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**A meeting of the Board of Directors will be held on Friday 28 April 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 Christine Hallett		
8.35-8.40	2. MINUTES OF PREVIOUS MEETING		
	a) Minutes of the meeting held on 31 March 2017	Approval	All
8.40-8.45	3. MATTERS ARISING		
	a) Updates to the Actions Log	Information	All
8.45-9.15	4. QUALITY		
	a) Patient Story (verbal)	Information	Paula Shobbrook
	b) Feedback from Staff Governors (verbal)	Information	David Moss
	c) Medical Director's Report (verbal)	Information	Alyson O'Donnell
	i. Guardian of Safe Working Hours Quarterly report (paper)		
9.15-10.00	5. PERFORMANCE		
	a) Performance Exception Report (paper)	Information	Richard Renaut
	b) Quality Report (paper)	Information	Paula Shobbrook
	c) Financial Performance Report (paper)	Information	Stuart Hunter
	d) Workforce Report (paper)	Information	Karen Allman
10.00-10.30	6. STRATEGY AND RISK		
	a) Clinical Services Review (paper)	Information	Tony Spotswood
	b) Progress against the Government's Mandate to NHS England for 2017-18 (paper)	Information	Tony Spotswood
	c) Emergency Preparedness, Resilience and Response (EPRR) Update (paper)	Information	Richard Renaut
	d) CCG Primary Care Strategy/ GP Forward View Delivery Plan (paper)	Information	Richard Renaut
	e) Update on Social and Community Services Integration (paper)	Discussion	Richard Renaut

- 10.30-10.35 **7. GOVERNANCE**
- a) Register of Interests (paper) Information *Karen Flaherty*
- 8. NEXT MEETING**
Friday **26 May 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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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 31 March 2017** in the Macmillan Seminar Room, Christchurch Hospital.

Present:	David Moss	(DM)	<i>Chairperson</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Tea Colaianni	(TC)	<i>Non-Executive Director</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>
	Steve Peacock	(SP)	<i>Non-Executive Director</i>
	Richard Renaut	(RR)	<i>Chief Operating Officer</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
In attendance:	Jane Bruccoleri-Aitchison	(JBA)	<i>Communications Officer</i>
	Julia Chappell	(JC)	<i>Trainee Advanced Care Practitioner, ED</i>
	Karen Flaherty	(KF)	<i>Trust Secretary</i>
	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NH)	<i>Director of OD and Leadership</i>
	Deb Matthews	(DMa)	<i>Director of Improvement</i>
	James Rowden	(JR)	<i>Patient Engagement Volunteer Coordinator</i>
	Cliff Shearman	(CS)	<i>Non-Executive Director Designate</i>
	Jacky Taylor	(JT)	<i>Voluntary Services Officer</i>
Public/ Governors:	David Bellamy		<i>Public Governor</i>
	Derek Chaffey		<i>Public Governor</i>
	Liz Corkell		<i>Chair, Friends of the Eye Unit</i>
	Eric Fisher		<i>Public Governor</i>
	Mark Hill		<i>Member of Public (IMS Maximus)</i>
	John Hodges		<i>Member of Public (UK Cloud)</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>
	Guy Rouquette		<i>Public Governor</i>
	Graham Swetman		<i>Public Governor</i>
	David Triplow		<i>Public Governor</i>
Apologies	None		

20/17 **WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Action

DM thanked those attending for the warm welcome he had been given since joining the Trust as Chairperson and paid tribute to his predecessor in the role, Jane Stichbury. He welcomed Cliff Shearman, who would join the Board

as a non-executive director from 1 April 2017, to the meeting. David Triplow was congratulated on his recent election as Lead Governor of the Council of Governors, with his appointment due to confirmed by the Council of Governors at its meeting on 12 April 2017.

The Communications team had won a national award in the 'Best Storytelling' category at the prestigious Association for Healthcare Communications and Marketing Awards for their story about 99 year old Victor Marston, believed to be the oldest person in Great Britain to survive major cancer surgery. The local and national press coverage focussed on teamwork and showed all the members of the team involved in the patient's care at the Trust. DM also highlighted the successful launch event for the new private patient unit in the Royal Bournemouth Hospital, Bournemouth Private Clinic, earlier that week. This had been a very successful evening and had also received very positive television coverage on local news which had showcased the wonderful new facility.

21/17 **MINUTES OF PREVIOUS MEETING**

(a) Minutes of the meeting held on 24 February 2017 (Item 2a)

The minutes of the meeting held on 24 February 2017 were **approved** as an accurate record of the meeting.

22/17 **MATTERS ARISING**

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

- 14/17(c) Regular meetings of the Junior Doctors Committee had been scheduled over lunchtime to help increase engagement and obtain feedback.
- 14/17(d) Following discussion at the Healthcare Assurance Committee (**HAC**) a working group consisting of both medical and nursing staff had been tasked to develop processes and provide clarification around the nature of consent. It was agreed that the action could be closed, having been remitted to HAC, however, the Board asked that the actions and recommendations following the review were presented to the Board given that the issue of consent reached across a number of areas;
- 04/17(d) Further detail on staff sickness absence would be provided at the Board meeting in April following analysis of the results of a scheduled review into persistent areas of poor performance by the Workforce Strategy and Development Committee;
- 81/16(d) Workforce data was being analysed to identify cost-effective solutions to reduce the use of medical agency staff. Solutions addressing recruitment had been developed in different areas to mitigate pressures and these were being monitored to ascertain whether they could be implemented elsewhere in the Trust. Detailed metrics would be provided to the Board once finalised.

Agenda

(a) Patient Story (Item 4a)

JT and JR from the Voluntary Services team highlighted to the Board the valuable support being provided by over 800 volunteers at the Trust, which complemented the patient care being provided. The important role of the volunteers in supporting delivery of the Trust's strategy, identifying areas for improvement and responding to demands in different areas in the hospitals was highlighted.

The roles in which the volunteers were being utilised throughout the Trust were explained and included:

- mealtime companions to assist staff and patients at mealtimes;
- dementia companions who spend time with patients on Older Persons' Medicine wards, either one to one or with group activities;
- 'Pets as Therapy';
- end of life volunteers, a new initiative in partnership with Macmillan Caring Locally, providing emotional support and comfort to patients and relatives;
- Stroke rehabilitation volunteer assistants, another new initiative, assisting patients with exercises to improve their mobility;
- speech and language therapy volunteer assistants, another new initiative, assisting patients with speech exercises to improve verbal communication; and
- conducting the Care Campaign Audits.

Opportunities for young volunteers had also been expanded and this had encouraged interest in careers in various healthcare professions.

Board members recognised the fantastic work of the volunteers but considered that some situations could be challenging for volunteers and asked what training and support was offered by the Trust. Assurance was provided that volunteers were given appropriate and tailored training for the different roles with regular review and support meetings and felt comfortable providing specific feedback on patient interactions.

The value that trained volunteers were providing in an acute setting was praised by the Board for the way it provided support to teams by reducing some of the demands on staff and enhancing the patient experience.

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

The first meeting with Staff Governors and the new Chairperson had been arranged in April and DM would report back to the Board after that meeting. No other feedback from Staff Governors had been received.

**(c) 2016/17 Quality Improvement Programme End of Stage Report
(Item 4c)**

The conclusion of the 2016/17 financial year provided an opportunity for reflection on progress with the Quality Improvement (QI) programme projects which had been designed to support the Trust's vision to be 'the most improved acute hospital in the UK by 2017'. Overall the projects had significantly contributed to improvements in various areas throughout the Trust including:

- Hospital Flow - improvements to early discharge, reductions in the average length of stay and the numbers of patients in hospital for over 14 days in Older Person's Medicine resulting in an overall cost reduction of £551,000 as well as a £3.2 million reduction in spending on agency staff;
- Surgical Productivity - 1,016 more procedures were completed in 2016/17 year to date following improvements in efficiency and scheduling in Theatres as well as a 50% reduction in overrunning operating lists;
- Safety Checklists - over the past 12 months no never events relating to checklists had been recorded following the standardisation and embedding of checklists for interventional procedures as part of the 'Never get to Never' campaign;
- Emergency Laparotomy - sustained reduction in the mortality rate and improvements to patient care and pathways with increased awareness throughout the Trust;
- Gastroenterology - improved processes and nurse led clinics culminated in a reduction in waiting times for urgent referrals; and
- Sepsis - development of electronic processes and improved communication leading to an increase in the number of patients receiving antibiotics within one hour.

These improvements had been supported through the development of a continuous improvement culture, building capacity and capability by training and engaging with staff, embedding the QI methodology into standard working practices and collaborating locally and nationally.

Three QI priorities had been identified for 2017/18: sepsis, hospital flow and escalation of the deteriorating patient. New techniques such as 'action learning weeks', appreciative inquiry, developing the QI alumni network, launching a junior doctor QI programme and establishing an internal QI fellowship model would support delivery of these priorities. Other areas of focus would include how to link the QI work with the NHS Improvement (NHSI) national framework for action on improvement and leadership development 'Developing People, Improving Care' and to explore opportunities to extend QI within non-clinical areas including schemes for procurement and agency staffing which would contribute to the Cost Improvement Plan (CIP) next year.

The Board were assured that the impact of QI projects would continue to be measured through improvements in key performance measures including patient experience, staff satisfaction, staff

engagement and productivity.

Board members discussed the importance of engaging staff at all levels to expand the QI work, in particular, junior doctors who formed a large part of the workforce but did not always feel valued. Board members considered how to encourage more applications for the QI fellowship from junior doctors such as including training grade doctors in the QI alumni network and contacting them individually to get them involved in projects around the three priorities for 2017/18. The Board also considered putting an emphasis on QI when advertising for medical roles which may make roles more attractive to individuals and encourage more applicants who wanted to be involved with this work. QI work would also be threaded through team objectives and part of leadership expectations in the Trust, helping make QI part of the job for every member of staff.

**DMa/
AOD**

In addition, the delivery of the CIP was part of the QI programme (rather than opposing aims) which was important given the scale of the CIP required in 2017/18.

To increase engagement amongst staff and public awareness of the impact and significance of the QI priorities for 2017/18 it was requested that the key messages were distilled and shared with staff and the public more widely.

DMa

The Board commended the progress made and thanked the team and all those involved in the QI projects.

(d) Medical Director's Report (Item 4d)

Overall performance for the Hospital Standardised Mortality Ratio (**HSMR**) and the Summary Hospital Mortality Indicator (**SHMI**) continued to reflect an improving trend with fewer patients dying in hospital. The data was always treated with caution and triangulated with crude mortality figures to provide additional assurance. It was anticipated that HSMR would increase in the next few months to reflect the increase in the number of deaths over winter but would remain in the 'better than expected' category.

Sepsis mortality for the Trust was within the 'as expected' range with the most recent data relating to deaths from Sepsis suggesting an improving trend. The Trust continued to drive focus on Sepsis through the QI priorities and for the improving trend to become established. Board members were keen to monitor progress on Sepsis and asked for this data to be presented in more detail.

AOD

Further reviews of the Dr Foster mortality alerts for low risk groups had not identified any safety concerns but had highlighted some issues relating to the partial coding of patient episodes and there was an opportunity to resubmit the correctly coded data following the alert.

The Trust was considering how best to support the reporting requirements for the formal reviews of all deaths of patients with

significant learning difficulties which would be mandated from August 2017. There was a degree of urgency with this as the first nationally reported data would be due in September. The Trust would most likely be feeding into the regional process as the responsibility for these investigations will largely sit with primary care and community providers. This would coordinate well with processes to support the timely review of all deaths, more accurate completion of death certificates and the approach of the newly appointed senior coroner for Dorset. The Board asked whether further support was required to meet these requirements and it was confirmed that while various options were being explored, there was sufficient support in place to meet the deadlines for implementation and reporting.

24/17

PERFORMANCE

(a) Performance Exception Report (Item 5a)

The performance exceptions were summarised and included:

- Emergency Department (**ED**) 4 hour wait - the trajectory had been achieved at the end of March 2017 and the Trust had been the 11th best performing ED nationally in January 2017;
- Cancer 62 days - performance remained challenging however there was lots of work ongoing to meet the trajectory for the quarter and the associated Sustainability and Transformation Fund (**STF**) payment ;
- Diagnostic 6 weeks - performance remained strong and was above the trajectory;
- Referral to Treatment (**RTT**) 18 weeks - STF funding had been achieved by performance in January and February, despite performance being below the national target of 92% in February. March performance was expected to achieve the performance trajectory, however demand and capacity to clear a backlog remained a challenge and whether this would be achievable would be known the following week.

NHS England had published the Next steps on the NHS Five Year Forward View that morning. Urgent and emergency care and cancer services were identified as the improvement priorities for 2017/18 and there was recognition that the waiting times for routine operations would grow given the financial constraints on the NHS. The Board acknowledged these announcements but **agreed** that the Trust should maintain its focus on meeting the 18 week RTT target and not divert resources elsewhere. This was the right thing for patients and it would be very difficult to recover the position if waiting times were to grow. The Trust's current budget had been set to achieve these targets and the work to manage patients differently would continue to run alongside this. The Board requested that there should be a consistent and clear message on the Trust's approach, whilst ensuring it had the support of NHS Dorset Clinical Commissioning Group (**CCG**).

One of the Non-Executive Directors questioned the increase in the number of fast track referrals for cancer over the previous three months. It was confirmed that there had been a 14% rise in fast

track referrals which was one of the reasons why the Trust was so close to the performance trajectory on 18 weeks RTT and there was a constant balance to be achieved between ED, cancer and RTT waiting times. There may be a further impact on RTT performance with the use of advice and guidance and direct access to checks, although again this was the right thing for patients, as some of the patients with less complex cases would be removed from the overall RTT performance measure.

It was noted that it would be more helpful for the Board to see these impacts when looking at the integrated dashboard for quality, performance, finance and leadership aligned with NHSI's Single Oversight Framework.

(b) Quality Report (Item 5b)

The quality performance data had been discussed in detail by the HAC. Two serious incidents had been reported in February including the Trust being one of a number of NHS organisations affected by a cybersecurity incident involving staff data held by Landauer, which was responsible for recording data on radiation exposure for staff. NHS Digital were leading on this investigation.

The Trust's New Harm Free Care score had decreased in month as a result of a slight increase in all of the four quality metrics. Although there appeared to be a reduction in performance on the previous year, the scores included patients who were admitted to hospital with pressure ulcers. Patient feedback and performance was very positive but more work was required to improve response levels in ED for the Friends and Family Test and QI work continued to address the issues on call bells, noise at night, food and drink and pain management highlighted by the Care Campaign Audit

The formal complaint response time in month was 100% against a standard of 75% reflecting that response processes had been successfully embedded. A responsive approach to concerns raised was leading to earlier resolution of any issues which, in turn, was reducing the number of formal complaints received. The addition of the information on the themes and learning from complaints was considered to be very useful.

(c) Financial Performance Report (Item 5c)

The Trust had delivered a cumulative deficit of £1.809 million as at the end of February, which was £637,000 better than planned. The Trust was expected to achieve a small surplus by the end of the year as a result of achieving its control total and a £1 million incentive payment from NHSI. Any additional bonus payment from NHSI was likely to be minimal.

In 2017/18 the STF would be linked principally to achieving the ED four hour wait performance standard which placed the Trust at risk of losing £1.9 million as its good performance in the previous year meant that 95% of patients would need to be seen within four hours

on a consistent basis. Board members raised concerns that this change did not incentivise high performing organisations and could discourage organisations from trying to achieve the 95% performance target. The Trust and the ED team remained motivated to achieve the standard as this was the right thing for patients and the Finance and Regulatory Performance Committee would consider the risk to the budget following the changes to the STF.

Good performance on agency costs meant the Trust would be set a lower target in 2017/18 but there would need to be a reduction in these costs overall. The Trust would end the year with a Financial Risk Rating of 1, being the best, if it delivered the budget. A small amount of non-recurrent funding had been provided to care Group C in recognition of its positive performance.

(d) Workforce Report (Item 5d)

The report was presented to the Board and the positive performance in a number of areas was noted. The Trust had been shortlisted for a national award for excellence and employee engagement following the launch of the Virtual Learning Environment (VLE) 'Green Brain' program for mandatory training. It was also noted that performance against the appraisal target of 90% was clustering at this level and may be creating a perverse incentive to stop when this level was reached which meant lots of staff were not receiving an appraisal.

The discussion centred on performance on sickness absence. The work of the Care Groups to address sickness absence was encouraging and the actions and support to both managers and staff were the right things to help reduce sickness absence levels. On a rolling twelve month basis performance was starting to improve in some areas.

Further information on sickness absence would be provided at the Board meeting in April or May and the future Blue Skies session on sickness areas could look at how the Trust's processes working in a range of different scenarios to allow more time to consider the factors involved and identify if there were links to the reduction in the use of agency staff or other possible explanations for the increase in sickness absence.

(e) Staff Survey Results 2016 (Item 5e)

The Trust's performance had been ranked highest with one another trust for its staff having had an appraisal in the past twelve months. The Trust's performance had also been ranked second out of all acute trusts in the country in terms of how staff feel about the leadership and culture of their trust by Listening into Action. Care Groups were currently preparing action plans alongside a Trust-wide action plan being developed through a series of Cultural Feedback sessions.

The Trust had performed significantly better on ten questions and significantly worse on two questions and overall there was only one

score the Trust was worse than average. Linking to the earlier discussion on sickness absence the staff survey did not indicate that staff were being put under pressure by managers to attend work when unwell but put themselves under pressure to attend work when unwell (one of the two questions where the Trust's performance had significantly worsened). The long-term sustainability of this may be a factor to consider, although there was positive feedback on the Trust's approach and action on staff health and wellbeing.

Staff not experiencing discrimination from patients/service users, relatives or members of the public was the other question on which the Trust's performance had significantly worsened, however, this needed to be understood in the context of the vote of the EU referendum in 2016, shortly before the survey had been circulated. The Board acknowledged the dedication of all EU staff and reaffirmed their support for retaining and attracting staff from the EU.

Other areas discussed included staff experiencing physical violence and the work which had been done training staff so that had the skills to deal with patients with dementia who were violent and deescalate hostile situations as well as seeking to prosecute in cases of violence against staff.

(f) Stroke Services Update (Item 5f)

The continued strong performance of the Stroke service was noted, maintaining its Level A in the Sentinel Stroke National Audit Programme. This was now being developed as a real-time management tool to support consistent performance and was one of the successes within the Vanguard stroke workstream.

DD congratulated the team on the transformation of the Stroke service to be an excellent service and sustaining this high level of performance through the winter.

25/17

STRATEGY AND RISK

(a) Clinical Services Review (Item 6a)

The CCG's consultation on the Clinical Services Review (**CSR**) had closed and 18,000 responses had been received, which included 5,000 from the Shaftesbury area where the proposals were to close a community hospital.

The responses from the other acute trusts had been supportive of the proposals in the CSR other than Poole Hospital NHS Foundation Trust. The Trust acknowledged that it was important for Poole Hospital that these views were expressed in public but both trusts continued to work collaboratively with clinicians across all sites to resolve these differences and implement a better model of care for Dorset.

The work to develop a capital case for NHS England and the

business case for the Competition and Markets Authority (**CMA**) to vary or remove the undertakings to allow implementation of the CST continued through establishing a Joint Programme Board and the appointment of a Programme Director. This would mean that the number of Board meetings would be reduced occurring bi-monthly to accommodate meetings of the Joint Programme Board and to implement the CSR. Lead Governors would be invited to attend the Programme Boards as observers and briefings would be provided to all governors.

Some initial capital funding would be available following the announcement by NHS England that Dorset was one of nine Sustainability and Transformation Plan areas that are 'likely candidates' to become the first Accountable Care Systems. However, it would be necessary to secure NHS England's commitment to provide all the capital required to implement the CSR to secure the variation or removal of the undertakings by the CMA.

(b) A338 Improved Road Access (Item 6b)

The paper was noted for information and the Trust was working closely with Bournemouth Borough Council and Dorset Local Enterprise Partnership to support the bid for funding to complete the improvements in the transport links to the Royal Bournemouth Hospital.

(c) Trust Response to Dorset CCG Mental Health Acute Care Pathway Consultation (Item 6c)

It was recognised that it was important for the Trust to respond as issues relating to the provision of mental health care services had impacted upon a number of areas including ED. It was requested that the response was shared with the ED team to ensure that the team's views were reflected in the response.

RR

The Board **endorsed** the response subject to incorporating any additional views from teams within the organisation.

26/17

GOVERNANCE

(a) Information Governance Annual Update (Item 7a)

The Trust had achieved compliance with all the requirements of the national Information Governance Toolkit. The Information Governance Manager was thanked for their dedicated work which was reflected in the positive result. The Trust's compliance with the time limits for responding to requests under the Freedom of Information Act 2000 had been discussed at the HAC and a series of actions agreed.

(b) Nomination and Remuneration Committee Terms of Reference (Item 7b)

The Board **approved** the amendments to the Nomination and Remuneration Committee terms of reference.

27/17 **DATE OF NEXT MEETING**
28 April 2017 at 8.30am in the **Conference Room, Education Centre, Royal Bournemouth Hospital**

28/17 **ANY OTHER BUSINESS**

DD was recognised for his contribution to the Trust over the past eight years both as a Governor and as a Non-Executive Director. DD reflected that he had appreciated working with the Council of Governors in both his role as a Governor and as Senior Independent Director where he had been able to continue a positive working relationship with Governors.

Key Points for Communication:

1. Staff survey results
2. QI Programme end of year review
3. Information Governance Toolkit compliance and support from Information Asset Owners.

29/17 **COMMENTS AND QUESTIONS FROM THE GOVERNORS AND PUBLIC**

Concerns were raised about the referral to treatment times for lung cancer was raised given the United Kingdom had some of the poorest levels of survival in Europe. The Trust was part of the Wessex Cancer Alliance with University Hospital Southampton NHS Foundation Trust and the three acute trusts in Dorset. 50% of patients were receiving treatment within the 62 day target and breaches related to the complex diagnostic pathways. High risk groups were being targeted for proactive screening to allow earlier identification of the disease.

David Triplow briefed the Board on his recent attendance at a meeting of the Lead Governors of the foundation trusts in Dorset. He reinforced the importance of increasing engagement with governors at Poole Hospital and Dorset County Hospital NHS Foundation Trust as part of the CSR.

Clarification was sought on the function and composition of the Joint Programme Board. It was outlined that the purpose of the Joint Programme Board was to oversee the work to implement the CSR and reshape acute hospital services across Dorset. This would also include overseeing the development of the business case to secure the capital, planning work to understand how the CSR could be delivered across all three sites, developing the patient benefits case to support the lifting of the undertakings by the CMA and transformation of community services. The terms of reference were still to be agreed but would be provided to governors once finalised.

30/17 **RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS**

The Board resolved 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.

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
31.03.17	23/17	QUALITY			
	(c)	<u>2016/17 Quality Improvement Programme End of Stage Report</u>			
		Board members considered how to encourage more applications for the QI fellowship from junior doctors such as including training grade doctors in the QI alumni network and contacting them individually to get them involved in projects around the three priorities for 2017/18.	DMA/AOD	In Progress	Updates to be incorporated in the QI workbook.
		To increase engagement amongst staff and public awareness of the impact and significance of the QI priorities for 2017/18 it was requested that the key messages were distilled and shared with staff and the public more widely.	DMA	In Progress	Update to be provided at the meeting.
	23/17	PERFORMANCE			
	(d)	<u>Medical Directors Report</u>			
		Board members were keen to monitor progress on Sepsis and asked for this data to be presented in more detail.	AOD	In Progress/ Agenda	More detailed information to be provided in a future report and incorporated within the QI workbooks.
	25/17	STRATEGY AND RISK			
	(c)	<u>Trust Response to Dorset CCG Mental Health Acute Care Pathway Consultation</u>			
		It was requested that the response was shared with the ED team to ensure that the team's views were reflected in the response.	RR	Complete	Consultation now closed
24.02.17	14/17	QUALITY			
	(c)	<u>Medical Director's Report</u>			
		Feedback elsewhere had indicated that not all junior doctors were aware of the committee so this needed to be publicised more widely.	JD	In progress	Ongoing. To be put in place for the next meeting of the junior doctors committee.

		The next survey would commence in April 2017 and the follow up visits in Anaesthetics and Surgery in early 2017 were expected to be positive. It was requested that an update on the progress against the actions be provided to the Board in April.	AOD	April	Update to be included in the Medical Director's Report once data becomes available.
	(d)	<u>Complaints Report</u>			
		It was requested that complaints relating to the issue of consent be addressed in the next report.	PS		Action agreed to be closed with recommendations and actions provided to the Board on completion.
28.01.17	04/17	QUALITY			
	(d)	<u>Medical Directors Report - Mortality</u>			
		Provide an update on the progress from the interim medical examiners group at a future meeting.	AOD/ Agenda item	In progress	Update to be provided at future meeting. Newly published national guidance and local adjustments to the coroner's process are feeding in to this.
	(d)	<u>Workforce Report</u>			
		An update would be submitted to the Board on sickness absence following further review by the Workforce Strategy Committee	KA	April	Additional information will be brought back to the April Board meeting, following discussion at the Workforce Strategy & Development Committee meeting on 27 February 2017.
16.12.16	(d)	<u>Medical Director's Report – Mortality and Sepsis</u>			
		Provide an update on the progress with systemic anti-cancer outcome data performance.	AOD	June	Data not yet available and no firm date has been set nationally for this. Update to be included in the Medical Director's Report once data becomes available.
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	Agenda	Work is underway to triangulate the information. Differential spend on non-core medical staffing has been shared and has highlighted significant differences. Three areas have been identified for targeted work. Detailed metrics to be provided to the Board once finalised.
Key:	Outstanding	In Progress	Complete	Not yet required	

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would expect for our own families*

BOARD OF DIRECTORS

Meeting Date:	28 April 2017 Part 1
Subject:	Medical Director's Report
Section on agenda:	Quality
Supplementary Reading (included in the Reading Pack)	N/A
Officer with overall responsibility:	Alyson O'Donnell, Medical Director
Author(s) of papers:	Dr Tanzeem H Raza, Guardian of Safe Working Hours
Details of previous discussion and/or dissemination:	TMB March 2017
Action required:	Information
Executive Summary: A verbal report will be provided by the Medical Director at the meeting. The Quarterly Report on Safe Working Hours for Doctors in Training is attached.	
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?	

Quarterly Report on Safe Working Hours for Doctors in Training: Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust

Executive summary:

This is the first report since the introduction of the new junior doctors' contract in October 2016. This report summarizes work undertaken by the guardian for safe working hours so far. To date we only have 33 trainees on this contract. To date there have been 27 exception reports and all were completed in accordance with the requirement of the contract.

The new contract necessitates very specific work schedules for each placement. It also needs a very active engagement from educational and clinical supervisors with additional demand on their time.

1. Introduction:

The role of Guardian of Safe Working Hours is an integral part of the 2016 trainee doctor's contract with a fundamental remit to ensure that the doctors working hours remain safe. The guardian is responsible for protecting the safeguards outlined in the 2016 contract terms and conditions of service (TCS) for doctors in training. The guardian needs to ensure that issues of compliance with safe working hours are addressed, as they arise. In addition the guardian needs to provide assurance to the trust board that doctors' working hours remain safe. I was appointed to this role on 27 July 2016.

Two O&G ST3 and above trainees were transferred on to the new contract in October 2016 followed by 32 Foundation year 1 trainees in December 2016. This is my first quarterly report to the Trust Board.

2. Activity so far:

- Attendance and presentation about guardian role at the induction of junior doctors in July (F1s) and senior trainees on 3 August 2016
- Attendance at the national meeting for guardians July 2016 – next meeting on 14 March
- Established a joint (with the DME) Junior Doctors committee with monthly meetings
- Working closely with the DME and Education Centre manager re contractual issues for trainees
- Setting up and attending monthly meetings of the steering group for implementation of the new contract
- Discussions of the guardian role with the (previous) Medical Director
- Presentation to the Trust Board on 2 September 2016
- Presentation on the role of the guardian to the Medical Staff Committee
- Attendance at the guardians meeting at the deanery
- Presentation at the Directorate of Anesthesia about the role of the guardian
- Presentation to F1s before introduction of the new contract in December
- Working closely and supporting medical workforce team re introduction of the new contract
- Liaising with trainee doctors, supporting them with their concerns

- Liaising with and supporting Educational/clinical supervisors in dealing with exception reports
- Reviewing exception reports as they are raised.

3. Issues:

New contract has yet to be embedded in the working of trainee doctors. There was a considerable unease at the start particularly in the context of industrial action led the BMA. However there appears to more acceptance of the new changes although many trainees remain quite apprehensive particularly those who might wish to work on less than full-time basis.

The new contract has very strict limitations on the working hours and that might have implications about the flexibilities in any rota affecting rota swaps or ability to cover colleagues etc.

However we have only had a limited experience (31 F1s since December) to see any specific pattern and draw any meaningful conclusions.

4. Exception Reports between 5 October 2016 and 1 March 2017:

Number of doctors / dentists in training (total):	170
Number of doctors / dentists in training on 2016 TCS (total):	33
Amount of time available in job plan for guardian to do the role:	1.5 PAs per week
Admin support provided to the guardian (if any):	0.2 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

4.1 Exception reports:

Since the introduction of new contract there have been a total of 27 exception reports – 24 about extra hours and 3 about educational opportunities/supervision issues

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	0	4	4	0
OPM/MFE	0	9	9	0
Cardiology	0	3	3	0
Psychiatry	0	5	5	0
Medicine	0	3	3	0
Educational		3	3	0
Total	0	27	27	0

All exception reports so far have been resolved at the level of educational/clinical supervisor.

5. Work schedule reviews:

The maximum number of exception reports was generated in OPM particularly in ward 4, which suggested a possible pattern rather than a one-off issue. As a result I had a preliminary meeting with the clinical director Dr Andrew Williams who is looking into the work pressures and patterns as well

as availability of middle grade support before considering a formal work schedule review. None of the exception reports so far has identified any specific issues with a particular rota or a part of a pattern that would require a work schedule review. Instead almost all exception reports have resulted from one-off unexpected circumstances like a colleague's absence or a patient getting unwell, which required the F1 to stay on longer. Almost all exception reports have resulted in compensatory payment to the doctor in question except in one case where time in lieu was agreed. Total compensatory payment so far has been £356.90 (this equates to a total of overtime 28.25hrs @ £12.6336 per hour).

6. Locum usage:

None of the F1s in medicine on this new contract has done any locum shifts during this time. Only 2 F1s have performed some locum work in surgery who had to be remunerated at the agreed locum bank rate.

7. Vacancies:

There were three gaps at registrar level as the deanery could not fill those posts. In addition there were gaps at SHO level in Emergency medicine as well as on going gaps in the Trust SHO posts. These vacancies can have some indirect effect on the working of F1 doctors who are on the new contract.

8. Next Steps:

Most of the remaining trainee doctors including the next batch of F1 doctors (total of 147 trainees) are due to be transferred on to the new contract in August 2017 which will entail a major piece of work by medical HR as well as by the guardian. In addition 5 new trainees will join in September 2017 and 15 in October 2017 and will be employed on the new contract. I am unable to give an estimated cost of these transitional arrangements at this stage.

The next report will be presented in June Trust Board meeting

Dr Tanzeem H Raza

Guardian for Safe Working Hours

03 March 2017

BOARD OF DIRECTORS

Meeting Date and Part:	28 April 2017 Part 1
Subject:	Performance Report to the end of March 2017
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack)	Performance Matrix
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Donna Parker / David Mills
Details of previous discussion and/or dissemination:	PMG, Finance Committee
Action required: Approve / Discuss / Information / Note	<p>The Trust Board is requested to note the performance exceptions to the Trust's compliance with the 2016/17 STF, Monitor Framework and contractual requirements.</p> <p>This includes compliance with STF trajectories and tolerances to date.</p> <p>Finally, the Board is also requested to note the detailed report on RTT and Diagnostics performance.</p>

Summary:

Overall the Trust has remained in a good position and compared to other trusts on performance. The Sustainability and Transformation Fund (STF) is expected to be achieved for the 4 key metrics (A&E 4 hour, RTT and Diagnostics 6 Week Wait) for Q4:

- **Diagnostics 6 Week Wait** – met national target and above NHS England performance.
- **A&E 4 hour** – met trajectory. Just below 95% for the year (94.6%) and continuing to benchmark in the national top quartile or higher on a monthly basis.
- **Cancer 62 Day** – expect to exceed monthly target in March, thereby achieving the national target for Q4. Above NHS England performance through most of the year.
- **RTT 18 Weeks** – Improved position expected in March (min of 91.7%) and within STF trajectory tolerance, though just below national 92% threshold. Above England average through the year.

All other Single Oversight Framework (SOF), NHS Constitution and key contractual targets were met for March except 28 Day Rebook Following Cancellation and Breast Two Week Wait was also below threshold in February (last reported month).

As per the quarterly reporting cycle, the report includes a focus this month on RTT and Diagnostics performance.

Going forward to 17/18, the 'Next Steps on the NHS Five Year Forward View' (FYFVNS) document, published on 31 March 2017, outlines A&E 4 hour as the single biggest national priority for 'performance'. However, the other key indicators above also form the operational performance metrics within the Single Oversight Framework (SOF), contributing to our NHS Improvement assessments and segmentation.

The new SOF dashboard for 2017/18 performance reporting will replace the existing performance matrix from next month.

Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 Yes Yes Yes Yes
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	The following risk assessments continue to be under regular review in light of the latest performance and STF rules of engagement: <ul style="list-style-type: none"> • Cancer 62 day wait. • 4 hour target due to improved performance. • RTT due to reduced performance in the latter part of the year. • The Trust's Urgent Care Risk Assessment based on the 4 key elements: Flow/frontdoor; Stranded Patients; Deteriorating Patient and Sepsis.

1. Executive Summary

The Sustainability and Transformation Fund is expected to be achieved for all of the 4 key metrics in March.

A&E 4 hour (12.5% of funds) –

Achieved 94.5%, above our trajectory requirement of 93% and secured STF. 94.6% for the year and in the national top quartile or higher on a monthly basis.

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

84.1% in February and March is expected to exceed the monthly target, thereby meeting the target and STF for the Quarter. Remained above the England performance through most of the year.

Diagnostics 6 Week Wait (0% of funds) –

Compliant in March achieving 99.9%, above the 99% threshold for STF and well above England performance each month.

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

February performance was 91.2% and March is expected to be a minimum of 91.7% thereby securing STF though below the national target and our trajectory of 92%. We remained above the England RTT performance month on month.

All other Single Oversight Framework, NHS Constitution and key contractual targets were met for March except 28 Day Rebook Following Cancellation and Breast Two Week Wait, with a very small number of breaches against each.

2. Key Risks to Performance

RTT 18 Weeks Incomplete Pathways – we will need to continue our recovery programme to fully achieve RTT at 92% on a sustainable basis. It should be noted however, that whilst undertaking additional

work to reduce backlogs, waiting lists and/or manage demand appropriately; a number of specialities have also seen a consequential reduction in the total number of patients on the 'incomplete pathways' waiting list. This has meant an increased number of backlog patients need to be treated proportionately to achieve 92%. Improvements were seen in some key specialities including Urology, Ophthalmology and Gastroenterology in the year. However, key risks remain in relation to Orthopaedics, Dermatology and visiting specialities. There is further overall risk in relation to the nationally recognised challenge of balancing routine treatments against urgent and cancer care demands as well as the financial challenge. Action plans are place.

A&E 4 hour – our QI work and winter planning continued to support our strong position, remaining within the top quartile in the country. Increased activity (7.2% non elective admissions YTD) and acuity, together with the limited social and community care capacity remains a risk. Therefore, the next phase of our QI programme on Flow, together with nationally mandated initiatives such as front door streaming (to include primary care), 7 day services and 'discharge to assess', will be key. It should be noted that the performance element of the STF will only be attributable to the A&E 4 Hour Target in 17/18 (30% of total STF - £1.92m).

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. This currently remains under review with commissioner support. A further risk is sudden absence of key medical staff and we also continue to work across providers to review pathways.

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 continue to be the key risks which are monitored. Additional activity and the potential for outsourcing continues. Planning for Cath Lab refurbishment will also be key.

Performance Report



For the period to end March 2017

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 March 2017 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 to be secured for Q4 with all 4 key targets being within the agreed tolerances.

Table 2 - Sustainability and Transformation Fund 2016/17 Key Indicators								
Target or Indicator (per Risk Assessment Framework)	National Target	STF Trajectory Target	Q4 16/17					
			Jan-17		Feb-17		Mar-17	
			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		**Est. within STF YTD tolerance threshold
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	90.0%		Above STF trajectory		Above STF trajectory		Above STF trajectory
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	85%		Est. within STF YTD tolerance threshold for Q4*		Est. within STF YTD tolerance threshold for Q4*	est.***	Est. within STF YTD tolerance threshold for Q4*
Diagnostic 6 week wait	99%	99%						

*Validated final Quarter position awaited - upload is early May
 **Await final upload 21/4 and NHSI confirmation
 ***Validated Mar performance awaited - upload is early May

Exception reporting to our commissioners and NHSI continues to be required in relation to 3 of the key targets (RTT, A&E 4 Hour and Cancer 62 Day) as well as for Delayed Transfers of Care, recognising that we remained within the STF YTD tolerances. This month we have also been required to provide a report for Breast Two Week Wait (see section 2.2). Overall however, the Trust has remained in a good position and compared to other trusts on all metrics.

Looking forward into 17/18, all 4 key targets will remain central to NHS Improvement's monitoring of our operational performance against the NHS Constitution and their segmentation (for mandated or other support) criteria. Failure for two consecutive months against any of the targets, significant deterioration or multiple failure across

targets, will trigger consideration of escalation. However, conditions relating to the operational performance elements of the Sustainability and Transformation Fund will only apply to the A&E 4 hour target, with 30% of the £6.4m fund being attributable (i.e. £1.92m at risk). We await guidance from NHSI in relation to their application of our submitted trajectories. These trajectories have reflected risk in relation to the targets as highlighted in last month's report; in particular RTT, Cancer 62 Day and A&E 4 hour.

These risks will require close monitoring and management.

RTT Incomplete Pathways (18 week) and 52 Week Breaches

Performance against the RTT Incomplete Pathway indicator for March 2017 is anticipated to be just below the 92% target with a minimum of 91.7% expected. The validated position will be available after 21 April following final submission to NHS England. However, this is a further improved position on the previous months (February 91.2%). We remained above (better than) England RTT performance through the year.

It should be noted however, that whilst undertaking additional work to reduce backlogs, waiting lists and/or manage demand; this position did reflect a consequential reduction in the total number of patients on the 'incomplete pathways' waiting list. This has therefore, meant an increased number of backlog patients need to be treated proportionately to achieve 92% in the month. This will assist waiting times and RTT pathways going forward but there will be a lag time to realise this benefit.

Further detail on improvements in a number of specialities, together with ongoing work in non-compliant specialities is outlined in Section 3.

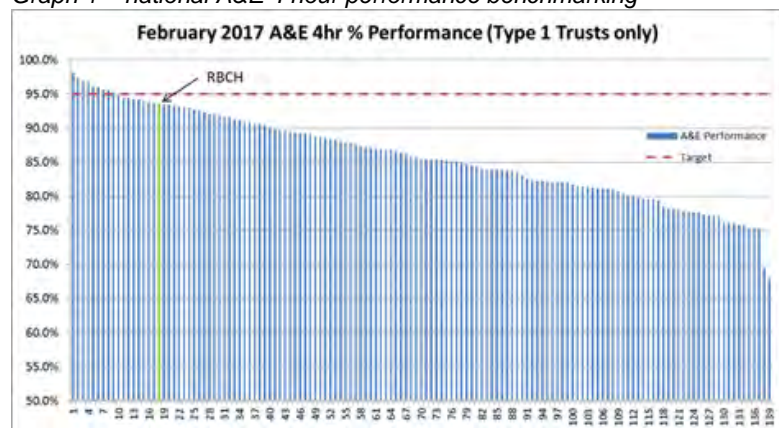
The challenge of balancing routine RTT backlogs with emergency and urgent/cancer care alongside the financial challenges for 17/18 has

been recognised by NHS England. Going forward our joint work across Dorset, including with GPs, on wellbeing initiatives to optimise patients for surgery as well as improved referral pathways which support advice to GPs and care closer to home; will all be key to managing our elective care in this context. This however, also has the potential to impact on RTT performance as alternatives are developed for simpler secondary care pathways.

No patients breached 52 weeks in February.

A&E 4 Hour Target and 12 Hour Breaches

Graph 1 – national A&E 4 hour performance benchmarking



The graph above shows our overall performance against the 4 hour target in February 2017 compared against the other Trusts with a Type 1 A&E Department. It continues to highlight the significant pressures faced by all Emergency Departments during February with only 9 providers above 95%.

Our performance improved to 93.5% in February and compares well Nationally, being 18th out of the other Type 1 Trusts.

In March we saw an increase in patients attending A&E and levels returned to pre February activity. 2016/17 attendances (types 1 & 2) were 6.4% above last year. Urgent care admissions also continued above last year's levels with a 7.2% increase. Performance improved slightly by year end to 94.6% for the year, remaining a strong position when benchmarked nationally and above our STF trajectory to secure funds. March performance also increased to 94.5%.

No patients waited longer than 12 hours to be admitted.

62 Day from Referral for Suspected Cancer to Treatment

For the month of February (*last formal reported month*) there were 14.5 breaches, under the 85% performance tolerance at 84.1%. This was a marginal improvement on the previous month. Whilst patient choice, medically related delay and capacity resulted in a few breaches, complexity of diagnostic pathways (2.5) and transfers between providers (3) were the two most common dominant reasons. There were 7 breaches across 6 specialities and 7.5 breaches in Urology (a much higher volume tumour site). The trust performance remained well above (better than) England performance for most months across the year.

Diagnostic 6 Week Wait

Our positive position continues in March with the final validated performance achieving over 99.9% and well above national performance. Interestingly both activity and our waiting lists increased in March, though there does not appear to be an apparent trend. This will be monitored. Performance currently remains on track in the key areas (Endoscopy, Radiology, Cardiology and Urology) though this continues to be closely managed. See detail in Section 3.

2.2 Other Single Oversight Framework, NHS Constitution and Contractual Indicators

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. March month performance is currently expected to be fully compliant.

Table 3 - Cancer and Infection Control Indicators

		16/17									
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
									Jan	Feb	Mar
Target or Indicator (per Risk Assessment Framework) not included within STF	%	Pred	Pred	Pred	Pred	Actual	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 May 17.

Unfortunately, we were just below threshold against the Breast 2 Week Wait target in February with 1 patient breach due to patient choice. Whilst we do expect compliance in March, sudden unplanned sickness absence has meant additional and locum sessions are required to sustain capacity. Substantive cover will be in place from July.

Detailed performance (%/no.) is included in the Performance Matrix. As highlighted above, a key risk to the cancer indicators remains the changing referral thresholds for GP fast track referrals which commenced from January and is being monitored. Furthermore, our close management of demand and capacity in relation to all elective

care (including cancer and RTT pathways) in light of the financial challenge for 17/18 will be key.

In relation to the C Difficile performance, there was one case due to lapse in care in March taking us to 2 cases above our annual stretch target of 14 (with a total of 16). Detailed reviews continue to take place on all cases.

Other Indicators

See Performance Indicator Matrix for full performance detail.

Compliance was maintained on all other reported key targets in March excepting two breaches of the 28 Day Rebook Following Cancellation standard. The 1st cancellation required joint input between Breast and UGI making it more difficult to reschedule within the 28 day limit. The 2nd cancellation was rebooked within 28 days; however due to the specialist case and leave required by the surgeon it unfortunately had to be rescheduled to outside 28 days. Both patients have now been treated.

2.3 Performance Reporting 2017/18

Following approval at the last Board, the new 2017/18 reporting dashboard of metrics relating to the Single Oversight Framework will be implemented from next month. This integrated dashboard will be submitted to the Trust Board of Directors monthly and be supported by the Executive Summaries for each of the key areas e.g. Quality, Performance, Finance. The Performance full narrative report will continue to focus on the key aspects (4 SOF Operational Performance Metrics). Exception reporting on other performance metrics included in the SOF and/or key contractual/local priorities will continue, as well the quarterly focus on the key themes (as per Table 1) which will continue to include trends and forecasting where appropriate.

3. Performance Focus - RTT, Diagnostics and Cancelled Operations

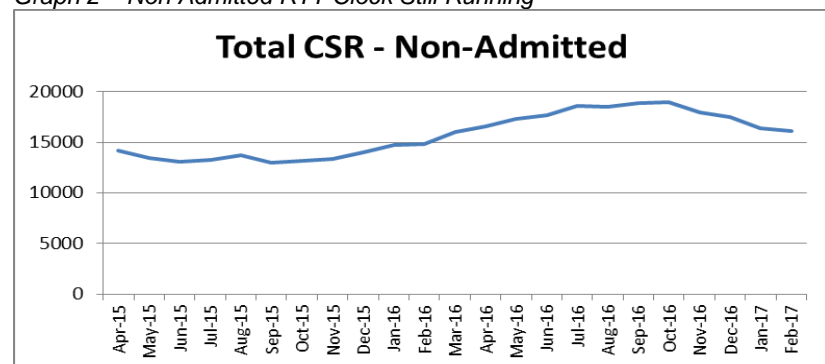
3.1 RTT 18 Weeks – Clocks Still Running

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
CLOCK STILL RUNNING (CSR) PERFORMANCE	92.3%	92.4%	92.4%	92.2%	91.8%	91.2%	91.4%	91.4%	90.3%	91.1%	91.2%
Total CSR (Patients)	23,237	23,938	24,072	24,997	24,868	25,174	25,526	24,456	24,210	23,205	22,822
Total CSR >18wks (Patients)	1,797	1,817	1,842	1,955	2,033	2,211	2,204	2,101	2,360	2,065	2,011

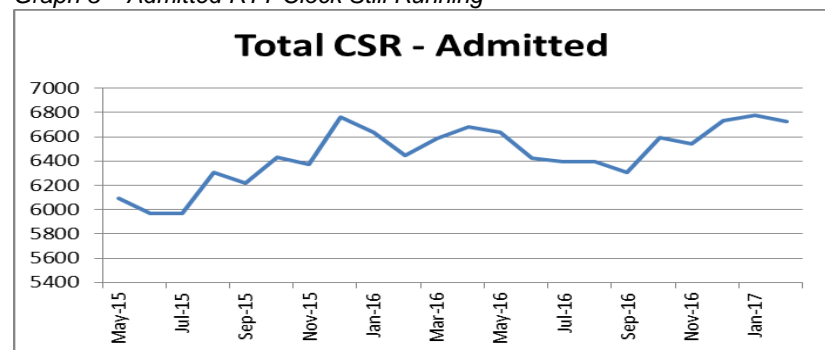
Table 4 – RTT 18 Weeks Clock Still Running Performance

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

Graph 2 – Non Admitted RTT Clock Still Running



Graph 3 – Admitted RTT Clock Still Running



Through the year our overall list grew, reflecting:

- 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.

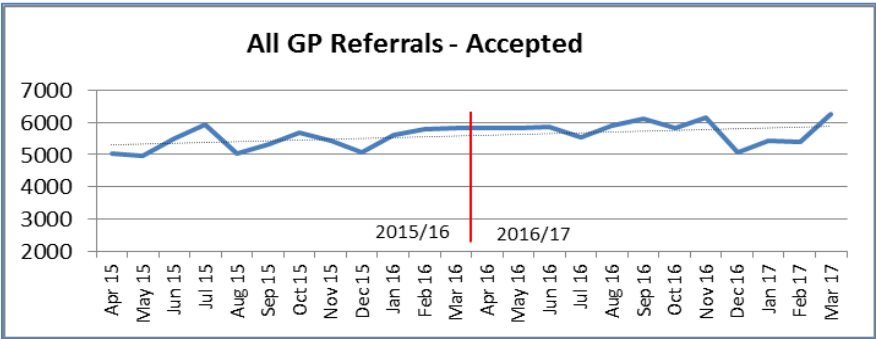
However, as a result of the recovery programme over recent months, we have finally seen the total list drop below April 2016 levels, with the number of both admitted and non admitted open pathways reducing. However, whilst the number of patients over 18 weeks has also reduced this is still not entirely proportionate to the overall reduction meaning that performance has remained below 92%. We do however, expect March performance to be much closer to 92%, at a minimum of 91.7%

3.2 Referrals

March saw the highest number of monthly accepted GP referrals with 6272 against an average of 5763 in 16/17. Over the year referrals increased by 6.2% against 2015/16. This demand has contributed to the increased challenge in maintaining RTT performance through the year. 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. 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*). This work includes improving the advice given to GPs to support patient care closer to home, as well as other health and wellbeing initiatives for patients to ensure they are as fit as possible

and will get the most benefit from surgical and other treatments. Further information will be provided in subsequent reports.

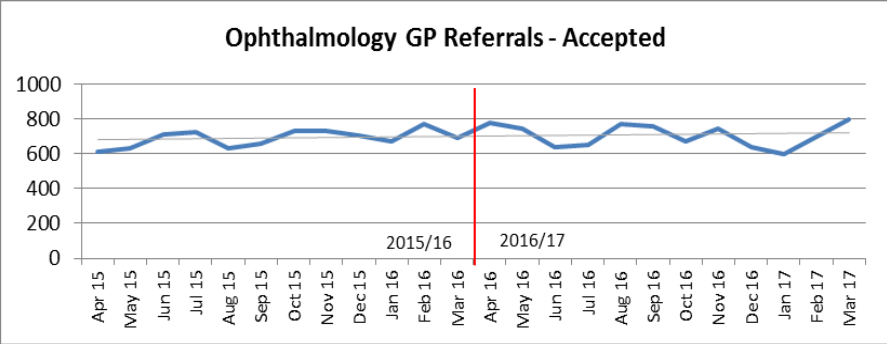
Graph 4



The following referral trends have been seen in the 9 key specialities at RBH:

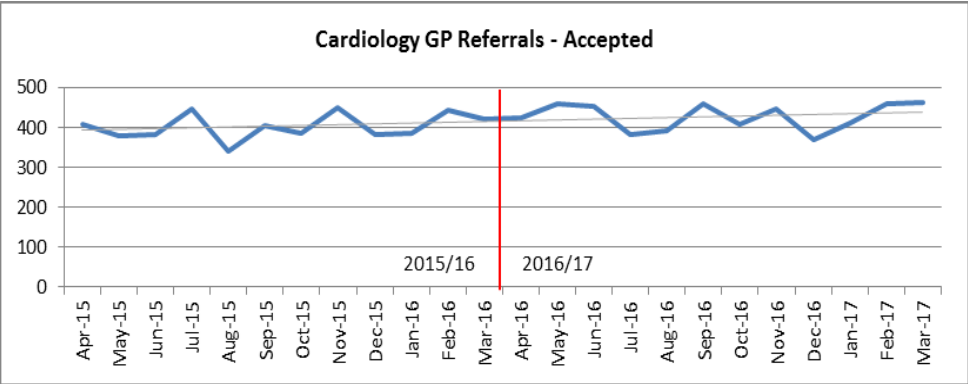
Ophthalmology +2.5% YTD on last year. Whilst the underlying trend has remained upward, growth this year is much lower than previously (+18.2% from 14/15 to 16/17). This may be an early sign of the positive outputs of our referral process and bookings work, however, this remains under review as an increase in March indicates some variation. Reduced waits can also result in patients choosing our services above others and this will need to be monitored.

Graph 5



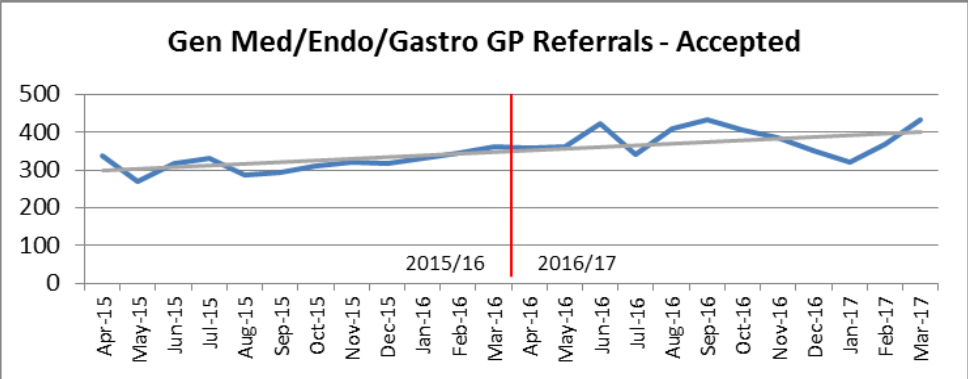
Cardiology +6.2% YTD compared to last year.

Graph 6



Gastroenterology and General Medicine +20.1% YTD compared to last year. As with Ophthalmology, significant work to improve outpatient waits may have contributed to the increase in referrals in March.

Graph 7

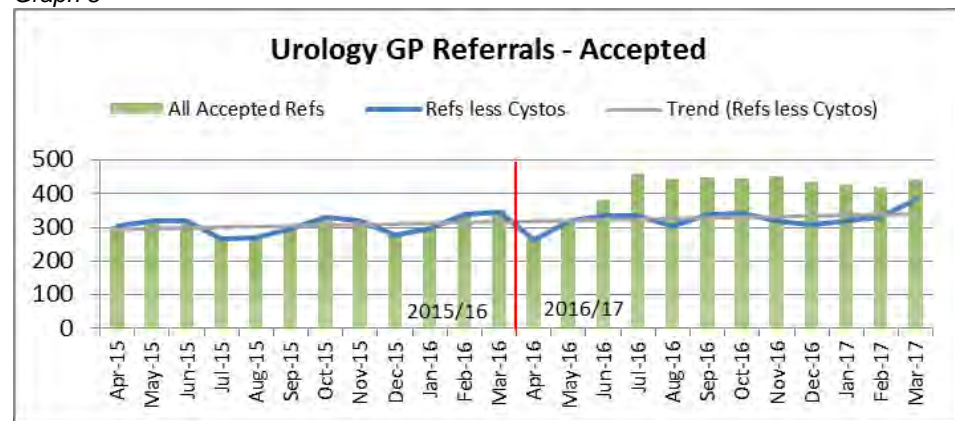


Performance Report

As at 19/04/2017

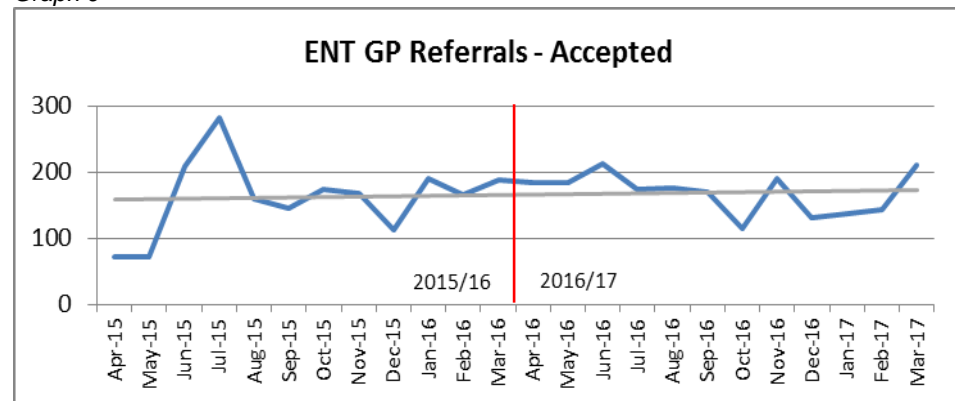
Urology +5.9% (excl pathway change relating to Cystoscopies).

Graph 8



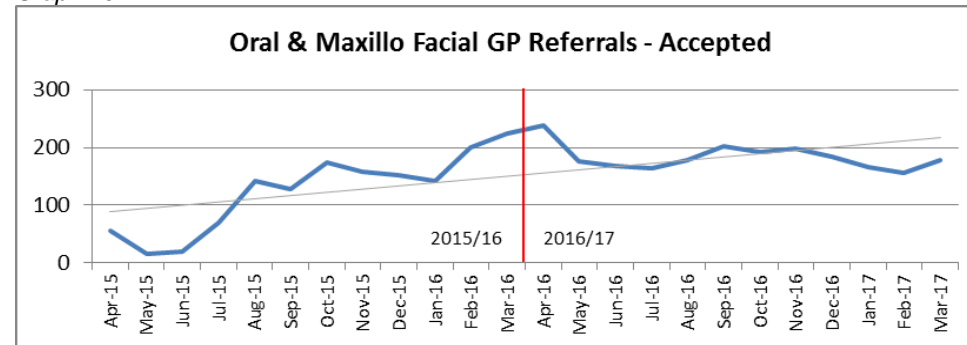
ENT +4.5% YTD compared to last year

Graph 9



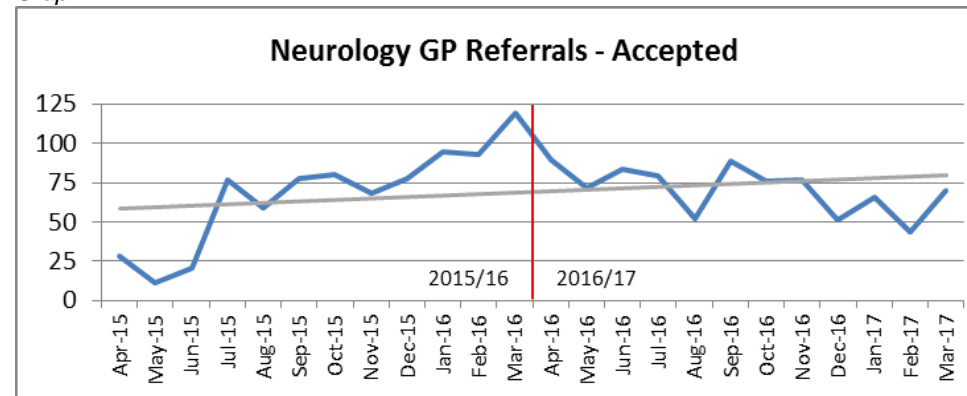
Oral Surgery & Max Fac +48.9% YTD compared to last year (though noting a pathway change during 2015).

Graph 10



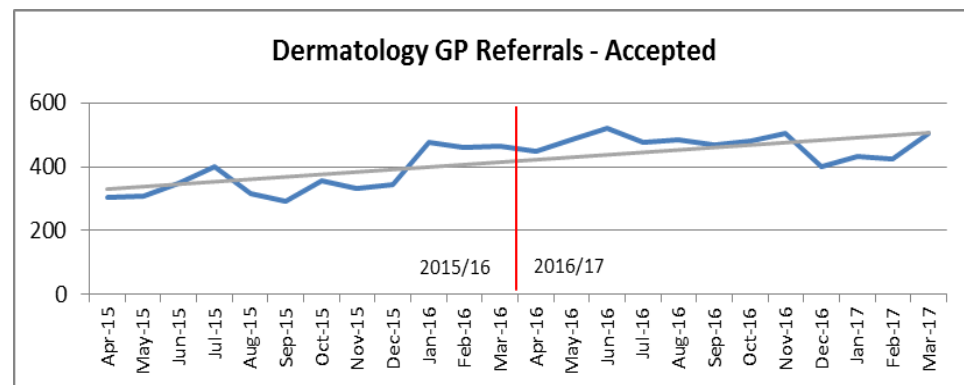
Neurology Noting a pathway change during 2015, comparing 14/15 to 16/17 there is a reduction of 24.1%, however, this continues to be monitored across the provider trusts.

Graph 11



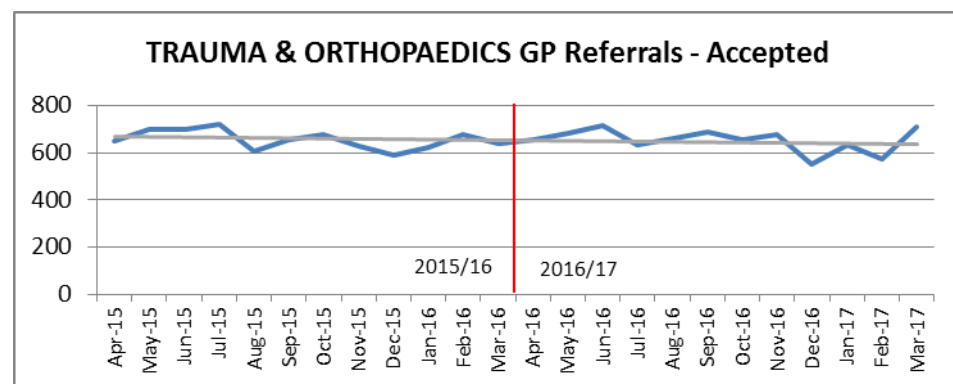
Dermatology +28.0% YTD compared to last year (though noting a pathway change last year).

Graph 12



TRAUMA & ORTHOPAEDICS has remained relatively stable this year at -0.4% YTD compared to last year, however, maintaining these levels will be key to managing the financial challenge for 17/18.

Graph 13

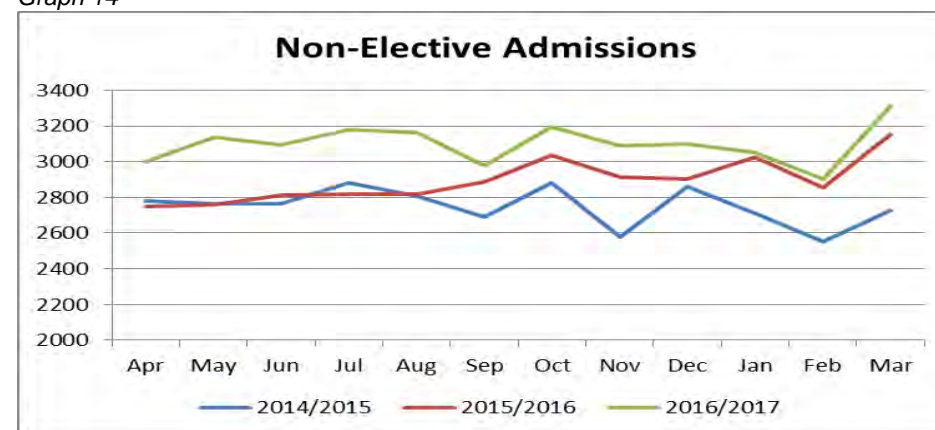


3.3 Emergency & Elective Admissions and Outpatient Activity

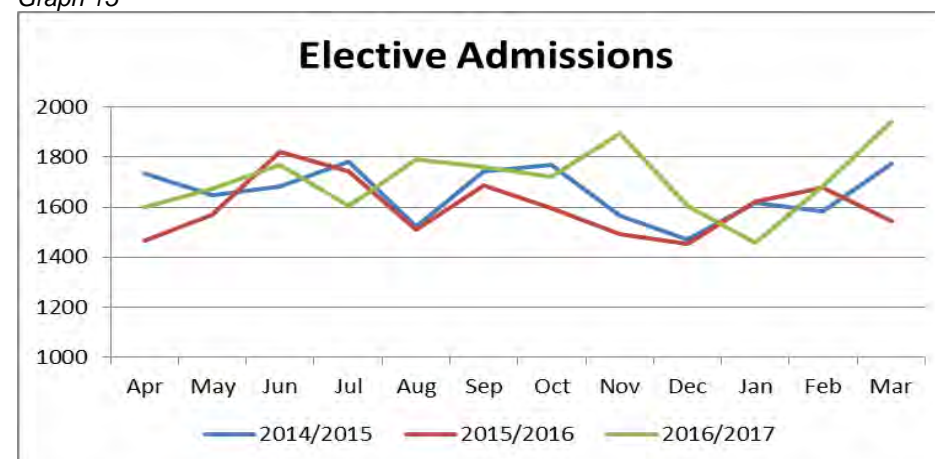
Emergency and Elective Admissions

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 14



Graph 15



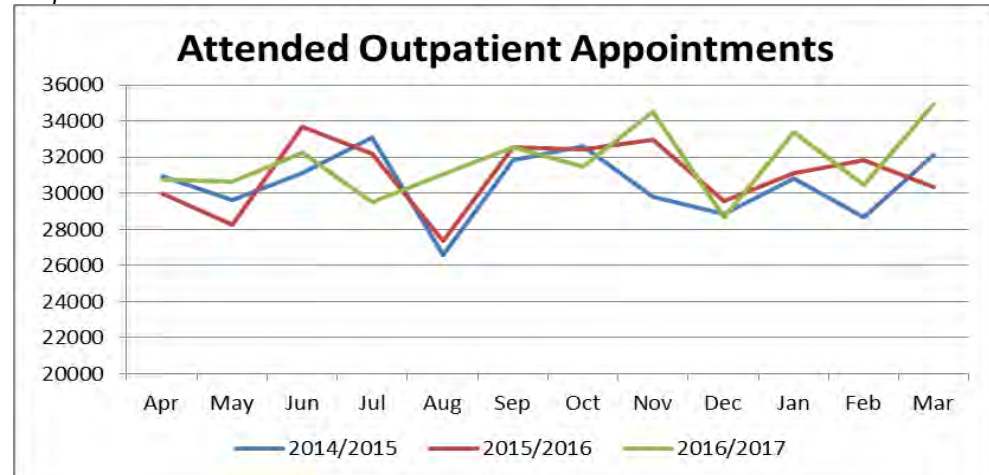
Performance Report

As at 19/04/2017

Inpatient elective activity has, however, increased by 6.9% from April 2016 to March 2017 compared to the same period last year. This is despite a corresponding increase of 7.2% 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 ring fence the Derwent Orthopaedic Unit during that period and prior to winter.

Outpatient Activity

Graph 16



Overall outpatient activity for new patients has increased on last year (6.3%) though a slight reduction has been seen in follow ups -0.9%. 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.

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; efficiency and demand optimisation approaches. This will continue to be key as part of the Dorset-wide programme referenced above.

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	Jan-17	Feb-17
100 - GENERAL SURGERY	90.9%	90.7%	91.0%	92.1%	91.5%	91.07%	90.73%	91.10%	91.61%	91.59%	90.76%
101 - UROLOGY	81.8%	84.9%	85.5%	85.1%	88.9%	88.34%	90.95%	93.03%	92.51%	93.37%	92.87%
110 - TRAUMA AND ORTHOPAEDICS	90.8%	90.7%	91.5%	91.6%	91.7%	90.48%	90.21%	88.80%	86.14%	85.41%	84.65%
120 - EAR NOSE AND THROAT	92.7%	90.8%	90.9%	90.5%	91.2%	90.26%	86.88%	88.14%	88.24%	87.34%	91.82%
130 - OPHTHALMOLOGY	91.4%	90.1%	89.0%	89.5%	87.4%	87.83%	89.07%	90.48%	88.71%	92.40%	93.06%
140 - ORAL SURGERY	99.3%	99.6%	98.3%	97.5%	92.0%	88.58%	88.44%	90.41%	89.07%	88.05%	89.28%
170 - CARDIOTHORACIC SURGERY	100%	100%	100%	100%	100%	-	100.00%	100.00%	100.00%	87.50%	100.00%
300 - GENERAL MEDICINE	96.9%	97.4%	96.4%	96.4%	95.3%	93.50%	91.85%	90.93%	90.17%	91.19%	94.66%
301 - GASTROENTEROLOGY	-	-	-	-	-	-	-	-	-	-	-
320 - CARDIOLOGY	91.5%	95.3%	96.1%	94.4%	95.7%	95.05%	94.87%	96.42%	95.28%	96.09%	96.36%
330 - DERMATOLOGY	97.8%	97.4%	96.6%	95.2%	94.3%	92.43%	92.84%	89.38%	87.86%	89.75%	86.72%
340 - THORACIC MEDICINE	96.4%	98.2%	99.1%	98.6%	98.5%	99.73%	98.91%	98.92%	98.65%	97.88%	97.97%
400 - NEUROLOGY	98.8%	97.1%	94.5%	96.2%	94.3%	92.17%	94.13%	93.92%	91.51%	95.64%	90.87%
410 - RHEUMATOLOGY	97.8%	97.2%	97.0%	95.0%	94.7%	96.27%	96.87%	97.00%	95.65%	97.17%	96.63%
430 - GERIATRIC MED	100.0%	100.0%	98.9%	97.4%	96.4%	98.90%	98.92%	98.84%	96.75%	95.10%	93.75%
502 - GYNAECOLOGY	90.5%	90.6%	89.5%	87.7%	88.4%	88.82%	91.18%	90.36%	91.72%	94.58%	93.61%
Other	94.5%	95.4%	96.6%	95.5%	95.4%	92.43%	91.74%	90.98%	90.29%	90.82%	92.52%
TOTAL	92.3%	92.4%	92.3%	92.18%	91.82%	91.22%	91.37%	91.41%	90.25%	91.10%	91.19%

Table 5 – Clocks Still Running Speciality Performance

As highlighted in Section 2.1 above, a number of specialities were below 92% at speciality performance level in February, reflecting the challenges outlined. Reduced proportionate 18 week backlogs have however, been seen in a number of specialities as a result of improvement to date. Urology have sustained their position both in admit and non-admit pathways and continue their work as part of the Dorset-wide Right Referral, Right Care Programme. Referral process

Performance Report

As at 19/04/2017

work together with backlog clearance capacity and innovative efficiency improvements in Ophthalmology has now seen performance return to a compliant position. Likewise, these and further actions continue as part of the Dorset programme. Furthermore, significant work to improve Gastroenterology outpatient pathways and reduced waits, as well as improved capacity and pathways in Gynaecology have also returned them to 92%+ performance.

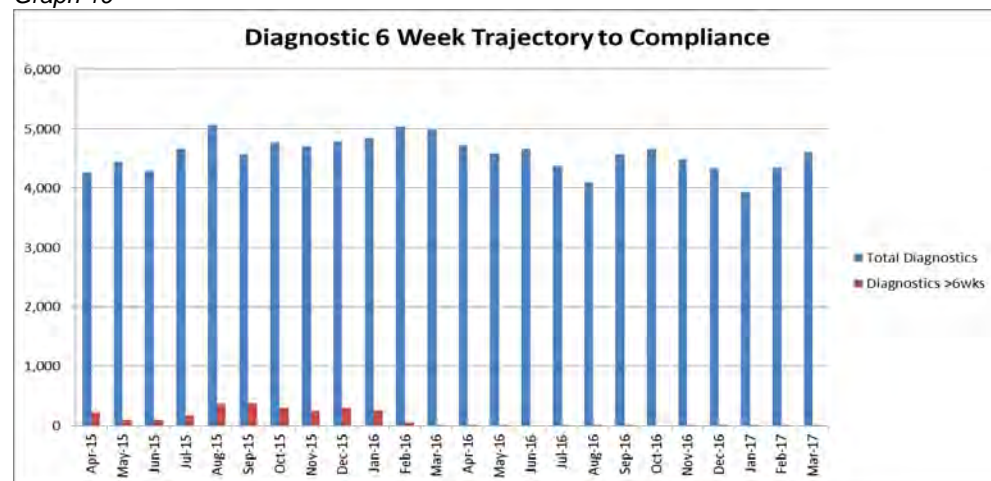
The following indicates the actions being taken across those specialities that continue to be below the 92% threshold, noting the challenge recognised by NHS England in balancing urgent and routine care, together with the overall NHS financial challenges. As a Trust however, we continue to focus on patient pathways and ensuring the majority of patients are treated within expected and clinically appropriate waiting times.

To support this and as part of our improvement work, we have invited the NHS Improvement Team to undertake a 'critical friend' review of our RTT processes. This is planned for April and outputs will be included in our future Board reports.

Speciality	RTT Key Issues	Recovery Plans Underway
ENT	<ul style="list-style-type: none"> - Medical staff shortages at provider Trust impacting on capacity available at RBH - 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 Right Referral, Right Care Programme
Oral Surgery	<ul style="list-style-type: none"> - Unplanned medical staff shortages at provider Trust impacting on capacity available at RBH - 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 Right Referral, Right Care Programme to include stakeholder and education session (May/June)
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 including nurse specialist support - Key speciality in the Dorset-wide Right Referral, Right Care Programme to include further development of Advice & Guidance process for GPs during Learning Week (May)
Allergy	<ul style="list-style-type: none"> - Capacity at provider Trust impacting on capacity available at RBH - Increased demand 	<ul style="list-style-type: none"> - Working with CCG to repatriate to lead provider trust, supporting local service - Additional sessions
General Surgery	<ul style="list-style-type: none"> - 45% increase in overall admitted backlog since April - 2% increase in overall non admitted backlog but in year peaks which have impacted in year or by transferring to admit list - Vascular non admit backlog - Colorectal non admit backlog - Increasing trends in Colorectal & Vascular admit backlogs - In year peaks in UGI and Breast admit backlogs - Breast sudden unplanned Dr absence - Additional medical posts focused on urgent care activity 	<ul style="list-style-type: none"> - Substantive consultant posts now in place in Colorectal, Upper GI and Vascular - need to review balance elective routine with non elective and urgent/cancer treatments - Manage down tails following peaks earlier in year - Backfilling to prevent lost lists during leave etc (e.g. UGI) - Breast locum, substantive arrangement from July - Theatre efficiency QI programme
Orthopaedics	<ul style="list-style-type: none"> - 100% increase in admit and non admit backlogs - increase non admit backlog patients (outpatient pathways) impacting on late additions to admit waiting list - sub speciality medical staff gaps increasing individual specialist backlogs - late transfers from other providers (esp where trauma capacity has been pressured at other providers) - impact of winter pressures 	<ul style="list-style-type: none"> - Ringfencing of Derwent Unit for Ortho - Backfill of/recruitment to medical vacancies - Theatre QI programme - Key speciality in the Dorset-wide Right Referral, Right Care Programme to include rollout of patient decision support video and CHAIN programme - Process improvement (e.g. PAC and TCI cards) to reduce pathway delays - Winter planning to minimise impact on elective activity reductions
Dermatology	<ul style="list-style-type: none"> - Continued demand vs capacity challenge - Mohs capacity - Referral increase - Follow up backlog - Key nurse gaps 	<ul style="list-style-type: none"> - Substantive consultant post and other (fixed term) posts now in place - Advertisement for Mohs sessions - Additional sessions - Key speciality in Dorset-wide Right Referral, Right Care Programme to include Telederm/A&G pilot in Learning Week

3.5 Diagnostic 6 Week Wait Trends

Graph 19



Overall the diagnostic waiting list has remained relatively stable though with some monthly variation. 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 through the year.

As highlighted earlier, the biggest risks to diagnostics currently are the new fast track referral forms and the 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. In addition, planning for the Cath Lab refurbishment programme will be key to maintaining current patient waiting times.

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 0.57% of total elective admissions and we have had a very small number of 28-day breaches (9) 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 some cancellations, these have generally been cancelled the day before and rearranged quickly.

4. Recommendation

The Trust Board or 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.

Finally, the Board is also requested to note the detailed report on RTT performance.

BOARD OF DIRECTORS	
Meeting Date and Part:	28 April 2017 Part 1
Subject:	Quality Report
Section on agenda:	Performance
Supplementary Reading (included in the Reading Pack):	n/a
Officer with overall responsibility:	Paula Shobbrook, Director of Nursing and Midwifery / 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"> • No Serious Incidents reported in March 2017. • New Harm Free Care score has improved from 96.1% in February to 98.1% in March 2017. • The Trust remains in the top quartile for inpatient and ED Friends and Family test scores. • Formal Complaints acknowledgement and response time performance is 87% sustaining the performance above the Trust standard of 75%. • Verbal Concerns response time performance is 99%. • Written concern response time performance is 97%. • Focus remains on quality of responses. 	
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 March
2017**

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 2017/18.

2.0 Serious Incidents

- 2.1 No Serious Incidents were reported in March 2017.

The Trust reported and investigated 25 serious incidents in 2016/17. This compares with 32 in 2015/16, 46 in 2014/15 and 66 in 2013/14.

The reduction in 2016/17 (22%) therefore represents a continued annual trend of improvement in patient safety.

The most significant reductions (over 50%) were seen in the reduction of serious incidents relating to patient falls and hospital acquired pressure ulcers.

3.0 Safety Thermometer

- 3.1 The Trust New Harm Free Care score has improved significantly in month as a result of a decrease in the hospital acquired pressure ulcers (5 compared to 10 in February 2017), falls with harm (3 compared to 5 in February 2017) and hospital acquired VTE (0 compared to 3 in February 2017).

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	85.41
Feb	89.51	83.80
Mar	89.29	86.87

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	95.76
Feb	98.35	96.11
Mar	96.77	98.16

4.0 Patient Experience Report – April 2017 (containing February 2017 data)

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

The national performance benchmarking below is taken from the national data provided by NHS England which is retrospectively available and therefore, represents February 2017 data.

- Inpatient and day case Friends and Family Test (FFT) national performance in February 2017 ranked RBCH Trust 3rd with 25 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 17.1%.

- The Emergency Department FFT performance in February 2017 ranked RBCH Trust 8th with 8 other hospitals out of 141 placing RBCH ED department in the second quartile. The response rate was 4.4% against the 15% national standard.
- Outpatients FFT performance in February 2017 ranked RBCH Trust 5th with 26 other Trusts out of 234 Trusts, placing the departments in the third quartile. Response rates are variable between individual outpatient departments; there is no national compliance standard.

	September	October	November	December	January	February
In-Patient Quartile						
Top	98.318%	98.143%	98.573%	98.548%	98.639%	98.222%
2						
3						
Bottom						

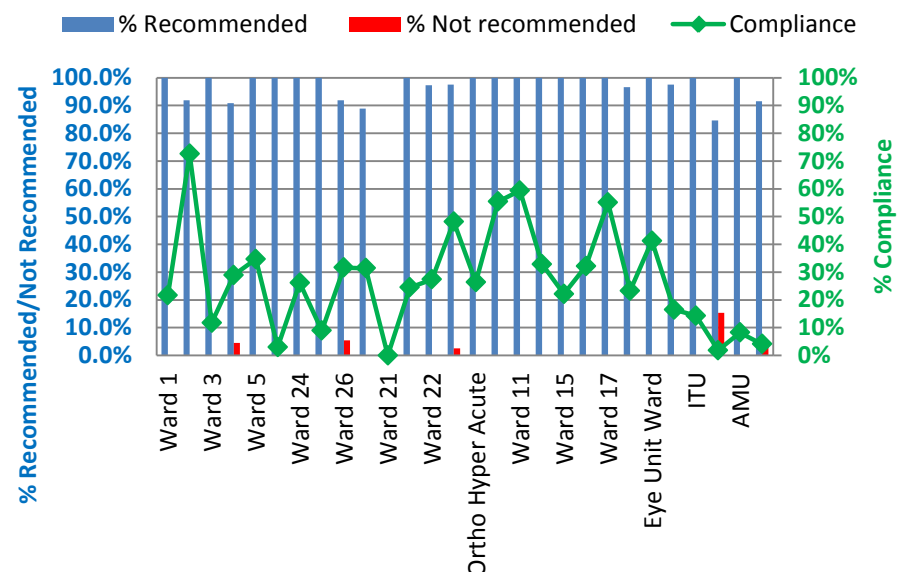
	September	October	November	December	January	February
ED Quartile						
Top	94.570%	94.737%	94.737%	94.131%	96.482%	
2						93.388%
3						
Bottom						

	September	October	November	December	January	February
OPD Quartile						
Top						
2	96.716%	97.008%	96.893%	97.549%	96.920%	
3						95.963%
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 Mar 2017 Overall Trust



4.3 Friends and Family 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	36	36	97.2%	2.8%
Main OPD Xch	N/A	12	9	88.9%	11.1%
Oral and Maxillofacial	N/A	32	32	100.0%	0.0%
Outpatients General	N/A	254	250	98.4%	1.2%
Jigsaw OPD	N/A	25	22	95.5%	4.5%
Corporate Total	N/A	359	349	98.0%	1.7%

4.4 Care Audit Trend Data

The Care Audit Campaign has been reviewed and some questions refined following feedback, and also to match current high priority areas. Quality improvement groups continue on call bells, noise at night, food and drink, and pain management. Questions have seen minor amendments for the coming year. This is reported into the Healthcare Assurance Group and Committee.

4.5 Patient Opinion and NHS Choices: March Data

15 patient feedback comments were posted in March, 13 express satisfaction with the staff attitude, care and information they received. 2 negative responses related to poor staff attitude and information. All information is shared with clinical teams and relevant staff, with Senior Nurses' responses included in replies following complaints.

5.0 Complaints and Concerns performance

The complaints performance is in respect of aggregate acknowledgement and **response performance for March 2017**. This is reported through the Healthcare Assurance Group and Healthcare Assurance Committee and operationally managed in the Complaints Performance Group.

Formal Complaints

Current Trust aggregate formal complaint response time in month (March 2017) is **87%** against a standard of 75% (20 of 23 responses due were on time).

- 31 formal complaints were received in March 2017.
- Acknowledgement times for March 2017 were **94%**.

Written and verbal concerns

The volume of written and verbal concerns (informal concerns) received through the PALS department is much higher than formal complaints.

- 74 verbal concerns were raised in PALS in March 2017 with **100%** acknowledgement.
- Verbal response performance time in March was **99%**
- 34 written concerns were raised in March 2017 with **100%** acknowledgment.
- Written response performance time in March was **97%**.

Themes and volume by Directorate March 2017

Of the 31 formal complaints received in month, surgery had the highest volume of complaints (n=8), with the next highest being Medicine, Older Peoples Medicine and the Emergency Department who had three complaints respectively.

The main themes were: Communication and Consent (n=9) and Implementation of care (n=8).

'Learning from Complaints' is reviewed by the Complaints Performance Group and Healthcare Assurance Committee before being placed on the Hospital website.

6.0 Recommendation

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

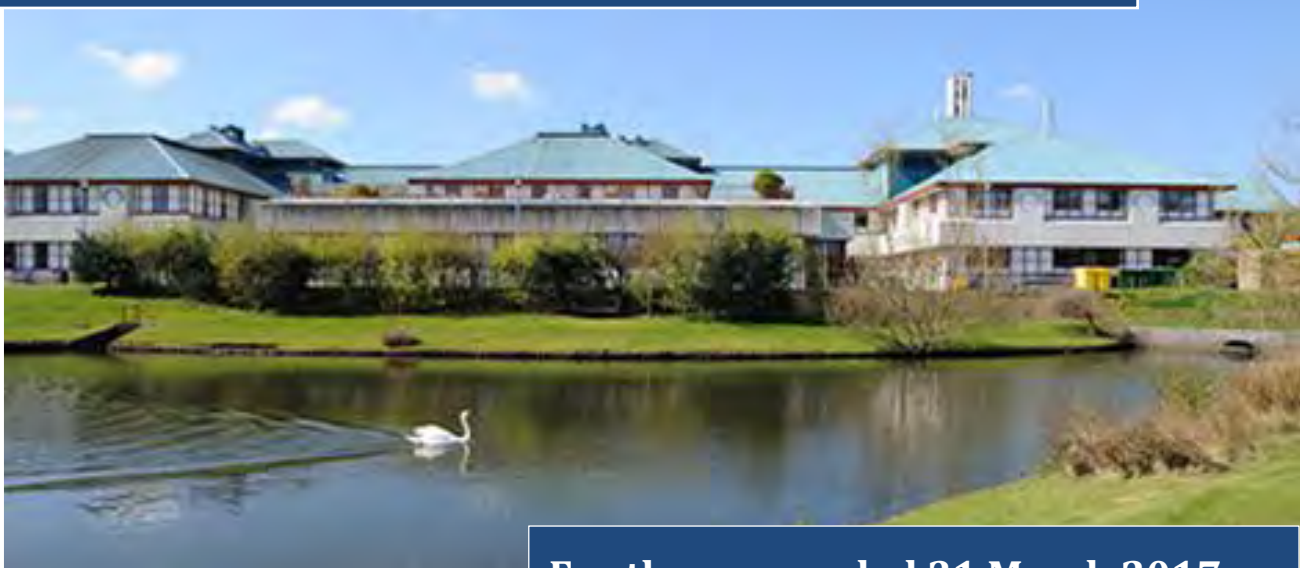
*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 April 2017 – Part 1
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 March
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?	Three 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 year ended 31 March 2017

Pete Papworth
Deputy Director of Finance

Executive Summary

The Trust is currently reporting a cumulative full year surplus of £0.674 million. This is £2.123 million better than the full year deficit budget of £1.450 million. However, the Trust will be advised of a further allocation of Sustainability and Transformation funding on Monday 24 April, which will improve this position further and inform the final outturn position for the year.

This favourable variance reflects the achievement of the forecast non-recurrent financial improvements together with the associated Sustainability and Transformation Fund incentive income.

Sustainability and Transformation Fund

The Trust has achieved its financial control total set by NHS Improvement and has achieved all relevant performance trajectories. This has secured the Fund income in full, amounting to £7.6 million. In addition, the Trust has benefited from additional Incentive Fund income amounting to £0.987 million as a result of the non-recurrent financial improvements noted above. A further allocation is expected to be announced shortly.

Cost Improvement Programme

Financial savings of £9.7 million have been achieved, which is £0.2 million better than the full year target of £9.5 million. A considerable amount of this has been achieved through non-recurrent schemes, representing a significant financial burden into the new financial year.

Employee Expenses

The Trust has reduced its reliance upon agency staff and is spending considerably less than the previous year. In addition, the Trust has operated within the agency ceiling agreed with NHS Improvement consistently throughout the year. As expected, expenditure was high during March with a particular increase in medical agency. This will continue to be the focus for further improvements during the coming year.

Capital Expenditure

The Trust committed £8 million of capital spend, which is £4.4 million less than planned. This reflects the slippage in relation to the refurbishment of the cardiology labs which will continue into 2017/18 following a very detailed procurement process, together with an under spend against the Christchurch Development.

Cash

The Trust has ended the year with a favourable cash position against its plan, with a current consolidated cash balance of £38.4 million.

Financial Risk Rating

The additional Sustainability and Transformation Fund incentive income has improved the Trusts Use of Resources score to a score of 1 in March. This is forecast to reduce to a score of 3 during 2017/18.

Recommendation

Members are asked to note the Trusts draft financial outturn for the year ended 31 March 2017.

Finance Report

As at 31 March 2017

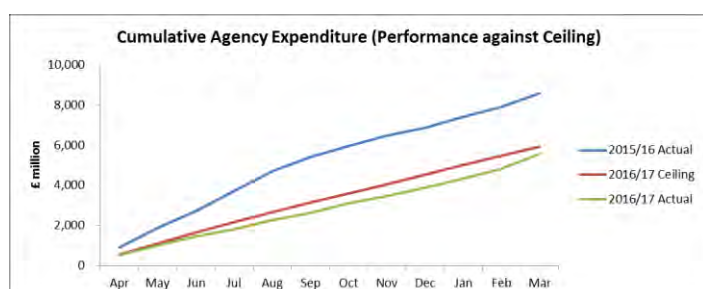
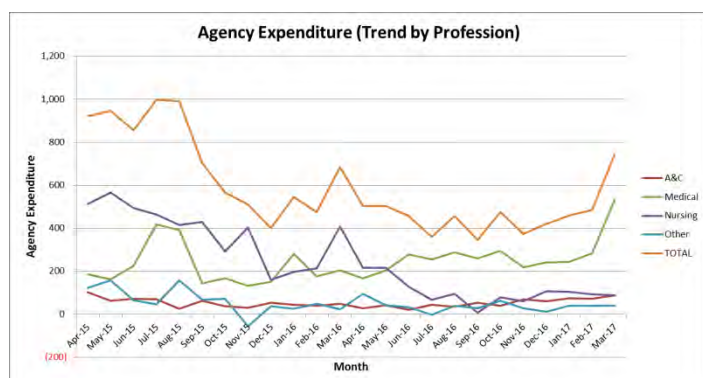
Income and Expenditure

Income and Expenditure Summary	Budget £'000	Actual £'000	Variance £'000
NHS Clinical Income	257,201	250,637	(6,564)
Non NHS Clinical Income	6,611	5,168	(1,443)
Non Clinical Income	31,598	33,517	1,919
TOTAL INCOME	295,410	289,322	(6,088)
Employee Expenses	177,549	174,706	2,843
Drugs	36,027	31,955	4,073
Clinical Supplies	37,780	38,060	(281)
Misc. other expenditure	45,504	43,927	1,577
TOTAL EXPENDITURE	296,860	288,648	8,212
SURPLUS/ (DEFICIT)	(1,450)	674	2,123

Income Analysis	Budget £'000	Actual £'000	Variance £'000
NHS Dorset CCG	175,781	175,892	111
NHS England (Wessex LAT)	51,360	44,617	(6,743)
NHS West Hampshire CCG	24,917	24,925	8
Other NHS Patient Income	7,723	7,712	(11)
Sustainability and Transformation Fund	7,600	8,587	987
Non NHS Patient Income	4,032	2,659	(1,373)
Non Patient Related Income	23,998	24,930	932
TOTAL INCOME	295,410	289,322	(6,088)

SUSTAINABILITY AND TRANSFORMATION FUND (STF) INCOME	FULL YEAR OUTTURN		
	BUDGET £'000	ACTUAL £'000	VARIANCE £'000
Financial: Control Total (70%)	5,320	5,320	0
Performance: A&E Trajectory (12.5%)	950	950	0
Performance: RTT Trajectory (12.5%)	950	950	0
Performance: Cancer Trajectory (5%)	380	380	0
STF Incentive Fund	0	987	987
TOTAL	7,600	8,587	987

Agency Expenditure



Care Group Performance

Care Group Performance	Budget £'000	Actual £'000	Variance £'000
Surgical Care Group	17,117	16,157	(960)
Medical Care Group	9,549	8,736	(813)
Specialties Care Group	4,968	5,354	386
Corporate Directorates	(35,475)	(35,126)	349
Centrally Managed Budgets	2,391	5,552	3,161
SURPLUS/ (DEFICIT)	(1,450)	673	2,123

Cost Improvement Programme

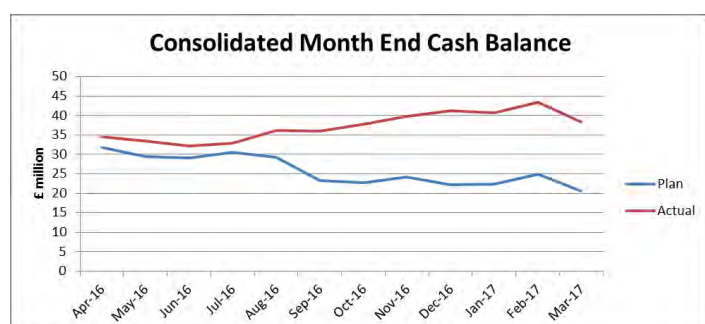
COST IMPROVEMENT PROGRAMME (CIP)	FULL YEAR OUTTURN		
	TARGET £'000	ACTUAL £'000	VARIANCE £'000
Surgical Care Group	(2,191)	2,106	(85)
Medical Care Group	(2,610)	1,831	(779)
Specialties Care Group	(2,116)	2,291	175
Corporate Directorates	(2,564)	2,609	45
Centrally Managed Schemes	0	873	873
Total	(9,481)	9,711	230



Capital Expenditure

CAPITAL PROGRAMME	YEAR TO DATE		
	BUDGET £'000	ACTUAL £'000	VARIANCE £'000
Estates	7,940	4,212	3,728
IT Strategy	3,409	2,343	1,066
Medical Equipment	1,000	1,420	(420)
TOTAL	12,349	7,975	4,374

Cash







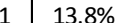
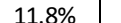






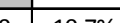
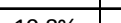


























*providing the excellent care we
would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 April 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
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 – APRIL 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 in the period 1/4/17-30/9/17; 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 2016.

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 March			Rolling 12 months to 31 March				At 31 March
Surgical	84.8% 	84.8% 	90.8% 	4.84% 	15887 	12.7% 	12.1% 	
Medical	89.1% 	79.8% 	90.2% 	4.25% 	21261 	13.8% 	11.8% 	
Specialities	96.2% 	85.2% 	94.0% 	3.90% 	11089 	10.7% 	10.8% 	
Corporate	92.4% 	50.0% 	94.4% 	3.92% 	12588 	8.1% 	10.9% 	
Trustwide	90.5% 	83.0% 	91.8% 	4.24% 	60825 	11.6% 	11.4% 	

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 31 March			Rolling 12 months to 31 March				At 31 March
Add Prof Scientific and Technical	95.5% 		95.0% 	4.05% 	1772 	14.7% 	15.4% 	
Additional Clinical Services	87.1% 		91.5% 	6.02% 	15232 	20.6% 	14.9% 	
Administrative and Clerical	92.8% 		95.2% 	3.89% 	11781 	9.2% 	10.8% 	
Allied Health Professionals	93.3% 		93.2% 	2.63% 	2369 	13.8% 	13.5% 	
Estates and Ancillary	91.3% 		93.4% 	5.32% 	6688 	8.3% 	11.6% 	
Healthcare Scientists	94.2% 		95.6% 	2.77% 	961 	13.7% 	15.7% 	
Medical and Dental		83.0% 	85.3% 	1.36% 	2150 	5.1% 	4.6% 	
Nursing and Midwifery Registered	89.0% 		91.7% 	4.68% 	19873 	9.1% 	9.7% 	
Trustwide	90.5% 	83.0% 	91.8% 	4.24% 	60825 	11.6% 	11.4% 	

1. Appraisal

Year 3 of the values based appraisal process has now commenced and performance against trajectories will be monitored at Workforce Committee and reported to Board in due course.

2. Essential Core Skills Compliance

Overall compliance increased to a highest-ever figure of 91.8%, which compares favourably with the 86.6% at the same point last year.

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

Directorate	Organisation	Headcount	Compliance	Trend
Surgery Directorate	153 Surgery - General 10085	36	76.63%	
Medicine Directorate	153 Medical General Staff 10075	73	78.70%	
Facilities Directorate	153 Portering 14615	36	79.26%	
ED Directorate	153 ED Admin Clerical/Receptionist 10456	32	79.57%	
Research Funds Directorate	153 Research - Central Admin 11400	52	81.11%	
ED Directorate	153 ED Nursing and Income 10455	96	81.36%	
Surgery Directorate	153 Surgical Admissions Unit 10535	17	81.58%	
Cancer Care Directorate	153 Haematology Snr.Medical 11346	20	83.13%	
Elderly Care Services Directorate	153 MFE Medical Staff 10077	47	83.57%	
Medicine Directorate	153 Ward 3 10598	35	83.64%	

Areas with highest compliance:

Directorate	Organisation	Headcount	Compliance	Trend
Finance and Business Intelligence	153 Fundraising Expenses 13576	12	100.00%	
Facilities Directorate	153 XCH I/H Dom Contract 14350	15	100.00%	
Finance and Business Intelligence	153 Information 13541	15	100.00%	
Informatics Directorate	153 Telecoms 13585	22	100.00%	
Cardiac Directorate	153 Cardiac Administration 11523	35	99.41%	
Informatics Directorate	153 Health Records 13540	39	99.23%	
Pathology Directorate	153 Microbiology 11380	23	99.17%	
Finance and Business Intelligence	153 Finance 13575	23	99.13%	
Specialist Services Directorate	153 XCH Medical Secretaries 13556	11	99.09%	
Estates and Support Directorate	153 Works Department 17000	53	98.95%	

The push is now on to reach 95% by December. Laminated posters are displayed in kitchen areas and other areas around the Trust encouraging staff to have a “green brain”. The team have been nominated and are finalists for an HPMA (Healthcare People Management Association) employee engagement award for the “green brain” initiative. Two members of the team will deliver a presentation on 5th May and attend the awards ceremony in June when the winners will be announced.



Conflict Training is experiencing a high level of DNAs; this course is key to staff keeping themselves safe and its importance needs to be recognised. Manager compliance reports include a “DNA” tab where they can view staff that have not attended ECS sessions for their area.

3. Sickness Absence

The Trust-wide sickness rate shows a slight improvement to 4.24% (4.26% last month) which is up on the 3.92% figure at the same point last year.

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

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Maternity Directorate	153 Antenatal Clinic 10520	11	13.97%	
153 Facilities Directorate	153 Portering 14615	38	10.57%	
153 Anaesthetics/Theatres Directorate	153 Day Surgery Services 10385	29	10.23%	
153 Ophthalmology Directorate	153 BEU Outpatients 10480	23	10.13%	
153 Specialist Services Directorate	153 XCH Dermatology 10362	26	9.36%	
153 Specialist Services Directorate	153 Department of Sexual Health 10090	41	8.88%	
153 Elderly Care Services Directorate	153 MFE Ward 5 10378	45	8.52%	
153 Pathology Directorate	153 Phlebotomy 11330	38	7.95%	
153 Medicine Directorate	153 Ward 3 10598	40	7.75%	
153 Surgery Directorate	153 Ward 17 10428	27	7.64%	

Areas with the lowest sickness:

Directorate	Organisation	Headcount	Absence Rat	Trend
153 Orthopaedics Directorate	153 Ortho Medical Staff 10160	34	0.34%	
153 Cardiac Directorate	153 Cardiac Medical Staff 10076	40	0.68%	
153 Finance and Business Intelligence	153 Information 13541	16	0.72%	
153 Surgery Directorate	153 Surgery - Urology 10084	18	0.74%	
153 Elderly Care Services Directorate	153 MFE Medical Staff 10077	53	0.81%	
153 Cardiac Directorate	153 Cardiac Rehab 11527	19	1.01%	
153 Medicine Directorate	153 Medical General Staff 10075	89	1.07%	
153 Surgery Directorate	153 Obs/Gynae Medical Staff 10100	22	1.07%	
153 Other Directorate	153 Postgraduate Centre 13531	13	1.18%	
153 Elderly Care Services Directorate	153 Speech and Language Therapy 12014	13	1.25%	

An in-depth review of sickness management was held at Workforce Committee on 10th April and a detailed paper was produced providing data and information. The reasons for sickness absence in the Trust follow the pattern of many similar organisations. Musculo-skeletal and mental health issues are the top causes of absence from the Trust. Sickness for these reasons is well supported by the staff physiotherapy service and the Employee Assistance Programme with both self referrals and management referrals available to staff and managers. In the period 1/3/16-28/2/17 these account for over 32% of the sickness absence.

We have reviewed the split between short and long term sickness absence and the HR operational team check reports to provide support to managers. Previously, we have identified that in a minority of cases management interventions were not always being made in a timely manner. We are continuing to provide sessions for managers and supervisors and the “Difficult Conversations “ workshops have been providing opportunities to understand how to manage these issues as well.

Data relating to sickness and other workforce metrics is now available on the Quality Dashboard and this allows detailed drill-down for all areas. We have also set up a working group with cross-Trust representation to consider what other initiatives we should develop and this will report through the Workforce Committee.

Care groups and corporate departments are continuing to review the level and actions for their areas ensuring that appropriate interventions are made.

4. Turnover and Joiner Rate

Joining rate and turnover rate both show a very slight increase over the previous month, with the joining rate remaining above the turnover rate.

5. Vacancy Rate

Vacancy rate information is not available at the time of writing, but is not expected to show any material change from last month's 6.3%, comparing favourably with other NHS Trusts. The figure will be reported at the meeting.

6. Safe Staffing February 2017

Registered Nurse (RN): Actual Day 87.6%	HCA Actual Day: 99.3%
Registered Nurse (RN): Actual Night 96.9%	HCA Actual Night: 113.8%

(Please note at the time of writing, these figures are awaiting final ratification.)

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would expect for our own families*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



BOARD OF DIRECTORS

Meeting Date and Part:	28 April 2017 Part 1
Reason for Part 2:	N/A
Subject:	Clinical Services Review
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Tony Spotswood, Chief Executive
Details of previous discussion and/or dissemination:	Previous Board meetings
Action required:	For information
Executive Summary: The Board is asked to note progress in advancing the CSR	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	All
Risk Profile: i. Impact on existing risk? ii. Identification of a new risk?	

Clinical Services Review

This paper provides a brief update on progress to advance the Dorset STP and specifically implement the Clinical Services Review. In drafting this report ahead of the Easter period, I will use the Board meeting to update the Board on progress.

The Five Year Forward View – Next Steps signalled that the Dorset health economy will have preferential access to the £325m capital announced in the recent budget. We will be competing with 8 other health systems for access to these funds. The bidding process requires the submission of initial proposals by the end of April. A decision on how much capital we will receive from this allocation will be made in June 2017. If successful it is envisaged this initial tranche of funding will underpin the detailed design of the planned and emergency sites and aid the transfer of some services into the community in order to free up capacity to allow building work to start to create the infrastructure necessary to accommodate the reorganisation of services.

It is understood that there will be a further opportunity to bid for capital in the autumn, work is also underway within NHSI to open up the potential for the NHS to access venture capital funds. In order to be in a position to set up our case for capital, we will appoint a partner to work with the Trusts to develop this case. The selection of a partner will be made in conjunction with the CCG. This appointment will be made on 28 April following the Board meeting.

In strengthening our infrastructure to underpin this work we will also make an appointment to the role of Programme Director on Thursday 27 April.

Work also continues to refine the Terms of Reference to guide the work of the Programme Board in concert with colleagues from Dorset County Hospital.

I will provide a further progress report to the Board at our meeting.

Tony Spotswood
Chief Executive

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would expect for our own families*

BOARD OF DIRECTORS

Meeting Date and Part:	28 April 2017 Part 1
Reason for Part 2:	N/A
Subject:	Progress against Government's mandate to NHS England 2017/18
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Tony Spotswood, Chief Executive
Author(s) of papers:	Sandy Edington, Associate Director of Service Development
Details of previous discussion and/or dissemination:	Not applicable
Action required:	For information
<p>Executive Summary:</p> <p>The NHS Mandate has been updated for 2017/18 and this paper describes the issues of significance for the Trust, together with an indication of our performance, where relevant.</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>	

Progress against the Government's mandate to NHS England for 2017/18

Introduction

The NHS Mandate was introduced some time ago and is annually updated to include NHS objectives for the new financial year. The recently updated and published document describes 7 overall objectives and then details specific 2017/18 requirements many of which we have as deliverables for our Trust. However, as we increasingly belong to and operate as a health system, the successful delivery of a wider set of objectives that are not directly within NHS Trusts will require significant partnership working and / or will impact on us.

A synopsis of the document was provided by NHS Providers and is at Appendix A.

NHS Objectives

The overall objectives are tabulated below and where there are specific targets or relevance for our Trust our position and anticipated performance for 2017/18 is indicated alongside.

Objective 1: Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities

1.1 CCG and STP performance

Objective 2: To help create the safest, highest quality health and care service

2.1 Improving service quality and achieving seven-day services

Mandate Statement	Trust Position
Work with NHS Improvement to rollout 7-day services in hospitals 4 priority clinical standards to (1) 50% of the population by April 2018 and (2) whole population for 5 specialist services by November 2017	Benchmarked well in Sept 16 audit. March audit in progress and we await results.

2.2 Patient experience

2.3 Cancer

Achieve the 62-day cancer waiting times standards and maintain performance against the other standards	Achieved Q2 & Q3 and anticipated for Q4 16/17
With partners, develop IT infrastructure and national guidance to allow data collection for the new 28-day faster diagnosis standard from April 2018	The Trust is one of the national pilot projects and already seeing improved performance as well as contributing to how this data can be collected.
Improve the proportion of cancers diagnosed at stages 1 & 2 over the previous year	Already reported internally and above national benchmark.

Objective 3: Balance the NHS budget and improve efficiency and productivity

3.1 Balancing the NHS Budget

Ensure CCGs better management of	Right Referral, Right Care stream
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demand in acute services through implementation of programmes including New Care Models, Right Care and Self Care	covering 9 specialities being led by 3 acute providers – commenced Dec 16. Also looking at Ready Fit & Able including schemes such as orthopaedic CHAIN programme and anaesthetist led pre-assessment programme
Ensure commissioning aims support delivery of provider productivity, including working with NHS Improvement in securing Carter efficiency savings and reducing spend on agency staff	Detailed review of savings identified opportunities within Cardiology and Older People's Medicine. On-going review of model hospital to identify and understand further options for increased productivity and better patient care. Significant work undertaken on reducing agency spend from c£8m (15/16) to c£6.5m (16/17) additional work for 17/18 is focused on a review of medical agency with changing approaches to recruitment and staffing

Objective 4: To lead a step change in the NHS preventing ill health and supporting people to live healthier lives

4.1 Obesity, diabetes and prevention

Reduce variation in the care for people with diabetes, including improving the achievement of the NICE recommended treatment targets whilst driving down variation between CCGs	The Trust is fully involved with development of the Dorset diabetic service. Particular subjects include improving equity of access to foot care and to insulin pumps and the development / extension of the BERTIE and REFOCUS education programmes
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4.2 Dementia

Maintain a minimum of two-thirds diagnosis rate for people with dementia	The Trust contributes to this by undertaking a 3 stage assessment process on all >75s. This has now been included in the electronic Nurse Assessment.
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Objective 5: to maintain and improve performance against core patient access standards

5.1 A&E, Ambulance and Referral to Treatment (RTT)

Co-implement the agreed A&E recovery plan with NHSI and deliver aggregate A&E performance in England above 90% in September 2017, with the majority of trusts meeting 95% in 2018, and aggregate performance in England at 95% within the course of 2018	Currently > 90%. Development of integrated hubs in Christchurch and Bournemouth
Agreed a plan for the staged roll out of integrated urgent care to 2020, and	Project underway re integration of local urgent care services and ED streaming,

implement for 2017/18	including capital bid.
With NHSI meet agreed standards on A&E, ambulance, diagnostics and RTT	A&E / Diagnostic / RTT above NHSE performance in 16/17, but some risk in 17/18
Working with NHSI and local government, reduce the NHS-related delayed transfers of care support a total reduction to 3.5% by September 2017	Developed discharge database to allow improved understanding of patients are medically fit. Working with CCG and community trust to reduce Delayed Transfers of Care.
Implement plans to moderate avoidable growth in demand for elective services, including through sharing benchmarking data with CCGs	Right Referral, Right Care stream

Objective 6: To improve out of hospital care

6.1 New models of care and General Practice

Deliver 2017/18 core requirements for access to enhance GP services, including evening and weekend access to a total of 40% of them population	Enhanced GP services may become part of the integrated urgent care offer.
Work with the DH on commitment for all over-75s to be able to access a same-day appointment with a GP	Likely to have an impact on us and may be an opportunity to integrate with hub and / or Trust frailty services.

6.2 Health and social care integration

6.3 Mental health, learning disabilities and autism

Objective 7: To support research, innovation and growth

7.1 Research and growth

Work with Genomics England to embed genomic medicine and application of genomic technologies into NHS care, building on the 100,000 Genomes Project and UK Strategy for Rare Diseases	Trust has participated in support of UHS and programme is now live at RBCH, with 2 patients recruited so far.
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7.2 Technology

Progress toward 100% of GP to first out-patient referrals through NHS e-RS by October 2018	Dorset CCG already has 80% utilisation – significantly higher than rest of Wessex. As part of Right Care – encouraging usage including use of Advice and Guidance
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7.3 Health and work

The Board is asked to note this report.



THE GOVERNMENT'S MANDATE TO NHS ENGLAND FOR 2017-18

NHS England is responsible for arranging the provision of health services in England. The mandate to NHS England sets the government's objectives for NHS England, as well as its budget. In doing so, the mandate sets direction for the NHS, and helps ensure the NHS is accountable to parliament and the public. Every year, the secretary of state must publish a mandate to ensure that NHS England's objectives remain up to date.

The **mandate for 2016-17** set out enduring objectives to 2020, and set NHS England's budget for five years. The **2017-18 mandate published today** continues the approach set out in 2016-17, maintaining the direction set and defining annual deliverables for 2017-18 that will keep health services on track to meeting those longer-term goals. In some objectives changes and clarifications have been made to reflect developments since 2016-17.

Key deliverables the mandate sets out for NHS trusts in 2017-18

Below we have highlighted the key deliverables that NHS trusts must meet for 2017-18. The full deliverables for 2017/18 that are set out in the mandate are outlined in a later section.

- Rollout 7-day services in hospitals four priority clinical standards to (1) 50% of the population by April 2018 and (2) the whole population for five specialist services (vascular, stroke, major trauma, heart attack and paediatric intensive care) by November 2017
- Deliver aggregate A&E performance in England above 90% in September 2017, with majority of trusts meeting 95% in March 2018, and aggregate performance in England at 95% by end of 2018
- Meet agreed standards on A&E, ambulances, diagnostics and referral to treatment
- Achieve the 62-day cancer waiting times standard, and maintain performance against the other cancer waiting times standards
- Reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas)
- Support delivery of the 2017-18 Mental Health Five Year Forward View Implementation Plan recommendations

NHS England's objectives

- 1 Through better commissioning, improve local and national health outcomes, and reduce health inequalities.
- The government expect NHS England to maintain the clinical commissioning group (CCG) improvement and assessment framework. NHS England is also expected to demonstrate improvements against the NHS Outcomes Framework and work with CCGs to ensure commissioning focuses on measurable reductions in inequalities in access to and people's experiences of health services and across a range of health outcomes.

2 To help create the safest, highest quality health and care service.

- NHS England must help ensure the NHS provides the same standards of care, seven days a week, for people who need urgent and emergency hospital care, and that harm is minimised by avoiding unnecessary complications or admissions to hospital.
- The government would like the NHS to become the world's largest learning organisation.
- The mandate states people should be empowered to shape and manage their own health and care and make meaningful choices. This includes carers being routinely given access to information about available support.
- A priority for NHS England will be to improve early diagnosis, services and outcomes for cancer patients.

3 To balance the NHS budget and improve efficiency and productivity.

- NHS England is expected to ensure overall financial balance in the NHS, working with NHS Improvement to support local areas in developing credible operational plans which align with STPs.
- The government want NHS England to ensure aggregate spending by commissioners does not exceed mandate funding, that appropriate contingency funding is maintained and to make sure commissioners discharge their duties in a way which enables commissioners and providers to meet their control totals.
- Commissioners are also expected to work collaboratively with local authorities to make the most efficient and effective use of health and social care funding.
- Both NHS England and NHS Improvement should determine affordable pricing arrangements for commissioners and allow providers to meet their financial duties. NHS England must achieve this while continuing to deliver high quality care and delivering against the objectives set out in the mandate.

4 To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.

- The government want the NHS to do more with partners on the broader prevention agenda: preventing avoidable ill health and premature mortality.
- In particular, NHS England should contribute to the government's goal to reduce child obesity and diabetes. NHS England is also expected to make measurable improvement in the quality of care and support for people with dementia, and to increase public awareness.

5 To maintain and improve performance against core standards.

- The government believe the real terms growth in the NHS budget should ensure the service can continue to perform well over the next four years, with the capacity to deal with rises in demand during the winter months. NHS England are expected to support the NHS to improve and maintain, where possible, access to timely, quality services for all patients.

6 To improve out-of-hospital care.

- The government expect NHS England to ensure easier convenient access to planned GP services, including appointments in the evenings and at weekends, and effective access to quality urgent and emergency care 24 hours a day across the whole week.
- NHS England should support the NHS to achieve the government's aim that health and social care are integrated across the country by 2020, including through the Better Care Fund.
- Overall there should be measurable progress towards the parity of esteem for mental health, particularly for those in vulnerable situations. NHS England must strive to reduce the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, through prevention, early intervention and improved access to integrated services. The also government wants to see a system-wide transformation in children and young people's mental health.

7 To support research, innovation and growth.

- The government expect NHS England to help the NHS contribute to economic growth, to support the NHS to reduce the impact of ill health and disability, and to support research and innovation to enable new cost effective treatments to reach patients more quickly. NHS England should work with the life sciences sector and government as it develops a life sciences strategy.
- NHS England should also support the NHS to make better use of digital services and technology to transform access to and use of health and care, including online access to personal health records.

NHS England's budget

NHS England's indicative revenue and capital budgets for each year of the parliament were set out in the [Mandate for 2018-17](#). Details of NHS England's revenue and capital budgets for 2017-18 and the indicative budgets for the remaining years of this parliament are as follows:

	2016-17 (Revised)	2017-18	2018-19 (indicative budget)	2019-20 (indicative budget)	2020-21 (indicative budget)
Total revenue budget (£m)	106,528	109,960	112,461	115,506	119,606
Capital budget (£m)	260	260	260	305	305

A further breakdown of these figures is provided in the [published financial projections](#).

NHS England will work with NHS Improvement to ensure overall financial balance in the NHS. To support this, £1.8bn of NHS England's budget for 2017-18 will be allocated through the sustainability and transformation fund.

Mandate goals and deliverables

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and key deliverables for 2017-18.

Objective 1: Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities	
1.1 CCG and STP performance	Overall 2020 goals:
	<ul style="list-style-type: none"> • Improve proportion CCGs rated 'good' or 'outstanding' against the CCG Improvement and Assessment Framework • Working with NHS Improvement, support delivery of agreed plans within each STP area
	2017-18 deliverables:
	<ul style="list-style-type: none"> • Publish the results of CCG improvement and assessment framework for 2016-17 • Working with NHS Improvement, ensure commissioners and providers deliver their 2017-18 operational plans, which will deliver year one of locally agreed STPs

Objective 2: To help create the safest, highest quality health and care service

2.1 Improving service quality and achieving seven-day services

Overall 2020 goals:

- Roll out of 7-day services in hospital to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards)
- With NHS Improvement, support providers to publish a Board level service quality improvement plan
- Support NHS Improvement to significantly increase the number of trusts rated 'good' or 'outstanding' and reduce the length of time trusts remain in special measures
- Work with DH and partners to reduce the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 20% by 2020
- Support the NHS to be well-led and demonstrate open, learning cultures
- Improve antimicrobial prescribing, resistance rates and healthcare associated infection rates to support the Government to meet its ambition to halve inappropriate prescribing of antibiotics by 2020

2017-18 deliverables:

- Work with NHS Improvement to rollout 7-day services in hospitals 4 priority clinical standards to (1) 50% of the population by April 2018 and (2) the whole population for 5 specialist services by November 2017
- Work with NHS Improvement to ensure that providers improve public engagement in developing their service quality improvement plan
- Begin implementation of the Maternity Transformation Programme
- With DH, support the development and publication of a baseline on brain injuries in babies that occur during or soon after birth
- Deliver actions agreed as part of the Leadership Development and Improvement framework for 2017-18
- Support the Government's ambitions on antimicrobial resistance by taking action to improve prescribing and surveillance and reduce E.Coli blood stream infections
- Work with partners to ensure NHS services play their part in the Government's Prevent programme

Overall 2020 goals:

- With NHS Improvement, improve percentage of NHS staff who report that patient and service user feedback is used to make informed improvement decisions
- Ensure patients and carers are involved in defining, assessing and improving quality of NHS services
- 50,000-100,000 people to have a personal health budget or integrated personal budget
- Improve patient choice, including in maternity, end-of-life care, elective care and for people with long-term condition

2.2 Patient experience

2017-18 deliverables:

- Implement findings from phase 1 and 2 of the Maternity Experience Challenge Fund
- Promote rollout of always events in 100 providers by April 2018
- Develop proposals for how complaints, whistleblowing and other feedback can be used more effectively to drive up quality and improve patient safety in primary care and specialised commissioning
- Continue to make measurable progress to embed Personal Health Budgets
- Identify metrics to assess quality and choice in end-of-life care for inclusion in the CCG improvement and assessment framework for 2018-19
- Develop with partners an implementation plan to take forward the recommendations from the Government's response to the end-of-life care Choice Review

2.3 Cancer

Overall 2020 goals:

- Deliver recommendations of the Independent Cancer Taskforce

2017-18 deliverables:

- Set out milestones for 2017-19 and deliver those agreed for 2017-18, building on Achieving World-Class Cancer Outcomes: Taking the strategy forward
- Achieve the 62-day cancer waiting times standard and maintain performance against the other standards
- With partners, develop IT infrastructure and national guidance to allow data collection for the new 28-day faster diagnosis standard from April 2018
- Improve the proportion of cancers diagnosed at stages 1 and 2 over the previous year
- Pilot an approach to measuring long-term quality of life for people living with and beyond cancer and agree an implementation plan to begin data collection in 2018-19
- Invest up to £340m in providing cancer treatments through the Cancer Drugs Fund

Objective 3: Balance the NHS budget and improve efficiency and productivity

Overall 2020 goals:

- Work with NHS Improvement to ensure overall financial balance in the NHS and the necessary efficiency and productivity improvements
- Ensure that commissioners discharge their duties in a way which enables commissioners and providers to live within their control totals, as individual organisations, across STP footprints, and in aggregate
- With DH and NHS Improvement, achieve 2-3% year on year improvements in efficiency and productivity
- Work with NHS Improvement to determine pricing arrangements that are affordable for commissioners, allow providers to meet their financial duties and are consistent with FYPW
- With NHS Improvement, support the Government's goal to raise £2bn and free space for 26,000 new homes by 2020 from releasing surplus NHS land

3.1 Balancing the NHS budget

2017-18 deliverables:

- Work with NHS Improvement to ensure overall financial balance in the NHS
- Ensure aggregate spending by NHS England and CCGs does not exceed mandate funding for 2017-18
- With NHS Improvement, before the end of the 2017-18 contracting round, provide formal assurance to DH that operational plans deliver mandate objectives and are based on credible planning assumptions
- Ensure CCGs better manage demand in acute services through implementation of programmes including New Care Models, Right Care and Self Care
- Improve primary care productivity
- Ensure commissioning aims support delivery of provider productivity, including working with NHS Improvement in securing Carter efficiency savings and reducing spend on agency staff
- Support DH to take forward the Government's commitment for the NHS to recover up to £500m from overseas chargeable patients

Objective 4: To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives

Overall 2020 goals:

4.1 Obesity, diabetes and prevention

- Measurable reduction in child obesity as part of the Government's childhood obesity plan
- 100,000 people supported to reduce risk of diabetes through NHS Diabetes Prevention Programme
- Reduce variation in the care for people with diabetes, including improving the achievement of the NICE recommended treatment targets whilst driving down variation between CCGs
- With Public Health England, contribute to the reduction of preventable illness and associated hospital admissions through the implementation of preventative interventions in the NHS

4.2 Dementia

2017-18 deliverables:

- Set out NHS England's contribution to the Government's childhood obesity plan by September 2017
- At least 60000 people referred to the Diabetes Prevention Programme
- Fund and deliver with Public Health England a programme from April 2017 to March 2019 to support the implementation of identified preventative interventions at scale by the NHS

Overall 2020 goals:

- Deliver the Challenge on Dementia 2020 Implementation Plan

2017-18 deliverables:

- Maintain a minimum of two thirds diagnosis rates for people with dementia
- Continue to develop an evidence based framework for a national treatment and care pathway and agree an affordable implementation plan for the 2020 Dementia Challenge

Objective 5: To maintain and improve performance against core patient access standards

5.1 A&E, Ambulances and Referral to Treatment (RTT)

Overall 2020 goals:

- 95% of people attending A&E seen within four hours
- 24/7 integrated urgent care service implemented in each footprint
- Meet ambulance response time standards for the most urgent calls and the A&E standard.
- At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks from referral; and less than 1% of patients waiting for a diagnostic test to wait more than 6 weeks from referral
- Ensure the NHS plays its part in reducing delayed transfers of care by developing new incentives

2017-18 deliverables:

- Co-implement the agreed A&E recovery plan with NHS Improvement and deliver aggregate A&E performance in England above 90% in September 2017, with the majority of trusts meeting 95% in March 2018, and aggregate performance in England at 95% within the course of 2018
- Agree a plan for staged rollout of integrated urgent care to 2020, and implement for 2017-18
- With NHS Improvement, meet agreed standards on A&E, ambulances, diagnostics and RTT
- Test new ambulance service performance metrics which reflect the clinical needs and outcomes for patients contacting 999 in England
- Working with NHS Improvement and local government partners, reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care to 3.5% by September 2017
- Implement plans to moderate avoidable growth in demand for elective services, including through sharing benchmarking data with CCGs

Objective 6: To improve out-of-hospital care

6.1 New models of care and General Practice

Overall 2020 goals:

- Implement the General Practice Forward View
- Reduce age standardised emergency admission rates and inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50% of the population.

2017-18 deliverables:

- Deliver 2017-18 core requirements for access to enhanced GP services, including evening and weekend access, to a total of 40% of the population

6.2 Health and social care integration

- Work with DH on commitment for all over-75s will be able to access a same-day appointment with a GP
- Support NHS Digital and DH to provide practices with clinical data by named GP
- Achieve 20% coverage of the population by the New Care Model programme
- Assess vanguard progress and identify consistent models that can be replicated across the country

Overall 2020 goals:

- Achieve better integration of health and social care in every area of the country, with significant improvements in performance against relevant indicators within the CCG improvement and assessment framework, including new models of care

2017-18 deliverables:

- Implement the Better Care Fund in line with 2017-19 Integration and Better Care Fund Policy Framework
- Accelerate implementation of health and social care integration
- Work with DH, other national partners and local areas to agree and support implementation of those local devolution deals which include health proposals
- With DH, increase proportion of NHS Continuing Healthcare assessments outside of an acute setting
- Collaborate with local authorities to support the sustainability of social care, including on programmes such as New Care Models, Urgent Care and Right Care

2017-18 requirements- NHS England is required to:

- Ring-fence £3.582bn within its allocation to CCGs to establish the Better Care Fund in 2017-18, and ensure the amount spent from within this on schemes identified in Better Care Fund plans as 'social care' in 2016-17 is maintained in line with inflation in every area
- Consult DH and DCLG before approving BCF plans drawn up by each local area, and before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund

Overall 2020 goals:

- Implement the Mental Health Five Year Forward View recommendations and ensure 1 million more people with mental health problems are accessing high quality care
- At least 70,000 more children and young people to access evidence based treatment

2017-18 deliverables:

6.3 Mental health, learning disabilities and autism

- Deliver the 2017-18 Mental Health Five Year Forward View Implementation Plan recommendations
- Work with system partners to deliver the Mental Health Five Year Data Plan, the Mental Health Workforce Strategy, the Future in Mind recommendations
- Embed access and waiting time standards for mental health services for Early Intervention in Psychosis, Improving Access to Psychological Therapies and eating disorders
- Implement a 5 year improvement programme for crisis and acute mental health care
- Work with DH and NHS Digital to collect robust data on acute out of area placements and establish baseline during 2017-18. Agree plans in 2017-18 to deliver year-on-year reductions to eliminate inappropriate acute out of area placements by 2020-21
- Reduce reliance on inpatient care for children, young people and adults with a learning disability and/or autism who display behaviour that challenges to achieve a bed reduction of 35-50% by March 2019

Objective 7: To support research, innovation and growth

7.1 Research and growth

Overall 2020 goals:

- Support DH and Health Research Authority to improve UK's international ranking for health research

- Implement research initiatives in the NHS England research plan
- Improve NHS uptake of innovations prioritised by the Accelerated Access Partnership
- Work with Genomics England to embed genomic medicine and application of genomic technologies into NHS care, building upon the 100,000 Genomes Project and the UK Strategy for Rare Diseases

2017-18 deliverables:

- Evaluate the implementation of the Excess Treatment Costs guidance
- Promote participation by NHS organisations and patients in research funded both by commercial and non-commercial organisations
- Improve NHS commissioner input into identifying research needs in the NHS
- Work with DH on implementation of the recommendations of the Accelerated Access Review
- Develop, jointly with Genomics England, approach to embed genomics into routine care

Overall 2020 goals:

- Support delivery of the National Information Board Framework on Personalised Health and Care 2020
- 95% of GP patients to be offered e-consultation and other digital services
- Ensure all clinical correspondence and transfers of care are shared electronically and the opening up of systems to enable sharing of care records

**7.2
Technology**

2017-18 deliverables:

- Implementing, with NHS Digital and NHS Improvement, the 2016 National Data Guardian for Health and Care review recommendations on data security
- Ensure high quality appointment booking app with access to full medical record available; implementing the new national opt-out model to be finalised following the 2016 independent review
- Practices to have a minimum of 10% of patients accessing primary care services online or through apps
- Progress towards 100% of GP to first outpatient referrals through NHS e-RS by October 2018

Overall 2020 goals:

- Contribute to reducing the disability employment gap
- Contribute to the Government's goal to increase integrated working between health services and work-related interventions, including through increasing the use of Fit for Work

**7.3 Health
and work**

2017-18 deliverables:

- Implement health-led employment trials from spring 2017, which will run for between 2 to 3 years
- With the Work and Health Unit and NHS Digital, support an increase in referrals by GPs to occupational health support, including Fit for Work
- Work with Government on regular data collection on musculoskeletal patients and services in England

NHS PROVIDERS PRESS STATEMENT

Responding to the document, the chief executive of NHS Providers, Chris Hopson, said:

"In our report, Mission Impossible? The NHS provider ask in 2017/18, we explain why - without additional support - the health service's commitments for the coming year are well beyond reach. The NHS mandate confirms these obligations are being extended, even as it's struggling to cope with unprecedented demand and severe financial constraints."

E target that appears in the mandate, projecting a longer timetable to reach the 95% standard by the end of 2018. It remains to be seen, given current pressures, whether this timetable can be met. It is disappointing that a similar approach to the 18 week target appears to have not been adopted.

"Taken together with the other commitments set out in the document, the gap between demands on the health service and the resources available in the coming year remains unbridgeable. We maintain that just stabilising the deterioration in performance would be an achievement in itself. We estimate that this year NHS trusts are on course to have a collective deficit of £800 - £900 million pounds. Given the pressures the health service faces, just reproducing that financial performance would be a stretching target."

For further information about this briefing please contact: [Clare Sand, policy advisor \(Regulation\)](#) or [Garry Ward, policy officer](#).

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For further information about this briefing please contact: [Clare Sand, policy advisor \(Regulation\)](#) or [Garry Hall, policy officer](#).

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BOARD OF DIRECTORS

Meeting Date and Part:	28 th April 2017 – Part 1
Subject:	Emergency Preparedness, Resilience and Response (EPRR) Update
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:	Malcolm Keith, ASMS & Resilience Planning
Details of previous discussion and/or dissemination:	EPRR report submitted to Board in January 2017
Action required: Approve / Discuss / Information/Note	For information
Executive Summary: <p>Following the audit at RBCH in September 2016 the Trust was not fully compliant with 7 out of the 34 EPRR core standards. Since the last update to Board in January 2017 progress has been made and we are now fully compliant with all but three. The attached Action tracker gives an update as at April 2017.</p>	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	 Yes Yes Yes Yes Yes
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. Since the last update to Board in January 2017 progress has been made and we are now fully compliant with all but three.

Action tracker for April 2017

EPRR Standard	Actions to achieve compliance	Progress	Completion date
• Core standard 2 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 April 2017 Emergency Planning Sub-group (EPSG)	April 2017
• Core standard 8 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	April 2017
• Core standard 14 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

<p>• 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.</p>	<p>Training exercise run by the Civil Contingencies Unit in December</p>	<p>Covered during the training and future dates being arranged to run similar courses for other staff in 2017</p>	<p>Completed</p>
<p>• 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</p>	<p>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</p>	<p>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</p>	<p>Completed</p>
<p>• Core standard 35 Arrangements include an on-going exercising programme that includes an exercise needs analysis and informs future working</p>	<p>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</p>	<p>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</p>	<p>Completed</p>
<p>• 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.</p>	<p>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</p>	<p>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. Excellent progress has been made since the initial assessment.</p>	<p>On-going professional development</p>

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BOARD OF DIRECTORS

Meeting Date and Part:	28 th April 2017 – Part 1
Subject:	CCG Primary Care Strategy / GP Forward View Delivery Plan
Section on agenda:	Strategy and Risk
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	Richard Renaut, Chief Operating Officer
Author(s) of papers:	Sandy Edington, Associate Director Service Development
Details of previous discussion and/or dissemination:	
Action required: Approve / Discuss / Information / Note	For information
Executive Summary: The CCG response to primary care issues is essentially contained in the documents noted below and a digest of these and their significance for RBCH are covered in the paper. Documents are: The Dorset development plan for Integrated Community Services (ICS); the Integrated Community and Primary Care Service (ICPS); the Primary Care Commissioning Strategy and the Dorset General Practice Forward View Delivery Plan.	
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?	

CCG Primary Strategy /Forward View Plan

1. Introduction

Primary care has been subject to similar pressures to the Trust, principally around finance and staffing, but significantly compounded by adverse demographics and associated workload. This has been unprecedented in its significance, with around 30% of local practices considered vulnerable.

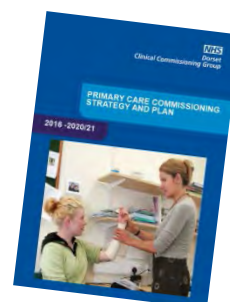
A fundamental prerequisite of the CSR and associated plans is the continued operation of a stable GP service – the CSR assumes ambitious reductions in referrals and emergency admissions of the order of 25% and this will only be possible if primary care is stable and capable of developing services in new ways. The Dorset development plan for Integrated Community Services (ICS), complementing the acute reconfiguration, now reflects the significance of the primary care challenges and has been amended to become the Integrated Community and Primary Care Service (ICPS).

As of the 1st April 2016, Dorset CCG took over responsibility for the commissioning of GP services from NHS England. With this in mind a Primary Care Commissioning Strategy was developed and, associated with this, a Dorset General Practice Forward View Delivery Plan. Alongside this a number of governance structures were set up at the CCG to oversee the future development of primary care in the Dorset CCG area.

The CCG response to primary care issues is essentially contained in the documents referred to above and a digest of these and their significance for RBCH are covered in the rest of this paper.

2. Dorset CCG - Primary Care commissioning Strategy and Plan 2016 – 2020/21

The foreword to this explains the rationale for the document (broadly as above), references some of the difficulties facing the general practice and exhorts the need for the health system to work together.



2.1 2020/21 Ambitions

By 2020/21 it is our ambition to have:	We intend to do this by:
Improved the Quality of our GP Services	Having a Rolling Annual Programme of Quality Improvement and Support to ensure all practices are rated at least "Good" by Care Quality Commission (CQC).
Improved Patient Experience, empowering people to take control of their own health	Commissioning a System of Health Care which removes traditional organisational boundaries, removes the need to repeat your story and where information is shared and available

Reduced the Health Inequality Gap tackling local factors impacting on health inequalities and health outcomes	Increase the focus on our Prevention Agenda and work with our partners and stakeholders to have a broader and more holistic view of the range of Factors that Impact on Health and Well-being and developing a joint plan to address them
Improved Outcomes, Reduced Unwarranted Variation and accurate Disease Prevalence, for all areas we are outliers	Having a Contract Management and Monitoring Process so that every practice has access to the right information and support in order to improve outcomes
All practices working At Scale within Collaborations as part of multi-disciplinary teams	Working with our Member GPs and their Teams, to move forward with different ways of collaborative working at scale whilst maintaining patient continuity. Modernise our approach to Commissioning
A Sustainable General Practice Model, which is attractive to work in	Using the National and Local programmes available to provide skills and resources to deliver financial and workforce sustainability. Continue to develop the Primary Care Workforce Centre
Improved, Extended and Consistent Access	Supporting our GP Practices to become sustainable and work as part of larger groups, so that Improved, Extended and Consistent Access can be achieved, ensuring the needs of rural, isolated and hard to reach communities are addressed
A Paperless health system	Delivering our Digitally Enabled Dorset

Key issues cited in the “Case for Change” are as follows:

- Vulnerability [of Practices] to remain open
- Prevention at Scale, to promote population health
- Right Care for ‘realistic medicine’ and best use of resources
- Premise & Infrastructure, and significant costs and backlog
- Commissioning and contracting improved to support the right outcomes
- System Transformation new models of care to deliver more, for less

2.2 Strategic Context

NHS England initiated a number of support programmes in this area including the Vulnerable Practice Programme (VPP), the General Practice Resilience Programme (GPRP) and the General Practice Development Programme (GPDP), but some of these have already been rebadged, and all are relatively small scale – a tabulation of the resources for this and other initiative is at Appendix A.

There is an explicit “Must-Do” from the NHS Forward View for the CCG to **“Develop and implement a local plan to address the sustainability and quality of General Practice”**.

The strategic section sees the development of Primary Care at Scale as a natural progression towards accountable care provision either via Super-Practices or GP federations. Urgent Care and Medicine Prescribing and Pharmacy also feature in this section and there are significant activities already underway in both areas. The CCG is in the process of developing an Integrate Urgent Care Access and Advice Service which will be subject to tender at some point. This subsumes the NHS 111 and GP OOH services currently provided by South West Ambulance Trust. We have had initial discussions with SWAST and local GPs and impetus has been added to this by recent Budget announcements of one off capital to be deployed by May, to support UCCs next to EDs.

The pharmacy development is supported by a national bidding process for the resources for practices to employ clinical pharmacists. In the latter case we have supported these bids, with the hope that we can enhance their likelihood of success and have also suggested that a process of joint recruitment might make the posts more attractive and make it less likely that a development in one area will merely denude the service in another area.

2.3 Future Model of General Practice

The following table shows the CCGs view of future care models for general practice.

	Current Care Models	Future Care Models
1	Hospital centred disease specific, specialist led often by GP referral	Community based teams and services in-reaching into specialist care centres. Teams bring together GP, specialists, nursing and therapy
2	Lack of capacity, often hospital led	Patient centred care planning with a named GP, health and social care co-ordination, rapid access to assessment, diagnosis, individual treatment and management plans, more responsive to intensive home based care needs, virtual ward models
3	Patient care managed by GP and Consultant by referral with care often not co-ordinated	Promoting self-management and pro-active self-care. Empowering patients and supporting carers, mobilising local community resources around groups of General practices enabled by teams working across care settings.
4	Provided by independent general practices through a patient list	Patient choice and ease of access to a local General Practice service. Local access to diagnostic and treatment services. Same high quality service offer and access for patients no matter where you live.
5	Separate GP practices provide in-hours for urgent patient need, high variation in access both in and out of hours.	Urgent in-hours care delivered at scale with access based on clinical need. Effectively streaming out the management of urgent and emergency care. Delivering care in the right place at the right time by the right care professional.

There is recognition that the primary care estate needs to be rationalised with larger more accessible modernised Primary Care Centres and with commensurate moves to closer working across practices and with community and social care. The Weymouth Hub is cited as a Dorset example of where this is working already. Christchurch Hospital is also set up to support this new way of working.

The delivery of the above strategy is largely developed in the Forward View Delivery Plan, explored below.

3. Dorset General Practice Forward View Delivery Plan December 2016



This document takes the above strategy and converts it into a more tangible plan. Key milestones include:

Milestones	17/18	18/19
Local blueprints Complete Co-production of local plans to improve health in partnership with local communities, health, social and voluntary organisations.	✓	
Commence implementation of local transformation programme to enable 40% the population to be receiving GP Services from practices who are part of a collaboration, working at scale		✓
Commence Technology enabling the delivery of care through implementing the Dorset Care Record and Digital Dorset	✓	
Complete estates and technology transformation plans. Improving the primary care estates , working in partnership with integrated community services infrastructure development priorities and plans		✓
Improve access to general practice – commence planning to provide additional consultation capacity per 1,000 population including on-line consultation systems, address inequality in access and commission additional capacity for evening and weekends reflecting local need		✓
Urgent primary care – develop improved care integration between GP extended care and out of hours		
Design a rolling Annual Programme of Quality Improvement and develop a set specific standards to address variation and improve outcomes	✓	
Commence work to address the General Practice workload challenge by local delivery of Releasing Time for Care Programmes and supporting the implementation of the 10 high impact changes	✓	
Deliver workforce development plans to address General practice resilience, supporting the development of skill-mixed teams for delivery of new models of care	✓	
Develop Prevention at scale –work with localities to develop models of care which facilitate supported self-care, improved health and wellbeing including training for care navigators	✓	
Commence the organisational development of general practice to enable primary care to be equal partners in new collaborative arrangements	✓	
Further develop commissioning of primary care to deliver care at scale		✓
Implementation of the integrated community services new care models to reflect local care needs		✓

3.1 The CCG Primary Care Support Offer includes the following;

- Named CCG senior link manager
- Protected learning and development time
- Project management support
- Facilitation Access to an expert team – local and national resources

With this in mind the CCG has moved to recruiting three Primary Care Programme Officers, to supplement the existing primary care team.

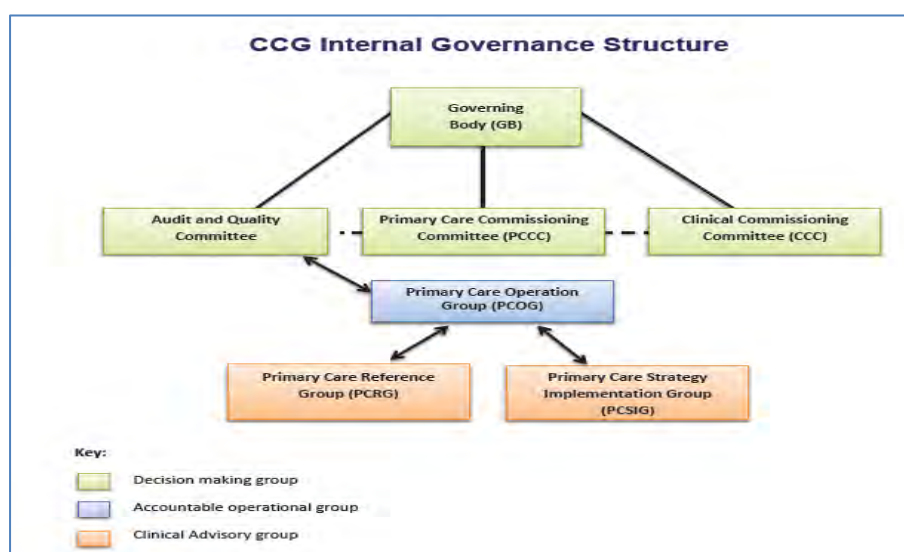
As part of the development of their plans the CCG will support the development of Locality Blueprints. These will take account of local circumstances and priorities and our intelligence would suggest the following being included:

- Clinical pharmacy in primary care

- Urgent Care developments
- Elderly / frailty / >75s
- Back office support

3.2 Governance Arrangements

The CCG have established a number of governance structures as shown in the following diagram. The notes of some of these are in the public domain and have included recently, agreement to specific practice mergers; a review of Over 75s initiatives; and the Phlebotomy 2017/18 Local Enhanced Service (LES).



4. Implications for RBCH

In response to the above issues the Trust has developed a diagrammatic representation of our plans to support or address these issues (Appendix C). This has been shared with local GP representatives and it is hoped that as their plans develop shortly, they will match those portrayed on the diagram. A key reflection on the above strategies and plans is our view of their realism in the face of past history and the level and variety of pressures facing the health system overall and general practice in particular. There are a number of significant risks facing the Bournemouth part of the Dorset health system and these are tabulated below:

Risk	Likelihood	Impact	Rank	Mitigation
Insufficient finances are available to ensure the stability of primary care and the development necessary to support the operation of RBCH and the CSR.	High	Med		Be prepared to invest our resources alongside GP resources to ensure Max impact and coherence

The CCG is a commissioning organisation and does not have the expertise (clinical / managerial) to support the level of change required	Med	High		Continue to offer our support., sound out internally re staff that might work in primary care.
There are some leaders in primary care, but this is insufficient to engineer the level of changes required.	Med	High		Appointment of three GPs to work across East Dorset, with the ICPS agenda.
Slow process to enact change.	Med	High		Develop JV or similar to share expertise, experience, responsibilities and rapid decision making e.g. over UCC.
The Trust continues to be seen as part of the problem rather than part of the solution and therefore we are not able to deploy our resources or expertise.	High	Med		Continue to develop relationships with GPs and CCG in this area. Develop a portfolio of support for practices, merged practices and federations.
Lack of discussion leads to overlap in initiatives i.e. GPs develop their own versions of QI & OD, over 75s	High	Low		Present GPs localities and CCG with synopses of our OD and leadership programmes
In a similar way to inter-organisation boundary disputes the GPs have exactly the same issue at practice level, making the level of trust required difficult to develop sufficiently quickly.	Med	Med		Try to develop as independent facilitator able to engender collaboration.

5. Recommendation

The associated paper on developing ICPS in the Bournemouth and Christchurch area sets out the wider agenda. Supporting the detailed work on practice development plans, led by primary care, requires RBCH to take a listening and facilitating role, aware of and mitigating the risks, but mindful that without a successful and flourishing primary care, secondary services will be overwhelmed. Therefore support for specific initiatives as they emerge is requested. The most pressing of these is the UCC proposal, considered in detail in the separate paper on this.

Appendix A

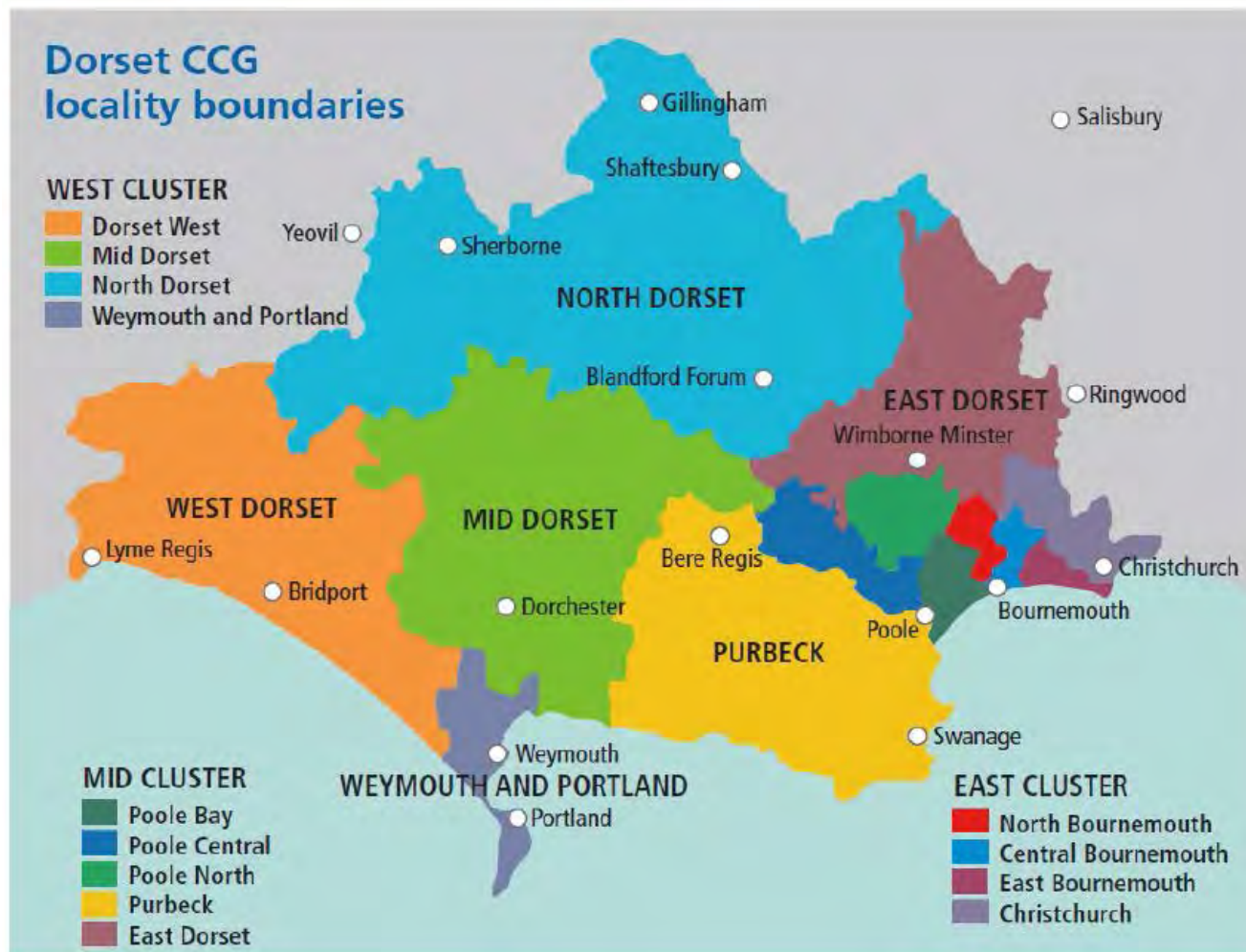
OUR PLANS FOR INVESTING IN GENERAL PRACTICE

There is a requirement for General Practice funding to be increased in line with CCG core growth which is 2% for 2017/18 or £165K. The CCG is planning to invest £200K to support the Primary Care transformation agenda in 2017/18.

Theme	Allocation Method	Ambition	Funding £M				
			2016-17	2017-18	2018-19	2019-20	2020-21
Primary Care Transformation Fund £3 per head	Non recurrent allocation NHSE	Investment over 2 years from core CCG allocation to secure sustainability, stimulate development of at-scale providers and 10 high impact changes	0.5				
	Reinvestment of existing funds	Redeployment of locality fund into Primary Care		0.8	0.8		
	New funding 2017/18 from CCG Core	New investment from CCG Core		0.2	0.4		
	Reinvestment of existing funds	Redeployment of 2016-17 Primary Care development fund		0.1	0.1		
			0.5	1.1	1.3		
Access (recurrent funding)	New funding 2017/18 as advised by NHSE within Operational Planning Guidance.	Increase consultation capacity by 45 minutes per 1,000 registered population			2.8	5.0	5.0
Patient on-line consultation systems (Non Recurrent)	New funding 2017/18 as advised by NHSE within Operational Planning Guidance.	Transformational change at practice level to provide on-line consultations		0.2	0.3	0.1	
Training for Care Navigators and Medical assistants for all practices (Non Recurrent)	New funding 2017/18 as advised by NHSE within Operational Planning Guidance.	Part of a General Practice development programme Admin and clerical training – signposting (2016-17); Training care navigators and medical assistants (2017-18)	0.1	0.1	0.1	0.1	0.1
General Practice Resilience (Non Recurrent)	New funding 2017/18 as advised by NHSE within Operational Planning Guidance.	Funds held by NHS England (Wessex) local team	0.2	0.1	0.1		
Estates Sustainability and Transformation* (Non Recurrent)	New funding 2017/18 as advised by NHSE within Operational Planning Guidance.	New funding awarded for successful bids	0.2	0.5	0.5	0.5	0.5
GPT	Funding held with NHS England	Nationally procured IM&T systems					
GP trainees	Funding held with Health Education England	Programmes managed by HEE					
Public Health	Funding held with NHS England	National programmes Section 7A, supporting payments to GPs for screening & immunisation services					
Mental health therapists	Funding held with NHS England	3,000 Practice Based MH Therapists					
Total Investment in Primary Care in Dorset			1.0	2.0	5.1	5.8	5.6
TOTAL			Over 5 years				
							19.6

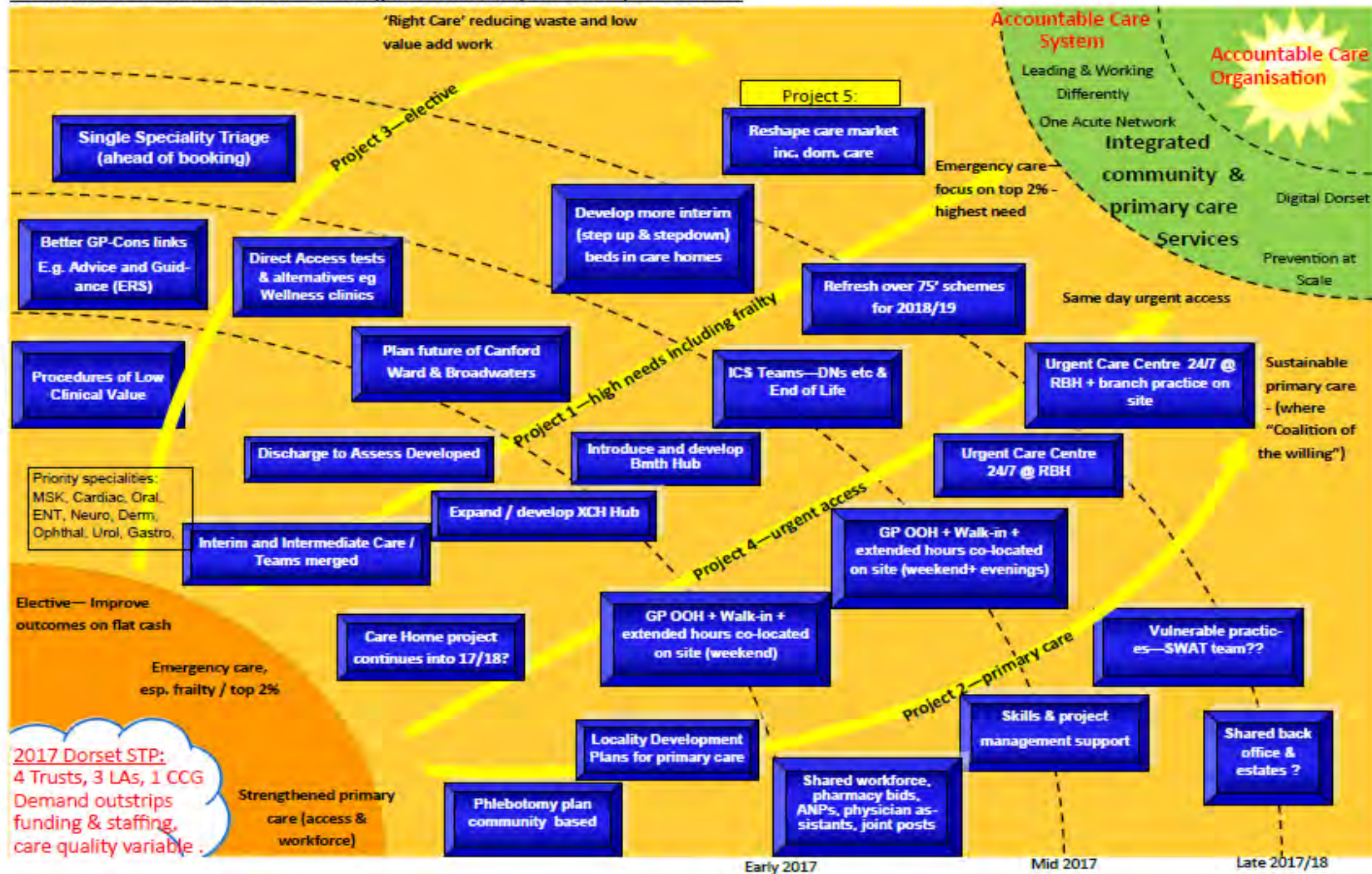
*additional Estates Capital subject to NHS England review and due diligence of recommended programmes

Appendix B



Appendix C

Bournemouth and Christchurch Cluster—Integrated Community and Primary Care Services



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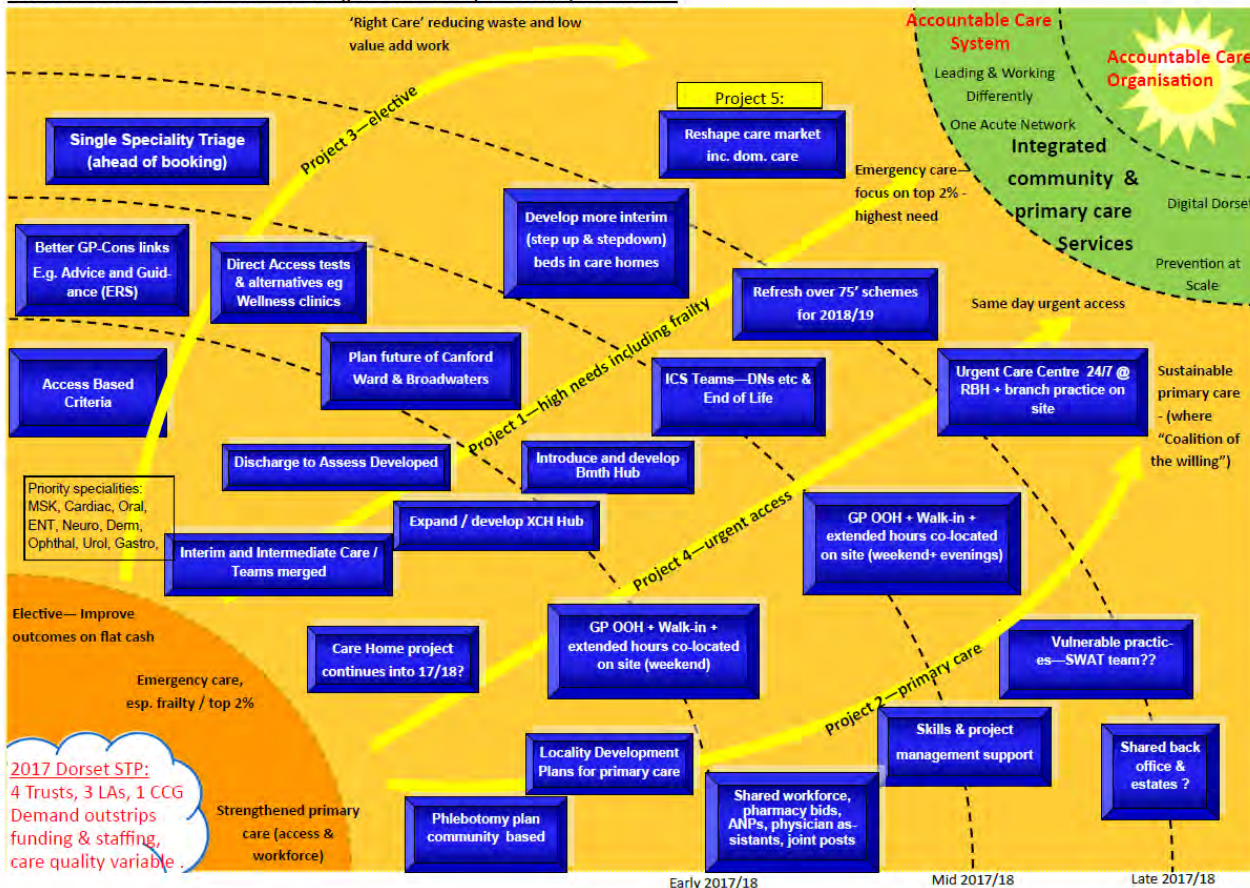
BOARD OF DIRECTORS

Meeting Date and Part:	28 th April 2017 – Part 1
Subject:	Update on Social and Community Services Integration (Reducing Emergency Demand & Delivering STP in 2017/18)
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:	Richard Renaut, Chief Operating Officer
Details of previous discussion and/or dissemination:	None
Action required: Approve/Discuss/Information/Note	For discussion and feedback
Executive Summary: This paper sets out the key developments proposed for the Bournemouth and Christchurch locality for 2017/18 under the banner of 'Integrated Community & Primary Care' (ICPS).	
Relevant CQC domain: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?	Yes Yes Yes Yes Yes
Risk Profile: i) Impact on existing risk? ii) Identification of a new risk?	<ul style="list-style-type: none"> ▪ Emergency Demand and 4 hour target ▪ Elective Demand Management

Update on Social and Community Services Integration (Reducing Emergency Demand & Delivering STP in 2017/18)

1. Exec Summary

Bournemouth and Christchurch Cluster—Integrated Community and Primary Care Services



This paper sets out the key developments proposed for the Bournemouth and Christchurch locality for 2017/18 under the banner of 'Integrated Community & Primary Care' (ICPS).

These are practical steps to best manage demand and reshape services in line with the vision of the Stability & Transformation Partnerships (STP). The strategic context is covered below. The focus of this paper is to provide a brief oversight of each of these developments within the wider context, (sense making how it fits together). Then to explain the governance so that these changes actually happen and deliver the benefits for the population we serve.

The work is multi agency and requires the Accountable Care System (ACS) approach. Dorset is a potential nationally recognised ACS, allowing new ways of working. This means moving away from payment by results and silo commissioning and providing and towards an integrated system, working towards shared success. However this policy context is of little use without real benefits to the population we serve, hence the focus of the paper is on tangible improvements.

Using the ICPS ‘project headings’ these are:-

Project 1

Focus on highest intensity needs (top 2% of population). Predominately work on patients in hospital, care homes or intense packages of care, or end of life pathways. A large part of this is frailty and the last two years of life.

Project 2

Medium intensity needs such as Long Term Conditions (LTC) through enhancing primary care, working at scale.

Project 3

Routine elective care, linking into the 9 specialties (see map) and Right Care projects, and re-design of traditional referrals and care pathways.

Project 4

Urgent care spanning primary care, out of hours and ED minors, with the development of an Urgent Care Centre (UCC) at RBH.

Project 5

Reshaping the care market for domiciliary, care and nursing homes, through direct support and commissioning.

There is other important work happening in children’s services, mental health, learning disabilities and elsewhere with actions and governance. However to have a manageable, focussed work plan for the year ahead, requires a defined scope, which the five projects cover.

2. Strategic Context

The quadruple aims of a health system are:-

Maximum health gain for defined population	High quality, person-centred care
Sustainable (for funding, workforce and facilities)	Meaningful work with motivated staff

The STP (including the Clinical Services Review[CSR]) is aiming to achieve the above through the programme areas of:-

Prevention at Scale
Integrated Community & Primary Care
One Acute Network

Supported by:-

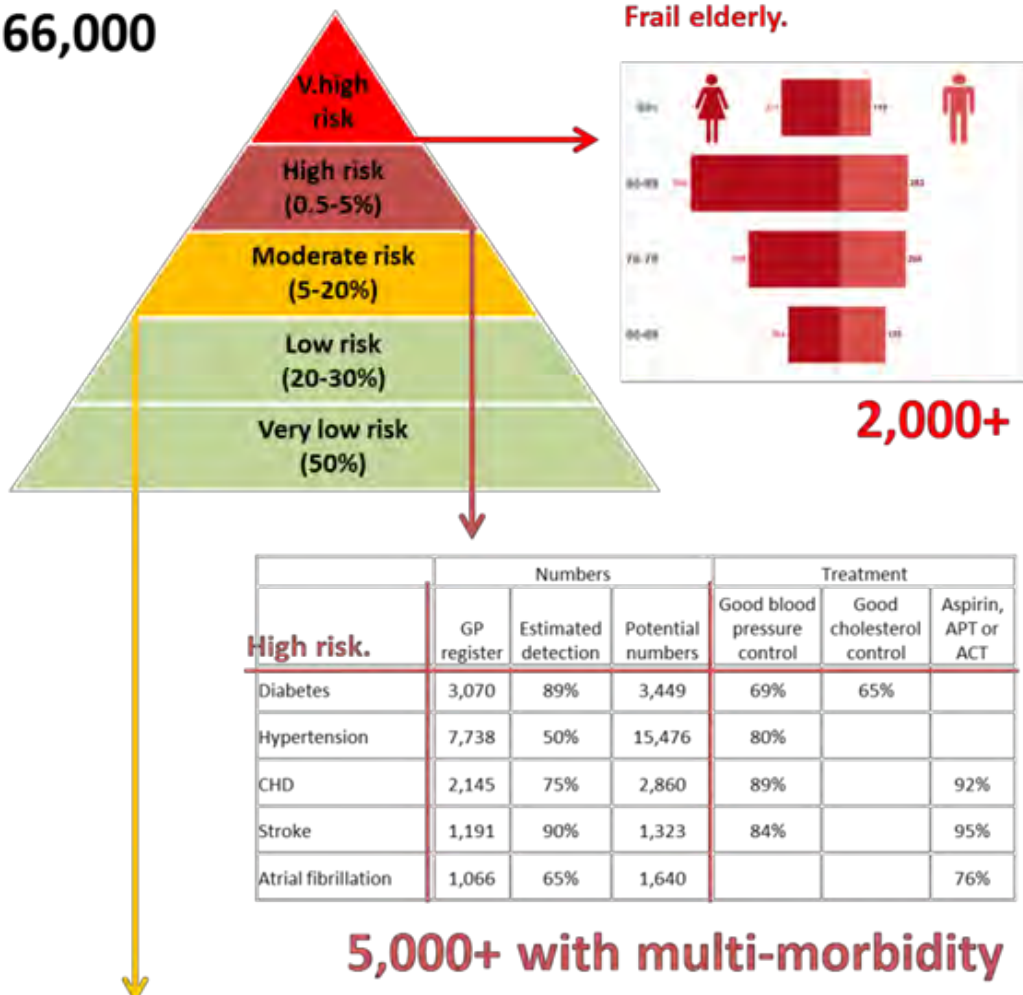
Digital Dorset
Working Differently

These five programmes represent the way the STP will be delivered over the coming years. The more the work is done via the ACS approach the more the focus on the quadruple aims and the less on organisational form. Hence why the ‘pyramid of need’ and ensuring the right focus is co-ordinated for the population, to maximise benefits for

example, the North Bournemouth locality has 66,000 population, and c2,000 as high need.

Patients in North Bournemouth locality

66,000



Moderate risk.		Count	%
Children living in poverty		2,450	20%
Admission to hospital with Alcohol related harm		1,650	-
GP register:	Mental health	588	1%
	Depression	3,637	6%
	Dementia	467	1%
	Learning disability	385	1%
	Visual impairment	-	1%
	Hearing impairment	-	4%

9,000+

Here and now, for 2017/18 the NHS and Local Authorities are judged on simple measures: staying within the budgets (with deficits for all acute NHS providers), and collectively achieving the 4 hour standard for Emergency Departments (ED). Quality measures (CQC ratings, etc.) also are pertinent. The reason, nationally, 4 hours is so important is that it reflects whether systems are working – from primary care, ambulances, hospitals, community services and social care. Any one of these struggling and the pressure plays out with full hospitals and ambulances unable to offload

emergency patients. This is at the heart of the publicly funded, and trusted, health service.

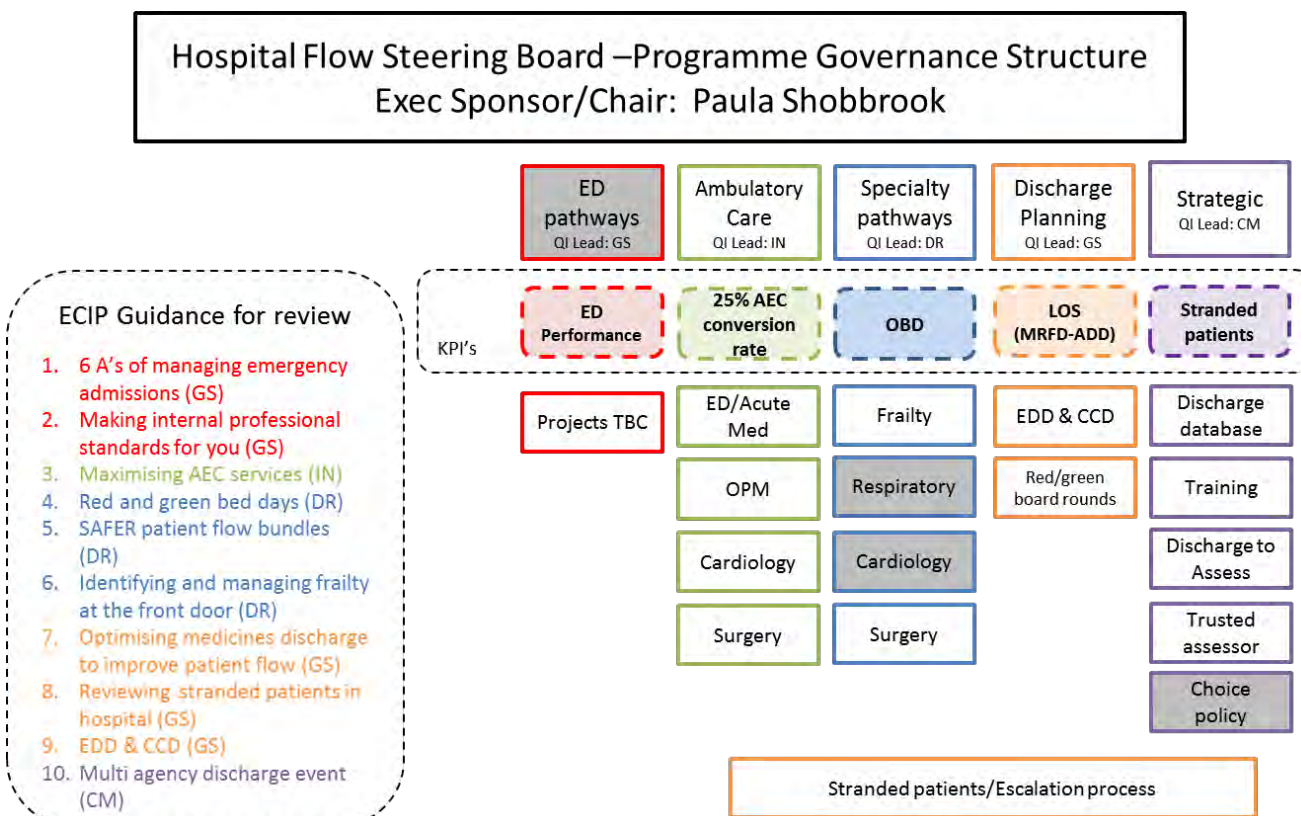
Dorset, (including Bournemouth and Christchurch) starts in a strong place, as in the top 10% for ED performance. Collectively we can take pride in this. However it is fragile and requires new ways of working and improvements every year to maintain this. This is why the following developments are proposed for 2017/18.

This paper focuses on the urgent care work streams. The elective (Project 3) and primary care (Project 2) are covered separately (see elective and primary care development plans).

All this work occurs in the “flat cash” (i.e. no new funding) for 2 years, so most of the effort is in reusing skills and resources in new and better ways, and diverting lower value activities to move to higher benefit work. The STP sets out the framework and vision. This paper attempts to move this to implementation, with the most pressing areas to address, with greatest benefit in meeting the 4 hours, budget and wider gains against the “quadruple aims”.

In parallel with this ICPS work RBCH is looking to improve its internal processes for emergency care. This will lead to better alternatives to admission (e.g. ambulatory care), better ‘processing’ at the front doors (e.g. ED, frailty and other clinical pathways), and better management of discharge processes (making it easier for partners to work seamlessly for patients). We have already seen in 2016 how improved frailty pathway leads to lower patient harm and greater independence, less bed days and a virtuous cycle for patients, staff and long term care costs.

The RBCH Quality Improvement (QI) plan for flow is:-



This work will be co-ordinated with the ICPS work, but can be progressed separately. The focus of the rest of this paper is on the ICPS.

3. 2017/18 Developments in Integrated Community & Primary Care

Project 1 – High activity needs, top 2% including frailty

(Actions for 2017/18 in Roman Numerals)

3.1 Enhanced primary care support in care homes

- i) Focus on homes with greatest need and highest ambulance call outs to improve staff skills and improve Anticipatory Care Plans (ACPs).
- ii) Better co-ordinated GP practice input into homes and move to more “1 home – 1 practice” with proactive care.
- iii) Development plan against the national best practice ‘steps’ to improvement, and co-ordinate input from public agencies (LA’s, CCG, SWAST, DH, RBCH, etc.).

3.2 Expand / Develop Christchurch Hub

Set up in 2016 good progress has been made to co-ordinate multi-agency resources for over 75’s in the Christchurch area. In 2017/18 to:-

- i) Have improved IT intra-operability.
- ii) Expand to admission avoidance work.
- iii) Better engaged GP’s and extended primary care.
- iv) Look to cover ‘Avon Valley’ GP’s in Hants (Ringwood, New Milton, etc.).
- v) Look to cover Southbourne/East Bournemouth locality.

3.3 Introduce and develop Bournemouth Hub

Using the Christchurch (and Weymouth) model to introduce this for Bournemouth residents; offices based at the Fearnies in Knyverton Road, Central Bournemouth.

- i) Focus on co-ordinated agency set up including IT.
- ii) Initially for discharges.
- iii) To develop admission avoidance and links with bed based project (see Fearnies, Canford and Broadwaters at 3.8).

3.4 Integrated Community Services (ICS)

The extended primary care team (“Primary Care Home”) mean primary, community and aspects of social care, all working as a cohesive whole. Based around populations of 50,000 these probably reflect similar footprints to localities, but with practice mergers they may become truly list based, integrated teams operating at scale, which may be Multi-Specialty Community Providers (MCP).

- i) Define project scope and populations served and services covered.
- ii) Align parties and agree change programme and success criteria.
- iii) Implementation in a phased way.

3.5 Refresh over 75's scheme for 2018/19

This practice based funding has been used in a variety of ways and reviewing and identifying what is working and what can be improved, and whether the scale of 50,000 populations will improve skill mix, resilience and outcomes. This would then test further and reinforce the benefits from care home work, hubs and ICS teams work.

- i) Review and refresh use of this funding.

3.6 Interim and Intermediate Care Teams Merged

These teams are both in the business of what defines intermediate care – rapid response to avoid admission and supported discharge. Bournemouth ICS (BICS) focuses on the former in Bournemouth and Interim Team on the latter (for the whole RBCH catchment, using directly provided reablement based care, and some interim placements in care homes). Bringing the teams together under single governance, with consultant community geriatricians able to take greater risk on discharge to allow earlier recovery will make the single service more than the sum of its parts. This would allow Discharge to Assess (D2A) and reduce acute beds and long term social care costs, in line with evidence from elsewhere in the UK.

- i) Agree approach to interim and intermediate care with DH, RBCH and Bournemouth Borough Council (BBC).
- ii) Map resources, skills, workloads and priorities.
- iii) Agree links with hubs, interim beds and care homes, and ICS teams.
- iv) Develop software to improve team deployment and shared records.

3.7 Discharge to Assess (D2A)

This is the highest impact intervention to reduce stranded patients in care, as long term assessment out of hospital is far more accurate and usually lower cost. To do this requires major change of mind sets, then process on NHS wards, as well as amongst hubs, community and social care. Having effective step down domiciliary care and interim beds is also crucial, so the flow works and you avoid assessment to get to D2A(!) and all patients follow a single pathway. The NHS funding the first two weeks out of hospital, while the discharge occurs and assessment happens is a key element.

Having a single process (rather than 4 LA's, self-funders and 2 x continuing healthcare [CHC] routes) requires significant trust, hence, trusted practitioners, training and systems (including an app) are being developed.

- i) Agree D2A and single Dorset approach/process.
- ii) Agree the project resources to implement and governance to drive it.

- iii) Significant training and systems development undertaken across partners.
- iv) Achieve 90% of D2A (and thus no DTOC's), and therefore flow of social work to community.

3.8 Plan for future of Canford Ward and Broadwaters

BBC plans to relocate 20 Broadwater beds to the Fearnese, and close Broadwaters. Canford ward is planned to close and the 16 beds could move and fill the 18 empty beds remaining at Fearnese. To be successful the criteria and staffing skill mix will need to be sufficient to take patients that cannot be support at home (i.e. sub-acute, and not simple rehab)

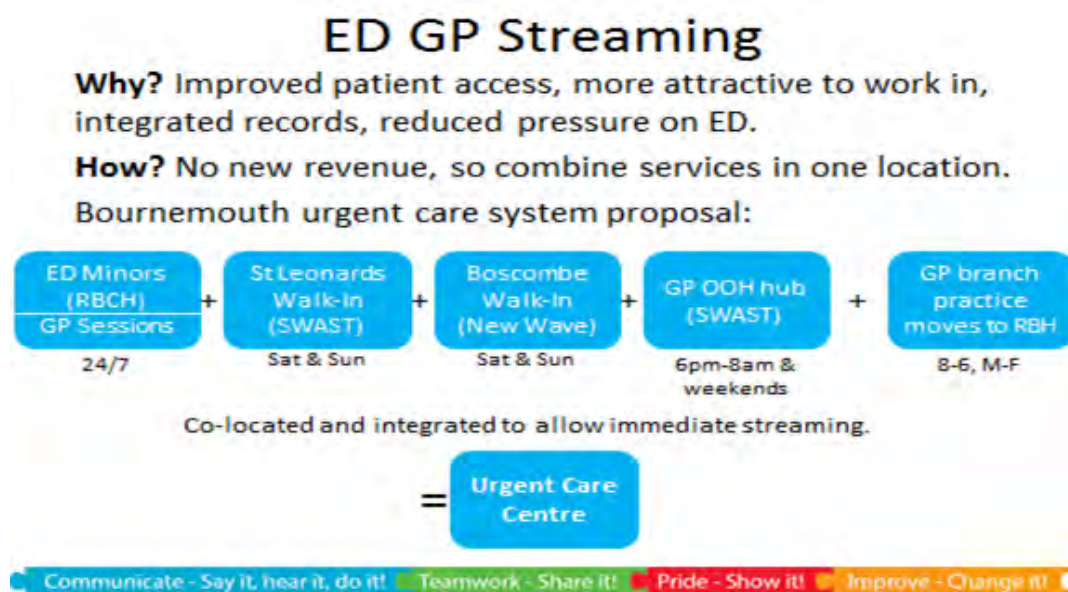
- i) DH, RBCH, Tricuro and BBC need to work together to agree the needs to be met for the locality and appropriate skilled staffing to achieve this.
- ii) To agree a timeline and budget for the new service along with success criteria for step down and eventually step up beds.

3.9 Interim Bed Capacity

Develop more interim bed capacity (in line with CSR consultation) as an expansion is required to support the green/major acute hospital configuration. This links with interim/intermediate team (3.7) and reshaping the care market (Project 5). The strategy of working with a small number of homes, with a small percentage of beds for interim (to avoid “all eggs in one basket” and overloading a home) will continue but with the aim to move from circa. 20 to circa. 40 beds and typical stays of two weeks without becoming ‘stranded’, e.g. move home or to permanent care home in that time.

- i) Brokerage teams work with new and existing homes to expand beds available
- ii) Refine needs the beds must meet, in light of demand and changing intermediate, interim and Fearnese facilities

4. Project 4 Urgent Care Access



The CSR/STP talks about an Urgent Care Centre (UCC) to reduce pressures on the ED for East Dorset, and serving the local area as a hub for urgent access. The population, understandably, is confused by extended GP hours, walk-in centres, minor injury units and ED's, and where to go. As a result, 20-30% of walk-in activity in ED's could be deemed 'urgent primary care'. Likewise much of GP practice workload for same day appointments could be seen by other professionals (paramedics/advance care practitioners, nurse practitioners, physio's or pharmacists). This skill mix is only possible when there is sufficient scale and volume. In rural areas travel distances may affect this, but the predominantly urban catchment means a UCC could serve all of Bournemouth and Christchurch.

As the public head to "where the light are on" the Keogh Review concluded it is better that UCC's are co-located with ED. The recent national announcement is that the "Luton Model" for this should be in place by September 2017, reusing existing resources for Bournemouth and Christchurch. This is the Boscombe and St Leonards walk-ins (on Saturday and Sundays), the GP OOH hub at RBH and the ED minors and weekend GP service. Stretching these resources to cover 8.00am to 11.00pm is a challenge. However, relocating a branch surgery to cover 8.00am to 6.00pm Monday – Friday for urgent care would allow this to become viable.

Long term, this UCC could host extended GP hours access for practices looking to collaborate on this change, required by the Government by 2019. With clear opening hours, a single site, GP governance, local connections with other practices, integration with other SWAST GP OOH hub and thus 111 and 999 services, this should make a significant improvement to urgent care in Bournemouth and Christchurch, within existing resources.

5. "Project 5" Reshape Care Market

The 3 LA's and CHC purchase the state funded care which is less than half the care market (as self-funders are a larger share). A short summary of work plans for 2017/18 includes:-

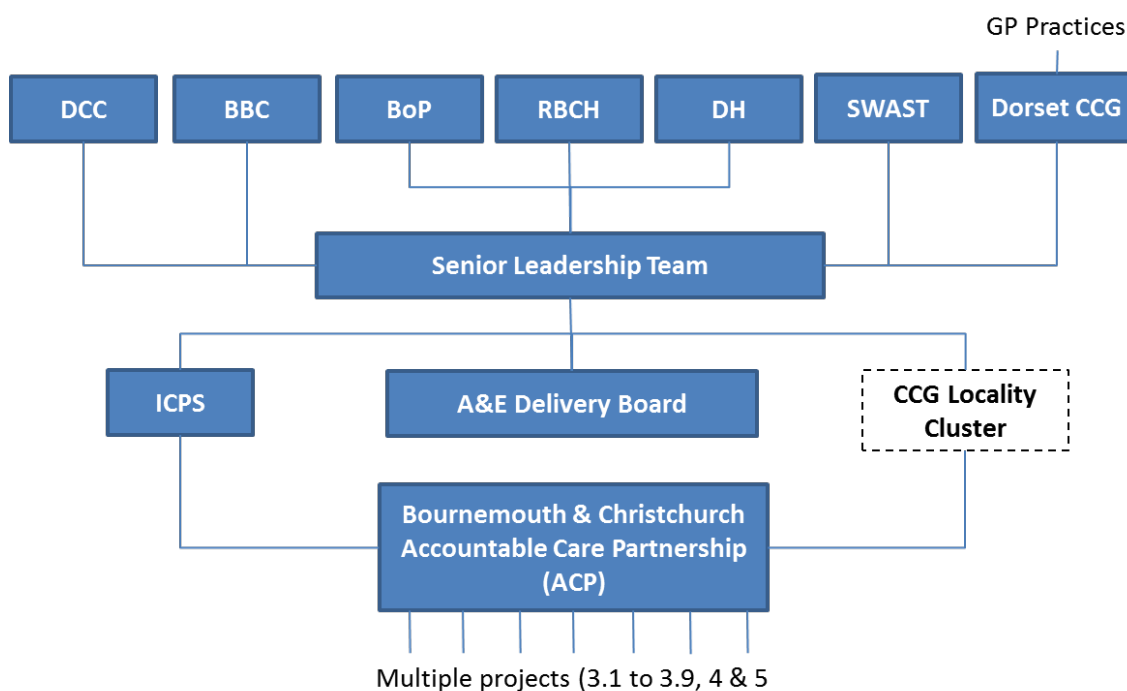
- i) Pooling DCC social care and DCCG CHC budgets to provide one brokerage and more aligned objectives.
- ii) New framework for domiciliary care, as Bournemouth and Poole LA's look to move more providers onto long term, sustainable contracts and thus improve availability.
- iii) Better Care Framework (BCF) update for 2017/18 including use of the additional £1bn nationally granted to reduce hospital bed occupancy, and shift resources to prevention and independence.
- iv) Reflect growing self-funder balance of delays in hospital by continuing bespoke self-funder support (e.g. CHS pilot), and targeted support for complex cases.

6. Governance and Progress

6.1 This is an extensive agenda of work, for one year. It comes from over two years discussion through CSR and draws heavily on the evidence and best practice. However, it is always in the implementation that the real difference is made for patients. Therefore this section is especially important. The ingredients are:-

- A. Leadership. Each project needs a project manager, medical and nursing/AHP lead that are recognised and respected by all partners.
- B. They require a scoping phase and a Project Initiation Document (PID) setting out aims, outcomes, resources, timescale, risks and mitigations, stakeholders and link leads for relevant organisations.
- C. These developments are in complex, adaptive systems requiring agile project management. Use of QI methodology and the NHS recommended approaches (e.g. PDSA, patient/user involvement) needs the skills and resources to achieve success, which is sustainable, and based on iterative experimenting.
- D. Oversight, escalation to remove barriers and persistence to overcome inertia requires senior multi-agency alignment and desire to succeed. The PID's require a method of escalation to ensure resources and outcomes are aligned.

6.2 Escalation requires the governance wiring diagram for this work to be considered as below, with ICPS and A&E delivery both looking to the ACP for delivery.



6.3 Progress will be required at pace, given the pressures on ED performance, practices and social care providers for budgets, workforce and standards. The strategy map broadly shows the quarters of the year that the tangible delivery needs to start from. The outcomes nationally expected are measured monthly by ED 4 hours and budget control. Locally other metrics will be used but these two are crucial for safety and public confidence. Local measures like occupied bed days, stranded patients, rates of long term care, numbers having D2A, public satisfaction with GP services etc. will also be tracked and shared via the ACP for Bournemouth and Christchurch.

Where the developments cannot be delivered before the winter of 2017/18 then partners will need to assess what greater resource is required to move things faster, or the risk of abandoning progress in year.

- 6.4 Accountability for RBCH is clear via the ED performance and budget control total. DH has a central total and has agreed to develop a risk share approach on ED. SWAST's ambulance handover performance is directly linked to ED. For LA's and CCG, the BCF has measures and the additional £1bn is linked to reduce DTOC's and beds with the "medically ready for discharge" (which will help the ED flow, if they improve). The BCF could expand to include other measures such as D2A ratios and waits for placements. The CCG's CHC performance will also need tracking as it can contribute to significant benefits such as End of Life care and D2A out of the acute beds.

7. Recommendation

Primary care development plans are under the leadership of the locality cluster GP leads, reporting to the CCG.

The elective work programme is under the Right Care and OFRG governance. Both are reporting into the Senior Leadership Team (SLT).

Feedback on both of these to the Bournemouth and Christchurch ACP will improve co-ordination and chances of overall system success. However the focus of this paper is the key projects for:-

- **high intensity, users including frailty;**
- **urgent care access; and**
- **reshaping the care markets.**

The specific projects for 2017/18 are as proposed in sections 3, 4 and 5. These are the priorities, and therefore other work is lower priority.

If this is supported then the actions of 6.1 A to D are required urgently. To pull this together will require each organisation to contribute and trust each other, and to sign off the finalised version by the end of April 2017.

Feedback on this approach should be to Richard Renaut, Chair of the Bournemouth and Christchurch ACP, before the end of April, and to then feed into the Dorset wide ICPS Programme Board.

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BOARD OF DIRECTORS

Meeting Date and Part:	28 April 2017 Part 1
Subject:	Register of Interests
Section on agenda:	Governance
Supplementary Reading (included in the Reading Pack)	None
Officer with overall responsibility:	David Moss, Chairman
Author(s) of papers:	Karen Flaherty, Trust Secretary
Details of previous discussion and/or dissemination:	Previous Board meetings where interests have been declared
Action required:	Information
<p>Executive Summary:</p> <p>The Trust is required to maintain a register of interests for its Directors. This facilitates the identification and management of potential conflicts of interests by the Board of Directors. The register is reviewed annually by the Board to ensure that it is up to date as the information will be used in determining any disclosure required in the Annual Report and Accounts.</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>	Well-led
<p>Risk Profile:</p> <p>i. Impact on existing risk?</p> <p>ii. Identification of a new risk?</p>	

REGISTER OF DIRECTORS AND DIRECTORS INTERESTS 2017/18

Director	Appointed/ Reappointed	Resigned/ Removed	Interests Declared	Acquired	Declared	Ceased
Karen Allman Director of HR	01/06/2007		Governor. Queen Elizabeth's School, Wimborne Minster	February 2017	April 2017	
Tea Colaianni Non-Executive Director	I. 01/11/2016		Non-Executive Director for Mothercare Plc. Non-Executive Director for SD Worx	October 2016 January 2017	November 2016 January 2017	
Peter Gill Director of Informatics	01/06/2016		No relevant or material interests.			
Interim Director of Informatics	01/02/2015	31/05/2016				
Christine Hallett Non-Executive Director	I. 29/06/2015		No relevant or material interests.			
Stuart Hunter Director of Finance	22/07/1999		Director of The Bournemouth Private Clinic Limited Director and member of The Bournemouth Healthcare Trust Management Board member of the Christchurch Fairmile Village LLP P	February 2016 February 2016 September 2014	July 2016 July 2014	
Alex Jablonowski Non-Executive Director	I. 20/06/2016		Director of Datalyx Ltd Director of High Performance Leadership Ltd Non-Executive Director for Valuation Office Agency Non-Executive Director for Wilton Park Non-Executive Director for Maritime Coastguard Agency Non-Executive Director for Office for National Statistics Programme Board Chair of City Fencing Club Chair of Defence Electronics and Components Agency Member of London Veterans Advisory and Pensions Committee		June 2016	
John Lelliott Non-Executive Director	I. 01/06/2016		Wife is a Physiotherapist at Bournemouth Nuffield Hospital Vice-Chairman of Asthma UK Chairman of Natural Capital Coalition Management Board member of the Christchurch Fairmile Village LLP	June 2016 July 2016 June 2016	December 2016 May 2016 July 2016 June 2016	
David Moss Chairperson	I. 13/03/2017		No relevant or material interests.			
Alyson O'Donnell Medical Director	07/11/2016		No relevant or material interests.			

REGISTER OF DIRECTORS AND DIRECTORS INTERESTS 2017/18

Stephen Peacock Non-Executive Director	I. 01/10/2009-30/09/2013 II. 01/10/2013-30/09/2016 III. 01/10/2016		Director of Corporate Finance for the Estee Lauder Companies Wife is a Non-Executive Director for Tricuro Limited and Tricuro Support Limited	April 2012 December 2015	April 2012 December 2015	
Richard Renaut Chief Operating Officer	12/09/2014		Married to Christine Renaut – an employee of the Trust (Pharmacist)	April 2009	April 2009	
Director of Service Development	29/10/2001	11/09/2014	Director of The Bournemouth Private Clinic Limited Management Board member of the Christchurch Fairmile Village LLP	January 2016 September 2014	July 2016 July 2014	
Cliff Shearman Non-Executive Director	I. 01/04/2017		Company Secretary of Wessex medical Reporting Limited Member, Council of the Royal College of Surgeons Chairman of the Grants Award Committee, Pelican Cancer Foundation Member of Programme Organising Board, Charing Cross International Vascular and Endovascular Symposium	July 2015 2015	April 2017 April 2017 April 2017	
Paula Shobbrook Director of Nursing and Midwifery/ Deputy CEO	05/09/2011		Husband is director of various group companies of Albany Farm Care care homes, Hampshire.	February 2014	February 2014	
Tony Spotswood Chief Executive	04/01/2000		Trustee Board Member of NHS Providers (formerly the Foundation Trust Network) Chair of Clinical Research Network, Wessex National Institute for Health Research - member of the Board and Chair of the remuneration committee Board member, Wessex Academic Health Science Network Director of The Bournemouth Private Clinic Limited Director and member of The Bournemouth Healthcare Trust	April 2010 February 2015 July 2016 May 2015 January 2016 January 2016	April 2010 February 2015 July 2016 March 2014	May 2016 January 2017

BOARD OF DIRECTORS MEETING – 28 APRIL 2017

PART 2 AGENDA - **CONFIDENTIAL**

The following will be taken in closed session i.e. not open to the public, press or staff

The reasons why items are confidential are given on the cover sheet of each report

Timings		Purpose	Presenter
11.00	1. MINUTES OF PREVIOUS MEETING		
	a) To approve the minutes of the meeting held on 31 March 2017	Approval	All
11.05	2. MATTERS ARISING		
	a) To provide updates to the Actions Log		All
11.10	3. STRATEGY AND RISK		
	a) Significant Risk and Assurance Framework (paper)	Discussion	Paula Shobbrook
	b) Clinical Services Review (verbal)	Information	Tony Spotswood
	c) Development of Trust Strategy (paper)	Approval	David Moss/ Tony Spotswood
	d) Reflections on Board to Board Meeting with Poole Hospital (verbal)	Information	Tony Spotswood
	e) Development of Vascular Network (paper)	Discussion	Alyson O'Donnell/ Sarah Hulin To Follow
	f) Ensuring Best Value from Flat Cash Resource – Programme Update (paper)	Information	Richard Renaut
12.10	4. GOVERNANCE		
	a) Well-led Action Plan (paper)	Discussion /Decision	Tony Spotswood
	b) Senior Independent Director (paper)	Decision	David Moss
	c) Non-Executive Director Appointment (paper)	Discussion	Karen Allman
	d) Draft Annual Report and Accounts and Quality Account (paper)	Review	Stuart Hunter/ Paula Shobbrook/ Karen Flaherty
	e) Sealing of Deeds (paper)	Decision	Karen Flaherty
12.45	5. ANY OTHER BUSINESS		
	a) Key Points for Communication to Staff		
	b) Reflective Review		

The meeting will be followed by a Blue Skies session on capacity and scenario planning for the implementation of the Clinical Services Review