national outcome measures for the ACC cohort, so these were not discussed.

Dorset is currently exploring options for the development of a Vanguard Evaluation Plan with Wessex AHSN, Bournemouth University and Public Health England.

This will be completed in 3 stages;

1. Design specification - Completed by Mar 17
2. Initial evaluation - Undertaken in July 17, Evaluation Aug 17
3. Second evaluation - Undertaken in Jan 18, Evaluation Feb 18

The evaluation methodology will use 4 key focus areas which Dorset has already used to assess which workstreams to take forward in summer 2016. These are;

- Quality Impact
- Affordability and value for money (financial sustainability)
- Workforce (Resource sustainability)
- Deliverability

A workshop session with PPEG was held to consider local outcomes that patients may want to be included in the evaluation.

4 What has changed for patients?

It is still early in the Dorset Vanguard Programme life-cycle, however, some changes have been made which should improve the patient experience.

- Improved quality of care in Stroke Services;

The Trusts have all agreed to capture and report data in a common way across the county, leading to more consistent county-wide reports and an inference that clinical and population outcomes will become consistent, removing variation.

Collaboration and sharing of best practice has improved significantly since the introduction of Vanguard working groups, evidenced by an improvement across the three Trusts from Q4 2015-16 to the first four months of 2016-17. (Performance moved from A, D, E to A, C, D for Bournemouth, Poole and Dorset County Hospital respectively.)

- Patient engagement and co-design

It was the decision of the Stroke Workstream that it was essential to work with patients who have recent experience of their services in order to ensure their views are based on current service provision. So, the Dorset Vanguard are working with the Stroke Association who are contacting patients who have experienced stroke services in the past 12 to 18 months to invite them to be involved and offer them a variety of ways in which they can be involved i.e. attending a focus group; to give feedback via email to a specific area of work; or to be contacted by mail/telephone for their feedback.

The Stroke Workstream is planning to hold 4 engagement workshops across Dorset to assist in the co-design of new models of care identified through the Strategic Outline Case. This will inform the Outline Business Case which includes an options appraisal on each model. Through the Stroke Association, patient stories are being developed that explain pathways and different access routes, which will aid this engagement activity.

- Speedier diagnosis of condition or testing required

Through the work of the Radiology workstream, cross-site reporting is now possible between 2 trusts (Bournemouth & Poole) which should enable best use of reporting staff. This should result in speedier diagnosis of condition for the patient and referral on to further tests where required. Developments in Cardiology, Women's Health and Ophthalmology will bring similar benefits.

- Appointments by e-mail

This will be trialled in 1 Trust meaning patients will receive their appointments quicker than when previously sent by letter in the post. Other sites are considering adoption.

- Reduced waiting time for cataract patients

Outsourcing has reduced waiting time for approximately 200 patients with cataracts in the West of the county. Although this may be further to travel for them, transport is being made available by the provider and the patient can choose this option if they wish to be seen sooner than at the hospital.

5 Financial governance including progress on spends related to the transformation fund, and progress with the conditions outlined in the approval letter

Dorset received confirmation of funding for 2016/17 of £1,090k. This funding has been allocated as follows:

Workstream/Project Description	£'000
Programme Team & Independent Chair	511
Clinical Backfill	365
Professional Fees	84
IT Project Team	64
Workforce, analytics & HR support	46
Legal advice	20
Total	1,090

The Vanguard Programme Team are now all in post, the programme structure aligns project managers to specific workstreams and deliverables. Clinical backfill is across all workstreams, providing the release of clinical director and managerial lead support to drive the programme forward.

The professional fees relate to a specific piece of work commissioned to review the current health informatics functions across the acute trusts, developing strategic direction and aiding delivery of the strategic outline case. IT project team, workforce, analytics and HR support all relate to workstream support for specific functional skills to provide options appraisals, assessment of current systems and modelling implications of changing from current to future state.

As submitted in the Q2 finance template, expenditure is on plan and is forecast to be spent in alignment with the plan.

The funding has enabled progress at pace within Pathology, who have an approved strategic outline case at the ESG and all three individual Boards. Pathology have also implemented a One Dorset Pathology management structure which is integral to delivering the vision across Dorset. The funding has also enabled the stroke workstream to release clinical and managerial capability which has been pivotal in creation of the service specification, subgroup formation and strategic outline case which is being presented at the December ESG.

6 Outline savings that have been made against plan

In the original ROI we had indicated potential counterfactual savings in 2016/17 from joint recruitment of a post however due to delays this will not deliver until 17/18.

7 Have all conditions attached to the funding been met? If not, what actions have been discussed?

All conditions for the release of 2016/17 transformation funding have now been met and Q3 funding released.

8 Outline an assessment of your care model development with reference to the new care models frameworks when they become publicly available

Note: The ACC framework is yet to be published; however an assessment against the two fundamental characteristics of an ACC has been made.

Evidencing the vanguard's position on the journey to a strong, consolidated decision-making mechanism that is supra-organisational and 'locks-in' decisions and partners

An Executive Steering Group (ESG) is the main consolidated decision-making body for the vanguard and includes Executive representation from each trust, CCG Accountable Officer and the Chair of PPEG. Where there is significant change, individual trust board approval is needed. Our first example of this is the Pathology Strategic Outline Case which was approved by ESG and then all 3 trust boards. This approach ensures that each partner is 'locked in' to recommendations from the Vanguard collaborative working.

Consolidation of back office functions are wider than the vanguard and the ESG meeting is partitioned to extend membership to Dorset HealthCare to provide a wider decision-making forum in this area, aligned with the STP health footprint.

How this consolidated decision-making mechanism will allow the vanguard to identify and address systematic issues through standardisation and evidence-based best practice

The Chief Executives of the Vanguard Programme are all members of the System Leadership Team which meets monthly to oversee the Sustainability and Transformation Plan - Our Dorset and consider system wide issues.

The Vanguard Programme have developed '10 Steps to Delivery' which provides a standard approach to developing new care models through a framework of development phases from strategic outline case to full business case and implementation .

A Strategic Outline Case was developed with external support for Pathology Services (non-clinical). This has been adapted for Stroke Services (clinical). The team are developing templates for these stages and creating skills in-house which can be replicated rather than using consultancy. It is Dorset's intention to prepare a 'how to' guide with these templates which will be shared with other vanguards through the collaboration tool.

9 Emerging learning for wider replication and sharing

Main replicable elements of the care model:

- The Joint Venture approach for pathology is considered replicable for other service and for other organisations.
- 10 Steps to Delivery & 'how to' guide for strategic and outline business cases
- Organisational development with leadership & executive teams
- Cross county working – 'recruit once, train once, work anywhere' approach

How vanguard is sharing learning with other vanguards and more broadly within the NHS:

- As an early adopter of Kahootz, One NHS in Dorset is intending to set up a workspace on the national collaboration tool in order to share learning with other vanguards and the wider community.
- Work is progressing on the development of good news stories which can then be included on the collaboration platform for wider distribution. This will include developments in Pathology, Stroke, Radiology, Business Support and Organisational Development.
- Dorset are connected with a number of other acute trusts and ACC vanguards including EMRAD and the Foundation Health Group, and Basildon and Thurrock University Hospitals NHS Foundation Trust, Aintree University Foundation Trust, Frimley Park etc.
- Organisational development work with executives and cross organisational working shared with the Merit Programme.
- Dorset are actively engaged in the ACC network and other national support networks including harnessing technology, communications, community of practice teleconferences etc.

10 Overview of challenges currently experienced since the last meeting and what additional support is required from the Programme?

Key challenges have been:

- Information sharing between trusts which has now been enabled through the use of Kahootz collaboration tool – Dorset is currently in the top 10 users
- Communications – a communications lead has now been identified
- Recruitment of a joint paediatric ophthalmic post – limited applicants and need to re-advertise
- Implementation of the high speed IT link to support the clinical workstreams. Proposals have been adapted and risks mitigated through the Health informatics Vanguard working group.
- Delay in funding notification has caused delays in securing clinical and managerial leads in some areas. This has now been resolved with the majority having identified the resources to deliver at the pace and scale required.

Additional support required;

- National guidance on developing consolidated services (Business support and Pathology)
- Establishment of finance network with contact list
- Information about other national support group activity with contact list for leads
- Transformation network for South

11 Any other business?

None

12 Summary

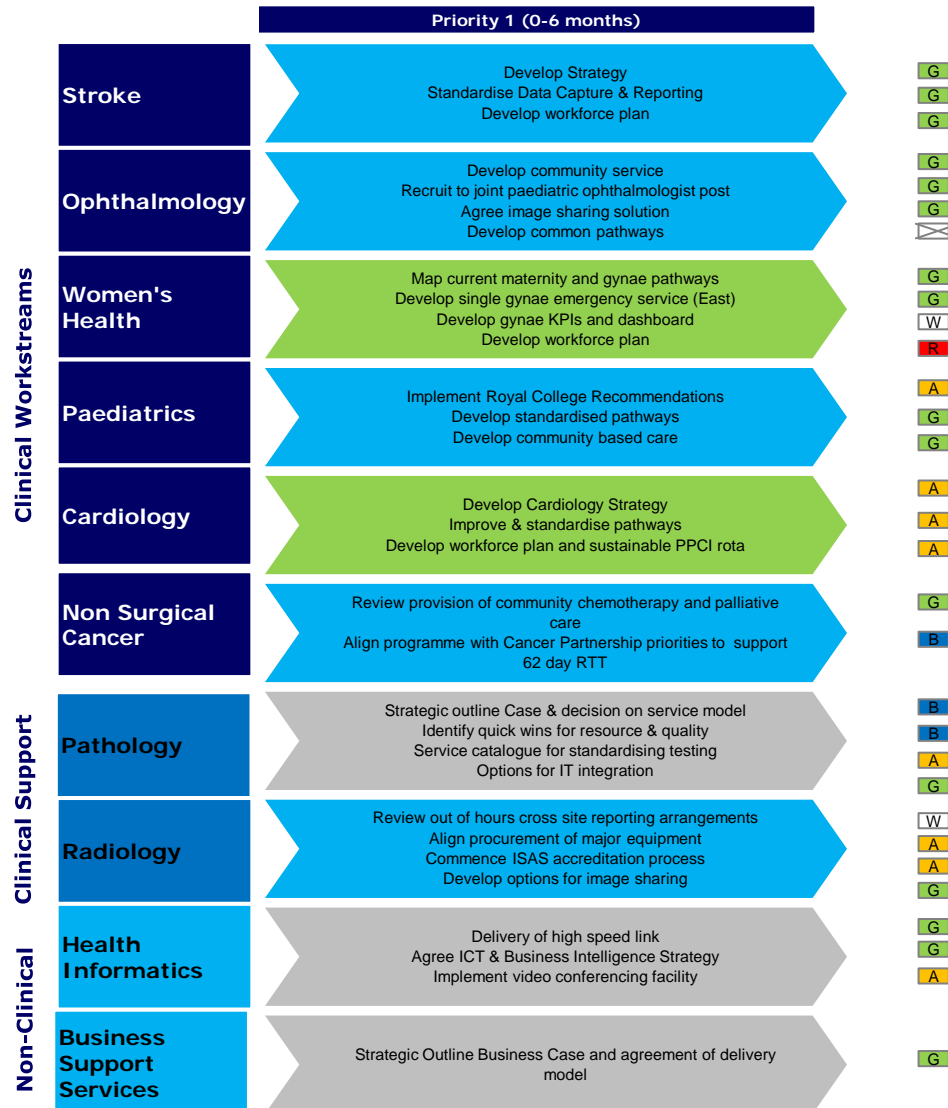
DRAFT

Progress Quarterly Review – November 2016

Improving consistency of care and removing unwarranted variation in **clinical outcomes**

Improving the **safety and quality** of services and improving **access to services** – which in turn improve **patient experience**

Creating **resource sustainability** and delivering value for money



Launch event held May 16 to consult on draft service specification developed by clinicians, adopted by CCG as Future Commissioning Framework Standardised data collection/reporting. Working with Stroke Association to identify recent stroke survivors to co-design new models of care and SOC being developed which has informed CSR consultation documents.

Recruitment underway and space identified in community for potential surgery sessions (Swanage, Wimborne & Blandford hospitals). Ensuring image sharing available for development of new community services. Pathways similar –all following NICE guidance.

Pathway mapping underway. Developing service specification for single gynae emergency service. Dorset STP agreed as Better Births Early Adopter to test a range of new and innovative ways of working to help transform maternity services

Adopting Wessex Healthier Together pathways. Links with GPs to ensure seamless pathways developed. Benchmarked current practice against national Facing the Future – Together for Health standards. Dependency and acuity tool aligned. Developing SOC for new paediatric community nursing service to move care closer to home.

Agreement of four sub-specialty areas to focus on standardising and improving cardiology pathways; Cardiac Rhythm management, chest pain, heart failure and Imaging. Drafting strategy and some work progressing on rota in East.

All deliverables within the scope of the Vanguard Programme will be delivered through the Dorset Cancer Partnership. Vanguard supporting one Clinical Lead for Dorset. End of Life Care Delivery Group reformed to progress more collaborative working. Lead on community chemotherapy agreed and work plan being developed.

SOC completed and agreement from all 3 Trusts to progress One Dorset Pathology Services to Outline Business Case and additional external support secured to lead on this. Appointed Clinical Director for Pathology. Defining requirements for common IT system. Quick wins being progressed.

Image sharing now possible between 2 trusts. Options for future provision Out of Hours reporting to be reviewed once cross site reporting Pan Dorset enabled. Discussion with potential suppliers commenced. Engagement in ISAS process across all Acutes and community providers. Developing business case for Pan Dorset Quality Manager.

Working across five organisations for integrated digital strategy solution and SOC being developed looking at preferred options. Finalising costs and options for videoconferencing. One gigabit cloud link agreed as interim solution until wider health and social care network is available. (Dec16)

5 Business Support Services have worked together to determine the vision and critical success factors for support services to support delivery of the STP. A case for change was submitted to NHS Improvement Oct 16. Workshops arranged to develop the right model for each specific service. Quick wins identified.

Key

Not yet started

Slippage – no plan needs attention

Slippage – plan in place

On track

Completed

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BOARD OF DIRECTORS

Meeting Date and Part:	27 January 2017 – Part 1
Reason for Part 2:	N/a
Subject:	Organisational Objectives for 2017/18
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	n/a
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Nicola Hartley, Director of OD and Leadership Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	Blue Skies session on 25 November 2016 and December Board
Action required: Approve/Discuss/Information/Note	Approval
<p>Executive Summary:</p> <p>The Board is asked to formally adopt the organisational objectives and support the approach to developing team and individual objective setting via the Trust's appraisal process.</p>	
<p>Relevant CQC domain:</p> <p>Are they safe?</p> <p>Are they effective?</p> <p>Are they caring?</p> <p>Are they responsive to people's needs?</p> <p>Are they well-led?</p>	All
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	

Adoption of the Organisational Objectives for 2017/18

Following earlier discussions with Board members the Trust Management Board has similarly endorsed the work of the Change Leaders in helping shape the core organisational objectives for 2017/18.


We are therefore requesting the Board to formally adopt the following objectives.

In 2017/18 our priority is to support continuous improvement for patients – we aim to do this by:

- Valuing our staff
- Improving quality and reducing harm
- Strengthening team working
- Listening to patients

These objectives will now form a basis for both team and individual objective setting across the organisation. In focusing on a small number of objections clearly articulated, the aim is to ensure they resonate and connect with all our staff, complementing our values and providing a clear link between the Trust's priorities and the work of the various teams within the organisation.

TMB have already agreed that a key focus for our continued quality improvement work will be improving flow within the hospital, management of sepsis and the care of the deteriorating patient. The Board will be regularly apprised of progress on each of these work streams. To aid the agreement of individual and team based objective setting as part of the appraisal process each objective is accompanied by a supporting statement.

Valuing our Staff	Recognising the contribution of our staff and helping them develop and achieve their goals
Improving quality and reducing harm	Focusing on continuous improvement and reducing waste
Strengthening team working	Developing and strengthening  to develop safe and compassionate care for our patients and shaping future healthcare across Dorset
Listening to our patients	Ensuring meaningful engagement to improve patient experience

The Objectives once finalised will be communicated widely throughout the Trust and in a variety of forms such as shown in the illustration below



A toolkit is being developed to cascade the objectives throughout the organisation. This will start with the agreement of team based objectives for the senior leadership team (SLT) at the end of January. The intention is that the SLT appraisals will be completed by March with full roll out of the 2017/18 appraisal process from 1 April 2017

Decision

The Board is asked to formally adopt the organisational objectives and support the approach to developing team and individual objective setting via the Trust's appraisal process.

Tony Spotswood
Chief Executive

Nicola Hartley
Director of OD and Leadership

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BOARD OF DIRECTORS

Meeting Date and Part:	27 January 2017 – Part 1
Subject:	Information Governance (IG) Strategy
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Peter Gill, Director of Informatics
Author(s) of papers:	Camilla Axtell, IG Manager
Details of previous discussion and/or dissemination:	IG Strategy agreed at the IG Committee in December 2016.
Action required:	Approve
<p>Executive Summary:</p> <p>The IG Strategy sets out the purpose, resources, policies and management framework for the IG work at the Trust. It is a stipulation of the national IG Toolkit that this strategy is approved by the Board of Directors.</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>	Safe, Effective, Well-led
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	No change

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Information Governance Strategy

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	4	January 2017	January 2018	Information Governance Manager

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1. Introduction

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

2. Purpose and Scope

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

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

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

3. Senior Roles

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

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

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

4. Key Policies

The Trust has the following Information Governance-related policies:

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

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

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

Policies relating to health records management and subject access requests will be ratified by the Electronic Document Management User Group and reviewed by the Information Governance Committee. IT related security policies will be ratified by the Informatics Steering Board and reviewed by the Information Governance Committee.

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

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

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

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

5. Governance

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

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

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

Compliance with the IG Toolkit is used as one of the measures reported in the Quality Report and Annual Governance Statement in the Annual Report and Accounts. This assures compliance with the Care Quality Commission's standards relating to Information Governance.

6. Resources

The Information Governance Manager is responsible for:

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

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

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

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

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

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

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

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

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

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

7. Training and Guidance

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

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

8. Incident Management

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

APPENDIX A

Legislative and Regulatory Framework

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

Legislation and common law

This includes:

- Access to Health Records Act 1990
- Access to Medical Reports Act 1988
- Common law duty of confidentiality
- Computer Misuse Act 1990
- Data Protection Act 1998
- Environmental Information Regulations (EIR) 2004
- Freedom of Information (FOI) Act 2000
- Human Rights Act 1998 (Article 8)
- National Health Service Act 2006
- Privacy and Electronic Communications (EC Directive) Regulations 2003
- Protection of Freedoms Act 2012
- Re-use of Public Sector Information Regulations 2005

Standards and Guidance

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

- Health Service Circular: HSC 1999/012 (requirement for NHS organisations to have a Caldicott Guardian)
- The Caldicott Principles
- The Caldicott Guardian Manual 2010
- Care Quality Commission Essential Standards Outcome 21: Records
- NHS Information Governance Toolkit
- NHSLA standards for Acute Trusts
- BS ISO/IEC 17799:2005; BS ISO/IEC 27001:2005; BS7799-2:2005 – Management Information Security compliance
- Information Security Management: NHS Code of Practice (April 2007)
- Confidentiality: NHS Code of Practice (November 2003)
- Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems (ISB 0160 2013)
- HSCIC: A guide to confidentiality in health and social care (September 2013)
- IG Alliance Records Management Code of Practice for Health and Social Care (July 2016)
- Information: To Share or not to Share – The Information Governance Review (“Caldicott 2”) (March 2013)
- National Data Guardian for Health and Care Review of Data Security, Consent and Opt-Outs (“Caldicott 3”) (June 2016)

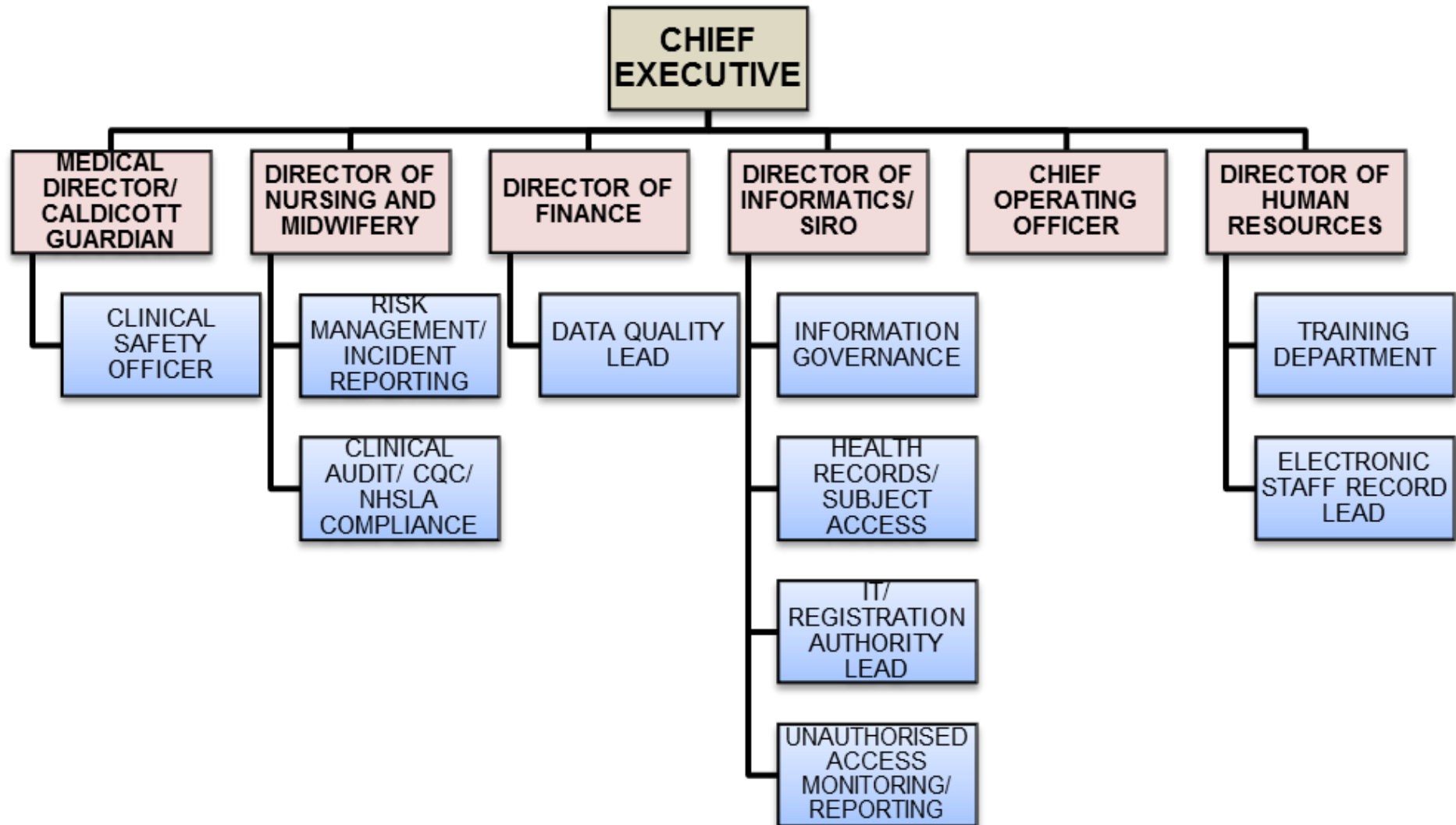
Professional Codes and Rules

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

- General Medical Council, Good Medical Practice – paragraph 37 (2006)
- General Medical Council, Confidentiality for Doctors (2009)

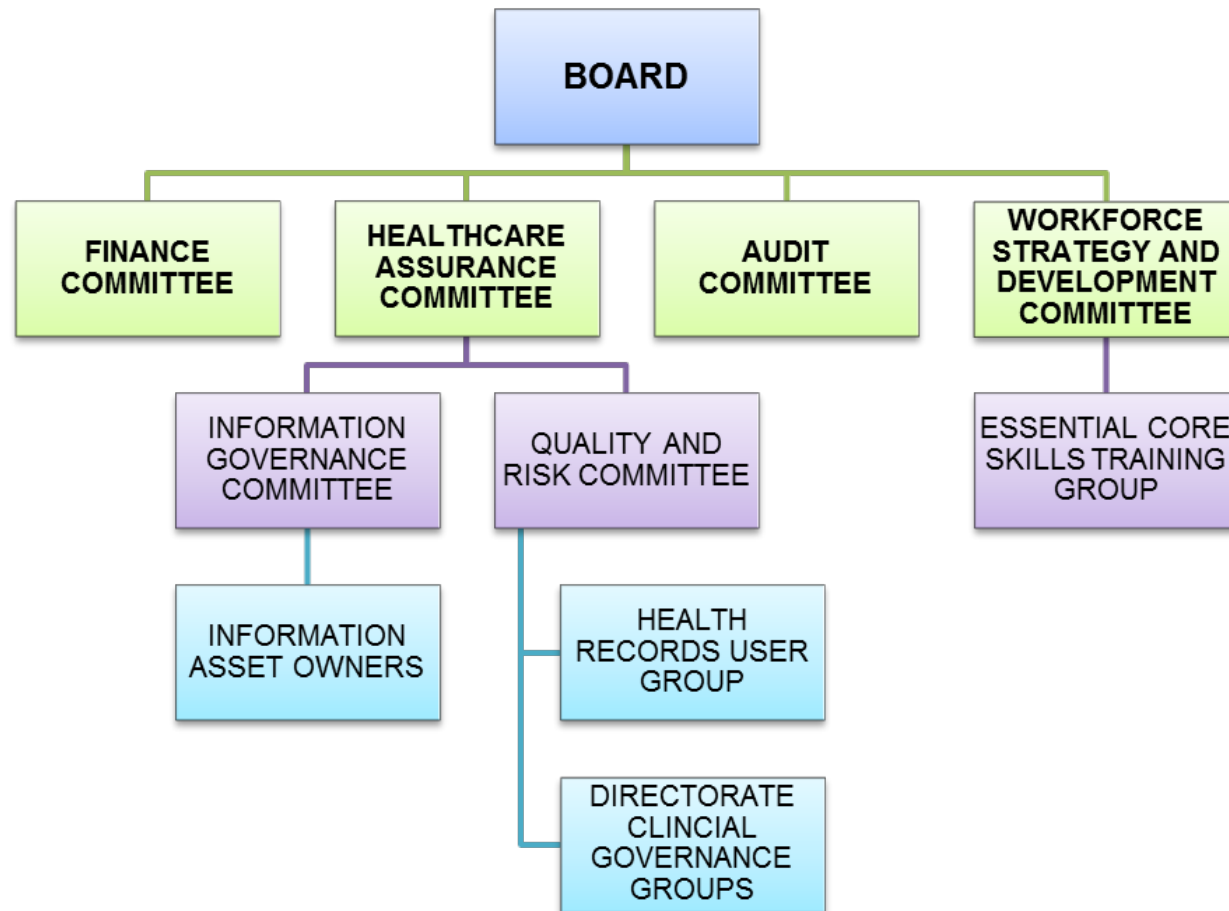
- Nursing & Midwifery Council, The code: Standards of conduct, performance and ethics for nurses and midwives produced by the— paragraphs 42-47 (May 2008)
- Nursing & Midwifery Council, Record keeping: Guidance for nurses and midwives (July 2009)
- General Pharmaceutical Council, Standards of conduct, ethics and performance – principle 3 (July 2012)
- Health & Care Professions Council, Standards of conduct, performance and ethics – principle 2 (2012)
- Chartered Society of Physiotherapy Rules of Professional Conduct (2nd edition) – Rule 3 (January 2002)
- British Medical Association, Confidentiality and Disclosure of Health Information Toolkit
- Royal College of Physicians, Generic Medical Records Keeping Standards (June 2015)

APPENDIX B
Overarching Information Governance Structure



APPENDIX C

Committee Structure



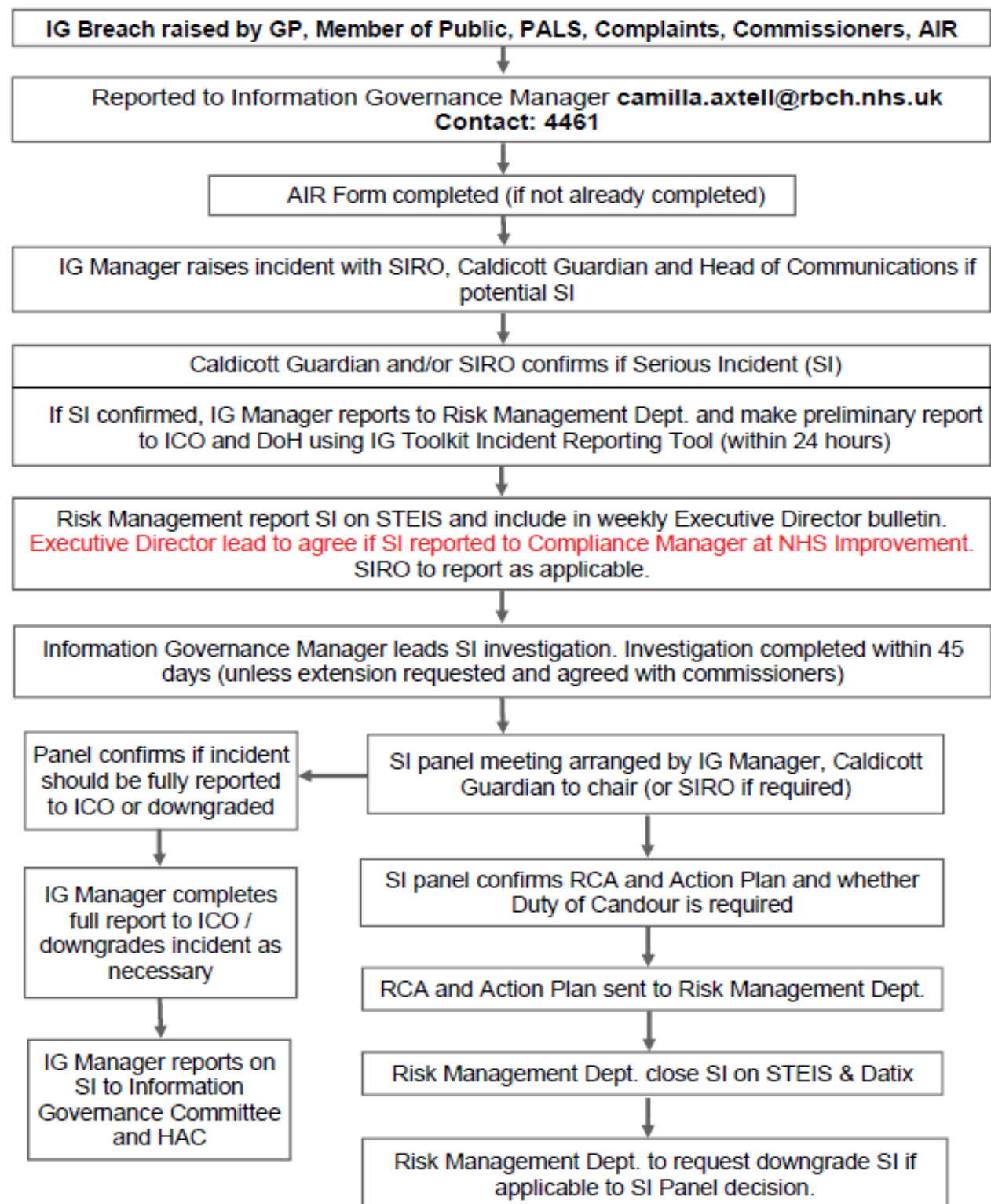
APPENDIX D

Information Governance Serious Incident Reporting Flowchart

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Information Governance - Serious Incident Reporting Flowchart



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BOARD OF DIRECTORS

Meeting Date and Part:	27 th January 2017 – Part 1
Subject:	EPRR Assurance Compliance Assessment
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	BJ Waltho / Malcolm Keith
Details of previous discussion and/or dissemination:	
Action required: Approve / Discuss / Information/Note	For Information
Executive Summary: Following the CQC Audit in September 2016, the Trust was not fully compliant with 7 out of the 34 EPRR Core Standards. Attached is an updated Action Tracker will all actions on target to be completed.	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	

RBCH EPRR Assurance Compliance Assessment

Following our audit in September 2016 the Trust was not fully compliant with 7 out of the 34 EPRR core standards:

Action tracker for December 2016

EPRR Standard	Actions to achieve compliance	Progress	Completion date
• Core standard 2 o Organisations have an annual work programme to mitigate (against) identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	EPO to agree work plan with BJW for the coming year based on the annual audit for EPRR, CBRNe and Business continuity. This to include a training programme and risk matrix following the LHRP model	Draft plan in place and awaiting agreement at Feb 2017 Emergency Planning Sub-group (EPSG)	Feb 2017
• Core standard 8 o Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation	Agreement reached at December LHRP subgroup to use NHS England south Wessex risk matrix	Cross referencing national and regional risk register plan to guide the trust on local risk rating for EPRR subjects. This is a Dorset wide project	March 2017
• Core standard 14 o Arrangements include a debrief process so as to identify learning and inform future arrangements.	Two exercise events, one in September and one in December has created the debrief along with the final event for the Live Dorset police Exercise Velocity	Lessons learnt submitted to the December LHRP Updates as standing agenda item at EPSG will ensure ongoing compliance	Completed

<ul style="list-style-type: none"> • Core standard 18 ○ Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response. 	Training exercise run by the Civil Contingencies Unit in December	Covered during the training and future dates being arranged to run similar courses for other staff in 2017	Completed
<ul style="list-style-type: none"> • Core standard 34 ○ Arrangements include a training plan with a training needs analysis and on-going training of staff required to deliver the response to emergencies and business continuity incidents 	Training Needs matrix completed and used to identify gaps for core staff during 2016, which lead to the first internal course being run in December	Training needs matrix to form part of the 2017 work plan for EPRR and any opportunities to be promoted in a timely fashion and targeted to relevant staff	Completed
<ul style="list-style-type: none"> • Core standard 35 ○ Arrangements include an on-going exercising programme that includes an exercise needs analysis and informs future working 	Agreement reached in November 2016 LHRP to work locally with other EPOs, CCU and NHS England to share the programme of potential exercising opportunities and to include local exercising on the work plan	ED has a training module set up for Jan to Mar 2017 for CBRNe decontamination and radiation monitoring training. Exercise programme to be a standing agenda item at EPSG	Feb 2017
<ul style="list-style-type: none"> • Core standard 37 ○ Preparedness ensures all incident commanders (on-call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation. 	Training needs matrix will be used to guide senior staff on maintaining their personal development portfolio. This will also form part of the work plan which will be monitored quarterly at EPSG and escalated to Board level if needed	Work plan to be monitored and approved by EPSG on a quarterly basis Future development planned in conjunction with training department to incorporate into BEAT programme	Feb 2017

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BOARD OF DIRECTORS

Meeting Date and Part:	27 January 2017 – Part 1
Subject:	Charitable Funds Committee Terms of Reference
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	No
Officer with overall responsibility:	Stuart Hunter, Director of Finance
Author(s) of papers:	Stuart Hunter, Director of Finance
Details of previous discussion and/or dissemination:	Charitable Funds Committee
Action required:	Approval
Executive Summary:	<p>Following review and approval at the Charitable Funds Committee meeting in August 2016, the Board of Directors is asked to approve the attached Charitable Funds Committee terms of reference.</p> <p>Minor changes have been made to the members and attendees of the committee. The requirement for the committee to provide a separate report to the Board of Directors on its activities has also been removed as reporting is already provided through the annual report and accounts of the Bournemouth Hospital Charity and the Trust's annual report and accounts.</p>
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	N/A

CHARITABLE FUNDS COMMITTEE

Terms of Reference

The Charitable Funds Committee reports to the Board of Directors whose members are the Trustees of the registered charity (registration number 1057366).

1 MEMBERSHIP

- 1.1 The Committee shall comprise the Director of Finance, Director of Human Resources, Director of Nursing and three Non-Executive Directors. All appointments to the Committee shall be made by the Board.
- 1.2 The Board shall appoint the Committee Chairman who should be a Non Executive Director. In the absence of the Committee Chairman and/or any appointed deputy, the remaining members present shall elect one of the Non Executive Directors present to chair the meeting. In the case of a tied vote the Chairman will have a casting vote.
- 1.3 Only members of the Committee have the right to attend committee meetings. However the Deputy Director of Finance, a Consultant and the Head of Fundraising shall normally attend meetings to provide information to the Committee. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate. Any Non Executive Director not appointed to the Committee may attend with the prior consent of the Chairman.
- 1.4 There will be one governor attending each meeting as an observer. Observers are not technically members of the Committee. This governor has been elected to undertake this duty by the Council of Governors by means of a ballot organised by the Trust Secretary in accordance with the process agreed by the Council of Governors.

2 SECRETARY

- 2.1 The Secretary of the Committee will be supplied by the Director of Finance.

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Board of Directors	Final	August 2016	August 2017	Stuart Hunter

3 QUORUM

- 3.1 The quorum necessary for the transaction of business shall be 2 members and should include not less than 2 Non Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4 FREQUENCY OF MEETINGS

- 4.1 The Committee shall meet quarterly and at such other times as the Chairman of the Committee shall require.

5 NOTICE OF MEETINGS

- 5.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chairman.
- 5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend, no later than 3 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6 MINUTES OF MEETINGS

- 6.1 The Secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.
- 6.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee and to the Board.

7 DUTIES

- 7.1 The Committee shall:
- 7.1.1 endeavour to make an adequate return on prudent investments;
- 7.1.2 consider and agree any changes to investment policy,

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	August 2016	August 2017	Stuart Hunter

- 7.1.3 regularly review the performance of current investments in terms of income and capital appreciation;
- 7.1.4 appoint independent advisors on investment policy as the Committee sees fit;
- 7.1.5 approve charitable fund bids in accordance with the relevant procedures
- 7.1.6 review annually the fund raising projects and recommend schemes to the Board for approval;
- 7.1.7 ensure that expenditure is controlled and utilised on suitable projects;
- 7.1.8 receive all necessary information from authorised fund signatories;
- 7.1.9 determine the format of the information required to effectively manage the charitable funds;
- 7.1.10 safeguard donated money;
- 7.1.11 ensure legacies are realised in a timely and complete manner;
- 7.1.12 review and approve the charitable funds annual accounts and annual report;
- 7.1.13 review and approve annually the overall fundraising strategy for the Charity department;
- 7.1.14 review and approve annually medium term strategy and annual operating plan for the annual objectives;
- 7.1.15 fully account to the Charity Commission and the public.

8 REPORTING RESPONSIBILITIES

- 8.1 The minutes of the Committee meetings shall be submitted to the Board after each meeting.
- 8.2 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	August 2016	August 2017	Stuart Hunter

- 8.3 The Committee shall provide a report on its activities to be included in the Trust's annual report.

9 OTHER

- 9.1 The Committee shall, at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

10 AUTHORITY

- 10.1 The Committee is authorised:

10.1.1 To oversee and authorise expenditure from charitable funds (subject to all process being in accordance with the Trust's Standing Orders and Standing Financial Instructions)

10.1.2 To seek any information it requires from any employee of the Trust in order to perform its duties

10.1.3 To obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	Final	August 2016	August 2017	Stuart Hunter

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BOARD OF DIRECTORS

Meeting Date and Part:	27 January 2017 – Part 1
Subject:	Audit Committee Terms of Reference
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	No
Officer with overall responsibility:	Steve Peacock, Audit Committee Chair
Author(s) of papers:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Audit Committee
Action required:	Approval
Executive Summary:	<p>Following review and approval at the Audit Committee meeting in January 2017, the Board of Directors is asked to approve the attached Audit Committee terms of reference.</p> <p>These have been updated in line with the latest corporate governance guidance and to provide additional clarification around some provisions.</p>
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	N/A

AUDIT COMMITTEE

Terms of Reference

The Audit Committee (the **Committee**) is a committee established by and responsible to the Board of Directors. The primary aim of the Committee is to monitor and review financial and other risks and associated controls, corporate governance and financial assurance.

1. Membership

- 1.1. The Committee shall be appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members, at least one of whom shall have recent and relevant financial experience. One member shall be the Chair of the Healthcare Assurance Committee. The Chairman of the Trust shall not be a member of the Committee.
- 1.2. In addition, the following will attend the Committee to provide advice as required:
 - 1.2.1. the Director of Finance
 - 1.2.2. a representative of the Internal Auditors
 - 1.2.3. a representative of the External Auditors
 - 1.2.4. a representative from the Counter Fraud service
 - 1.2.5. the Clinical Director for Clinical Audit
 - 1.2.6. the Director of Nursing and Midwifery (also Deputy Chief Executive)
 - 1.2.7. the Chief Operating Officer
 - 1.2.8. any other director, as required.
- 1.3. Only members of the Committee have the right to attend Committee meetings. Any other directors may attend following notification to the Chairman. The chief executive should be invited to attend, at least annually, to discuss with the audit committee the process for assurance that supports the annual governance statement. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.
- 1.4. Appointments to the Committee shall be for a period of three years, which may be extended for a further three year period.
- 1.5. The Board of Directors shall appoint the Committee Chairman (the **Chairman**) who shall be a Non-Executive Director and member of the Committee. In the absence of the Chairman and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4	January 2017	January 2018	Trust Secretary

- 1.6. The Committee shall provide an opportunity to meet with the External and Internal Auditors or the representative from the Counter Fraud Service without any Executive Director present.

2. Secretary

- 2.1 The Trust Secretary (the **Secretary**) or their nominee shall act as the secretary of the Committee.

3. Quorum

- 3.1 The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4. Frequency of Meetings

- 4.1 The Committee shall meet at least quarterly and otherwise as required.

5. Notice of Meetings

- 5.1 Meetings of the Committee shall be called by the Secretary at the request of any of the Committee members or at the request of External or Internal Auditors if they consider it necessary.
- 5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Trust Secretary or their nominee.
- 5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting. Where possible, supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of Meetings

- 6.1 The Secretary shall minute the proceedings and resolutions of all Committee meetings, including recording the names of those present and in attendance.
- 6.2 The Secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.
- 6.3 Minutes of Committee meetings shall be agreed by the Committee Chairman prior to being circulated to all members of the Committee unless a conflict of interest exists. The Secretary shall aim to prepare the minutes within one week of the meeting date.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4	January 2017	January 2018	Trust Secretary

7. Duties

The duties of the Committee are set out below.

7.1 Internal Control, Risk Management and Corporate Governance.

7.1.1 The Committee shall review the implementation and ongoing effectiveness of the system of internal control, risk management and corporate governance, with particular reference to the organisation's assurance framework.

7.1.2 In particular, the Committee will review:

7.1.2.1 The adequacy of all risk and control related disclosure statements, together with any accompanying reports from Internal or External Auditors or other appropriate independent assurance, before making recommendations to the Board of Directors. In reviewing the annual governance statement, the Healthcare Assurance Committee will need to provide assurance on their activities during the year through its Chair.

7.1.2.2 The effectiveness of the foundation trust's internal controls, board assurance framework and risk management systems.

7.1.2.3 The operational effectiveness of relevant policies and procedures including but not limited to:

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as recommended by the appointed Counter Fraud service;
- The policies and procedures in place for ensuring economy, efficiency and effectiveness in the use of resources.

7.1.2.4 The Clinical Audit Programme to ensure that it is robust, reflecting both national and local priorities, comprehensive and embedded across all clinical teams (management arrangements, planning, reporting, communication and learning) with the outcomes used to drive improvement and enhance the overall quality of clinical care.

7.2 Internal Audit

The Committee will:

7.2.1 Appoint the Internal Auditors, set the audit fee and resolve any questions of resignation and dismissal.

7.2.2 Ensure that the Internal Audit function is adequately resourced, has appropriate access to information to perform its function effectively and is free from management or other restrictions.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4	January 2017	January 2018	Trust Secretary

- 7.2.3 Review the internal audit programme, consider major findings of internal audit investigations (and management's response), and ensure co-ordination between the Internal and External Auditors.
- 7.2.4 Report non-compliance with, or inadequate response to, Internal Audit Reports to the Board of Directors.
- 7.2.5 Meet with the Internal Auditors at least once a year, without executive management being present.
- 7.2.6 Conduct an annual review of the internal audit function.

7.3 External Audit

The Committee will:

- 7.3.1 Oversee a market testing exercise and consider the appointment of the External Auditor, the audit fee and any questions of resignation and dismissal. Make a recommendation to the Council of Governors on appointing the External Auditor for a three year period.
- 7.3.2 Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with Internal Audit and the representative from the Counter Fraud service.
- 7.3.3 Assess the External Auditor's work and fees each year and make a recommendation to the Council of Governors with regard to the continuation of the appointment for the remaining period. This assessment should consider a review of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.
- 7.3.4 Review External Audit reports, including the annual audit letter, together with the management response, and monitor progress on implementation of recommendations.
- 7.3.5 Report non-compliance with, or inadequate response to External Audit Reports to the Board of Directors.
- 7.3.6 Consider any reports on the provision of non-audit services made to the Committee by the Director of Finance.
- 7.3.7 Meet with the External Auditors at least once a year, without executive management being present.

7.4 Counter Fraud Service

The Committee will

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4	January 2017	January 2018	Trust Secretary

- 7.4.1 Appoint the Counter Fraud service, set the fee and resolve any questions of resignation and dismissal.
- 7.4.2 Ensure that the Counter Fraud function has appropriate standing within the organisation.
- 7.4.3 Review the Counter Fraud programme, consider major findings of investigations (and management's response), and ensure co-ordination between the Internal Auditors and Counter Fraud.
- 7.4.4 Report non-compliance with, or inadequate response to, Counter Fraud reports to the Board of Directors.

7.5 Financial Reporting

The Committee will review the annual report, annual governance statement and annual financial statements before submission to the Board to determine completeness, objectivity, integrity and accuracy. The Committee will focus particularly on:

- 7.5.1 Changes in, and compliance with, accounting policies and practices.
- 7.5.2 Major judgemental areas and explanation of estimates or provisions having material effect.
- 7.5.3 Significant adjustments resulting from the audit and any reservations and disagreements between the External Auditor and management that have not been satisfactorily resolved.
- 7.5.4 The clarity and completeness of disclosure in the foundation trust's financial reports and the context in which statements are made.
- 7.5.5 All material information presented with the financial statements, such as the Annual Governance Statement and forward plan relating to the audit and risk management.
- 7.5.6 The impact of the Trust's Cost Improvement Programme on clinical risk.

7.6 Whistleblowing

- 7.6.1 The Committee will review arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4	January 2017	January 2018	Trust Secretary

8. Reporting Responsibilities

- 8.1 The minutes of the Committee shall be submitted to the Board of Directors after each meeting.
- 8.2 The Committee shall make whatever recommendation to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.
- 8.3 The Committee shall compile a report on its activities to be included in the Trust's annual report.
- 8.4 The Committee shall compile a report on its activities to be submitted to the Board of Directors annually within three months of the end of the financial year.

9. Other

- 9.1 The Committee shall:
 - 9.1.1 have access to sufficient resources in order to carry out its duties, including access to the Trust Secretary's Office for assistance as required;
 - 9.1.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
 - 9.1.3 give due consideration to laws and regulations and the provisions of the NHS Foundation Trust Code of Governance;
 - 9.1.4 be responsible for co-ordination of the Internal and External Auditors and Counter Fraud through the Director of Finance;
 - 9.1.5 oversee any investigation of activities which are within its terms of reference;
 - 9.1.6 at least once a year review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

10. Authority

- 10.1 The Committee is authorised:
 - 10.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties;
 - 10.1.2 to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference;
 - 10.1.3 to call any employee to be questioned at a meeting of the Committee as and when required.

Approval Committee	Version	Approval Date	Review Date	Document Author
Board of Directors	V4	January 2017	January 2018	Trust Secretary