

2016/17 Annual Plan for Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Introduction

The annual plan for the Royal Bournemouth and Christchurch Hospitals NHS FT for 2016/17 will ensure that we deliver the priorities for the NHS, including the 9 must-do priorities in the Monitor guidance, as well as the Trusts own local and immediate priorities. There is a substantial overlap between these and all are covered in the sections below. In particular whilst continuing to develop higher quality services we recognise that we must do so within the financial envelope indicated by our Control Total whilst providing services that meet the associated performance criteria.

As part of the development of this plan we have developed a set of objectives for the Trust in 2016/17 and these summarise much of the focus for our efforts for next year. We will use these objectives as one of the monitoring vehicles for the care groups and directorates to ensure that we deliver the objectives we have set ourselves in this plan. The objectives are also used to support a number of key processes such as staff appraisals, supporting the quality improvement programme and as the basis for a communication programme – the latter will ensure that all staff are aware of the Trust objectives and their relevance for their part of the organisation. A summary of the objectives is below – the full set are at Annexe A.

This annual plan is structured according to the guidance provided, but many of the initiatives and programmes cross the boundaries between, for example, quality planning and activity planning and therefore whilst they may appear under one heading, they may also have a significant impact in many other areas within the overall plan. This also includes delivering the nine “must do” which feature in many of the sections of this document.

In concert with the development of this draft there has been a number of documents published which will have bearing on the substantive version of this plan. This includes our latest CQC report, following an inspection in October 2015; the Carter Report, published in February 2016; and the on-going development of both Vanguard and Dorset Clinical Service Review (CSR) developments, referenced elsewhere in this document.

Summary of Objectives

- **QUALITY:** To continue to improve the quality of care ensuring it is safe, compassionate and effective.
- **IMPROVEMENT:** To drive continued improvements in patient experience, outcome and care across the whole Trust.
- **STAFF:** To support and develop our staff so they are able to realise their potential and give of their best within a culture that encourages engagement, welcomes feedback and is open and transparent.
- **STRATEGY:** To develop and refine the Trust’s strategy to give effect to the agreed outcomes following the CCG led Dorset Clinical Service Review
- **PERFORMANCE:** To ensure the Trust is able to meet the standards and targets necessary to provide timely access to high quality, responsive elective diagnostic and emergency services.
- **FINANCE:** To ensure the Trust achieves its financial plan with emphasis on reducing agency spend, cutting waste and securing improvements in efficiency and productivity without detriment to patient care.

Approach to activity planning

Capacity and demand planning to deliver NHS Constitution Standards

The Trust has significantly strengthened its forward planning capability, allowing better assessment of capacity and demand. However there remains a considerable range of assumptions underpinning such modelling, meaning the outputs always remain a judgement call, trading cost, demand and performance levels.

Key assumptions are:

- Level of demand e.g. emergency admission numbers, GP referrals;
- Backlog of demand e.g. size and complexity of cases on waiting lists;
- Capacity, mainly staffing with the right skill sets;
- Emergency care capacity, especially into the community, such as residential care and domiciliary care, as well as community beds and packages;
- Variation in demand, especially for short term peaks hidden amongst monthly averages, which can impact performance significantly e.g. peak in ambulances arriving over a weekend, leading to 4 hour + waits;
- Cost is the biggest variable, for commissioner and provider affordability, and the requirement for Cost Improvement Programme (CIP) savings leads to a downward pressure on capacity e.g. taking out beds, or flex capacity;
- Productivity improvement is the mainstay to reconcile cost and performance, such as reduced length of stay. These however are in year improvements (i.e. above baseline), therefore if they do not deliver the level of productivity gain then cost or performance suffers.

All these assumptions are then modelled. The underpinning data is crucial, and we have significantly improved our systems and data to allow better modelling. This is especially for the c20,000 patients on Referral To Treatment (RTT) pathways, endoscopy patients and cancer pathways. The latter has relied on detailed Root Cause Analysis of longer waits.

As a result of this work the capacity plan for 2016/17 indicates:

- Quality Improvements (QI) for reduced bed occupancy is crucial to deliver over 30 bed days improvement everyday (5%) and to absorb 5% growth in emergency demand;
- Whole system improvement to reduce delayed transfers of care, both formal and informal. Currently the trend is to worsen. This could easily negate the QI work. For this reason, and because of risks to emergency demand, the 4 hour target is at risk;
- Theatre and elective pathway productivity gains, especially in Orthopaedics and Urology are crucial;
- Endoscopy demand is likely to rise considerably, once again, as a result of more active cancer surveillance to achieve the 99% within 6 weeks, and 93%+ for two weeks. This is likely to require 16% more procedures in 2016/17.

The proposed activity levels are as set out in the financial and activity schedules. These are yet to be agreed with commissioners, but the modelling indicates they are the best balance between activity, demand, performance and affordability (based upon improved productivity levels).

The improvement trajectory for performance is then considered. This is set on a monthly basis and is shown below.

Declaration of risks against healthcare targets and indicators for 2016/17																	
These targets and indicators are set out in the Risk Assessment Framework Updated August 2015 Definitions can be found in the Risk Assessment Framework Updated August 2015																	
Target or Indicator (per Risk Assessment Framework)	Threshold or Target YTD	Scoring under Risk Assessment Framework	Risk declared at Annual Plan	Scoring under Risk Assessment Framework	Planned performance against metric if declared a risk												
					YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	YTD Month Ending	
Refer to treatment site, 15 weeks in aggregate, inoperative pathways	355	10	1	1	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
A&E Cancer Study - Test Time is A&E under 4 hours	355	10	1	1	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Cancer 60 Day Wait for first treatment (from urgent GP referral for suspected cancer)	355	10	1	1	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Cancer 60 Day Wait for first treatment (from NHS Cancer Screening Service referral)	355	10	1	1	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Cancer 91 day wait for second or subsequent treatment - surgery	345	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Cancer 91 day wait for second or subsequent treatment - soft cancer drug treatment	345	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Cancer 91 day wait for second or subsequent treatment - radiotherapy	345	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Cancer 2 week wait for urgent referral (cancer response)	355	10	1	1	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Cancer 2 week wait for symptomatic breast patients (cancer not initially reported)	355	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Care Programme Approach (CPA) follow up within 1 day of discharge	355	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Care Programme Approach (CPA) formal review within 12 months	355	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
A&E cancer to report serious bed issues to ensure resolution 1 week treatment team	355	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Meeting commitment to care new psychiatric cases by early intervention teams	355	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Ambulance Category A 30 Minute Response Time - Road & Call	355	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Ambulance Category A 30 Minute Response Time - Road & Call	355	10	0	0	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%	31.0%
Clostridium Difficile - meeting the C-Diff objective	14	10	1	1	6	6	6	6	6	6	6	6	6	6	6	6	6
Maintaining MRSA infection free of care	47.55	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Early intervention in psychosis: first episode treated with a NICE approved package within 2 weeks	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Improving access to psychological therapies: treated within 6 weeks of referral	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Improving access to psychological therapies: treated within 10 weeks of referral	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Data completeness: MRSA infection	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Data completeness: MRSA infection	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Compliance with requirements regarding access to healthcare for people with a hearing disability	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Community care - referral to treatment information completeness	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Community care - referral information completeness	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Community care - activity information completeness	355	10	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Risk of, or school, failure to deliver Commission Requested Services	N/A																
CDC compliance within 12 months (to 31 Mar 2016)	N/A																
CDC enforcement action within last 12 months (to 31 Mar 2016)	N/A																
CDC enforcement action (including serious) currently in effect (to 31 Mar 2016)	N/A																
Major CDC concerns or impact regarding the safety of healthcare provision (to 31 Mar 2016)	N/A																
Unable to maintain, or comply, a minimum published CNST level of 10 or less in three appropriate alternative arrangements	N/A																
Score of 4 or less in standard 1 assessment of four FHSMA CNST inspection (intensity or all services)	N/A																
Trust unable to declare ongoing compliance with minimum standards of CDC registration	N/A																
Risks left to complete																	
Total Score																	
Score																	0

This would allow for the Trust to be compliant with a green governance rating of 3 or less in each quarter, but with heightened risk for Q4 (winter pressures impact on 4 hours, *Clostridium Difficile* seasonal profile, with limited headroom for any cancer or RTT slippage).

Approach to quality planning

The Trust has a Quality Strategy split into three distinct sections- Patient Safety, Clinical Effectiveness and Patient Experience. This is reviewed and refreshed annually, in Q4 ready for approval at year end, in parallel with the preparation of the Annual Plan and the Trusts objectives. The Quality Strategy sets out the strategic quality goals of the Trust in relation to clinical priorities set against the previous year's risk profiles, patient outcomes and new clinically based evidence or published guidance. Each of the three sections has this distinct quality patient focussed goals to achieve to deliver the strategic aim, and sets out how this will be monitored and the governance framework within which it will be monitored against. This is developed with key stakeholders in the Trust led by the Associate Director of Quality, Governance and Risk and Deputy Director of Nursing and is approved and monitored by the Healthcare Assurance Committee (HAC) as subcommittee of the Board of Directors. The HAC scrutinises the plans and approves them, monitoring monthly the quality performance, together with the risk profiles and the Trust Assurance Framework. Quality profiles included in this are Pressure Damage, Falls, medications management, Friends and Family Test (FFT), developing patient and public engagement and complaints management, sustaining duty of candour, clinical audit plan compliance and further development of the risk assurance and Trust Assurance process.

Improving the Patient Experience

Our patient experience plans for 2016/17 include:

- Contribute to service and strategy development for a framework of discharge support provided by the local Voluntary sector.
- Redesign and re-launch the Dignity pledge
- Perform independent observational dignity audits every 6 months.
- Design and drive a campaign for Protected mealtimes and protected night time
- Action the improvements from the National Inpatient Survey
- Design a visible framework for actioning feedback from Diverse groups
- Work with Communications to develop a plan for expanding the patient and public engagement role
- Further develop the Voluntary body in terms of age diversity and roles to perform.

Avoidable Mortality

A specific area of focus for this year will be the development of our understanding of “avoidable mortality” and our pursuit of its reduction. We have used the letter and guidance from the NHS England to check our own mortality review process and whilst we had already adopted most of the suggestions in the guidance, it has nevertheless provided an opportunity to highlight areas where we believe we can improve our approach. These include:

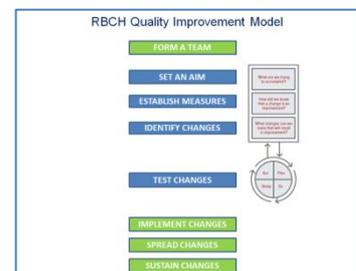
- All deaths will have a consultant review
- Junior medical staff must discuss death certification of individual patients with the relevant consultant(s)
- The Medical Director will report annually to Part One Board of Directors meeting and monthly to the Healthcare Assurance Committee (HAC), a subcommittee of the Board of Directors
- Invitations to the Mortality Surveillance Group (MSG) will be extended to the CCG and to HealthWatch
- The eMortality form will be adjusted to include:
 - venous thromboembolism and nutrition issues
 - whether the death was expected at the time of admission (yes / no)
 - source of admission
 - adoption of the Confidential Enquiry into Stillbirths in Infancy (CESDI) mortality classification bandings:

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

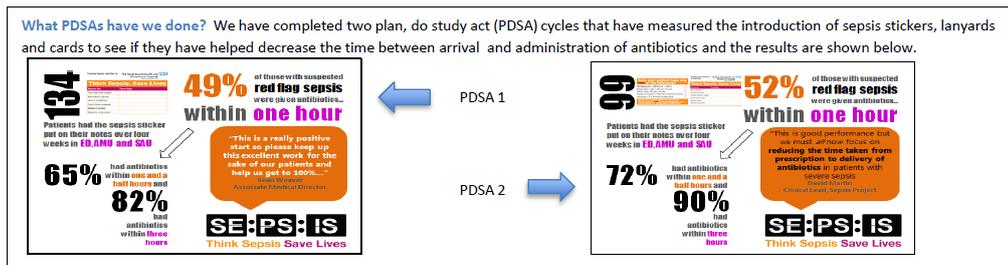
- Establish the full list of relevant audits and ensure all actions arising from these all appropriate audits need to come to the MSG on a calendarised basis
- The Complaints Manager will alert MSG to any complaints relating to a death and the resulting action plan. We will look for clusters, for example, wards / procedures / clinicians
- We will undertake an annual notes review on high risk patient groups including pneumonia, congestive cardiac failure, sepsis, stroke and acute kidney injury. This will entail a thorough notes review, and a walk-through of the patient pathways.

Quality Improvement

We adopted a formal approach to Quality Improvement in 2014, with a Plan, Do Study, Act (PDSA) approach and an initial tranche of 5 projects and we appointed a Director of Transformation, Deborah Matthews, to lead this. The initial 5 projects were Sepsis, Hospital Flow, GI Cancer (2 weeks waits), Safety Checklists, and Non-Elective Laparotomy.



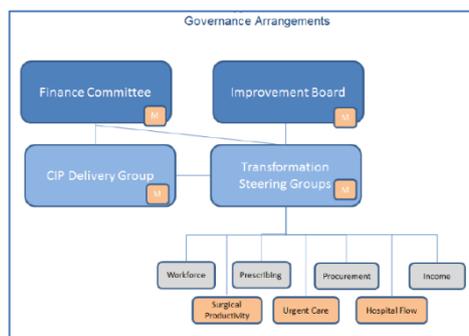
We substantially updated our approach to Sepsis via the Quality Improvement process which had a much stronger focus on the definition (i.e. what constitutes sepsis), measurement (developing processes for measuring various metrics such as door or diagnosis to antibiotic time), and communication (involving the Trust Communications Team). This has had a significant impact and we are now preparing for QI Cycle 3. An example of the results for Cycles 1&2 is below.



Since then the QI programme has been expanded to include the following priorities:

- Implementing the Department of Health’s best practice guidance for effective discharge and transfer of patients from hospital and intermediate care.
- Improving surgical productivity and operating theatre efficiency to reduce ‘lost’ theatre time and release patient slots.
- Reducing last minute clinic cancellations by 50% and Did Not Attend (DNA) rates to an average of 4% in outpatients through more effective utilisation of current resource and standardisation of clinic templates
- Embedding the use of VitalPac within the Trust and its application as a trigger tool for escalation. Development of a clear escalation protocol and the accompanying education.

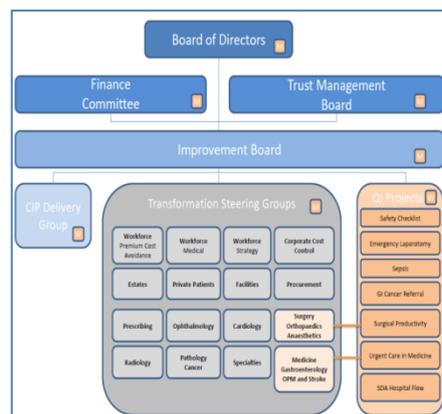
The Trust has had an Improvement Board in place for some time and this has overseen the Quality Improvement Programme and linked this into the Programme (CIP). This relationship is shown in the diagram alongside.



We have now developed this a stage further, with the introduction of a series of Transformation Steering Groups (TSGs) relating to specific work streams. The governance arrangements for this are shown below.

The TSGs are a fundamental and crucial element of our governance for delivery of the 2016/17 CIP programme. The Terms of Reference for each TSG will be to:

- compile and be accountable for the delivery of a range of schemes and ensure that these are translated into genuine delivery;
- support achievement of the required cost avoidance for 2016/7 and beyond;
- ensure all schemes are fully risk assessed according to the QIA criteria and appropriate actions taken to minimise any identified risks;
- provide a forum for discussion on local and national guidance and recommendations to support service redesign, delivery and quality assurance;
- maintain an iterative approach to continuous ideas development;
- collectively review all savings, income and cost avoidance opportunities and determine which individual or group has responsibility to develop and deliver the schemes as they are generated;
- ensure that sub groups or individuals produce a rolling action plan and the sub-group or individual delivers the products and provides regular progress reports to the TSG, and in turn to the Improvement Board.



Seven Day Services

Of the 10 key standards for the development of 7 day services, 4 have been selected as short term targets along the road to full implementation of all 10 by 2020. The 4 core standards are: Time to first consultant review; Diagnostics; Intervention / key services; On-going review

There have been significant increases in 7 day consultant delivered care at the front door in 2015/16 both in the Emergency Department and for patients admitted to the Acute Admissions Unit. The levels of consultant delivered care will continue to increase during 2016/17 with the last consultant vacancies filled in January 2016, resulting in the ability to implement new consultant rotas with greater coverage into the evenings and weekends.

Building on the investment in medical and nursing resources for Ambulatory Care in previous years we are working towards an integrated ambulatory care service based within the template of our Acute Admission Unit that will operate seven days a week. This unit will support the flow of those patients who require specialist medical review out of the Emergency Department and provide senior medical and nursing assessment earlier in the patient's pathway, increasing same day discharges with robust medical follow-up when indicated.

In parallel with the above we have seen the development of separate on-call rotas for cardiology, including interventional, interventional radiology, vascular surgery and urology. Gastroenterology now delivers a gastric bleeding endoscopy list at weekends.

The HiSLAC report in 2015 showed improvements in the deployment of consultant hours over the previous year and this will continue in 2016.

		«Det_A»					
		2014	Sunday 2015	2016	2014	Wednesday 2015	2016
Consultants and Associate Specialists per 10 Beds ⁶ :		0.19	0.29		1.45	1.31	
Consultant and Associate Specialist Hours per 10 Beds ⁶ :		1.08	1.37		5.03	5.64	
Consultants and Associate Specialists per 10 Emergency Admissions ⁶ :		1.67	2.25		10.80	8.55	
Consultant and Associate Specialist Hours per 10 Emergency Admissions ⁶ :		9.50	10.49		37.47	36.96	

Quality Impact Assessment (QIA)

The revised Trust QIA process has been developed to ensure that we have the appropriate steps in place to safeguard quality whilst delivering significant changes to service delivery. This process is used to assess the impact that any individual CIP, service development or improvement project may have on the quality of care provided to patients and service users at RBCH. A flowchart describing the QIA process is described in Annexe B.

QIA documents are populated during the development of the CIP by the care group and / or corporate department. They are measured in terms of patient experience, patient safety and clinical quality. Key Performance Indicators (KPIs), risk ratings and mitigations are assigned and agreed by the executive sponsor and the project lead and regularly challenged throughout the development phase. The risks associated with the deliverability of the schemes and the amount of financial savings to be delivered are also assessed, risk rated and appropriate mitigations identified. A regular reassessment of the quality impact of CIP schemes is an integral part of the monitoring arrangements by the Quality Impact Assessment Review Group.

The QIA Review Group receives feedback against quality milestones from the schemes / projects and discusses escalated quality Issues. Quality issues which cannot be resolved will be escalated by the Medical Director and/or Director of Nursing and Midwifery to the Improvement Board and Health Assurance Committee (HAC) as appropriate. The Group will also ensure appropriate benchmarking information is made available wherever possible in order to triangulate confirm assurances over viability and safety of any proposed scheme.

It is the collective responsibility of the Board of Directors to ensure that a full appraisal of the quality impact assessment is completed and recorded and that arrangements are put in place to monitor schemes. A final review of the full 2016/17 CIP programme will be signed off prior to approval of the 2016/17 financial plan.

Triangulation of indicators

The Healthcare Assurance Committee is attended by all the Executive directors and Chief Executive Officer, and seeks to ensure scrutiny on integrated governance, and discuss and ensure the risks in the Trust are reviewed and appropriately challenged in terms of their scoring, mitigation and resolution planning.

The Trust Assurance Framework is also reviewed collectively in terms of its content against the strategic aims of the Trust, and the scoring and mitigation of it.

Approach to workforce planning

Workforce Planning

The Trust has recognised the need to develop stronger workforce plans that support our overall plans and strategies and our recruitment planning, education, training, and development and transformation programme activities. The current workforce cost is unsustainable and difficult to recruit to and it is vital that we develop comprehensive workforce plans based on our model of future service delivery and knowledge of demographic and other changes.

As part of this and our transformation and cost improvement work we established a Strategic Workforce Transformation Steering Board. Specific work streams identified and being scoped currently include the following with indicative timescales

- Implementation of vacancy freeze and stringent review of planned recruitment across support roles – in place
- A review of administrative and clerical/support functions and roles identifying areas for greater automation, reduction in duplication and validation- the introduction of Electronic Document Management (EDM) has led to a reduction in Health Records staff
- Review of management roles and structures in the Trust
- Review of long-term temporary bank/agency bookings and where appropriate making substantive appointments to avoid premium costs
- Revisit Consultant/Medical Secretary provision, exploring alternatives such as voice recognition software, order communications and the integration of IT systems more generally
- Review and development of salary sacrifice options and uptake
- Reviewing the structure, numbers, banding of therapy roles across the trust by extending the use of eRostering
- Developing a Mutually Agreed Redundancy Scheme (MARS) supporting the cost release from many of these other programmes

In addition there are a number of other initiatives relating to the workforce included in other transformation steering groups such as Premium Cost Avoidance, and Medical Staffing (job planning and locum usage).

An external strategic workforce planner was commissioned to provide a Strategic Workforce Plan (SWP) for the Trust for the period 2015/16 to 2019/20. This considered the current workforce and how it is likely to change, developed specific plans for each of 14 staff groups and drew conclusions and developed actions. The report was discussed at the Board of Directors and the Trust Management Board (which includes the clinical directors) in December 2015.

A summary of the key recommendations from the report is below;

- Review management roles and structures in the Trust in parallel with the Organisation Development programme (see below) currently underway in the Trust.
- Develop the medical and dental workforce plan as more is known about changes arising from the acute collaborative project in Dorset and the review of postgraduate education by Health Education England.
- Enhance the infrastructure in the Trust to increase the numbers of support workers prepared for Band 3 and Band 4 roles in the nursing workforce.
- Maximise recruitment from the adult nursing programmes at Bournemouth University and the University of Southampton, through attendance at job fairs and other events.
- Explore incentives and contractual arrangements to increase recruitment and working time in groups in the nursing workforce, for example: a one-off joiner allowance to new starters; a one-off payment to existing staff for introducing applicants who are appointed; 40-hour contracts.
- Continue existing international recruitment efforts to supply additional registered nurses.
- Enhance the infrastructure in the Trust to increase the numbers of support workers prepared for Band 3 and Band 4 roles in physiotherapy and occupational therapy.
- Increase the deployment of operating department practitioners in place of registered theatre nurses. Do further work to decide the extent of this substitution.
- Complete the option appraisal for the future provision of catering, housekeeping and portering services and revise the demand and supply forecasts for this staff cluster.

eRostering

The Trust has been operating an eRostering system for some years and has recently upgraded this to the latest cloud-based version. The system is in use in 90 different areas across the Trust and continues to be rolled out to new areas. We have developed training programmes for this and performance data and have recently purchased a “safe staffing” module.

The new upgrade offers a live interface, combining patient acuity and staffing and allows us to make the best of staffing resources and allows us to respond to variations in need.

Temporary Staffing / Agency Spend

The Trust has experienced similar problems to others with the recruitment of staff into an expanded professional workforce. We have made efforts to extend the support the bank offer to the Trust and have substantially increased the size of contracted staff numbers via a variety of recruitment events and we are developing this to include a bank for medical staff as well.

Over the last years we have seen a significant increase in expenditure on agency expenditure and to this the Trust put in place a process to address this. Supporting this, the head of the bank/agency department reports to the Executive team on weekly basis on the current position in terms of spend on

temporary staffing. We are exploring whether we can extend the role of the staff bank to helping GP practices with their recruitment issues.

Local Developments

We also participate in wide variety of local and regional workforce groups; the HR Director is a member of the Local Education Training Board and also chairs the Dorset and South Wiltshire Workforce Development Group. In addition to this and of particular strategic significance is the workforce component of the Clinical Service Review (CSR). To support this a Workforce Reference Group for Dorset was established, including senior representation from NHS providers, Health Education Wessex, Thames Valley and Wessex Leadership Academy. In recognition of the shared workforce challenges, the membership of this group has been extended to local authority partners. The overarching remit of the group is to play a collective role to support the current and future sustainability of NHS services across Dorset, championing organisational development in line with Dorset's local and system transformational programmes. Each section of the plan has informed comment and has been validated by the CSR Clinical Delivery Group Chairs, and senior leaders and managers from across the system.

There are some workforce challenges which have been identified through the development of the workforce plan and through discussions across the system. Just a few of the hot spots in Dorset are as follows:

- GPs- in practice roles and covering junior doctor rotas, out of hours rotas, 111 and urgent care centres;
- Consultants- including emergency medicine, maternity and paediatrics, radiologists, dermatologists, rheumatologists, critical care, respiratory, stroke, psychiatrists;
- Middle grades doctors- notably in maternity and paediatrics, radiologists, critical care;
- Paramedics;
- Nurses – particularly in mental health, critical care, primary care practices, social care settings. In addition the demand for nurses in acute settings is having an effect on the recruitment in community setting;
- Support staff- particularly domiciliary care.

There are many examples and best practice evidence which support new ways of working to deliver new models of care. This ranges from the development and introduction of new roles such as GPs With a clinical Special Interest (GPSI), advanced care practitioners, or health and social care coordinators to the introduction of new employment models which support integrated services. Dorset is not unique in its aspiration to change the ways services are configured and maximise the capacity, capability and deployment of its workforce.

Network rotas: In recognition of the number of consultants available currently and the impending gap of future supply, consultants are working together in many specialties to develop network rotas. This will ensure the needs of the services locally will be met, as well as working across the system to provide consultant cover over more hours of the week.

Integrated teams: We have good examples in Dorset of integrated service models delivered through multi-professional and multi-agency workforce arrangements which mirror national good practice examples;

- The Integrated Urgent Care hub which will be in place from 1 April 2016 will bring together a range of healthcare professionals to ensure the delivery of the service
- GP federations have emerged in Dorset covering the vast majority of practices and 5 community vanguard projects are bringing together multi-agencies to plan future integration, including workforce integration

- The Labour line will shortly be implemented working across the system and staffed by midwives from each acute trust

Education and Training: there is progress across the county in both health and social care, which will not only ensure the continued professional development of the workforce but also create an attractive working environment for a new workforce to come to Dorset.

Engagement: Investment in the engagement of the new, current and future workforce in Dorset has been a key enabler to support continued professional development, networking and also to create an attractive working environment.

Attraction: A number of organisations are working in partnership to attract and recruit across a number of professions, including a joint presence at education recruitment fairs.

Organisational Development

There is compelling evidence that health care organisations secure better outcomes for patients where there is a collective approach to leadership where all staff take responsibility for the success of the organisation in delivering continually improving, high quality and compassionate care.

We have launched an ambitious culture change programme led by our Director of Organisation Development (OD) and Leadership to help achieve our vision and strategy.



The aim is to:

- Develop a long term vision and strategy for culture change
- Engage with our staff to define the culture we want to create
- Design a sustainable and strategic approach to changing culture through our clinically led leadership model
- Develop our leaders to help them create and sustain that new culture ensuring they are skilled, competent and confident to meet our leadership challenge

This work will take time and commitment and we have appointed a team of dedicated Change Champions to lead the first phase of a three phase programme. The Discovery phase is designed to find out, through interviews and focus groups, what it feels like to work here and what needs to change. The Change Champions will report back their findings to the Trust Board in June 2016 and make recommendations for the Design phase.

Our plan for developing a Leadership Strategy:

0-6 months Discover (complete June 2016)	What are the gaps between what we have and what we need to deliver? Mission, vision, values Needed vs. existing capabilities – number of leaders, qualities, diversity, medical/clinical Review against CQC culture measures
6-12 months Design	A clear and unique Leadership Strategy to deliver priorities for the next three to five years to improve patient care, performance and

(complete December 2016)	finances Talent, organisation design, leadership culture and development
12-24 months Deliver	Talent management Leadership development – programmes and interventions Organisation development – culture, teams, boundary spanning, collaboration

We will continue to support our staff and to embed the new care group structure by providing bespoke development programmes. These will be further refined once the results of the Discovery phase are known. We have made great progress in the implementation of the new values based appraisals – training over 800 staff so far. We will continue to provide focused and bespoke training in order to continually improve the quality of the appraisal process in order to ensure that every member of staff understands how their work contributes to the success of the organisation.

Approach to financial planning

Financial Context

Historically the Trust has performed very well financially and through the delivery of significant surpluses over many years, has been able to accumulate a considerable cash balance. This has underpinned investments in services and particularly supported a measured expansion in staffing infrastructure.

However, an annual increase in activity, coupled with the sustained reduction in the national tariff has resulted in a significant financial pressure. This has been exacerbated by the debilitating marginal rate payments for emergency admissions, which given the increase in non-elective activity (particularly in 2014/15) has resulted in a material shift between profitable elective activity and loss making emergency activity. Specifically the rapid increase in emergency admissions, allied to a doubling in the number of patients who remain in hospital when medically fit for discharge has resulted in an unsustainable financial pressure. Moreover this has almost obviated scope to achieve efficiencies, with the Trust compensating both through additional bed provision and interim teams in the community compensating for the inadequate provision of community and social care. These factors have been compounded by a significant premium pay cost as a result of an increased reliance upon expensive agency staff due to national workforce shortages (particularly over the last two years); unfortunately, this has resulted in an unprecedented financial challenge.

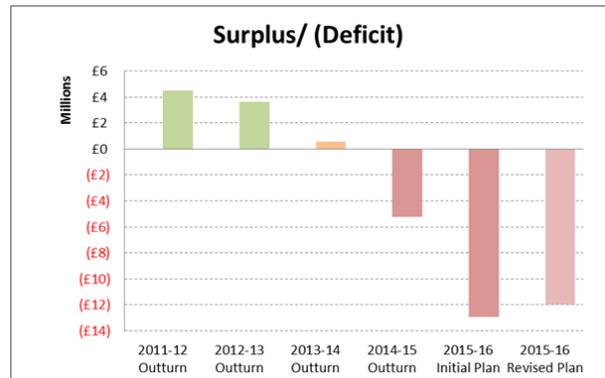
The Trust has worked consistently to identify and deliver new cost improvement schemes each and every year, and whilst the Trust’s performance is comparable with the national average, neither has been sufficient to meet the tariff requirement in full in any of the last 4 years.

These unprecedented financial challenges are being faced consistently across the provider sector, and have resulted in 73% of Foundation Trusts and 97% of medium acute Foundation Trusts (of which the Trust is one) reporting a deficit during 2015/16.

In addition to these challenges, the Trust has continued to implement its vision and aspiration to be the most improved hospital in the country by 2017. This has included important investments underpinning safety and improving patient outcomes, in line with improvements requested by the Care Quality Commission including investment in nurse staffing levels, increased weekend infrastructure leading to a reduction in Trust wide mortality, responding to discharge delays by the development of an in-house interim care team to compensate for social services not offering this service to the required level, and the associated establishment of Ward 9 as a base for medically fit patients.

As a result of the above factors, the Trust's financial performance has significantly deteriorated as illustrated below:

The current deficit is being sustained through the utilisation of the Trusts strong cash balance, and a financial strategy has been approved which focuses on reducing the deficit each and every year to ensure the future financial sustainability of the Trust.



2016/17 Financial Plan

The Trust has undertaken a detailed activity and financial planning process to ensure an appropriate and achievable operational revenue budget is approved for 2016/17. Specifically, the following key steps have been undertaken:

- Detailed demand and capacity planning has been completed by Care Group management teams (clinical and operational), supported by finance and information colleagues;
- Income budgets have been calculated based on this activity plan, including the impact of the 2016/17 tariff package;
- The expenditure (marginal cost) impact of this activity plan has been calculated and included within directorate budgets;
- Directorate specific cost pressures have been discussed and budgeted where appropriate;
- Corporate cost pressures have been assessed and budgeted, including nationally agreed pay inflation, the financial impact of changes to the Pensions Act, 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 has been agreed at directorate level, and removed from the budget.

The draft Operational Revenue Budget based on the above work is set out within the detailed finance template, and confirms a planned deficit of £1.450 million.

The high level bridge from the 2015/16 forecast outturn to the 2016/17 draft operational revenue budget can be summarised as follows:

2015/16 Forecast Outturn	(11.9)
Tariff Income from Activity Growth	9.9
Cost of Activity Growth	(7.5)
Net impact of reduced Private Patient Activity	(0.7)
Tariff Inflation	2.5
Cost Improvement Programme	6.4
Pay, Pensions, CNST, Rates, Utilities, Other	(7.8)
Sustainability and Transformation Fund	7.6
2016/17 Draft Operational Revenue Budget	(1.5)

Through the submission of the draft Annual Plan, the Trust signalled its intent to accept the offer of payment from the Sustainability and Transformation Fund (STF). This amounts to £7.6 million, and includes the following conditions:

- Agreement of a milestone-based recovery plan and agreement to a revenue control total. The maximum deficit control total for 2016/17 is £1.473 million.
- Agreement of a capital control total for 2016/17 (value to be confirmed).
- Financial improvement plans which include milestones for Carter implementation, including reporting and sharing data in line with the national timetable.
- Compliance with the NHS Improvement agency controls guidance.
- Agreeing a credible plan for maintaining performance trajectories for the delivery of core standards for patients, including the four-hour A&E standard and the 18-week referral to treatment standard.
- Working with commissioners to develop an integrated five-year plan in line with the national Sustainability and Transformation Plan timetable.
- Continue to make progress towards achieving seven-day services in 2016/17.

The Trust is mindful however, that it is being asked to agree to these conditions, in particular the revenue control total, before the contracting process with its commissioners has been concluded. As such, whilst the Trust is confident that it can accept this offer with associated conditions, there remains some risk due to the current position in relation to final contract agreement.

The Trust's sensitivity analysis has highlighted a number of risks to the financial plan for 2016/17. Key risks can be summarised as follows:

1. Commissioned Activity/ Income

The Trusts detailed demand and capacity modelling is forecasting significant activity growth during 2016/17. This reflects the current waiting lists, expected demand increases, and the additional capacity required to achieve the national access standards.

Whilst acceptable contracts have now been agreed with two of the Trusts three main commissioners, the contract for specialist activity, amounting to over £40 million, remains outstanding. As such, there remains a risk that the Trust will not be commissioned for the forecast and budgeted specialist activity.

This would result in three risks:

1. Loss of the current contribution included within the draft plan;
2. An inability to achieve the national access standards resulting in the loss of the Sustainability and Transformation Fund income;
3. A significant financial pressure due to demand continuing to increase, with the Trust required (for patient safety reasons) to undertake this activity without the corresponding payment.

2. Cost Improvement Programme

The Trust is targeting 2% across clinical directorates and 3.5% across corporate directorates; amounting to £6.4 million. However, when added to the recurrent shortfall from the current year, the CIP requirement for 2016/17 is £8.9 million.

At present the Trust has a credible plan to achieve this through risk adjusted schemes. However, there remains a risk that schemes may not achieve as quickly or to the level currently predicted.

3. Commissioning for Quality and Innovation (CQUIN)

It has been confirmed that with the introduction of the Sustainability and Transformation Fund, there will be no 'double jeopardy' whereby if the Trust fails to achieve the agreed performance improvement

targets, it will lose the Sustainability and Transformation Fund monies and also be fined by its Commissioners through the NHS standard contract.

However, the guidance is currently unclear as to whether CQUIN is included within this. In the absence of this clarity, the Trust has assumed that as CQUIN is an incentive payment rather than a contractual penalty/ fine, this will still be live within the contract and thus 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. 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, the detailed bed modelling currently being finalised, when aligned with the lack of appropriate community provision and associated increase in delayed discharges, may have a negative financial impact.

5. Capital flexibility

When accepting the Sustainability and Transformation Fund, the Trust will be committing to agree a capital control total for the year. This significantly reduces and potentially removes the Trust's flexibility to agree additional capital schemes in year.

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 the current year, mainly in relation to private cardiology procedures. The latter has been reflected within the proposed budget, mitigating this risk to a manageable level.

However there is a significant income opportunity to increase income in relation to private patients. This is not limited to cardiology, with growth expected in a number of specialties.

2016/17 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.

A number of options papers have been considered by the Board of Directors, with a range of schemes progressing (either in terms of further work-up, or in terms of actual delivery) and a number of schemes being 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 savings target required during 2016/17. It should be emphasised however, that many of the schemes are complex and require significant work to ensure full delivery in a timely fashion. As a result, there remains a risk to the delivery of the overall programme. With this in mind, all Quality Improvement (QI) projects have already commenced and are being supported by the Improvement Programme Team.

The key themes and projects that make up the 2016/17 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. Reduction in substantive nursing templates to align with the peer group average.
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.
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.
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
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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 2016/17 and beyond.

2016/17 Capital Programme

The Trust has been considering its 2016/17 capital programme for many months, and through a risk based approach has reduced the initially requested items to 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 2016/17 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:

- Agreement of contract values for 2016/17, including activity growth assumptions
- Future years tariff packages, and the impact of HRG4+
- 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 2016/17 and beyond. This provides confidence that in the base case scenario, the Trust remains financially sustainably during this Comprehensive Spending Review period, with a return to surplus, and a sustainable cash balance.

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

Link to the emerging ‘Sustainability and Transformation Plan’ (STP)

Dorset CCG commenced a Dorset Clinical Services Review (CSR) in 2015, with a view to transforming the acute services across Dorset and developing a health system that is financially and clinically sustainable. This has been supported by a number of supporting reviews including specifying the costs of the capital development of the acute Trusts and a review of the obstetrics, maternity and paediatrics provision jointly done by the Royal Colleges of Obstetrics & Gynaecology and Paediatrics. The CSR has progressed to the point where it has been established that there is a need for one major acute hospital in the east of the County, with a reciprocal hospital in the east undertaking predominantly elective work. Thus two principal options have been described; one option considers Royal Bournemouth Hospital (RBH) as the major acute organisation and the other with Poole hospital in this role. We believe that we are best placed to take on this role for reasons of being in main population centre, having a large estate easily accommodating the level of expansion required and the most modern existing facility and part of our strategies and plans is to place us in the best position to become the major acute facility. The financial review undertaken by Dorset CCG shows RBH to be 50% less expensive than developing Poole as the main emergency hospital.

In addition to the CSR development Dorset has a number of Vanguard developments underway. These include the Dorset Integrated Community Service Vanguard in which groups of GP practices and localities and their associated community and social service providers will pilot a number of novel community models. In parallel with this, we are part of an acute services vanguard project “One NHS in Dorset”, whereby certain services will be committed to a joint venture model and shared across the County. Under this initiative there are developing proposals to unify and standardise patient pathways, thereby strengthening the quality of service for patients across Dorset in the Vanguard specialities of maternity, paediatrics, stroke, cardiology, imaging, ophthalmology, non-surgical cover and diabetes. This will be taken forward throughout 2016 and it is intended that a joint venture vehicle will be in place by November 2017. This will therefore operate as a prelude to the wider integration and

reconfiguration envisaged by the CSR. Both of these Vanguard developments and this Annual Plan constitute components of a Dorset Sustainability and Transformation Plan (STP) and a schematic representation of this can be seen below.

Beyond the key features of the STP development indicated above the Trust has a number of key developments agreed to be taken forward in 2016/17, including:

- To develop proposals to evaluate the introduction of an integrated pathology service for Dorset.
- To establish a dedicated private patients facility.
- To complete work to create an integrated community hub offering a range of services and facilities at Christchurch including radiology, outpatients, a GP practice, and a community pharmacy

As indicated above other key enabling strategies that support the STP and our participation in it, are Workforce and IT. Our Strategic Workforce Plan is covered elsewhere in this Plan, but key strategic IT developments include:

- Embed Electronic Document Management (EDM) so that it no longer appears on the Trust's risk register.
- Undertake all the necessary preparatory work to enable RBCH to move to Graphnet Electronic Patient Record (EPR) by April 2017.
- Implement Order Communications in the four diagnostic areas
- Achieve full compliance with the IG Toolkit.
- Participate in the development of a joint informatics strategy for the three acute trusts in Dorset
- Respond to the seven clinical Vanguard areas with effective IT solutions to enable their clinical strategies

Membership and elections (NHS foundation trusts only)

Governor Report 2015/16 and Plan 2016/17

April 2015 – to date, January 2016

Elections

There have been a number of elections held during the year:

Staff Governor – Medical and Dental

Staff Governor – Nursing, Midwifery and Healthcare Assistants

Public Governor – Bournemouth and Poole (2 positions)

Public Governor – New Forest, Hampshire and Salisbury

Engagement with Patients, Public and Members

Governors had many opportunities in the year to engage with patients, public and members at various events, tours, and via surveys including:

Understanding Health Talks,

Listening events held in the hospital

Taking part in PLACE national audit

Governors participating in the Executive walkrounds (monthly) and Infection Control walkrounds (fortnightly)

Patient and Public Outpatient Survey

Governors visiting community groups e.g. Patient Participation Group (PPG), Residents Associations, Townswomen's Guild

Career events for school pupils

Training

Training delivered to Governors includes:

Safeguarding – Adult and Paediatrics

Workforce planning development and education commissioning

Medical Recruitment, Appraisals and Revalidation

An Update on Health Professional Education and Research

Public Health

SSNAP Stroke Data

Cancer Service

Speaking to the Media

Member and Public Engagement and effective questioning and challenge

CSR / Vanguard and CQC / Monitor

PLAN - April 2016-March 2017

Elections

A number of elections are planned for the following constituencies:

Staff Governor – Medical and Dental

Staff Governor – Nursing, Midwifery and Healthcare Assistants

Public Governor – Bournemouth and Poole (2 positions)

Public Governor – Christchurch and Dorset County.

Annexe A

Trust Objectives 2016/17

1. To continue to improve the **quality of care** we provide to our patients ensuring that it is safe, compassionate and effective, driving down variations in care whilst ensuring that it is informed by, and adheres to, best practice and national guidelines. Our specific priorities are:
 - Creating a **fair and just culture**; being transparent when things go wrong and **embedding learning**, measured by a reduction in Serious Incidents and avoidance of Never Events
 - Promoting the **recognition of avoidable mortality** and potential links to deficiencies in care by **improved and comprehensive eMortality review**. Monitor eMortality review compliance and ensure lessons are disseminated and actions completed.
 - Ensuring patients are cared for in the most appropriate place for their needs by:
 - **Improving the flow** of patients and reducing the average number of outlying patients and non-clinical patient moves by at least 10%.
 - Supporting more patients who want to die at home to achieve this.
 - To deliver consistent standards in quality care for our patients demonstrated by further improvements in **reducing the number of avoidable pressure ulcers and falls** which happen in our hospital in 2016/17 by a further 10%, measured through Serious Incident Reports
 - To ensure that there are **no MRSA cases** and that the Trust achieves its target of **no more than 14 Clostridium Difficile cases** due to lapses in care
 - To be within the **top quartile of hospital reported patient satisfaction** via the Family and Friends Test
 - To address all issues highlighted within the **CQC Report** during 2016/17
2. To drive **continued improvements in patient experience, outcome and care across the whole Trust**. The Trust will use a QI methodology to support this work. Key priorities are:
 - **Improve the management of sepsis**, ensuring we implement 'sepsis 6' within one hour of patients being identified as having severe sepsis or being in septic shock
 - Implementing the **Department of Health's best practice guidance** for effective discharge and transfer of patients from hospital and intermediate care. These including developing a clinical management plan for every patient within 24 hours of admission; all patients having an estimated date of discharge within 24-48 hours of admission; use of a discharge checklist, daily discharge board rounds and the

involvement of patients and carers to make informed decisions about their on-going care and discharge.

- Implement internal professional standards - '**5 Daily Actions**' and a new frailty pathway to improve hospital flow and ensure every patient has the right care, in the right place, at the right time
 - Improve **surgical productivity and operating theatre efficiency** to reduce 'lost' theatre time and release patient slots. This will include a reduction in variation, removing waste and improving flow across elective pathways in orthopaedics and urology
 - **Reduce last minute clinic cancellations** by 50% and **DNA rates** to an average of 4% in outpatients through more effective utilisation of current resource and standardisation of clinic templates
 - Applying standards of care for all patients undergoing **emergency laparotomy** with the aim of maintaining mortality below 5%
 - Uniform use of **surgical checklists** across the whole organisation with the intention that there are no Never Events associated with failure to use checklist. Monitor compliance, response and better education.
 - Implementing the **NICE guidelines for patients referred with suspected GI cancer** ensuring a minimum of 93% of patients receiving an appointment within two weeks.
 - To **embed the use of VitalPac** within the Trust and its application as a trigger tool for escalation. Development of a **clear escalation protocol** and the accompanying education. Measurable reduction in SIs related to lack of escalation.
 - **Exploit the opportunities for automation** using advanced IT systems where possible, to reduce human error.
3. To **support and develop our staff** so they are able to realise their potential and give of their best, within a culture that encourages engagement, welcomes feedback, and is open and transparent in its communication with staff, public and service users. Key priorities include:
- To ensure **all staff have a values based appraisal and agreed personal development objectives** which reflect both the needs of the service and their own development requirements
 - Providing support and interventions for the **health and wellbeing of our staff**.
 - Providing appropriate **education, training and development opportunities and support** for staff, and demonstrate the return on investment for the organisation, ensuring 95% of staff complete mandatory training.
 - To develop and implement a **comprehensive leadership and organisational development strategy** which reflects the organisation's values and views of staff and focuses on good organisational health and a positive development and learning culture. Strategy completed by December 2016

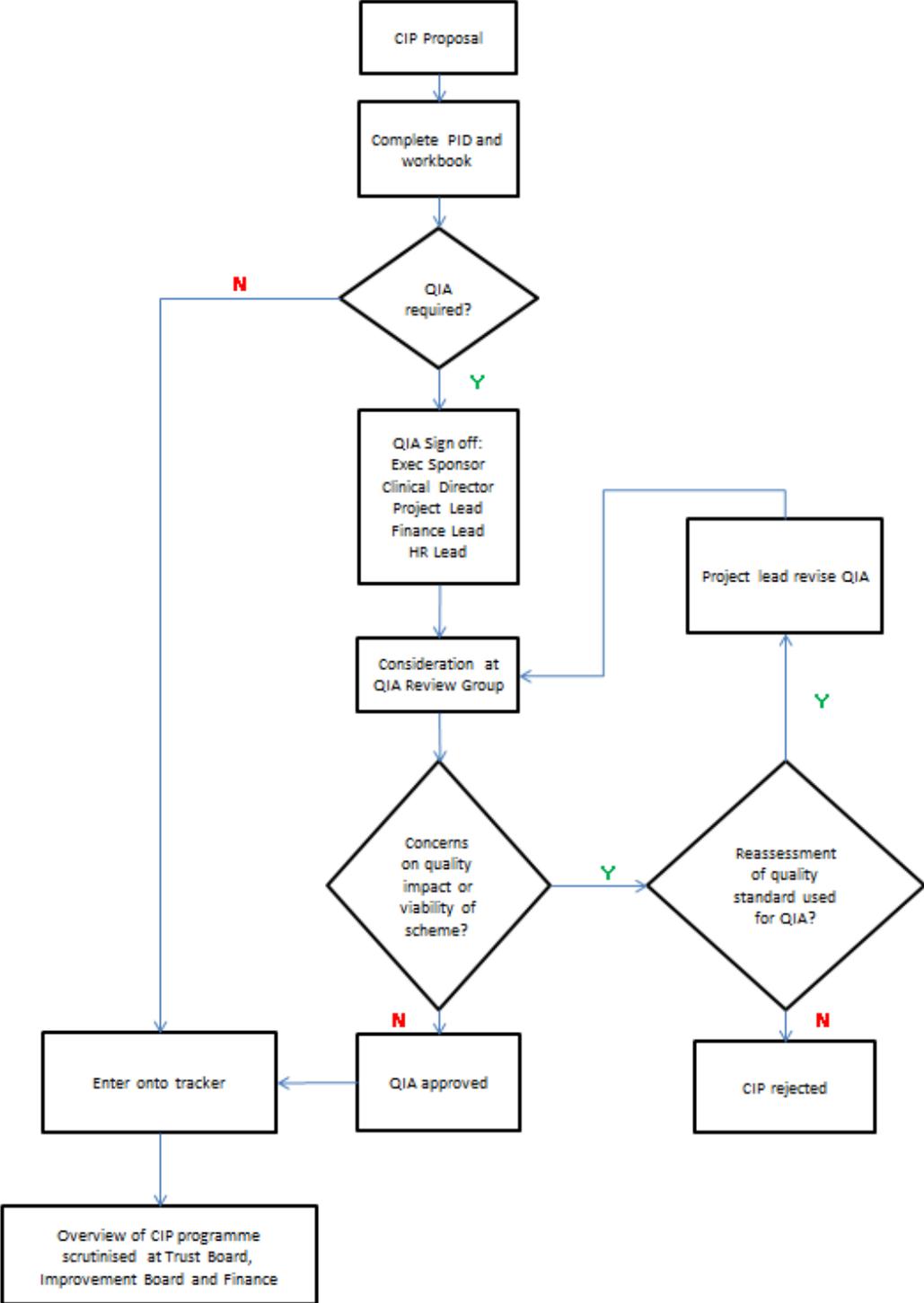
- To build the management and leadership capability of the Trust through the development of a **comprehensive leadership development programme** that reflects the needs of the Trust and individuals at all levels who are managing and leading services.
 - To **strengthen levels of staff engagement** within the Trust, creating opportunities for staff to contribute to the design and delivery of services and improvement ideas. This engagement will be measured by an improvement in the national Staff Survey (2016) engagement scores and by an increase in the quarterly Staff Impressions measure of engagement.
 - To **promote collective responsibility for the success of the Trust** and greater autonomy for staff to manage and deliver their services, within a clear framework of responsibility and accountability.
4. To develop and refine **the Trust's strategy** to give effect to the agreed outcomes following the CCG led Dorset Clinical Service Review. Key priorities include:
- To implement the **Trust's strategy** within the context of the *emerging Clinical Service Review* being led by Dorset CCG.
 - To establish the **Vanguard "One NHS in Dorset"** and implement proposals to unify and standardise patient pathways, thereby strengthening the quality of service for patients across Dorset in the following areas of maternity, paediatrics, stroke, cardiology, imaging, ophthalmology, non-surgical cover and diabetes. This will be taken forward throughout 2016.
 - To develop proposals to evaluate the introduction of an **integrated pathology service** for Dorset. Proposal developed for the conurbation by 2017.
 - To establish a **joint venture vehicle** by November 2016 to facilitate provision of a range of Dorset wide hospital services
 - Work with the Dorset Community Trust, primary care and local authority partners to extend the range of services available to **support patients discharged from hospital** and to help local people maintain their independence and health without recourse to admission to hospital.
 - To shape and develop proposals to support and agree a **new model of care** for hospital and out of hospital services, promoting the **Royal Bournemouth Hospital as a future major emergency site for Dorset and West Hampshire residents**
 - To implement in full the **Trust's Capital Programme** ensuring the Trust services remain safe for patients, visitors and staff and compliant with all health and safety requirements.
 - To establish a **dedicated private patients facility** by April 2017
 - To complete work to create an **integrated community hub** offering a range of services and facilities at Christchurch including radiology, outpatients, a GP practice, and a community pharmacy
 - Implement the **resilient Data Network**, telephone system and refreshed computer room.

- **Embed Electronic Document Management (EDM)** so that it no longer appears on the Trust's risk register.
 - Undertake all the necessary preparatory work to enable RBCH to move to Graphnet **Electronic Patient Record (EPR)** by April 2017.
 - Implement **Order Communications** in the four diagnostic areas
 - Achieve **full compliance with the IG Toolkit**.
 - Participate in the development of a **joint informatics strategy** for the three acute trusts in Dorset
5. To ensure the Trust is able to meet the **standards and targets** necessary to provide timely access to high quality responsive elective diagnostic and emergency services. The key targets are:
- 95% of patients **waiting no more than 4 hours from arrival in ED** to their admission discharge or transfer
 - 93% of patients referred using the **fast-track cancer pathway** being seen within 14 days of referral
 - 93% of patients referred to the **symptomatic breast clinic** seen within 14 days of referral
 - 96% of patients **diagnosed with cancer** receiving treatment within 31 days
 - 85% of patients **receiving their first treatment** within 62 days of urgent GP referral with suspected cancer.
 - To achieve 92% or better for patients on an incomplete 18 weeks referral to treatment pathways

A key deliverable linking the above will be the need to deliver the performance targets associated with the 16/17 Sustainability and Transformation Fund.

6. The Trust **achieves its financial plan** operating to a deficit control total of no more than £1.7m deficit, with emphasis on **reducing agency spend, cutting waste and securing improvements in efficiency and productivity** without detriment to patient care. The Trust will fully engage with the Lord Carter of Coles work to assist with the objective to improve productivity and efficiency including reporting and sharing data in line with the national timetable and compliance with the NHS Improvement agency controls guidance. This work will include the development of a financially sustainable plan for 2017/18 and beyond.

Annexe B – Quality Impact Assessment - Process



Annexe C – Quality Impact Assessment Form

Quality Impact Assessment for CIP Scheme											
Project/Scheme Name				Unique Scheme Reference			Project lead			Date Completed	00/01/1900
Project Description				Transformation Steering Group			Clinician completing assessment			Date updated	02/06/2015
				Workstream Lead							
Quality Indicators and KPIs	Indicator or KPI	Brief description of potential impact	If negative impact - possible mitigation	Monitor KPIs	Indicator or KPI	Brief description of potential impact	If negative impact - possible mitigation				
Patient Safety	Details of improvement or risk			Consequence	Likelihood	Score	Mitigation actions controls (Free Text)	Consequence	Likelihood	Score	
Clinical Outcome/Effectiveness	Details of improvement or risk			Consequence	Likelihood	Score	Mitigation actions controls (Free Text)	Consequence	Likelihood	Score	
Patient Experience	Details of improvement or risk			Consequence	Likelihood	Score	Mitigation actions controls (Free Text)	Consequence	Likelihood	Score	
Other relevant issues: Staff Experience Adverse publicity Equality and Diversity	Details of improvement or risk										
Risk Score						0					0
Sign off	First Quality Review Date			Final Quality Review Date			Date Approved			Signatures	
										Medical Director	
										Director of Nursing	