Operational Plan 2017/18 & 18/19

Activity planning

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

Modelling Demand and Capacity

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

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

Elective Care

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

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

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

Non Elective Care

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

Managing Demand and Developing Capacity

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

System-wide Demand Management

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

Main programmes	Action	Stage 1 Deadline	Accountability
Stream 1			
a. Referral Management	Define work programme, with specific interventions by specialty focussing on; • Doing things differently e.g. best practice, In-house second opinion, Educational Interventions & structured referral guidelines • Productivity improvements e.g. follow-up review & advice & guidance • One Dorset Approach to referral process e.g. peer review, with specialist feedback	**by 31 January 2017** • Speciality Clinical Meetings to be established • Review Data pack • Agree opportunities and develop plans for implementing • Monthly Update to Joint COO /Medical Director Meeting **by 28 Feb 2017** • Update Clinical Commissioning Committee 15 February 2017 • CRG February **by 31 March 2017** • Implement changes across the speciality	**AB:** • Dermatology • ENT • Neurology • Oral surgery **CD**: • Gastro • Ophthalmology • Orthopaedics • Urology **EF:** • Cardiology
(b) Primary Care Demand Management – referrals and triage	Mobilisation plan for Q1-4 2017/18 with specific focus on: • Reducing variation • Peer review of referrals • Triage of key specialties	**By 15 February 2017** Final plan to be signed-off at the Clinical Commissioning Committee, to include transparent KPIs for monitoring across all 13 localities **by 31 March 2017** Implement changes across the speciality	**GH** supported by IJ
Stream 2			
(a) Low Priority Procedures	Review and endorse limited clinical value procedures process (e.g. Hampshire)	**by 31 January 2017** • CRG briefing 5 January 2017 • Provider clinical executive meetings in January **By** 15 February 2017 • Clinical Commissioning Committee	**KL** working with 4x Medical Directors MN (CCG)

Main programmes	Action	Stage 1 Deadline	Accountability
(b) RightCare, value care and 'realistic medicine'	Mobilisation plan for quick wins Q1-4 2017/18.	**By 31 January 2017** • Provider clinical executive meetings in January **By 15 February 2017** • Clinical Commissioning Committee	**OP** to lead with IJ (CCG) & QR (RBH) link to COOs/ MDs to ensure ownership at each provider & GP ownership.
(c) Getting It Right First Time (GIRFT)	Mobilisation plan for quick wins Q1-4 2017/18.	**by 31 January 2017** • Provider clinical executive meetings in January • CRG February	**Medical Directors x4** speciality leads to be specified
Stream 3			
(a) NEL Demand Management work and 5 high impact changes	Outline delivery plan for Quarter 1-4 2017/18.	**By 11 January 2017** Draft plan to A&E Delivery Board, **By 19 January 2017** SLT	**KL,** working with COOs
(b) Opportunities of integration between community, secondary and local authority care	Outline delivery plan for Quarter 1-4 2017/18.	**by 31 January 2017** • CEOs/Chief Officers to compile list of suggested service areas that need to be reviewed and evaluated • prioritise the list together, so that attention is first focused on the specialties that will deliver most benefits through further integration • Develop greater integration, and whole system accountability in the conurbation and across Dorset. Accountable Care Partnership models may emerge from this work programme. **by 28 Feb 2017** • Mobilisation Plan to be shared with the Senior Leadership Team	**ST** working with CEOs, supported by KL and UV, GP leads to be identified **WX**, YZ (West) **BC, DE,** CD, AB (East) **and** KL
(c) Integrated Community Services and Primary Care Services (ICPS)	Outline quick wins for implementation in 2017/18	By 31 January 2017 • Dorset system to agree transparent KPIs for community services to demonstrate optimal utilisation of funded capacity	**FG** supported by HI
(d) Improved mental health services	Outline delivery plan for Quarter 1-4 2017/18.	**By 31 January 2017** • Plan to improve local capacity and reduce out of area placements as part of MH acute care pathway revision	**JK** supported by LM **OP**

Main programmes	Action	Stage 1 Deadline	Accountability
		• Plan to improve access to psychological services (IAPT) to meet new target thresholds	
Stream 4			
(a) Avoiding delayed transfers of care	Mobilisation plan for quick wins Q1-4 2017/18.	**by 31 January 2017** • Establish feasibility of common real-time reporting for DTOCs • Establish list of hotspots by patient/ward/service • Agree common protocols and service level agreements for timely discharge. • Draft Plan to make better use of system bed-capacity both in community and in acute hospitals **by 28 Feb 2017** • Mobilisation Plan to be shared with the Senior Leadership Team	**Chief Operating Officers** supported by Local Authorities

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

Developing Capacity - Elective

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

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

Developing Capacity – Non Elective

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

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

Operational Performance

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

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

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

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

Quality planning

1. Approach to quality improvement

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

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

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

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

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

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

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

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

The QI model structure ensures that there is a strong emphasis on metrics to monitor progress and demonstrate returns on investment using outcome, process and balancing measures identified and reported.
The RBCH Improvement Academy has been established to provide improvement skills training to all areas and has so far trained over 120 employees including consultants, nurses, AHPs managers and support staff. The emphasis is on providing staff with the skills to enable them to contribute to the larger projects as well as implementing smaller improvements at a local level.

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

2. Summary of quality improvement plan

Priorities for 17/18

HOSPITAL FLOW

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

This will be delivered through:

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

ESCALATION OF THE DETERIORATING PATIENT

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

This will be delivered through

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

SEPSIS

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

This will be delivered through

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

7 Day Services

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

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

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

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

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

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

Clinical Audit

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

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

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

The Trust QI programme will support compliance with national and local CQUINS.
The Trust will continue to focus on the importance of ensuring harm free care for patients, maintaining current improvements in the reduction in patient falls and hospital acquired pressure ulcers.

Anti-microbial resistance

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

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

Safe Staffing

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

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

Patient Experience

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

End of Life Care

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

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

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

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

STP priorities

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

3. Summary of quality impact assessment process

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

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

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

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

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

4. Summary of triangulation of quality with workforce and finance

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

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

Workforce planning

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

System Workforce

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

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

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

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

Local Workforce

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

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

Recruitment & Retention

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

Staff Development & Education

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

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

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

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

ORGANISATIONAL DEVELOPMENT AND LEADERSHIP STRATEGY

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

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

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

10 leadership behaviours that support collective leadership:

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

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

Financial planning

2017/18 and 2018/19 Financial Plans

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

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

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

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

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

2016/17 Forecast Outturn	**(1.5)**

National Tariff and Activity Demand	0
Normalising Adjustment	(4.4)
Pay, Pensions, CNST, Rates, Utilities, Other	(8.8)
Cost Improvement Programme	9.3
Movement in Sustainability and Transformation Fund	(1.2)

2017/18 Draft Operating Plan	**(6.6)**

National Tariff and Activity Demand	0.4
Normalising Adjustment	(1.6)
Pay, Pensions, CNST, Rates, Utilities, Other	(6.8)
Cost Improvement Programme	8.2
Movement in Sustainability and Transformation Fund	0

2018/19 Draft Operating Plan	**(6.4)**

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

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

1. Commissioned Activity/ Income

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

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

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

2. Cost Improvement Programme

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

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

3. Commissioning for Quality and Innovation (CQUIN)

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

4. Capacity

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

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

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

2. ***Cost Improvement Programme***

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

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

Cost Improvement Programme

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As noted above we are reviewing the Carter recommendations and metrics to identify areas of opportunity for the organisation to improve. Many of the recommendations align with the areas that sit within our Vanguard programme and its review of back office services. The STP is actively engaging in developing an understanding of the benchmarking data and how the organisations compare in terms of the service we deliver. This will enable us to identify early opportunities for savings as well as developing long term plans for a consolidation and reduction of spend. This will be one of the key areas that our Strategic Workforce Review will review.
Our diagnostics and imaging services are part of another Vanguard work-stream. Given the complexity of developing a robust service offering, we envisage that this will deliver savings in the longer term future but are cautious about how this will look given there are a range of potential options as to how the service is delivered. As such the plan does not yet contain figures related to this work-stream.

Capital Programme

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

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

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

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

Financial Sustainability

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

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

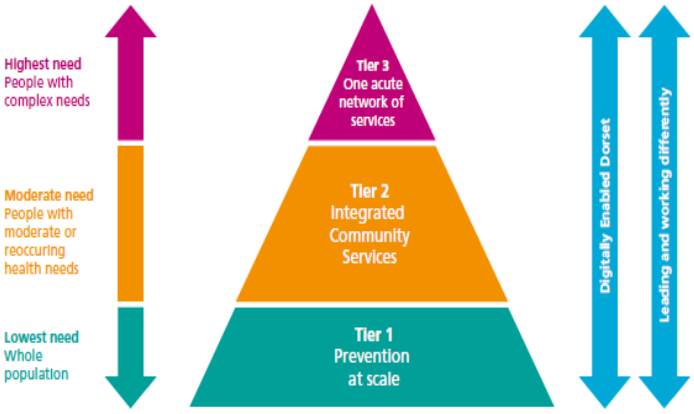
As a result, it is difficult to prepare detailed financial forecasts over the medium term with any degree of certainty. However, the most up to date information has been factored in to the Trusts financial projections for 2017/18 and beyond. This provides confidence that in the base case scenario, the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

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

Link to the local sustainability and transformation plan

Delivering 'Our Dorset' Sustainability and Transformation Plan

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



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

Our three programmes of:

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

These programmes are supported by two enabling workstreams of:

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

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

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

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

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

well as preparing the organisation for the implementation of the selected option.	
<u>Acute Vanguard Programme</u> The acute vanguard programme is a collaborative programme across clinical specialists and back office functions. Developments within this include a single pathology service for Dorset, a network approach to cardiology and stroke services and the rationalisation of back office services.	The Acute Vanguard programme is a pan-organisation precursor to the CSR implementation itself, encompassing progressive integration across clinical and non-clinical services.
<u>Merger and the Competition and Markets Authority (CMA) Undertakings</u> Undertakings given to the CMA at the time of the intended merger with Poole preclude merger within 10 years. However, there is work underway to rescind these restrictions, but in the interim Poole and RBCH are developing an aligned approach to the CSR and to the coordinated operational running of the two hospitals.	Although the STP itself does not consider changes in organisational form in any depth, it is recognised that with the significant change of services envisaged, changes in organisational structure are likely to take place in future, with the potential for the emergence of Accountable Care Organisations (ACO). There is discussion about developing STP governance structures that support East and West Dorset programmes.
<u>Vertical and Horizontal Integration</u> The CSR and Vanguard programmes above, can be seen as a form of horizontal reorganisation and in concert with this is the substantial work on a more vertically integrated approach, illustrated by the Integrated Community Services (ICS) programme. This will facilitate patients moving more seamlessly across the interfaces between health and social care and between primary and secondary care and this will deliver improvements in admissions avoidance and hospital flow.	The ICS is one of the main components of the STP developing aspects of the interface across the primary and secondary care and health and social; care boundaries reducing the requirement for hospital care and facilitating better discharge and flow. As services integrate, developing the capacity to exchange information across the health and social care system will become even more important and the development of our own Electronic Patient Record (EPR) in 2017 and its integration with the Dorset Care Record will facilitate this.
<u>Develop our QI Approach and Programmes</u> The Trust's QI programme is now in its 3rd year of operation and we anticipate in the immediate 2 years an approach that will include: • Integration and coordination of QI with our leadership and cultural programmes • Improve patient flow through the hospital • Develop a more consistent approach to the escalation of deteriorating patients and to the diagnosis and treatment of sepsis	Many of the plans outlined in the quality section, require the successful collaboration with partners within the health system. The STP provides the vehicles and discussion fora for developing this more successfully than has been possible in the past. For example, patient flow through the hospital depends critically on services supporting the avoidance of unnecessary admission and the timeliness of discharge.
<u>Culture and Leadership Work</u> The Trust has embarked on a programme to develop a more consistent leadership improvement culture. We have now completed the diagnostic phase of this work and are designing a number of new leadership and development projects: • Partnership with NHSI, Kings Fund, Centre for Creative Leadership and RBCH • Increasing the visibility of senior leaders • Align our vision, QI and OD work – leading improvement • Progressing our Well Led assessment to the review and action stages	A fundamental component of the STP is the leading and working differently programme and our cultural and leadership work will contribute to this by strengthening our leadership at all levels within the organisation and particularly with quality improvement in mind. We will also contribute to the development of the system leaderships as increasingly we operate on a system wide basis.

Membership and elections

Elections 2016/17
The following elections for governors were held in 2016:

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

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

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

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

Elections 2017/18 and 2018/19
Elections in the following constituencies are planned for 2017/18:

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

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

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

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

Engagement Activities between Governors, Members and the Public
The membership strategy has been focussed on recruitment of younger members following the reduction in the minimum age for membership in 2014.

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

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